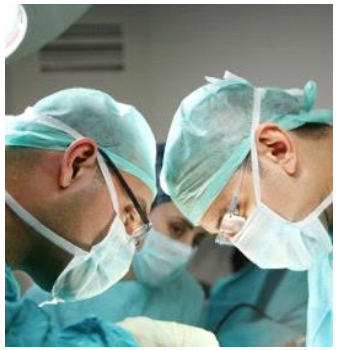
APPENDIX 1

Sheffield Teaching Hospitals NHS
NHS Foundation Trust





INTEGRATED **PERFORMANCE** REPORT


BOARD OF DIRECTORS

15 November 2017

REPORT TO THE BOARD OF DIRECTORS

Subject:	Integrated Performance Report
Supporting Directors:	Kirsten Major, Deputy Chief Executive; Neil Priestley, Director of Finance; Hilary Chapman, Chief Nurse; Mark Gwilliam, Director of Human Resources and Organisational Development; David Throssell, Medical Director.
Author(s):	Balbir Bhogal, Performance and Information Director; Joanne Weaver, Senior Information Analyst;
Status (see footnote):	A*

PURPOSE OF THE REPORT: To provide the Board with a detailed assessment of performance against the agreed indicators and measures. The report describes the specific actions that are under way to deliver the required standards.

KEY POINTS:

RECOMMENDATIONS

The Board is asked to:

a) Receive the Integrated Performance Report for September 2017.

b) Note the performance standards that are being achieved.

c) Be assured that where performance standards are not currently met, a detailed analysis has been undertaken and actions are in place to ensure an improvement is made.

IMPLICATIONS		
STH Strategic Aims		Tick as appropriate
1	Deliver the best clinical outcomes	☑
2	Provide patient centred services	☑
3	Employ caring and cared for staff	☑
4	Spend public money wisely	☑
5	Deliver excellent research, education and innovation	☑

APPROVAL PROCESS			
Meeting:	Trust Executive Group	Finance and Performance Committee	Board of Directors
Approved Y/N:			
Date:	8 November 2017	6 November 2017	15 November 2017

A = Approval; A* = Approval and Requiring Board Approval; D = Debate; N = Note

EXECUTIVE SUMMARY

DELIVER THE BEST CLINICAL OUTCOMES

- There have been 0 cases of Trust assigned MRSA bacteraemia recorded for the month of September. The year to date total is 1 case.
- There was 1 Trust attributable case of MSSA bacteraemia recorded in September. The full year performance is 34 cases of MSSA against an internal threshold of 21 cases.
- The Trust recorded 6 cases of C.diff for September. The full year to date performance is 40 cases of C.diff against an internal threshold of 39 and an NHS Improvement threshold of 44.
- Hospital standardised mortality ratio is within the 'as expected' range.
- There was one serious incident reported in September.
- The number of incidents not approved after 35 days remains higher than target.
- The average length of stay for elective patients was below the Dr Foster benchmark and for non-elective was above.
- The number of patient falls is less than the internal threshold and was lower in September than in previous months.
- The proportion of patients who received a VTE risk assessment was above the internal target
- The standard in the safety thermometer was 92.5% in September against a target of 95.0%

Summary of the Healthcare Governance Committee meeting held on 25 September 2017

- The CQC Insight dashboard had been launched and included the 'composite indicator' score, comprising 12 key performance indicators. An engagement meeting had recently taken place and positive feedback had been received regarding the Trust's work in relation to delayed transfers of care. The well-led review process had commenced at a number of trusts.
- The Quality Report Timetable was presented and highlighted that planning for completion of the Quality Report 2017/18 had commenced. The final draft of the Quality Report would be submitted to the Healthcare Governance Committee in February 2018, to the Trust Executive Group in March 2018 and to the Board of Directors in May 2018.
- The Committee received a presentation providing an update on progress in relation to the Sign Up To Safety work. Significant progress was noted in relation to key workstreams including the successful introduction of Safety Huddles on 26 wards. A business case was currently being prepared to support the further progression of key areas of this work.
- The Specialised Commissioned Services Quality Surveillance Programme 2017/18, Self-Declarations and 2018/19 Approach report was presented. The outcome of the Trust's self-declaration for all specialised commissioned services was outlined along with the newly agreed internal approach for meeting the requirements of the programme from 2018-19. The Trust would receive confirmation of the 2018/19 national visit programme in late 2017 or early 2018.
- Four new SUIs were reported, and these incidents were summarised within the report. Eight incidents were closed during the period and ten incident reports had been completed and submitted to the CCG.
- The Water Quality Annual Report 2016/17 was presented. The Trust's new External Water Quality Authorising Engineer was appointed in 2016. Training on the collection of water samples would be provided to relevant staff in September 2017 and the Responsible Persons for Water would receive update training during the current financial year.
- The Staff, Student and Public Incidents January-June 2017 report was presented. 997 staff, student and public incidents were reported during the period and 27 RIDDOR incidents were reported. The Sentencing Council's Definitive Guideline for Health and Safety Offences, Corporate Manslaughter and Food Safety and Hygiene Offences is having a significant impact on the level of health and safety fines being imposed on organisations.
- The updated Hospital at Night Policy was reviewed and approved.
- The 2016/17 Estates Return to the Information Centre (ERIC) report was presented, along with the 2015/16 return. The 2016/17 return had been subject to

significant change in terms of the amount and scope of the data required and therefore, due to the number of data changes, direct comparison between the two years was difficult. The NHS Estate and Facilities Dashboard for 2015/16, generated from the ERIC data, enabled benchmarking with the Model Hospital and peer group Trusts.

- The Yorkshire and Humber Emergency Preparedness Resilience and Response Assurance report was presented. Following a self-assessment against the 52 Standards, STH had a 'substantial' compliance level, with 50 green, two amber and no red standards. Where individual standards had been assessed as amber, an improvement plan was required to show that plans were in place to appropriately address all the Core Standards.
- The External Visits, Accreditations and Inspections report was presented. The report outlined recommendations and action plans following visits from six external bodies. Two action plans were confirmed as completed.
- The Mortality Update report was presented. This was in addition to the report presented in July and therefore covered only HSMR, as no new SHMI data had been released since the July report. The HSMR remained 'as expected' at 103.1.

PROVIDING PATIENT CENTRED SERVICES

- Complaints – 97% of complaints were responded to within 25 working days.
- FFT score inpatient – the score for September was 96% which is better than the internal target of 95%.
- FFT score A&E – the score for September was 87% which is better than the internal target of 86%.
- Maternity score – the score for September was 97% which is better than the internal target of 96%.
- Mixed sex accommodation – the Trust reported 0 breaches in September. The internal target is 0.
- Referrals received during September 2017 were below the baseline level included in the Trust's plan
- New outpatient activity for September 2017 was 6.6% below the contract target. For the year to date performance is 3.0% below target.
- Follow up outpatient activity for September 2017 was 0.8% below the contract target. For the year to date performance is 1.9% above target.
- Accident and Emergency activity was slightly over target (0.5%) in September 2017 and is 0.5% below target for the year to date.
- Elective activity for September 2017 was 2.6% below the contract target and is 1.4% below for the year to date.
- Non-elective activity for September 2017 was 1.3% below the contract target and is 0.6% below for the year to date.
- The average number of patients who had a delayed transfer of care in September was 55 compared to 75 in August, 74 in July, 88 in June, 87 in May and 100 in April.
- The number of operations cancelled on the day for non-clinical reasons in September was 78 compared to 47 in August, 60 in July, 75 in June, 57 in May and 73 in April.
- In September 2017 89.80% of patients attending A&E were seen within 4 hours compared to the Sustainability & Transformation Fund agreed trajectory of 90.00% and the national target of 95%. There were 7 days when the Trust exceeded the 95% target.
- The turnaround time taken for the handover of ambulance patients was 82.05% occurring within 15 minutes compared to 69.70% in August. For patients where the handover time was more than 30 minutes, this indicator was 4.08% of patients.
- The percentage of patients who have been waiting less than 18 weeks for their treatment was 95.7% which is better than the national target (92%). The percentage of patients who received treatment in September and had waited less than 18 weeks was 86.9% for admitted patients and 94.0% for non-admitted patients (compared to the local targets of 90% and 95% respectively).
- At the end of September there were no patients waiting over 52 weeks for treatment.
- At the end of September the number of patients who were waiting more than 6 weeks for their diagnostic test was 91.24% which is below the target of 99%.
- The percentage of outpatient appointments cancelled by the hospital and cancelled by patients, remains higher than the national bench mark.
- The percentage of patients that did not attend for their outpatient appointments was better than the national bench mark.
- As reported at the September Board meeting, the cancer waiting time targets were achieved for Q1 of 2017/18 apart from the 62 days from referral to treatment (GP referral), although this was achieved for patients whose pathway originated at STH. At 18/10/17 the Q2 performance for 62 day referral to

treatment was 85.2% for STH pathways and 77.4% for all pathways. Confirmation of the Q2 position will be available in November 17.

- The percentage of appointments booked by GPs through the e-Referrals Service was 30.87%.

EMPLOYING CARING AND CARED FOR STAFF

- Sickness absence for September was 3.67% with a year to date position also of 3.67%, compared to the Trust target of 4.0%
- The year to date short term absence rate has remained at 1.28%. The year to date long term absence rate has decreased from 2.42% to 2.37%
- The appraisal rate decreased from 87.65% to 86.3%. The HR Operations Director is reviewing this monthly. Directorate level action plans are being established to address the areas of concern.
- Compliance levels for mandatory training are at 90.3%.
- Annual turnover rate was 7.75% and the lowest turnover rate was 5.43% for Healthcare Scientists.
- The retention rate for the Trust was 87.7%, which is above the target of 85%
- The proportion of temporary staff was 9.40%
- Safer staffing – overall, the actual fill rate for day shifts for registered nurses was 88.9% and for other care staff against the planned levels was 112.4%. At night these fill rates were 91.9% for registered nurses and 121.0% for other care staff. In any instances where the fill rate fell below 85% the reasons for this have been explored in detail at the Healthcare Governance Committee.

SPEND PUBLIC MONEY WISELY

- The Month 6 position shows a £2,920.7k (0.6%) deficit against plan after release of £5m of contingencies. Excluding contingencies, this is a further slight improvement on trend but maintains the disappointing performance year-to-date.
- There was a cumulative activity over-performance against plan of £0.5m at Month 6 which represents a £0.3m improvement in September. It should be noted that this represents a significant over-performance against commissioner plans.
- There was an overspend of £0.8m (0.3%) on pay to the end of September, a small improvement on the August position. Medical staffing remains the main pressure area, largely due to agency costs to fill critical vacancies, with deterioration in the month. Bank and Agency costs are £1.6m lower than for the same period last year.
- There was a £0.9m under delivery against efficiency plans for the first 6 months of the year.
- Overall, Directorates reported positions £5.9m worse than their plans at Month 6.
- The Financial Plan and current position assume receipt of all of the £18.6m of national Sustainability and Transformation funding (STF) available to the Trust. To receive this the Trust has to deliver its financial “Control Total” and, if this is met, then 30% of the STF depends on achieving A&E 4 hour target trajectories and other plans related to streaming patients to new Primary Care services. The Control Total is a £4.2m deficit (equating to the Financial Plan deficit of £6m). The position will again be assessed on a quarterly basis. The Quarter 1 STF has been received and it is assumed that the Quarter 2 STF has also been achieved. However, the first two quarters only represent 15% and 20% respectively of the annual sum as the STF is weighted more towards the latter quarters.
- There are no issues of concern at this stage in respect of the working capital position, balance sheet or capital programme, although NHS Receivables still remain exceptionally high.
- The key risks for 2017/18 relate to internal delivery of activity, efficiency and financial plans; residual contracting issues; receipt of CQUIN and System Resilience funding; financial, workforce, service and infrastructure pressures; and receipt of the STF.
- Work therefore continues to be required to drive activity delivery, control expenditure, mitigate possible contract income losses, improve efficiency and maximise contingencies.

DELIVER EXCELLENT RESEARCH, EDUCATION & INNOVATION

- STH performance for 2017/18 for recruitment to trials is on target, as demonstrated by both the total number of patient accruals to portfolio studies and the percentage of clinical trials meeting the NIHR 70 day benchmark, which is used nationally as an indicator of efficient study setup.
- The number of patient accruals to portfolio adopted grant and commercial studies for 2017/18 Q1 was 2166. This was 94.5% of our Yorkshire and Humber Clinical Research Network (YHCRN) YTD at Q1 target of 2291.
- Performance for clinical trials meeting the NIHR 70 day benchmark (from receipt of a Valid Research Application to Recruitment of First Eligible Patient) for 2017/18 Q1 was 88.5%. This is significantly above the NIHR national target of 80%.
- STH continues to maintain research performance as a result of several factors including shortened R&D setup times, active recruitment by researchers and ongoing collaborative working between the Clinical Research & Innovation Office, YHCRN, and STH research facilities.

TRUST PERFORMANCE OVERVIEW

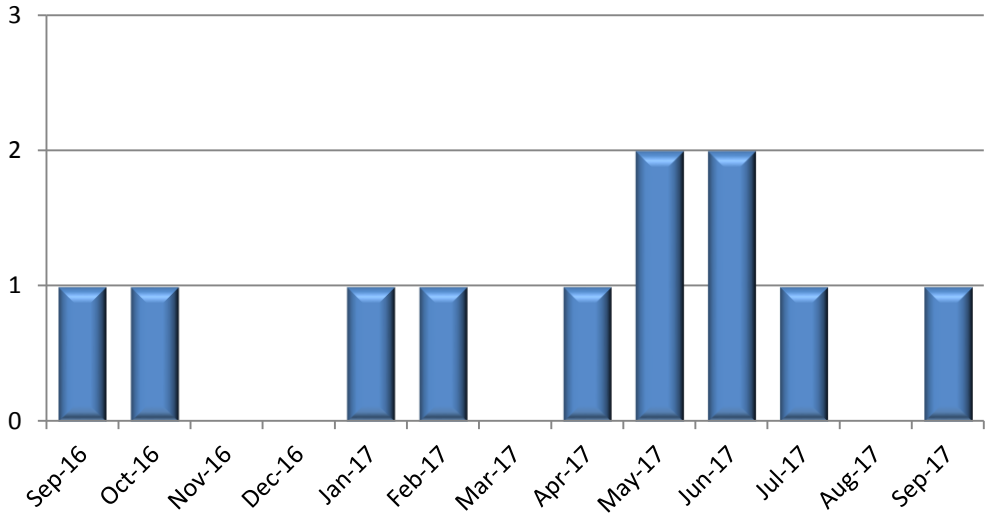
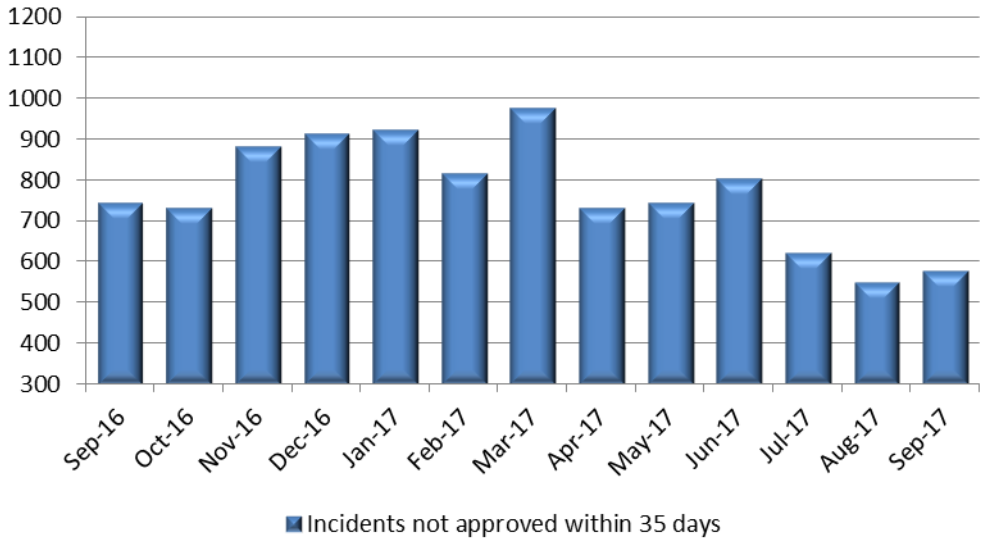
Indicator	Measure	Standard	Target Type	Current Data Month	Month Actual	YTD	Trend	Data Quality
CQC Compliance	Outcome of CQC inspection	Good in all five domains	National	September				
NHSI Segmentation	Compliance with Monitor defined targets	Green/Amber or better	National	Q1 17/18				
Deliver The Best Clinical Outcomes								
Hospital Mortality	HSMR	As expected or lower	SOF	Jul-16 to Jun-17				
Hospital Mortality	SHMI	As expected or lower	SOF	Apr-16 to Mar-17				
Hospital Mortality	HSMR (weekend only)	As expected or lower	SOF	Jul-16 to Jun-17				
MRSA bacteraemia	Actual numbers	Zero cases	SOF	September				
MSSA bacteraemia	Actual numbers	Max 3.5 case a month	Local	September				
C Diff	Actual numbers	September = 7	SOF	September				
C Diff - infection rate	to be determined	to be determined	SOF	September				
Serious Incidents	Number of serious incidents (SI)	Number	Local	September	1	17		
Serious Incidents	Approved SI Report submitted within timescales	No overdue reports	Local	September				
Incidents	Total number of incidents reported	Number of incidents reported	Local	September	1195	11524		
Incidents	Incidents not approved after 35 days	Zero	Local	September				
Incidents	Potential under reporting of patient safety incidents	to be determined	SOF	September				
Average Length of Stay (by discharges)	Average LOS Elective	4.37 days (Dr Foster)	Local	Jul-16 to Jun-17				
	Average LOS Non Elective	4.98 days (Dr Foster)	Local	Jul-16 to Jun-17				
C-Section rate	Emergency Caesarean section rate as proportion of all births	to be determined	SOF	September	17.5%	18.5%		
Patient Safety Alerts	Number of outstanding Patient Safety Alerts	Zero	SOF	September				
Patient Falls	Number of patient falls	331 per month (5% reduction from 14/15)	Local	September				
Never Events	Number of never events	Zero	SOF	September				
Readmissions within 30 days	Readmissions as proportion of all emergency admissions	to be determined	SOF	September	16.9%	17.5%		
VTE	VTE Risk Assessment completed as proportion of all inpatient admissions	95%	SOF	Q2 17/18				
Safety Thermometer	Harm free	95% harm free	National	September				
Provide Patient Centred Services								
A&E 4-hour wait	Patients seen within 4 hours	95%	SOF	September				
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours	Zero	National	September				
Ambulance turnaround	Time taken for ambulance handover of patient	100% within 15 minutes	National	September				
Ambulance turnaround	Time taken for ambulance handover of patient	0% in excess of 30 minutes	National	September				
18 week waits referral to treatment time	Percentage of admitted (un-adjusted) patients treated within 18 weeks	90%	Local	September				
	Percentage of non-admitted patients treated within 18 weeks	95%	Local	September				
	Percentage of patients on incomplete pathways waiting less than 18 weeks	92%	SOF	September				
52 week waits	Actual numbers	Zero	National	September				
6 week diagnostic waiting	Percentage of patients seen within 6 weeks	99%	SOF	September				
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons	75 per month	Local	September				
	Number of patients cancelled on the day and not readmitted within 28 days	Zero	Local	September				
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital	6.78% (National figure 2015/16)	Local	September				
	Percentage of out-patient appointments cancelled by patient	6.36% (National figure 2015/16)	Local	September				
DNA rate	Percentage of new out-patient appointments where patients DNA	8.11% (National figure 2015/16)	Local	September				
	Percentage of follow-up out-patient appointments where patients DNA	8.44% (National figure 2015/16)	Local	September				
Cancer Waits	Patient seen within 2 weeks	93%	National	Q1 17/18				
	Breast symptomatic seen within 2 weeks	93%	National	Q1 17/18				
	62 days from referral to treatment (GP referral)	85%	SOF	Q1 17/18				
	62 days from referral to treatment (Cancer Screening Service)	90%	SOF	Q1 17/18				
	31 day first treatment	96%	National	Q1 17/18				
	31 day subsequent treatment (Surgery)	94%	National	Q1 17/18				
	31 day subsequent treatment (Radiotherapy)	94%	National	Q1 17/18				
	31 day subsequent treatment (Drugs)	98%	National	Q1 17/18				
e-Referral Service	Percentage of appointments booked through e-Referral	50%	Local	September				
Ethnic Origin data collection	% valid ethnic group	85%	National	September				
Elective Inpatient activity	Variance from contract schedules	On plan	Local	September				
Non elective inpatient activity	Variance from contract schedules	On plan	Local	September				

