University Hospitals of Leicester NHS
NHS Trust

Cover report to the Trust Board meeting to be held on 7 February 2019

	Trust Board paper K

Report Title:	**Quality and Outcomes Committee – Committee Chair's Report** (formal Minutes will be presented to the next Trust Board meeting)
Author:	Gill Belton – Corporate and Committee Services Officer

Reporting Committee:	**Quality and Outcomes Committee**
Chaired by:	Col (Ret'd) Ian Crowe – Non-Executive Director
Lead Executive Director(s):	Andrew Furlong – Medical Director Carolyn Fox – Chief Nurse
Date of meeting:	31 January 2019

Summary of key public matters considered by the Committee and any related decisions made:

This report provides a summary of the key issues considered at the Quality and Outcomes Committee on 31 January 2019:

- **Nursing and Midwifery Quality and Safe Staffing Report** – the report provided triangulated information relating to nursing and midwifery quality of care and safe staffing, and highlighted those wards triggering a level 3, 2 or 1 concern in the judgement of the Chief Nurse and Corporate Nursing team. In November 2018, 0 wards had triggered a level 3 concern (as in October 2018), there were 7 wards triggering a level 2 concern (4 more than in October 2018) and 22 wards triggering a level 1 concern (1 more than in October 2018). Particular note was made of a recently held HCA recruitment event, which had proven very successful, along with a recently held Recruitment Event for Registered Nurses. In light of the need, on occasion, to rotate substantive nursing staff between wards at times of particular pressure to maintain appropriate staffing levels, specific note was made of the plans underway to assist such staff in feeling appropriately orientated to the new environment (as was already the case for agency staff). Members discussed the Nursing Staff Bank, which also managed Medical Bank and Locums, and note was made of an impending report on the Staff Bank due to be submitted to a future meeting of the Executive Board and thereafter to the People, Process and Performance Committee (potentially in April 2019). QOC members sought, and received, assurance of continued focus on the 'time to hire' metric, which was discussed regularly at the monthly CMG performance review meetings. In further discussion on this report, members discussed means by which to improve recruitment and retention in CHUGGS and also discussed the contents of appendix 4 (i.e. the gap analysis from the NHSI Workforce Initiative), including the move towards a competency based model, which would be further developed and reflected in the bi-annual nurse staffing reports.

- **Monthly Highlight Report from the Director of Safety and Risk** – QOC considered information relating to (i) 'Developing a Patient Safety Strategy for the NHS – Proposals for Consultation' document being led by the NHS National Director of Patient Safety and the CQC document 'Opening the Door to Change' (ii) progress with the Never Event action plan (iii) feedback from Never Event specific Director led safety walkabouts (iv) patient safety data and (v) complaints data. In discussion, particular note was made that time had been secured by the Director of Safety and Risk on the medical student curriculum for the provision of training to Year 2 medical students on Never Events, which was welcomed by QOC. Specific discussion took place regarding staff's understanding of Never Events, albeit noting that the most important message to convey to staff was the need to consistently follow agreed processes, and the Chief Executive noted that such matters were addressed through the Trust's Quality Strategy. Note was made of the potential benefit in sharing good practice regarding the dissemination of Never Event information within CMGs and the Director of Safety and Risk undertook to request that the Quality and Safety Leads progressed this matter accordingly. The Committee also considered the role of the 'Patient Advocates for Safety' as referenced within the National Patient Safety Strategy and how this might align with the current role of the Patient Partner.

- **Symptomatic Breast Backlog Management** – this report, as presented by the Director of Operational Improvement, described the growing gap between available capacity and demand for the 2 week wait symptomatic breast service which crossed both Breast Surgery (within the MSS Clinical Management Group) and Breast Imaging (within the CSI Clinical Management Group) and the reasons for this gap. It also provided the plan to mitigate the shortfall and deliver the breast 2 week wait performance. There had been a 14.4% growth in Symptomatic Breast referrals this year against the same period last year. As of 1 January 2019, the backlog was zero and the CMGs were now offering appointments within breach date (i.e. within 14 days). A working group had been convened to meet for the first time in January 2019 to plan transformation change to consistently bridge the

gap between capacity and demand. The Committee welcomed the successful work undertaken in this respect.

- **Seven Day Services: Board Assurance Framework** – a new Seven Day Services Board Assurance Framework had been introduced, in trial form, in the Autumn, replacing the National 7DS Survey. The process involved Trusts completing a Seven Day Service self-assessment template with Trust Boards then required, on a bi-annual basis, to provide formal assurance that the assessment was an accurate and true reflection of delivery. The trial required completion in February 2019, using 2018 data to create a baseline for future reporting. ***The completed self-assessment (as appended to this summary), having also been reviewed by the Executive Quality Board prior to submission to the Quality and Outcomes Committee, was now recommended onto the Trust Board for formal approval prior to submission to regional and national 7DS teams.***

- **Information for Patients Service: An Option Appraisal** – this report referenced the need for a 'fit for purpose 'Information for Patients' service as a fundamental requirement to support safe, high quality care for patients' and set out a vision for such an adequately resourced system within UHL. This report had previously been presented to both the Executive Quality Board and Revenue and Investment Committee, both of whom had supported option 3 of the options appraisal (i.e. optimal additional resources) and now required funding to be identified as part of business planning for 2019/20. QOC supported the recommendations of this report, noting the intended development of a related work programme. Particular discussion took place regarding the need for recognition of differing literacy levels and accessibility of information to patients, both in terms of accessibility to patients of differing languages and accessibility in terms of the medium in which the information was produced and presented, such that the Trust produced information relevant to its population. In concluding discussion, the QOC Chairman expressed the Committee's thanks in respect of all the work undertaken to progress this area and noted the need to continue this work onto the next level, with continued refinement and improvement. It was agreed that a report on progress would be submitted to a QOC meeting in six months' time (i.e. in July 2019).

- **Update from the VTE Task and Finish Group –** this report provided the first update from the VTE Prevention Task and Finish Group. The Committee was specifically asked to (i) note the Terms of Reference for the VTE Prevention Task and Finish Group and (ii) note that an overall work programme would be developed for the VTE prevention work programme with monthly updates to the Executive Quality Board. It was specifically noted that a further report on this matter was due for submission to the February 2019 meeting of the EQB and thereafter would be presented at the QOC meeting to be held on 28 February 2019. The Committee received and noted the contents of this report, noting that effective communication would be key to this work.

- **End of Life Care: Update –** UHL was the major provider of end of life care for its local population. Work continued to ensure that the care provided at the end of life at UHL continued to improve, with the development of a draft strategy for EOLC, a draft dashboard, business case to increase specialist palliative care capacity and improved resources for staff and patients, all of which were referenced within the report presented. This work was welcomed by the Committee, who noted that this strategy focussed specifically on adult patients and the need, therefore, to highlight at the front of this strategy that it was not applicable to young patients.

- **CQC Update –** this report detailed (i) a copy of the latest CQC Insight Report and a summary of the action underway to address outlier or deteriorating indicators and (ii) a summary of the recent enquiries raised by the CQC directly with the Trust. Members received and noted the contents of this report and requested additional information in respect of PROMS (patient related outcome measures) data when a further such report was submitted to QOC. The Committee also requested that the summary section detailed within future iterations of the report focus on genuine deteriorations in performance (i.e. not those which represented a deterioration on only last year's figures and for which the Trust remained performing at the national average) and included more narrative.

- **2018/19 Quality Account –** the Quality Account was a legal requirement for all NHS providers, with the aim of enhancing accountability to the public and reporting on the quality of services looking at the three domains of clinical effectiveness, safety and patient experience. The Committee was requested to note (1) this year's Quality Account guidance received from NHS Improvement and (2) that a draft of the 2018/19 Quality Account will be presented at the QOC meeting in March 2019. The Committee received and noted the contents of this report, noting relevant links with the Quality Strategy.

- **Cancer Performance Quarters 1 and 2 (2018/19) – 62 Day Breach Thematic Findings and 104 Day Harm Reviews –** the Committee received and noted the contents of these reports, as presented by Dr Barnes, Cancer Centre Clinical Lead. Particular discussion took place regarding the development of a new post within the East Midlands Cancer Alliance. It was proposed, in discussion, that these reports are scheduled, on a quarterly basis, in future, within the Joint PPPC / QOC session given the attendance of colleagues within the Operations directorate at the joint sessions whose input into these discussions would be valuable. ***The papers presented relating to this item are appended for receipt and noting by the Trust Board.***

- **Deteriorating Adult Patient Board Update (EWS and Sepsis) –** this update report noted that EWS and sepsis reporting was now undertaken electronically and it identified the key challenges in obtaining consistently reliable data. It further highlighted the actions already taken and those planned to address the issues described. EWS and sepsis performance reports were included and the work undertaken to ensure compliance with the introduction of NEWS2 to adult areas was also described. The contents of this report were received and noted and particular discussion took place regarding the accurate determination of 'time zero', especially for ward-based patients.

- **Reports for information –** QOC received and noted the CIP Quality and Safety Impact Assessment Update.

- **Minutes for information** – QOC received the Executive Quality Board minutes from 4 December 2018 and actions from 8 January 2019, and the Executive Performance Board minutes from 18 December 2018.

- **Any Other Business – Surgical Site Surveillance –** the Chief Nurse reported verbally to inform the Committee of notification received from Public Health England (PHE) with regard to the Trust being an outlier for surgical site surveillance in relation to elective knee surgery. Upon investigation it was found that there was no specific cause for concern and the finding was attributable to less procedures having been carried out due to the winter period.

Matters requiring Trust Board consideration and/or approval:

Recommendations for approval:-

- Seven Day Services – Board Assurance Framework
- Cancer Performance Quarters 1 and 2 (2018/19)

Matters referred to other Committees:

- Matters relating to the Staff Bank - as discussed during consideration of the Nursing and Midwifery Quality and Safe Staffing Report – a report on this matter was anticipated for submission to the ***People, Process and Performance Committee in April 2019***, following its prior submission to an appropriate Executive Board meeting and
- Quarterly Cancer Performance – for the reasons described within the body of the text above, it was proposed to schedule this item, in future, within the ***Joint PPPC / QPC session*** on a quarterly basis.

Date of next meeting:	28 February 2019

University Hospitals of Leicester NHS Trust: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2018/19

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Weekday across the Trust - 76%. Weekends across the Trust 79%. Overall compliance 77%. For Specialities the percentages below show Week day , Week end, Overall complianxce: Emergency Med 95% 83% 90% Geriatric Med 89% 80% 88% Surgery LRI 64% 88% 69% Surgery Inc Urology LGH 59% 75% 64% Peadriatric medicine 83% 82% 83% Obs + Gynae 92% 100% 93% cardiology 52% 33% 50% Respiratory 84% 67% 81% Other Specialities 81% 80% 81% Significant improvement has been made in respiratory. Surgery requires consultants to complete TWO ward rounds per day to see all new patients.- Am and PM. The capacity of the consultants to do this over 2 sites is not there, and will not be met until all emergency surgery is on one site. Further potential appointments of 2 surgeons in April may improve the Autumn Figures. Cardiology Consultants are being appointed which will support improvement of the standards but will potentially still not be met as there will not be enough Cardioloists to cover CDU 7 days a week.	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	All the tests are available on Site over 7 seven days. However to date we have yet to measure the turnaround times to meet the standards. A full report was sent to EQB to highlight the issue and discussions with NHSE have taken place.	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	All interventions are available across the Trust	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Yes available on site	Yes available on site	
		Percutaneous Coronary Intervention	Yes available on site	Yes available on site	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	Patients requiring 1 review per day - Compliance overall on weekdays was 99% and weekends 84%. Overall across the week compliance was 95%.	Once daily: Yes the standard is met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	Twice daily: Yes the standard is met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Transition period for this template uses last survey data. Data for these elements were not reported on. Sources of evidence for UHL are listed below and a report for the Next submission will be completed. Patient experience: Patient experience surveys on quality of care eg FFT. R2G Data, Patient Complaints Data. Multidisciplinary team review: R2G/IDT Data Shift Handovers: R2G in week, Board rounds / ward rounds Mental Health: Assurance of Liaison Mental Health services responding to referrals and providing urgent and emergency mental health care 24/7, 7 days a week Transfer to community, primary and social care: IDT Data Quality improvement; Informatics team provide data on outcomes over 7 Days LOS, Mortality and readmissions. This data is currently being worked on at Service level by day of the week.

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 5	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 6	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency
Clinical Standard 8	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
This section has been completed by NHSE and forwarded from our last NHSE Survey.

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Cancer Performance Q1 & Q2 18-19 – 62 Day Breach Thematic Findings

Author: Sarah Morley – Deputy Head of Performance - Cancer
Sponsor: Andrew Furlong, Medical Director

Executive Summary **QOC 31.1.19 - Paper L1**

Context

This report will provide an overview of the Cancer 62+ day breach findings for Quarter 1 and 2 18-19 providing the individual tumour site data around key themes and, where appropriate, actions identified to improve waiting times. In line with recent changes to report requirements from NHS England, this report will also review and identify avoidable non clinical delays for this cohort of patients.

