Agenda item: 19a

West Hertfordshire Hospitals NHS
NHS Trust

OPERATIONAL RECOVERY PLAN

24 April 2015

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SECTION 1: UNSCHEDULED CARE

1. Background

WHHT is not currently compliant with the national Emergency Access standards which require 95% of patients attending A&E to be seen and treated or admitted within 4 hours. YTD, (April 2015) the Trust performance across all sites is 85.8% (all attendance types). As a result of this, the Trust has also seen a significant decline in achieving ambulance handover within 30 minutes.

The primary cause of A&E breaches is capacity issues in the inpatient wards; across the Acute Admissions Unit as well as the specialty wards. (over 55% of all breaches are due to lack of bed availability).

In assessing the root causes of the lack of capacity, the unscheduled care programme has looked at patient flow across the pathway of care, considering the impact of

- Average length of stay for medical patients is consistently higher than peers (4.9 days compared to 3.9 days for NEL medical patients)
- 80% of daily discharges occur after 12pm, with 58% occurring between 3pm and Midnight
- Only 13% of discharges occur at weekends (improvement effected by programme)
- There are 52 Delayed Transfers of Care, with total of 91 system waits in hospital (as of April 2015)
- 38% of GP heralded admissions arrive between 4pm and 8pm
- GP patients who arrive later in the day are 20% more likely to be admitted than those who arrive before 12
- Trust wide nursing vacancy rate of 18%, resulting in significant lack of capacity on the wards to manage the patient's next steps.

The Unscheduled Care programme was refreshed in February 2015, with a programme of work designed to improve flow through the hospital, reduce length of stay, and tackle a number of the issues causing patient flow to slow down and cause A&E to fill up. The core work streams in place are as follows:

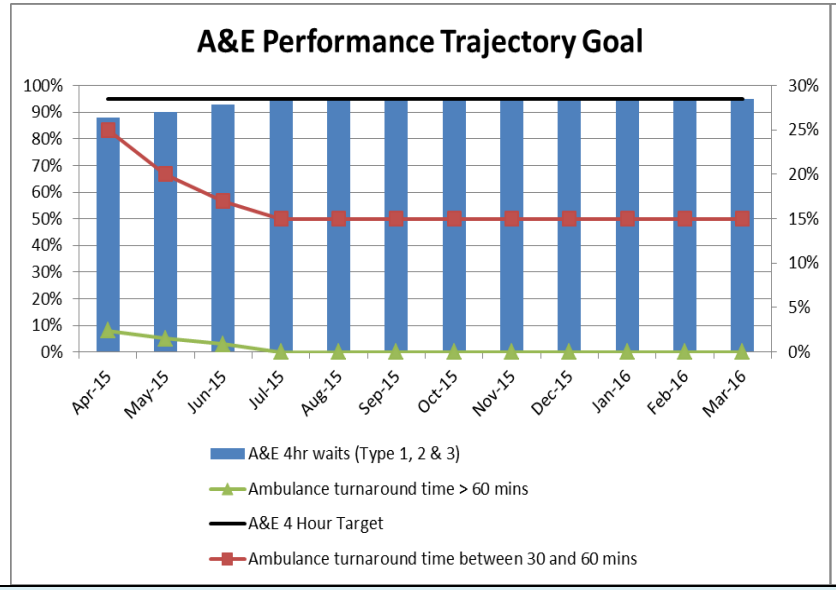
Ward Improvements:

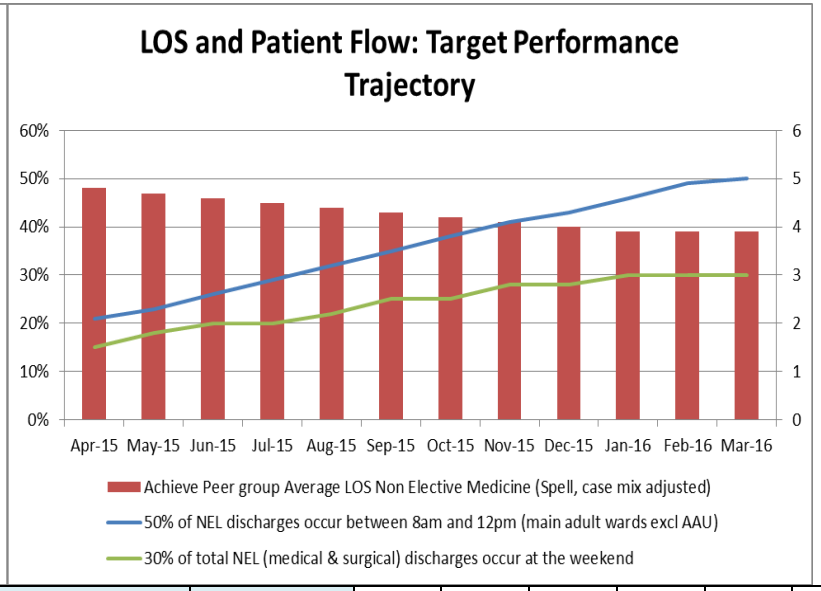
- Standardised board and ward rounds to enable effective MDT working
- Criteria led discharge to enable weekend and daily discharges
- Review of all roles linked to discharge to implement a live bed state and improve patient flow management

A&E Transformation

- Develop proposal for full Emergency Department redesign, including change to the flow of admitted patients
- Implement weekly breach analysis and department level improvements for non-bed related breached
- Work with EEAST to improve ambulance handover performance

The key performance indicators which have been applied to the programme, as well as planned improvement trajectory are as follows:





KPI / standard	2014/5 March YTD	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
A&E 4hr waits (Type 1, 2 & 3)	85.8%	89%	91%	93%	95%	95%	95%	95%
A&E 12hr trolley waits	3	0	0	0	0	0	0	0
Ambulance turnaround time between 30 and 60 mins	17%	25%	20%	17%	15%	15%	15%	15%
Ambulance turnaround time > 60 mins	3%	8%	5%	3%	0%	0%	0%	0%
50% of NEL discharges occur between 8am and 12pm (main adult wards excl AAU)	18%	21%	23%	26%	29%	32%	35%	38%
Achieve Peer group Average LOS Non Elective Medicine (Spell, case mix adjusted)	4.9	4.8	4.7	4.6	4.5	4.4	4.3	4.2
Achieve Peer group Average LOS Non Elective Surgery (spell, case mix adjusted)	3.8	3.7	3.6	3.5	3.4	3.3	3.2	3.1
30% of total NEL (medical & surgical) discharges occur at the weekend	12%	15%	18%	20%	20%	22%	25%	25%
Cancelled Operations within 24hrs due to lack of beds (per month)	20.4	18	16	14	12	10	8	6
Medical Ambulatory Care Admissions % of all NEL Medical admissions	23%	25%	25%	25%	30%	30%	30%	30%
NEL Admissions to ED attendance ratio	48%	46%	44%	42%	42%	40%	40%	38%
% of patients with a LOS on AAU1 >72 hours	6%	5%	5%	5%	3%	3%	3%	0%
Number patients (per month) with >3 ward transfers within one week's stay	25	20	15	10	10	5	0	0

2. System Wide support needed to Achieve the recovery targets

The A&E performance goal is reliant on not just the hospital improving processes internally and removing blockages to patient flow. There are a significant number of external factors which will need to improve in order to achieve the improvement trajectory:

- Significant reduction in DTOCs blocking hospital beds
- Significant reduction in overall system waits
  GP heralded patients managed flow throughout the day to allow the hospital teams to deal with a steady flow of admissions and reduction in "batched" arrivals
- Improved ambulance traffic management (reducing peaks in arrival numbers and further batching)
- Sufficient CAMHS capacity
- Sufficient Neuro Rehab capacity
- District Nurse capacity (as well as a streamlined referral process)
- Transport contract with flexibility which supports the Trust's needs

3. Progress to date

The programme has been embryonic in development for the past 8 weeks but is now formally in progress with 10 work streams sitting within two core projects – Ward Improvements, and A&E Transformation. Since the start of the programme in February 2015, the programme team have achieved the following:

- New governance structure in place, with clear accountability and weekly monitoring of actions and progress
- Completed system wide "Super Discharge Week" to boost the patient flow, identify more details of the causes of delays, and trial new ways of working, achieving 95% A&E performance for 3 consecutive days
- Implemented a trial Discharge Matron role
- Implemented a trial ED Floor Walker – Clinical Quality Nurse
- Created weekly dashboards to begin monitoring at ward, team and consultant level patient flow
- Created weekly dashboards with greater detail of A&E breaches, and a weekly task force in place to act on department level issues and tackle breach reasons which are not related to bed capacity.
- Implemented additional weekend consultant ward rounds
- Initiated a weekly review of all Long Stay patients to remove blockages and expedite discharge
- Undertaken 6 workshops to review all roles relating to discharge, working closely with the newly appointed Programme Director for IDT to develop new proposals for how discharges (simple and complex) should be managed

4. Next steps – May 2015

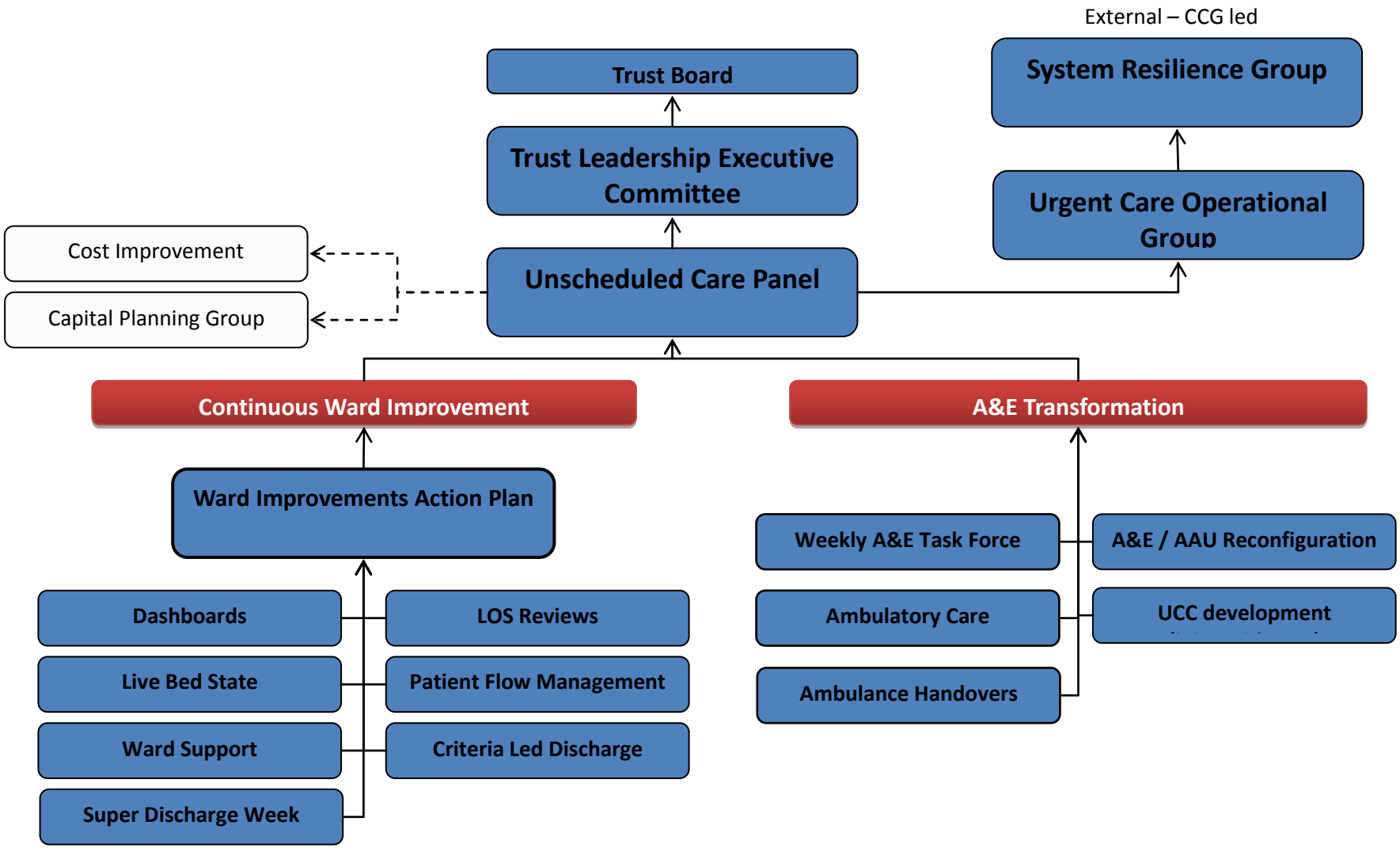
The programme of work is planned over 6 months, with the majority of work taking place in the next 2-3 months to establish and finalise changes to existing processes, pathways, and resources which will improve patient flow. Key activities planned for May 2015:

- Finalise the proposal for reconfiguration of the emergency department
- Initiate trials of proposed pathways in ED
- Finalise proposal for restructure of discharge roles and teams across the wards
- Roll out consultant level readmission and LOS data
- Detail plans for pathway specific LOS improvements in Cardiology, Care of the Elderly, and Respiratory
- Implement Queue Nurse and additional administrative support in A&E
- Finalise plans for improvements to the discharge lounge to take stretcher patients
- Agree final paperwork & criteria initiate trial areas identified for criteria led discharge

5. Risks & Mitigations

Date Raised	Risk / Issue	Impact (1-5)	Likelihood (1-5)	Total (1-25)	Mitigating Action	Owner
31-Mar-15	Risk that ED reconfiguration has a negative impact on Trust revenue forecast	4	4	16	To be clarified - financial assessment to be undertaken as part of the SOC	**Don Richards**
31-Mar-15	Risk that the ED Reconfiguration patient flows have not been fully assessed by the Clinical leadership of the Trust, which could mean that they are either not fully thought through or not supported by key stakeholders	4	4	16	Proposals and patient flows are being discussed at Clinical Cabinet and have input from across the Consultant Team. Nursing input needs to be clarified - discussed at UC Panel meeting on 14/04 and to be taken forward with Tracey Carter / Angela White to ensure appropriate engagement is undertaken	**David Gaunt**
31-Mar-15	Risk that CCG forecast does not anticipate increase in ambulatory care utilisation, negatively impacting the financial position of the Trust should the programme deliver its' goals of increasing AEC utilisation	3	5	15	To be clarified -what mechanisms can be put in place to ensure financial dis-incentives do not stop good practice but the Trust is not financially worse off as a result of plans	**Don Richards**
31-Mar-15	If ED Reconfiguration proposals do not have enough robust analytical modelling to demonstrate the evidence behind the plans there is a risk that the case will not be approved or the plans will not deliver the right answer to support improved patient flow	4	3	12	Simul8 software licences have been purchased, with 2 WTE currently allocated to be trained. High level analysis only will be available for the initial business case submitted on 28th May	**Lisa Emery**
31-Mar-15	Risk that the focus of the unscheduled care programme becomes weighted towards the ED reconfiguration, losing drive and momentum on the ward improvements	3	3	9	Programme is currently supported by 1 EY support and 1 ops manager. The scale of work required for the ED reconfiguration needs to be assessed and resourced appropriately to ensure the rest of the programme has the right level of support to deliver.	**Caroline Landon**

6. Governance Framework



SECTION 2: REFERRAL TO TREATMENT

1. Background

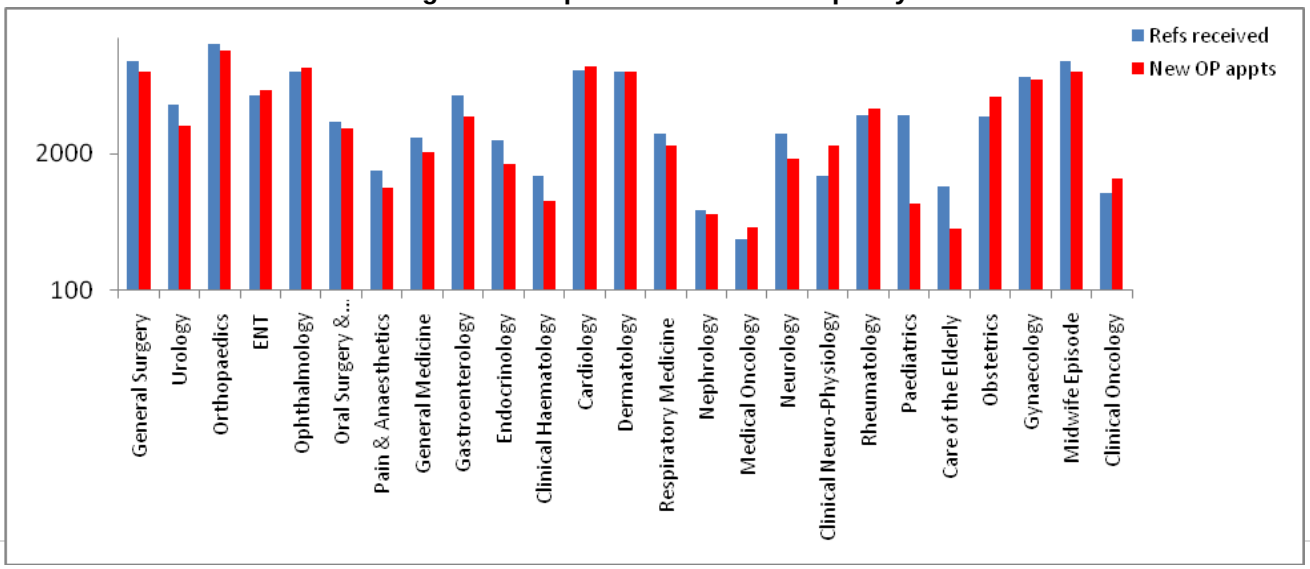
WHHT is not currently compliant with the national RTT standards which require 95% of non-admitted and 90% of admitted patients to receive their elective care within 18 weeks of referral.

The primary focus in the Trust during January and February 2015 was to reduce the number of patients waiting over 18 weeks on both non-admitted and admitted pathways, from a starting position of 4659. The Trust agreed a target for backlog reduction to a total of 2299 across non-admitted and admitted pathways, to be evidenced in the February submission. In early March 2015, although significant progress had been made, it was apparent that the Trust was not going to achieve the 2299 and this was revised to 2550. At submission on 18 March 2015 the Trust reported a total of 2537 patients in the backlog, of which 824 were on an admitted pathway and 1713 were non-admitted.

The number of patients waiting over 18 weeks for treatment needs to reduce further if WHHT is to achieve and maintain compliance with the national RTT standards.

There is a shortfall between demand (referrals received) and capacity (new outpatient slots) in a number of specialties, as demonstrated in the graph below (based on 2014/15 data, year to date).

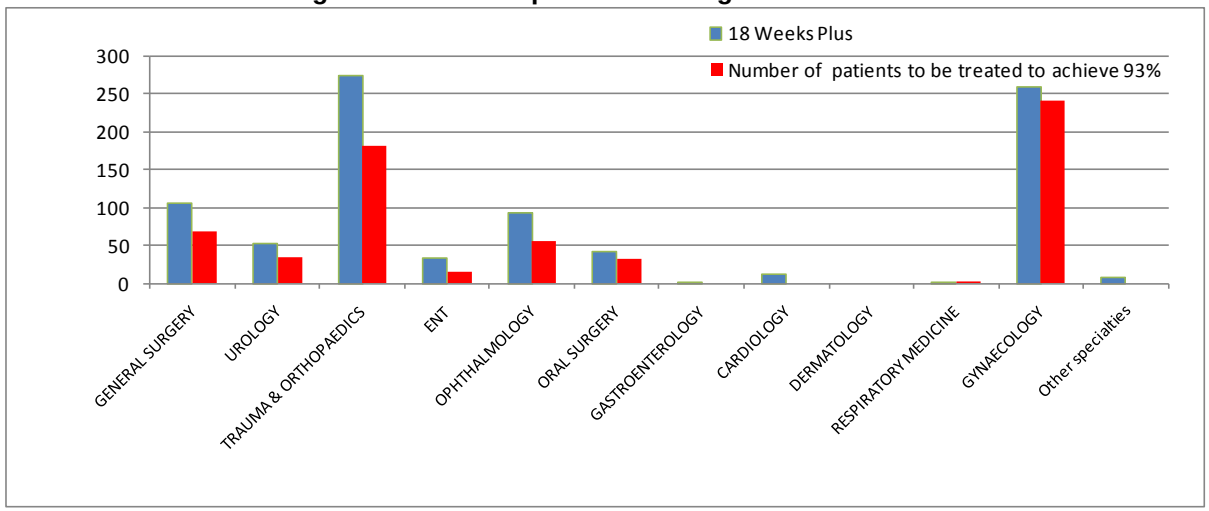
Figure 1: Outpatient Demand & Capacity



There are also shortfalls between theatre capacity and demand. This is evidenced by the number of incomplete pathways over 18 weeks, which is above the national standard of 92 percent, and the internal stretch target of 93 percent.

