Achieving the 18 Weeks Referral to Treatment Standard in Neurological Services

Task & Finish Group Output Report
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Foreword

The work of the Neurological Services Task and Finish Group was sponsored by the Scottish Government’s 18 Week RTT Operational Delivery Team, consisting of NHS clinicians, managers and members of the Scottish Government, and ultimately by the Scottish Government’s Delivery Directorate. The contents of this output report is commended to you by the Operational Delivery Team to support detailed assessment of your service and intensive action where required. It is essential that all opportunities for streamlined service management and ongoing improvement and transformation are optimised, with the patient’s interests right at the centre. Delivery and improvement will require whole systems ownership and strong organisational leadership (both clinical and managerial) in order to embed and operationalise change on a sustainable basis.

The core elements commended to Health Communities and NHSBoards for strategic action are:

1. Use ‘A Practical Guide to Achieving 18 Weeks’ (available on www.18weeks.scot.nhs.uk) to identify the priority areas for change that apply to your service, and work with stakeholders and change champions to drive their implementation, making full use of the extensive range of tools and techniques available through the Improvement and Support Team.
2. Use baseline data, local knowledge and analysis of ‘what if?’ scenarios to identify key areas for urgent change and drill into the processes which will ‘unlock’ these bottlenecks.
3. Undertake comprehensive Demand, Capacity, Activity, Queue analysis to firstly understand and secondly to proactively manage the demand/capacity balance in your service. Seek assistance from the Improvement and Support Team if necessary.
4. Reinforce continuous focus on quality by implementing QIS Standards and 18 Wk RTT improvements in parallel.

It is expected that Boards will continue to develop their local Neurological Services Action Plans. The improvement and Support Team will continue to provide implementation support to ensure Boards achieve the 18 Weeks RTT Standard. Should 18 Weeks RTT performance in this specialty prove unsatisfactory, the escalation process could include further action planning with the Access Support Team, more detailed tailored support, intervention as needed and submission of detailed recovery plans.

Boards’ progress on implementation may be reviewed at the Chief Executives’ meeting and individual mid-year reviews.

Robert Calderwood – Chair of the 18 Weeks Operational Delivery Team
Chair’s Reflections

I was pleased to be invited to chair the Task and Finish Group for Neurological Services, commissioned by the Operational Delivery Team of the 18 Weeks Referral to Treatment [RTT] Programme. A risk analysis identified Neurological Services as one of the specialties most likely to need additional support to achieve 18 Weeks RTT, largely due to the complexity of diagnosis and the long term condition management patients require.

Neurological problems are not uncommon and place considerable demand on primary and secondary care services. Referrals to Neurology Outpatients have been associated with waits to see specialists, or to have investigations, leading to delays in diagnosis. This has highlighted the need to look more closely at how services are delivered and how improvements could be made.

The Neurological Services Task and Finish Group was established in November 2008. Membership included Senior Managers, Clinicians, GPs and Scottish Government members to harness expertise across NHSScotland and consider the existing evidence base for delivery of the 18 weeks RTT standard for Neurology. The purpose was to explore best practice across NHSScotland and support Boards in the use of tools and techniques to support service improvement to enable delivery. A comprehensive engagement strategy was adopted that included an initial workshop, clinical and managerial engagement sessions and a full stakeholder event for Neurology Services in June 2009.

This Task and Finish Group Output Report should be considered in conjunction with the work of the Long Term Conditions Collaborative and the QIS Standards for Neurological Services (See Appendix D). Recognising that one size does not fit all, the Task and Finish Group has provided NHS Boards with ‘A Practical Guide to Achieving 18 Weeks RTT in Neurological Services’ (available on www.18weeks.scot.nhs.uk). This offers a range of improvement actions that encompass enhancing primary and secondary care relationships, getting patients on the right pathways, standardising and improving pathways, improving access, managing waiting lists, balancing Demand, Capacity, Activity and Queues, maximising the value of information, ensuring timely diagnostics, making the most of your workforce and equality of access, quality and safety.

