

THE CLATTERBRIDGE CANCER CENTRE

TITLE: INTEGRATED PERFORMANCE REPORT – MONTH 6
2017/18

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**RESPONSIBLE
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FINANCE DIRECTOR

FOR: DISCUSSION / DECISION

1. INTRODUCTION

As the Trust implements its new governance structure, the performance management framework is also being realigned to support this. Part of this work involves ensuring that each forum, from Trust Board to ward meetings, has the information it needs to carry out its responsibilities and be held accountable to its purpose.

One aspect of the new governance structure is a move towards Trust Board overview and assurance of a reduced number of key pan-organisational metrics to provide assurance of the performance of the Trust, with accountability and responsibility for improvement appropriately stratified and cascaded throughout the organisation. Alongside performance information on these key metrics, the Board will also receive the CEO's report as well as meeting reports from its committees which will provide further assurance and highlight any risks.

In line with this direction of travel, a presentation was made to the Trust Board at the Board Development session on 4th October 2017 outlining a revised format for the Trust Board's Integrated Performance Report (IPR). This approach was agreed in principle and this IPR is presented in the revised format for the Board's consideration and agreement on the format going forward.

Alongside this review of the IPR, the information (including Key Performance Indicators (KPIs)) reported to the Board Committees is also being reviewed,

followed by the same exercise for the Sub Committees and then for the various groups below them. In doing this, the Trust will ensure that it is still reporting the information previously reported to Board, but at a more appropriate level within the organisation.

Many KPIs are, and will continue to be reported at all levels of the organisation, but at different levels of detail and for varying purposes depending on the responsibility of the group. This includes reporting and challenge at the quarterly Directorate and Corporate Service Performance Review Meetings, chaired by the CEO.

Papers are on the agendas of October's Quality Committee, and Finance and Business Development Committee to outline and agree this approach, with a proposal that the Head of Performance and Planning (in conjunction with the DoN&Q and DCE/DoF respectively) finalises the details of reporting to each committee and sub-committee, ready to introduce this approach for the next round of meetings.

A report detailing the new performance management strategy framework for the Trust, reflecting the new governance arrangements will be taken to the Governance and Compliance Committee in Q4 2017/18.

Appendix 3 is the dashboard of metrics usually received by Trust Board. It is proposed that this no longer forms part of the IPR report, but the KPIs within it are considered at alternative committees and sub committees as previously explained.

2. KEY FEATURES OF THE NEW INTEGRATED PERFORMANCE REPORT

There are three parts to this report;

- The latest performance, as at end September 2017
- Further details of non-compliant KPIs
- Alert KPIs

This revised IPR presents performance in 6 categories, providing an overview that enables the Board to more easily receive assurance of organisational performance. There are 3-8 metrics in each of the 6 categories, which give assurance that the organisation is delivering on each category. The choice of categories reflects the

Approach outlined in the Carter Report: Safe, Effective, Caring, Responsive, People: Well-Led and Money and Resources.

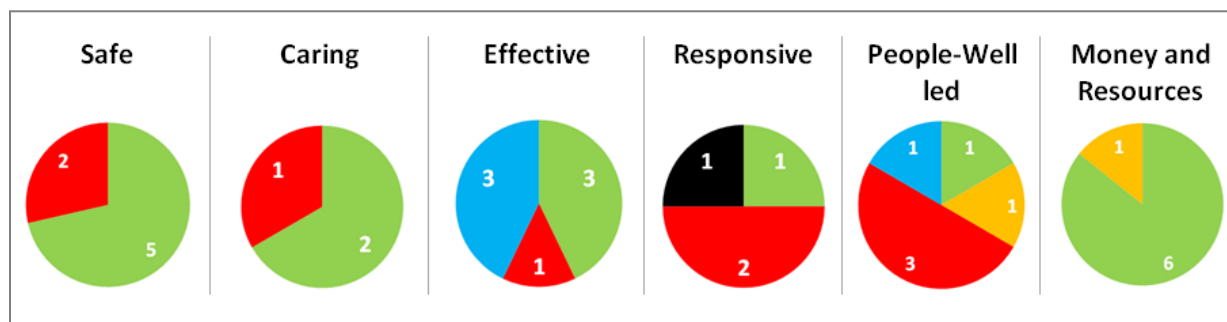
Performance will be displayed for 34 key performance indicators (KPIs), appropriately categorised, rather than the 101 previously reported. As well as the core list of 34, there are a further 35 KPIs (including 15 tumour group specific 62 Day Cancer Waiting Times KPIs) which we have identified as 'alert' KPIs. These KPIs will not be routinely reported in the core IPR each month but will be shown as alerts when they meet set criteria (**e.g. 'red' for 2 or more consecutive months**), specific to each KPI.

NHS Improvement's Single Oversight Framework (SOF) is currently out for consultation, with a final version due to be published at any time. The choice of metrics included in this revised IPR has been informed by the draft SOF and any changes to the final version will be reflected in future versions of this report.

3. LATEST PERFORMANCE: AS AT END SEPTEMBER 2017

Attached at Appendix 1 is a copy of the new Trust Board Performance Dashboard for September.

In summary, based on the revised pan-organisational metrics, the performance across the six categories contained in the Dashboard for September 2017 is as follows:



In September 2017, 18 of the 34 KPIs are green, 2 are amber, 9 are red, 4 have no target set (blue shading) and 1 is undergoing data validation between the Trust and RLBUH (black shading).

