Action Plan Subject:		Review Date:	Monitoring Body:
Intensive support team visit		Monthly at Cancer Management Committee	TEC
Related Performance Indicator	**and Target:**	**Performance against KPI as at date of Review:**	**BAF/Risk Register Reference:**
		Not Applicable	- Always put the needs and care of the patient first. - Implement new technologies and systems that will improve patient care. - Ensure and maintain compliance with regulatory, performance and quality indicators. - Further develop the Trust's strategic position as a community asset for West Norfolk and beyond.
Conditions / Triggers for Escalation/Exception reporting to Board / Senior Committee (determined by Monitoring Body):			

Ref. No.	Issue being addressed and cause of issue	Weighting H,M,L	Action (to address the cause of underperformance / risk)	Responsi-bility	Progress update	Date for completion	Outcome plan
Key recommendations							
1	Development of a Trust Cancer Strategy	L	To write a Trust Cancer Strategy	Val Woods		End of May	Trust Cancer Strategy agreed and ratified by TEC
2	Clarification of processes through production of written evidence to support practice (such as triage process)	M	SOP to be written/reviewed for the referral triage process	Michael Brown			SOP approved and available for reference
3	Implementation of route cause analysis for all breaches on all stages of the pathway	L	All breaches reviewed 2ww, 62 and 31 day.	Kate Jackman	**Completed.**	March 2014	**Evidence found on Cancer Service shared drive**

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4	Patient pathway coordinators (PPC) continue to track patients where the absence of cancer has been confirmed(NCATT) until patient has been advised of the outcome	M	Process in place to ensure patients are tracked until they are informed.	Kate Jackman	**Completed.**	March 2014	**Evidence can be found in the tracking notes on Somerset**
5	Co-location and single management of MDT coordinators and PPCs should continue	L	None needed	Kate Jackman	**Completed.**	March 2014	**Evidence location of the team**
6	MDT coordinator and PCCs should utilise the nationally produced training materials to support understanding and enhance existing knowledge to the benefit of the whole team		Confirm materials with IST and implement a training plan	Kate Jackman			
7	Raise the profile of Cancer at a directorate through management team meetings.	M	A letter to be written to clinical lead and ensure cancer is in the SQABB agendas	Andrew Stenton	**Email sent 10/04/2014**	On standing agendas from end May	Review SQABB agendas and minutes
8	Modelling of Demand and capacity to help support service provision and forward planning	M	All tumour sites to complete demand and capacity planning model for the whole pathway	Andrew Stenton	**Lung, Gynae, Urology, dermatology completed 2ww Demand and capacity**		Completed demand and capacity models used to determine service provision
9	Improved engagement with local CCG and GPs to support service delivery, improve patient understanding around the rational for referral and enhance the quality of	M	Discuss communication routes in “clinician to clinician” meeting held by Medical Directors	Andrew Stenton/Bev Watson	Agreement on GP liaison – methods of communication and feedback being designed	June 2014	GPs and CCG fully aware of trust’s cancer strategy, pathways and service provision

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	referrals.						
10	Establish tumour group specific referral proformas.	M	Obtain examples and implement new referral form	Michael Brown	**New referral proforma for use in Breast in preparation**		New referral form approved and in use
11	Timed robust clinical pathways development supporting activity, especially for two-Trust pathways	H	Obtain examples and implement	Dr Karanth /Divisional directors	**Pathways will have been assessed by end May.**	July 2014	
12	Escalation of issues in a timely manner to promote intervention supporting apposite treatment of patients within national timescales	M	Write an escalation policy	Kate Jackman	**Completed**	March 2014	Evidence – policy written and approved by EDS
Leadership and Governance							
1	Communicate executive leadership for Cancer within the Trust	L	Communication to be sent out	CEO	**Executive Director responsibilities circulated and on Intranet. Completed**	Complete	All staff made aware of Trust Cancer Lead
2	Communicate governance arrangements for the Cancer Committee to ensure that the lines of accountability are clear and documented appropriately in terms of reference.	L	PTL to be minuted Management meeting to be minuted Quarterly cancer meeting to be minuted	Kate Jackman	**PTL and quarterly meetings are minuted. AS to organise admin support to minute the management meetings Completed**	In place	Evidence – minutes held on Cancer shared drive

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Multidisciplinary Team Coordinator and Patient Pathway Coordinator							
1	Implement route cause analysis and reporting for all breaches to ensure trends and patterns are identified and action taken.	L	All breaches reviewed 2ww, 62 and 31 day. Shared with divisions and SBARS completed	Kate Jackman	**Completed.**		**Evidence found on Cancer Service shared drive**
2	Breach analysis should be shared with clinicians	M	A letter to be written to clinical lead and ensure cancer is in the quality meeting agendas	Andrew Stenton	**Email sent 10/04/2014**	On standing agendas from end May	Review SQABB agendas and minutes
3	Review of action plans to mitigate for breaches should be considered at the Cancer Committee	M	Add as agenda item to the quarterly cancer review meeting	SKK			Action plans regularly reviewed and monitored
4	Develop and document a range of internal milestones to support the delivery of the national cancer indicators across all tumour sites and monitor and report performance against the milestone at an appropriate internal forum	H	Development and implement time pathways for each tumour site	Divisional Directors	**Investigate and review examples from other Trust.**	Sept 2014	
5	Development of a robust, timed escalation process to facilitate follow up of issues and concerns identified by staff within the cancer team	H	Escalation process written	Kate Jackman	**Completed**	April 2014	**Escalation process written and approved by EDs on 2nd April. To start 7th April**
6	Establish a process to provide assurance that patients with upgrade or incidental finding of cancer are added to the Cancer wait system within 24 hours.	L	Cancer services receive a paper copy of all histology reports which show an incidental finding of cancer. Cancer services receive a paper copy of all consultant upgrades form.	Kate Jackman	**Completed**	March 2014	Evidence can be found on Somerset

