Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**23rd February 2015**
Board Sponsor:	**Chief Financial Officer**
Paper Author:	**Director of Scheduled Care and Service Transformation**
Subject:	**18 week referral to treatment position and centralised booking hub**

Executive summary

The report provides an update to the Board of Directors on:

- The revised trajectory to enable sustained delivery of the 18 week standard from referral to treatment (RTT)
- The centralised booking hub

The delivery of this programme has been challenging during the most recent period with higher levels of cancellations, due to unscheduled care pressures. The Trust has committed to reducing the number of long waiting patients by 31st March 2014, with the most pressured specialties being digestive diseases surgical and spinal services.

Work continues to deliver a sustainable and RTT position and to deliver the 5 high level actions to improve performance in the central booking hub.

Links to strategic objectives	Best and Safest Care √ High Performing √
Identified risks and risk management actions	• Risk of patients waiting longer for treatment • Risk of urgent patients waiting longer to be assessed • Risk of capacity not fully utilised • Financial risk with additional resources required to ensure overall activity is not reduced • Risk of potential harm to patients
Resource implications	Revenue and service implications
Legal implications	Breach of the NHS Constitution
Report history	Board of Directors – regular updates
Appendices	(1) Joint Implementation Plan (2) Values and Behaviours Bulletin

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.

Report to the Board of Directors, 23rd February 2015

18 Week Referral to Treatment Position

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.

1.2. RTT performance has been significantly challenged since the end of Q2 and BSUH has worked with commissioners to implement an RTT Delivery Plan to achieve compliance and improve patient experience with a refreshed and clear focus to achieve aggregate compliance:

- Making maximum use of internal capacity already available;
- Additional outpatient and inpatient (theatre sessions) secured internally and in the independent sector;
- An absolute focus on data quality;
- Capacity and demand modelling to sustain performance going forward.

This is enabled by a strong operational focus, rigorous performance management through weekly performance management meetings and weekly individual speciality review meetings focussed on the additional activity and the accuracy of data.

1.3. The execution of this programme during the winter period has been extremely challenging and levels of cancellations have been high, due to extreme unscheduled care pressures. Whilst we have been able to undertake the most serious cases our elective work has been significantly compromised. This has been an issue nationally for the NHS and has received national media attention.

In December 2014 77 operations were cancelled on the day of surgery – 34 were classified as urgent and 7 were cancelled twice. Five patient operations were cancelled the day before planned surgery.

In January 2015 95 operations were cancelled on the day of surgery - one third were classified as urgent and 6 were cancelled twice. The day before planned surgery operations were cancelled for 129 patients.

Norovirus at Princess Royal Hospital in February has resulted in further cancellations as affected wards have been closed to new admissions for infection prevention and control reasons.

These cancellations have impacted on the service received by patients and on the workload of BSUH

- Our patients have not received the service that we would want to deliver
- We have not been able to utilize theatre time effectively
- The booking teams have been working hard to arrange additional slots for these patients.

1.4. In recognition of the level of risk across the system, TDA asked that all Trusts maintain an absolute focus on the longest waiting patients during the month of February whilst continuing to ensure timely care and treatment for urgent cases. BSUH started the month with a total of 4304 cases waiting longer than 18 weeks for their treatment – that is 200 higher than at the end of December 2014 - and has committed to reduce the number of long waiting patients down to 3750.

1.5. The actions taken in February to achieve this reduction on long waiting patients include:

- Working to bring forward outpatient appointments booked outside their 18 week breach date into additional clinics to be run either internally or in the independent sector, focussing on the specialties with significant numbers of long waiting patients - *gastroenterology, neurology, neurosurgery, oral surgery, ophthalmology and paediatrics*
- Using additional focus on administrative and clinical validation to intensify administrative and clinical validation;

We investigated use of endoscopy lists in independent sector but this has not been possible to achieve within the timeframe.

1.6. Digestive Diseases (surgical) and spinal patients will make up over half of the total number of patients still waiting longer than 18 weeks following delivery of the 3750 target. We have used the IST modelling tools to understand number of patients who need to be treated and the additional resources that are required in order to ensure sustained delivery going forward.

Digestive diseases surgical

Action is already underway in this speciality:

- 'Routine' patients in Brighton and Hove are being told the indicative wait time for a BSUH outpatient appointment (currently 16-18 weeks) and offered a choice of alternative providers. Of the 290 patients referred since end of December 179 have chosen to go to another provider;
- We are continuing to outsource into the Independent Sector. A total of 460 will be seen by end of March with one third already completed and 102 elective cases to be completed.

