# NHS Ayrshire & Arran

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| **Meeting:** | **Ayrshire and Arran NHS Board** |
| **Meeting date:** | **Monday 1 February 2020** |
| **Title:** | **Performance Report** |
| **Responsible Director:** | **Kirstin Dickson** |
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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 has been continuously adapting throughout the COVID-19 pandemic to effectively and safely respond to the ongoing challenges and presence of COVID-19. Re-mobilisation commenced in the summer months to restart as many of its normal services as possible, and as safely as possible. However, the resurgence of COVID-19 in the autumn and winter months has placed considerable pressure on services.

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.

The Strategic Emergency Management Team 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 is intended to provide assurance to NHS Board members that services continue to monitor and review their extensive plans to reduce, where possible, the negative impact of COVID-19 on the provision of unscheduled and planned care for our citizens.

## 2.2 Background

The cancellation of outpatients and elective appointments at the outset of the COVID-19 pandemic, in addition to reduction in the numbers of diagnostic tests being undertaken has had a significant impact on key National Waiting Times targets. Current performance is therefore not truly comparable to system performance prior to the start of the period of the COVID-19 pandemic, as cancellation of appointments was a necessary step to ensure the safety of the population.

A re-mobilisation process over the summer months supported the re-introduction of some planned care and prioritised planned care patient activity on the basis of clinical urgency rather than length of wait, therefore on this basis Inpatient/Daycase and New Outpatient compliance will remain at a lower level.

The increasing prevalence of COVID-19 during the autumn months has however resulted in a decision to again pause some of the planned care. In particular elective surgery was reviewed on the basis of a clinical prioritisation matrix, and Priority 3 and Priority 4 elective surgery was paused week in commencing 9th November 2020 (with the exception of paediatric cochlear implant in Priority 3 and cataract surgery in Priority 4 which has continued).

Some measures have remained stable or indeed improved throughout the initial response and through into the recovery stages. 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 or a suspicion of Cancer.

Rising COVID-19 positive patients presenting at hospital over the winter months and an increasing number of delayed discharged has placed consderiable pressure on Unscheduled Care.

We continue to monitor the effect of the pandemic across all areas of Performance routinely reported to NHS Board.

## 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; and 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

| | | | | |
|---|---|---|---|---|
| UHA A&E | 2,151 Nov 2020 | 2,989 Nov 2019 | attendances at UHA Emergency Department | |
| | 76.9% Nov 2020 | 73.8% Nov 2019 | ED attendees were treated, admitted or discharged within 4 hours of arrival | ⊕ 95% |
| | 7 Nov 2020 | 166 Nov 2019 | ED attendees waited over 12 hours to be treated, admitted, or discharged | |
| UHC A&E | 4,097 Nov 2020 | 6,255 Nov 2019 | attendances at UHC Emergency Department | |
| | 84.6% Nov 2020 | 85.2% Nov 2019 | ED attendees were treated, admitted or discharged within 4 hours of arrival | ⊕ 95% |
| | 69 Nov 2020 | 176 Nov 2019 | ED attendees waited over 12 hours to be treated, admitted, or discharged | |

## Medical and Surgical Bed Occupancy

| | | |
|---|---|---|
| 87.0% Nov 2020 | 95.1% Nov 2019 | occupancy of acute medical and surgical beds at University Hospital Ayr |
| 84.9% Nov 2020 | 93.2% Nov 2019 | occupancy of acute medical and surgical beds at University Hospital Crosshouse |

## Combined Assessment Units

| | | | | |
|---|---|---|---|---|
| | 1,411 Nov 2020 | 1,532 Nov 2019 | 1,405 Nov 2020 | 1,555 Nov 2019 |
| | presentations to UHA CAU | | presentations to UHC CAU | |

## Emergency Admissions

| | | | | |
|---|---|---|---|---|
| | 682 Nov 2020 | 811 Nov 2019 | 1,074 Nov 2020 | 1,395 Nov 2019 |
| | admissions to UHA via ED/CAU | | 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 ⊕ 0 | North Ayrshire HSCP | | East Ayrshire HSCP | | South Ayrshire HSCP | |
|---|---|---|---|---|---|---|
| | 9 Nov 2020 | 52 Nov 2019 | 0 Nov 2020 | 0 Nov 2019 | 21 Nov 2020 | 46 Nov 2019 |

***** 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)

**Unscheduled Care**

ED attendances initially experienced a significant reduction at both UHA and UHC following the lockdown restrictions at the end of March 2020. Attendances then steadily increased month on month, and by August 2020 had returned to levels similar to that experienced in the pre-COVID-19 period. However from September 2020 onwards, attendances have again been reducing, with numbers in November 2020 falling to the 2nd lowest level recorded.

The new 'Redesigning Urgent Care' programme was launched on 3rd November 2020, which aimed to route all unscheduled care attendances via NHS24, to be triaged and directed to the most appropriate care service, which in many cases would be away from the Emergency Department. It is likely that this, combined with Tier 4 restrictions implemented on 20th November 2020, has contributed to the reduction in ED attendances in November 2020.

The number of COVID-19 confirmed cases started to increase in early October 2020. This has presented an ongoing challenge in terms of appropriate space for these patients to be reviewed within the ED and CAU, and in turn affected the ED 4-hour target.

**Emergency Department**

Comparing November 2020 against November 2019, there were 838 fewer **ED attendances** at UHA, representing a 28.0% decrease. Similarly at UHC, there were 2,158 fewer ED attendances in November 2020 than in November 2019, representing a decrease of 34.5%. The reduction is predominantly in relation to Flow 1 (Minor Injury) and Flow 2 (Acute Assessment, including Major Injury) attendances.

The **ED 4-Hour Wait** compliance at NHS Board level has reduced to 82.0% in November 2020, having previously exceeded the 95% target in each of the calendar months between April 2020 and July 2020. Compliance has been steadily reducing at both sites since August 2020.

Compliance at UHA in November 2020 was 76.9%, an increase of 3.1 percentage points when compared to the previous year, however is a noticeable decrease from the previous month (October 2020: 83.3%). At UHC, compliance was 84.6% for November 2020, a marginal decrease of 0.6 percentage points from the previous year, and a decrease on the previous month (October 2020: 86.9%).

There were 76 **12 hour breaches** at both UHA and UHC in November 2020; 7 at UHA and 69 at UHC. This is a sizeable decrease from the 110 recorded in the previous month (October 2020: UHA, 36; UHC, 74), and is also a significant decrease on the 342 recorded in the same month of the previous year.

**ED Attendances**

Ayrshire and Arran Health Board region entered Tier 4 lockdown restrictions on 20th November 2020. ED attendances overall dropped by around 7% after this lockdown and total attendances are still considerably lower than pre-March 2020.

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'.

The work around ED scheduling of Minor Injuries is ongoing. The scheduling of Minor Injuries has been successful with demand being matched to capacity on site.

As part of the Redesigning Urgent Care programme, the local Flow Navigation Centre has been established on the UHC site and forms part of the Ayrshire Urgent Care Service. There are ongoing discussions focussing on modelling of activity and staffing required. The Critical Respiratory Hub included as part of the COVID-19 Assessment Pathway is now part of the Flow Navigation Centre. Work is ongoing around workforce planning, and also the agreement of referral criteria for GPs referring to the hub.

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

November 2020 was another 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.

Throughout November 2020, ward and room closures due to COVID-19 infected patients severely impacted patient flow through both hospitals and this in turn meant the 4 hour standard had been more difficult to achieve.

The discharge teams on both sites work collaboratively with partner organisations to expedite patient discharges.

**Combined Assessment Units**

**CAU Presentations** have reduced at both sites, with 121 fewer presentations at UHA in November 2020 compared to November 2019, a decrease of 7.9%, and 150 fewer presentations at UHC in November 2020 compared with the same month of the previous year, a decrease of 9.6%.

In terms of sources of referral, the decrease at UHA is most prominent in GP referrals, with numbers down by 19.2%, 133 fewer referrals in November 2020 when compared with the same month of the previous year. Meanwhile at UHC, the decrease is predominantly in ED referrals which have reduced by 19.2%, 145 fewer referrals in 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 at both sites, with 129 fewer admissions at UHA in November 2020 when compared to the previous year and 321 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 also decreased at both sites in recent months, having previously experienced sustained increase in the period up to August 2020. In November 2020, occupancy at UHA was 87.0%, a decrease of 8.1 percentage points on the same period last year and a marginal decrease of 0.1 percentage points on the previous month (October 2020: 87.1%). Similarly at UHC, occupancy was 84.9% in November 2020, a decrease of 8.3 percentage points on the previous year and a marginal decrease of 0.1 percentage points on the previous month (October 2020: 85%).

The decrease at UHC and UHA compared to November 2019 could be as a result of additional surge beds being opened. In addition to this a number of beds are 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. Furthermore, occupancy is based on a count at midnight but this doesn't always 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**

A high number of suspected COVID-19 patients on the red pathway in the 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.

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.

**Admissions and Occupancy**

Throughout November 2020, bed capacity has been reduced at both sites due to ward closures imposed by infection control as a result of patient COVID-19 infections. This has impacted on patient flow and Length of Stay (LOS) as patients can neither be admitted nor discharged from these wards. In turn, bed occupancy for this period appears significantly lower due to the reason outlined above and also due to a lack of staffing for flexible beds, which can't currently be opened.

During November 2020, patient flow was also impacted by suspected COVID-19 patients awaiting results in CAU with test results taking up to 48 hours to be returned. Even with a consistent number of ED attendances throughout November 2020, this has continued to be challenging with red and green pathways in place at the front door.

Following the resurgence of COVID-19 in November, capacity within the acute hospital settings has continued to be extremely challenging. 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 restarted surgical services in line with clinical prioritisation.

At UHA, an extreme team has been established, commissioned by the Site Director and Head of Service within South Ayrshire HSCP. They are currently supporting a test of change around scheduling of GP appointments into CAU and plan to commence a second test of change looking for the Enhanced Intermediate Care Team (EICT) to triage appropriate patients in the community to avoid attendances at CAU. Future extreme team work may include the expansion of mobile attendants out of hours to facilitate discharges from CAU and early patient referrals to social work for assessment. Other work includes an active appraisal of patients with > 7 days LOS at UHA and a separate initiative at UHC where patients with an LOS > 14 days have a review led by a senior clinician with support from HSCP colleagues, Allied Health Professions (AHPs) and the Unscheduled Care Team.

**Delayed Discharges**

**Delayed Discharges >2 Weeks (excluding complex code 9 delays)** have risen from 14 in October 2020 to 30 in November 2020. There were 9 delays over 2 weeks for North Ayrshire HSCP residents at the end of November 2020, up from 4 the previous month and down from 52 in the same month of the previous year. For South Ayrshire HSCP residents there were 21 delays over 2 weeks at the end of November 2020, up from 10 the previous month, however a decrease from 46 recorded 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 November 2020, up by 385 bed days to a total of 2,995 when compared to the previous month (October 2020: 2,610; November 2020: 2,995), however have decreased by 2,053 when compared with the previous year (November 2019: 5,048).

In North Ayrshire, there were 113 fewer OBDs in November 2020 when compared with the previous month (October 2020: 843; November 2020: 730), in East Ayrshire, there were 102 additional OBDs (October 2020: 412; November 2020: 514), and in South Ayrshire there were an additional 396 OBDs (October 2020: 1,355; November 2020: 1,751).

