To:	**Trust Board**
From:	Mark Brassington, COO
Date:	19th September 2018
Healthcare standard	Key Operational Constitutional Standards

Title:	Operational Capacity and Delivery Plan, Update September 2018

Author/Responsible Director:
Simon Evans, Director of Operations and Mark Brassington, COO

Purpose of the report: To update the board on current progress against the agreed actions within the Operational Capacity and Delivery Plan, as approved in July 2018, current performance against constitutional standards is provided through the Integrated Performance Report

The report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Information	X

Summary/key points:

The paper outlines the current position against the operational capacity and delivery plan. It highlights planning assumptions that were included within the activity plan having not been delivered (c.£5m more than M1-5 2017/18) The result is that expected improvements have not as yet materialised. There remains a significant risk that the level of current activity is not sustainable within current resources even after the contained investment within this paper.

Recommendations: That the board notes the content of the report.

Strategic risk register	**Performance KPIs year to date Included within IPR**
Resource implications (eg Financial, HR) Financial implications already supported	
Assurance implications within the report	
Patient and Public Involvement (PPI) implications not identified	
Equality impact not required	
Information exempt from disclosure	
Requirement for further review? Yes	

Operational Capacity and Delivery Plan: Update September 2018

1.0 Purpose of this paper

This update relates to the operational capacity and delivery plan v10 signed off by the Trust Board in July 2018. It articulates the progress against urgent care, constitutional standards for elective care, managerial capacity targets described in the plan together with appropriate narrative where there is deviation. This paper does not include extensive performance information as this is produced as part of Urgent and Planned care performance updates and the integrated performance report.

2.0 Performance Progress to Date

2.1 Urgent Care

2018-19 ambitions for Urgent Care projected a substantial improvement in the 4-hour urgent care standard performance. This forecast system delivery of 90% by September 2018 with 95% by March 2019. This initial target of 90% by September was not achieved. ULHT Type 1 performance within the system trajectory in September was set at 81.41% and this was not achieved.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Trajectory Type 1 Activity	69.69%	72.03%	74.38%	76.72%	79.07%	81.41%	82.22%	83.02%	79.07%	76.72%	77.53%	86.24%
Actual Type 1 Activity	68.23%	72.42%	72.82%	69.47%	69.37%	66.79%						
Trajectory ULHT + Streaming	72.04%	74.33%	76.63%	78.92%	81.22%	83.51%	84.39%	85.26%	81.22%	78.92%	79.79%	88.74%
Actual Type 1 Activity	70.70%	75.01%	75.08%	71.96%	72.35%	70.27%						
Trajectory ULHT + Streaming & Type 3	82.07%	83.68%	85.30%	86.91%	88.52%	90.13%	90.94%	91.75%	88.52%	86.91%	87.72%	95.00%
Actual Type 1 Activity	80.30%	83.62%	83.53%	81.47%	82.45%	80.15%						

Underpinning the above trajectory were a set of assumptions that included;

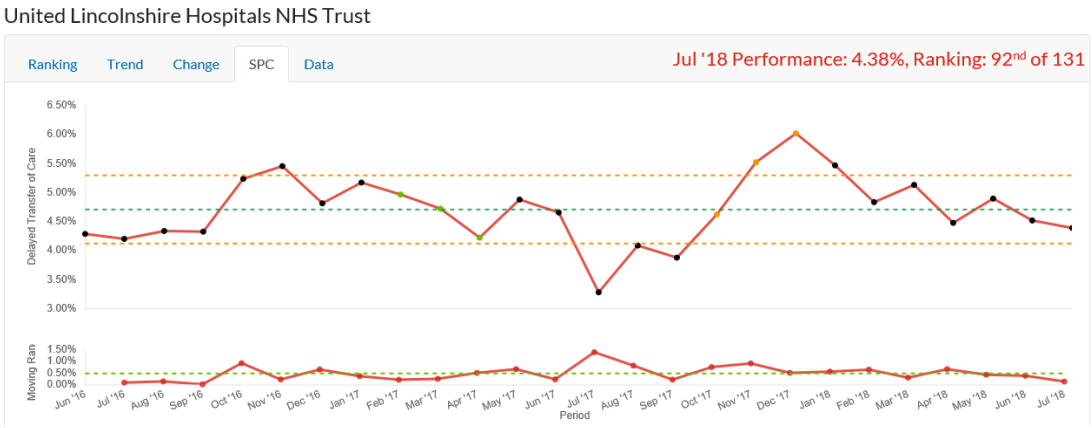
- A&E attendances to remain within the planned activity levels as this was used to set the workforce model. During M1 to 5 A&E attendances are 10.8% above plan. This equates to 41 more patients a day than planned for.

- Non-elective (NEL) admissions would remain within the anticipated growth within the activity plan as this set the expected bed requirements. After the first 4 months of the year excluding Neonatal, Obstetrics and paediatrics (as these beds cannot be used to accommodate adult patients), NEL medical demand is 9.9% above plan. (See table below.) Extrapolating the impact of this in terms of inpatient bed usage this would equate to need for more than 60 more inpatient medical beds to accommodate growth alone at Lincoln and Pilgrim hospitals.

