Paper 5.1

TRUST BOARD
24th September 2015

TITLE	**Performance Report**
EXECUTIVE SUMMARY	The Trust missed the 4 hour A&E standard in August with performance recorded at **91.65%**. Patient flow was difficult due to surges in admissions & a high number of patients medically fit for discharge creating consequential impact on A&E 4hr compliance. Trustwide 18 weeks RTT Incomplete Standard continued to be recorded 3% points higher than the national average. [Admitted & Non-admitted standards are no longer enforced by commissioners or regulators]. The Trust was compliant for all Cancer standards except the Subsequent 31 day Surgery Standard due to a complex case breach (compounded by exceptional seasonal dermatology capacity constraints), and the 62 day Referral to Treatment Standard where a higher than usual incidence of complex pathways, delays at tertiary centres and patient unavailability created a high number of breaches. The Trust was required to submit a self-assessment of its position against the 8 key Cancer Priorities identified for cancer improvement & 62 Day Cancer Standard Improvement Plan by the end of August. These are attached as Appendices A (8 Key Cancer Priorities) & B (62 Day Cancer Standard Improvement Plan).
BOARD ASSURANCE (RISK) / IMPLICATIONS	Compliance is reflected in the Board Assurance Framework. BAF Risk 1.1 National targets and priorities.
ALIGN TO TRUST RISK REGISTER	**SO1:** To achieve the highest possible quality of care and treatment for our patients, in terms of outcome, safety and experience. **SO3**: To deliver the Trust's clinical strategy of joined up healthcare.
STAKEHOLDER / PATIENT IMPACT AND VIEWS	Patient expectations in terms of access are reflected in NHS performance targets.
EQUALITY AND DIVERSITY ISSUES	None identified
LEGAL ISSUES	None identified
TRUST BOARD is asked to:	Review the paper and discuss the contents seeking additional assurance as necessary.
Submitted by:	Robert Peet, Chief Operating Officer
Date:	17 September 2015
Decision:	For Assurance

A&E PERFORMANCE UPDATE

					Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sparkline
A&E	A&E	INPUTS	Attendances	**Total**	**7630**	**8032**	**7795**	**8064**	**7610**	
				Avg Att per day	*254*	*259*	*260*	*260*	*245*	
			Admissions	**Total**	**1849**	**1988**	**1804**	**1867**	**1920**	
				Avg Adm per day	*62*	*64*	*60*	*60*	*62*	
		CONTROLS	Breaches	**Total**	**918**	**715**	**859**	**857**	**995**	
			% Breaches late Specialty	**Total**	**25.3%**	**13.4%**	**23.9%**	**17.4%**	**30.3%**	
			% Breaches late Dr/ENP	**Total**	**3.6%**	**3.5%**	**2.5%**	**2.5%**	**4.2%**	
			Number of Breaches by Minors	**Total**	**94**	**94**	**85**	**111**	**103**	
			Delay Transfers of Care	**Total**	**938**	**748**	**817**	**527**	**622**	
			Complex Discharges	**Total**	**1214**	**1424**	**1099**	**1041**	**920**	
		OUTPUTS	A&E 4hr Performance % (Monitor)	**Total**	**92.51%**	**94.25%**	**93.09%**	**93.21%**	**91.65%**	
			A&E 4hr Performance % (St Peters)	**Total**	**87.96%**	**91.07%**	**88.99%**	**89.37%**	**86.91%**	

Performance:

The Trust missed the 4 hour A&E CCG contract standard in August with St Peters site A&E, GUM & EPU performance recorded at 88.56% [Monitor performance (inc Ashford) = 91.65%] which was 1.9% below the 90.5% recovery trajectory for August.

August's A&E attendances at 7,601 were lower than the previous month, July (8,064) with a daily average of 245 patients attending per day. This figure is comparable with the number of attendances in August 2014 although admissions via A&E for August at 1,906 were higher than June & July - & with over 100 additional patients admitted compared to August 2014. This level of admissions places August's admitted conversion rate at 25.1%, which was 1.1% higher than the YTD average of 24.0%.

The 0-15 age group & 75+yr age groups still have the highest YTD admissions increases at 13.9% & 4.7% respectively, with an overall 3.1% (287 patients) increase in admissions compared to this point last year.

Progress is being made implementing the dedicated Urgent Care System Recovery programme of improvements that are currently underway in conjunction with NWS Surrey CCG to improve hospital patient flow, although the introduction of the Urgent Care Centre has been delayed.
Interim support measures are currently being developed.

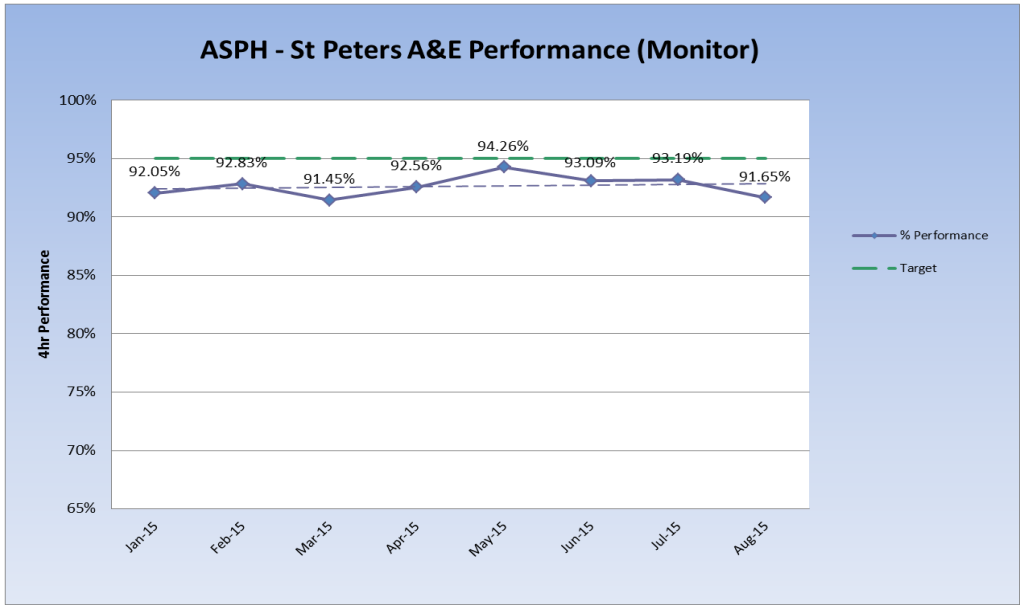
The Trust has also been working with CCG & system providers agreeing the 2015/16 winter measures to provide additional winter resilience.

