

Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	29th March 2016
Board Sponsor:	Dr Mark A Smith Chief Operating Officer
Paper Author:	Lisa Kelly - Interim Deputy Chief Operating Officer (Scheduled Care) Shaun Carr – Directorate Manager, Cancer Services David Garrett – Directorate Manager, Central Clinical Services Karen Rowland – Interim 18-week Lead
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 <i>excellent outcomes; great experience; empowered skilled staff; and high productivity</i>
Identified risks and risk management actions	<p>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:</p> <p>Risk 1 - Patients wait too long for treatment with inefficient booking processes and significant rework.</p> <p>Risk 2 – Patients exercise choice and move to other providers and commissioners securing alternative capacity.</p> <p>Risk 3 – Action from regulator (NTDA) for not achieving NHS constitution access targets.</p> <p>Risk 4 – Commissioners applying contract penalties.</p> <p>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.</p>
Resource implications	Significant potential revenue implications
Report history	Monthly exception reports on planned performance have been made to the Trust Board since 2015
Appendices	(A) Planned Care Governance Structure (B) Revised Trajectory for Compliance

	(C) Trust-wide Patient Access Meeting
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Action required by the 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, 29th March 2016 Planned Care

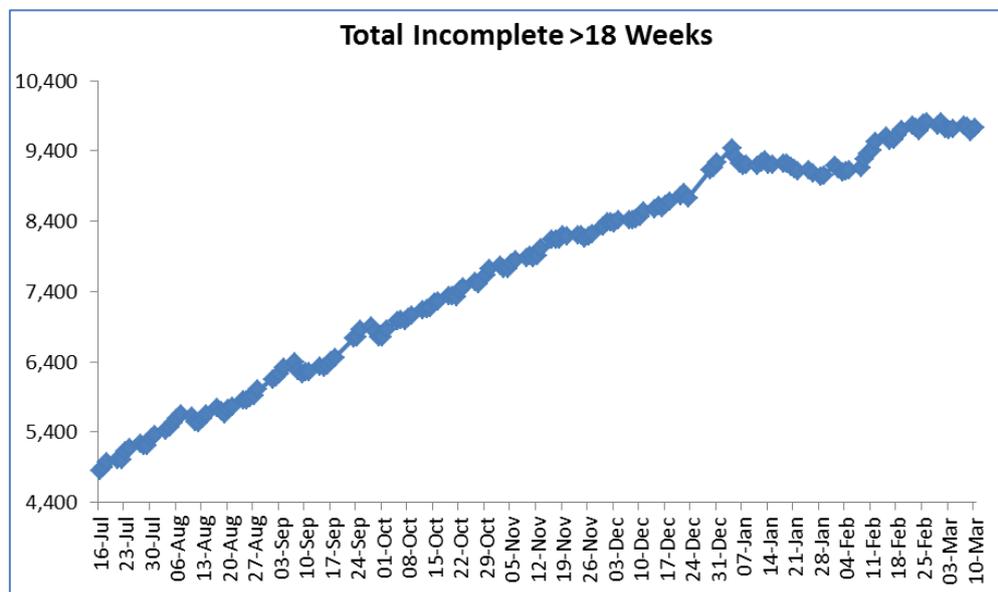
1. Introduction

The Deputy Chief Operating Office for Planned Care commenced on 20 January 2016 to provide senior leadership support to the planned care agenda. The interviews for the substantive appointment take place 1 April and will lead to further stability in the senior management of this agenda. Please see *Appendix A*, which outlines the revised governance structure. The first Planned Care Board will meet monthly commencing on 31 March.

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 – continuing the trend of 2% deterioration in position month-on-month since June 2015. The backlog continues to grow with circa 9,860 patients waiting over 18-weeks as at 16 March. There is a continuing deterioration in Digestive diseases (surgery and medicine) who account for 30 % of this number and in neurosciences which holds 20%. The total increase in the incomplete position is shown below:



As at the end of February there were 89 patients that have waited over 52-weeks for treatment. 77 of those patients are DD surgical pathways and have no date for treatment as at writing. The remaining 12 are across a range of specialties but are all dated.

