University Hospitals of Leicester NHS
NHS Trust

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **28TH FEBRUARY 2013**

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

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DIVISIONAL DIRECTOR: **ANDREW FURLONG**

SUBJECT: **62 DAY CANCER TARGET**

1.0 Present state

The Trust delivered 84.6% in the month of December on the 62 day. The cumulative position (year to date) is currently at 84.9% against a target of 85%.

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

Although there are dips in monthly performance in many of the tumour sites, when the year to date performance is reviewed it shows that the main tumour sites not delivering the target are as follows:

April to December Cumulative Position

	Total No. of Patient	Total treated within 62 days	Total No. of breaches	Year to date position %	National Average (approximate)
Gynaecology	98	76	22	77.6%	86%
Haematology	70.5	56	14.5	79.4%	83%
Head and Neck	48	28	20	58.3%	79%
Lower GI	99.5	57	42.5	57.3%	78%
Upper GI	94	69.5	24.5	73.9%	81%
Urology	244.5	198.5	46	81.2%	83%

2.0 Action plan

Each of the tumour sites have been asked to report on what the main issues are in terms of delivering their current performance and what actions are being taken to improve their position to deliver the National average for their tumour site.

Upper GI

There were three key themes identified that blocked the diagnostic part of the pathway and prevented the decision to treat being made by day 31.

The three main pressure points for this tumour site are:

- Access to EUS
- Waiting times for CT/MRI (a minimum of 2 weeks but evidence that some patients were dated up to 3 weeks after referral)
- Waiting times for PET (a minimum of 2 weeks but clear deterioration and evidence of patients waiting up to 4 weeks for a date)

When reviewing the 31 day target position - which is generally met – it suggests that the above issues in relation to diagnostics is the main issue rather than anything to do with capacity except for occasions when access to Critical Care beds can be an issue.

The service has put together an action plan that can be seen in Appendix 2. It should be noted that this is work in progress and will be updated over the next two weeks. A project group has been set up to work through this action plan and the first meeting was on the 29th January.

Haematology

The Haematology performance has fluctuated throughout the year but currently has a year to date performance of 79.4% but is not delivering the National average consistently. It is important to note that the national mean is approximately 83% i.e. below the overall target of 85%.

The service has reviewed the breaches that have occurred over the last year and the main themes are summarised below:

The majority of patients come to the Haematology service through other tumour sites and in terms of the breaches they came from the following:

- 9 were originally referred from the head and neck pathway
- 2 were haematology referrals
- 2 were from the breast service
- 1.5 from LOGI service

The breach reasons are as follows:

- Multiple referral entry routes = multiple diagnostic preferences
- Access to timely biopsy service
- Referral to lymphoma team too late in the 62 day pathway as further staging requests are required
- Timely access to staging tests required, including screening for trials
- Complexity of the diagnostics – tests not conclusive/showed something unexpected which meant further tests required. (2 patients fall into this category).

In terms of future actions to get this service to the national average, please see appendix 3.

Gynaecology

Although performance for December was 90.9%, over the year the performance has been less than 85% and has not been delivering the national average for this tumour site.

When reviewing the breach maps over the last quarter, the main issue is a lack of one stop outpatient clinics and one complicated case where the patient was cancelled due to a lack of HDU facilities.

An action plan has been devised (see appendix 4) to address some of the issues regarding breach reasons and avoidance. One of these was to increase capacity of the one stop outpatient clinic issues and there will be an increase of 1 clinic per week (6 patients once the general Gynaecology consultant post has been recruited to). This should be by May 2013. In the meantime they have reviewed all other capacity and looked to increase where appropriate.

The service is also in the process of reviewing the same day scanning for suspected ovarian cancer patients at the Gynaecology Oncology clinics and looking to increase these where required. They are currently reviewing job plans, clinics, days and sites as a locum consultant joins the team. They are also liaising with imaging to ensure capacity is available.

Head and Neck

The ENT and Maxillofacial services at UHL consistently deliver 2ww target but consistently fail to achieve the national target and national average for 62days. However, the number of confirmed treated cases per month is small, resulting in big fluctuations in % numbers.

The MDT has met and worked together to identify and address bottlenecks in both pathways. See Appendix 5.

It should be noted that treatment for ENT H&N cancers tend to go towards IMRT(Radiotherapy) which has a 3wk planning time, making the decision to treat point critical to occur at day 31 or before to allow planning time. Currently ENT deliver 31day target.