**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 discharges as part of the whole system approach. We have reviewed processes and reporting structures. In addition the Senior Management Team have put concerted effort in to ensuring all aspects of necessary activity such as assessments are carried out efficiently. As a result, North Ayrshire HSCP are now fully aware of actual demand and are more accurately identifying need. For example, in the community the number of people waiting for care home placement has reduced significantly. As a result there is less demand in the whole system freeing up capacity for care homes to take patients directly from acute sites where appropriate.

Daily scrutiny of performance remains in place and the Head of Service now seeks daily assurance around the position and actions taken. There is also a daily review of care at home capacity and allocation. Meetings to ensure connectivity with acute and community services took place in early October 2020. A new hospital team manager was appointed in October 2020 to improve on-site influence, quicker detection of need and to ensure timely activity regarding the discharge arrangements required.

North Ayrshire HSCP have reviewed capacity, and have increased staff hours, in addition to recruiting and providing contracts to the care at home service to provide further capacity to assist in reducing delayed discharges. Recruitment plans are ongoing to provide additional capacity to meet demands of increased referrals, community waiting lists and to provide cover for absence in the care at home service.

North Ayrshire HSCP have also re-configured the Anam Cara dementia respite service by converting 9 beds for interim placement for individuals awaiting care at home services to reduce delayed discharges, whilst maintaining 5 respite beds to ensure support is available where required.

A further proposal is being developed to take into account the significant level of vacancies across older people's care homes. We are currently working with one care home reutilising 10 beds to provide interim placements for individuals awaiting their care home of choice to allow movement out of acute sites.

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 there remain approximately 14 people waiting long periods due to guardianship

processes. The management team have implemented improved processes to manage the application arrangements for Guardianship Orders.

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 is working 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. The current challenge relates to the lack of capacity across internal and external Care at Home. Discussions are being held with private providers to highlight the challenges they are facing in terms of capacity and consider how the HSCP can support them. Vacancies for internal Care at Home staff have been advertised and the Reablement service is also advertising for 40 more staff. Interviews are expected to be held in January 2021. A Test of Change with The Mobile Responder Service will be implemented from 11th January 2021 which will provide additional support to facilitate transport home from the hospital outside of normal working hours and also to help prevent admissions where possible.

Initial discussions have taken place with the Heads of Community Health and Care in North and East Ayrshire HSCPs and Assistant Directors for University Hospital Ayr and University Hospital Crosshouse in relation to Home First principles and developing a systematic approach to the implementation of these across Ayrshire. Work is planned, with support from the iHub through Health Improvement Scotland, to conduct a whole system self-assessment using the 10 Home First principles as set out by the Joint Improvement Team (and any other more recent guidance). This evaluation will allow the HSCPs to establish a baseline position across the 3 partnerships and the two acute sites and inform a strategic Ayrshire wide approach which aligns to Caring for Ayrshire. It will also be linked to work being undertaken by Scottish Government and the iHub to improve discharge planning.

### 2.3.1 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

| | | | |
|---|---|---|---|
| **33.9%** Nov 2020 | 77.0% Nov 2019 | of patients were waiting fewer than 12 weeks for Inpatient or day case treatment | |
| **42.4%** Nov 2020 | 81.7% Nov 2019 | of patients were waiting fewer than 12 weeks for a New Outpatient appointment | ◎ 95% |
| **69.4%** Nov 2020 | 80.6% Nov 2019 | of patients waited fewer than 18 weeks from Referral to Treatment | ◎ 90% |

### Diagnostics

| | | | |
|---|---|---|---|
| **21.9%** Nov 2020 | 71.6% Nov 2019 | of patients were waiting fewer than 6 weeks for Endoscopy | ◎ 100% |
| **50.9%** Nov 2020 | 79.6% Nov 2019 | of patients were waiting fewer than 6 weeks for Imaging | ◎ 100% |

### Cancer

| | | | | | |
|---|---|---|---|---|---|
| **100.0%** Nov 2020 | 99.0% Nov 2019 | ◎ 95% | **79.7%** Nov 2020 | 81.7% Nov 2019 | ◎ 95% |
| of patients started treatment within **31 days** following decision to treat | | | of patients with suspicion of cancer started treatment within **62 days** | | |

### Child and Adolescent Mental Health

| | | |
|---|---|---|
| **97.7%** Nov 2020 | 91.7% Nov 2019 | ◎ 90% |
| of children and young people started treatment within18 weeks of initial referral to CAMH services | | |

### Psychological Therapies

| | | |
|---|---|---|
| **84.9%** Nov 2020 | 73.8% Nov 2019 | ◎ 90% |
| of patients started treatment within 18 weeks of their initial referral for psychological therapy | | |

### Drug and Alcohol Treatment

| | | |
|---|---|---|
| **98.6%** Nov 2020 | 97.8% Nov 2019 | ◎ 90% |
| of clients waited no longer than 3 weeks from referral to appropriate drug or alcohol treatment that supported their recovery | | |

### MSK

| | | |
|---|---|---|
| **74.5%** Nov 2020 | 45.9% Nov 2019 | ◎ 90% |
| of adult patients were waiting fewer than 4 weeks for MSK services | | |

**Inpatient/DayCases and New Outpatients**

To effectively and safely manage the pressures of COVID-19, the delivery of Inpatient/Daycase and Outpatient planned care has been continuously adapted through the pandemic. In March 2020 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. This in turn impacted on the number of patients waiting and as a direct consequence affected compliance against the National Waiting Times targets.

A re-mobilisation process over the summer months supported the re-introduction of some planned care. This re-mobilisation process prioritised planned care patient activity on the basis of clinical urgency rather than length of wait, therefore Inpatient/Daycase and New Outpatient compliance remain at a lower level, although services are being restarted safely and are being prioritised for the patients most at need.

The increasing prevalence of COVID-19 during the autumn months has resulted in a decision to again pause some of the planned care. In particular elective surgery was reviewed on the basis of clinical prioritisation matrix, and Priority 3 and Priority 4 elective surgery was paused week commencing 9th November (with the exception of paediatric cochlear implant in Priority 3 and cataract surgery in Priority 4 which has continued).

With a reduction in planned and elective care activity and a renewed focus on ensuring timely delivery of patient care for those most urgent at need, compliance under 12 weeks will remain low.

**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 November 2020, 33.9% 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 1.7 percentage points, from 32.2% at October 2020. Prior to the impact of COVID-19, performance at February 2020 was 71.8%. The number of patients waiting has increased by 10.8% from 4,016 at Febraury 2020 to 4,451 at November 2020.

A comparison of the number of patients waiting is outlined below:

| | Number waiting (including unavailable patients) | As at 29 February 2020 | As at 31 October 2020 | As at 30 November 2020 |
|---|---|---|---|---|
| Inpatients / Day cases | > 12 weeks | 1,103 | 2,922 | 2,944 |
| | < 12 weeks | 2,913 | 1,398 | 1,507 |
| | All waits | 4,016 | 4,320 | 4,451 |

Source: Local monthly management reports, Information Team

The Treatment Time Guarantee (TTG) 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 November 2020, there were 766 patients admitted under this standard. Of those patients seen, 64.1% 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 ongoing pressures of COVID-19. At the outset of the pandemic, the number of patients being admitted under this standard reduced, with only urgent or urgent cancer suspected cases, which resulted in higher levels of compliance being recorded in April and May 2020. Services started to resume in July 2020, with the re-mobilisation process prioritising planned care on the basis of clinical urgency. The number of patients admitted under the TTG increased from 457 in June 2020 to 940 in October 2020. Numbers have decreased to 766 in November 2020 after the decision to pause some planned care.

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

| | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 |
|---|---|---|---|---|---|---|---|---|---|
| <= 12 weeks | 886 | 228 | 213 | 297 | 374 | 381 | 412 | 526 | 491 |
| > 12 weeks | 292 | 21 | 31 | 160 | 330 | 449 | 515 | 414 | 275 |
| Total | **1,178** | **249** | **244** | **457** | **704** | **830** | **927** | **940** | **766** |
| **% within 12 weeks** | **75.2%** | **91.6%** | **87.3%** | **65.0%** | **53.1%** | **45.9%** | **44.4%** | **56.0%** | **64.1%** |

Source: Local monthly management reports, Information Team

**Inpatient and Daycases**

The Surgical re-start process had progressed well with 69% of activity recovered by September 2020 when compared to the same period in 2019.

The increasing prevalence of COVID-19 over the autumn led to a decision to further pause non-urgent surgery from the week commencing 9th November 2020. It is estimated that elective surgery activity levels as at early December 2020 are in the region of 10-15% of pre-COVID levels. The pausing of non-urgent surgery is being reviewed on a fortnightly basis in order that a decision to re-start surgery can be facilitated at the earliest, appropriate point in time.

**New Outpatients**

Local management information at the end of November 2020 indicates, 42.4% of patients waiting for a new outpatient appointment had been waiting 12 weeks or less. This is a decrease of 0.9%, from 43.3% at October 2020. Prior to the impact of COVID-19, performance at February 2020 was 81.1%. The number of patients waiting has increased from 21,200 at February 2020 to 31,857 at November 2020.

A comparison of the number of patients waiting is outlined below:

| | Number waiting (including unavailable patients) | As at 29 February 2020 | As at 31 October 2020 | As at 30 November 2020 |
|---|---|---|---|---|
| New Outpatients | > 12 weeks<br>< 12 weeks<br>All waits | 4,012<br>17,188<br>21,200 | 17,551<br>13,417<br>30,968 | 18,347<br>13,510<br>31,857 |

Source: Local monthly management reports, Information Team

Please note that the total numbers for New Outpatients and Inpatients/Day cases in the above table include unavailable patients. Compliance figures for National Report exclude unavailable patients.

**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. There has been a significant shift towards the use of NHS Near Me and face-to-face consultation, with these consultations now making up 22% of all activity.

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 November 2020, the remobilisation of Outpatient Clinics has recovered 60% of new patient activity and 80% of review patient activity.

**18 Weeks Referral to Treatment**

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.

The target for 18 week Referral to Treatment (RTT) compliance is 90% and local management information indicates that compliance has decreased by 1.1 percentage points,

from 70.5% in October 2020 to 69.4% at November 2020. Prior to the impact of COVID-19, performance at February 2020 was 79.7% and had been showing an improving trend.

**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, we are prioritising the reduced treatment capacity for Urgent Cancer Suspected (UCS) and Urgent patients, and less urgent patients are not being treated. Therefore the 18 weeks RTT measurement cannot be meaningfully compared to performance prior to the COVID-19 outbreak

**Diagnostics**

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 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.

The re-mobilisation process has prioritised 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.

Compliance against the 6 weeks Access Target for **Endoscopy** has increased by 4.4 percentage points, from 17.5% at October 2020 to 21.9% at November 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. Following a month on month increase from 735 as at the end of February 2020 to 2,947 at October 2020, the number of patients waiting has shown a reduction at the end of November 2020 to 2,861. A comparison of the number of patients waiting is outlined below:

| | Number waiting (including unavailable patients) | As at 29 February 2020 | As at 31 October 2020 | As at 30 November 2020 |
|---|---|---|---|---|
| Endoscopy | > 6 weeks<br><6 weeks<br>All waits | 735<br>1,295<br>2,030 | 2,947<br>657<br>3,604 | 2,861<br>804<br>3,665 |

Source: Local monthly management reports, Information Team

**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 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 was secured, however the planned scheduling of additional weekend lists has been curtailed by the challenging nurse staffing situation.

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 has also been able to investigate those referred on an 'Urgent' basis since October 2020. There continues to remain no capacity to investigate routine referrals.

To support clinical triage and to ensure the patients are investigated in a timely fashion, we have implemented quantitative faecal immunochemical testing (qFIT) from 6th September 2020 for new referrals. Since the introduction of qFIT, the small number of those whose results indicated high risk had their colonoscopy procedure expedited.