4. DETAIL OF NON-COMPLIANT KPI'S

For each non-compliant KPI, and for those KPIs which are showing a deteriorating trend towards non-compliance, this section outlines, the reason for non-compliance, details of actions taken, a trajectory for improvement, details of the relevant forums providing assurance and the accountable Executive lead.



Of the 7 KPIs in the **Safe** category, 2 are red as follows:

Clostridium Difficile	
Reason for non-compliance	We have had 5 C difficile infections attributed to CCC since April 2017. RCAs have been carried out and verified by NHSE for 2 cases so far. These identified that neither infection was due to a lapse in care by CCC.
Action Taken	RCAs completed for 2 cases and in progress for 3.
Trajectory for improvement	
Assurance provided by	Infection Control Committee / Quality and Safety Sub Committee / Quality Committee
Executive Lead	Helen Porter, Director of Nursing and Quality

Percentage of patients with no new harms	
Reason for non-compliance	92.5% of patients suffered no 'new' harms (identified by the monthly snapshot Safety Thermometer survey), against a target of 95%.
Action Taken	<p>The harm suffered by 6 out of 80 patients was as follows:</p> <ul style="list-style-type: none"> • a fall resulting in minor harm, • 3 new VTEs (2 of which were diagnosed on admission), • a grade 2 pressure ulcer (further review of this case identified no lapse in care) and • a patient who had both a catheter and a new UTI (following further review, this was determined not to be a hospital attributable CAUTI). <p>Each harm is reviewed at the relevant forum and actions identified for improvement where any lapse in care is identified.</p>
Trajectory for improvement	The Trust is focussing on falls as one of its Quality Account Improvement Priorities for 2017/18, therefore we expect to see a reduction by the end of 2017/18.
Assurance provided by	Quality and Safety Sub Committee / Quality Committee

Executive Lead	Helen Porter, Director of Nursing and Quality
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Of the 3 KPIs in the **Caring** category, 1 is red as follows:

Complaints	
Reason for non-compliance	18 formal complaints have been made since 1 st April 2017. No trends have been identified.
Action Taken	Action is taken specific to each complaint where appropriate, however due to a lack of themes, no overarching actions have been identified and pursued.
Trajectory for improvement	
Assurance provided by	Quality and Safety Sub Committee / Quality Committee
Executive Lead	Helen Porter, Director of Nursing and Quality



Of the 7 KPIs in the **Effective** category, 1 is red as follows:

Patients not meeting CUR criteria	
Reason for non-compliance	Please see the Clinical Utilisation Review paper on the Trust Board agenda 1 st November 2017.
Action Taken	The target of 37% is for the end of March 2018 rather than in each month.
Trajectory for improvement	
Assurance provided by	Quality and Safety Sub Committee / Quality Committee
Executive Lead	Helen Porter, Director of Nursing and Quality



Of the 4 KPIs in the **Responsive** category, 2 are red as follows:

National Position on Cancer Waits

The spotlight is firmly on cancer waiting times at a national level, including in the media, with the BBC reporting on 18th October that the proportion of people waiting over 62 days for cancer treatment having risen by a third in the past four years and nearly one in five patients is now waiting longer. NHS England had mandated that nationally we achieve the 85% target for 62 day waits and has increased the level of scrutiny and support for Trusts including CCC, including weekly calls to check our latest weekly performance, request our predicted performance figure for the month and to understand the issues we face (including those at referring Trusts) which are resulting in non-compliance.

Trust level detail:

62 Day Waiting times - classics (pre and post allocation)	
Reason for non-compliance	We are not meeting the 'pre allocation' target, largely due to the significant numbers of patients referred late to CCC by other Trusts. In September, a high proportion of patients breaching 62 days, decided to delay their treatment. This unusually high number of delays, due to patient choice, meant that it was not possible for us to meet the target.
Action Taken	Although this patient choice accounts for a significant number of delays, we still have some opportunities for improvement including reducing delays in the Radiotherapy pathway (related largely to job planning) and increasing capacity with recruitment of consultants and supporting roles such as ANPs and consultant radiographers and pharmacists. Significant improvement has been made at the start of the pathway with over 80% of patients now having their first appointment within 7 days. We are working closely with NHSE and the Cancer Alliance to support improvements in referring Trusts, which will improve our performance.
Trajectory for improvement	Performance for October as at the 23 rd October is significantly higher than September, although still below the 85% target. The greatest opportunity for improvement relies on the recruitment of staff and revision of consultant job plans, therefore consistent achievement of the target is unlikely to be seen in the short term.
Assurance provided by	Trust Operational Group / Operational Delivery & Service Improvement Sub-Committee / Finance and Performance Committee
Executive Lead	Barney Schofield, Director of Operations and Transformation

2 Week Wait	
Reason for non-compliance	This data relates mainly to Haemato-oncology patients and is in the process of being validated by CCC information analysts and the Cancer Waiting Manager in conjunction with their counterparts at the Royal Liverpool and Broadgreen University Hospitals NHS Trust (RLBUH).
Action Taken	
Trajectory for improvement	The Trust is continuing to develop robust information flows of RLBUH data, a process which is hampered by the use of both different IT systems across the two organisations and reporting timescales.
Assurance provided by	Trust Operational Group / Operational Delivery & Service Improvement Sub-Committee / Finance and Performance Committee
Executive Lead	Barney Schofield, Director of Operations and Transformation



Of the 6 KPIs in the **People – Well led** category, 3 are red as follows:

