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Meeting:	**Brighton and Sussex University Hospitals NHS Trust Board of Directors**
Date:	**31 May 2016**
Board Sponsor:	**Dr Mark A Smith Chief Operating Officer**
Paper Author:	**Shaun Carr Directorate Manager, Cancer Services**
Subject:	**Planned Care**

Executive summary This report updates the Trust Board on a continuous programme of work to deliver planned care.	
Links to corporate objectives	Enables ***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. 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: Risk 1 - Patients wait too long for treatment with inefficient booking processes and significant rework. Risk 2 – Patients exercise choice and move 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: 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.
Resource Implications	Significant potential revenue implications.
Report history	Monthly exception reports on planned performance have been made to the Trust Board bi-monthly in 2016.
Action required by the Trust Board	The Trust 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, Diagnostic and Cancer standards

Report to the Board of Directors – 31 May 2016
Planned Care

1. Introduction

Shaun Carr commenced his 6-month secondment as Deputy Chief Operating Officer for Planned Care on 25 April 2016. This will provide much needed stability and continuity in senior leadership to the planned care agenda.

The Trust also welcomed interim Sharon Osterfield as Trust-wide 18-week Lead on 3 May 2016 for an initial period of 3-months. Sharon brings a wealth of experience on planned care access, RTT rules and general best practice in the management of waiting lists.

2. RTT 18-weeks

2.1 Current Position

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 73% of patients waiting no more than 18-weeks.

The backlog is now reducing with a total of 8,954 patients waiting over 18-weeks as of the 10 May. The deterioration in Digestive Diseases (Surgery and Medicine) has slowed down however they are unable to clear the current backlog with the current demand and capacity. Comprehensive plans are being developed to address the deterioration within Paediatrics especially ENT. Pain management continues to deteriorate and will require additional capacity in both admitted and non-admitted performance.

There are 100-patients that have waited over 52-weeks for treatment at the end of April. Of the 100-patients, 89 are within Digestive Diseases. 64-patients are awaiting surgery and the remaining 25-patients are awaiting investigations and follow-up appointments. The remaining 11-patients are across a range of specialties, but are all dated. The forecast is that only 18-patients will require dating in DD by July 2016.

There are now circa 5,000 patients transitioning through the NULL cohort of the Patients with Unknown Status (PUS). It will reduce further as systems and processes are improved and until such time is being routinely validated. The trust has commissioned an external IT specialist to review the current 'business rules' that generate our PTLs to ensure that we are reporting correctly and have sight of all patients.

Following the extensive validation of April month end, the external validation team focussed on validating the 'planned outpatients' who have had no target date assigned. This work was completed as the team finished. Work continues to validate the 'to be checked', 'planned' and 'non-RTT' cohorts of patients and ensure that we have full visibility of them, we are certain of the appropriateness of reporting and we have sufficient capacity to treat.

2.2 Contributing Factors

The Trust is committed to ensuring patients are seen in a timely manner, however treating the longest waiting patients remains challenging. As reported previously there are a number of contributing factors including:

- A genuine imbalance between capacity to treat and demand for service most notably in Digestive Diseases and Neurosciences.

- It appears that some patients have been booked out of chronological order -
  Pat Keeling is working with booking teams to ensure appropriate booking.

- 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 remains an area of concern.

- Lack of choice being offered by the referral management provider OPTUM to our challenged specialties e.g. DD Surgery. By the 1 July the new DD job plans will provide choice to patients in terms of OPD, admitted and diagnostic care. Theatre schedules will be produced 6-weeks in advance (as opposed to the current position of 2-weeks in advance).

- Delayed referrals from the Sussex MSK Partnership – patients are being referred waiting over 18-weeks and on occasions over 42-weeks.

- Loss of activity as a result of industrial action.

- High level of cancellations at the Princess Royal Hospital (PRH) and the Royal Sussex County (RSCH) where non-elective pressures for beds have resulted in cancellation of surgery.

- Productivity and efficiency in job planning, outpatients and theatres.

- IT infrastructure e.g. not using full functionality of Oasis, no e-referral, order comms or e-outcoming.

- Informatics capacity and business intelligence.

2.3 Overview of work underway

We have submitted through our commissioners a revised trajectory for delivery of the 92% standard to the Trust Development authority (TDA). This does not deliver aggregate performance until March 2018. It requires significant internal and system support to deliver this position. This is being built into the broader annual planning process, annual operating plan and contracting round. At present the indicative cost for additional activity is circa £2m. The revised trajectory indicates performance of 76.4% at March 2017 - this revised trajectory has been broken down by specialties and will be submitted to the CCG on 11 May 2016. The trust is currently performing

above the revised trajectory April month end predicting a backlog of 9,231 against a trajectory of 9,713.