The content of this report is supported from data analysed via monthly breach review meetings held with each tumour site.

Please note, patients treated at 104 days or more are reviewed as part of the quarterly 104 Day Harm report, however thematic analysis now includes all patients over 62 days inclusive. .

Questions

1. How many patients have waited 62+ days from referral to their first definitive treatment in Q1 & Q2?
2. Why did these patients wait?
3. What actions are being taken to reduce the waiting times?

Conclusion

1. In Q1 & Q2 a total of 394 patients were treated beyond Day 63 from referral to first definitive treatment, of these 84 were late tertiary referrals ranging from Day 39 to Day 175 at the point of transfer. This resulted in 362 breaches apportioned to UHL for the 2 quarters.
2. In Q1 & Q2 the Trust has seen a significant increase in referrals with a Trust YTD variance of 17.8% with some tumour sites experiencing increased levels of up to 30%. Conversion rates remain relatively stable with the exception of Skin, Urology and Lower GI.
3. Key themes have been identified some of which are related to late tertiary referrals, patient choice and fitness, outpatient and surgical capacity, inter-specialty referral delays, diagnostic test and reporting and anaesthetic reviews.
4. Actions have been identified in the body of the report with the majority in compliance with the Cancer Action Recovery Plan (RAP). Noting, the RAP does not form part of this document but is provided as an Appendix for reference purposes along with the monthly Cancer Reports provided to EPB.

Input Sought

The Executive Quality Board is requested to note the content of this report and support the continued breach review process of 62+ day breach review process by the Cancer Centre.

For Reference
Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Yes
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Not applicable
Financially sustainable NHS organisation	Not applicable
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register — Not applicable
b. Board Assurance Framework — Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken: None

4. Results of any **Equality Impact Assessment**, relating to this matter: None

5. Scheduled date for the **next paper** on this topic: TBC

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO: **Executive Quality Board**

DATE: **8 January 2019**

REPORT FROM: **Sarah Morley – Deputy Head of Performance – Cancer**

SUBJECT: **Q1 & Q2 18-19 62 Day Breach Review Analysis**

Introduction

The purpose of this report is to highlight the following:

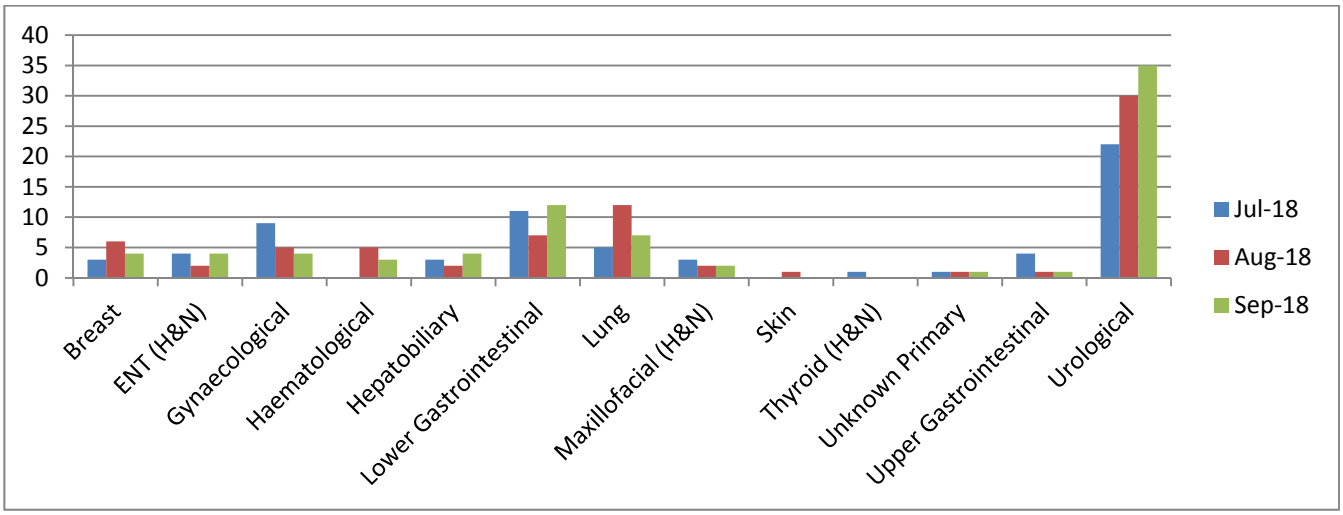
- Number of 62+ day breaches by month
- Thematic review of contributory factors impacting on delays
- Avoidable non clinical delay reasons

The national threshold for the 62 day target reflects an understanding that some pathways are clinically complex or affected by patient choice factors and are therefore not deliverable within the timeframe. For such patients – a pathway in excess of 62 days (breach map) is recorded on Infoflex. The review of prolonged pathways aims to elicit those themes and situations where inefficiencies or inadequacies in the process have occurred.

Where themes identified are deemed to be within the gift of the Trust to resolve, these are added to the Cancer Action Recovery Plan (RAP) which is challenged internally as well as with NHSI and City CCG to ensure a robust approach to performance improvement.

Quarter 1 01/04/2018 – 30/06/2018

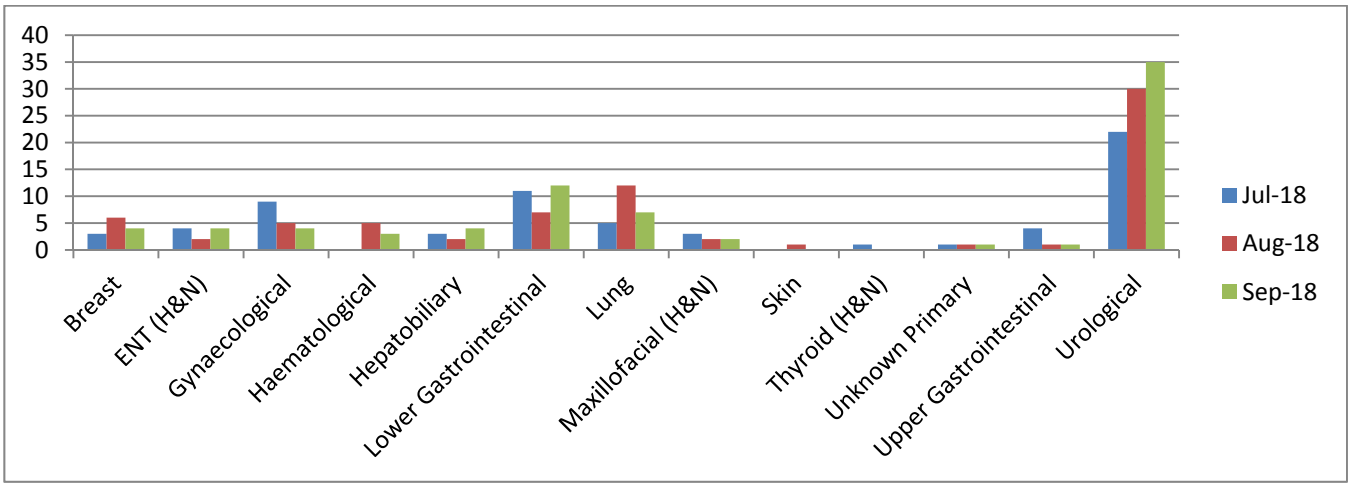
The graph below outlines the number of cancer patients treated beyond 62 days by month by tumour site in Q1 2018-2019.



Of the 177 breaches, 27 were Tertiary referrals.

Quarter 2 01/07/2018 – 30/09/2018

The graph below outlines the number of cancer patients treated beyond 62 days by month by tumour site in Q2 2018-2019.



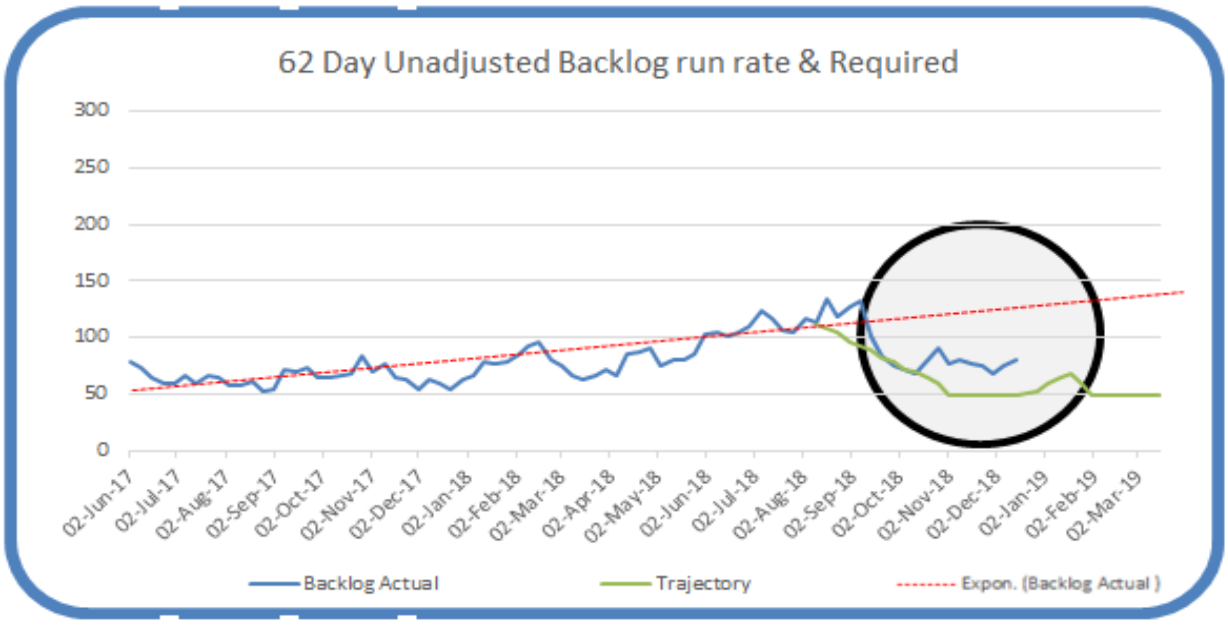
Of the 217 breaches, 33 were late tertiaries.

In August 2018, the Trust agreed a recovery trajectory for 62 day performance which focussed on a reduction/clearance of the backlog in order to achieve the standard by December 2018. This is reflected in the increased number of treated breaches along with a reduction in the backlog which is demonstrated below.

Backlogs

The graph below demonstrates the unadjusted backlog trajectory agreed, demonstrating the reductions evidence towards the end of Q2 up to the latest position at the time of reporting.

Of note is the continued downward trajectory of patients waiting longer than 104 days, in Q2 particularly having peaked at 30 patients sits at 14 at the time of reporting.



Performance

Comparing Q1 versus Q2 performance for 62 Day shows stability maintained in Breast and Skin. With the 62 day trajectory for recovery as noted above, deterioration in performance was expected across the majority of tumour sites as the backlog is treated/ cleared.

Tumour Site	Q1	Q2
Breast	91.8%	87.7%
Gynae	60.7%	60.0%
Haem	65.2%	73.3%
Head & Neck	51.1%	43.4%
Lower GI	57.9%	56.3%
Lung	73.0%	72.4%
Sarcoma	50.0%	100.0%
Skin	95.8%	99.3%
Upper GI	69.4%	67.4%
Urology	71.3%	62.6%

Contributory Factors

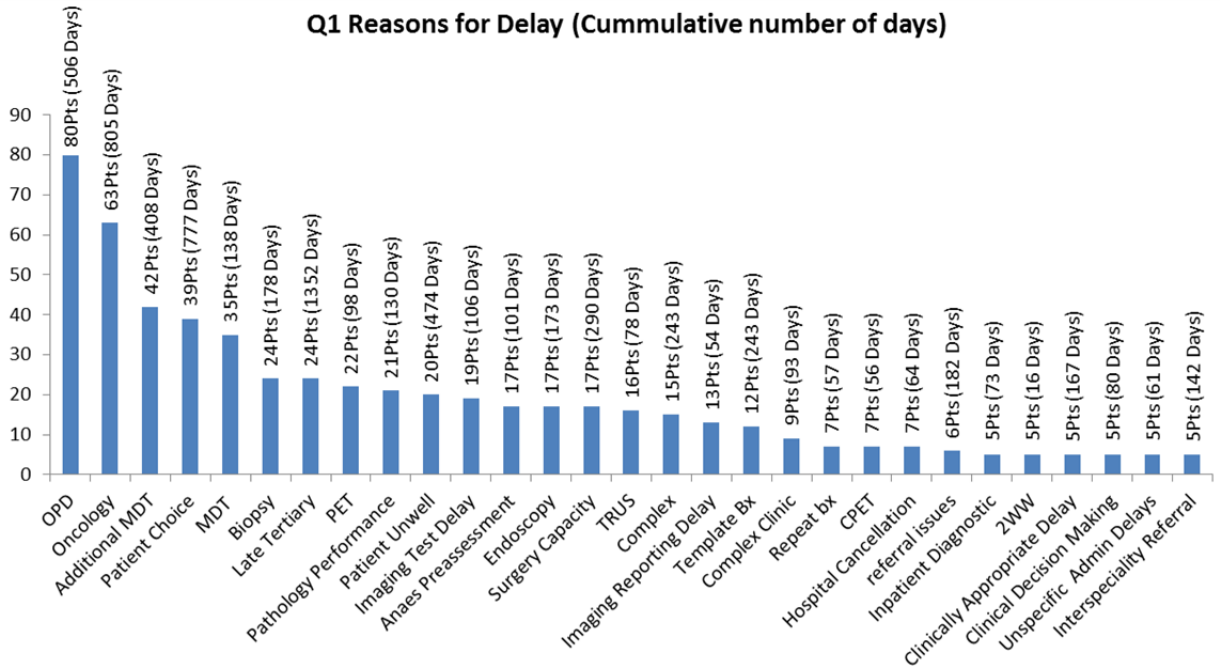
Primary Delay reasons taken from Open Exeter categorisation for breach delays as below.