Through engagement with patients throughout the redesign process, these improvement actions will place the patient at the centre of the planning and design for neurological services. Providing improved access to high quality care by designing out unnecessary waits and delays that add no value to the patient will improve the patient experience. In essence, striving to ensure the patient is seen the first time by the right person, at the right time and in the right place.
A ‘Who’s Doing What…Best Practice Matrix’ (available on www.18weeks.scot.nhs.uk) has also been developed to identify the key areas of improvement currently taking place across NHSScotland Boards. It includes a brief description of each project and signposts the main contacts.

These improvement resources should enable Clinicians, Service Managers, Members of Multi-Disciplinary Teams and 18 Weeks Teams to drive their local improvement strategy to deliver the 18 Weeks RTT Standard for December 2011, provide a platform to support the improvement necessary to deliver NHS QIS standards and ultimately to improve services for patients.

I believe that the Task and Finish Group has created a momentum for change within Neurological Services. I wish you every success as you move forward in transforming your service and delivering the 18 Week RTT Standard.

Rosemary Lyness – Chair of the 18 Weeks Neurological Services Task and Finish Group
1 Introduction

1.1 The 18 Weeks Referral to Treatment Standard

The 18 Weeks Referral to Treatment (RTT) Standard builds on the considerable improvements Boards have made in recent years to patient waiting times for first outpatient appointment, access to eight key diagnostic tests and inpatient/daycase treatment. The 18 Weeks RTT Standard means that from December 2011, 18 weeks will become the maximum wait from referral right through to treatment for non-urgent patients. The 18 Weeks RTT Standard shifts concentration on managing waiting for each stage of treatment to whole pathways of care. The 18 Weeks RTT Programme is designed to support NHS Boards in the delivery of joined up treatment and services and to further improve early diagnosis, treatment and patient experience.

1.2 The 18 Weeks RTT Programme Structure

The 18 Weeks RTT Programme Board has four Delivery teams reporting to it. These teams are the Operational Delivery Team, the Information Delivery Team, the Diagnostic Steering Group and the Emergency Access Delivery Team, all with members from NHS Boards and the Scottish Government. Within the Scottish Government’s Delivery Directorate there are also two teams focussing on 18 Weeks RTT. These are the Improvement and Support Team and the Access Support Team. To ensure absolute focus on achieving the 18 Weeks RTT and managing associated risks to delivery, these teams link closely with each Board’s 18 Week team to ensure progress on all work-strands.

1.3 Task & Finish Groups

At the start of the programme, the Operational Delivery Team undertook analysis to identify the specialties most likely to need additional support to achieve the 18 Weeks RTT Standard. Neurological Services was identified as one of six such specialties. This was on the basis of neurological services being largely an out-patient specialty where diagnosis can be complex and patients often require ongoing management of long term conditions. In addition to the specialty based Task and Finish Groups two cross-cutting groups have recently been formed to address Diagnostic and Capacity Demand Management. The Capacity Demand Management group has sub groups to look at the detail of demand and capacity planning and management and remote and rural issues.
1.4 Neurological Services Facts and Figures

‘Disorders of the nervous system are common. It is estimated that ten million people in the UK live with some form of neurological condition which has an impact on their lives. They are associated with significant morbidity and the single most common disorder, headache, has major economic consequences in terms of lost working days. Neurological conditions account for one in five emergency hospital admissions, one in eight general practice consultations and a high proportion of disability, particularly severe and progressive, in the population.’

NHS QIS Clinical Standards for Neurological Health Services, Oct 2009

Neurological conditions include Headache, Epilepsy, Multiple Sclerosis, Motor Neurone disease and Parkinson’s disease. Scottish Neurological Services estimate that in the region of 20% of all their referrals are for headache. It is also estimated that GPs only refer 2% of the headache patients they see (Latinovic et al JNNP 2005). It is therefore extremely important to ensure the clarity of pathways and referral protocols for headache.

Boards have made significant progress in improving waits for Neurological Services and achieving the Scottish Government ‘Stage of Treatment’ target of no more than a 12 week wait for the first outpatient appointment. Achieving a full referral to treatment standard of 18 weeks by Dec 2011 will however be a considerable challenge for Neurological Services. The following charts show an assessment of the risk as of September 2009.

This graph shows the total number of patients on Neurology waiting lists for a first appointment during 2008 and 2009 (Referrals from GPs only).