For the Head and Neck Tumour site there has been significant progress made in creating MRI capacity for the maxillofacial diagnostic pathway and a one stop service. The key enabler for improving the ENT position and also, due to the numbers involved, improving the overall 62day position is dependent on the delivery of the additional diagnostic list which will be enabled through the job planning round. Support has been gained from the Divisional Director and key meetings with the clinicians involved will commence week beginning 18.02.2013.

There is an expectation that with the actions being implemented, performance can be delivered to the National average. It should be noted though that nationally, the average for this tumour site is not delivering the 85% target.

Urology

The performance of this tumour site has deteriorated in the last quarter where it delivered 72.4% against a national average of 84.2%.

It has noted that all the patients were initially seen towards to the end of a 2 week wait period (average of 12.1 days). The patients then waited between 14 and 32 days for investigations to commence (mean of 20.5 days). The main problem area is prostate cancer. The investigations consisted of a Trus biopsy, MRI, CT scans, Uroflex, and bone scans (average 60.2 days)

Therefore, there is a need to aim at reducing the initial two week wait to see a consultant, facilitated by the new cancer pathway. The new prostate cancer pathway proposed by Mr Griffiths (Consultant Urologist, Cancer MDT Lead) will eradicate unnecessary delays at this stage by cohorting patients for investigations on immediate receipt of a referral.

Additionally, there were delays in investigations and these will require input from radiology to support the new cancer pathway. The two longest delays were related to patients joining the clinical trial of TRUS and template biopsy.

Time delays are noted where patients are given an opportunity to reflect and choose their options. This often necessitates gathering of advice and opinion from other disciplines and the patient requires enough time to make an informed decision. Additionally, where investigations are inconclusive, repeat tests may be necessary. Mr Butterworth (Consultant Urologist) has recently commenced a complex surgery outpatient clinic to ensure timely and focused consultation for patients requiring information to aid their decision on future treatment. The clinics operate twice monthly with six slots (some patients require more than one slot).

Where patient's were listed for surgery, there were delays because of bed capacity particularly when requiring an HDU bed. The new consultant will be commencing post on the 4th March and they will relieve some pressure by concentrating on the cancer pathway and rearranging job plans to accommodate uro-oncological subspecialty theatre time.

Delays in pre-assessment for complex patients have been addressed by the anaesthetists who now have dedicated anaesthetic review clinics.

Critical Care capacity remains an issue. Patients requiring critical care post surgery are delayed in theatre start times until a post theatre bed in critical care is confirmed and available.

3.0 Date when recovery of target or standard is expected

All the key tumour sites that have contributed to the current performance have developed action plans to improve the position to deliver at least the National average (for their tumour site). Tumour sites have produced trajectories over the coming months and there

is an expectation that the 85% target will be delivered by April 2013 onwards.

When reviewing the action plans for the tumour sites, although a lot or work continues to be happening to improve performance, there remains a risk that the Trust will not deliver the cumulative position of 85% by the end of the end of the year (31st March 2013). This is based on unvalidated data that we currently have on the prospective reports and a review of the current backlogs that exist. It should be noted that there is currently a withholding payment penalty against this target of circ. £600K until the 85% cumulative position is delivered. To mitigate against this the following steps are 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
- Formal round of meetings with the corporate operations team
- Data validation

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

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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	YTD
Brain/Central Nervous System	% Meeting the standard uhl	--	--	--	--	100.0%	--	--	100.0%	--	--	--	--	100.0%
	% Meeting the standard national	--	--	--	--	100.0%	--	--	100.0%	--	--	--	--	
Breast	% 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%	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%	
Gynaecological	% 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%	77.6%
	% 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%	
Haematological	% 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%	79.4%
	% 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%	
Head and Neck	% 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%	58.3%
	% 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%	
Lower Gastrointestinal Cancer	% 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%	57.3%
	% 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%	
Lung	% 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%	88.7%
	% 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%	
Other	% 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%	83.3%
	% 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%	
Sarcoma	% Meeting the standard uhl	--	100.0%	100.0%	--	66.7%	0.0%	100.0%	60.0%	0.0%	100.0%	0.0%	57.1%	65.0%
	% 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%	
Skin	% 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%	99.5%
	% 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%	
Upper Gastrointestinal Cancer	% 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%	73.9%
	% 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%	
Urological (excluding testicular)	% 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%	81.2%
	% 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%	
3.7 Rare Cancers	% 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%
	% 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%	
Grand Total	% 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%	84.9%
	% Meeting the standard national	88.0%	87.2%	86.6%	87.3%	87.0%	88.3%	86.5%	87.2%	87.2%	87.8%	88.3%	87.7%	