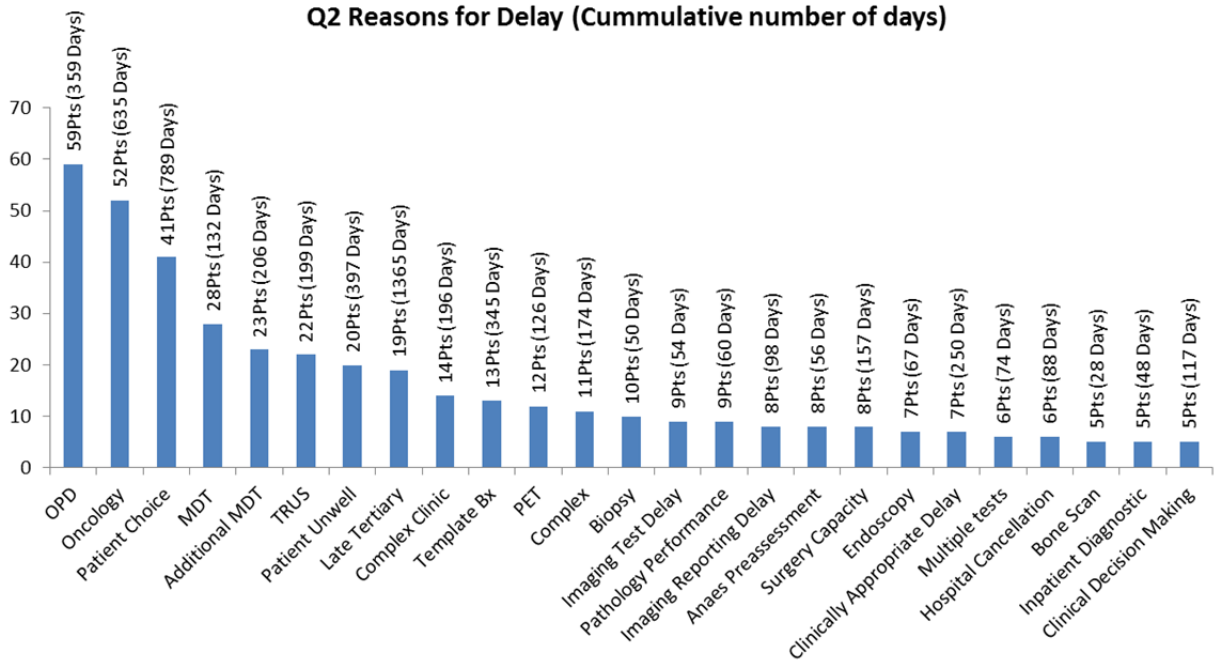
Reason	Q1	Q2
Outpatient Capacity	19	11
Administrative Delays	2	7
Elective cancellation (non-medical reasons)	0	1
Elective Capacity	4	15
Complex Diagnostic Pathway	50	43
Treatment delayed for medical reasons	13	8
Diagnosis delayed for medical reasons	4	3
Patient Choice/Patient initiated delay	14	35
Health Care Provider Initiated delay to diagnostic test and/or treatment planning	38	69
Other *typically very late tertiary referrals.	32	20

A more detailed review of delay reasons can be found in the following thematic review by Tumour site.

Themes by Tumour Site

On a monthly basis, all 62 Day breaches are reviewed by the tumour sites and analysed with the Cancer Centre, mapping out all pathway delays in accordance with Next Steps. This analysis is circulated to all tumour sites to use in assessing their service RAP actions to ensure recurrent themes are being addressed in order to improve 62 day performance.





Avoidable Non Clinical Factors

The avoidable non clinical delays/issues identified through breach analysis are reviewed by the services and where appropriate, added to the Cancer Recovery Action Plan (RAP - Appendix 1) in order to ensure improvement action is taken.

The RAP was ratified during Q2 and now details the top 3 or 4 high impact priority actions for each tumour site expected to improve 62 day performance.

Recommendations:

The Executive Quality Board is requested to note the content of this report, the Cancer Action Recovery Plan and the following recommendations:

- HOOPs (Heads of Operations) for each tumour site are requested to ensure CMG Leads review all breach maps within their tumour site, identifying avoidable and unavoidable delays, both clinical and non-clinical in readiness for the monthly breach map review meetings with the Cancer Centre and where appropriate, ensure prior clinical involvement in reviewing the pathway is carried out.

- HOOPs for each tumour site are requested to ensure the mandatory attendance of CMG Leads at the breach map review meetings with the Cancer Centre.

- HOOPs for each tumour site are requested to ensure CMG Leads remain focussed on ensuring that where appropriate, thematic learning from completion of the breach map reviews is fed back to the clinical teams to prevent future recurrence and ongoing education

- HOOPs for each tumour site are requested to ensure CMG Leads focus operationally in supporting effective pathway management for all patients on a Cancer pathway and that this remains a top priority within their services

- HOOPs for each tumour site are requested to ensure CMG Leads provide a timely response to the Recovery Action Plan updates in line with the deadlines provided on a monthly basis, ensuring all actions have been reviewed in detail with narrative to explain any specific delays. In addition, where new issues are identified through breach map reviews and/or operational pressures, that these items are added to the RAP where it is indicated they would have a positive impact on improved performance against the 62 Day standard.

RAG Key:

1	Not Started/New
2	Significant delay/No Plan
3	In progress, some risk or delay
4	On Track
5	Complete

TUMOUR SITE /SERVICE	ACTION	DETAIL	LEAD	COMPLETION	RAG	PROGRESS	Notes
SKIN	To ensure compliance with 2 week wait performance	Establish capacity demand to achieve target throughout the year	GH	~~01/01/2019~~ 1/02/19	2	**Update 18/12/18:** transformation lead and GM to work with HOS to establish baseline capacity and process applying LEAN principals to pathway to achieve consistently. capacity work commenced and LEAN process to start mid January 2019 **For next taskforce capacity and demand work to be shared and plan of lean programme**	
		93 % pts seen in 10 days	GH	~~30/09/2018~~ 1/2/2019	2	**Update 18/12/18:** November validated position resulted in an average of 12 days for the 2WW appointment with 23% of patients being seen at 10 days or less. **For next taskforce capacity CMG plan to improve position to be shared**	
		Next steps in place for all patients	GH	~~14/01/2018~~ ~~28/02/2018~~ ~~31/05/2018~~ ~~30/10/2018~~ 1/2/2019	2	**Update 18/12/18:** No update due to Q3 figures not being available. **For next taskforce service to provide results of October audit and if any further actions are required to improve performance**	
		Establish if alternative workforce can be used to deliver demand and seasonal fluctuation	GH	01/01/2019	5	**Update 05/12/18**: Steer from HoS for Derm is that current pathway is in line with NICE guidance. No clinical evidence to support change in pathway. **Action required before this is closed - Explore what other Trusts are doing. Dan Barnes and Elaine Graves to meet with Derm and Plastics to establish if anything else can be done.**	
	To ensure compliance with 31 day performance	offer all pts Rx decision to treat to treatment to 21 days	GH	01/12/2018	2	**Update 18/12/18** 31 day performance for November was at 98.2% . Building work to commence Qtr 4 2018. Explored using inpatient theatre areas but constraint is around due to lack of supervision trainee staff cannot work unsupervised, so not suitable. **Need a new delivery date and an action plan at next meeting**	
CSI	Ensure all diagnostics and pathology achieve the next steps timeframes	Develop a dashboard for tracking to be shared with all tumour sites - Imaging	MA	01/10/2018	5	**Complete**	
		Develop a dashboard for tracking to be shared with all tumour sites - Pathology	MA	21/12/2018	2	**Update 19/12/18** BIS/path finalising report for go-live **Need a new delivery date at next meeting**	
		Ensure capacity meets demand for all tumour sites - H&N, GIGU	MA	~~01/10/2018~~ 30/11/2018	5	**Complete**	
		Ensure capacity meets demand for all tumour sites - Breast Imaging	MA	~~01/10/2018~~ 30/11/2018	2	**Update 04/12/18:** Breast Imaging partially bridging capacity gap through WLIs, locums and additional post-EMRAD slots. Remainder relies on additional doctors being sourced. **Needs a new delivery date for next meeting and a reference to the action log which needs to be attached**	
	Ensure MDT stability	Robust reporting and management of MDT issues to ensure MDT's function as required providing user pack/training for each Navigator	MA	~~21/12/2018~~ 30/1/2019	2	**Update 18/12/18** Face to face training developed, January dates going into diary for face to face training of MDT co-ordinators **In order to close CSI need to survey MDT staff (survey monkey)**	
PROCESS	Implementation and audit of new MDT SOP to drive improved MDT efficiencies	Sign off new MDT SOP at Clinical Cancer Board and communicate to all UHL Clinicians	DB	30/09/2018	5	**Complete**	
		Agree implementation plan with each tumour site MDT lead ensuring all relevant actions are noted for effective rollout	DB	~~31/12/2018~~ 30/01/2019	3	**Update 4/12/18:** - Meetings with MDT leads in progress to agree implementation plans and due to diary challenges this will now run into January 2019.	
		On completion of rollout, audit implementation and quantify process improvement gains - summary report to Cancer Performance Board	DB	31/03/2019	1	Awaiting completion of action above	
CCG	LLR CCG Strategy/Primary Care Leads to: Communicate with all Practice Managers asking if Locums (Non-Substantive Clinicians) undertake 2ww referrals and if 'yes' confirm that as part of the induction the LLR process for 2ww is specifically referenced/highlighted and supporting induction packs are in place and up to date	Initial communication with the Strategy/Primary Care Leads	LLR CCG Strategy/Primary Care Leads	05/10/2018	5	Complete	
		Communication to all practices, provide timeline for response. Leads to follow up on any outstanding. Primary Care to confirm induction packs are in place and up to date		31/10/2018	5	**Update 20/11/18:** All 3 CCGs communicated with their practices and follow-up process in place Feedback received from practices. Follow up in place with those very few practices that did not have 2ww in their induction pack	
		Spot check audits to be undertaken at a number of practices from each locality during quarter 3 and fed back via the Cancer Performance Board with any subsequent actions identified.		31/01/2019	1	No update provided	
ALL	Ensure flexible reactive capacity plans are available to provide a prompt response to spikes in demand across all tumour groups	All tumour groups to baseline capacity for 2WW and develop plans for additional activity provision as a result of seasonal variation and health awareness campaigns to mitigate risk to performance delivery, to include high volume stages of the full 62 day pathway where applicable	All CMG's	15/01/2019	4	**Update 5/12/18:** weekly dashboard available demonstrating activity volumes by tumour site at 2WW and timed brackets along the pathway. Health awareness campaign calendar sent to all leads. Bank holiday annual leave plans requested from CMGS to ensure cancer activity is prioritised and can be maintained over Christmas/New year. Need to ensure use of dashboard is embedded in tumour sites	
CANCER CENTRE	Ensure local CMG PTL meetings are consistent and fit for purpose improving focus on deliverables and senior management input is value added	Through a process of observation and collaborative working with the General Managers for each tumour site assessing the existing PTL Policy as appropriate	Cancer Centre Management Team	31/01/2019	5	**Update 4/12/18**: Not on the priority list at present as resources focussed on December performance drive. Intent to agree a plan by end December Close and return pending feedback from NHSI	
RADIOTHERAPY	Develop radiographer roles to alleviate clinical oncologist pressures and minimise patient pathway delays	Set up radiographer led palliative service (subject to UHL approval)	SN	~~31/07/2018~~ 31/01/19	3	**Update 19/12/18:** approval given by Consultants, job description to be updated and sent for approval **beginning of January.** **Update required at next meeting**	
		Implement Radiographer independent prescribing	SN	~~30/12/2018~~ 31/01/19	3	**Update 19/12/18:** Exam board now meeting 8/1/18 for submission of portfolio **Update required at next meeting**	
ONCOLOGY	Fully establish Oncology workforce to ensure delivery of 85% of all outpatient appointments are offered at 7 days	Recruit to remaining 2.85WTE vacancies remaining from original business case - exploring alternative workforce solutions due to national shortage of oncologists	SN	01/04/2019	4	**Update 19/12/18:** There are still 2 x clin onc vacancies. A locum will be commencing in January to support x1 clinical oncology post. Other changes in job plans will not provide an overall net increase in PAs at this time, however better cover across single practitioner tumour sites (H&N). Plan to re-advertise in Feb to attract possible trainees eligible for CCT.	
		Provide weekly reporting identifying current gaps in tumour site service delivery and mitigating actions	SN	30/09/2018	5	Complete	
ONCOLOGY	Establish minimum datasets for Oncology referrals between MDTs by tumour site to improve delays and patient experience.	Complete pilot within LOGI	SN	30/11/2018	5	**Update 19/12/18:** Colorectal/Anal Proforma updated and now in use in LOGI MDT and by Oncology Clinic Co-ordinators. - pilot complete. Lung proforma has been agreed, awaiting confirmation of start date. Further roll out planned.	
		Agree and finalise the ONC Minimum dataset process between the Cancer Centre and Oncology	SN	~~30/11/2018~~ 30/01/2019	2	**Update 4/12/18:** SN/SM to meet and agree before end January to finalise process **Update required at next meeting**	
		Rollout across all tumour sites	SN	01/02/2019	4	**Update 4/12/18.** Second Proforma drafted for Lung referrals based on Minimum Data Set agreed by consultants. To be trialled from December 2018. **Decision on who will add breach date to the Proforma for next meeting**	
ONCOLOGY	Review future capacity requirements to meet tumour site demand changes for clinical and medical oncologist workforce	Use Cancer dashboard to foresee increased activity from tumour sites and plan accordingly	SN	30/10/2018	5	**Complete**	
		Develop business case where gaps are identified to future proof the service offering	SN	31/12/2018	2	**Update 4/12/18:** Business case in development for additional resource to meet demand. Will include extended roles, Non-Medical staff and options to deliver chemo in a community setting in the medium/long term. To go to SMT in January 2019. **Business case to be provided at next meeting**	