It shows a seasonal trend and a small reduction in the numbers on waiting lists in 2009 compared with the previous year.
This graph identifies that in September 2009, Boards were achieving the Stage of Treatment target of no more than a 12 week wait for first outpatient appointment for all referrals from GPs. Note that the target for March 2010 is for all source referrals.

Although this shows achievement of a ‘stage of treatment’ target, this is only one of the important steps towards achieving the 18 Weeks RTT Standard.
This graph shows seasonal variation in additions and removals from the waiting list. It highlights months where removals did not balance additions and waiting lists grew. It is essential for Boards to understand their own variation and to plan sustainable capacity accordingly.

The Task and Finish Group would have liked to plot referral volumes over time but unfortunately this information is not readily available. As a proxy, additions to the waiting list can be analysed. This is not all referrals received but represents those that the service has considered appropriate to add to a waiting list. The figures show a significant seasonal variation and also a possibly significant overall increase (e.g. Jan ’08 – 2250, Jan ’09 – 2500, Sep 09 – 2750). Figures for all referrals received will be available from ISD in the near future.

There is not currently an understanding of the likely rise in future demand as waits reduce, population ages etc. A piece of research will be commissioned with expert public health input to build this picture.
This graph calculates the indicative number of weeks required to clear the waiting list at each Board based on their recent activity (the two bars show this calculation using annual activity and then just the most recent months activity).

Activity is a measure of all activity including waiting list initiatives as well as core activity. The measure is for the stage of treatment target and does not relate directly to 18 weeks RTT. If the indicative number of weeks required to clear the list is greater than the stage of treatment target (e.g. 12 weeks) this indicates risk; if the indicative number of weeks required to clear is less than the stage of treatment target this does not guarantee there is no risk – for example, activity could be being increased by unsustainable waiting list initiatives.

It is important for boards to understand the level of activity required for ‘business as usual’, i.e. to meet appropriate demand as opposed to the once-off activity required for ‘back-log clearance’.
Number of weeks to clear first appointment waiting list based on annual activity by specialty for NHS Scotland, June 09

This graph uses ‘number of weeks to clear the 1st appointment waiting list’ as an indicator of risk for each specialty. This measure is a ‘Stage of Treatment’ measure and will be replaced by an 18 Weeks measure once they become available.

N.B. Activity is not same as capacity. Boards may be under or over utilising available capacity.
2 Neurological Services Task & Finish Group

The Neurological Services Task and Finish Group was set up in November 2008 and ran as a short-life working group until December 2009. The group included service managers, neurology consultants, a neurophysiology consultant, GPs and Scottish Government members (see Appendix A for full membership). The philosophy of the 18 Weeks RTT programme is to support Boards to embed sustainable change, encourage them to move away from reliance on waiting list initiatives and develop whole system working with quality and safety as a central tenet.

The Task and Finish group considered the existing evidence base from a wide variety of sources such as; the Scott Moncrieff report, Action On Neurology report, evidence from English services such as The Walton Centre for Neurology and Neurosurgery in Liverpool and King’s College London and examples of Scottish best practice (see Appendix D for details). The group also maintained a close working relationship with Quality Improvement Scotland (QIS) during their development of QIS Standards for Neurological Services published in October 2009. The group worked through the following eight work-streams; Measurement and Definitions; Demand/Capacity/Activity/Queue (DCAQ); Primary Care Solutions; Performance Management; Service Redesign and Transformation (including Neurophysiology); Cultural; Workforce and Communication.

2.1 Risks to Delivery

Through consultation with Boards, the following risks to delivery of the 18 Weeks RTT in Neurological Services were identified from the outset:

- Difficulties in measuring performance and improvement due to un-integrated and disparate IT systems.
- Significant variation in patient experience in terms of the pathways they follow.
- Significant variation in the service provided for patients living in Boards with a regional centre and those without.
- Significant variation in terms of the time it takes from referral to treatment. For example, the gaps between the ‘value-adding’ steps of the pathway and the number of ‘non-value-adding’ steps included.
- Diagnostic test bottlenecks that may prevent the overall 18 week RTT pathway being achieved.
- Significant variation in the scheduling, clinical management and discharge of patients with long term conditions in terms of whether they are supported largely in primary or secondary care and by whom.
2.2 Priority Task & Finish Group Improvement Actions