POD Grp Desc 2	Spec Code	Spec Desc	2018-19 YTD Activity Plan	2018-19 YTD Activity Actual	2018-19 YTD Activity Variance	Last year activity	Summary	%age Greater than plan	%age Greater than last Year
Non Elective Spells	**300**	General Medicine	9,073	10,457	1,384	8,857	1,600	15.3%	18.1%
Non Elective Spells	**307**	Diabetic Medicine	24	16	- 8	11	5	-32.2%	45.5%
Non Elective Spells	**340**	Respiratory Medicine	78	68	- 10	288	- 220	-13.1%	-76.4%
Non Elective Spells	**430**	Geriatric Medicine	445	33	- 412	408	- 375	-92.6%	-91.9%
Grand Total			**9,620**	**10,574**	**954**	**9,564**	**1,010**	**9.9%**	**10.6%**

- Staffing would not deteriorate as a stable substantive workforce is critical in managing flow and also undertaking the required improvement actions across the hospital sites. During the initial months of 2018/19 vacancy rates for medical and nursing staff has increased. This is especially so within urgent and emergency care. The sites are affected differently across the pathway. However there has been a disproportionate impact at Pilgrim.

- Out of hospital capacity to support discharge would remain consistent to support a 3% DToC rate. In addition to increased demands, levels of patients in delay (DTOC) have not returned to planned levels of 3.5% or to the aspiration of 3.0%. Although they have decreased from winter peak in December, they continue to be within the 3rd quartile performance nationally and represent decreased levels of community provision compared to that expected.



The urgent care services ambitions and key actions described in the Capacity and Delivery Plan are as follows:

2.2 Ambulance Handovers and Conveyance

2.2.1 Background

Conveyance rates in Lincolnshire are amongst the lowest in the regions that EMAS operate in although Model Hospital suggests the % of attendances by ambulance is above the national median. Despite this ambulances per hospital bed are high, which is perhaps more suggestive of a bed base that benchmarks lower for the level of activity. Variation is a problem with significant peaks at times of year (winter months most notably). Additional variation occurs daily both naturally occurring through 999 calls as well as artificially when the hospital batches release as well as batching caused by crew shift patterns.

2.2.2 Key actions for improvement

- Fully implement Straight to Community Hospital Pathways (CCG) – Complete but little usage. EMAS/CCG required to further increase usage.
- Reduce care home conveyance with better care planning for patients (CCG) Incomplete no date for implementation.

- Fully implement the falls pathway and associated community service, reducing the number of conveyances for falls with no significant injury (CCG) Incomplete: service decommissioned. Alternative services have been developed with EMAS and are being piloted. Further evidence to be obtained but initial feedback is positive.
- Implement the catheter service to reduce the number of conveyances for issues with catheters (CCG) Incomplete; service not recommissioned.
- With support from SSG Health refine the handover processes (ULHT) Complete and has shown marked improvement. No further funding has been identified and programme has now plateaued. Additional support has been requested from NHSi and NHSE to carry on the improvements made to date.

2.2.3 Anticipated Impact

- Reduce overall conveyances by 10% from last year 80th %ile rate: **Off Track overall conveyances 2% increase from Quarter 1 2017/18 to Quarter 1 2018/19**
- Improve to 2nd quartile of 60 min handover with <1% 2 hour handovers: **Partially Achieved: 60 minute handover remains 4th quartile (poorest)** however **<1% of handovers >120 minutes has been achieved on all sites in September 2018.**

2.3 Streaming to services co-located or outside of Emergency Department

2.3.1 Background

Analysis completed in early 2017-18 indicated that a large proportion of patients attending the Trust's Emergency Departments did not require emergency care. Original targets were set at 35% of all patients being streamed outside of the Emergency department. A recent review has suggested that this ambition may not be achievable.

2.3.2 Key Actions

- Switch streaming nurses to LCHS and increase PHB streaming to 16% by end of June. 25% by end of August 2018. (CCG & LCHS)
  In June 10.2% were streamed (in hours of operation) increasing to 13.8% in August. This missed the overall target but represented significant improvements in line with the national review expectation.
- Switch streaming nurses to LCHS and increase LCH streaming to 20% by end of June and 30% by end of August 2018 (CCG & LCHS) **In June 16.3% were streamed (in hours of operation) increasing to 24.4% in August. This missed the overall target but represented improvements in line with the national review expectation.**
- All other specialties to define GP referral accepting areas alternative to ED where patients are stable to remove overcrowding in EDs (ULHT) by the end of August 2018. **As part of the Pilgrim Reconfiguration scheme all GP referrals will bypass EDs from 2nd October. LCH pathways for surgery will also bypass in ED however not all other pathways have been completed.**

- Dear Doctor referral pathways to be banned with a new SOP and system for reporting primary care breaches to be implemented (CCG & ULHT) by 30th June 2018 **Not consistently in place. This will be aligned to reconfiguration work at PHB hospital and improvements at LCH as part of the urgent care improvement plan. Anticipated completion will be November 2018.**

2.4 Pilgrim and Lincoln Emergency Department Staffing and Emergency Department Processes

2.4.1 Background

46% of breaches in 2017-18 were the result of ED medical Delays and ED delays to treatment. This was the single largest cause of failure to meet the 4-hour standard. Staffing vacancies in medical, nursing and managerial positions have been a challenge throughout 2018-19. Analysis on presentations in A&E as well as the impact on times to assessment and times to treatment were used previously to judge the most appropriate shift patterns to match demand.