There are a number of ways we are strengthening our grip internally. These include:

- Robust recovery plan incorporating IST recommendations:
  - Leadership and governance
  - Training
  - Data, reporting and DQ
  - Business planning and contracting
  - Clinical leadership
  - Operational delivery
  - Policies and procedures
  - Communications

- The Patient Access Meeting will follow a 2-week rolling rota, alternating between full and half-day meetings, where we will continue to focus on the
  5 key specialities that have been targeted for significant and sustained improvement.

- The Clinical Review Group meets monthly to review the patients treated over 52-weeks in the previous month. Progress and outputs of the Clinical Review Panel are shared at the internal Safety & Quality meeting and the Quality Review Meeting (QRM) with commissioners each month.

- Booking Hub Review – a paper was presented to the Trust Board and the recommendations are now being progressed.

- RTT Assurance Meetings – these weekly meetings have been reprioritised to focus on information provision, active revision of outcome sheets and clear analysis of weekly performance by directorate.

- Validation – the additional 16 validators have now completed the validation exercise required, this included validating the entire backlog of 9,703 for April month end and the 'planned outpatients' with no target date. A validation plan has been submitted that articulates the priorities and approach for validation of the Trust moving forward.

- Training – the RTT Trainer will now attend the weekly Patient Access Meeting to provide instant training updates to any hotspots identified.

- Using alternative providers where possible - working with commissioners and the national PMO to identify any additional capacity both with NHS and independent providers, although this remains challenging for our longest waiting patients.

The areas of system support we are looking for at this stage include:

- Further collaboration with the MSK Partnership including an opportunity to decommission pain services at BSUH.

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- Maximizing the opportunities of choice at source with referral management service OPTUM.

- Cessation of all new referrals for our DD service with immediate effect for a
  6-month period to allow us to radically review and improve this service.

- Commissioning of alternative capacity for our neurosciences services ensuring all new referrals go to the MSK Partnership (a suggestion at the tripartite session).

- Working with specialised commissioning colleagues to develop an IMOS service for dental (Brighton appears to be the only area that does not have this).

- Identifying additional community service support where appropriate e.g. ENT. A meeting will take place on 18 May with B&H CCG to look at recruiting consultants from acute trusts across Sussex and Hampshire to provide additional support for both paediatric and adult ENT.

- Backlog clearance to be included in 16/17 plan.

- Appropriate use of 2WW referrals. There is now a joint piece of work with the Cancer Board, GP Leads and CCG Commissioners to assess the impact of a reduction in referrals from 5 - 3%.

- Support in redesigning pathways e.g. straight-to-test endoscopy. Meetings will take place on 19 May to commence the mapping of three separate DD pathways.

Key risks to delivering the trajectory and more timely care to patients include:

- The ability to undertake a significant increase in activity in challenged specialties.

- The ability for alternative providers to deliver volume of additional activity requested.

- Maximizing clinic/theatre utilization and job plans.

- Affordability of recovery.

- System-wide support to effectively manage demand and redesign pathways.

- Time to mobilize additional resources and ability to recruit.

- Internal management capacity and consistency.

- Capacity and capability to deliver informatics capacity and DQ.

- Patients exercising their right to choice.

- Continued cancellation of elective activity due to non-elective pressures.

3. Diagnostics

The Trust continues to work towards each modality reporting less than 1% of patients as breaches as a proportion of the total diagnostic waiting list by October 2016 in line with the agreed trajectory submitted to the Trust Development Authority. This is managed through the internal governance processes described in earlier reports.

For April, BSUH is reporting a position of 6.57% due to a total of 423 breaches against the national diagnostic standard. These are made up of 16 MRI, 16 CT, 176 ultrasound, 6 echo cardiac tests, 6 urodynamics tests and 203 mixed endoscopies. Endoscopy performance was better than expected and ahead of trajectory and both sleep studies and neurophysiology reported zero breaches of the 6-week standard for April. The main area to fall behind trajectory was imaging, with ultrasound underperforming due to a combination of increased demand and reduced capacity due to staffing shortages.

As a result of April's ultrasound performance, special measures have been put in place to recover the position in May and bring performance back in line with the agreed trajectory. Additional sessions have been set up using consultant radiologists and appropriately qualified registrars in both NOUS and Gynaecology US. Although at time of writing the booking of these sessions is still ongoing, estimates of month-end performance show ultrasound should recover the ground lost in April. Both CT and MRI are expected to return single digit breach numbers in May. Endoscopy is on course to deliver their trajectory target in May and there are no other modalities predicting significant breach numbers.

4. Cancer Services

The 2WW cancer wait performance for March was 91.48%. There has been some improvement in the 2WW position for Colorectal (61.35%). However, upper GI has not shown any significant improvement (77.4%). The Cancer Directorate has been given assurance that both Digestive Diseases tumour sites will be complaint in May.

