THE ROYAL WOLVERHAMPTON HOSPITALS NHS TRUST

REPORT TO: Trust Board - 17 January 2011

REPORT OF: Chief Operating Officer

SUBJECT: Operational Performance

AUTHOR: Performance & Service Improvement Manager

RECOMMENDATION:

The Trust Board is asked to

NOTE:

- The Performance Report (November 2010)

Contents

Key to Symbols

CQC E	Existing Commitments
CQC N	National Priorities
PCT	Host Primary Care Trust
SHA	Strategic Health Authority
L	Local
M	Monitor
Dr F	Dr Foster Good Hospital Guide
QA	Quality Account
BCBV	Better Care, Better Value
NHS C	NHS Constitution
CQ	Cquin

1) EXECUTIVE SUMMARY

Healthcare Acquired Infections - C Diff reported cases for the month of November is at 9, above the target of 7.5 for the month. This is against our internal target. It is important that C Diff infection is diagnosed accurately and promptly to enable optimal management of the affected patient and appropriate infection prevention precautions to be instituted in a timely manner. The Trust is looking at changing to a two-step Algorithm test for C Diff sometime in January or February 2011. It is inevitable that there will be a change in the number of cases diagnosed in RWHT when the more sensitive and specific testing method is introduced. Although it is impossible to accurately predict the short term impact of the introduction of molecular testing for C Diff, almost certainly the number of cases detected will increase. We continue our excellent performance in relation to MRSA Bacteraemia.

Cancer - We achieved a score of '1' for the month of November. We continue to maintain a focus on delivering against cancer targets with Divisional Manager lead specialty specific meetings 4 times per week. We have now received the final report following the visit that was undertaken by the National Intensive Support Unit during November 2010 (Appendix 1). An action plan has been implemented to address specific concerns (Appendix 2) and is being reviewed weekly through Divisional and Directorate meetings and by the Chief Operating Officer.

Contract Queries - One received in November - In respect of Assurance of complying with Data Protection Legislation. RWHT provided a response confirming that the Trust would comply with the data protection act and ensure the security and confidentiality of patient information, and that this will be in accordance with the requirements of the Information Commissioner's findings. RWHT also submitted an action plan for security of ICCU charts. The Divisional Manager for ICT and Health Records has confirmed that the Information Commissioner accepted that the Trust had taken all reasonable steps to protect the data and was content that significant safeguards were in place.

1.1 Foundation Trust - Compliance Framework

Performance Indicator	Threshold	Weighting	Quarter 2 Numerator	Quarter 2 Denominator	Quarter 2 Result	Quarter 2 Weighted Score	Oct-10 Numerator	Oct-10 Denominator	Oct-10 Result	Oct-10 Weighted Score	Nov-10 Numerator	Nov-10 Denominator	Nov-10 Result	Nov-10 Weighted Score
Clostridium Difficile year on year reduction	0	1.0	21	26.4	5.4	0.0	8	8.8	0.8	0.0	6	8.8	2.8	0.0
MRSA year on year reduction (year end target)	0	1.0	0	0	0	0.0	0	0	0	0.0	0	0	0	0.0
62 day wait for first treatment from urgent GP referral to treatment - all cancers	85%	1.0	158.5	203	78.08%	1.0	39	51.5	75.73%	1.0	50	60	83.33%	1.0
62 day wait for first treatment from consultant screening service referral - all cancers	90%		19	22	86.36%		10	11	90.91%		14.5	14.5	100.00%	
31 day wait for second or subsequent treatment surgery	94%	1.0	101	107	94.39%	0.0	30	30	100.00%	0.0	36	38	94.74%	0.0
31 day wait for second or subsequent treatment - anti cancer drug treatments	98%		206	206	100.00%		39	39	100.00%		84	84	100.00%	
Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	0.5	37920	38306	98.99%	0.0	11575	11676	99.13%	0.0	13315	13450	99.00%	0.0
31 day wait from diagnosis to first treatment - all cancers	96%	0.5	492	517	95.16%	0.5	147	148	99.32%	0.0	175	176	99.43%	0.0
Two week wait from referral to date first seen - all cancers	93%	0.5	1513	1610	93.98%	0.5	487	500	97.40%	0.0	522	539	96.85%	0.0
Two week wait from referral - symptomatic breast	93%		378	413	91.53%		142	146	97.26%		143	143	100.00%	
Screening all elective in-patients for MRSA	-	0.5	19939	13236	150.64%	0.0	6526	4066	160.50%	0.0	7024	4703	149.35%	0.0
CQC Registration (without condition)	-	0.4				0.0				0.0				0.0
				Total		2		**Total**		1		**Total**		1

Green	<1
Amber Green	1-1.9
Amber Red	2.0-3.0
Red	>3

2) PATIENT SAFETY

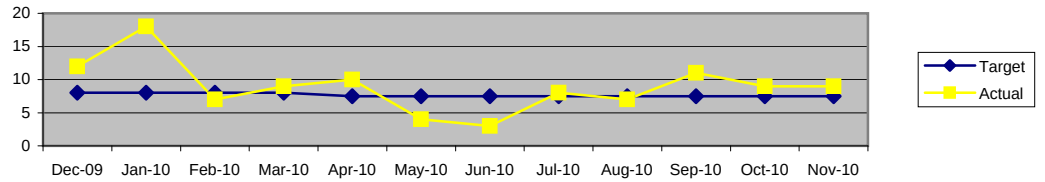
2.1 Healthcare Acquired Infections (HCAIs)

Clostridium Difficile (C Diff) and Methicillin Resistant Staphylococcus Aureus (MRSA) are an important indicator of infection prevention and control. The target for C Difficile is 90 per annum for 2010/2011 which equates to 7.5 per month. In respect of MRSA Bacteraemia, the target is 4 for the year and for the purposes of monthly reporting the target will be zero.

2.1.1 Clostridium Difficile - hospital acquired for ages >2 years

CQC N | PCT | SHA | L | M

Number of C Diff Cases	Cum Plan	Cum Actual	Cum Variance	Yr end Forecast
90	60	61	1	91.5

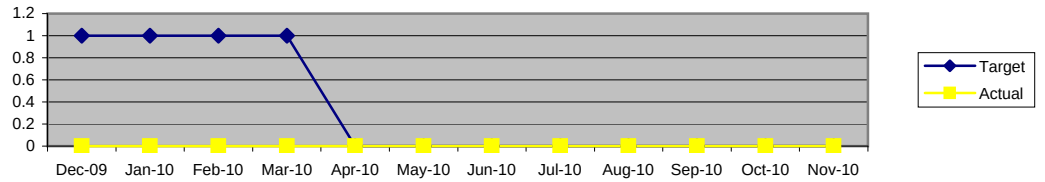


Analysis: No periods of increased incidence

2.1.2 MRSA Bacteraemia

CQC N | PCT | SHA | L | M

Number of MRSA Cases	Cum Plan	Cum Actual	Cum Variance	Yr end Forecast
4	0	0	0	0



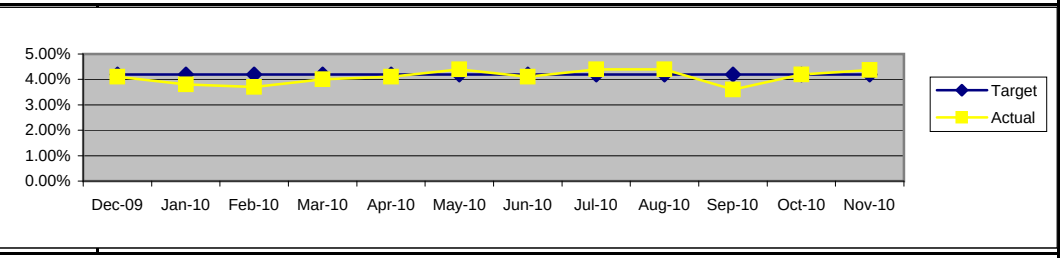
Analysis: This is the seventeenth consecutive month without an MRSA Bacteraemia

2.3 Readmissions

L | BCBV

Emergency Readmissions may be as a result of less than optimal treatment in hospital, badly organised rehabilitation or inadequate support services when a person is transferred home following treatment. This indicator measures the number of patients who are readmitted to hospital, following their discharge from hospital, within 14 days as a percentage of all discharges

Target	Sep-10	Oct-10	Nov-10	Current Month Variance
4.19%	3.60%	4.20%	4.37%	-0.18%



Analysis: Percentage of emergency re-admissions within 14 days has deteriorated in month from 4.20% in October to 4.37% in November, therefore, the position remains above target by 0.18%.