Staff Sickness	
Reason for non-compliance	Absence figures have remained relatively static at 4.2% and 4.3% for the last three months. Stress related absence increased for August 2017 however there has been a decrease of work related stress cases with only 4 and a rise in personal stress related cases with 18.
Action Taken	At the last Workforce and Organisational Development (WOD) Department's performance review it was agreed that the Trust's Attendance Policy should be reviewed and that WOD will provide greater support to managers in identifying when staff have hit triggers. The Trust has recently expanded the counselling services it provides via Cheshire and Wirral Partnership NHS FT; now with an onsite clinic, for which the uptake has been good. The National Staff Survey results will be shared at department level and reviewed at the relevant quarterly performance reviews. Following benchmarking with peers using the Model Hospital tool, the WOD senior team has arranged a visit to Christies learn how they manage to maintain a lower sickness absence level.
Trajectory for improvement	Trajectories with associated action plans will be developed with individual Directorates and Corporate Services.
Assurance provided by	Workforce Sub-Committee / Quality Committee
Executive Lead	Andrew Cannell, Chief Executive Officer

Staff Turnover	
Reason for non-compliance	Turnover has been marginally above the threshold, at 12.3% and 12.6% for the last 2 months respectively. No current trends have been identified through exit interviews, with work/life balance and promotion remaining as the top reasons.
Action Taken	Exit interviews are not conducted with all leavers. This process will be reinvigorated with managers to ensure we maximise the opportunity to capture the reasons for staff leaving the organisation and identify actions as appropriate.
Trajectory for improvement	The threshold of 12% is currently under review and is likely to be adjusted in light of the upcoming period of significant organisational change.
Assurance provided by	Workforce Sub Committee / Quality Committee
Executive Lead	Andrew Cannell, Chief Executive Officer


Personal Appraisal and Development Review	
Reason for non-compliance	The Trust has increased compliance significantly over the last 12 months; however the figure fell from 93% to 89% this month. The compliance for both the IM&T and Finance departments is below the target. Conway and Delamere ward figures have fallen in the last month.
Action Taken	Trajectories with associated action plans will be developed with non-compliant areas.
Trajectory for improvement	
Assurance provided by	Workforce Sub Committee / Quality Committee
Executive Lead	Andrew Cannell, Chief Executive Officer

5. DETAIL OF ALERT KPIs

These KPIs are not routinely reported in the core dashboard each month but will be shown as alerts when they meet set criteria, yet to be agreed. The alert criteria for each KPI will take into account the variability of the performance month to month and the implications in terms of impact on both patients and Trust reputation as well as the national level of scrutiny. The criteria will be reviewed regularly in the first year and the sensitivity amended where necessary to ensure effective alerting of risks and concerns. All of the alert KPIs are reported routinely to the relevant committee below Trust Board at various levels of granularity.






Details of the alert KPIs which will be regularly reviewed and brought to the Board's attention by exception can be found in Appendix 2.

For September the following Alert KPIs are red and drawn to the Board's attention.

	'Alert' KPIs: <ul style="list-style-type: none"> • Radiotherapy Activity (% growth YTD) and • Inpatient Activity (% growth YTD)
Reason for non-compliance	Key issues include: <ul style="list-style-type: none"> • In-patients – reduced excess bed days and LoS reduction • RT – impact of hypofractionation and data quality concerns relating to reconciliation between Aria and Contract management system.
Action Taken	<ul style="list-style-type: none"> • Data extraction scripts from Aria have been amended and underperformance expected to reduce to by 3.7% per month.
Trajectory for improvement	<ul style="list-style-type: none"> • TCC activity model being refreshed, future bed and RT capacity requirements to be reviewed in the light of this.
Assurance provided by	Operational Delivery & Service Improvement Sub-Committee / Finance and Performance Committee
Executive Lead	Barney Schofield, Director of Operations and Transformation

6. CARE HOURS PER PATIENT PER DAY (CHPPD)

It is a mandatory requirement that this information is presented to Trust Board. Whilst the Trust captures this information, monitors trends and compares across wards internally, external benchmarking will not be possible until access to other Trusts' data becomes available. This is likely to be accessible in the future via NHS Improvement's Model Hospital resource.