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 is well underway with estimated 'Go-Live' in early January 2021. Both of these initiatives introduce other procedures for the investigation of GI symptoms, which is expected to aid the re-mobilisation of endoscopy.

**Imaging** compliance as whole for all four modailities (CT, MRI, Barium Studies and Non-obstetric Ultrasound) against the 6 weeks Access Target of 100% has increased by 8.3 percentage points, from 42.6% at October 2020 to 50.9% at November 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 2,633 patients at the end of November 2020, although there has been a decrease from a high of 4,272 patients at the end of June 2020. Overall waiting lists for MRI have decreased from 2,331 at February 2020 to 1,469 at November 2020.

A comparison of the number of patients waiting for CT and MRI is outlined below:

| | Number waiting (including unavailable patients) | As at 29 February 2020 | As at 31 October 2020 | As at 30 November 2020 |
|---|---|---|---|---|
| CT | >6 weeks | 316 | 2,122 | 1,635 |
| | <6 weeks | 1,380 | 976 | 796 |
| | All waits | 1,696 | 3,098 | 2,431 |
| MRI | >6 weeks | 1,112 | 825 | 743 |
| | <6 weeks | 1,219 | 626 | 726 |
| | All waits | 2,331 | 1,451 | 1,469 |

Source: Local monthly management reports, Information Team

**Imaging**

During COVID-19 there has been a significant reduction in the imaging service. To mitigate the impact of the reduced capacity a number of initiatives were implemented:

- CT - Additional weekend and evening sessions have been run using a combination of overtime and locum staff. In January 2021, NHS Ayrshire & Arran will take delivery of a temporary 'CT Pod' provided by the UK Government, and associated staffing. This will remain in place at Ayrshire Central Hospital for a period of 12 weeks and will provide significant additional CT capacity during that period;
- MRI - the mobile MRI van remains in place at UHA and is working 12 hours, 7 days per week. This has been confirmed until end June 2021; and
- Ultrasound - An additional locum ultrasonographer has been in post for several months and is delivering additional capacity.

Furthermore, updated demand and capacity analysis has been completed by the Radiology team. Discussions are ongoing regarding options to deliver additional CT and MRI capacity in particular over the longer term, including proposed ongoing use of mobile MRI and Mobile CT scanners until such time as permanent additional scanners are procured.

## Cancer

Throughout the COVID-19 outbreak, Cancer cases continued to be assessed and treated 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.

Performance against the **31 day Cancer target** of 95% has been consistently met and maintained throughout the COVID-19 outbreak with performance reaching 100% in October 2020 and 100% being maintained in November 2020.

Compliance against the 95% **62 day Cancer target** has decreased by 1.0% from 80.7% in October 2020 to 79.7% in November 2020. This compares to 81.7% in November 2019. Prior to the outbreak of the pandemic, the 62 day Cancer target was on an improving trajectory, reaching 89.6% in February 2020. Performance levels remained high for the 62 day Cancer

Target until August 2020, but have since been decreasing as newly diagnosed cancer patients require treatment.

**Cancer**

The remobilisation of cancer services continues to be a priority and full re-start is being guided by clinical priority, equitable access and delivery of care in the safest possible environment.

As at the end of November 2020 there is no notable delay in cancer treatment, and once diagnosed, patients proceed to treatment promptly. This position is continually reviewed particularly in light of the changing operating theatre staffing availability.

There continues to be pressure on the diagnosis stage of the cancer pathways, particularly in upper GI endoscopy and colonoscopy as previously outlined. This means that many patients have exceeded the 62-day target before they have the investigation which diagnoses their cancer.

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 included; 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 Emergency Departments, such as the implementation of Mental Health Practitioners across Ayrshire to support screening and signposting at GP practice level, as well as the provision of care locally and safely through the use of digital technologies. A successful tender for Distress Brief Intervention (DBI) being has been completed under tight restriction during lockdown, with an anticipated launch in early 2021 involving the Minister for Mental Health.

Inpatient services have 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**

Psychological Therapies waiting times continue to remain below the 90% compliance standard. However, waiting times have improved through the COVID-19 period, and the total number of patients waiting and the number waiting more than 18 weeks have both reduced. Psychological Therapies compliance is 84.9% at November 2020, this compares to 85.3% at October 2020. Prior to the impact of COVID-19, performance at February 2020 was 74.9%.

While acknowledging that waiting times have improved through the COVID-19 restrictions, the greater improvements reported in recent months must be considered with caution. The improvements may reflect recent changes to service delivery such as the positive increase in patients accessing the new computerised cognitive behavioural digital options being offered as well as the re-instatement of face-to-face clinics and the selection of cases who had not yet breached the waiting times standard on the grounds of urgency and high risk.

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. Particularly in Community Paediatrics, there has been a preference from a number of families to wait for face-to-face appointments, rather than using video conferencing. The age and specific difficulties of the children referred to this service have also posed a challenge to remote working. There is also a predominance of neurodevelopmental and neuropsychological work within these Specialties, where direct assessment is necessary to complete assessments.

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 further 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;
- Increase face-to-face clinical contact in outpatient and inpatient settings (which commenced in August 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 roll-out in late October 2020 of the Internet-Enabled (IESO) CBT digital option has further increased 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 (which commenced in 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;
- Continue to provide 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 compliance is 90%, and local management information indicates that CAMHS continues to exceed the target with performance of 97.7% at November 2020. This is a 0.5 percentage point increase from the previously reported positon of 97.2% in October 2020 and is the second highest reported position in the last two years. Prior to the impact of COVID-19, performance at February 2020 was 94.6%.

**Note:** Following discussions with Public Health Scotland and the Scottish Government in early September 2020, Internal Referrals, which were included following a change in data recording guidance as of February 2020, are now 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, where 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.

Waiting lists were refreshed early September 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.

**CAMHS**

Since the beginning of the first Academic Term for schools in August 2020, CAMHS have been working to develop relationships and understanding with colleagues in Education. An example of this is the collaborative approach to design a meaningful presence of CAMHS in what is now the largest school in Scotland, the Barony Campus in Cumnock, East Ayrshire. The school brings together what was originally six separate educational facilities, two secondary schools, two primary schools and two nurseries. A co-produced approach with Teachers, Health Staff, CAMHS and young people will help to map-out how best support can be delivered to promote health and wellbeing within the campus and what role CAMHS can play in this.

CAMHS have also expanded their workforce, with a specific focus upon supporting care and treatment pathways for children and young people experiencing neurodevelopmental delay and Attention Deficit Hyperactivity Disorder (ADHD). The expansion of the workforce includes two Non-Medical Nurse presribers posts. The previously mentioned 'self-monitoring' project for young people with ADHD will form part of the role managed by the clinicians in these two new posts which cover the whole of Ayrshire and bring the number of Non-Medical Nurse prescribers in the service to three.

Further development in relation to the management of care pathways for patients requiring medication as part of their treatment, care and therapy will be the introduction of a Pharmacy Prescriber which will be funded for 12 months through Innovation funding.

Other innovations within the service include the securing of funding to appoint a Participation Officer for 12 months and additional finance to develop physical health, education and wellbeing for children and young people diagnosed with Autistic SPECTRUM Disorder or awaiting the diagnosis.

CAMHS have been kindly supported by Endowments to fund 'breakfast blethers' with families as we look to ensure that the views of those receiving care and their families have input into the development of our services and interventions.

The National Secure Adolescent Inpatient Service Project Team will immanently complete the Full Business case to be submitted to the Scottish Government with the construction of the facility beginning in March/April 2021. In light of this and anticipation of the recruitment phase of the project, the team have now been joined by Dr Smith who is one of only two psychiatrists dual trained in Child and Adolescent Mental health and Forensic Psychiatry. She has worked as a consultant for nearly 10 years and brings with her a wealth of experience and an abundance of motivation. Dr Smith is the Clinical Lead for the West of Scotland CAMHS Network and Chair of the Royal College of Psychiatrists in Scotland Executive Committee as academic secretary.

Additional information on CAMHS reform and progress against the Scotland wide commitment to children and young people's mental health can be found here A&A CAMHS Reform.

**Mental Health – Drug and Alcohol Treatment**

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

**East, North and South Ayrshire Addiction Services** continue to provide safe, essential alcohol and drug related support. Staff continue to offer all interventions with all new referrals being offered a face to face, in person, assessment. Staff have also increased face to face, in person, client review contacts over the last three months alongside regular telephone communication (with some clients also able to utilise Near Me technology).

Staff have also reintroduced recovery focussed group work programmes (albeit with smaller group sizes).

Pre COVID-19, Mental Health Practitioners were implemented across Ayrshire to support screening and signposting at GP practice level.

In North Ayrshire Drug and Alcohol Recovery Service (NADARS), staff have also been scoping out new developments including Test of Change pilots with the Service Access Team (utilising the support of NADARS peer workers), NADARS direct involvement in a new Housing First initiative with NAC Housing and the local CMHT and staff are finalising a community based pathway response to individuals who have presented at Crosshouse Hospital due to a non-fatal overdose.

In South Ayrshire Community Addiction Services, staff have also been scoping out new developments including a Test of Change pilot using Medication Assisted Treatment (MAT) standards. Staff from the Community Addiction Service also work closely with the multi-agency service Connect 4 Change and the wider recovery networks within South Ayrshire.

**Musculoskeletal**

Local management information indicates 74.5% of patients were waiting fewer than 4 weeks at November 2020, an increase of 2 percentage points from 72.5% at October 2020. Prior to the impact of COVID-19, performance at February 2020 was 53.1%.

**Musculoskeletal**

As part of the Physiotherapy Continuity Plan ITU, HDU, Medical High Care and Acute Respiratory areas take priority over other services. Due to the resurgence of COVID-19 and associated increased workload that would bring to Physiotherapy services in the acute setting MSK Physiotherapy staff were re-deployed back to acute services.

Since October 2020, a phased and blended approach has been taken to bring more physiotherapists in from MSK to acute services.

COVID-19 illness and self-isolation has also reduced capacity which will impact on waiting lists and other service provision.

Tests of change are targeting new ways of managing referrals (Active Clinical Referral Triage) and reducing waiting times currently averaging 8 weeks.

Escalation pathways to orthopaedic Advanced Practice Physiotherapists 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.

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 in to 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 seek to balance re-mobilising our services with continued response to COVID-19 and deal with the normal impact of winter on our system as a whole, systems and procedures continue to be in place to monitor and manage the impact on performance in our provision of unscheduled and planned care for our citizens to ensure high quality of care for patients.

### 2.3.4 Workforce

A sustainable workforce and recruitment levels are imperative across all services as we provide services within the current circumstances.

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 throughout the current resurgence of COVID-19.

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 of the health and care system during the COVID-19 pandemic.

