Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**24 August 2015**
Board Sponsor:	**Chief Operating Officer**
Paper Author:	**Director of Scheduled Care and Service Transformation**
Subject:	**18 week performance and centralised booking hub**

Executive summary

This report updates the Board on work underway to deliver and sustain 18-week performance, against the cancer standards and in relation to diagnostic services which form part of these pathways for patients. It also references work on the centralised booking hub.

The report describes performance in June and July against the 18 week Referral to treatment performance standards (the RTT standards). At present, we are showing a deteriorating position with an increase in the number of patients waiting more than 18 weeks for their treatment. Work is being finalised on a trajectory to deliver compliance against those standards and a programme of work is underway to improve overall performance and enable delivery.

Links to strategic objectives	Both programmes of work are designed to enable ***excellent outcomes; great experience; empowered skilled staff; and high productivity***
Identified risks and risk management actions	The delivery of constitutional standards remains a key priority for the NHS and in recognition of the challenges and risks to delivery, a structured approach of oversight and support is being taken nationally. In terms of RTT, providers have been segmented based on the incomplete performance for May 2015 and clearance times – that is how long it would take to treat the current volume of patients on the waiting list. 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 therefore as follows: Risk 1 - Patients wait too long for treatment with inefficient booking processes and significant rework. Risk 2 – Patients exercising choice and moving to other providers and commissioners securing alternative capacity. Risk 3 – Action from regulator (NTDA) for not achieving NHS constitution access targets. Risk 4 – Commissioners applying contract penalties. Mitigations include: training; full implementation of the revised

	Patient Access policy; developing the reporting methodology and Patient Tracking Lists (PTLs; 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 completed and plans for patients commenced (TCI).
Resource implications	Significant potential revenue implications
Report history	Monthly exception reports on RTT performance have been made to the Board from September 2014

Action required by the Board

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

Report to the Board of Directors, 24 August 2015

18 week performance and centralised booking hub

1. 18 Week Performance

1.1. The three 18 week standards from referral to treatment are:

- 90% admitted patients should start consultant-led treatment within 18 weeks of referral.
- 95% of non-admitted patients should start consultant-led treatment within 18 weeks of referral.
- 92% of patients who have not yet started treatment should be waiting no more than 18 weeks (Incomplete standard).

Performance from April to July 2015 is set out below. There will be a change in the monitoring arrangements in the Autumn following Sir Bruce Keogh's recommendation that trusts will only report on Incomplete pathways (the total size of the waiting list) but the actions that we are required to take will remain as set out below.

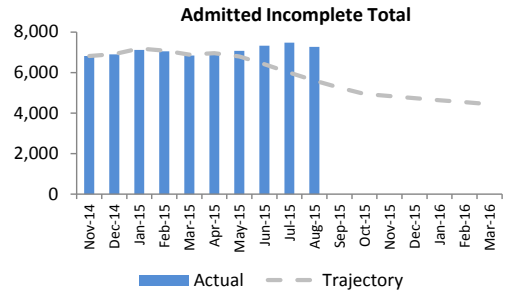
	Target	**Performance April**	**Performance May**	**Performance June**	**Indicative performance July**
Admitted Pathways	90%	71.5%	72.24%	72.29%	73.17%
Non-admitted Pathways	95%	88.9%	90.8%	87.86%	85.20%
Incomplete Pathways	92%	87%	87.19%	87.2%	84.89%

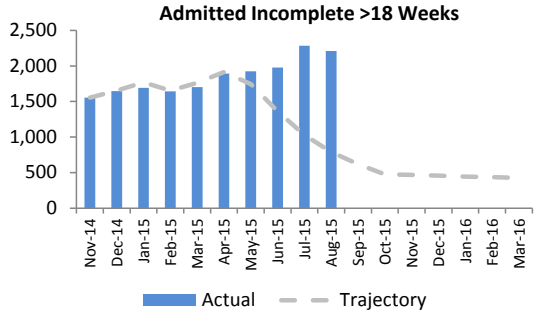
1.5 The original draft RTT Trajectory prepared during business planning assumed compliance from October 2015. However this included a number of assumptions from individual Directorates around additional capacity that are not affordable or in some cases practical in particular use of the independent sector and additional consultant appointments and sessions.