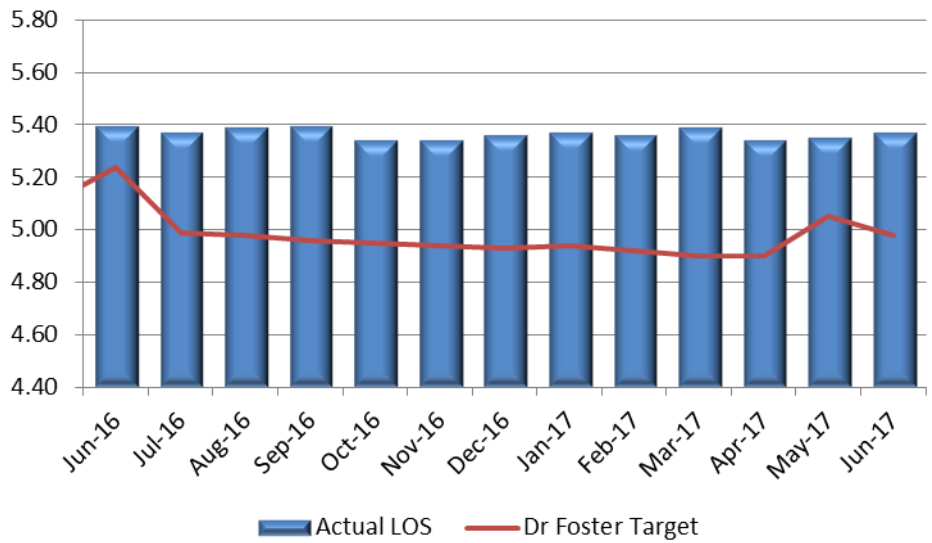
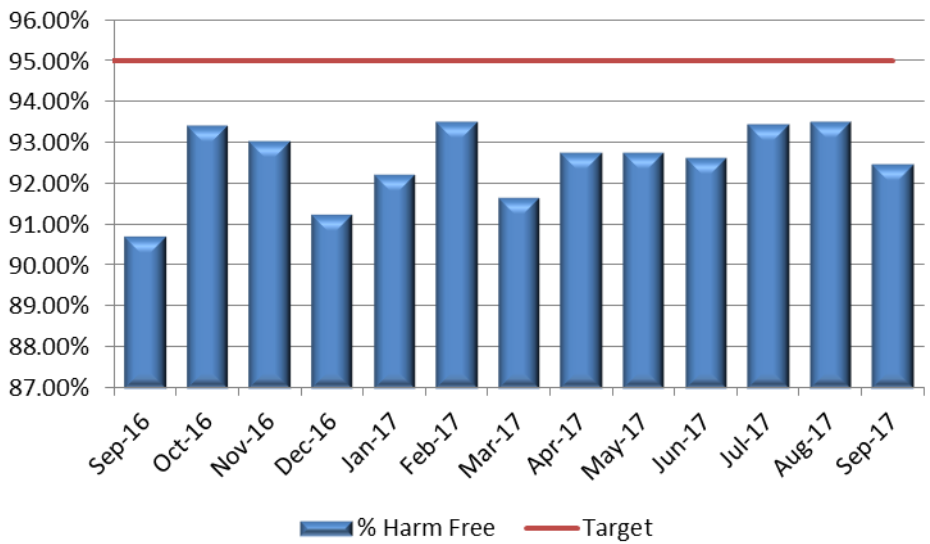
A = Accuracy, **V** = Validity, **R&C** = Reliability & Consistency, **T** = Timeliness, **R** = Relevance, **C&C** = Completeness & Coverage

Indicator	Measure	Standard	Target Type	Current Data Month	Month Actual	YTD	Trend	
Provide Patient Centred Services								
New outpatient attendances	Variance from contract schedules	On plan	Local	September				
Follow up op attendances	Variance from contract schedules	On plan	Local	September				
A&E attendances	Variance from contract schedules	On plan	Local	September				
Complaints	Percentage of complaints answered within 25 working days	85% answered within 25 days	Local	September				
Written Complaints Rate	Written complaints rate per 10,000 fces	Total number upheld	SOF	Q1 17/18	146			
FFT Recommended	Patients recommending STH for inpatient treatment	95%	National	September				
FFT Recommended	Patients recommending STH for A&E treatment	86%	National	September				
FFT Recommended	Patients recommending STH for Maternity treatment	95%	SOF	September				
FFT Recommended	Patients recommending STH for Community treatment	95%	Local	September				
Community care –information completeness	RTT information completeness	50%	National	2016/17				
	Referral information completeness	50%	National	2016/17				
	Activity information completeness	50%	National	2016/17				
Day surgery rates	BADS - day surgery rates	88%	Local	September				
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard	Zero	SOF	September				
Employ Caring & Cared for Staff								
Sickness Absence	All days lost as a percentage of those available	4.00%	SOF	September				
Appraisals	Completed appraisals in last year	90%	Local	September				
Mandatory Training	Overall percentage of completed mandatory training	90%	Local	September				
Safer Staffing	Percentage of planned shifts worked by Registered Nurses/midwives during the day	85% of planned hours or greater worked	Local	September				
	Percentage of planned shifts worked by Registered Nurses/midwives during the night	85% of planned hours or greater worked	Local	September				
	Percentage of planned shifts worked by Clinical Support Workers during the day	85% of planned hours or greater worked	Local	September				
	Percentage of planned shifts worked by Clinical Support Workers during the night	85% of planned hours or greater worked	Local	September				
Staff Turnover	Executive Team turnover	to be determined	SOF	September				
	Number of leavers as a percentage of total head count (rolliing 12 months)	to be determined	SOF	September	7.75%			
	Retention Rate	85%		September	87.87%			
Temporary Staff	Proportion of temporary staff	to be determined	SOF	September	9.40%			
Agency spend	Distance from provider cap	<=0%	SOF	September				
	Agency and bank spend as a percentage of total pay budget	8%	Local	September				
Spend Public Money Wisely								
I & E	YTD actual I & E surplus/deficit in comparison to YTD plan I & E surplus/deficit	>=0%	SOF	September				
I & E Margin	I & E surplus or deficit asa percentage of total revenue	>1%	SOF	September				
Cost Reduction	Aggressive cost reduction plans	Under development	SOF	September				
Contract performance	Variance from plan	On plan	Local	September				
Efficiency	Variance from plan	On plan	Local	September				
Cash	Actual	Above profile	Local	September				
Liquidity	Days of operating costs held in cash or cash equivalents including wholly committted lines of credit available for drawdown	>0	SOF	September				
Capital	Capital Service Capacity - degree to which provider's generated income covers its financial obligations	>2.5times	SOF	September				
	Expenditure - variance from plan	On plan	Local	Q1 17/18				
Distance from Plan	Distance from control total or financial plan	On Plan	Local	Q1 17/18				
Deliver Excellent Research, Education & Innovation								
Recruitment to trials	Total number of patient accruals to portfolio studies	9000	Regional -Y&H	Q1 2017/18				
	70 Day Benchmark for recruitment of first patient to a clinical trial	80%	National	Q1 2017/19				
Annually Reported Indicators								
Quality recommendation	% staff who would recommend STH to a friend / relative for treatment	69%	SOF	2016				
Work recommendation	% staff who would recommend STH as a place to work	61%	National	2016				
Staff Engagement	Staff engagement score	3.80	SOF	2016				
CQC Inpatient Survey	RAG rating for overall score determined by CQC	to be determined	SOF					

A = Accuracy, **V** = Validity, **R&C** = Reliability & Consistency, **T** = Timeliness, **R** = Relevance, **C&C** = Completeness & Coverage

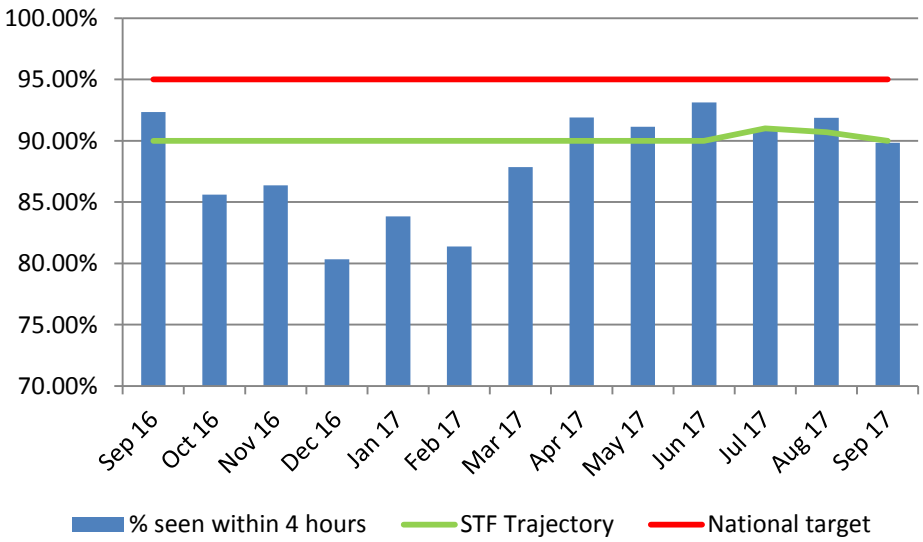
DELIVER THE BEST CLINICAL OUTCOMES

SERIOUS INCIDENTS (SUI investigations beyond 60 day deadline)	INCIDENTS (Incidents Not Approved After 35 Days)
	
Lead: David Throssell, Medical Director **Timescale**: December 2017	**Lead:** David Throssell, Medical Director **Timescale**: March 2018
Key Issues: One incident investigation report has been delayed as the scope of the investigation was wider than had originally been indicated. The CCG have been notified of the delayed response.	**Key Issues:** Perfomance this month in relation to the number of incidents not approved within 35 days remains consistent with performance during August. This follows a period of continued improvement in performance since April 2017.
Key Actions: The report is being finalised and will shortly be submitted to the CCG.	**Key Actions:** • Directorates continue to be provided with monthly performance reports to assist them in monitoring their own performance and developing improvement plans. • The monthly reports are presented and discussed at each Safety and Risk Management Board meeting and directorates with lower compliance are required to provide details of improvement plans. • New arrangements for managing incidents not approved within 35 days have been approved by TEG and will be implemented from 1st January

NON-ELECTIVE LENGTH OF STAY (Average LOS Non Elective)		SAFETY THERMOMETER (Harm Free)	
			
Lead: Kirsten Major, Deputy Chief Executive	**Timescale**: March 2018	**Lead:** David Throssell, Medical Director	**Timescale**: March 2018
Key Issues: The average LOS continues to be above the Dr Foster target and the rolling 12 month position has varied between between 5.39 and 5.34 days for the past 12 months.		**Key Issues:** Work is on-going to ensure consistency and accuracy of reporting across all areas.	
Key Actions: Real-time information about patient discharge date, admissions and bed numbers via the electronic whiteboards at the Royal Hallamshire Hospital enables Duty Matrons and the Patient Flow Team to manage capacity and demand. Roll-out to the Northern General Hospital where non-elective workload is greater is underway. The Vital Room continues to be a focus for system wide undersatnding on improvements to the emergency pathway across the organisation. This has enabled new work across departmental boundaries to improve flow from the emergency department to assessment units and increase utilisation of the discharge lounge. The Trust Executive Group has recently approved winter plans.		**Key Actions:** The Safer Care Committee reviews the Safety Thermometer data on a monthly basis to monitor trends, improve accuracy and identify any concerns. The Committee is attended by a Nurse Director along with specialists in each of the four specific harm indicators (falls, pressure ulcers, VTE and catheter associated UTIs). The feedback from these specialists is being used to guide the education of staff involved in the data collection and validation. In addition, any inaccuracies in data are being identified and corrected prior to national submission. This education is being undertaken in collaboration with other electronic data collection and reporting programmes (e.g. Nursing and Midwifery Dashboard) and patient safety groups (e.g. Falls Steering Group) to ensure a coordinated approach. Safety Thermometer also includes community data which has a different data collection process and work is underway to refine and improve this process.	

PROVIDE PATIENT CENTRED SERVICES

A&E 4 HOUR WAIT
(Patients Seen & Discharged or Seen & Admitted Within 4 Hours)



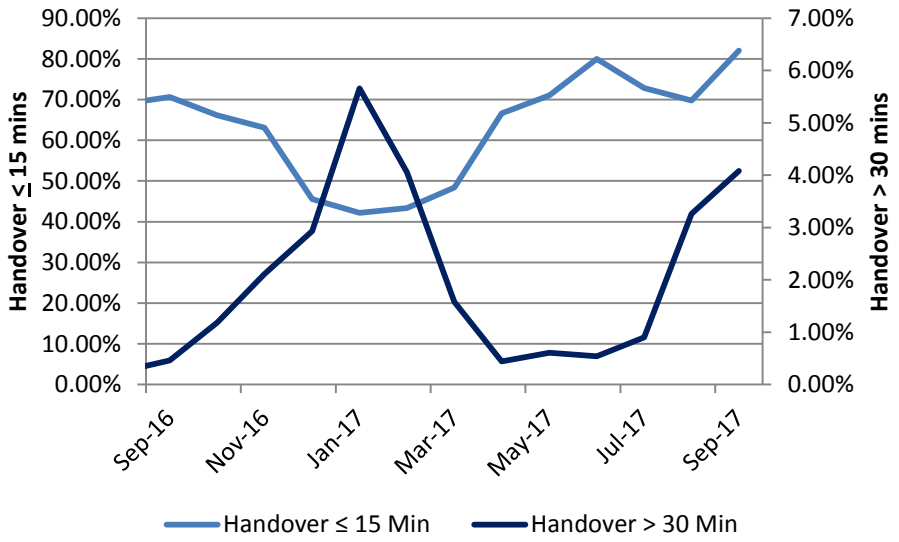
Lead: Kirsten Major, Deputy Chief Executive

Timescale: March 2018

Key Issues: The percentage of A&E attendances that were seen within 4 hours in September was 89.80%. The quarter two position was 91.00% This met the agreed Sustainability and Transformation fund trajectory of 91.00%. There were 7 days when the Trust exceeded the 95% target.

Key Actions: Performance is managed daily through the Morning Operational Group Meeting. A weekly score card is now in use and discussed at a weekly performance meeting between the A&E team and the Chief Operating Officer and the Performance and Information Director. Root cause analysis is now undertaken for days of anomalous performance, which is reviewed at the weekly performance meeting and used to identify actions to sustain improvement. It is planned to established the new model of front door working during November which is expected to aid performance.

AMBULANCE TURNAROUND
(Time Taken for Ambulance Handover of Patient)



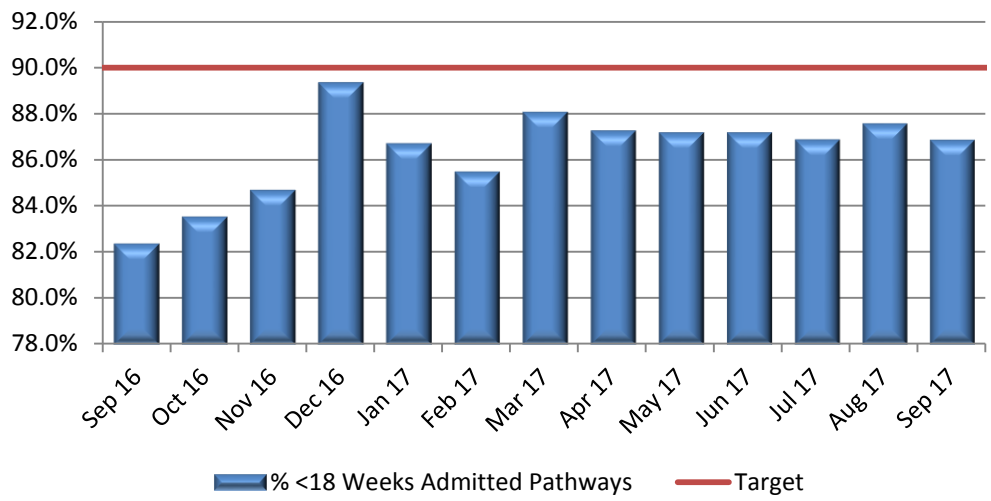
Lead: Kirsten Major, Deputy Chief Executive

Timescale: March 2018

Key Issues: The percentage of ambulance patients where handover was completed within 15 minutes in September was 82.05% compared to 69.7% in August , 72.78% in July, 77.97% in June and 70.98% in May. The percentage of handovers that took longer than 30 minutes in September was 4.08% compared to 3.3% in August and 0.7% of patient arrivals in July. There were 8 handovers that took longer than 60 minutes.

Key Actions: Performance is managed daily through the Morning Operational Group Meeting. A weekly score card is now in use and discussed at a weekly performance meeting between the A&E team and the Chief Operating Officer and the Performance and Information Director. The department continues to work closely with the Ambulance Service to develop and improve handover processes. The department is currently in phase one of delivering a new model for ambulance handover to improve handover times and flow through the department.

