University Hospitals of Leicester NHS
NHS Trust
Caring at its best

Planned Care Division

Report to: Interim Director of Operations

Report from: Divisional Manager, Planned Care

Report prepared by: Michael Nattrass, CBU Manager

Date: 31 January 2013

Subject: 2 Week Wait Cancer Performance

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1. Introduction

This paper explains the performance year to date of the 2 week wait (2ww) cancer target and explain why there has was a drop in performance for the month of November along with the actions that have been taken to improve this performance. The National target to be delivered is 93%.

2. Current Position

The overall position on this target up to the end of November can be seen in Appendix 1. In summary, it shows that since April 2012 the Trust has been achieving the target of 93% every month except for November. The cumulative position (year to date) is currently at 93.1%, which is inclusive of the November position which only achieved 90.6%.

Although the target has been achieved month on month except for November, the performance has on the whole been just above the target and when compared with the National average each month, there is scope for further improvement.

The performance against this target at tumour site level is shown in appendix 2.

Although there are dips in monthly performance in many of the tumour sites, when the year to date performance is reviewed, this shows the main areas of concern in terms of not delivering are the following tumour sites:

3. April to November Cumulative Position

	Total No. of Patient referrals	Total seen within 2 weeks	Total No. of breaches	Year to date position %
Brain/CNS	37	33	4	89.2%
Haematology	41	36	5	87.8%
Lower GI	1540	1267	273	82.3%
Upper GI	1061	890	171	83.9%

For the areas of Brain/CNS and Haematology, it can be seen that the numbers are very small throughout the year and their % performance fluctuates considerably from month to month. On this basis, the relevant specialities have been asked to address this problem to ensure that they are performing on a more consistent level.

The main concern due to the numbers involved are Lower and Upper GI which are consistently month on month failing to deliver the target and it is these areas that are having the main impact on the Trusts bottom line performance on this target. It should also be said that not delivering this target also potentially affects the performance on the 62 day Cancer target.

4. November Position

The reported position for the 2 Week Wait Cancer Target in November is that we delivered 90.6% against a target of 93%. As stated the main areas of concern are the 2 tumour sites highlighted above but there was poor performance in that particular month in the following areas. Although it must be said that the areas below do generally deliver month on month we do need to understand why they had a drop in their November performance.

Children's	81.8% (2 breaches, patient Choice)
Gynaecology	89.6% (19 breaches in total, Patient cancellations 12, Patient Choice 2, letters not received in time 2, Admin delay 1, capacity 2)
Urology	89.9% (15 breaches in total, Patient cancellation 13, Patient Choice 2),

5. Main Challenge

It is clear that some of the smaller tumour sites need to have a more consistent performance but the main areas where performance must improve is Lower GI and Upper GI.

Major tumour sites, like Lower GI, have been reviewed and made recent changes to their pathways to improve performance. This is also the case, albeit to a lesser degree, for Upper GI.

Lower GI re-designed their 2ww pathway and launched this on 1 October 2012 to support the improved and consistent delivery of the 62 day cancer target. It was recognised by the clinical team that Lower GI has struggled to maintain a 2ww performance both at National and Local levels and the impact on the 62 day target because of this. There were key themes identified that impacted on the service achieving this including:

- Capacity – this was aggravated by the need to repeat tests
- DNA's – the service saw significant DNA's at 2ww referral
- Inappropriate Tests – patients triaged based on information on the 2ww referral which meant they attended for one test and then moved to need another and delayed decision making.
- Unfit for procedure on the day due to inaccurate referral information
- Procedures aborted due to failed bowel prep
- Patient Choice

To improve the position at the start of the pathway some key changes were implemented as detailed below:-

- Pre-assessment of all Lower GI 2ww referrals in Endoscopy to assess suitability and fitness for procedure
- Patients deemed unfit at pre-assessment to be automatically deferred to OPD for full clinical assessment
- Bowel Prep prescribed for both flexible sigmoidoscopy and colonoscopy patients to minimise cancellation on the day because of poor bowel prep.
- Barium enema was taken off the 2ww pathway as a "frontline" test.