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7	Establish a report on Cancer waits to highlight duplicate/data errors	M	Cancer Service to run the check reports available on Somerset.	Kate Jackman	**All PPCs to run the Somerset check reports regularly and ensure all data is accurate by the 28th of each month**	Completed	Continue to run report
8	Establish regular monitoring, audit and sampling of pathway adjustment to ensure they are only done where appropriate and in line with the Trust Access policy for Cancer.	M	Rolling monthly audit of notes	Kate Jackman	**System in place. Audit to start May 2014**		Monthly report
9	Monthly review of patient pathways for compliant patients to assess errors and highlight action required as apposite.	M	Rolling monthly audit of notes	Kate Jackman	**System in place. Audit to start May 2014**		Audits and subsequent actions documented and monitored for compliance
Access and choice							
1	Improve GP communication with patients regarding the reason for their referral, including those referred to exclude a diagnosis of cancer to hospital and the likely timescale for appointments	H	Communication with the CCG's	Michael Brown / Andrew Stenton	**Letter regarding Breast referrals to all GPs re-enforcing guidelines**	August 2014	GPs and CCG fully aware of trust's cancer strategy, pathways and service provision
2	Undertake demand and capacity analysis to determine capacity requirements for first appointment to enable initial patient appointment within 7 days of referral where possible	M	All tumour sites to complete demand and capacity planning model for the whole pathway	Andrew Stenton	**Lung, Gynae, Urology, dermatology completed 2ww Demand and capacity**	June 2014	Completed demand and capacity models for all tumour sites used to determine service provision

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3	Review of operational and Access policies by the IST with recommendation noted.	M	Cancer operational policy to be reviewed and changes made. Trust Access policy to be reviewed	Kate Jackman / Michael Brown	**Cancer operational policy to be changed and presented at the Trust quarterly cancer committee on 14th May. Trust Access policy -**	May 2014	Operational policy agreed and ratified by TEC. Trust Access Policy reviewed, amended as appropriate and ratified
Radiology							
1	The Trust metrics for the monitoring of service performance including the establishment of quality indicators for the purpose of supporting consistent service standards, for example 95% of reports reported with agreed timescale	M	Radiology to continue to audit service performance	Val Woods	**Completed**		Monthly radiology audit report available. Any deviation from target to be investigated
2	Establishment of a process to ensure tumour sites can readily identify missing referrals and ensure they are followed up with diagnostic imaging	H	Review of process for all results	Andrew Stenton			No missing referrals reported
3	Trust to consider opportunity for electronic referral for diagnostic service	M	Trust Strategy to implement order comms	Andrew Stenton / Dan Rose	**Reviewing trust IT infrastructure**	August 2014	
4	Review radiologist job plan and workforce to ensure appropriate attendance at MDT meetings	M	Radiology to explore all routes for recruitment including joint appointments Trust to consider alternates to Consultant Radiologists	Dan Rose	**Currently recruiting Locum identified**		Consistent Radiologist attendance at MDT

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Endoscopy							
1	The team to continue to pursue the options of providing nurse endoscopy support to service delivery, considering the options of using nursing staff to provide elements of backfill for consultant leave.	M	Review Nurse Endoscopist role. Agree business case	Cursty Pepper	**Consultant Locum in place to fill gaps in timetable.**	July 2014	All endoscopy sessions fully staffed and utilised
2	The team develop a more robust mechanism for ensuring all appropriate patients are booked appointments. In addition, a list of those patients referred for endoscopy could be sent on to the team following the "cashing up" of the clinic		Endoscopy management team to redesign process.			August 2014	All patient agree their appointments and trust is appropriate paid for work undertaken
3	Development of an electronic system of generating referrals may be beneficial.		Electronic requests to be considered within IT programme				
4	Review of endoscopy utilisation to establish utilisation levels in core hours, with the further recommendation that the team consider options to increase core hours working where possible.				Endoscopy Management Committee now reviewing utilisation x2 per month. Three session working under consideration. Saturday working in place on ad-hoc basis		Full utilisation of all endoscopy lists with the option of patient choice to be seen outside regular working hours
Dermatology							

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1	Undertake demand and capacity analysis for two week wait clinic requirements	M	IST demand and capacity model to be completed	Bridget Castle	**Completed and shared the Dr Dootson**		Completed demand and capacity models used to determine service provision
1	Continue to review the recommendation following the Peer review	M	See separate action plan	Hugh Warren / Geraldine Dennis			Upper GI peer review successful
2	Review demand and capacity for patients	M		Julie Arnold	Capacity redesign following completion of Demand and Capacity modelling	June 2014	Completed demand and capacity models used to determine service provision
3	Conduct team meetings quarterly to enhance improvements in the service and feedback on the action plan developed following Peer review	M		Hugh Warren / Geraldine Dennis	**Completed**		Enhanced team working. Review and monitoring of actions in action plan
4	Feedback progress through the wider cancer team forum ultimately to the Trust Board		Attendance at the Quarterly cancer meeting	Dr Karanth	**Completed**		Minutes from the meeting

KEY: RAG Rating					
	Complete		On track for delivery		Behind plan and action needed to bring back on target (see Recovery Plan column)
KEY: WEIGHTING					
H	High Priority	**M**	Medium Priority	**L**	Low priority