18 WEEKS RTT
% of Admitted Patients Treated within 18 Weeks



Lead: Kirsten Major, Deputy Chief Executive

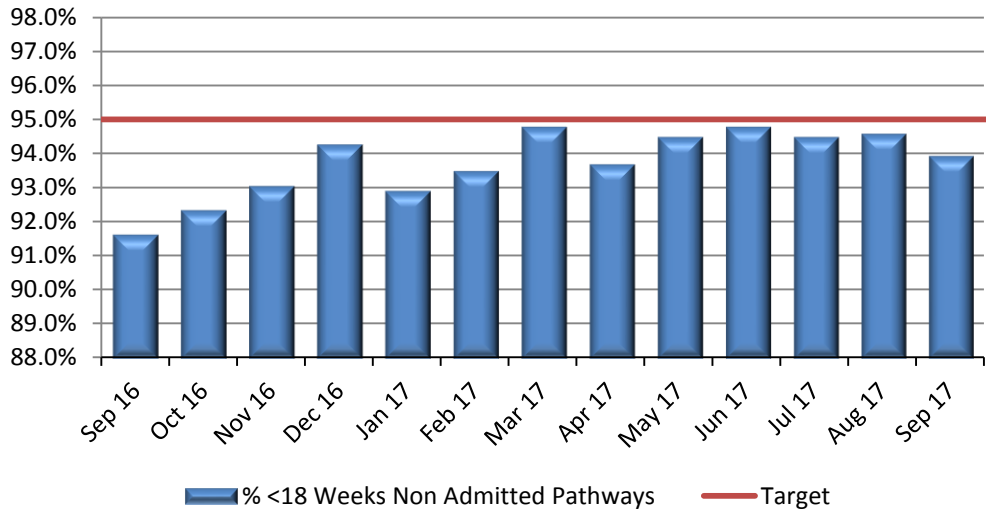
Timescale: March 2018

Key Issues: The percentage of admitted patients treated within 18 weeks of referral in September was 86.9% compared to 87.6% in August and 86.9% in July

Key Actions: Delivery plans are in place for servces not delivering the standard. These are reviewed at the monthly RTT Activity Group and issues are escalated to the Waiting Times Performance Overview Group.

Clinic and theatre utilisation contiues to be monitored on a regular basis.

18 WEEKS RTT
% of Non Admitted Patients Treated within 18 Weeks



Lead: Kirsten Major, Deputy Chief Executive

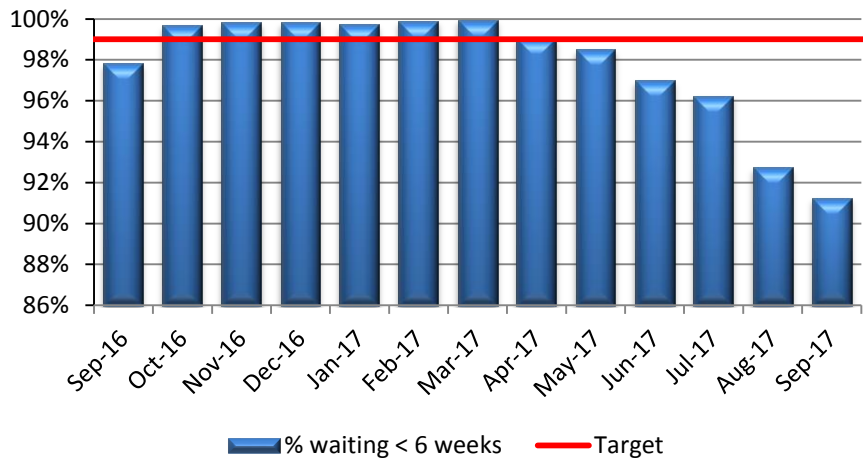
Timescale: March 2018

Key Issues: The percentage of non-admitted patients treated within the 18 weeks in September was 94.0% compared to 94.6% in August and 94.5% in July.

Key Actions: Delivery plans are in place for servces not delivering the standard. These are reviewed at the monthly RTT Activity Group and issuesare escalated to the Waiting Times Performance Overview Group.

Clinic and theatre utilisation contiues to be monitored on a regular basis.

DIAGNOSTIC WAITS
(% waiting more than 6 weeks)



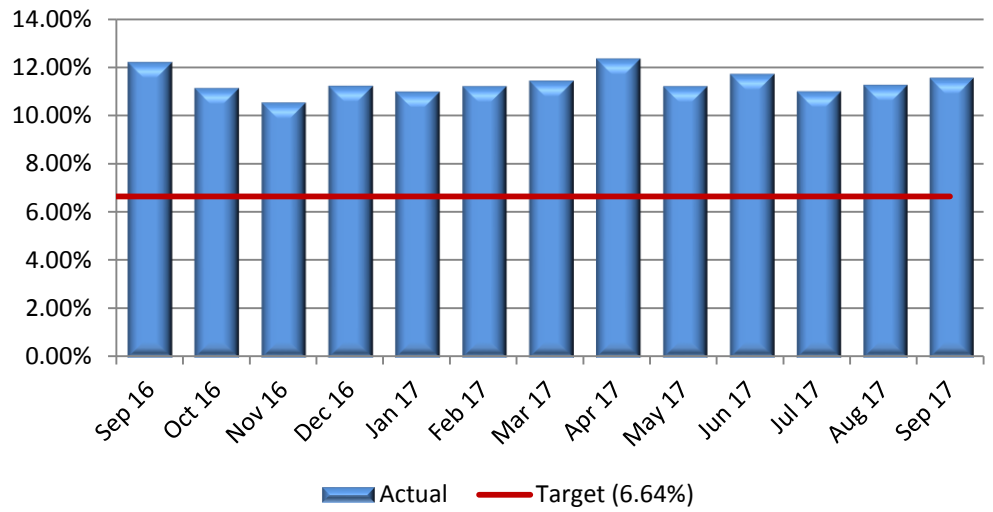
Lead: Kirsten Major, Deputy Chief Executive

Timescale: March 2018

Key Issues: At the end of September 91.24% of patients were waiting less than 6 weeks for their diagnostic test compared to the target of 99%. The modalities that did not achieve the target were Echocardiography, DEXA scans, Audiology Assessments and Sleep Studies

Key Actions: Actions are in place across all these services to improve the position. These include the provision of additional sessions, ongoing recruitment, review of demand and securing support from other local centres. A fuller report on actions to improve the echocardiography position will be brought to the Board of Directors in December, this will include an update on work being undertaken with partners across South Yorkshire, who are also experiencing challenges in delivering the target for this particular diagnostic test.

CANCELLED OUTPATIENT APPOINTMENTS
(% of Outpatient Appointments Cancelled by Hospital)



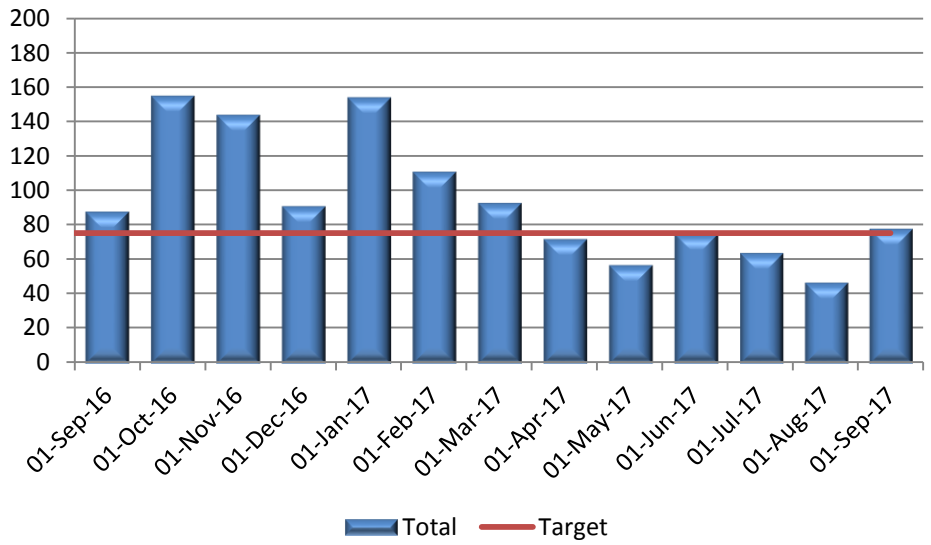
Lead: Kirsten Major, Deputy Chief Executive

Timescale: March 2018

Key Issues: The percentage of outpatient appointments cancelled by the hospital in September was 11.59%. This is higher than the 11.29% in August.

Key Actions: Directorates continue to review their booking processes and identify areas for improvement. The Lorenzo Improvement Group is currently consulting with Directorates on new rules that may help in reducing this rate.

CANCELLED OPERATIONS
(Number of Operations Cancelled in the Day for Non Clinical Reasons)

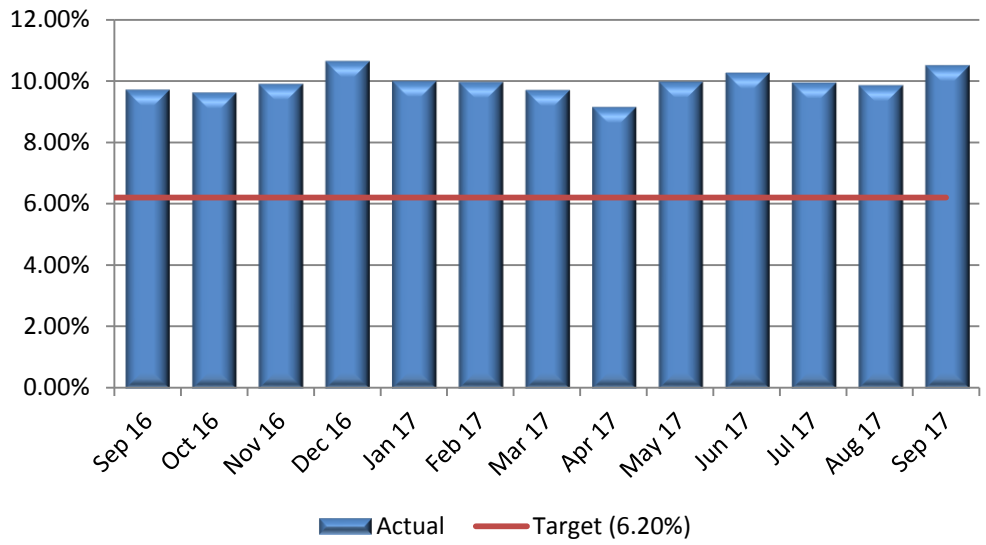


Lead: Kirsten Major, Deputy Chief Executive | **Timescale:** March 2018

Key Issues: In September 78 patients had their operation cancelled on the day for non-clinical reasons against a threshold of 75.

Key Actions: Details of cancelled operations are sent out daily to Operational Directors and are fully investigated.

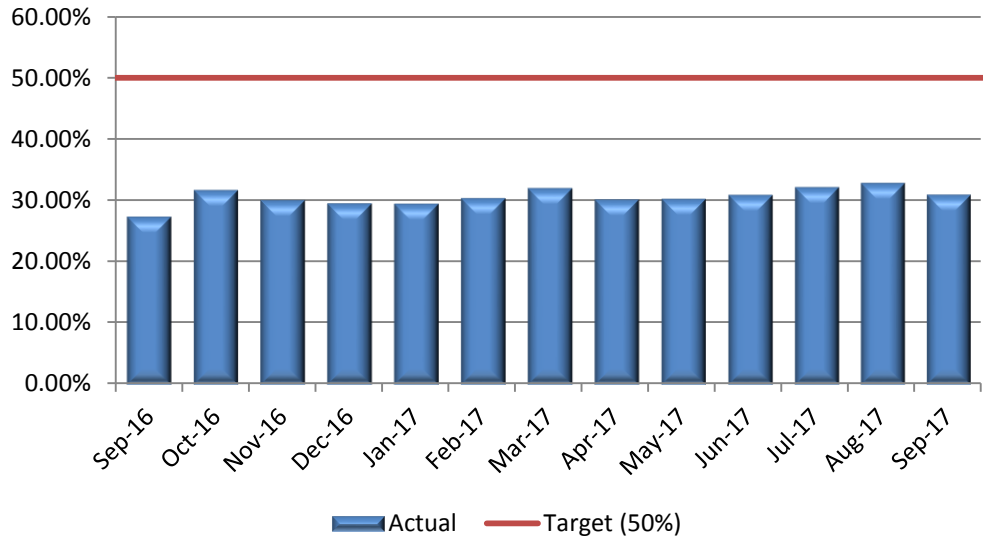
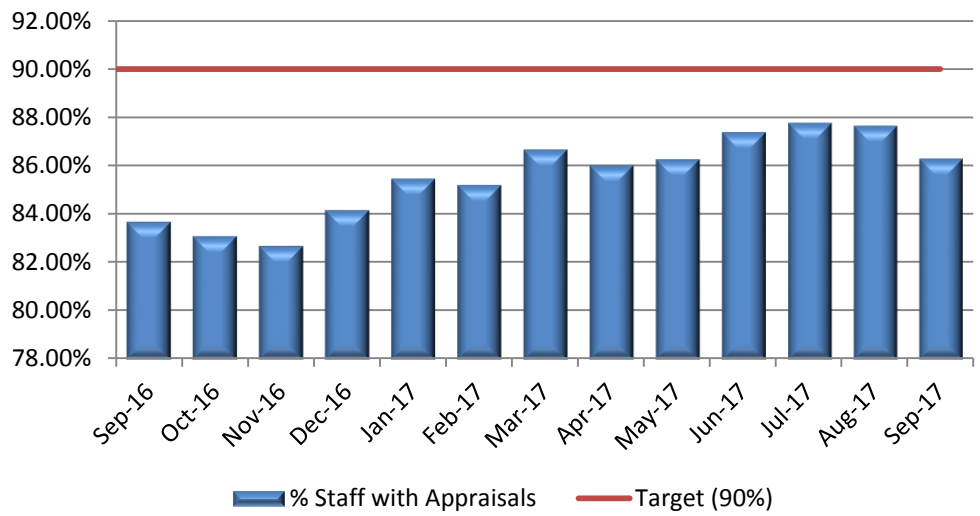
CANCELLED OUTPATIENT APPOINTMENTS
(% of Outpatient Appointments Cancelled by Patient)



Lead: Kirsten Major, Deputy Chief Executive | **Timescale**: March 2018

Key Issues: The percentage of outpatient appointments cancelled by the patient in September was 10.51%, compared to 9.87% in August and 9.95% in July.

Key Actions: Directorates continue to review their booking processes and identify areas for improvement.

e-REFERRAL SERVICE (% of Appointments Booked Through e-Referral)		APPRAISALS (Completed Appraisals in Last 12 months)	
			
Lead: Kirsten Major, Deputy Chief Executive	**Timescale**: October 2018	**Lead:** Mark Gwilliam, Director of Human Resources	**Timescale**: March 2018
Key Issues: The percenatge of outpatients seen in September where the appointment was made through e-RS was 30.87% which is a slight deterioration on previous months.		**Key Issues**: The cumulative position for completed appraisals during the past twelve months at the end of September is 86.30 % compared to the target of 90%; focus will continue on the achievement of this target.	
Key Actions: A project is underway in the Trust, in collaboration with NHS Sheffield and NHS Improvement to improve the utilisation of e-RS to support the move to a paper less referral process. The first milestone of this project is for all directorates to release all of their new outpatient appointment slots to e-RS by March 2018. This milestone will be achieved.		**Key Actions:** Directorates have developed action plans in conjunction with their HR Business Partners in order that they can achieve compliance of the target in 2017/18 This will include the need to realign the timing of appraisals.	

APPENDIX 1: DEEP DIVE – CANCER WAITING TIMES

Deep Dive – Cancer Waiting Times

1 Introduction

This is a second deep dive into cancer waiting times performance. The Report seeks to provide further detail and information to assist Board members in understanding about how the nine national cancer standards are measured and which pathways they relate to for patients. It also outlines recent performance and provides analysis to show the impact of different factors as well as outlining the key programmes of work being pursued by the Cancer Executive. To address the above objectives, this Report has been organised as follows:

- Outline of the national standards
- Description of the activity and trends across the different pathways
- Performance over time against the standards
- Comparison between Sheffield Teaching Hospitals NHS Foundation Trust (STHFT) and other providers
- Exploration of influences on performance and activity levels
- Outline of the work programme being pursued by the Cancer Executive
- Potential risks to future performance

2 Outline of National Standards

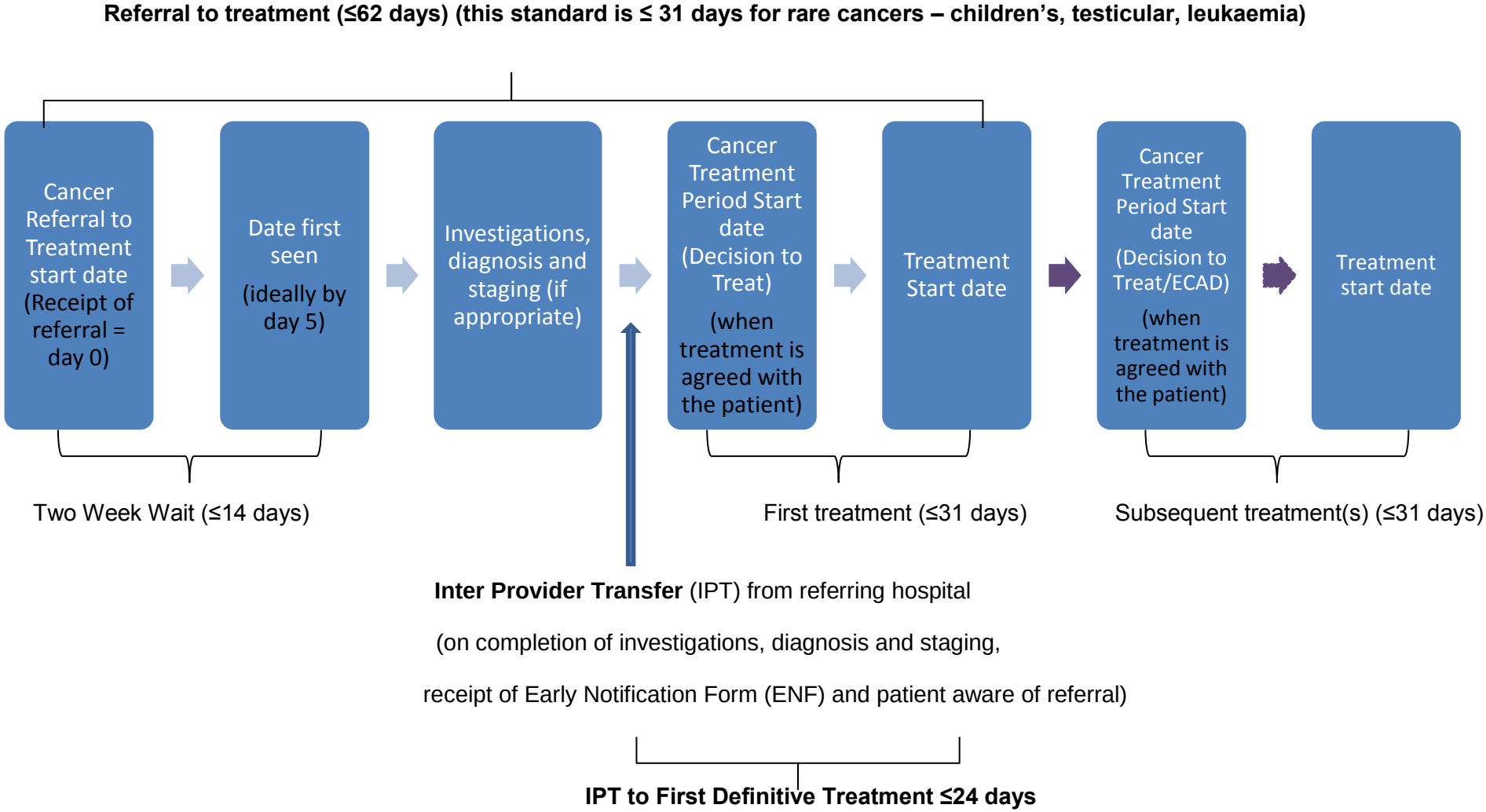
Since the introduction of Cancer Waiting Times (CWT) in 2001 there have been a series of changes. The Trust works to the National Cancer Waiting Times Monitoring Dataset Guidance – Version 9.0 (October 2015). The guidance states that; “It is not expected that all patients will be seen and treated within these time frames. Some patients will choose to wait longer and others will not be clinically fit to be seen/treated within these time frames”. With this in mind, ‘operational standards’ were set to allow for a proportion of patients to breach these standards due to medical reasons or choice. Operational standards are for all tumour sites taken collectively. Some tumour sites are expected to exceed these standards while other tumour sites are likely to be below these operational standards due to the complexity of patients or treatment planning inherent to particular tumours.