2.4.2 Key Actions

- Implement the 19-man middle grade rota at PHB and LC with no significant increase in agency (through recruitment and bank - ULHT) – **16 man rota implemented from September. Currently both sites maintaining a 16 man rota due to 13 gaps against establishment of 19WTE.**
- Use the most recent analysis to revise rota patterns to match demand of all grades at both LCH and PHB from the 1st June 2018. Where rotations require further notice 1st August 2018 (ULHT). **New timings and better matching of capacity and demand has been put in place where rota fill rates accommodated. *More than 100 hours/week at each hospital went unfilled in August 2018.***
- Complete a team-based nursing rota and overlay shift patterns against demand and occupancy to improve shift and coverage and safe staffing levels. Identify requirements and develop redeployment where necessary by June 2018 (ULHT). **Partially completed at Lincoln A&E, incomplete at PHB. Vacancies in nursing establishment have lowered registered nurses down to <50% of establishment, hence delayed until establishment increased.**
- Improve the RAIT process at PHB in line with recommendations, reducing turnaround time and assessment times – by end of July 2018 (ULHT) **Unsuccessful change. Audits have indicated RAIT performance has not improved and as such a further RAIT stream will be required to match demand, or for alternative medical workforce to be found to replace the existing locum/agency teams working in these areas.**
- Introduce safe handover and cohort nursing processes at LCH and PHB utilising appropriate staffing of nurses/paramedics/technicians – by end of June 2018 (ULHT) **Successfully Implemented as part of Ambulance handover stream. Fill rates for agency technician teams at times pose a challenge to this, but overall process is being embedded.**
- Develop ACPs at LCH and PHB, recognising the likely loss of 3 ACPs at PHB. Utilising the ADPRAC expert ACP team procured for 2018-19. Programme to be fully defined by end of

April 2018, and majority complete by March 31st 2019 (ULHT) **Programme fully identified. Loss of 5 ACPs at PHB, however programme anticipating the development of 4 or more ACPs for 2019.**

- Complete the inter-professional standards document for all specialties and services that support Emergency Departments. Sign off by all CDs, all doctors and put in place a rotational induction system that has all new doctors signing off on each rotation. By the end of May 2018 (ULHT). **Signed off, however reviews showing poor adherence to the standards. Further establishment during the next rotation including individual doctor sign off sheets will be put in place.**

2.5 Admissions areas and flow management

2.5.1 Background

In 2017-18 19% of breaches were related to exit block and breaches through lack of bed capacity. Although emergency department staffing and processes contributed significantly to the deterioration in urgent care performance throughout 2017-18 the most significant factor, particularly in winter months, was exit block caused by poor flow.

2.5.2 Key Actions

- Introduce specialty delay monitoring (specialty labelling) on admission wards (MEAU AMU SEAU) to drive improvement in flow from admissions to wards to base wards by end of June 2018 (ULHT). **Not in place. Awaiting response for IT system capture capability on WebV system. Cost identified, however unlikely to be significant <£5,000.**
- Complete job planning to ensure all ward rounds start at 08:00 – Complete by October 2018 (ULHT) **Partially complete. Now incorporated as part of the next round of team job planning/capacity process with KPMG and financial turnaround.**
- Update 7-day medical services review and identify gaps for medical discharge capabilities at weekend. – Complete review by the end of May (ULHT) **Gaps identified, and partially mitigated through reconfiguration work at PHB. LCH incomplete and requires new model/or alternative recruitment plans.**
- Extend the Red 2 Green process and performance management process to all diagnostic and referring services. Fully implement with senior operational leads for Red 2 Green by end of May 2018 (ULHT) **In place. Further improvements planned for Q3/Q4 2018/19.**
- Implement the Medically Fit for Discharge SOP – June 2018 (CCG, LCHS&ULHT) **Pilot in place and running on Carlton-Coleby Ward. Roll out from there will commence Q3.**
- Introduce twilight bed manager shifts at Lincoln and Pilgrim – 18:00 - 02:00 **On track, starting Q3 2018.**
- Introduce a support post to the new Urgent Care Lead post. Additional Site Duty Manager to assist cover for sickness, supporting Red to Green Meetings and developing plans such as weekend / bank holiday plans. **Recruitment on track at LCH and in place at PHB. Recent resignation will require recruitment again at PHB likely to be a gap in Q3.**

- Discharge all "hyper stranded" medically stable to transfer (MSTT) patients >50day LOS by 1st July 2018 utilising complex discharge hub and MDTs where necessary (CCG, LCHS&ULHT) **Now replaced with the super stranded scheme. Update included in urgent care update.**
- Drive the 10x10 discharges and pull from admissions ward each day, with clear planning each day to secure early movement on admissions wards. To be delivered each weekday by June 2018, weekends included by 1st September 2018. **Still poor delivery of the 10x10, with only partial achievement on weekdays and very poor levels at weekends. Recovery actions being developed including reviewing roles of administrative teams in/with wards to support discharge.**

2.6 Large Scale Trust Bed Re-configuration

2.6.1 Background

10% of all breaches in 2017-18 were associated with Overcapacity in A&E and a further 19% of breaches were related to exit block and breaches through lack of bed capacity.