The Neurological Services Task and Finish Group identified the following priority actions for the group:

- To gain an understanding of the Demand and Capacity balance through collection and analysis of Baseline Information for Neurological Outpatient Services across Scotland.
- To undertake ‘What if’ scenario planning of key metrics and to identify improvement focus areas.
- To drill down into the Baseline Information and ‘What if’ analysis to identify local, regional and national planning and training requirements, risk areas, high impact changes, improvement opportunities, benchmarking and the identification of best practice.
- To identify ways to reduce the number of appointments with consultants by ensuring patients access care at the most appropriate place e.g. direct access to diagnostic tests and increase supported management of patients with long term conditions in primary care.
3 Task & Finish Group Outputs

The Neurological Services Task and Finish Group achieved the following outputs:

<table>
<thead>
<tr>
<th>Task &amp; Finish Group Outputs</th>
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<tbody>
<tr>
<td><strong>1 Measurement &amp; Definitions</strong></td>
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<tr>
<td>- Design of a neurology specific form for recording of National Clinical Outcomes, including 18 Week clock start &amp; stops and neurological services specific information e.g. which diagnostic tests patients are being sent for.</td>
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<td>- Piloting of Board specific versions of the form at NHS Lanarkshire and NHS Greater Glasgow and Clyde.</td>
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<tr>
<td><strong>2 Demand, Capacity, Activity and Queue</strong></td>
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<tr>
<td>- Collation of Baseline Information provided Demand and Capacity data for identification of improvement opportunities, benchmarking and the identification of best practice.</td>
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<tr>
<td>- Analysis of ‘What if’ scenarios on key metrics identified improvement opportunities and benchmarking opportunities to maximise Capacity and Activity and reduce Demand and Queues (See next section).</td>
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<td>- Evaluation of indicators to identify of whether capacity, activity and demand are in balance (See next section).</td>
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<tr>
<td><strong>3 Primary Care Solutions</strong></td>
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<tr>
<td>- Design of a pilot project with NHS Lanarkshire of GP referral guidance and SCI Gateway referral forms for first seizure. Benefits for GPs, patients and secondary care being measured.</td>
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<td>- CCI-developed pathways reviewed for appropriateness for greater use across neurological services.</td>
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<td>- Development of Headache guidance for GPs to encourage appropriate referrals and optimised work-up prior to referral.</td>
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<td>- Learning from Forth Valley’s action plan regarding managing variation in GP referral patterns.</td>
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<td>- Contribution of the Long Term Conditions Collaborative in the Task and Finish Group ensured that focussed work on primary care and community services input to pathway improvement was included. It also ensured that neurological conditions were considered in the development long term conditions improvement resources (See Appendix D – Bibliography).</td>
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<tr>
<td><strong>4 Performance Management</strong></td>
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<tr>
<td>- Use of New Ways and Scottish Morbidity Record [SMR] data submitted by Boards to ISD to identify trends and risk areas requiring additional focus and support.</td>
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<td>- Liaison with QIS to ensure their development of standards for neurological services complement 18 Weeks RTT.</td>
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<td>- Linked with 18 Weeks regional and Board teams to support their improvement work.</td>
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| 5 Service Redesign and Transformation | Development of a ‘Who’s Doing What?’ matrix to facilitate Boards in the sharing of results from pilot projects and best practice examples.  
Convening of a Neurophysiology Focus Group to identify improvements impacting on Neurology and Orthopaedics.  
Specific focus on pathways that include neurophysiological tests and ways of using the skills of the professionals involved for appropriate tasks. Significant capacity improvements for tests such as Nerve Conduction Studies have been made in some Boards and are being worked on in others.  
Encouragement of electronic solutions for non-GP initiated referrals (e.g. consultant to consultant within Boards and between Boards)  
Encouragement of formalisation of a for ‘Advice Only’ channel for GPs to gain advice that delays or prevents referrals being necessary.  
Facilitation of a regional service managers group to exchange improvement ideas and best practice. |
| 6 Cultural | Promotion of models of care, making greater use of nurse specialists and GPs that include reassurance for patients that they will get ‘recalled’ if appropriate. |
| 7 Workforce | Collation of Baseline figures for the number of Neurology Consultants and Nurse Specialists (whole time equivalents) working in each Board.  
Promotion of pilot projects for nurse led clinics and extended roles  
Promotion of projects for neurophysiology technicians to undertake and report on tests with consultant support and mentoring.  
Assessment of local, regional and national workforce planning and training issues and relevance to capacity. |
| 8 Communication | Hosting of a Neurological Services National Networking Event (June ‘09) including learning opportunities from English colleagues. All Boards were asked to identify top 3 actions and take them forward.  
Organisation of visits to high performing English sites, such as Kings College London (see Appendix D – Bibliography).  
Development of ‘A Practical Guide to achieving 18 Weeks RTT in Neurological Services’. |
4 The Demand, Capacity & Activity Balance

