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| **Meeting:** | **Brighton and Sussex University Hospitals NHS Trust**<br>**Board of Directors** |
| **Date:** | **30 March 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**

To provide an update to the Board of Directors on work underway on two key areas in relation to scheduled care:

- Delivery of the 18 week standard from referral to treatment (RTT), ensuring that this performance is then maintained and with appropriate monitoring arrangements in place so we identify and deal with any potential issues before they become significant problems;
- Work to ensure that the Centralised Booking Hub is able to deliver its key objectives going forward and provide a booking service of the highest standard.

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| **Links to strategic objectives** | Best and Safest Care √<br><br>High Performing √ |
| **Identified risks and risk management actions** | • Patients waiting longer for treatment<br>• Urgent patients waiting longer to be assessed<br>• Capacity not fully utilised<br>• Financial risk with additional resources required to ensure overall activity is not reduced<br>• 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** | Not applicable |

**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, 30 March 2015 - 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.

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. However the execution of this programme during the winter period has been extremely challenging. The volume of cancellations of patients awaiting admission for surgery including urgent cancer cases has been in excess of the numbers that we have seen in previous years with 467 patients cancelled on the day of or the day before their planned elective treatment. The majority (434) were due to have their surgery at the Royal Sussex County or Princess Royal Hospitals, 63 were urgent and 17 were 'urgent critical'. Our teams worked hard together to ensure these patients had their treatment as soon as possible. Of this total, we are left with four who asked to be treated at a later date and two others who are being booked at the time of writing – all are 'routine'. In terms of performance against the requirement to rebook within 28 days this has led to a deteriorating position (as referred to in the Board performance report).

1.4. We have continued to concentrate our efforts into patients on non-admitted pathways and targeted work on data quality. This has enabled us to exceed our agreed target reduction of patients waiting more than 18 weeks, reducing the overall number of patients waiting more than 18 weeks by 732 in February, 178 ahead of our target position. The challenge is now to deliver against the admitted pathways standards with one in four patients waiting more than 18 weeks for admission. Our clinical site teams are continuing to work closely with our Directorate teams to ensure prioritisation of urgent elective cases and that cancellation of elective care is kept to an absolute minimum.

1.5. In terms of the total numbers, Digestive Diseases (surgical) and spinal patients currently make up over half of the total number of patients still waiting longer than 18 weeks. We have used the IST modelling tools to understand number of patients who need to be treated in order to ourselves back into balance and the additional resources required in order to ensure sustained delivery going forward:

**Digestive diseases - surgical**

The modelling shows a shortfall of 90 outpatient slots a week which equates to 70% of current template capacity. The inpatient list is largely balanced. We are continuing to run additional sessions both internally and in the independent sector. Our commissioners have ensured that any patient needing a routine referral is made fully aware of the current waiting times so they can choose to go elsewhere. Whilst this has stopped a continued rise in overall numbers we remain with a large number of patients who have already waited over 18 weeks and require treatment. This equates to 12 weeks of work and will require additional slots above current levels. A business plan has been developed to increase consultant capacity to both address the back log and ensure sustained delivery of 18 weeks performance from October 2015.

**Spinal**

Modelling has been completed for T&O spinal cases and we are working on a combined model which includes neuro spinal demand. For T&O the model showed a shortfall of 26 outpatient slots each week and two all day inpatient slots a week. Additional neurosurgical capacity has been put in place. Two consultants are in post and a third is due to start in April and plans are being finalised to ensure that we use all available time and resource, both internally and externally to best effect in order to treat all our longest waiting patients. Once we have the new combined capacity and demand model we will be able to share a robust recovery trajectory. As noted previously, this is a very small service with significant pressures nationally and therefore limited options for using services elsewhere.

Until we are back into balance both services are carrying an extremely high risk in relation to long waiting patients with 20 patients currently waiting between 46 and 52 weeks.

1.6. Discussions are also continuing in oral surgery with commissioners where we are continuing to receive referrals that do not actually need to be referred into an acute hospital and we do not have the capacity to treat. Capacity and demand modeling is underway but the service is not currently able to deliver compliant performance.

1.7. Performance in January and February was as follows:

| | **Target** | **Performance January** | **Performance February** |
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| **Admitted Care** | 90% | 73.4% | 71.16% |
| **Non-admitted Care** | 95% | 86.8% | 86.41% |
| **Incomplete backlog** | 92% | 87.1% | 88.1% |

It should however be noted that the national expectation was that all providers to deliver a target reduction in the overall number of patients waiting over 18 weeks. As referenced in paragraph 1.4 we exceeded delivery by 178.

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 original consultant and she had her surgery on 11 March.

1.8. We continue to work with our commissioners and other providers to deliver a sustainable RTT position. The volume of patients still waiting and the pressures in DD surgical and spinal services continue to present a significant risk going forward.

In order for us to deliver this a number of specialties will need additional lists and surgical capacity, notably T&O where there are particular pressures on foot and ankle services, gynaecology, paediatrics and oral surgery. These have been identified within the business planning process.

