Agenda Item 11.3

Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

ULHT OPERATIONAL CAPACITY AND DELIVERY PLAN 2018-19

Version 1.04 19th June 2018

Abstract

This operational capacity plan brings together analysis on urgent care, constitutional standards for elective care, managerial capacity, considerations of the delivery of quality improvement plans and the delivery of financial improvement plans. It articulates the improvement plans agreed, the scope of work to be undertaken, and the necessary additional resources to deliver them.

Corporate Operations Team

Chief Operating Officer, Director and Deputy Directors of Operations

Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

Operational Capacity and Delivery Plan 2018-19

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Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust

Version Control			
Version	**Edited/Author**	**Comments**	**Review by**
0.1-0.6	S Evans/ M Brassington/ A Prydderch / N Ellis	Drafts pre review	
0.7	S Evans	Paper Reviewed with Sign-off in principle – further revisions required	Executive Team
0.8	D Picken, S Evans	Revised and updated finances, added Bed position narrative. Cancer trajectory confirmed.	
0.9	M Brassington	Paper reviewed, amended	M Brassington
1.01	S Evans	Minor amendments structure and formatting prior to sign off	Executive Team
1.02-3	S Evans	Updated with previous years investments request from ET	M Brassington
1.04	S Evans	Updated with Chemotherapy extension, and minor updates to Urgent Care section	M Brassington

1.0 Purpose

This operational capacity plan brings together analysis on urgent care, constitutional standards for elective care, managerial capacity, considerations of the delivery of quality improvement plans and the delivery of financial improvement plans. It articulates the improvement plans agreed, the scope of work to be undertaken, and the necessary additional resources to deliver them.

The proposals within each of the sections of this report are considered changes required to deliver all aspects of 2018-19 standards. Clinical directorates and Corporate operations departments have been reviewed as part of this exercise and all other support functions are assumed to see no change from 2017-18 levels. Should any corporate departments change in size or scope of support then this review would need to be amended to consider.

In 2017-18 Urgent Care, Cancer and Management capacity all received investments to address shortfalls in capacity. Cancer investments through the System Executive Team (SET) monies were time limited and non-recurrent measures and as such are referenced any further in this report. Urgent Care and Management Capacity investments were however recurrent funding. They are described in more detail in each section to follow.

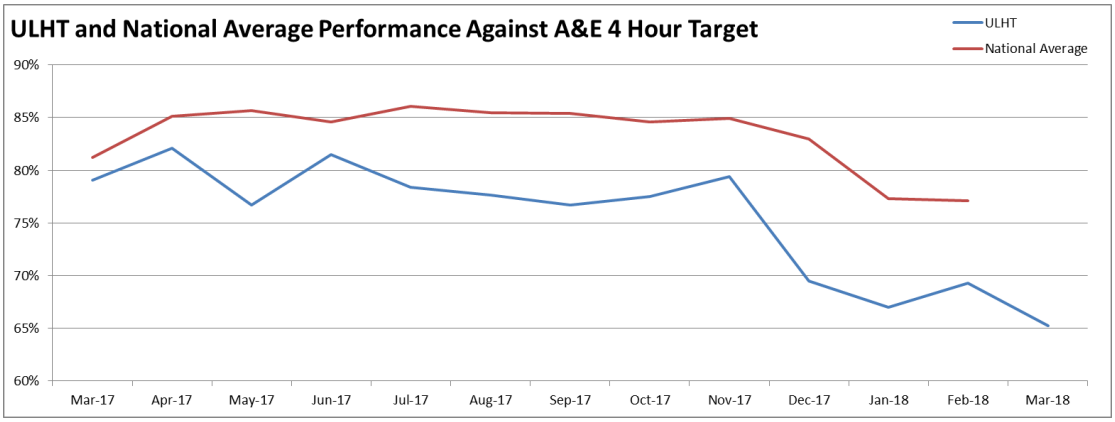
2017/18 Scheme	Type	WTE	2017/18 FYE
Management	Staffing	3.00	209,500
Management	Grand Total	3.00	209,500
Urgent Care	A&E Phase 1	12.63	951,200
Urgent Care	A&E Phase 2	49.10	2,511,400
Urgent Care	Grand Total	61.73	1,160,700

Productive services and the “pipeline” of projects from the 2021 programme that will require operationalisation are considered in this report where stated. In summary these are limited to: Theatres Optimisation, Endoscopy Optimisation, Outpatient Services Optimisation, Trauma and Orthopaedic improvements and General Surgery optimisation. Further schemes moving into the Productive Services programme may require additional resource to guarantee delivery.

2.0 Summary of 2017-2018 Performance

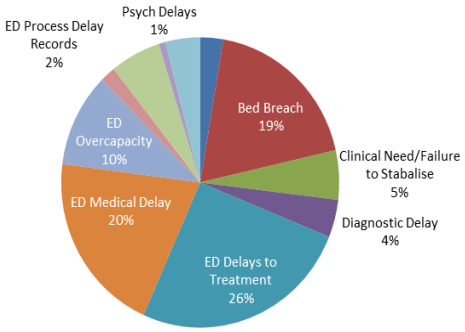
2.1 Urgent Care 2017-18

The Trusts performance for urgent care has been below plan and below the national average throughout 2017-18. Against the 4-hour target performance has been poor and we have seen long delays for ambulances bringing patients in to the hospital.



The underlying reasons for poor performance change throughout the year in severity but remain a constant negative impact. The reasons for breaches of the 4 hour are described overleaf.

ULHT Grouped Breach Reason Allocation Last 14 Months

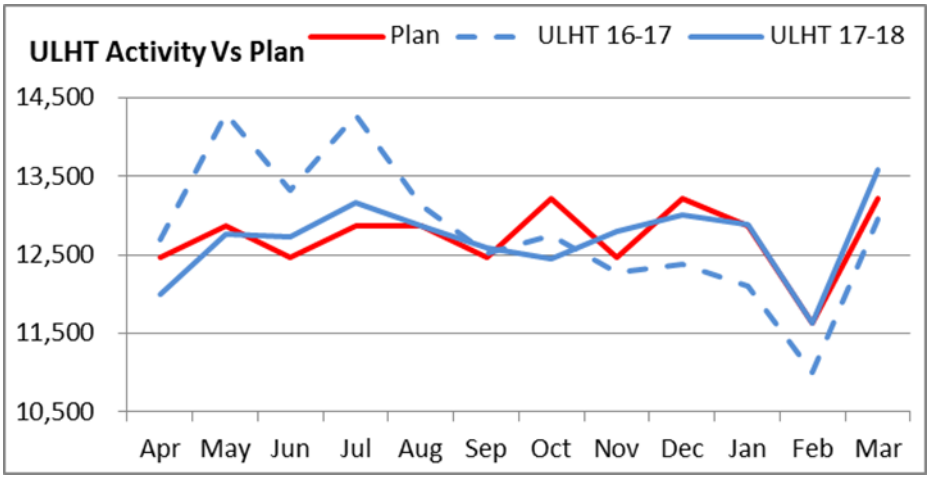


Improvement plans as well as winter plans included greater actions, larger investment and larger ambitions for improving performance than in previous years. This is set against a greatly reduced level of substantive medical and nursing staffing in A&Es compared to previous years, and an increasingly more acute, and greater proportion of acutely unwell patients, particularly in winter.

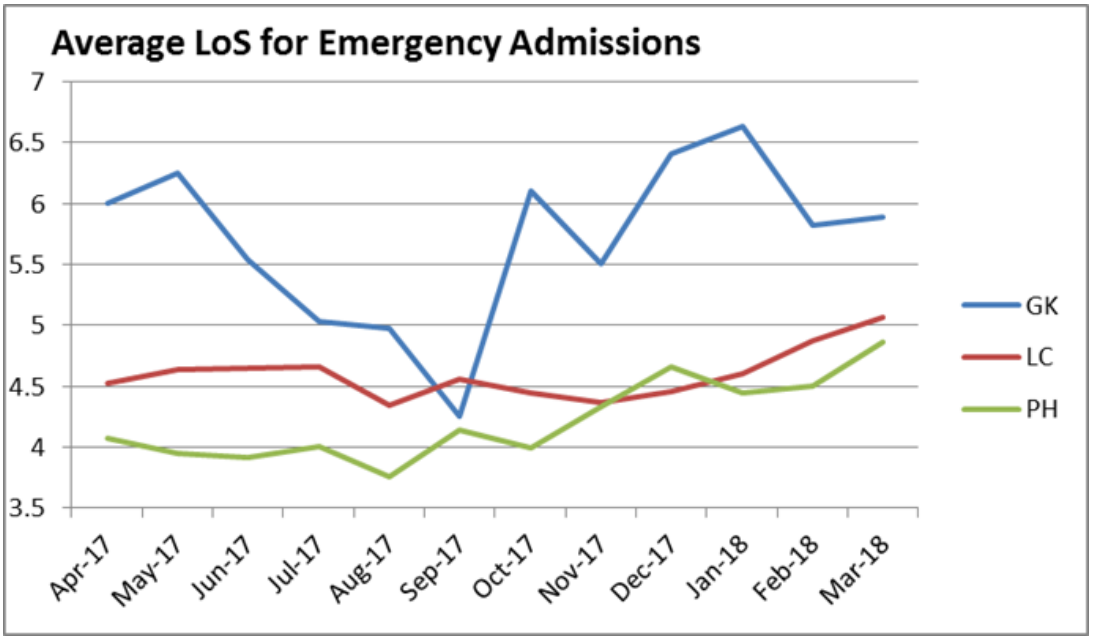
As a result relatively few of the improvement schemes made substantial impact on performance. With key challenges around staffing levels reducing the effect of many of the schemes, often with disproportionate levels of agency and locum staff being employed to fill substantial gaps.

Attendances at A&E increased last year on the previous year and were often above the monthly planned volumes the trust agreed with commissioners. This was despite reduction in Grantham A&E operating hours. In order to help relieve the pressure on the departments £1M capital was invested in providing new “GP Streaming” facilities. Some patients who

attend A&E do not present with time critical emergencies and could have been seen at an urgent care centre, their GP practise or by pharmacies. These patients are now being streamed away from A&E and into a collocated area staffed by GP's and nurses who work in primary care.



The trust has seen high bed occupancy rates throughout the year and in particular over the winter months when hospitals see higher admissions of patients with more complex conditions which take longer to treat. These more complex conditions increase the length of stay (LoS) in hospital which means less beds are available for patients waiting to be admitted from the GP or the "emergency admissions" in the A&E department.

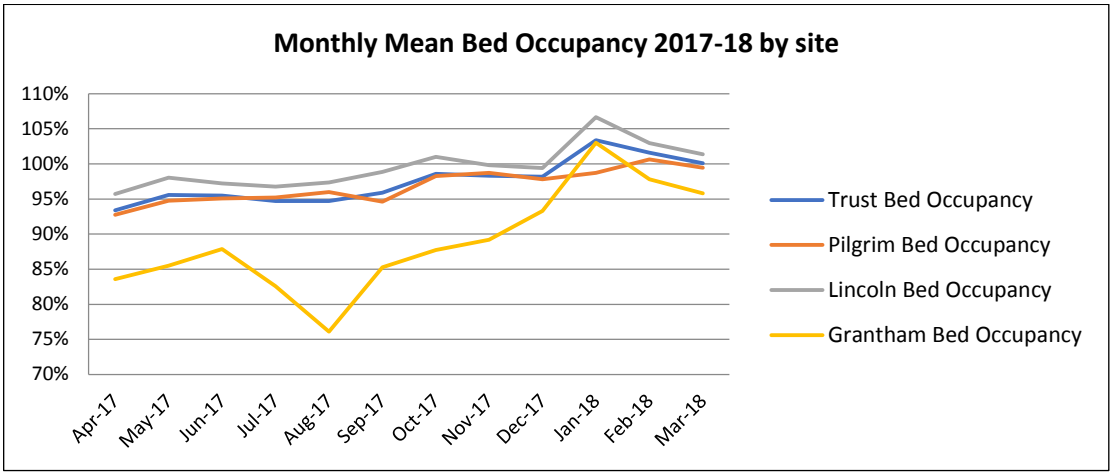


There has been an increase in LOS on all sites (GK – Grantham, LC – Lincoln County, PH – Pilgrim Hospital Boston) over the winter months. To reduce LoS and bed occupancy the trust implemented the SAFER patient flow bundle – a series of good practice initiatives to get patients treated efficiently and the "Red to Green" initiative which attempts to eliminate delays and supports the SAFER bundle. There have also been a number of "surge" planning

weeks, sometimes called system reset or "Perfect Weeks" where additional resources and support from partner agencies such as Lincolnshire Community Health Services NHS Trust, Adult Social Care and commissioners is put in place to support patient's recovery and discharge.

Overall bed planning and resulting occupancy reflected that throughout 2017-18 the Trust operated a deficit of beds. Examining this at site level showed that a relatively lower level of occupancy at Louth and Grantham hospitals was masking an even more pronounced bed deficit at LCH and PHB.