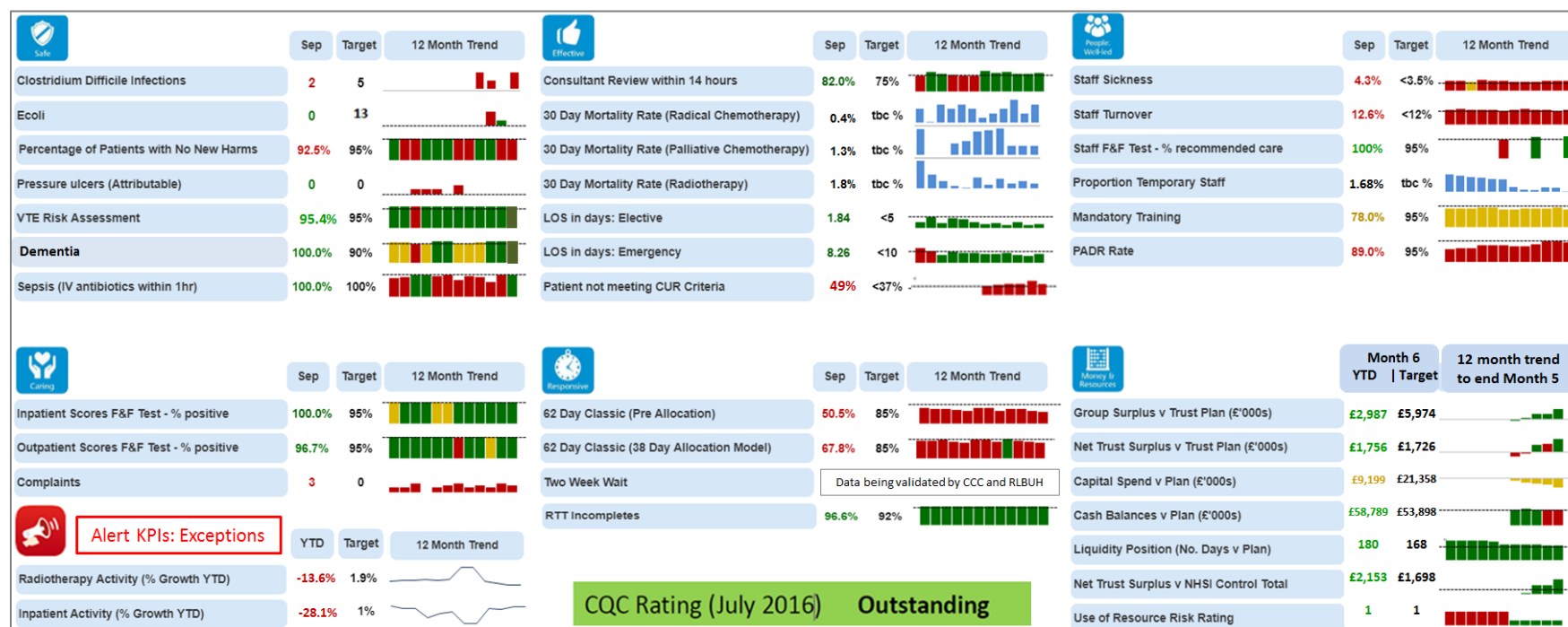
Key Performance Indicator	Director	Target	Directive	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	12 month trend
Care hours per patient day: Conway Ward	HP	Awaiting inclusion of KPI in 'Model Hospital' Portal	NHSI	6.2	6.2	7.5	7.2	6.5	6	
Care hours per patient day: Sulby Ward	HP		NHSI	9	10	11.7	14.4	9.6	11	
Care hours per patient day: Mersey Ward	HP		NHSI	7.3	7.4	8.4	8.4	7.9	7.1	
Care hours per patient day: 7Y	HP		NHSI				6.1	6.3	6.2	
Care hours per patient day: 10Z and 7X	HP		NHSI				12.2	12.8	12	

7. RECOMMENDATIONS

The Trust Board members are asked to:

- a. Consider the new IPR format and agree the approach going forward.
- b. Note Trust performance as at the end of September.

APPENDIX 1: TRUST BOARD PERFORMANCE DASHBOARD FOR SEPTEMBER 2017



Key points to note:

- The dashboard shows the performance over the six categories for the latest month against the target. The exceptions to this are the Money and Resources category, and the alert KPIs in which the year to date (YTD) figures are shown.
- The bar charts show the RAG rated performance for the last 12 months.
- The alert KPIs are shown in the bottom left corner; in the absence of criteria having been developed as yet for each alert KPI, all those which are 'red' for September 2017 have been included in the exception report..
- Year to date information will be available from the next version of this report onwards. External benchmarking information will be introduced as and when meaningful comparisons can be made.
- The targets for E. coli and C. diff are for the year rather than for the month. The target of 37% for Patients not meeting the CUR criteria is to be achieved by 31st March 2018, rather than in every month. This is 'red' for September as the September figure is not aligned to the improvement trajectory towards 37%. This will be reflected more appropriately in the next IPR.
- Not all data is inclusive of Haemato-oncology (HO); systems are being developed to include this for all KPIs. Appendix 3 shows which KPIs include HO data.

APPENDIX 2: IPR ALERT KPI LIST

- MRSA
- Never Events
- Chemotherapy Medication Errors per 1000 doses
- Radiotherapy Treatment Errors per 1,000 fractions
- Mixed sex accommodation
- Cancer Waiting target: 6 weeks to diagnostics
- Cancer Waiting target: 62 Day 'classics' by tumour group
- Recruitment: Time to hire
- Executive Team Turnover
- Radiotherapy Activity (percentage growth YTD)
- Chemotherapy Activity (percentage growth YTD)
- Haemato-oncology Activity (percentage growth YTD)
- Inpatient Activity (percentage growth YTD)
- Outpatient Activity (percentage growth YTD)
- Drugs spend
- Agency staff spend
- Agency Medical Locum Spend

