Brighton and Sussex University Hospitals NHS Trust

# Reducing Waiting Times

By Michael Wilson

Deputy Chief Executive

# The NHS Journey

1

## NHS Established - 1948

- Healthcare available to all regardless of wealth
- Free at the point of delivery
- Financed entirely through taxation

2

## Building Capacity in the system

- NHS Plan 2000 saw greatest investment in the history of the NHS
- Public demand translated into political targets
- More doctors, more nurses, better facilities

3

## Introducing the reforms

- Patient choice and payment by results
- Foundation trusts
- Stronger commissioning

# Who'd want to work in the NHS?

**NHS managers could be charged over MRSA deaths**

Hospital managers could face criminal charges if patients catch super-bugs on dirty wards, the new health secretary, Patricia Hewitt, has warned.

**NHS staff harassed but satisfied**

Hospitals and health clinics are dangerous places to work according to a recent survey from the Commission for Health Improvement. Some 37% had been harassed, bullied or abused at work. Most incidents involved patients or their relatives, but a significant minority complained of bullying by colleagues or managers.

**NHS managers 'fiddle figures'**

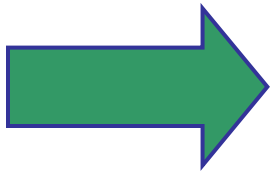
**Rise in NHS staff will help deliver reform agenda say health service leaders**

The new figures reveal the discrepancy between public perceptions and the reality of NHS management numbers and costs. A straw poll of 150 members of the public reveals today that on average people questioned thought that 20% of NHS employees were either managers or senior managers when the actual figure is just 2.6% - down from 3% in 2001. Over 80% of people questioned believed that 20% of the NHS budget is spent on management costs when the actual figure is 4p in every pound - much lower than other health systems elsewhere.

# The reform agenda

# A&E Standard

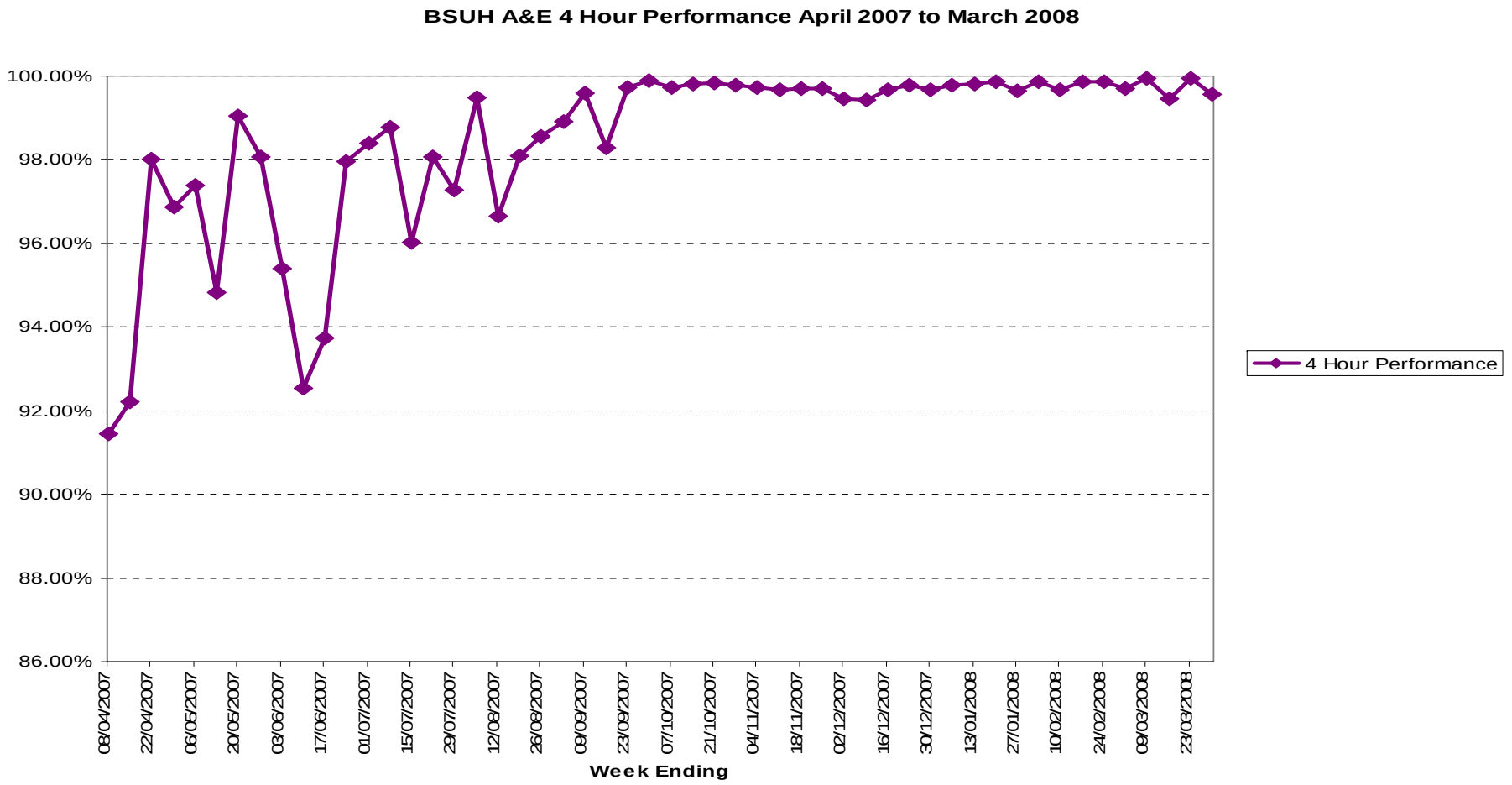
*“The Evening News reported ambulances queuing for more than an hour outside the hospital” Sept 2000*



*The NHS target requires that at least 98% of patients spend four hours or less in any type of A&E from arrival to admission, transfer or discharge from January 2005 onwards.*

# National A&E Position

| Region | Performance | Rank | Total number of Trusts | Number of Trusts below 98% | Total number of breaches | Total number of attendances |
|---|---|---|---|---|---|---|
| R1 | 98.6% | 2 | 17 | 3 | 434 | 31,374 |
| R2 | 97.9% | 10 | 8 | 3 | 495 | 23,759 |
| R3 | 98.2% | 8 | 25 | 6 | 1,170 | 65,509 |
| R4 | 98.1% | 9 | 15 | 6 | 692 | 35,589 |
| R5 | 98.3% | 6 | 10 | 4 | 405 | 24,181 |
| R6 | 98.5% | 3 | 27 | 6 | 1,148 | 77,426 |
| R7 | 98.4% | 5 | 16 | 4 | 643 | 39,551 |
| R8 | 98.5% | 4 | 17 | 4 | 480 | 32,342 |
| R9 | 98.3% | 7 | 13 | 4 | 483 | 28,036 |
| R10 | 99.3% | 1 | 8 | 1 | 159 | 21,313 |
| ENGLAND | 98.4% | | 156 | 41 | 6,109 | 379,080 |