Actions: PCT intervention to introduce an improvement target in December. Current discussions are a 10% improvement on the previous 2 years

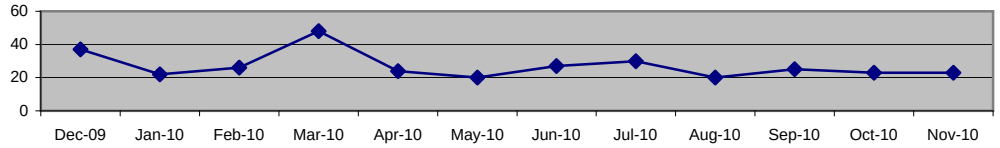
3) PATIENT EXPERIENCE

3.1 Formal complaints

L | NHS C

The following indicates the number of formal complaints received during the month. There is no target in relation to the number of complaints received as the Trust welcomes all feedback as this helps us to continually improve the services we provide. (always one month behind)

Current Month Nov-10	Cum Actual	Yr End Actual 2009/10	Yr End Actual 2010/11
23	192	379	288

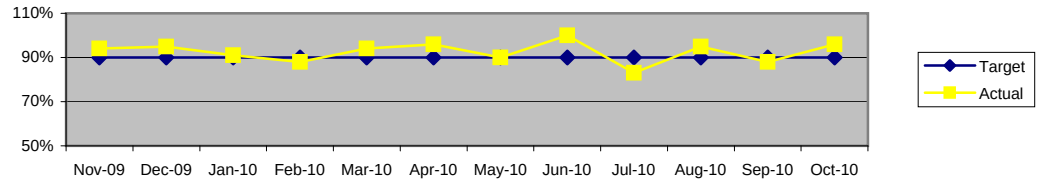


3.2 Complaints resolved within 25 days

L | NHS C

The Trust aims to provide first class responses to greater than 90% of all complaints within 25 working days. Due to the 25 day turnaround target, we will only know the outcome of complaints received between 1st & 14th of the current reported month. Therefore, data reported in the monthly report reflects the previous months position.

Target	Aug-10 Validated	Sep-10 Validated	Oct-10 Validated
90%	95%	88%	96%



Analysis: 23 complaints were received in October, 13 of which were responded to within 25 workings days. 4 complaints took longer than 25 working days, all of which had obtained consent to breach (1 = EAU, 1 = Oncology, 1 = Urology & 1 = Ophthalmology). 6 complaints remain open, 5 of which have consent to breach (1 = Care of the Elderly, 2 = EAU, 1 = Ophthalmology & 1 = A&E) These are due to the complexity of the cases and number of people involved in the responses. 1 complaint (Respiratory) does not have consent to breach.

3.3 PROMS (Patient Recorded Outcome Measures)

CQC

The new Standards NHS Contract for Acute Services includes a requirement to report from April 2009 on PROMs. There are 4 conditions where PROMs data will be collated, using condition specific questionnaires. These are, Primary Unilateral Hip replacement, Primary Unilateral Knee replacement, Groin Hernia Repair & Varicose Vein Procedures. As part of the CQUIN account with Wolverhampton PCT targets have been set in relation to the percentage of eligible patients completing a pre-operative questionnaire.

Procedure	Target	Oct-10	Variance	Nov-10	Variance
Varicose	81%	54%	-27%	51%	-30%
Groin Hernia	76%	82%	6%	78%	2%

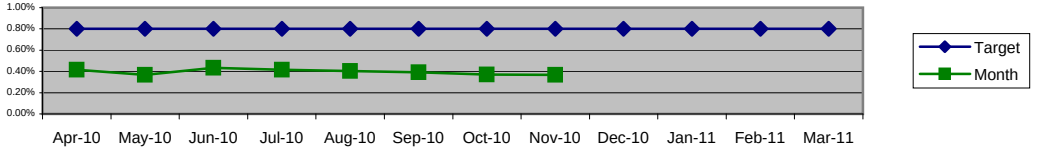
Procedure	Target	Oct-10	Variance	Nov-10	Variance
Hip	72%	79%	7%	78%	6%
Knee	75%	76%	1%	80%	5%

Analysis: Hip, Knee and Groin Hernia participation rates remain above the target agreed with the PCT whilst Varicose Vein continues to be below target. There are problems around collecting data for Varicose Vein Surgery, this is mainly due to some procedures happening in outpatient clinics. This reported position is based on internal collection of data against the agreed targets with the PCT.

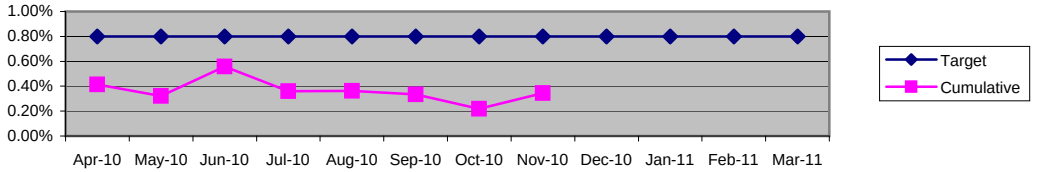
3.4	**Short Notice Cancellation of Operations**	**CQC E**	**L**					

The aim of this measure is to reduce the number of operations cancelled at short notice for non-medical reasons. Short notice is defined as "on the day of procedure or day of admission". Short notice cancellation not only leads to poor patient experience but also results in a loss of operating capacity. When a patient's operation is cancelled by the hospital at the last minute for non clinical reasons, we must offer another binding date within a maximum of the next 28 days or fund the patient's treatment at the time and hospital of the patient's choice - a potential further cost to the organisation.

Target Month	Nov-10 Actual	Oct-10 Actual	Sep-10 Actual
0.80%	0.37%	0.37%	0.39%



Cumulative	Nov-10	Oct-10	Sep-10
Cancellations	188	165	152
Elec Procedures	51318	44659	38687
Cum %	0.37%	0.37%	0.39%



Analysis:

	Anaes not available	Kit Not Available	Ran out of Theatre	More Urgent Case(s)	No Beds	Cons not avail or ill	No ITU/HDU Bed	Total
Urology			2					**2**
Gen Surg			3	1				**4**
Cardiac			1	2	1		2	**6**
Gynae								**0**
Ortho			2					**2**
Cardiology				1	3			**4**
H&N			3		1			**4**
Ophth		1						**1**
								0
Total	**0**	**1**	**11**	**4**	**5**	**0**	**2**	**23**

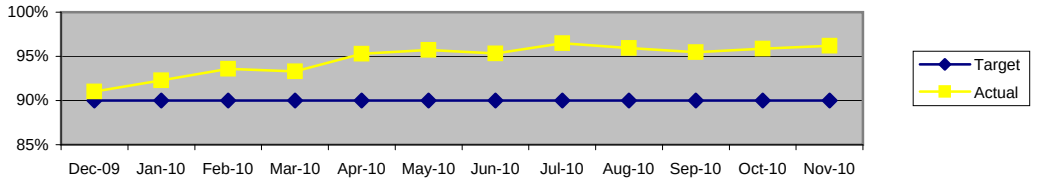
Actions: 23 operations were cancelled during November, this is a deterioration from 13 in October. A root cause analysis continues to be undertaken for every cancelled operation to ensure that systems can be put in place to minimise cancellations for non-medical reasons therefore improving the patient experience.

4)	EFFICIENCY AND EFFECTIVENESS							
4.1	Service Delivery							
4.1.1	18 week Referral to Treatment (RTT)	CQC N	PCT	QA				

In the 2009-2010 Operating Framework there is a commitment that all patients will be treated within 18 weeks with effect from 1st April 2009. This expands the 18 week RTT operating standard to cover non Consultant led services but also those services provided by Allied Health Professionals and Nurses. The only exceptions to the 18 week operating standard are in relation to patient choice and clinical complexity. By Quarter 4 (2009/2010) all specialties must achieve and maintain the 18 week standards. The NHS Constitution makes this a right for patients from 1st April 2010.

Admitted

Target	Nov-10
90%	96.18%



Analysis:-

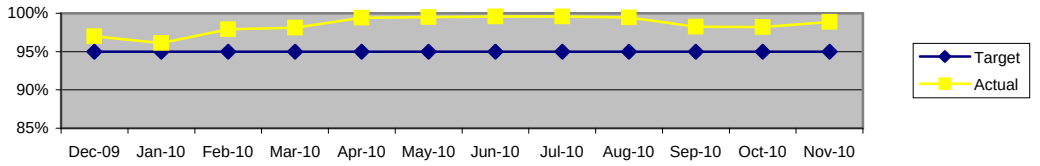
Specialty:
Specialty:

Comments

All specialties achieved the target in November

Non-Admitted

Target	Nov-10
95%	98.87%



Analysis:-

Specialty:
Specialty:

Comments

All specialties achieved the target in November

4.1.2	A&E 4 Hour Wait	CQC E	PCT	SHA	M	QA		

98% of patients accessing emergency services (including, A&E Departments, PCT Walk-in Centre and Doctors on-call) should spend no more than four hours in the 'department' from their arrival to admission, transfer or discharge. The 2% tolerance is in place to reflect complexity of clinical condition.