APPENDIX 3: PERFORMANCE AGAINST THE PREVIOUS INTEGRATED PERFORMANCE REPORT KPIS



Integrated Performance Report: 2017/18 Month 6



Key Performance Indicator		Inc. HO	Director	Target	Directive	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	12 month trend
Safe																			
Harm Free Care	Total incidents resulting in harm to patients	Yes	HP		Internal	16	10	11	11	5	2	18	17	13	8	8	NYP	64	
	Percentage of Patients with no 'new' harms (ST)	Yes	HP	95%	C, SU2S, OH	96.6%	94.8%	94.6%	95.1%	96%	98%	94%	95%	97%	99%	95%	93%		
	Number of patients recorded as having a category 2-4 hospital acquired pressure ulcer (CCC lapse in care)	Yes	HP	0	OH	0	0	1	1	1	0	2	0	0	0	0	0	2	
	Clostridium difficile infections (attributable)	Yes	HP	5	C, OH, SOF	0	0	0	0	0	0	0	0	2	1	0	2	5	
	MRSA infections (attributable)	Yes	HP	0	C, OH, SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of Never Events	Yes	HP	0	DoH, C, SOF	0	0	0	0	0	0	0	0	0	0	0	0	0	
	Number of falls per 1,000 admissions	Yes	HP	TBA	OH	31	28	20	15	19	12	19	19	23	16	10	10		
	Chemotherapy Medication Errors per 1000 doses	Yes	HP	TBA	C, QR	0.67	0.99	0.69	0.46	0.17	0.14	1.43	0.84	0.76	0.77	0.42	NYP		
	Number of Chemotherapy Medication Errors	Yes	HP	TBA	C, QR	4	6	4	3	1	1	9	6	5	5	3	7	35	
	Radiotherapy Treatment Errors per 1,000 fractions	N/A	HP	TBA	C, QR	1.1	1.16	1.2	1.6	1.1	0.76	0.62	0.94	0.57	1.09	1.18	1.5		
	Percentage of adult admissions with VTE Assessment	No	HP	95%	C, SOF	97.7%	97.9%	95.0%	99.0%	96.9%	95.5%	97.2%	97.7%	96.7%	96.6%	97.0%	95.4%		
	Percentage of patients at risk of VTE who have received prophylaxis	No	HP	100%	Internal	93%	93%	93%	90%	96%	89%	93%	97%	100%	97%	94%	97%		
Medication	Dose Banding Adult Intravenous SACT		HP	Q1 baseline, Q2: 70%, Q3: 75%, Q4: 80%	CQUIN	76%					95%		95%		93%	94%	88%		
Dementia	Composite Indicator for Dementia Screening	No	HP	R: <95%, A: 95%-99%, G: 100%	Internal	93%	92%	82%	84%	100%	100%	89%	88%	92%	100%	100%	100%		
AKI	Percentage completeness of the AKI data items (four per discharge)		HP	R: <95%, A: 95%-99%, G: 100%	Internal							92%	86%	96%	NYP	NYP	NYP		
Sepsis	Percentage of patients requiring screening for sepsis, who have been screened as part of the admission process.	No	HP	100%	Internal	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%		
	Percentage of patients presenting with severe sepsis, Red Flag Sepsis or Septic Shock, who have received IV antibiotics within an hour of presentation.	No	HP	2017/18: R: <95%, A: 95%-99%, G: 100%	Internal	83%	86%	100%	100%	90%	96%	76%	90%	88%	64%	94%	100%		
Effective																			
Mortality	Total number of in-hospital deaths	Yes	HP/PK		Internal	7	4	8	7	8	7	5	6	7	9	6	8	41	
	30 day mortality rate (radical chemotherapy)	No	HP		QR	0.3%	0%	0%	0.1%	0.2%	0.3%	0.3%	0.3%	0.1%	0.1%	0.1%	NYP		
	30 day mortality rate (palliative chemotherapy)	No	HP		QR	2.3%	1.7%	1.4%	1.2%	1.1%	1.6%	1.3%	1.5%	1.3%	1.4%	1.3%	NYP		
	30 day mortality rate (radical radiotherapy)	N/A	PK		QR	2.5%	3.4%	3.2%	3.6%	2.9%	1.9%	1.8%	2.1%	2.4%	3.2%	1.8%	NYP		
	30 day mortality rate (palliative radiotherapy)	N/A	PK		QR														
Time to Consultant Assessment	Percentage of patients admitted as an emergency by A&E or directly from the community, who have a documented assessment by a consultant, within 14 hrs of arrival at hospital.	No	HP	75%	C, Royal College of Physicians	68%	86%	80%	72%	71%	70%	93%	83%	89%	78%	78%	82%		