A continuation of these arrangements over the next 5 months will enable the service to treat its longest waiting patients.

The additional work completed thus far has resulted in an additional pressure in relation to delivery of endoscopy waits and, this, in combination with our needing to use the endoscopy suite at the Royal Surrey County Hospital has resulted in 87 additional breaches of the 6 week diagnostic target. A recovery plan will be put in place to ensure that we are able to catch up on this work going forward.

Spinal

This is a small service and the recovery time will therefore be greater. Options to safely manage patients in the independent sector are also limited.

Two neurosurgeons specialising in spinal work have recently been recruited in addition to the existing two spinal consultants.

Inpatient demand continues to outstrip capacity and the MSK and Neuroscience Directorate Teams are meeting later this month to begin the detailed planning around use of capacity within the integrated service. In the meantime resource is focussed on ensuring that our longest waiting in-patients are treated.

Oral surgery

1.7. Discussions are also continuing in oral surgery where we are still seeing increased demand for patients who could be treated outside the hospital setting. CCG colleagues remain in discussion with NHS England at the time of writing to put in place alternative pathways.

1.8. Performance in January is expected to be as follows(subject to final validation)::

	National Standard	Actual Performance
Admitted Care	90%	75.3%
Non-admitted Care	95%	87.7%
Incomplete backlog	8%	12.5%

There was one breach of the 52 weeks standard in spinal services. The patient was only willing to have surgery under the care of her current consultant and arrangements are now in place for surgery to go ahead.

1.9 The original modelling is being refreshed to ensure we have taken account of both the impact of the significant volume of cancellations and the continuing work to reduce the total number of patients waiting over 18 weeks.

1.9. We continue to work with our commissioners and other providers to deliver a sustainable RTT position and the Joint Action Plan is attached at Appendix One.

1.10. The Patient Access Policy has now been re-drafted following review by the National Intensive Support Team to make it easier to follow. It will go for consultation with CCG colleagues before final sign off by the Board in April. Thereafter we will need to put in place an internal training programme and monitoring and ensure compliance with mandated rules and standards.

1.11. The team has also checked that patients with incomplete pathways who sit outside the 18W data return are appropriately assigned - . Our internal team with help from external expert support have sampled and validated over 7000 patients and the results are now being drawn together into a single report which will provide an appropriate level of re-assurance and a summary of the additional data quality issues that need to be addressed.

1.12. In terms of delivery of a service to our cancer patients, the position for elective procedures in January has remained stable, with no greater volume of cancellations than the previous month, but both elective cancer and diagnostic work has continued to be cancelled as a result of emergency pressures and this has caused distress to patients awaiting their treatment. We delivered on the 62 day standard (62 day wait from urgent GP referral to starting first treatment) for the month of December.

The key issues have been the route to diagnostics, with endoscopy, flexi-cystoscopy and elective general anaesthetic (GA) diagnostic cancellations, due to extra diagnostic areas being used for extra capacity or elective cancellations preventing diagnostic GA procedures taking place.

In order to help improve the current situation the Cancer Directorate is in discussion with Queen Victoria Hospital NHS Trust in East Grinstead on additional capacity for our head and neck cancer patients and arrangements are being made for urgent urology patients to have their surgery in the independent sector. The Directorate manager and our Clinical Directors are also actively involved daily to ensure that we continue to minimise the last minute cancellation of cases, ensuring that those with cancer and other life threatening conditions are the last to be cancelled and only when the hospital finds itself in extreme circumstances.

2. Centralised booking hub

2.1. As reported since November we now have 5 high level actions:

1. Ensure that we book all patients within 5 working days
2. Maximise use of clinic capacity with patients assigned to the right clinic first time through partial booking, triage efficiency and ensuring that the right letter with the right details reaches the patient.
3. An absolute focus on eliminating missed calls with an initial target for all calls to be answered within one minute
4. Fully engage with our clinical directorates to minimise clinics cancelled with less than 6 weeks' notice and ensure a 6 week look ahead for all clinicians so they and the booking team have a shared understanding of the work to be done and can work together to resolve queries as they arise.
5. Introduce a Patient Focussed Booking Programme convenient for all patients. This will follow on once we have made sufficient progress on objectives one to four.