General Surgery, Urology, Trauma & Orthopaedics, ENT, Oral Surgery and Gynaecology are the specialties with the greatest number of patients waiting over 18 weeks who need to be treated so that the specialties can achieve a sustainable position.

Figure 2: Admitted patients waiting over 18 weeks



Recent improvements in data quality from the significant validation efforts to improve the backlog position have enabled a clean PTL from which to model the number of patients which need to be treated each week to the end of quarter 1 to achieve a stretch target of 93%.

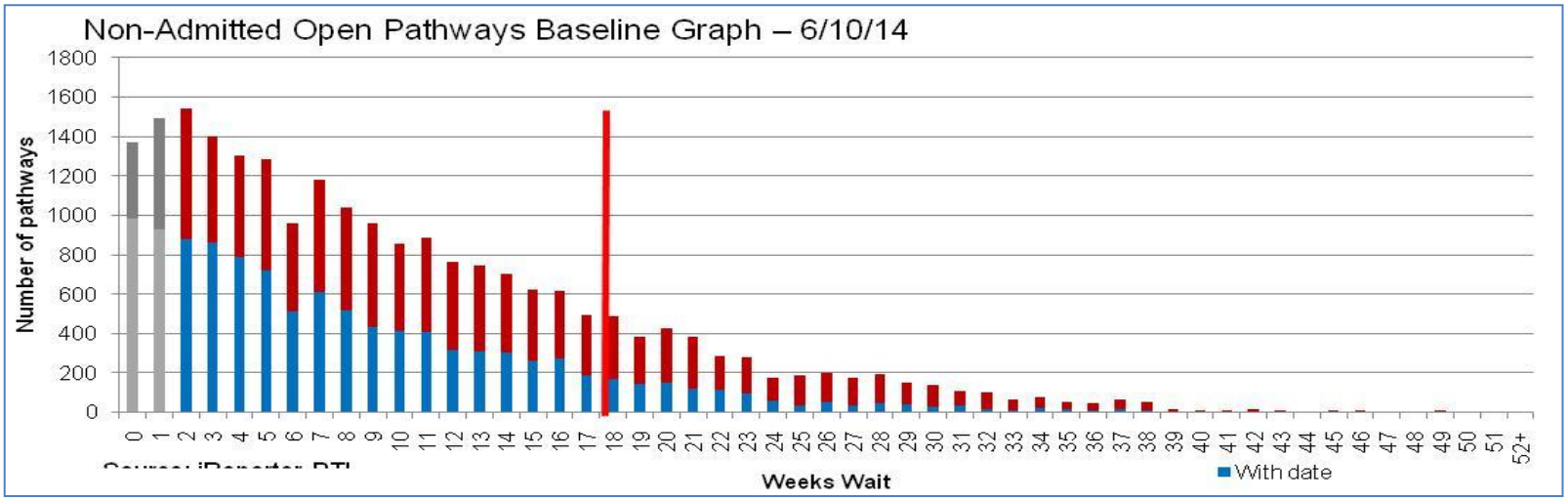
Recent incidents concerning elective and cancer care highlighted concerns regarding the transparency of the waiting list position and revealed a lack of robust administrative processes that underpin waiting list management. In addition the high turnover at service level operational management (Assistant Divisional Managers - ADMs) resulted in a lack of continuity, ownership and oversight.

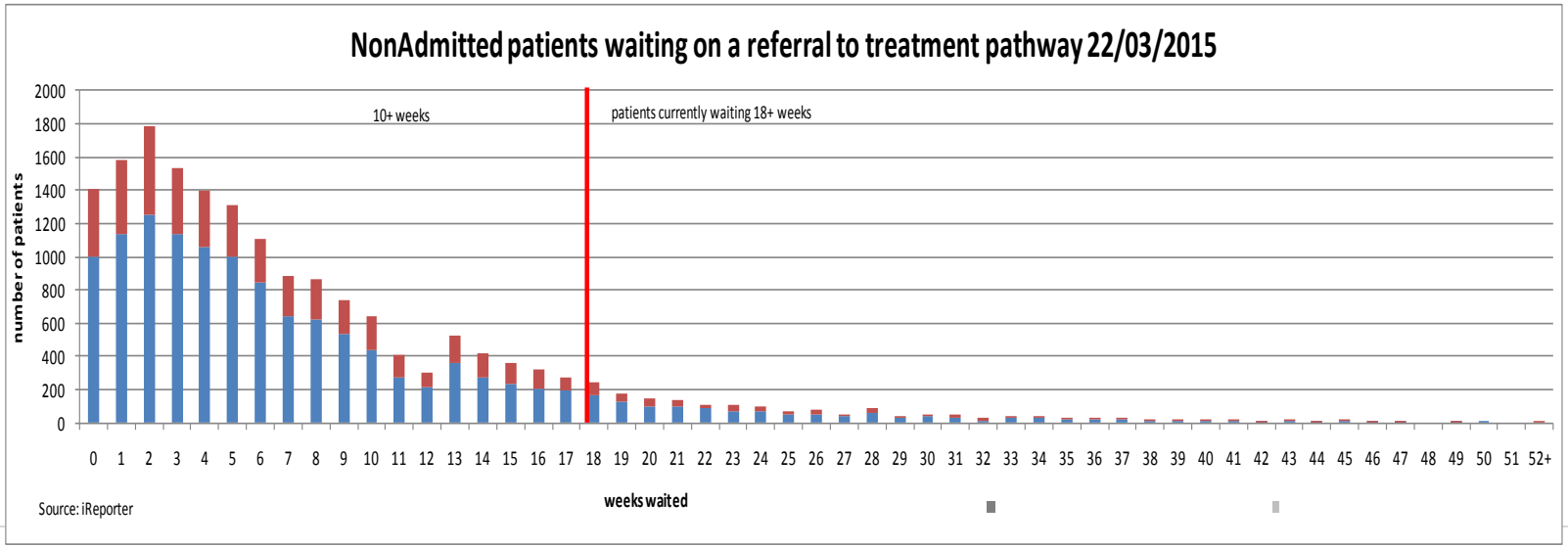
2. Progress to date

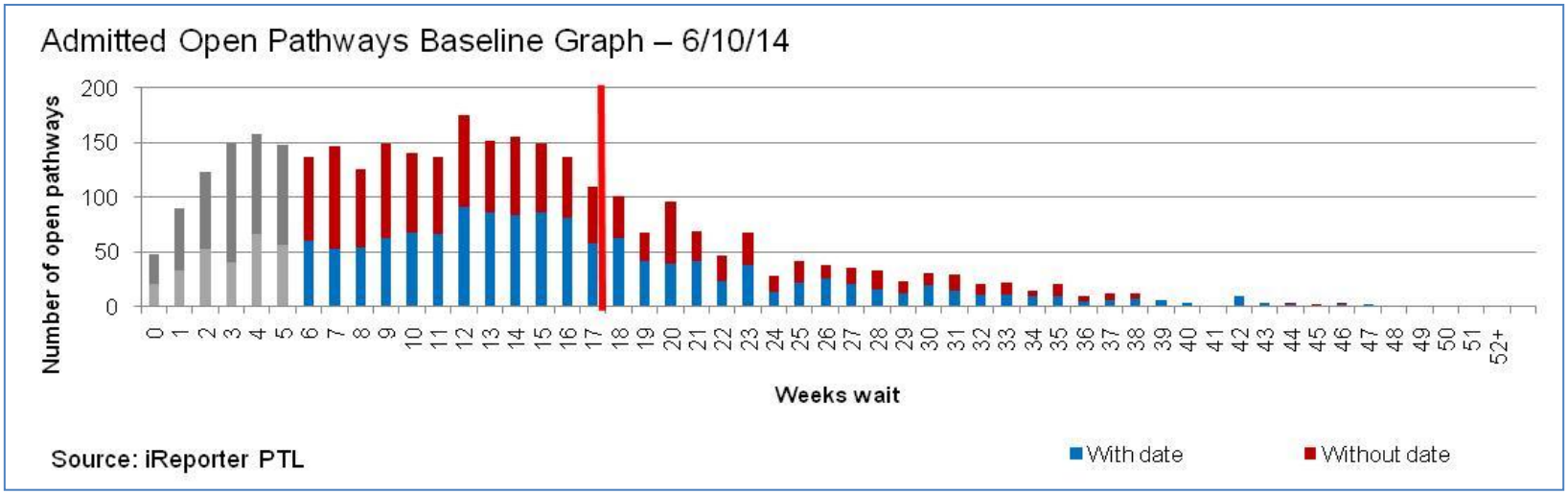
- Specialty level recovery plans (using IST capacity models) were drafted with the aim of achieving organisational compliance while acknowledging the additional time it will take for more challenged specialties to achieve compliance.
- More robust RTT Access, Admissions and Outsourcing teams are now in place. Outsourcing has become part of "business as usual" for a number of specialties.
- Recruitment to vacant ADM posts has been successful which has strengthened waiting list governance, engagement in the Access agenda and provided better support to the services.
- Ring-fencing of some elective surgical beds on the WGH site have has reduced cancellations due to lack of beds.
- Consistent and comprehensive validation has delivered a "clean" PTL and has started to become routine practice.
- Adherence to the Trust's Access Policy is improving.
- A new Clinical Outcome Form has been implemented.
- The focus on reducing the number of long waiters during January & February 2015 was successful, achieving a net backlog reduction of 2201 at the time of February's submission.

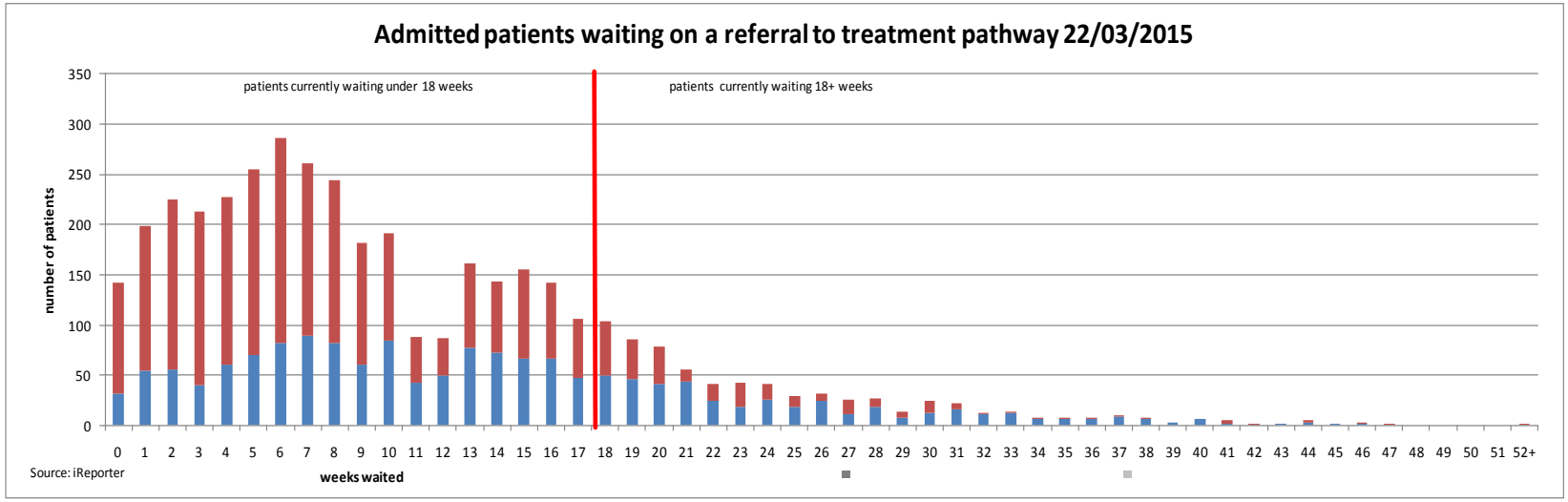
Profiling of the current waiting lists to form a baseline was undertaken in October 2014, and this can be compared with further profiling in March 2015.

Figure 3: Waiting List Profiles









These profiles demonstrate the significant improvement in both the non-admitted and admitted waiting lists over the 5 months between October 2014 and March 2015. Further profiling will be undertaken on a monthly basis to provide assurance that progress continues.

3. Key Priorities & Next steps

The number of patients waiting over 18 weeks needs to reduce further if WHHT is to achieve and maintain compliance with national standards. The Trust will work to a stretch target of 93% for open pathways under 18 weeks to allow a greater degree of flexibility within services and to safeguard compliance for the national target of 92%.

A range of short, medium and long term actions have been identified to support the transition to a compliant position by the end of Q1-2015/16. These are summarised below, but are included in an action plan (appendix 1).

- A debrief session is planned for all staff involved in the January/February 2015 backlog reduction. The expectation is that through sharing lessons learned, WHHT can move towards a future where ownership and accountability for comprehensive and robust pathway management is part of business as usual.

- Embed good practice in to business as usual, e.g application of the Trust's Access Policy in real time which will reduce the dependence on retrospective validation to manage RTT pathways appropriately.

- Trajectories have been built at specialty level, to enable staff to track activity against the plan to achieve organisational compliance by the end of Q1 (appendix 2, including assumptions that inform these). These have been shared with the teams and will be reviewed weekly at the Trust's Access meeting, where underperformance will be discussed and actions agreed to bring services back to plan.

- Specialty level recovery plans are to be written for services with significant challenges in managing demand and capacity while achieving RTT compliance.

- The Trust's Access meeting will introduce a forward looking perspective to RTT pathway management, incorporating a review of month to date and a projection of month end performance, allowing services to respond to potential non-compliance in a proactive way, and therefore reducing the reliance on retrospective validation at month end.

- A review of the Trust's Access Policy will be undertaken to ensure all aspects of pathway management are clearly defined and explained, to include Radiology, Therapies, Orthotics and to confirm responsibility and accountability for the relevant staff groups/individuals.

- The Trust's Access Policy will be re-launched following the de-brief session, to ensure all staff understand their responsibility for ensuring pathway events are accurately and properly recorded in real time, reducing the need for such extensive and exhaustive validation on an ad hoc basis.

- Undertake an assessment of the knowledge of 18 week RTT pathway management in relevant staff groups, using a short questionnaire, to identify priority areas for training and support.

- Robust demand and capacity modelling will be undertaken during 2015/16 following the commissioning of a new tool, funded by Herts Valley CCG.

- Review of common referral pathways to identify opportunities for streamlining and improving patient experience.

- Continue the development of comprehensive patient tracking lists to include a “GOO” (general other outcome) PTL which captures patients who have had a first appointment but no outcome or plan has been entered on the pathway. This will give greater visibility of all patients on an RTT pathway and will provide opportunities for managing pathways within 18 weeks.

- Implementation of schemes to release follow up capacity for services, eg Supported Discharge, results review virtual clinics.

- Further develop plans to ensure maximum use is made of SACH for elective care.

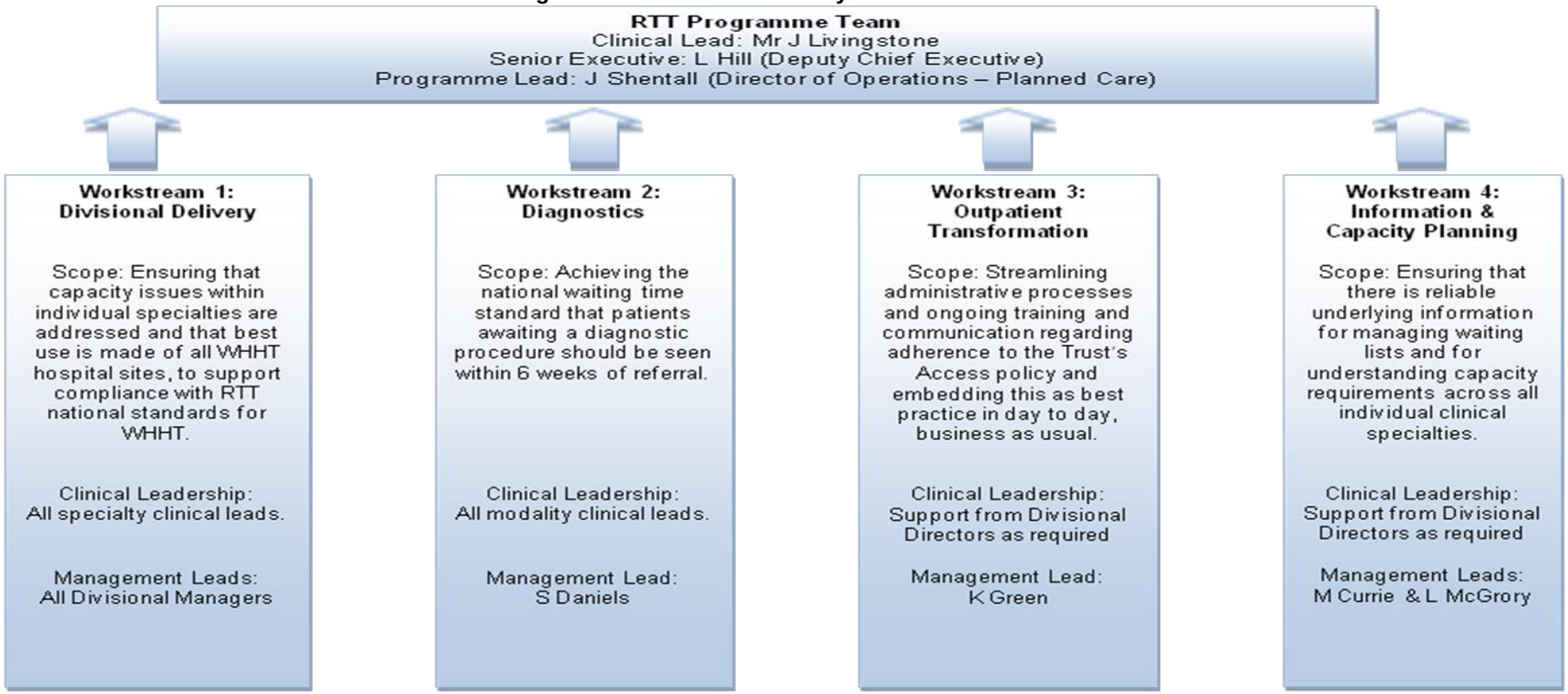
- Working in conjunction with Primary Care colleagues to streamline referral processes and introduce one-stop clinics.

- Undertake a theatre scheduling and improvement model (ATOM) project, to deliver efficiencies in scheduling and operating session throughput.

- Review the pre-operative assessment (POA) process and POA capacity to ensure there is no shortfall in assessment slots as this has the potential to impact on the efficient scheduling of theatre sessions.

These key priorities for 2015-16 can placed in to four distinct work streams as demonstrated in Figure 4 (below). Operational delivery is underpinned by robust demand and capacity planning and making the best use of the resources (outpatient and theatre sessions) available. This is the focus for work stream 1 and is owned by the divisions. Pathway management, including better understanding of common referral pathways and key milestones, is fundamental to successful delivery of compliance and therefore compliance with the national waiting times requirements for diagnostic tests is absolutely necessary. This work stream is further discussed in Section 2 of this operational recovery plan. The administrative processes associated with pathway management must be efficient and effective and underpinned by a strong knowledge base and these are part of work stream 3. Finally, to be assured that our information is accurate and reliable, and fit for purpose, work stream 4 will focus on Information, supporting the divisions in demand and capacity planning and developing reports and systems that enable teams to properly and comprehensively monitor patients at all stages of the pathway.