BSUH A&E 4 Hour Performance April 2007 to March 2008
100.00%
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
08/04/2007
22/04/2007
06/05/2007
20/05/2007
03/06/2007
17/06/2007
01/07/2007
15/07/2007
29/07/2007
12/08/2007
26/08/2007
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04/11/2007
18/11/2007
02/12/2007
16/12/2007
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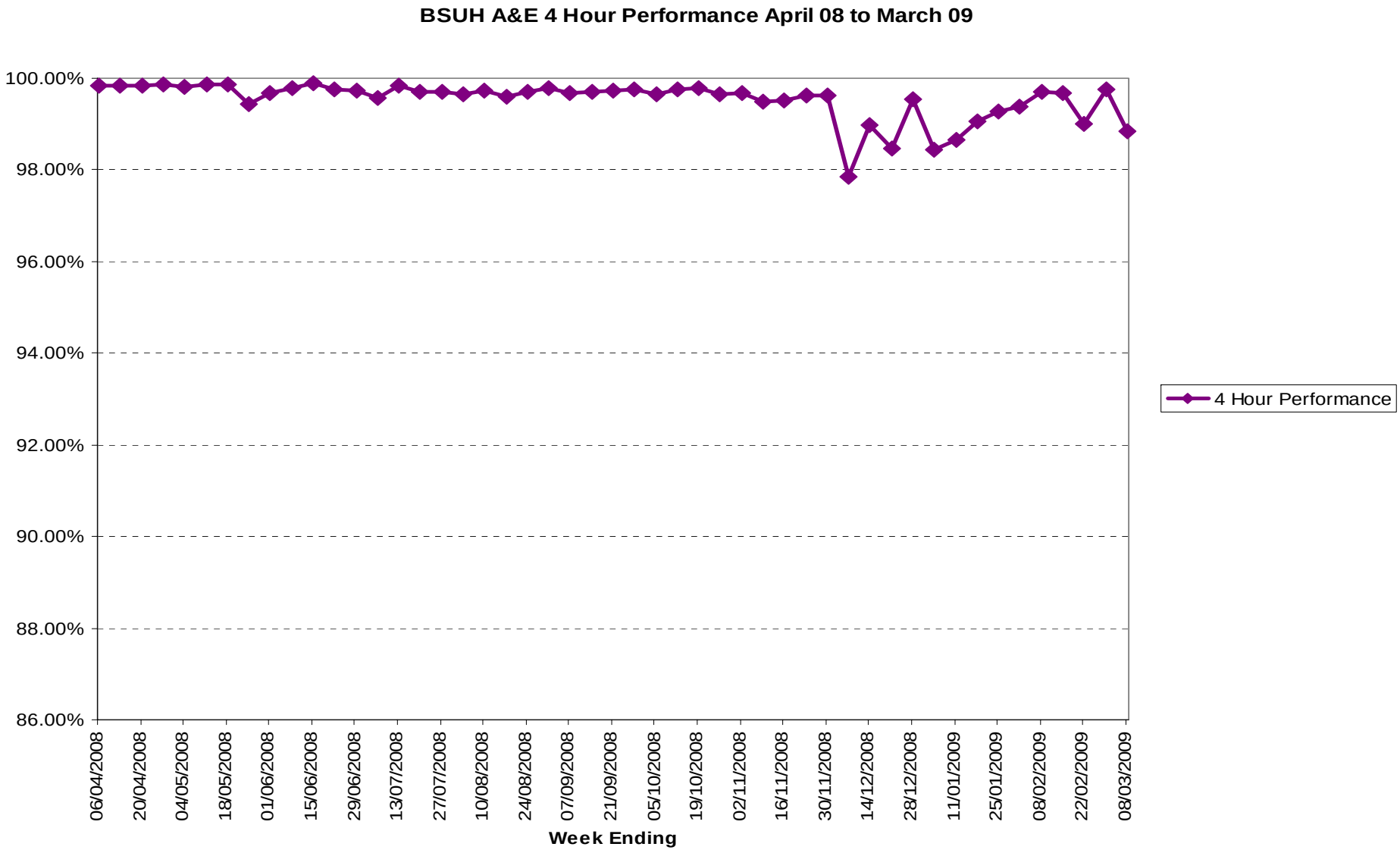
09/03/2008
23/03/2008
Week Ending
4 Hour Performance