Patients need certainty of appointment and communication of the highest standard. Progress to date is set out below.

2.2. **One. Ensure that we book all patients within 5 working days**

The hub is booking, on average, 1229 patients a day, a combination of new and follow up appointments. The booking team is adding patients to the system within 24 hours of referral being received and we are now working towards clinical triage within 48 hours. The current referral management software (RMS) is not as clear as it could be for end users and we have purchased an upgrade to the software which will add a triage code. This will allow consultants to choose from a drop down menu listing relevant triage codes, rather than entering free text. This is designed to make it easier to use and minimise the chance of booking s to the incorrect clinic. This will be a mandatory field and will therefore ensure clear booking instructions are provided to the booking team.

The date of triage will be added to results reporting. This will allow us to identify the time lapse between referral receipt and consultant triage so we can monitor our progress triaging patients within the next 48 hours, a key component of booking appointments within 5 working days.

Figures for January indicate that we are booking 73% of patients within 5 days but there are still some specialties with longer waits where patients cannot be dated to a clinic on receipt because there are no available slots within the next 6 weeks. These are being targeted as part of the RTT work referenced earlier in this paper.

2.3. **Two. Maximise use of clinic capacity with patients assigned to the right clinic first time through partial booking, triage efficiency and ensuring that the right letter with the right details reaches the patient**

The RMS upgrade already referenced will help us allocate patients to the 'right clinic first time'. We will also be adding an interface between RMS and our patient administration system (PAS) to automatically populate new RMS patient records with their unique patient details. This will include an automatic data quality check that will flag up any need to update patient demographics on PAS. This will help us to ensure that we send letters to the correct address.

In the meantime the hub is now working to the following rules in terms of appointment letters:

Over 10 working days' notice	Letter by second class post
8-10 working days' notice	First class post
7 working days or less	Telephone the patient to agree date and time and note the call the PAS record

This is supported by text reminders where patients have given their mobile number. We are also looking to change to two way messaging so patients can cancel by text if they are unable to attend.

The proxy measure we are using at present is DNA rates which are around 8/9 % in most specialties, although there are a few examples of higher and lower DNA rates.

Recent analysis showed that although calls were made to patients over the Christmas period they still did not attend their clinical appointments and we would like to actively address this once we have more confidence that our systems are 100% reliable. This will include publicising the DNA figures more widely and work with patient groups to understand what else we can do to bring about a reduction in these numbers.

2.4. **Three. An absolute focus on eliminating missed calls with all calls to be answered within one minute in the first instance**

In January 2015 there was an average of 1134 calls (range 900-1800) a day with 90% answered within 51 seconds. For February we are showing 98% of calls answered within 20 seconds. This is a much improved position from July when performance of calls answered was 60.9% with an average pick up time of just under 2 minutes. In the event of booking hub staff being unable to deal with the call they are passing the caller to a specialty lead to avoid a dropped call and therefore a repeat caller. Details from each call are noted on PAS including date and time to enable an audit and reference point for later queries.

2.5. **Four. Fully engage with our clinical directorates to minimise clinics cancelled with less than 6 weeks' notice and ensure a 6 week look ahead for all clinicians so they and the booking team have a shared understanding of the work to be done and can work together to resolve queries as they arise.**

A simpler 'look forward' report was developed for clinical teams to check the clinic schedule. In terms of the current performance, in January we saw a total of 1204 clinics cancelled, 121 with less than 6 weeks' notice impacting on 532 patients.

As referenced in the January Values and Behaviours work on 'process amnesty' (Appendix Two) the team has worked with systems experts to redesign the process for clinic cancellations. An improved manual process is already in place and this new technical solution will make it easier for the requests to pass through the relevant authorisations with records held on a central data base to assist our monitoring and reporting of the reasons for cancelled clinics. The system requires some further development and is intended for implementation in April 2015. Reducing clinic cancellations e would have a positive impact on the staffing budget which is currently overspent.

2.6. All the enhancements described assist us achieve a more accurate processes, bring improved booking efficiency to our patients. First time accuracy will potentially reduce our DNAs rates (i.e. patients not getting letters), reduce the need for re-work caused by appointments being booked into the wrong clinics from to unclear instructions/processes, and increase clinic utilisation.

2.7. The team has also addressed outstanding queries on datix and were also invaluable contributors to an investigation team focussing on a serious incident.

