OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: JEZ TOZER, INTERIM DIRECTOR OF OPERATIONS

DATE: 25th APRIL 2013

REPORT BY: NIGEL KEE, PLANNED CARE DIVISIONAL MANAGER

REPORT PREPARED BY: CHARLIE CARR, HEAD OF PERFORMANCE IMPROVEMENT
MICHAEL NATTRASS, CANCER CENTRE MANAGER

DIVISIONAL DIRECTOR: ANDREW FURLONG

SUBJECT: 62 DAY CANCER TARGET

1.0 Present state

The Trust delivered 75.6% performance in February, 79.4%% in the month of January. The cumulative position (year to date) is currently at 83.7% against a target of 85%.

The performance against this target at tumour site level is shown in appendix 1.

Although there are variations in monthly performance in many of the tumour sites, when the year to date performance is reviewed it shows that the main tumour sites that continue to underperform are as follows:

April 2012 to February 2013 Cumulative Position

	Total No. of Patients	Total treated within 62 days	Total No. of breaches	Year to date position %	National Average (approximate)
Gynaecology	127	94	33	74%	83.4%
Haematology	85.5	66	19.5	77.2%	81.4%
Head and Neck	61	32	29	52.5%	73.7%
Lower GI	113.5	66	47.5	58.1%	75.9%
Upper GI	114.5	79	35.5	69%	78.2%
Urology	296	244.5	51.5	82.6%	83.5%

The current underperformance can in part be attributed to the factors detailed in section 2.0 below, but in addition the current emergency pressures within the Trust have compounded this, resulting in the cancellation of operations for cancer patients. This will require the rebooking of patients for surgery, a number of which will be beyond their 62 day breach dates, this will affect future performance.

2.0 Action plan

Each of the tumour sites developed action plans in February and these have been updated in April. The areas have been asked to report on what the main factors are in terms of delivering their current performance and what actions are being taken to improve their position to deliver the national average(peer acute Trusts) for their tumour site.

Diagnostic delays

It is clear from the action plans that the main obstacles are in the diagnostic part of the patient pathway across most of the tumour sites. All the tumour sites have submitted an assessment of their capacity constraints relating to the diagnostic element of the 62 day pathway, and an urgent assessment of the gap between what is required and what is provided is being undertaken. A significant proportion of these gaps are in imaging modalities mainly relating to turnaround times for tests and reports.
The Trust requires the Imaging CBU to commit to a 7 day turnaround from request to report in order that the 31 day decision to treat date is achievable.

Additionally the process for clearly identifying to the imaging CBU that these patients are on a cancer pathways has been reviewed and imaging request forms will be amended to address the potential for delay, this is planned to be in place by the end of April.

2ww referral process

Improvement in processes to deliver the two week wait target has significant positive impact on the 62 day target. During January and into February new processes have been implemented which mean a reduced the time from receipt of referral to the time patients receive a booked appointment, and this change has delivered the 14 day target which increases the likelihood of early diagnosis.

Implementation of direct booking of pre assessment for colonoscopy due to start in April will reduce delays in the 2ww process.

Cancer centre and patient tracking

An urgent review is underway by the Planned care Division to strengthen the existing management structure of the Cancer Centre. It is recognised that senior clinical leadership needs to be strengthened to make sure there is ownership of the entire cancer pathway at tumour site level. A senior clinician appointment on an agreed number of sessions to work closely with all cancer MDT's has been agreed by the Planned Care Division. In addition the Data manager (vacancy) in the cancer centre had been appointed to and they will start in post 15th May. Two additional tracking posts, 1 specifically to support urology, but also to provide cross cover are anticipated to be in post mid May. An additional senior tracker role is also being appointed to; and this role will provide additional management support to the tracking and MDT process.

Meetings with key MDT leads
During April the Divisional Director, Divisional Manager and Head of Performance Improvement have met with key MDT clinical chairs to identify tumour site issues that impact on achievement of the 62 day standard and to reinforce the requirement for clinical buy in and adherence to the standards. Common themes were identified; these were particularly around diagnostic delays in current processes and in some cases the lack of clearly documented diagnostic pathways with key trigger points. All clinical leads have been asked to provide a locally defined diagnostic pathway, in a standardised format, that achieves a decision to treat date by day 31 of the 62 day pathway.

Further meetings with the remaining MDT chairs are taking place shortly.