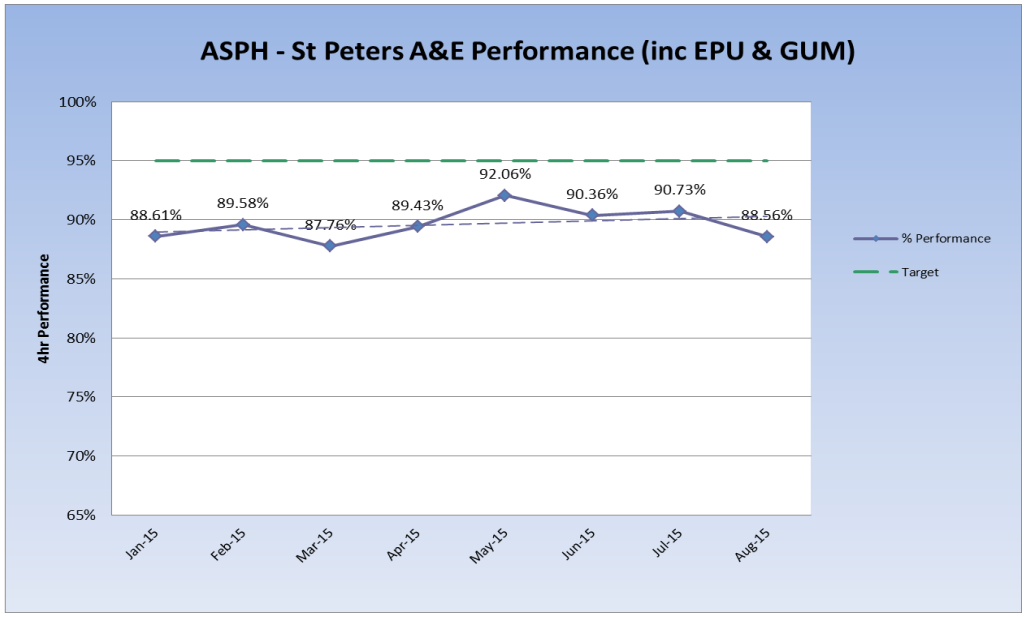
Improvement Activity:

An extensive Urgent Care Improvement Programme is underway with the following workstreams to expedite patient care, signposting & efficient treatment;

W1 - Revision of the ED Acute Referral to Specialty Policy to expedite clinical specialty review
W2 - Revision of Standard Operating Procedures to include innovation (Rapid Assessment & Treat, Acute Hub & Point of Care testing)
W3 - Initiatives to reduce patient ward Length of Stay & Early Supported Discharge
W4 - Reduce Delayed Transfers of Care & Complex Discharges (including creation of an Integrated Discharge Team)
W5 - Create an Urgent Care Centre as the front door triage to A&E
W6 - Create a Paediatrics Assessment Unit co-located with Paed's ED
W7 - Local health & social care providers (led by NWS CCG) have engaged with Alamac Consultancy to improve system healthcare performance & change management support

Performance:





RTT PERFORMANCE UPDATE

					Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sparkline
RTT	GENERAL SURGERY	INPUTS	Referrals	*Colorectal*	*395*	*328*	*383*	*409*	*337*	
				Breast	*257*	*260*	*295*	*281*	*258*	
				Upper GI	*98*	*56*	*47*	*85*	*63*	
				Vascular	*160*	*139*	*162*	*143*	*144*	
				Total	**910**	**783**	**887**	**918**	**802**	
		CONTROLS	Admitted Pathway Activity	**Total**	**291**	**293**	**270**	**363**	**296**	
			Non-Admitted Pathway Activity	**Total**	**585**	**531**	**644**	**603**	**606**	
		OUTPUTS	RTT Admitted Pathway %	**Total**	**81.79%**	**88.21%**	**87.36%**	**83.84%**	**81.33%**	
			RTT Non-Admitted Pathway %	**Total**	**88.53%**	**89.40%**	**90.81%**	**87.06%**	**90.51%**	
			RTT Incomplete Pathway %	**Total**	**91.02%**	**92.93%**	**90.77%**	**89.51%**	**91.91%**	
			Waiting List Size	**Total**	2695	2695	2688	2659	2598	
			Backlog Size (>18wks)	**Total**	241	196	248	279	236	

Performance:	General Surgery has experienced delays in upper gastro-intestinal and colorectal pathways as a result of the Trust's position in endoscopy. Knock on breaches have also continued during August whilst the specialty resolves the re-scheduling of patients required due to the staffing issues experienced at Ashford during June. Improvement Activity: A number of improvement actions have been underway, which include; 1 - Adherence to the 6-4-2 rule ensuring theatre sessions are fully booked, staffing optimised & utilisation maximised 2 - Providing additional surgical lists during the week & at weekends to reduce the backlog 3 - Tracking & expediting long waiting patients 4 - Providing additional outpatient clinics 5 - A Colorectal pathway improvement event where pathways have been reviewed with actions to optimise being implemented Incomplete Pathway performance is reliant on improvement being seen in the Trust's endoscopy position. Additional external resources to enhance the Trust's endoscopy capacity commenced mid-June with good progress being made in resolving the backlog. This arrangement has been extended into October which will provide a positive impact on General Surgery's Incomplete Pathways from August onwards.

RTT PERFORMANCE UPDATE

					Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sparkline
RTT	UROLOGY	INPUTS	Referrals	**Total**	**380**	**330**	**325**	**295**	**292**	
		CONTROLS	Admitted Pathway Activity	**Total**	**126**	**90**	**103**	**133**	**110**	
			Non-Admitted Pathway Activity	**Total**	**237**	**192**	**229**	**198**	**145**	
		OUTPUTS	RTT Admitted Pathway %	**Total**	**68.25%**	**80.90%**	**87.38%**	**91.73%**	**80.91%**	
			RTT Non-Admitted Pathway %	**Total**	**92.80%**	**94.82%**	**97.82%**	**94.44%**	**90.63%**	
			RTT Incomplete Pathway %	**Total**	**95.26%**	**96.29%**	**94.85%**	**92.45%**	**95.00%**	
			Waiting List Size	**Total**	805	854	796	796	823	
			Backlog Size (>18wks)	**Total**	42	36	41	59	42	

Performance:

Urology has continued to manage their waiting list size with the backlog showing a decrease.
The specialty has been providing additional capacity with good improvements being seen in the Incomplete standard, however tackling the waits at the beginning of the pathway remains a significant challenge.