It was expected that these changes would improve the flow of patients through the 62 day pathway and ensure that a decision to treat could be made by day 31.

The November result did not benefit from these changes as it was discovered in mid month that appointments were being posted to patients and that patients often received their appointment letter after the date. This was promptly changed to an initial telephone service to patients and the positive results can be evidenced by December's performance.

As stated previously Lower GI saw a "dip" in performance in November. Lower GI reported 39 "breach" patients for this month. Full validation of these patients has been undertaken and the following themes emerged:

- 18 "breach"
- 21 "patient choice".

The service did declare 9 true capacity breaches at the Trust's Access Meeting on 8 November 2012. This related to an upsurge on OPD capacity (in GI Medicine).

The remaining 9 patients were broken down as follows:-

- 4 patients delayed attending their pre-assessment appointment until between days 10 – 12 (despite being offered an earlier date). Because of their late attendance, the service struggled to find a suitable date for the patient within 2 to 4 days.

- 5 patients deviated from the agreed clinical pathway and were sent straight for CT colonogram following attendance at the Endoscopy pre-assessment clinic and not been picked up as urgent 2ww by radiology.

It is also noted that Upper GI have suffered similiary, particularly around patient choice. Out of their 35 reported "breaches", 24 of these were "patient choice".

6. ACTION TAKEN

The following are additional agreed "actions" to manage the capacity and dating of patients:

- A 2ww "provisional" date for those patients going via Endoscopy needs to be agreed with the patient over the phone at the same time as the pre-assessment appointment and this needs recording on the HISS system at the time. The Endoscopy team were asked to ensure that they keep offering pre-assessment right up to the day before (if required) be but encourage patients to accept the procedure date.

- Additional OPD capacity was flexed throughout the rest of November. GI Medicine put on 6 additional clinics to manage the flow of OPD referrals.

- Weekend procedure dates to be offered to 2ww patients if list is covered by a Consultant.

- Patients who find it difficult to attend for a face to face pre-assessment will have a phone pre-assessment and if required the bowel prep will be dispatched to the patient via the post following this discussion

7. Other Considerations for Lower GI and Upper GI

7.1 Patient Choice

One of the biggest challenges the service consistently faces is "patient choice". The service has capacity to offer the patient a procedure or OPD date within the 14 day target, but the patients choose not only to delay their pre-assessment appointment but also their procedure date. The impact of this on the service's ability to consistently deliver the 93% 2ww target cannot be underestimated. In particular, Christmas

and New Year has been difficult with patients both being difficult to contact and DNA'ing their appointments on the day. This will also make the January performance challenging.

7.2 GP Re-education

The Lower GI clinical team have attended multiple GP meetings to re-launch the pathway and talk about the importance of being clear with the patient about the pathway they have been referred on.

7.3 December pre-validation position

The early cut data for December shows an improved position for both Lower GI (91.7%) and Upper GI (91.0%) which indicates the above actions improved the process. This will continue to be closely monitored.

8. Summary

The Trust's November position for delivery of the 2ww cancer target was 90.6%. The main areas of concern have been identified as Lower GI and Upper GI who are consistently failing the target but do have actions going forward to improve performance as evidenced in their pre-validated December position. There is a trajectory for both these sites to deliver the 93% by 1st April 2013 as follows:

Site	January	February	March	April
Lower GI	88%	90%	92%	93%+
Upper GI	85%	88%	90%	93%+

In terms of the smaller tumour sites, where performance fluctuates, the issues are being explored further and actions put in place to improve their performance on a more consistent basis and this will be actioned through the Divisional Manager for Planned Care in conjunction with the Cancer Centre Manager.

The pre-validated position for December against this target is currently at 95.1%.