In addition the following continue to be in place:

- Daily monitoring of performance including the prospective reports
- Rapid escalation of any issue/s that may cause any delay of treatment
- Weekly review at Activity meetings
- Data validation
- Tumour site action plans reviewed by the Planned Care Divisional Director and Manager on a monthly basis to ensure that they are on track to deliver anticipated benefits.

3.0 Date when recovery of target or standard is expected

Early indications for performance in March are that the Trust will not achieve the 85% target.

Sustained performance against the 85% target is expected from the start of the 2nd quarter (July 2013), with improved performance in the preceding months.

The trajectory for recovery of the 85% standard at Trust level is as follows and is associated with key actions detailed in section 2.0 and in the tumour site action plans:

	April	May	June
Anticipated performance	80%	83%	85%
	• Impact of actions in tumour site action plans submitted in February	• Impact of actions in tumour site action plans submitted in February • Diagnostic review and changes to some tumour site processes	• Strengthening of cancer centre including: additional clinical leadership • Data manager Trackers

Commissioner support via the Contract and Performance Meeting (CPM) to bring about further sustained improvements will include primary care clinicians (CCG Board GP's) reviewing and 'signing off' agreed tumour site pathways and plans with MDT leads.

Once all the revised processes are embedded, Trust performance beyond June 2013 is anticipated to improve to bring tumour site performance in line with the national average (peer acute Trusts). Bottom line this is circa 86%.

4.0 Details of senior responsible officer

Divisional Clinical Director: Mr Andrew Furlong

Divisional SRO: Nigel Kee, Divisional Manager, Planned Care

Corporate SRO: Charlie Carr , Head of Performance Improvement

APPENDIX 1

APPENDIX 1

University Hospitals of Leicester NHS Trust

62-Day (Urgent GP Referral To Treatment) Wait For First Treatment: All Cancers Inc Rare Cancers