Figure 4: 2015/16 RTT Delivery Work Streams



4. Risks & Mitigations

A number of processes are already in place to monitor performance against the trajectories, including the weekly Trust Access meeting, held on a Friday and chaired by the Director of Operations for Elective Care.

In addition, divisions are required to dial in to conference calls on Monday and Wednesday afternoons to report progress against the actions from the previous week's Access meeting. These calls will provide an opportunity for further action to be agreed and undertaken and for any issue or concern to be raised at an early stage to avoid unnecessary delay.

A comprehensive table of risks and mitigations (Figure 5, below) has been in place since January 2015, and this has been reviewed regularly at the weekly RTT Programme Board.

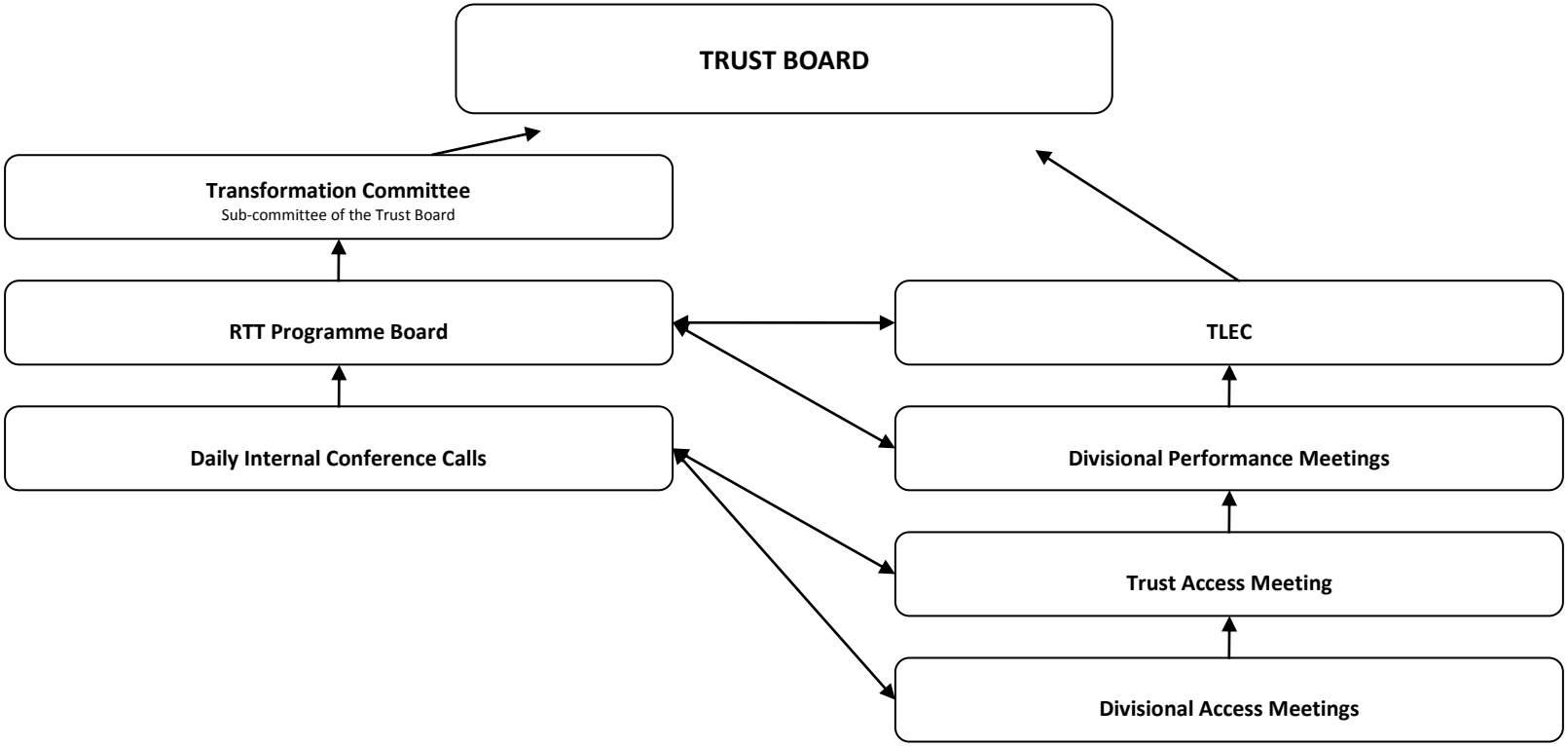
Regular updates are presented to the Trust Leadership Executive Committee and the Deputy Chief Executive presents a monthly update on progress to the Trust Board. The RTT Programme governance framework is shown in Figure 6.

The Trust's progress and RTT position (including long waiters) is reviewed on a weekly basis in the weekly performance conference call, which includes participants from the Trust, the TDA, NHS England and the CCG and is an opportunity for external stakeholders to seek assurance that progress continues and demonstrates patient level monitoring and awareness at Executive level within the Trust.

Figure 5: RTT Risks & Mitigations

Issue/Risk	Mitigation/Controls	Risk score (1-5)	Executive Risk Owner	Current status
Reduction in capacity as a result of essential theatre maintenance and ventilation improvement works. A week's down time per theatre is required to address the ventilation issue.	This can be scheduled to coincide with periods of annual leave etc, and co-ordinated across weekends. Contingency plans are in development but there will be an inevitable loss of capacity.	5	Lynn Hill Deputy CEO	Open
Inability to sustain the pace at which additional activity needs to proceed to achieve compliance within the timescale and the variable availability of clinical staff to provide this activity.	Weekly monitoring of progress against plan/trajectories at Access meeting. Daily RTT conference call for Operational teams. Escalation of issues to Director of Ops for Elective Care/Deputy CEO	5	Jane Shentall Director of Operations Lynn Hill Deputy CEO	Open
Inability to increase theatre session utilisation and efficiency resulting in wasted capacity	ATOM project to deliver efficiencies in scheduling and theatre list throughput	5	Jane Shentall Director of Operations	Open
Non-adherence to the Trust's Access Policy / National Standards and guidance, eg booking patients in order	Review and re-launch of Access Policy Continuous reinforcement of policy Scrutiny of booking processes at Access Meeting Targeted training programmes Performance management for persistent non-compliance	4	Jane Shentall Director of Operations	Open
Capacity shortfalls restricting the ability to manage demand and reduce backlogs	Demand & capacity modelling Individual specialty recovery plans	4	Jane Shentall Director of Operations	Open
Insufficient POA capacity resulting in inefficient theatre session utilisation and increased risk of cancellations on the day	Management of change underway Process mapping session to be undertaken	4	Jane Shentall Director of Operations	Open

Figure 6: RTT Programme Governance framework



SECTION 2: CANCER WAITING TIMES RECOVERY PLAN

1. Introduction& Background

The focus of this paper is on the 62 day and 31 day pathways given the challenges experienced with achieving the cancer waiting time standards.

The plan will describe the key actions associated with achieving performance for the Urology and Colorectal tumour sites as these are the areas that have been identified as underachieving against the standards and contribute significantly to the breach total. By focussing attention on these two tumour sites, we will achieve Trust compliance against the standards.

This paper is not an exhaustive plan for recovering Cancer performance. It should be noted that a Trust Cancer Action Plan is already in place and will continue to deliver improvements across the tumour sites (please refer to the Trust Cancer Action Plan).

It is imperative that every specialty is tracked at patient level, managed through the pathway by the respective cancer and operational teams to ensure that any breaches as a result of non-clinical (except for patient choice) reasons is eliminated from the system. The cancer team and the clinical management teams continue to work closely to ensure patient level tracking across all the specialties is geared towards achieving an improved position at Trust level.

West Hertfordshire Hospitals NHS Trust recognises that over the past year it has been regularly challenged by the cancer 62 day first treatment standard and 31 day decision to treat to first treatment standard where performance has been extremely volatile; both at Trust level and within some tumour sites.

The Trust has seen a 43% increase in 2 week wait referrals from 12/13 with a predicted 11400 referrals being received by the end of 14/15 and a rise of 40% in the number of 2 week wait referrals for symptomatic breast patients.

The trend in the increase in the 2 week wait has been demonstrated across all tumour types.

The Trust has also seen a 10% rise in the number of treated patients within the 31 day and 62 day standards over the last 2 years.

Having analysed the performance data, the most challenged specialties by standard type are:

Table 1

Standard	Specialty	Average performance across 14/15
2 week wait (93%)	Breast	71.3%
2 week wait for Symptomatic Breast Patients (93%)	Breast	65.8%
31 day first definitive treatment (96%)	Urology Colorectal Skin	92.6% 93.5% 91%
31 day subsequent – surgery (94%)	Urology Colorectal	77.8% 77.8%
62 day classic (85%)	Urology Colorectal Lung Gynaecology	71.1% 55.7% 54.8% 84.2%
62 day wait for first treatment from Screening Service (90%)	Colorectal	61%

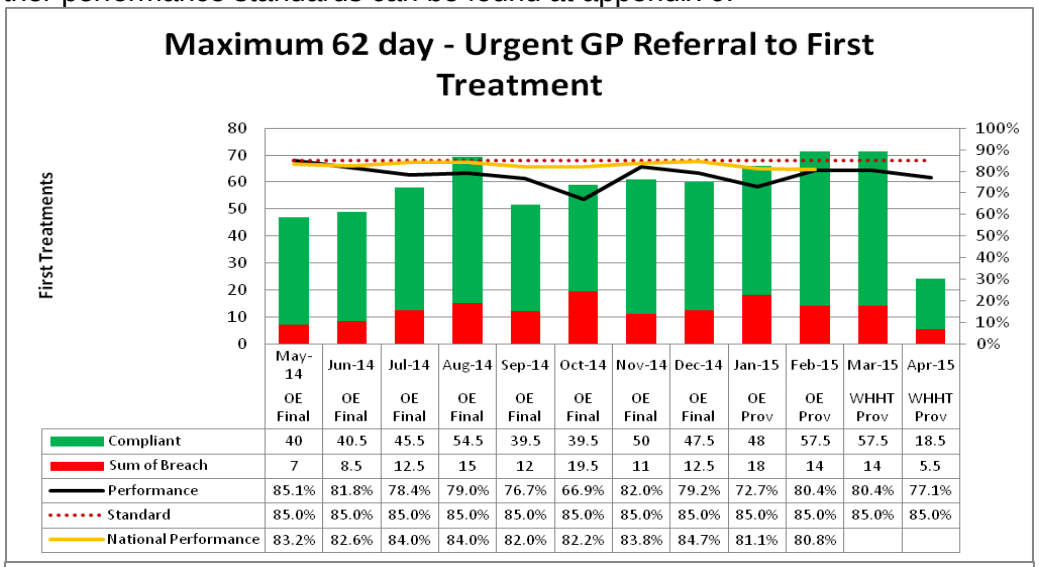
Note – where the standard is being met, this is not included

The main specialties that have contributed to the under performance of the 62 day pathway in 14/15 are:

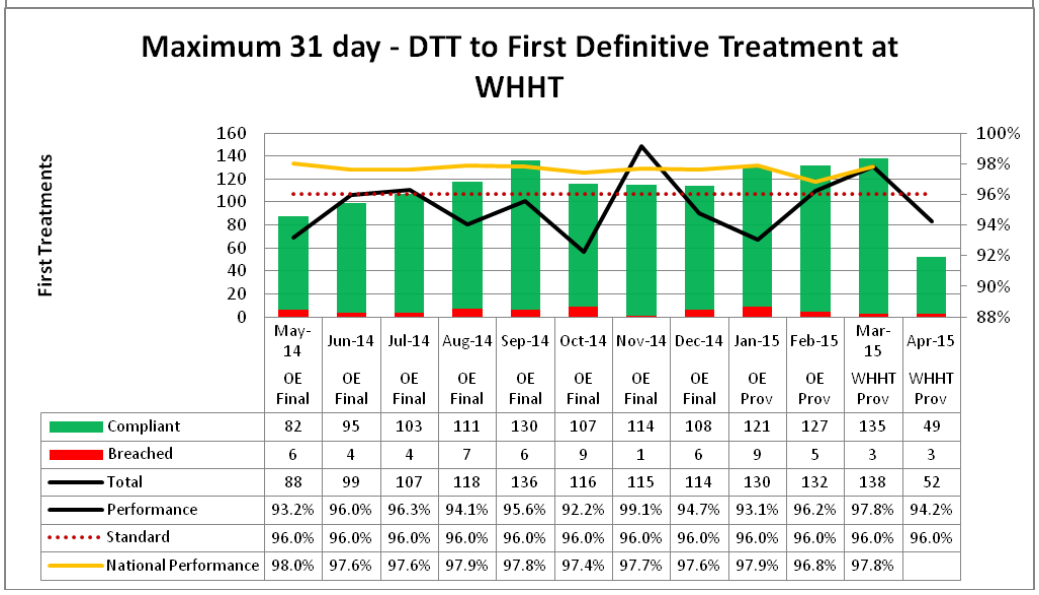
Table 2

Specialty	% Breach contribution
Urology	16.3%
Colorectal	9.3%
Lung	5.5%
Gynaecology	3.4%

The graphs below illustrate Cancer Waiting Time Performance (year to date) for 62 day classic and 31 day decision to treat (DTT) to first definitive treatment (FDT). All other performance standards can be found at appendix 6.



	May-14 OE Final	Jun-14 OE Final	Jul-14 OE Final	Aug-14 OE Final	Sep-14 OE Final	Oct-14 OE Final	Nov-14 OE Final	Dec-14 OE Final	Jan-15 OE Prov	Feb-15 OE Prov	Mar-15 WHHT Prov	Apr-15 WHHT Prov
Compliant	40	40.5	45.5	54.5	39.5	39.5	50	47.5	48	57.5	57.5	18.5
Sum of Breach	7	8.5	12.5	15	12	19.5	11	12.5	18	14	14	5.5
Performance	85.1%	81.8%	78.4%	79.0%	76.7%	66.9%	82.0%	79.2%	72.7%	80.4%	80.4%	77.1%
Standard	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%
National Performance	83.2%	82.6%	84.0%	84.0%	82.0%	82.2%	83.8%	84.7%	81.1%	80.8%		



	May-14 OE Final	Jun-14 OE Final	Jul-14 OE Final	Aug-14 OE Final	Sep-14 OE Final	Oct-14 OE Final	Nov-14 OE Final	Dec-14 OE Final	Jan-15 OE Prov	Feb-15 OE Prov	Mar-15 WHHT Prov	Apr-15 WHHT Prov
Compliant	82	95	103	111	130	107	114	108	121	127	135	49
Breached	6	4	4	7	6	9	1	6	9	5	3	3
Total	88	99	107	118	136	116	115	114	130	132	138	52
Performance	93.2%	96.0%	96.3%	94.1%	95.6%	92.2%	99.1%	94.7%	93.1%	96.2%	97.8%	94.2%
Standard	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%	96.0%
National Performance	98.0%	97.6%	97.6%	97.9%	97.8%	97.4%	97.7%	97.6%	97.9%	96.8%	97.8%	

The services undertake Root Cause Analyses on all 62 day classic breaches to ensure that common themes are identified and lessons are learnt. The reasons for all Urology and Colorectal breaches in 2014/15 can be found below. The next steps described in the main document are focussed on the main contributing breach reasons.

Urology 62 day:

Breach Reason	Number of Breaches
Administrative delay	2
Clinic cancellation	1
Complex diagnostic pathway (many, or complex, diagnostic tests required)	3.5
Diagnosis delayed for medical reasons (PATIENT unfit for diagnostic episode, excluding planned recovery period following diagnostic test)	2
Elective cancellation (for non-medical reason)	2
Elective capacity inadequate (PATIENT unable to be scheduled for treatment within standard time)	4.5
Health Care Provider initiated delay to diagnostic test or treatment planning	4.5
Other reason	13
Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)	6
Patient cancellation	1
PATIENT Choice (PATIENT declined or cancelled an offered APPOINTMENT DATE for treatment)	1.5
PATIENT initiated (choice) delay to diagnostic test or treatment planning, advance notice given	4.5
Treatment delayed for medical reasons (PATIENT unfit for treatment episode, excluding planned recovery period following diagnostic test)	1

Further analysis of 'Other':

Breach reason	Number of breaches
Outpatient capacity	6
Patient choice	2
Medical	2
TRUS delays	1.5
Unknown	1.5

Outpatient capacity remains the most significant factor for breach reasons in Urology.

Colorectal 62 day breach reasons:

Breach Reason	Number of breaches
Complex diagnostic pathway (many, or complex, diagnostic tests required)	4.5
Elective capacity inadequate (PATIENT unable to be scheduled for treatment within standard time)	8.5
OPD Capacity	1
Other reason	10
Out-patient capacity inadequate (i.e. no cancelled clinic, but not enough slots for this PATIENT)	0.5
Patient cancellation	1.5
Patient declines with offer	1
Patient declines without offer	1
PATIENT Choice (PATIENT declined or cancelled an offered APPOINTMENT DATE for treatment)	1
Treatment delayed for medical reasons (PATIENT unfit for treatment episode, excluding planned recovery period following diagnostic test)	1.5

Further analysis of 'Other':

Breach reason	Number of breaches
Outpatient capacity	2
Patient choice	2
Medical	1
Diagnostic delays	1
Complex pathway	2
Unknown	1
Elective capacity	1

Historical and recent data confirm the following reasons as the cause for the failure of the 62 day standard for Colorectal Cancer:

- Elective capacity is the principal reason for delays within the colorectal pathway. The service evidently has inadequate Consultant and theatre capacity to meet the volume of diagnosed colorectal cancer cases.

- Complex diagnostic pathway (many, or complex, diagnostic tests required) is the second major reason for cancer waiting time breaches.

- The referral pathway for the national bowel scope screening programme pathway also contributes to the delays within the 62 day pathway for the colorectal service. Currently the organisation does not have a robust tracking system in place to monitor these patients.

3. Progress to date

Through the delivery of the Cancer Action Plan improvement in some areas has already been delivered. Some of the key progress is described below:

- An operational issue within the breast service interrupted the provision of a 'one stop shop' affecting 2ww performance in May, June, July and August 2014. This was resolved ensuring adherence to the 2 week wait from September 2014 to date.

- Planning for the impact of bank holidays on the cancer service is now part of business as usual. Specialty teams identify capacity lost and replacement capacity to ensure performance is not affected.

- More robust cancer pathway tracking and clinical engagement has been effective within colorectal with a much improved 62 day position.
- Strengthened MDT coordinator team with identified resource for urology.
- PTL has been developed for cancer to monitor the patients on pathways which is used in weekly PTL tracking meetings with MDT coordinators, escalation process for pathway delays and weekly PTL reviews with specialty teams.
- Substantive Cancer Programme Lead and Cancer Services Manager in post.
- A second cancer information analyst is now in post.
- Robust validation of breaches is performed on a weekly and monthly.
- 91% reduction of patients waiting over 62 days and a 96% reduction in the number of patients waiting over 100 days.
- Improved administrative processes relating to the 2 week wait pathway.
- Cancer waiting times training has been delivered for all MDT teams and OPD administrative staff.
- Cancer administrative support based within the central booking team which ensures tracking of patients from referral.
- A “Straight to Test” pathway has been introduced within the Lung tumour site.
- Outsourcing Urology patients on an RTT pathway to release capacity for cancer cases to be performed at West Herts.

4. Next steps

The cancer performance recovery plan is predicated on improvement in 2 key tumour sites (Urology and Colorectal) in the first 6 months of delivery. However, it should be noted that a Trust Cancer Action Plan is already in place and will continue to deliver improvements across the tumour sites (please refer to the Trust Cancer Action Plan). This will deliver sustainable improvement in the 31 day and 62 day standard for Cancer Services across the Trust. The recovery trajectory and trajectory calculators can be found in appendices 3 and 4. The specialty based action plan can be found at appendix 5.