APPENDIX 1

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CANCER TREATMENT

		Apr-12	May-12	Jun-12	Qtr 1	Jul-12	Aug-12	Sep-12	Qtr 2	Oct-12	Nov-12	YTD	Target
1.1 - Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers	Total Referrals Seen During the period	1,433	1,584	1,301	4,318	1,479	1,514	1,241	4,234	1,614	1,554	11,720	
	Seen within 2 weeks	1,334	1,478	1,210	4,022	1,403	1,417	1,165	3,985	1,501	1,408	10,916	
	Breaches	99	106	91	296	76	97	76	249	113	146	804	
	% Meeting the standard uhl	93.1%	93.3%	93.0%	93.1%	94.9%	93.6%	93.9%	94.1%	93.0%	90.6%	93.1%	93%
	% Meeting the standard national	94.6%	95.9%	94.9%	95.2%	95.5%	95.3%	95.4%	95.4%	95.7%	95.7%		

APPENDIX 2

Two week wait for an urgent GP referral for suspected cancer to date first seen for all suspected cancers

		Apr-12	May-12	Jun-12	Qtr 1	Jul-12	Aug-12	Sep-12	Qtr 2	Oct-12	Nov-12	YTD
Brain/Central Nervous System	% Meeting the standard uhl	100.0%	66.7%	100.0%	85.7%	85.7%	100.0%	88.9%	90.5%	83.3%	100.0%	89.2%
	% Meeting the standard national	95.3%	95.9%	95.7%	95.6%	97.9%	96.4%	97.1%	97.2%	97.6%	96.3%	
Breast	% Meeting the standard uhl	99.7%	97.1%	98.1%	98.3%	97.0%	97.5%	97.8%	97.4%	96.3%	95.4%	97.3%
	% Meeting the standard national	96.7%	97.9%	96.7%	97.2%	97.3%	97.4%	97.6%	97.4%	97.8%	96.9%	
Children's	% Meeting the standard uhl	100.0%	100.0%	100.0%	100.0%	100.0%	75.0%	100.0%	93.3%	100.0%	81.8%	94.3%
	% Meeting the standard national	95.7%	97.2%	96.0%	96.3%	94.9%	91.2%	95.7%	93.9%	97.1%	96.1%	
Gynaecological	% Meeting the standard uhl	97.6%	95.8%	97.7%	97.1%	97.3%	92.8%	94.6%	95.0%	96.9%	89.6%	95.2%
	% Meeting the standard national	95.7%	96.6%	95.8%	96.1%	95.9%	95.8%	95.9%	95.8%	96.2%	96.6%	
Haematological	% Meeting the standard uhl	100.0%	80.0%	100.0%	91.7%	100.0%	80.0%	100.0%	94.1%	66.7%	83.3%	87.8%
	% Meeting the standard national	95.5%	96.6%	97.7%	96.8%	97.1%	96.5%	96.1%	96.7%	97.2%	96.9%	
Head and Neck	% Meeting the standard uhl	99.1%	100.0%	98.7%	99.3%	98.2%	97.1%	97.3%	97.5%	100.0%	95.1%	98.2%
	% Meeting the standard national	95.6%	96.7%	95.2%	95.9%	96.1%	95.9%	95.7%	95.9%	96.4%	96.0%	
Lower Gastrointestinal Cancer	% Meeting the standard uhl	77.5%	80.5%	81.5%	79.7%	89.2%	84.0%	85.1%	86.0%	84.4%	79.3%	82.3%
	% Meeting the standard national	92.3%	94.1%	94.2%	93.5%	94.5%	94.2%	94.7%	94.5%	94.3%	94.3%	
Lung	% Meeting the standard uhl	95.8%	100.0%	98.5%	98.4%	95.7%	100.0%	100.0%	98.4%	100.0%	97.2%	98.5%
	% Meeting the standard national	97.1%	98.1%	96.8%	97.4%	97.1%	97.0%	97.3%	97.2%	97.8%	97.6%	
Sarcoma	% Meeting the standard uhl	100.0%	92.3%	100.0%	98.0%	100.0%	100.0%	94.1%	98.1%	100.0%	100.0%	98.6%
	% Meeting the standard national	97.2%	97.5%	96.5%	97.1%	96.7%	96.5%	95.5%	96.2%	97.2%	97.4%	
Skin	% Meeting the standard uhl	99.5%	98.1%	96.8%	98.1%	92.8%	94.8%	93.5%	93.8%	92.8%	96.0%	95.4%
	% Meeting the standard national	94.8%	95.7%	94.4%	95.0%	94.8%	94.4%	94.4%	94.5%	94.9%	95.6%	
Testicular	% Meeting the standard uhl	100.0%	92.9%	100.0%	96.4%	100.0%	90.9%	100.0%	97.3%	100.0%	100.0%	97.7%
	% Meeting the standard national	97.1%	98.2%	96.6%	97.4%	97.7%	96.8%	97.1%	97.3%	98.5%	98.8%	
Upper Gastrointestinal Cancer	% Meeting the standard uhl	78.9%	89.8%	76.1%	81.9%	92.6%	81.8%	89.9%	88.7%	81.8%	79.0%	83.9%
	% Meeting the standard national	91.4%	93.6%	91.7%	92.3%	93.8%	93.3%	94.0%	93.6%	93.6%	93.8%	
Urological (excluding testicular)	% Meeting the standard uhl	92.4%	89.2%	86.7%	89.7%	94.0%	96.2%	93.7%	94.8%	94.2%	89.9%	92.4%
	% Meeting the standard national	94.9%	95.7%	94.6%	95.1%	95.3%	95.5%	95.0%	95.3%	95.5%	95.6%	
Grand Total	% Meeting the standard uhl	93.1%	93.3%	93.0%	93.1%	94.9%	93.6%	93.9%	94.1%	93.0%	90.6%	93.1%
	% Meeting the standard national	94.6%	95.9%	94.9%	95.2%	95.5%	95.3%	95.4%	95.4%	95.7%	95.7%	