Improvement Activity:
A number of improvement actions have been underway, which include;
1 - Adherence to the 6-4-2 rule ensuring theatre sessions are fully booked, staffing optimised & utilisation maximised
2 - Providing additional surgical lists including the April 'super weekend' to reduce the backlog
3 - An additional Urology consultant to reduce the Trust's capacity gap
4 - Tracking & expediting long waiting patients
5 - Providing additional outpatient clinics
6 - A Urology pathway improvement event where pathways have been reviewed & optimised

The specialty team have reviewed the demand & capacity flow and are implementing an action plan to address the wait to first appointment & backlog reduction required to reduce & sustain a wait to first appointment to max 6wks. Approval has been given for an additional consultant Urologist post as part of this plan.

CANCER UPDATE

					Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sparkline
CANCER	Cancer: two week wait from referral to date first seen	INPUTS	Referrals	Total	785	876	848	964	862	
		CONTROLS	Breaches due to Patient Choice	Total	48	32	28	36	33	
			% Breaches - Patient Choice	Total	6.1%	3.7%	3.3%	3.7%	3.8%	
			Breaches due to Hospital Capacity	Total	21	8	1	13	7	
			% Breaches - Hospital Capacity	Total	2.7%	0.9%	0.1%	1.3%	0.8%	
		OUTPUTS	2 Week Wait %	Total	91.20%	94.66%	96.10%	94.92%	93.16%	

Performance:

This standard is recorded as compliant at 93.2% (provisional). Whilst this is lower than the planned trajectory, the Trust experienced referral rates equivalent to a 25% increase across all tumour sites during August when compared with the previous year (on which the improvement trajectory is based).

2 Week Referral	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Referrals Seen	603	661	764	674	669	647	715	593	656
Referrals Seen Within Standard	533	622	688	615	614	603	668	560	620
Performance Trajectory	88.4%	94.1%	90.1%	91.2%	91.8%	93.2%	93.4%	94.4%	94.5%
Performance Actual	88.4%	94.1%	90.1%	91.2%	94.7%	96.1%	94.9%	93.2%	

With a revised escalation & engagement process having been introduced, we continue to see better engagement & resilience and ongoing compliance; although patient choice remains a significant risk and by far biggest contributory cause to breaches of the TWR standard.

Improvement Activity:

A number of improvement actions have been underway, which include;

1 - A revised Cancer Services 2 Week Rule escalation process

2 - Revised 2 Week Rule booking form for GP Surgeries to aid patient engagement

3 - Protected Straight to Test Endscopy slots to enable earlier endoscopy provision for cancer patients (& further availability post 1st appointment - although still within 14 days)

4 - An additional Urology consultant to reduce the Trust's capacity gap

5 - An additional Advanced Practitioner Breast Diagnostician to reduce the Trust's capacity gap

6 - Revised Cancer Services & Radiology reporting to monitor performance

CANCER UPDATE

					Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sparkline
CANCER	All cancers: 62-day wait for first treatment (GP Referral)	INPUTS	Treatments	Total	61	53	50.5	69	45	
		CONTROLS	*Breaches - ASPH*	Total	5	3	2	8	7	
			Breaches - Shared	Total	5	3.5	3.5	9	3	
			Total Breaches	Total	10	6.5	5.5	17	10	
		OUTPUTS	62 Day GP Referral to Treatment %	Total	83.6%	87.7%	89.1%	75.4%	77.3%	

Performance:

This standard is recorded as non-compliant at 77.3% (provisional).

August's performance represents a position approximately 3.5 breaches in excess of the tolerance against the 85% standard. Preliminary breach analysis show 1.5 breaches were as a result of delays to diagnostics or treatment at tertiary providers and 1.5 breaches due to patient initiated cancellations of diagnostics & treatments. The remaining breaches are being fully analysed to ensure remedial pathway improvements are implemented.

62 Day GP Referral	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Patients Treated	61	40	32	40.5	45.5	46	46	44.5	59
Patients Treated Within Standard	48.5	30.5	23	29	36	39	40.5	40	54
Performance Trajectory	79.5%	76.3%	71.9%	71.6%	79.1%	84.8%	88.0%	89.9%	91.5%
Performance Actual	78.4%	76.3%	76.3%	83.6%	87.7%	89.1%	75.4%	77.3%	

Many of the risks to performance against this standard require continued careful monitoring.
The Trust continues to deliver its Cancer Improvement Action Plan which aims to further address the recent issues regarding cancer performance.

Improvement Activity:
A number of improvement actions have been underway, which include;
1 - Revised clinic templates to improve capacity & expedite radiology requests
2 - An additional Urology consultant to reduce the Trust's capacity gap
3 - An additional Advanced Practitioner Breast Diagnostician to reduce the Trust's capacity gap
4 - Review of key cancer pathways to minimise delays
5 - Ongoing discussions with Tertiary Centres to further reduce the risk of delays
6 - Revised Cancer Services & Radiology reporting to monitor performance

The Trust was required to submit an improvement plan addressing 62 day pathway performance at the end of August, along with a self assessment of its position against the 8 key priorities identified for cancer improvement - both are attached as appendices.

Tumour site	No. of Patients Treated in the Period	<62 days	>62 days	Breach %
Breast	7	6	1	14%
Breast Symptomatic	1	0	1	100%
Colorectal	6	4	2	33%
Gynaecology	3	3	0	0%
Haematology	5	2	3	60%
Head and Neck	1	1	0	0%
Lung	4.5	3	1.5	33%
Sarcoma	1	0.5	0.5	50%
Skin	6	6	0	0%
Upper GI	0.5	0.5	0	0%
Urology	10	8	2	20%
TOTAL	**45**	**34**	**11**	**24%**

STROKE PERFORMANCE UPDATE

				Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sparkline
STROKE	INPUTS	Total stroke discharges	Total	37	53	61	58	48	
	OUTPUTS	Proportion of patients admitted to stroke ward <4hrs	Target = 90%	38%	51%	56%	72%	65%	
		Proportion of patients spending 90% on stroke ward	Target = 80%	57%	83%	83%	85%	79%	
		Proportion of patients scanned within 1hr	Target = 50%	66%	76%	66%	73%	72%	
		Proportion of patients scanned within 24hrs	Target = 100%	100%	100%	100%	100%	100%	
		Patients eligible & receiving thrombolysis	Target = 100%	100%	100%	100%	100%	100%	
		Non-urgent TIA cases assessed within 7 days	Target = 100%	100%	100%	100%	100%	100%	
		High-risk TIA cases treated within 24hrs	Target = 100%	100%	100%	100%	100%	100%	

Performance:

The Trust experienced difficulty meeting the top 2 KPIs due to 2 reasons;
(1) non-elective bed pressures within the Trust where stroke ward beds had to be used to avoid patients waiting in A&E (inc overnight DTA's), &
(2) referral delays from supporting teams in A&E, MSSU & MAU

A revised escalation protocol for ring-fencing beds within the stroke ward was implemented, although non-elective bed pressures during August have continued to effect stroke bed capacity.