		Apr-12	May-12	Jun-12	Qtr 1	Jul-12	Aug-12	Sep-12	Qtr 2	Oct-12	Nov-12	Dec-12	Qtr 3	Jan-13	Feb-13	YTD
Brain/Central Nervous System	Total Referrals Seen During the period	0.0	0.0	0.0	0.0	1.0	0.0	0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
	Seen within 62 days	0.0	0.0	0.0	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
	Breaches	0.0	0.0	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	% Meeting the standard uhl	--	--	--	--	100.0%	--	--	100.0%	--	--	--	--	--	--	100.0%
	% Meeting the standard national	--	--	--	--	100.0%	--	--	100.0%	--	--	--	--	--	--	
Breast	Total Referrals Seen During the period	16.0	43.0	27.0	86.0	28.0	37.0	26	91.0	24.0	33.0	29	86.0	28.0	24.0	315.0
	Seen within 62 days	16.0	41.0	27.0	84.0	27.0	37.0	25.0	89.0	24.0	33.0	28.0	85.0	27.0	24.0	309.0
	Breaches	0.0	2.0	0.0	2.0	1.0	0.0	1	2.0	0.0	0.0	1	1.0	1.0	0.0	6.0
	% Meeting the standard uhl	100.0%	95.3%	100.0%	97.7%	96.4%	100.0%	96.2%	97.8%	100.0%	100.0%	96.6%	98.8%	96.4%	100.0%	98.1%
	% Meeting the standard national	98.2%	97.7%	98.1%	98.0%	97.6%	97.7%	98.2%	97.8%	97.7%	97.7%	97.0%	97.5%	97.3%	96.8%	
Gynaecological	Total Referrals Seen During the period	16.0	10.0	16.0	42.0	7.0	8.0	12	27.0	8.0	10.0	11	29.0	14.0	15.0	127.0
	Seen within 62 days	16.0	6.0	11.0	33.0	5.0	6.0	10.0	21.0	4.0	8.0	10.0	22.0	10.0	8.0	94.0
	Breaches	0.0	4.0	5.0	9.0	2.0	2.0	2	6.0	4.0	2.0	1	7.0	4.0	7.0	33.0
	% Meeting the standard uhl	100.0%	60.0%	68.8%	78.6%	71.4%	75.0%	83.3%	77.8%	50.0%	80.0%	90.9%	75.9%	71.4%	53.3%	74.0%
	% Meeting the standard national	87.8%	84.3%	84.1%	85.3%	84.7%	85.2%	85.2%	85.2%	88.7%	89.0%	88.8%	89.0%	83.4%	84.1%	
Haematological	Total Referrals Seen During the period	9.5	7.0	7.0	23.5	12.0	9.0	7	28.0	8.0	5.0	6	19.0	8.0	7.0	85.5
	Seen within 62 days	7.0	6.0	4.0	17.0	12.0	7.0	6.0	25.0	6.0	4.0	4.0	14.0	5.0	5.0	66.0
	Breaches	2.5	1.0	3.0	6.5	0.0	2.0	1	3.0	2.0	1.0	2	5.0	3.0	2.0	19.5
	% Meeting the standard uhl	73.7%	85.7%	57.1%	72.3%	100.0%	77.8%	85.7%	89.3%	75.0%	80.0%	66.7%	73.7%	62.5%	71.4%	77.2%
	% Meeting the standard national	83.2%	83.3%	83.6%	83.3%	82.7%	83.2%	84.9%	83.5%	86.0%	84.0%	83.6%	84.4%	81.4%	82.6%	
Head and Neck	Total Referrals Seen During the period	8.0	7.0	3.0	18.0	9.0	3.0	2	14.0	7.0	4.0	5	16.0	5.0	8.0	61.0
	Seen within 62 days	6.0	4.0	1.0	11.0	4.0	1.0	1.0	6.0	6.0	1.0	4.0	11.0	2.0	2.0	32.0
	Breaches	2.0	3.0	2.0	7.0	5.0	2.0	1	8.0	1.0	3.0	1	5.0	3.0	6.0	29.0
	% Meeting the standard uhl	75.0%	57.1%	33.3%	61.1%	44.4%	33.3%	50.0%	42.9%	85.7%	25.0%	80.0%	68.8%	40.0%	25.0%	52.5%
	% Meeting the standard national	77.6%	74.9%	75.9%	76.4%	79.5%	74.7%	73.1%	75.8%	79.4%	80.9%	81.4%	80.8%	73.7%	71.9%	
Lower Gastrointestinal Cancer	Total Referrals Seen During the period	6.5	20.0	14.5	41.0	15.0	9.0	10	33.5	8.0	6.0	11	25.0	6.0	8.0	113.5
	Seen within 62 days	1.5	9.0	3.0	13.5	10.0	6.0	6.5	22.5	6.0	5.0	10.0	21.0	4.0	5.0	66.0
	Breaches	5.0	11.0	11.5	27.5	5.0	3.0	3	11.0	2.0	1.0	1	4.0	2.0	3.0	47.5
	% Meeting the standard uhl	23.1%	45.0%	20.7%	32.9%	66.7%	66.7%	68.4%	67.2%	75.0%	83.3%	90.9%	84.0%	66.7%	62.5%	58.1%
	% Meeting the standard national	81.2%	75.5%	75.2%	77.3%	75.5%	80.1%	81.6%	79.0%	79.1%	79.4%	81.3%	79.9%	75.9%	77.8%	
Lung	Total Referrals Seen During the period	15.5	18.0	26.5	60.0	20.5	27.0	22	69.0	29.0	13.0	15.0	57.0	14.5	15.5	216.0
	Seen within 62 days	14.5	17.0	22.5	54.0	17.5	22.5	17.0	57.0	27.0	13.0	14.0	54.0	9.5	10.5	185.0
	Breaches	1.0	1.0	4.0	6.0	3.0	4.5	5	12.0	2.0	0.0	1.0	3.0	5.0	5.0	31.0
	% Meeting the standard uhl	93.5%	94.4%	84.9%	90.0%	85.4%	83.3%	79.1%	82.6%	93.1%	100.0%	93.3%	94.7%	65.5%	67.7%	85.6%
	% Meeting the standard national	83.1%	84.1%	80.9%	83.0%	80.9%	81.8%	78.0%	80.4%	77.9%	80.8%	83.3%	80.4%	79.0%	80.7%	