	Target	Nov-10	Variance	Cumulative	Variance
Internal	98%	98.62%	0.62%	98.62%	0.62%
Overall	98%	99.05%	1.05%	99.12%	1.12%

Analysis: The analysis above shows RWHT internal performance and the overall health economy performance, both by latest full month and cumulatively. Although the DH threshold for A&E has been reduced to 95% in the revised Operating Framework, we continue to monitor against an internal target of 98% which indicates our commitment to ensuring patients admitted via emergency portals receive quality care as quickly as their clinical condition allows.

Actions: Winter plan activated with full participation across the Trust

4.1.3 Care Quality Commission - Existing Commitments & National Priorities (not already covered in report). Indicators for 2010/11 are yet to be finalised therefore reporting will continue against those indicators used in the 2009/2010 Periodic Review process.

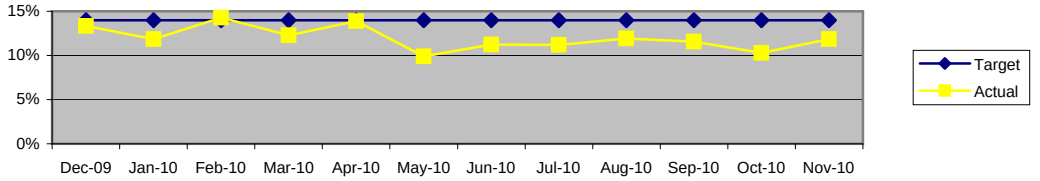
	Current	Comments
Access to Genito Urinary Medicine - 100% of patients will be offered an appointment within 48 hours	100%	Patients being seen within 48 hours is just 65.29% - this is a deterioration of 12.53% from the one reported in October (77.82%), this figure is due to patient choice.
In order to monitor the reduction of health inequalities related to ethnic diversity, it is essential that data quality on ethnic group is >/= 95%	95.09%	This is the fourth consecutive month this target has been achieved. This target is 10% above the threshold used by the CQC in previous years
Reducing delays in transfer of care will enable us to measure the impact of community-based care in facilitating timely discharge from hospital and the mechanisms in place within the hospital to facilitate timely discharge.	77	This is a very slight deterioration from the October position of 75

	Existing Commitments & National Priorities - Continued		
	No patient will wait longer than 26 weeks for in-patient care	0	
	No patient will wait longer than 13 weeks for out-patient consultation	0	
	No patients will wait longer than three months (13 weeks) for revascularisation	0	
	2 week waiting time for Rapid Access Chest Pain Clinic	100.00%	
	62 days from urgent GP referrals to first definitive cancer treatment: All Cancers (85%)	83.30%	**13 breaches** - 2 complex pathways, 3 delay for further investigations, 5 patient initiated, 2 tertiary referrals received at 62 days or more, 1 capacity issue
	62 day wait for first treatment from consultant screening - all cancers (90%)	100.00%	
	62 days for first treatment for those patients who are upgraded with a suspicion of cancer (Threshold still outstanding)	96.15%	
	31 day (diagnosis to Treatment) Wait for First Treatment - All Cancers (96%)	99.43%	
	31 day wait for second or subsequent treatment: Anti Cancer Drug Treatment (98%)	100.00%	
	31 day wait for second or subsequent treatment: Surgery (94%)	94.74%	
	31 day wait for second or subsequent treatment: Radiotherapy Treatments (shadow monitoring until Dec 10) - (94%)	100.00%	
	All Cancer Two week Wait (93%)	96.85%	
	Two week wait for symptomatic breast patients (cancer not initially suspected) (shadow monitoring until Dec 09) - (93%)	100.00%	
	Cancelled operations - patients not admitted within 28 days	0	
	Infant health and inequalities (smoking and breastfeeding initiation) - identify all mothers	100.00%	

4.1.4	**Pre-Op Length of Stay**	**L**	**BCBV**					

This indicator is a sum of all the bed days between date of patient admission and the date of their procedure. It is expressed as a percentage of all bed days for the hospital.

Target per Month	Nov-10	Variance
14%	11.85%	2.15%



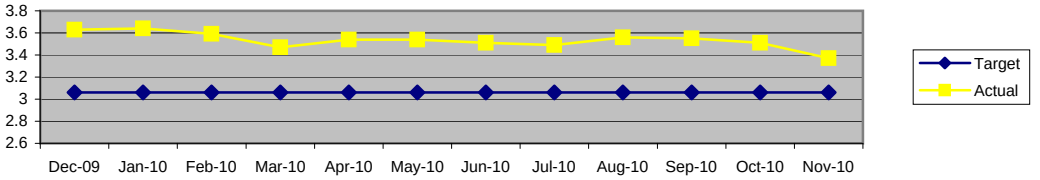
Analysis: Percentage of bed days spent pre-operatively continues to remain below target

Actions:

4.1.4	**Elective Length of Stay**	**L**						

We continually strive to reduce length of stay in an effort to improve the patient experience by avoiding unnecessarily long stays in hospital. This also ensure that we are optimising the available bed capacity. In order to deliver contract activity levels for 2009/2010 a 10% reduction was applied to the LOS target. Figures below show a 6 month moving average. The target for 2010/2011 remains unchanged pending the commencement of the capacity and demand project.

Target per Month	Nov-10	Variance
3.06	3.37	-0.31



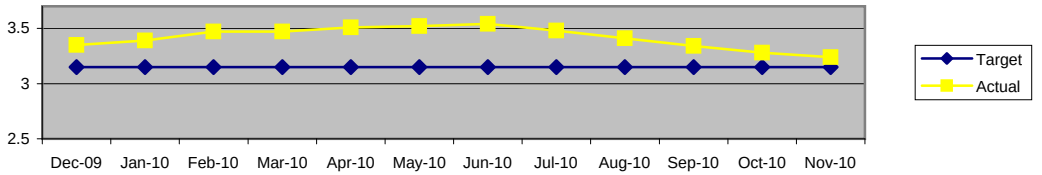
Analysis: Remaining above target by 0.31%

Actions: Continue to focus on reducing long stayers, timely discharge and admission avoidance increasing day case rates

4.1.4	**Non-Elective Length of Stay**	**L**							

We continually strive to reduce length of stay in an effort to improve the patient experience by avoiding unnecessarily long stays in hospital. This also ensure that we are optimising the available bed capacity. In order to deliver contract activity levels for 2009/2010 a 10% reduction was applied to the LOS target. Figures below show a 6 month moving average. The target for 2010/2011 remains unchanged pending the commencement of the capacity and demand project.

Target per Month	Nov-10	Variance
3.15	3.24	-0.09



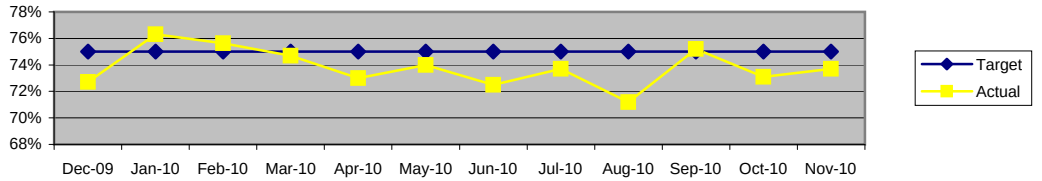
Analysis: This is an improved position from that reported in October (3.28%), however, the position remains above target

Actions: See actions associated with Elective Length of stay (above)

4.1.5	**Day Case Rates**	**L**	**BCBV**						

The calculation of performance is based on our position against benchmarks set by the British Association of Day Surgery (BADS)

Target per Month	Nov-10	Variance
75%	73.71%	1.29%

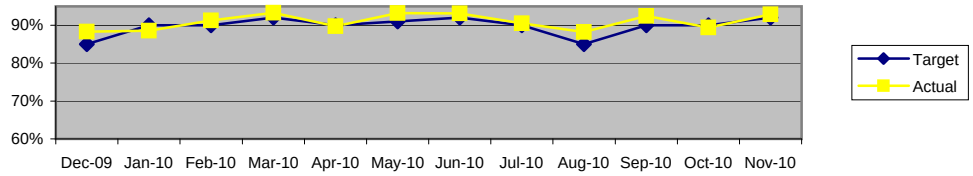


Analysis: This is a slight improvement on that reported in October (73.1%) by 0.61%.