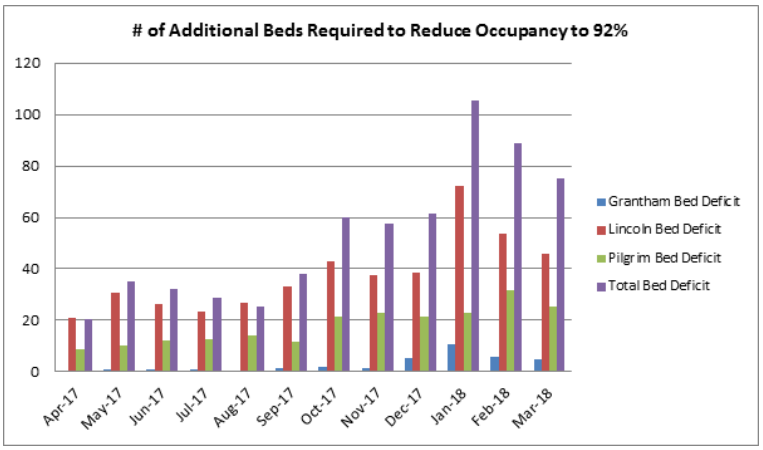
To compensate this each hospital increased bed occupancy above the 87% recommended occupancy level, and in some cases in excess of 100%. This occurred when all beds were full, all escalation beds were full and there were patients in ambulatory settings without a bed. In addition to this, and not factored into this occupancy information were the patients in ED waiting for beds overnight. This was in addition to the numbers shown in the occupancy chart.



In order to reduce bed occupancy back down to 92% (there is an argument that this remains too high) which will enable a reduction in cancellations and improve flow for ED there are a number of options;

- Reduce demand into hospital beds through community diversion and reduction in conveyance rate by EMAS. Model Hospital suggests there may be some opportunity but this remains limited
- Reduce LoS, however Model Hospital demonstrates that we are top performing quartile for Non-Elective LoS
- Open additional beds particularly at Lincoln to address the bed deficit however staffing remains a very real challenge

The bed deficit during 2017/18 to achieve 92% bed occupancy was 20-105;



If this was reduced to a bed occupancy of 87% the bed deficit would have been c.60-150 (LC 40-100; PHB 20-48; GK 0-15).

There is no activity growth assumed between 2017/18 outturn and 2018/19 contracted activity for non-elective but 4.3% for elective growth. This will further compound the bed deficit.
In 2017-18 there were a number of areas that received investment to "right-size" key areas for anticipated demand as well as to address some tactical improvements.

A&E Investment Part 1 – was to address the correct sizing of medical workforce in-line with guidelines from the Royal College of Emergency Medicine

- This was a recurrent investment of 12.63wte/£951,200
    - A&E Lincoln 7.63wte/£498,200 FYE
    - A&E Boston 5.00wte/£453,000 FYE
- This includes an additional 5.00wte Middle Grades for each site, in addition to which Lincoln received 2.63wte Band 2 in relation to Nurse Streaming

A&E Investment 2

- This was a recurrent investment of 49.10wte/£2,511,400
    - A&E Lincoln 30.49wte/£1,413,800 FYE
    - A&E Boston 18.61wte/£1,097,600 FYE
- This includes an additional 2.00wte Consultants and 3.00wte Middle Grades for both Lincoln and Boston, some investment in nursing for both sites, and investment in housekeeping/portering/reception at Lincoln.

Discharge Investment

- This was a recurrent investment of 15.47wte/£457,000 (this was non-recurrent investment made each year, now made recurrent)
    - Lincoln Discharge 8.15wte/£270,300 FYE
    - Pilgrim Discharge 7.32wte/£186,700

7 days pharmacy services – made recurrent throughout the year, instead of previously relying on winter funding for part year impacts.

- This was a recurrent investment of £249,200 FYE .

The sum total of this investment brought A&E teams and discharge teams up to RCEM guidance levels for 2016/17. It did not factor in growth see in 2011/18 nor any changes in staffing models. i.e. staffing to maximum capacity (instead of the RCEM guidance which describes staffing to the number of attendances)

2.2 Constitutional Standards 2017-18

2.2.1 Cancer

Cancer performance within ULHT was below the national standards for 14-day and 62-day during 2017/18. 31-day first treatment, subsequent Chemo and subsequent Radiotherapy are on track to achieve during 10 of the 12 months, however 31-day subsequent surgery performance has been less consistent. The table below shows 2017/18 performance for each cancer standard split by quarter, including March's partially validated position:

17/18	Q1	Q2	Q3	Q4		YTD		Std
14 Day	90.50%	87.50%	91.20%	83.40%		88.20%		93%
Breast	75.40%	91.70%	89.60%	54.90%		74.10%		93%
31 First	95.80%	96.40%	96.80%	96.90%		96.50%		96%
31 Drug	99.00%	99.60%	98.10%	99.30%		99.00%		98%
31 RT	93.40%	96.00%	97.30%	97.80%		96.20%		94%
31 Surgery	91.40%	91.70%	96.60%	90.70%		92.40%		94%
62 Classic	69.90%	69.00%	70.90%	75.50%		71.30%		85%
62 Screen	84.10%	87.90%	90.10%	87.20%		87.60%		90%
62 Upgrade	84.60%	89.90%	82.20%	90.10%		86.60%		85%

There was a 9% increase in referrals on a suspect cancer pathway during 2017/18 compared with the previous year, nationally there was a 4% increase comparing the same periods. However, conversion rates remained broadly in line with the national average. The increase in 2WW referrals into ULHT between 2016/17 and 2017/18 was particularly significant in the following tumour sites – Breast (17.6%), Skin (14%), lower GI (12.9%).

In addition, the delivery of cancer treatments was significantly affected during the winter by the impact of Urgent Care pressures and adverse weather, with over 35 surgical cases for cancer patients cancelled during Q4.

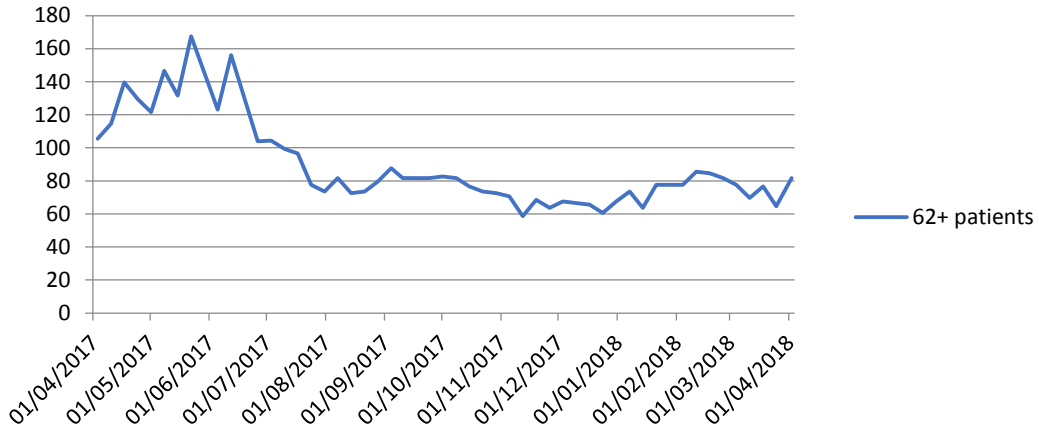
The Trust focused on reduction of the backlog of patients over 104 days and 62-days during 2017/18, both reducing significantly in-year with 62-day performance improving. The Trust is targeting a reduction of patients;

- over 104 without a planned treatment date to less than 6

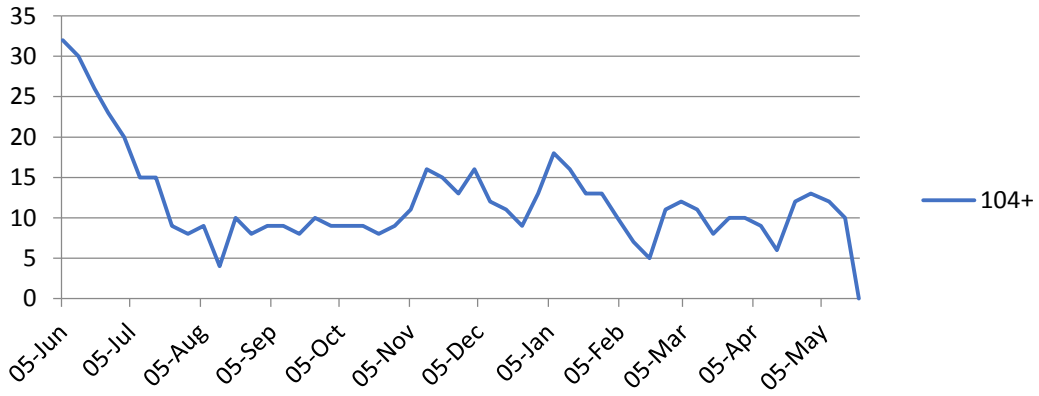
-within 62-day backlog down to 40 patients by July 2018

The above actions are expected to deliver the recovery trajectory during September 2018.

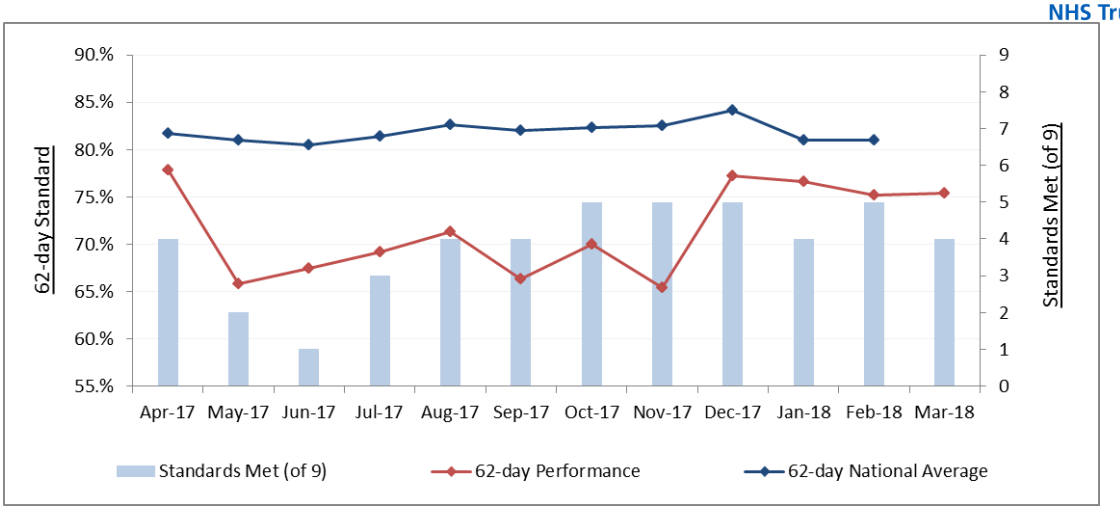
No of patients past 62-day breach date weekly within 2017/18



Number of 104+ days waiters remaining on a cancer pathway during 2017/18 - reaching 0 21st May



The Trust is on course to achieve four consecutive months in excess of 75% for the first time since 2014.



62-day breach contributory factors

Each month, prior to central submission of performance figures, the Clinical Directorates complete RCAs relating to all patients who breached the 62-day cancer standard for that month. These are submitted to the Cancer Team and are reviewed at a monthly meeting between the Cancer Lead Clinician, Cancer Lead Nurse, Cancer Centre Manager and Deputy Director of Operations for Planned Care. During this meeting themes from each case are identified which are considered to have contributed to delays within the pathway. This information is then collated for each month giving a summary of the key factors which have contributed to delays within the patient pathways which breached during that month, which is reviewed by the Cancer Management Committee each month. The table overleaf gives a summary of the delay themes for the last 12 months (one pathway will often have multiple delay factors):

	Breach contributing reasons																							
	Primary Care	Admin	IT Issues (cyber-attack)	First OPA/Clinic Capacity	OPA/Clinic Capacity	Oncology Clinic Capacity	Endoscopy Capacity	Pathology	MRI Capacity	CT Capacity (inc CTGBx & CTC)	U/S Capacity (inc U/S GBx)	Other Radiology Capacity	ICU/HDU Bed Capacity	Theatre Capacity	Chemo Capacity	RT/Brachy Capacity	Complexity or procedural	Patient Fitness/Medical	Patient Choice/Co-operation	Holistic needs	Pathway Processes	MDT	Tertiary diagnostic/opinion delays	Tertiary treatment delays	No. pt pathways impacted
Total	11	101	8	21	102	93	72	164	59	117	40	38	18	124	14	12	156	96	155	16	15	47	101	53	1633