1.9. It should also be noted that the new MSK service commissioned from Sussex MSK Partnership will impact on our activity and waiting list numbers going forward. At present patients who are seen by our consultants in outpatients are included in our outpatient and waiting list numbers. The new model of service commissioned requires that these patients are seen in community locations by multi-disciplinary teams. Our specialists will work as part of these teams.

Reporting arrangements are still being finalised at the time of writing and CCG partners are fully briefed.

1.10. In terms of data quality:

1.10.1. The Patient Access Policy is undergoing a final review following CCG comments ahead of Board review in April 2015 and is key to getting our data quality into a better place.

1.10.2. The team has also now concluded its review of patients sitting outside the 18W data return. As noted previously the Trust had a list of patients with incomplete pathways who were not actually recorded on the system as waiting for anything. We wanted to ensure that they could now have their 18 week clocks stopped without any untoward consequences. We validated a large number of records, taking a meaningful sample (usually around 10%) from some of the larger groups, and more/all of the smaller groups. We have not found any patients who had a clinical condition that was negatively impacted by their status on PAS. The results are now being drawn together into a single report for the Medical Director on behalf of the Executive Team and CCG colleagues.

1.10.3. We are now recruiting for Performance and Assurance Manager to lead our validation team.

1.11. In terms our ability to plan capacity requirements going forward:

1.11.1. We have re-engaged with the NHS IMAS Intensive Support Team and are planning a follow on session for our Directorate teams on 15 April to ensure all parties understand the principles of capacity and demand planning and have appropriate mechanisms in place to ensure that they recognise and respond to peaks and troughs in workload going forward;

1.11.2. We are extending our capacity and demand modeling across our specialties;

1.11.3. And are now working with IMAS to extend the current Board dashboard so we provide more detail to enable the board be fully briefed on performance and any associated risk.

1.12. In terms of delivery of a service to our cancer patients, we will deliver the 2 week rule and 31 day cancer pathways for January to March 2015 but as expected will fail the 62 pathway standard for that same period (62 day wait from urgent GP referral to starting first treatment).

As reported previously the key issues impacting this performance 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.

An agreement is now in place with Queen Victoria Hospital NHS Trust in East Grinstead on additional capacity for our head and neck cancer patients and arrangements have been made for other urgent urology patients to have their surgery in the independent sector. The Directorate manager and our Clinical Directors continue to be involved daily to ensure that we minimise last minute cancellation of cases and put alternatives in place as soon as possible.

## 2. Centralised booking hub

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

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

***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.

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

**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.

**Five**
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.

Progress to date on one to four is set out below.

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

2.2.1. For the month of February the booking hub booked on average 1100 patients a day, which was a combination of new and follow up appointments. All patients, on average 580 a day in February are being added to the referral management system within 24 hours of receipt.

2.2.2. We are now working towards clinical triage within 48 hours. The referral team are proactively monitoring the referrals received and highlighting to the directorates any service that exceeds the target of 48 hours. Once identified, the directorates are notified for chasing.

2.2.3. An RMS software upgrade will enable a drop down menu making it easier for consultants to use . The trial to be up and running by end of March in a test environment with roll out across the whole system expected by mid - late April. The date of triage will also be added to results reporting by mid April.

2.2.4. In February we booked 72% of patients 0- 5 days with 90% of patients being appointed in 0 - 10 days. The booking team have requested an altered report to enable specialities to clearly see how many are being booked 0- 5 days and 6- 10 days. The hub is still experiencing issues with capacity in certain specialities and is working closely with the PAMS to identify appropriate slots.

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**

2.3.1. The RMS software upgrade will also help us allocate patients to the 'right clinic first time' as it will automatically populate new RMS patient records and include an automatic data quality check including address. We are also trialling more software to enable us to track when a letter has been generated, printed, folded and collected. This will show us exceptions which will give further assurances that the right letter reaches the right patient.

2.3.2. We are continuing to telephone any patient to be booked with less than 7 working days' notice to ensure they are able to make the date and have it noted in their diary.

2.3.3. Text reminders continue (where patients have given their mobile number). We continue to explore a two way messaging so patients can cancel by text if they are unable to attend. The current service provider will stay in place until further options have been evaluated. We are working with IT to move this forward and put in place a timescale plan for implementation.

2.3.4. The Booking Centre is working with the Trust CIU (Central Information Unit) team to obtain compile and validate a DNA report that will include where letters have not been sent (taking into account appointments made under 7 working days where contact will have been made via phone) and also where no text reminder has been generated. Once we have analysed the report we can publicise the DNA figures more widely and work with directorates and 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**

2.4.1. In February the booking team received an average of 1036 calls (range 835-1564) a day with 94% being answered within an average pick up time of 30 Seconds.

2.4.2. A missed / dropped call report is run daily and if a telephone number is logged as having waited over 45 seconds we will contact the caller to ensure that there query is resolved. Detailed logging practice continues.