4.1 The Principles
Maintaining a balance between demand, capacity and activity, to ensure an efficient service where queues do not develop, requires robust information. It also requires a detailed understanding of the parameters and the impact that a change in any of the parameters has on the others. For example, demand can vary weekly or seasonally and can increase or decrease gradually over-time. Actions can be taken to influence a decrease in demand for secondary care appointments. Efficiencies can be gained through management and redesign that optimise capacity utilisation or some demand can be redirected to other professionals.

4.2 Assessing the National Balance
The Task and Finish Group undertook national Demand, Capacity, Activity and Queue analysis to gain an understanding of the overall picture and scope for making optimal use of the existing capacity available. It is important to recognise, however, that this analysis was undertaken to demonstrate the type of analysis Boards could do at a regional or local level to identify improvement opportunities that will maximise capacity and activity and reduce demand and queues. National calculations are indicative to focus improvement effort and cannot be used to understand local or regional balance. The analysis used the Neurological Services Baseline data – May ’09, Activity data submitted to ISD – SMR00 ’08 and New to Return data submitted to ISD – 2008. It is not intended that local Improvement Plans focus on the productivity of individuals, but should be aimed at improving systems and processes that optimise capacity utilisation and increase flow and throughput across the service.

The table on the following page summarises the National Demand, Capacity and Activity Analysis undertaken. This involved making a number of assumptions detailed in the table.
### National Demand, Capacity and Activity Analysis

#### Consultant Capacity Assumptions:

- A consultant on a standard full time job plan could run three outpatient clinics a week for 42 weeks a year.
- They could see 15 new patients a week and 18 return patients.
- This results in a capacity of 630 new patients per full time consultant per annum (These figures are in-line with the Association of British Neurologists – ‘Good Job Planning Guide’ - see Appendix C).
- A consultant could maintain an average New to Return Ratio of 1 new patient to 1.2 return patients (i.e. aiming to reduce the need for patients to return).
- Three clinics lasting 4 hours gives a total of 720 minutes per week. Fifteen new patients, each allocated a 30 minute appointment slot, would take 450 minutes. This leaves 270 minutes for 18 return patients at 15 minutes per slot.
- N.B. There will be some local variation between boards e.g. those with DGHs and those with regional centres and between consultants to allow for differences in new to return ratios between sub-specialties.

#### National Capacity Calculation:

- The annual capacity of each full time consultant to see 630 new patients can be multiplied by the 47.5 FTEs currently working in Scotland, giving a **national capacity for 29,925 new appointments**. With the use of SpRs, Nurse Specialists and GPwSI this figure may be higher.
- The total of the baseline data collected directly from Boards gives a **capacity of 34,057 new slots**.

### Activity

The ISD activity data for 2008 identified **28,714 new appointments** having taken place.

### Demand

In the baseline data, Boards reported a total of **35,628 new referrals per annum**. N.B. It is likely that this may include some double counting of patients who have already had their first appointment being referred on to specialist nurses etc.
4.3 ‘What If…’ Scenario Analysis

The National Demand, Capacity and Activity Analysis undertaken suggests that achieving a balance between demand, activity and capacity in neurological services is not too far out of reach. This takes account of best practice capacity planning guidelines of ensuring that available capacity can cope with at least 80% of the variation in demand to ensure that queues do not build up.