Table 1 CWT Standards, Definitions and Operational Targets

Standard	Definition	Operational Target
Two Week Wait	Time from urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first outpatient attendance	93%
Breast Symptom Two Week Wait	Time from referral of any patient with breast symptoms (including where cancer is not suspected) to first hospital assessment	93%
31 Day First Treatment	Time from decision to treat to first definitive treatment	96%
31 Day Subsequent Treatment	Time from decision to treat/Earliest Clinically Appropriate Date (ECAD) to start subsequent treatment for all cancer patients including those diagnosed with a recurrence where the subsequent treatment is: ➢ Surgery ➢ Drug treatment ➢ Radiotherapy	 94% 98% 94%
62 Day Standard	Time from urgent GP (GMP, GDP or Optometrist) referral for suspected cancer to first treatment	85%
62 Day Screening Standard	Time from urgent referral from an NHS Cancer Screening Programme (breast, cervical or bowel) for suspected cancer to first treatment	90%
62 Day Consultant Upgrade Standard	Time from referral with a consultant upgrade of 'urgent and suspicious' to first treatment	No operational standard

STHFT strives to achieve all standards for all patients, regardless of tumour site. Our intention is to investigate and treat patients with a timely, clinically appropriate pathway that incorporates patient choice, if necessary. The key dates of a sample cancer pathway are detailed in **Figure 1**. It is worthy of note, that there are no 'clock pauses' for example if a patient goes on holiday or wants to take more time to think about treatment options, rather than attend an appointment or proceed with treatment, this creates additional challenges in meeting the standards. The challenges of patient choice effect different tumour pathways in different ways.

Figure 1 Key Dates of a Sample Cancer Pathway



National Cancer Breach Allocation Guidance, April 2016

In April 2016, the National Cancer Breach Allocation Guidance was launched with the purpose of providing a fair system of treatment and breach allocation guidance between referring and treating Trusts. It advised that all cancer providers use day 38 as a maximum handover date to the treating Trust, thus allowing 24 days for the treating trust to meet the 62 day standard. The national guidance promotes joint working between providers and commissioners.

The guidance is summarised in **Table 2**

Table 2 National Cancer Breach Allocation Guidance, April 2016

Scenario	Referral timeframe	Total timeframe And impact on STHFT	Allocation
1	> 38 days	< 62 days New. Treating trust 'rescues' the breach. Positive - gain of 0.5 treatment record	100% of success allocated to the treating provider
2	< 38 days	< 62 days As now Positive record shared	50% of success allocated to the referring provider and 50% allocated to the treating provider
3	< 38 days	>62 days Treating trust has caused the breach. Negative – gain of 0.5 breach	100% of breach allocated to the treating provider
4	> 38 days	> 62 days, but treating trust treats within 24 days New. Treating trust could not 'rescue' the breach but did treat within 24 days. Positive – loss of 0.5 breach to referrer	100% of breach allocated to the referring provider
5	> 38 days	> 62 days and treating trust treats in >24 days As now Breach record shared	50% of breach allocated to the referring provider and 50% allocated to the treating provider

In May 2017, the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance launched a 'Cancer Inter-Provider Transfer Policy', which is applicable to **all** 62 day pathways with a Day 0 on/after 1st October 2016. Within the guidance the referral for treatment (or specialist diagnostics) should be made no later than the agreed Inter Provider Transfer (IPT) day specified in the site specific pathway. Implementation of the guidance has commenced whilst on-going work within Head & Neck and Upper GI Task & Finish Groups continue.

An IPT is applied to all 62 day pathways commenced outside of STHFT regardless of the geographical area of the referring hospital for patients treated at STHFT. Additionally, an IPT is applicable to all 62 day pathways that commence at STHFT but the patient is treated outside of the organisation. An example includes patients referred to STHFT with a suspicion or diagnosis of penile cancer, and referred to Leeds for specialist treatment.

3 Description of the activity and trends across the different pathways

3.1 Two Week Wait Referrals

All patients referred directly to STHFT with a suspicion of malignancy are referred as a Two Week Wait referral. Patients have a constitutional right to be offered an appointment within 14 days from receipt of referral. At STHFT, we currently aim to offer patients an appointment by day 5 in their pathway. At the time of the previous cancer Deep Dive the Trust aimed to offer an initial appointment by day 7. Over the past year, teams have been encouraged to reduce the wait for an initial appointment with the aim of improving patient experience. By and large, teams have embraced this request and notably, the ENT Directorate regularly offer an appointment on the same day as referral or within 2 working days in the pathway.

The overall rationale for offering early appointments to patients is three-fold:

1. By reviewing patients early in their pathway the aim is to improve the patient's experience by having a specialist appointment as soon as possible after being referred by their GP. By progressing the patient's pathway swiftly, either the suspicion of malignancy is eliminated or the patient can be reassured by the progression of their pathway with specialist support, in a timely manner

2. By booking an initial appointment before day 5 this does increase the chance of achieving the 62 day pathway and promotes a pathway, as short as possible, from receipt of the referral to treatment
3. It provides some time to offer a further alternative appointment within 14 days, if the first offer is not suitable

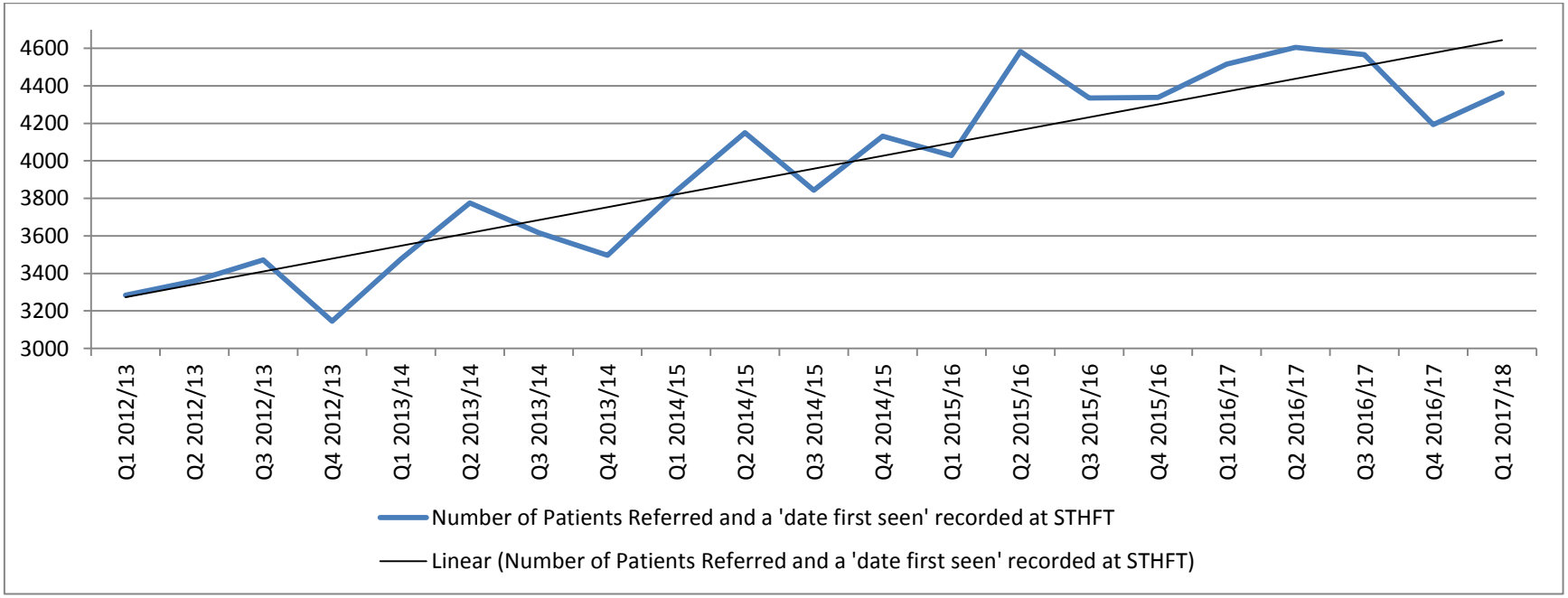
The number of patients sent into the Trust with an 'urgent and suspicion of malignancy' referral is increasing (34.8% increase since 2012/13). This is a constant challenge to teams to increase capacity year on year (**Table 3 and Figure 2**).

Table 3 Number of Two Week Wait Referrals and a 'date first seen' recorded at STHFT

	2012/13	2013/14	2014/15	2015/16	2016/17
Referral Numbers	13,260	14,365	15,964	17,287	17,879

Information source: Open Exeter

Figure 2 The Number of Patients Referred with an 'Urgent and Suspicion of Malignancy' Referral and a 'date first seen' recorded at STHFT from Q1 2012/13 to Q1 2017/18



Information source: Open Exeter

Two Week Wait Referral Guidelines

In November 2016, the two week wait referral guidelines into STHFT were revised in line with NICE guidance. This was a joint piece of work between Sheffield Clinical Commissioning Group and STHFT.

The Offer of Appointments to Patients Referred to STHFT with a Suspicion of Malignancy

To promote the achievement of this standard, the aim of the Trust is to offer patients multiple appointments within 14 days from receipt of referral to accommodate patient choice. A 'snap shot' of the next available two week wait appointment is captured weekly, and circulated throughout the organisation, to raise awareness of the next available appointment that can be offered. The aim is to assist Directorates to continue to offer appointments within 5 days (**Table 4**).

With the move to book patient appointments via the e-referral system, the appointments are booked directly by the GP or the patient liaises with the Contact Centre to book/change appointments. One challenge with e-referral is that STHFT staff lose the opportunity to respond verbally to patient choice in booking an appointment over the telephone, and to encourage the patient to attend as soon as possible. On occasion patients need the urgency of their referral reiterated and need to be encouraged to attend as soon as possible. The Cancer Executive is working with the Performance and Information Director to ensure the opportunity to interact with patients is not lost with the expansion of electronic referrals.

Table 4 Cancer Waiting Times Snap-shot of day of First Offer of a two week Wait Appointment, Recorded in Day in Pathway for Q2 2017/18

Tumour Site	03/07/2017	10/07/2017	17/07/2017	24/07/2017	31/07/2017	07/08/2017	14/08/2017	21/08/2017	28/08/2017	04/09/2017	11/09/2017	18/09/2017	25/09/2017	Average Day of first offer of 2WW -
Brain/CNS	1	7	8	7	8	14	7	3	8	14	8	11	7	8
Breast	7	7	7	4	1	3	4	3	3	3	1	1	1	3
Breast Symptomatic	4	7	7	4	1	3	4	3	3	3	1	1	1	3
Gynaecology General	3	5	4	3	10	3	2	8	7	4	2	8	8	5
Gynaecology Hysteroscopy	8	8	4	3	10	3	10	8	7	11	8	8	7	7
Myeloma	8	8	15	8	8	2	9	1	2	9	9	2	1	6
Lymphoma	8	8	2	8	8	2	9	1	2	3	3	2	1	4
ENT	4	2	3	No Data	2	1	2	2	2	8	1	8	1	3
OMF	5	8	2	8	1	7	2	4	2	2	3	1	4	4
LGI Surgical OPA	2	1	2	1	1	2	10	1	1	1	2	1	1	2
UGI/LGI Medicine OPA	4	6	5	5	3	6	6	3	3	9	5	3	1	5
Lung (OPA)	8	3	15	16	9	8	4	8	6	8	2	9	8	8
Lung (CT)	5	5	5	5	5	5	5	5	5	5	5	5	5	5
Sarcoma	2	3	2	3	11	8	4	3	1	2	1	13	4	4
Thyroid	4	4	1	2	4	4	14	8	3	1	1	1	11	4
Dermatology	7	3	9	9	9	8	4	1	8	7	7	7	7	7
Plastics	2	9	10	3	14	1	8	8	2	4	3	2	3	5
UGI Surgical Endo	3	9	7	7	3	7	7	3	7	11	7	4	7	6
UGI Surgical OPA	3	4	2	2	3	3	8	3	6	3	2	3	2	3
UGI Medicine OGD	3	1	2	3	2	1	2	1	1	4	7	1	3	2
HPB Surgical OPA	4	2	1	2	4	1	8	1	6	4	3	4	1	3
Urology OPA	3	1	3	1	3	7	3	7	2	1	3	1	4	3
Urology OPA (Prostate)	3	3	3	3	7	7	1	3	2	1	1	7	4	3
Urology (Flexi)	3	4	1	2	4	2	2	2	1	3	2	1	4	2
Testicular	3	1	3	1	3	7	3	7	2	1	3	4	4	3
Ocular	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	No referrals	

Colour code					
	Day 5 or under		Days 6-7		
	Days 8-10		Days 11-12		
	Days 13-14		no data submitted		

Information source: Clinical Directorates

As a note, when discussing the two week wait standard, the terminology used within the Trust changes to discussing pathways length in terms of days. All teams are encouraged to view all cancer pathways in terms of days rather than weeks as our aim is to offer and see patients within 5 days rather than two weeks with the catch phrase of, ‘every day counts’. This language continues throughout the pathway.

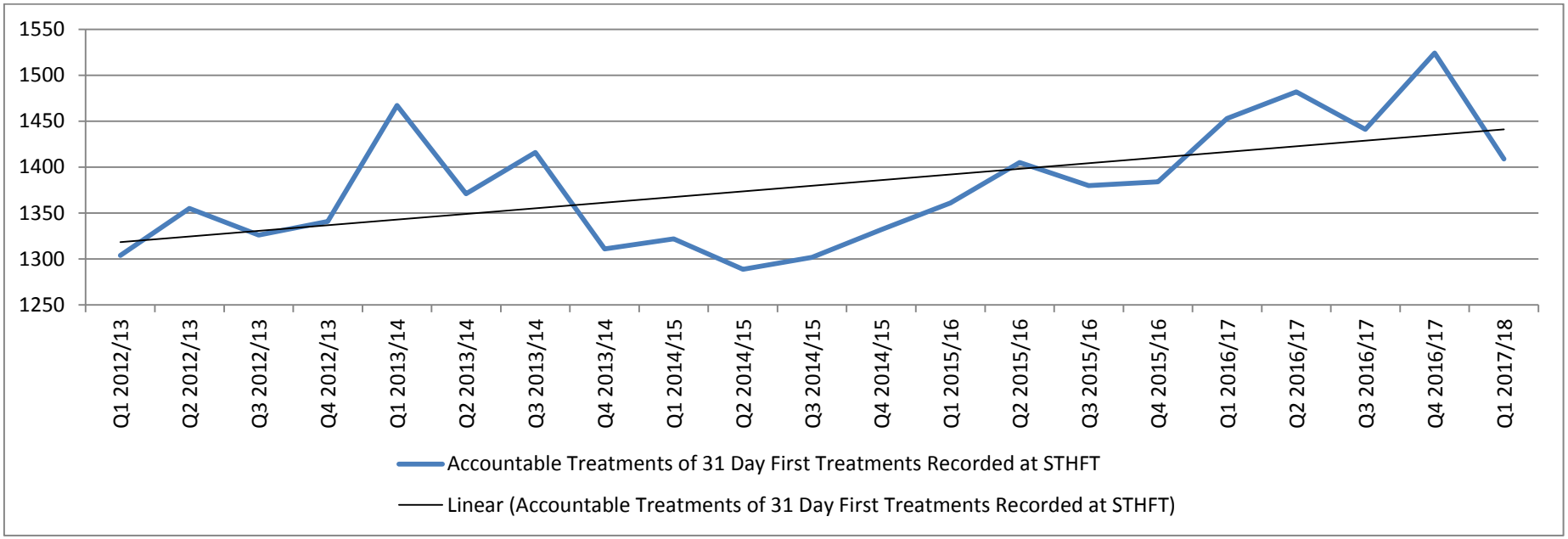
3.2 31 Day First Treatment Standard

The 31 day first treatment standard is a maximum one month (31 days) from a decision to treat to the first definitive treatment. The variations in the volumes of treatments delivered at STHFT are detailed in **Table 5 and Figure 3**. Since 2012/13 there has been a 10.8% increase in treatments delivered at STHFT. It is worthy of note that the rise in urgent referrals for suspected cancer is considerable greater than the rise in the number of cancers diagnosed (an approximate 3-fold difference).