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. A full report on PUS will be presented to the board in April.

There is work on-going 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 those validated.

2.2 Contributing Factors

The Trust is committed to ensure 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.
- Patients must be treated in clinical priority order and so some long waiting patients are delayed by those more clinically urgent e.g. cancer patients.
- 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.
- Behavioural changes around referral patterns i.e. increase in 2WW referrals in DD.
- Delayed referrals from the Sussex MSK Partnership – patients are being referred waiting over 18 and on occasions over 42-weeks.
- Recruitment and retention of clinical and non-clinical staff.
- 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.
- Lack of robust processes and SOPs e.g. completion of outcome forms, variation in booking practices.
- Clinical understanding and ownership.
- Productivity and efficiency in job planning, outpatients, 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 (see *Appendix B*). 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. A system wide meeting occurred on 17 March to confirm need for the CCGs to commission alternative providers for overstretched specialties at BSUH. Consideration is being given to the request to pause referrals to the DD service to allow it to recover the position and be able to start delivering timely care to patients.

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
- A full-day weekly access meeting commenced on 3 February 2016 ensuring individual long waiting patients are reviewed as well as addressing issues as they arise (see *Appendix C*). The attendance at this meeting includes all support services that are essential to the delivery of RTT performance.
- We commenced the Very Intensive Support package offered by the IST on 22 February 2016.
- Re-focused the Clinical Review Group - now chaired by Heather Brown, Deputy Medical Director - which will review all patients waiting over 52-weeks to establish whether any harm has come to the patient. The first meeting was held on 4 February, 42 patients have been reviewed to date; three were escalated as needing further specialty review, of those 1 is following the duty of candor process. No SI identified. Progress and outputs of the Clinical Review Panel are shared at the internal Safety & Quality meeting and the Quality Review Meeting with commissioners each month.
- Booking Hub Review – recommendations of which to be shared with the board in March.
- RTT Assurance Meetings – these weekly meetings have been reprioritised to focus on administrative and informatics support required to support the planned care agenda.

- Validation – there are a total of 17 validators in the Trust. A plan is being drafted to articulate the priorities and approach for validation of the Trust.
- Training – a dedicated trainer is focussing on priority staff groups and is developing a training plan.
- The DD Recovery and Sustainability Taskforce - chaired by the Clinical Director and Directorate Manager - with resources drawn from the Operational Support Unit (OSU) is underway. The programme of work includes pathway changes including enabling some patients to be referred 'straight to test' without the need for an outpatient appointment.
- Using alternative providers where possible - working with commissioners and the national PMO to identify any additional capacity both with NHS and Independent providers.

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.
- Maximizing the opportunities of choice at source with referral management service Optum.
- Cease 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 and ensure 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.
- Backlog clearance to be included in 16/17 plan.
- Appropriate use of 2WW referrals.
- Support in redesigning pathways e.g. straight to test endoscopy.

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 utilisation 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 now has an established weekly diagnostics meeting inviting each modality lead reporting over 1% breaches to discuss their weekly, in-month and following month expected performance and recovery plan.

For February we have reported a position of 2.19% against the national diagnostic standard. This is based on a total waiting list size of 5,995 - 131 breaches made up of 13 MRI, 4 CT, 8 ultrasound, 5 echocardiograms, 2 urodynamics and 99 endoscopy.

This represents a further improvement on January's 4.9% (288 breaches).

With cardiac echos, urodynamics and neurophysiology now below 1%, the two areas of focus remain Imaging and Endoscopy.

MRI breaches remain largely a paediatric general anaesthetics problem, one which the department is engaged with Paediatrics and Anaesthetics to resolve as soon as possible. However, due to the complexity of aligning job plans and physical capacity across three departments this may take until May to reduce to <1%.