Integrated Performance Report: 2017/18 Month 6



	Key Performance Indicator	Inc. HO	Director	Target	Directive	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	12 month Trend
Efficiency	Length of Stay Elective Care (Average number of days on discharge)	N/A	HP	5	Internal	2.6	4.61	2.25	4.40	3.82	2.59	1.78	2.05	1.34	2.42	1.36	1.84		
	Length of Stay Emergency Care (Average number of days on discharge)	N/A	HP	10	Internal	13.15	10.04	6.91	9.61	8.96	8.94	7.42	8.04	8.41	6.77	6.13	8.26		
	% of patients not meeting the 'Clinical Utilisation Review' criteria	N/A	HP	TBC with NHSE	CQUIN							40%	45%	47%	48%	53%	49%		
	Linac Downtime	N/A	PK	2%	Internal	3.90%	2.72%	1.53%	4.04%	2.74%	2.34%	2.36%	2.38%	4.56%	4.17%	2.93%	2.02%	3.07%	
	Linac Utilisation	N/A	PK	85%	Internal	86.5%	89.0%	80.9%	83.3%	96.4%	94.8%	86.7%	87.2%	87.2%	92.6%	80.3%	83.3%		
	Care hours per patient day: Conway Ward	N/A	HP	Awaiting inclusion of KPI in 'Model Hospital' Portal	NHSI	5.6	6	6.3	5.9	6	6	6.2	6.2	7.5	7.2	6.5	6		
	Care hours per patient day: Sulby Ward	N/A	HP		NHSI	9.4	8.5	10.8	7.3	7.4	7.3	9	10	11.7	14.4	9.6	11		
	Care hours per patient day: Mersey Ward	N/A	HP		NHSI	6.1	6.8	6.7	6.6	6.7	6.3	7.3	7.4	8.4	8.4	7.9	7.1		
	Care hours per patient day: 7Y	HO only	HP		NHSI										6.1	6.3	6.2		
	Care hours per patient day: 10Z and 7X	HO only	HP		NHSI											12.2	12.8	12	
	Time to recruit staff (% within 60 working days)	Yes	AC	R: <90, A: 90-94, G: >=95	Internal	TBC	100%	95%	100%	90%	91%	100%	100%	100%	100%	91%	97%		
Clinical Trials	Number of patients enrolled into clinical trials	Yes	PK	465 per annum	Internal	Q3 = 87 (excluding HO)			Q4 = 71 (excluding HO)			Q1 = 86 (excluding HO)			Q2 = 62(excl HO)				
Caring																			
The NHS Friends and Family Test (FFT): Inpatients	Total responses as a percentage of those eligible to respond.	Yes	HP	30%	C	19.10%	23.10%	10.80%	10.95%	13.80%	15.00%	15.80%	8.50%	8.10%	5.10%	5.10%	3.10%		
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	Yes	HP	R: <90, A: 90-94, G: >=95	C, O&H, SOF	94.10%	97.01%	96.88%	100.00%	94.11%	93.30%	100%	100%	100%	100%	96.67%	100.00%		
The NHS Friends and Family Test (FFT): Outpatients	Percentage of respondents who were either likely or extremely likely to recommend to friends and family.	N/A	HP	R: <90, A: 90-94, G: >=95	C	96.68%	96.36%	96.88%	96.44%	96.92%	95.07%	89.52%	96.53%	97.81%	94.67%	97.73%	96.71%		
Waiting Times	Percentage waiting 30 minutes or less in a CCC outpatient clinic	No	HP	65%	Internal	79.23%	77.48%	73.24%	77.46%	72.74%	77.27%	74.07%	71.44%	76.81%	74.04%	76.26%	74.78%		
	Percentage waiting 30 minutes or less for Radiotherapy	N/A	PK	80%	Internal	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC	DC		
	Percentage waiting 30 minutes or less for Delamere	N/A	HP	80%	Internal	90%	91%	87%	86%	87%	86%	86%	83%	84%	82%	82%	83%		
	Percentage waiting 30 minutes or less for outpatient peripheral clinics	No	HP	65%	Internal	96%	93%	94%	93%	88%	86%	86%	84%	83%	88%	88%	87%		
Complaints	Number of Complaints	Yes	HP	0	C, SOF	2	2	4	0	2	3	4	2	3	2	4	3	18	
Responsive																			
All Cancers: 62 Day Wait for First Treatment	From urgent GP referral to treatment (classic) post allocation* - English Patients	Yes	BS	85%	SOF, C	80.0%	78.5%	80.2%	74.4%	78.0%	81.4%	81.5%	72.5%	85.50%	79.50%	74.70%	68.10%		
	From urgent GP referral to treatment (classic) pre allocation* - English Patients	Yes	BS	85%	SOF, C	67.90%	68.90%	65.90%	64.00%	60.90%	65.80%	67.00%	54.10%	65.90%	65.20%	55.50%	51.00%		
	From urgent GP referral to treatment (classic) post allocation* - All Patients	Yes	BS	85%	SOF, C	79.10%	78.70%	78.30%	75.50%	77.20%	81.40%	81.50%	73.10%	85.70%	78.30%	74.00%	68.10%		
	From urgent GP referral to treatment (classic) pre allocation* - All Patients	Yes	BS	85%	SOF, C	68.60%	68.20%	64.30%	65.20%	61.30%	64.00%	67.00%	55.10%	65.60%	64.20%	55.00%	51.00%		