BREAST	Ensure consistent delivery of 2WW performance by providing sufficient capacity to meet demand working in conjunction with radiology	Weekly review of demand/capacity working with Imaging colleagues to maximise utilisation of 2WW slots ensuring working assumption of 200 slots/week is routinely delivered	LC	~~01/12/2018~~ 31/1/19	2	**Update 17/12/18.** Working group including COO and MD established, weekly meetings in progress. Working with private sector provider (Nuffield) and outsourcing provider (Your World) to increase capacity over the next 2-3 months. Super Sunday clinic for 80pts on Sunday 30th December and potentially 6th January 80pts in addition to in week and evening WLI. Uplift in clinic slots to 28 per clinic. Bringing forward magseed clinics (additional 3 slots per clinic from mid January) **To attach updated action log for next meeting**
		Review other models of care at high performing Trusts developing a business case around options to improve baseline capacity to meet demand and future proofing of service delivery	LC	~~01/12/2018~~ 31/1/19	2	**Update 17/12/18.** Task and finish group set up first meeting 11th January 2019 **Update on date to deliver NUH at next meeting**
GYNAE	Complete timed pathways for all sub-specialty pathways within Gynae taking best practice from other high performing Trusts and evaluation from Sheffield peer review in order to minimise pathway delays, improve patient experience and performance	Agree timed pathways and rollout engaging with key partners/ECAG	DY	31/01/2019	4	**Update 4/12/18:** pathways drafted but not fully signed off across the service, for next consultant meeting for sign off for the Gynaecology lead element 18.01.19. There does require Trust wide discussion regarding the time frames within the pathways relating to essential support services namely Imaging, Pathology and Oncology for them to be fully realised. **Timed pathways to have been discussed with other services by next meeting**
		Implement across the service	DY	28/02/2019	4	**Update 4/12/18:** await completion of the above action. All clinicians aware, comms via the meeting on the 18/1/19 for finalisation of action
		Monitor and evaluation through audit for a period of 3 months post implementation to ensure BAU	DY	31/03/2019	4	**Update 4/12/18:** Audit to commence in December to support identification of issues against delivery of the timed pathways working with support services.
GYNAE	Complete recruitment of Gynae consultant with specialist interest (1 WTE) to increase diagnostic, outpatient and treatment capacity	Obtain Royal College approval and submit case of need to ERCB for recruitment	DY	~~30/10/2018~~ 31/12/18	2	**Update 4/12/18 -** JD has been approved and finalised by RCOG, approved by RIC awaiting ERCB process **Delay to be escalated to ensure progressed**
		Advertise post and conduct interviews	DY	TBC	1	**Update at next meeting**
GYNAE	Complete the extension of the Gynae MDT to support the booking of diagnostic/surgical procedures direct from MDT reducing pathway delays and improving performance	Review process of booking surgical and diagnostic procedures to see if this can be changed to real time	DY	31/01/2019	4	**Update 1/12/18:** Outlook diaries to be trialled at dating meetings from January 2019
		Take best practice from Sheffield peer review output and align to UHL processes	DY	31/01/2019	4	**Update 1/12/18:** Meeting has taken place. Action plan to be developed on recommendations to be taken forward and RAP to be updated accordingly - CMG meeting on 7/12/18.
H&N	Review all ENT cancer pathways, agree UHL timed pathways eliminating delays and improving cancer performance	Complete clinical review with the support of the Lead Cancer Clinician and agree with ENT clinical team	LC	31/01/2019	4	**Update 17/12/18:** all reviewed and agreed by clinicians. In the process of documenting them - for review as part of DB timed pathway actions
LUNG	Phased implementation of the Leicester Optimal Lung Cancer Pathway	Implement CXR to CT with daily triage/MDT reviews	ST	31/12/2018	2	**Update 18/12** Concerns raised re element of the CXR - CT - Triage process meeting arranged for 21/12 to discuss and agree way forward anticipated start date 07/1/19 **Update required at next meeting**
		Implement additional bronchoscopy sessions	ST	31/12/2018	2	**Update 3/12/18:** 3 of 5 lists agreed - start dates rollout from January through to Feb. **Update 18/12** as per previous **Update required at next meeting**
		Improve histology TAT and purchase capital equipment identified	MA	31/03/2019	4	**Update 5/12/18:** awaiting CV finalisation to proceed with procurement - to commence process for purchasing equipment required **Update to be provided by CSI at next meeting**
		Increase palliative care input through recruitment of posts as per business case	ST	31/03/2019	4	**Update 18/12** as per previous will be chased at project group meeting in January
		Confirm phased go live dates producing project highlight reports for review at Cancer Performance Taskforce	ST	31/12/2018	2	**Update 18/12** CCG update reviewed and will be in use at future project group meetings **KPI's to be added to highlight report for next meeting**
GI	Reduce 2WW first seen appointments to 7 days to assist with achievement of 62 day operational target and FDS 28 day standard	Complete analysis on demand vs capacity across LOGI/UPGI for 2WW to enable assessment of additional capacity required to bring the wait time down to 7 days	SN	30/11/2018	5	**Complete**
		Commence monthly review of 2WW prospective report to identify capacity issues/wait time and delays.	SN	01/04/2019	4	**Update 4/12/18:** On track. Weekly adjustment of RTT clinics to prioritise cancer patients into available appointments. Meeting 2ww standard. To meet 7 day standard additional clinics are required. Additional clinics needed to meet 7 day target - At present we see approx. 11 patients a week in 7 days - additional capacity required would be 43 additional slots per month to meet the 7 day target -this would equate to an additional 1 x 2WW clinic per week. Service reviewing how this can be achieved.
		Achieve all GI Surgery OPD 1st appointments within 7 days (patient choice excluded)	SN	01/04/2020	4	**Update 4/12/18:** Liaising with outpatients to find a suitable time/location to run an additional clinic. Review of job plans and whether new consultants can pick up an additional 2ww clinic.
UROLOGY	Increase operating capacity for major surgical cases (cystectomies, nephrectomies and robotic procedures) to improve 31 & 62 day cancer performance	Implement x1 3 session day/week (in-week) in agreement with ITAPS working through current theatre staffing issues	SN	01/01/2019	2	**Update 19/12/18 -** no further additional UHL capacity able to be provided due to theatre staffing vacancies and skill mix. Weekends are continuing x4 sessions at UHL. Obtaining Urologist availability to use some weekend capacity in Derby fro January. ITAPS staffing unavailability and in-ability to put major cases through additional theatre lists is an issue. CHUGGS working with ITAPS lead to obtain plan. ITAPS out for more agency staff, ongoing recruitment with open adverts. **Update required by ITAPS at next meeting**
		Increase baseline in-week capacity by x2 sessions/week	SN	~~31/10/2018~~ 30/12/18	5	**Complete**
		Increase utilisation and provision of Derby capacity (patient choice dependant)	SN	31/12/2018	2	**Update 30/11/18:** Meeting has been held and Derby are reviewing whether they can offer Wed in week capacity. **Update on Derby capacity at next meeting**
		Revisit baseline capacity gap for cancer sessions with NHSI support	SN	30/11/2018	5	**Complete - see IST RAP**
UROLOGY	Reduce 2WW first seen appointments to 7 days to assist with achievement of 62 day operational target and FDS 28 day standard	With support of IST, review demand vs capacity for 2WW across the Urology pathways to understand gap	SN	~~30/01/2018~~ 31/1/19	4	**Update 30/11/18:** Meeting has been held, objectives being reviewed and x2 weekly meetings scheduled.
		Review existing clinics to identify potential to convert routine activity to cancer activity	SN	~~30/01/2018~~ 31/1/19	4	**Update: 30/11/18:** NHS I have confirmed that to reach the 75 centile we would need to put on 32 additional 2ww slots per week. Service currently flex's routine activity to prioritise cancer work.
		Confirm requirements to enable service to deliver 2WW at 7 days - working with IST	SN	01/01/2019	5	**Update: 30/11/18:** NHS I have confirmed that to reach the 75 centile we would need to put on 32 additional 2ww slots per week on top of the additional already in place weekly - to review if this can be achieved through pathway changes working with IST **27.12.18** NHSI capacity tool has been used to establish capacity required
UROLOGY	Increase clinical capacity for template biopsy provision to reduce diagnostic waiting times and improve overall pathway performance	Confirm appropriate consultants to be trained to perform template biopsies	SN	01/10/2018	5	**Complete**
		Complete sign off confirming increased capacity provision generated	SN	~~01/10/2018~~ 30/12/18	2	**Update 30/11/18:** Urologists required to complete another 1 training session. Current numbers requiring TBx are not enough to run a training list, without delaying pathway. Likely to have sufficient numbers without impacting pathways late December/early January. **Update required at next meeting**
UROLOGY	Review all Urology cancer pathways, identifying opportunities to reduce the number of follow up appointments/unnecessary steps creating agreed timed pathways within the operational standard.	Work through all pathways with CNS and consultant leads identifying key areas of opportunity to shorten pathway	SN	~~01/01/2019~~ 30/01/2019	4	**Update 19/12/18:** Final work being done, to pull info together and discuss at next Consultant meeting for sign off - 10 January 2019

		Use IST support to complete the pathway tool analyser and review outputs before agreeing actions to move pathways forward	SN	01/01/2019	2	**Update 30/11/18:** Pathway reviews mapped out and NHSI timed pathway analysis completed. Service now working through where adjustments can be made to reduce overall timescales and what is required. **Update required at next meeting**	
H&N	Ensure sustainable delivery of ENT cancer provision as a result of 2 substantive members of the surgical team leaving in 2019	Obtain Royal College approval of substantive JD	LC	31/12/2018	2	**Update 17/12/18.** despite further chasing this has still not come back from the college, approval given to go ahead with recruitment 19.12.18	
		Obtain ERCB approval	LC	31/12/2018	5	**Complete**	
		Advertise x2 posts substantively and concurrently advertise for fixed term locum posts for 6-12 months to reduce potential surgical gap	LC	TBC	1	Update required at next meeting	GW to provide delivery date
		Agree date by which NUH will take back the 2WW deferred referrals from 1/1/19 due to lack of UHL resource	LC	~~17/12/2018~~ 31/12/2018	2	**Update 19.12.18** - to confirm with contracts a formal notification to NUH. Update required at next meeting	
		Interview and appoint substantive and fixed term posts	LC	TBC	1	Update required at next meeting	

