Agenda item: 8

SUMMARY REPORT		South Tees Hospitals NHS NHS Foundation Trust	
Board of Directors		Date of meeting: 31 May 2016	
Subject	Integrated Performance Board Report		
Prepared and presented by	Ruth James, Director of Quality and Risk, Maxime Hewitt-Smith, Director of Finance		
Purpose: To provide the Board of Directors with a summary of quality, finance, workforce and performance measures in March 2016		Decision	
		Approval	
		Information	●
		Assurance	●

Executive Summary
Areas identified as off track for April and / or at risk for Q1 2016/17 are : Finance - CIP - Capital Expenditure Performance - Cancer 62 day standard - Two week wait standard Operational metrics - Delayed transfers of care Workforce - Appraisal rates - Mandatory training

Supports Trust Strategy Map in the following areas							
quality & patient safety		**business sustainability**		**operational excellence**		**organisational capability**	
deliver integrated care		improved cost control		improved patient flow		improved information	
forefront of clinical innovation		increased productivity		improved innovation processes		continuous service improvement culture	
specialised services development		increased revenue & market share		strong governance & risk management	●	workforce development	
service quality and safety	●	enhanced services				strong partnerships & engagement	

If a key risk(s) has been identified, please describe below
SLT performance funding is at risk if performance trajectories are not achieved, these trajectories will be incorporated into the dashboard for the April data.

Integrated Quality, Finance, Performance and HR Dashboard 2016/17

April 16

			15/16						16/17								
		Threshold	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Trend (April 15- to date)	2016/17 Q1 Forecast	End of Year Forecast
Quality & Patient Safety	MRSA (zero tolerance)	0	0	0	0	1	0	0	0								
	Clostridium difficile (cumulative position)	50	35	42	49	56	60	61	4								
	Rate of falls per 1000 bed days (flag SPC)	5.7	4.2	3.8	5.0	4.0	5.1	4.0	4.7								
	Category 3 or 4 pressure ulcers (20% reduction)	4 per month	2	1	4	2	2	4	3								
	Medication incidents (flag SPC)		65	72	56	75	83	55	69								
	% of incidents graded as moderate or above (not greater than previous year)	2.30%	2.9%	2.4%	1.8%	2.1%	2.1%	2.5%	2.7%								
	Rate of formal complaints per 1000 spells (flag SPC)	2.5	1.1	0.8	0.8	1.1	1.3	1.3	1.1								
	Inpatient FFT - % highly likely or likely to recommend	90%	97.9%	97.9%	97.2%	97.8%	98.4%	97.7%	98.4%								
	SHMI (rolling 12 months - 4 months behind)	As expected	108	108	108	107	108	107	108								
	HSMR (rolling 12 months - 3 months behind)	As expected	117	117	116	116	115	116	113								
	Crude mortality rate		1.2%	1.2%	1.2%	1.5%	1.5%	1.3%	1.5%								
	Total deaths in hospital		154	159	150	186	196	168	191								
	Percentage died with specialist palliative care coding		28.6%	19.0%	30.0%	20.4%	26.5%	26.0%	19.9%								
	CQUIN achievement	>95%															
Business Sustainability	EBITDA	Per Plan															
	Underlying surplas /(Deficit)	Per Plan															
	CIP programme	Per Plan															
	Cash and Liquidity	Per Plan															
	Capital Expenditure	Per Plan															
	Continuity of Service risk rating.																
Operational Excellence	Incomplete pathways - % of patients on an RTT pathway waiting 18 weeks or less	92%	92.5%	92.6%	92.2%	92.6%	92.5%	92.3%	92.5%								
	Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	95%	96.4%	95.7%	95.0%	93.8%	92.8%	93.3%	95.5%								
	Cancer waits 2 week wait target	93%	94.2%	95.6%	95.5%	94.0%	92.2%	93.5%									
	2 week wait breast symptom referrals - % seen within 2 weeks	93%	90.5%	93.3%	96.2%	93.9%	95.6%	90.4%									
	Cancer wait 31 day wait for first definitive treatment for all cancers	96%	96.9%	94.3%	97.1%	97.5%	98.6%	100.0%									
	Cancer wait 31 day wait for subsequent drug treatments for all cancers	98%	100.0%	100.0%	100.0%	90.5%	100.0%	100.0%									
	Cancer wait 31 day wait for subsequent surgery treatments all cancers	94%	94.9%	88.1%	95.3%	94.0%	94.6%	88.6%									
	Cancer wait 31 day wait for subsequent radiotherapy treatments all cancers	94%	98.0%	99.0%	100.0%	100.0%	98.8%	96.6%									
	Cancer wait 62 day wait for the first definitive treatment for all cancers	85%	74.8%	74.6%	84.1%	78.6%	78.0%	75.6%									
	Cancer wait 62 day wait for treatment of all cancers referred from a National screening service.	90%	NA	87.5%	87.5%	100.0%	100.0%	57.1%									
	Cancer wait 62 day wait for first definitive treatment following consultant upgrade - please note the latest position is year to date as per local agreement	90%	100.0%	63.6%	100.0%	100.0%	87.5%	80.0%									
	Bed occupancy (average per month)	85%	89.6%	89.3%	85.8%	90.2%	94.7%	94.8%	TBC								
	Average Elective Length of Stay		3.60	3.81	3.82	3.35	3.44	3.22	3.17								
	Average Non Elective Length of Stay		4.36	4.46	4.62	4.64	4.61	4.63	4.96								
	Delayed Transfers of Care	<=4%	3.7%	3.7%	3.8%	3.5%	4.6%	5.1%	5.4%								
	Total guest bed days		744	732	392	1015	1320	1462	1340								
	Closed Beds (average per month)		23	32	29	35	27	32	33								
	Cancelled operations		36	34	29	47	41	20	14								
HR	% sickness absence	Within normal confidence limits	4.6%	5.0%	4.6%	4.7%	4.3%	4.5%	4.5%								
	% attendance at mandatory training	90%	81.8%	82.4%	83.7%	83.7%	85.7%	88.2%	82.9%								
	% appraisals completed	80%	68.7%	69.0%	69.9%	70.3%	70.30%	68.20%	66.30%								
	Vacancy rate		4%	3%	4%	4%	4%	3%	TBC								