Actions: We are continuing to look at any specialties that are significantly below expectation

4.1.6	**Theatre Utilisation**	**L**						

This indicator shows the number of theatre sessions used expressed as a percentage of sessions planned. With the launch of Productive Theatre, indicators associated with theatre utilisation may be amended during the course of 2010/2011.



Target this Month	Nov-10	Variance
92%	92.90%	0.90%

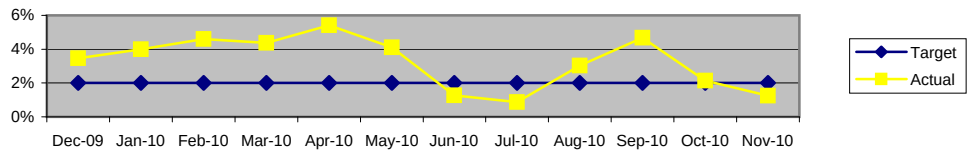
Analysis: The overall Trust position for theatre utilisation is above target for the month of November.

Actions: Productive Theatre project continues, the events that ran during November were well attended by a good mix of staff including Consultants. Work will continue during January, with audits taking place and regular meetings.

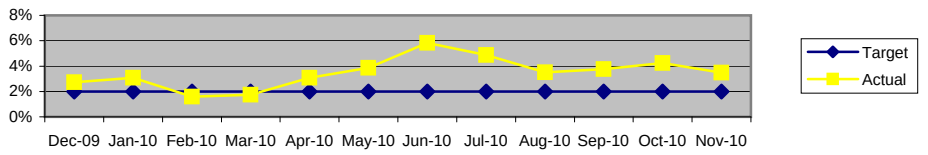
4.2	**Workforce**							
4.2.1	**Recruitment and Retention**	**L**						

Recruitment is seen as a key priority for the Trust, most particularly into nursing posts. Keeping vacancies to a minimum will not only improve patient and staff experience, it will also help with our aim to reduce the reliance and therefore expenditure on temporary staff.

Vacancies - Trained Nursing Staff



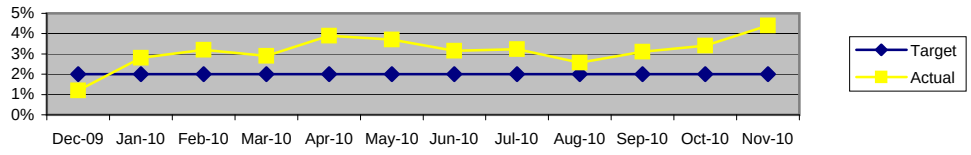
Vacancies - Non Trained Nursing Staff



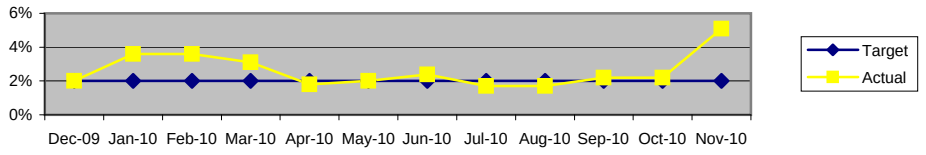
Analysis: Trained nursing vacancies have decreased slightly but no major changes. Recruitment to the winter wards continues through the generic advert.

Actions: Post specific recruitment is ongoing for the specialist areas. Ongoing generic recruitment to Band 5 nursing posts continues in order to recruit to vacancies.

Vacancies - Medical Training Grades



Vacancies - Non Training Grades



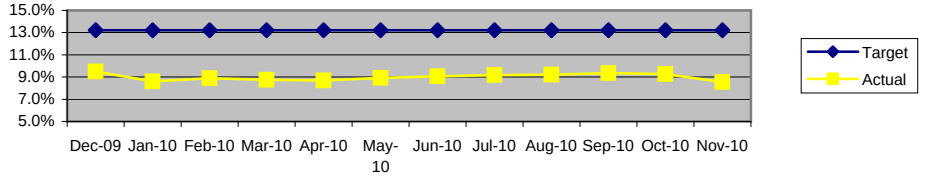
Analysis: Training and non-training grade vacancies continue in Medicine, Ophthalmology, Anaesthetics and ENT with a Consultant vacancy in Urology

Actions: All vacant post are being advertised.

4.2.2	**Turnover**	L						

Figures from the Chartered Institute of Personnel and Development's Recruitment and Retention Survey 2008, indicated that the annual turnover rate in the UK is 17.3% and within the NHS has increased from 12.1% to 13.2%. The Trust internal target for last year was 11.5% but given the change in the national turnover rate, the target has been set at 13.2%.

Target	Nov-10	Variance
13.20%	8.54%	4.66%

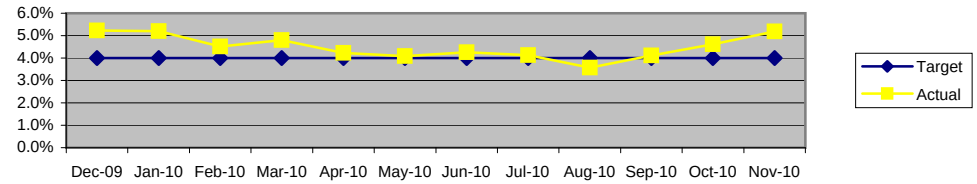


Analysis: We continue to achieve a much better turnover rate than the national NHS rate of 13.2%

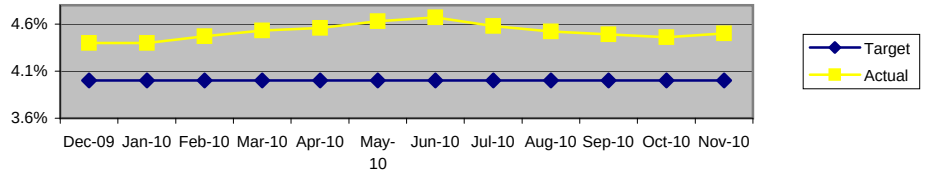
Actions

4.2.3	**Sickness Absence**		**L**						

In Month Actual - The Trust target is 4%



Moving Annual Average - The Trust target is 4%

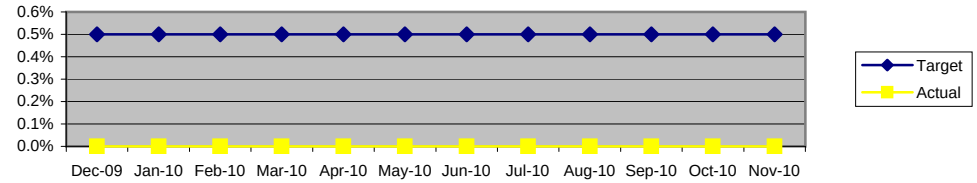


Analysis: Sickness absence for the month of November 2010 has increased by 0.57% from 4.61%% in October to 5.18% in November 2010. Figures also show a 0.42% increase when compared with the same period in 2009. A third of the total sickness absence in November 2010 was attributable to muscular skeletal disorders and mental health conditions. There was little change in total hours lost due to viral illness and influenza when compared with October 2010, however, there was a 28% increase in hours lost due to diarrhoea and vomiting, which accounted for 6.83% of the total sickness absence (D&V accounted for 5.93% of total sickness absence during the same period in 2009). Of the total 5.18% absence, 3.18% was due to long term sickness, over 25% of which was due to mental health conditions. The main reasons for short term sickness were viral illness and influenza, which accounted for 30% of short term sickness hours lost.

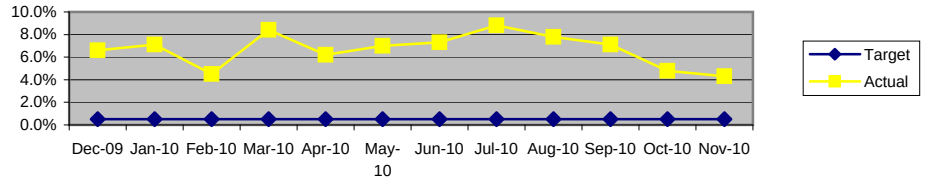
Actions: Sickness absence workshops have continued in many areas, although a number have been postponed during December due to clinical/operational commitments of managers and matrons. The flu vaccination programme continues, with additional sessions being provided out of hours 7 days a week. The Infection Prevention Team have issued advice to managers with regards to the management and control of a potential Norovirus outbreak affecting patients and/or staff.