Urology Recovery

Key areas for action have been discussed with the Urology team using retrospective data analysis to inform the discussion. These actions have been identified as key to reducing delays within the patient pathway.

- Improved access to joint oncology clinics (JOC) to ensure weekly provision for patients requiring a joint clinic appointment
- Improved scheduling of TRUS biopsies and follow up appointments to reduce delays. Consider the booking of TRUS biopsies directly from clinic to reduce administrative delays.
- Regular designated MRI slots and improved reporting times for cancer patients
- Ensure patients on a cancer pathway are 'flagged' to Trust staff to improve visibility of patients to reduce cancellations, improve reporting and improve escalation.
- Implementation of the PSA surveillance pathway (patients who meet the agreed guidelines will be discharged back to their GP for PSA surveillance). The Urology Consultant team will ensure this practice is embedded within the Urology team with supervision being provided for middle grade doctors to enable appropriate decision making .
- Dedicated 2 week wait slots to be provided within the clinics in line with demand.
- A Locum Consultant should be employed to provide additional outpatient and theatre capacity and release current consultant team to perform more complex cancer cases.
- Robust capacity and demand modelling for 2 week wait, joint oncology clinics and surgery to ensure resources are appropriately allocated.

- In the short term, the Consultants have agreed to provide additional 3rd session theatre lists subject to appropriate theatre staffing being made available.

- In the longer term, the implementation of a ‘one stop’ diagnostic clinic is crucial to the success of cancer performance within the Trust.

- Develop and deliver stage of treatment milestones and escalation points.

Colorectal Recovery

- A review of the screening pathway is required to ensure that the correct patient pathway start date is being utilised for reporting purposes and to ensure that, where appropriate, breaches are being shared with the National Screening Service.

- Implementation of straight to test.

- Deliver additional theatre capacity.

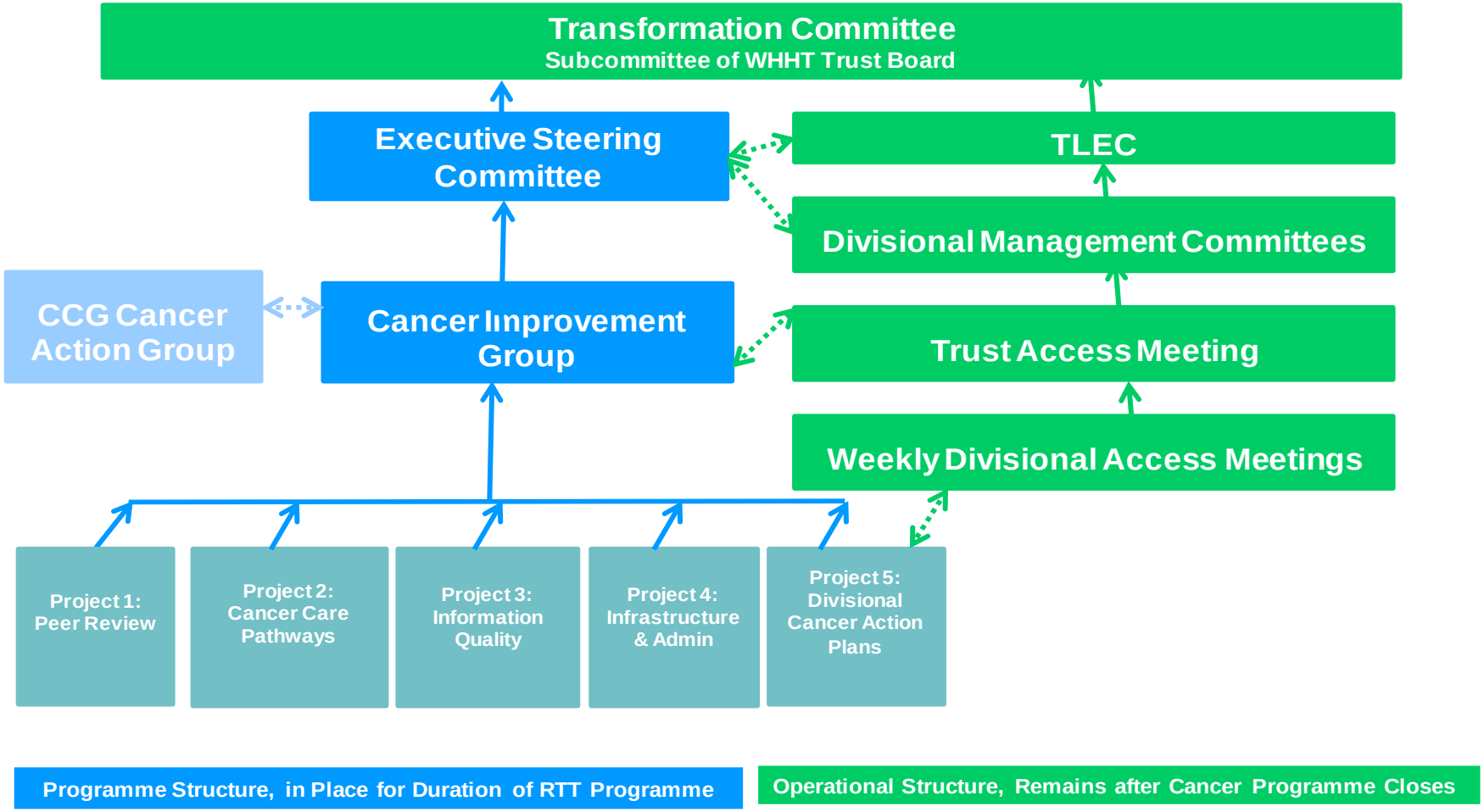
- A locum consultant should be employed to provide additional outpatient and theatre capacity

5. Risks and mitigations

Issue/Risk	Mitigation/Controls	Risk Score (1-5)	Executive Risk Owner	Current Status
Funding the recovery plan	Divisional ownership of the recovery plan. Divisional plans to incorporate funding requirements to meet the cancer standards Escalation to Executive	5	Lynn Hill Deputy CEO	Open
Inability to increase OPD and theatre capacity to proceed to achieving compliance within the timescales	Monitoring of progress against plan at the Monthly Improvement meeting. Weekly monitoring of progress against trajectories at Cancer Access Meetings. Escalation of risks associated with compliance at divisional and executive level.	4	Lynn Hill Deputy CEO	Open
Inability to recruit to Locum Consultant posts	Reallocation of less urgent cases. Escalation to Director of Operations and Deputy CEO.	5	Lynn Hill Deputy CEO	Open
Inability to implement PSA pathway due to lack of capacity within primary care	Work with CCGs to ensure GP collaboration and support	3	Lynn Hill Deputy CEO	Open
IT infrastructure to support visibility of pathways through reporting	Weekly Cancer Informatics Meeting to plan information requirements and escalation of issues Cancer information system to be 'fit for purpose'	5	Lisa Emery Chief Information Officer	Open
Data Quality issues disrupting trajectory and compliance	Regular informatics meeting to raise issues and concerns. Regular reports to MDTs to ensure visibility and 'sense checking' of data	5	Lisa Emery Chief Information Officer	Open

6. Governance Framework

Existing Cancer Governance Structure & Operational Governance Structure:



Cancer Programme Meetings & Membership:

Transformation Committee
(as Sub-Committee of WHHT Trust Board)

Executive Steering Committee

Meeting Frequency: Fortnightly
Chair: Chief Executive
Remit: To provide overall strategic direction for the Trust's Transformation Programme; to receive updates from each programme, to consider links and wider implications to remove any obstacles that are impeding progress.
Membership: All Executive Team

Cancer Improvement Group

Meeting Frequency: Weekly
Chair: Cancer Programme Senior Responsible Owner ie Deputy CEO
Remit: To deliver the cancer improvement programme according to plan, identify dependencies between projects and ensure coherent approach.
Membership: Clinical Lead for Cancer, Medicine Divisional Manager, All Project Leads, Women & Children's Divisional Managers, Surgery Divisional Manager, Clinical Support Divisional Manager, Associate Director for Performance & Information.

Project team meetings for each individual project as required.
A dedicated weekly meeting is already in place for the cancer information & quality project.

SECTION 2: DIAGNOSTIC WAITING TIMES RECOVERY PLAN

1. Historic Performance

The Trust has achieved the national waiting times standard for diagnostic tests only once in the last 12 months as evidenced in Figure 7, below.

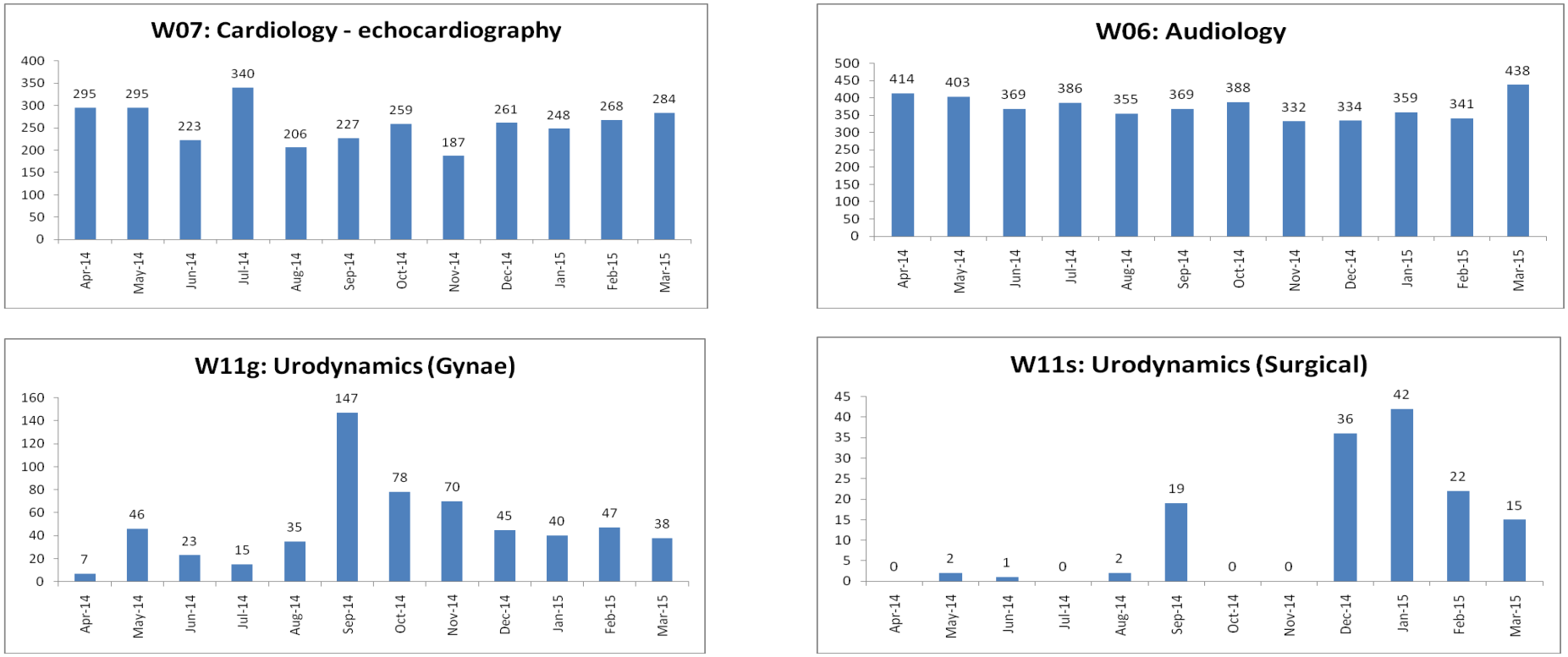
Figure 7: WHHT Diagnostic waiting times performance

	Apr 2014	May 2014	Jun 2014	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015
Magnetic Resonance Imaging	4	3	4	5	8	3	3	3	0	0	0	0
Computed Tomography	1	1	2	2	2	2	1	0	0	0	0	0
Non-obstetric ultrasound	17	7	9	5	3	0	0	0	0	0	0	0
Barium Enema	0	0	2	0	0	0	0	0	0	0	0	0
DEXA Scan	3	2	1	9	6	0	1	0	0	0	0	0
Audiology - Audiology Assessments	32	27	19	10	2	6	7	5	1	24	2	6
Cardiology - echocardiography	111	76	42	53	53	72	31	47	47	71	74	68
Cardiology - electrophysiology	0	0	0	0	0	0	0	0	0	0	0	0
Neurophysiology - peripheral neurophysiology	101	10	21	27	10	2	1	0	5	6	0	1
Respiratory physiology - sleep studies	0	1	0	0	0	0	0	0	0	0	0	0
Urodynamics - pressures & flows	4	3	13	4	15	26	9	4	17	25	10	9
Colonoscopy	15	18	15	9	17	11	1	1	0	1	0	0
Flexi sigmoidoscopy	1	0	0	4	6	2	0	0	0	0	0	1
Cystoscopy	18	11	0	0	0	0	0	0	0	0	0	1
Gastroscopy	5	8	7	13	10	5	2	0	0	1	0	0
Total number of patients waiting over six weeks	312	167	135	141	132	129	56	60	70	128	86	86
Percentage of waiters within 6 weeks	94.0%	96.9%	97.4%	97.3%	97.2%	97.5%	99.0%	98.9%	98.7%	97.5%	98.4%	98.5%

This confirms that the modalities with the most significant number of patients waiting in excess of 6 weeks are Echocardiography, Urodynamics and Audiology. Although colonoscopy was also under some pressure in the first half of 2014/15, the service responded to this and provided additional capacity, the impact of which is clearly demonstrated in the number of patients waiting over 6 weeks for this investigation in the second half of the year and as a result this investigation is not considered to be as challenged as previously.

Demand for the investigations where performance needs to improve is evidenced in the following charts.

Figure 8: Demand in Echocardiology, Audiology & Urodynamics

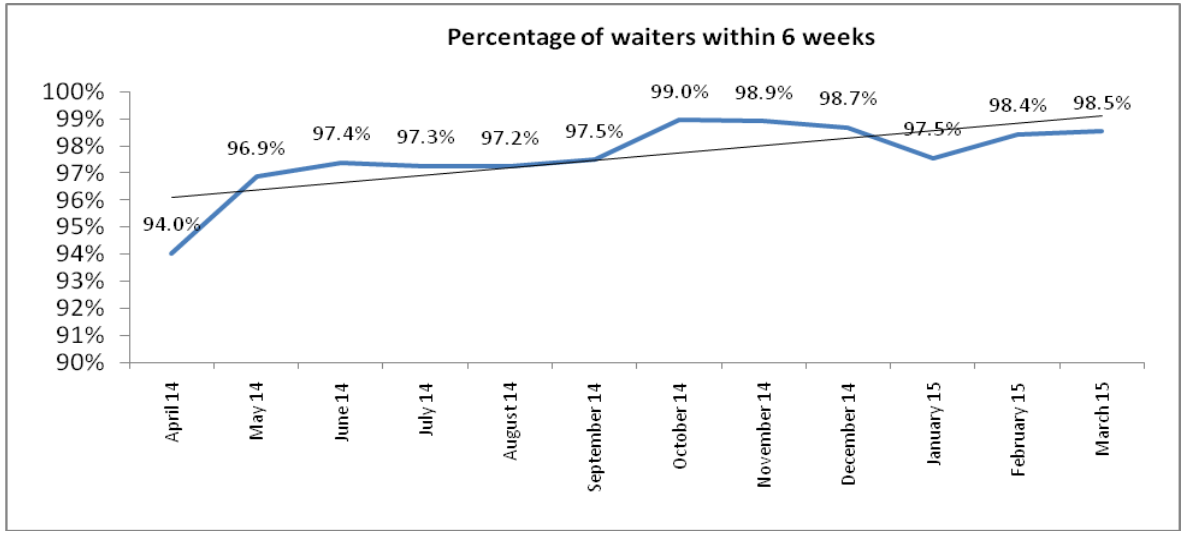


2. Progress to date

Capacity within the independent sector is available for a number of these investigations and the Trust regularly outsources surgical Urodynamics (to Luton & Dunstable and to the Clementine Churchill Hospital, Harrow, who also provide additional capacity for EMGs. A standard operating procedure has been circulated which guides staff through the process for managing surgical Urodynamics outsourcing (appendix 7).

Additional internal capacity in the form of ad hoc sessions, is being provided in Imaging to support demand for Ultrasound and to provide additional resource for MRI MSK scan reporting. DEXA scans are also outsourced to Mount Vernon Hospital and the possibility of increasing capacity through additional weekend sessions is currently being explored. This extra capacity, combined with increased use of outsourcing has resulted in improved performance as demonstrated in figure 9, where the trend suggests that this will continue and the Trust will achieve a compliant position.

Figure 9: 2014/15 Diagnostics Waiting Times performance & trend



The Endoscopy Service is coping with the significant demand although this is a challenge. Additional capacity has been provided in the form of evening and weekend lists both for gastro and urology. The Trust is expanding the Endoscopy Service and this is scheduled for completion towards the end of 2015.

3. Key Priorities & Next steps

The most recent monthly submission in March 2015 (appendix 8) shows that the services where breaches occurred are Audiology, Neurophysiology, and both Surgical and Gynaecological Urodynamics. There was 1 breach in Neurophysiology, 2 in Gynae Urodynamics, 6 Audiology and 8 Surgical Urodynamics and therefore these areas will not be the focus of the plan to achieve compliance. The expectation is that these services will not require additional support and that they will continue to provide additional internal capacity and make use of independent sector capacity to ensure compliance.

However, there were 71 Echocardiology breaches and this service will require additional support and resource to improve performance.

Echocardiology

Lack of capacity, vacancies within the Physiology establishment, an under-resourced administrative team (based across two sites) and a lack of support in terms of day to day operational management have contributed to many issues within the service.

There have been some longstanding concerns relating to administrative processes and resource (resulting in a backlog of requests and clinical correspondence typing) which have yet to be addressed with a permanent solution, and in addition, Operation Smart (an investigation relating to the interpretation of echocardiogram results). For these reasons, there is a reluctance to outsource as the clinical team require completed oversight of the service to give the assurance that the service is being delivered appropriately.

Regrettably a further incident was reported in April 2015, relating to the discovery of a number of requests and clinical letters which do not appear to have been processed appropriately. Validation is currently underway to ascertain the position as it may be that these requests and letters have been actioned. However, the likelihood is that there will be outstanding requests and correspondence. This incident is being investigated in accordance with Trust policy and process but it should be noted that when the true position is understood, there will be a significant adverse effect on performance.

The Echocardiology Service will therefore be a high priority for the Trust in regard to the resources required to achieve compliance, underpinned by robust administrative processes. A specialty specific plan will be developed in conjunction with the recommendations from the investigation in to the most recent incident.

In the short term however, additional capacity is to be provided in the form of ad hoc weekend sessions, additional slots on weekday lists and consideration is currently being given to the leasing or purchase of an additional ultrasound machine to allow further additional sessions to be provided.

The prioritised next steps for this service include:

- Ongoing provision of additional internal capacity at weekends and in the evening – in May just under 200 additional slots will be provided
- Further consideration of outsourcing to provide capacity externally
- Purchase/lease of an additional ultrasound machine to enable 2 echo lists to run concurrently.
- Review of the staffing – clinical and administrative – to ensure the service is supported appropriately.
- Robust demand and capacity modelling will be undertaken.

4. Risks & Mitigations

As with the RTT and Cancer performance recovery plans, a number of processes are already in place to monitor performance, including the weekly Trust Access meeting, held on a Friday and chaired by the Director of Operations for Elective Care. The Trust has a designated Diagnostics Lead who oversees organisational diagnostics performance, liaising with the surgical and medical specialties who also provide a diagnostic service.

The Trust's diagnostic performance is reviewed on a regular basis in the weekly performance conference call, which includes participants from the Trust, the TDA, NHS England and the CCG and is an opportunity for external stakeholders to seek assurance that progress continues and demonstrates awareness at Executive level within the Trust.

