Trust Board Meeting in public: Wednesday 9 September 2015

TB2015.109

Title	**Update on Action Plans for Urgent Care, Cancer and Elective Care in Relation to the Trajectory for Operational Performance in Q3**

Status	For information and review
History	TB2015.55_Operational Performance Trajectory Q1 and Q2 was submitted to Trust Board on 13th May 2015. FPC2015.39_Update on Action Plans and Operational Performance submitted to Finance & Performance Committee on 12th August 2015. TME2015.198_ Update on Action Plans for Urgent Care, Cancer and Elective Care in Relation to the Trajectory for Operational Performance in Q3

Board Lead(s)	**Paul Brennan, Director of Clinical Services**			
Key purpose	Strategy	Assurance	Policy	**Performance**

Executive Summary

1. This paper provides an update to the action plans previously received by the Trust Board on 13th May 2015, Finance & Performance Committee on 12th August 2015 and Trust Management Executive on 27th August 2015 attached at Appendices 3, 4 and 5.
2. The trajectory of attendances and breaches for the four hour standard is attached at Appendix 1.
3. The trajectories to Q3 for the RTT, 62 Day Cancer and 4 Hour Standards together with actual performance to date is attached at Appendix 2.
4. **Recommendation** The Trust Board is asked to: • Note actual performance to date for Q1. • Review the Urgent Care, RTT and Cancer Action Plans in the context of the proposed trajectory. • Support the trajectory set out in Appendix 1 and Appendix 2.

Paul Brennan
Director of Clinical Services

1 September 2015

Appendix 1

ED Attendances and Breaches Trajectory and Actual
April 2015 to March 2016

Month	Attendances		Breaches		Monthly Performance	Quarter Performance	
	Trajectory	**Actual**	Trajectory	**Actual**	**Actual**	Trajectory	**Actual**
April	13,000	**13,517**	1,300	**1,198**	**91.14%**		
May	10500	**10673**	735	**386**	**96.38%**		
June	11500	**11257**	690	**429**	**96.20%**		
Q1 Total	35,000	**35,447**	2,725	**2,013**		92.21%	**94.33%**
July	12,200	**12,282**	440	**434**	**96.50%**		
August	12000		470				
September	11400		443				
Q2 Total	35,600	**12,282**	1,353	**434**		96.19%	
October	13,100		490				
November	11,100		447				
December	10,600		420				
Q3 Total	34,800	**0**	1,357	**0**		96.10%	
January	12,200						
February	10,100						
March	11,200						
Q4 Total	33,500	**0**	0	**0**			
2015/2016	**138,900**						

Appendix 2: Trust Standards and Trajectories 2015/2016

Trust Actual Performance 2015/2016 Standard		Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Annual Average
Cancer Waits:	Treated < 62 days - Tumour Type	85%	78.4%	79.8%	85%										
	Treated < 62 days - Screening	90%	83.33%	100%	91.7%										
	Treated < 31 days	96%	97%	97.6%	98.4%										
	Treated < 31 days subsequent surgery	94%	94.8%	95.3%	97.6%										
	Treated < 31 days subsequent drug	98%	100%	100%	100%										
	Treated < 31 days subsequent radiotherapy	94%	100%	97.5%	99%										
	Seen within 2 weeks of referral	93%	93%	96.8%	95%										
	Seen within 2 weeks of referral - breast symptoms	93%	96.9%	100%	97.8%										
18 Week RTT:	Admitted Trust	90%	86.24%	87.81%	87.32%	88.08%									
	Non-admitted Trust	95%	95.07%	95.13%	95.02%	95.03%									
	Incomplete Trust	92%	93.05%	93.2%	93.27%	92.09%									
Diagnostic Waits: 1% Maximum over 6 weeks		1%	19	18	19	21									
VTE:		95%	96.47%	97.36%	97.63%	96.6%									
A&E 4 Hour:		95%	91.14%	96.38%	96.2%	96.5%									
Delayed Transfers of Care - System-Wide Monthly Average:		n/a	167	152	152	174									
C Difficile:		69	3	4	8	8									23

Trust Trajectories 2015/2016

Standard	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Annual Average
Trajectory for Achievement of the A&E 4 Hour Standard	95%	90%	93%	94%	96.4%	96%	96%	96.2%	96%	96%				

Standard	Target	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
Trajectory for Achievement of the Admitted Standard	90%	87%	87%	87%	90%	88%	90%	90.5%	90.5%	90.1%
Trajectory for the Non-Admitted Standard	95%	95.1%	95.5%	95.5%	95.5%	95.5%	95%	95.1%	95.2%	95%
Trajectory for the Incomplete Standard	92%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.4%	92.2%	92.1%

Standard

Trajectory for achievement of the 62 day Cancer Standard	85%	75%	78%	83%	86%	83.5%	85.5%	86%	86%	85%

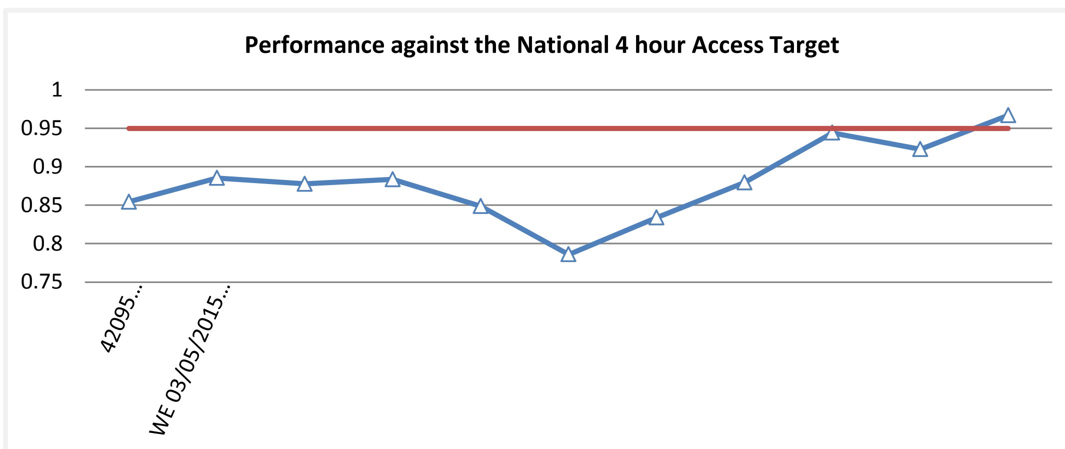
Oxford University Hospitals NHS Trust

URGENT CARE IMPROVEMENT PROGRAMME

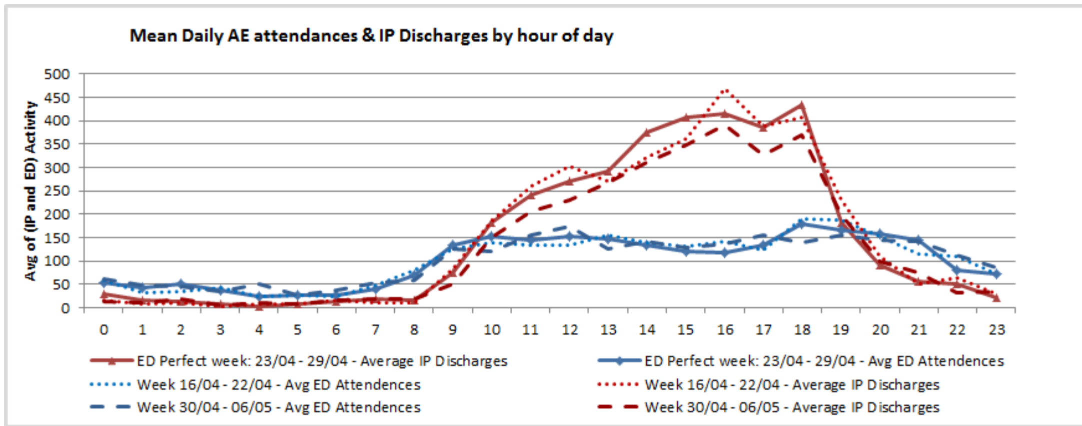
1. Context
The Trust has failed to achieve the four hour access target in all but two quarters since the start of 2013/14. Quarter 3 and 4 of 13/14 were particularly challenging with the Trust rarely performing above 85%.
In October/November 2014 the Emergency Care Intensive Support Team (ECIST) undertook a whole system review of the emergency and urgent care system covering both health and social care and made a number of recommendations. In addition, the Trust undertook the ECIST initiative "Breaking the Cycle/ A Perfect Week" , 23 - 29 April 2015. This urgent care improvement plan includes the recommendations of the ECIST review and the lessons learned from the perfect week.

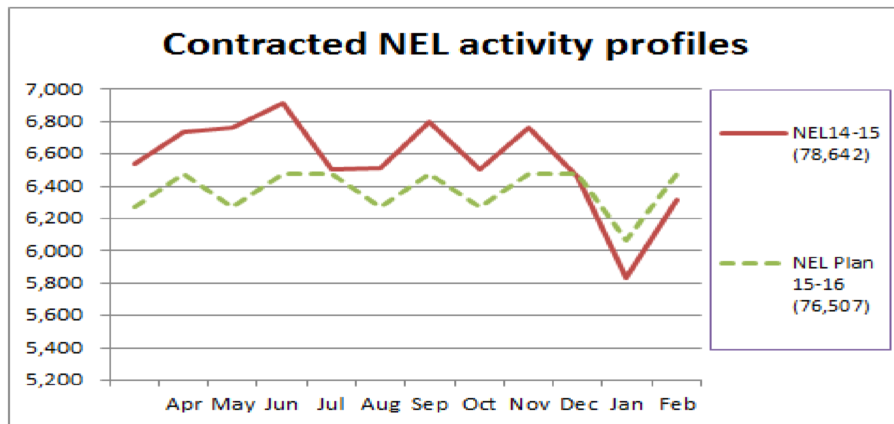
2. Reasons for Under Performance
The majority of Breaches (over 50%) are due to lack of available in-patient bed capacity. Although ambulatory pathways are utilised as much as possible, there has been a significant increase in admission of very sick, elderly patients who require a greater level of care, longer stay in hospital and an increase in post-acute support. ECIST also undertook a length of stay review at John Radcliffe Hospital and identified that 43% of the “fit for discharge” cohort were waiting for post-acute community support.

3. **Breaking the Cycle / The Perfect Week**
The graph below shows the 4 hour performance prior to, during and and since the perfect week.
Although the Trust did not recieve any additional capacity from community services, there was an improvement in 4 hour performacne.
The main factors that seemed to have the most impact on improved flow and perfromance were:
1. trust wide command and control structure with early escalation of delays and improved communication
2. Tighter operational focus with twide daily action focused operational planning meetings with senior management and clinical attendances
3. Seven day working with provision of clinical support services and social care support.
4, early morning ward rounds.
The actions required to implement lessons learned have been incorporated into this plan.



The graph below shows that the majority of attendances to ED occur at a fairly steady rate between 9am and 9pm, but discharges occur predominatly between 12pm - 6pm.
This mis-match between admissions and discharges is further amplified late into the night as a back log of patients waiting builds up.
The main contributors to lack of flow through inpatient beds are:
1. lack of assessment space and emergency assessment unit beds , blocking flow out of ED.
2. Numbers of medically fit patients awaiting discharge to a community or social care placement
2. Reduced numbers of discharges at week-ends and discharges occurring late in the day.
During the perfect week there was an increase in the number of earlier discharges with the curve shifting to the right. In addition, there was a focus during the perfect week in always creating assesment capacity and no patient with LOS greater than 12 hrs on EAU. This had a significant impact on flow out of EAU and assessment capacity and therefore a positive impact on 4 hour performance.





The graph above shows the profile of 2014/15 non elective activity against the NEL plan for 2015/16. If attendances remain at the same rate it is likely that the trust will over perform against plan by approximately 2000 episodes, representing an additional 6 patients per day to ED.

In addition, there has been a continued increase in the number of patients attending the A&E department in the 70 years of age and above age range , representing an annual increase of 10% since January 2012.
The trust is working with a specialist informatics analysist at the CCG to undertake statistical modelling work looking at ED demand and the correlation with patient acuity, bed capacity and staffing resource. It is hoped that this work will support the development of a forecasting tool for Ed activity and enable better capacity planning and allocation of staff resource.