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Trust Board Paper R2

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: TRUST BOARD

DATE: 31st JANUARY 2013

REPORT BY: JEZ TOZER , INTERIM DIRECTOR OF OPERATIONS

AUTHOR: NIGEL KEE , DIVISIONAL MANAGER, PLANNED CARE

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:
Quarter 4, ASI rate shall be no greater than 5% measured **monthly.**
During quarter 4, 2012 / 13 onwards failure to comply with the ASI target will result in financial penalties.

UHL performance in December
The Trust performance in December was 8%. Although this was an improvement on the November position of 13%, it was short of the commissioner trajectory of 8% for Quarter 3. Throughout 2012-13 performance against this target has been unstable with no month being at or below the required threshold.

Causes of underperformance

- Long waiting times within 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 are limited to a small number of specialties: ENT/ Ophthalmology / Colorectal surgery / Gastroenterology / Orthopaedics

2.0 Action plan

A number of key actions took place during December and early January, 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
- Provision of prospective C&B report to Divisions to aid management of future slot availability on a daily basis

Trust Board Paper R2

The following additional actions are being taken to ensure ongoing compliance:

- Weekly review of all C&B services future capacity by Corporate Operations
- Appropriate Divisional / specialty actions in response to future capacity constraints identified
- Further reductions in waiting times for 1st OPD appointments for key specialties, including general & colorectal surgery and gastroenterology

3.0 Date when recovery of target or standard is expected

Following the actions detailed above and at the time of writing this report, the Trust has met the required national and contractual standard for 3 consecutive weeks which it has never done previously.

Date	ASI rate	Volumes of referrals via C&B
November (cumulative)	13%	-
December (cumulative)	8%	
w/e 30/12/12	3%	696
w/e 6/1/13	3%	1332
w/e 13/1/13	3%	1952

Risks:

Risk of ASI increasing due to actions detailed in section 2 not being carried through.