BSUH A&E 4 Hour Performance April 08 to March 09
100.00%
98.00%
96.00%
94.00%
92.00%
90.00%
88.00%
86.00%
06/04/2008
20/04/2008
04/05/2008
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15/06/2008
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13/07/2008
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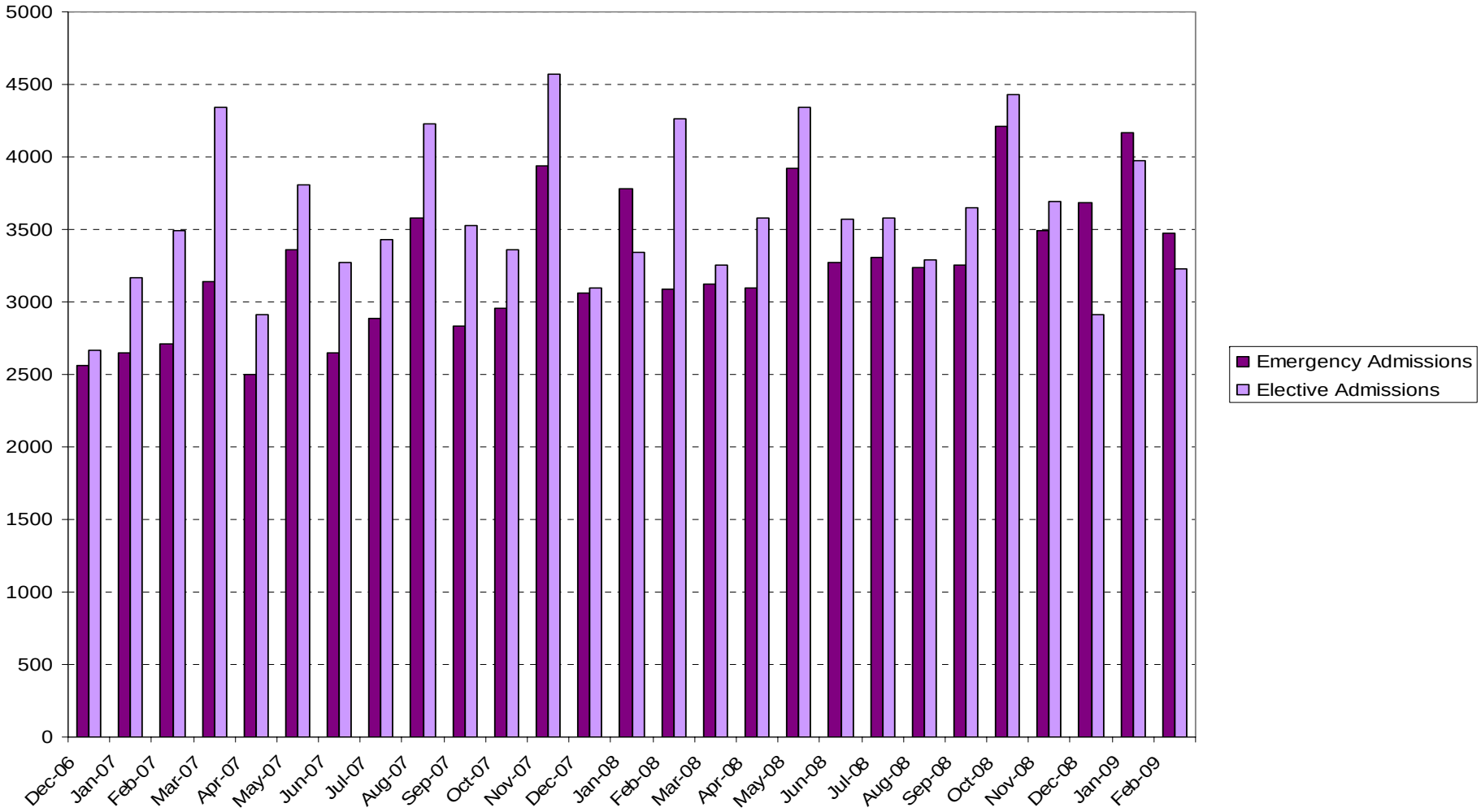
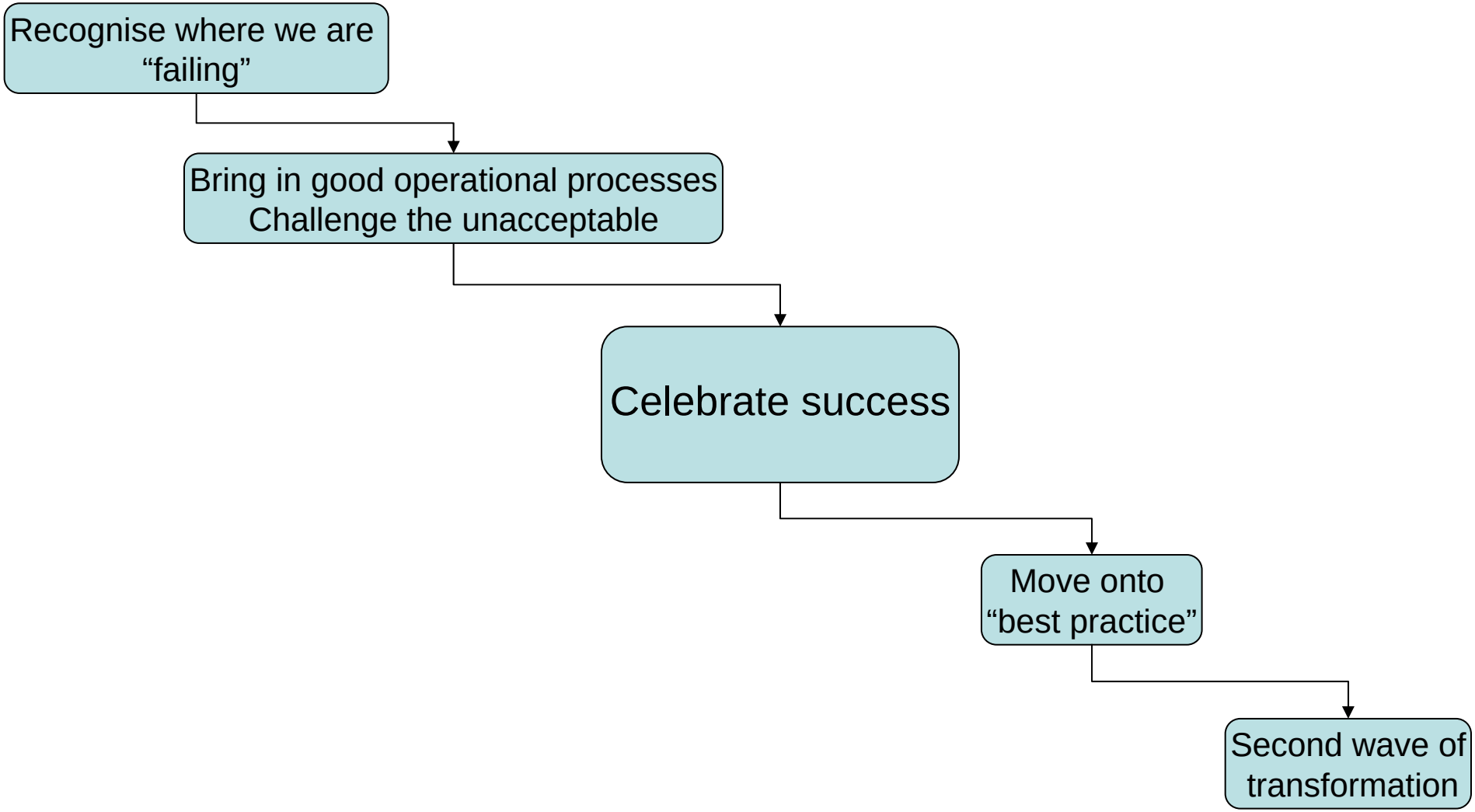
25/01/2009
08/02/2009
22/02/2009
08/03/2009
Week Ending
4 Hour Performance

**BSUH Monthy Emergency/Elective Admissions December 2006 to February 2009**



# The Journey


Recognise where we are
“failing”
Bring in good operational processes
Challenge the unacceptable
Celebrate success
Move onto
“best practice”
Second wave of
transformation

# Tell the Staff

- Position locally & nationally
- Future of the hospital in doubt
- Everyone else has fixed this stuff
- External advisors

# What did we do?

1. Review teams
2. Tell the truth upwards
3. Help the staff understand that this is better care for Patients
4. Improve basic processes
5. Work with staff who don’t recognise the problem and don’t want to be part of the solution

# How?

- Engage staff
- Identify champions
- Develop a frame work that supports clinical engagement
- Close working relationship with PCTs & GPs
- Work with patients and wider public

- Understand Demand
- Match Capacity to Demand
- Further develop team working
- Reduce DToCs

# Motivating Staff

- Executive leads
- Listen to staff
- Give positive feedback
- Right structures
- Right processes
- Right culture
- Desire to make it happen
- “Can do approach”