### 2.3.8 Other impacts

**Best value**:
Successful management of waiting times requires leadership, and engagement with clinical staff. 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

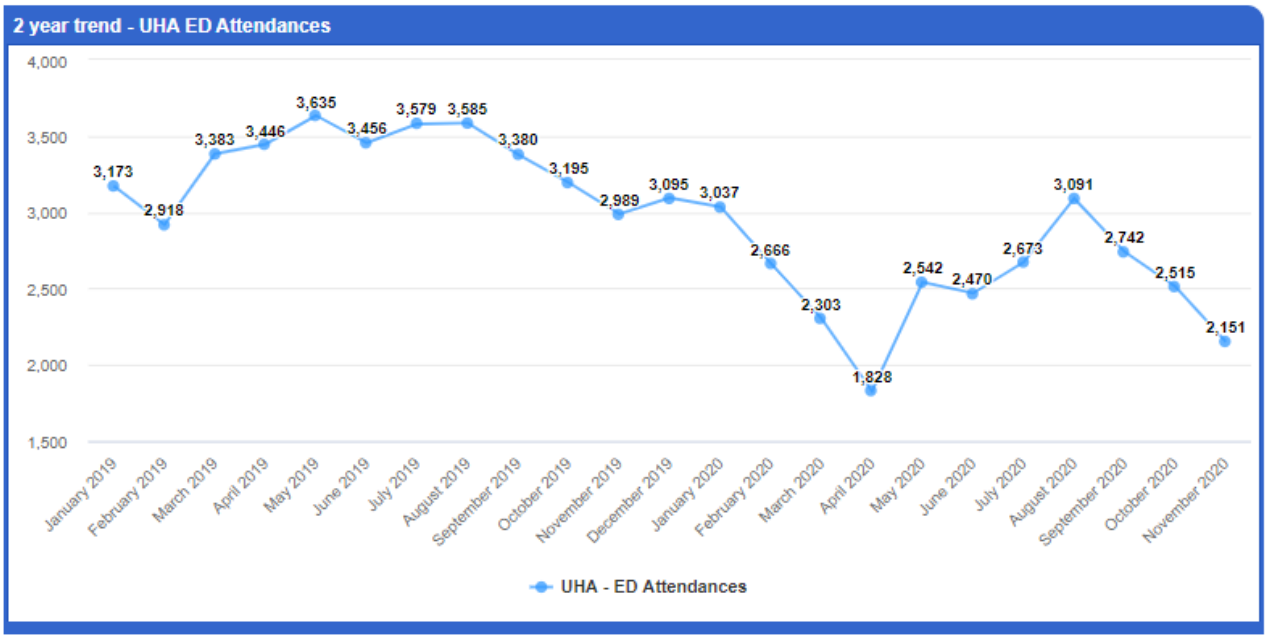
NHS Board members are asked to discuss the information provided in this report which provides assurance that systems and procedures are in place to monitor and manage the impact of COVID-19 on our provision of unscheduled and planned care for our citizens.

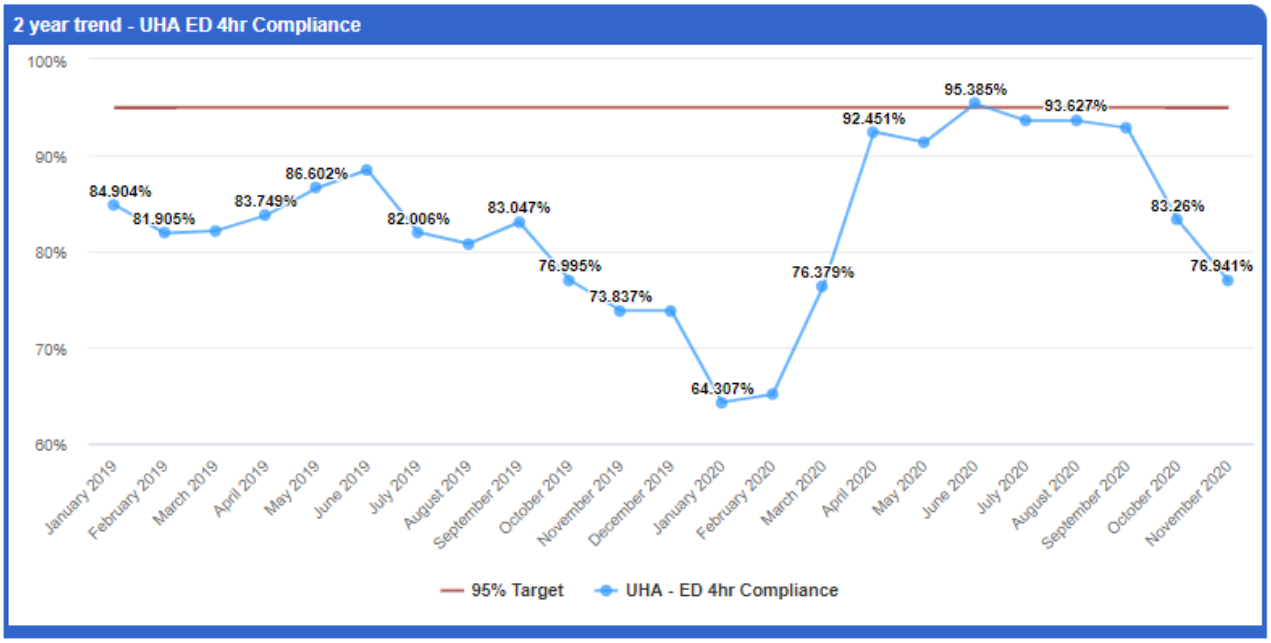
## 3. List of appendices

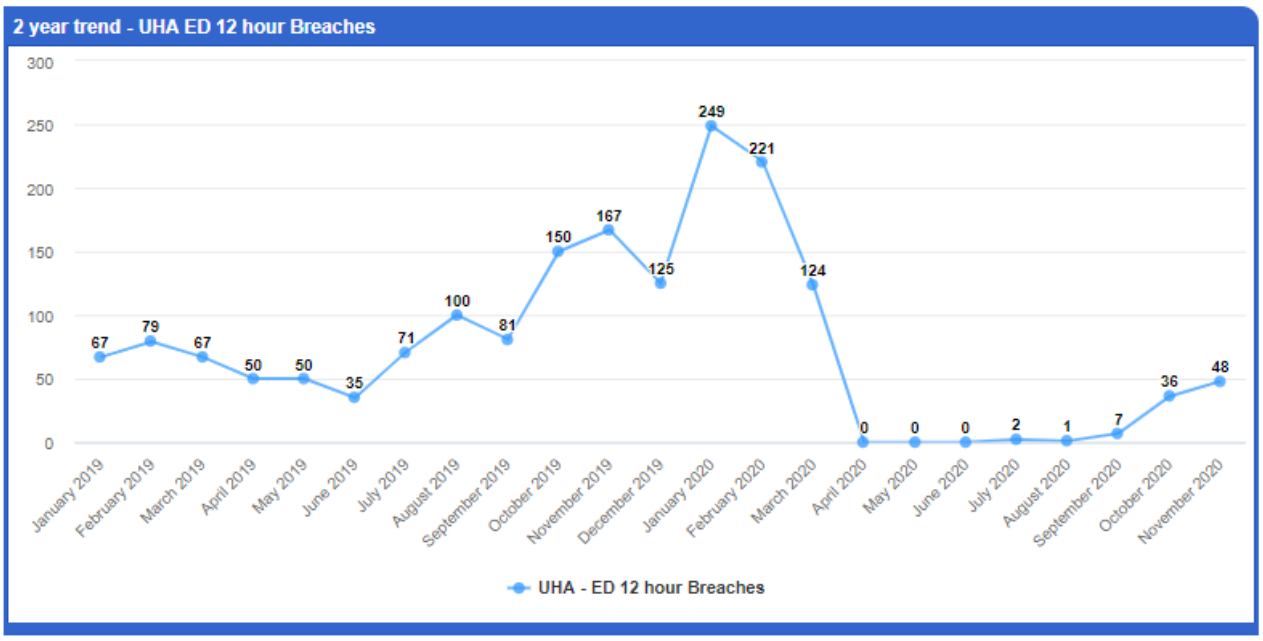
There are two appendices to support this report. Appendix 1 provides detailed trend charts for elements of the planned and unscheduled care performance as described within those sections in this paper. Appendix 2 includes a breakdown of the latest National Data in relation to both planned and unscheduled care performance.

## 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
67
79
67
50
50
35
71
100
81
150
167
125
249
221
124
0
0
0
2
1
7
36
48
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
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May 2020
June 2020
July 2020
August 2020
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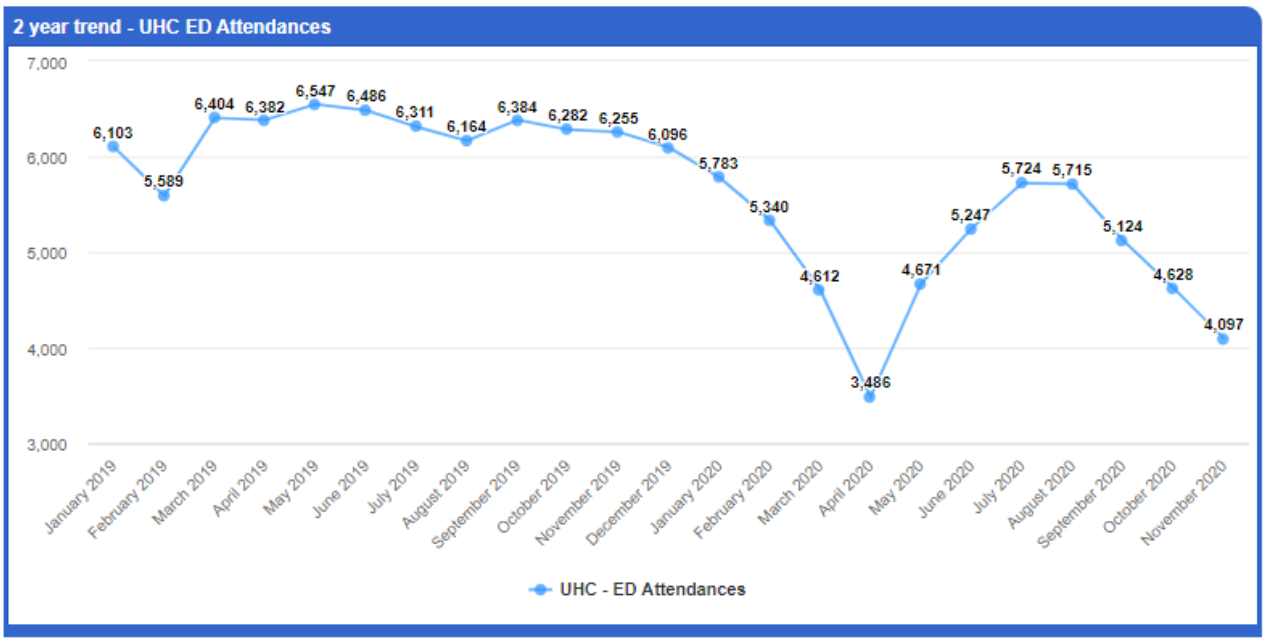
October 2020
November 2020
UHA - ED 12 hour Breaches