Other	Total Referrals Seen During the period	1.0	0.0	1.0	2.0	1.5	1.5	3	6.0	2.0	3.0	2.0	7.0	0.0	1.0	16.0
	Seen within 62 days	1.0	0.0	0.0	1.0	1.0	1.5	3.0	5.5	2.0	2.0	2.0	6.0	0.0	1.0	13.5
	Breaches	0.0	0.0	1.0	1.0	0.5	0.0	0	0.5	0.0	1.0	0.0	1.0	0.0	0.0	2.5
	% Meeting the standard uhl	100.0%	--	0.0%	50.0%	66.7%	100.0%	100.0%	91.7%	100.0%	66.7%	100.0%	85.7%	--	100.0%	84.4%
	% Meeting the standard national	80.6%	--	81.7%	80.8%	82.8%	84.7%	76.9%	81.3%	80.4%	81.8%	77.9%	80.2%	--	73.5%	
Sarcoma	Total Referrals Seen During the period	0.0	0.5	1.0	1.5	3.0	1.0	1	5.0	0.5	2.0	1.0	3.5	2.0	0.0	12.0
	Seen within 62 days	0.0	0.5	1.0	1.5	2.0	0.0	1.0	3.0	0.0	2.0	0.0	2.0	1.0	0.0	7.5
	Breaches	0.0	0.0	0.0	0.0	1.0	1.0	0	2.0	0.5	0.0	1.0	1.5	1.0	0.0	4.5
	% Meeting the standard uhl	--	100.0%	100.0%	100.0%	66.7%	0.0%	100.0%	60.0%	0.0%	100.0%	0.0%	57.1%	50.0%	--	62.5%
	% Meeting the standard national	--	72.1%	80.6%	78.3%	86.0%	82.2%	81.2%	83.9%	83.6%	78.3%	88.3%	84.0%	80.0%	--	
Skin	Total Referrals Seen During the period	14.0	24.0	19.5	57.5	27.0	27.5	20	74.5	22.5	23.5	16.5	62.5	14.5	14.5	223.5
	Seen within 62 days	14.0	24.0	19.5	57.5	26.0	27.5	20.0	73.5	22.5	23.5	16.5	62.5	14.5	14.5	222.5
	Breaches	0.0	0.0	0.0	0.0	1.0	0.0	0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
	% Meeting the standard uhl	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	98.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.6%
	% Meeting the standard national	97.7%	98.0%	97.6%	97.8%	97.7%	98.3%	97.5%	97.9%	97.0%	96.8%	97.5%	97.1%	95.5%	97.1%	
Upper Gastrointestinal Cancer	Total Referrals Seen During the period	9.0	14.0	11.5	34.5	9.5	8.5	7	24.5	12.0	8.0	15.0	35.0	9.0	11.5	114.5
	Seen within 62 days	3.5	14.0	9.5	27.0	8.5	6.0	4.0	18.5	9.0	6.0	9.0	24.0	3.0	6.5	79.0
	Breaches	5.5	0.0	2.0	7.5	1.0	2.5	3	6.0	3.0	2.0	6.0	11.0	6.0	5.0	35.5
	% Meeting the standard uhl	38.9%	100.0%	82.6%	78.3%	89.5%	70.6%	61.5%	75.5%	75.0%	75.0%	60.0%	68.6%	33.3%	56.5%	69.0%
	% Meeting the standard national	80.9%	81.2%	79.6%	80.7%	81.4%	80.9%	79.1%	81.0%	80.2%	84.1%	82.4%	81.3%	78.2%	77.7%	
Urological (excluding testicular)	Total Referrals Seen During the period	33.0	34.0	18.5	85.5	22.0	25.0	19	65.5	32.5	32.0	29.0	93.5	27.5	24.0	296.0
	Seen within 62 days	31.0	30.0	13.0	74.0	19.0	22.0	16.0	57.0	24.5	22.0	21.0	67.5	26.0	20.0	244.5
	Breaches	2.0	4	5.5	11.5	3.0	3	3	8.5	8.0	10.0	8	26.0	1.5	4.0	51.5
	% Meeting the standard uhl	93.9%	88.2%	70.3%	86.5%	86.4%	88.0%	86.5%	87.0%	75.4%	68.8%	72.4%	72.2%	94.5%	83.3%	82.6%
	% Meeting the standard national	84.6%	84.8%	83.0%	84.4%	83.4%	83.3%	81.8%	83.0%	82.7%	85.2%	84.6%	84.2%	83.5%	80.1%	
3.7 Rare Cancers	Total Referrals Seen During the period	2.0	0.0	3.0	5.0	2.0	2.0	2.5	6.5	3.0	1.0	2	6.0	1.0	1.0	19.5
	Seen within 62 days	2.0	0.0	3.0	5.0	2.0	2.0	2.5	6.5	3.0	1.0	2.0	6.0	1.0	1.0	19.5
	Breaches	0.0	0.0	0.0	0.0	0.0	0.0	0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	% Meeting the standard uhl	100.0%	--	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
	% Meeting the standard national	96.0%	--	92.5%	93.5%	92.9%	92.6%	95.5%	92.9%	95.5%	93.2%	98.8%	95.0%	87.2%	94.3%	
Grand Total	Total Referrals Seen During the period	130.5	177.5	148.5	456.5	157.5	158.5	129.5	445.5	156.5	140.5	142.5	439.5	129.5	129.5	1,600.5
	Seen within 62 days	112.5	151.5	114.5	378.5	135.0	138.5	112.0	385.5	134.0	120.5	120.5	375.0	103.0	97.5	1,339.5
	Breaches	18.0	26.0	34.0	78.0	22.5	20.0	17.5	60.0	22.5	20.0	22.0	64.5	26.5	32.0	261.0
	% Meeting the standard uhl	86.2%	85.4%	77.1%	82.9%	85.7%	87.4%	86.5%	86.5%	85.6%	85.8%	84.6%	85.3%	79.5%	75.3%	83.7%
	% Meeting the standard national (Excl Rare Cancers)	88.0%	87.2%	86.6%	87.3%	87.0%	88.3%	86.5%	87.2%	87.2%	87.8%	88.3%	87.7%	85.5%	85.3%	