Quality and Performance Interim Board Report

1. Executive Summary

Quality

Mortality data continues to show the trust as an outlier, the underlying analysis is as previously reported. Crude mortality rates and numbers of deaths continue to show a stable position. A summary of mortality indicators and palliative care coding is shown in appendix 1.

Income and Expenditure

EBITDA: Actual for April (month 1) is £1.1m ahead of plan mainly due to an underspend in clinical supplies and services within CDS and planned care centres due to tight cost controls. At this early stage in the year monthly forecasts are projected to be in line with plan; this position will be closely monitored.

Control Total: Actual for April (month 1) is £1m ahead of plan mainly due to the underspend in EBITDA £1.1m as highlighted above which is partly off by restructuring costs £0.1m. At this early stage in the year monthly forecasts are projected to be in line with plan; this position will be closely monitored and proactive action taken to ensure the Trust keeps within the control total. The full year gap between the run rate and plan is £13.3m (£4.8m deficit compared to £8.5m surplus, respectively). The main areas that will close this gap are the delivery of CIP £35m off-set by the non-recurrent full year effect of month 1 benefit £12m and restructuring costs £4m. The 2015/16 control total has been 'normalised' though adjusting for 2016/17 pay, non-pay and income inflation to ensure a useful comparison. The main areas that bridge between the normalised 2015/16 control total and 2016/17 plan are CIP £35m and STP funding £14.6m off-set by tariff changes £4.6m, non-recurrent cost efficiencies £8.8m and contingency £4.6m.

CIP: Actual for April (month 1) is £0.3m which is behind plan by £0.7m due to finalisation of CIP delivery plans. In line with 2015/16, the delivery profile of CIP is forecast to increase during the year (and bridge the gap between the run rate and plan) as the laying the foundations programmes financial benefits are realised.

Balance Sheet

Net Current Assets: Actual net current assets for April (month 1) are £3.3m higher than plan due to outstanding 2015/16 NHS debtors ,specifically for specialised commissioning which have been paid in May. Actual net current liabilities and specifically trade payables are higher than plan by £1.7m due the timing of the weekly payment run at the end of April.

Cash flow: The actual cash balance at the end of April (month 1) stood at £2.9m, £0.2m ahead of plan. The Trust has utilised £1.9m of the approved Working Capital Loan in May and is in discussions with Monitor and the Department of Health to agree the drawdown for June amounting to £6.8m. The submission of utlisation documentation to the Department of Health was actioned on 25 May 2016.

Capital Expenditure: Actual for April (month 1) is £0.3m which is behind plan by £0.9m. The Trust is in the process of approving the programme for 2016/17 and details of the schemes to support the investments included in the programme are provided for information.