4.2.4	**Temporary Staffing**		**L**						

Temporary Nursing Staff (cumulative spend)



Temporary Medical Staff (cumulative spend)



Analysis: There has been no agency expenditure for nursing staff during November. In terms of medical agency there has an overall decrease for the fourth consecutive month of 0.5% in month 8 from 4.8% in October to 4.3% in November. **Division One** has seen a slight increase in month from £79K in October to £82K in November. Agency expenditure in Head & Neck is high due to the use of NHS Locum's covering a Consultant post and 3 junior doctor posts. **Division Two** saw a reduction in month from £143K in October to £121K in November. Agency expenditure in Neurology remains high due to the use of Commercial services being used for Consultant Neurophysiologist work. Spend also remains high in Emergency Services - nursing staff in EAU (bank nursing) and EAU Consultant will remain the same until vacancies have been filled.

Actions: As above

	Compliance with European Working time Regulations		**L**						

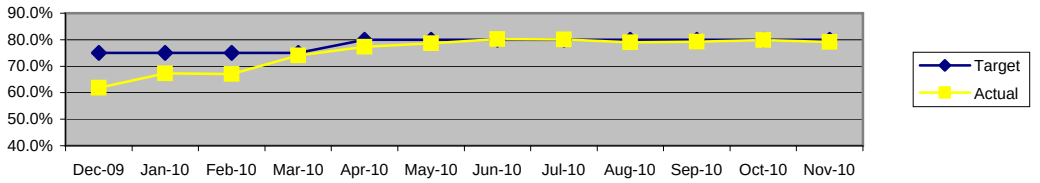
The European Working Time Directive lays down minimum requirements in relation to working hours, rest periods, annual leave and working arrangements for night workers. The EWTD is a legal requirement and leads to a better health and safety and work life balance for all employees.

Analysis : For Junior Medical Staff we are 100% compliant.

4.2.6	**Education and Training**	**L**	**NHS C**					

Annual Appraisal: Workforce performance outcomes will be addressed through the Trust's annual appraisal and personal development processes. This indicator shows the percentage of all staff who have had an appraisal in the last 12 month. For 2010/2011 the target has been increased from 75% to 80% as year two progress towards 95% at year five.

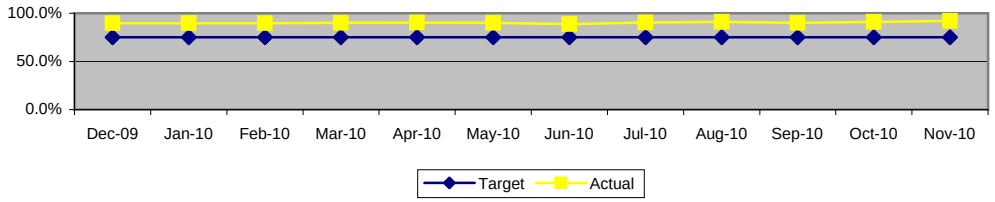
Target	Nov-10	Variance
80.00%	79.10%	0.90%



Analysis: November's position has seen a slight deterioration from that reported in October, therefore, the overall Trust position remains just below the target set for 2010/2011. There are 12 areas showing as red i.e. <70% compliance, the number of staff with no appraisal in the last 12 months is shown in brackets. **Division 1** - Ophthalmology (42), Urology (8) **Division 2 -** Capacity & Emergency Planning (6), Emergency Medicine (39) **Estates and Facilities** - Catering (77), Linen Services (4), Industrial Services (3), Mechanical Services (10) **Corporate** - Director of Finance (32), Medical Director (25), Director of Nursing (17), Trust Management Team (9)

Mandatory Training: The Trust has a list of eight mandatory training topics which are generic and therefore applicable to all staff. The areas of focus are: Customer Care, Fire Safety, Hand Hygiene, Information Governance, Risk Management/Incident Reporting. Safeguarding Adults & Safe Guarding Children

Target	Nov-10	Variance
75.00%	92.00%	17.00%



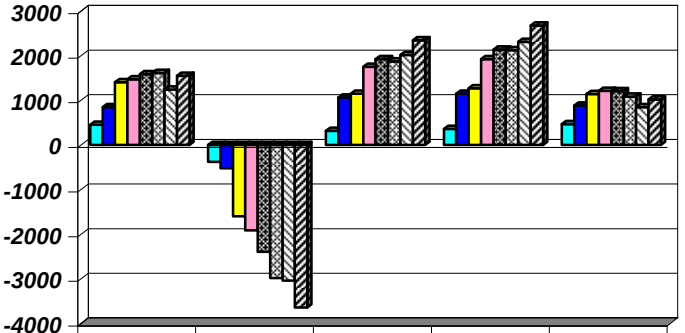
Analysis: Improvement in month from 91% to 92%, remaining well above target. Three areas with departments showing <65% compliance i.e. 'red' performance are **Fire Safety** (Governance & Legal Services, Infection Prevention, Director of Estates Development, Trust Management Team, Capacity & Emergency Planning Team, Linen Services, Buildings & Horticultural Services & Industrial Services) **Hand Hygiene** (Governance & Legal Services, Director of Estates Development, Dermatology, Capacity & Emergency Planning, Catering, Linen Services, Staff Accommodation & Industrial Services) **Safeguarding Children** (Director of Estates Development)

Actions:

5) FINANCE

5.1 SLA Income v plan
5.2 EBITDA to date vs plan
5.3 Income & expenditure surplus to date vs plan
5.4 Forecast income & expenditure vs plan
5.5 Cash balance to date vs plan

Analysis: With the exception of expenditure variance vs plan, all areas are reporting a favourable position at month eight



	Income variance vs. Plan	Expenditure variance vs. Plan	EBITDA is in line with plan	Achieve income and expenditure	SLA income against plan
Apr-10	455	-378	316	358	465
May-10	848	-523	1066	1150	887
Jun-10	1406	-1595	1149	1269	1144
Jul-10	1471	-1916	1752	1927	1211
Aug-10	1590	-2396	1923	2141	1210
Sep-10	1618	-2983	1873	2126	1086
Oct-10	1246	-3040	2021	2314	852
Nov-10	1552	-3641	2346	2678	1020

5.6 Delivery of Cost Improvement Programme

	October	November
2010/11 Total	£10,631	£10,631
Quarter 3	£8,505	£8,505
Current	£6,384	£8,258
Variance against Q1 plan	**-£2,121**	**-£247**

The table above shows year to date actual delivery of CIP against plan for Quarter 3. This equates to 78% removed from budgets against a plan of 80% for quarter 3

5.7 Actual Performance against contract

	Plan	Actual	Var.
Emergency In-patients	29,558	29,934	**376**
Elective In-patients	7,132	6,549	**-583**
New Out-patients	58,808	64,074	**5266**
All Out-patients	132,925	150,483	**17558**

The table above shows year to date actual performance against cumulative plan

6) ENVIRONMENT

6.1 Capital programme is delivered to CRL

Annual Plan	Year End Forecast	Variance
£18,035,000	£18,499,949	**£464,949**

Analysis: Total forecasted annual is £464K over plan (2.6%)

6.2 Capital spend is managed within plan

Cumulative Plan	Cumulative Actual	Variance
£11,628,484	£9,790,830	**-£1,837,654**

Analysis: Cumulative spend is £1,838K under plan (-16%)

7) Better Care, Better Value — L

The NHS Institute for Innovation and Improvement supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership. With a mantra of "Effective healthcare is efficient healthcare" the institute states that the NHS must demonstrate that it is making the most effective use it can of public money to deliver quality healthcare. Their website is designed to help local NHS organisations do this. It is based around 15 high-level indicators of efficiency that identify potential areas for improvement in efficiency. The indicators, primarily aimed at Commissioners (PCTs) and Acute Hospital Providers (AHTs) were published for the first time in October 2006 and are updated and republished every quarter thereafter.

