

Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	25 January 2016
Board Sponsor:	Dr Mark Smith, Chief Operating Officer
Paper Author:	Sally Howard, Director of Service Transformation Shaun Carr, Directorate Manager – Cancer Services Karen Rowland, 18-week Lead David Garrett, Directorate Manager - Central Clinical Services
Subject:	18-Week Performance
Executive summary	
<p>This report updates the Board on a continuous programme of work to deliver 18-week performance.</p> <p>There is a further 12-month period of intensive work to conclude work started on data quality and to ensure that we are balancing our capacity to treat patients and demand for services and ensure best use of outpatient and theatre slots.</p>	
Links to strategic objectives	Enables <i>excellent outcomes; great experience; empowered skilled staff; and high productivity</i>
Identified risks and risk management actions	<p>The delivery of constitutional standards remains a key priority for the NHS. In recognition of the challenges and risks to delivery, a structured approach of oversight and support is being taken nationally and within BSUH. The volume of long waiting patients in our system means that we have been identified as one of the national 10 high-risk systems. Risks are as follows:</p> <p>Risk 1 - Patients wait too long for treatment with inefficient booking processes and significant rework.</p> <p>Risk 2 – Patients exercise choice and move to other providers and commissioners securing alternative capacity.</p> <p>Risk 3 – Action from regulator (NTDA) for not achieving NHS constitution access targets.</p> <p>Risk 4 – Commissioners applying contract penalties.</p> <p>Mitigations include: full implementation of the revised Patient Access Policy; training and support; improving the data suites; aligning capacity and demand at trust/specialty level; robust validation; directorate delivery of recovery plans; a clear focus on data quality to ensure accurate RTT outcomes are recorded.</p>
Resource Implications	Significant potential revenue implications.
Report history	Monthly exception reports on RTT performance have been made to the Board of Directors since 2014.

Action required by the Board of Directors

The Board is asked to note the current programmes of work underway and next steps and the associated risks in relation to the delivery of performance against the RTT standards.

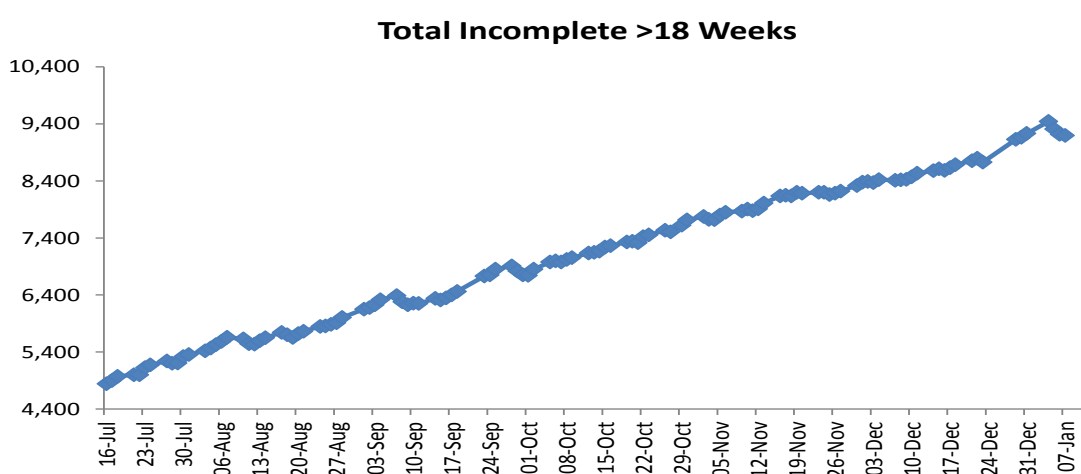
Report to the Board of Directors on 25 January 2016

18-Week Performance

1. 18-Week Performance

1.1 The operational standard is that 92% of patients who have not yet started treatment should be waiting no more than 18-weeks. At BSUH, we are currently reporting 75% of patients waiting no more than 18-weeks – continuing the trend of a 2% deterioration in position month on month since June 2015.