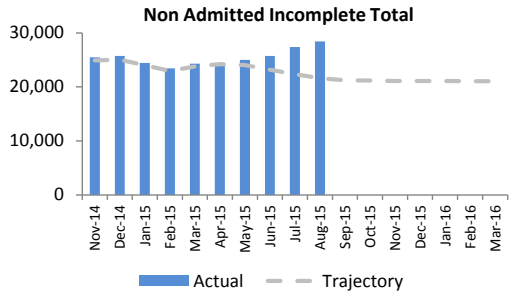
We are also seeing a spike in the number of patients waiting over 18W of 1054 patients, the majority in Head and Neck, Neurology, digestive diseases (surgical) and paediatrics (ENT). These specialties also make up 74% of the total patients waiting over 18 weeks with MSK (as one of the largest services) holding 18% of the balance. Consequently, we are now part of the national 10 high-risk systems.

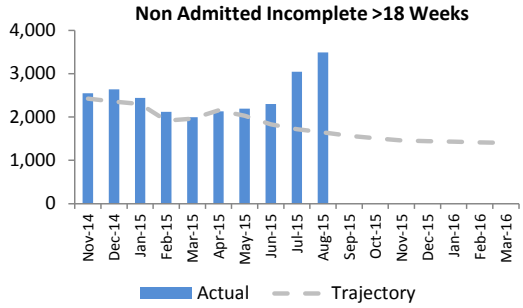
1.6 Current level of performance against the RTT standard means we can no longer ensure delivery in October 2015. We remain with continuing pressures from unscheduled care, a significant imbalance between capacity and demand in the specialities above and further work to do to ensure that our internal systems and processes are in line with our new Patient Access Policy.

We anticipate that it will be a further 9-12 months from now before we are in a position to report aggregate compliance and compliance by speciality (some specialties maybe even longer given the size of their backlogs). The graphs below illustrate the size of the challenge. The number waiting over 18 weeks is growing with 5701 patients waiting as at 18 August 2015:









1.7 The delivery of constitutional standards remains a key priority for the NHS and in recognition of the challenges and risks to delivery, a structured approach of oversight and support is being taken nationally. In terms of RTT, providers have been segmented based on the incomplete performance for May 2015 and clearance times – that is how long it would take to treat the current volume of patients on the waiting list. The volume of long waiting patients in our system means that we have been identified as one of the national ten high-risk systems. As such, we have been asked to complete a monthly template, which will be sent separately, and our performance and return will be reported and reviewed at a national level.

1.8 Each Directorate is re-working the assumptions that were made earlier in the year within the financial envelope that is actually available and providing assurance that they are:

- Delivering to contract unless that is simply not possible within the resource available;
- Following the Trust's annual leave policy in relation to a minimum of 6 weeks' notice of annual leave or study leave;
- Have an agreement in place for maximum number of consultants away at one time;
- Have completed job plans for this year.

1.9 We have a number of high-risk specialties, digestive diseases (surgery), head and neck, neurosciences (neurology and spinal), trauma and orthopaedics, where there are mismatches between demand for services and capacity to treat. Intensive work is underway to ensure a realistic trajectory for reducing the waiting time for these patients. However additional resource will only be allocated where there is clear evidence that all measures are in place to maximise the use of current resources. All Directorates are finalising their figures at the time of writing and will formally sign off their plans following review with the Chief Operating Officer.

1.10 In addition we have a delivery and development programme and are:

- Strengthening and re-energising the performance management system. This will include clinical directors engagement in a new group to be chaired by the Chief Operating Officer;

- Securing intensive training for a range of staff including Patient Access Managers and Directorate Managers on capacity and demand planning and working closely with high risk specialties to ensure capacity and demand are in balance;

- Fully implementing the new Patient Access Policy. Work is already underway on a comprehensive competency based training programme and we are running IST led sessions with individual clinical teams to ensure absolute compliance across the different patient pathways;

- In terms of data quality:

    - Completing a patient by patient review of the waiting list entries for longer waiting patients in high risk specialties so we can be absolutely confident we are not holding patients on our lists who do not need to be there;
    - Ensuring all our Directorates have session(s) booked at their next clinical governance forum to review current practice in relation to completion of clinic outcome sheets which are fundamental to correct data capture in 18 weeks;

- In addition, a half-day seminar is scheduled for September 2015 for both booking staff and clinical leads to ensure everyone knows what is expected. We have a patient speaker and case studies identified together with interactive sessions so everyone knows what is expected.