APPENDIX 1 – PROJECT STATUS REPORT, UNSCHEDULED CARE

1. Project status							
Work stream	**Project RAG**	**Key activities this period**	**Activity planned next period**	**Key Milestones**	**Planned date**	**Due date**	**% Complete**
Board & Ward Rounds		A draft standard operating protocol for board rounds has been written and shared with medical consultants for feedback. Each team has been asked to set standards for their area, Case note audits have been undertaken twice so far, but no regular audit programme in place. This is being explored with clinical audit department with a view to it being junior Dr led monthly audit.	Standards for all teams agreed Meet with Matrons & ADMS to agree local monitoring processes Presentation at Site meeting (12/05)	All specialties to have agreed start times for board / ward rounds – plans in place Standardised board rounds functioning effectively across all medical wards Regular Case Note Audit to be in place with a schedule for wards to monitor management plans and EDD	31 March 30 May 31 March	30 April	50% 25% 25%
Criteria Led Discharge		Partially Completed: Initial meeting has taken place with nursing teams, and consultant teams have been asked to set local criteria for a trial.	Criteria to be set with teams, one Matron allocated to developing protocols and rolling out trial	Trial for Nurse led discharge completed Proposal for roll out plan for Nurse led discharge completed	30 April 31 May		60% 40%
Dashboards		Weekly monitoring process in place for A&E and Wards. Dashboards are in place but not yet automated.	Automation of dashboards Role out of specialty / consultant level data on LOS and readmissions (LOS reviews work stream)	Weekly monitoring structure agreed & dissemination process activated Dashboards in place	06 March 31 March		100% 90%
Live Bed Sate		Partially completed: Interim solution identified and proposal submitted to Executive Team by 31/03. Project team in place to redefine the roles of ward clerks, discharge co-ordinators and ops	Project work stream to be merged with Patient Flow. Full proposal for review of all discharge related roles to be finished, presentation at Site meeting 12/05 and discussed	Proposal for admin resource for the wards completed Training & roll out plan in place	31 March 31 May	30 April	70%

		team for a longer term solution. Consultation may be required which will push end timescales back by c.30 days.	with key stakeholders throughout the month	Monitoring & Accountability process in place Full live bed state in place	30 June		
Patient Flow Management		Recruitment taken place to get to full complement of WTE D/C co-ordinators. Discharge lounge plan has been drafted, but estates are now trying to work out how to deliver In progress; IDT Programme Director in post funded by CCG to review full IDT service. Bed Management review in progress, aim is to link the two programmes of work effectively Medical Matron role has been reviewed - Project has been linked to live bed state to review a range of roles in place to support discharge.	As above – work streams to be combined to deliver the full review of all roles, linking with IDT programme review	Discharge planner / Co-ordinator in place per ward Relocation plan for discharge plan complete and presented to UCP on 12/05d Review completed of IDT, Bed Bureau, & Bed Management Team Review & proposals for medical matron role, incl. Discharge nurse	20 March 31 March 15 April 30 April	12/05	50% 50% 50% 80%
LOS Reviews		Consultant / Specialty level information is being validated, with pilot roll out areas identified as Sarratt, Croxley & Aldenham wards / COE, Cardiology & Respiratory Weekly LOS meeting chaired by Dr Catnach in place to tackle longest stay patients.	Roll out data with Respiratory, COE and Cardiology Work through long term stay patients	Defined scope and plan for review in place Weekly LOS meeting in place with appropriate cross organisation members in attendance	31 March 06 March	31 March 15 March	100% 100%
Ward Support		ECIST review scheduled for June 2015.	Physician's Assistant role to be included in the roles review work	Business case for Physicians Assistant completed	31 March	30 April	10%

				Review of therapy services by ECIST	30 April	10 May	10%
A&E Reconfiguration		First draft of the patient flow model completed, discussed at UCP on 14/04 High level estates plans completed, but Simul8 software licences purchased. Workforce review in progress in line with proposed patient flow model.	Further development needed dependent on flow modelling. Financial impact assessment Need to align resources to Simu8 model to ensure maximum use is gained from the system & agree how this will feed into the business case. Plan is for the SOC to go to TLEC on 28th May.	1st Proposal for redesign drafted and submitted to UCP Estates & financial work up of plans Flow modelling / analytics completed to test the design against current and future demand Staffing review & proposal completed Business case completed and submitted to Trust Board Staffing changes in place	01 April 01 May 31 May 31 May 15 June 31 August		100% 80% 25% 25% 80% 0%
UCC Development		Not completed: awaiting availability of CCG GP to complete audit; scheduled for completion by end of April. A Care Alliance trial completed of GP in ED over Easter Weekend. Follow up arranged to discuss longer term options. Paediatric GP/ENP – no progress yet made on this	Audit to be completed Financial impact to be assessed	Completion of Audit to see who could be seen by a GP Proposal based on data analysis & audit (*CCG LED Milestone*) GP/ENP in HUC from 7pm to see 5 paediatric patients an hour	31 March 31 April September 2015		
Ambulatory Care		Review of Cardiology data suggests further opportunity to improve Ambulatory Care in Heart Failure conditions	Follow up Heart Failure Opportunity & develop plan for improving use of Ambulatory Care	Plan to be developed identifying areas for improvement of current processes Project team in place and actions initiated	31 April 30 May	15/05	30%
Ambulance Handover		The ambulance handover process is now being audited and new computers have been ordered for AAU to ensure ambulances are	Further work ongoing to identify other ways to improve process, including looking at Pit Stop discipline	Identification of issues with current processes & Proposal for improvement & better	31 March		50%

		tracked in a timely way.		use of support staff developed jointly with EEAST Agreed plan for implementation of changes & ongoing monitoring via A&E task force	30 April		

RAG: Green = All projects delivering to plan, no major issues, no actions required. Amber = One or more workstream projects has a problem that will negatively effect delivery of outcomes to time, within the resource envelope, mitigation identified and can be dealt with by the team. Action being taken to resolve. Red = Significant issue with one or more projects in the workstream. Projects require corrective action to meet the workstream objectives. Escalation required to mitigate.
Milestones: Grey = not yet started Green = On track , minor issues Amber = Moderate delays or issues Red = significant delays or issues Blue = complete / closed

APPENDIX 2 – Action Plan

WEST HERTFORDSHIRE HOSPITALS NHS TRUST – RTT RECOVERY ACTION PLAN
VERSION CONTROL DATE: 17/4/2015
AUTHOR: Jane Shentall, Director of Operations for Elective Care

ITEM No.	ACTION	OUTCOME EXPECTED	DELIVERY DATE	RESPONSIBLE OWNER	RAG (progress)
1	Ring fence 25 elective beds on Watford site for Cardiology, Surgery and Gynaecology	Reduction in number of elective patient cancellations	by 30/3/15	Lynn Hill Deputy Chief Executive	
2	Complete national audit of waiting lists	Clean PTL	01/04/2015	Lynne McGrory Head of RTT Access Lynn Hill Deputy Chief Executive	
3	Improve information reporting arrangements	Development of a system of alerts to support the achievement of compliance with natoinal waiting times standards across all specialties	30/06/2015	Lisa Emery Chief Information Officer	
4	Staff debrief session following achievement of backlog reduction target by end of February 2015.	Sharing lessons learned. Setting the scene for the way forward. Identify and agree best practice	17/04/2015	Jane Shentall Director of Operations	
5	Embed RTT pathway management good practice in to business as usual.	Real time pathway management. Decreased reliance on month end validation. Ownership and accountability at all points in the pathway.	From 17/4/15 onwards	Jane Shentall Director of Operations Lynne McGrory Head of RTT Access	

ITEM No.	ACTION	OUTCOME EXPECTED	DELIVERY DATE	RESPONSIBLE OWNER	RAG (progress)
6	Develop and implement specialty level trajectories to support the achievement of RTT compliance.	Development of a forward looking, proactive approach to RTT pathway management Accurate visibility of performance against plan. Ability to flex scheduling to achieve desired performance outcome	10/04/2015	Mark Currie Associate Director, Performance & Information Jeremy Lowe 18 week RTT analyst	
7	Development of specialty level recovery plans	Clear, achievable plans/steps to ensure service level compliance with RTT standards	From 7/4/15	Divisional & Assistant Divisional Managers	
8	Inclusion of month to date and month end performance projection as part of weekly Access meeting	Development of forward looking proactive approach to RTT pathway management Ability to flex scheduling to achieve desired performance outcome	7/4/15 and ongoing	Jane Shentall Director of Operations Jeremy Lowe 18 week RTT analyst	
9	Review and re-launch of Trust Access Policy	Inclusion of specific sections for support services eg Radiology, Therapies Clarification of ownership, responsibility and accountability for staff groups/individuals	01/05/2015	Jane Shentall Director of Operations Lynne McGrory Head of RTT Access	
10	Assess knowledge of 18 week pathway management in all relevant staff groups and implement training programme	Understanding of knowledge gaps within workforce Tailor made training programmes targeted to specific staff groups/individuals Opportunities for managing performance in cases of consistent non-compliance or capability issues 18 week training to become mandatory for relevant staff	01/05/2015	Lynne McGrory Head of RTT Access Sam Ingram Head of Outpatients Rebecca Laws Admissions Manager Jane Shentall Director of Operations	

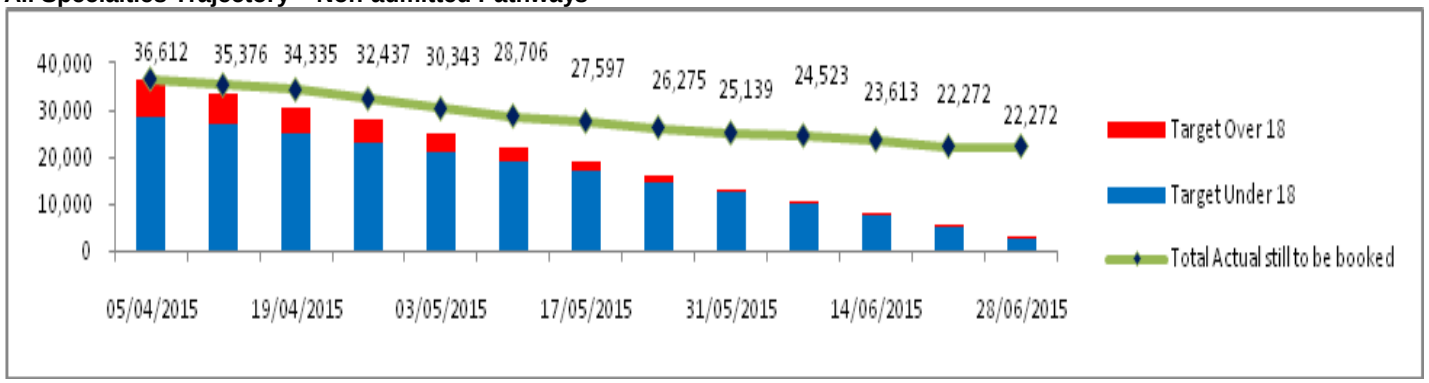
ITEM No.	ACTION	OUTCOME EXPECTED	DELIVERY DATE	RESPONSIBLE OWNER	RAG (progress)
11	Demand & Capacity modelling using CCG funded tool	Clear understanding of capacity shortfalls Outcomes to inform service level plans	tbc	CCG Jane Shentall Director of Operations Mark Currie Associate Director, Performance & Information Divisional & Assistant Divisional Managers	
12	Specialty level review of capacity using Demand & Capacity Model (see above)	To ensure sufficient capacity to meet demand and to sustain a compliant performance to national waiting times standards	tbc	Assistant Divisional Managers Mark Currie Associate Director, Performance & Information	
13	Review of common referral pathways	Identification of opportunities for streamlining pathways Improved patient experience	Underway 01/04/2015	Assistant Divisional Managers & Clinical teams	
14	Development of a GOO (general other outcome) PTL	Visibility of patients beyond 1st outpatient attendance, with no clear plan Development of a proactive approach to managing pathways within 18 weeks	Underway 02/04/2015	Mark Currie Associate Director, Performance & Information Jeremy Lowe 18 week RTT analyst	
15	Identification & implementation of schemes to release follow up capacity, eg Supported Discharge, virtual clinics	Reduced waiting times for follow up appointments Follow up capacity freed up for patients who need face to face consultations	Underway 01/04/2015	Assistant Divisional Managers & Clinical teams	

ITEM No.	ACTION	OUTCOME EXPECTED	DELIVERY DATE	RESPONSIBLE OWNER	RAG (progress)
16	Streamlining of referral processes and introduction of one stop clinics	Development of referral criteria, eg for Spinal referrals Shortened pathways Improved patient experience	tbc	CCG Jane Shentall Director of Operations Divisional & Assistant Divisional Managers Clinical Leads/teams	
17	Project to review scheduling and theatre utliisation/efficiency (ATOM)	Increased throughput and theatre utilisation Intelligent theatre list scheduling	tbc	Jane Shentall Director of Operations Mary Richardson Divisional Manager,Surgery Matthew Sykes Theatre Manager, SACH Ann Gully Theatre Manager, WGH Rebecca Laws Admissions Manager	
18	Review of Pre-operative assessment capacity & processes	Plans to address capacity shortfalls Better scheduling of theatre lists Reduction in number of on the day cancellations	Underway	Amanda Budd Matron for Surgery Mary Richardson Divisional Manager,Surgery Rebecca Laws Admissions Manager	
19	Develop plans for SACH as an elective treatment centre	Increased elective activity Improved theatre utlisation Centralisation of services as appropriate	30/06/2015	Esther Moors Head of Service Planning Jane Shentall Director of Operations Lynn Hill Deputy Chief Executive	

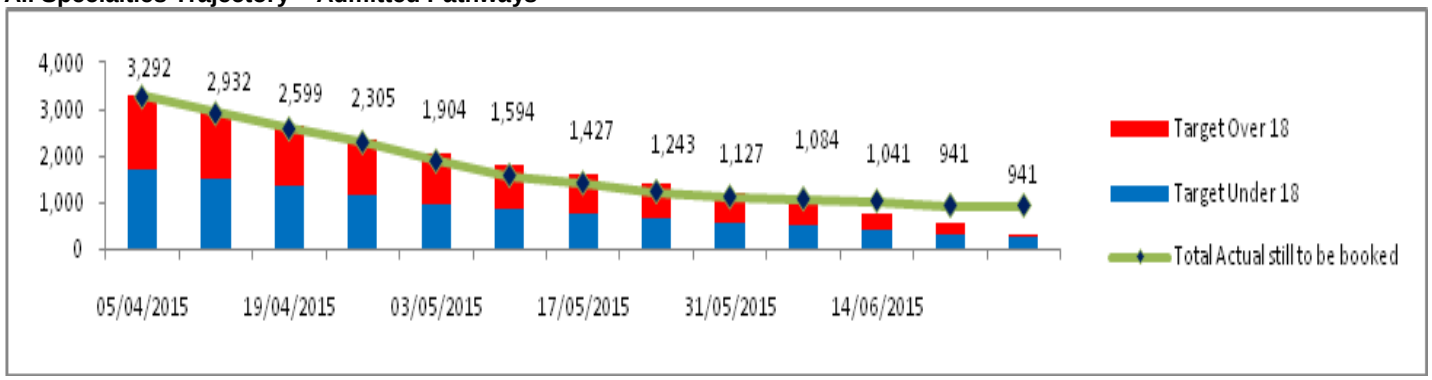
APPENDIX 3: Trajectories (at 13/4/2015)

All trajectories were modelled to demonstrate the activity required to achieve compliance at the end of Q1 2015/16. It is recognised that as a result, very high levels of activity would be required in some specialties. This has allowed the Trust to identify the services where there are the greatest challenges and will be used to direct the focus of resources and support appropriately. This will support the work required to achieve organisational compliance within the agreed timeframe, and will inform the timescale for compliance for the services where Q1 is an unrealistic expectation.

All Specialties Trajectory – Non-admitted Pathways



All Specialties Trajectory – Admitted Pathways



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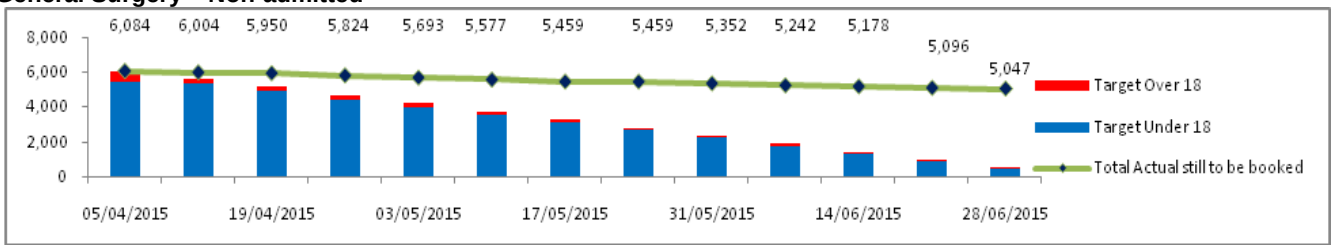
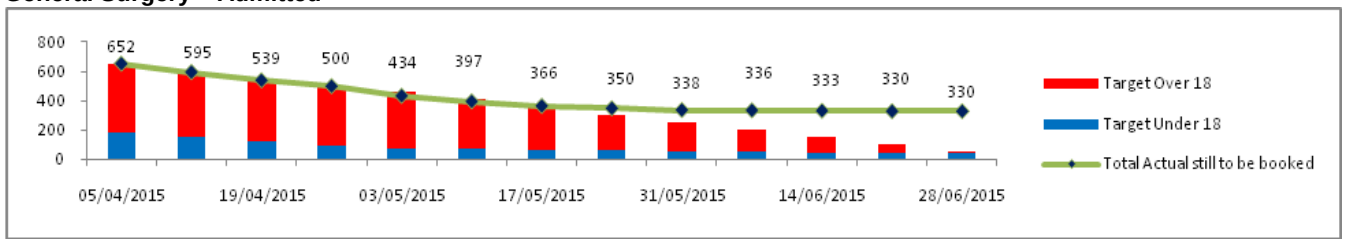
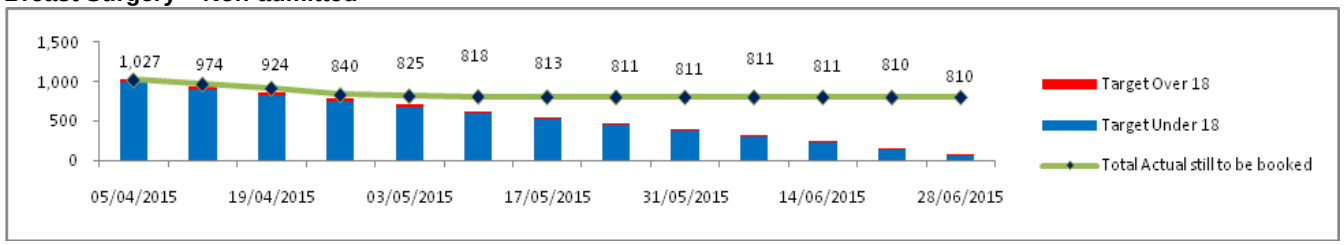
General Surgery – Non-admitted