Integrated Performance Report: 2017/18 Month 6



	Key Performance Indicator	Inc. HO	Director	Target	Directive	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	YTD	12 month Trend
2 Week Wait	For patients referred with suspected cancer symptoms to see a specialist	HO only	BS	93%											66.70%	100.00%	77.78%		
Internal Cancer Wait Supporting KPIs	% of patients who have their first appointment within 7 days	No	BS	75%	Linked to 62 Day waits						54.55%	47.50%	57.80%	66.04%	71.90%	70.30%	70.40%		
	% of patients who are treated within 24 days of referral to CCC	No	BS	85%	Linked to 62 Day waits						71.50%	63.29%	67.37%	74.44%	72.28%	72.03%	80.00%		
All Cancers: 62 Day Wait for First Treatment (All tumour specific figures are year to date)	All Tumours	Yes	BS	85%	DoH	88.40%	89.60%	88.30%	89.10%	89.10%	89.2%	87.5%	76.7%	79.4%	88.3%	77.4%	76.5%		
	Brain/CNS	Yes	BS	85%	DoH						100.0%				-	100.0%	100.0%		
	Breast	Yes	BS	85%	DoH	93.10%	97.10%	94.94%	95.74%	96.00%	96.2%	87.5%	93.3%	93.8%	94.6%	96.2%	96.4%		
	Gynaecological	Yes	BS	85%	DoH	100%	100%	100%	100%	100%	93.1%	100.0%	40.0%	83.3%	83.3%	75.0%	74.1%		
	Haematological	Yes	BS	85%	DoH	100%	100%	100%	100%	100%	100.0%	100.0%		50.0%	66.6%	50.0%	66.7%		
	Head & Neck	Yes	BS	85%	DoH	73.30%	73.30%	76.81%	78.38%	80.5%	80.2%	100.0%	80.0%	80.6%	70.0%	63.4%	59.4%		
	Lower GI	Yes	BS	85%	DoH	100%	100%	91%	90%	90%	91.3%	86.7%	75.0%	75.0%	77.2%	71.8%	71.6%		
	Lung	Yes	BS	85%	DoH	90.50%	90.80%	92.59%	93.89%	93.70%	92.7%	100.0%	84.1%	84.0%	83.4%	79.8%	78.5%		
	Other	Yes	BS	85%	DoH	86.70%	88.20%	80.00%	76.00%	78.60%	79.3%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%		
	Sarcoma	Yes	BS	85%	DoH		33.30%			100.0%	100.0%		50.0%	50.0%	50.0%	50.0%	50.0%		
	Skin	Yes	BS	85%	DoH	100%	66.70%	50.00%	55.56%	55.60%	55.6%		100.0%	66.6%	66.6%	66.6%	77.8%		
	Upper GI	Yes	BS	85%	DoH	83.80%	84.20%	83.78%	85.88%	82.40%	83.5%	60.0%	47.8%	58.8%	60.5%	60.4%	60.9%		
	Urological	Yes	BS	85%	DoH	75%	78%	81%	83%	83%	85.7%	42.9%	68.4%	66.6%	77.7%	80.4%	75.9%		
	Urological/Testicular	Yes	BS	85%	DoH														
	Not Specified	Yes	BS	85%	DoH														
	From consultant screening service referral post reallocation* - English Patients	Yes	BS	90%	SOF, C	100%	80%	100%	0%	67%	100%	100%	67%	100%	80%	100%	71%		
	From consultant screening service referral post reallocation* - All Patients	Yes	BS	90%	SOF, C	100%	80%	100%	0%	67%	100%	100%	67%	100%	80%	100%	71%		
All cancers: 31 day wait from	Decision to Treat to first treatment - English Patients	Yes	BS	96%	DoH, C	97.70%	98.50%	98.20%	97.10%	100.00%	96.70%	98.80%	96.40%	97.80%	98.50%	97.30%	92.90%		
	Decision to Treat to first treatment - All Patients	Yes	BS	96%	DoH, C	97.90%	98.50%	97.60%	96.30%	100.00%	96.40%	98.30%	96.50%	97.90%	98.60%	97.40%	93.00%		
	Decision to Treat to subsequent treatment	Yes	BS	98%	DoH, C	97.90%	99.40%	99.50%	96.70%	99.70%	98.70%	97.00%	98.40%	99.20%	99.30%	97.90%	96.60%		
	Anti cancer drug treatment - English Patients	Yes	BS	98%	DoH, C	98.00%	99.40%	99.00%	96.90%	99.70%	98.80%	97.10%	98.50%	99.30%	99.30%	97.90%	96.00%		
	Decision to Treat to subsequent treatment	N/A	BS	94%	DoH, C	96.80%	98.50%	97.80%	97.40%	98.30%	98.90%	98.0%	97.8%	98.6%	97.0%	98.8%	97.3%		
	Radiotherapy - English Patients	N/A	BS	94%	DoH, C	96.90%	98.50%	97.90%	97.30%	98.20%	98.70%	97.8%	98.0%	98.7%	97.2%	98.9%	97.2%		
	Radiotherapy - All Patients	N/A	BS	94%	DoH, C	96.90%	98.50%	97.90%	97.30%	98.20%	98.70%	97.8%	98.0%	98.7%	97.2%	98.9%	97.2%		
Referral to treatment waiting times (18 weeks)	Admitted patients	Yes	BS	90%	DoH, C	100%	100.0%	100.0%	100.0%	95.2%	96.9%	100.0%	100.0%	100.0%	90.0%	100.0%	92.9%		
	Non-admitted patients	Yes	BS	95%	DoH, C	99.2%	98.7%	98.3%	98.3%	96.2%	98.5%	98.3%	97.8%	97.8%	97.1%	95.9%	97.8%		
	Incomplete Pathways	Yes	BS	92%	SOF, C	95.1%	96.7%	96.3%	96.1%	96.1%	96.7%	96.9%	96.7%	96.6%	97.0%	95.9%	96.5%		
	Zero tolerance RTT waits over 52 weeks for Incomplete pathways	Yes	BS	0	DoH	0	0	0	0	0	0	0	0	0	0	0	0		
Referral to diagnostics	Patients waiting less than six weeks at month end as a percentage of total waiting (Diagnostics)	N/A	BS	99%	C	100%	100%	98.9%	98.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		
People Management and Culture: Well Led																			
Staff Attendance and Turnover	Attendance (Sickness Level)	Yes	AC	R: >=4%, A: 3.6% - 3.9%, G: <=3.5%	SOF	4.49%	4.28%	3.79%	4.84%	4.14%	4.14%	4.05%	4.09%	4.03%	4.20%	4.34%	4.35%		
	Retention (Turnover FTE rolling 12 months)	Yes	AC	<12%	SOF	13.43%	13.56%	13.24%	13.14%	12.92%	12.28%	12.81%	13.69%	13.22%	12.95%	12.37%	12.63%		
Staff Development <small>(The figures recorded for each month are rolling 12 month figures, rather than for the month only)</small>	Statutory Mandatory Training (Rolling 12 months)	No	AC	R: <75%, A: 75% - 94%, G: >=95%	Internal	82%	83%	83%	85%	85%	80%	80%	81%	82%	82%	85%	78%		
	Performance Development Reviews (PADR) (Rolling 12 months)	Yes	AC		Internal	57%	60%	61%	75%	76%	73%	70%	68%	77%	93%	93%	89%		