1.11 Significant additional capacity is not affordable and it will therefore take longer for us to deliver the required reduction in waiting times for our patients. Our analysis suggests a further nine to twelve months from now because a sustainable approach through efficiency measures and work around data quality takes longer to embed.

1.12 We will also focus on the total volume of cancellations and our ability to re-book patients within 28 days where our performance is well below standard.

1.13 The NHS IMAS Intensive Support Team (IST) continues to work with us and is currently working with our clinical teams to assure the quality of our data capture.

Cancer services

1.14 In terms of delivery of a service to our cancer patients, we remain with a significant challenge around the timely booking of slots for surgery (62 day wait from urgent GP referral to starting first treatment). Our improvement plans for cancer standards are aligned with the 8 High Impact Changes for Cancer and a separate report forms part of the Board papers.

Diagnostics

1.15 As reported previously we already had challenges in cardiac CT – demand exceeding supply - and in MRI where we have the machines in need of urgent replacement, scheduled for December

2015. However, it became apparent in June this year that we had been excluding consultant referrals for echocardiograms from the monthly diagnostic return in error. All direct access referrals – that is referrals from GPs – were being seen well within the 6 week waiting time for diagnostic services and recorded correctly.

1.16 This is turn prompted us to:

- Ensure any potentially urgent referrals were seen straight away – this has been done – no harm had come to any patients who waited over 6 weeks;
- Thereafter begin work with our treating clinicians to assign patients awaiting echocardiograms into:
    - 'planned' (needs to be done at a particular time and not before) and
    - diagnostic (needs to be done within 6 weeks to enable diagnosis)
- This work is half way through and will be completed in by the end of August so we can report any patients on diagnostic pathways awaiting echocardiogram over 6 weeks.

1.17 We also completed a full and thorough check that we were correctly reporting activity across all other modalities. We found that we were under reporting our activity on sleep studies and in relation to urodynamic tests for gynaecology patients seen at Lewes Victoria Hospital. Although relatively small services the reporting of these numbers has led to a deterioration in performance against the 1% target down to 4.1% in June and a slightly improved position of 2.9% in July. Both areas are putting plans in place to catch up and expect to be back on track within the next 4 months.

1.18 A weekly diagnostic meeting has also been put in place and is working well. We are using this meeting to ensure consistency in recording practice across all our diagnostic modalities which sit across 5 of our 12 Directorates and to anticipate and manage issues before they become problems that result in a delay for our patients.

Data quality

1.19 Rather than assuming that our recording of performance is correct unless told otherwise we have actively encouraged clinical teams to come forward to identify any issues that may be out of step with the new Patient Access Policy and arranged a diagnostic slot with IST to check practice. There is an audit and sign off process behind this work. Our internal audit team will begin a separate programme of work in September to provide the necessary Board assurance that recording is in line with national requirements.

1.20 All of this work is further supported by:

- Taking the learning from our work on Values and Behaviours as we engage and enable our clinical teams to perform at their best;
- Ensuring an absolute focus on delivery of scheduled (as well as unscheduled) care through our performance reviews and in our daily conversations;

- Strengthening senior management presence at PRH (our major elective site) to ensure that we maximize the use of this hospital as our major elective centre;
- Ensuring individual staff objectives and appraisal focus 100% on the delivery of this agenda;
- Strengthening support from IST over the next 6 months at least.

2 Centralised booking hub

2.1 As reported since November, the Booking Centre is continuing to work to 4 high level objectives. This work also forms part of the Service Development Improvement Plan, part of our contract for 2015/16. The programme of work thus far has served to stabilise the booking hub and we are now planning the second phase of this work, which will run from September onwards. Detailed assurance has been given through the CQC compliance action report.

3 Conclusion

3.1 Overall we remain with significant risk in relation to delivery but the actions in train will help to ensure we build internal capability, performance management and develop a set of robust trajectories that will deliver the required performance.

4 Recommendation

4.1 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.

Sally Howard
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August 2015