4.0 Details of senior responsible officer

Divisional SRO: Nigel Kee, Divisional Manager

Corporate SRO: Charlie Carr , Head of Performance Improvement

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Trust Board Paper R3

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: TRUST BOARD

DATE: 31st JANUARY 2013

REPORT BY: JEZ TOZER , INTERIM DIRECTOR OF OPERATIONS

AUTHOR: NIGEL KEE , DIVISIONAL MANAGER, PLANNED CARE

SUBJECT: SPECIALITY LEVEL ADMITTED RTT FAILURE IN DECEMBER

1.0 Present state

The Trust is required to achieve admitted referral to treatment targets at a cumulative level as part of the operating framework. Achievement at speciality level (90%) is required contractually on a monthly basis and is good patient care in line with the NHS constitution. Failure to achieve at speciality level results in an automatic financial penalty.

UHL performance in December

The Trust performance in December for ophthalmology was 86.3%, 14 patients short of the 90% target. This will result in an automatic penalty of £35k (estimated).

Causes of underperformance

The main reasons for this underperformance include:

- Planned daycase building work did not complete until October 2012 and this resulted in an increase in the admitted backlog (over 18 weeks RTT). This increased the number of patients at risk of breaching the 26 week stage of treatment waiting time in the speciality. In order to mitigate this risk, these very long wait patients were booked for treatment in early December, however the volume of these long waiters coupled with the reduced activity carried out, including patients unwilling to come in at short notice, leading up to and during the Christmas period resulted in the speciality being unable to meet the 90% target performance of patients treated under 18 weeks.
- The specialty continues to have an admitted RTT backlog of circa 150 patients that contribute to the risk.

2.0 Action plan

- Maximise the volumes of activity that are treated in the updated day case facility, which is 'protected' from external bed pressures to begin to reduce the backlog.
- Continue with the planning for backlog reduction during Q4

Trust Board Paper R3

and Q1 to mitigate against future risks, this will include additional activity. - Robust waiting list management, Operational Manager in post (January 2013). - Improved daily monitoring and validation
3.0 Date when recovery of target or standard is expected It is expected that the standard will be recovered in January and maintained going forward. Weekly activity and performance monitoring will be maintained by the Division and Corporate Operations to address any shortfall at an
4.0 Details of senior responsible officer
Divisional SRO: Nigel Kee, Divisional Manager Corporate SRO: Charlie Carr , Head of Performance Improvement

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OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **31/01/2013**

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

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

SUBJECT: **Stroke Quality Indicators**

1.0 Present state

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

1. 90% stay in a dedicated stroke bed: Target = 81% threshold (Qtr 3); Performance = 77% (Qtr 3), 79% (2012/13 TYD). The main issue is that stroke patients are not accessing stroke beds on ward 25/26 directly from ED, they are spending some of their stay on AMU or another medical ward. The LoS on Ward 25 (hyperacute stroke) is less than 3 days, therefore any time spent elsewhere in the patient episode will mean a performance lower than 90% stay.
2. Swallow assessment of query stroke patients within 4 hours of attending ED: Target = 80% threshold; Performance = 73% (Qtr 3), 70% (2012/13 YTD). The main issue is consequent to point 1 above i.e. patients are not receiving their swallow assessment within 4hrs as they are not getting to a stroke bed first time. Audit has shown that there is a 10% rise in performance when patients are directly admitted to the ASU. An additional factor is the current reduction in experienced nursing staff due to leavers, resulting in new staff not being trained to assess swallow function. Staffing numbers do not always allow the thrombolysis nurse to attend ED as the nurse is included in the ward numbers and not supernumerary to these.
3. Joint care plans for stroke patients on discharge: Target = 95% threshold. Performance = 86% (Qtr 3), 87.5% (2012/13 YTD). The main issue is related to out of hours junior doctors and their failure to complete the dedicated stroke discharge letter/TTO.