The Task and Finish Group undertook analysis to explore what impact an improvement in one or more of the parameters could have on the demand, capacity and activity balance. There may be, however, some factors affecting the balance outwith Boards’ control. The scenarios considered by the group and a summary of the conclusions are provided below. The Task and Finish Group recommend that this national analysis be repeated by Boards at Board level and also at sub-specialty and consultant level to identify variation and improvement opportunities. The Task and Finish Group’s ‘Practical Guide to Achieving the 18 Weeks RTT Standard in Neurological Services’ provides a wealth of improvement suggestions aimed at tackling each of the ‘what if…’ scenarios (available on www.18weeks.scot.nhs.uk).

What if… all GPs referred at median rate per 100,000 of population?
This analysis required calculating one median for regional Boards and another for the other Boards as regional Boards accept referrals from across the region as well as from their own resident population. This analysis identified that there could be a potential national reduction of nearly 2,000 referrals. This analysis would be more meaningful and lead to a GP/Consultant engagement and education action plan at Board level. Boards can use the Locally Enhanced Services process to improve working between primary and secondary care.

What if… the New to Return appointment ratio was at least as good as average?
If those Boards with an above average return to new ratio were to achieve the average, new attendances could potentially increase from 28,714 to 30,304. This assumes the clinic minutes saved by having fewer follow-up appointments are used to see new patients and takes account of the different average appointment minutes for each type of appointment. Some local variation between boards will remain e.g. those with DGHs and those with regional centres and between consultants to allow for differences in new to return ratios between sub-specialties.
What if… all consultants saw as many new patients as the upper quartile of their peers?

Improvements should be aimed at systems and processes to optimise capacity utilisation across the service not at individual productivity. This analysis showed a significant variation in the number of new patients seen. The average per consultant was in the region of 300 to 400 new patients per annum. This is significantly below the suggested achievable capacity for 630 per full time consultant (It should be noted, however, that at national level it was not possible to identify and take account of part-time or locum consultants with a lower capacity).

The ‘What If’ analysis was undertaken using activity data i.e. actual patients seen. The following table shows the variation in New Patient Capacity per Neurologist calculated from the new clinic slot and workforce information reported by the Boards. The reasons behind the significant variation will of course be specific to each Board and Boards will therefore wish to explore where systems and processes could be improved to reduce the variation.

<table>
<thead>
<tr>
<th>NHS Board area</th>
<th>Annual New Patient Slots per Whole Time Equivalent Consultant</th>
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<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>556</td>
</tr>
<tr>
<td>Borders</td>
<td>525</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>702</td>
</tr>
<tr>
<td>Fife</td>
<td>712</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>986</td>
</tr>
<tr>
<td>Grampian</td>
<td>483</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>497</td>
</tr>
<tr>
<td>Highland</td>
<td>519</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>317</td>
</tr>
<tr>
<td>Lothian</td>
<td>399</td>
</tr>
<tr>
<td>Tayside</td>
<td>511</td>
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<tr>
<td>SCOTLAND</td>
<td>496</td>
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</tbody>
</table>
What if… all scheduled new clinics went ahead?
This analysis showed a significant number of cases where there were fewer than 42 weeks of activity for individual consultants. This would indicate that not all scheduled clinics are going ahead e.g. they may be cancelled for a valid reason but not reinstated if that reason is no longer an issue. Again, it should be noted that at national level it was not possible to identify and take account of part-time or locum consultants with a lower capacity.

What if… all slots at scheduled clinics were utilised?
This analysis showed a significant variation in the number of new patients seen each week by each consultant. This might indicate that not all scheduled new slots are being utilised for new patients. This offers the opportunity to consider appointing general neurology referrals to specialist clinics.

What if… all new appointments were 30 minutes & follow-ups were 15 minutes?
This analysis identified a potential saving of 331,215 minutes. If these were redeployed at the current new to return ratio an additional capacity for 6,900 new slots could be generated. This does not take account of certain sub-specialties and cases that are more complex than others and therefore require more time.

What if… some clinics ran for more than 42 weeks a year?
This scenario is only relevant where space is a rate limiting factor rather than consultant availability. This may be relevant at some Boards where other consultants can use the space for clinics in the weeks where the normal clinic is not running.