2.8. These initiatives represent a significant continuous improvement programme and require proper resourcing. With this in mind we are establishing a dedicated senior development and transformation lead to work alongside the new manager joining the Trust as Head of Centralised Booking and Clinical Administration Services to continue the work started and embed systematic and sustained change.

The Head of Service will initially focus on the introduction of service level agreements with our Clinical Directorates that will clearly set out responsibilities across all clinical administration services.

This will involve a wide range of stakeholders to ensure that we build our service – both the booking hub and all the other associated clinical administration services –to enable our patients and clinicians to know and trust the services.

The Development and Transformation Lead will work on the development and delivery of system wide changes which aim to deliver a gold standard service for our patients and clinical teams. This will include the roll out of a competency based training programme for all administration staff, ensuring the patient access policy is understood and adhered to, data quality is improved and motivate staff to truly value the importance of excellence communications and data entries that are right first time, every time.

The initial results of our work thus far have already been shared this month with CCG colleagues and a key patient representative and discussions are now following on about how we can ensure our patients feel comfortable to ask their treating clinician about their plan for treatment and next steps and how we can ensure that local GPs are clear about waiting times so there are no surprises for GP or patient.

2.9. It is difficult to accurately assess the qualitative and quantifiable benefits, especially the monetary efficiency from pay cost reduction but by reducing inefficiency, the booking team's costs can be planned and controlled. The inefficiencies still exist following the introduction of the booking hub back in October 2013. Savings assumed from day one have therefore not been delivered. The 2015/16 budget is now being re-based with a two phase approach: phase one – utilising the business planning process to assess staffing levels to meet current demand and phase two: to reflect system improvements and benchmarking against other booking centres, to rebase staffing needs.

3. Conclusion

3.1. As reported previously, work in relation to RTT still requires a significant programme of work and is not without risk, particularly with our continued pressures on unscheduled care. That said, RTT continues to receive an absolute focus at BSUH through weekly performance management meetings, Directorate Performance Management meetings, Clinical Management Board, Executive Management Board and individual speciality meetings, also through the Single Performance Conversation and the Local Health Economy Scheduled Care Board. A review of the issues surrounding the management of the RTT targets during 2014 is also being completed so that lessons for the future can be identified and learned.

3.2. In terms of the Booking Hub we have identified a clear improvement programme and put robust measures in place to ensure that the Booking Hub delivers a gold standard service along with processes and regular audits of performance to ensure that small problems never again develop into massive threats to the delivery of best and safest care.

3.3. We would also want to ensure continued clinical leadership and support going forward. Both Dr Jonathan Andrews and Dr Simon Thorp have made a real difference to the way we have been able to engage intelligently with our clinicians on both RTT and on our providing the highest standards of clinical administration.

Sally Howard
Director of Scheduled Care and Service Transformation
12 February 2015

Appendix One - Joint Implementation Plan – RTT – Page 1 of 2

1	**Maximise internal efficiency**			
1.1	Request the each Directorate maximised its efficiency and ensure regular review at weekly RTT meetings	01/11/2014	30/11/2014	100%
1.2	Cross check current position withcentral booking hub to understand barriers to booking and potential solutions	01/11/2014	30/11/2014	100%
1.3	Agree clear objectives for booking hub going forward and monitor weekly	15/11/2014	31/03/2015	50%
1.4	Tighten theatre allocation process so all dropped templated lists are re-allocated to speciality with the most to do	01/12/2014	31/03/2015	40%
1.5	Redesign admin process to ensure that each speciality communicates clearly with the booking hub and that no clinic is canx <6 weeks notice	01/12/2014	31/03/2015	50%
2	**Put in place a full and thorough plan for validation**			
2.1	Strengthen leadership of current validation team to ensure they focus on correct priorites	01/10/2014	31/10/2014	100%
2.2	Ensure full clinical review and audit trail for any patient who has breached 52W using east sussex approach and with engagement from CCG clinical lead	01/11/2014	31/01/2015	50%
2.3	Put in place clinical validation of all patients who have waited >42W	01/10/2014	31/10/2014	100%
2.4	Secure substantive funding for current validation team	01/11/2014	04/12/2014	100%
3	**Continue with outsourcing programme to minimise wait times for patients**			
3.1	Identify additional requirements by sub-specialty and source additional capacity to deliver in line with service requirements	01/12/2014	31/12/2014	100%
3.2	Maximise contribution from national 10-15 week programme and set in place programme infrastructure	12/12/2014	31/03/2015	50%
4	**Validate patients with a clock start but no further treatment pending at present who are not currently reported on the PTL**			
4.1	Secure external support to validate patients with a clock start but no further treatment pending at present	15/11/2014	01/12/2014	100%
4.2	Set contract in place	01/12/2014	05/12/2014	50%
4.3	Put in place a training programme for the team and bEgin validation from 4 December with daily feedback reports	05/12/2014	16/03/2015	70%
5	**Undertake comprehensive C&D modelling with four highest risk specialites - spinal, DD Surg, Neurosciences and Urology**			
5.1	Secure IST support to enable this work to go forward at pace	15/11/2014	01/12/2014	100%
5.2	Hold introductory workshop	15/11/2014	01/12/2014	100%
5.3	Secured additional business management support for C&D modelling in spinal services and DD surgery	01/12/2014	31/12/2014	100%