Performance

The trust has achieved the referral to treatment (RTT) target in April. Orthopaedics, Neurology and Ophthalmology are non-compliant at specialty level.

The trust continues to be non-compliant with the cancer 62 day target; a KPI dashboard and an action plan framework are included in this report.

A & E performance for April was above the 95% target at 95.5%. Early indications in May suggest that the trust will remain compliant in May

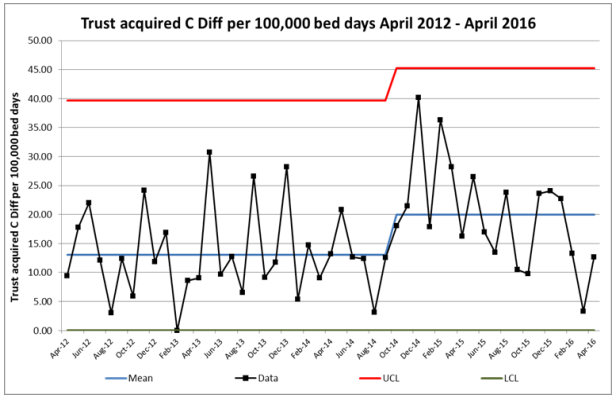
Workforce

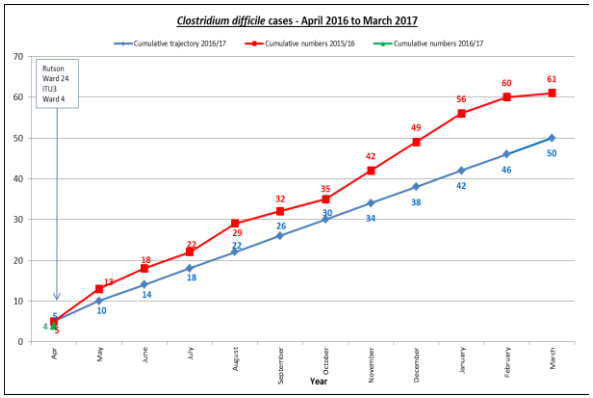
Appraisal rates have not improved. The trust is to implement a revised approach to appraisal in quarter 1.

2. Exception Reporting

2.1 Clostridium difficile

CDI Key Performance Indicators Dashboard





	Target	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16
Compliance with assessment of diarrhoea in A&E	>=90%	93.0%	98.7%	98.2%	96.2%	97.5%	95.0%	96.2%	97.5%	96.2%	95.0%	92.5%	97.50%
Stool chart compliance	>=95%	96.0%	83.0%	97.5%	98.4%	98.1%	96.1%	98.9%	95.8%	97.0%	89.9%	90.0%	
All elements of DATchart completed	>=95%												25%
C. Diff patients isolated within 2 hours (%)	>=90%	93.0%	77.0%	100.0%	81.0%	85.7%	71.4%	70.0%	66.7%	77.7%	71.0%	60.0%	60.0%
C. Diff patients isolated within 2 hours (actual number)		13 out of 14	10 out of 13	8 out of 8	13 out of 16	6 out of 7	5 out of 7	7 out of 10	6 out of 9	7 out of 9	5 out of 7	3 out of 5	3 out of 5
Antibiotic prescribing													
Antibiotic audit - Audit of choice of antibiotic regimen	>=90%	98.6%	98.5%	97.2%	99.5%	98.9%	99.4%	99.0%	97.4%	98.8%	****	****	99.30%
Antibiotic audit - Stop date recorded	>=90%	68.0%	71.5%	76.6%		70%	74%	77%	72.4%	75.5%	****	****	76.30%
Hand hygiene competencies													
Hand hygiene competencies (Trajectory Q1-25%, Q2-50%, Q3 -75%,Q4->=95%)	>=95%	****	29%	****	****	58.4%	****	****	75.24%	****	****	98.53%	****
Clean your Hands compliance	>=90%	86.4%	86.7%	87.7%	88.1%	88.5%	93.2%	92.5%	93.7%	92.9%	93.4%	94.2%	91.80%

<u>Current position</u>
There were 4 cases of Clostridium Difficile in April against a trajectory of 5.

Forecast position

The target for 2016/17 remains no more than 50 cases. The trust is in discussion with NHS England to align the target with our peer group now that the trust has been re-classified as a large acute teaching hospital. This would increase the target to 56.