Breaking the cycle / A perfect week - developing an ongoing programme
In order to continue to identify improvement from the perfect week an ongoing programme of perfect weeks is planned which will focus on one site at a time. This will enable a much more focused review and identify specific pathway issues with the aim of identifying more opportunities for removing delays in patient journeys and improve flow and performance.

URGENT CARE IMPROVEMENT PROGRAMME

Oxford University Hospitals NHS
NHS Trust

	Programme Workstreams	
	Emergency Department Work stream	
	Clinical Lead: Dr Larry Fitton Nursing Lead: Louise Rawlinson, Management lead: Siophan Hurley	
Numbe	Objectives	KPIs
1	No less than 95% of patients are assessed, treated and admitted, transferred or discharged within 4 hours of arrival	• % pts discharged within 4 hour standard
2	All patients will be assessed within 15 minutes of arrival or ambulance handover which ever is the quickest.	• time to Initial assessment from arrival
3	Ambulance handovers will take place within 15 minutes of arrival	• time to treatment
4	All patients will have a management plan within 2 hours of arrival	• time from attendance to DTA/ plan
5	5. No patient will wait on a trolley for more than 12 hours from decision to admit	•Time from DTA to discharge from ED
6	To provide safe high quality care for all patients attending ED/EAU or SEU	•LOS in emergency dept
7	There will be a model of staffing in place that meets peaks and troughs in demand, with an appropriate skill mix that enables safe, high quality patient care and effective management of patient flow.	•Family and friends score •Number of reported untoward incidents and near misses
8	No patient will be delayed in the Emergency Department waiting for diagnostics or specialty assessment	4 hour breach report
9	To avoid overcrowding in Emergency Department	Escalation trigger scores. 4 hour breach report
	Emergency Assessment Unit and Ambulatory Care Work Stream	
	Clinical Lead: Dr Suhdir Singh Nursing Lead: Lily O'Connor Management Lead: Siobhan Hurley	
	Work Stream Objectives	KPIs
10	To ensure there is an appropriate multidisciplinary staffing model in place in EAU to ensure safe, high quality patient care and effectively manage patient flow.	Average LOS by consultant/ day of the week
11	To ensure LOS on EAU or SEU does not exceed 12 hours and aim for 20-35% of patients refered to be managed on an ambulatory pathway	Number of patients with LOS over 12 hours in EAU
12	To ensure rapid clinical assessment takes place within 15 minutes of arrival	Ambulance turnaround times. escalation trigger scores.
13	To enable rapid response from therapies and social care to enable early discharge direct from ED/ EAU and avoid unecessary admission to an inpatient bed.	number of discharges direct from EAU with social care or SHDS intervention.
	Inpatient Flow and discharge planning Work Stream	
	Clinical Lead: Dr James Price Nursing Lead: Lily O'Connor Managerial Lead: Kathleen Simcock	
	Work Stream Objectives	KPIs
14	All patients will have a consultant review each day seven days a week	Number and time of wards rounds over a seven day period
15	All patients will have a clinical management plan within 24 hours of admission	Number of pts with EDD. Number of wards with twice daily board round.
16	All patients will have a clear discharge plan that starts on admission with all relevant members of the MDT involved.	Discharges by ward. DTOC report LOS by specialty/wards
17	40% of patients discharged each day will vacate the inpatient bed by lunch time so that it is free for the next admission.	% of discharges before lunch time % discharges by day of the week
18	All patients who are admitted to an inpatient bed will follow an optimum patient journey with all interactions adding value and no avoidable elays.	DOC report. LOS and bed occupancy
19	All patients who require post discharge community support will be able to access the appropriate post acute pathway when they are medically fit for discharge and no longer need to occupy an acute hospital bed.	DTOC report LOS from referral to discharge
20	To mininise the number of days a patient is delayed awaiting repatriation or transfer to another acute hospital.	Number and LOS of pts waiting repatriation

Oxford University Hospitals NHS Trust

Urgent Care Improvement - No Delays.

Programme to implement the ECIST review recommendations.

Updated 27 August 2015

19/01/2015

	Milestones and associated actions	Objective number the milestone/ task relates to	Activity Type	Task owner	revised due date	likely Impact	Comments	Activity Status
	EMERGENCY DEPARTMENT WORKSTREAM							
1	**To develop an appropriate medical and nursing staffing model that meets NICE and CEM guidance and is sufficient to meet clinical needs of patients and respond to varying levels of activity within the 4 hour access target**	1.2.3.4.5.6.7.9	Milestone	Dr Larry Fitton	01/04/2015	This would enable staffing levels and particularly senior clinical staff rotas to be closely aligned to periods of peak activity and reduce risk of breaches particuarly out of hours.	perfect week identified that out of hours continues to be vulnerable and the time when most breaches occur. Given the difficulties with consultant and nursing recruitment, further work is required to review optimum staffing model that best fits activity and acuity requirements. Analysis, undertaken by the informatics group will inform this.	Complete
2	To increase the consultant presence in ED from 12.3 WTE to 16.3 WTE to provide 2 consultants at peak times in order to enhance the capacity for timely management of patients in ED.	1.4.6.7	Task	Dr Larry Fitton	01/04/2016	Most significant impact would be the ability to have senior decision makers on duty late evening.	Following interviews in April an additional consultant was appointed. There is still a gap of 3 WTE. Recruitment continues to be a challenge.	In progress
3	To review medical and senior nursing support in ED out of hours to ensure effective	1.4.6.7	Task	Paul Brennan	01/09/2015	More rapid clinical decision making and consequently	Nursing recruitment continues to be a challenge. Plan in place to develop band 4	In progress
4	Expand GP capability in ED with the introduction of the GPSI (General Practitioner	1.4.6.7	Task	Dr Larry	01/02/2016	ability to improve ED throughput with Gp assessment	to consider the role of GPSI in paediatrics ED	In progress
5	Provide senior nursing leadership 24 hrs a day with band 7 and 6 experienced nurses as shift coordinators	1.2.3.6.7	Task	Louise Rawlinson	Ongoing	Improved shift management and monitoring of 4 hour target	To undertake and further review of out of hours support	Complete
6	Train internal staff to develop the ANP workforce to a total of 5.5 WTE to provide 1 per shift in ED	1.4.6.7	Task	Louise Rawlinson	01/01/2017	Ability to expand and further develop nurse led see and treat patient stream.	longer term action- 2 post funded but a business case is being developed for a further three posts.	In progress
7	Review and further develop the role of flow navigator to monitor adherence to the 4 hour target and support patient flow.	1.6.9	Task	Louise Rawlinson	01/05/2015	early escalation of delays and reduction in breaches occuring as a result of lack of internal action	An emergency flow- capacity planning escalation triggers have been developed to aid flow navigators in identifying when risks of ED crowding are developing.This is supported by a set of escalation actions to prevent 4 hour and 12 hour breaches.	Complete
8	**To develop an appropriate Rapid Assessment/ Treatment and referral process for all patients who attend ED**	1.2.3.6	Milestone	Dr Larry Fitton	01/04/2015	Early ordering of diagnostics and streaming of patients into correct clinical stream.	currently process is rapid nurse assessment which works well. Occasionally supported by a consultants during peak activity but this is dependant on availability of a second consultant on shift. There is opportunity to expand the benefits of this model by developing a process s for early identification of patients who will be medically referred and can move to EAU quickly	Complete
9	Introduce nurse led RAT process 24 hrs day	1.2.3.6	Task	Louise Rawlinson	01/06/2015		in place and working well.	Complete
10	Implement a rapid referral pathways for patients with fracture neck of femur pathway on the JR site to ensure patients are assessed and admitted within 2 hours	1.2.8	Task	Claire Pulford / Larry Fitton	01/04/2015	To reduce long wait for trauma review and rapid access to trauma bed	New rapid pathway for suspected fractured neck of femur patients has been agreed and is being trialled	Complete
11	Reinforce MaxFax, Plastic and ENT pathway for direct GP referrals (to SSIP). Ensure patients who present in ED and are RNA as requiring surgical opinion are transferred to SSIP	1.2.8	Task	Neil Cowan		To reduce the number of surgically accepted patients waiting in ED for clinical review	ED Consultants now have direct access to book to HAPI clinic in Plastics which has also helped with flow as they can book appts in ED and patients go home and come back to Plastics next day. In January 2015 the SSIP GP referral unit treated and admit or discharge 181 patients, up from 32 in January 2014 equating to an entire days JR ED activity and helping relieve operational pressure in the system. The MOPS room at NOC also became fully operational for Plastics Trauma patients in 2015, and in February 2015 it saw 120 patients treated on the NOC site, nearly all Trauma patients were treated the same day where clinically appropriate, all of whom would have been treated the JR in February 2014.	Complete
12	**Develop a culture of zero tolerance for avoidable breaches of the 4 hour access target**	1.5.6	Milestone	S Shannon	01/09/2015	increased enagement and achievement of 4 hour access target	launched during the perfect week and will be developed as a trust wide campaign.This will include a marketing and publications programme with all divisions included. initial meeting with comms and marketing set up to discuss approach	Complete
13	Launch trust wide No delays campaign, use marketing and promotions to reinforce no delays message.	1.5.	Task	S Shannon	01/06/2015	Increase staff awareness and engagement to create a culture chage whereas there is zero tolerance of avoidable delays.	Campaign in development. All promotions have been ordered and the launch of the campaign will commence to coincide with the breaking the cycle - no delays week 9-13 septmber 15.	In progress
14	Develop a whole system escalation process with clear and rapid response actions from all health partner.	1.5.6.9	Task	Paul Brennan	29/01/2015	Aims to facilitate a health economy response to Trust increased escalation.	In place and agreed. Cobra conference calls take place when Trust on red escalation	Complete
16	Develop a set of emergency flow capacity triggers and an escalation process with defined action at key time points to avoid 4 hour breaches	1.5.6.8.9	Task	S Shannon	01/04/2015	rapid response to escalation of delays and reduction in breaches as a result of avoidable delays.	In place and tested during the perfect week	Complete
17	Develop a standard escalation process which includes ED consultants admitting directly to specialty beds if there is no response within 30 minutes to request for specialty opinion.	1.4.5.6.8.	Task	Dr Larry Fitton	01/07/2015	reduction in breaches due to delays in specialty response.	SLAs in place. Compliance to be monitored at daily breach meeting and specialty trends monitored and discussed at weekly breach meeting	Complete
18	**Develop a set of processes to avoid children in emergency department breaching for non clinical reasons.**	**1.2.4.5.6.8.**	Milestone	Nettie Dearmum/ Tony Mcdonald	**01/09/2015**	reduction in paediatric breaches	The majority of breaches are due to children waiting for a bed or long waits to be seen in ED.	**In progress**
19	To review the process for managing children in ED and PCDU and reduce unecessary delays in process	**1.4.7.8**	Task	Nettie Dearmum/ Tony Mcdonald	**01/09/2015**	reduction in wait to be seen	Following a meeting paediatrics lead and ED clinicial lead it has been agreed that ED will manage all children who attend Ed and paediatrics will manage all GP referrals.	**Complete**
20	To avoid a reduction of paediatric bed capacity due to staffing levels through increased recruitment	**1.5.6**	Task	Nettie Dearmum/ Tony Mcdonald	**01/09/2015**	reduction in paediatric breaches due to capacity	Recruitment ongoing to fill all paediatric vacancies. Bed capacity is flexed as much as possible to accommodate children waiting in ED.	**In progress**
21	Improve access to PCDU and implement an escalation process to avoid children being kept overnight in ED	1.5.6	Task	Nettie Dearmum/ Tony Mcdonald	30/03/2015	reduction in children remaining in Ed waiting for a bed.	New SPR appointed, Transfer to CDU/Escalation to Children's Manager on Call. Paeds SLA in place. This item is now on the workplan for the trust wide 4 hour access breach meeting. Progress will be reported back at the bi-weekly performance meeting	In progress
23	**Develop a robust system whereby information is used for forecasting, operational planning and and clincal decision making**	1.9	Milestone	sandra shannon/Alyn Still	01/08/2015	to enable resources to be matched to expected activity and monitor impact on performance	ED dashboard in draft development. First draft likely to be available in the next week or so. A new bed management report has been developed and will launch on 23rd march which will aid planning and decision making.	Complete
24	Establish performance standards for steps within the 4 hour timeframe – to initial assessment, to be seen and treatment - discharge	1.2.3.4.5.6.8.9	Task	Dr Larry Fitton	01/05/2015	To inform escalation actions	In place and included in the ED capacity planning escalation matrix.	Complete
25	Include all performance standards on the ED/ EAU dashboard and review at bi-weekly performance meetings	1.2.3.4.5.6.8.9	Task	Lily O' connor	01/07/2015	to identify which standards have the most impact on patient flow.	Dashboard in development	In progress
26	Develop a system that uses historic and current data to predict future activity including likely peaks in demand.	1.6.9	Task	sandra Shannon	01/07/2015	A forecasting model would enable better foreward planning of staffing levels and skill mix and identify when additional capacity is likely to be required in order to better manage activity and performance. It will also enable staffing and skill mix to be aligned to expected activity levels.		In progress
27	Develop a system that uses the predicted activity data to plan increased staffing levels to mitigate risk to patients.	1.6	Task	Siobhan Hurley/ Larry Fitton	01/07/2015		A forecasting model is in draft, further analysis is to be undertaken to review the correlation of staffing against activity on performance. Analysis has been undertaken using decision tree analysis.	In progress
28	map availability of senior decision makers at times of peak activity and analyse impact on 4 hour access performance	1.5. 6.	Task	Siobhan Hurley	01/07/2015		previously undertaken and identified the need for more out of hours and weekend management support for early escalation.	Complete
29	Introduce daily and weekly breach and agree actions for improvement	1.6	Task	Siobhan Hurley/ Sandra Shannon	01/06/2015	daily analysis will identify quick wins for improvement. Weekly review of trends will identify process changes required and agree changes.	daily breach meetings in place and weekly breach meetings in development. Draft SOP circulated for approval.	Complete
30	Introduce a trust wide fortnightly 4 hour access breach meeting	1.6	Task	sandra Shannon	01/08/2015	Trust wide ownership of the 4 hour access target and improved cooperation and communication between specialties and ED	The first two meetings have taken place which where well attended by consultant and senior managers. The meeitng focuses on the key themes that have affected performance and actions agreed. These will form the basis of an ongoing work plan and will be monitored at the bi-weekly performance meeting.	Complete
	EMERGENCY ASSESSMENT AND AMBULATORY CARE Steering group							
31	**Develop an operational model based on a multidisciplinary team approach that enables effective and efficient management of patient Flow and LOS on EAU**	10.11.12	Milestone	Louise Rawlinson		Early clinical assessment and review, early discharge of patients. Optimum LOS		Complete
32	Develop an optimum staffing model on EAU that makes best use of available nursing resources and supports effective patient flow	10.11	Task	James Price / Sudhir Singh	01/04/2015	Efective and efficient patient flow.Safe staffing levels and improved Quality of care for patients.	Recruitment is ongoing and there is a senior nurse coordinator on duty at all times.	Complete