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APPENDIX 2 Upper GI Action Plan

	Issue	Action	By when	Responsible Officer
1	EUS capacity needs reviewing	• Review the number of EUS procedures between 2010/11, 2011/12. Identify if there has been an increase in capacity and look at potential development of service over next 3 to 5 years.	26 Feb 2013	Lisa Gowan
2	Ring Fence EUS slots for Upper GI MDT	• LRI to carve out 3 to 4 dedicated EUS slots per week. • Review job plans for those consultants who can offer EUS service (currently limited to 3 consultants who can offer an independent service) • Ensure there is cover for EUS for 52 weeks a year between consultants.	4 March 2013	Lisa Gowan Karen Emery
3	Limited EUS scopes	• Currently only one scope in Trust. • If scope breaks identify plan to ensure patients are still treated within a week of referral	4 March 2013	Lisa Gowan Fay Gordon
5	Review the booking process of EUS scopes	• MDT Coordinator or CNS to confirm names of patients to be booked with Service Manager • Referral forms to be taken to Endoscopy on the day of MDT and to be given to the team to add immediately to enable patients to be contacted to agree a TCI date. • Capacity issues to be escalated to the Service Manager or CBU Manager in the SM's absence.	31 January 2013 (for ongoing review)	Lisa Gowan Cathy Thompson Karen Emery
6.	Patients currently waiting for a minimum of 2 weeks for CT/MRI	• Reduce turnaround time for CT/MRI to 7 days. Imaging to review capacity for CT/MRI requests from UGI team.	11 March 2013	Cathy Lea
7.	Patients currently waiting for a minimum of 2 weeks for PET Scan	• Review available capacity for PET scan within UHL • UHL contracts team to link in with external provider (in health) to look at what additional capacity can be provided. • UGI team to identify patients who have waited in excess of 2 weeks for appt and contact Imaging Dept to chase. • Work with Imaging to ensure they are aware of all UGI referrals in a timely fashion.	18 March 2013	Cath Lea Lisa Gowan Cathy Thompson
8.	Ensure pathway is robust enough to run in the absence	• Re-circulate the upper GI pathway with specified timescales against key elements of the pathway	26 February 2013	Lisa Gowan Cathy Thompson

	of key personnel	• Re-education session with Imaging teams and Endoscopy teams		

APPENDIX 3 Haematology Action Plan

	Issue	Action	When	By Whom
1.	Transferring patients internally from other tumour sites (particularly Head and Neck) in a timely manner.	Meet with leads in ENT, General Surgery and Breast to discuss lymphoma process	Completed	Dr Miall, AR
2.		Services collecting prospective data regarding haematology referrals	March 2013	Miss Shokuhi, Mr Conboy, Mr Miller, FM, AR
3.	Inconsistent availability to biopsy lists that causes delay in diagnosis.	Identify weekly access to biopsy list in ENT	Awaiting update	PJC, GH
4.	Processes within Haematology pathways both for 2ww and 62 day are not fit for purpose.	Review haematology 2ww referral and pathway. Consider – CT first test? Haem OPA first? Haem consultants to list directly onto general surgical lists? Standardise diagnostic pathway	March 2013 • 2ww referral redrafted.	FM, AR
5.	Referral pathways not giving the speciality time to treat the patients.	Review meeting with ENT, breast and general surgery with data collected and suggested referral pathways	April 2013	FM, SS, PJC, GH, SP, AM, LG

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APPENDIX 4 Gynaecology Action Plan

	Issue	Action	When	By Whom
1.	Throughput of Patients on Theatre Lists due to cancellations on the day.	Monthly review of Gynaecology Oncology patients cancelled on the day to assess route cause for cancellations on the day.	Monthly review	Ian Scudamore/Quentin Davies/ Donata Marshall /Caroline Sissling
	Increase in Gynaecology Oncology theatre capacity required.	David/Sarah to liaise with TAPs regarding additional list per week.	ASAP	David Yeomanson/Sarah Taylor
		Theatre schedule reviewed and 0.5 lists per week identified and job planned.	Completed 01.02.13	Quentin Davies/ Donata Marshall
	As above	In the interim contract negotiated with Nuffield 3 lists in Month of Feb/March for selected cancer cases		Donata Marshall /Sarah Taylor
		Negotiated x 2 lists in Feb 2013 at LGH Saturday am for selected cancer cases		Donata Marshall
2.	Review of capacity and demand of same day, one stop ultrasound scans for suspected ovarian cancer patients	Capacity and demand study commenced Monday 18.02.13 to confirm true demand for patients attending Gynaecology oncology clinics requiring same day ultrasound.	To commence 18.02.13 for 28 days	Donata Marshall/ Karen Whitfield