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **APRIL 2013**

REPORT BY: **JEZ TOZER, INTERIM DIRECTOR OF OPERATIONS**

AUTHOR: **CHARLIE CARR, HEAD OF PERFORMANCE IMPROVEMENT**

SUBJECT: **CHOOSE AND BOOK (C&B) APPOINTMENT SLOT AVAILABILITY (ASI)**

1.0 Present state

The Trust must provide adequate volumes of new outpatient appointments to enable a minimum of 96% of all 1st bookings to be successful (tolerance of 4% ASI rate). Commissioners have detailed the following contractual requirements:
From quarter 4, 2012 / 13 onwards ASI rate shall be no greater than 5% measured **monthly**, failure to comply with the ASI target will result in financial penalties.

UHL performance
The March performance at 9% is a slight improvement on February which was 10%.

Causes of underperformance

- Long waiting times in some OPD specialties reducing the available C&B 'window'
- Real capacity issues within a limited number of specialties
- Limited proactive C&B capacity management
- Administrative delays in OPD slots being made available to C&B

The majority of the issues were limited to a small number of specialties: ENT / breast/ colorectal / neurology / orthopaedics

2.0 Action plan

A number of key actions have taken place these included:

- Review of problem services at clinic level
- Increased waiting times set on 'C&B window' where appropriate
- Additional clinic capacity being made available
- Prospective daily C&B reports to Divisions to aid management of future slot availability
- Recruitment of locum Neurologist (now in post) and Specialist Registrar, the effect of these posts on will be seen in May.

The following additional actions are required on an ongoing basis to ensure recovery and future compliance:

- Weekly review of all C&B services future capacity by Corporate Operations.

Recruitment of central Operations team (3 staff) to be managed by the Head of performance Improvement, will be in post from May 2013.

- Appropriate Divisional / specialty actions in response to future capacity constraints identified
- Further reductions in waiting times for 1st OPD appointments for key specialties.

3.0 Date when recovery of target or standard is expected

A sustained recovery to below 5% at Trust level is unlikely to happen until July 2013 based on the need for waiting times for 1st OPD appointments to be reduced. A number of key specialities are aiming to reduce waiting times as part of their management of RTT during this period and until this is well underway the risk to ASI remains.

The table below shows ASI performance:-

Date	ASI rate
November (cumulative)	13%
December (cumulative)	8%
January (cumulative)	5%
February (cumulative)	10%
March (cumulative)	9%
April (week 1)	5%
April (week 2)	7%

Risks:

Operational: patients not getting their appointments in a timely and clinically appropriate way

Financial: Based on the current performance the Trust risks contractual penalties which may be in the region of £40-£60k per month.(From the new financial year 13-14 there is no financial penalty within the contract)

Reputation: GP's and patients may choose to go elsewhere

These risks will be mitigated by the ongoing actions detailed in section 2 above.