The 2WW compliance for April currently sits at 88.62% (1,654 patients seen, 188 below target), which relates to the upper and lower GI backlog. Colorectal for April 2016 is delivering 69.57% due to 70 of the 230-patients seen breaching the standard. Upper GI is currently delivering 80.49% as 32 of the 164-patients seen have breached. These are unvalidated positions.

The performance against the 62-day target for March was 81.9%. The trust experienced a high volume of breaches, particularly in Urology, which were due to some complex pathways as well as late referrals from tertiary providers. Analysis of diagnostic waits, which are a major cause of Prostate delays, has begun (see actions below). The current position for the 62-day pathway for April is 78.3% however this is not yet a fully validated position.

At the end of April a total of 1,196-patients are on the current list of patients who are undiagnosed, diagnosed and treated in the current month. This means we are tracking approx. 1,200 patients weekly compared to 400 – 500 reported 12-months previously.

- 225.5 undiagnosed patients have already breached the 62-day standard and require a diagnostic outcome;

- 397.5 undiagnosed patients have less than 31-days remaining on their pathway and require a diagnostic outcome;

- 62-patients have been waiting over 104-days of which 12-patients have a confirmed Cancer diagnosis.

Screening performance for March was 73.8%. April is currently 78% but this is not yet validated.

Actions taken this month by the cancer information team to ensure trajectory compliance by September include the following:

- Analysis of 2WW turnaround times to see at what day of the pathway patients are being booked at. This has been shared with all Service managers and added to the cancer dashboard.

- Worked with the Imaging Department to ensure Lung CT delays will be reduced from
  14-days to 7-days.

- Raised concerns with the Imaging Department regarding their 'rejected referral' process. This action is now sitting with them for resolution.

- Established an escalation process to resolve any issues with PET CT bookings for lung patients.

- Put plans in place to visit Guys & St Thomas this month to discuss shared lung patient pathways with their team.

- Analysis of wait times for Urology TRUS biopsies and Prostate MRIs which has been shared with Imaging & Urology service manager as delays to the prostate pathway remain a major risk to 62 day compliance.

- Pathology turnaround times remain a concern. Histopathology turnaround times of
  14-days are being raised at cancer PTL with Liz Berry. MDT coordinators are also flagging up any delays weekly, directly to the reporting pathologist as well as the PTL meeting.

- Additional Sarcoma MDT support put in place which has now released the Coordinators time to devote to improved Upper GI tracking.

5. Highlights: Performance Management & Delivery

All specialties are reporting on a weekly-basis against fixed and agreed targets for compliance. All discussions are recorded to ensure ownership of delivery, accountability and sustainability.

Additional support is being provided to our most challenged directorates - DD, Head & Neck, Spinal and Neurosciences – with dedicated 1:1 sessions being provided by

the Deputy Chief Operating Officer (DCOO) for planned care and supported directly by the Chief Operating Officer (COO).

A Theatre utilisation meeting has been established with Theatre Leads, Clinical Leads and Directorate Managers. The purpose of the meeting is to establish the Perioperative Directorate as a key service provider and its role in working with individual specialties to maximise current capacity. Moving forward, graphs will be provided on a weekly-basis for individual theatres. These will highlight: commissioned activity, backlog position, activity to be undertaken and activity delivered. It is essential that we join up our most expensive asset to the overall delivery programme.

Full utilisation of Lewes Victoria Hospital (LVH) is being addressed and designated DD patients - meeting the agreed criteria - have been directed for rapid access to surgery at this site. Bi-weekly meetings with Eileen Collings, Lead Nurse at LVH have been established and clear deliverables have been agreed. We are currently in the process of agreeing a volume-specific monthly target for delivery. This will target long-waiting patients and create capacity to prevent DD patients tipping over 52-weeks.

In conjunction with procurement, we continue to work with IS providers to ensure all contracts are effectively managed i.e. case mix, cost, activity and volumes are realistic and delivered within agreed timeframes. These will be approved by Spencer Prosser, Chief Financial Officer before any outsourcing activity is undertaken.

The Clinical Lead and Directorate Manager for DD and DCOO for planned care have been meeting weekly to undertake a dating-session of long-waiting patients. The session also provides an opportunity to allocate consultants to empty theatre sessions and a review of 2WW delivery across the service. The 52-week position in DD is improving and the 2WW rule position will show compliance (85%) from May, which is a significant change from the position reported in March (36%) for upper and lower GI.

In paediatric rheumatology we have agreed an additional 1.25 PAs for Dr Kelsey Jordan and the additional sessions to be undertaken will ensure this service is compliant from September 2016.

Paediatric allergy – this service should have a zero backlog from the end of July 2016.

6. Recommendations

The Trust 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, Diagnostic and Cancer standards.

Shaun Carr
Interim Deputy Chief Operating Officer - Planned Care
May 2016