2.6.2 Key Actions

- Recruit a programme manager and then deliver the reconfiguration plan at PHB, increasing admissions beds and reallocating beds to the correct specialty to deliver predicted requirements. – Complete by 1st October 2018 (agreed) **Recruited and reconfiguration is on track for October 2018. First wave complete second wave commences 24th September.**
- Resus expansion on both sites to move LCH to 8 bays and PHB to 6 at an indicative cost of £4.5M. Business case will be produced by end of May 2018. **Business case produced and submitted. Awaiting feedback.**
- Piloting a new configuration of Orthopaedic Services to hot and cold sites reallocating and transferring beds to specialties and across sites to deliver GiRFT recommendations – Complete by the 16th August 2018. **Pilot running and ward configurations changed at LCH and PHB during September 2018.**
- Develop AEC and SEAU surgical pathways at LC and PHB to be incorporated into estates changes and service commencement. July 2018. **SAU business case submitted and approved and work underway at LCH. PHB incorporated into reconfiguration plan.**
- Develop a plan to safely open and manage Digby ward in winter 2018/19. To be in place from 2nd January 2019 – 5th April 2019. **Planning still being discussed. Digby options are maturing, however the use of the Bostonian for winter is still considered very high risk.**
- Large scale re-profile of the remaining elective operations at LCH, Louth, Grantham and PHB to reduce demand on PHB and LCH over winter 2018-19. **Re-profiling complete as part of winter plan. Further work to consider contingency and further mitigation on going.**

2.7 Investment

The table below provides a summary of the expected costs with FYE and PYE impact:

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	2018/19	2019/20
Urgent Care	Pay	-	Developing Band 5's at LCH and PHB, making the Medic Now role trust wide and substantive.	Band 5's	11.00			478,700	478,700
Urgent Care	Pay	Admissions areas and flow	5 areas at LCH and 4 at PHB - average cost for 9	Consultant	3.60	120,000	5	180,000	432,000
Urgent Care	Pay	Admissions areas and flow	5 areas at LCH and 4 at PHB - average cost for 9	Middle	3.60	89,000	5	133,500	320,400
Urgent Care	Pay	Admissions areas and flow	5 areas at LCH and 4 at PHB - average cost for 9	Junior	7.20	50,900	5	152,700	366,500
Urgent Care	Pay	Admissions areas and flow management	7 day Therapy Services Provision for General Medicine (Previous Winter Plan Action now FYE)		6.00		8	199,867	99,900
Urgent Care	Pay	Winter Plan Specific	Utilise Digby as Winter Ward - 3months Agency	Consultant	1.00		Q4 Only	66,000	0
Urgent Care	Pay	Winter Plan Specific	Utilise Digby as Winter Ward - 3months Agency	Middle	1.00		Q4 Only	40,500	0
Urgent Care	Pay	Winter Plan Specific	Utilise Digby as Winter Ward - 3 months Agency	Junior	2.00		Q4 Only	25,500	0
Urgent Care	Pay	Winter Plan Specific	3 RN on every shift - Agency	Band 5	16.70	36.20	Q4 Only	294,713	0
Urgent Care	Pay	Winter Plan Specific	2 HCSW In every shift - Agency	Band 2	11.00	15.43	Q4 Only	82,743	0
Urgent Care	Pay	Winter Plan Specific	Twilight Bed Manager Shift	Band 4		96,900	8	64,600	96,900
Urgent Care	Sub-Total - Pay				63.10			1,718,823	1,794,400
Urgent Care	Non Pay		General provision for Computer H/W, Office Eqpt & Furniture, Training & Travel based on 5%		0.00			57,238	84,900
Urgent Care	Non Pay		Ward Non-pay Costs		0.00			33,000	0
Urgent Care	Non Pay	Ambulance Handovers and Conveyance	SSG Support Until July 2018 (Funded NHSi Quality Scheme)		0.00		3	0	0
Urgent Care	Non Pay	locating or outside of the Emergency Department	No additional costs other than those within Pilgrim reconfiguration		0.00			0	0
Urgent Care	Sub-Total - Non Pay				0.00	0	3	90,238	84,900
Urgent Care	Grand Total				63.10			1,809,062	1,879,300

As described in section 2 nearly all areas of urgent care investment are on track and being spent in line with financial profiling. Those areas that are off track are:

- A&E Medical staffing
- 7 day services additional capacity at LCH. (PHB is on track)

3.0 Constitutional Standards

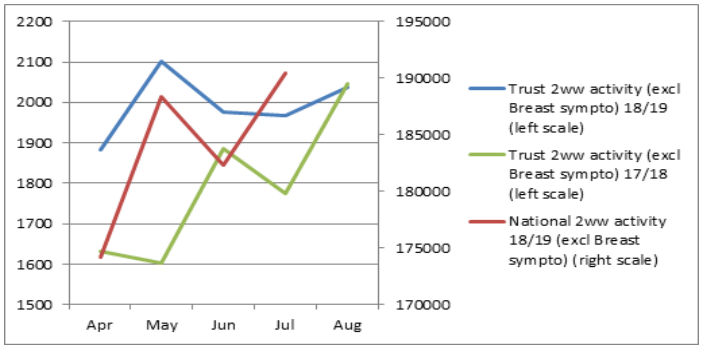
3.1 Cancer

3.1.1 Performance Improvement Trajectory

The improvement trajectory described in the Capacity and Delivery plan was:

Cancer 62 Day	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Total number of completed 6	155	155	155	155	155	155	155	145	155	155	155
Number of completed pathw	121	124	127	129	132	132	132	123	124	124	127
Percentage pathways comple	78%	80%	82%	83%	85%	85%	85%	85%	80%	80%	82%
> 62 Day Backlog (as at month	60	52	45	40	40	40	40	40	40	40	40

Underpinning the above trajectory was the expectation that demand remained within National expectations. However referrals on a 2ww pathway have outstripped national expectations.