Improvement Activity:

A number of improvement actions have been underway, which include;
1 - Demand and capacity analysis undertaken to establish the required number of ring-fenced beds
2 - Clear process introduced for CSNPs, Senior Support Managers and Directors on Call for use of ring fenced beds
3 - Protocols for transfer of stroke patients into and out of stroke & rehab beds re-established
4 - Standard Operating Procedure for stroke unit capacity management re-established
5 - Monitoring use of acute stroke beds to ensure they are optimised for stroke patients
6 - Improveing Length Of Stay on Chaucer Ward, including reducing delayed transfers of care
7 - Meeting with ED team reaffirming the pathway for stroke patients
8 - Root cause analysis of each breach with learning & mititations discussed at clinical governance
9 - Stroke performance reviewed at weekly Trustwide Performance meetings

An action plan remains underway to improve performance which includes a number of additional activities to upskill colleagues, with regular monitoring & feedback of breaches to reduce re-occurrence.

OTHER PERFORMANCE CONCERNS &/OR RISKS

Endoscopy

Additional endoscopy capacity using an external supplier commenced mid-June with continuing good progress being made towards returning to compliance fulfilling all diagnostic tests within 6 weeks of referral. The Trust reported DM01 standard at 97.3% for August, 2.3% ahead of the 95% recovery trajectory.

NW Surrey CCG have implemented plans for demand management with a GP led revised protocol for reducing endoscopy referrals for a proportion of under 55's & through the introduction of a commissioning referral triage centre for these referrals. The impact of this scheme on endoscopy referrals to the Trust continues to be limited.

The reduction in endoscopy waiting list & backlog is detailed below against the originally modelled waiting list & backlog clearance.

		02-Jun	09-Jun	16-Jun	23-Jun	30-Jun	07-Jul	14-Jul	21-Jul	28-Jul	04-Aug	11-Aug	18-Aug	25-Aug	01-Sep
A1	Waiting Actual	1717	1715	1626	1650	1646	1476	1467	1416	1337	1297	1106	976	905	845
A2	Waiting Estimated	1864	1912	1932	1864	1796	1714	1632	1550	1468	1386	1304	1267	1185	1103
A3	*Waiting Variation*	-147	-197	-306	-214	-150	-238	-165	-134	-131	-89	-198	-291	-280	-258
B1	>6wks Actual	740	770	798	801	819	768	732	628	516	467	371	309	226	156
B2	>6wks Estimated	619	624	556	674	606	538	470	402	334	266	198	161	79	0
B3	*>6wks Variation*	121	146	242	127	213	230	262	226	182	201	173	148	147	156

The overall waiting list has reduced ahead of projection, although the backlog clearance is slightly behind.

The Trust remains on track to eliminate the remaining backlog in September. Recognising the intrinsic capacity shortfall in Endoscopy, the Trust also plans to retain the services of the external provider into October to maintain the required additional capacity for continued backlog clearance and avoid waiting time growth in the future.

IMPROVING OUTPATIENT SERVICES PROJECT

Improvement Activity:

A number of improvement actions have been underway to improve the Patient outpatient experience, these include;

1 - Organisational change clarifying individual role & responsibilities, inc targetting & performance management within the Appointment Centre

2 - Employee engagement, mentoring & support

3 - Training on systems & streamlining processes

4 - Introduction of standard operating procedures & work rotation to provide resilience

5 - Increases in staffing levels consumate with the increase in activity levels

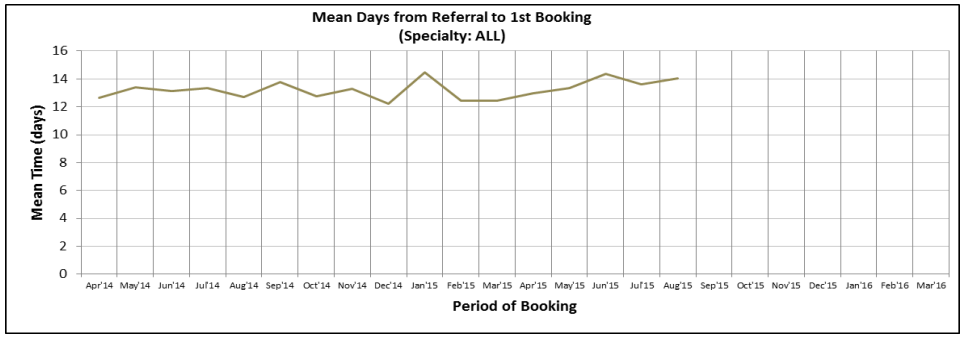
6 - Clarity of role & touch points with Appointment Centre & Clinical Offices

7 - Technological innovation to reduce manual handling & repitition with time savings

8 - Cooperating with Specialty Service Managers to optimise workflow & reduce re-work

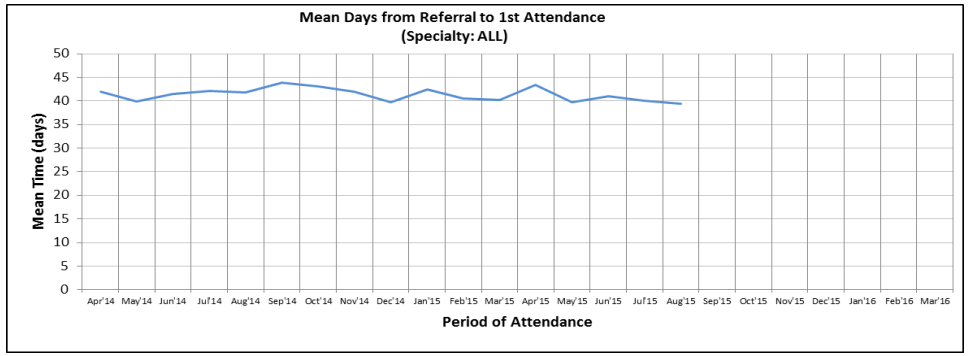
Improvement Activity:

REDUCING TIME TO BOOK FIRST APPOINTMENT



Improvement Activity:

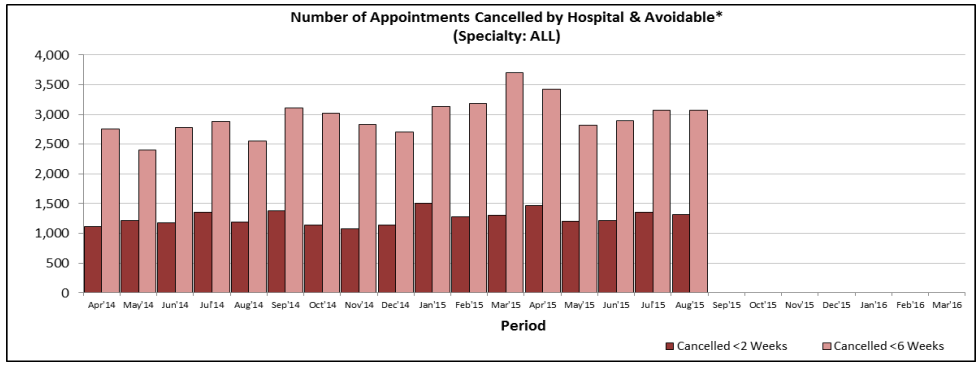
REDUCING TIME FROM REFERRAL TO FIRST APPOINTMENT



IMPROVING OUTPATIENT SERVICES PROJECT

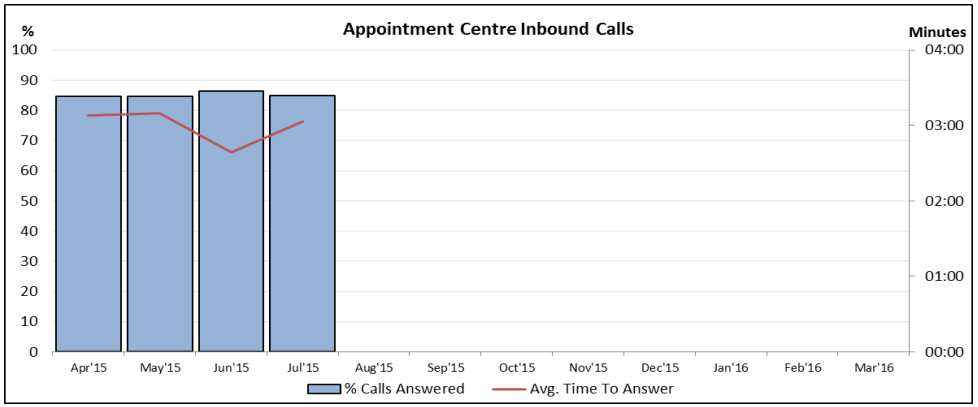
Improvement Activity:

REDUCING AVOIDABLE CANCELLATIONS



Improvement Activity:

REDUCING TELEPHONE ANSWERING TIME FOR PATIENTS



Improving and Sustaining Cancer Performance - 8 Key Priorities

Purpose: To provide assurance over the implementation of the 8 key priorities, based on a thorough self-assessment of the current situation and supported by delivery of the 62 day Cancer Standard Improvement Plan and individual tumour group improvement plans.

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
1.	The Trust Board must have a named Executive Director responsible for delivering the national CWT standard.	Interim Chief Operating Officer (COO) as nominated by Chief Executive	Trust Executive Lead to be confirmed and ratified in new Cancer Operational Escalation Policy.	Cancer Services Manager	Approval by Trust Executive Committee and Cancer Board by October 2015 followed by Trust Board ratification November 2015	New Cancer Operational Escalation Policy currently in development for presentation at Cancer Board 07.09.15
2.	Boards should receive 62 day cancer wait performance reports for each individual cancer tumour pathway, not an all pathway average.	Internal weekly performance report includes the requisite information although this is not published at this level of detail within Trust Board documentation. Trust Board informed of change at July Board meeting.	Head of Performance to review with informatics team. Standardisation of all cancer performance reporting documentation. Current Board scorecard to be updated to include specialty specific data.	Associate Director of Performance	September 2015	Tumour group 62 day performance already published weekly for use at divisional level. First revised Trust Board report in preparation and to commence from 24 September Trust board
3.	Every Trust should have a cancer operational policy in place approved by the Trust	Cancer Operational Escalation Policy to be developed by September 2015 which will be based	Current SOPs to be reviewed & updated to form Cancer Operational Escalation	Cancer Services Manager	November 2015	New Cancer Operational Escalation Policy is in

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
	Board. This should include: • the approach to auditing data quality and accuracy,	on the existing set of Standard Operating Procedures (SOPs) that are now under review. Current Access Policy includes detailed cancer guidance. Completeness of data availability & entry into Somerset Cancer Registry (SCR) seen as fundamental to delivery of the plan. SCR in established use in ASPH. Current establishment includes 1 x band 6 Cancer Operations Manager, 6.9 WTE MDT Coordinators at band 5, 1 WTE band 4 MDT Support worker and 1 PT band 2 notes collector Regular team meetings	Policy. This will be submitted for approval by Trust Board on 24th September. Trust Access policy to be reviewed to ensure alignment with revised Cancer Operational Escalation Policy by 31st October. Any amendments to be signed off by Trust Executive Committee in November. Revised Cancer Operational Escalation Policy to determine updated data entry requirements & audit regime. Auditing of SCR data completeness & accuracy to be established within the revised SOP.	Cancer Services Manager	November 2015	development. Advice sought from IST on identification of exemplar sites 25/08/15.

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
		with all MDT Coordinators in place. Team meeting on 4/9/15 to include discussion on training requirements and review of work plans.				
	• the Trust approach to ensure the MDT coordinators are effectively supported to ensure there is sufficient dedicated capacity to fulfil the function effectively.		Full review of MDT Coordinator resource and role to be undertaken in line with new SOPs and Cancer Operational Escalation policy by 24/12/15 Process for regular review of individual workloads based on performance and referral numbers to be introduced. Updated training and development programme for MDT coordinators to be created	Cancer Services Manager	November 2015	1-1s underway to establish individuals training needs and levels. A review of work plans has commenced and is 50% percent complete Targeted one to one training is underway for all MDT coordinators and team members. SCR Super User training is outstanding, next available course is November. 2 members of staff are booked and the third requiring training is on maternity leave currently.