2.2 CQUIN

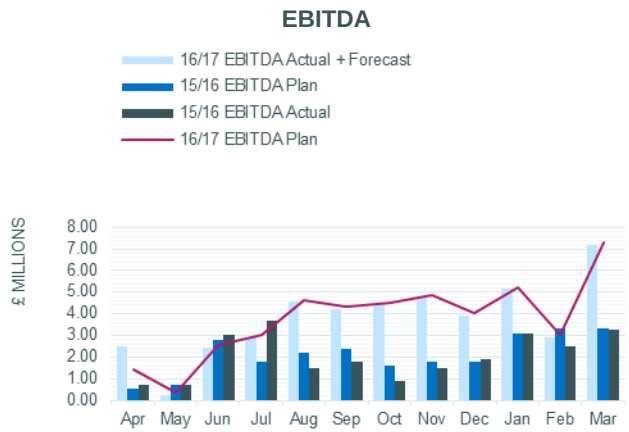
Current position

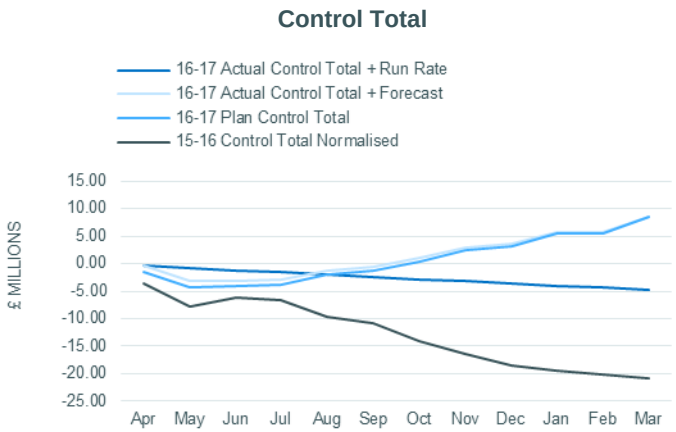
CQUIN schemes for 2016/17 are still under discussion

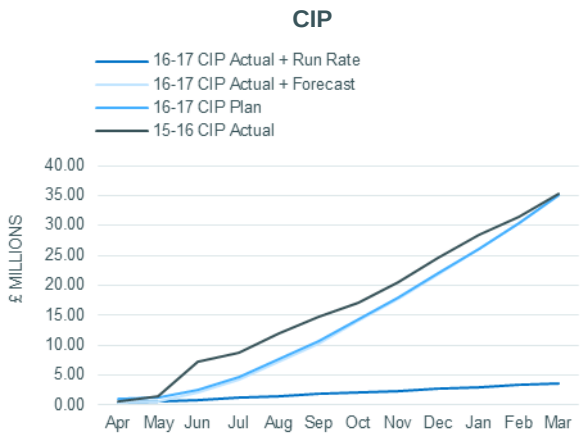
2.3 Finance

Income and Expenditure

Financial Risk Ratings	15/16 M11	15/16 M12	16/17 M1	Plan 16/17 M1
Headline Financial Performance (Overall Rating) The month 1 YTD I&E position before impairments and donation adjustments (income & depreciation relating to donated assets) is **£1.0m ahead** of plan. Total Income is **£0.2m behind** plan at month 1, pay costs are **£0.4m ahead** of plan and non pay costs **£0.9m ahead** reductions in costs are due to tight cost control process in place across the Trust.	2	2	2	2
Operational Performance (Capital Service Cover) EBITDA is **£1.1m ahead** of plan and capital service costs that includes interest on borrowings, PFI and finance lease remain on plan and amount to £2.3m at month 1. The improvement in EBITDA has strengthened the capital service cover metric but the overall rating remains at 1.	1	1	1	1
Operational Performance (I+E Margin) The retained deficit I&E performance is a deficit of £0.4m, **£4.1m ahead** of plan at month 1. This variation is due to impairments being **£3.0m ahead** of plan at month 1 due to re-profiling of impairment reviews along with the improved operational performance, as above.	1	2	2	1
Operational Performance (I+E Margin Variance from Plan) The month 1 deficit position is **£4.1m ahead** of plan, a £0.4m deficit against a planned value of a deficit of £4.5m.This in month variance of £4.1m has contributed to the improved margin performance of 4 against a planned value and previous month's value of 3.	3	3	4	3