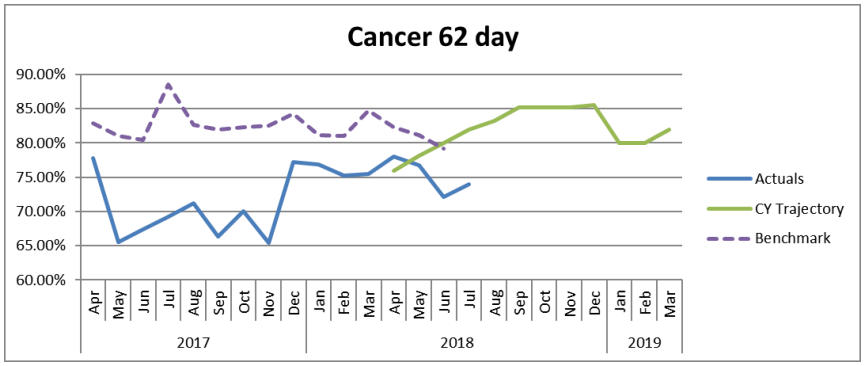
Local growth has been c.11% against national growth of c. 4%.

Cancer 14 Day	Apr	May	Jun	Jul	Aug
Trust 2ww activity (excl Breast sympto) 17/18 (left scale)	1632	1601	1886	1774	2045
Trust 2ww activity (excl Breast sympto) 18/19 (left scale)	1883	2102	1975	1966	2037
Percentage increase	15.4%	31.3%	4.7%	10.8%	-0.4%

The volume of completed treatments is also 12% above the expected monthly volume of 155.

Cancer 62 Day	Apr-18	M2 May-18	M3 Jun-18	M4 Jul-18	M5 Aug-18
Total number of completed pathways	170.5	183	184.5	167	161.5
Number of completed pathways in target	133	140.5	133	123.5	132
Percentage pathways completed in target	78.0%	76.8%	72.1%	74.0%	81.7%

Despite the level of unprecedented growth and additional activity performance achieved in 2018/19 has been the strongest performance in cancer 62 day standards since 2014 and representing a step change. August performance is predicted to be c. 81.5% and above the National average. However performance did not achieve the recovery trajectory.



3.1.2 Investment required for step change in performance

Key themes from the RCA breaches which are considered to remain 'live' issues where further improvement is required in order to effect the level of change needed to deliver to above trajectory were as follows:

- Administrative capacity to pro-actively track and expedite pathways
- Radiological reporting capacity
- Tertiary diagnostic delays
- Compliance with national optimal pathway for Lung and Prostate
- Oncology capacity – including additional Chemotherapy
- Capacity and demand – Dermatology and Breast

3.1.3 Priority actions during Q1 of 2018/19

There are a number of key actions which are currently underway, with a view to full delivery in Q1 of 2018/19 as part of the Trust's plan to increase performance further, following on from the improvements demonstrated within Q4's performance. These actions include:

- Complete recruitment processes and commence roll out of 7-day CT, MRI and Endoscopy Services – CT 7-day service commenced; MRI and Endoscopy recruitment ongoing with partial 7-day service through additional duty hours. However significant radiologist vacancies 14wte v establishment of 27.
- Pilot nurse led triage within Urology pathway – successful pilot demonstrating 8 day reduction in time to diagnosis. Substantive service commenced in September 2018.
- Targeted backlog reduction approaches within Urology and Lower GI – Reduction in lower GI backlog to target levels achieved by end of Q1, with slight deterioration during Q2. Urology remains above target level
- Capacity/demand review across segments within pathways for key tumour sites – KPMG visual Management Tool project commenced in September
- Introduction of pathway facilitators for lung and Lincoln Surgery – in place from the beginning of Q2
- Cross site scheduling to optimise cancer theatre delivery – Trust wide 6-4-2 in place
- Work with CCGs to implement East Midlands Cancer Alliance pathway priorities – Q1/2 funding submission signed off. Recruitment commenced for priorities
- Introduce advice and guidance for Breast referrals – In place from Q2
- Develop business case for breast 6-day service – To be completed by October

The following additional resources required to address the outstanding issues and enable the Trust to make this step-change in performance are:

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	2018/19	2019/20
Cancer	Pay	Administrative capacity	8 x Band 4 Cancer Trackers	Band 4	8.00	27,900	7	130,200	223,200
Cancer	Pay	Administrative capacity	4 x Band 4 cancer Facilitators (1 for Radiology, 1 for Endoscopy 1 for Oncology, 1 for Urology)	Band 4	4.00	27,900	7	65,100	111,600
Cancer	Pay	Administrative capacity	1 x Band 8B Cancer Performance role	Band 8b	1.00	73,500	5	30,625	73,500
Cancer	Pay	Oncology capacity	1 x Band 7 Oncology Palliative CNS	Band 7	1.00	52,400	6	26,200	52,400
Cancer	Pay	Radiological capacity	3 x Consultant Radiologists	Consultant	3.00	132,600	5	165,750	397,800
Cancer	Pay	Radiological capacity	Radiology Medical Secretaries	Band 3	1.50	24,300	5	15,188	36,500
Cancer	Pay	Tertiary diagnostics	3 PAs Respiratory Consultant	Consultant	0.00	12,100	3	9,075	36,300
Cancer	Pay	Tertiary diagnostics	0.5 Band 7 sonographer	Band 7	0.50	52,400	6	13,100	26,200
Cancer	Pay	National optimal pathway	1 x Band 7 Urology Nurse link to triage	Band 7	1.00	52,400	6	26,200	52,400
Cancer	Pay	Oncology capacity	1 x Consultant Oncologist	Consultant	1.00	132,600	5	55,250	132,600
Cancer	Pay	Oncology capacity	Medical Secretary for Oncologist	Band 3	0.50	24,300	5	5,063	12,200
Cancer	Pay	Oncology capacity	Choice and Access Support for Oncologist	Band 2	0.12	22,100	5	1,105	2,700
Cancer	Pay	Oncology capacity	Phlebotomy for Chemotherapy	Band 2	1.00	22,100	5	14,733	22,100
Cancer	Pay	Oncology capacity	Chemo Schedulers	Band 3	2.00	24,300	6	28,350	48,600
Cancer	Pay	Oncology capacity	1 x Band 6 Chemotherapy trained Nurse	Band 6	2.00	44,500	7	51,917	89,000
Cancer	Pay	Oncology capacity	1 x Band 5 Chemotherapy trained Nurse	Band 5	8.41	35,700	8	115,490	300,200
Cancer	Pay	Capacity and demand	1 x Consultant Dermatologist	Consultant	1.00	128,000	5	53,333	128,000
Cancer	Pay	Capacity and demand	Medical Secretary for Dermatologist	Band 3	0.50	24,300	5	5,063	12,200
Cancer	Pay	Capacity and demand	Choice and Access Support for Dermatologist	Band 2	0.18	22,100	5	1,658	4,000
Cancer	Pay	Capacity and demand	1 x Band 3 Breast co-ordinators	Band 3	1.00	24,300	8	16,200	24,300
Cancer	**Sub-Total - Pay**				**37.71**			**829,598**	**1,785,800**
Cancer	Non Pay	Administrative capacity	Desk top Computers and Monitors - Cancer trackers		0.00		8	5,616	0
Cancer	Non Pay	Administrative capacity	Personal Computers - Facilitators		0.00		4	2,808	0
Cancer	Non Pay	Administrative capacity	General provision for Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			41,480	89,300
Cancer	Non Pay	ADministrative capacity	Extension of check in booth and software to oncology		0.00			15,000	15,000
Cancer	Non Pay	Tertiary diagnostics	EBUS/EUS equipment		0.00			160,000	0
Cancer	**Sub-Total - Non Pay**				**0.00**			**224,904**	**104,300**
Cancer	**Grand Total**				**37.71**			**1,054,502**	**1,890,100**

Progress against the recruitment of these roles is delayed and although many posts have progressed there are a number that have failed to recruit are part of planned delays for financial reasons. Updates on each are as follows:

- 8 x band 4 cancer trackers => Interviews completed. **75% complete. 6 posts offered and accepted (including one internal promotion). Remainder of the funds for posts will be used after a 3 month pause as part of financial turnaround measures.**
- 4 x band 4 facilitators => **50% complete. Urology and Oncology posts in place. Diagnostics posts are not recruited to and will be subject to 3 month pause as part of financial turnaround measures.**
- 1 x band 8B Dep General Manager Cancer Specialist => **Out to advert currently; on track for recruitment Q4.**
- 1 x band 7 Oncology palliative CNS => **Delayed: currently at job matching panel.**
- 3 x Consultant Radiologists => **Currently not filled baseline establishment yet due to recruitment difficulties, will begin to fill these 3 once baseline filled. Recruitment processes ongoing, 6 offers pending which would take to baseline funded establishment.**
- 1.5 x Radiology Med Secs => **Not yet advertised until above are identified.**
- 3PAs Respiratory Consultant => **Not being utilised currently, and is dependant upon the eBUS model which is ultimately agreed, links with EMCA discussions.**
- 0.5 x Band 7 sonographer => **Failed to recruit. To go back out to advert again.**
- 1 x Band 7 nurse for Urology triage => **Service being provided by overtime using non-recurrent funds from EMCA, however substantive post is now out to advert.**
- 1 x Consultant Oncologist => **Not yet at baseline establishment as loss of other consultant capacity since plan was developed.**
- 0.5 x band 3 med sec for Oncologist => **In post**
- 0.3 x band 2 in C&A (link to Oncologist and Dermatologist) => **Not recruited to currently**
- 1 x band 2 phlebotomist for Chemotherapy => **At advert stage.**
- 2 x band 3 chemotherapy schedulers => **In post**
- 2 x band 6 chemotherapy nurses => **Interviewing 20/09/2018**
- 8.4 x band 5 chemotherapy nurses => **Out to advert**
- 1 x Consultant Dermatologist => **Delayed and currently seeking college approval for Job plan**
- 0.5 x band 3 med sec for Dermatologist => **Not started recruitment yet, linked to the above**
- 1 x band 3 Breast co-ordinator => **Interview completed. Suitable candidate found, to be offered post.**
- EBUS equipment => **still in discussion with EMCA re proposed model. We have asked for delivery in county by a different provider as the preferred option, but have asked for EMCA to help support/facilitate.**