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No.	Theme	UHL Lead	IST Lead	Trust objective / IST recommendation	Steps required	Progress	Expected Completion date	RAG
1	Prostate Pathway review	Charlotte Langford / Dan Barnes	Danya Taylor	Undertake a detailed review of the current pathway using the IST Pathway Analyser Tool to assess scope for quick wins to remove unnecessary steps, with a specific focus on diagnostic steps and booking/admin processes.	Work with the trust to review current pathways using the IST Pathway Analyser tool. Support the trust's cancer services manager and urology managers in creating and implementing an action plan for any identified improvements.	30/11/18 - Pathway Analyser has been completed. To be discussed with Nikki on 21/12 and agree key actions to be taken forward.	21/12/2018	4
					Pathway map to be reviewed with NHS I at next face to face meeting. Trust to arrange internal clinical meeting for pathway discussions	30/11/18 - Meeting has taken place. Six key actions have been agreed which should shorten pathway for specfic cohorts of patients once implemented. These are to be worked through and mapped out at meeting on 21/12	21/12/2018	4
2	Demand & Capacity	Charlotte Langford / Dan Barnes	Danya Taylor & Lynn Neat	Undertake demand and capacity modelling for Urology 2WW appointments and other key pathway milestones e.g. biopsy.	Introduce the IST demand and capacity models ands support the Urology teams to populate them.	**30/11/18** Model reviewed with Nikki. Next Steps and actions to be discussed and agreed on 21/12. Number of additional slots required weekly has been identified.	21/12/2018	4
3	Operational Management	Sarah Morley	Danya Taylor	Review the trust's corporate and local cancer PTL meetings to ensure they deliver best practice with operational reports that support operational managers in the proactive management of the cancer pathways. Review escalation processes to ensure swift resolution of pathway delays.	Critical observation of local urology and trust-wide cancer PTL meetings using a PTL checklist to identify opportunities to strengthen PTL management and increase operational grip. Review cancer PTL and associated reports, and escalation processes and advise on any areas to improve. Support chair and service teams to deliver on any improvement recommendations.	**30/11/18 -** Further discussions to take place between NHSI and Sam Leak to discuss what changes are required if any.	30/01/2019	4
4	Administrative processes and SOP's	Angela Barnard	Lynn Neat	Review administrative and booking processes for the urology cancer pathways to ensure they are consistent and streamlined.	Undertake a review of administrative and booking processes for the urology cancer pathways including: 2WW bookings, clinic outcomes, diagnostic bookings, theatre bookings, tracking and escalation. Support cancer and urology managers to write/update SOPs and implement these with the relevant teams to ensure consistent application of streamlined processes.	**8.11.18** - Awaiting IST allocation of support so this can be started as requires IST support to inform on best practice then UHL can implement	1.12.18	3

5	Training and Expertise		Lynn Neat	Develop a competency assessment for the cancer e-learning module Make the e-learning module compulsory for all staff involved in the care of cancer patients	Support the Trust in creating the competency assessment exercise.	**8.11.18** - Awaiting IST allocation of support so this can be started as requires IST support to inform on best practice then UHL can implement **12.11.18** The e-learning module we have already has a competency assessment at the end – there is no requirement for support for this but we would welcome a critical view of the existing e-learning module as previously fed back.	1.1.18	3
6	Cancer Information		N/A	Have a dedicated informatics resource for cancer to ensure timeline internal and external reporting, and development of new reports as required to respond to operational pressures and changes in CWT guidance.	Recommendation that the Trust employs a Cancer Information Analyst in line with best practice	**8.11.18** - The Business information team are able to provide the support to the caner team. The timeliness of reports and support will be reviewed for a further review of an additional post next financial year. If required a business case will be submitted.	1.11.18	5

5 - complete
4- on track
3 - some delay expected to be completed as planned
2 - significant delay not expected to be completed as planned
1 - not started

Ref		ACTION	DETAIL	LEAD	CMG Inter-dependency	DELIVERY DATE	RAG	PROGRESS
	Performance		1. Audit of 25 sets of breach maps for pathway timings	DM		End Dec 18		
			2. Evaluate key reasons for breaches	DM		First week Jan 19		
			3. Demand and Capacity exercise for each step of the pathway to align with timed pathways	QD/LS/SM/DM	CSI ITAPS	End Jan 19		
			4. Remedial actions to be discussed and confirmed withint the CMG and interdependent CMGs	QD/LS	CSI ITAPS	TBC		
1		Pathway "Deep Dive" to gain an understanding of challenged performance	5. D&C review of Pre-op assessment (including high risk anaesthetic)	RB		End Dec 18		
2.1	Process	Review the process of handling 2 week wait referrals	No review required				HOLD	
2.2		Choose & Book for 2 week wait referrals	Not to be progressed at present as only achievable with the correct amount of bookable capacity				HOLD	
			1. Review PRISM forms	OB/QD		Jan-19		
		Reducing non compliant 2 week wait	3. Comms to all GPs	OB/QD		Feb-19		
2.3		referrals	4. PLT feedback sessions	OB/QD		Apr-19		
2.4		Redesign of gynae 2 week wait referral process	1. USS scan appointment prior to 2 week wait referral based on 4mm Endometrial thickness 2. Confirm Ultrasound capacity within CSI 3. Confirm new pathway with commissioners 4. Identify any tariff implications	OB/ME/DM/Rba	CSI Contracts/commissioning	Apr-19		
			1. Identify process for informing patients with no cancer identified	DM/LS/SM	Cancer Centre	Mid Jan 19		
2.5		28 Day Faster Diagnosis	2. Identify capacity required by tumour site to deliver 28 day diagnosis	QD/DM/LS	Dependent on action ref 1.0	End Feb 19		
			1. D&C exercise to identify additional clinic capacity by tumour site	DM/LS	Dependent on implementing action ref 2.4	Mid Jan 19		
			2. Identify any deficit in workforce to resource additional capacity	DM/LS		End Jan 19		
2.6		7 day turnaround to first appointment	3. Identify physical clinic capacity to accommodate additional clinic capacity	DM		Mid Feb 19		
2.7		Atypical Complex Hyperplasia	The current process for managing this category of patient will be maintained				HOLD	Patients will remain on the PTL until cancer has been ruled out through treatment (hysterectomy)
2.8		Monitor breaches against timed pathways	1. Investigate the use of Infoflex to monitor breaches	SM/LS	Cancer Centre	End Dec 18		
2.9		Availability of Clinical notes	Process to identify confirmed cancers for notes to be ordered prior to MDT	DM/LS		Immediate		
			1. Agree with general gynae clinicians who will take on benign/simple cancer procedures	QD/IWS		Immediate		
2.10		Process for Non-CWT surgical procedures	2. Comms to all key stakeholders to confirm process	IWS		Immediate		
2.11		Explore the use of video conferencing facilities to maximise attendance at MDT	Avoid unnecessary travel cross site	QD/LS				Attendance at MDT is job planned and does not cause a problem.
	Clinical		See point 2.6 - Confirm agreement to using 4mm endomtrial thickness as indication for 2 week wait pathway	OB/QD		Immediate		
3.0		Adherence to BGCS Guidance	2. Comms to all key stakeholders to confirm process (include in comms for new referral process)	OB/QD		Immediate		
3.1		Redesign GROC/Oncology Clinic	1. Reconfiguration meeting	QD/Kboyle	CHUGGS	Apr-19		
			1. Introduce electronic diary for booking all surgical TCIs - commence trial at dating meeting	LS		Jan-19		
			2. Ensure all key stakeholders have access to diaries	LS		Dec-18		
			3. Maintain current dating meeting	QD				
			4. Book surgical procedures from MDT	QD		Feb-19		
3.2		Improving the turnaround time to booking surgical appointments	5. Explore the feasibility of booking appointment at point of contact with patient in clinic	LS/QD	Dependent on 3.2.1			
3.4		Maximise CWT Theatre Session Allocation	1. Engage with ITAPs theatre activity planning for 2019/20	LS/LF	ITAPs	Dec-18		

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Caring at its best

62 Day Thematic Breach Analysis – Appendix 2

October 2018

Operational Delivery Unit

One team shared values

Gynaecology Breach Analysis

University Hospitals of Leicester NHS
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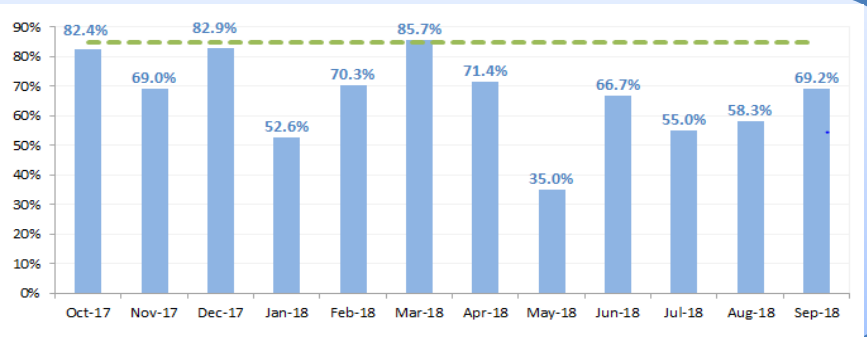
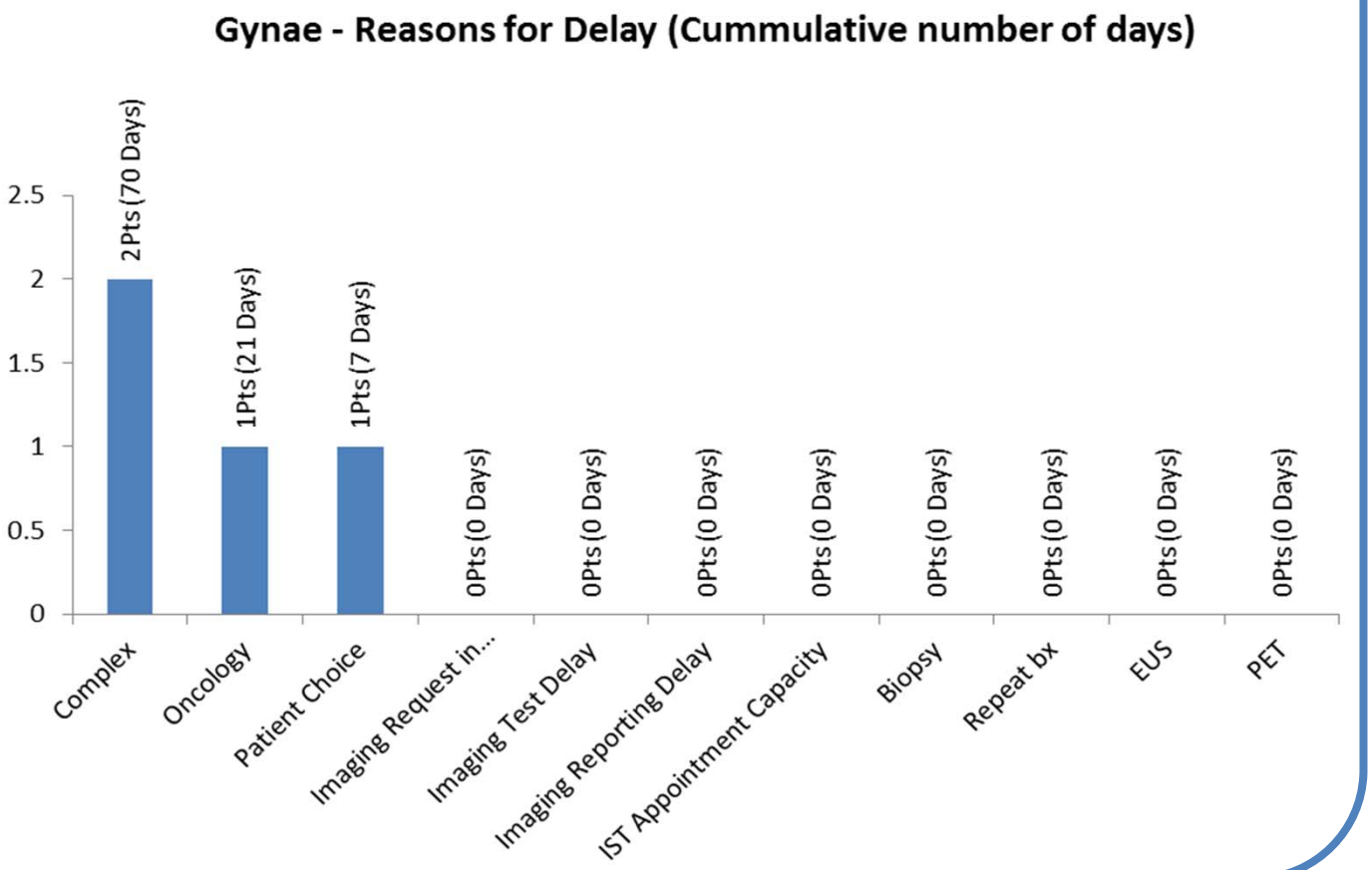
62 day performance for gynaecological cancer was 69.2% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

- **Complex** – 2 patients delayed by a total of 70 days.
- **Oncology** – 1 patient delayed by a total of 21 days.
- **Patient Choice** – 1 patient delayed by a total of 7 days.