Actions undertaken to improve performance

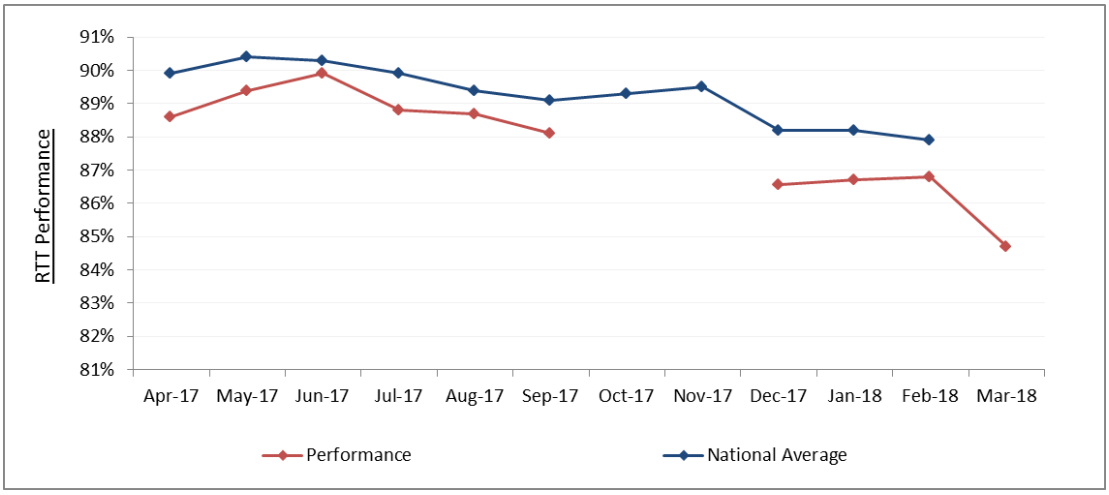
During the course of 2017/18 a programme of improvement has been undertaken within the Trust in order to improve the timeliness of assessment, diagnosis and treatment of patients on cancer pathways. This improvement programme was overseen at a corporate level via the fortnightly Cancer Recovery and Delivery Group which is chaired by the Deputy Director of Operations for Planned Care. Key changes implemented during 2017/18 include:

- Lower GI Nurse Led triage implemented across whole Trust, in order to reduce the time between referral and diagnosis
- Introduction of level 1 beds on Lincoln site, designed to reduce cancellations of surgery related to ICU capacity constraints. The impact of this has been restricted by bed pressures from urgent care
- Upper GI straight to test pathway established, in order to ensure that the patient has undergone initial diagnostics prior to their first outpatient appointment.
- Review and redesign of chemotherapy pathways, streamlining blood test and booking processes
- Introduction of chemo-scheduler roles, to keep oversight of chemotherapy treatment in relation to the patients 62-day target date.
- Review and redesign of diagnostic flow processes, in order to prioritise cancer cases, with the aim of achieving 90% of cases from referral to a Radiology report with 7-days and referral to Endoscopy within 10 days. As at the end of April 2018 Radiology is performing at 68% and Endoscopy 91% against these measures (significant improvement)
- Same day Radiology and Endoscopy booking commenced, enabling the patient to leave the Hospital after an Outpatient appointment with confirmation of the next step in their pathway, reducing booking delays
- Redesign of Urology pathway, introducing specific 2WW new appointment clinics to optimise decision making and reducing time between MDT and follow-up
- Development and approval of CT Business Case. This is to be fully operational, providing increased capacity 7-days per week on all sites from September 2018
- Development and approval of Endoscopy Business Case to deliver increased Endoscopy capacity. All day weekend lists at Lincoln and Pilgrim to be delivered from May 2018; in September extending to Grantham and evening lists to be delivered on the Lincoln and Pilgrim sites
- Development and approval of MRI Business Case, to be implemented July 2018
- Standardisation of transfer process between tumour sites in order to prevent delays in patient pathways once a decision made to transfer to a new tumour site
- Worked with partners to introduce PET Service (type of scan) within Lincolnshire, which is now provided 2 days per week from the Lincoln site
- Re-design and commence implementation of optimised lung pathway, with straight to test CT introduced in January in order to improve the effectiveness of the first Outpatient appointment by having the CT results available
- Path Links procured and commenced utilisation of outsourcing capacity in order to enable prioritisation of cancer workload and reduction of waits.
- Developed new tertiary pathways for Head & Neck and Urology cases, in line with Quality Surveillance recommendations
- Commenced allocation of Oncology appointments within MDTs, in order to enable early appointment planning

- Standardisation of cancer communications project, to support our administrative staff during conversations with patients to ensure that they make informed decisions when booking subsequent appointments.

2.2.2 RTT

RTT performance deteriorated during 2017/18 within the Trust and the country as a whole, as illustrated by the below graph. The Trust's incomplete performance in April 2017 was 88.6%, and had deteriorated to 84.7% by March 2018.



The Trust didn't submit RTT performance data for 2 months during 2017/18 (October and November) due to the impact of the Medway upgrade, and the requirement to construct a new Business Intelligence report. The enhanced reporting functionality following the Medway upgrade enabled patients at the pre-operative stage between outpatients and inpatients to be included within the reported figures, which contributed to a deterioration within the Trust's reported performance.

In addition, the level of cancelled operations during 2017/18 has led to a significant increase in the backlog of patients waiting over 18 weeks on an admitted pathway. During 2017/18, 4853 operations were cancelled on the day or day before surgery, which is an 83% increase compared with 2016/17. The highest volume cancellation reason was the lack of beds as a result of urgent care pressures. The volume of patients waiting over 18 weeks for an operation rose from 1018 at the end of April to 2456 at the end of March.

A third key factor within the deterioration of the Trust's RTT performance at the end of the year was the cancellation of c.2750 outpatient appointments at the end of February/beginning of March as a result of the adverse weather conditions.

Additionally, specialities such as ENT and Breast, which historically relied upon additional clinics at weekends have found provision of this additional capacity more challenging since the standardisation of payment rates in line with the Agenda for Change contract.

In 2017/18 there was investment in waiting list management and validation, in order to better understand waiting list information and increase confidence about performance data: (described below)

Waiting List validation

- This was a recurrent investment of 3.00wte/£75,000
- In addition to which was a non-recurrent investment of £255,000 for costs of Ideal Health

3.0 Ambitions for 2018-2019 Performance

3.1 Urgent Care

2018-19 ambitions for Urgent Care will see a substantial and step change improvement in 4-hour urgent care standard. This will deliver 90% by September 2018 with 95% by March 2019.

	Feb	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ULHT Type I	67.34%	69.69%	72.03%	74.38%	76.72%	79.07%	81.41%	82.22%	83.02%	79.07%	76.72%	77.53%	86.24%
ULHT + Streaming	69.74%	72.04%	74.33%	76.63%	78.92%	81.22%	83.51%	84.39%	85.26%	81.22%	78.92%	79.79%	88.74%
ULHT + Streaming & Type 3	80.46%	82.07%	83.68%	85.30%	86.91%	88.52%	90.13%	90.94%	91.75%	88.52%	86.91%	87.72%	95.00%

In order to deliver this improvement, the Trust will need to deliver the improvements described in the sections 4.3-4.7. In addition to this there is an assumption that there will not be a disproportionate growth in A&E attendances, non-elective admissions, deterioration in staffing or community capacity to support discharge.

3.2 Constitutional Standards 2017-18

3.2.1 Cancer

The Trust has agreed to the following improvement trajectory for 62-day cancer performance during 2018/19.

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

3.2.2 RTT

The ambition is for the Trust to move to the national average performance for RTT incompletes by the end of March 2019. The national position for March 2018 is not known at the time of writing, however given the national impact of the adverse weather and the timing of Easter at the end of March, it is anticipated that it will be in the region of 87%, therefore for the purposes of this paper it is anticipated to be c.2.3% ahead of ULHT's March performance position. In order to achieve this level of improvement the Trust will need to reduce the number of patients waiting as incompletes over 18 weeks by 1040. Below is the proposed trajectory for RTT performance improvement during 2018/19:

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%

3.3 Investment Required to Deliver Step Change in Performance

The total investment to support the stated trajectories can be found below. However please note that it does not deliver a bed occupancy of 92% nor address all of the known capacity constraints. The identified schemes have been prioritised to address the most critical components to ensure improvement against a set of planning assumptions;

Scheme	Type	WTE	2018/19 PYE	2018/19 FYE
Management	Income	0.00	0	0
Management	Staffing	13.00	471,792	743,700
Management	Non Staffing	0.00	23,590	37,200
Management	Grand Total	13.00	495,381	780,900
Cancer	Activity Income	0.00	-375,410	-1,189,720
Cancer	Cancer Alliance	0.00	-332,250	0
Cancer	Staffing	37.71	829,598	1,785,800
Cancer	Non Staffing	0.00	209,904	89,300
Cancer	Grand Total	37.71	331,842	685,380
RTT	Activity Income	0	-181,432	0
RTT	Staffing	2	189,750	71,400
RTT	Non Staffing	0	127,082	3,600
RTT	Grand Total	2.00	135,400	75,000
Urgent Care	Winter Income	0.00	-1,000,000	0
Urgent Care	Staffing	63.10	1,718,823	1,794,400
Urgent Care	Non Staffing	0.00	90,238	84,900
Urgent Care	Grand Total	63.10	809,062	1,879,300
7 Day Services	Planning Assumptions		-1,000,000	-1,000,000
Total		**115.81**	**771,684**	**2,420,580**

In 2018/19 planning assumptions contingencies have been noted to the values below. The naming of the contingencies may not fully describe each scheme, however is planned with a specific purpose to support the schemes described within this report.

Scheme	Type	2018/19 PYE	2018/19 FYE
Planning Assumptions	7 day working	1,000,000	1,000,000
*Anticpated non-recurrent Income to offset any expenditure	"New Winter" Monies	1,000,000	1,000,000
Total		2,000,000	2,000,000

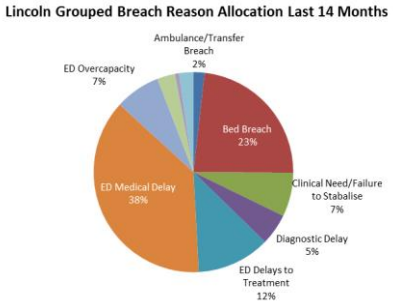
4.0 Urgent Care

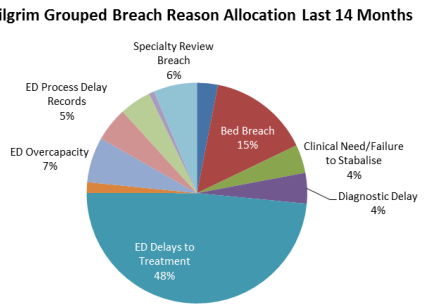
Urgent care services remain an area requiring considerable improvement in 2018-19 after having deteriorated throughout 2017-18. Despite a number of developments, new services and changes in leadership 4-hour performance has deteriorated, and Emergency Departments have increased levels of risk and safety concerns.

Residual challenges for 2018-19 after improvements in 2017-18 can be categorised as:

- Workforce; challenges with recruitment and retention as well as some behavioural aspects
- Demand outstripping capacity; in particularly variation in demand at times being multiple standard deviations from the mean
- Bed Deficit / Occupancy, associated with demand but also the change in complexity and dependency, LOS and Delayed Transfers of Care (DTOC)
- Leadership in key areas of urgent care

These challenges are seen predominantly, but not exclusively, at Lincoln County Hospital and Pilgrim Hospital Boston.





This report describes the output of a number of forums internally and externally with regulators, all synthesized into a single high-level approach to improving urgent care in 2018-19.

The report is not designed to be an exhaustive report of all aspects that require improvement, instead to identify areas of greatest impact that with recognition to limited resources in change and operational capacity will lead to the targeted improvement.

4.1 Performance Trajectory

The programme of work described in 6.3-6.7 is required to achieve the following improvement trajectory;

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
ULHT Type I	69.69%	72.03%	74.38%	76.72%	79.07%	81.41%	82.22%	83.02%	79.07%	76.72%	77.53%	86.24%
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%
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%

4.2 Winter Planning

4.2.1 Winter Planning 2017-18

Preparations for Winter 2017-18 started in August 2017. Planning for the anticipated increase in acuity, demand on urgent care services and the wider urgent care system was completed by September 2017 although final sign off of the winter plan was not until October 2017.

Additional winter funding was not planned at the outset of 2017-18 contract year, however additional funding was approved nationally in December 2017. This was then extended further with a full system wide budget of £2.37m.

The initial statement in planning rounds for 2017-18 indicated that winter funding would not be forthcoming. As a result, in Q1-2 plans did not include any additional capacity, limited 7 day services and was based on a reduction of elective services and a efficiency and effectiveness improvement trajectory to create the necessary capacity for winter.

Towards the end of Q2 it was apparent that improvements made would not be sufficient on their own to deliver the necessary capacity for winter. At this point additional measures were planned.

Scheme Name	Key Measures	Anticipated Outcome
10 by 10	# of patients discharged and then pulled from admission ward by 10:00	Improved early flow
7 day therapy,	Number of hours provided vs plan Number of weekend discharges achieved	Improved AE performance

Escalation of AEC (PHB) and SAL (LC)	Number of days escalated	Improved AE performance AEC performance Reduction AE admissions
Additional weekend medical team (Lincoln and PBH)	Number of additional hours provided vs plan Weekend discharges	Improved AE performance Improved patient experience
Enhanced phlebotomy service	Number of additional hours provided vs plan	Improved patient experience Improved weekend performance
Digby Ward – ULHT then LCHS then closed	Number of beds	Improved flow
Discharge Calls Daily	Increase complex discharge rates	Improved flow
Surge Weeks	Increase discharge	Decrease Occupancy
Changes to R2G and Point Prevalence	Number of discharges (pre-noon)	Improved flow
Elective Operations Profiling	Reduced number of elective	Reduced occupancy improved flow

These measures were authorised in December 2017 shortly before the holiday season commenced and two months into increased winter demands on urgent care.