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The NHS Friends and Family Test (FFT): Staff	Percentage of respondents who were either likely or extremely likely to recommend to friends and family as a place to work.		AC	R: <90, A: 90-94, G: =>95	O&H			No report due to National Staff Survey			22%			75%			100%		
	Percentage of respondents who were either likely or extremely likely to recommend to friends and family as a place for treatment or care.		AC		SOF, O&H			No report due to National Staff Survey			83%			96%			100%		
Finance and Activity																			
Finance (The figures recorded for each month are YTD figures, rather than the month only)	Operating Surplus (EBITDA margin) YTD	Yes	YB	8.9%	Internal	10.2%	10.6%	10.1%	10.1%	9.9%	10.8%	2.1%	6.6%	9.5%	8.3%	8.7%	8.6%		
	Net Surplus (Net Income & Expenditure Margin) YTD	Yes	YB	2.8%	Internal	5.3%	5.7%	5.1%	5.1%	4.8%	5.9%	-5.6%	-0.3%	2.8%	2.1%	2.8%	2.8%		
	Net Surplus versus Trust Plan (£'000s) (YTD)	Yes	YB	1,726	SOF	3,377	4,136	4,168	4,631	4,816	6,544	-461	-51	769	813	1,396	1,756		
	Net Surplus versus NHSI Control Target (£'000s) (YTD)	Yes	YB	1,698	SOF	3,508	4,305	4,354	4,841	5,492	5,921	-398	113	1,124	1,068	1,774	2,153		
	C-I-P Savings (Percentage of identified savings) YTD	Yes	YB	37.5%	Internal	57.8%	65.7%	72.0%	81.5%	89.6%	103.9%	5.1%	10.4%	19.9%	26.1%	32.4%	39.3%		
	Capital Spend versus Plan (%) YTD	Yes	YB	48.3%	Internal	22.6%	27.4%	33.6%	59.0%	62.7%	99.5%	7.8%	3.1%	7.6%	12.3%	14.3%	20.8%		
	Cash Balances versus Plan(£'000s) (YTD)	Yes	YB	53,898	Internal	75,806	76,015	72,983	76,640	89,213	62,831	58,661	59,075	58,361	57,705	57,713	58,789		
	Liquidity Position (Liquid ratio in days) YTD	Yes	YB	168 days	SOF	266	265	259	255	252	210	213	212	212	190	195	180		
	Use of Resources	Yes	YB	1	SOF	3	3	3	3	3	3	1	1	1	1	1	1		
	Agency Staff Spend (£'000s) YTD	Yes	YB	513	SOF	1,500	1,620	1,700	1,820	1,885	1,940	96	156	227	288	352	400		
	Agency and Bank Staff Spend (£'000s) YTD	Yes	AC	513	Internal	1,519	1,644	1,729	1,857	1,929	1,980	97	163	241	307	400	0		
	Agency medical locum spend (reduce by £75K by the end of 2017/18 compared to 2016/17 outturn spend)	No	YB	256	SOF												249	302	
Activity (The figures recorded for each month are YTD figures, rather than the month only)	Contract versus Plan (£) - excluding drugs	No	YB	31,698,602	Internal	36,441,467	41,590,185	46,615,956	52,230,726	57,405886	63,358,686	5,678,936	10,542,689	16,159,187	20,796,552	26,361,665	31,527,126		
	Radiotherapy Activity (percentage growth YTD)	N/A	PK	1.9%	C	-9.9%	-9.3%	-9.3%	-8.2%	-9.1%	-8.6%	1.9%	1.9%	-10.2%	-12.0%	-12.9%	-13.6%		
	Chemotherapy Activity (percentage growth YTD)	No	HP	5.0%	C	-5.7%	-2.9%	-0.8%	4.3%	4.5%	4.7%	5.0%	5.0%	7.8%	4.7%	4.7%	3.9%		
	Inpatient Activity (percentage growth YTD)	No	HP	1%	C	8.0%	8.8%	9.3%	-2.4%	-3.4%	-3.0%	1%	1%	-26.3%	-26.9%	-28.0%	-28.1%		
	Outpatient Activity (percentage growth YTD)	No	HP	1%	C	7.5%	6.6%	6.4%	3.1%	4.7%	5.3%	1%	1%	6.4%	6.1%	7.1%	7.1%		



Titles key: Directive = Rationale for inclusion (see detailed key below), YTD = Year to date

Directive key: Department of Health (DoH), NHS Improvement (NHSI), Single Oversight Framework (SOF), CQUIN (CQUIN), Quality Report (QR), Sign up to Safety campaign (SU2S), Contract KPIs (C), Open and Honest (OH)

General key: DC = Data capture system under development, TBA = To be agreed, TBC = To be confirmed, QR = Quarterly Reporting, NYP = Data not yet published for this time period, NA = Not Applicable, ST = Safety Thermometer (this is a survey carried out on one day a month on all wards. The data relates only to the inpatients present on that day, rather than capturing all harm data for the month), Grey shaded cells = Not applicable, or data not available for this period.