Table 5 31 Day First Treatment Standard – Accountable Treatments at STHFT

	2012/13	2013/14	2014/15	2015/16	2016/17
Accountable Treatments	5326	5565	5245	5530	5900

Figure 3 31 Day First Treatment Standard – Accountable Treatments at STHFT from Q1 2012/13 to Q1 2017/18



Information source: Open Exeter

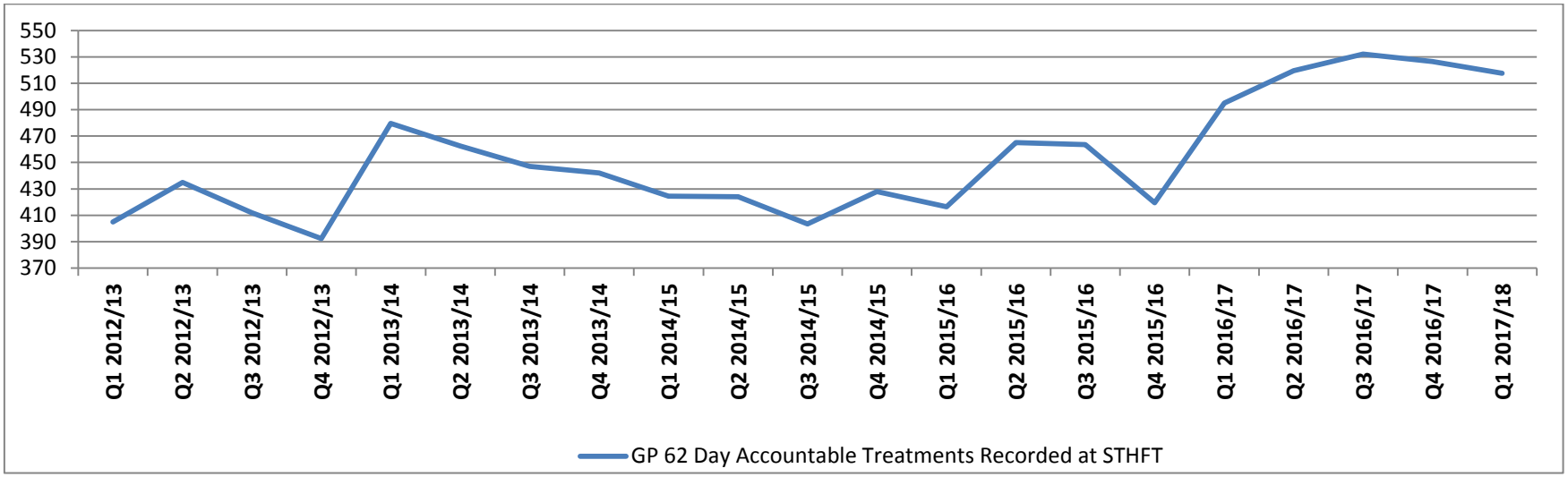
3.3 GP 62 Day Standard

All patients referred by a GP (GMP, GDP or Optometrist) as an urgent referral for suspected cancer who receive a first definitive treatment for cancer are included in the GP 62 Day Standard. Pathways can commence at another provider (or STHFT) with a treatment at STHFT **OR** pathways can commence at STHFT with the patient being treated in another provider.

Table 6 GP 62 Day Standard – Accountable Treatments at STHFT without the Application of the National Cancer Breach Allocation Guidance (2016)

	2012/13	2013/14	2014/15	2015/16	2016/17
Accountable Treatments	1644.5	1831	1680	1764.5	2073

Figure 4 GP 62 Day Standard - Accountable Treatments at STHFT from Q1 2012/13 to Q1 2017/18 without the Application of the National Cancer Breach Allocation Guidance

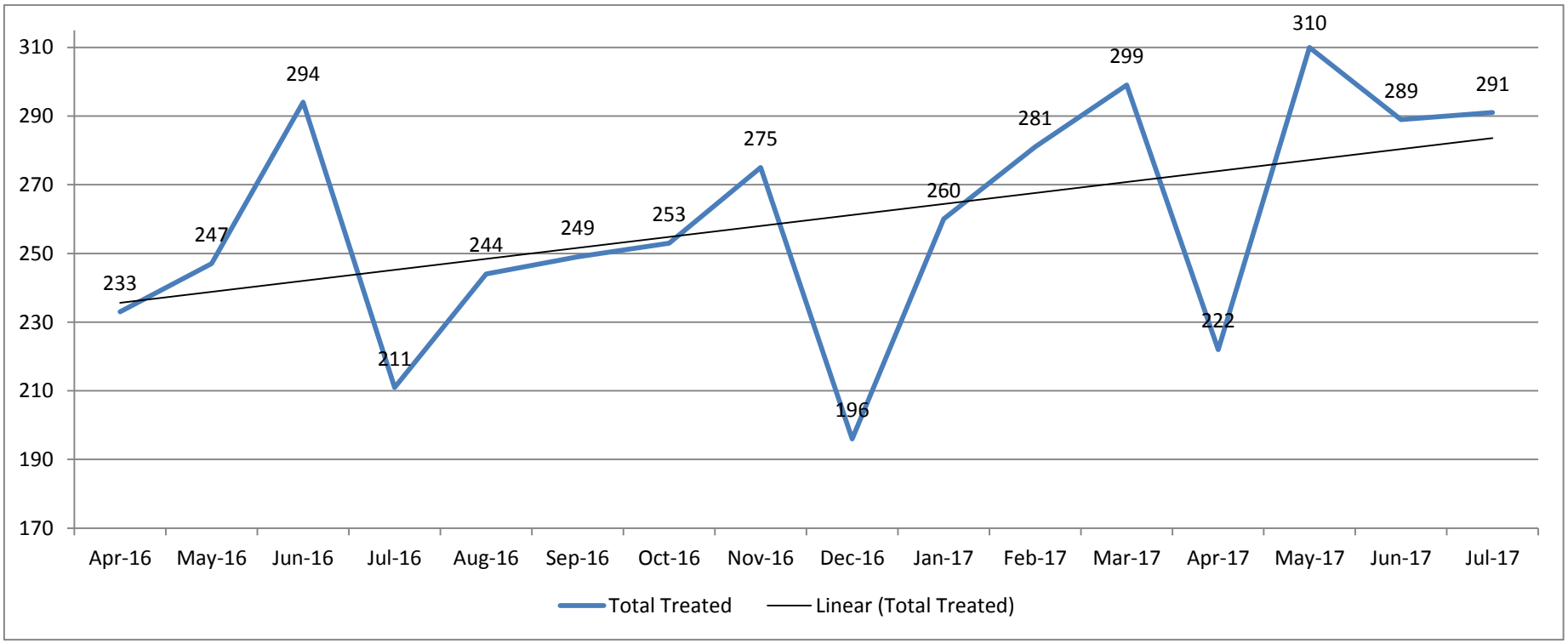


Information source: Open Exeter

3.4 Subsequent Radiotherapy Standard (31 day standard)

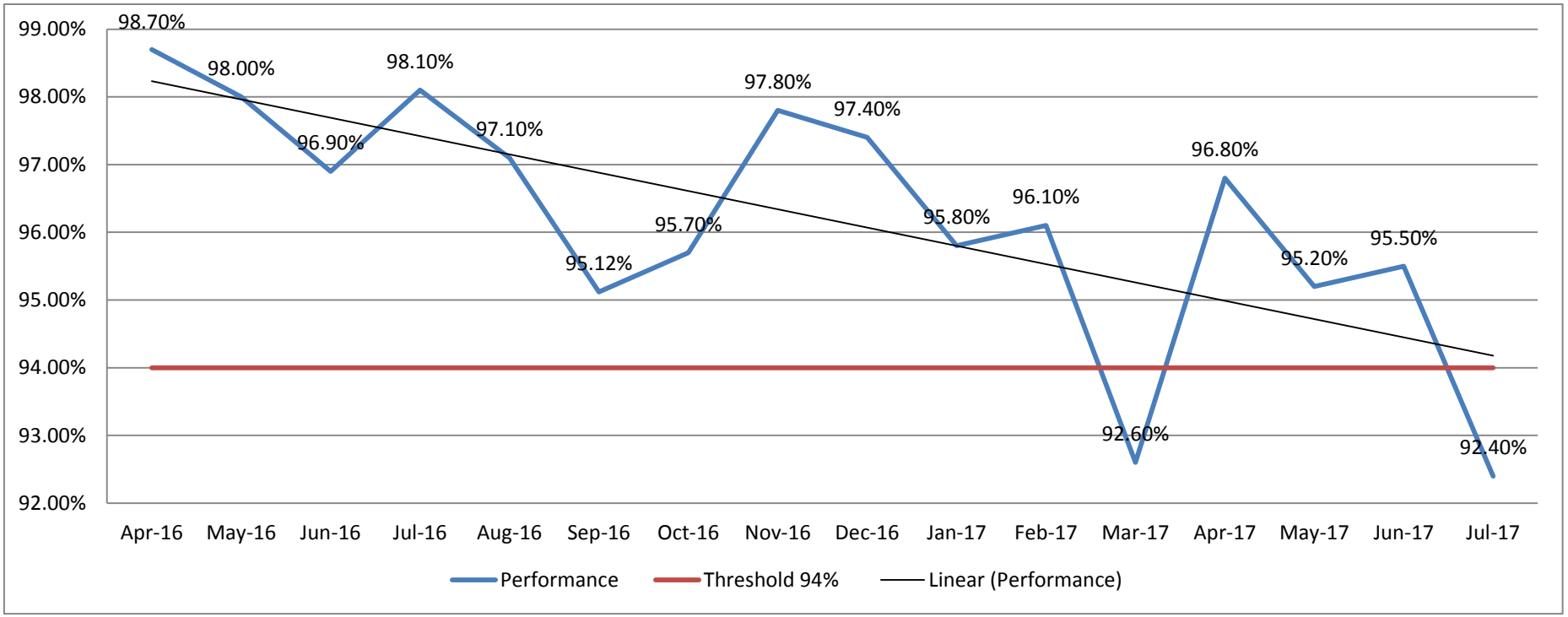
Over the past year the number of overall subsequent radiotherapy treatments has increased somewhat whilst performance has declined **(Figures 5 and 6).**

Figure 5 All 31 Day Subsequent Radiotherapy Treatments from April 2016 to July 2017



Information source: Open Exeter

Figure 6 All 31 Day Subsequent Radiotherapy Performance from April 2016 to July 2017



Information source: Open Exeter

The decline in performance is due to several factors:

1. A modest increase in need for radiotherapy treatments **(Figure 5)**
2. Spike in Head & Neck referrals over the summer 2017, which is an especially challenging tumour type for radiotherapy planning and delivery.
3. Lack of oncologist capacity in some tumour sites. There are capacity issues for some tumour sites in terms of clinic and planning radiotherapy treatments. The Management Team within Specialised Cancer, Medicine and Rehabilitation are actively working to resolve consultant oncologist capacity issues but this is a slow and on-going process in the face of national shortages in this specialty.
4. A growth in patients receiving specialist radiotherapy (such as SABR) and in tumour sites such as Head & Neck where complex radiotherapy planning takes considerably more clinical oncologist and physicist time. More patients require 5 days consecutive days of treatment which often are scheduled to commence on a Monday (on occasions this group of patients breach by 1 or 2 days due to bank holidays).
5. Patient choice regarding treatment dates, especially over the holiday periods, can be an influence.

3.5 Reporting of Cancer Referrals and Treatments

CWT pathway records are recorded on InfoFlex (Trust's CWT information system). Records are continually uploaded to Open Exeter (the national database for CWT records). Performance is reported monthly along with a commentary on the most up to date quarterly position. The Trust is performance managed on the quarterly rather than monthly performance due to the variation that occurs on a month by month basis.

In view of the implementation of the National Cancer Breach Allocation Guidance, April 2016, it is anticipated that there will be significant changes to the CWT dataset on Open Exeter from April 2018.

3.6 Accountability for CWT Performance

The named Executive Director with responsibility for delivery of national CWT standards is Kirsten Major, Deputy Chief Executive. The Executive Director is supported by Alan Gillespie, Associate Medical Director (Cancer) who leads the Cancer Executive Team of the Cancer Management Group. Each Cancer tumour site has a Lead Clinician who is accountable for tumour site performance.

Each tumour site specific Multi-Disciplinary Team (MDT) has a Lead Clinician. In total, the Trust has 23 cancer MDTs, which in general, meet weekly **(Appendix 1**).

4 Performance over time against the standards

4.1 Compliance with CWT Standards

The performance of STHFT against CWT standards is, in general, very good and we are frequently asked for advice and support from other cancer centres. From Q1 2011/12 until Q4 2014/15 (inclusive) the Trust achieved all of the CWT standards every quarter. This equated to 16 quarters of achievement. Since Q1 2015/16 achieving the targets has become more challenging, this is due to a combination of factors including demand, capacity, pathway complexity, late referrals and patient choice.

Compliance with all the CWT operational standards Q1 2016/17 to date is set out in **Table 7**

Table 7 Compliance with all the CWT Standards 2016/17 and Q1 2017/18

Standard	Compliance threshold %	Q1 % 2016/17	Q2 % 2016/17	Q3 % 2016/17	Q4 % 2016/17	Q1 % 2017/18
Two Week Wait	93	94.1	94.4	95.2	96.3	95.8
Breast Symptom Two Week Wait	93	97.6	98.4	99.0	93.4	95.4
31 Day first treatment	96	95.3	97.5	97.6	96.7	98.2
62 Day Standard without breach reallocations (all pathways)	85	77.0	81.7	78.9	78.9	78.6
62 Day Standard with breach reallocations (all pathways)	85	78.4	83.1	-	-	-
62 Day Standard with the Application of the National Cancer Breach Allocation Guidance and Re-allocations (all pathways)	85	n/a	n/a	80.1%	85.3	83.8
62 Day Standard of STHFT only pathways	*85*	*83.8*	*90.3*	*86.4*	*85.2*	*85.1*
62 Day Consultant Upgrade Standard	none set	76.4	74.2	86.4	76.0	74.0
31 Day Subsequent Treatment Radiotherapy	94	97.8	96.7	97.0	94.8	95.6
31 Day Subsequent Treatment Anti-Cancer Drug	98	99.8	100	100	99.7	99.8
31 Day Subsequent Treatment Surgery	94	95.0	99.9	98.4	98.9	98.6
62 Day Screening Standard	90	93.0	93.9	95.1	93.2	98.9

Information source: Open Exeter and InfoFlex

Performance is circulated across the organisation during and at the end of each reporting period. Increasingly, the Trust receives queries from referring Commissioners regarding performance and individual patient pathways.

4.2 Impact of the Application of the National Cancer Breach Allocation Guidance

The National Cancer Breach Allocation Guidance has been applied retrospectively to GP 62 Day performance for Q4 2016/17 and Q1 2017/18. The remodelled performance for Quarter 4 2016/17 and Q1 2017/18 are reflected in **Tables 8 and 9** and consist of Open Exeter reported performance, reallocations and performance based on application of the National Cancer Breach Allocation Guidance. The methodology used to calculate performance comprised of a manual review of all pathways in Q4 2016/17 and for Q1 2017/18, and applying the scenarios in **Table 2** in conjunction with the site specific IPT date.

Table 8 Adjusted Quarter 4 2016/17 GP 62 Day Performance

Q4 2016/17	GP 62 Day Target Threshold 85%			
Post Open Exeter close	Open Exeter STHFT only pathways	Open Exeter STHFT all pathways	Open Exeter + new allocations	Open Exeter all + new allocations + re-allocations
Accountable treatments	386	526.5	554.5	554.5
Accountable breaches	57	111	82.5	81.5
Performance	85.2%	78.9%	85.1%	85.3%

Table 9 Adjusted Quarter 1 2017/18 GP 62 Day Performance

Q1 2017/18	GP 62 Day Target Threshold 85%			
Post Open Exeter close	Open Exeter STHFT only pathways	Open Exeter STHFT all pathways	Open Exeter + new allocations	Open Exeter all + new allocations + re-allocations
Accountable treatments	383	517.5	541	541
Accountable breaches	57	110.5	88	87.5
Performance	85.1%	78.6%	83.73%	83.82%

It is noted that, for a small number of pathways, the IPT date is not agreed between the referring and treating organisations. This discrepancy is acknowledged as part of the implementation process and will be addressed as part of an implementation review led by the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance. It is clear that there is a considerable improvement in STHFT performance using the new methodology, but there is still detailed work to be undertaken in some tumour sites to improve delivery and performance.

From Q3 2017/18 STHFT 62 Day performance will only be reported with the application of the National Cancer Breach Allocation Guidance, April 2016.

4.3 Analysis of Breach Reasons for Q1 2017/18

Key breach reasons allocated to GP 62 Day shared pathways are:

1. IPT after breach date
2. IPT late in pathway
3. Complex diagnostic pathway (many, or complex, diagnostic tests required)

Key breach reasons allocated to STHFT only GP 62 Day pathways are:

1. Healthcare provider delay to diagnostic tests or treatment planning
2. Complex diagnostic pathway (many, or complex, diagnostic tests required)
3. Patient initiated (choice) delay to diagnostic test or treatment planning, advance notice given

Healthcare provider delay to diagnostic tests or treatment planning

The allocation of the breach reason, 'Healthcare provider delay to diagnostic tests or treatment planning' is allocated to a pathway where is it considered that the Trust has contributed to a pathway delay. Examples of delays include:

- Delays to discussing a test with the patient
- Delays to requesting diagnostic tests
- Delays to triaging/booking diagnostic tests
- Delays from receipt of a request to diagnostic investigation (e.g. radiology, endoscopy)
- Delays to reporting of investigations (e.g. reporting of radiology investigations or histopathology)
- Delays to patient discussion at MDT meetings (referrals received after the MDT cut-off time, cancelled MDT meetings due to public holidays, administrative delays)
- Delays to diagnostic test (non NHS provider)
-

Histopathology Input into Cancer Pathways

Histopathology at STHFT plays an integral role in cancer pathways and supporting multiple cancer MDT meetings (**Appendix 1**). The Directorate has developed systems to support the MDT requirements. These include:

- Prioritisation of cases which are for MDT meeting, where this is indicated on the request form, through all stages from receipt to report authorisation
- Dedicated team secretaries who are responsible for managing the MDT meeting lists and tracking samples through the department

- A triage system within the laboratory, based on clinical requirements

It is acknowledged that STHFT do not control the process from end to end. The pattern of referrals from other hospitals can cause bottlenecks in pathways.

The department is currently working with Cancer Executive to clarify specific MDT meeting requirements and to put in place a plan to deliver these requirements, where there are delays to the pathways the team work to identify and resolve any operational issues which have contributed to this.

The team engage regularly with the Cancer Executive to receive feedback on the service they provide.

Endoscopy Input into Cancer Pathways

In total 20,000 endoscopy procedures are performed per year for patients on cancer and non-cancer pathways. The investigation, mainly performed without overnight admission, vary in complexity and length of procedure. The ranges of procedures include Endoscopic Ultrasound (EUS), colonoscopy, flexible sigmoidoscopy, gastroscopy, endoscopic retrograde cholangio-pancreatography (ERCP) and double balloon enteroscopy (DBE). The majority are planned procedures, for symptomatic investigation and/or surveillance, but there are also emergency, screening, and therapeutic cases performed within the Trust for patients on cancer and non-cancer pathways. To add to the complexity not all endoscopists are able to perform the full range of endoscopic investigations and, nor can all the practitioners perform therapeutic procedures. For some investigations such as bowel screening colonoscopy, EUS and ERCP there are a very limited number of practitioners. This is a complex service.