Haematology Breach Analysis

University Hospitals of Leicester NHS
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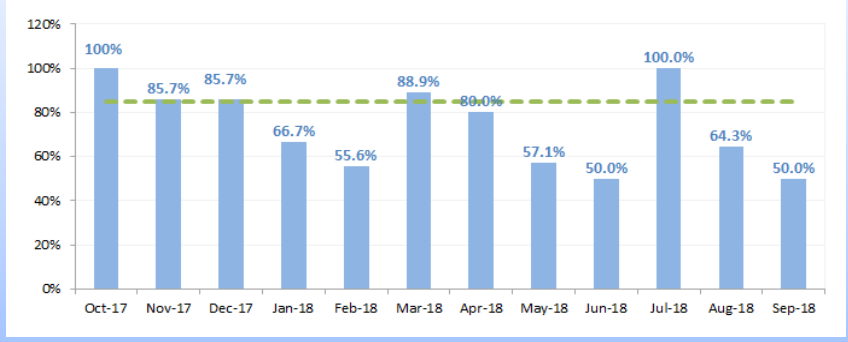
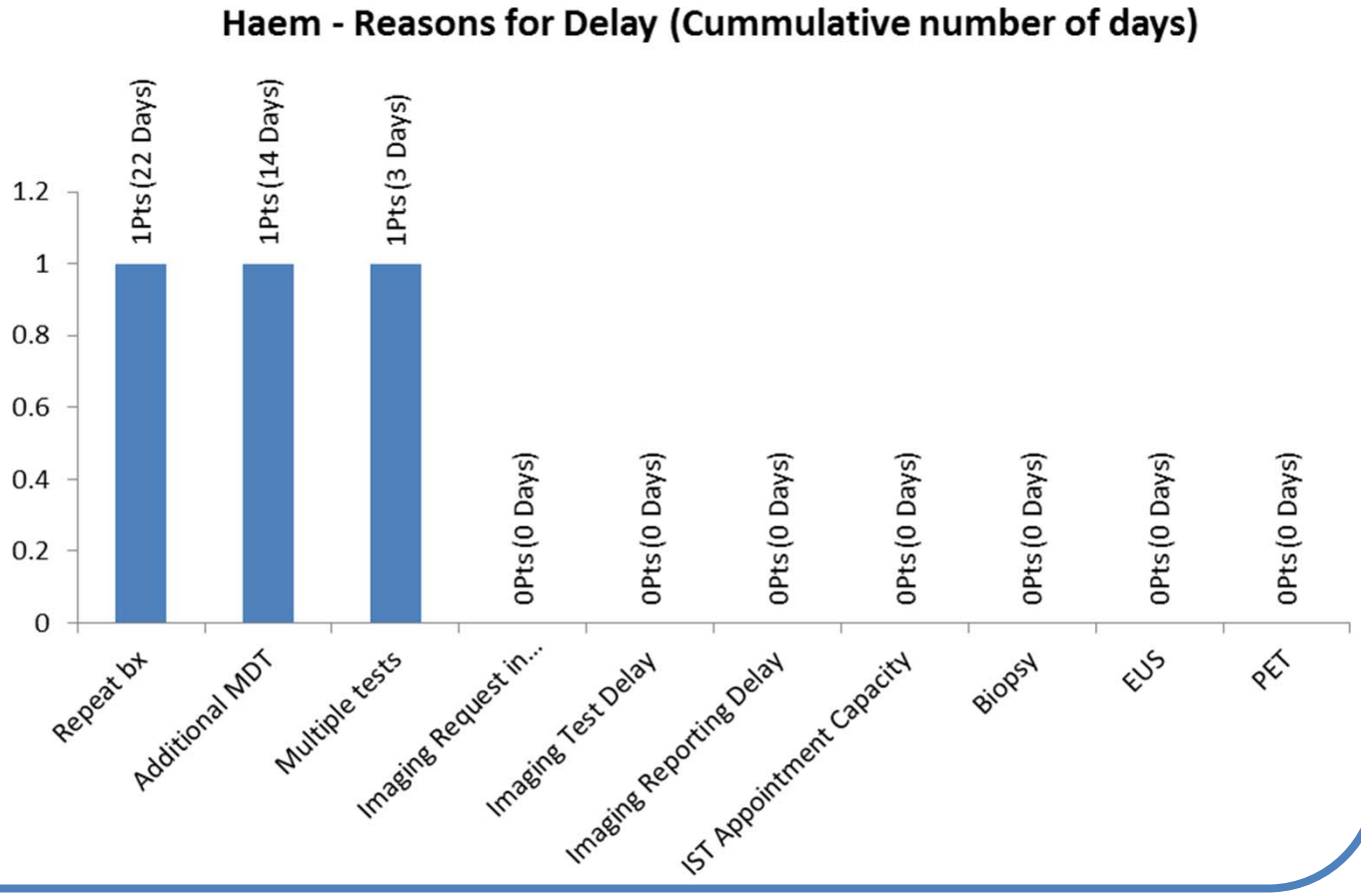
62 day performance for Haematological cancer was 50% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

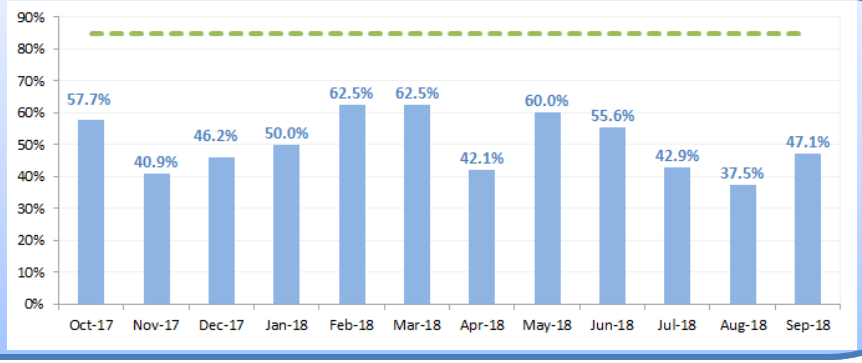
- **Repeat Bx** – 1 patient delayed by a total of 22 days.
- **Additional MDT** – 1 patient delayed by a total of 14 days.
- **Multiple Test** – 1 patient delayed by a total of 3 days.



Head & Neck Breach Analysis

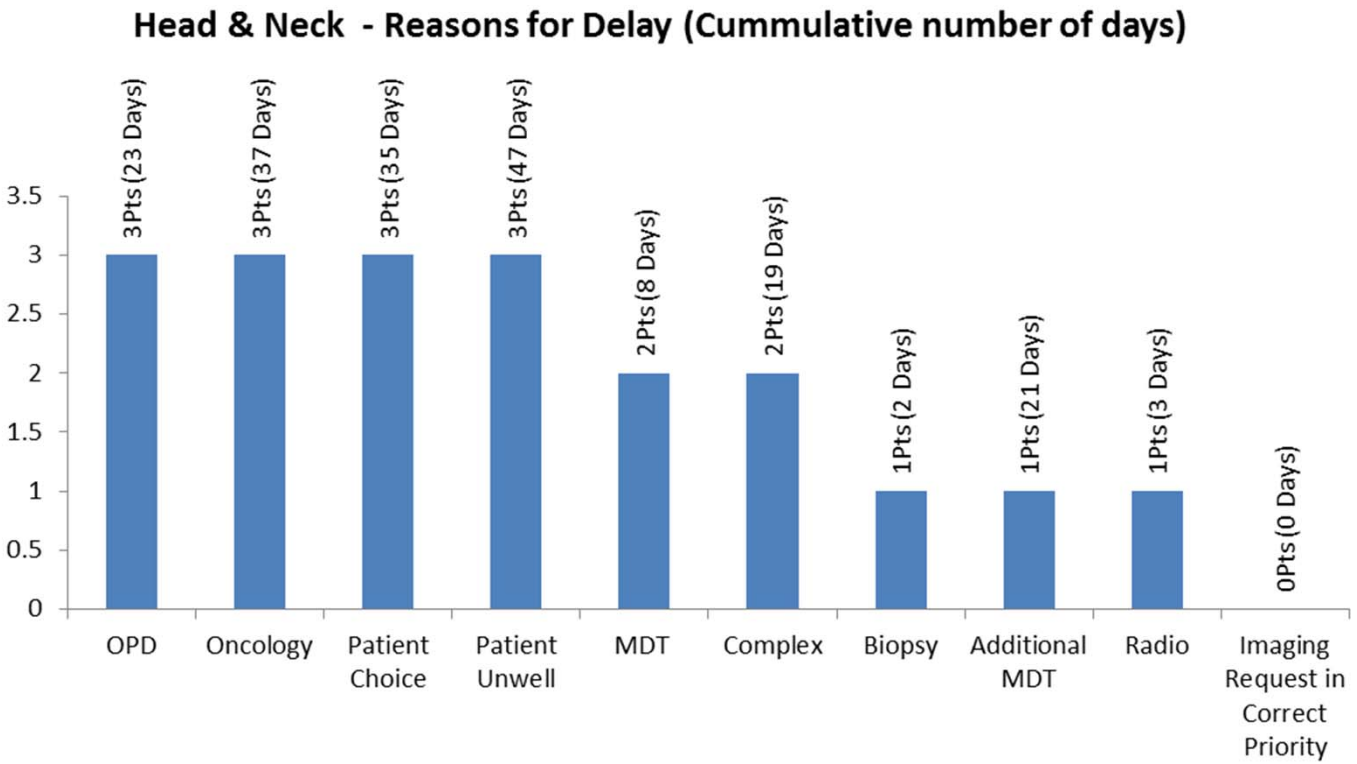
University Hospitals of Leicester NHS
NHS Trust

62 day performance for Head & Neck was 47.1% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

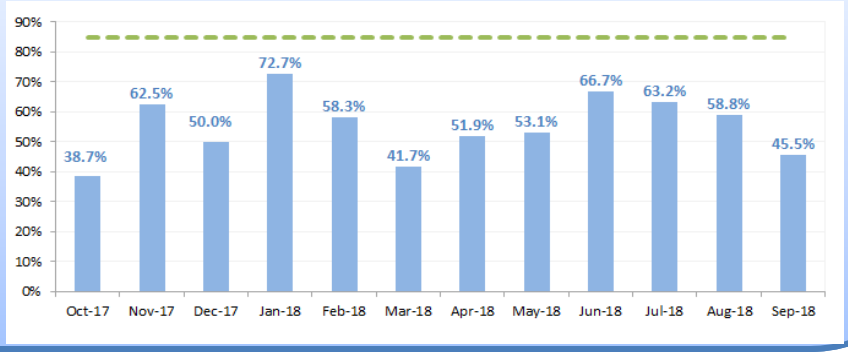
- **OPD** – 3 patients delayed by a total of 23 days.
- **Oncology** – 3 patients delayed by a total of 37 days.
- **Patient Choice** – 3 patients delayed by a total of 35 days.
- **Patient Unwell** – 3 patients delayed by a total of 47 days.
- **MDT** – 2 patients delayed by a total of 8 days.
- **Complex** – 2 patients delayed by a total of 19 days.
- **Biopsy** – 1 patient delayed by a total of 2 days.
- **Additional MDT** – 1 patient delayed by a total of 21 days.
- **Radio** – 1 patient delayed by a total of 3 days.



Lower GI Breach Analysis

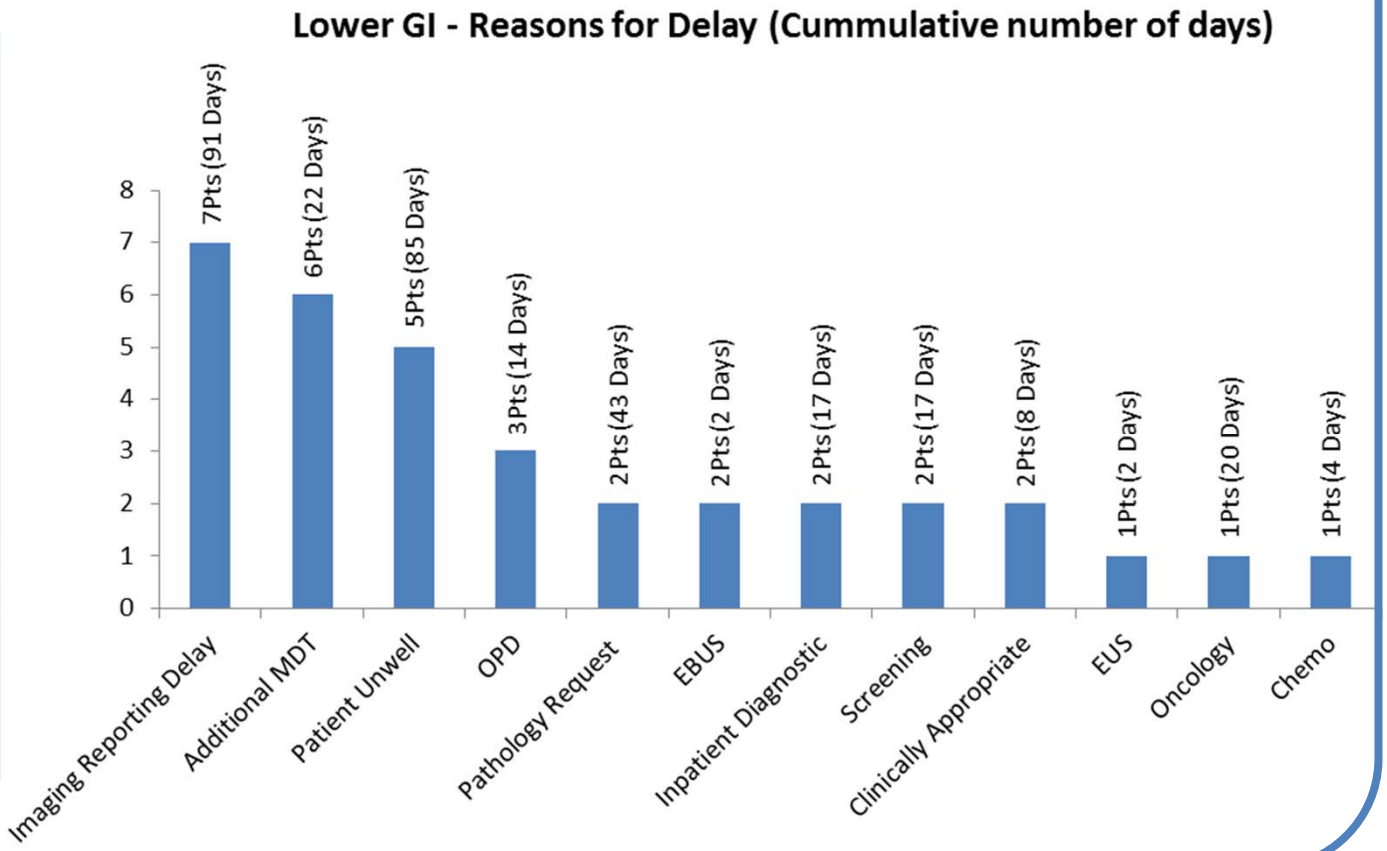
University Hospitals of Leicester NHS
NHS Trust