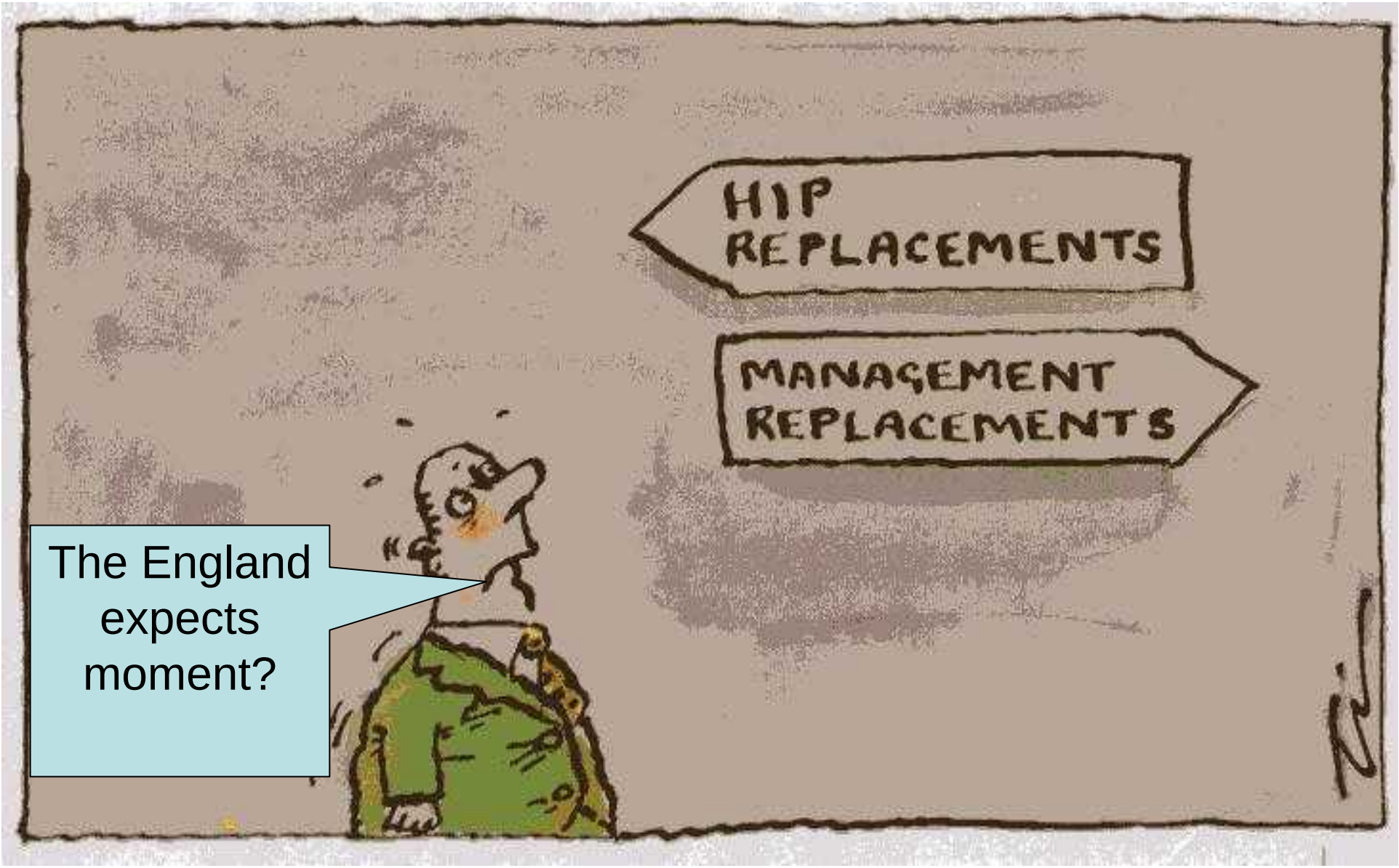
# Second wave of transformation

1. Thank the staff
2. Tell the public
3. Focus on quality
4. Build the organisation
   - competency and culture

# 18 Weeks – The Target

No-one should now have to wait more than 18 weeks from The time they are referred to the start of their treatment, unless it is clinically appropriate or they choose to wait longer. Performance will be judged against the following standards:

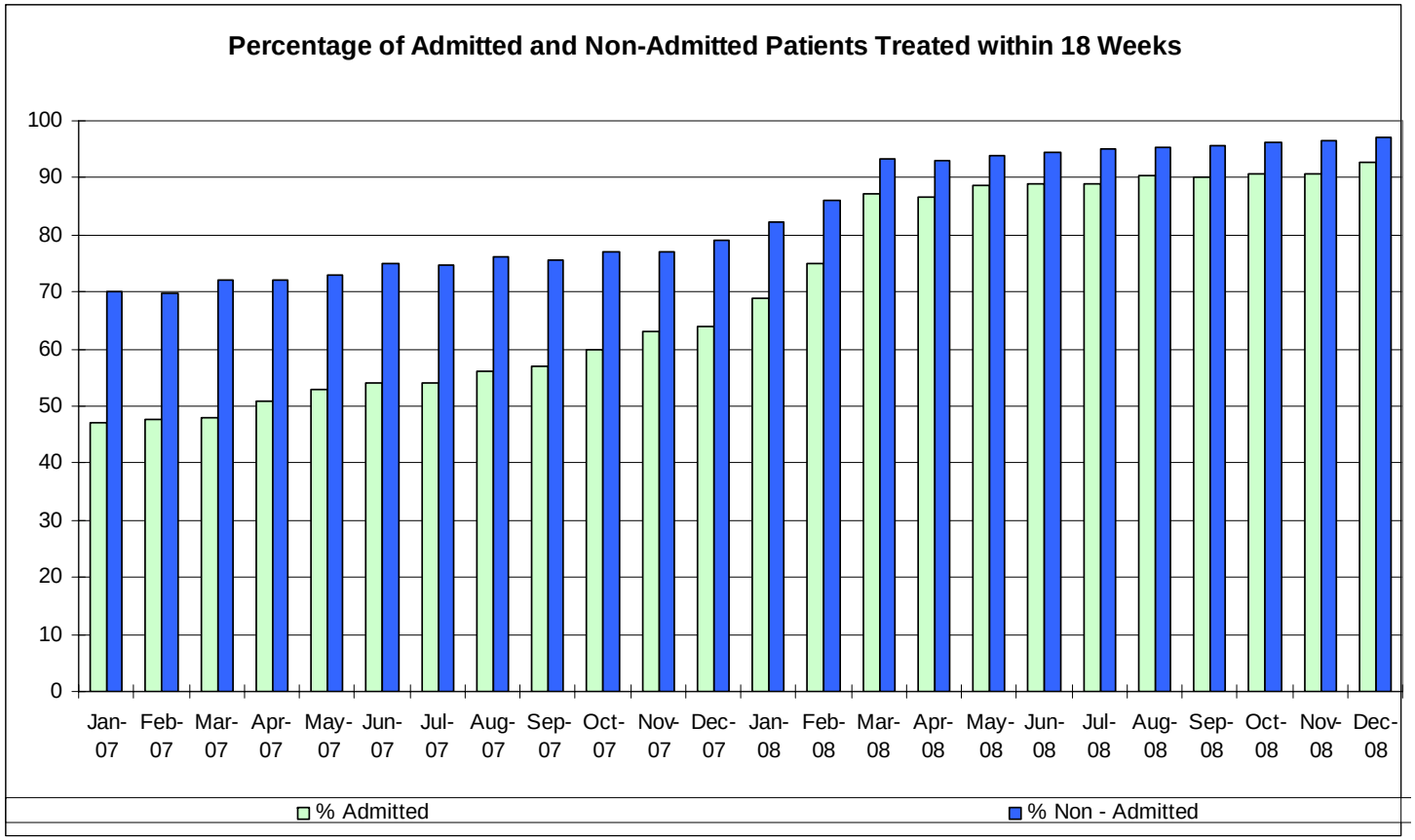
- 90 per cent of pathways where patients are admitted for hospital treatment should be completed within 18 weeks; **and**
- 95 per cent of pathways that do not end in an admission should be completed within 18 weeks.