4.2.1 Lessons Learnt

Two Winter, and adverse weather debriefing workshops have been run in 2018/19 to consider the impact of winter 2017/18 and what lessons could be learnt from planning and execution of the plans.

The first and most significant of all the lessons learnt is the delay in authorisation of additional schemes. This theme runs through nearly all of the additional capacity schemes, as well as some of the improvement schemes. Original planning would have delivered the extra measures from October 2017 when the first step change of winter acuity and demand started to be felt across urgent care system.

Other lessons learnt about execution was the capacity to staff areas of escalation and additional capacity. Although this also relates to the delay, there was an over-reliance on agency staffing in a number of areas, where at times this risk meant either further delay, or in some cases the start and then stop of a scheme temporarily when staffing became a significant theme.

Holiday period planning was another key theme, with Christmas week and the actual holidays working extremely well, with stronger performance and coverage of staffing across all areas of the winter plan. This then failed in the period 1st January – 7th January when demand was at its peak but staffing reduced post the bank holidays.

Other key areas of learning from workshops were (this is not the exhaustive list):

- The Red2Green discharge/delay management process was changed a number of times in escalation, but lost effectiveness in Q4 2017/18
- Escalation levels are too sensitive for the demands upon the Trust and must therefore be set to a new level of occupancy and demand, whilst always reflecting safety
- Operations centre become overcrowded and leadership was not always clear
- Silver-on-call managers were operating for extended periods throughout the night and at weekends for up to 24 hours. Fatigue and stress were at unacceptable levels by the end of Q4.
- Communication of key levels of escalation was not always effective. Clinical and medical teams were often not aware of the severity of the urgent care pressures
- Support for A&E was often a broad-brush approach with multiple specialties and services attending and supporting but without need. At other times support was not forthcoming
- Additional Bed Capacity was introduced and changed configuration to adapt to staffing levels. The lack of planning for this final stage of capacity (Digby Ward) introduced risks, and final change of ownership to LCHS whilst successful was not sustainable, therefore reducing the positive impact. (Although there was a very significant and positive effect when it was initiated)
- Daily calls with adult social care and LCHS with CCG input to expedite external delays were highly effective when initiated although impact did tail off, with agencies reducing the level of attendance.
- Many more patients were cancelled than planned with the largescale loss of daycase elective patients as well as overnight stay patients. It is likely this led to the loss of over £2.7m income.

4.2.2 Key Actions for winter 2018-19

The list of key actions that are incorporated into improvement and investment plans are as a consequence of the learning in the above section.

- Authorisation for winter schemes involving funding must therefore receive earlier authorisation to be successful.
- Winter plans for over capacity must have a reduced level of dependency on agency staff, and must use existing staff systems or block bookings.
- Winter planning must focus on peak points not just on holiday periods for staffing plans. Additional teams and resilience must be put in place for these known pinch points.
- Red 2 Green must be consistent and well led. In escalation must receive more focus and support but not change.
- OPEL levels must be reviewed to see if the thresholds are correct which may lead to fewer times when Level 4 is enacted, but with a greater impact when this happens.

- Roles and responsibilities, with action cards must be further developed, and then simulated throughout the summer.
- Silver rotas must be reviewed and potentially doubled for the days particularly at weekends.
- Put in place additional technological and face-to-face systems of escalation.
- Planning for escalation beds up to maximum physical ward capacity should be developed even if not expected to be utilised. These contingency plans will reduce risk of safety concerns.
- Communications systems such as the delay external daily calls must be planned and well attended, with clear roles and responsibilities defined. Support from the CCG urgent care team should be planned alongside that.
- Develop A&E escalation protocol alongside the overcapacity protocol and Inter-professional-standards (IPS) policy. Better planning of the switch round of wards from surgery to medicine, will incorporate stronger medical teams managing outliers. Movement of lists and theatres in their entirety to Louth and Grantham hospitals as well as outsourced activity will be required. This is heavily dependent on early authorisation as well as reconfiguration elements in improvement plans.

Some of these elements have been incorporated into the urgent care improvement schemes, whereas some will form part of the winter plan. These are described in the detailed list of investments later in section 6.

4.3 Ambulance Handovers and Conveyance

4.3.1 Background

Analysis shows ambulance arrivals have not significantly increased at ULHT in 2017/18 compared with 2016/17. 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.

4.3.2 Key actions for improvement

- Fully implement Straight to Community Hospital Pathways (CCG)
- Reduce care home conveyance with better care planning for patients (CCG)

- Fully implement the falls pathway and associated community service, reducing the number of conveyances for falls with no significant injury (CCG)
- Implement the catheter service to reduce the number of conveyances for issues with catheters (CCG)
- With support from SSG Health refine the handover processes (ULHT)

4.3.3 Anticipated Impact

- Reduce overall conveyances by 10% from last year 80th %ile rate
- Improve to 2nd quartile of 60 min handover with <1% 2 hour handovers

4.3.4 Costs

- SSG support until July 2018 – £50k *(Approved and funded)*

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

4.4.1 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. Typically 35% of all attendances to each of the PHB and LCH departments could be seen in another department without the requirement for emergency services only available within the ED. Two work-streams were started as part of the urgent care improvement programme.

The first focussed on the delivery of the mandatory primary care service operating in the emergency department scheme. Known as "primary care streaming" or "urgent care streaming" outside of the Trust, this required a £1m capital build. Although not complete the scheme did reallocate a sizeable proportion of the PHB and LCH departments to primary care assuming 25% of all patients would be streamed. Jan-Mar performance indicated 16% of patients at LCH and 9.6% of patients at PHB were being streamed. The streaming nurse previously put in place by ULHT teams, switches over to being LCHS led from May 2018, increasing nursing capacity back into the EDs.

The second work stream did not receive priority because of the national edict on primary care streaming and hence focussed limited attention on streaming to AEC and to Early pregnancy/gynaecology services. This was to deliver 10% of patients streamed away from the EDs however only delivered 4% at its peak. This was largely due to ongoing staffing challenges and conversion of AEC departments mainly at PHB but also at LCH to inpatient escalation areas.

4.4.2 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)

- Switch streaming nurses to LCHS and increase LCH streaming to 20% by end of June and 30% by end of August 2018 (CCG & LCHS)
- 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.
- 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

4.4.3 Anticipated Impact

- Reduce numbers of patients seen within ED by 35% from 1st September 2018

4.4.4 Costs

- Nil expected
- Redefine GP referrals to AEC / SEAU / AMU at PHB will be linked to the site reconfiguration plans.

4.5 Pilgrim and Lincoln Emergency Department Staffing and Emergency Department Processes

4.5.1 Background

46% of breaches in 2017-18 were the result of ED medical Delays and ED delays to treatment 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 2017-18. 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. Increases in medical middle grade rotas were approved amongst uplifts in nursing establishment.

Little progress with the education and development was made in 2017-18 for ACPs working in ED although significant progress was made with planning and the ACP strategy. Currently ACPs at PHB are not able to undertake advanced roles with 1-2 exceptions and almost all operate limited capabilities in minors streams.

Processes within the ED at PHB have been shown to be overly risk averse and sub-optimal, creating bottlenecks and increasing overcrowding and risk. Separate reviews by NHSi clinical experts and external consultants have indicated improvements are required to update processes in line with current RCEM safe and effective practice.

4.5.2 Key Actions

- Implement the 19-man middle grade rota at PHB and LC with no significant increase in agency (through recruitment and bank - ULHT)

- 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).
- 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).
- Improve the RAIT process at PHB in line with recommendations, reducing turnaround time and assessment times – by end of July 2018 (ULHT)
- Introduce safe handover and cohort nursing processes at LCH and PHB utilising appropriate staffing of nurses/paramedics/technicians – by end of June 2018 (ULHT)
- Develop ACPs at LCH and PHB, recognising the likely loss of 3 ACPs at PHB with increases in banding to more senior 8a level of some. 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)
- 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).

4.5.3 Anticipated impact

- Right sizing staffing vs demand in each Emergency department
- Improve coordination and safety of PHB department with clear nursing allocation and team based response
- Increase throughput of RAIT, reduce time to initial assessment, improving safety and 4 hour performance
- Reduce delays in handover and improve safety of crews awaiting handover
- Reduce reliance on agency doctors and improve quality and staff satisfaction for ACPs through development of ACP role
- Reduce specialty delays in ED, overcrowding, waits to be seen, reduce admissions through improved response of specialties/diagnostics.

4.5.4 Costs

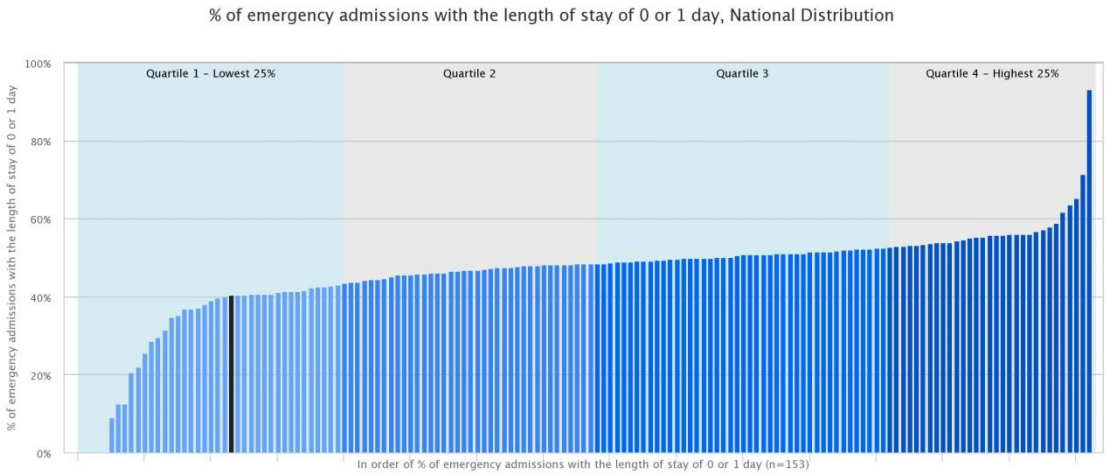
- Step change in right sizing medical staffing would require 1 MG Dr at PHB and 1 consultant and 1 MG Dr at LCH (FYE impact from 2017/18)
- 5.49 suitable trained clinical staff (nurse, technician, paramedic) to be appointed at each site for cohorting and taking handover. Role currently being undertaken by Medic Now agency staff.

4.6 Admissions areas and flow management

4.6.1 Background

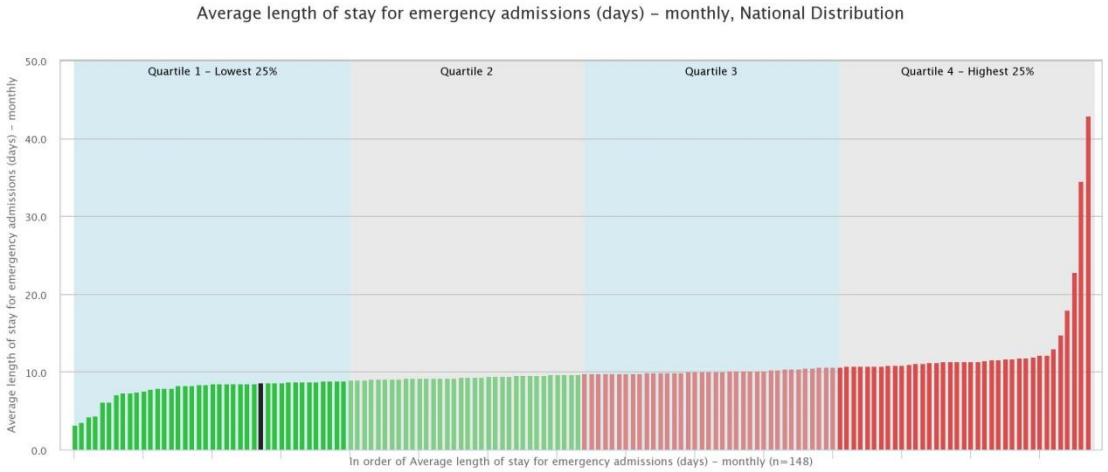
In 2017-18 19% of breaches were related to exit block and breaches through lack of bed capacity. Although emergency department staffing and processes contributed significantly to the deterioration in urgent care performance throughout 2017-18 the most significant factor, particularly in winter months,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

Bed occupancy increased throughout the year to record levels. This led to additional bed capacity being opened to partially mitigate risks as well as a large increase in the number of elective cases cancelled. Admissions wards and ambulatory units have the ability to significantly reduce this impact, by continuously pulling patients out of ED. Analysis shows that high numbers of same day discharges improves flow and reduces overcrowding in ED. Last year performance showed that 0 and 1 day emergency discharges were lowest quartile nationally.