1.2 Of the circa 9,241 patients waiting over 18-weeks as at 12 January, there is a continuing deterioration in Digestive diseases (surgery) who account for 25% of this number and in neurosciences who hold 18%. The total increase in the incomplete position is shown below:



1.3 As reported previously there are a number of contributing factors including:

- The work to resolve the 11,447 patients with an uncertain clock status has resulted in some additional patients being added to the PTL who had waited more than 18-weeks (see *Appendix 1*). Routine validation also went on hold whilst this work was done;
- A genuine imbalance between capacity to treat and demand for service most notably in digestive diseases and neurosciences;
- A delay in the new referral service commissioned by Brighton and Hove CCG, which resulted in large numbers of referrals not coming through in a timely manner and an understatement of the number of patients waiting less than 18-weeks. This has only just been resolved;
- Cover for medical staffing in some key areas, notably junior doctors in oral surgery and consultant sickness in other key areas;
- Loss of activity as a result of industrial action and the level of cancellations at the Princess Royal Hospital and the Royal Sussex County where pressures for beds have resulted in cancellation of surgery on the day.

2. Overview of work underway

2.1 Directorate action plans are in place and each one has a weekly meeting now with their bookers to check overall position together with a 2/3 weekly review with the Deputy Chief Operating Officer for Scheduled Care and Chief Operating Officer as appropriate to check progress against these plans and overall position. However:

- Our basic clinical administration is at full stretch with insufficient rota co-ordination, validators, secretarial and booking resources in some areas and the need for urgent additional investment in Patient Access Managers. These staff work within a directorate, fully understand the daily demand for services and pressure points and troubleshoot solutions where possible;
- Two of our directorates – Abdominal Surgery & Medicine and Neurosciences – cannot resolve their long waiting times without additional help.

2.2 As a result and in addition to the work that was already underway including using a RTT Recovery fund of £1million for additional hospital capacity, internally and elsewhere, along with validation resource we are:

- Putting in targeted investment to a small number of key pressure points in clinical administration and in two Directorates - Abdominal Surgery & Medicine and Neurosciences - with dedicated senior business support and administrative support;
- Using other providers as far as possible for very long waiting patients who we cannot date within BSUH. BSUH currently has circa 100 patients who have waited over 52 weeks for their treatment and 25 of these are waiting for surgery under Digestive Diseases. These discussions are continuing;
- Following a really helpful meeting with the Chief Clinical Officer, Brighton and Hove CCG, Dr Steve Holmberg, Medical Director and other colleagues, working on actions including a revised script to ensure a consistent message to patients who understandably are calling to enquire as to when they may be treated;
- Working with commissioners and the national PMO who hold the ring on capacity in other hospitals to ensure we make best use of all capacity elsewhere;

2.3 We have also:

- Set in place a Digestive Diseases Recovery and Sustainability Taskforce, chaired by the Clinical Director and Directorate Manager, with resources drawn from the Operational Support Unit (OSU). The programme of work includes pathway changes including enabling some patients to be referred 'straight to test' without the need for an outpatient appointment, bringing together the booking teams and Patient Access Managers under one roof and making best use of what we do have available.
- Similar work will follow in neurosciences, where possible drawing on the expertise of Sussex MSK Partnership who are commissioned to provide MSK services across Sussex including spinal services;

- Had the first of a series of engagement with the National Intensive Support team to offer support over and above their current portfolio, including to the programmes of work in Abdominal Surgery & Medicine and neurosciences above;
 - Agreed that all the work of our current Data Quality and Performance meeting will now be focussed solely on getting the right systems and processes in place once and for all so we do not have patients who have an 'uncertain status' on our Patient Administration System going forward. This essential work was not getting the priority needed. In the meantime we have arranged for our PAS supplier to close down any clocks that should not be running in the first place;
 - Appointed a new Interim Deputy Chief Operating Officer for Scheduled Care to chair the regular directorate review meetings and provide additional senior leadership to this work, and enable the Director of Service Transformation to focus on delivering actual improvement;
 - Secured expert consultancy support to enable us to extend the automation of some of our current processes within the Centralised Booking Hub.
- 2.4 We have also submitted through our commissioners a revised trajectory for delivery of the 92% standard to the Trust Development authority (TDA). As presently stated, this does not deliver aggregate performance until December 2017.