Ultrasound has once again emerged as a potential risk due to increased demand in February (from an average of 5,000 per month to nearly 6,000) and at time of writing have 100 unbooked cases to accommodate before the end of the month. Additional sessions are being set up to reduce this to as small a number as possible, including weekend and evening working.

Endoscopy March month end is predicted to be similar to February, largely due to colonoscopy capacity being exhausted, despite additional weekend sessions being in place since the beginning of February and on-going (apart from Easter weekend). Plans to bring in an external RSCH-based provider have been delayed due to governance issues, but are still planned for April. Endoscopy recovery back to within 1% is therefore delayed until June/July 2016.

4. **Cancer Services**

The Cancer PTL meeting format specifically targets key areas of concern that have deteriorated from November 2015. DD remains a significant concern with all key areas. 2WW, 31 and 62-day pathways are all non-compliant. To ensure each

individual session has clear objectives and outcomes, each meeting has minutes and agreed actions circulated within 42-hours of the meeting. We have refreshed our assurance and trajectory model which was completed on the 24 February 2016, the original document was submitted in October 2015. The new trajectory, indicates growth in the 62-day pathway activity (c20%), RAG rating by tumour group, a specific colorectal review and pathology turnaround times.

The 2WW cancer wait performance for January was 80.0%. The effect of 166 Colorectal 2WW breaches (27.2% compliance) continues to have a significant impact on our performance of all cancer wait time measures. The 2WW compliance for February currently sits at 86.3% (1,567 patients seen, 215 below target), which relates to the upper and lower GI backlog. Colorectal for February 2016 is delivering 38.2% due to 107 of the 173 patients seen breaching the standard. Upper GI is currently on way to deliver 75.8% as 38 of the 157 patients seen breached.

The performance against the 62-day target for January was 80.3%, the total number of patients seen has been lower than anticipated. The current position for the 62-day pathway in February is 74.5% however this is not yet a fully validated position. Due to ongoing compliance issues in Digestive Diseases there are 9 colorectal breachers. If we were to exclude colorectal, we would anticipate that the 62-day position would be compliant once all of the activity had been fully validated.

104+ day patients, currently stands at 19 of which 3 have a cancer diagnosis. These are reviewed weekly at the Cancer PTL meeting with CCG sign off. An agreed reporting mechanism is in place with the CCG's, the report indicates patients both with and without a cancer diagnosis.

At the end of February a total of 963 patients are on the current list of patients who are undiagnosed, diagnosed and treated in the current month. This means we are tracking over 900 patients weekly compared to 400 – 500 reported 12 months previously.

145.5 undiagnosed patients have already breached the 62-day standard and require a diagnostic outcome.

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

Screening performance for January is 93.6%. February is currently 44% but this is not as yet a fully validated position.

5. Areas of Particular Concern

Trajectories submitted for these areas require significant support and change management in order to bring these areas of the trust into RTT compliance. System-wide discussions are focussed on these key areas.

5.1 Digestive Diseases (DD)

DD represents the largest proportion of the backlog and the highest number of over 52-week breaches each month. This service is now beginning to pull down the Trust-wide 2WW performance as it is simply not able to cope with the increase in referrals (reflective of a service in crisis – where there are long waits for routine appointments GPs will use urgent process to fast track

patients through the system). A request has been submitted to commissioners to pause all referrals to this service for a 6-month period. A recovery and sustainability programme has commenced for DD, prioritising recruitment of additional clinical staff, job planning, securing additional endoscopy capacity, weekend working, intense support from the IST on demand and capacity modelling and outsourcing where appropriate.

5.2 Neurosciences (incl. spinal)

There are still some reconfiguration issues to resolve across neurosciences to maximise productivity e.g. providing admin support on the RSCH site, additional HDU capacity on PRH site, theatre scheduling and bed modelling on RSCH. This division has just appointed a substantive Patient Access Manager (PAM) but may also need further investment in management capacity. Job planning and rota coordination are priorities for the senior team. Again where appropriate outsourcing opportunities are being sought and further collaboration with the MSK partnership.