2.0 Action plan

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

90% stay in a dedicated stroke bed:

- Discharge Coordinator for stoke wards to liaise closely each day with the corporate Bed Coordinator to ensure patient flow.
- Embed processes to ensure at least one bed is empty on the ASU at all times supported by remodelling of medical bed base.
- More effective use of ward 24 bed base to increase availability of beds for stroke

patients.

Co-ordinator guidelines to be distributed 28th January 2013.

Swallow assessment of query stroke patients within 4 hours of attending ED:

- Staff to be booked onto training by the SALT team and completed by March 2013, this includes both competency and clinical assessments.
- Weekly audit of swallow assessments within 4 hours and review of target breaches to understand the issues or review and exclude exceptions. **Commenced.**
- Increase direct admissions to the ASU as above.
- 4 Staff commencing in February 2013. Further recruitment drive 26th January 2013 to recruit to outstanding vacancies.

Joint care plans for stroke patients on discharge:

- Ensure all juniors have guidelines including joint care plan information when commencing on the stroke rotation.
- Laminated guidelines for junior doctors on all computers on the stroke unit to ensure stroke the discharge letter is written at all times.
- Weekly audit of target breaches and feedback to junior doctors directly with Dr Amit Mistri, Stroke Consultant.

3.0 Date when recovery of target or standard is expected

Indicator	February 2013	March 2013
90% stay in a dedicated stroke bed	>70% direct admissions 81% threshold	>75%Direct admissions 85% Threshold
Swallow assessment of query stroke patients within 4 hours of attending ED	80% threshold	85% threshold
Joint care plans for stroke patients on discharge	95%	95%

4.0 Details of senior responsible officer

Name and position of SRO

Monica Harris, Acute Divisional Manager.

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

OPERATIONAL PERFORMANCE EXCEPTION REPORT

REPORT TO: **TRUST BOARD**

DATE: **31 January 2013**

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

AUTHOR: **Neil Doverty, Divisional Manager Clinical Support Services**

SUBJECT: **Imaging Performance Against 6 weeks DH Target.**

1.0 Present state

National Department Of Health (DH) target of no more than 1% of total diagnostic requests waiting over 6 weeks was at 1.2% for the month of December 2012, equating to 20 patients over threshold.

The waiting list deterioration was caused by the loss of 50 patient episodes from MRI which is already working at full capacity for the time periods commissioned. This was due to two days of breakdown. Additional staff sickness, vacancy and the public holidays have impacted on our ability to fully resolve the performance gap quickly.

2.0 Action plan

- Validate current waiting list and formulated delivery plan at patient level to achieve required target, by modality
- Daily review of waiting list to CBU level; deviation from planned recovery trajectory is reportable to Divisional level
- Revising current referral management practice that permit referrers to request individual radiologists to perform particular scan investigations, so widening and optimising slot utilisation
- Additional 5 extra MR lists put in place and funded through winter pressure monies
- Cancelled a planned preventative maintenance service on another MRI scanner (25 slots)
- Addition US list / MSK US list
- Increased to number of booking slots via additional sessions above the breach numbers to mitigate against increase in activity, staffing constraints and patient choice.

3.0 Date when recovery of target or standard is expected

Target will be met by 31 January 2013 and is subject to day to day tracking and reporting to the Divisional Manager.

However we are at risk from receiving delayed / late internal referrals and there is a risk of

equipment breakdown. The service is mitigating these risks by building in additional slots, at cost associated. Our 7 MRI scanners are working to 98% uptime delivering 20 slots per day.

The Division has taken an Imaging expansion business case to the January 2013 meeting of the Trust's Commercial Executive and is developing this further in response to the discussion held. A key objective of the business case is to ensure a long term sustainable delivery of all key national access targets, local contractual standards, and internal professional standards. The Division is also taking forward the agreed scanner replacement programme upgrades during 2013 and a plan to more actively manage demand for imaging diagnostics from internal referrers is also in progress.

4.0 Details of senior responsible officer

Carl Ratcliff – CBU Manager