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	Issue	Action	When	By Whom
3.	Management of 2 week wait referrals by central 2ww team	Gynaecology MDT to produce clinical protocols for the 2 week wait administration teams to facilitate booking of all Gynaecology suspected cancers into the appropriate clinic capacity.	To commence new booking process Monday 11.03.13	Caroline Sissling/ Debbie Keeber
4.	Review of capacity and demand for same day, one stop ultrasound scan/ hysteroscopy (PMB clinics) for suspected endometrial cancer patients	Capacity and demand study commenced Monday 18.02.13 to confirm true demand for patients attending Gynaecology oncology clinics requiring (PMB) same day ultrasound and hysteroscopy. Liaise with multi disciplinary teams and establish funding and/or incorporating into existing job plans once true need identified.	To commence 18.02.13 for 28 days	Donata Marshall/ Karen Whitfield
5.	Cross site Gynaecology Oncology clinics and the reviewing of patients clinical results and patients notes from them	Week commencing 18.02.13 Gynaecology admin, operational or service manager to ensure that all notes are reviewed each week. Patients for review will be identified at the PTL meeting and then outcomes will be reported to service manager (who manages PTL) Thursday pm in readiness for the Friday am LGH clinical decision making meeting.	To commence 18.02.13	Debbie Keeber/ Karen Whitfield/ Caroline Sissling / Dona Marshall
6.	GP Protocol for referring patients on a 2WW pathway	Meeting to be held with the Oncology Management Team to discuss and agree a protocol. GP lead to be involved with communication and roll-out to GPs. GP lead identified from CCG	New Gynaecology 2 week wait GP protocol to be launched Tuesday 2nd April 2013 Was originally requested for implementation 31.01.13	Caroline Sissling Quentin Davies
7.	2WW Referral Template	Meeting to be held with the Oncology Management Team to review, discuss and agree an updated referral form. To be involved with communication and roll-out to GPs.	New Gynaecology 2 week wait pro-forma to be	MDT Caroline Sissling Quentin Davies

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	Issue	Action	When	By Whom
			launched Tuesday 2nd April 2013 Was originally requested for implementation 31.01.13	
8.	Introduction of Polypectomy Clinic	The infrastructure in terms of equipment, nursing staff and rooms are in place. Yet to establish how this will be integrated into a Consultant's job plan.	31.12.12	Caroline Sissling
9.	LRI Friday PM ultrasound scanning Teaching List. No electronic recording of images	In the interim all notes to be taken to admin management team where by scan results can be copied and brought to consultant's attention.	04.03.13	Donata Marshall

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APPENDIX 5 Head and Neck Action Plan

	Issue	Action	When	By Whom
1.	Delay to diagnostic GA Procedures in ENT	Specific weekly theatre list to be identified for diagnostics (in addition to usual Head and Neck lists) • List and capacity identified through job planning round • Agreement with consultants Robust scheduling process • Working with Accenture to deliver	Complete 18th February 2013 w/b 11/03/2013	Head of Service and GH
2.	Delay to imaging specifically CT and US/FNA for ENT	Secure additional same day FNA session with imaging • US/FNA delivered on Thursday pm Work to deliver same day CT at the LRI • Agreement in principle with imaging • Await confirmation from job planning on specific weekly times of 2WW clinics in relation to a dedicated theatre list	Complete Complete w/b 18/02/2013	GH GH GH/DT
3.	Demand and capacity challenge in clinic – shortfall of 1 clinic per week in ENT	Specific weekly clinic identified • Capacity identified in job plan • Agreement with Consultants	Complete w/b 18/02/2013	GH/DT
4.	Delay in diagnostic pathway in Maxillofacial	Development of diagnostic pathway with MRI same day at the LRI. • MRI same day with reports verified following morning Cardiac investigations same day	Complete Complete	GH/DT GH/DT

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		Dedicated LA biopsy capacity	Complete	GH/DT
5.	Delay to dental assessment	Require dedicated weekly capacity with restorative dentists at LRI	Complete	GH/DT