2 year trend - UHC ED Attendances
7,000
6,000
5,000
4,000
3,000
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
4,628
4,097
January 2019
February 2019
March 2019
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August 2019
September 2019
October 2019
November 2019
December 2019
January 2020
February 2020
March 2020
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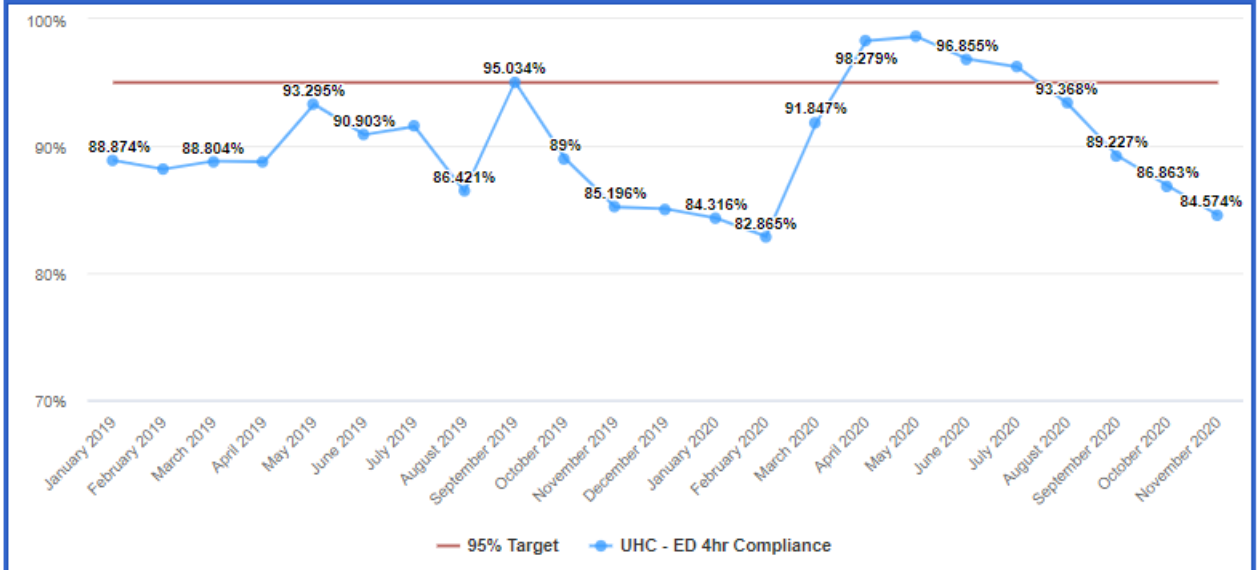
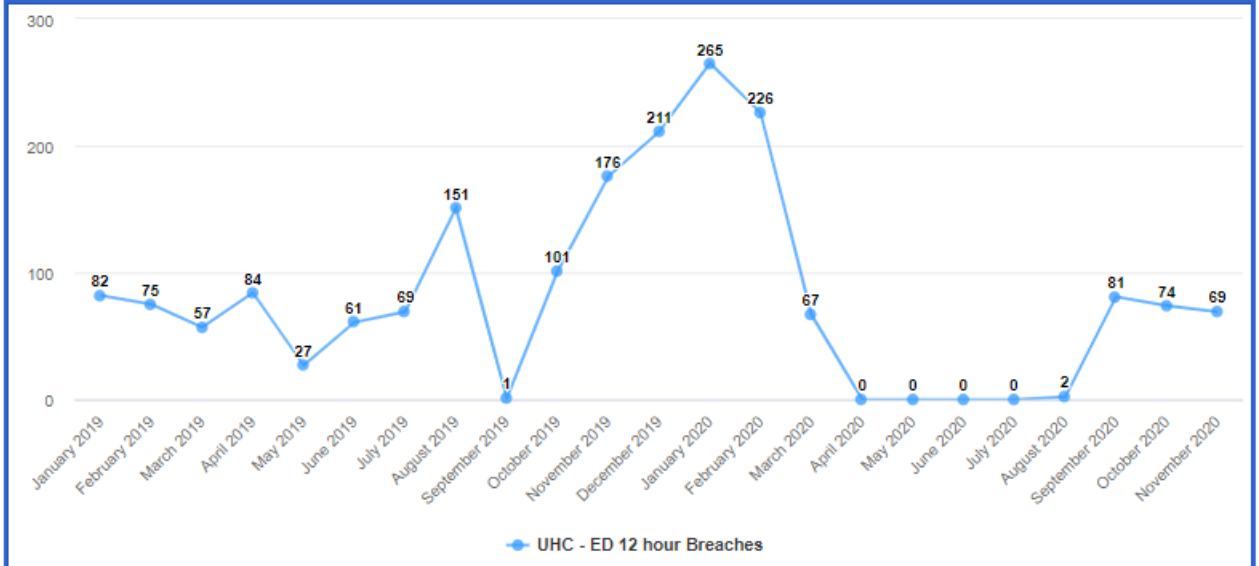
October 2020
November 2020
UHC - ED Attendances