Request for additional funds to support the growth in neurology referrals has been submitted as part of the business planning cycle. A focus on productivity in both outpatients and theatres, pooling lists where appropriate will follow. Neurosciences are also receiving additional support from the IST on demand and capacity.

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.

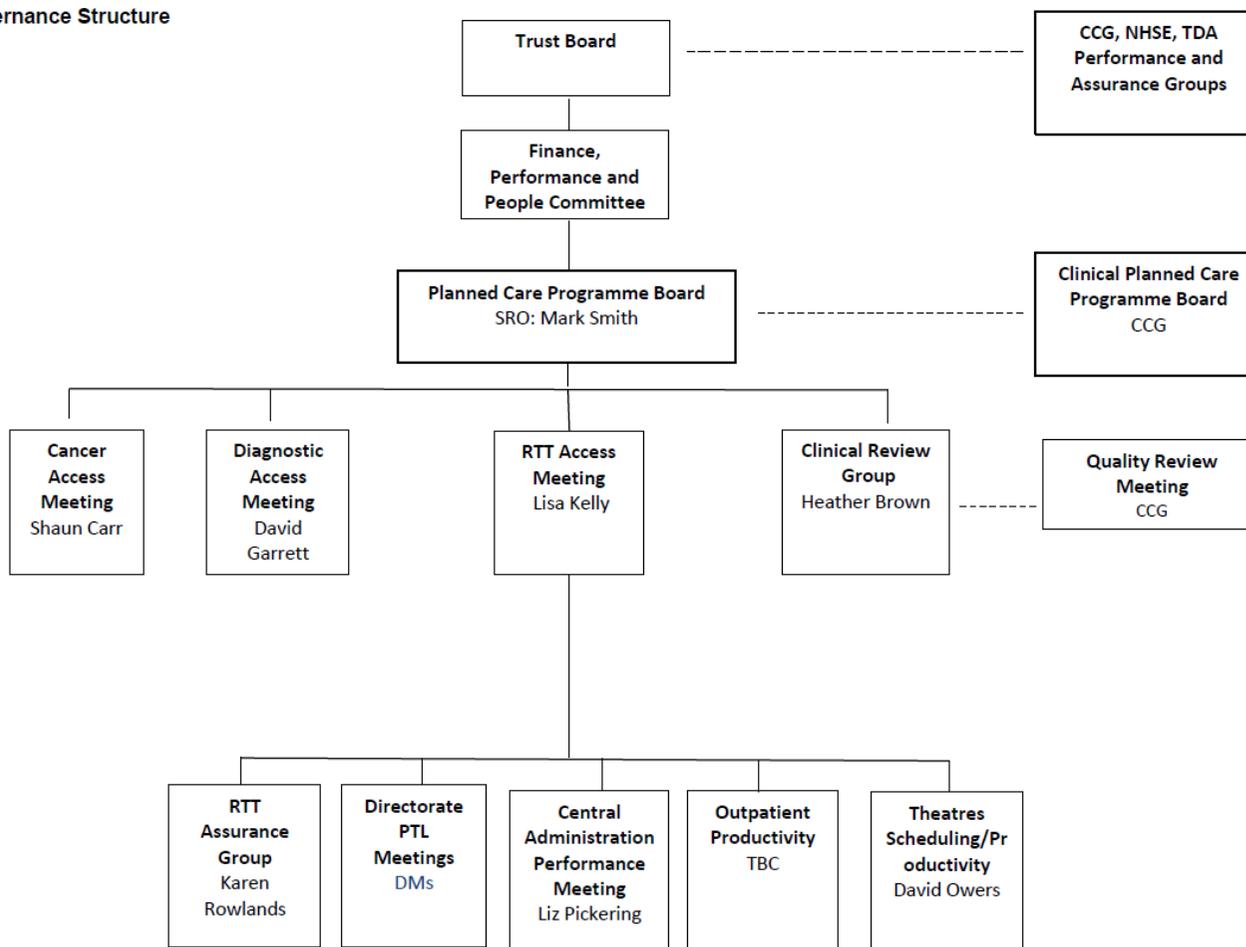
Lisa Kelly

Interim Deputy Chief Operating Officer (Scheduled Care)

