To: NHS Board CAMHS HEAT Leads
    NHS Board Psychological Therapies HEAT Leads

22 November 2012

Dear Colleague

Operationalisation of NHSScotland Waiting Times for Mental Health Access Targets

Over recent months we have been working with NHS Boards to assess the applicability of NHSScotland Waiting Times Guidance to the Psychological Therapies and CAMHS Access Targets. This included detailed work with two NHS Boards (NHS Greater Glasgow and Clyde and NHS Borders) and stakeholder sessions opened to representatives from all NHS Boards. Our aim was to provide guidance for NHS Boards on how they should be operationalising the waiting times principles set out in the NHSScotland Waiting Times within the context of Mental Health services and guidance on what data should be reported nationally. The following summarises the conclusions from this work:

1. For Mental Health Access Targets, NHS Boards have the option to make clock adjustments in line with NHSScotland Waiting Times Guidance. **However, these adjustments should be for reporting purposes only and should not determine clinical decisions on the timing of any offers of appointments to patients.**

2. Given how rarely unavailability and refusal of reasonable offer applies, NHS Boards may choose not to apply adjustments for unavailability and refusal of reasonable offers where the costs of adjusting IT systems and/or the costs of administering the adjustments are prohibitive. However, NHS Boards have the option to use them if cost effective to do so.

3. Due to the potential impact on deliverability of the target, it is recommended that all NHS Boards put systems in place for resetting the clock for DNA/CNA. **However, these adjustments should be for reporting purposes only and should not determine clinical decisions on the timing of any offers of appointments to patients.**

4. To ensure transparency of reporting and to aid interpretation of the data; the nationally published data on adjusted waits will highlight which of the three main adjustment categories are in use (ie DNA/CNA, unavailability, refusal of reasonable offer).
5. Nationally, judgements on performance will be made on the basis of adjusted waits. However, NHS Boards will also be asked to report unadjusted waits nationally as a balancing measure.

6. In addition to adjusted waits, all NHS Boards must report unadjusted waits at a local level to ensure that managers and clinicians remain sighted on the actual waiting times of individuals. Further NHS Boards need to ensure local breach reporting systems (based on unadjusted waits) are in place to understand the reasons why any individual waits longer than the target.

7. A 10% tolerance is initially applied nationally to the CAMHS 26/18 week target and the 18 weeks psychological therapies target. This will be reviewed by Oct 2013.

The rationale for these recommendations is summarised in Appendix A. If you have any questions or wish to discuss any of these recommendations further, please contact Ruth Glassborow, National Lead, Mental Health, Quality and Efficiency Support Team on ruth.glassborow@scotland.gsi.gov.uk in the first instance.

Yours Sincerely

Geoff Huggins
Head of Mental Health and Protection of Rights Division

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NHS Board Psychological Therapies Information Leads
NHS Board CAMHS Information Leads
Judith Stark, Principal Information Analyst, Waiting Times, ISD
Ruth Glassborow, National Lead, Mental Health, QuEST
Joyce Wardrope, Health Information Consultant, Access Support Division
Appendix A
Summary Report on the Application of NHSScotland Waiting Times Guidance to Mental Health HEAT Access Targets

1. Aim of report
The aim of this report is to make recommendations on the application of the NHSScotland Waiting Times Guidance (hereafter referred to as Waiting Times Guidance) to the CAMHS 26 week access target and the Psychological Therapies 18 week access target.

This report summarises the recommendations resulting from detailed work with CAMHS and Psychological Therapies services across two NHS Boards (Greater Glasgow & Clyde and Borders). These recommendations were developed following feedback on the test site work to three stakeholder workshops: one which was opened up to Psychological Therapies HEAT management, clinical and information leads from all NHS Boards; one which was opened up to CAMHS HEAT management, clinical and information leads from all NHS Boards and one with three service user representatives from VOX, which is a Scotland wide mental health service user representative organisation.

2. Recommendations
The following recommendations represent a pragmatic way forward that seeks to balance out the need to make fair judgements about NHS Boards performance, the need to maximise the incentives in the system to improve services for patients and the need to minimise the additional costs attached to collecting and reporting data. They do not imply any policy change to Waiting Times Guidance for mental health but seek to provide guidance for NHS Boards on how they should be operationalising Waiting Times Guidance in the context of Mental Health services and guidance on what data should be reported nationally. In producing these proposals the needs of the patients have remained central and this guidance on how Waiting Times Guidance should be operationalised across Mental Health services provides a structured approach to measuring and managing waiting times across NHSScotland, thus providing equity of service access for all patients.

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| 1. For Mental Health Access Targets, NHS Boards have the option to make clock adjustments in line with Waiting Times Guidance. **However, these adjustments should be for reporting purposes only and should not determine clinical decisions on the timing of any offers of appointments to patients.** | The test work highlighted that some patients will breach the 18/26 week target due to issues outside the control of the NHS Board. Therefore, to ensure NHS Boards are not unfairly judged as having breached the target, a mechanism is needed to control for this.  