3.2 RTT

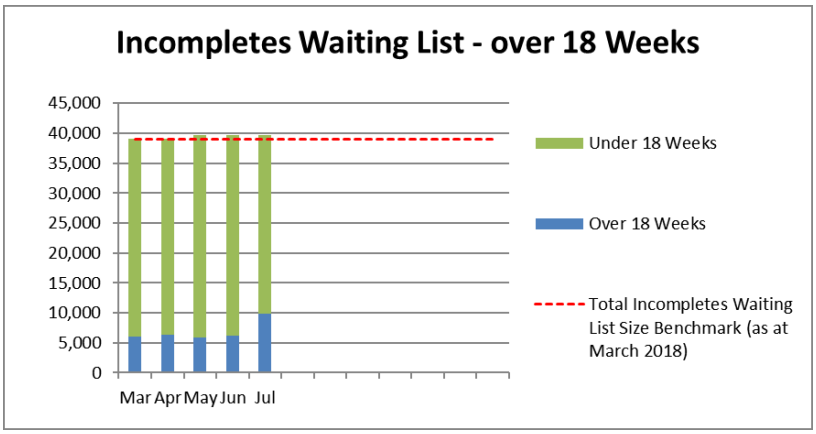
3.2.1 Priority Actions for 2018/19

The proposed level of backlog reduction in 2018/19 was as per below:

Referral to Treatment - Trajectory 2018/19	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9	Month 10	Month 11	Month 12
Number of incomplete RTT pathways <=18 weeks	33,054	33,054	33,054	33,054	33,054	33,054	33,054	33,054	33,054	33,054	33,054	33,054
Number of incomplete RTT pathways >18 weeks	5,978	5,838	5,688	5,538	5,388	5,238	5,088	4,938	4,938	4,938	4,938	4,938
Trust level RTT performance	84.70%	85.00%	85.30%	85.60%	86.00%	86.30%	86.70%	87.00%	87.00%	87.00%	87.00%	87.00%

Despite Outpatient activity being c.4500 ahead of plan and daycase over 1000 patients ahead of plan actual performance to date has not delivered this trajectory. The principle reasons are demand growth above planned levels, NEL demand significantly above planned levels thereby crowding our elective activity (550 below plan but c.1200 operations cancelled) and a number of specialties with significant workforce challenges causing significant capacity constraints.

Incomplete waiting list size at the end of month 4 has grown by c. 800 patients and is as follows:



This level of improvement needs to be delivered through a combination of speciality level actions and Trust-wide system improvements. The following six specialities are currently all reporting performance below 83.5% against the incomplete RTT standard. Improvement in these specialities performance between 4-5.5% (varying by speciality) will bring the Trust in line with national average:

- General Surgery (backlog reduction of 195 patients required)
- T&O (backlog reduction of 170 patients required)
- ENT (backlog reduction of 367 patients required)
- OMF (backlog reduction of 101 patient required)
- Pain (backlog reduction of 65 patients required)
- Gastro (backlog reduction of 142 patients required)

3.2.1 Investment required for step change in performance

The table below describes the full investment required (assuming all other elements of capacity and demand remain the same) to deliver the 2018-19 ambitions for RTT.

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	2018/19	2019/20
RTT	Pay	RTT	Outsourcing/Insourcing Support Manager	Band 5	1.00	35,700	9	26,775	35,700
RTT	Pay	RTT	Choice and Access Trainer	Band 5	1.00	35,700	9	26,775	35,700
RTT	Pay	RTT	6 months of a full-time Gastro locum at £120/hour at Lincoln	Consultant	0.00		6	136,200	0
RTT	Pay	RTT	6 Months Access & Choice Gastro Support	Band 2	0.12	22100	6	1,326	0
RTT	Pay	RTT	6 Months Clinic Staffing - Gastro	Band 5	0.11	35700	6	1,964	0
RTT	Pay	RTT	6 Months Clinic Staffing - Gastro	Band 2	0.11	22100	6	1,216	0
RTT	Sub-Total - Pay				2.34	71400	42	194,255	71,400
RTT	Non Pay	RTT	Personal Computers		0.00			1,404	0
RTT	Non Pay	RTT	General provision for Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			2,678	3,600
RTT	Non Pay	RTT	Outsourcing - extension to current budget		0.00			123,000	0
RTT	Non Pay	RTT	Medinet insourcing - details to be confirmed		0.00			0	0
RTT	Sub-Total - Non Pay				0.00	0	0	127,082	3,600
RTT	Grand Total				2.34	71400	42	321,337	75,000