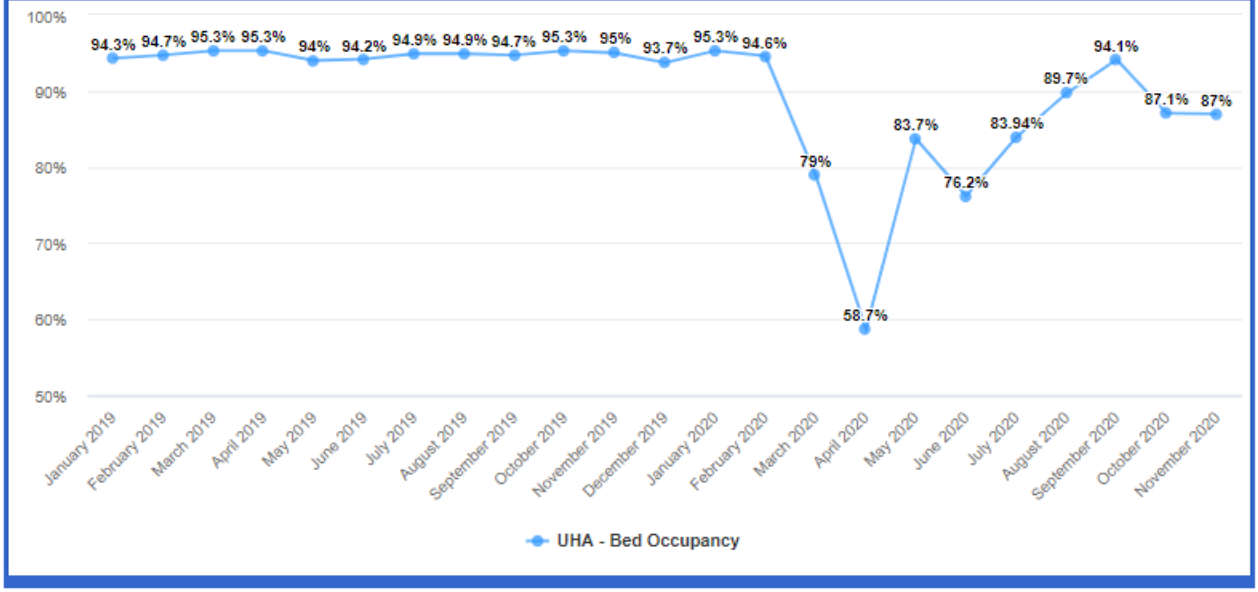
## 2 year trend - UHC ED 4hr Compliance



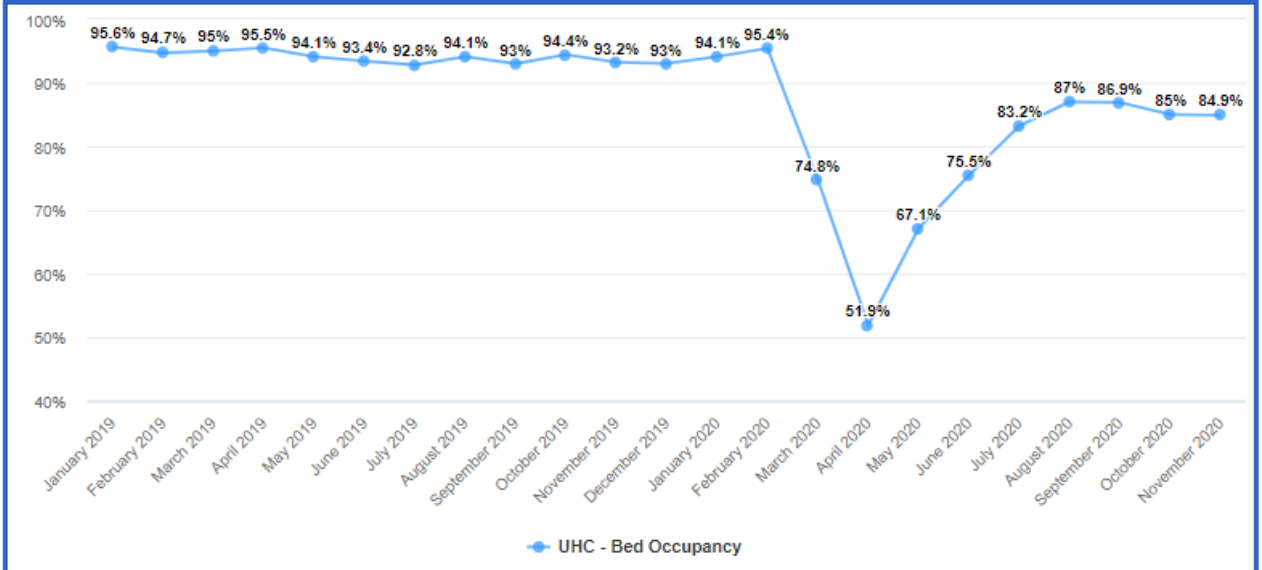

## 2 year trend - UHC ED 12 hour Breaches



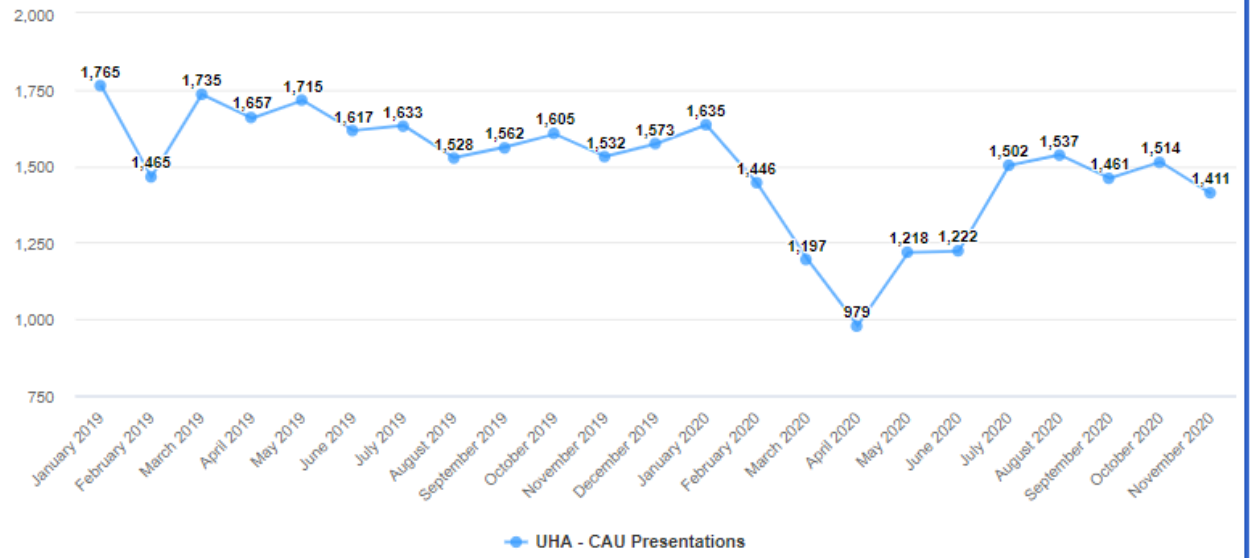

## 2 year trend - UHA Medical & Surgical Bed Occupancy



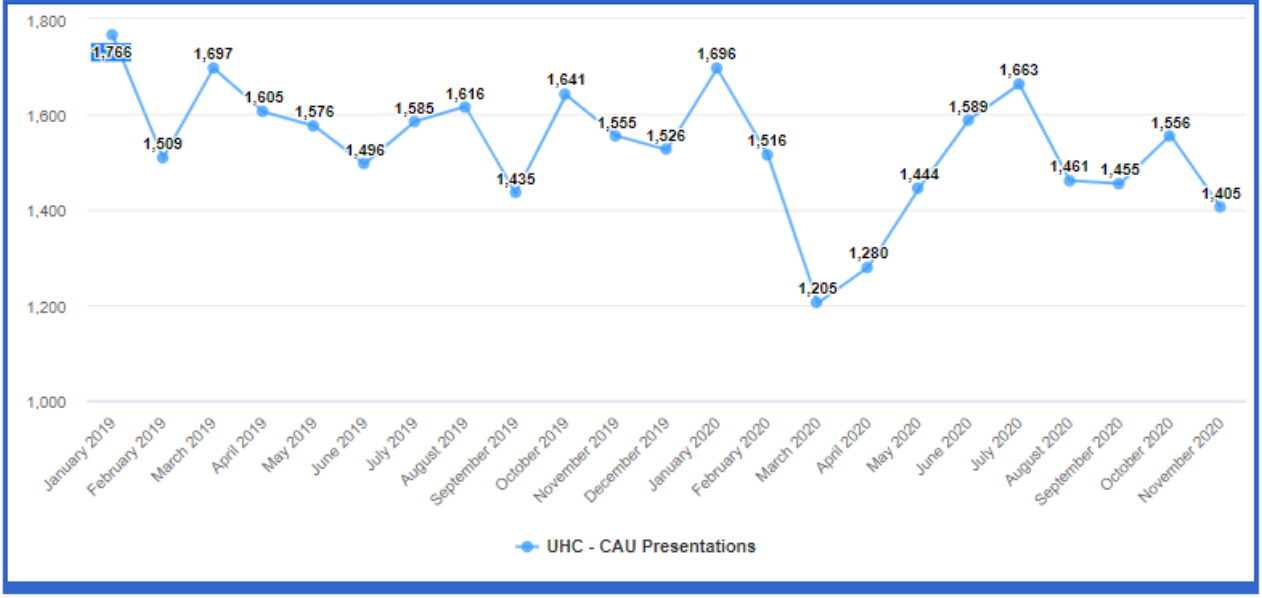
## 2 year trend - UHC Medical & Surgical Bed Occupancy



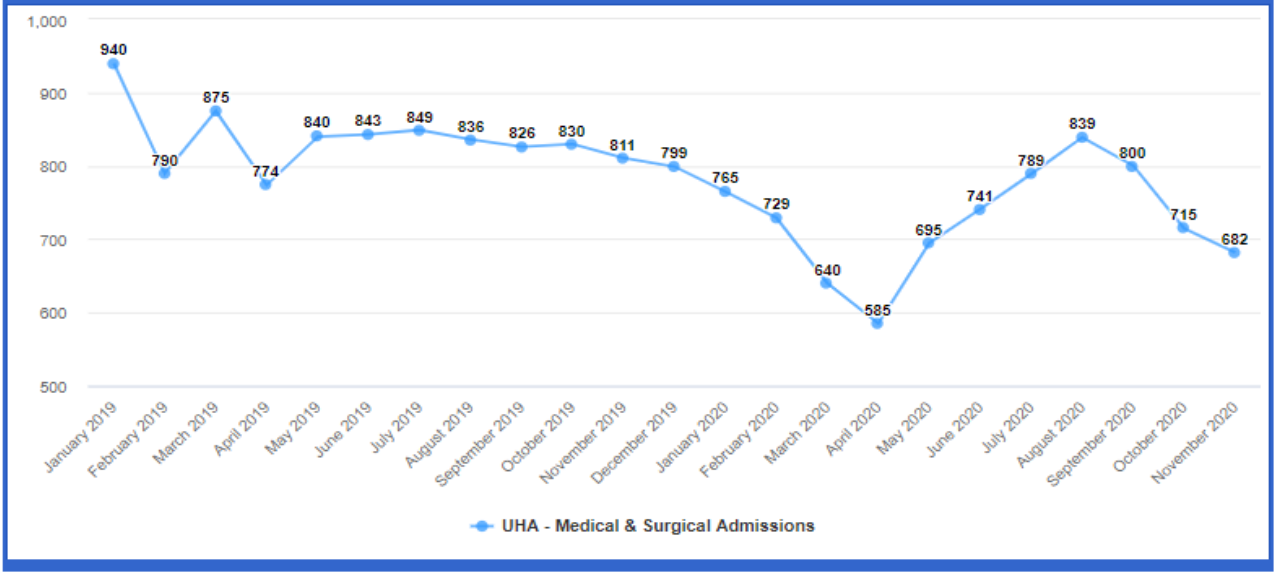

## 2 year trend - UHA CAU Presentations



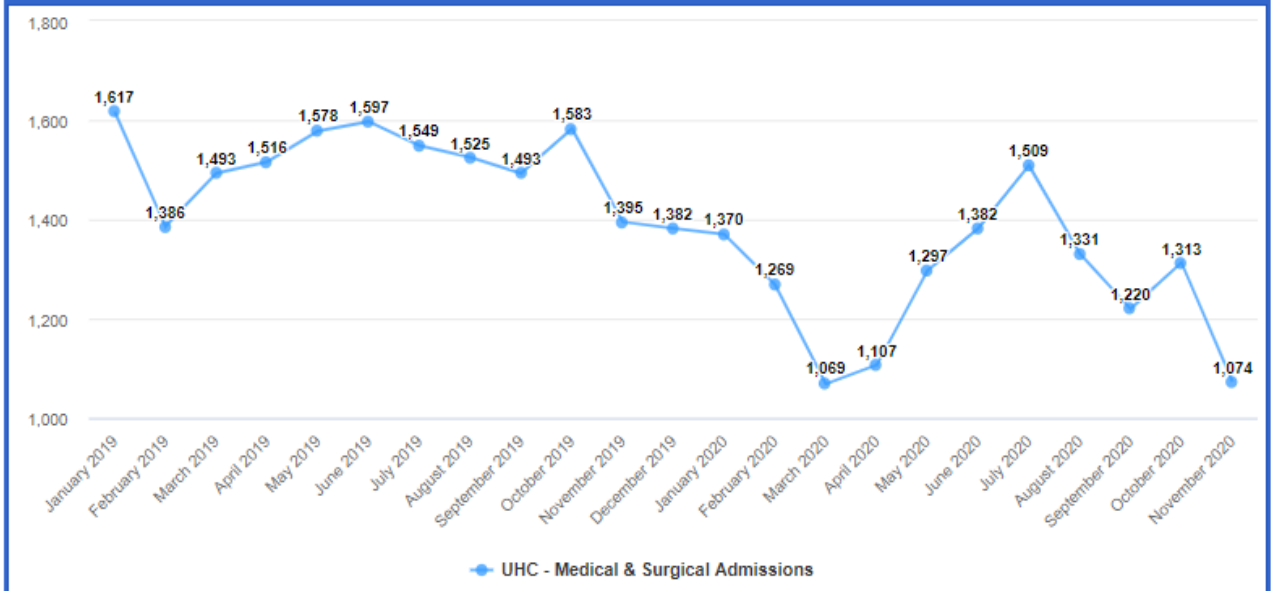

## 2 year trend - UHC CAU Presentations



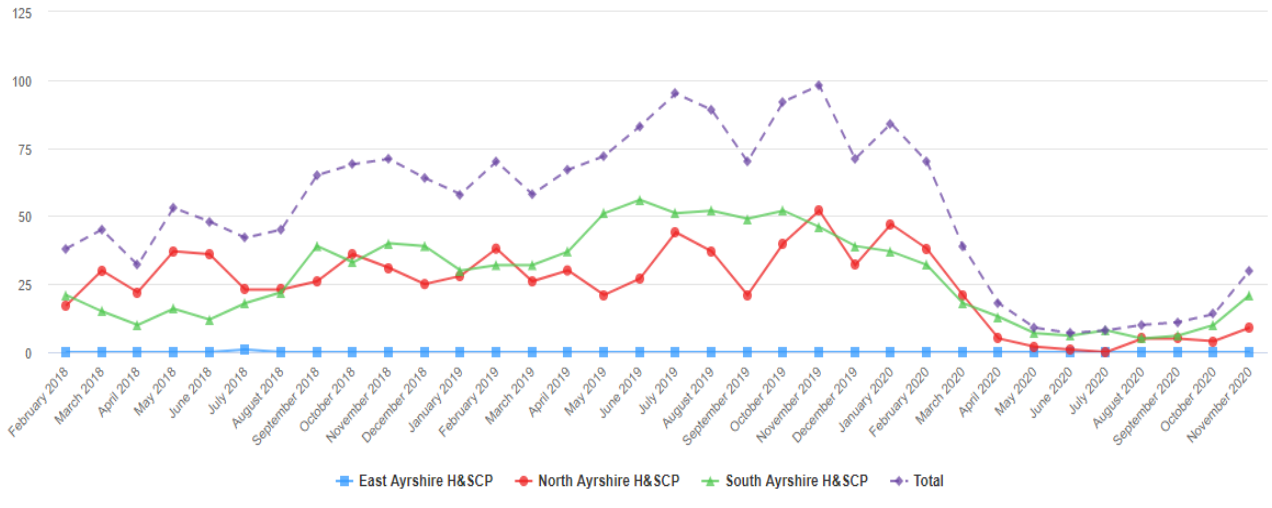
## 2 year trend - UHA Medical & Surgical Admissions