HIP REPLACEMENTS
MANAGEMENT REPLACEMENTS
The England expects moment?

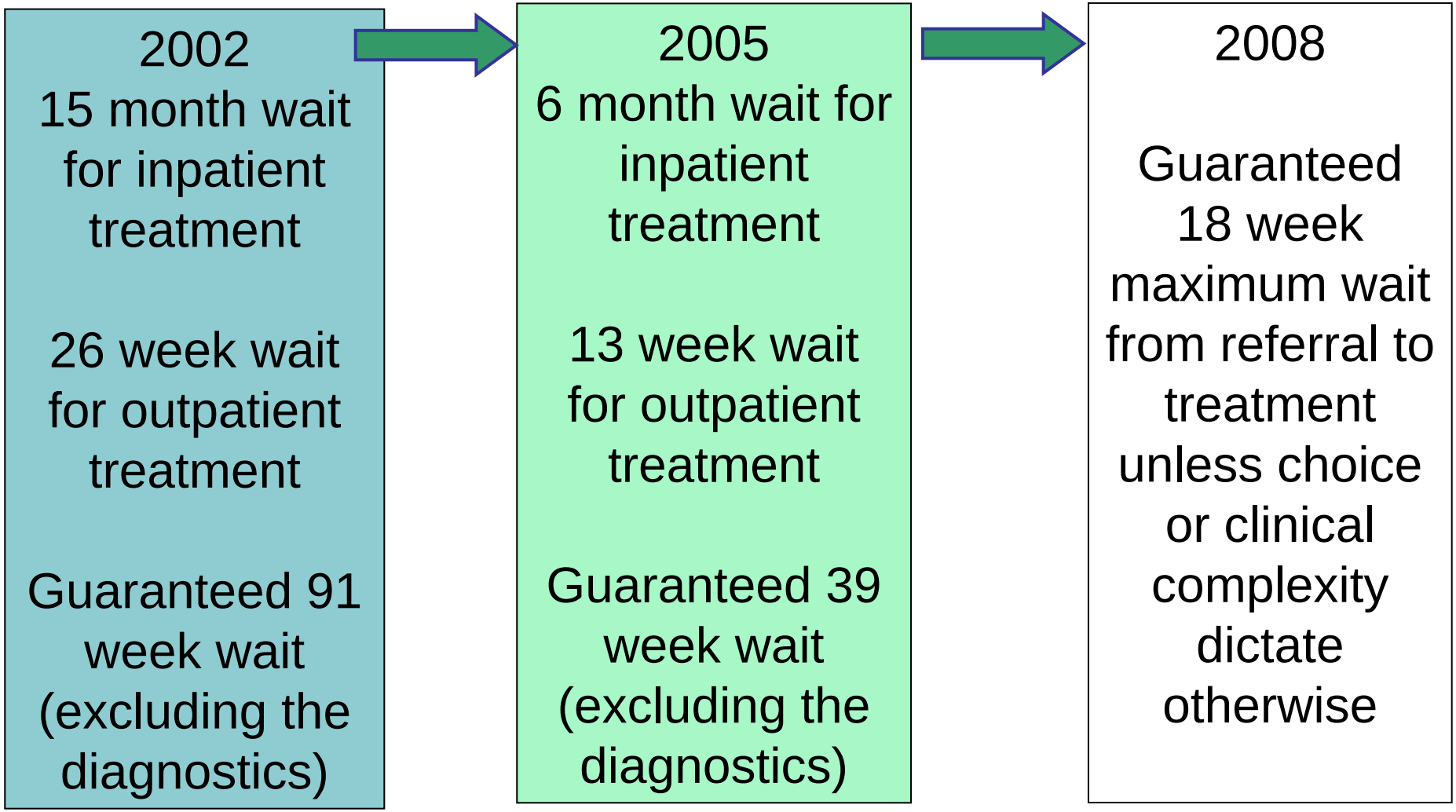
# 18 Weeks – National Picture

*"In May 2000 almost 50,000 people had been waiting longer than 12 months for hospital admission"*

*"By 2008, no-one will wait longer than 18 weeks from GP referral to hospital treatment"* *NHS Investment Plan 2004*



# What could the tax payer expect?



# We kept it simple …

## 2007/8

Made sure we understood our own data

Learnt how to work a new counting system

Calculated how much extra work we needed to do to reduce our waiting times in outpatients, diagnostics and from our inpatients waiting lists and got on with it

## 2008/9

Continued to support staff so they get data entry right every day

More capacity and demand modeling to ensure specialties with more to do could deliver

Changed our patient literature and reviewed our booking processes with patient groups