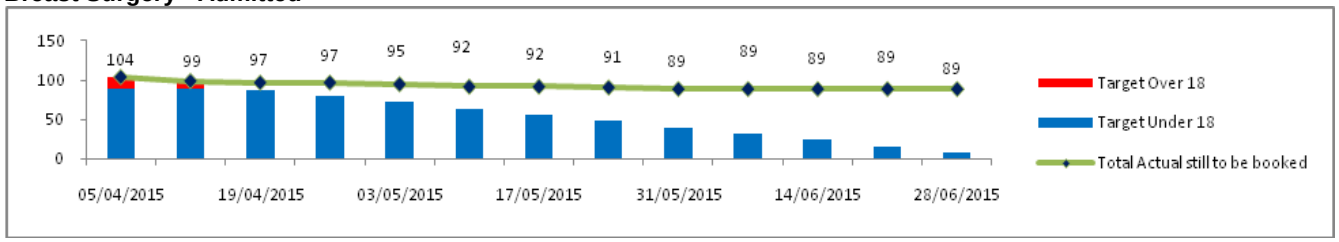
General Surgery – Admitted



Breast Surgery – Non-admitted



Breast Surgery - Admitted



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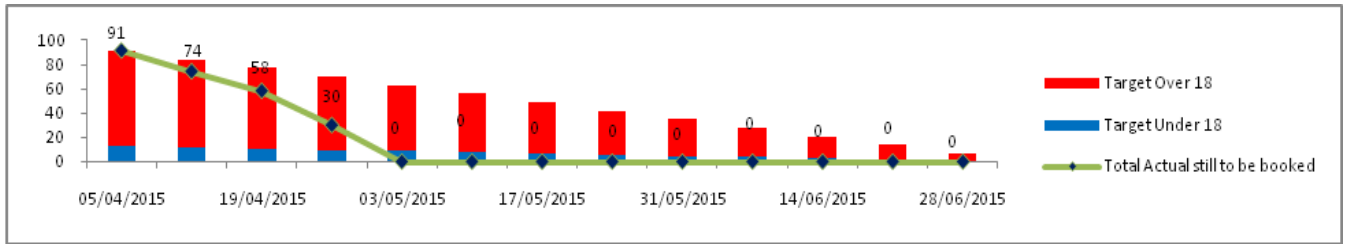
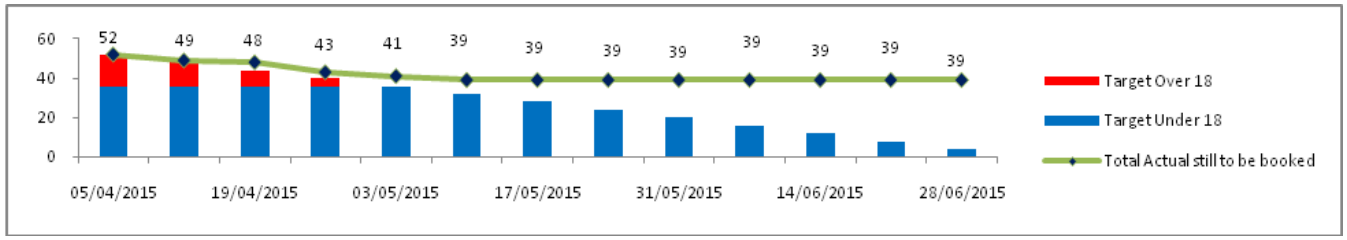
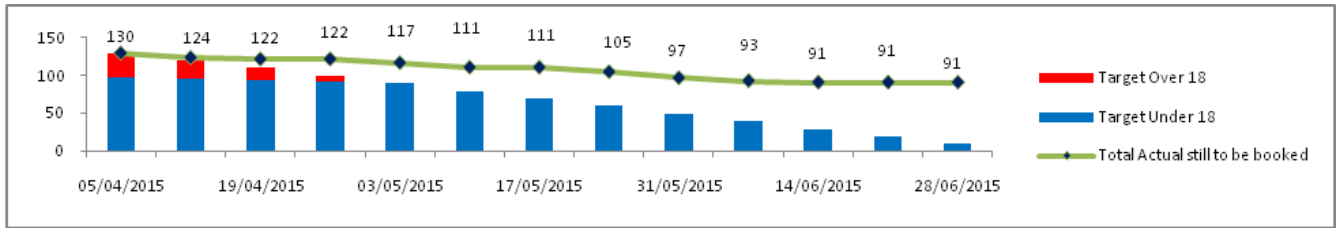
Colorectal – Non-admitted



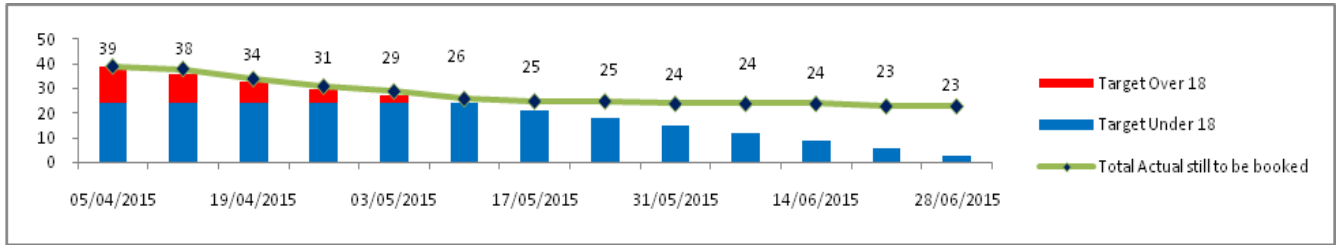
Colorectal – Admitted



Vascular – Non-admitted



Vascular – Admitted



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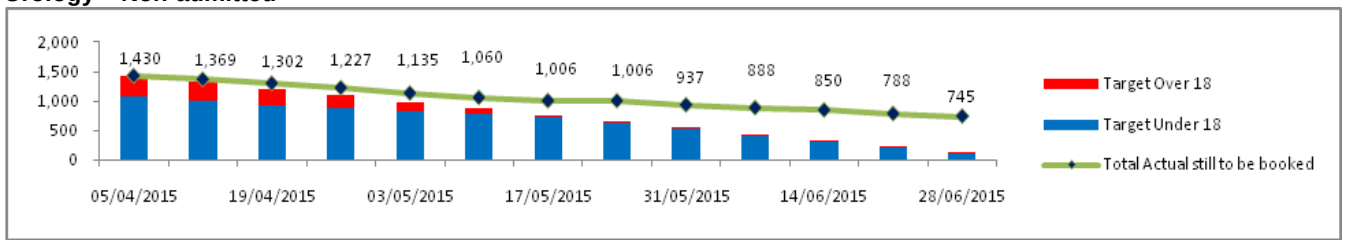
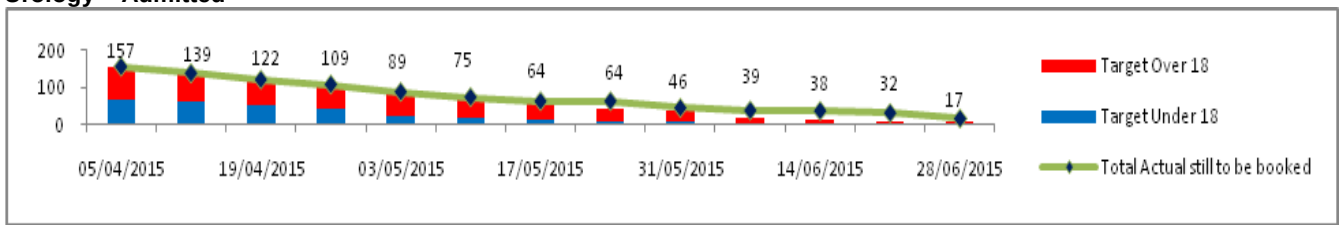
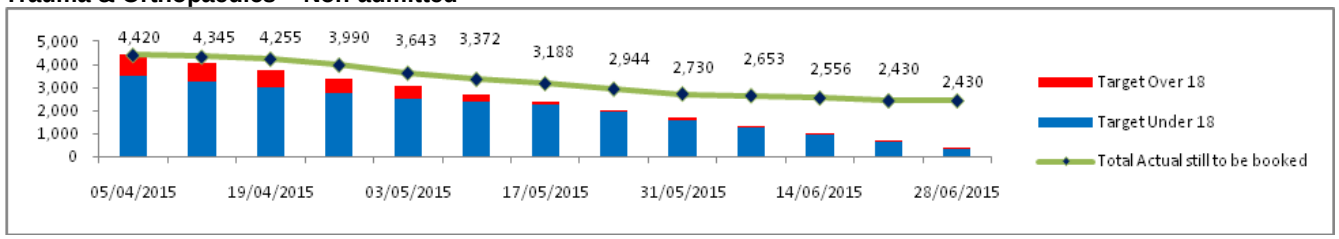
Urology – Non-admitted



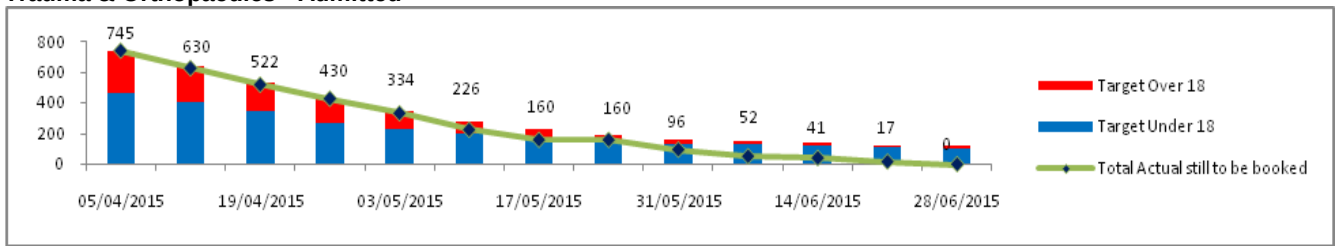
Urology – Admitted



Trauma & Orthopaedics – Non-admitted



Trauma & Orthopaedics - Admitted



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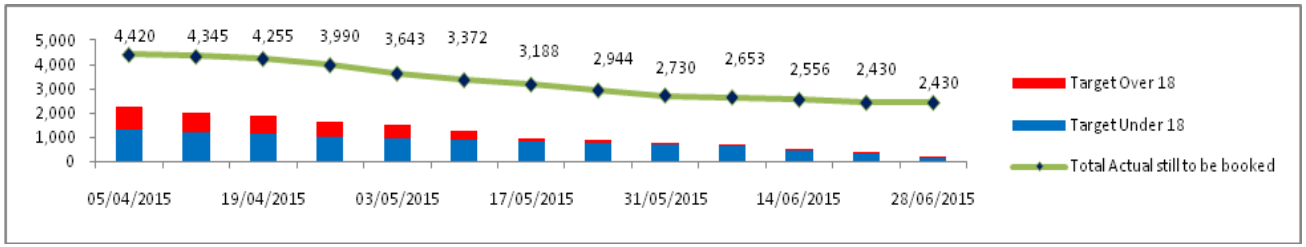
ENT – Non-admitted



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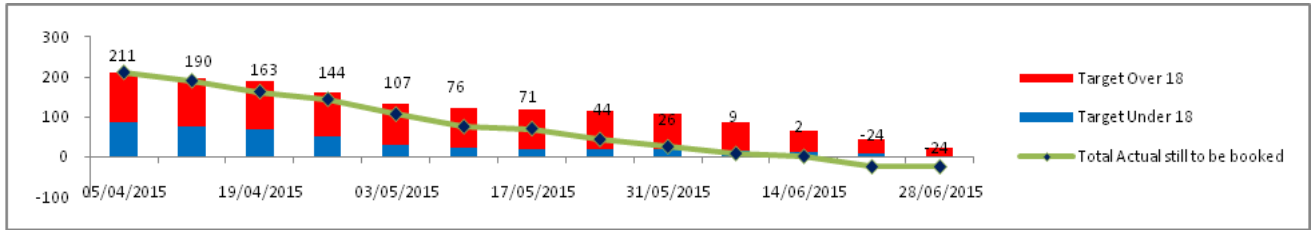
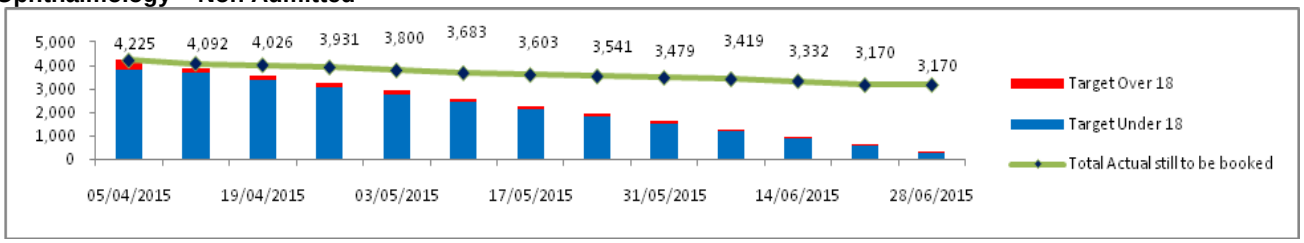


Ophthalmology – Non Admitted



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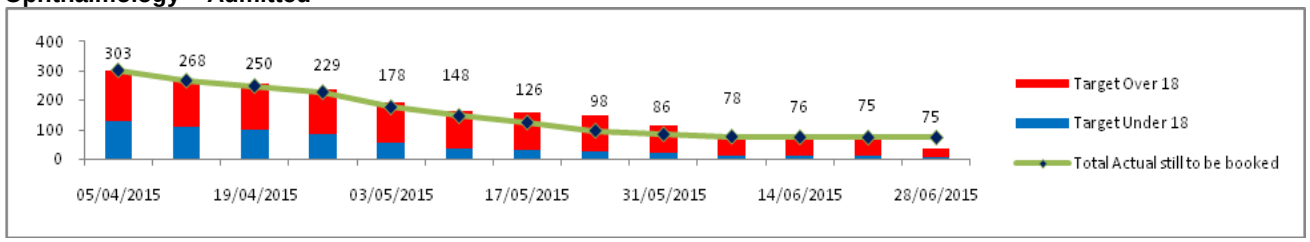

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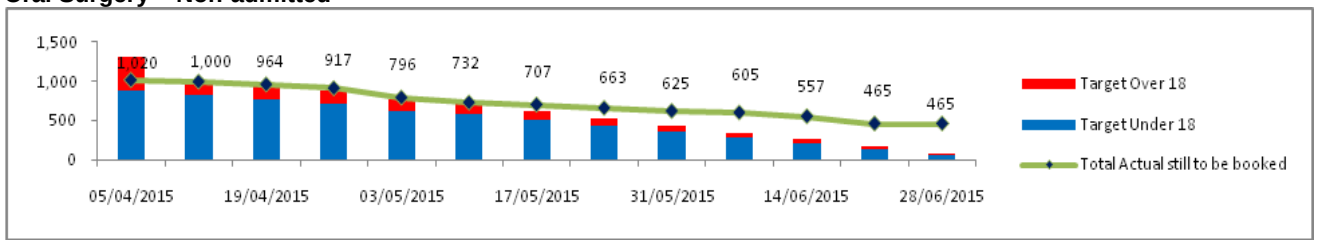
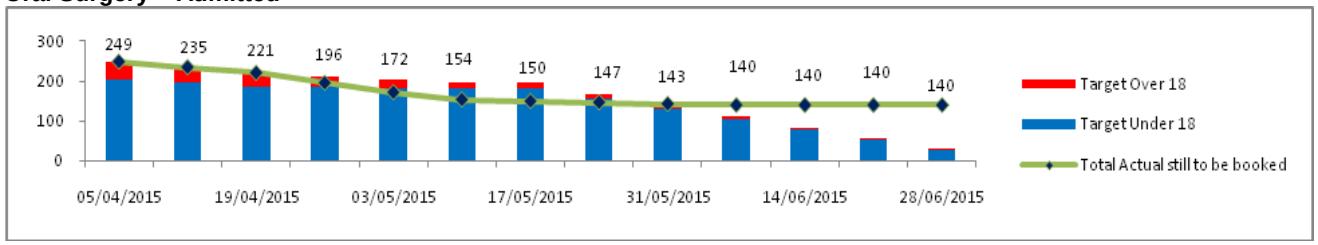
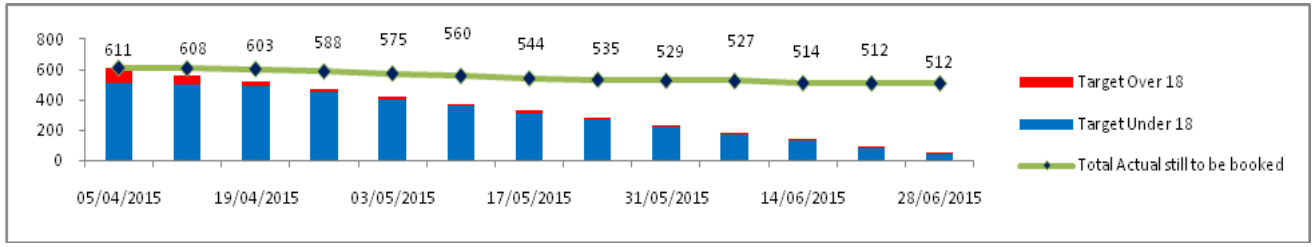
Oral Surgery – Non-admitted



Oral Surgery – Admitted



Orthodontics – Non-admitted



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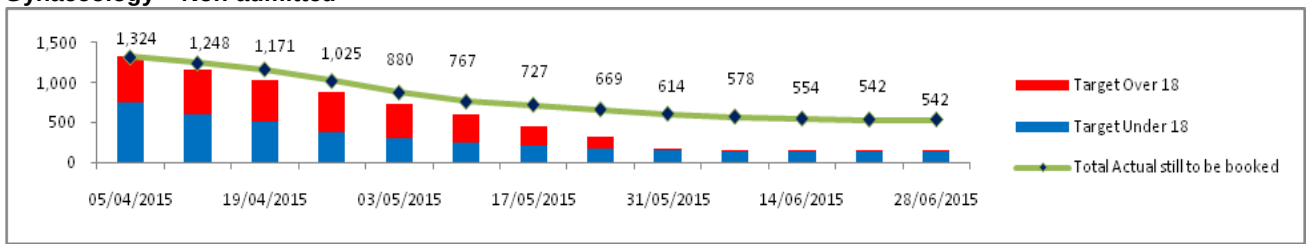
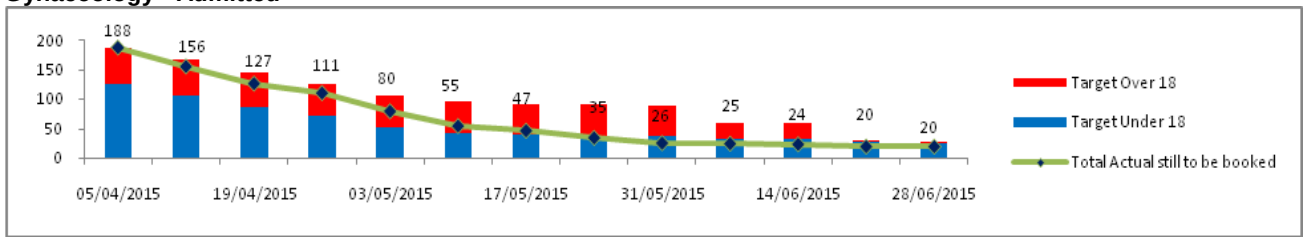
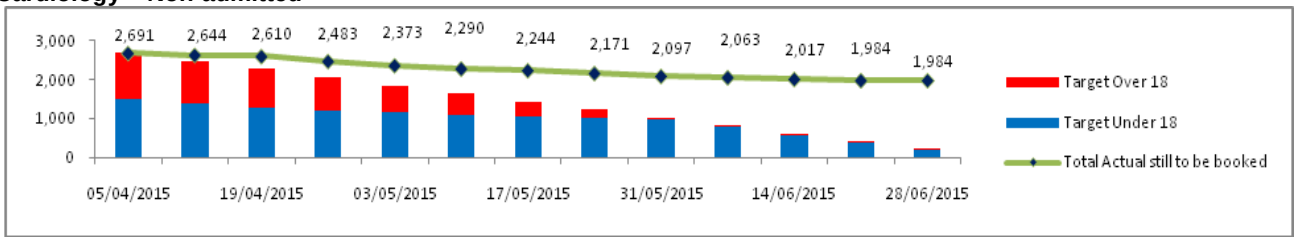
Gynaecology – Non-admitted