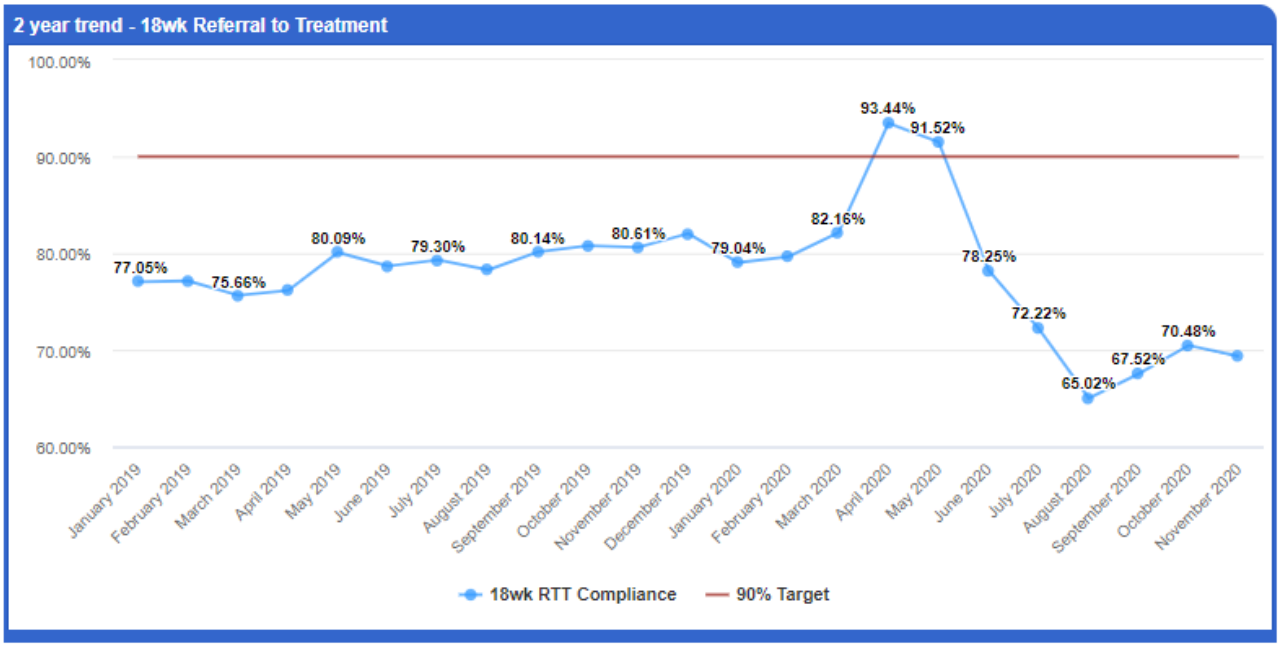

## 2 year trend - UHC Medical & Surgical Admissions



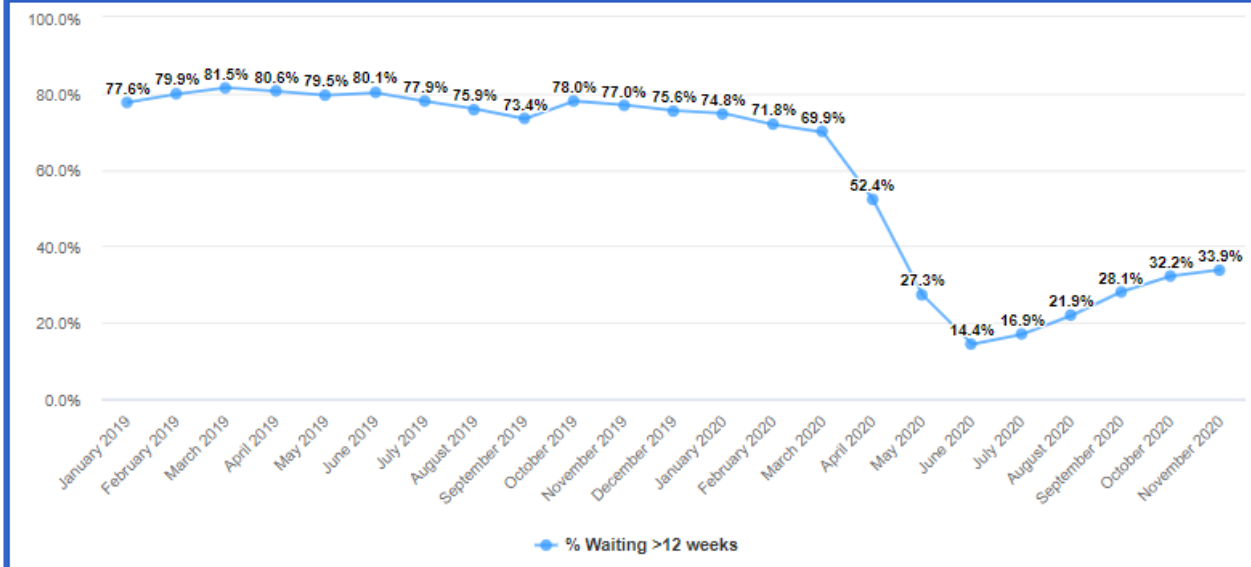

## Monthly numbers of delayed discharges over 2 wks, excluding code 9



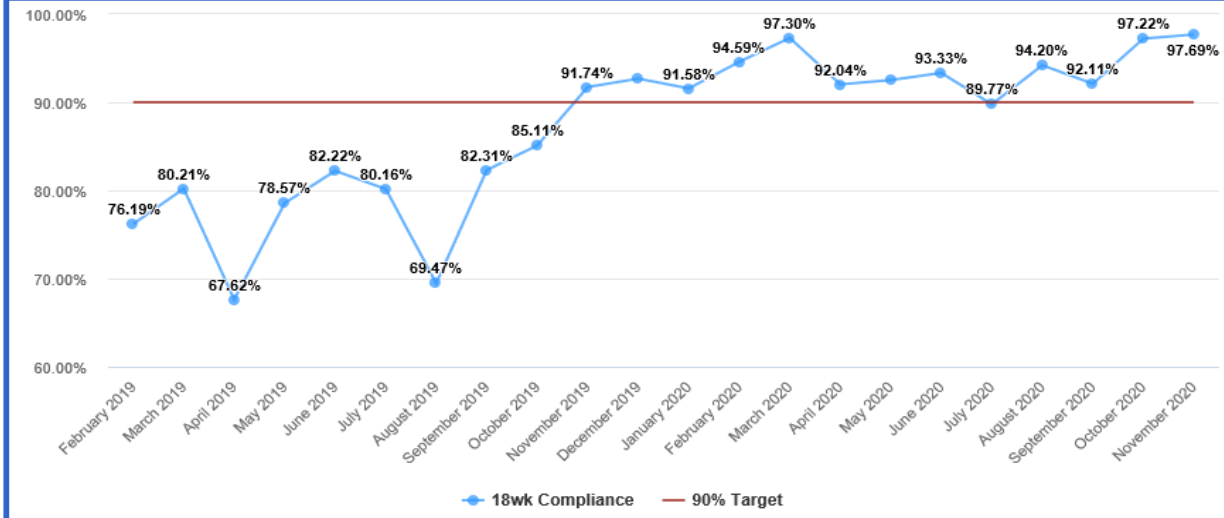

2 year trend - 12wk New Outpatients
100.0%
80.0%
60.0%
40.0%
20.0%
78.5% 78.5% 82.7% 82.3% 82.7% 81.5% 83.0% 81.8% 79.9% 81.2% 81.7% 82.2% 80.8% 81.1% 80.4% 58.6% 35.4% 29.1% 36.7% 42.1% 43.9% 43.3% 42.4%
January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 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 October 2020 November 2020
12wk New OP Compliance
95% Target


2 year trend - 18wk Referral to Treatment
100.00%
90.00%
80.00%
70.00%
60.00%
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% 70.48%
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 October 2020 November 2020
18wk RTT Compliance
90% Target

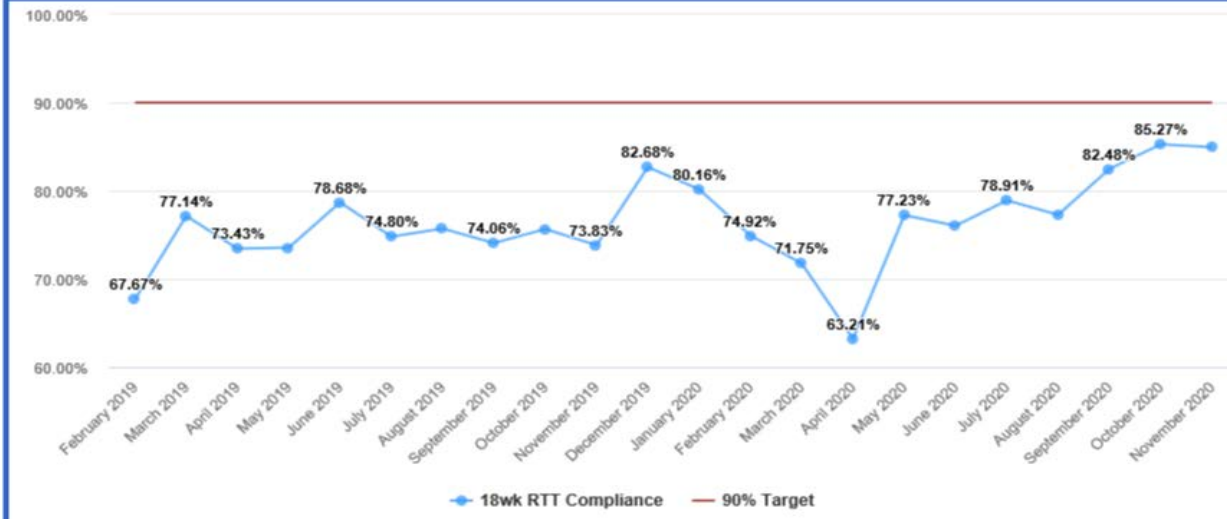
## 2 year trend - IPDC % waiting over 12 weeks