	Milestones and associated actions	Objective number the milestone/ task relates to	Activity Type	Task owner	revised due date	likely Impact	Comments	Activity Status
33	Write up proposal for medical model of "on take" that separates the in-patient medical ward teams from EAU/ short stay Map out resources required and develop workforce plan to track progress toward optimum model	10	Task	James Price / Sudhir Singh	01/08/2015	consultant on take will review and discharge from EAU and follow patients through SSW. Smaller number of consultants on EAU will support efficient patient flow.	A revised medical model hads been agreed which splits the	Complete
34	Develop standard processes for the medical take, managing the patient journey on EAU and optimising LOS.	10.11.12	Task	C Mills/ L Rawlinson / J Lighthowler	01/05/2015	less variation in practice will support improved discharge planning	The perfect week demonstrated that keeping assessment spaces available and focusing on no patients over 12hrs in EAU significantly improved flow.	Complete
35	Implement twice a day operational huddle to agree actions required/ patient moves to create bed capacity and assessment spaces by 10 am and 10pm each day	9.11.	Task	L Rawlinson/ S Hurley	01/05/2015	Assessment spaces will be available at all times		Complete
36	Agree escalation triggers for decision making and LOS in EAU	9.10	Task	Louise Rawlinson/ Sudhir Singh	01/06/2015	No patient will be on EAU greater than 12 hours other than for clinical reasons or pending discharge.	Timeline developed but being mapped against a few patient journeys. New optimum patient journey developed and will form the basis of an SLA with specialties. specilties.	Complete
37	Implement First Net in EAU to support effective and efficient management of the patient journey.	9.10	Task	Pete Male	01/09/2015	To enable closer monitoring of pathway management and LOS on EAU.	Dependant on Millenium development timescale. Good progress is being made and the module is now at the testing phase.	In progress
38	Regularly record direct discharge rates and LOS by consultant and day of the week and use the information to support standard practice and minimise variation in practice.	9.10.11.	Task	Dr James Price	01/08/2015	Will provide internal benchmarking information and enable	This infomation is now available on orbit and is used in consultant appraisal.	Complete
39	To negotiate with Carillion to have a minimum of 2 dedicated porters available on ED /EAU 24 hrs day without the need to use the telephone referral system.	9.0	Task	Alex Monaghan	01/05/2015	No delays in patients being moved to a bed, supporting flow from ED	Additional porters were allocated during the perfect week which improved flow. This is in place and working well. 2 porters based in EAU at peak times and also in discharge lounge to assist with moves.	Complete
40	**Ensure emergency ambulatory care is available for all patients who meet the criteria to avoid unecessary admission to a hospital bed.**	1.10.11.	Milestone	Louise Rawlinson/ Sudhir Singh	01/06/2015	No unecessary overnight admissions.		In progress
41	Implement a clinically led system of telephone triage of all GP referrals and provide advice on alternatives to emergency referrals.	1. 11	Task	Louise Rawlinson	01/04/2015	Gps provided with alternatives to patient admission to EAU.	in place but can be further developed	Complete
42	To further develop a RAT approach in EAU involving medical, nursing, SHDs and therapy clinicians 8am - 7pm	12	Task	Louise Rawlinson	30/01/2015	Rapid assesment of patients, early diagnostics and clinical decision making	works well at present	Complete
43	To utilise near patient testing to support early assessment and diagnosis and to support early direct discharge from EAU.	11.12	Task	Sudhir Singh	30/03/2015	timely access to blood results to aid decision making		Complete
44	To develop a range of condition specific pathways;- to include PE. DVT, renal colic and low risk chest pain.	11	Task	Sudhir Singh	01/10/2015	avoidance of inpatient admission for patients who meet the ambulatory pathway criteria	awaiting clincial consensus and national guidance from RCRP.	In progress
45	Join the ECIST/NHS Innovations Ambulatory Network	11	Task	Paul Brennan	30/03/2015	sharing of benchmarking information to support improvements in clinical practice		Complete
46	Join the next Society of Acute Medicine Benchmarking Audit	10.11.	Task	Dr James Price			not due	Not started
47	**Implement a system whereby early social care or community support can facilitate early discharge direct from EAU**	11.13	Milestone	Siohan Hurley	01/05/2015	rapid assessment and access to short term care or domicillary support to avoid unecessary hospital admission.	SHDs and social workers regularly attend EAU to facilitate discharge. Currently community beds are cancelled after 8 hours so SPA will alert operational managers of any patient who has been in hospital 8 hours to confirm if they are remaing in hospital or whether they will potentially be discharged in the next few hours. So patients who need a period of assessment greater than 8 hours can be discharged back to the same bed but if not the bed can be allocated to the next patient.	Complete
48	Include social worker and OH community therapist as part of the ambulatory care team to undertake directed home visits and support discharges home direct from EAU.	13	Task	Kathleen Simcock	01/05/2015	access to short term support at home and avoid unecessary admission	Funding had been provided to social care to provide dedicated social workers 7 days a week to be based in ED and EAU to support rapid discharge and avoid in-patient admission	Complete
49	Develop a process whereby care packages remain in place for patients admitted and likely to be discharged within 24 hours or after 24 hrs, restarted within 12 hours of being fit for discharge.	11.13	Task	Kathleen Simcock	29/2/15	ward staff can restart packages of care without a new social care referral and avoid delay in discharge	Staff are reminded at each delays meeting to ensure they keep in regular contact with agencies so the package is available as soon as the patinet is fit for home.	Complete
50	**Develop an SEU operational model that is appropriately staffed to effectively and efficiently manage the surgical emergency pathway**	6.9.10.11	Milestone	Becky Easton	01/04/2015	regular senior clinical review on SEU and no patients delayed waiting for emergency surgery	The perfect theatre week identified a number of opportunities for improvement. A paper summarising the findings and recommendaitons is to be presented to Clinical Directors and to TME. A programme of improvement will be implemented.	Complete
51	Increase JR dedicated surgical consultants to 4.	6.8.10.11.15	Task	Alison Cornal	30/03/2015			Complete
52	Increase from 5 to 7 day consultant physician presence on the surgical wards	11.14.15	Task	Reiner Buhler	30/08/2015			Complete
	PATIENT FLOW AND DISCHARGE WORK STREAM							
53	**Maintain the momentum of care - ensure there is a senior review of every inpatients care plan every day**	14.15	Milestone	Dr James Price	01/07/2015	Clinical decisions on care will take place in a timely manner and there will be no delay in the patient journey		
54	All patients will have a senior review each day seven days a week or twice a day on short stay wards	14.15	Task	Dr James Price	01/07/2015	All patients will be seen by a competent clinical decision maker within 12 hours of arrival who will instigate an appropriate management plan	To be included in best practice audit. See 35.	In progress
55	Implement "one stop" ward rounds whereby TTHs and ordering of test are undertaken by junior doctors at the time of review rather than after the ward round	14.15.18	Task	Sudhir Sing	01/07/2015	No delays in discharge as a result of waiting for TTOs to be prescribed. Patients can transfer to the discharge lounge at an earlier time.	This happens on most of the wards. A report has now been developed to monitor the number of TTOs written the day before discharge.	In progress
56	Develop a robust system of daily board rounds with Senior doctors, nurses, AHPs, and social worker as appropriate.	15.18	Task	Louise Goddard	01/07/2015	supports effective discharge planning and avoids delay in patient journey	In place on all wards	Complete
57	**Ensure that all wards comply with best practice standards in discharge planning.**	14.16.17.18	Milestone	Lily O' Connor	01/07/2015	Increase in number of patients who will be discharged earlier in the day.	standards agreed and audit tool developed. Following the no delays week a programme of audit will be undertaken.	Complete
58	EDDs for all to be set and visible on white boards at the first consultant review and updated daily at the board round	16.18	Task	Sudhir Singh	01/07/2015	Improved discharge planning	to be audited as part of the ward standards best practice audit. The no edlays week will also include a focus on correct EDD	In progress
59	For patients who may require social care support, ensure S2 is submitted as soon as possible after admission but within at least 48 hrs.	16.18.19	Task	sandra shannon	01/07/2015	earlier involvement of social care and identification of very complex discharges	new S2 and 5 guidance has been developed for staff. Staff to submit S2 within 24 hrs of admission.	Complete
60	include TTO notification check in daily board round	17	Task	Luisa Goddard	01/07/2015	increase in number of TTOs ordered the day before.	There has been an increase in the number of TTOs written in advance and early morning discharges. This has helped patient flow.	Complete
61	**Review model of physian allocation at HGH including designation of short stay beds (MAU, SS)**	14.18.	Milestone	**Dr James Price/ sandra shannon**	**01/12/2015**	To manage patient flow by expected LOS. To develop 2 streams of medical patients -short stay and medical.	A strategy has been agreed. This will require a detailed implementation plan and consultantion and engagement with clinical staff	In progress
62	Establish a system whereby no patients are delayed in their pathway of discharge as a result of waiting for diagnostics	17. 18.	Task	Lily OConnor	01/06/2015	Internal response times are adhered to and there are no delays in patients waiting for diagnostics. An escalation process will exist	a daily inpatient report is available on the intranet to track where every patient is up to waiting for diagnostics.	Complete
63	**To develop a system whereby no patients are delayed whilst waiting to be repatriated back to their original ward/ DGH with tighter escalation process**	20	Milestone	sandra Shannon	01/08/2015	improved capacity through reduced number of patients waiting for repatriation.	escalation process in place but the perfect week demonstrated that the ploicy is not effective. Raised with CCG.	Complete
62	**Develop a system whereby there is greater visibility across the health economy of community capacity and demand.**	1.18.19	Milestone	sandra Shannon	01/05/2015	to support foreward planning of discharge of patients requiring post acute support.	All services have access to the R4 list.	Complete
63	Develop a simple patient tracking system to monitor referral, assessment and time to discharge for patients requiring social care support.	18.19	Task	Sandra Shannon	30/03/2015	To avoid delays in discharge by closer monitoring of patients progress	All services have access to the R4 list.	Complete
64	Undertake a capacity and demand review of post acute domicillary and reablement requirements	1.18.19	Milestone	sandra shannon	01/07/2015	To inform discharge planning of patients with post acute support needs	This has been completed and analysis shows there is a lack of post acute capacity. OUFThave requested a further analysis to confirm the exact capacity gap as they feel it may be over estimated.	Complete
65	**Develop a system whereby information can be used for forecasting, decision making and discharge planning**	1.9.	Milestone	sandra Shannon	**01/07/2015**	To inform operational flow demand and capacity planning and management	Informatics steering group in place. Predictive modelling is progressing well and is being developed into a forecasting tool for use at operational level.	**In progress**
66	Ensure all ward staff follow best practice and utilise standard processes and practice in discharge planning.	1.9.16.18	Task	Lily O' Connor	01/06/2015	prevent avoidable discharge delays	New choice policy in place. S2 and S5 flow chart in place. Discharge planning workshops are being undertaken for all staff.	Complete
67	Develop a corporate trust wide integrated discharge team and develop a consistent approach to managing discharge for patients requiring post discharge support	1.9.16.18.19	Task	sandra Shannon	01/08/2015	to develop closer working with operations team and discharge team and support improved	Workshops have been implemented for all staff to improve knowledge and to introduce standard ways of working.	Complete
68	**To develop 7 day working to increase capacity and support improved patient flow over winter.**	**1.9.14.16.18.19.**	**Milestone**	Paul Brennan	**01/09/2015**	There will be increased therapy, pharmacy, diagnostics and clinical assessment over winter across 7 days.	all funding allocations to support 7 day working and the winter plan has been approved.	**Complete**
69	Expand pharmacy 7 day working at JR, Horton and churchill	1.11.17.18	Task	Bulesh Vahder	**01/09/2015**	increase in weekend discharges as no delays waiting for medication. Significant increase in out of hours support	funding agreed and recruitment commenced.	**Complete**