62 day performance for Lower GI was 45.5% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

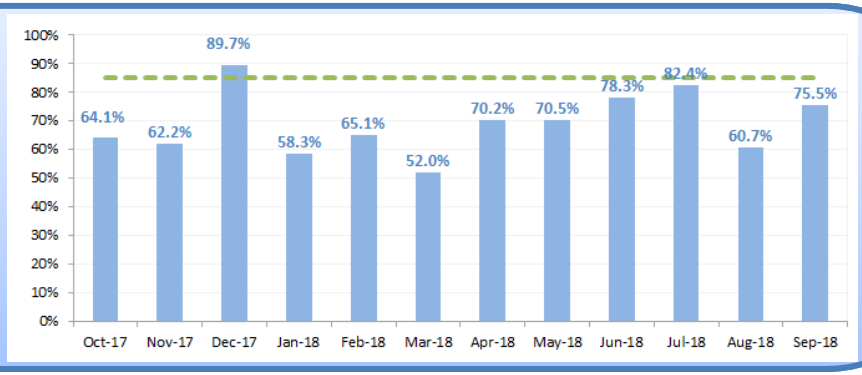
- **Imaging Reporting Delay** – 7 patients delayed by a total of 91 days.
- **Additional MDT** – 6 patients delayed by a total of 22 days.
- **Patient Unwell** – 5 patients delayed by a total of 85 days.
- **OPD** – 3 patients delayed by a total of 14 days.
- **Pathology Request** – 2 patients delayed by a total of 43 days.
- **EBUS** – 2 patients delayed by a total of 2 days.
- **Inpatient Diagnostics** – 2 patients delayed by a total of 17 days.
- **Screening** – 2 patients delayed by a total of 17 days.
- **Clinically Appropriate** – 2 patients delayed by a total of 8 days.



Lung Breach Analysis

University Hospitals of Leicester NHS
NHS Trust

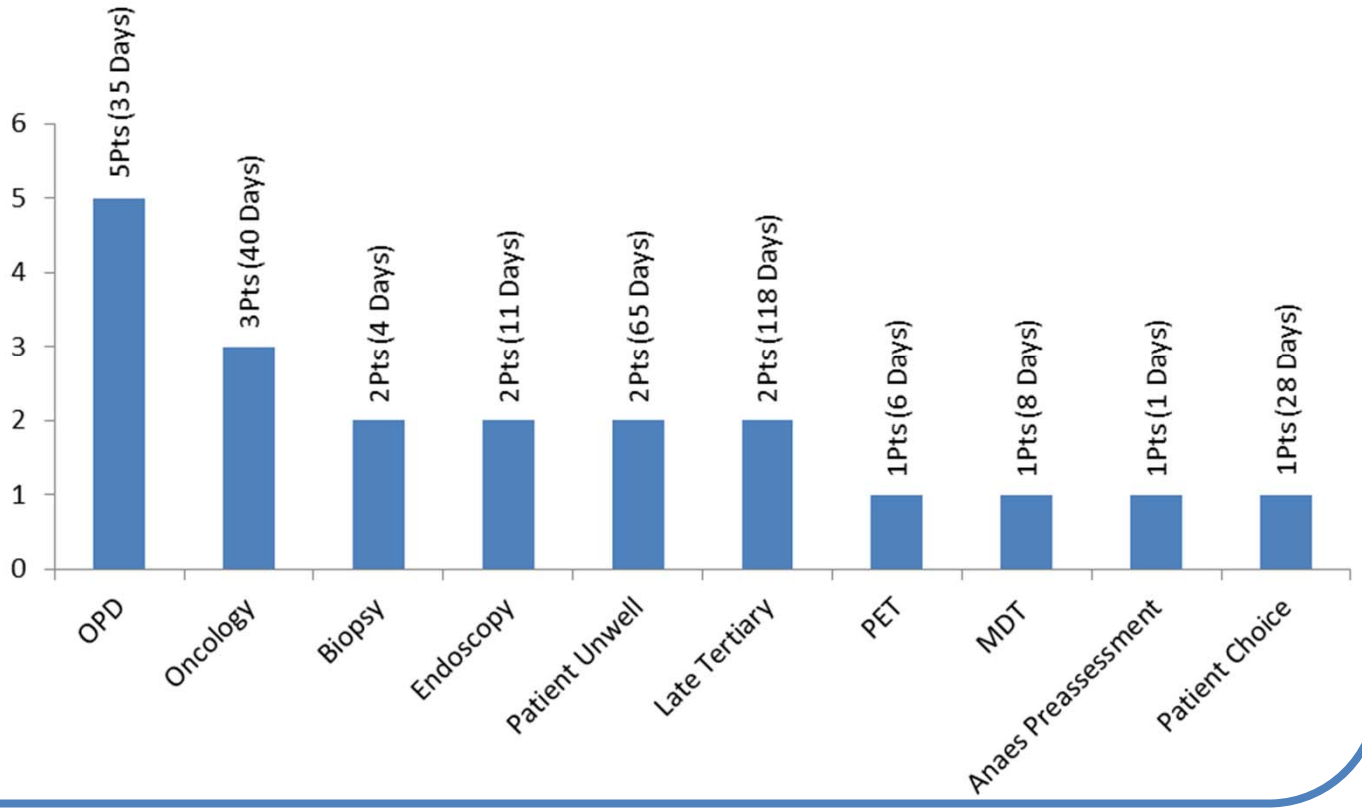
62 day performance for Lung was 75.5% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

- **OPD** – 5 patients delayed by a total of 35 days.
- **Oncology** – 3 patients delayed by a total of 40 days.
- **Biopsy** – 2 patients delayed by a total of 4 days.
- **Endoscopy** – 2 patients delayed by a total of 11 days.
- **Patient Unwell** – 2 patients delayed by a total of 65 days.
- **Late Tertiary** – 2 patients delayed by a total of 118 days.
- **PET** – 1 patient delayed by a total of 6 days.
- **MDT** – 1 patient delayed by a total of 8 days.
- **Anaes Preassessment** – 1 patients delayed by a total of 1 day.
- **Patient Choice** – 1 patients delayed by a total of 28 day.

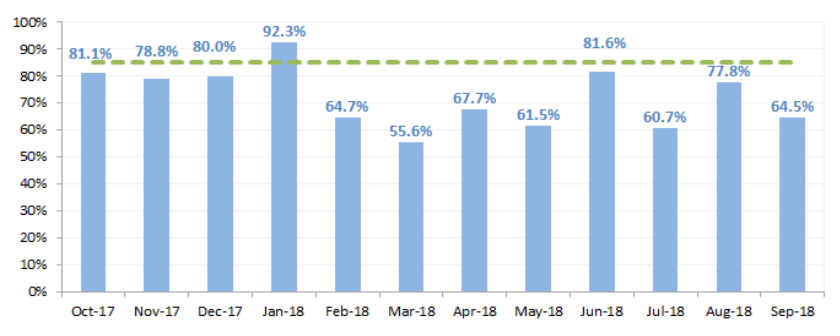
Lung - Reasons for Delay (Cummulative number of days)



Upper GI Breach Analysis

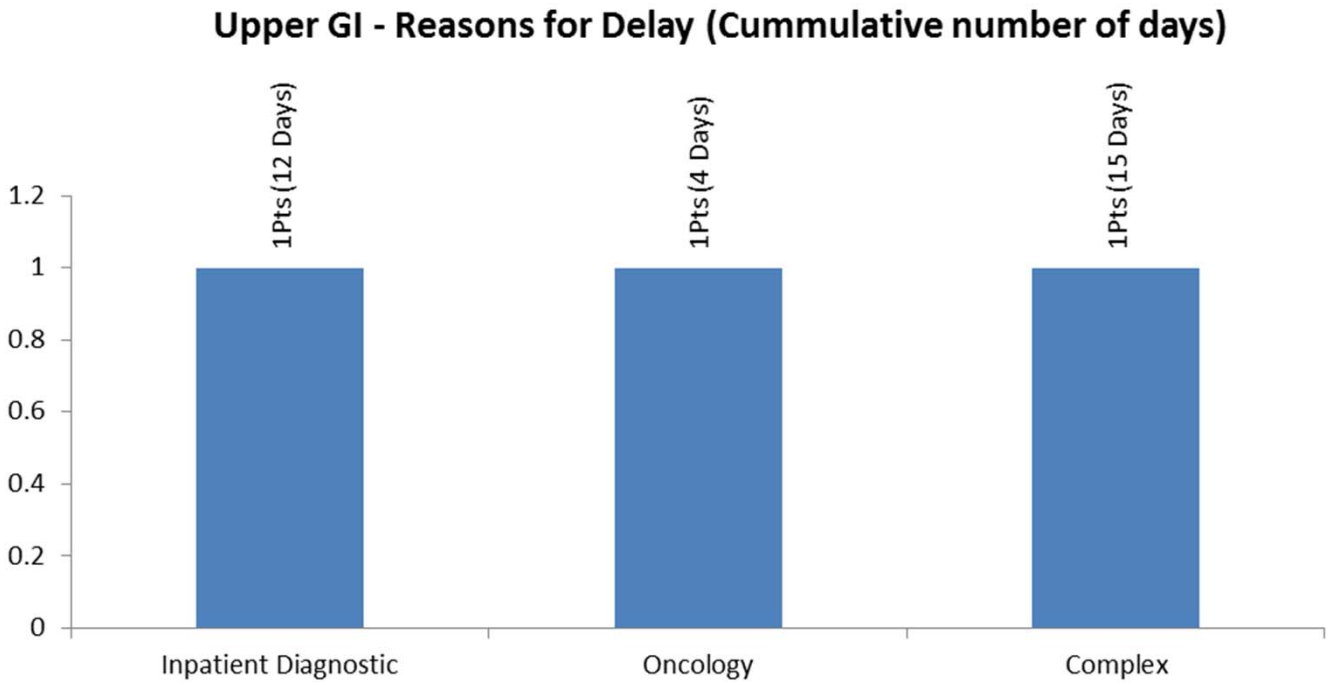
University Hospitals of Leicester NHS
NHS Trust

62 day performance for Upper GI was 64.5% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

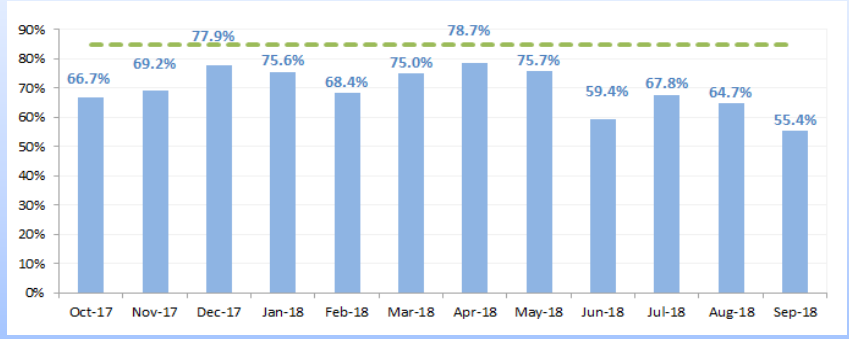
- **Inpatient Diagnostic** – 1 patient delayed by a total of 12 days.
- **Oncology** – 1 patient delayed by a total of 4 days.
- **Complex** – 1 patient delayed by a total of 15 days.