**Source Model Hospital*

Reduction of delays both internally and externally have shown real improvements in flow in 2017-18. The early introduction of Red2Green improved flow markedly reducing overcrowding and making a substantial improvement in 4 hour performance. Despite poor performance nationally on 0-1 day LOS the Trust benchmarks very well against Average LoS for the last 6 months August2017 -January 2018 with lower quartile performance.



Discharge volumes are in line with National median. However weekend discharges consistently underperform against weekday discharge levels and on average increase the need for beds by 1 ward for LCH and PHB. Benchmarked discharge rate shows that Saturday and Sunday Discharge Ratios are in the 3rd or 4th Quartile the country and substantially less than weekdays.

Daily discharge ratios	Period	Trust Actual	Peer Median	National Median	Info	Variation	Trend
Monday - Discharge Ratio	Jan 2018	1.03	-	1.08			
Tuesday - Discharge Ratio	Jan 2018	1.26	-	1.18			
Wednesday - Discharge Ratio	Jan 2018	1.34	-	1.32			
Thursday - Discharge Ratio	Jan 2018	1.10	-	1.12			
Friday - Discharge Ratio	Jan 2018	1.23	-	1.23			
Saturday - Discharge Ratio	Jan 2018	1.10	-	1.08			
Sunday - Discharge Ratio	Jan 2018	0.96	-	0.92			

4.6.2 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).
- Complete job planning to ensure all ward rounds start at 08:00 – Complete by October 2018 (ULHT)
- Update 7-day medical services review and identify gaps for medical discharge capabilities at weekend. – Complete review by the end of May (ULHT)
- 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)
- Implement the Medically Fit for Discharge SOP – June 2018 (CCG, LCHS&ULHT)
- Introduce twilight bed manager shifts at Lincoln and Pilgrim – 18:00 - 02:00

- 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
- 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)
- 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

4.6.3 Anticipated impact

- Reduced overcrowding in EDs
- Improved and early flow in emergency pathways, to contribute to reduced admission levels.
- Reduced delays for base wards
- Reduced bed occupancy

4.6.4 Costs

- 7 day medical services across 9 sub specialty areas at LCH and PHB would require additional 0.4 WTE consultant, 0.4 WTE registrar and 0.8 junior doctor each. This would build 7 day medical services across all emergency care/urgent care disciplines at a cost of £1.19M
- 7 Day Therapy services to match 7 day working in urgent care. £199.8k
- Twilight Bed Manager Shifts – 18:00 – 02:00 to support increased evening demands will be incorporated into Winter planning

4.7 Large Scale Trust Bed Re-configuration

4.7.1 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.

The configuration of bed and specialty allocation in 2017-18 was identified as requiring substantial change. Complexities with safety fire works and the overall estates provision at PHB was such that a reconfiguration scheme developed in the summer was not delivered. Lincoln bed occupancy saw substantial outlier numbers of medical patients into surgical wards, including daycase unit, which in turn led to increase in LOS for patients exacerbating the situation and increasing bed occupancy.

Digby ward previously allocated to the pain service, was reallocated at first as additional medical bed capacity and then was transferred to LCHS to accommodate patients that were medically fit. The unit is currently closed.

Professor Briggs Get it Right First Time review for Trauma and Orthopaedics identified significant failures in the inability to ring fence beds for elective Orthopaedic patients.

4.7.2 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)
- 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.
- 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
- Develop AEC and SEAU surgical pathways at LC and PHB to be incorporated into estates changes and service commencement. July 2018.
- 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.
- 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.

4.7.3 Anticipated impact

- Reduced bed occupancy at LCH and PHB over Q3 and Q4
- Safety of seriously ill patients at LCH and PHB improved
- Reduced elective cancellations winter 2018-19
- Improved safety of bed planning, reduced risk of poorly staffed beds.

4.7.4 Costs

- Programme manager for PHB works – 133K (Capitalised)
- Resus expansion both sites £4.5M capital. No revenue Required.
- Develop Surgical AEC at LCH – £264k revenue, 35k Capital
- Digby as winter ward for 3 months - £509k

4.8 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

5.0 Constitutional Standards

5.1 Cancer

5.1.1 Performance Improvement Trajectory

The Trust has agreed to the following improvement trajectory for 62-day cancer performance during 2018/19:

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

If the Trust were to achieve this trajectory this would be the Trust's best 62-day cancer performance since 2012/13. Given the level of increase in referrals which have taken place over the last 5 years (c.45%) and the additional demands currently experienced within the Trust there is a need for significant levels of investment in order to achieve this level of performance.

5.1.2 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 are 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

5.1.3 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
- Pilot nurse led triage within Urology pathway
- Targeted backlog reduction approaches within Urology and Lower GI
- Capacity/demand review across segments within pathways for key tumour sites
- Introduction of pathway facilitators for lung and Lincoln Surgery
- Cross site scheduling to optimise cancer theatre delivery
- Work with CCGs to implement East Midlands Cancer Alliance pathway priorities
- Introduce advice and guidance for Breast referrals
- Develop business case for breast 6-day service

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

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

The Lincolnshire STP has been allocated £443k resources in order to support implementation of three optimal cancer pathways (Lung, Prostate, lower GI) and the national living with and beyond priorities. The proportion of this allocation which will be available to support 62-day performance improvement is to be confirmed but assumed to be £332,250.

The following issues don't require specific additional investment at this time, but are also key to the successful delivery of cancer services:

- Pathology turnaround times have improved significantly since January 2018, however they aren't yet consistently below 7-days. The improvement required in

this area will be managed through contracting processes and collaborative working with Path Links to improve Pathology pathways.

- The Theatres Optimisation Committee will ensure that cancer surgical capacity is reviewed as part of this programme of work.

5.2 RTT

5.2.1 Priority Actions for 2018/19

This level of improvement will need 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)

This level of backlog reduction will enable the submitted trajectory to be achieved.

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%

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.

5.2.2 Speciality Level Actions

General Surgery and T&O

Approximately 80% of the 18 week+ backlog within General Surgery and T&O is within the admitted aspect of pathways, and therefore this is where the main focus for actions are required in these specialities. Reconfiguration of the delivery model for T&O by late summer will assist with this position in the second half of the year. Additionally, it is anticipated that the Theatres Improvement Programme will deliver an additional 290 cases above baseline during 2018/19 and therefore the delivery of these two schemes will enable T&O to meet its backlog reduction target.

The Theatres Improvement Programme is forecast to deliver an additional 143 cases during 2018/19 for General Surgery. It is anticipated that the remainder of the backlog reduction for General Surgery will need to be delivered through outsourcing to the independent sector. During 2017/18 the Trust outsourced activity to the value of c.£445k in total. Currently the Trust's financial plans for 2018/19 allow for c.£322k of outsourcing. It is suggested that outsourcing to the value of £445k will be required in 2018/19 in order to enable delivery of RTT improvement to the national average position. Outsourcing is assumed to be above contract and is therefore cost neutral to the organisation.

OMF and Pain

The 18 week+ backlog within OMF and Pain are more evenly split between admitted and non-admitted elements of the pathway. It is considered that the combined benefits from the Theatres and Outpatient Improvement Programmes will deliver the backlog reduction within OMF (theatres 38, outpatients 63) and Pain (theatres 28, outpatients 37). Additionally, the commissioners have served notice relating to the current Pain service provision. Discussions are scheduled to commence shortly with commissioning colleagues which are hoped to provide clarity regarding arrangements for any potential service transition and enable the service to effectively plan backlog reduction during 2018/19.

ENT

The Theatre programme is expected to deliver an additional 50 ENT cases in 2018/19. The Outpatient programme is anticipated to deliver over 300 additional clockstops within this speciality. However, due to the additional risks within this speciality related to Paediatric surgery, the potential impact of tertiary cancer services on capacity and the impact of a reduction in additional clinics, it is considered that insourcing sub-tariff through Medinet will still be required during 2018/19. This activity will be considered as over performance against the activity plan and will therefore add a positive contribution. A band 5 Support Manager is required to co-ordinate the Outsourcing and in-sourcing requirements for RTT during 2018/19 due to their complexities and the associated administrative workload

Gastroenterology

There is an outpatient backlog across all sites within Gastro, however the most significant backlogs are on the Grantham and Lincoln sites. The backlog developed rapidly due to Clinical vacancies in the first half of last year, and has somewhat stabilised in recent months. It is considered that the Outpatient Improvement Programme will deliver sufficient additional capacity in order to provide sufficient outpatient capacity to reduce backlog incompletes in excess of 142 patients. However, there is a risk that long term planned sickness at Lincoln will reduce service capacity and restrict the ability to exploit this opportunity. It is recommended that a locum Consultant Gastroenterologist is engaged for 6 months at Lincoln. Additional income above contract will be generated.

Data Quality

Data quality significantly impacts upon RTT performance, with poor data quality leading to the requirement for cycles of validation in order to correct work. This duplication is inefficient and diverts time from proactively addressing service delivery. To oversee the required improvements Clinical Support Services require funding for a choice and access trainer (band 5).

5.2.1 Investment required for step change in performance

The table overleaf 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

6.0 Trust-wide Improvement Programmes

The objectives of the Theatres Optimisation efficiency plan include the following:

- Improve booking and scheduling processes so that lists are fully booked, the first patient on the list is a daycase where this is possible, and patients are booked at the most appropriate site, clinically
- Improve the pre-operative assessment so that there is a pipeline of patients fit for surgery that can be booked, and to reduce short notice and on the day cancellations due to issues with pre-operative assessment
- Improve peri-operative efficiency so that as many patients as possible who are booked to come in, are operated on (reduce late starts/ early finishes/ turnaround/ overruns)
- Improve the day case and short stay surgical pathway so that all patients who can be treated a daycase/ short stay, are, improving patient experience and reducing pressure on the bed base
- Implementation of enhanced recovery to improve patient outcomes and reduce pressure on the bed base

The objectives of the Outpatients efficiency plan include the following:

- Increase overall slot utilisation within outpatients

- Expand the consultant clinic templates for specialities not included within the 17/18 review
- Continue to reduce reliance on additional payment sessions delivered at premium cost.
- Close underutilised clinics, remove PAs or change clinic type to generate more income).

Therefore the success of these 2 Trust-wide schemes will be integral to the successful delivery of improvement within RTT during 2018/19, running alongside the speciality specific actions highlighted previously, and requires the resource support outlined within the respective PIDs and already in place.

7.0 Clinical Directorate Managerial Capacity

7.1 Review of Divisional Structure

On 19th April 2018 Clinical Management Board reviewed the work undertaken by KPMG on divisional structure proposals. The recommendation agreed was for a task and finish group to be established to undertake a more detailed piece of work to convert the proposal into a detailed solution. This work will commence in Q1 of 2018-19 and unlikely to deliver in full during 2018/19. There are likely to be a number of benefits from this restructure over time. Clearer lines of responsibility and improved communications can lead to reduction in waste and potentially the reduction in overall management capacity required. This plan refers to 2018-19 and as such any benefit is not assumed in the review of Clinical Directorate and Operational Capacity.

7.2 Other programmes of work

When considering the total demands on clinical directorates and corporate operations teams, it is important to include all domains. For that reason, all elements of the 2021 Delivering Excellence domains have been considered in this report. As generalist and clinical management teams quality, reconfiguration and strategy, people management as well as financial improvement programmes must be considered as significant demands on teams. This review considers each of these together with the main operational programmes in elective and urgent care.

In 2017/18 in recognition of the challenges faced by senior management team at PHB, the Directorate was split into Pilgrim Surgery and Pilgrim Medicine. In addition to this, in recognition to the Urgent Care challenges faced both Medicine Directorates received an additional B8a business manager post. This investment was a recurrent change as per below:

Additional Management Support

- Additional 2.00wte 8C General Manager / Head of Nursing at Boston
- Additional 2.00wte 8A Business Managers for A&E – 1.00wte for Lincoln and 1.00wte for Boston

This was a recurrent investment of 4.00wte/£297,000 FYE

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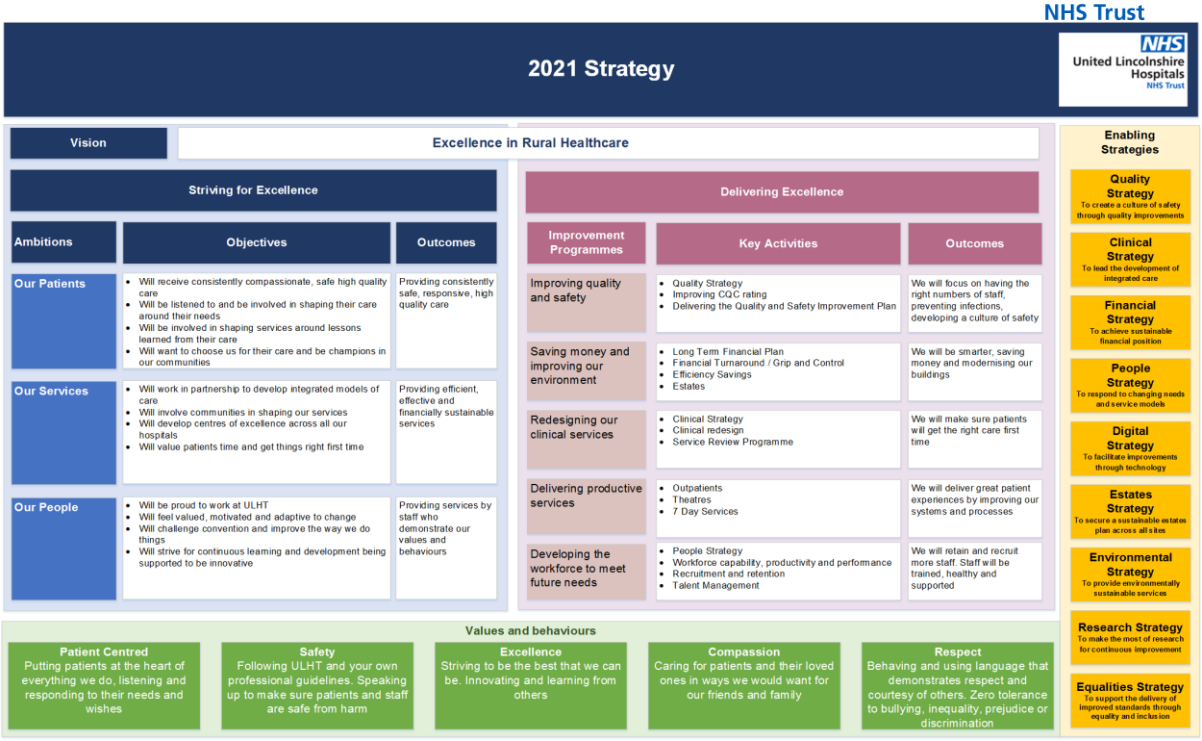


Quality Programmes and Response to CQC

Significant investment has been made in quality matrons, and associated Quality and Services Improvement QSIP management in order to deliver the necessary changes in the QSIP programme. Quality and safety management and improvement presents a continuous demand on operational and clinical management teams. However it is assumed that any increase in this workload and demand will come with additional capacity through the QSIP and quality programmes and not through any increase in baseline operational and clinical management capacity.