	Milestones and associated actions	Objective number the milestone/ task relates to	Activity Type	Task owner	revised due date	likely Impact	Comments	Activity Status
70	To provide 7 day general MRI lists at the JR.	1.8.9.11.18.	Task	Amanda Middleton	**01/09/2015**	Increase in weekend discharges. No discharge delays waiting for MRI	funding agreed and MRI in place over 7 days	**Complete**
71	Provide 7 day cardiac echo for inpatients	1.8.9.11.18.	Task	Kathleen Simcock	01/09/2015	no delayed discharge for patients waiting for cardiac echo	funding agreed and recruitment commenced.	In progress
72	Provide additional dedicated social worker support to EAU/ medical short stay to provide on site 7 day support	1.9.13.18.19.	Task	Paul Brennan	01/09/2015	Increase in weekend discharges and an increase in discharges direct from EAU/ ED of patients requiring social care support	agreed with Social care	Complete
73	Provide additional therapy cover on Saturday and Sunday in ED/EAU/and AGM at the JR and the Horton.	1.9.13.17.18.	Task	Liz Mowbrey	01/08/2015	Improved patient flow and no delayed discharge for patients waiting for therapy assessment.	funding agreed and recruitment commenced. Currently being covered on an ad hoc basis by voluntary overtime.	Complete
74	provide an additional Inpatient endoscopy list at the weekend	1.9.18.	Task	Ben Wright	01/08/2015	Improved patient flow and no delayed discharge for patients waiting for endoscopy	funding agreed and plan in place.	Complete
	To provide additional senior medical support in ED with 3 additional consultants and a GP.	12.4.5.6.7.9.	Task	larry Fitton		increase in out of hours senior decision makers	funding approved and reuitment commenced	Complete
75	**Reduce the number of breaches due to capacity through Improved operational control and management**	1.9.16.18.19.20	**Milestone**	Sandra Shannon	**01/07/2015**	improved operational command and control removal of patient delays	the command and control structure will provide 7 day on site management support across all four sites and a robust management escalation.	**Complete**
76	Undertake the first Trust wide breaking the cycle initiative / the perfect week.	1.9.11.16.18.19.20	Task	sandra shannon/ sara Randall	29/04/2015	lessons will be learned that can inform the urgent care	now completed. Evaluation in progress and plan to be revised to take account of lessons learned. Performance during the perfect week 96.4%	Complete
77	To develop a system whereby there is flexible allocation of porters to avoid delays in patients flow due to waiting for porters	1.9.18	Task	sarah Randall	01/05/2015	improved flow due to flexible use of porters to undertake patient moves during busy periods.	the porters operational manager now attends the operational planning meeting and picks up any issues escalated	Complete
78	Develop a command and control structure to support day to day operational management of the Trust	1.8.9.11.17.18.19.	Task	sandra shannon	**01/07/2015**	Improved operational grip on patient flow and improved capacity management across the trust.	final structure agreed and presented to management team. To commence 1/8/15	**Complete**
79	Develop an SOP for standard working within the command and control structure	1.5.8.9.11.17.18.19.	Task	sandra shannon	**01/07/2015**	Standard working and standard response to escalation. Using the rigger matrix will act as an early warning system to generate action.	final structure agreed and presented to management team. To commence 1/8/15	**Complete**
80	Develop capacity escalation matrix and action cards to support early and effective response to capacity pressures in EAU and ED	1.2.3.5.6.8.9.11..17.19.	Task	sandra shannon	**01/07/2015**		New capacity escalation trigger tools in place and effectiveness will be monitored.	**Complete**
81	Introduce twice daily EAU huddle at 5am and 5pm to focus on creating assessment bed capacity	1.2.3.5.6.8.9.11..17.19.	Task	sandra Shannon	01/06/2015	develop a pull system from ward, create early monring and overnight bed capacity	In place. SOP agreed and working well	Complete
82	Bed meeting to be replaced with a more focused operational planning meeting with senior clinical and managerial representative	1.9.17.18.20	Task	Sandra Shannon	01/06/2015	rapid response to escalation and more action focused	meeting working well. Really good engagement from staff involved.	Complete
83	Implement a new process of booking transport to avoid delays due to transport.	1.9.17.	Task	Helen Wiskin	01/08/2015	improved patient flow due to no delays due to patients waiting for transport	Additional trust transport provided.Regular meetings with SCAS and KPIs monitored. New guidance for staff provided. Transport manager attends operational planning meeting so delays can be escalated and to provide advice as	**Complete**
84	To develop a system whereby there is flexible allocation of porters to avoid delays in patients flow due to waiting for porters	1.9.	Task	sarah Randall	01/05/2015	improved flow due to flexible use of porters to undertake patient moves during busy periods.	the porters operational manager now attends the operational planning meeting and picks up any issues escalated	Complete
85	To develop a system whereby no patients are delayed whilst waiting to be repatriated back to their original ward/ DGH with tighter escalation process	20	Task	sandra Shannon	01/08/2015	improved capacity through reduced number of patients waiting for repatriation.	escalation process in place but the perfect week demonstrated that the ploicy is not effective. Raised with CCG.	Complete
86	**Improve Emergency flow by improving the management and utilisation of emergency theatre**	6.11.15.18.	**Milestone**	sandra shannon	01/10/2015	A reduction in the number of patients delayed to theatre	the theatre perfect week identified opportunities for improvement in how emergency lists were managed and tracked.	In progress
87	Undertake the perfect theatre week to identify opportunities for improvement.	1.9.11.17.19.20	Task	sandra shannon/ sara Randall	01/08/2015	improved patient flow and to ensure sustainability of 4 hour performance	Planned to take place week commencng 11/7/15. All plans in final stage.	**In progress**
88	Introduce a process for close tracking and monitoring of all patients from listing for emergency surgery through to operation.	1.9.11.17.19.20	Task	sandra shannon/ sara Randall	01/09/2015	reduction in delays to theatre and no breaches in wait category by clinical need.	This worked well in the perfect week and made a significant improvement in the management of the emergency lists. A nurse practitioner has been seconded to undertake this role.	**Complete**
89	**Improve bed capacity by reducing by 50% the number of patients and length of time waiting for transfer to a post acute pathway**	1.5.9.11.18.19	**Milestone**	Lily OConnor	01/08/2015	Increase in available bed days due to reduction in delayed transfers of care	A whole system DTOC perfect week is planned for 9-16 september	**In progress**
90	Write a new DTOC reduction plan that focuses on numbers and days of delays	1.9.18.19	Task	sandra Shannon	01/07/2015	greater focus on areas whereby trust action can make a reduction	A new plan has been developed and will be tested out in a DTOC perfect week 9-16 September	Complete
91	Set up a new internal delays meeting outside of the weekly formal dtoc counting meeting to identify actions to reduce delays	1.9.18.19	Task	sandra Shannon	01/07/2015	Early identification of delays that can be avoided through rapid action and escalation of issues.	new weekly meeting set up with a formal escalation process	Complete
92	Implement a patient tracking system to monitor and manage timescales for all patients referred for care home placement.	1.9.18.19	Task	Sandra Shannon	01/06/2015	Improved monitoring and management of discharge planning process and patient choice	A proposal has been developed to transfer patients waiting for assesment and decisions about long term care to an interim bed in the community.	Complete
93	Write and implement a system wide Choice Policy with a specific timeline for management action to reduce delays due to patient choice.	1.9.18.19	Task	Sandra Shannon	01/06/2015	standard processes for managing patient choice within minimum timeframe	in place and more user friendly	Complete
94	To ensure a standard approach to capturing and coding delayed transfers of care	18.19	Task	paul Brennan	01/06/2015	reduction in number of Dtoc disputes	new policy implemented	Complete

Oxford University Hospitals NHS Trust

Appendix 4

Consultant Lead:Professor Mark Middleton
Cancer Manager: Helen Baker

Cancer Performance Dashboard

KPI No	KPI	Operational Standard		National Performance (data taken from CWT national data) 2014/15 national average %	Apr-15 % Seen Within Standard	May-15 % Seen Within Standard	Trust Performance 15/16 Apr-15	May-15	Jun-15
1	At least 93% of patients referred from a GP with suspected cancer will be seen within 2 weeks of referral.	93.0%		94.1%	92.7%	94.3%	93.0%	96.8%	95.0%
2	At least 93% of patients referred from a GP with breast symptoms but not suspected cancer will be seen within 2 weeks of referral.	93.0%		93.4%	92.7%	94.5%	96.9%	100.0%	97.8%
3	At least 96% of patients will recieve treatment within 31 days of a decision to treat.	96.0%		97.7%	97.3%	97.6%	97.0%	97.6%	98.4%
4	At least 85% of patients will recieve their first treatment within 62 days of referral from a GP.	85.0%		83.3%	83.1%	81.2%	78.4%	79.8%	85.0%
5	At least 94% of patients will be receive subsequent treatment with surgery within 31 days of decision to treat.	94.0%		95.6%	94.2%	95.3%	98.3%	96.5%	98.5%
6	At least 98% of patients will be receive subsequent treatment with anti cancer drug regimen within 31 days of decision to treat.	98.0%		99.6%	99.7%	99.6%	100.0%	100.0%	100.0%
7	At least 94% of patients will be receive subsequent treatment with radiotherapy within 31 days of a decision to treat	94.0%		97.5%	97.4%	97.7%	100.0%	97.5%	99.0%
8	At least 90% of patients will receive their first treatment following referral from a screening service	90.0%		93.1%	92.9%	92.6%	83.3%	100.0%	91.7%