Some of the difficulties the service has experienced are:

- Increasing number of referrals for patients in all categories, such as, cancer referrals, planned surveillance procedures, routine and therapeutic procedures
- Patients cancelling colonoscopy procedures on the day. This results in some patients requiring repeated investigations as bowel preparation may not be adequate
- In recent times, up to an 11% patient cancellation rate, whereby patients change their appointments
- Until 2016 a Did Not Attend (DNA) rate of 6%
- Combination of service endoscopy lists and screening service lists competing for the same capacity
- Difficulty in recruiting to consultant vacancies
- Difficulty in recruiting and retaining experienced endoscopy trained nurses
- Screening service with separate and specific governance arrangements
- Patient choice
-

The team have made a number of improvements to improve patient experience and maximise capacity:

- The opening of a Contact Centre for patients to arrange/rearrange appointments in an efficient manner. The centre is open from 8.30am – 5.00pm Monday to Friday

- A more consistent approach to looking forward for vacant slots/empty sessions to ensure capacity is used fully. This involves proactively seeking cover for vacant lists well in advance
- An electronic Endoscopy Tracker records effective utilisation of slots per session. The tracker also records DNA rates and patient cancellation rates
- Evening administrative sessions (Monday to Thursday until 9pm), in line with endoscopy lists, where by clerical staff call patients 3 days ahead of planned procedures to ensure they fully understand preparation for procedures. The timing of these sessions allow clinical availability should this be required. As a result, the DNA rate has reduced by 2%. The DNA rate for 2017/18 is currently 4.25%
- Utilising off site capacity
- The service has appointed 4 Consultants Gastroenterologists & 1 Honorary Lecturer who will all provide endoscopy capacity as part of their job plans. Starting dates ranged from November 2016 to October 2017
- Regular weekend lists on site – these lists tend to have fewer DNA/cancellations and are deemed to be popular with patients
- Additional evening lists are available Monday to Thursday every week (4 lists per evening)
- An Endoscopy Nurse from the Trust has been accepted on the Health Education England Clinical Endoscopist Course. On completion of the seven month course, they will be trained to perform flexible sigmoidoscopy procedures. The training programme started in September 2017 and is due to complete in May 2018. There is an expectation that this will increase capacity in 2018/19
- Bespoke adverts to attract skilled endoscopy nurses to the Trust
- Introduction of 12 hour days for nursing staff to cover evening lists
- Increased cancer tracker role from 1.0 WTE to 1.6 WTE supported by a Pathway Coordinator
- Reviewed and improved administrative processes. All 2WW referrals are scanned and added to Lorenzo. This process is supported by an SOP
- Improved administrative processes for the handover of referrals between Gastroenterology & General Surgery
- Improved process of triaging all UGI and LGI 2WW referrals to progress the patients' pathways and forward referrals to the relevant administrative teams in a timely manner
- Increased managerial focus on breach reports to glean learning points

Radiology Input into Cancer Pathways

A high proportion of patients require a radiological investigation as part of their cancer pathway.

Challenges to Radiology:

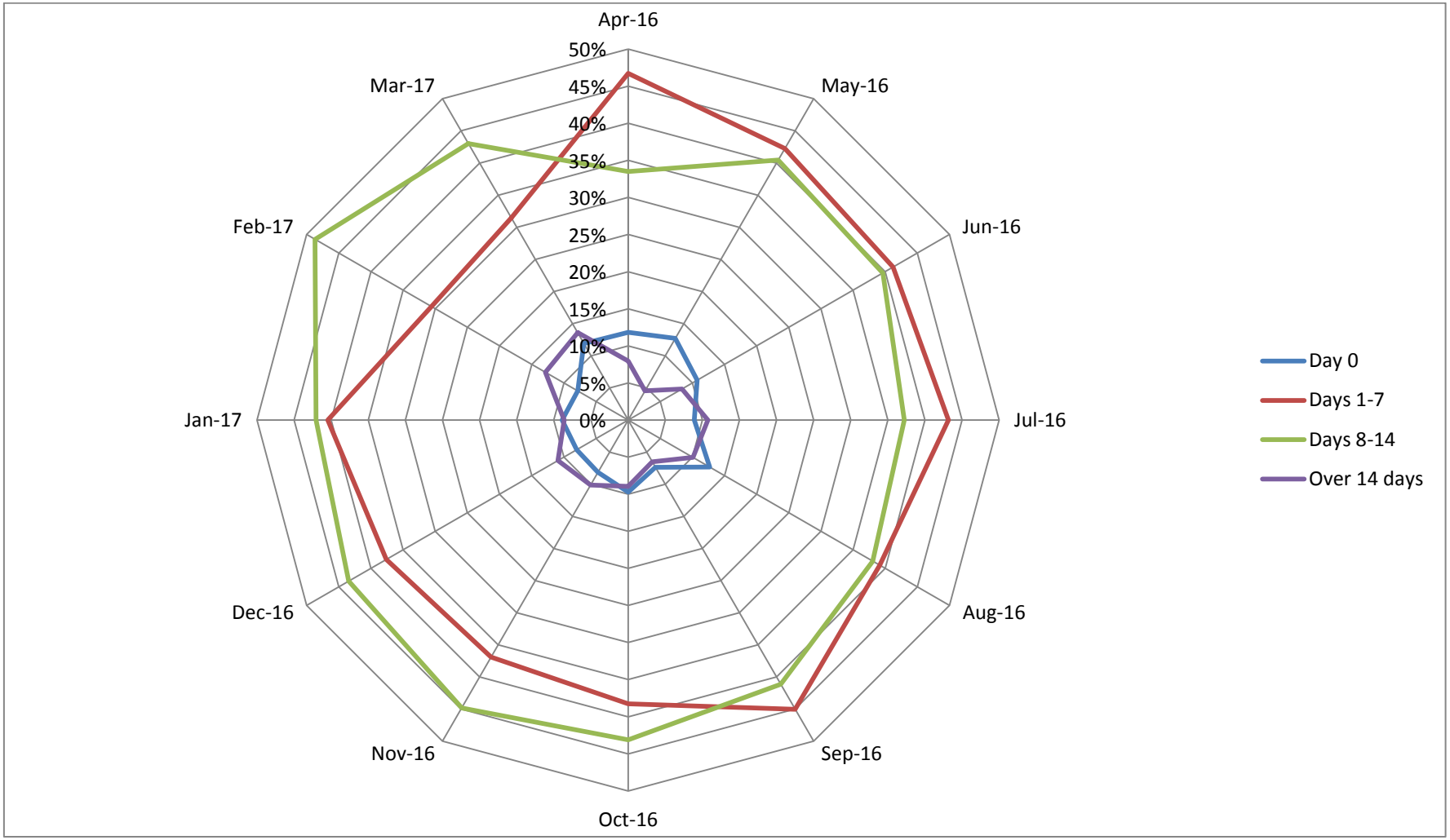
- Accessibility to patients – at times, the team has difficulty contacting the patients to arrange appointments. This can be especially problematic for procedures that require patient preparation and involve invasive examinations
- Sonographers – to support recruitment and retention of this key group of staff, Medical Imaging and Medical Physics (MIMP) Directorate are encouraging an increasing range of advanced practice roles and also providing more training opportunities to enter into this profession
- Radiologists – a national shortage of Radiologists is putting pressure on the ability of the service to report images promptly. The Directorate uses reporting capacity data to target recruitment to key areas of shortfall

Recent Positive Radiology Actions to Expedite Patient Pathways:

- One stop clinics for Breast (symptomatic and non-symptomatic referrals) and Urology pathways (2 week wait referrals – consultant appointment and ultrasound scan) – the patient attends for their consultant clinic appointment and radiology appointment on the same day to progress the pathway. The team continue to review other areas where one-stop clinics could be incorporated into the pathways
- Imaging on Demand – offer same day imaging service for outpatients wherever possible. The uptake of this service continues to be promoted.
- Improved vetting protocols to decrease the number of imaging requests (with a focus on Gastrointestinal and Head and Neck)
- Use of voice recognition – by the end of 2017, voice recognition will be implemented across Radiology to reduce the typing and verification turnaround times. Reports dictated will be available instantly on ICE
- An increased focus with monthly Radiology Executive review of 2ww pathways and weekly review of performance in the CT, MRI and Ultrasound Meetings. This process reviews:
    - Request to scan
    - Reporting turnaround
    - Typing of report turnaround times

Figure 7 Request to Imaging Turnaround Times for Patients on a Cancer Pathway, by month, for 2016/17

(MRI, Ultrasound and CT Scans)

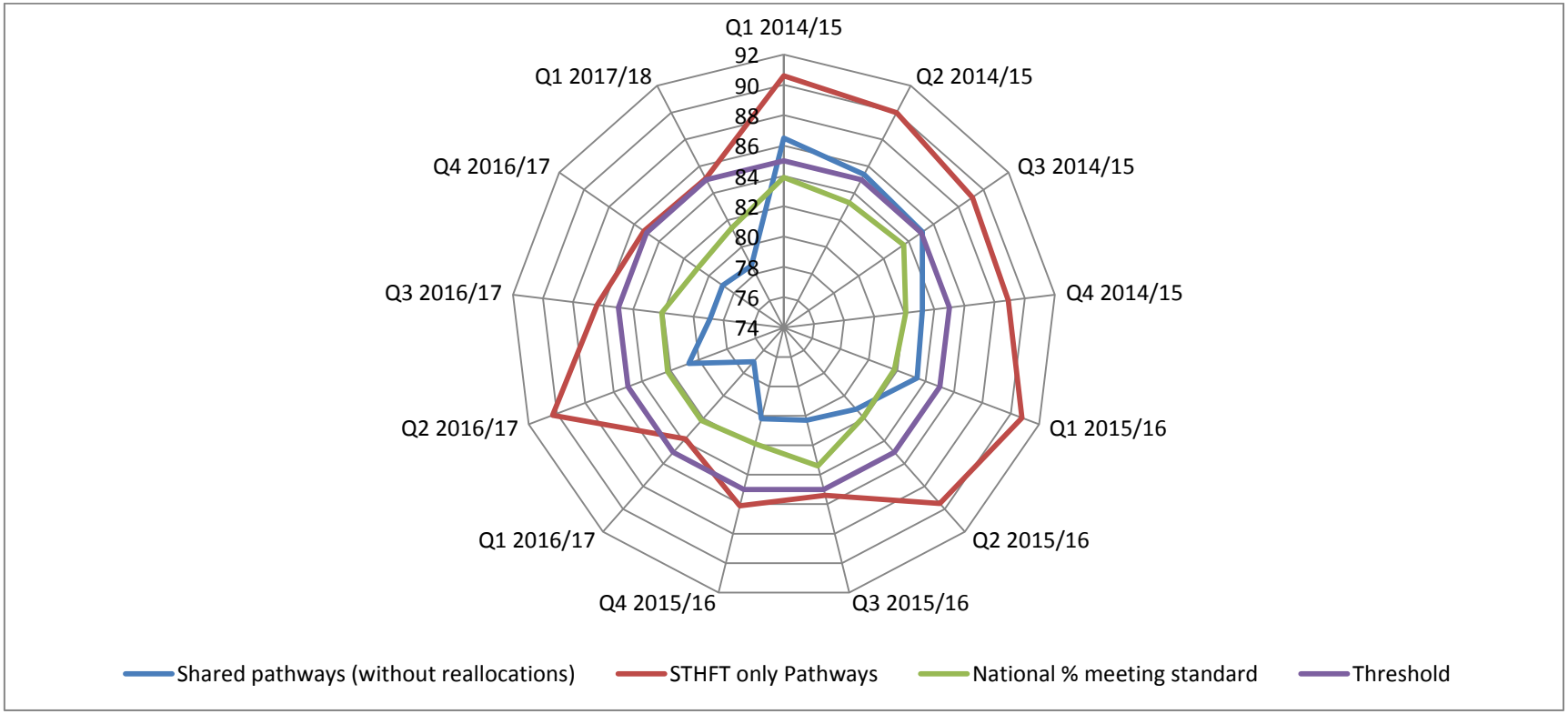


Information Source: Radiology Directorate

5 Comparison between STHFT and other Providers

Historically, the Trust has performed well for STHFT only pathways (Two Week Wait, Breast Symptomatic, GP 62 Day, 31 Day, screening and subsequent pathways). In particular, STHFT has performed above the national average for the GP 62 Day shared pathways up to and including 2015/16 and consistently for STHFT only pathways until Q1 2016/17. From this time, achieving the threshold has been a challenge to STHFT **(Figure 8)**.

Figure 8 GP 62 Day Performance Comparing Shared and STHFT Only Performance against National % Meeting Standard by Quarter from 2014/15 onwards



Information source: Open Exeter

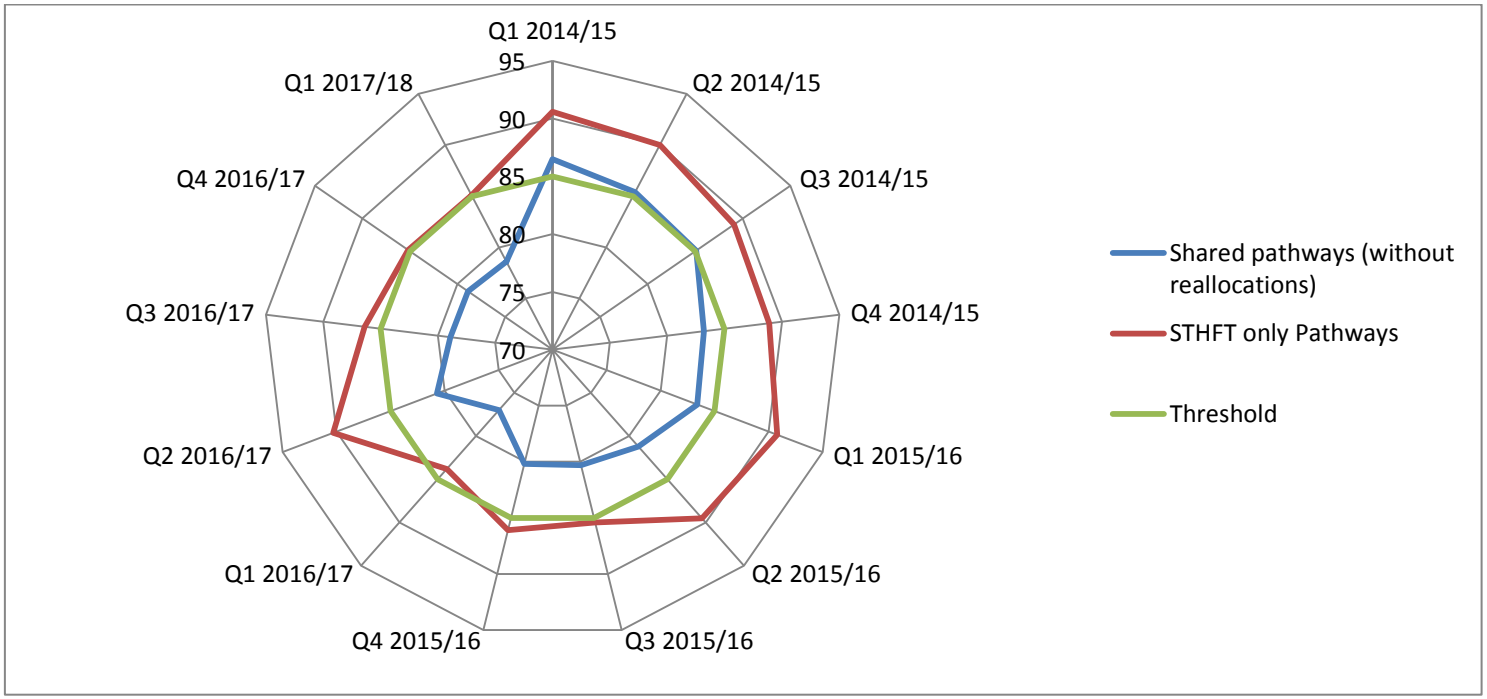
6 Exploration of Influences on Performance and Activity Levels

6.1 Shared Pathways

Historically, STHFT has needed to perform well above the GP 62 Day threshold to mitigate the major risk to the achievement of the operational standard from late referrals from other secondary care providers. Despite this mitigation, and the on-going proactive management of CWT performance, including regular discussions with referrers and commissioners about shared breaches resulting from late referrals, the GP 62 Day threshold has not been achieved consistently from 2014/15.

The consequence of late referrals into STHFT is significant and affects our ability to treat patients within the 62 Day standard **Figure 9**.

Figure 9 GP 62 Day Shared and STHFT only Performance from Q1 2014/15 to Q1 2017/18



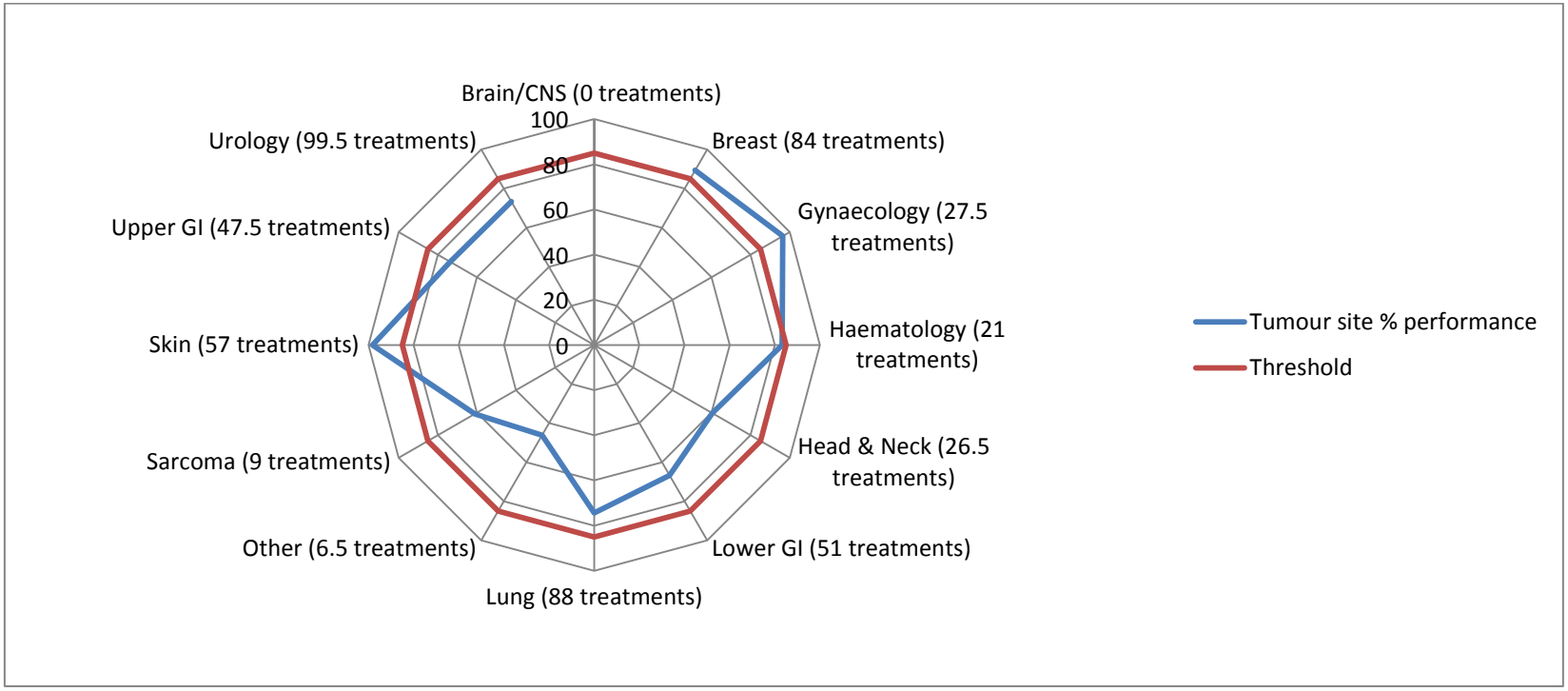
Information source: Open Exeter

The impact of the National Cancer Breach Allocation Guidance is anticipated to improve STHFT overall performance. However, focus continues to be to improve all pathways and ensure cancer investigations, IPT and treatment is delivered in a timely and efficient way for all patients regardless of the treatment and breach allocation.