Financial Improvement Programme

Financial Efficiency Projects and the overall financial turnaround programme also has significant demands on operational teams. In 2018-19 teams will benefit from the support of KPMG as an improvement partner, who will increase overall capacity and capability significantly. Experience in 2017-18 has shown however that operational and clinical leads are required to put in place significant managerial capacity to ensure the delivery of financial improvement schemes as well as to validate suggested changes.

The financial improvement programme is considered in the increase in operational and clinical management capacity and is one of the domains that is reflected in the analysis of each directorates capacity. In proposing increases in management capacity, the clinical directorates are agreeing to the full delivery of the financial improvement target for 2018-19. This final figure has yet to be completely signed off in budget setting, but the large-scale target is understood and signed up to in this proposal.

Other areas of Performance Improvement

Performance improvement in the key areas of RTT and Cancer are described in some detail throughout this paper, however there are a number of other performance improvement objectives that sit outside of these schemes that operational teams are expected to deliver.

- Typing turnaround will be improved to 7 days and sustained across all specialties
- Introduction of eReferrals and Advice and Guidance on all new outpatient services
- Future IT releases for Theatreman, Medway PAS, WebV and order communications systems will require planning and deployment across administrative and clinical teams
- Services specification adherence and improvement plans in core and specialist services such as Vascular, paediatric services, maternity matters, screening services to name but a few.

7.3 Capacity Review

7.3.1 Integrated Medicine Lincoln

Integrated Medicine have seen an increase of 1.0 WTE B7 A&E service manager in 2017/18. As such increased capacity required is less associated to Urgent Care. Other elements of Cancer and elective care have been described in those sections earlier in this report.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands
High	A&E	High	High	High	Medium
		Multiple Cross Trust			With Oncology

In order to support the combined financial operational and quality agendas an additional B8b deputy Head of Nursing and B5 business analyst are proposed. This is the same as Integrated Medicine PHB.

Description	Band	WTE	2018/19	2019/20
Deputy Head of Nursing to support Urgent Care Programme and Day to Day Operational	NURSE MANAGER BAND 8B	1.00	49,000	73,500
Business Analyst to support Urgent, Elective, Financial and Directorate Specific Improvement schemes	A&C CLINICAL BAND 5	1.00	17,850	35,700

7.3.2 Integrated Medicine Pilgrim

Urgent care demands are the same if not greater, demands from elective care and cancer are less, as is the financial stretch when compared to integrated medicine in Lincoln. Although there are cross Trust run services, there are not the number and complexity of services.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands

Medium	Extreme	Medium	Medium	High	Medium
	A&E Section 31				

The most significant demand on management capacity in 2018/19 will continue to be the Section 31 enforcement action in place for A&E at PHB. Although corporate support has been focussed in this area, the overall impact on senior operational teams is and will continue to be substantial.

Description	Band	WTE	2018/19	2019/20
Deputy Head of Nursing to support Urgent Care Programme and Day to Day Operational	NURSE MANAGER BAND 8B	1.00	30,625	73,500
Business Analyst to support Urgent, Elective, Financial and Directorate Specific Improvement schemes	A&C CLINICAL BAND 5	1.00	17,850	35,700

*Although the proposed increase in establishment for Deputy HoN is 8b, decision was taken in early 2018-19 to appoint to a full 8c HoN as an interim measure although funding is not identified .

7.3.3 Diagnostics and Clinical Support Services

Diagnostics and clinical support services has the greatest breadth of services, of which the outpatients service and associated booking and clerical staff are one of the largest proportion along with radiology. Outpatient services remains challenging in terms of delivering the required quality improvement, and much has been both delivered and is still yet to deliver in this domain.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands
High	High	Medium	High	Low	High
	Outpatients				

Increase in managerial capacity in elective care described earlier has a significant benefit on Diagnostics and Clinical Support Services, although this does not deliver anything for the directorate when considering the very significant financial improvement required.

Description	Band	WTE	2018/19	2019/20
Band 7 Operational Service Manager for Outpatient Services and Rehab Medicine	A&C CLINICAL SUPPORT BAND 7	1.00	30,567	52,400
nurses x2 to support safety improvements, financial and efficiency schemes	ALLIED HEALTH PROFS BAND 6	2.00	44,500	89,000
Matron across diagnostics and rehab medicine. Part time split currently with Outpatients.	SENIOR MANAGER BAND 8A	1.00	40,667	61,000

Pharmacy spend in managerial cost centres should not continue to be an area of overspend in 2018-19 and therefore overspend shown in management costs centres should greatly improve in 2018-19.

7.3.4 Grantham Clinical Directorate

Grantham Clinical Directorate has the smallest management team, reflecting the relative size of the directorate. Although both staff and special measures has little impact on the management capacity relatively, there are moderate to high impacts from the ability to manage other services at Grantham, as well as cross Trust services such as Dermatology, that do not have the dedicated managers that other directorates have. Despite as a service Dermatology's relatively significant size and impact on cancer and financial targets.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands
Low	Low	Medium	Medium	Medium	High
					Dermatology

An additional B7 post to support Dermatology is proposed for Grantham to support the effective delivery of services in line with expectations. In addition, this post will support the shared project post with LCH and PHB surgery, and the improvements in corporate Cancer services.

Description	Band	WTE	2018/19	2019/20
Band 7 Operational Service Manager for Outpatient Services and Rehab Medicine	A&C CLINICAL SUPPORT BAND 7	1.00	30,567	52,400

7.3.5 Boston Surgery TACC & Head and Neck Clinical Directorate

Boston surgery potentially has the most challenged management team compared to overall managerial capacity. This is due to the current vacancies as well as the combined demands of financial improvements required, the cross Trust complexity of Head and Neck and Breast services, and the very significant challenges with the fragility of those services.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands
Medium	Medium	High	High	Low	High
	Head and Neck				Breast H&N

Improvement in managerial capacity is required from recruitment to existing vacancies as well as an additional Band 8a business manager. This will ensure that Breast and Head and Neck services have

the dedicated input from senior operational managers that they require, whilst other surgery and vascular continue to develop financial improvements and secure their future with specialist commissioners.

Description	Band	WTE	2018/19	2019/20
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

7.3.6 Lincoln Surgery TACC & T&O Clinical Directorate

Lincoln surgery is one of the best placed managerial capacity teams, although this will be more challenged with the imminent maternity leave of the T&O business manager. The most significant demands on the Directorate are in the form of financial, cancer management and the need to deliver reconfigurations of T&O and General Surgery services in 2018/19.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands
Medium	Low	Medium	High	Low	High
					Urology

Considering these demands the clinical directorate will need to recruit to vacancies swiftly and effectively. As a fixed term post an additional senior project manager will support the operational teams from LCH PHB and Grantham in reconfiguring elective services ahead of winter 2018/19. This role will spread across all hospitals however the majority of focus will be on Orthopaedic changes required in 2018/19.

Description	Band	WTE	2018/19	2019/20
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

7.3.7 Women's and Children's Clinical Directorate

Women's and Children's services have been strong performers in nearly all domains until the end of 2017/18 when the frailly of Children's services took a step change alongside the loss of Clinical Director and Head of Service. Workforce issues in nursing and medical staffing have demanded extensive management intervention at all levels, and as such have demanded major tactical redesign. This has meant the reprioritisation of projects and work within the directorate on improvement, delaying and derailing schemes originally planned.

Number of Staff	Services Under Special Measures	Complexity of services	Financial Efficiency Challenge	Urgent Care Operational Demands	Elective Care and Cancer Demands
High	Extreme	High	Medium	Low	Low
	PHB Childrens				

The recruitment of two new posts, one business manager and one head of nursing for Children's will re-baseline the managerial capacity to an acceptable level, giving both operational and clinical leadership for Women's and Children's services separately. Enabling improvement work as well as urgent operational intervention.

Description	Band	WTE	2018/19	2019/20
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
Additional role of Children's services lead nurse/ Head of Nursing	NURSE MANAGER BAND 8C	1.00	72,917	87,500

7.3.8 Total Operational Capacity Investment

The total increase in capacity proposed for clinical directorates is described 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

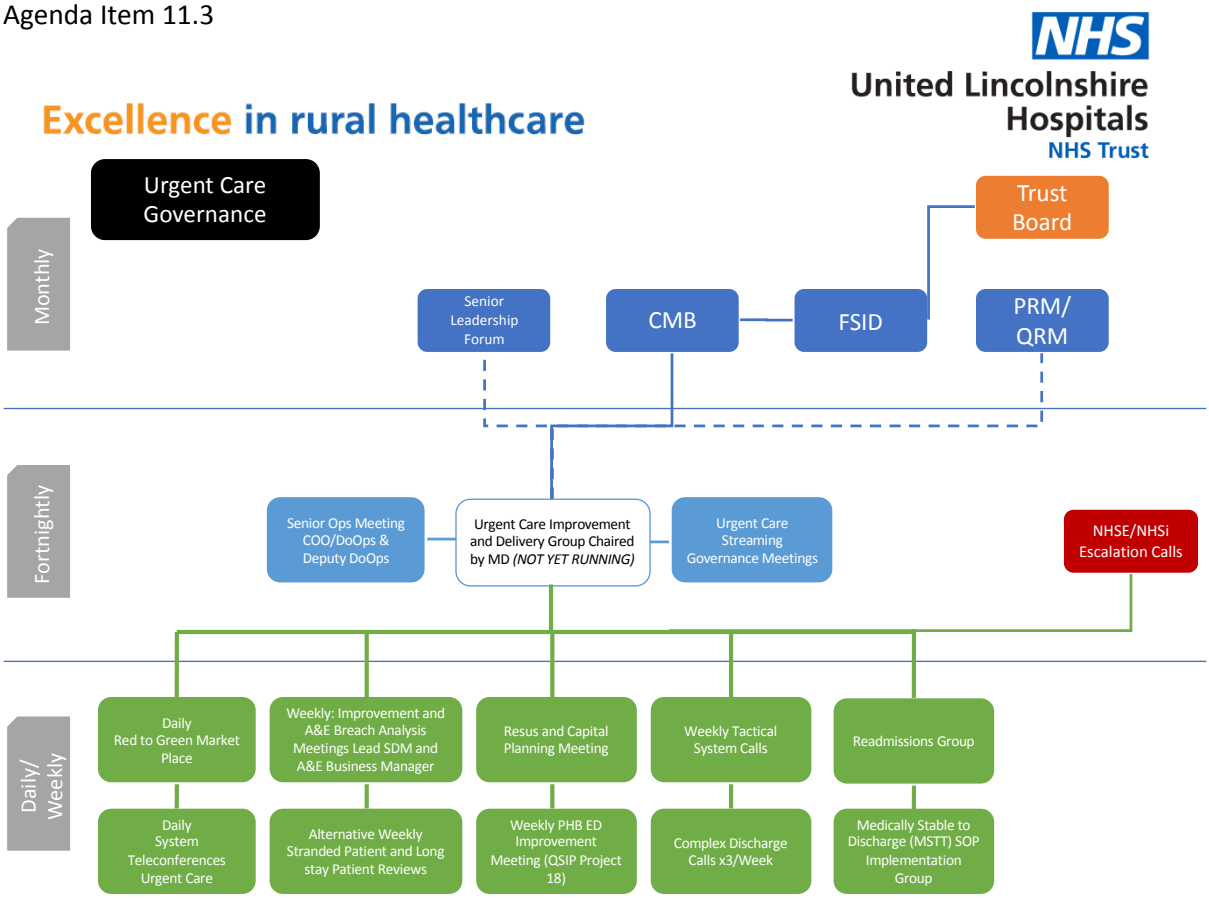
PYE anticipates that recruitment to these roles will at best be a 9 month impact within the year reflecting recruitment for many posts will be 3 months, although some may be 1 month appointments.