KPI No	KPI	Operational Standard	Tumour group	National Performance 2014/15 national average %	Q4 Top 50% (local target)	Trust Performance 15/16 Apr-15	May-15	Jun-15	Jul-15
9	To achieve the national top 50% 62 day performance for each tumour group	85.0%	Breast	96.0%	99.7%	90.0%	97.1%	100.0%	
		85.0%	Lower Gastrointestinal	73.0%	85.0%	43.8%	52.4%	77.8%	
		85.0%	Lung	75.0%	87.4%	71.4%	55.6%	60.0%	
		85.0%	Skin	96.5%	98.8%	96.4%	100.0%	100.0%	
		85.0%	Urological (Excluding Testicular)	78.0%	87.6%	79.0%	74.7%	84.1%	
		85.0%	**All Other**: Includes the following tumour groups	77.7%	86.5%	78.4%	79.8%	85.0%	
			Gynaecological			54.5%	84.2%	59.1%	
			Haematological			80.0%	78.9%	60.0%	
			Head & Neck			81.3%	50.0%	60.9%	
			Sarcoma			100.0%	100.0%	40.0%	
			Upper GI			68.2%	63.6%	79.2%	
			Thyroid						
			Testicular						
			Trust Total			78.4%	79.8%	85.0%	

KPI No		Trust 62 day backlog	Apr-15	May-15	Jun-15	Jul-15
10	Total 62 day backlog for all tumour groups to be below 60	suspected	64	73	25	
		confirmed new cancer	34	46	30	
		Total backlog all tumour sites	98	119	55	
		Urology 62 day backlog				
		suspected	19	32	12	
		confirmed new cancer	11	9	8	
		Urology Backlog	30	41	20	

Milestone

Oxford University Hospitals NHS Trust

Cancer Care Improvement - No Delays.

Updated 27 August 2015 2015

Responsible Director : Mr Paul Brennan, Director of Operational Services

task no	Tumour sites	Standards Performance Monitoring and Management	KPI number the milestone/ task relates to	Activity Type	Task owner	Original Due Date	Comments	Activity Status
1	All	**To ensure the appropriate management strucure and informatics support are in place to enable effective monitoring and management of cancer targets**	**1.2.3.4.5.6.7.8**		**HB**	**Jun-16**	**meeting took place to review PTL and reports. Some amendments agreed to make more user friendly**	**Complete**
2	All	All managers providing cancer services to attend bi weekly performance meetings and provide management report by specialty.	1.2.3.4.5.6.7.8.9.10	Task	HB	May-15	performance meetings now commenced fortnightly with Director of Clinical Services. Performance across all measures by specialty is reviewed and managers feed back actions to improve compliance.	Complete
3	All	Develop a weekly cancer target forward look report to identify early any risks to target	1.2.3.4.5.6.7.8.	Task	SES	May-15	A precheck cancer report by tumour site is published twice weekly which is used by specialties to monitor current performance and forecast performance against all targets. It also provides an early warning system of risks in any tumour site against any standard.	Complete
4	All	Review the cancer support team structure and informatics support required	1.2.3.4.5.6.7.8.10	Task	HB	Nov-15	Informatics support is already provided as well as a team structure for cancer management. A proposal developed for a new support structure which will provide a more robust communication and management control structure. A briefing paper to provide the rationale for the new structure has been written and will be submitted to TME for approval.	In progress
5	All	To provide regular reports on 62 day performance by tumour group to the Trust Board.	1.2.3.4.5.6.7.8.10	Task	AS	Aug-15	The standard format of the Trust board performance report has been revised to include performance by tumour site as well as overall against each standard. reports by tumour group are available and reported at the fortnightly performance meeting.	Complete
6	All	Review and update the Trust operational policy which will include audit and data quality.	1.2.3.4.5.6.7.8.9.10	Task	SES	Sep-15	Now completed the Trust policy will includes guidance on the operational management of cancer access standards, standard operating processes for MDT functioning, escalation processes, audit and data quality. .	Complete
7	All	Set up bi weekly cancer care improvement meetings to be attended by senior cancer management team	1.2.3.4.5.6.7.8.9.10	**Task**	RB/KM	May-15	Bi-weekly meetings take place to review progress of the cancer improvement plan and identify further opportunities for improvement.	Complete
8	All	To develop a clear escalation system from trackers to departmental managers to clincal leads and divisional managers which describes what response is required to avoid a potential breach of the 62 day target	4.9	Task	MS/JR	May-15	weekly escalation meetings in place with clinical involvement for any tumour site not meeting any of the cancer standards. A tighter escalation process is also in place with clear guidedance to MDT coordinators and cancer trackers about when they should escalate and to whom.	Complete
9	All	Undertake a weekly review of all cancer ptls with cancer trackers and identify any pathway delays	1.2.3.4.5.6.7.8.	Task	HB	May-15	Each tumour site has a weekly PTL meeting to review every patient until the patient is taken off the pathway following treatment of exclusion of cancer. For challenged specialties such as urology and lower GI, PTL review meetings take place daily or three times a week.	Complete
10	All	undertake a weekly review of all patients on the 62 day backlog and agree plan to complete pathway	9	Task	HB	May-15	At the PTL review meetings a patient by patient review is undertaken which focuses on plans for reducing the number of patients over 62 days. This is monitored by specialty at the bi weekly performance meeting	Complete
11	All	To ensure there is sufficient inpatient capacity to ensure all measures can be met across all specialties.	4.9.	Task	SES	Jul-15	If a capacity shortfall is identified in any tumour site which potentially causes a risk to any of the cancer targets then an escalation meeting is arranged with all relevant departments to agree a plan to increase capacity. Managers are also asked to provide assurance that there is sufficient capacity to meet demand as part of the bi-weekly performance meetings. Additional day case capacity has been provided for urology, Gynaecology and head and neck.	Complete
12		Develop a specialty improvement plan for any tumour group not meeting all cancer standards.	1.2.3.4.5.6.7.8.	Task	SES	Jul-15	specialty improvement plans have been incorporated into this trust wide improvement plan.	Complete
13	All	**Reduce the number of breaches of the 2ww standard through patient choice to DNA, cancelling or change appointments**	1.2	**Milestone**	LC/SH	Jun-15	Information sent in August GP newsletter re , 2WW proforma, (agreed with LMC). Includes questions; If cancer is suspected, is the patient aware? Is the patient available for an appointment within the next 14 days?	In progress
14	All	to work with the CCG to develop a public health campaign that will raise patient awareness of the need to take up 1st appointment within two weeks of GP referral and be available for diagnostics and treatment over the period of the pathway.	1.2.4.	Task	LC/SH	Jun-15	See above	In progress
15	All	Invite GPs to an education event and include feedback on performance	1.2.4.	Task	LC/SH	Nov-15	Macmillan GP developing programme of education for GP's to start this year.	In progress
16	All	reintroduce TWEEK Leaflet(two week wait) to GP practices , promote via clinical lead and via locality news letter.	1.2.4.	Task	HB	Jun-15	TWEEK leaflet sent out in the GP newsletter and will be promoted over September and October as part of locality visits	Complete
17	All	**Avoid breaches of the 2ww target through incorrect referral process by GP resulting in patients not being booked into clinc within two weeks.**	1.2	Milestone	LC/SS/PC	ongoing	Information sent in August GP newsletter re , 2WW proforma, (agreed with LMC). Includes questions; If cancer is suspected, is the patient aware? Is the patient available for an appointment within the next 14 days? Locality communications programme to commence in September 15	Complete
18	All	Send out communications to all GP practices that all suspected cancer referrals must be sent on the appropriate 2ww proforma	1.2	Task	LC/SH/HB	Sep-15	To be sent out as a Trust/CCG comunication. The be discussed at CCG meeting on 7th May	In progress
19	All	Develop rapid feedback system to GPs when suspected cancer referrals are not sent on the correct proforma or do not provide the required clinical information	1.2.4	Task	PC	Oct-15	Feedback given to GPs vis CCG leads re using the correct profoma	In progress
20	All	**To avoid breaches of the 2ww standard due to insufficient out patient capacity**	**1.2.9**	**Milestone**	all	ongoing		Complete
21	All	Develop an escalation process whereby booking clerks will alert managers if there is no OPA capacity to accommodate a 2ww referral	**1.9**	**Task**	LP	May-15	There is a standard escalation process for clerks to alert managers immediately if there are no 2WW appointments.	Complete
22	All	To develop a monthly process to monitor performance by specialty as an early indicator of capacity or management problems	**1.9**	**Task**	HB	May-15	See above. Tighter management controls are in place with regular updates on 2ww performance.	Complete
23	urology	Agree the patient pathway across the Trust for the five main urology cancers	1.3.4.9.10	Task	AC	May-15	currently use the agreed network pathways (prostate, renal, urethelial, bladder, testicular).	Complete
24	urology	To review the bladder pathway against latest nice guidance	1.3.4.9. 10	Task	AC	Jul-15	Now in place	Complete
25	urology	Provide Gps with PSA guidance following testing	1.3.4.9. 10	Task	HB	May-15	Guidance is included in follow up letters to GPs. The urology 2WW referral proformas also include guidance for GPs on when referral is appropriate.	In progress
26	urology	Provide patients with supported thinking time (7 days) to support patients to make decision about treatment option and enable treatment within target time scale.	3.4.9.10	Task	FH	ongoing	Current emphasis is for the pt to contact when ready, however, the specialist nurses will support and contact pts as appropriate.	Complete