4.0 Details of senior responsible officer

Divisional SRO: Nigel Kee, Divisional Manager, Planned Care.

Monica Harris , Divisional Manager, Acute Care

Corporate SRO: Charlie Carr , Head of Performance Improvement

University Hospitals of Leicester NHS
NHS Trust

Trust Board Paper Z – Exception Report 3

OPERATIONAL PERFORMANCE EXCEPTION REPORT

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DATE:	**25th April 2013**
REPORT BY:	**JEZ TOZER , INTERIM DIRECTOR OF OPERATIONS**
AUTHOR:	**NIGEL KEE, DIVISIONAL MANAGER, PLANNED CARE**
DIVISIONAL DIRECTOR:	**ANDREW FURLONG**
SUBJECT:	**CANCELLED OPERATIONS**

1.0 Present state

Brief description of target or standard , the current position. Cause of current position.

The Trust is required to ensure that the percentage of operations cancelled on/after the day of admission of all elective activity for non-clinical reasons is no more than 0.8%.

Full year performance shows that the percentage of operations cancelled on/after the day of admissions of all elective activity for non clinical reasons was 1.2% against a target of 0.8%. The main reason for the increase in short notice cancellations during March was due to an increase in emergency demand creating pressure on the bed capacity and elective bed capacity not being 'protected'.

	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	YTD
Operations cancelled for non-clinical reasons on or after the day of admission	1.1%	1.2%	1.2%	0.9%	0.5%	0.9%	1.1%	1.6%	1.2%	1.6%	1.5%	1.6%	1.2%

The percentage offered a date within 28 days of the cancellation was 94.2% against a threshold of 95%.

2.0 Action plan

In addition to the actions identified in the previous report, the following further actions are being taken:

- Additional recovery 'chairs' have been purchased this month which will increase the day case capacity on the LRI site.
- Further options are being explored around how elective activity (both in-patient and day case) can be moved off the LRI site in the short term (ahead of the ambulatory care centre development and service reconfiguration)
- Some elective urology activity has been transferred to the Independent sector
- Continual escalation and challenge to the Acute Division is regularly undertaken

Risks:

The main risk is that Divisions do not keep within their agreed bed base and that elective capacity is not protected.

3.0 Date when recovery of target or standard is expected

Date by which target or standard will be recovered, details of any other relevant dates such as completion of key actions that will lead to recovery

The re-dating of cancellations within 28 days (95%) is being delivered during April. As per previous reports the decrease in cancelled operations is a key deliverable under the Theatre Transformation Project.

4.0 Details of senior responsible officer

Divisional Clinical Director: Mr Andrew Furlong

Divisional SRO: Nigel Kee, Divisional Manager, Planned Care

Corporate SRO: Charlie Carr , Head of Performance Improvement

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **12/04/2013**

REPORT BY: **JEZ TOZER, INTERIM DIRECTOR OF OPERATIONS**

AUTHOR: **MONICA HARRIS, ACUTE DIVISIONAL MANAGER**

SUBJECT: **Stroke Quality Indicators**

1.0 Present state

1. ***80% of patients with 90% stay in a dedicated stroke bed*:** Target = 82% Performance = 77.8% (QTR 4) Annual position 79%.

Key Issues:

- Difficulty in protecting hot bed on ASU for direct admission from ED. This is due to high emergency inflow, capacity constraints and competing priorities for admission to base ward beds. Due to the low LoS of stroke patients on the hyper-acute ward, any time spent elsewhere in the patient episode will mean a performance lower than 90% stay.
- High in-flow and subsequent medical bed capacity issues in February and March significant and have impacted on target achievement.

2. ***Swallow assessment of query stroke patients within 4 hours of attending ED*:** Target = 85% threshold; Performance = 79% (QTR 4).

Key issues:

- Direct impact of target 1 above. Patient admission to ASU first time will enable swallow assessment on all patients within 4 hours. Audit shows 10% rise in target achievement when patient admitted to ASU direct.
- Vacancies within stroke ward nursing establishment (7.5 WTE) do not enable consistent attendance of thrombolysis nurse to ED.

3. ***Joint care plans for stroke patients on discharge***: 89% performance against 95% target
- Dedicated stroke TTO letter required – failure to complete appropriately out of hours.