The preferred option from 2 of the 3 stakeholder meetings was for breach reporting. However, because a number of Boards are moving Mental Health onto Waiting Times Guidance compliant systems, breach reporting is not a cost effective option. Therefore a pragmatic solution has been identified which means that, where clocks are reset, this is for reporting purposes only **and does not impact on the timing of any offers of appointments to patients.** This is the solution that is already in place for those CAMHS... |
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<td>services that are resetting waiting times clock. It recognises that it is rarely clinically appropriate in mental health services to reset the clock, whilst at the same time ensuring services are not judged as having failed to meet a target for an issue that may be outside their control. All NHS Board clinicians will take all reasonable steps to appropriately prioritise the waiting time priority for patients taking into account the patients clinical needs, the clinical needs of other patients waiting and the overall waiting time for all patients. This approach received clinical and managerial support in testing. Further work may be needed in some NHS Boards to ensure that in Mental Health their appointment booking systems do not automatically put the patient to the end of the queue when the clock is reset.</td>
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<td>2. Given how rarely unavailability and refusal of reasonable offer applies, NHS Boards may choose not to apply adjustments for unavailability and refusal of reasonable offers where the costs of adjusting IT systems and/or the costs of administering the adjustments are prohibitive. However, NHS Boards have the option to use them if cost effective to do so.</td>
<td>The test work highlighted that unavailability and refusal of a reasonable offer rarely impacts on mental health waiting times. However, DNA and CNA levels do impact and not adjusting for these is likely to result in significant numbers of patients breaching an 18/26 week target. Where Mental Health Services are on, or moving onto IT systems which are already Waiting Times Guidance compliant; the systems are set up to automatically adjust when relevant data is entered. In these situations there are likely to be considerable additional costs attached to not applying Waiting Times Guidance adjustments for unavailability and refusal of reasonable offers. However, where Mental Health Services are on systems that are not already Waiting Times Guidance compliant, the costs of making them Waiting Times Guidance compliant are likely to be considerable. Therefore, given how infrequently unavailability and refusal of reasonable offers appears to be an issue, the decision to adjust for these is left to local NHS Boards to make. <strong>This balances out the cost pressures that would be incurred by either moving 100% to unadjusted waits or 100% to adjusted waits.</strong> Those services on IT systems which are not Waiting Times Guidance compliant may want to consider the GG&amp;C Psychological Therapies approach which has enabled them to export data out of their existing systems and then adjust for DNA/CNA only. This allows them to report their performance activity without incurring the significant costs which would be attached to changing their processes so they can adjust for unavailability and refusal of reasonable offers. However, there are costs attached to the analyst time needed each month to make the adjustments in this way.</td>
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<td>3. Due to the potential impact on deliverability of the target, it is recommended that NHS Boards put systems in place for resetting the clock for DNA/CNA. However, these adjustments should be for reporting purposes only and should not determine clinical decisions on the timing of any offers of appointments to patients.</td>
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<td>4. To ensure transparency of reporting and to aid interpretation of the data; any nationally published data on adjusted waits is clear on which of the three main adjustment categories are in use.</td>
<td>When publishing national information it is important to be transparent about the level of comparability of different data sets. The recent work has highlighted considerable variation across NHS Boards in which adjustments are being applied to CAMHS services. These recommendations mean that this variability is likely to continue. Therefore it is not sufficient to simply report whether the data has been adjusted, the report needs to highlight which of the three main adjustment categories are in use.</td>
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| 5. That nationally, judgements on performance are made on the basis of adjusted waits. However, unadjusted waits are also reported as a balancing measure. | The adjusted data means that NHS Boards will be judged on their performance on issues that are within their control. However, asking NHS Boards to report unadjusted waits nationally as a ‘balancing measure’:  
  - ensures a continued understanding of the waiting times actually being experienced by patients.  
  - enables a comparison between the levels of adjustments being made by NHS Boards.  
  - enables any significant changes to levels of adjustments over time to be identified. |
| 6. That in addition to adjusted waits, all NHS Boards use unadjusted waits at a local level to ensure that managers and clinicians remain sighted on the actual waiting times of individuals. Further NHS Boards need to ensure local breach reporting systems (based on unadjusted waits) are in place to understand the reasons why any individual waits longer than the target. | Recent discussions with NHS Boards highlighted that some areas who were adjusting their CAMHS waits were not reporting or using unadjusted waiting times data locally. It is vital for improvement work that services remain focused on how long patients have actually waited to be seen and seek to understand the reasons why any person actually waits longer than 26/18 weeks. The necessity for this was summed up by a service user who highlighted that services need to “see the real picture, find out why not meeting the target and do something about the causes”.  
All the clinicians and service managers involved in the workshops agreed with this principle and the importance of them seeing unadjusted data locally and understanding the reasons behind breaches. |
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<td>7. A 10% tolerance is initially applied nationally to the CAMHS 26/18 week target and the 18 weeks psychological therapies target. <strong>This will be reviewed by Oct 2013.</strong></td>
<td>There will always be rare circumstances when, due to the complexity of the patient pathway, a waiting time target is breached. An example of this is an individual whose complex needs mean a protracted assessment period is needed to identify the most effective therapeutic response, including the rare situation where the challenges of the formulation are such that more than one clinical opinion is needed. Further, the immaturity of robust IT systems across mental health services, and the fact that in most NHS Boards multiple systems are in use, presents significant challenges to the measurement, management and delivery of this target. An initial 10% tolerance recognises these challenges and also reflects that this access target is a referral to treatment one and hence covers a patient journey rather than individual stages. However, this tolerance is simply to control for the above issues and should not detract from NHS Boards working towards seeing 100% of individuals in the target time. Further, the requirement for NHS Boards to have local breach reporting systems in place that identify why any individual waits over the target will ensure that a focus remains locally on all waits over 26/18 weeks and provide clarity on the reasons for any breaches that can then inform further work to improve access.</td>
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