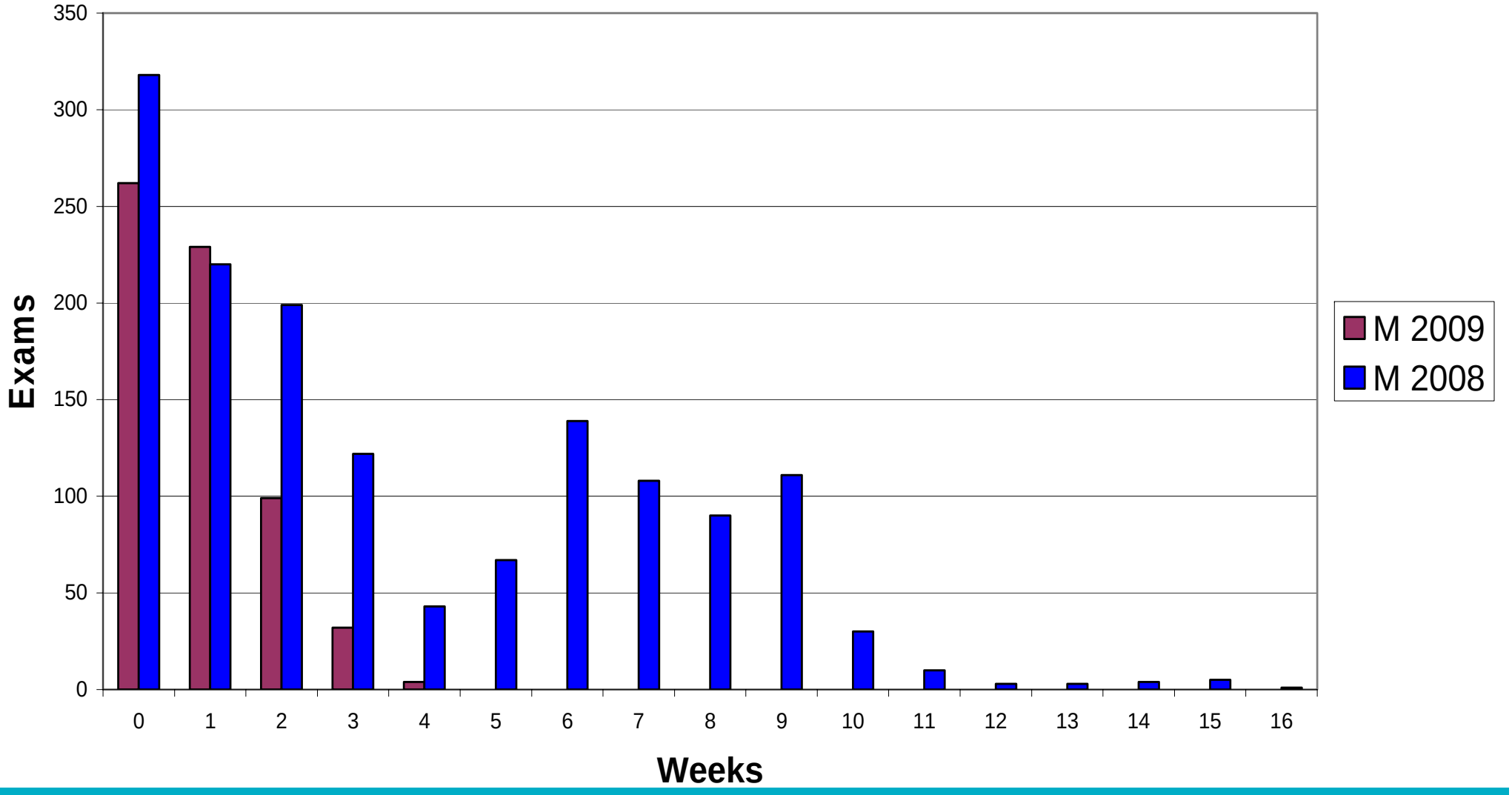
## 2009/10

Continuing this work

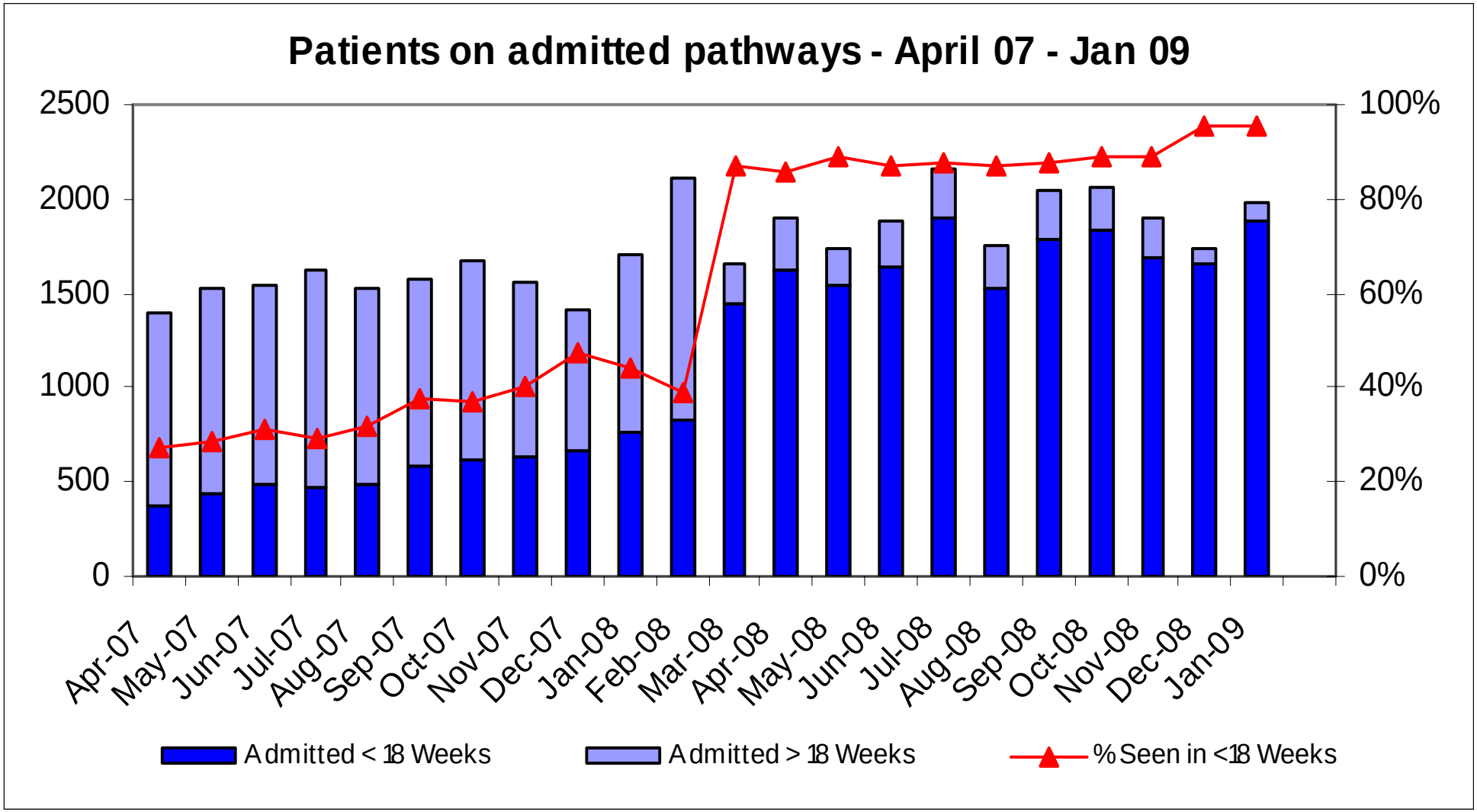
Focusing on the pathways – what our GPs can do before referral, number of steps in the pathway

Continuing work on booking processes & extending work on outcome measures & patient experience