What if… all clinics ran for at least 4 hours?
The analysis identified a significant variation in the length of scheduled clinic times. A significant number of clinics are scheduled to run for only 2.5 hours. There may be historic reasons for this. The Task and Finish Group recommended that where possible these clinic profiles are re-negotiated as it is likely that a minimum of 4 hours is more efficient use of the time for all the staff involved.

As stated above, the Task and Finish Group recommend that all of the ‘What if…’ scenario analysis is undertaken by Boards at Board level and also at sub-specialty and consultant level to identify variation and improvement opportunities. The ‘Practical Guide to Achieving the 18 Weeks RTT Standard in Neurological Services’ then provides a wealth of improvement suggestions aimed at tackling each of the ‘what if…’ scenarios through different ways of working and efficient use of available skills.
4.4 Neurological Services Workforce

As outlined in the ‘Assessing the National Balance’ section, the Task and Finish Group believe that achieving a balance between demand, activity and capacity and therefore a reduction in queues in neurological services is not too far out of reach. It is up to each Board to determine how they can achieve a sustainable balance. The improvement opportunities identified by the Task and Finish Group and detailed in ‘A Practical Guide to Achieving the 18 Week RTT Standard’ (available on www.18weeks.scot.nhs.uk) will support Boards in making significant progress towards achieving a balance. The group recognises that some Boards may undertake detailed analysis and improvement projects and identify that a gap still exists between available capacity and predicted demand. This resource gap may be best met with a combination of additional neurologists, specialist nurses, GPwSIs, neurophysiologists, neurophysiology technicians or admin and clerical staff. Any planning of additional resource should take full account of the scope for extended roles and competencies.

There is at present considerable variation between boards in the number of neurologists per hundred thousand of population (e.g. Forth Valley – 1/190,000 and Fife 1/150,000 compared with Lothian, GG&C, Tayside and Grampian each 1/90,000) which does not appear to reflect differences in the incidence of neurological disease. N.B. some of this apparent inequality is explained by provision of neurological services in regional centres covering more than their own resident population and will be best understood at the local or regional level.

Detailed understanding of the Demand, Capacity, Activity and Queue balance and improvements that are achievable through redesign, will inform decision making regarding the requirement to employ additional staff. Further, Boards should be cognisant of the possibility that there may be considerable unmet need in the provision of outpatient neurology services (evidenced for instance in social inequalities in rates of referral), and that the introduction of the 18 Week RTT Standard may encourage GPs to refer patients (and the associated risk) for management in secondary care where this had previously been managed in primary care. In addition, the age related incidence of many neurological diseases, coupled with demographic change will create further demand on outpatient neurology services.

The Task and Finish Group considers it is likely that annual growth in demand of at least 5% per year will be seen over the next 5 years at least. As additional neurology workforce is likely to be required and given the long lead times involved, consideration should be given to this in Workforce Planning, both within Boards, in NES and in SGHD. The Task and Finish Group would welcome the commissioning of an academic led Scotland wide assessment of likely future needs for Neurology outpatient clinics (based on demographic factors, current inequalities in provision, likely future developments) as a prelude to a discussion of how these might best be met.

It will be important to match an increase in capacity to quantified need not infinite demand. As demand increases it will become increasingly important to identify which patients would benefit most from specialist consultant neurologist input and who could be cared for by other professionals in primary and secondary care.
5 Catalysts for Change

The Task and Finish Group believe that they have created a momentum for change within Neurological Services. The group recommend to all 18 Weeks teams, service managers and clinicians that there should be a continuing focussed improvement effort on neurological services. There are two key resources that can be used to focus the improvement effort. These are ‘A Practical Guide to Achieving 18 Weeks Referral to Treatment Standard in Neurological Services’ and the ‘Who’s Doing What Matrix’ (available on www.18weeks.scot.nhs.uk). A summary of both documents and contact details for discussing any elements of them have been included in Appendix B and C.

The Practical Guide encourages Boards to implement improvements which ensure effective use of capacity and decrease demand for secondary care appointments. This will reduce queues and improve the quality of neurological services and access to them along a referral to treatment pathway. Relatively small changes to a service can make it more effective and more responsive to the needs of people with long term neurological conditions. Working in partnership and ensuring the right person with the right skills is available to help an individual at the right time in their illness provides tangible benefits for the patient.