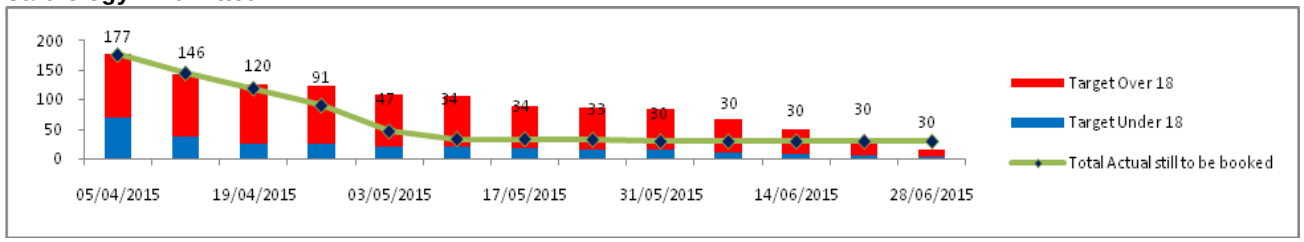
Gynaecology - Admitted



Cardiology – Non-admitted



Cardiology – Admitted



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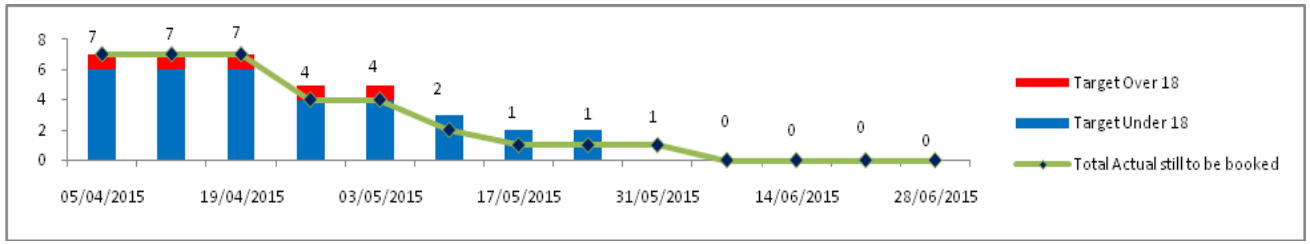
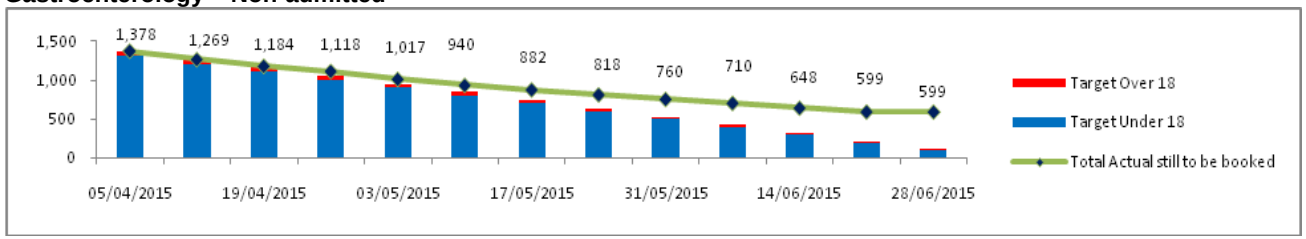
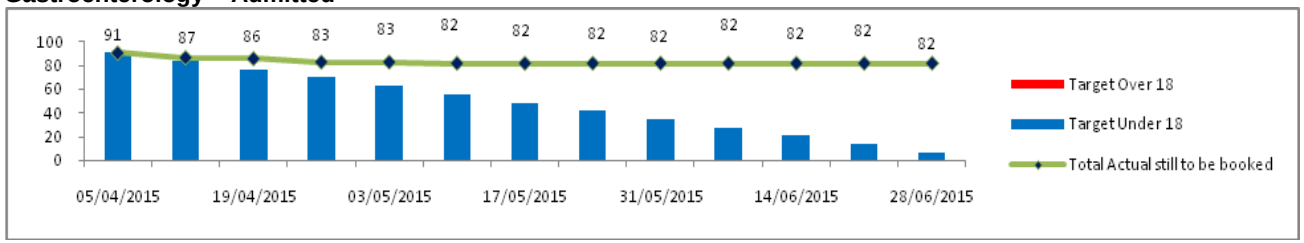
General Medicine – Non-admitted



Gastroenterology – Non-admitted



Gastroenterology – Admitted



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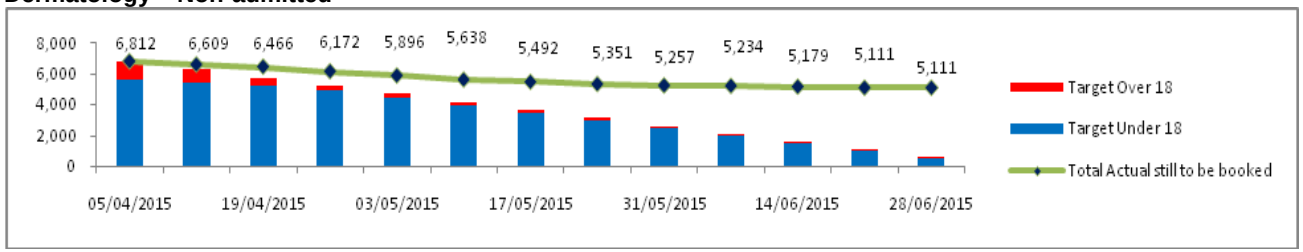
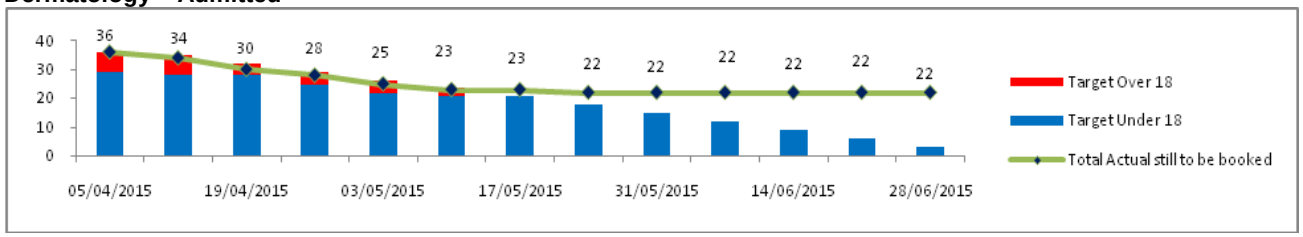
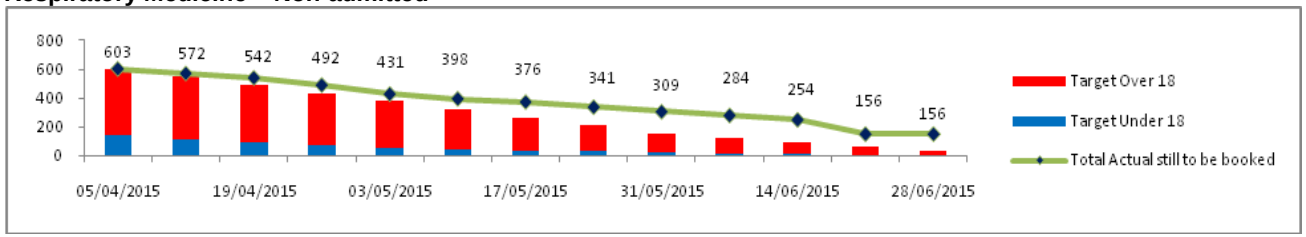
Dermatology – Non-admitted



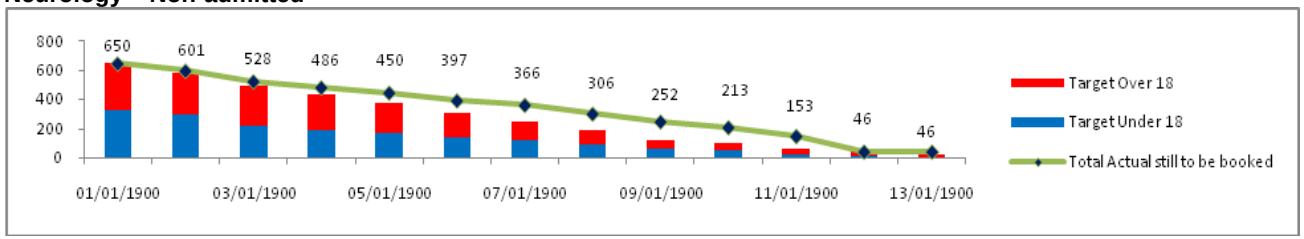
Dermatology – Admitted



Respiratory Medicine – Non-admitted



Neurology – Non-admitted



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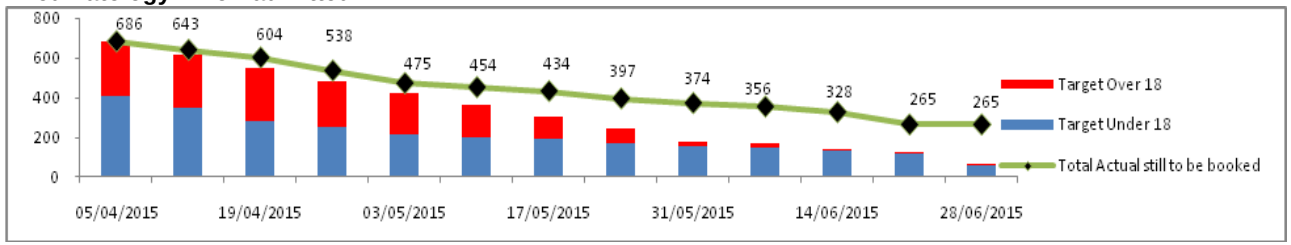
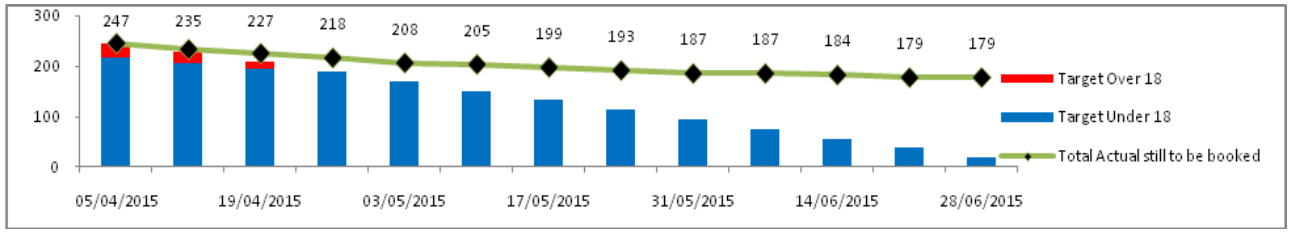
Rheumatology – Non-admitted



Geriatric Medicine – Non-admitted



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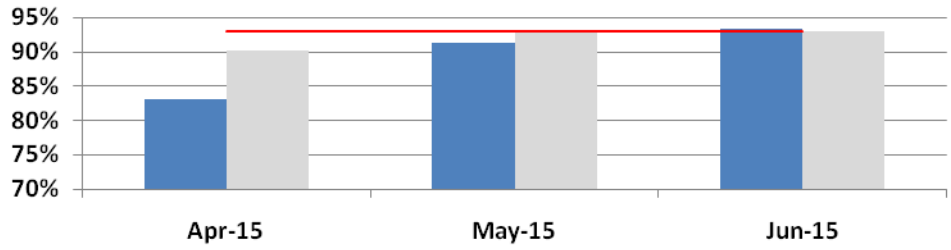
Assumptions relating to the trajectories

- The model is based on the objective of achievement 93% by the end of Q1 2015/16.
- The number patients waiting over and under 18 weeks at the end of June was calculated for both admitted and non admitted waiting lists.
- The number of patients over 18 weeks on the admitted waiting list was calculated using the following methodology.
  1. Number of patients on the admitted waiting list currently waiting over 18 weeks
  2. Plus the number of patients on the admitted waiting list currently waiting over 5 weeks and under 18 weeks
  3. Plus the expected conversion from outpatients where patients had already waited 18 weeks (based on historic evidence)
  4. Plus the expected conversion from outpatients of patients waiting between 5 and 17 weeks who would be waiting over 18 weeks by the end of Q1.
- The number of patients under 18 weeks on the admitted waiting list waiting were calculated using the following methodology.
  1. Number of patients on the admitted waiting list currently waiting between 0 and 14 weeks
  2. Plus the expected conversion from outpatients where patients waited between 0 and 17 weeks who would not be waiting over 18 weeks by the end of Q1.
- The number of patients over 18 weeks on the non-admitted waiting list were calculated using the following methodology.
  1. Number of patients over 18 weeks on the non admitted waiting list
  2. Plus the number of patients over 5 weeks and under 18 weeks on the non admitted waiting list
  3. Plus the expected conversion from outpatients where patients have already waited 18 weeks (based on historic evidence)
  4. Plus the expected conversion from outpatients where patients who have waited between 5 and 17 weeks would be waiting over 18 weeks by the end of Q1.
- The number of patients under 18 weeks on the non-admitted waiting list was calculated using the following methodology.
  1. Number of patients currently waiting between 0 and 14 weeks on the non admitted waiting list
  2. Plus the expected conversion from outpatients where patients who have waited between 0 and 17 weeks would not be waiting over 18 weeks by the end of Q1.
- The following formula was applied to inform the activity required to achieve 93% of the waiting list under 18 weeks.
  ((93 * number of patients waiting over 18 weeks) – (7 * number of patients waiting under 18 weeks))/93
- The trajectories examine what is booked over and under 18 weeks. If there is any spare capacity (based on historic activity) these are filled with 18 week patients.
- The number of patients to be cleared at the start of each week is the number of patients to be cleared over 18 weeks at the start of the previous week – the number of over 18 weeks patients booked in the previous week.
- This continues each week until the backlog is cleared.
- At this point the trajectories assume that capacity will be filled to achieve compliance (90% under 18 weeks for admitted and 95% for non admitted).

This table illustrates the estimated performance for patients on an admitted and non admitted incomplete pathway. Performance will achieve the internal stretch target of 93 percent of incomplete pathways within 18 weeks by June 2015. This improvement reflects the reduction in

patients waiting over 18 weeks as a result of the specialty booking trajectories. These trajectories will be monitored on a weekly basis to ensure that patients are booked in the correct order and to the volumes required to meet the plan.

The achievement of the 93 percent stretch target is a necessary condition for the Trust to meet its completed pathway standards at a Trust level from July 2015.



	Apr-15	May-15	Jun-15
Admitted incomplete pathways < 18 weeks	83.0%	91.3%	93.4%
Non admitted incomplete pathways <18 weeks	90.1%	93.0%	93.0%
Internal stretch target	93%	93%	93%

The following table demonstrates speciality level compliance by the end of Q3 2015/16.

Specialty	Incomplete	Admitted	Non Admitted
(100) GENERAL SURGERY	2015 Jun	2015 Jul	2015 Jun
(101) UROLOGY	2015 Jul	2015 Aug	2015 Jul
(110) TRAUMA & ORTHOPAEDICS	2015 Jun	2015 Jun	2015 Jul
(120) ENT	2015 Jun	2015 Jun	2015 Jul
(130) OPHTHALMOLOGY	2015 Jun	2015 Jul	2015 May
(140) ORAL SURGERY	2015 Jun	2015 Jul	2015 May
(300) GENERAL MEDICINE	2015 Jun	2015 Jul	2015 May
(301) GASTROENTEROLOGY	2015 May	2015 Jun	2015 May
(320) CARDIOLOGY	2015 Jun	2015 May	2015 Jul
(330) DERMATOLOGY	2015 May	2015 Jun	2015 May
(340) RESPIRATORY MEDICINE	2015 Nov	2015 Aug	2015 Dec
(400) NEUROLOGY	2015 Jun	N/A	2015 Jul
(410) RHEUMATOLOGY	2015 Jun	N/A	2015 Jul
(430) GERIATRIC MEDICINE	2015 Apr	N/A	2015 May
(502) GYNAECOLOGY	2015 Apr	2015 May	2015 May
(X01) Other*	2015 May	2015 May	2015 Jun
Total	2015 May	2015 Jun	2015 Jun

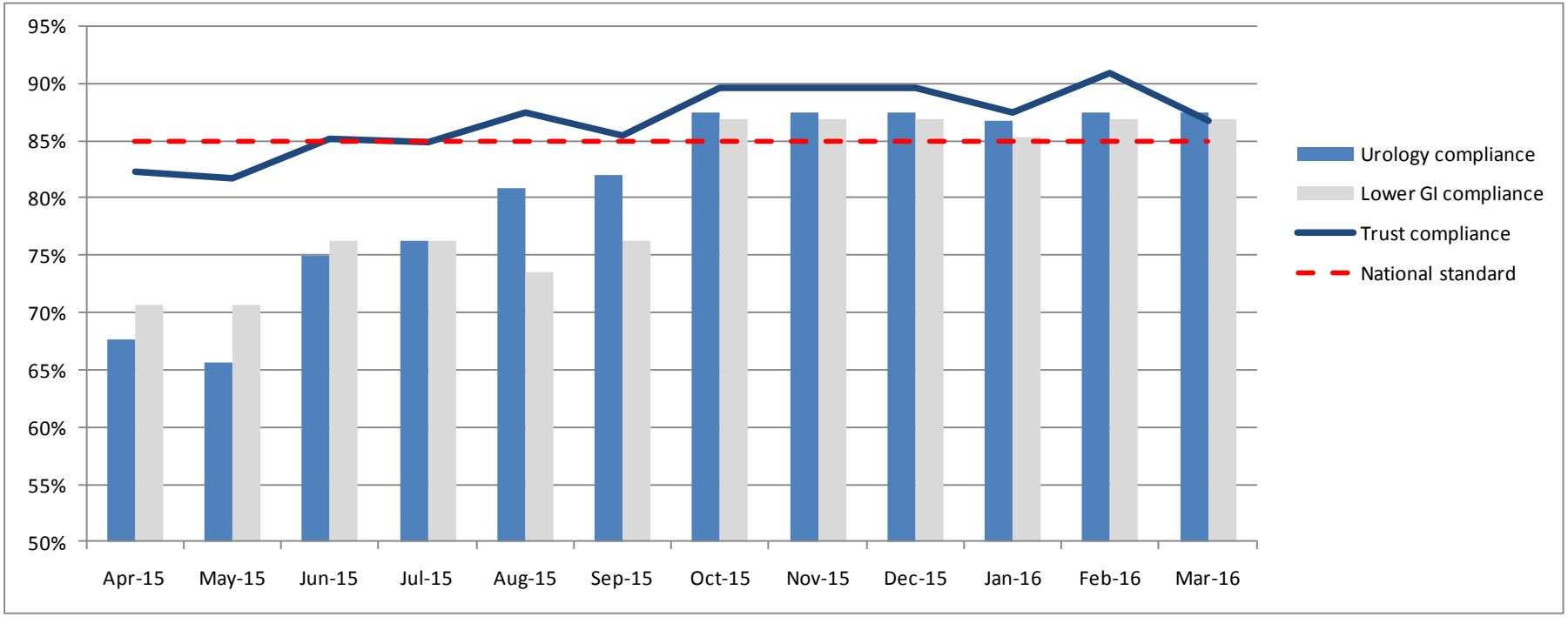
Note 3: Other specialties inlcude:
103) BREAST SURGERY
104) COLORECTAL SURGERY
107) VASCULAR SURGERY
143) ORTHODONTICS
191) PAIN MANAGEMENT*
211) PAEDIATRIC UROLOGY
216) PAEDIATRIC OPHTHALMOLOGY
251) PAEDIATRIC GASTROENTEROLOGY
252) PAEDIATRIC ENDOCRINOLOGY
257) PAEDIATRIC DERMATOLOGY
302) ENDOCRINOLOGY
303) CLINICAL HAEMATOLOGY
306) HEPATOLOGY
307) DIABETIC MEDICINE
328) STROKE MEDICINE
329) TRANSIENT ISCHAEMIC ATTACK
361) NEPHROLOGY
370) MEDICAL ONCOLOGY
420) PAEDIATRICS
658) ORTHOTICS
800) CLINICAL ONCOLOGY

Note 1: The incomplete compliance was split between admitted and non admitted and the compliance of the latest month was taken

Note 2: The month of compliance for admitted and non admitted was a month after the incomplete was compliant.