6	**Identify and actively manage growth specialities / those that were in alignment but now have a new imbalance between capacity and demand**			
6.1	Dermatology - CCG had awarded the contract to a new provider but arrangements fell through. Plan to now catch up the backlog that has grown meanwhile.	01/12/2014	31/01/2015	100%
6.2	Oral surgery - CCG in d/w LAT to either introduce a triage or IMOS service	01/12/2014	31/03/2015	50%
7	**Review Patient Access Policy**			
7.1	Secure IST review of policy against their RAG status	15/11/2014	01/12/2014	100%
7.2	Review and adapt policy accordingly	01/01/2015	16/01/2015	75%
7.3	D/W Internal Audit who were asked to conduct a review also	15/12/2014	16/01/2015	100%
7.4	Review with CCG and patient groups and secure internal and external sign off	16/01/2015	16/03/2015	0%
7.5	Roll out training programme across all booking staff to ensure full compliance and put in place monitoring to ensure delivery against key standards	31/01/2015	31/03/2015	0%
8	**Develop a rolling programme to ensure data quality**			
8.1	Use the learning from current validation to develop a 'dos and don'ts' list for use across all services.	06/01/2015	31/03/2015	0%
8.2	Clarify the expected contribution of patient access managers to ensure consistency across all services and ensure delivery.	01/01/2015	31/03/2015	50%
8.3	Introduce a new and senior 'trouble shooting' resource within the new validation team to work with service users on remedying common errors.	06/01/2015	31/03/2015	25%
8.4	Introduce a competency framework for all service users and ensure compliance.	01/04/2015	31/05/2015	0%

Appendix two

Extract from Values and Behaviours Bulletin January 2015

A better process for clinic management in the Booking Hub

You may remember that before Christmas we asked you to tell us what processes you would like to see changed, fixed or done away with altogether as part of a **V&B process amnesty**? There was a great response (over a hundred submissions) and you told us about lots of organisational 'treacle' which stops you working effectively and efficiently. The submissions were prioritised and some were chosen to improve which would give the most benefits using the project resources and time available. One of these was the **Booking Centre Clinic Management process**

What was the problem with the clinic management process?

There was a lack of awareness about what happened when a clinic was cancelled
There were no clear roles and responsibilities
Both patients and staff had a frustrating experience managing clinics and appointments, especially when clinics were cancelled more than once
It was taking a really long time to sort out the admin after a clinic was cancelled

Main aims of improving the process were to reduce:

the number of cancelled clinics and to increase the number of clinics available
the cost of processing cancelled clinics
the number of patients affected by cancelled clinics and them being cancelled more than twice

How did staff improve the process?

A series of five workshops were held to identify how improvements could be made:
A vision for the Booking Centre service was devised with measureable objectives
A detailed review of the current process was carried out and all the issued were identified
A new, draft process for clinic management was produced with clear requirements
New roles and responsibilities were assigned to everyone involved in the process

How is the clinic management process going to get better for staff and patients as a result?

There will be a completely new process and a new digital solution to replace the existing form
The Booking Centre will then regularly feedback to the directorates on clinic management activity
The Booking Centre will continually test the process with staff and use their feedback to keep improving
There will be two people in each directorate to act as gatekeepers for clinic management requests, who will be given training and support on the new clinic management process
New roles and responsibilities will be agreed between the Booking Centre and the directorates to ensure the new process works

The end result is a clear process for staff which will mean better care for patients, with clinics being cancelled less frequently and patients being re-booked more quickly. If you would like to know more about the new clinic management process please contact Niki Porter on Trust email.