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
4.	Maintain and publish a timed pathway for which key activities should be carried out, such as OP assessment, key diagnostics, inter-provider transfer and TCI dates, which should be: • agreed with commissioners & other providers involved in the pathway • Take advice from Clinical Networks for lung, colorectal, prostate and breast	Cancer treatment pathways are in place for all tumour groups but these do not have detailed timing and are not actively used to manage pathways. ASPH timed pathways are more clearly defined than those for tumour groups produced by SEC SCN	Agree timescales for development with MDT clinical leads Review good practice in existing pathways (e.g. breast), national guidance, expert networks & available benchmarking. Establish workshops to define pathways, including commissioners Sign off pathways at MDTs and Cancer Board.	Cancer lead clinician	30 October 2015 for completion of pathways Full Cancer Board sign off 15 December 2015	St Luke's Cancer Alliance Draft Inter Trust Referral (ITR) SLA currently being reviewed Breast compliance percentage consistently well above the target threshold. Colorectal pathway event held 1st June and comprehensive improvement plan in place with revised timescales for diagnostics including endoscopy, overseen by the Transformation Programme Board.
5.	Maintain a valid cancer specific PTL and carry out a weekly review for all cancer tumour pathways to track patients and	Weekly PTL established for each tumour group with divisional service managers	Review ToR, attendees, data availability and escalation policy in	Cancer Services Manager	October 2015	

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
	review data for accuracy and performance. Individual patients who have deviated from the pathway standards should have corrective action agreed.	in attendance. Actions currently arranged although a process to identify pathway deviations (at the process level) requires to be introduced.	order to optimise the meetings effectiveness & efficiency. Deviations from the agreed pathway process standards to be made available in a revised PTL report. Expectations of process & escalation to be established within the revised Operational Escalation Policy (Inc. inter-Trust referrals & tertiary partners).	Cancer Services Manager / Head of Informatics	October 2015	Advice sought from IST cancer lead on 25/08/15 on which Trusts use Somerset Cancer Register to best effect
6.	A root cause analysis (RCA) should be carried out for each pathway not meeting the standards. A review of the last 10 breaches should be carried out to identify issues. RCA to be carried out for near misses (would have breached	Root Cause Analysis for TWR & 62 day breaches is currently undertaken & fed back to specialties for improvement opportunities.	Review of RCA to be undertaken, including whether some tumour groups should RCA non-cancer patients and/or near misses. Improvements in data entry & automated reporting to be implemented. Process to review & improve communication,	Cancer Services Manager Cancer Services Manager / Clinical Leads	November 2015	Reporting on RCAs for cancer breaches in place at monthly performance reviews with Executive team Reports shared with CCG and primary care cancer lead

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
	within 48 hours) A review of these should be carried out in the PTL meetings.		accountability & improvement (including tertiary partners) to be established (& included within the O&E policy).		November 2015	
7.	Capacity and demand analysis for key elements of the pathway not meeting the standard (1st OPA and treatment by modality)	Service Managers (with the Performance & Informatics teams) currently undertake D&C modelling using IST model.	Agree priority suite of D&C models to be created, based on performance and RCA data. Agree next priority set based on timed pathway development and outputs from diagnostic demand and capacity review. Work with IST to ensure current best practice in D&C modelling being used. Escalation processes to be reviewed per specialty for capacity issues, triggers & expectations (i.e. stretch & emergency	Cancer Services Manager to oversee programme Service Managers to lead on D&C for individual services Head of Performance to provide expert support	30th November 2015 for priority areas Remainder to be completed by 31/01/16	D&C modelling has been completed for Urology, General Surgery (includes Colorectal, Upper GI, breast) and Endoscopy in July and has been scrutinised in detail with IST through July and August. Actions taken: FBC for expansion of endoscopy unit approved. Lead in time 6 months. Interim solution in place through 3rd party to bridge capacity gap and reduce backlog. 2 additional clinical fellows approved to increase colorectal

No.	National Recommended Priorities	Current Situation	Actions to be taken	By Whom	By When	Progress
			capabilities).			capacity. 7th Urology Consultant approved.
8.	An improvement plan should be prepared for each pathway not meeting the standard, based on breach analysis, current demand modelling, describing a timetabled recovery trajectory for the relevant pathway. This needs to be agreed by local commissioners and any other providers agreed in the pathway (with advice from local clinical networks)	An improvement action plan (overarching for Cancer Services and by specialty) is in place and monitored by the Cancer Board	Improvement actions (for each pathway not meeting their process standard) will be reviewed identifying key drivers for underperformance, remedial action plan and trajectory for improvement. Consultation and agreement with internal key stakeholders & external providers (MRI etc), tertiary partners & CCG. To be overseen by Cancer Improvement Programme Board	Cancer Services Manager	15th September Implementation during Q2/Q3	A joint ASPH/Primary Care improvement plan is in place. Reviewed collectively bi-monthly and internally through the Cancer Board. This is agreed with Commissioners.

62 Day Cancer Standard Improvement Plan

This plan is intended to capture the key reasons for non-compliance with the 62 Cancer Standard trajectory of 85% and describe the actions your trust are undertaking to meet the standard at the earliest possible opportunity and by 31 March 2016 at the latest.

The plan is in addition to the statement that your trust must complete to provide assurance on implementation of the 8 Improving and Sustaining Performance Priorities for the 62 Day Cancer Standard.

Submission Details		
NHS Trust Name		ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST
Submission Date		28-Aug-15
Date agreed by Trust Board		24-Sep-15
Completed by	Name	Lorraine Knight & Tom Smerdon
	Role	Interim COO & Associate Director Operations Medicine
Contact details	Telephone	01932 872000
	E-mail	Lorraine.Knight@asph.nhs.uk
Signed off by Acute Trust Chief Executive	Name	Suzanne Rankin
Signed off by CCG Accountable Officer	Name	Julia Ross

Please submit the completed template to the following e-mail account: england.me-ops@nhs.net by 31 August 2015

If you have any queries regarding the completion of the template please contact your TDA/Monitor/NHS England account manager.

Section 1 - Expected date of achievement of the overall 62 Day Cancer Standard:
Please provide the expected date of achievement of the 62 Day Cancer Standard

Cancer standard	Specific recovery date (DD-MM-YY)	Has this been agreed with commissioners in a Remedial Action Plan?	Comments
62 Day Cancer Standard	31-Dec-15	YES	

Section 2 – Month by month trajectory for achievement of the 62 Day Cancer Standard

Please complete the table detailing the month by month trajectory for achievement of the 62 Day Cancer Standard. NB: This should not be back loaded and should show steady improvement as agreed with commissioners.

	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	
Overall Cancer 62 Day Standard - Trajectory for Achievement	**84.6% (actual)**	**87.4% (actual)**	**89.1% (actual)**	**78.1% (actual)**	**77.1% (est)**	**78.0%**	**78.7%**	**79.2%**	**85.0%**	**90.2%**	**90.9%**	**90.9%**	
Has the CCG agreed to this recovery trajectory?	**YES**												
Is this trajectory formalised in a Remedial Action Plan?	**YES**												

Section 3 - Reasons for non-compliance with the 62 Day Cancer Standard

Please briefly and clearly outline the key reasons for non-compliance with the 62 Day Cancer Standard. You should be able to provide evidence for the reasons identified and if you have had a recent review by the Cancer IST or the Cancer Clinical Network, your response should incorporate the key findings.