task no	Tumour sites	Standards Performance Monitoring and Management	KPI number the milestone/ task relates to	Activity Type	Task owner	Original Due Date	Comments	Activity Status
27	All	**Avoid breaches of the 2ww target due to insufficient clinician capacity**	1.2.	**Milestone**			All specialties meeeting the 2WW target	Complete
28	urology	create additional 2ww capacity by converting urgent access slots to 2WW 'one stop shop' clinics to run daily Mon - Thurs with additional capacity in general clinics	1.2.4.9	Task	AMW	Apr-15	The 2ww clinic runs Mon – Thurs with 8 slots per day, so total of 32 per week. In addition there are a total of 30 x 2ww flexible cystoscopy slots per week so this should provide sufficient capacity.	Complete
29	All	create additional 2ww capacity by providing 'one stop shops' for high volume specialties which enables conversion of FU appointments to new	1.2	Task	Hb/ KM	Apr-15	urology provide some one stop clinics. The majority of skin treatments are undertaken at first appointment. The majority of patients referred to breast service are able to attend a one stop clinic.	Complete
30	Breast	Increase capacity of breast 2ww capacity by introducing GP specialist clinics	1.2.	Task	JOJ	Nov-15	Due to a consultant vacancy the service has been reconfigured with the appointment of 2GPs with special interest who will undertake 2 sessions each at breast one stop clinics. The remaining surgeons will undertake the additional surgery required. This will also provide cross cover and avoid cancellation of OPD and theatre sessions during annual leave	
31	Breast	Implement early discharge pathway for women who have had 2 years follow up symptom free with rapid access back though Gp or self referral	1.2	Task	HB/SO	Apr-15	1. The Early Discharge Programme has been running for some while 2. Patients who have had cancer are discharged from EDP at 6 months. 3. If they have further problems they are advised to call the rapid Telephone service (clinical) where a decision is made as to the appropriate next step – this may be back to surgeons or to oncologists or nurses. 4. The aim is to remove the need for GP involvement to refer back in to secondary care. This will also make better use of oncology clinic capacity where these patients would normally be followed up.	Complete
31	All	Create additional 2ww capacity by developing nurse led follow up clinics which release consultant capacity for 1st appointments	1.2	Task	HB/KM	Apr-15	nurse led follow up is available in a number of specialties, breast, colorectal.	Complete
32	lung	Undertake a pathway review following a significant increase in 2 wait referrals to identify options for managing 2ww demand within available capacity	1.4.9	Task	KH/AS	Apr-15	There has been a 58% increase in Lung pathway 2ww referrals from 2009- 2013. 2ww performance 100% in Nov & Dec 14.	Complete
32	urology	Release consultant time by providing a nurse surveillance cystoscopy service	1.4.9	Task	SO/HB	01/09/2015	This is in place, patients who are not suitable for flexible cystoscopy will have a rigid cystoscopy under GA,which are undertaken by a consultant.	Complete
33	All	**Reduce the time to diagnosis by introducing straight to test processes**	1.2.4.9.10	**Milestone**		Apr-15	a number of tumour sites now have direct to test processes. Work is ongoing to identify other opportunities to bring forward diagnostics into pro=imary care setting so they can be undertaken prior to 2ww referral.	In progress
33	gynaecology	To reduce the early part of the gynaecology pathway by introducing one stop hysteroscopy clinics.	1.2.4.9.10	Task	SES/TMc	Jan-16	A meeting has taken place to review the current hysteroscopy service and agree a plan for the development of one stop hysteroscopy service. A working group will be set up to implement this	In progress
34	lung	provide GP direct access for chest X ray with rapid reporting of abnormal films.	1	Task	HB/AS	Apr-15	GP direct access for CXR is provided. If the request is marked urgent this is reported within 48hrs. routine request are reported within 7 calendar days.	Complete
35	lung	Provide CT scan in appropriate patients within 7 days prior to first appointment	1.4.9	Task	HB/AS	Apr-15	In lung service if patients require CT prior to 1st appointment Where CT is required prior to first appointment this is available - For other 2WW patients CT scans are provided within 14 calendar days and reported within 7 calendar days.	Complete
36	LGI	Develop a system whereby patients referred with suspected Lower GI cancer go to triage within 24 hrs and straight to test. - GP complete bowel prep.	1.4.9	Task	JOJ	Apr-15	All referrals are being triaged within 24 hours. 90% of patients referred for endoscopy are seen within 2 weeks. If not suitable for bowel prep they are referred to CT colonoscopy or in some cases referred to clinic but this will be small numbers of patients.	Complete
37	All	**Ensure Trust systems support patients being treated at the right time, by the right person in the right place.**	1.2.3.4.9.10	**Milestone**				Complete
38	urology	Provide joint urologist and oncologist clinic	3.4.9.10	**Task**	SO/HB	Apr-15	currently able to provide same session clinics due to capacity. In place but under further development	Complete
39	lung	Provide joint clinics with respiratory physician, thoracic surgeon and oncologist	3.4.9.10	**Task**	AS/EB/HB	Apr-15	currently same session appointments	Complete
40	lung	Develop nurse led clinics for patients with haemoptysis and normal chext xray.	3.4.9.10	**Task**		Apr-15	Nurse led follow up clinics are in place. For first visit all patients will be seen by a consultant.	Complete
41	All	**Ensure no delay in diagnosis occur due to lack of diagnostics capacity**	3.4.9.10	**Milestone**	KH/AS	Apr-15		Complete
42	lung	Undertake a capacity and demand review and identify the number of EBUS Bronchoscopy slots required	3.4.9.10	Task	KH/AS	Apr-15	Bronchoscopy service moved to to radiology JR to increase capacity, improving clinical support and improved histology turnaround times. Prts now able to have bronchoscopy and EBUS within 2 weeks	Complete
43	lung	Purchase a 3rd CT PET scanner to increase capacity and reduce wait from 3-4 weeks to 7 days	3.4.9.10	Task	KH	Apr-15	wait for CT PET now 7 days	Complete
44	lung	provide clinics at the churchill and increase template to provide additional slots	1.3.4.9.10	Task	RT/EB	Apr-15	Pts. now seen <7 days MDT discussion.	Complete
45	lung	increase availability of Radiofrequency ablation for lung tumours	3.4.5.9	Task	TM	Nov-15	Although an infrequent treatment option, waiting times can be up to six weeks. There is a plan to increase capacity to two sessions per week.	In progress
45	All	**To ensure there is sufficient radiology capacity to meet demand for treatment within 31 days from diagnosis.**	1.3.4.7.9.10	**Milestone**	**SA/TM**	**Jul-15**	In place, all radiology access targets being met.	Complete
44	All	To reduce the number of patient pathway delays due to patients choosing to take holidays within the planned pathway.	1.2.3.4.8.9.10	Milestone	CC/SS	Jun-15	Trust and CCG to develop communications plan to include clinicians. CCG to raise awareness at Locality meetings and in GP bulletin	In progress
45	All	Work with the CCG to raise patient awareness through a public health campaign of the need for patients to be available for treatment throughout the pathway	1.2.3.4.8.9.10	Task	CC/SS	Jun-15	Development of a plan jointly in progress.	In progress
46	All	**To reduce the number of breaches of the 62 day standard due to longer and complex pathways in patients with metastatic disease/ more than one tumour site/ patient fitness.**	3.4.9.10	Milestone	CC/SS	Jun-15		Complete
47	All	restructure patient tracking lists to enable earlier identification of patients with complex pathways	3.4.9.10	Task	HB	May-15	there are still patient with complex pathways but these are being identified earlier and tracked closely to minimise the overall pathway timescale.	Complete
48	colorectal	To reduce the number of pathway delays due to "tight" deadline for MDT referrals by extending the time to MDT list closing by 24 hours to Thursdays to provide more flexibility in adding cases for discussion.	3.4.9.10	Task	CC	May-15	Dead line has been extended but impact will be monitored over the next few months to before signing off. Pathology and Radiology are also present at the MDT	Complete
49	All	To undertake breach root cause analysis of all 62 day breaches with complex pathways to identify opportunities for reducing the pathway.	3.4.9.10	Task	HB	Jun-15	Weekly breach review meetings are taking place to undertake detailed root cause analysis of all breaches. Where breaches are due to late referrals from another Trust then the trust are asked to contribute to the action plan.	Complete

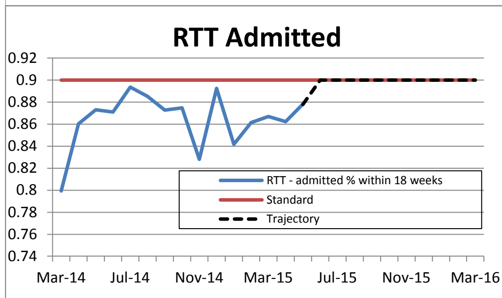
task no	Tumour sites	Standards Performance Monitoring and Management	KPI number the milestone/ task relates to	Activity Type	Task owner	Original Due Date	Comments	Activity Status
50	colorectal/ lung/urology	**Focus improvement actions on high volume tumour groups of colorectal, urology and lung so that improvement has the biggest impact on overall trust performance**	3.4.9.10	Milestone	HB/SES	Nov-15	weekly escalation meetings take place with urology, lung and colorectal. A detailed action plan is in place for all three.	Complete
51	All	**Work with referring DGHs to reduce the number of 62 day breaches due to late referrals**	3.4.9	Milestone	HB/SES	Dec-15	The majority of 62 day breaches in Urology, lung, head and gynaecology are due to late referrals from DGH's. Meetings have been set up with clinicans and managers to improve performance	
51	All	**To avoid breaches of the 62 day target occurring due MDT functioning and pathway coordination**	3.4.9.10	Milestone	**CC**	**May-15**	weekly meeting to be set up with all trackers to review every patient on PTL	Complete
52	urology	Develop a new urology proforma for referral to MDT within the NICE guidance	3.4.9.10	Task	AMW	May-15	In place from January 15	Complete
53	urology	improve pathway monitoring and increase clinical involvement in PTL management.	3.4.9.10	Task	HB	May-15	Daily PTL review takes place in urology,all other tumour sites are reviewed 2 or 3 times weekly as well as specialty escalation meeting with clinical involvement. The focus is on treating as many patients within breach time as possible and reducing the number of confirmed and suspected cancer on the 62 day backlog.	Complete
56	urology	Appoint additional cancer pathway trackers to ensure high volume PTLs can be kept up to date in 'real time'	4.9	Task	HB	May-15	2 WTE trackers are now in post to focus on urology. All tumour sites now have dedicated MDT and tracker support	Complete
57	urology	Review functioning and timings within the MDT meeting to enable all patients to be discussed and to avoid delays in progress of pathway	3.4.9.10	Task	PC	20.10.14	protocols and MDT ratification is used to reduce the need for long discussion and save MDT time.	Complete
58	urology	Reduce the number of patient pathway delays due to more than one discussion at MDT through early referral and close pt tracking	4.9	Task	HB/KM/PC	May-15	MDT coordinators are closely monitoring patients who are likely to need more than one MDT discussion to ensure they are referred as early as possible. This is also monitored through the weekly PTL meetings.	Complete
54	gynaecology	Reduce the gynaecology pathway by removing the triage process and providing clear guidance for 2ww staff as to the appropriate clinic to refer to.	3.4.9.10	Task	HB	Nov-15	The gynaecology referral proforma is being redesihned to make explicit which clinic to send patients to without the need for triage. An SOP will be provided for staff.	In progress
55	All	Review MDT role/ banding/career progression in order to improve retention of MDT co-ordinators and reduce high staff turnover.	4.9	Task	HB	May-15	MDT coordinators have a key role in facilitating MDTs and pathways monitoring. A new role has been implemented whihc will focus on staff training and development.The proposed new structure also provides more opportunity for promotion.	Complete
59	All	**To avoid breaches of the 62 day standard due diagnostic , OPA or surgical capacity**	**3.4.9.10**	Milestone	**AS/KH/HB**	May-15	standard currently being met across all tumour sites. Capacity is reviewed at all ptl meetings. Escalation in place if capacity issues arise.	In progress
60	Lung	Relocate the bronchosopy service to Radiology dept at JR to increase capacity with improved clincial support and improved histology turnaround times.	**3.4.9.10**	Task	AS/KH	Apr-15	25/3/15 EBUS/ cancer bronchoscopies are performed within 2 weeks.	Complete
61	Lung	Provide 3rd PET CT scanner to provide additional capacity	**3.4.9.10**	Task	KH	Apr-15	Waits now reduced to < 7 days	Complete
62	Lung	appoint an additional cardiothoracic surgeon to provide additional OPA and cross cover for leave.	**3.4.9.10**	Task	RT/EB	Apr-15	3rd surgeon now in post with operating lists 5 days a week and cross cover for leave.	Complete
63	lung	increase the number of OPA slots by relocating all clinics to the Churchill site and increasing the number of clinc slots	**1.3.4.9.10**	Task	RT/EB	Apr-15	patients are now seen < 7 days of MDT discussion	Complete
64	urology	Ensure close monitoring of all stages of the patient and escalate any delays to ensure earlier diagnosis by day 21 and decision to treat by day 31	3.4.9.10	Task	HB	May-15	daily review of cancer PTL and compliance with escalation.Access to direct access clinic is improving. To review day in pathway average. Ongoing issue is the clinical pathway.	Complete
65	urology	Review current clincal pathway and introduce MRI pre biopsy	3.4.9.10	Task	RB	May-15	01/05/15 meeting with Urology MDT to review progress on revised pathway and discuss pre Bx MRI	Complete
66	urology	To develop joint/parallel clinic sessions within 7 days of MDT/ results clinic to ensure patient given diagnosis by a consultant and referred for early MRI as appropriate	3.4.9.10	Task	AMW/HH	Jun-15	Restructure of consultant clinics is underway. The existing nurse clinics will continue with them providing the patient with the diagnosis and an overview of possible treatment options, with consultant clinics to follow 3-4 days later or once the MRI result is known if the patient requires one	Complete
67	urology	Create an additional clinic and review appointment lengths to create sufficient new and FU appointments.	3.4.9.10	Task	AMW	May-15	Future consultant clincis will run on Tuesdays, Wednesdays and Fridays. Clinics will be sent for building w/c 30.3.15	Complete
68	urology	Avoid breaches occuring through lack of capacity by reviewing arrangements for cross cover/ annual leave	3.4.9.10	Task	AMW/MS	May-15	clinics will not be cross covered as job plans do not allow for this but the arrangements for annual leave have been revised to ensure all consultants are not off at the same time and there is enough cover without impacting on cancer performance.	Complete
69	urology, gynae,	Increase surgical capacity by an additional 3 lists per week. Currently sat lists. Business case in place. Send non cancer work to private sector.	3.4.9.10	Task	MS/AM/RB	May-15	Interim contract with Manor has been agreed to undertake surgical cases in urology and ENT. Additional Saturday list are being undertaken in gynaecology and urology	In progress
70	urology	Submit business case to increase capacity across the urology service including theatre, clinic and inpatient beds. Additional throughput would be 40 - 50 per month. 18 week.	3.4.9.10	Task	MS/AM/RB	May-15	PID in development. Awaiting financial input to complete for submission to BPG	In progress
71	urology	Provide training session on cancer pathway/ targets for admin staff	3.4.9.10	Task	HM/AM	Apr-15	training provided and staff now have a better understanding of the importance of the targets and early escalation.	Complete