The Task and Finish Group recognise that not all ideas will be relevant to all Boards. Boards should, however, be encouraged to consider all suggested actions to develop their own improvement strategy. Service redesign and transformation, ongoing assessment of best practice and ongoing use of information to manage the service are all key to success. In particular, whole system working across primary and secondary care and linking with the Long Term Conditions agenda are essential (See Appendix D). To ensure a focus on quality, the QIS Standards for Neurological Services and 18 Weeks improvements should be implemented in parallel.

We hope that this report supports your local Action Planning process to drive delivery of the 18 Weeks RTT in Neurological Services in your board - Over to you!
Appendices

Appendix A – Task & Finish Group Membership

<table>
<thead>
<tr>
<th>Members</th>
<th>Board &amp; Role</th>
<th>Contact Email</th>
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<tbody>
<tr>
<td>Rosemary Lyness - Chair</td>
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<tr>
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Appendix B - ‘A Practical Guide to Achieving the 18 Weeks RTT Standard’

The diagram on the following page provides a summary of the ‘Practical Guide to Achieving the 18 Weeks RTT Standard’ prepared by the Task and Finish Group. It can be used as an input to the development of a local improvement action plan.

A full copy of the Practical Guide is available on (www.18weeks.scot.nhs.uk). If you would like to discuss any of the recommendations, please speak to your 18 Weeks Regional Manager.

North - Kerry.wilson@scotland.gsi.gov.uk, South & East – June.watters@scotland.gsi.gov.uk and West – Kirsty.murray@scotland.gsi.gov.uk
Scottish Government Health Directorates
Directorate of Delivery
Neurological Services Task & Finish Group

- Equity of access, Quality & Safety
- Make the most of your Workforce
- Enhance Primary / Secondary Care Relationship
- Ensure patients get on the right pathway
- Standardise & Improve Pathways
- Improve Patient Access
- Maximise the Value of Information
- Balance DCAQ
- Manage Waiting Lists & Clinic Slot Utilisation

Achieving 18 Wks RTT in Neurological Services

- Reduce variation in referral patterns
- Understand referral volumes
- Enable ‘Advice Only’ referrals
- Link with Long Term Conditions strategy

- Guidance at GPs finger-tips
- Effective e-referrals
- Efficient e-vetting

- Understand pathway segments & identify value-adding steps
- Remove waste / ensure flow
- Smooth hand-offs & encourage E-transfer

- Ensure user-friendly booking & Treat in Turn'
- Implement telemedicine facilities

- Pool lists
- Reduce DNAs
- Manage ‘Short-notice’ lists
- Manage return appointments differently

- Involve patients in redesign & transformation
- Link to Quality Standards

- Understand workforce capacity & skills
- Review extend roles

- Review access to tests & protocol criteria

- Ensure clinical outcome recording
- Analyse patient journeys for improvement
- Share best practice

- Understand & manage demand
- Optimise capacity & improve utilisation
- Reduce/remove queues
- Plan a sustainable service

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### Appendix C – Summary of Improvement Pilots & Best Practice Examples – Who is Doing What Matrix

Collated by the Task and Finish Group from information supplied by Boards (Full document available on www.18weeks.scot.nhs.uk).

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#### Key

- **Possible Pilot being Discussed**
  - Symbol = ☼
- **Pilot in Progress**
  - Project Outline with Timescales Available
    - Symbol = ☻
- **Pilot Complete**
  - Case Study with Evidence Available
    - Symbol = ☻

Updated by Dumfries & Galloway, Forth Valley and Greater Glasgow and Clyde in January 2010.

*If you would like to find out more about any of the projects please speak to your 18 Weeks Regional Manager*

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- **West** – Kirsty.murray@scotland.gsi.gov.uk
## Appendix D - Bibliography

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<th>Source</th>
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<td>Department of Health – Transforming Clinical Neurophysiology Diagnostic Services to Deliver 18 Weeks – A Good Practice Guide</td>
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<td>Association of British Neurologists – Good Job Planning Guide - 2006</td>
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