4. *One hour Brain Scan for ED patients meeting urgent criteria*: 91% achievement against 90% target
5. ***High Risk TIA seen within 24 Hours***: 77% performance against 62%
6. ***Mood assessment***: Target = 90% threshold. Performance = 84%
- Direct link to Joint care target (3)

7. ***MDT assessment within 72 hours****:* 78% performance against 90%
- Performance directly linked to point 1, admission to stroke bed

2.0 Action plan

- **Protection of 'hot bed' on ASU at all times** – liaison with bed and duty management team, ED and Stroke team, agree escalation plan, communicate/raise profile, audit and review. 24/04/13 lead – Service Manager
- **Dedicated recruitment drive for stroke nursing in parallel with nursing agency contract for 3 months** 19/04/13 – lead Service Manager and Lead Nurse
- **Review of Discharge Co-ordinator Role and responsibilities and exclusion from general off-duty** 24/04/13 – lead Service Manager and Matron

- **Re-launch of Neurosciences Policy to encourage/enable bed availability** – reconfiguration of medical specialties ward base arrangements to increase neurosciences bed base. 24/04/13 agree configuration, 6/05/13 implement – lead CBU Manager and Service Manager
- **Re-education of Junior doctors on importance of correct joint care and mood assessment prescribing** – 26/04/13 – lead Service Manager and Education Lead

3.0 Date when recovery of target or standard is expected

Indicator	Performance Trajectory 30.04.13	Performance Trajectory 31.05.13	Performance Trajectory 30.06.13
80% of patients staying 90% of their time in a dedicated stroke bed	80% performance	82% performance	85% performance
Swallow assessment of query stroke patients within 4 hours of attending ED	80% performance	82% performance	85% performance
Joint care plans for stroke patients on discharge	92% performance	95% performance	95% performance
Brain scan within 1 hour (ED patients)	>90% performance	>90% performance	>90% performance
Urgent TIA patients seen with 24 hours	>65% performance	>65% performance	>65% performance
Mood Assessment	85% performance	88% performance	90% performance
Assessed and managed by all relevant members of stroke MDT	80% performance	85% performance	90% performance

4.0 Details of senior responsible officer

Name and position of SRO

Monica Harris, Acute Divisional Manager.

Pete Rabey, Acute Divisional Director

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OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **25th April 2013**

REPORT BY: **JEZ TOZER , INTERIM DIRECTOR OF OPERATIONS**

AUTHOR: **NIGEL KEE, DIVISIONAL MANAGER, PLANNED CARE**

DIVISIONAL DIRECTOR: **ANDREW FURLONG**

SUBJECT: **ADMITTED RTT TARGET FOR ENT SERVICE**

1.0 Present state

Brief description of target or standard , the current position. Cause of current position.

The Trust is required to ensure that at least 90% of patients on an admitted pathway are seen and treated within 18 weeks form time of referral. For 2013/2014, this target is measured at specialty level.

March performance shows that the RTT admitted percentage for ENT was 73.6%. (The service did deliver the non-admitted pathway).

The main reason for this specialty not delivering was as a direct result of emergency pressures in medicine resulting in cancelled operations on the day (see paper on cancelled operations). It should be noted that decisions to cancel surgery on the day are based on clinical priority and therefore the ENT service will be disproportionately affected.

The number of ENT cancelled operations on the day was as follows:

October	November	December	January	February	March
11	32	23	38	26	19

The March position was significantly affected by the high numbers of cancellations in the previous 3-4 months which had created 'long wait' patients that needed to be treated in March as a priority.

2.0 Action plan

Bullet point actions that are being taken to resolve the problem and recover the standard.

- Additional day case 'chairs' have been ordered to create further day case capacity on the LRI site
- Improved scheduling of patients as a result of the work with Accenture has begun significantly improving theatre optimisation
- Moving some activity to a Saturday (as a 'normal' session) is being rapidly explored with surgeons and theatres. This will better 'protect' activity.
- Long wait patients are mostly being treated in April which will aid recovery of the target in May
- Use of the Independent Sector is also being explored.

3.0 Date when recovery of target or standard is expected

Date by which target or standard will be recovered, details of any other relevant dates such as completion of key actions that will lead to recovery

The admitted RTT standard for ENT is expected to be recovered by May 2013.

4.0 Details of senior responsible officer

Divisional Director: Mr Andrew Furlong

Divisional SRO: Nigel Kee, Divisional Manager, Planned Care

Corporate SRO: Charlie Carr, Head of Performance Improvement