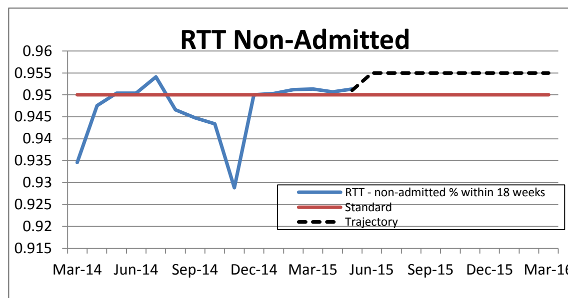
Oxford University Hospitals NHS
NHS Trust

ELECTIVE CARE IMPROVEMENT PROGRAMME

The Trust has failed to achieve the RTT Admitted performance of RTT since September 2013, with the most recent submitted performance being at 88.08% for July 15. The Non-Admitted target has been achieved since December 2014, with the most recent submitted performance being at 95.03% for July 15 The Incompletes target of 92% has been achieved by at trust level now since the end of Q1, September 2014. With the most recent submitted performance for July 15 at 92.09%.

Clinical Quality Performance Indicator	Target	Apr	May	Jun	Qtr 1	Jul	Aug	Sep	Qtr 2	Oct	Nov	Dec	Qtr 3	Jan	Feb	Mar	Qtr 4	Annual
Admitted RTT	90%	86.24%	87.81%	87.32%		88.08 %												
Non Admitted RTT	95%	95.07%	95.13%	95.02%		95.03 %												
Incomplete RTT	92%	93.05%	93.2%	93.27%		92.09 %												





High volume specialties with significant backlogs of patients waiting have developed additional capacity plans, specifically orthopaedics, urology, ENT and ophthalmology. Plans include temporary locum appointments, additional elective activity across the week, Saturday lists and maximising theatre capacity at the Horton General Hospital. Additional options of outsourcing elective work are being considered.
Overall waiting list increased in 2014/15 from 11,191 to 12,052 representing an increase of 861 patients, 7.7% increase .
The graph below shows the contacted activity plans for 14/15 and 15/16 with an increase of 5940 elective spells.

2015/16 Activity plans (compared with 14/15) and capacity implications, for key RTT admitted specialties.

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Annual total
Urology	2014/15 EI&DC Contracted Spells	300	346	390	384	357	296	329	308	328	302	335	327	4,002
Urology	2015/16 EI&DC Contracted Spells	341	324	375	392	324	375	375	358	341	341	358	358	4,259
Urology	2015/16 IMAS extra EL	47.0	47.0	47.0	47.0	47.0	47.0	47.0	47.0	47.0	47.0	47.0	47.0	564
ENT	2014/15 EI&DC Contracted Spells	143	146	135	155	126	126	130	153	111	124	139	187	1,675
ENT	2015/16 EI&DC Contracted Spells	134	128	148	155	128	148	148	141	134	134	141	141	1,679
ENT	2015/16 IMAS extra EL	52.0	52.0	52.0	52.0	52.0	52.0	52.0	52.0	52.0	52.0	52.0	52.0	624
Ophthalmology	2014/15 EI&DC Contracted Spells	451	566	627	541	514	431	404	516	377	455	485	522	5,889
Ophthalmology	2015/16 EI&DC Contracted Spells	479	455	526	550	455	526	526	503	479	479	503	503	5,982
Ophthalmology	2015/16 IMAS extra EL	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	77.0	924
T&O	2014/15 EI&DC Contracted Spells	490	550	625	582	546	595	572	547	468	468	504	558	6,505
T&O	2015/16 EI&DC Contracted Spells	549	522	604	632	522	604	604	577	549	549	577	577	6,864
T&O	2015/16 IMAS extra EL	62.0	62.0	62.0	62.0	62.0	62.0	62.0	62.0	62.0	62.0	62.0	62.0	744
Remainder of Trust	2014/15 EI&DC Contracted Spells	6,222	6,172	6,502	7,192	6,481	6,816	7,181	6,772	6,035	6,817	6,518	7,023	79,731
Remainder of Trust	2015/16 EI&DC Contracted Spells	6,627	6,298	7,287	7,618	6,298	7,287	7,288	6,957	6,628	6,628	6,956	6,958	82,827
Remainder of Trust	2015/16 IMAS extra EL	257	257	257	257	257	257	257	257	257	257	257	257	3,084

Divisional focus in recent months has been on reducing waiting lists through treating or validating all patients waiting over 35 weeks on the inpatient and outpatient PTL (please note these are not all on 18 week reportable incomplete pathways) leading to a reduction in over 35 week patients from 9252 to 3832 representing a reduction of over 58.6%.
Focus will now be on further reduction of waits to no more than 26 weeks.

There were 8 patients   > 52 weeks reported in July 2015 (5 admitted, 1 non admitted and 2 incomplete). The 2 remaining incomplete patients are patient choice to wait.

The Trust has continued to maintain less than 1% of patients waiting > 6 weeks since July 2014 for the 20 reportable diagnostic tests & investigations.

Area	Ref.	Clinical Quality Performance Indicator	Threshold	Apr	May	Jun	Qtr 1	Jul	Aug	Sep	Qtr 2
18 Weeks	S4	Maximum of 1% of total diagnostic waiting list waits above 6 weeks -- DiagWaits	Diagnostic waits < 6 weeks - 99%	99.83% (10849/ 10868)	99.83% (10779/ 10797)	99.84% (11247/ 11265)		99.83 % (11679/ 11699)			

Oxford University Hospitals NHS Trust

Elective Access Improvement - No delays

Updated 27th August 2015

Each division needs to use this template to deliver and sustain a service by service model that meets all Elective care standards and milestones and is sufficient to meet clinical needs of patients and respond to varying levels of activity. This is to be used in conjunction with the Elective improvement plan that details explicitly the requirements that need to be delivered by each specialty.

		Elective Access KPI numbers	Objectives	KPI's	May-15	Jun-15	Jul-15
Incompletes	Non Admitted	1	Clearance of backlog	0 patients waiting over 52 weeks (excluding stops within month)	0	0	0
		2	Clearance of backlog	Less than 8% "non admitted" patients waiting over 18 weeks (Submitted Incomplete pathways)	93.42%	94.50%	93.29%
		3	Referral to DTA time commensurate with 18 week pathway	95% of patients to wait no longer than 12 weeks from referral to DTA for surgical pathways	93.80%	93.30%	92.80%
		4	Trust level compliance with target	95% patients seen and treated within 18 weeks	95.13%	95.02%	95.03%
	Admitted	5	All reportable diagnostics seen within maximum 6 weeks	No more than 1 % of patients waiting > 6weeks for a diagnostic investigation	0.17%	0.17%	0.17%
		6	Clearance of backlog	0 patients waiting over 52 weeks (excluding stops within month)	3	7	2
		7	Clearance of backlog	Less than 8% patients on an admitted pathway waiting over 18 weeks (Submitted Incomplete pathways)	89.86%	88.12%	87.25%
		8	Clearance of backlog	All patients over 18 weeks to have an admission date (data from INP/DC PTL)	72.20%	70.90%	67.80%
		9	Overall reduction in waiting list size	Removals from the admitted PTL are to be greater than the additions (based on total W/L size excluding IMAS figures)	2.30%	-4.87%	-1.82%
		10	Trust level compliance with target	90% patients seen and treated within 18 weeks	87.81%	87.32%	88.08%

Oxford University Hospitals NHS Trust

Elective Access Improvement - No delays

Updated 27th August 2015

The below is to be used in conjunction with the Elective access key milestones that details explicitly the requirements that need to be delivered by each specialty.

Elective Improvement plan numbers	Milestones and associated actions	Activity Type	Original Due Date	Related Indicator numbers from the Elective Access KPI's (column C)	Corporate comments	Activity Status - to support corporate comments
1	Establish and stick to weekly PTL meeting and develop a standard escalation process which includes validation deadlines for all elective care targets and highlights and problems achieving the data sets, are Trajectories agreed at local level, has everyone within the service understanding of the key milestones they are working towards for Elective care?	Milestone	May-15	1,2,3,4,5,6,7,8, 9,10	Services have established weekly PTL meetings. Corporate team are attending to check consistency across the divisions. Minutes requested to be sent to monthly Divisional PTL meetings	complete
2	to review Last months RTT Performance -Admitted (approx. number of clocks that are expected each month to stop)	Task	May-15	8,9,10	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	complete
3	to review Last months RTT Performance Non-Admitted (approx. number of clocks that are expected each month to stop)	Task	May-15	2, 3, 4	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	complete
4	to review Last months RTT Performance Incompletes (approx. number of clocks that are expected each month to be waiting for first definitive treatment)	Task	May-15	2, 3, 4, 6, 7, 8, 10	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	complete
5	Predicted RTT Performance for the next month-Admitted % of compliant pathways (using the IP/DC PTL data produced & PTL's)	Task	May-15	6, 7, 8, 9, 10	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	complete
6	Predicted RTT Performance for the next month -Non-Admitted % of compliant (using OP PTL & knowledge of diagnostic pathways & patients in a follow up status - incompletes Pathways Data will	Task	May-15	1, 2, 3, 4	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	complete
7	Predicted RTT Performance for the next month-Incompletes % of compliant pathways, data will need to be validated,(if PTL's are validated this list should be in good shape)	Task	May-15	1, 2, 3, 6, 7, 8	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	complete
8	trend analysis of breaches - previous weeks breaches, reasons actions taken to prevent the same thing happening	Task	Jun-15	1,2, 3, 4, 5, 6, 7, 9, 10	Breach reason capture now available on locally developed RTT validations access database. All services trained to use not all services appear to be using	complete
9	Establish a process to review ,validate and resolve all RTT invalid date reasons actions taken to prevent the same thing happening (this could lead to retraining/technical changes) AP/NP & IP	Task	May-15	1, 2, 3, 4, 6, 7, 8, 10	currently corporate 18 week team clean up the majority of the RTT invalid dates. Any training requirements are fed back to services where appropriate	complete
10	multiple open pathways outpatient/Inpatients/incompletes i.e. Duplicate IP waiting list entries or duplicate referrals on the outpatient PTL	Task	May-15	1, 2, 3, 4, 6, 7, 8, 10	Currently using 18 week team to aid clean up patients with multiple open pathways for same treatment function reduction of 3376 erroneous open pathways	complete
11	Develop a process to review and manage RTT Status' inconsistent with waiting list status on the IP/DC & outpatient PTL this should be discussed weekly in the performance meetings held within service	Task	on-going	6, 7, 8, 10	Corporately the INP/DC PTL > 40 weeks is reviewed on a weekly basis, the inconsistent RTT codes are amended and findings fed back to the divisions. The patient level detail is sent on the PTL's to the divisional teams on a daily basis	In progress
12	Review ,validate and resolve discharges without clock stops (this information is sent to services on a daily basis via RTT Email)	Task	Jan-15	7, 9, 10	Currently corporate 18 week validation team are supporting this work, the patient level data is sent to the divisional teams on a daily basis.	complete
13	zero active RTT patients waiting > 35 weeks dated and undated (unless patient choice)	Task	May-15	1, 2, 3, 4, 6, 7, 8, 10	Bi-weekly performance meetings held with divisions (1xPTL and 1xTrust Performance per month) Total numbers over 35 weeks on IP PTL (excluding planned) have dropped by 566 since March 2015. Total number on OP PTL (all RTT status) over 35 weeks have dropped by 4854 since March 2015	complete
14	Establish a clear process/SOP for all Tertiary referrals and make sure we have all relevant minimum data set information, understand the approximate numbers of Tertiary referrals that come into the service each month.	Task	Jan-15	2, 3, 4, 5, 6, 7, 8, 9, 10	Corporate Tertiary referral audit in progress, part of the IST recommendation	In progress
15	Review the volume of patients on the inp/DC waiting list @ 0-6 weeks action when the numbers of this cohort of patients increase by over 7% each month	Task	Apr-15	9	Focus currently on patients waiting >35 weeks & data quality validation through the Bi-weekly PTL meetings	In progress
16	Review the volume of patients on the inp/DC waiting list @ 6-12 weeks action when the numbers of this cohort of patients increase by over 7% each month	Task	May-15	9	Focus currently on patients waiting >35 weeks & data quality validation through the Bi-weekly PTL meetings	In progress
17	Review the volume of patients on the inp/DC waiting list @ 12-18 weeks action when the numbers of this cohort of patients increase by over 4% each month	Task	May-15	7, 10	Focus currently on patients waiting >35 weeks & data quality validation through the Bi-weekly PTL meetings	In progress
18	Review the volume of patients on the outpatients PTL waiting list @ 6 and over weeks action when the numbers of this cohort of patients increase by over 7%	Task	May-15	2, 3, 4	Review of number of patients on outpatient PTL over 6 weeks as part of outpatient steering group.	In progress
19	Establish a process to resolve the volume of past TCIs on the EAL. (this data can be found on the IP/DC PTL and DQ dashboard ORBIT report) - what actions are required to clear this to zero	Task	on-going	10	Corporate team send past TCIs for services to action on a weekly basis. Past TCIs are discussed as requiring action at Monthly corporate divisional PTL meetings	In progress
20	Establish a admitted PTL validation status using the IP/DC PTL- Process Agreed prospective management by breach date **without TCI dates** - patients already breaching > 52 weeks - what actions are required?	Task	Apr-15	6, 7, 8, 10	Corporate review of Inpatient PTL (excluding planned over 40 weeks on weekly basis) comments escalated to divisions for action	complete