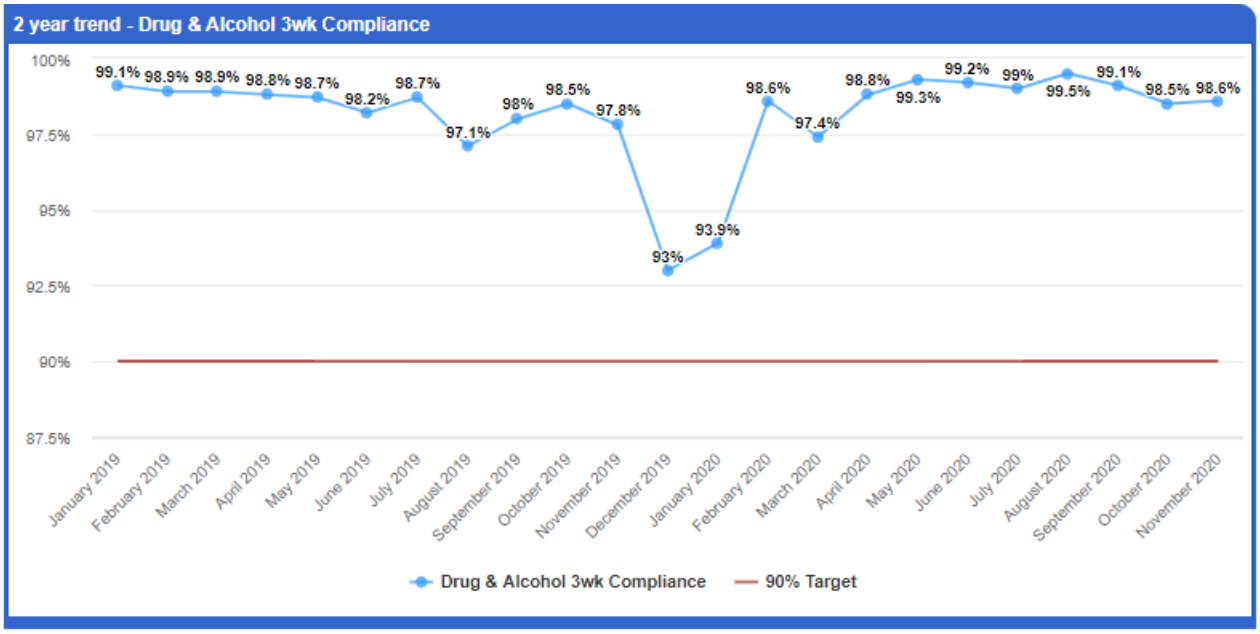


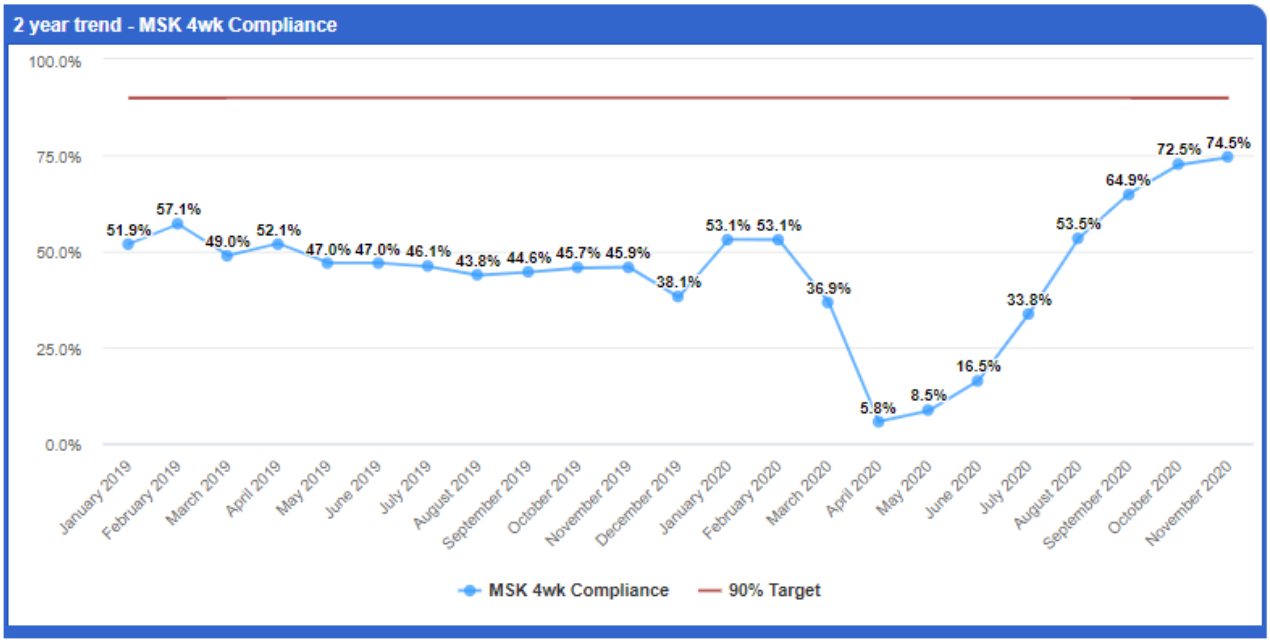

## 2 year trend - Child & Adolescent Mental Health (CAMHS)

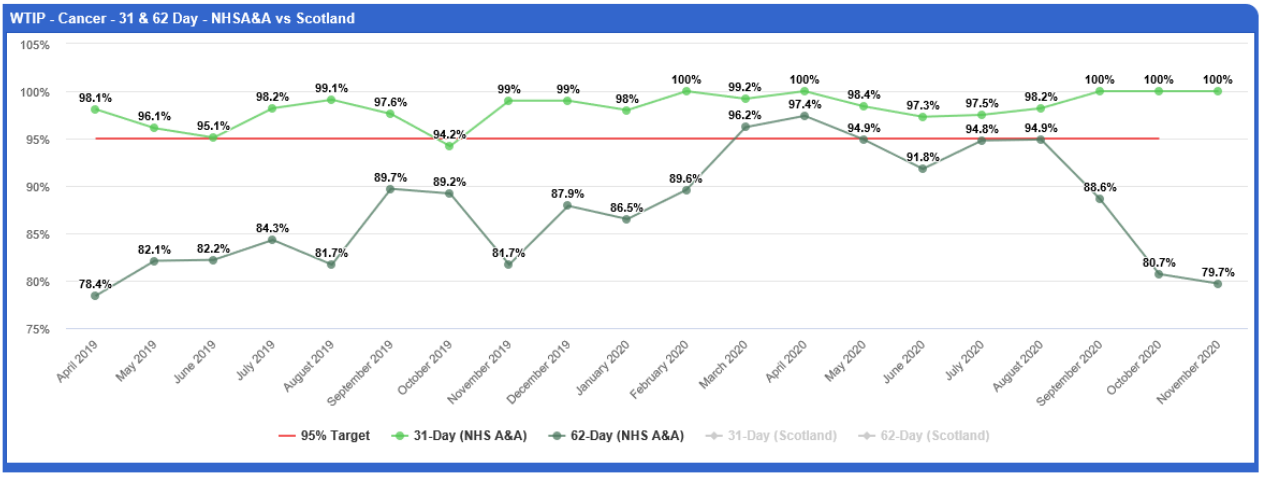



## 2 year trend - Psychological Therapies 18wk RTT Compliance

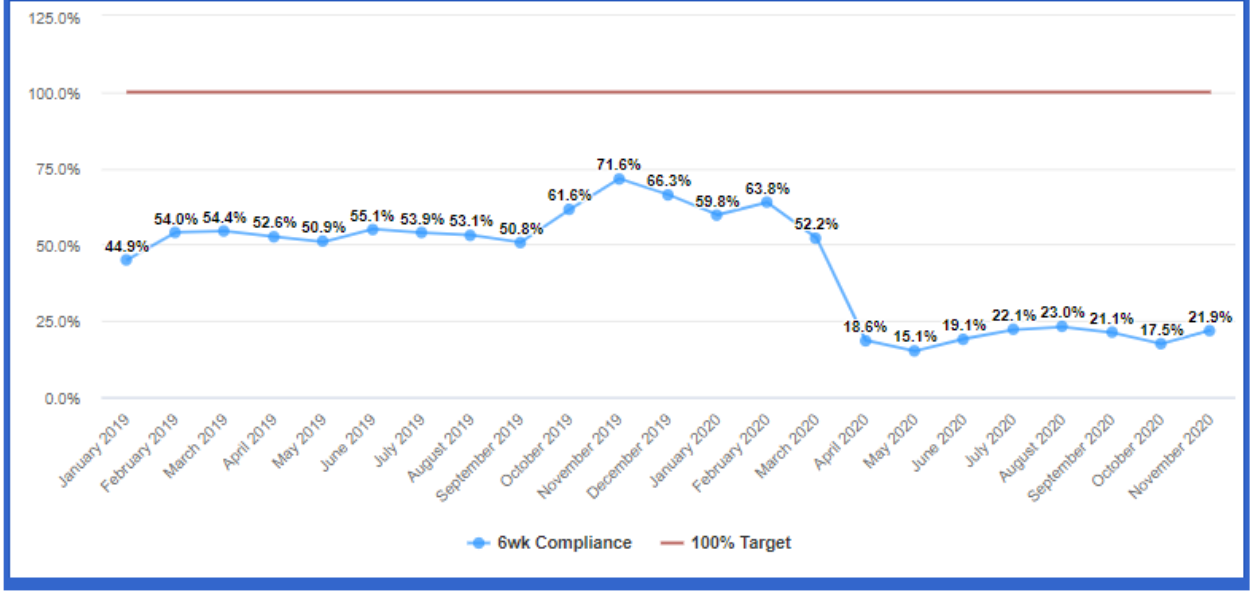



2 year trend - Drug & Alcohol 3wk Compliance
100%
97.5%
95%
92.5%
90%
87.5%
99.1% 98.9% 98.9% 98.8% 98.7% 98.2% 98.7% 97.1% 98% 98.5% 97.8% 93% 93.9% 98.6% 97.4% 98.8% 99.3% 99.2% 99% 99.5% 99.1% 98.5% 98.6%
January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September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

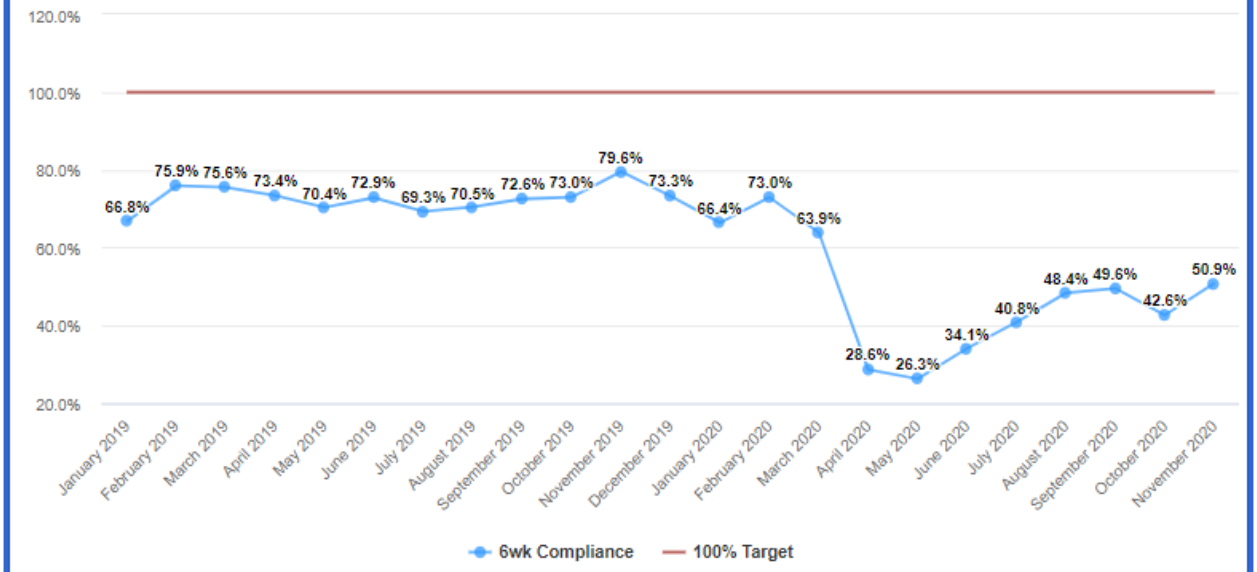

2 year trend - MSK 4wk Compliance
100.0%
75.0%
50.0%
25.0%
0.0%
51.9% 57.1% 49.0% 52.1% 47.0% 47.0% 46.1% 43.8% 44.6% 45.7% 45.9% 38.1% 53.1% 53.1% 36.9% 5.8% 8.5% 16.5% 33.8% 53.5% 64.9% 72.5% 74.5%
January 2019 February 2019 March 2019 April 2019 May 2019 June 2019 July 2019 August 2019 September 2019 October 2019 November 2019 December 2019 January 2020 February 2020 March 2020 April 2020 May 2020 June 2020 July 2020 August 2020 September 2020 October 2020 November 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% 100% 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% 80.7% 79.7%
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 October 2020 November 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




## 2 year trend - 6wk Imaging Access



**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 | 45.1% Sept 2020 | 42.4% Nov 2020 | (-) | | 46.5% Sept 2020 |
| Referral to Treatment* | 67.5% Sept 2020 | 69.4% Nov 2020 | (+) | | 66.9% Sept 2020 |
| Inpatients/Daycases | 31.0% QE Sept 2020 | 33.9% Nov 2020 | (+) | | 30.0% QE Sept 2020 |
| CAMHS | 91.9% QE Sept 2020 | 97.7% Nov 2020 | (+) | | 60.6% QE Sept 2020 |
| Psychological Therapies | 77.1% QE Sept 2020 | 84.9% Nov 2020 | (+) | | 75.0% QE Sept 2020 |
| Drug and Alcohol | 99.2% QE Sept 2020 | 98.6% Nov 2020 | (-) | | 97.2% QE Sept 2020 |
| MSK | 56.2% QE Sept 2020 | 74.5% Nov 2020 | (+) | | 52.5% QE Sept 2020 |
| Cancer 31 Day | 98.6% QE Sept 2020 | 100% Nov 2020 | (+) | | 98.4% QE Sept 2020 |
| Cancer 62 Day | 94.8% QE Sept 2020 | 79.7% Nov 2020 | ( -) | | 87.3% QE Sept 2020 |
| Endoscopy | 21.1% Sept 2020 | 21.9% Nov 2020 | (+) | | 28.6% Sept 2020 |
| Imaging | 49.6% Sept 2020 | 50.9% Nov 2020 | (+) | | 64.9% Sept 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 versus Published data | | Latest Published **Scotland** Data |
|---|---|---|---|---|---|
| ED 4 HR Compliance (%) | 86.1%<br>Oct 2020 | 82.0%<br>Nov 2020 | (-) | | 89.6%<br>Oct 2020 |
| Delayed Discharges > 2 weeks (excluding code 9s) | 30<br>Nov 2020 | 15<br>4th Jan 2021 | (+) | | 299<br>Nov 2020 |