Comparison with other Trusts - The table below shows RWHT ranking out of 170 Trusts that are currently reported in the Better Care, Better Value indicators

	Quarter 4 2009/10		Quarter 1 2010/11	
LOS	26th	Positive	18th	Positive
Day Case Rates	64th	Negative	No Longer Measured	
Pre-Op (Non-elective)	138th	Negative	No Longer Measured	
Pre-Op (Elective)	70th	Positive	80th	Negative
DNA	81st	Negative	117th	Negative
New to Review	137th	Negative	127th	Positive

Comparison with Trusts in the West Midlands - The table below shows RWHT ranking against 12 other Trusts in the West Midlands with a similar portfolio i.e. single specialty and very small organisations have been excluded

	Quarter 4 2009/10		Quarter 1 2010/11	
LOS	1st	Static	1st	Static
Day Case Rates	4th	Positive	No Longer Measured	
Pre-Op (Non-elective)	10th	Negative	No Longer Measured	
Pre-Op (Elective)	4th	Positive	5th	Negative
DNA	5th	Static	10th	Negative
New to Review	10th	Negative	10th	Static

8)	NHS Performance Framework - RWHT Report Card - Q2 2010/2011	L	

Finance

Indicator Weight	Indicator	Finance Score
1.0	Initial Planning	3
1.0	Year to Date	3
1.0	Forecast Outturn	3
1.0	Underlying Financial Position	3
1.0	Better Payment Practice Code	2
1.0	Balance Sheet Efficiency	3

	Current Performance Total:	Upper Threshold	Lower Threshold
Current Performance Total:	3	3	1
Overall Finance	Performing		

Standards and Vital Signs

Indicator Weight	Indicator	Standards & Vital Signs			Upper Threshold	Lower Threshold
		Performance	Score	Weighted Score		
1.00	A&E waits (YTD)	99.1%	3	3.0	95%	94%
1.00	Breaches of 28 days readmission guarantee as % of cancelled ops (YTD)	0.0%	3	3.0	5%	15%
1.00	MRSA (YTD - measured against SD from trajectory)		3	3.0	0.0	1.0
1.00	CDIFF (YTD - measured against SD from trajectory)	-3.2	3	3.0	0.0	1.0
0.50	RTT - Admitted (Median)	8.9	3	1.5	11.1	
0.50	RTT - Admitted (95th Percentile)	17.9	3	1.5	27.7	
0.50	RTT - Non-admitted (including audiology) (Median)	4.6	3	1.5	6.6	
0.50	RTT - Non-admitted (including audiology) (95th Percentile)	13.5	3	1.5	18.3	
0.50	RTT - Incomplete pathway (Median)	5.0	3	1.5	7.2	
0.50	RTT - Incomplete pathway (including audiology) (95th Percentile)	17.1	3	1.5	36.1	
1.00	48 hours GUM access (YTD)	100.0%	3	3.0	98%	95%
1.00	Percentage of patients whose transfer of care was delayed, averaged over the reference period (YTD)	4.9%	2	2.0	3.5%	5.0%
0.50	2 week GP referral to 1st outpatient, cancer (YTD)	94.3%	3	1.5	93%	88%
0.33	31 day second or subsequent treatment (surgery) (YTD)	93.9%	2	0.7	94%	89%
0.33	31 day second or subsequent treatment (drug) (YTD)	100.0%	3	1.0	98%	93%
0.33	31 day diagnosis to treatment for all cancers (YTD)	95.5%	2	0.7	96%	91%
0.33	62 day referral to treatment from screening (YTD)	84.6%	0	0.0	90%	85%
0.33	62 day referral to treatment from hospital specialist (YTD)	89.5%	3	1.0	85%	80%
0.33	62 days urgent referral to treatment of all cancers (YTD)	77.7%	0	0.0	85%	80%
0.50	Percentage of patients referred for evaluation/investigation of "breast symptoms" seen within 14 days	90.5%	2	1.0	93%	88%
1.00	2 week RACP (YTD)	100.0%	3	3.0	98%	95%
1.00	Patients that have spent more than 90% of their stay in hospital on a stroke unit	78.9%	3	3.0	60%	30%
1.00	Thrombolysis 'call to needle' within 60 minutes	Low Numbers		3.0	68%	48%
	Proportion of people receiving PCI within 150 minutes	92.8%	3		75%	60%

	Current Performance Total:	Upper Threshold	Lower Threshold
	2.72	2.40	2.10
Current Performance Total:	Performing		

Registration

Indicator Weight	Indicator	Quality & Safety Current Value	Quality & Safety Score
1.0	Registration	No Conditions	3
	Current Performance Rating:	Performing	

User Experience

Indicator Weight	Indicator	User Experience Current Value	User Experience Score	Average	Standard Deviation
1.0	Access & waiting	84.4	1.0	85.0	3.4
1.0	Safe, high quality co-ordinated care	64.2	1.0	64.4	4.5
1.0	Better information more choice	61.9	0.0	66.8	4.3
1.0	Building closer relationships	82.0	1.0	82.9	3.0
1.0	Clean comfortable, friendly place	77.9	1.0	79.1	2.8

	Current Performance Total:	Upper Threshold	Lower Threshold
	4.0	4	2
Current Performance Rating:	Performing		

Overall Quality	Performing

The NHS Performance Framework was introduced at Q4 2008/09 and was initially applied to only Acute and Ambulance Trusts. It was extended to cover Mental Health Trust and PCT providers in October 2009 and was further extended to cover PCT Commissioners in April 2010. The Framework does not extend to Foundation Trusts. Based on the metrics underpinning the Performance Framework, organisations will be categorised into one of four categories:- 1) Performing 2) Performance under review 3) Underperforming 4) Challenged.

Comments: RWHT is reported as 'performing'. A position which has remained unchanged from the opening assessment in Q4 2008/09. Out of the surrounding Trusts the following are reported as 'performance under review' for Overall Quality and also for Quality Standards & Vital Signs - Shrewsbury & Telford Hospital and University Hospital of North Staffordshire.

APPENDIX 1

Summary of the Intensive Support Team visit to The Royal Wolverhampton Hospitals NHS Trust held on 22 November 2010

1. Introduction

1.1. Reasons for engagement

The IST was invited to the Trust by the Chief Operating Officer as part of an assurance visit to review the Trust's cancer pathways and processes in place to deliver the cancer waiting time standards (in particular the 62-day referral to first treatment standard). The aims of the visit were to validate the work currently ongoing at the Trust to improve its services and where possible to make further recommendations to facilitate delivery and sustainability of the 62 day standard.

The report below is a summary of the IST Cancer Team's diagnostic visit and summarises the themes and issues that came out of the meetings that were conducted throughout the visit. Recommendations to take forward are included within each section.

This report follows on from the informal feedback provided at the end of the visit.

1.2. Trust cancer performance: April – September 2010

The Trust's cancer waiting times performance data is summarised in the table below:

	Standard	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10
2WW Suspected Cancer	**93%**	95.1%	96.0%	93.9%	93.2%	93.2%	94.5%
2ww Breast Symptomatic	**93%**	87.5%	96.0%	84.7%	88.4%	93.4%	93.1%
31 Day (First)	**96%**	98.9%	94.5%	93.2%	92.3%	97.6%	96.9%
31 Day (Sub Surgery)	**94%**	100.0%	96.9%	86.8%	94.1%	87.5%	100.0%
31 Day (Sub Drug)	**98%**	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
62 Day (All Cancers)	**85%**	81.1%	75.2%	73.8%	76.3%	82.8%	79.2%
62 day (Screening)	**90%**	86.4%	100.0%	76.0%	58.3%	100.0%	90.9%
31 Day (Sub Radiotherapy)	**94%**	98.6%	94.4%	94.0%	100.0%	97.8%	99.2%

1.3. Specific concerns

The IST Cancer Team met with the key clinicians, managers and administrators from the Trust from whom to gain some further understanding into the way their cancer services function and where any improvements may be made.

The Trust is currently achieving all cancer standards accept for the 62-day all cancer pathway (September 2010 CWT data). Although delivery of the other standards has been met, this has not been on a regular basis. The Trust has failed to meet the 62 day standard each month in this financial year and highlighted five tumours groups with which to focus the review on; Gynaecology, Urology, Lower and Upper GI and Head and Neck. The Trust would like to create more sustainable services and processes capable of delivering the cancer waiting times across all tumour groups.

2. Leadership and Management

Delivering high quality cancer services and achieving the national cancer operational standards are considered a high priority for the Trust. The IST noted the high level of executive, senior management and clinician engagement during the diagnostic visit.

2.1. Reporting lines

The organisation has clear reporting structures for cancer. There is a designated Trust executive lead, Clinical Lead, and Directorate Manager for Cancer Services.

The local health community performance structure for cancer was briefly touched on with a discussion about how the standards were picked up in the cancer LIT and referrals/conversion rates in contractual meetings. The PCT was also particularly focussed on the patient experience for those on a gynaecological cancer pathway.

In terms of operational delivery it is clear that ownership and responsibility of the cancer targets sits with the two divisions (1 and 2) and cancer services sits across these divisions providing specialist knowledge.

2.2. The role of the MDT co-ordinators and trackers

There is a combination of MDT co-ordinators and tracking clerks for each of the different tumour sites. Each of the specialities has a separate MDT co-ordinator and tracker.

The Trust relies heavily on the ability of the patient tracker to understand every pathway detail for each patient and it is clear that they do. Of concern is the level of cover should a tracker be absent from work. Current escalation processes are initiated by each tracker when they feel that a patient has waited a longer than necessary time on a particular part of the pathway (highlighting a possible breach).