Urology Breach Analysis

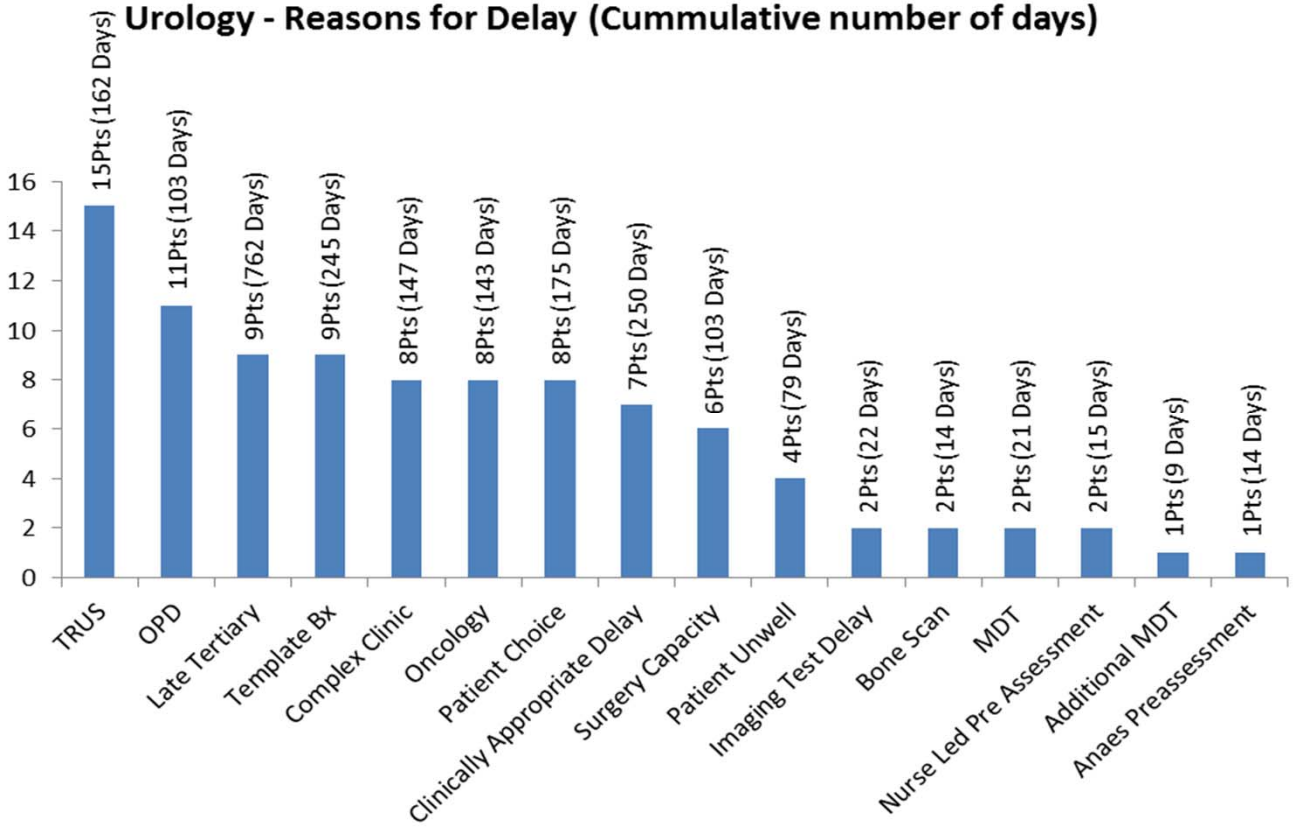
University Hospitals of Leicester NHS
NHS Trust

62 day performance for Urology was 55.4% for September.



Below is a summary of the main reasons for Delay based on the number of patient: -

- **TRUS** – 15 patients delayed by a total of 162 days.
- **OPD** – 11 patients delayed by a total of 103 days.
- **Late Tertiary** – 9 patients delayed by a total of 762 days.
- **Template Bx** – 9 patients delayed by a total of 245 days.
- **Complex Clinic** – 8 patients delayed by a total of 147 days.
- **Oncology** – 8 patients delayed by a total of 143 days.
- **Patient Choice** – 8 patients delayed by a total of 175 days.
- **Clinically Appropriate Delay** – 7 patients delayed by a total of 250 days.
- **Surgery Capacity** – 6 patients delayed by a total of 103 days.
- **Patient Unwell** – 4 patients delayed by a total of 79 days.



Cancer Performance Q1 and 2 -104 Day Harm Review Findings

Author: Dan Barnes, Clinical Lead Cancer Centre & Jane Pickard, Macmillan Lead Cancer Nurse
Sponsor: Andrew Furlong, Medical Director

QOC 31.1.19 - Paper L2

Executive Summary

Context

This report will provide an overview of the Cancer 104+ day performance for Quarters 1 and 2, 2018 in line with the National Cancer Waiting Times Backstop Policy 2015.

The report illustrates the Trust overall current position and individual tumour site data where applicable. It recommended that this report is read in conjunction with the Cancer Performance – 62 Day Breach Thematic Findings report.

Questions

1. How many patients have waited 104+ days from referral to their first definitive treatment
2. Was there any potential harm caused to the patients as a result of the wait?
3. Why did these patients wait?
4. What actions are being taken to reduce the waiting times?

Conclusion

1. In Q1 & 2 a total of 93 patients waited over 104 days from referral to first definitive treatment.
2. No patient harm was identified as a result and therefore no root cause analysis required.
3. Key themes have been identified including, late tertiary referrals, capacity for prostate robotic surgery, capacity for oncology appointments and Next Steps compliance.
4. Actions have been identified in the body of the report.

Input Sought

The Executive Quality Board is requested to note the content of this report and support the continued monitoring process of 104+ day harm review process by the Cancer Centre.

For Reference

Edit as appropriate:

1. The following **objectives** were considered when preparing this report:

Safe, high quality, patient centred healthcare	Yes
Effective, integrated emergency care	Not applicable
Consistently meeting national access standards	Not applicable
Integrated care in partnership with others	Yes
Enhanced delivery in research, innovation & ed'	Not applicable
A caring, professional, engaged workforce	Yes
Clinically sustainable services with excellent facilities	Not applicable
Financially sustainable NHS organisation	Not applicable
Enabled by excellent IM&T	Not applicable

2. This matter relates to the following **governance** initiatives:

a. Organisational Risk Register — Not applicable

b. Board Assurance Framework — Not applicable

3. Related **Patient and Public Involvement** actions taken, or to be taken: None

4. Results of any **Equality Impact Assessment**, relating to this matter: None

5. Scheduled date for the **next paper** on this topic: Quarterly

6. Executive Summaries should not exceed **1 page**. My paper does comply

7. Papers should not exceed **7 pages.** My paper does comply

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

REPORT TO:	**Executive Quality Board**
DATE:	**20TH December 2018**
REPORT FROM:	**Dan Barnes - Clinical Lead Cancer Centre** **Jane Pickard - Macmillan Lead Cancer Nurse**
SUBJECT:	**Quarterly Cancer Performance -104 Day Harm Review Findings**

Introduction

In October 2015 the National Cancer Waiting Times Taskforce requested all NHS England Trusts introduce a 'Backstop' policy for prolonged pathways. Specifically the policy should promote a clear, transparent review of pathways which exceed 104 days, to determine whether clinical harm has been caused to the patient by the delay. This is aligned with the reporting capabilities of the Open Exeter data collection system.

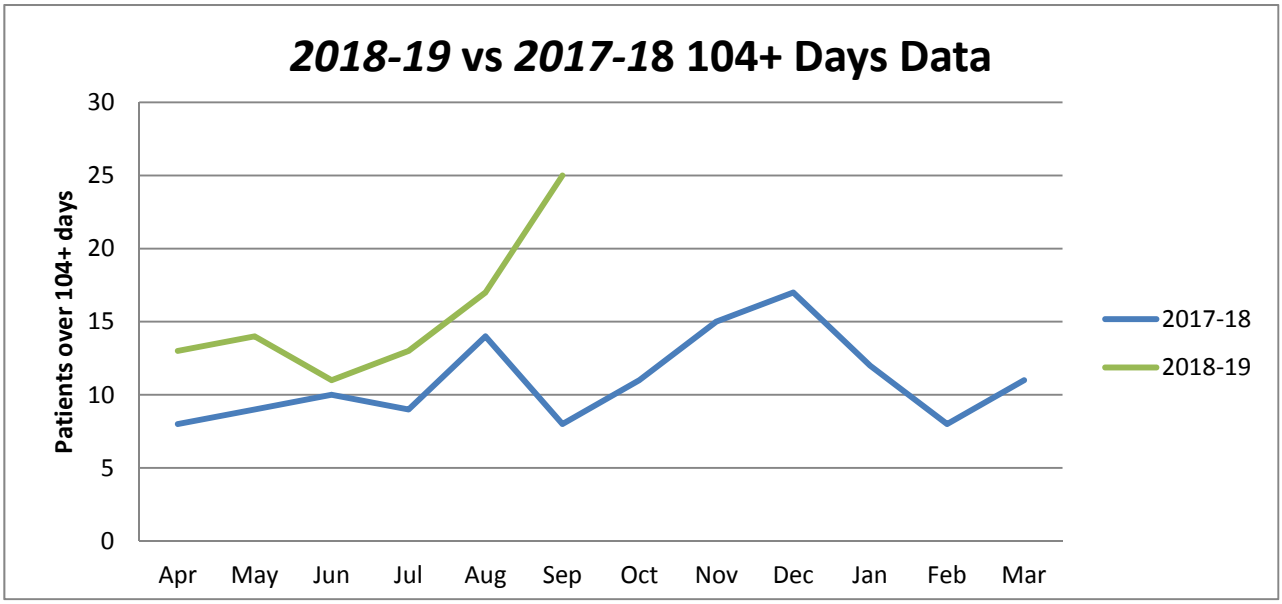
The purpose of this report is to highlight the following:

- Number of 104+ day breaches by month
- Number of 104+ day breaches which has resulted in harm to the patient
- Root Cause Analysis findings for those where harm has been identified
- Thematic review of contributory factors impacting on delays

The national threshold for the 62 day target reflects an understanding that some pathways are clinically complex or affected by patient choice factors and are therefore not deliverable within the timeframe. For such patients – a pathway in excess of 62 days (breach map) is recorded on Infoflex. The review of prolonged pathways aims to elicit those themes and situations where inefficiencies or inadequacies in the process have occurred.

Quarters 1 & 2 01/04/2018 – 30/09/2018

The graph below includes Q41 and 2 and outlines the number of cancer patients breaching 104 + days from April 2018 – September 2018 in comparison to April 2017 – March 2018.



Quarters 1 & 2 Breaches by Tumour Site:

Tumour Site	No of Patients 104+Days	April 2018	May 2018	June 2018	July 2018	August 2018	Sept 2018
Head & Neck	4	1	2	1	0	0	0
Haematology	3	0	0	0	0	2	1
HpB	5	1	2		1		1
Lung / Mesothelioma	12	1	1	3	1	3	3
Urology	50	5	5	6	6	11	17
Gynaecology	5	1	0	1	3	0	0
Lower GI	14	4	4	0	2	1	3
Total	**93**	**13**	**14**	**11**	**13**	**17**	**25**

Number of completed clinical harm reviews in Q1 & 2 = 90

Number of outstanding clinical harm reviews in Q2 = 3

Number of Clinical Harms:

The clinical harm review forms received from the MDT Clinical Leads for Q1 & 2 have not identified any clinical harm to patients.

The process continues to be monitored via the weekly Cancer Action Board and at Cancer Board.

Avoidable Non- Clinical Factors

By reviewing each individual 104 day clinical harm form enables avoidable non clinical factors that contribute to delays to be identified as below:

- Oncology capacity including uro-oncology joint clinic
- Robotic Capacity – Prostate pathway
- Next steps process compliance – capacity for high risk anaesthetic assessment, CPET, bone scans and TCI dates

- Late tertiary referrals. Total of 33. In Q1 there were 12 and in Q 2 there were 21

Given the increasing number of patients waiting 104+ days when compared to previous years, it is evident that the largest contributing factor is late tertiary referrals.

In total there were 33 late tertiary referrals of which 23 were urology which are Lincoln, Kettering and Northampton.

The specific actions to address the above are contained within the Cancer Recovery Action Plan (RAP).

Thematic Review of Continuing Contributory Factors:

The factors identified above continue to remain the key themes.

Recommendations

The Executive Quality Board is requested to note this report and the following recommendations:

- To continue to enforce the agreement that tertiary referring centres will provide a root cause analysis if the patient is referred after Day 39
- CMG Leads are requested to ensure that 104+ day clinical harm process remains a priority and that the forms are submitted to the Cancer Centre within 14 days as per the SOP
- CMG Leads are requested to remain focussed on ensuring that if potential harm is indicated on completion of a clinical review, that this is escalated timely for subsequent investigation in line with policy
- CMG Leads to ensure where potential harm is identified this is discussed at Quality and Safety Boards

Cancer Performance Q1 & 2 2018/19 – 104 Day Harm Review Findings

In Q1 and 2, a total of 93 patients waited over 104 days from referral to first definitive treatment.

No patient harm was identified and therefore no root cause analysis required.

Key themes have been identified including, late tertiary referrals, capacity for prostate robotic surgery, capacity to oncology appointments and Next Steps compliance.