6.2 Specialist Pathways

As a specialist centre, the Trust receives referrals for patients from across the network (and wider) who require specialist investigation and treatment. It has become apparent over time that some patient pathways are becoming more complex during the planning and delivery of cancer treatments. It is more challenging for tumour sites with complex pathways to meet with CWT threshold (**Figure 10**).

Figure 10 Q1 2017/18 GP 62 Day Performance (with accountable treatments)



Information source: Open Exeter

6.3 Seasonal Influences in Referral Patterns

For some tumour sites, there are seasonal influences in the referral patterns throughout the year. In particular, the number of patients referred with a suspicion of skin cancer, increases markedly over the summer months (**Figure 11**). Historically, for skin pathways, this has resulted in:

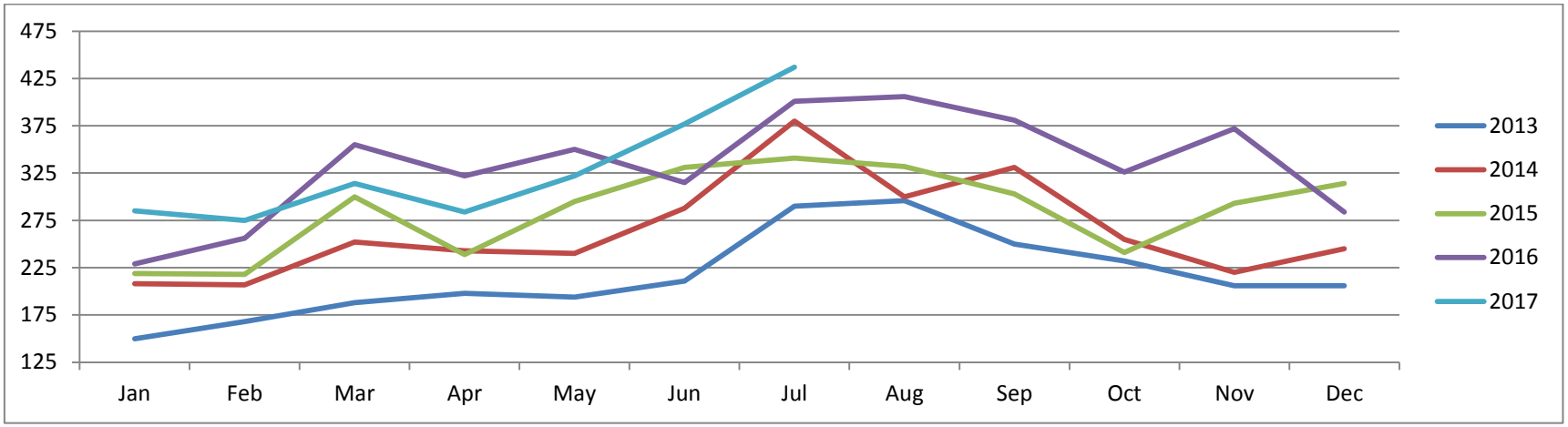
- Patients being offered a first appointment towards the end of the two week pathway (days 12 to 14)
- Less patient choice to facilitate attendance within 14 days
- Largely unplanned, adhoc clinic activity to ensure all patients were offered a two week wait appointment within 14 days
- Potentially reduced patient experience
- Under performance of the two week wait standard (**Figure 12**)
- Expectation that other tumour sites would 'over perform' to ensure the Trust two week wait standard was met

To alleviate the above, the Dermatology and Plastic Surgery Teams have been working collaboratively to plan capacity for the summer increase in referrals in 2017. Of particular note:

- Capacity has been incrementally increased from October 2016 onwards
- If required, 'general clinic slots' have been converted into '2 week wait slots' to provide additional capacity. This has been managed proactively
- The range of appointments has expanded throughout the week and to include an additional evening clinic. This provides a variety of clinic choices being presented to patients to encourage attendance. Additional capacity also includes an extra evening nurse led biopsy clinic
- If there are any unfilled 'routine clinic slots' these are converted to '2 week wait slots' to ensure all available capacity is utilised. Also, any 'target slots' that are vacant are converted to 'routine slots' to maximise capacity and respond to changes in referral patterns. This ability to respond quickly has the benefit of being able to ensure there are adequate follow-up slots are available for patients on a skin cancer pathway
- Capacity is monitored and discussed regularly amongst the managerial and clinical teams to ensure proactive management of the service. Planning is underway for summer 2018

The managerial and clinical team have worked together to improve the skin cancer pathway for patients.

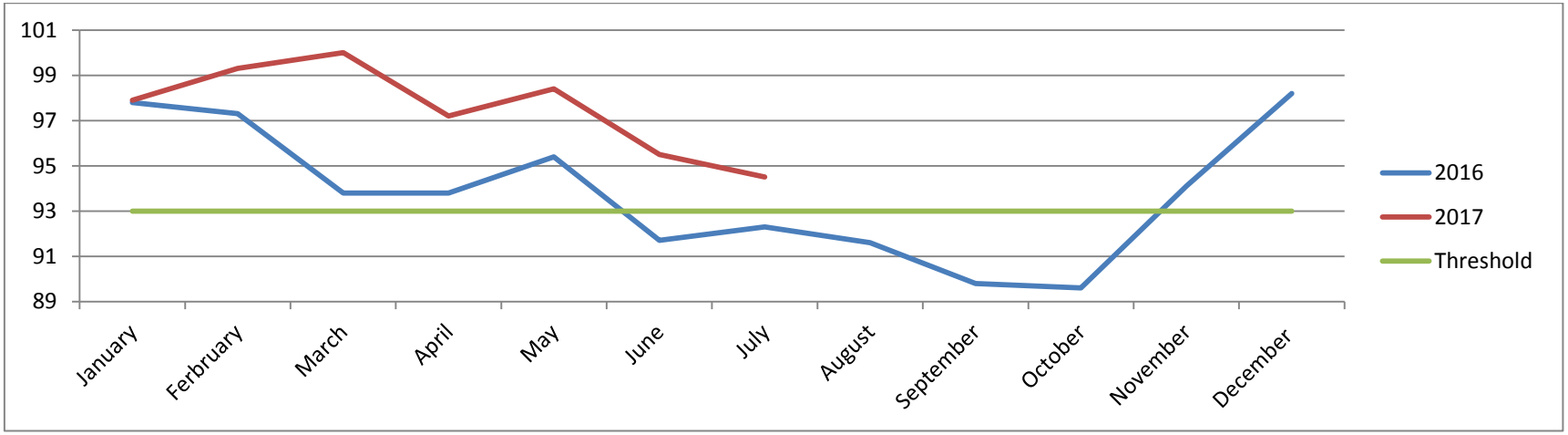
Figure 11 Skin Two Week Wait Referrals with a 'Date First Seen' at STHFT from January 2013 to July 2017



Information source: Open Exeter

As a result of the proactive management of capacity, Two Week Wait Skin Cancer Performance has been above the 93% threshold in 2017 (**Figure 12**)

Figure 12 Two Week Wait Skin Cancer Performance from January 2016 to July 2017



Information source: Open Exeter

6.4 Be Clear on Cancer Awareness Campaigns

In January 2011, Public Health England, working in partnership with the Department of Health, launched the 'Be Clear on Cancer' brand. The aims of the campaigns are to improve early diagnosis of cancer by raising public awareness of the signs and symptoms of cancer, and to encourage people with symptoms to see their GP without delay. To date, examples of campaigns have included:

- 'Blood in Pee'
- Respiratory symptoms
- Breast cancer in women over 70
- Oesophago-gastric
- Bowel

The campaigns are piloted in advance of national campaigns to determine the potential impact of the campaign and providers have varying amounts of time to prepare for such events. Such campaigns can have dramatic effects on referral patterns (often both suspicion and non-suspicion of malignancy) into the Trust. There are currently no awareness campaigns scheduled.

7 Outline of the Work Programme being pursued by the Cancer Executive

7.1 Inter Provider Transfer

The Trust continues to work with the South Yorkshire, Bassetlaw and North Derbyshire Cancer Alliance to embed the 'Cancer Inter-Provider Transfer Policy' into practice. As part of this work, the Executive Director for Cancer leads a Cancer Intelligence Workstream across the Alliance to drive a cross organisational approach to improving outcomes across whole pathways of care for the Alliance's population.

7.2 Breach Analysis

Generally, patients receive appropriate and swift treatment and care within STHFT. All exceptions to this (evidenced by some breach reports) are investigated with a view to improving pathways.

A breach report is required for all patients who breach a CWT standard. An exception to this is for patients on a Two Week Wait pathway; breach reports are only required if a patient breaches a Two Week Wait standard for non-patient choice reasons. For patients on a pathway shared with another provider who breach a CWT target, it is the responsibility of the STHFT cancer tracker, in the service where the treatment was delivered, to coordinate the completion of the report. This includes requesting pathway activity from the referring teams within/outside of STHFT. All reports are analysed by either the Operations Director or Service Manager and Cancer Executive at STHFT, to assign a breach reason which is agreed between STHFT and the referring Trust, when required. The breach reports provide a rich information source for teams to review as a basis for pathway improvement, as required. Individual pathways that show the need for general efficiency improvements are forwarded to the appropriate senior management team for action. Feedback is required as assurance that the reason for delay have been reviewed and appropriate action taken to prevent a delay in the future. All cancer trackers are required to attend a Trust Cancer Breach Reporting Workshop as part of the induction into this role and on an annual basis.

7.3 Patient Tracker List

The Cancer Executive Team are working with the Trust Information Services to design a patient tracker list for Directorates to use. Initially a Two Week Wait and Breast Symptomatic Report will be available from mid October 2017 followed by a GP 62 Day Report. This will facilitate improved prospective management of pathways.

In addition, a CWT Report reflecting performance with the application of the National Breach Allocation Guidance will be available from October 2017. The report is currently in a testing phase.

7.4 Inter Trust Messaging

As part of the Working Together Programme, the Trust is collaborating with Trusts in South Yorkshire, Bassetlaw and North Derbyshire to implement the electronic transfer of Early Notification Forms (ENF) to support cancer target pathways and clinical dataset of patients on a cancer pathway (and other relevant administrative and clinical information) to support MDT referral between the Trusts' separate InfoFlex based Cancer Information Systems.

The Trust has participated in two pilots to date. A third pilot is in discussion whilst the overall benefits of the system are being explored.

7.5 Cancer Waiting Times Performance Improvement Groups

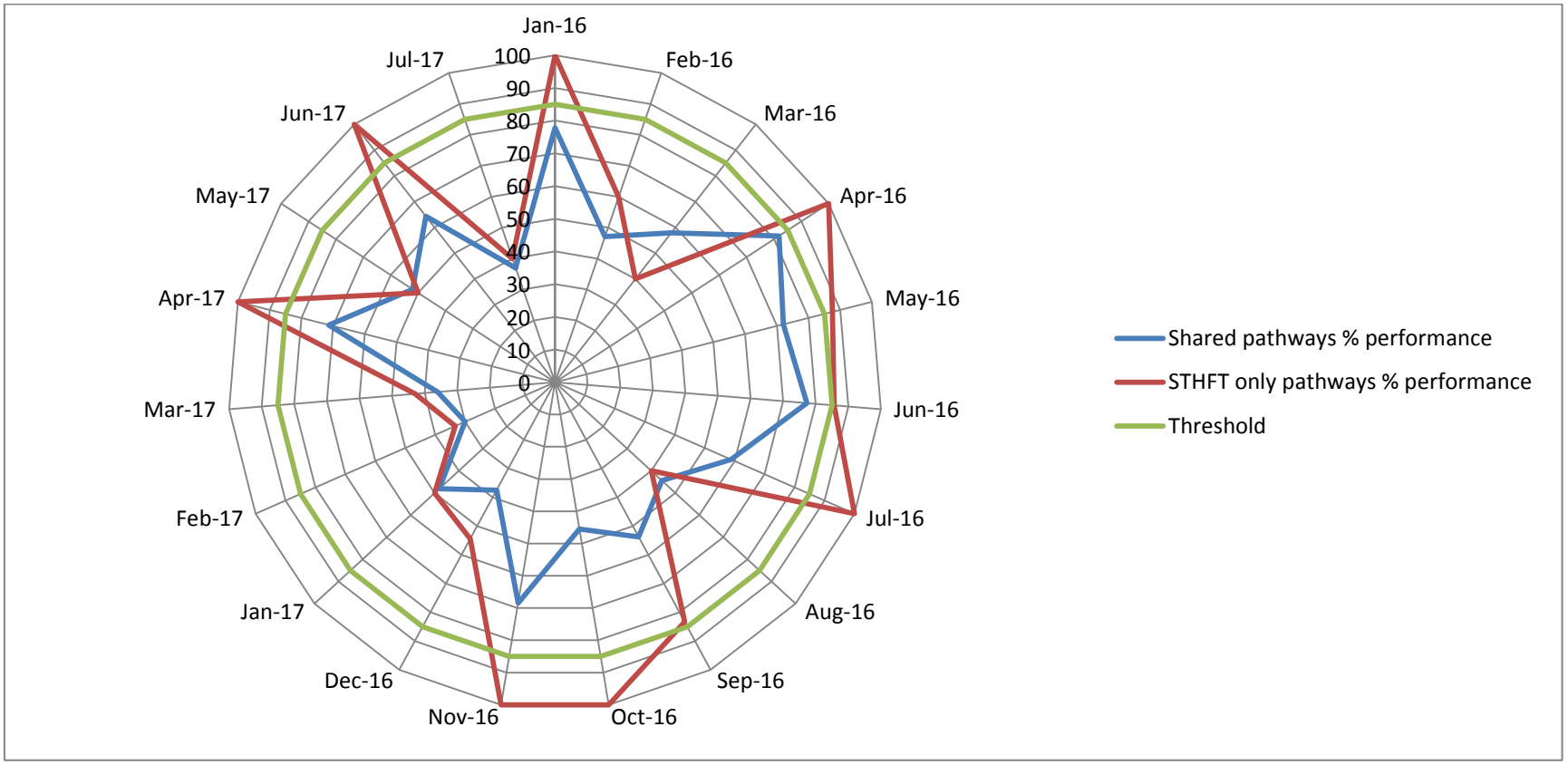
There are currently two STHFT site specific task and finish groups led by the Executive Director for Cancer with the aim of improving GP 62 day pathways, patient experience and performance. The work streams involve the Head and Neck and Upper/Lower GI teams. The group is represented by all contributing services, e.g. for UGI – Gastroenterology and General Surgery; for Head and Neck – Radiology, MIMPs, Oncology, Ear, Nose and Throat Directorates.

Head and Neck Task Performance Improvement Group

The Head and Neck Performance Improvement Group are currently working on the following areas:

- Consistent offer of a 2 week wait referral into OMF by Day 5 of the pathway
- Appropriateness of 2 week wait referrals
- 'One stop' diagnostic clinic with ENT Directorate with Radiology input
- Agreement of a diagnostic pathways to reduce waits between investigations
- Timing of MDT meeting around public holidays
- Weekly surgical planning meeting
- Oncology consultant recruitment
- Focused and in-depth breach analysis
- Development of a Patient Tracker List (PTL) with Information Services and Cancer Executive
- Development of a single cancer tracking team

Figure 13 Head and Neck GP 62 Day Performance, by month from January 2016 to July 2017



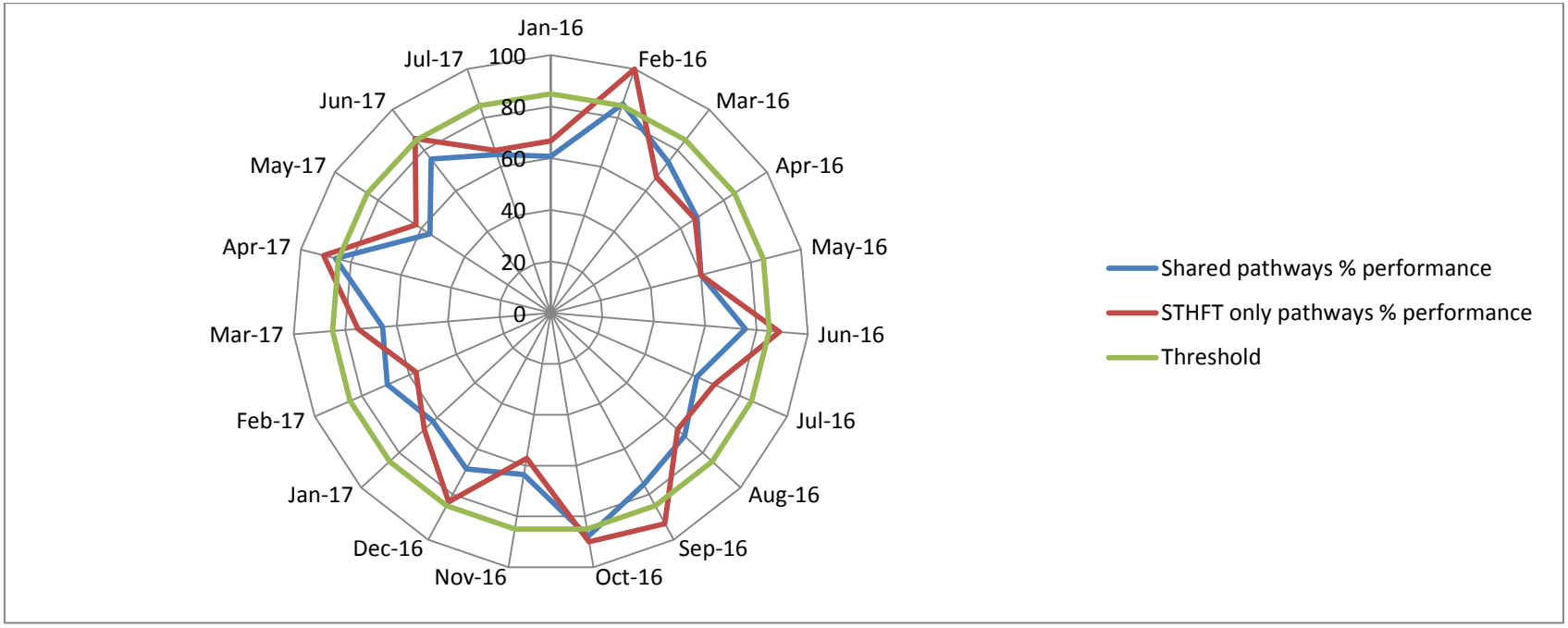
Information source: Open Exeter

Upper and Lower GI Performance Improvement Group

The Upper and Lower GI Performance Improvement Group are currently working on the following areas:

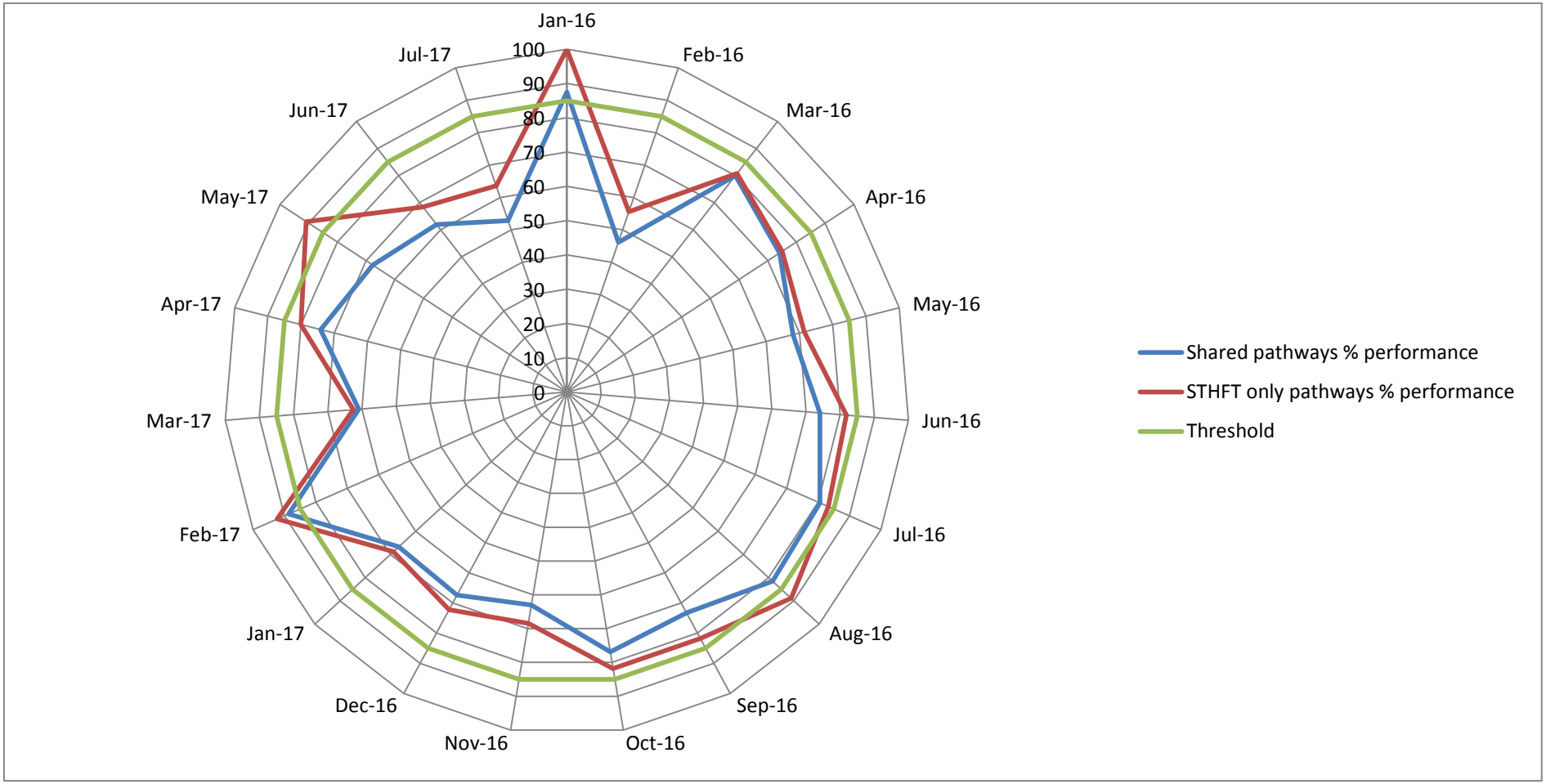
- With the Service Improvement Team, reviewing processes and developing ways to encourage patients to attend a first offered 2 week wait appointment by day 5 of the pathway. This has involved detailed work as to why some patients choose not to accept a first appointment and developing a script for administrative staff to use when inviting patients to attend; with Sheffield CCG revising a patient information leaflet and liaising with other providers to glean solutions in this area
- Focused and in-depth breach analysis
- Development of a Patient Tracker List (PTL) with Information Services and Cancer Executive
- Capacity review of the Bowel Cancer Screening Programme
- Access for Endoscopic Ultrasound
- Timing of MDT outpatient appointments following MDT meeting
- Referral process into MDTs
- Agreement of IPT across the Cancer Alliance (UGI)
-

Figure 14 UGI GP 62 Day Performance, by month from January 2016 to July 2017



Information source: Open Exeter

Figure 15 LGI GP 62 Day Performance, by month from January 2016 to July 2017



Information source: Open Exeter

7.6 Prolonged Pathways

Some time ago, STHFT agreed to carry out an audit on any 100+ day pathways within our own organisation. Of the pathways analysed, there were several contributing factors for patients being treated after 100 days, including service capacity, complex medical reasons, and patient choice.

Since this initial review of prolonged pathways the CWT Taskforce developed a 'Managing long waiting cancer patients – policy on "backstop" measures' in October 2015. We implemented the policy for patients with pathways of 104+ days in April 2016. The number of completed RCA returned was low and provided limited insight into the cause of the prolonged pathways. One contributing factor was the number of pathways commencing outside of STHFT but whereby the patient received a treatment at STHFT. As a result, the Cancer Executive agreed to halt the request for RCA on prolonged pathways and focus on reducing the overall number of 104+ day pathways.

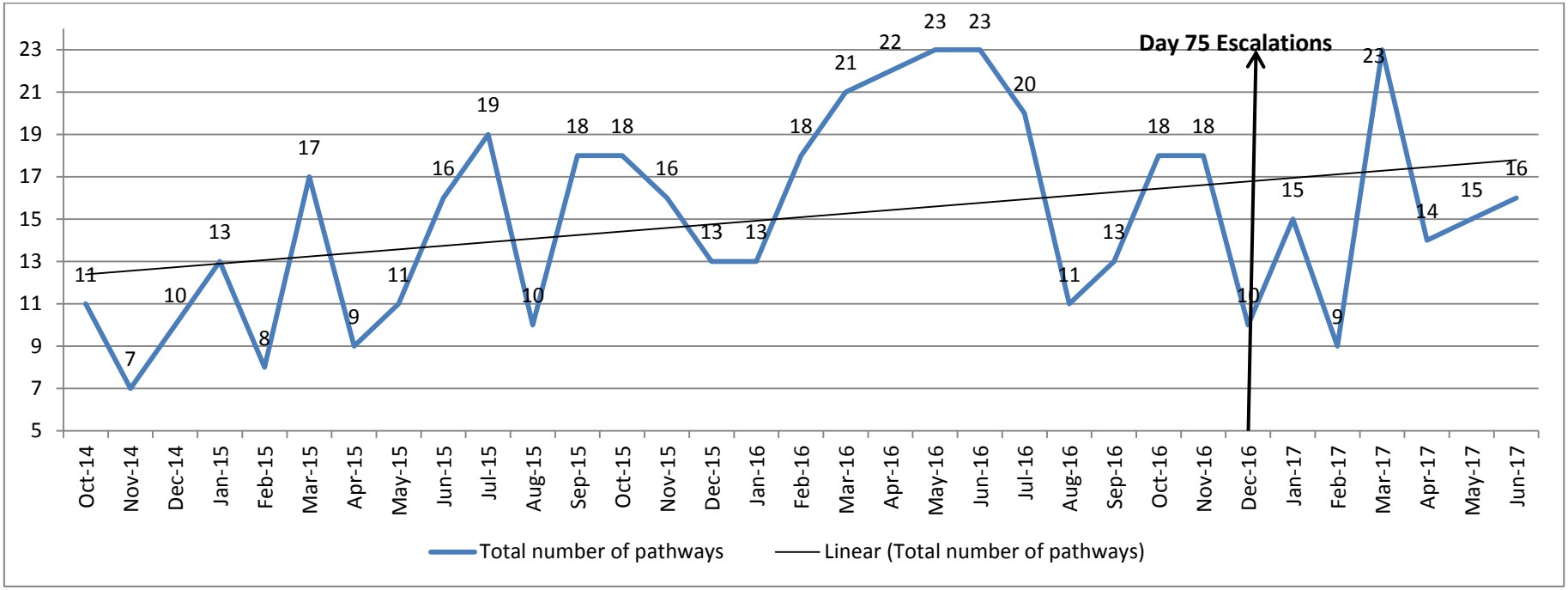
From December 2016, there was a move to reduce the number of long pathways by escalating all patients approaching day 75 (within the next 7 days). Pathways approaching day 75 are identified by the Cancer Pathway Analysts via an InfoFlex report and circulated to the relevant cancer team (named individuals identified by the Cancer Site Lead Clinician and Operations Director) to manage the patient's pathway proactively. There is a requirement that all pathways will be reviewed clinically. This process continues.

In spring 2017, a Long Pathways Group has been established at STHFT led by the Performance and Information Director with the aim of raising the profile of the issue within the Trust and reducing the number of pathways of 104+ days.

The current situation:

1. Since escalating patients approaching day 75 of their pathway within the next seven days (5th December 2016) the number has fluctuated
2. The number of 104+ day pathways continues to be between 3-8% of all 62 day pathways **(Figure 16)**
3. Pathways commencing in the DGHs continues to be a feature of the majority of 104+ day pathways, but there also remain a number of STHFT only 104+ day pathways
4. The tumour sites with the majority of long pathways are Urology, Lung, UGI and LGI (which are among the highest volume pathways)**.** However, most tumour sites feature at some point

Figure 16 Total Number of Patients with a Pathway of 104+ days from October 2014 to June 2017



Information source: InfoFlex

7.7 Clinical Engagement

Within the Trust, the Cancer Executive strives to ensure all those involved in the delivery of cancer pathways are kept up to date with new national and local developments, and receive feedback as to the issues affecting the delivery of care. In March 2017 the 3rd Annual Cancer Meeting invited local and national speakers to the Trust to deliver key messages regarding the delivery of cancer services. As in the previous year, a focus on the past year's performance and new developments regarding achieving CWT standards going forward was a key theme of the meeting. As with the initial meeting the event evaluated extremely well. A date has been circulated for a 4th Annual Cancer Meeting 2018. The programme is followed up by quarterly Cancer Lead Clinician Forums. The last Cancer Lead Clinician Forum was attended by the National Clinical Director for Cancer, NHS England and Medical Director (Strategy), The Christie NHS Foundation Trust.

In association with this, the Cancer Executive holds Lead Cancer Manager and Cancer Tracker meetings monthly to discuss CWT performance and guidance. In July 2016 the Cancer Executive and Informatics Team launched an 'STH Guide to Recording Cancer Data' to support cancer trackers in the recording of cancer data in InfoFlex. This has since been revised and re-circulated.

7.8 Earlier Diagnosis by 2020

The Report, 'Achieving World-Class Cancer Outcomes, A Strategy for England 2015-2020' published in July 2015 included a recommendation to achieve earlier diagnosis. An ambition that by 2020, patients referred for testing by a GP; "should either be definitively diagnosed with cancer or cancer excluded and the result should be communicated to the patient within four weeks. The ambition should be that CCGs achieve this target for 95% of patients by 2020, with 50% definitively diagnosed or cancer excluded within 2 weeks". The rationale is that the standard would focus more on the investigative pathway leading to patients being reviewed by a specialist quickly, promoting an earlier diagnosis or exclusion of cancer, with the overall aim of improving patient experience and outcomes. It is anticipated that this will present STHFT and other providers with a challenge. The Trust has started to collate some 'proxy' data whilst further national guidance is awaited. It is expected a STHFT report on the 'proxy' data will be available late autumn 2017.

8 Potential Risks to Future Performance

An assessment has been carried out on the potential risks to future performance. They include:

- Ability to recruit key clinical members to specialised services
- Increasing demand and complexity of cancer diagnostic and treatment
- Increasing incidence of cancer
- Delay to IPT from referring Trusts
- Earlier Diagnosis by 2020
- Disruption to services due to inclement weather and unforeseen circumstances
- Local and national cancer awareness campaigns and television storylines
- Patient choice to attend the first offered consultant and diagnostic appointments
- Competing demands for capacity from cancer and non-cancer services

9 Conclusions

To conclude it is noted that:

- Cancer pathway standards are complicated
- Demands on cancer services are increasing
- Care and treatment of patients with cancer are becoming more varied and complex
- Detailed work to improve pathways and care is underway at a corporate level and within individual teams and MDTs

10 Recommendations

The Board is asked:

1. To receive the detailed descriptions of the activities of the Cancer Executive to meet the CWT standards
2. To be assured that all actions are being progressed

Appendix 1 List of Cancer MDTs Hosted at STHFT

1. **Brain/CNS MDT**
2. **Skull Base MDT**
3. **Ocular MDT**
4. **Breast MDT**
5. **Gynaecology MDT**
6. **Chorio MDT**
7. **Haematology MDT**
8. **HODs Meeting**
9. **Head and Neck MDT**
10. **Thyroid MDT**
11. **Lower Gastrointestinal MDT (including Anal)**
12. **Liver Resection MDT**
13. **Lung MDT**
14. **Neuro Endocrine Tumour MDT (including Pituitary)**
15. **Cancer of Unknown Primary MDT**
16. **Specialist Palliative Care MDT**
17. **Teenage and Young Adults MDT**
18. **Sarcoma MDT**
19. **Skin MDT**
20. **Testicular MDT**
21. **Oesophago-Gastric MDT**
22. **Hepato-Pancreatico-Biliary MDT**
23. **Urology MDT**

APPENDIX 2: DIRECTORATES DASHBOARD

Indicator	Measure	Diab & Endo	Emerg Med	Gastro	Pharm	Resp Med	Integ Comm Care	GSM	Prim Care & Int/Serv	Therap & Pall Care	CCDS	ENT	Neuro	Ophthal
MRSA bacteraemia	Actual numbers													
MSSA bacteraemia	Actual numbers													
C Diff	Actual numbers													
Serious Incidents	Approved SI Report submitted within timescales													
Serious Incidents	Number of serious incidents (SI)	0	2	0	0	0	0	1	0	0	0	1	0	2
Incidents ⊙	Number of Incidents	270	930	242	228	296	473	1423	231	158	295	171	480	147
Incidents ⊙	Incidents not approved after 35 days													
Average Length of Stay (by discharges) ⌖	Average LOS Elective													
	Average LOS Non Elective													
Patient Falls	Number of patient falls													
Never Events	Number of never events													
18 week waits referral to treatment time ⊙	Percentage of admitted (unadjusted) patients treated within 18 weeks (90%)													
	Percentage of non-admitted patients treated within 18 weeks (95%)													
	Percentage of patients on incomplete pathways waiting less than 18 weeks (92%)													
52 week waits	Actual numbers													
6 week diagnostic waiting ⊙	Percentage of patients seen within 6 weeks													
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons													
	Number of patients cancelled on the day and not readmitted within 28 days													
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital													
	Percentage of out-patient appointments cancelled by patient													
DNA rate	Percentage of new out-patient appointments where patients DNA													
	Percentage of follow-up out-patient appointments where patients DNA													
Cancer Waits ⌖	Patient seen within 2 weeks (93% compliance)													
	Breast symptomatic seen within 2 weeks (93% compliance)													
	62 days from referral to treatment (85% compliance)													
	31 day first treatment (96% compliance)													
e-Referral Service	Percentage of appointments booked through e-Referral													
Ethnic Origin data collection	% valid ethnic group (85%)													
Elective Inpatient activity	Variance from contract schedules													
Non elective inpatient activity	Variance from contract schedules													
New outpatient attendances	Variance from contract schedules													
Follow up op attendances	Variance from contract schedules													
Complaints	Percentage of complaints answered within 25 working days													
FFT Recommended ⊙	Patients recommending STH for treatment													
Day surgery rates	BADS - day surgery rates													
Mixed Sex Accommodation	Number of breaches of Mixed Sex Accommodation standard													
Sickness Absence	All days lost as a percentage of those available													
Appraisals ⌖	Completed appraisal in last year													
Mandatory Training ⌖	Overall percentage of completed mandatory training													
Agency spend	Agency and bank spend as a percentage of total pay budget													
I & E	Variance from plan													
Contract performance	Variance from plan													
Productivity & Efficiency	Variance from plan													

APPENDIX 2: DIRECTORATES DASHBOARD - continued

Indicator	Measure	Lab Med	MIMP	OGN	MSK	OSSCA	Cardiac	Renal	Vasc	Comm Dis & Spec Med	Spec Rehab	Spec Cancer	Gen Surg	Plastic Surg	Urology
MRSA bacteraemia	Actual numbers														
MSSA bacteraemia	Actual numbers														
C Diff	Actual numbers														
Serious Incidents	Approved SI Report submitted within timescales														
Serious Incidents	Number of serious incidents (SI)	0	0	3	1	0	2	0	0	0	0	0	5	0	0
Incidents ⊙	Number of Incidents	696	350	736	775	708	600	324	150	470	199	358	354	58	93
Incidents ⊙	Incidents not approved after 35 days														
Average Length of Stay (by discharges) ⌖	Average LOS Elective														
	Average LOS Non Elective														
Patient Falls	Number of patient falls														
Never Events	Number of never events														
18 week waits referral to treatment time ⊙	Percentage of admitted patients treated within 18 weeks (90%)														
	Percentage of non-admitted patients treated within 18 weeks (95%)														
	Percentage of patients on incomplete pathways waiting less than 18 weeks (92%)														
52 week waits	Actual numbers														
6 week diagnostic waiting ⊙	Percentage of patients seen within 6 weeks														
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons														
	Number of patients cancelled on the day and not readmitted within 28 days														
Cancelled Outpatient appointments	Percentage of out-patient appointments cancelled by hospital														
	Percentage of out-patient appointments cancelled by patient														
DNA rate	Percentage of new out-patient appointments where patients DNA														
	Percentage of follow-up out-patient appointments where patients DNA														
Cancer Waits ⌖	Patient seen within 2 weeks (93% compliance)														
	Breast symptomatic seen within 2 weeks (93% compliance)														
	62 days from referral to treatment (85% compliance)														
	31 day first treatment (96% compliance)														
e-Referral Service	Percentage of appointments booked through e-Referral														
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Mandatory Training ⌖	Overall percentage of completed mandatory training														
Agency spend	Agency and bank spend as a percentage of total pay budget														
I & E	Variance from plan														
Contract performance	Variance from plan														
Productivity & Efficiency	Variance from plan														

Performance is YTD unless specified: ⊙ Last Complete Month ⌖ Rolling 12 months ⌖ Current quarter to data