The TDA shares our concerns about the proposed timescale for recovery and has called a tripartite meeting where we have been asked for a refreshed recovery plan that fully takes into account the benefits that will follow from the changes and investment above, from commissioner actions and the very intensive support from IST. That tripartite meeting is scheduled for 21 January.

Diagnostics

- 2.5 We will be reporting 293 breaches of the standard for December, a significant improvement against the October figure of 510. This represents a 5.43% performance against the 1% target. The reduction of the echocardiography backlog continues as planned along with improvements in Imaging. Endoscopy remains the focus and additional sessions are in place in January while further additional capacity is commissioned. Due to staffing constraints and the need to improve performance before the end of March this would be from an external supplier delivering the work within BSUH endoscopy facilities, details of which are being finalised now.

Cancer Services

- 2.6 The established weekly Cancer PTL meeting continues, with each individual speciality to ensure a review of all patients who may breach their cancer targets is undertaken and appropriate actions taken where possible to mitigate breaching patients. Directorate Managers and PAMS are expected to attend; we also have Radiology, pathology and CCG representation. Each meeting has minutes and agreed actions circulated. We have seen a marginal improvement in Pathology reporting and direct access is in place for the Lung ACE pathway, which launches on the 25 January 2016.

- 2.7 The two-week cancer wait has been delivered - the November position was 93.68%.
- 2.8 The delivered performance against the 62-day target, in November was 86%, which marginally exceeded our previous indication.
- 2.9 The current position for the 62-day pathway in December, which at this point is not a fully validated position, is 87.8%.
- 2.10 The 2WW compliance for December sits at 86.3% (1,468 patients seen, 200 out of target), which relates to the upper and lower GI backlog, Colorectal for December 2015 delivered 27% because 104 of the 142 patients seen breached the standard. Upper GI delivered 82% because 32 of the 175 patients seen breached.
- 2.11 A total of 492 patients are on the current list of patients who are undiagnosed, diagnosed and treated in the current month:
- There are 13.5 confirmed breaches of the standard in November;
 - 41 undiagnosed patients have already breached the 62-day standard and require a diagnostic outcome;
 - 190 undiagnosed patients have less than 31 days remaining on their pathway and require a diagnostic outcome.

The appropriate provision is in place to monitor all activity and individual patients on a daily basis.

3. **Conclusion**

The Board is asked to note the current programme of work underway, next steps and the associated risks in relation to the delivery of performance against the RTT standards.

Appendix 1

Update on patients with uncertain status

The intensive validation process was to address 11,447 patient records. Current figures show that of these 11,447 records:

- 10,105 have been closed – this includes records where the validation process showed that the patient was not awaiting treatment or has been treated.
- 34 records are for patients who have been identified for regular review; that might for example be an annual appointment.
- 200 records are for patients who the validation process showed should be on a waiting list for an inpatient procedure. These patients are now on the right waiting lists and will be seen in a timely way.
- 885 records are for patients who the validation process showed should be on a waiting list for an outpatient appointment. These patients are now on the right waiting lists and will be seen in a timely way.
- 223 records are going through a final checking process, which will complete in the next few days.

For all patients who have waited more than 52-weeks from referral to treatment, irrespective of the reason for this, the Clinical Lead for Planned Care has carried out a review of the notes. 160 patients in the intensive validation cohort were identified as having waited over 52-weeks from referral to treatment, of which 30 have not been treated at the time of writing this paper.