The table below provides FY2015 April to July, 62 Day Referral to Treatment activity with breach analysis;

62 Day Referral to Treatment - Breach Analysis - FY2015 April to July (Inclusive)

						Breach Analysis					
	0-31 days	**within 31 days**	**31-62 days**	**within 62 days**	**Over 62 days**	*Delayed Diagnosis*	*Pathway Mgt*	*Tertiary Delay*	*Patient Choice*	*Capacity*	**TOTAL**
Brain/CNS	0	100.0%	0	100.0%	0						0
Breast	6.5	15.5%	35.5	100.0%	0						42
Breast Symptomatic	**4**	28.6%	**9**	92.9%	1						**14**
Colorectal	2	8.0%	20.5	90.0%	2.5	*1*	*1.5*				25
Gynaecology	3	24.0%	6	72.0%	3.5	*3*	*0.5*				12.5
Haematology	2	40.0%	1	60.0%	2	*2*					5
Head & Neck	2.5	25.0%	4.5	70.0%	3	*2.5*		*0.5*			10
Lung	3	18.8%	9.5	78.1%	3.5	*3*	*0.5*	*1*			16
Paediatrics	0	0.0%	1	100.0%	0						1
Sarcoma	0	0.0%	0	0.0%	2		*1.5*	*0.5*			2
Skin	50	71.4%	17	95.7%	3		*2*	*1*			70
Upper GI	1	8.7%	5.5	56.5%	5	*3.5*	*0.5*	*1*			11.5
Urology	13	32.5%	16	72.5%	11	*1.5*	*2*	*1*	*3.5*	*3*	40
TOTAL *Inc Breast Symptomatic*	**87**	34.9%	**125.5**	85.3%	**36.5**	***16.5***	***8.5***	***5***	***3.5***	***3***	**249**
						45.2%	**23.3%**	**13.7%**	**9.6%**	**8.2%**	

The key themes to address areas of underperformance relate to; (1) Delay achieving diagnosis, (2) Delay within pathway & administrative management, (3) Delay at Tertiary Centres, (4) Patient choice to delay & (5) Capacity constraints causing delay.This plan has been reviewed with IST and we will continue to work closely with them to ensure best practice is applied.

Growth of up to 10% was included within FY2015 future planning, although as can be seen from the following tables both Cancer Referral & Cancer Treatment Activity levels during Q1 & the revised estimate for Q2 are being signficantly exceeded.

TWR Referrals - Activity Review - FY2014 & FY2015 Q1 & Q2 (est)

	FY2014				FY2015			
	Q1	Q2	Q3	Q4	Q1	*Increase %*	Q2 (est)	*Q2 Increase % (est)*
Brain/CNS	9	11	9	8	9	*0%*	22	*100%*
Breast	320	295	295	309	336	*5%*	263	*-11%*
Breast Symptomatic	332	319	295	338	325	*-2%*	316	*-1%*
Colorectal	370	352	445	405	375	*1%*	418	*19%*
Gynaecology	138	176	167	164	168	*22%*	208	*18%*
Haematology	17	25	25	19	19	*12%*	14	*-44%*
Head & Neck	167	187	183	165	211	*26%*	221	*18%*
Lung	105	76	84	100	102	*-3%*	117	*54%*
Paediatrics	15	12	16	11	12	*-20%*	22	*80%*
Sarcoma	7	9	17	20	14	*100%*	18	*100%*
Skin	451	479	421	356	502	*11%*	553	*16%*
Upper GI	179	163	184	259	244	*36%*	335	*106%*
Urology	206	211	236	207	189	*-8%*	153	*-27%*
***TOTAL** Exc Breast Symptomatic*	**1984**	**1996**	**2082**	**2023**	**2181**	***10%***	**2345**	***17%***
***TOTAL** Inc Breast Symptomatic*	**2316**	**2315**	**2377**	**2361**	**2506**	***8%***	**2623**	***13%***

62 Day Referral to Treatment - Activity Review - FY2014 & FY2015 Q1 & Q2 (est)

	FY2014				FY2015			
	Q1	Q2	Q3	Q4	Q1	*Increase %*	Q2 (est)	*Q2 Increase % (est)*
Brain/CNS	0	0.5	0	0	0	*0%*	0.5	*0%*
Breast	14	28	29.5	20.5	27	*93%*	35.0	*25%*
Breast Symptomatic	11.5	8	3	8	12	*4%*	8	*0%*
Colorectal	14.5	13	13	15.5	22	*52%*	13	*0%*
Gynaecology	8	6.5	6	6.5	10.5	*31%*	9	*38%*
Haematology	5.5	16	8	13.5	3	*-45%*	6	*-63%*
Head & Neck	2.5	8.5	8	7	7	*180%*	6	*-29%*
Lung	7	10.5	6	7.5	11.5	*64%*	22	*110%*
Sarcoma	0	0	1	1	1.5	*150%*	0	*0%*
Skin	36.5	35.5	44.5	30	49.5	*36%*	45	*27%*
Upper GI	10	5	5.5	6.5	7	*-30%*	9	*80%*
Urology	37	39	29.5	34	28	*-24%*	36	*-8%*
***TOTAL** Exc Breast Symptomatic*	**135.0**	**162.5**	**151.0**	**142.5**	**168.0**	***24%***	**225.5**	***39%***
***TOTAL** Inc Breast Symptomatic*	**146.5**	**170.5**	**154.0**	**150.5**	**180.0**	***23%***	**234.0**	***37%***

We therefore need to address reasons/themes causing breach although also ensuring sufficent capacity can meet the increasing demand.

1. Pathway issues, specifically reducing the time to complete diagnostics, follow up clinics & MDT reviews.

2. Ensuring we have sufficient capacity for first & follow up clinics, diagnostics & treatment with efficient & effective administrative processes enabling delivery.

3. Working with Tertiary partners to reduce inter-Trust delays, through reducing late referrals, improve communication, pathways & joint working.

4. Support patients to reduce patient initiated delays.

5. Update demand & capacity modelling to ensure pathway capacity will meet the increasing demand.

Section 4 - Key Actions to address performance issues raised in sections 1 to 3 above

Please use the table below to detail the key actions you are taking to address performance issues in sections 1 and 2. Where the actions are in response to a Cancer IST or Cancer Clinical Network recommendation, please reference this.