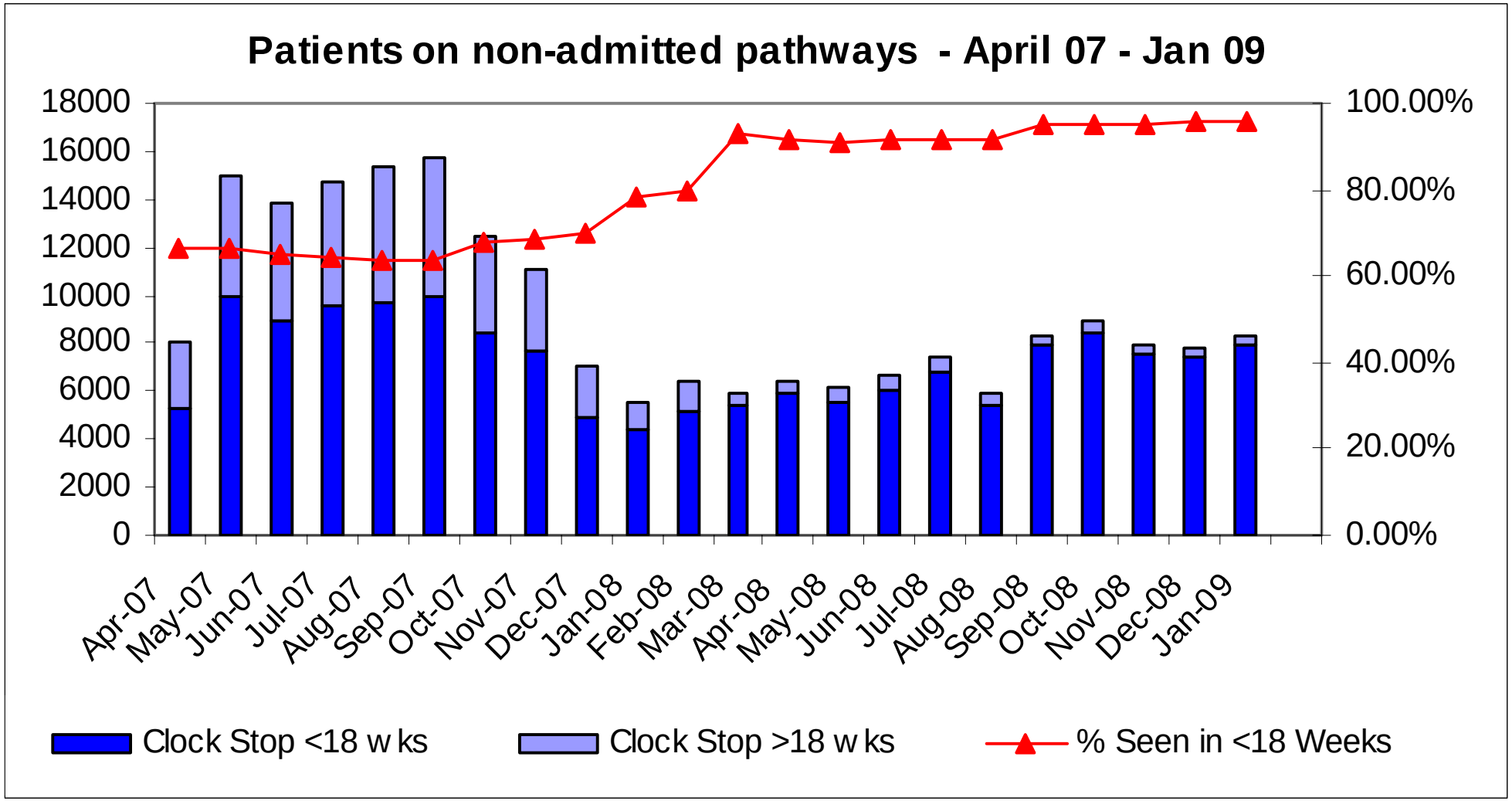
# MRI wait times in Jan 08 & Jan09
# Comparison of time elapsed from referral to scan



# Admitted performance to January 2009
# Current performance – 95.17% - Target 90%



## Non-admitted performance to October 08
## October monthly performance – 95.94% - Target 95%



# What really works



- Knowing why this is important
- Ambition – for all the right reasons
  Because it matters to patients
- Leadership that enables the right diagnosis and engages staff in its delivery
- Explaining simply, clearly, consistently what needs to happen and why
- Remaining unapologetically focused
- Engendering a sense of pride & ‘can do’
- Recognising achievement and rewarding it publicly …

# Differences between the two reforms

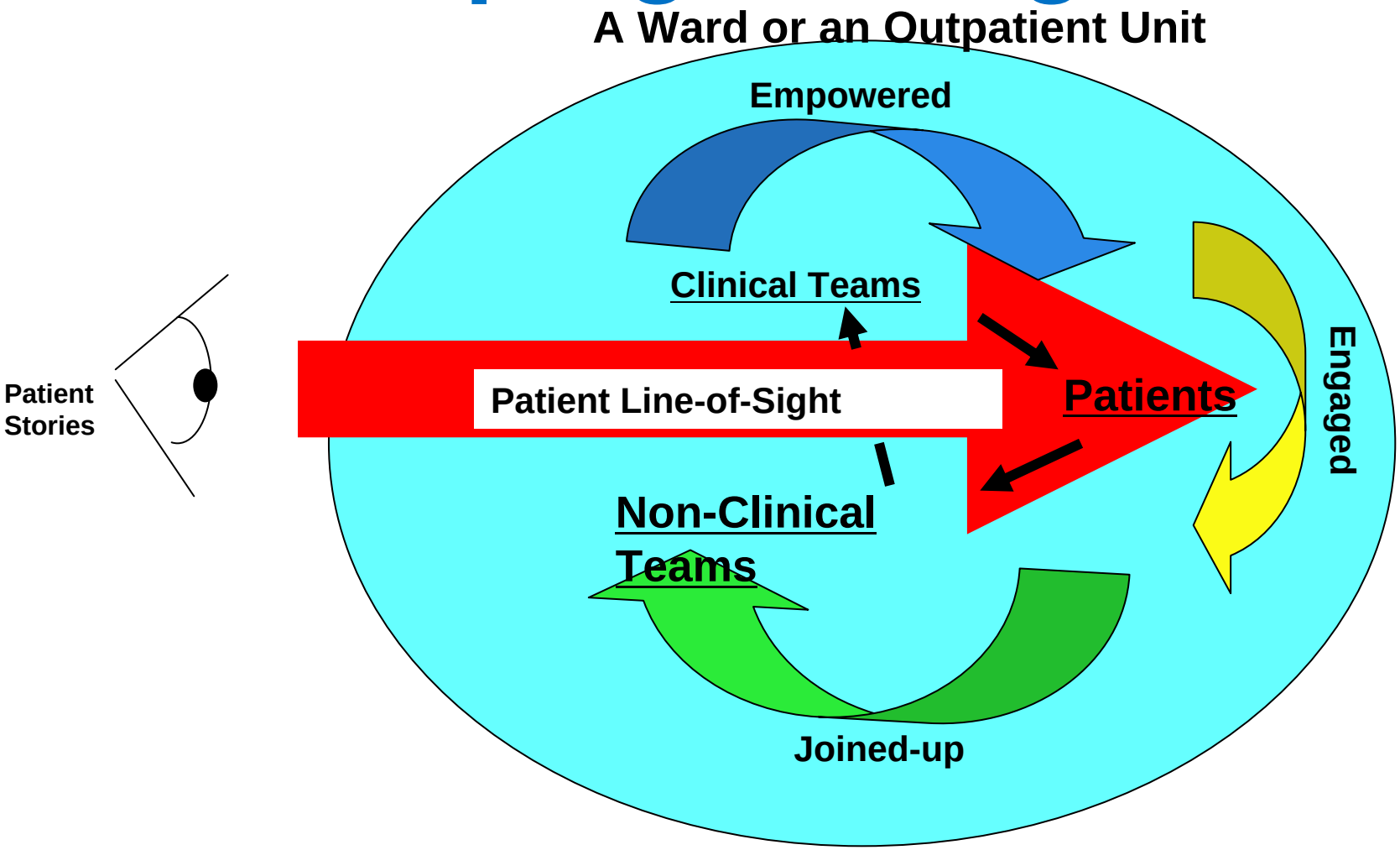
## A&E:

- Resistance from clinicians – compromised their clinical judgment?
- Taking longer to achieve

## 18 Weeks:

- Strong clinical buy-in and leadership
- Quickly achieved

# Developing the organisation



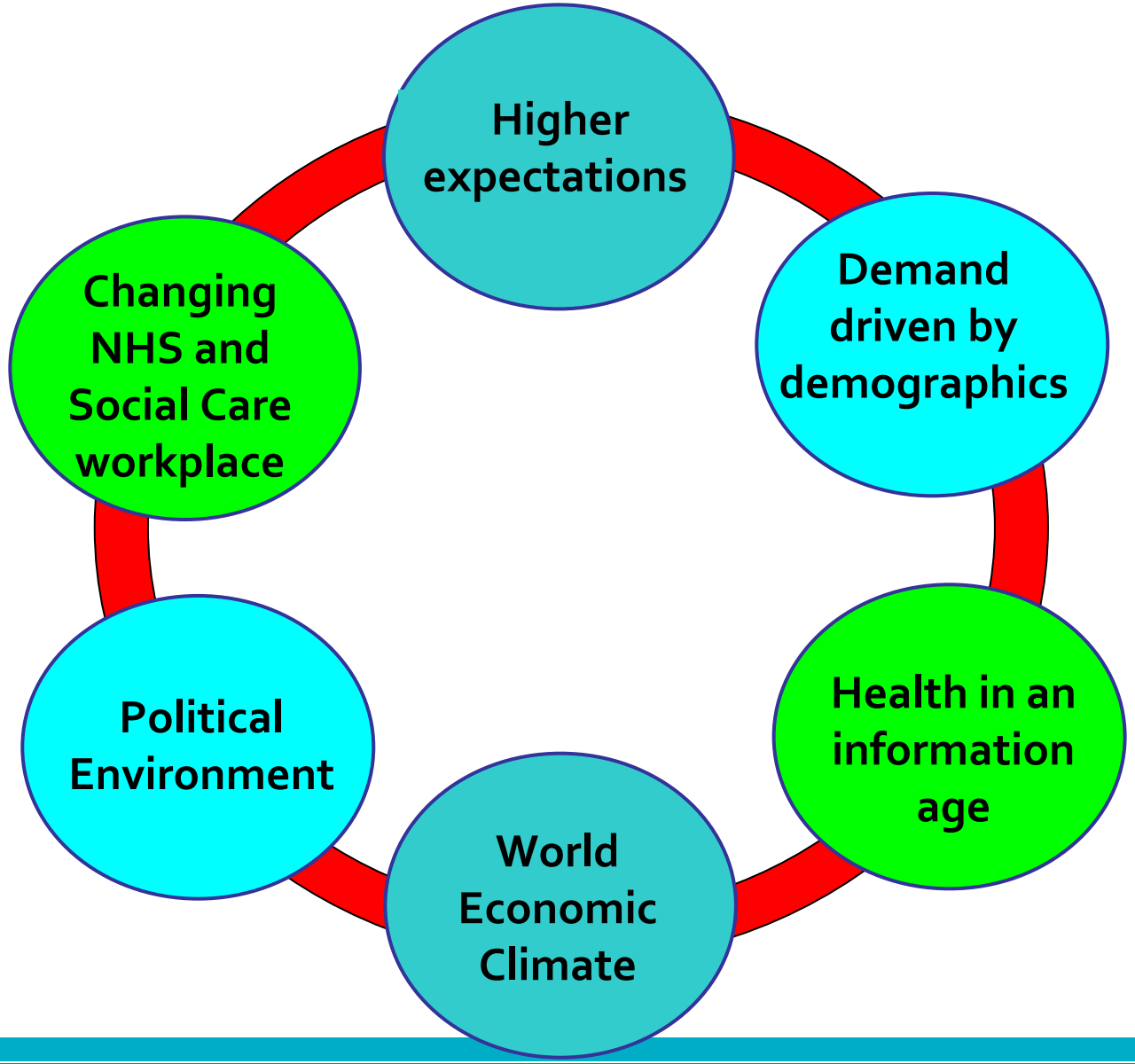
# Did we achieve this at the expense of other things?

- 6 core priorities for the Hospital
- 1.A&E
- 2. Infection Control
- 3. 18 weeks
- 4. Patient Safety
- 5. Taking forward our Strategy
- 6. Financial Balance

# We Say no!

1. A&E exceeds 98%
2. 18 weeks achieved
3. MRSA rates reduced by 50% & C.diff. rates reduced by 45% in 08/09
4. SOC being progressed- strong clinical involvement
5. Now projecting break-even for 2008/09

# What next? Future Challenges



# Any Questions?

# Patient Case Study

## This is why it really matters

Patient X was a 'young' 72' looking forward to a long and active retirement. He noticed chest twinges whist participating in water sports on holiday in Australia, January 08. By July 08 this was described as central chest tightness radiating to both arms and he visited his GP on 4 July.

The GP was not overly concerned, he had had a negative exercise test 2 years previously but referred him to Rapid Access Chest Pain Clinic at his local hospital, Princess Royal (part of BSUH) to rule out a cardiac cause. The GP has Mr X's bloods and ECG at his surgery so these were available at his clinic appointment.

He was seen on 17 July in the nurse led rapid access chest pain clinic and his case discussed with the consultant cardiologist. Consultation and tests were completed on the day and there was a strong suspicion of coronary artery disease hence referral for diagnostic angiogram at the Royal Sussex County (part of BSUH).

This was performed on 14 August as a day case by the registrar under the supervision of the consultant cardiologist who then referred him to a consultant interventional cardiologist for percutaneous coronary intervention (PCI) to a complex lesion.  Due to the complexity of the lesion his case was discussed at the weekly conference with the surgeons where it was agreed PCI was the best option.

Patient X was admitted on 25 September and had had a successful PCI and stent insertion. Due to the complexity of the lesion he stayed overnight. He was very happy with his treatment, the pathway and the time waited but most of all he talked about the excellent care he has received at all stages …he even liked the sandwiches! He is now looking forward to resuming his active lifestyle.

**That was 12 weeks from referral to treatment …. 18 weeks is a maximum … we will offer treatment sooner if that works for the patient**