March 2016

**APPENDIX A:
Planned Care Governance Structure**

Planned Care Governance Structure



**APPENDIX B:
Revised Trajectory for Compliance**

Specialty	DM	52 week compliance date	18 week compliance date	Key enablers and risks in 16/17
General Medicine	TR	Feb-16	Jan-16	
Cardiology	TE	Feb-16	Mar-16	CPAU beds used for outliers TAVI – NHSE capped payment
Dermatology	TR	Feb-16	Mar-16	
Geriatric Medicine	TR	Feb-16	Mar-16	
Rheumatology	TR	Feb-16	Mar-16	
Thoracic Medicine	TE	Feb-16	Mar-16	
Cardiac Surgery	TE	Feb-16	May-16	Bed availability
Breast	SC	Feb-16	Jun-16	2 Additional theatre lists required per month until December 2016
Vascular	TE	Feb-16	Jul-16	Additional DC list until July
Other	LP and others	Mar-16	Jul-16	Paediatrics – under review – further detail required. Pain - close service
Oral Surgery	JM	Mar-16	Aug-16	3 additional theatre lists per week. Continue IS outsourcing
ENT	JM	Mar-16	Dec-16	Appointment of GPSI and WLIs
Gynaecology	HT	Mar-16	Dec-16	1 additional theatre session per month
Ophthalmology	JM	Mar-16	Feb-17	Additional lists and clinics
Gastroenterology	FM	Under Review	May-17	Recruitment of consultant
Urology	FM	Mar-16	Nov-17	Additional theatre and bed capacity
T&O	CA	Mar-16	Dec-17	HDU bed capacity. Overrun of emergency theatre lists. Additional Consultant, Podiatrist, ESP and SCP for foot and ankle

Specialty	D M	52 week compliance date	18 week compliance date	Key enablers and risks in 16/17
DD Surg	FM	Under Review	Under Review	Stop referrals for 6-months with immediate effect. New consultants starting and job planning
Neurology	K M	Under Review	Under Review	Recruitment of 1 consultant, a registrar and a nurse specialist
Neurosurgery	K M	Under Review	Under Review	In patient bed capacity.
Spinal Surgery	K M	Under Review	Under Review	Rotas' agreed 6-months in advance. 6 additional outpatient clinics per month. Return to previous productivity (non-elective displacing elective). Maximise PRH site
Trust			Mar-18	
Trust without DD			Dec-17	

APPENDIX C: Trust-wide Patient Access Meeting (Terms of Reference)

1. Aim and Scope

To ensure that adequate progress is being made against the remedial action plan and trajectories to return the Trust to 18-week compliance. A full review of all long waiting patients and performance of support services to enable delivery.

2. Objectives

- To have oversight of the 18-week RTT performance target and associated patient safety and experience.
- To closer monitor all patients booked over 18-weeks.
- To help unblock any issues preventing compliance.
- To enhance communication between internal and external stakeholders.
- To engage the support services to support delivery.

3. Meetings & Communications

- Frequency – weekly.
- Action tracker to be maintained in real-time.
- Escalation as appropriate of issues to Chief Operating Officer/Executive Team.
- Terms of Reference (ToR) to be reviewed every 3-months.

4. Membership

- Deputy Chief Operating Officer – Planned Care (Chair)
- Trust 18 week Lead
- Directorate Managers
- Informatics Representative
- Head of Central Administration
- Others by invitation of the Chair

Project Management support will be provided by the Operational Support Unit.

5. Quorum

A quorum of Deputy Chief Operating Officer or nominated deputy and either 18-week Lead or Informatics Lead must be present to constitute a valid meeting.