Key actions (prioritised list)	Owner	Key milestones	Completion date	How will you measure progress/delivery?	Expected outcomes/impact	Which tumour sites do the actions relate to?

1. Timed pathways for each specialty	MDT lead clinicians	Pathway Event(s) Sign off of pathways by MDTs Sign off of pathways by Cancer Board	Pathway event completed by 30/10/2015. Lung pathway event by 30/09/15. UGI pathway refresh by 30/09/15. Gynae by 10/10/15. Head & Neck by 20/10/15. Urology by 30/10/15. MDT sign off 30/11/15. Cancer Board sign off by 15/12/15 Programme for remaining pathways to be agreed in January 2016	Pathway events booked and completed, key learning shared and recommendations implemented Detailed project plan with strict deadlines Oversight of the process via Cancer Improvement Programme Board	Immediate identification of cancer patient and pathway, and of deviations from pathway Immediate escalation following prescribed escalation process. Reduction in unexpected events and better patient navigation	Lung, UGI, Gynae, Head & Neck, Urology
2. Demand and capacity modelling	Cancer Services Manager	Agree scope and suite of D&C models required Completion of timed pathways Completion of data sets (input) Production of D&C models Agreement of refresh process for D&C modeling Action plans produced	Priority suite of D&C models to be completed by 30/10/15 Remainder to be completed by 31/01/16	Inclusion of detailed suite of D&C models within Cancer Improvement action plan Agreement of resource to carry out D&C modeling Engagement of MDT leads and teams in the process Oversight by Cancer Improvement Programme Board Opening of 3rd endoscopy room by 1 March 2016 (business case already agreed).	Better understanding of flows and peak times, improved ability to respond to challenges and changes in demand Clear understanding of capacity constraints to be factored into improve timed pathway development. Systematic approach to correcting C&D imbalances in critical	Lung, UGI, Urology, Endoscopy, Radiology, Pathology (IST demand & capacity model in use. LGI, Urology and Endoscopy D&C undertaken in July and assessed by IST)
3. Focused review of diagnostic demand and capacity	Cancer Services Manager	Within the overall D&C programme (above) carry out specific and detailed D&C modeling for diagnostic imaging and pathology. Philips to produce cancer-specific D&C for MRI, CT, US & mammography, to include reporting. SPS to produce cancer-specific D&C for cytology & histopathology	All D&C work to be completed by 30/10/15	Confirmation of timescales and required outputs with Philips and SPS Production of D&C models Engagement with MDTs to enable link with pathway development Identification of areas requiring further work/investment, for further detailed planning.	Resolution of diagnostic capacity constraints and delays, affecting a number of pathways.	All

4. Improve administrative processes for referrals and booking.	Cancer Services Manager	Initial draft of standard operating procedures (SOP) out for review Finalisation of SOPs Formal sign off of SOPs at Cancer Board Post implementation review of effectiveness	Draft SOP 01/10/2015. Final SOPs produced 30/10/15. Cancer Board approval 30/11/15. Effectiveness review 15/01/16	SOPs and Escalation policies ratified Administrative job roles and performance standards aligned to new SOPs	Better training and understanding of CWT across all key personnel. Improved performance of administrative staff. Better support to MDTs Sustained reduction in deviations from timed pathways Reduction in RCAs owing to administrative causes	All
5. Review MDT Coordinator role, resource, structure, performance management and training.	Cancer Services Manager	Review of team structure and capability vs new SOPs Review of team establishment and development of business case if required. Consultation on structural changes if needed. Approval of changes by Cancer Board	Structure & capability review 24/12/15. Consultation 31/01/2016	Inclusion of key milestones within Cancer Improvement Plan Monitoring of progress via Cancer Improvement Programme Board	Improved staff satisfaction and team working Closer working between Cancer Services team and specialty management teams Sustained reduction in deviations from timed pathways Reduction in RCAs detailing administrative causes	All
6. Improve systems for cancer pathway tracking and reporting	Cancer Services Manager	Review use of Somerset in other Trusts, including use of add-ons Engage IT support - if required Complete specification for cancer pathway reporting system, linked to new SOPs Develop new system(s) Develop and implement training on new system(s)	Somerset review 30/11/15. Complete specification 31/01/16	Inclusion of key milestones within Cancer Improvement Plan Monitoring of progress via Cancer Improvement Programme Board	Improved staff satisfaction and team working Greater visibility of individual patient pathways across MDT and management teams More efficient processes for cancer tracking and reporting Produce data for PTLs and for RCAs to ensure that patients are effectively managed through their pathways and analysis of breaches enables rapid identification of stages at most risk of failure	All

7. Strengthen Inter Trust Referal Process.	St Lukes Cancer Alliance	Draft SLA for approval Finalised SLA issued	By 31/11/12	Involvement in discussions to create new SLA Formal input to draft SLA Final ratification of SLA and incorporation of any new requirements into SOPs, policies etc Agree processes for enforcing SLAs and dealing with exceptions	Tertiary referral date set as part of timed pathways. Monitoring of referral by agreed time enabling improvement trajectory to be delivered.	Head & neck, lung, sarcoma, skin, UGI, urology

Section 5 – Support requirements

Please identify the specifc support requirements from the IST/Cancer Network or other bodies to deliver your improvement plan.

Support requirement	Which body would provide this support?
1 Development and enforcement of an inter-trust referral process SLA	**St Lukes Cancer Alliance**
2 Identification of best practice use of Somerset	**IST**
3 Production of D&C for diagnostics	**Philips (managed equipment provider to ASPH); Surrey Pathology Services**

Section 6 – Governance and programme management arrangements

Please use this space to describe the governance and programme management arrangements in place to ensure this improvement plan will be implemented and achieve the standard by the date provided in Section 1 above. Please highlight any vacant posts and workforce recruitment issues in the structure.

Governance:

The primary governance body for this plan will be the Cancer Board, chaired by the Cancer Lead Clinician. The terms of reference for this Board will be reviewed to ensure sufficient scrutiny of the new improvement plan, and a formal link to the Trust Board will be made. Currently the ongoing management of cancer performance takes place via the weekly Cancer Performance meeting, and reported to the Trust Board each month via the financa and performance sub-committee. The Cancer Board will oversee the work of the Cancer Improvement Programme Board.

Programme Management:

A Cancer Improvement Programme Board will be established from early September. This will be chaired by the COO and will meet fortnightly. The Board will be accountable for the successful delivery of the 8 key interventions,, as well as overseeing the delivery of individual tumor group improvement plans, and will track the detailed project plan outlined above.