Recommendation

- **Ensure adequate cover for patient trackers (buddy system) to ensure all absences are covered.**

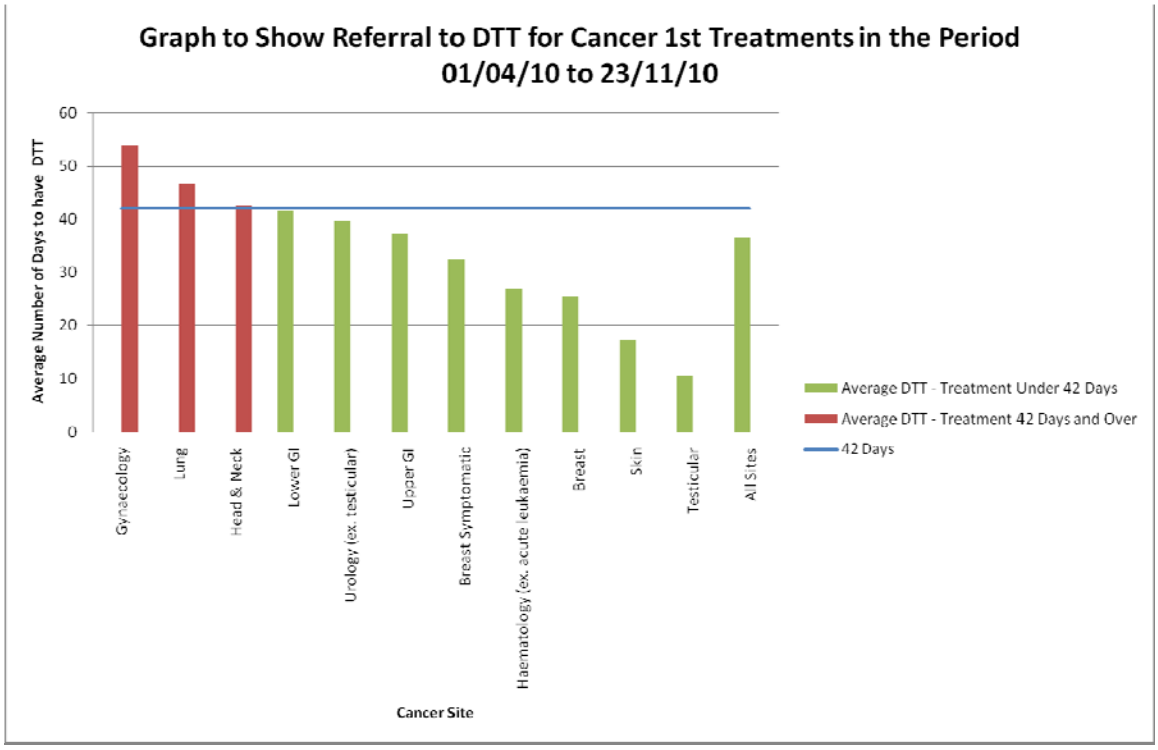
3. Reporting and Governance

3.1. Internal monitoring

Internally, there are operational meetings held four times a week. These meetings are led by the appropriate Divisional Manger and attended by the Directorate manager, Cancer Services Manager and relevant MDT co-ordinator and patient tracker. During this meeting each potential breach patient and actual breach is reviewed. Managers are expected to attend the meeting with a progress update on each of the patients. Due to time constraints the IST was unable to observe this meeting so cannot comment on its attendance, structure and format

The organisation has a rich resource of reports to support the monitoring of cancer performance. It was clear from discussion with the clinical and managerial teams that there is an abundance of reports, some of which are not fully utilised by the teams. The information team regularly run bespoke reports for the teams.

The following is a chart provided by the Trust at the request of the IST. It clearly demonstrates the excellent level of information available however this was not a current standard report.



Recommendation:

- **The Trust to agree regular reports with the information team to the clinical and managerial teams. With a wealth of information on cancer it is essential that regular reports are agreed for relevance and accuracy to operationally manage urgent cancer patients by agreed trigger points (referral to DTT to be one of these).**
- **It was also suggested that the team start to review the last 10 patients for selected tumour sites so they can pick up any issues or bottlenecks in the pathways (data subsequently forwarded by the Trust)**

3.2. External working

Externally, the Trust has links with the local Cancer Network and PCT (although it was discussed that further work with the GPs and PCT with regards to managing patient expectations and providing baseline patient details could be improved). The PCTs have nominated lead managers for cancer and meet with the Trust regularly to review the Trust's performance around cancer waiting times, discuss the delivery of cancer and local service improvement projects.

3.3. Cancer tracking and reporting

The Trust has started to use the Somerset system to track patients on a live PTL. The system is updated on a daily basis and it is clear that the trackers are confident in using the tool despite having only used the system in this way for the last few months. As the system is updated in real time (including MDT outcomes) trackers always have the most up to date information. The system does not currently link to the diagnostic modules i.e. for radiology and pathology.

4. Access and choice

4.1. Appointment booking process

The Trust has a central booking office where all 2ww referrals are booked. As 2ww performance was not highlighted as an issue by the Trust this was not discussed in detail.

Recommendation:

Trust and PCT to ensure there are robust and clear communication processes in place to feedback to primary care any issues concerning referral processes, the use of inappropriate 2WW referrals, and missing minimum referral dataset items.

5. Capacity and demand

The Trust outlined that it has completed some demand and capacity analysis for each of the tumour sites. The main challenged areas are gynaecology and head and neck. Capacity and demand analysis is produced each six months and fed into generic action plans.

Recommendation:

All divisions to review capacity and demand by tumour group on a monthly basis.

6. Meetings with multi-disciplinary teams

6.1. Gynaecology

62 day performance was reported as 42% for September 2010, however the Trust are achieving the 31 day standard. The service has previously run with 3 consultants however is currently running as a single handed service (cover is available for out patients but not theatre). One consultant will return in January, leaving one vacant clinical fellows post. The clinical team also has two clinical nurse specialists. It was noted that due to the ongoing staffing issues this remains a fragile service.

The service runs a one stop service however there are clear diagnostic delays for a hysteroscopy. A breach analysis by the Trust identified that five out of the seven breaches in September were to due to long waits for a hysteroscopy (between 28 and 51 days on the waiting list). The Trust presented data that showed patients waiting up to two months for a diagnosis which the IST would highlight as not providing a good service for local women.
Following a capacity and demand study by the Trust, the service is reporting a shortfall of 7.5 fast track out patient slots per week (12.5 actual slots: 20 required).

Recommendation

- **Gynaecological team to sit down together to look breach reasons and information from the last 10 pathways**
- **Hysteroscopy remains a bottle neck and the Trust to ensure that demand and capacity has been fully understood going forward.**

6.2. Urology

The team highlighted the prostate pathway as the main area of difficulty for the service to manage within the 62 day pathway. The management of patients who need a thinking time period before making a decision to treat was an area the team felt needed addressing as well as the increased demand for laparoscopic surgery (covered in part by the new surgeon).

The service highlighted the issue of late referrals from Dudley and Stafford as an area requiring additional work along with delays accessing an MRI following biopsy which was reported as taking up to four weeks. It was unclear as to the impact of the inter provider transfers on performance as additional data from the Trust has shown that none of the September breaches were due to this factor.

6.3. Radiology

In a brief discussion with the Head of Radiology Services, it was reported that waits for MRIs were increasing as the department was at full capacity. The service runs an extended day (12 hours a day) and is open seven days a week. Although CT scans have shorter waits, current pressure on the system means that waits are starting to increase. The service stressed that they prioritise query cancer patients and aim to have reports completed within 24hours. Where reports are not written up prior to an MDT, a verbal report is available. Concern was expressed that due to pressure on the service, they are not fulfilling their obligation to be present at all MDT meetings (85% cover). This will mean that active cases could be deferred to a later MDT.

Recommendation:

- **Trust to review/introduce internal Service Level Agreements between diagnostics and pathology and the tumour sites. This should link in with the work to agree internal pathways with 'key event triggers'.**

6.4. Upper and Lower GI

Both upper and lower GI are reported as achieving the 62 standard in September (86% and 91% respectively). The service stated that there has been a 30% increase in referrals from the bowel cancer screening service.

All referrals in to the service are triaged and straight to test is not offered as the service is concerned about the number of inappropriate referrals.

Lower GI has an average referral to decision to treat time of 42 days and Upper GI 38 days. The IST would suggest that this is a longer than appropriate time to wait for a diagnosis and to be able to provide appropriate treatment within 62 days on a sustainable basis.