8.0 Governance Structures

8.1 Urgent Care

The plan will be managed locally through the site teams, heads of nursing, general managers and Clinical Directors / Heads of Service. There are local meetings looking at performance, breach analysis, flow as described below. These groups feed into the Urgent Care Recovery and Delivery Group, chaired by the Medical Director. Attendance is required from the Clinical Directorates including the Clinical Directors and Heads of Service as well as General Managers and Heads of Nursing.

The UCD&RG reports into the Chief Operating Officers Senior Team Meetings and the Clinical Management Board, which is chaired by the trusts Chief Executive. There is also a system wide Urgent Care Delivery Board which will review the actions.



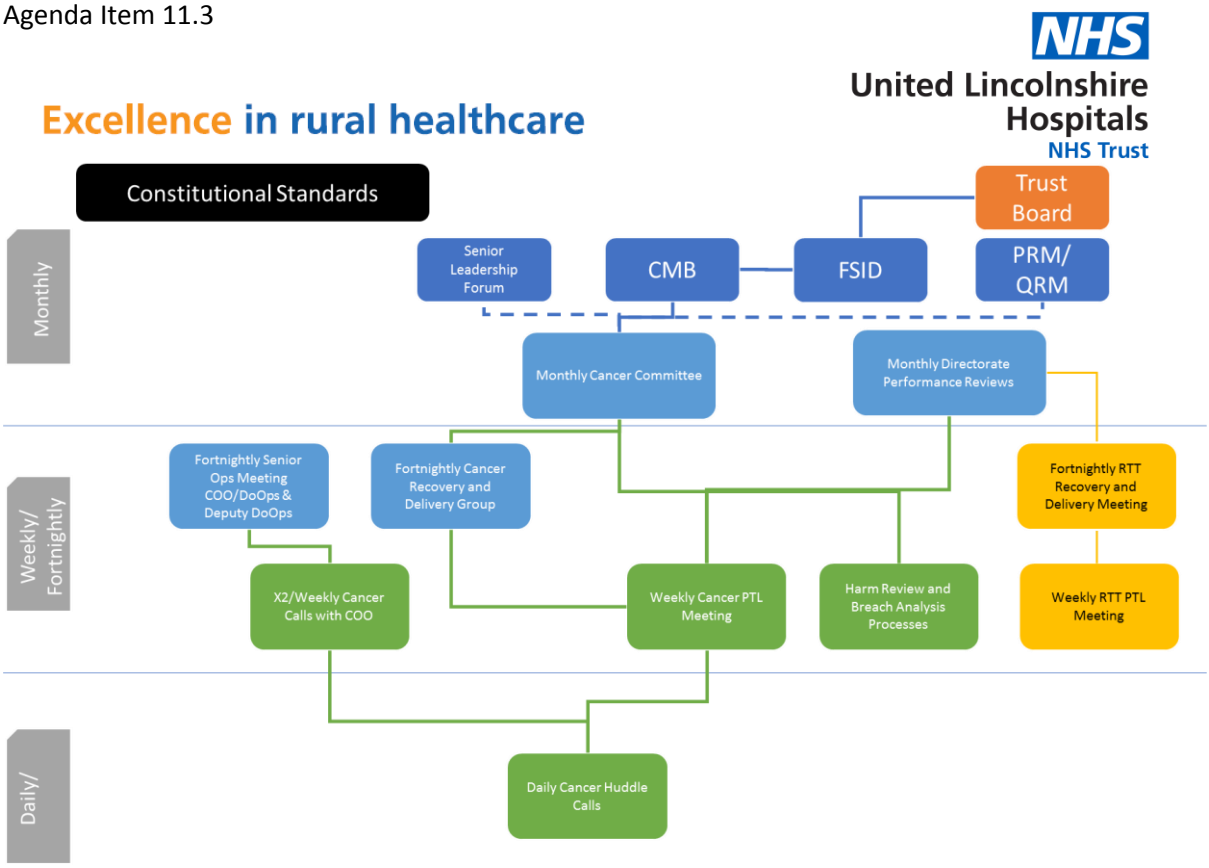
8.2 Constitutional Standards

Alongside the changes highlighted earlier, the Trust has enhanced the Governance structures relating to Cancer performance within the Trust. In addition to the monthly Cancer Committee (chaired by the Cancer Lead Clinician) and fortnightly Cancer Recovery and Delivery Group, the Trust's collaborative working with partners has been over-seen through the fortnightly Health System Cancer Improvement Meeting.

Daily Cancer Operational Meetings were introduced in Q3, which enable timely escalation and resolution of delays with patient pathways. Additionally, the COO chairs a weekly cancer meeting with the Clinical Directorates, which includes patient level pathway reviews and challenge.

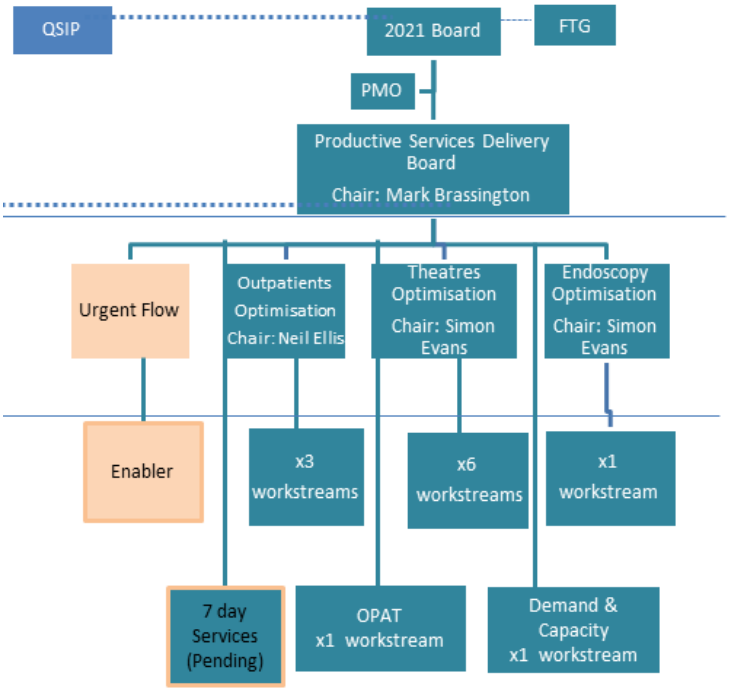
The Trust's weekly cancer PTL was enhanced during 2017/18 with the introduction of tumour site specific milestones, in order to ensure that delays within patient pathways are appropriately identified and escalated.

RTT governance structure is comparably weaker than cancer, reflecting the priority that cancer has had in 2017-18 and relatively little focus. Monthly performance reviews with clinical directorate encompass all standards including RTT Cancer Urgent care and Diagnostics, and this is ultimately the forum whereby the standards are managed to their operational unit.



8.3 2021 and Programme Governance

2021 Programme Governance is graphically illustrated in the organogram below, with reference to the three current streams of Productive Services Delivery, alongside the enabler scheme of urgent care.



As previously described there are also workstreams in Orthopaedic and General Surgery also coming on stream in 2018-19 and managerial capacity has been reviewed to consider this. 7 Day service review is referenced and addressed partially in this report as a response to the weekend discharge issues the Trust faces, however the limitations of those schemes are solely referenced to urgent care. Not the full 7 day programme.

The Productive Service Board chaired by the COO is designed to align with the Constitutional Standards and Urgent Care improvement workstreams described within this report. All decision making forums have appropriate representation from clinical directorates and senior operations team and as such should share the vision and ambitions described within this report.

9.0 Summary & Recommendations

Having reviewed 2017-18 and the deterioration in performance standards across a number of indicators and improvement in others, it is clear that substantial change is required. Ambitions to deliver step change improvement across all indicators will require substantial investment in many areas. This will include the day to day operational teams leading clinical directorates as well as corporate operations support and information analysis.

It is therefore recommended that this report once scrutinised be approved, and that investment be planned in 2018-19 as articulated within. The necessary business cases should then be completed and authorisation to recruit commence immediately thereafter. This is essential to prevent similar failures to 2017-18.

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10.0 Appendix A – Full Cost Profile *(Excludes income)*

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2018/19	2019/20
Management	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	61,000	8	0	0	0	0	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	40,667	61,000
Management	Pay	W&C	Additional role of Children's services lead nurse/ Head of Nursing	NURSE MANAGER BAND 8C	1.00	87,500	10	0	0	7,292	7,292	7,292	7,292	7,292	7,292	7,292	7,292	7,292	7,292	72,917	87,500
Management	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	61,000	7	0	0	0	0	0	5,083	5,083	5,083	5,083	5,083	5,083	5,083	35,583	61,000
Management	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	12	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	61,000	61,000
Management	Pay	Grantham	Band 7 Operational Service Manager for Outpatient Services and Rehab Medicine	A&C CLINICAL SUPPORT BAND 7	1.00	52,400	7	0	0	0	0	0	4,367	4,367	4,367	4,367	4,367	4,367	4,367	30,567	52,400
Management	Pay	D&CS	Band 7 Operational Service Manager for Outpatient Services and Rehab Medicine	A&C CLINICAL SUPPORT BAND 7	1.00	52,400	7	0	0	0	0	0	4,367	4,367	4,367	4,367	4,367	4,367	4,367	30,567	52,400
Management	Pay	D&CS	nurses x2 to support safety improvements, financial and efficiency schemes	ALLIED HEALTH PROFS BAND 6	2.00	44,500	6	0	0	0	0	0	0	7,417	7,417	7,417	7,417	7,417	7,417	44,500	89,000
Management	Pay	D&CS	Matron across diagnostics and rehab medicine. Part time split currently with Outpatients.	SENIOR MANAGER BAND 8A	1.00	61,000	8	0	0	0	0	5,083	5,083	5,083	5,083	5,083	5,083	5,083	5,083	40,667	61,000
Management	Pay	LCH Medicine	Deputy Head of Nursing to support Urgent Care Programme and Day to Day Operational	NURSE MANAGER BAND 8B	1.00	73,500	8	0	0	0	0	6,125	6,125	6,125	6,125	6,125	6,125	6,125	6,125	49,000	73,500
Management	Pay	LCH Medicine	Business Analyst to support Urgent, Elective, Financial and Directorate Specific Improvement schemes	A&C CLINICAL BAND 5	1.00	35,700	6	0	0	0	0	0	0	2,975	2,975	2,975	2,975	2,975	2,975	17,850	35,700
Management	Pay	PHB Medicine	Deputy Head of Nursing to support Urgent Care Programme and Day to Day Operational	NURSE MANAGER BAND 8B	1.00	73,500	5	0	0	0	0	0	0	0	6,125	6,125	6,125	6,125	6,125	30,625	73,500
Management	Pay	PHB Medicine	Business Analyst to support Urgent, Elective, Financial and Directorate Specific Improvement schemes	A&C CLINICAL BAND 5	1.00	35,700	6	0	0	0	0	0	0	2,975	2,975	2,975	2,975	2,975	2,975	17,850	35,700
Management	**Sub-Total - Pay**				**13.00**			**5,083**	**5,083**	**12,375**	**12,375**	**28,667**	**42,483**	**55,850**	**61,975**	**61,975**	**61,975**	**61,975**	**61,975**	**471,792**	**743,700**
Management	Non Pay		General provision for Computer H/W, Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			254	254	619	619	1,433	2,124	2,793	3,099	3,099	3,099	3,099	3,099	23,590	37,200
Management	**Sub-Total - Non Pay**				**0.00**			**254**	**254**	**619**	**619**	**1,433**	**2,124**	**2,793**	**3,099**	**3,099**	**3,099**	**3,099**	**3,099**	**23,590**	**37,200**
Management	**Grand Total**				**13.00**			**5,338**	**5,338**	**12,994**	**12,994**	**30,100**	**44,608**	**58,643**	**65,074**	**65,074**	**65,074**	**65,074**	**65,074**	**495,381**	**780,900**