The update is as follows;

- 1 x band 5 outsourcing support manager => **Delayed in 3 month recruitment pause linked to new vacancy restrictions for financial turnaround.**
- 1 x band 5 choice and access trainer => **Delayed in 3 month recruitment pause linked to new vacancy restrictions for financial turnaround.**
- 6 months of locum Gastro Consultant => **In post and will deliver required benefits.**
- Medinet => **No agreement in place with Medinet yet, however value for money test is likely to present use of Medinet as not financially viable**

Alongside the speciality level actions, the Trust-wide improvement programmes within Outpatients and Theatres will deliver improved capacity utilisation for all specialities in order to deliver increased productivity within existing resources. Outpatient improvement plans are delivering additional capacity, beyond that forecasted and is over performing substantially. This is in both numbers of appointments but also in a financial sense. Theatres programme is not performing to projected levels as the number of cancellations have increased. These are predominantly for reasons of bed availability. However plans for reconfiguration of services in Orthopaedics as well as wider service reconfiguration at PHB will support the programme getting back on track.

4.0 Clinical Directorate/Divisional Managerial Capacity

4.1 Review of Divisional Structure

Since the development of the Capacity and Delivery plan, Divisional restructure proposals have changed significantly. Interim models have started to be put in place and therefore elements of the management capacity plan have delivered sooner than predicted whilst others may be delayed or deferred indefinitely. As this element of the capacity and delivery plan has become part of the future Trust Operating Model programme, it is likely that future reporting will be a specific report solely around that programme. The future management financial envelop I now made up of the exiting spend plus the financial value agreed as part of this operational capacity and delivery plan.

4.1.1 Total Operational Capacity Investment

The total increase in capacity proposed for clinical directorates/divisions was planned as per below.

Type	Breach Reason Addressed	Description	Band	WTE	2018/19	2019/20
Pay	W&C	Additional Business Manager to split Women's services and Gynaecology from Children's services. Both sides with 8a that covers operational and improvement roles.	SENIOR MANAGER BAND 8A	1.00	40,667	61,000
Pay	W&C	Additional role of Children's services lead nurse/ Head of Nursing	NURSE MANAGER BAND 8C	1.00	72,917	87,500
Pay	LCH Surgery	Additional B8a Project Manager to Work alongside Grantham PHB Surgery on delivery of General Surgery and T&O Reconfiguration	SENIOR MANAGER BAND 8A	1.00	35,583	61,000
Pay	PHB Surgery	Additional B8a Business Manager to split General surgical services & vascular, from Breast, Pain and Childrens	SENIOR MANAGER BAND 8A	1.00	61,000	61,000
Pay	Grantham	Band 7 Operational Service Manager for Outpatient Services and Rehab Medicine	A&C CLINICAL SUPPORT BAND 7	1.00	30,567	52,400
Pay	D&CS	Band 7 Operational Service Manager for Outpatient Services and Rehab Medicine	A&C CLINICAL SUPPORT BAND 7	1.00	30,567	52,400
Pay	D&CS	nurses x2 to support safety improvements, financial and efficiency schemes	ALLIED HEALTH PROFS BAND 6	2.00	44,500	89,000
Pay	D&CS	Matron across diagnostics and rehab medicine. Part time split currently with Outpatients.	SENIOR MANAGER BAND 8A	1.00	40,667	61,000
Pay	LCH Medicine	Deputy Head of Nursing to support Urgent Care Programme and Day to Day Operational	NURSE MANAGER BAND 8B	1.00	49,000	73,500
Pay	LCH Medicine	Business Analyst to support Urgent, Elective, Financial and Directorate Specific Improvement schemes	A&C CLINICAL BAND 5	1.00	17,850	35,700
Pay	PHB Medicine	Deputy Head of Nursing to support Urgent Care Programme and Day to Day Operational	NURSE MANAGER BAND 8B	1.00	30,625	73,500
Pay	PHB Medicine	Business Analyst to support Urgent, Elective, Financial and Directorate Specific Improvement schemes	A&C CLINICAL BAND 5	1.00	17,850	35,700
Sub-Total - Pay				13.00	471,792	743,700
Non Pay		General provision for Computer H/W, Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00	23,590	37,200
Sub-Total - Non Pay				0.00	23,590	37,200
Grand Total				13.00	495,381	780,900

All areas with the exception of PHB Medicine and LCH surgery were not due to deliver these extra managerial posts until Q3 of this year. Both those areas have successfully recruited, however other posts associated to the delivery of the future operating model are unlikely to be in place for the Q3 and Q4 as they are being appropriately fitted and structured into the new divisional teams. A full update of progress and the structures themselves will be available in a separate future paper.

5.0 Summary

The paper has outlined the current position against the operational capacity and delivery plan. It is clear that the planning assumptions that were included within the activity plan have not been delivered. As a result over £2m more activity than plan has been completed by the end of M5 (c.£5m more than M1-5 2017/18). As a result the expected improvements have not as yet materialised. Furthermore there is a significant risk that the level of current activity is not sustainable within current resources even after the contained investment within this paper.

6.0 Recommendation

The Trust Board is asked to note the progress made against the operational capacity and delivery plan actions.