Elective Improvement plan numbers	Milestones and associated actions	Activity Type	Original Due Date	Related Indicator numbers from the Elective Access KPI's (column C)	Corporate comments	Activity Status - to support corporate comments
21	Establish a admitted PTL validation status using the IP/DC PTL-Process Agreed prospective management by breach date **without TCI dates** - patients already breaching > 35-52 weeks - what actions are required?	Task	Apr-15	6, 7, 8, 10	Corporate review of Inpatient PTL (excluding planned over 40 weeks on weekly basis) comments escalated to divisions for action	complete
22	Establish a admitted PTL validation status using the IP/DC PTL-Process Agreed prospective management by breach date **without TCI dates** - patients already breaching > 18-35 weeks - what actions are required?	Task	Apr-15	7, 8, 10	Focus currently on patients waiting >35 weeks & data quality validation through the Bi-weekly PTL meetings - this should be a part of local weekly PTL meetings	In progress
23	Establish a process to manage & escalate the patients who are new to the admitted PTL (IP/DC) who have dropped in from the non admitted PTL/or completely new to the PTL (waiting list officers should know this number as they should know and understand the breach date of the patient when adding them to the waiting lists for treatment) - what actions are required?	Task	Jun-15	6, 7, 8, 9, 10	Corporate review of Inpatient PTL (excluding planned over 40 weeks on weekly basis) comments escalated to divisions for action	In progress
24	Establish a process to manage & escalate the patients who have moved from 17 to 18 weeks dated and undated - what actions are required?	Task	Apr-15	2, 3, 4, 7, 10	Focus currently on patients waiting >35 weeks & data quality validation through the Bi-weekly PTL meetings - this should be a part of local weekly PTL meetings. Corporately we try to look at this cohort of patients with the validations team.	In progress
25	approve a process to review % of patients with a decision to admit date (DTA) at X weeks (an internal milestone set by specialty)	Task	Apr-15	3, 7, 10	pathway mapping has been actioned in most surgical specialties, some are still required to be completed and returned to the corporate team.	complete
26	Develop a method of managing additions to List-lag time and when issues should be escalated and how. (patients should be added to the WL within 24/48 hrs. of DTT date	Task	Sep-15	3, 9, 10	this is an important part of tracking a patient through the pathway and making sure that patients are not missed from the W/L etc., a safety net process is required to avoid clinical risk, also to adhere to the EA policy	Not started
27	Review any on the day cancellations from the previous week and action with TCI dates if not done so by this stage. Discuss any trends that are beginning to appear with cancellations and escalate from the weekly PTL meeting	Task	Apr-15	7, 8, 10	this should be embedded in the weekly service PTL meetings, the information is sent through to the divisional teams at patient level on a weekly basis	complete
28	All patients readmitted within 28 days of an on the day cancelation & avoidance of all on the day cancellations where at all possibly.	Task	Apr-15	7, 8, 10	Weekly on the day elective cancellations data provided to services from corporate team for review/validation and escalation. July 2015 2 patients were not readmitted within 28 days of cancellation. These have now been treated.	complete
29	Review Total size of OP PTL on a regular basis (weekly look at trends and increase/decease in numbers) develop an escalation process where appropriate any big difference and investigate reasons -In line with the IMAS modelling	Task	Apr-15	2, 3, 4,	this information is available on a daily basis and is sent to services.	Complete
30	zero past appointment dates within outpatients working towards successful direct booking within each service	Task	Apr-15	2, 3, 4	Number of past appointment dates on outpatient PTL has reduced by 3517 since 31/03/2015	In progress
31	Review the Number of DNA's last month - both outpatients & diagnostics(work in line with transformation team project)	Task	Apr-15	2, 3, 4, 5,	This work is being picked up corporately as part of a Transformation team project. A new report is now available on ORBIT showing details of Outpatient DNAs	In progress
32	Understand the Percentage of Hospital Outpatient Cancelled appointments what impact is this having on capacity and start of patient pathway	Task	Sep-15	2, 3, 4,	work in beginning to take place with the outpatient steering group regarding outpatient cancellations.	Not started
33	Review Number of patients on C&B Breach list & ASI list in excess of 2 days for C&B patients and 24 hrs. for ASI patients take action immediately to book patients for outpatient apt	Task	Jan-15	2, 3, 4,	this information is available on a daily basis and is sent to services.	Complete
34	regular review of the Outpatient Triage Process -Turnaround by consultants? -Automated?	Task	Sep-15	4	Running inline with Directly bookable roll out plan	In progress
35	Outcome Forms Relevant to Specialty are they usable - can we check in & out electronically within this service?	Task	Apr-15	4	this work is being picked up corporately as part of future EPR project roll outs	In progress
36	Outcome and Attended Status Completeness /are they filled out (develop a regular audit process that everyone including clinicians are involved in)	Task	Jun-15	4	This forms part of the divisional quarterly compulsory data quality audits	complete
37	Real time check in & check out by clinician for all appointments	Task	Sep-15	4	this work is being picked up corporately as part of future EPR project roll outs	In progress
38	Regular review of utilisation Rates - Capacity vs. booked look at all patients > 6 weeks on the outpatient PTL dated and undated-validate/date/remove/bring forward are the patients booked within the specialty agreed milestone?	Task	on-going	2, 3,4	All service link regularly with the business intelligence team to plot capacity and demand using the IMAS model.	In progress
39	Establish a process for review and amending appointments missing a follow-up (this data can be found on the DQ dashboard ORBIT report)	Task	on-going	2, 3,4	a review of EPR has been escalated to Cerner with options to alter the appointment outcome. This will allow the staff to manage this list more effectively	In progress
40	Review any potential 6 week diagnostic breaches and actions that need to be taken to resolve them and meet the standard - required watching the patients at 4 weeks undated closely	Task	Apr-15	2,3,4, 5	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	Complete
41	Review and develop Service Level Agreements in with all diagnostic services that are not delivered within the same specialty - how are the results reviewed and updated and actioned with the timeframe required for the pathway.	Task	Jul-15	2, 3,4, 5,	IMAS recommendation. Some services already have this regarding Cancer so have great connections. Reports are now shared with turn around times for Radiology and expected delays. This is discussed in the PTL meetings that are held Bi-Weekly.	In progress
42	Monitor/review/validate/resolve all patients that are dated over 6 weeks for a diagnostic investigation, if not a patient choice issue then can they be bought forward?	Task	Apr-15	2, 3, 4 5,	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	Complete

Elective Improvement plan numbers	Milestones and associated actions	Activity Type	Original Due Date	Related Indicator numbers from the Elective Access KPI's (column C)	Corporate comments	Activity Status - to support corporate comments
43	Introduce within weekly PTL meetings DM01 validation accuracy, completion any discuss any problems in achieving the deadline review all data and breaches for sign off on a monthly basis.	Task	Apr-15	2, 3, 4, 5	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	Complete
44	Review the volume of patients on the Diagnostics PTL waiting list @ 4-5 weeks action when the numbers of this cohort of patients increase by over 4%	Task	Apr-15	2, 3, 4, 5	Focus on patients waiting >35 weeks & data quality validation	In progress
45	Establish a process in the weekly PTL meetings that all paused patients on the INP/DC waiting list are reviewed. Make sure all patients clinically reviewed.	Task	Apr-15	6, 7,8, 10	this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	Complete
46	Develop a method of managing patients on the planned with all planned patients having a valid clinical ready by date (TBD) date attached to their EPR/CRIS record. Review these dates in the weekly PTL meetings	Task	Jan-15		Corporate quarterly deep dive of planned patients (4 services per year). Each service requested to do a quarterly planned audit. Results table for the past 3 years held corporately.	Complete
47	Review, manage and potentially Escalate patients on the planned waiting list that have past their TBD date (this could be either Inpatient/DC/diagnostic or at the outpatient stage of treatment). There should be zero planned patients waiting 6 weeks past their treatment by date	Task	Apr-15		this should be embedded in the weekly service PTL meetings, it is listed in the suggested terms of reference as an important indicator	Complete
48	zero planned waiting list patients with an active RTT code	Task	Apr-15		This has reduced from 869 to 396. Further work on-going with services.	In progress
49	Review the volume of planned patients on the waiting list and monitor and action and changes in additions & removals & planning capacity for planned patients	Task	Apr-15		Services requested to complete quarterly planned audit. 60 % of services have returned their audit in Q1 and have confirmed review of planned numbers.	Complete
50	Establish audit programme to assure the directorate that locally data quality is improving to a sustainable position, develop a method that enables service leads to retrain staff where necessary.	Task	Jun-15		Corporate audit programme in place. Directorate DQ audits report into DQ group	Complete
51	written process for managing and reporting of medical staff leave in line with the Elective access policy	Task	May-15		Procurement of medical roster system underway to be able to monitor leave in real time.	In progress
52	Key service redesign issues identified with delivering 18 Week Compliance across whole specialty, this should include pathway mapping exercise that was recommended by the IST to reduce long waiting times	Task	on-going		Corporate team meeting with divisions to complete pathway mapping.	In progress
53	Level of ownership and responsibility across the directorate for the entire patient pathway from referral to treatment, including planned patients & direct diagnostic waits.	Task	May-15		Significant senior clinical & non-clinical focus in divisions on elective acre pathway. This is also a point of discussion in Bi-weekly PTL meetings.	In progress
54	Avoid variation in practice by making sure all service standard operating process are in order and up to date especially if staff turnover is high and new starters are expected to follow them from the start.	Task	May-15		Requested standard operating procedures from divisions. Awaiting feedback, this is a discussion point in the Bi-weekly PTL meetings	In progress
55	Establish a learning programme, whereby issues from audits, previous breaches and complaints are reviewed and shared across the teams to embed best practice.	Task	Jun-15		Shared learning at DQ meeting. Corporate formal 18 week training available. 18 week E-Assessment available. 18 week intranet page link moved to homepage to make more accessible.	Complete