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.**

2.5.1. A 'look forward' report is sent weekly to directorates to review their clinic schedule. Current performance in February saw 976 clinics cancelled with 135 with less than 6 weeks' notice impacting on 907 patients. We continue to work on the cancellation process including authorization and reasons for cancellation and we expect that this electronic clinic management form will be implemented by Mid to late April.

2.5.2. We continue to work on improving the booking efficiency to ensure first time accuracy in all points of the system to ensure we reduce ineffective working processes. A dashboard showing performance over time across all four areas is being prepared – data showing volume of bookings and calls handled is attached at Appendix One.

2.5.3. A paper is going to the Finance and Workforce Committee in relation to the 15/16 budget and plans for improving efficiency during the year. We have also earmarked dedicated development time to ensure we embed the right systems and processes into our business going forward and ensure a robust training programme to run alongside.

## 3. Conclusion

3.1. Whilst our programme of work over the last four months has absolutely focussed on the right things, there is still significant work to be done and this is not without risk, particularly with our continued pressures on unscheduled care.

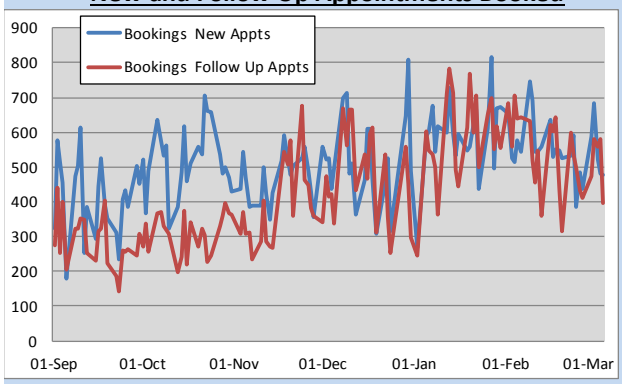
3.2. In terms of the Booking Hub we have identified a clear improvement programme and put robust measures in place to ensure that the Booking Hub delivers the required level of service.

**Sally Howard, Director of Scheduled Care and Service Transformation** **23 March 2015**

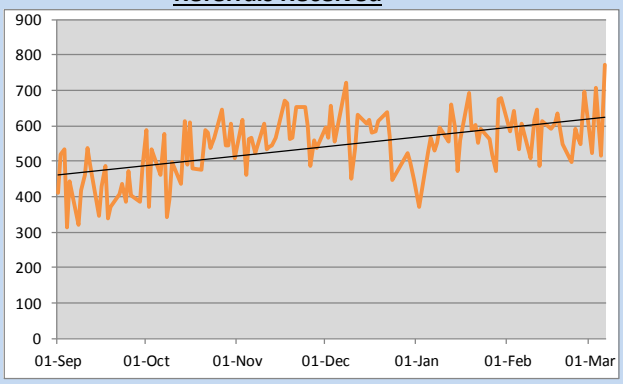
**Appendix One - Performance Dashboard – Central Booking Hub**

## BOOKING CENTRE PERFORMANCE DASHBOARD - PERIOD 1ST SEPT 14 - 6TH MARCH 15

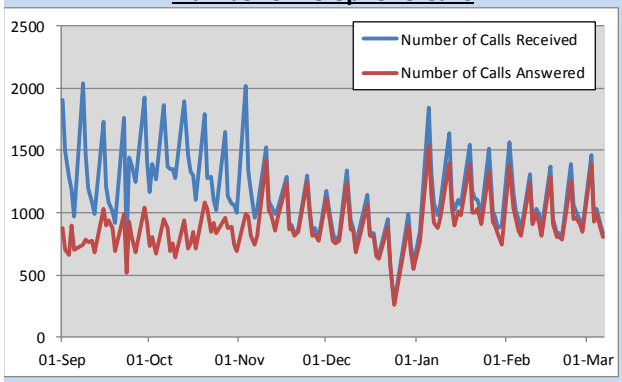
### New and Follow Up Appointments Booked



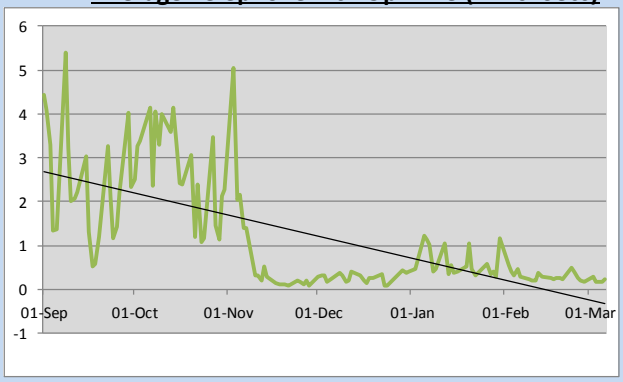

### Referrals Received




### Number of Telephone Calls




### Average Telephone Pick Up Time (Mins: Secs)




### Percentage of Calls Received and Answered