Recommendations:

- **The Trust continues to explore with the local GPs the introduction of a straight to test pathway and what needs to be in place to make this happen i.e. improving number of inappropriate referrals.**
- **The Trust work through demand and capacity in relation to endoscopy and identify if there is a backlog to clear.**

6.5. Head and Neck

62 day performance for September was reported as 33% which was the lowest for the Trust. Half of those patient breaches occurred due to late inter provider transfers past day 62 (generally Walsall referrals). The Trust is a net importer of head and neck cancers from other organisations so the focus is on getting them across as soon in the pathway as possible.

The head and neck services comprises of 5 consultants (2 ENT and 3 Maxillofacial). The ENT out patient clinic currently runs bi-weekly but will soon run weekly. Dental assessments are completed within the department.

It was felt by the team that with these service changes and an increased focus on pulling patients across from other Trusts performance would improve.

7. General observations/recommendations

The following general observations were made following discussions with the teams;

General recommendations:

- **Internal milestones are used alert staff to potential breaches earlier in the pathway and key event triggers will allow escalation to the appropriate team or manager.**
- **For audit and improvement purposes, it would be beneficial for the Trust to generate reports identifying patients who have breached these internally agreed milestones.**

8. IST Support

The IST would be pleased to offer support to the Trust in the following areas:

- **Generating an appropriate information pack**
- **Support through the sharing of demand and capacity analysis tools for the Trust to use with its current work (Tumour groups and diagnostics)**
- **Verification of capacity and demand work already undertaken by the Trust to expand/sustain services**
- **Review patient breaches in line with internal pathway milestones**

9. Conclusion

The Trust has a good understanding of the issues that are impacting on its ability to achieve the National 62 day standard and must continue to work with the PCT to deliver these.

Delivering a high quality cancer service and achievement of the cancer operational standards are a high priority at the Trust and this was clearly demonstrated by the enthusiasm and hard work of the clinical, managerial and administrative teams. To take the organisation to a position where the cancer standards are consistently achieved in the most efficient way possible, it will be important for each of the tumour sites to have locally agreed pathways with inbuilt milestones and key event triggers and for individual elements of these pathways to be audited for compliance.

Whilst the summary report does highlight some recommendations that will allow the Trust to move to the next level in terms of operating a much more efficient cancer system, the IST feels that the organisation has the focus, commitment and capacity to address these areas and bring about a sustainable improvement. However it must be noted that the issues within the gynaecological pathway are long standing and the Trust is currently not able to provide an optimal service to patients whilst they continue to have long delays from referral to diagnosis due in the main to delays for a hysteroscopy.

The Intensive Support Team will be happy to support implementation of the recommendations where appropriate.

Ros Gray
Head of, Intensive Support Team

Lyndsay Pendegrass
Manager, Intensive Support Team

Intensive Support Team – Cancer (NHS IMAS)
6th December 2010

Action Plan to support the delivery of the Cancer 62-Day Target

Department	Action	Lead	Due Date	Progress / Comments
Cancer Team	Review tertiary referral policy to be agreed between CEOs at all sites referring to NX; await updated guidance on breach reallocation process to be published in Cancer Reform Strategy refresh (expected January 2011).	Maurice Hakkak	Feb 2011	Wait until Cancer Reform Strategy refresh published (? February 2011)
Cancer Team & Directorates	Review last 10 breaches within Skin, Lung, Breast and Haematology to identify areas for possible improvement to these pathways and learning for other specialties; share findings with Directorates	Maurice Hakkak	Jan 2011	Reports complete To discuss at Cancer Leads meeting on 13th January 2011
Cancer Team	Consolidate reports produced by the Cancer Team into a single portfolio	Maurice Hakkak	Jan 2011	JO to produce portfolio - complete MH to discuss with CIST w/c 10th January 2011
Cancer Team & Directorates	Add timelines to pathways including trigger points for escalation (e.g. Ref-to-DTT); to be part of pathway review	Directorate Managers	Feb 2011	LG to implement pathway review group
Cancer Team & Directorates	Ensure correct mark-up of radiology and pathology requests to ensure that they are appropriately expedited and discharged from the 62 day pathway	Directorate Managers	Jan 2011	Radiology – complete Pathology – complex as many areas; will need to rely on PTL to track specimens
Cancer Team	Enumerate OPD clinic slots required by specialty to reduce 2ww to 1ww	Maurice Hakkak	Jan 2011	Complete LG to review implementation
Directorates	Ensure that all patients referred under 2ww are offered a first appointment within seven days. May require review of TAL window	Directorate Managers	March 2011	As above
Cancer Team & Directorates	Identify investigation capacity/demand required to allow booking of all investigations within 7 days	Directorate Managers	Jan 2011	JO to provide report
Directorates	Ensure all investigations are booked within seven days	Directorate Managers	Jan 2011	As above
Cancer Team	Identify review OPD and investigation capacity required to allow full booking by Fast Track Team following MDT discussion	Maurice Hakkak	Jan 2011	Complete LG to review implementation

Department	Action	Lead	Due Date	Progress / Comments
Cancer Team & Directorates	Review capacity/demand by tumour group on a monthly basis. Should include capacity required for first definitive treatments for 62 day patients	Directorate Managers	Jan 2011 & Ongoing	JO to provide report
Directorates	Ensure capacity available for first definitive treatments for 62 day patients	Directorate Managers	Jan 2011	As above
Cancer Team	Implement Fast Track booking following MDT decision	Maurice Hakkak	Feb 2011	Await directorate plans to provide capacity
Gynaecology	Review last 10 breach reports to identify areas for possible improvement to pathways	Zena Dalton	Jan 2011	Breach reports complete Directorate review ongoing
Gynaecology	Undertake capacity/demand review for hysteroscopy	Zena Dalton	Jan 2011	Ongoing
Endoscopy	Undertake capacity/demand review for OGD, Colonoscopy and flexible sigmoidoscopy	Dean Gritton	Feb 2011	Ongoing
Colorectal Surgery	Review straight-to-test for colorectal referrals	Dean Gritton Ruth Horton	Feb 2011	DR to discuss with colorectal surgeons
Urology	Urology pathways process mapping	Ruth Horton	Jan 2011	Part of pathway review group (LG)
Head & Neck	H&N pathways process mapping	Heather Adams	Jan 2011	Part of pathway review group (LG)
Cancer Team	Review number of patients by tumour site who have had MDT decision postponed due to absence of core member(s) at MDT	Maurice Hakkak	Jan 2011	JO to provide list of patients re-listed at MDT
Radiology	Ensure full attendance by core member radiologist (or cover) at MDT meetings	Anthony Leese	Feb 2011	Ongoing
Radiology	Review role and/or capacity for faecal tagging	Anthony Leese Ruth Horton Maurice Hakkak	Feb 2011	Complete; capacity now available
Oncology	Ensure full attendance by core member oncologist (or cover) at MDT meetings	Maurice Hakkak	Feb 2011	Job Plan review complete
Cancer Team	Review cover arrangements for Patient Trackers and MDT coordinators to ensure that year-round service is maintained	Maurice Hakkak	Jan 2011	Complete

Department	Action	Lead	Due Date	Progress / Comments
Cancer Team	Review JD and role of MDT coordinators to ensure that maximum time is spent delivering core MDT and Fast Track business	Maurice Hakkak	Jan 2011	Ongoing
Trust & PCT	Review communication processes in place to feedback to primary care any issues concerning referral processes, the use of inappropriate 2ww referrals and missing minimum referral dataset items	Dave Rowlands	Jan 2011	DR to take to Wolverhampton LIT
Directorates	Review/introduce SLAs between diagnostics, pathology and the tumour sites. Should link in with pathway reviews and escalation triggers	Directorate Managers	Jan 2011	Ongoing
CIST	CIST to support with generating an appropriate information pack	Maurice Hakkak	Jan 2011	Report complete MH to share with CIST w/c 10th January 2011
CIST	CIST to support with sharing of demand and capacity analysis tools for the Trust to use with its current work (tumour groups and diagnosis)	Maurice Hakkak Directorate Managers	Jan 2011	MH to contact CIST w/c 10th January 2011
CIST	CIST to support with verification of capacity and demand work already undertaken by the Trust to expand/sustain services	Maurice Hakkak Directorate Managers	Feb 2011	
CIST	CIST to support with review of patient breaches in line with internal pathway milestones	Maurice Hakkak Directorate Managers	Feb 2011	
Theatres Radiology Outpatients	Review process for transferring specimens to the pathology laboratory; need to include details of 62-day breach date	Directorate Managers	Jan 2011	To be managed through PTL To review specific areas with delays - GD