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2018/19	2019/20
Cancer	Pay	Administrative capacity	8 x Band 4 Cancer Trackers	Band 4	8.00	27,900	7	0	0	0	0	0	18,600	18,600	18,600	18,600	18,600	18,600	18,600	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	0	0	0	0	0	9,300	9,300	9,300	9,300	9,300	9,300	9,300	65,100	111,600
Cancer	Pay	Administrative capacity	1 x Band 8B Cancer Performance role	Band 8b	1.00	73,500	5	0	0	0	0	0	0	0	6,125	6,125	6,125	6,125	6,125	30,625	73,500
Cancer	Pay	Oncology capacity	1 x Band 7 Oncology Palliative CNS	Band 7	1.00	52,400	6	0	0	0	0	0	0	4,367	4,367	4,367	4,367	4,367	4,367	26,200	52,400
Cancer	Pay	Radiological capacity	3 x Consultant Radiologists	Consultant	3.00	132,600	5	0	0	0	0	0	0	0	33,150	33,150	33,150	33,150	33,150	165,750	397,800
Cancer	Pay	Radiological capacity	Radiology Medical Secretaries	Band 3	1.50	24,300	5	0	0	0	0	0	0	0	3,038	3,038	3,038	3,038	3,038	15,188	36,500
Cancer	Pay	Tertiary diagnostics	3 PAs Respiratory Consultant	Consultant	0.00	12,100	3	0	0	0	0	0	0	0	0	0	3,025	3,025	3,025	9,075	36,300
Cancer	Pay	Tertiary diagnostics	0.5 Band 7 sonographer	Band 7	0.50	52,400	6	0	0	0	0	0	0	2,183	2,183	2,183	2,183	2,183	2,183	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	0	0	0	0	0	0	4,367	4,367	4,367	4,367	4,367	4,367	26,200	52,400
Cancer	Pay	Oncology capacity	1 x Consultant Oncologist	Consultant	1.00	132,600	5	0	0	0	0	0	0	0	11,050	11,050	11,050	11,050	11,050	55,250	132,600
Cancer	Pay	Oncology capacity	Medical Secretary for Oncologist	Band 3	0.50	24,300	5	0	0	0	0	0	0	0	1,013	1,013	1,013	1,013	1,013	5,063	12,200
Cancer	Pay	Oncology capacity	Choice and Access Support for Oncologist	Band 2	0.12	22,100	5	0	0	0	0	0	0	0	221	221	221	221	221	1,105	2,700
Cancer	Pay	Oncology capacity	Phlebotomy for Chemotherapy	Band 2	1.00	22,100	5	0	0	0	0	1,842	1,842	1,842	1,842	1,842	1,842	1,842	1,842	14,733	22,100
Cancer	Pay	Oncology capacity	Chemo Schedulers	Band 3	2.00	24,300	6	0	0	0	0	0	4,050	4,050	4,050	4,050	4,050	4,050	4,050	28,350	48,600
Cancer	Pay	Oncology capacity	1 x Band 6 Chemotherapy trained Nurse	Band 6	2.00	44,500	7	0	0	0	0	0	7,417	7,417	7,417	7,417	7,417	7,417	7,417	51,917	89,000
Cancer	Pay	Oncology capacity	1 x Band 5 Chemotherapy trained Nurse	Band 5	8.41	35,700	8	0	0	0	0	2,975	5,950	11,900	14,875	14,875	17,850	22,045	25,020	115,490	300,200
Cancer	Pay	Capacity and demand	1 x Consultant Dermatologist	Consultant	1.00	128,000	5	0	0	0	0	0	0	0	10,667	10,667	10,667	10,667	10,667	53,333	128,000
Cancer	Pay	Capacity and demand	Medical Secretary for Dermatologist	Band 3	0.50	24,300	5	0	0	0	0	0	0	0	1,013	1,013	1,013	1,013	1,013	5,063	12,200
Cancer	Pay	Capacity and demand	Choice and Access Support for Dermatologist	Band 2	0.18	22,100	5	0	0	0	0	0	0	0	332	332	332	332	332	1,658	4,000
Cancer	Pay	Capacity and demand	1 x Band 3 Breast co-ordinators	Band 3	1.00	24,300	8	0	0	0	0	2,025	2,025	2,025	2,025	2,025	2,025	2,025	2,025	16,200	24,300
Cancer	**Sub-Total - Pay**				**37.71**			**0**	**0**	**0**	**0**	**6,842**	**49,188**	**66,050**	**135,532**	**135,632**	**141,532**	**145,826**	**148,801**	**829,598**	**1,785,800**
Cancer	Non Pay	Administrative capacity	Desk top Computers and Monitors - Cancer trackers		0.00		8	0	0	0	0	5,616	0	0	0	0	0	0	0	5,616	0
Cancer	Non Pay	Administrative capacity	Personal Computers - Facilitators		0.00		4	0	0	0	0	2,808	0	0	0	0	0	0	0	2,808	0
Cancer	Non Pay	Administrative capacity	General provision for Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			0	0	0	0	342	2,459	3,303	6,782	6,782	7,082	7,291	7,440	41,480	89,300
Cancer	Non Pay	ADministrative capacity	Extension of check in booth and software to oncology		0.00			0	0	0	0	0	0	0	15,000	0	0	0	0	15,000	15,000
Cancer	Non Pay	Tertiary diagnostics	EBUS/EUS equipment		0.00			0	0	0	0	160,000	0	0	0	0	0	0	0	160,000	0
Cancer	**Sub-Total - Non Pay**				**0.00**			**0**	**0**	**0**	**0**	**168,766**	**2,459**	**3,303**	**21,782**	**6,782**	**7,082**	**7,291**	**7,440**	**224,904**	**104,300**
Cancer	**Grand Total**				**37.71**			**0**	**0**	**0**	**0**	**175,608**	**51,643**	**69,353**	**157,413**	**142,413**	**148,713**	**153,118**	**156,241**	**1,054,502**	**1,890,100**
RTT	Pay	RTT	Outsourcing/Insourcing Support Manager	Band 5	1.00	35,700	9	0	0	0	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	26,775	35,700
RTT	Pay	RTT	Choice and Access Trainer	Band 5	1.00	35,700	9	0	0	0	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	26,775	35,700
RTT	Pay	RTT	6 months of a full-time Gastro locum at £120/hour at Lincoln	Consultant	0.00		6	0	0	0	0	0	0	22,700	22,700	22,700	22,700	22,700	22,700	136,200	0
RTT	**Sub-Total - Pay**				**2.00**	**71400**	**24**	**0**	**0**	**0**	**5,950**	**5,950**	**5,950**	**28,650**	**28,650**	**28,650**	**28,650**	**28,650**	**28,650**	**189,750**	**71,400**
RTT	Non Pay	RTT	Personal Computers		0.00			0	0	0	1,404	0	0	0	0	0	0	0	0	1,404	0
RTT	Non Pay	RTT	General provision for Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			0	0	0	298	298	298	298	298	298	298	298	298	2,678	3,600
RTT	Non Pay	RTT	Outsourcing - extension to current budget planning		0.00			0	0	0	0	0	0	41,000	41,000	41,000	0	0	0	123,000	0
RTT	Non Pay	RTT	Medinet insourcing - details to be confirmed		0.00			0	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT	**Sub-Total - Non Pay**				**0.00**	**0**	**0**	**0**	**0**	**0**	**1,702**	**298**	**298**	**41,298**	**41,298**	**41,298**	**298**	**298**	**298**	**127,082**	**3,600**
RTT	**Grand Total**				**2.00**	**71400**	**24**	**0**	**0**	**0**	**7,652**	**6,248**	**6,248**	**69,948**	**69,948**	**69,948**	**28,948**	**28,948**	**28,948**	**316,832**	**75,000**

Excellence in rural healthcare

NHS
United Lincolnshire Hospitals
NHS Trust

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	2018/19	2019/20
RTT	Pay	RTT	Outsourcing/Insourcing Support Manager	Band 5	1.00	35,700	9	0	0	0	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	26,775	35,700
RTT	Pay	RTT	Choice and Access Trainer	Band 5	1.00	35,700	9	0	0	0	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	2,975	26,775	35,700
RTT	Pay	RTT	6 months of a full-time Gastro locum at £120/hour at Lincoln	Consultant	0.00		6	0	0	0	0	0	0	22,700	22,700	22,700	22,700	22,700	22,700	136,200	0
RTT	Pay	RTT	6 Months Access & Choice Gastro Support	Band 2	0.12	22100	6							221	221	221	221	221	221	1,326	0
RTT	Pay	RTT	6 Months Clinic Staffing - Gastro	Band 5	0.11	35700	6							327	327	327	327	327	327	1,964	0
RTT	Pay	RTT	6 Months Clinic Staffing - Gastro	Band 2	0.11	22100	6							203	203	203	203	203	203	1,216	0
RTT	Sub-Total - Pay				2.34	71400	42	0	0	0	5,950	5,950	5,950	29,401	29,401	29,401	29,401	29,401	29,401	194,255	71,400
RTT	Non Pay	RTT	Personal Computers		0.00			0	0	0	1,404	0	0	0	0	0	0	0	0	1,404	0
RTT	Non Pay	RTT	General provision for Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			0	0	0	298	298	298	298	298	298	298	298	298	2,678	3,600
RTT	Non Pay	RTT	Outsourcing - extension to current budget planning		0.00			0	0	0	0	0	0	41,000	41,000	41,000	0	0	0	123,000	0
RTT	Non Pay	RTT	Medinet insourcing - details to be confirmed		0.00			0	0	0	0	0	0	0	0	0	0	0	0	0	0
RTT	Sub-Total - Non Pay				0.00	0	0	0	0	0	1,702	298	298	41,298	41,298	41,298	298	298	298	127,082	3,600
RTT	Grand Total				2.34	71400	42	0	0	0	7,652	6,248	6,248	70,698	70,698	70,698	29,698	29,698	29,698	321,337	75,000

Scheme	Type	Breach Reason Addressed	Description	Band	WTE	Budget	(PYE) to reflect likely Recruitment Months	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	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			39,892	39,892	39,892	39,892	39,892	39,892	39,892	39,892	39,892	39,892	39,892	39,892	478,700	478,700
Urgent Care	Pay	Admissions areas and flow	5 areas at LCH and 4 at PHB - average cost for 9 posts	Consultant	3.60	120,000	5	0	0	0	0	0	0	0	36,000	36,000	36,000	36,000	36,000	180,000	432,000
Urgent Care	Pay	Admissions areas and flow	5 areas at LCH and 4 at PHB - average cost for 9 posts	Middle grade	3.60	89,000	5	0	0	0	0	0	0	0	26,700	26,700	26,700	26,700	26,700	133,500	320,400
Urgent Care	Pay	Admissions areas and flow	5 areas at LCH and 4 at PHB - average cost for 9 posts	Junior	7.20	50,900	5	0	0	0	0	0	0	0	30,540	30,540	30,540	30,540	30,540	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	0	0	0	0	24,983	24,983	24,983	24,983	24,983	24,983	24,983	24,983	199,867	99,900
Urgent Care	Pay	Winter Plan Specific	Utilise Digby as Winter Ward - 3months Agency	Consultant	1.00		Q4 Only	0	0	0	0	0	0	0	0	0	22,000	22,000	22,000	66,000	0
Urgent Care	Pay	Winter Plan Specific	Utilise Digby as Winter Ward - 3months Agency	Middle grade	1.00		Q4 Only	0	0	0	0	0	0	0	0	0	13,500	13,500	13,500	40,500	0
Urgent Care	Pay	Winter Plan Specific	Utilise Digby as Winter Ward - 3 months Agency	Junior	2.00		Q4 Only	0	0	0	0	0	0	0	0	0	8,500	8,500	8,500	25,500	0
Urgent Care	Pay	Winter Plan Specific	3 RN on every shift - Agency	Band 5	16.70	36.20	Q4 Only	0	0	0	0	0	0	0	0	0	113,351	90,681	90,681	294,713	0
Urgent Care	Pay	Winter Plan Specific	2 HCSW In every shift - Agency	Band 2	11.00	15.43	Q4 Only	0	0	0	0	0	0	0	0	0	31,824	25,460	25,460	82,743	0
Urgent Care	Pay	Winter Plan Specific	Twilight Bed Manager Shift	Band 4		96,900	8	0	0	0	0	8,075	8,075	8,075	8,075	8,075	8,075	8,075	8,075	64,600	96,900
Urgent Care	Sub-Total - Pay				63.10			39,892	39,892	39,892	39,892	72,950	72,950	72,950	166,190	166,190	355,366	326,331	326,331	1,718,823	1,794,400
Urgent Care	Non Pay		General provision for Computer H/W, Office Eqpt & Furniture, Training & Travel based on 5% of Pay		0.00			1,995	1,995	1,995	1,995	3,244	3,244	3,244	7,906	7,906	7,906	7,906	7,906	57,238	84,900
Urgent Care	Non Pay		Ward Non-pay Costs		0.00			0	0	0	0	0	0	0	0	0	11,000	11,000	11,000	33,000	0
Urgent Care	Non Pay	Ambulance Handovers and	SSG Support Until July 2018 (Funded NHSi Quality Scheme)		0.00		3	0	0	0	0	0	0	0	0	0	0	0	0	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	0	0	0	0	0	0	0	0	0	0	0	0
Urgent Care	Sub-Total - Non Pay				0.00	0	3	1,995	1,995	1,995	1,995	3,244	3,244	3,244	7,906	7,906	18,906	18,906	18,906	90,238	84,900
Urgent Care	Grand Total				63.10			41,886	41,886	41,886	41,886	76,194	76,194	76,194	174,096	174,096	374,271	345,236	345,236	1,809,062	1,879,300
Grand Total					115.81			47,224	47,224	54,880	62,532	288,149	178,691	274,136	466,530	451,530	617,006	592,375	595,499	3,675,776	4,625,300

Excellence in rural healthcare

United Lincolnshire Hospitals NHS Trust