Appendix 4: Trajectory – for 62 day classic only

The diagram below shows recovery of the 62 day standard for Urology, Colorectal and the overall Trust position. This describes the trajectory for Trust compliance by June 15. The detailed trajectory calculators can be found in appendix 4.



Assumptions relating to the trajectory:

- The model is based on the objective of achievement of 85% 62 day classic standard by the end of Quarter 1.
- The recovery is calculated using average breach totals per month and projecting growth in activity of 1 – 1.5% pa.
- The recovery is calculated using a phased breach reduction approach in Urology and Colorectal over a period of 6 months to allow the maximum time to implement specialty based plans but to facilitate compliance of the Trust position by end of Q1.
- The recovery plans are based on breach reasons for 14/15. These could vary for 15/16.
- The recovery plan does not take into account unplanned spikes in activity out of the control of West Herts.
- This plan assumes that resolution of pathway barriers on the 62 day standard will maintain the 31 day compliance.

Appendix 5: Trajectory calculators

	Description	Historical data			Projected figures per month											
		Dec-14	Jan-14	Feb-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Urology	Total pathways	14	21	18	18	17	19	20	18	19	19	19	19	18	19	19
	WHHT pathways	13	20	15	16	15	17	18	16	17	17	17	17	16	17	17
	Tertiary pathways	1	1	3	2	2	2	2	2	2	2	2	2	2	2	2
	Total breaches	3	9	7	5.5	5.5	4.5	4.5	3.3	3.3	2.3	2.3	2.3	2.3	2.3	2.3
	AVG WHHT breaches per month	3	8	5	5	5	4	4	3	3	2	2	2	2	2	2
	AVG Tertiary breaches (counted at 0.5) per month	0	1	2	1.0	1.0	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
	AVG % compliance per month	77.8%	56.1%	57.6%	67.6%	65.6%	75.0%	76.3%	80.9%	81.9%	87.5%	87.5%	87.5%	86.8%	87.5%	87.5%

	Description	Historical data			Projected figures per month											
		Dec-14	Jan-14	Feb-14	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Lower GI	Total pathways	10	13	7	10	10	11	11	10	11	11	11	11	10	11	11
	WHHT pathways	6	10	6	7	7	8	8	7	8	8	8	8	7	8	8
	Tertiary pathways	4	3	1	3	3	3	3	3	3	3	3	3	3	3	3
	Total breaches	4.0	5.0	1.0	2.5	2.5	2.3	2.3	2.3	2.3	1.3	1.3	1.3	1.3	1.3	1.3
	AVG WHHT breaches per month	3	5	1	2	2	2	2	2	2	1	1	1	1	1	1
	AVG Tertiary breaches (counted at 0.5) per month	2	0	0	1.0	1.0	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5
	AVG % compliance per month	50.0%	56.5%	84.6%	70.6%	70.6%	76.3%	76.3%	73.5%	76.3%	86.8%	86.8%	86.8%	85.3%	86.8%	86.8%

	Description	Historical data			Projected figures per month											
		Dec-14	Jan-14	Feb-14	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16
Trust level	Total pathways	72	77	84	81	78	86	92	81	86	86	85	85	81	85	85
	WHHT pathways	48	58	58	55	53	59	63	55	59	59	59	59	55	59	59
	Tertiary pathways	28	21	27	26	25	27	29	26	27	27	26	26	26	26	26
	Total breaches	12	19	15	12	12	11	12	9	11	8	8	8	9	7	10
	AVG WHHT breaches per month	8	16	11	9	8	9	8	6	8	5	4	6	5	4	7
	AVG Tertiary breaches (counted at 0.5) per month	8	4	5	6	8	4	8	5	5	5	7	3	7	5	5
	AVG % compliance per month	80.6%	73.0%	79.7%	82.4%	81.7%	85.2%	84.8%	87.5%	85.5%	89.7%	89.6%	89.6%	87.5%	91.0%	86.8%

Appendix 6: Urology & Colorectal Action Plan

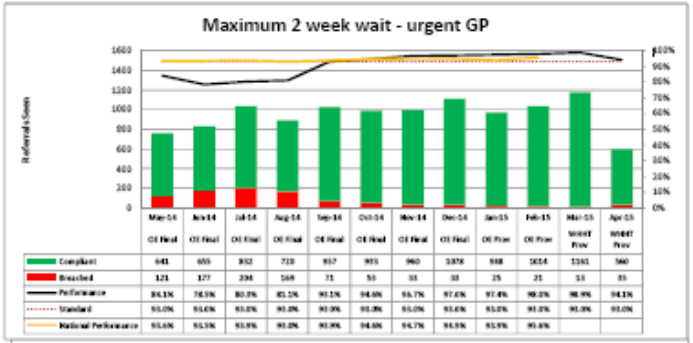
The actions in the plan below are those that are believed to be the most significant in achieving sustained compliance with the standard for Colorectal and Urology Services.

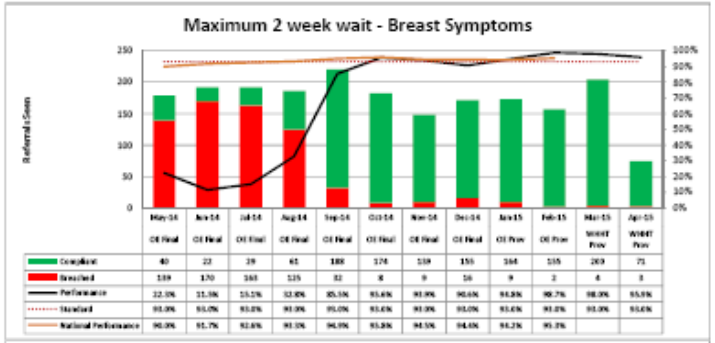
Tumour Site	Issue	Actions	Action Owner	Target Finish date	RAG Rating for Completion on Time
Urology	Elective capacity inadequate	Improve scheduling of TRUS biopsies – redesign administrative roles/requirements for scheduling Urology	Susan Davies/Freddie Banks	May 15	
		Book TRUS directly from clinic	Susan Davies/Freddie Banks	May 15	
		Deliver dedicated MRI slots	Radiology	June 15	
		Reduce waiting times for reporting	Radiology	June 15	
		Provide additional 3rd session theatres	Susan Davies/Freddie Banks	April 15	
	Inadequate Outpatient Capacity	Improve access to Joint Clinics through restructure of Joint clinics	Stephanie Johnson/Susan Davies	May 15	
		Implement PSA surveillance pathway	Freddie Banks	July 15	
		Perform 2ww demand and capacity modelling.	Stephanie Johnson/Susan Davies	May 15	
		Provide protected and dedicated 2ww slots	Susan Davies/Freddie Banks	May 15	

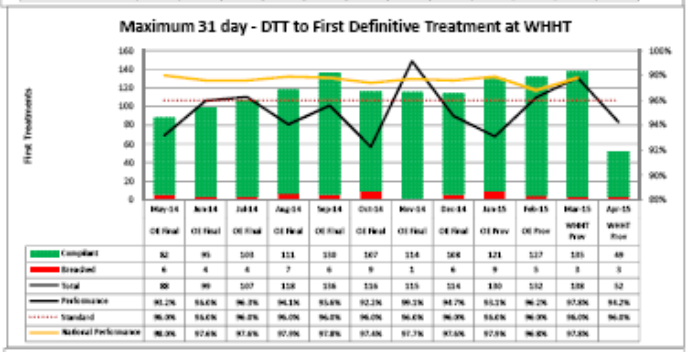
Tumour Site	Issue	Actions	Action Owner	Target Finish date	RAG Rating for Completion on Time
		Employ a locum Consultant	Susan Davies/Freddie Banks	June 15	
	Complex diagnostic pathway (many, or complex, diagnostic tests required)	Deliver one stop shop	Susan Davies/Freddie Banks/Mary Richardson	June 16	
	Pathway	Map pathway Agree stage of treatment milestones Agree escalation points along pathway	Fateha Zaman/Mandy Gaskell	May 15	
Colorectal	Elective capacity inadequate	Additional theatre capacity to be allocated Locum Consultant	Susan Davies/Ross Cheetham/Mary Richardson	Oct 15 Oct 15	
	Complex diagnostic pathway (many, or complex, diagnostic tests required)	Implementation of straight to test	Susan Davies/Ross Cheetham	Oct 15	
	National Bowel Screening Pathway	Review of pathway to ensure correct start date Review of pathway to ensure correct allocation of breaches	Stephanie Johnson/Pauline Sweeney/Sarah Cerys	April 15 April 15	
	Pathway	Map pathway Agree stage of treatment milestones Agree escalation points along pathway	Fateha Zaman/Mandy Gaskell	May 15	

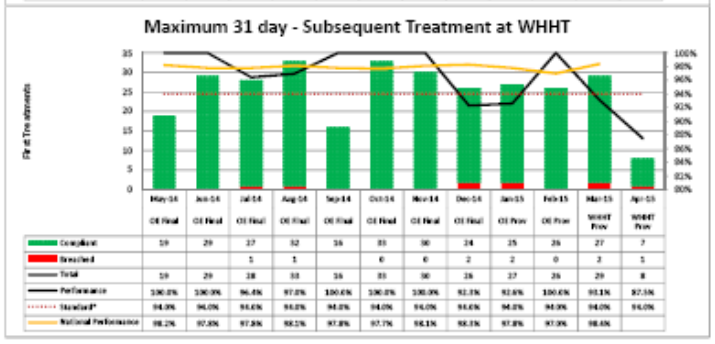
Appendix 7: Trust Performance

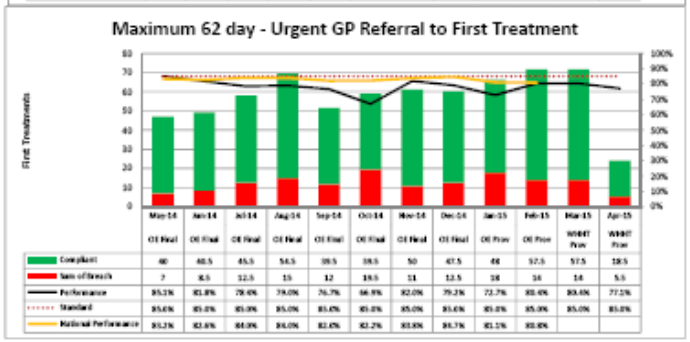
WHHT - Cancer Waiting Times Performance: Rolling 12 months (with MTD @ 19 Apr 2015)

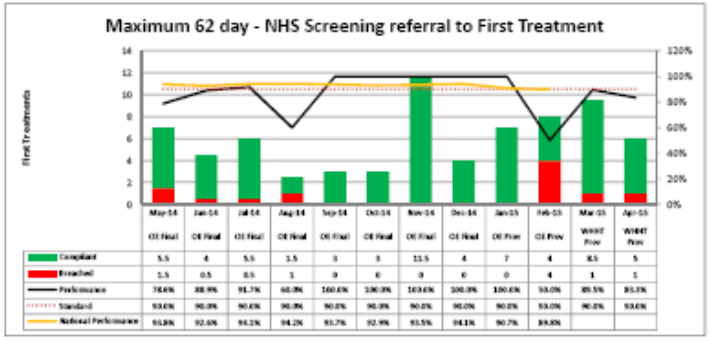












Appendix 8

Urodynamics (URDYN)Capacity Management Process

Purpose
The purpose of this capacity management process is to ensure that there is a coordinated and well managed approach to ensuring that additional capacity that needs to be created for URDYN patients is used in a timely manner and the administrative processes that sit around it are robust.

Scope
This process applies to patients within the surgical URDYN pathway but may include those within the Urogynaecology pathway to depending on capacity.

Internal Capacity
We will aim to treat all our patients within our own existing capacity first before any decision to outsource to external providers is taken. Efforts will be made to create additional capacity in house before other options are explored.

External Capacity
Standard URDYN patients can be outsourced to the Luton& Dunstable. Video URDYN patients can be outsourced to the BMI Clementine in Harrow.

Capacity management Process
The booking secretary within the URDYN service will not book anyone into a clinic that cannot be done within 6 weeks. (Diagnostic wait time standard)

The booking secretary will escalate the patient details to the ADM (Assistant Divisional Manager, ASM (Assistant Service Manger) and Lead Clinician for Urology.

There will be a one week window for the service to arrange the additional capacity needed to book the patient within 6 weeks. This is to ensure that the clinic can be set up with enough notice for all parties especially the patient.

If the service cannot create the additional capacity needed to see the patient within the diagnostic wait time standard then the patient will be offered outsourcing to one of the two selected hospitals depending on the needs.

The ADM and or ASM will be responsible for making contact with the external provider to arrange transfer of necessary medical information as agreed.

Once the patients has been treated results will be transferred back to the service and the ADM/ ASM will coordinate the recording of results with the administrative staff within the service

Risk Management and Clinical
The safety of our patients is paramount and it is important to ensure that we monitor the quality of interventions that are being carried out by external provider

The ADM and Clinical Lead will be responsible for developing the appropriate audit tools to measure both patient's satisfaction and clinical outcomes

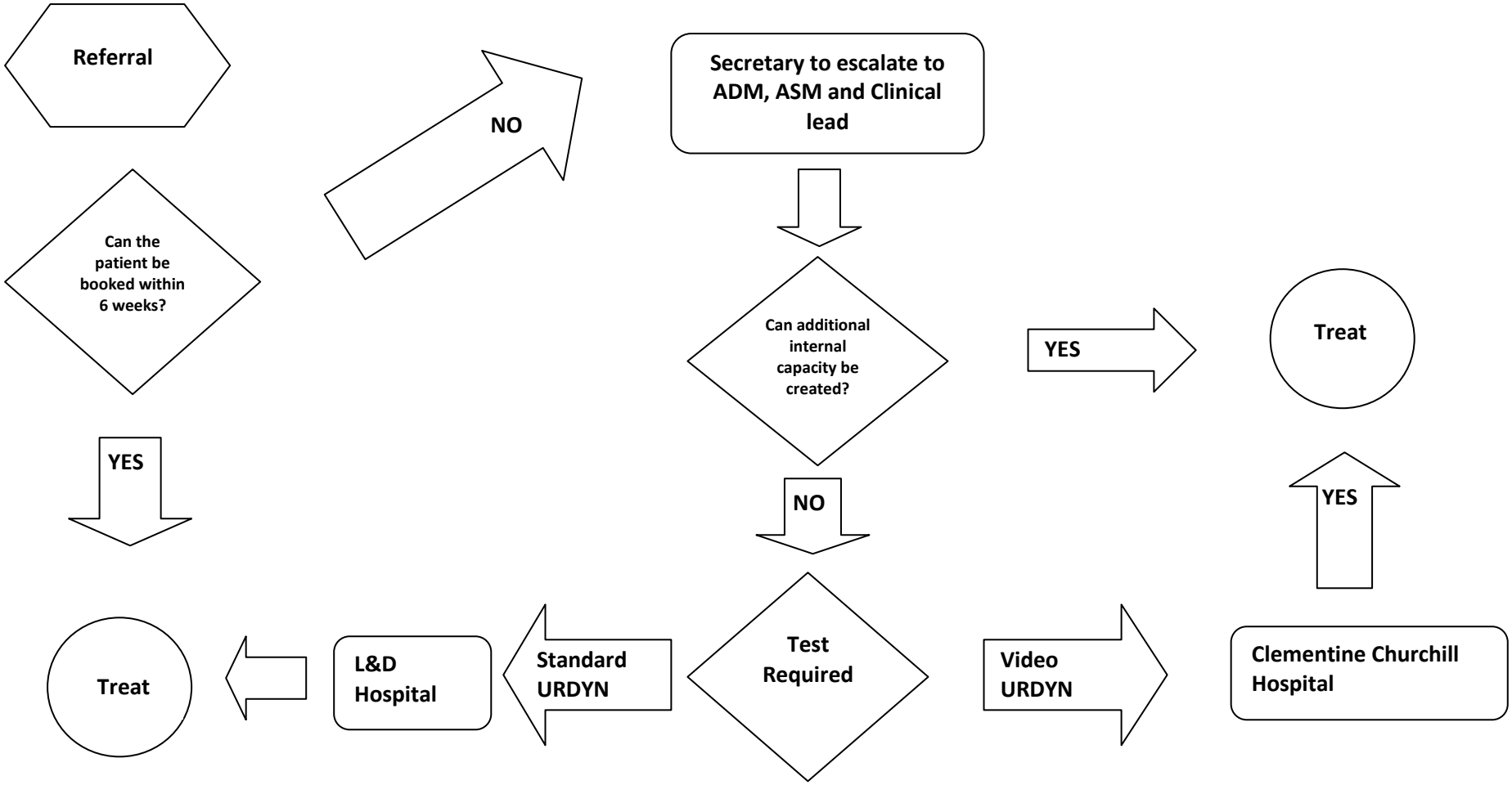
These will be agreed jointly with the providers and quarterly results will be shared in the respective MDT's

Finance management
The ADM will be responsible for making sure that the providers are paid for the activity that is carried out
Projections will need to be made with the Head of finance for the Division to ensure that costs associated with the projected levels of outsourcing are accurately captured within the forward look

SLA Management
It is important that any potential points within the year where there may be a reduction in capacity from external providers in adequately planned for and active steps are taken within the SLA to ensure that patients are still treated on time

Review
The Service SMT will be responsible for reviewing this process and making any additions and or changes that may be needed as part of an evolving and ever changing internal and external health economy

Capacity Management Process Map



Appendix 9

Diagnostics Performance March 2015

Description	0->1	1->2	2->3	3->4	4->5	5->6	6->7	7->8	8->9	9->10	10->11	11->12	12->13	13+	Total	% within 6 weeks
W01: Imaging - Magnetic Resonance Imaging	194	235	232	192	47	10	0	0	0	0	0	0	0	0	910	100.0%
W02: Imaging - Computed Tomography	151	152	95	50	18	3	0	0	0	0	0	0	0	0	469	100.0%
W03: Imaging - Non-obstetric ultrasound	446	618	705	571	307	57	0	0	0	0	0	0	0	0	2704	100.0%
W04: Imaging - Barium Enema	7	22	25	9	1	0	0	0	0	0	0	0	0	0	64	100.0%
W05: Imaging - DEXA Scan	32	27	42	34	29	11	0	0	0	0	0	0	0	0	175	100.0%
W06: Physiological Measurement - Audiology - Audiology Assessments	98	80	110	77	54	14	3	3	0	0	0	0	0	0	439	98.6%
W07: Physiological Measurement - Cardiology - echocardiography	43	17	43	17	43	17	16	17	13	10	8	3	1	3	251	71.7%
W08: Physiological Measurement - Cardiology - electrophysiology	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
W09: Physiological Measurement - Neurophysiology - peripheral neurophysiology	2	17	31	21	8	9	0	1	0	0	0	0	0	0	89	98.9%
W10: Physiological Measurement - Respiratory physiology - sleep studies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	#DIV/0!
W11g: Physiological Measurement - Urodynamics - pressures & flows (Gynae)	36	7	7	3	1	0	1	1	0	0	0	0	0	0	56	96.4%
W11s: Physiological Measurement - Urodynamics - pressures & flows (Surgical)	3	7	6	1	3	1	3	1	0	1	0	0	0	4	30	70.0%
W12: Endoscopy - Colonoscopy	74	28	20	22	5	2	0	0	0	0	0	0	0	0	151	100.0%
W13: Endoscopy - Flexi sigmoidoscopy	46	19	11	13	8	1	0	0	0	0	0	0	0	1	99	99.0%
W14: Endoscopy - Cystoscopy	48	28	25	16	15	5	0	0	1	0	0	0	0	0	138	99.3%
W15: Endoscopy - Gastroscopy	148	54	62	48	36	7	0	0	0	0	0	0	0	0	355	100.0%
Total	**1328**	**1311**	**1414**	**1074**	**575**	**137**	**23**	**23**	**14**	**11**	**8**	**3**	**1**	**8**	**5930**	**98.5%**