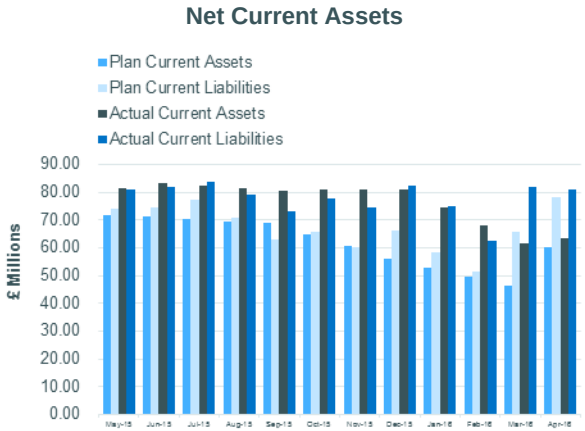


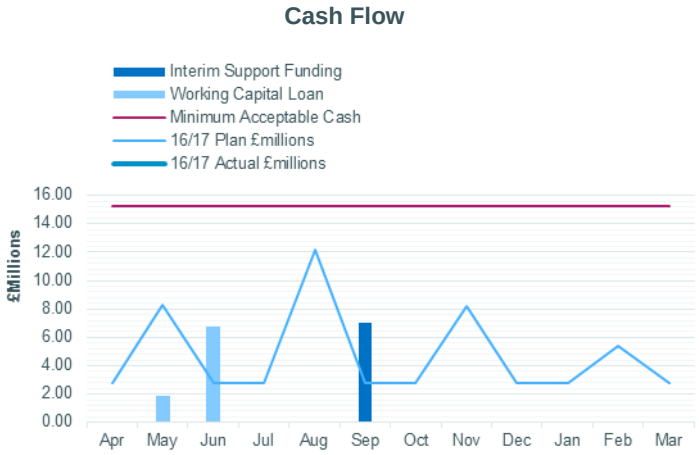


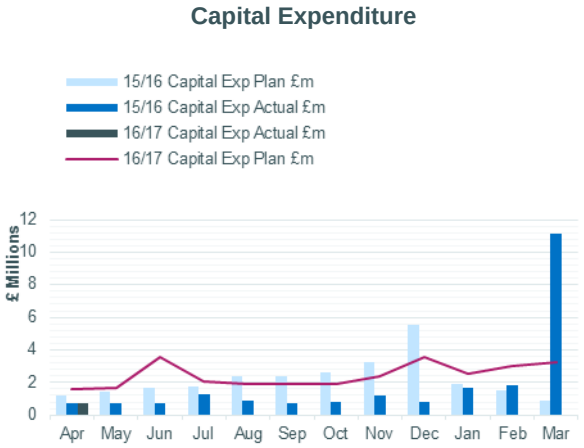
Risk Indicators	May-15	Jun-15	Q1	Jul-15	Aug-15	Sep-15	Q2	Oct-15	Nov-15	Dec-15	Q3	Jan-16	Feb-16	Mar-16	Q4	Apr-16
EBITDA as a percentage income (rolling 12 months)	1.6%	6.4%	3.3%	7.8%	3.4%	3.9%	5.1%	2.0%	3.3%	4.0%	3.1%	6.6%	5.3%	7.1%	6.3%	5.3%
Trust Certifies that FRR may be less than 3 in next 12 months	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2
Two or more changes in Finance Director in twelve month period	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Interim Finance Director in place over more than one quarter end	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No

Balance Sheet

Financial Risk Ratings	15/16 M11	15/16 M12	16/17 M1	Plan 16/17 M1
Cash & Balance Sheet Performance (Liquidity) The value of working capital include net current assets which were **£3.2m higher** than plan due mainly to outstanding NHS debt outstanding from 2015/16 relating to specialised commissioners. These outstanding invoices have been cleared in May. Current liabilities were **£2.6m higher** than plan due to the timing of the payment run at the end of April. Operating expenses were **£1.3m ahead** of plan and the liquidity rating remains at 1 in line with plan.	1	1	1	1







Risk Indicators	May-15	Jun-15	Q1	Jul-15	Aug-15	Sep-15	Q2	Oct-15	Nov-15	Dec-15	Q3	Jan-16	Feb-16	Mar-16	Q4	Apr-16
Working capital facility used in quarter	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No	No
Debtors > 90 days past due account for more than 5% of total debtors balances	4.9%	4.7%	4.0%	56.3%	36.6%	8.7%	16.6%	5.3%	5.7%	8.1%	5.3%	39.7%	8.3%	25.9%	5.3%	5.4%
Quarter end cash balance < 10 days of operating expenses (c.£15.0m)	15.2	17.3	45.7	17.6	24.9	5.4	47.9	9.2	12.0	3.6	24.8	3.0	6.7	2.8	12.4	2.9
Capital Expenditure within +/- 15% of plan YTD	50.8%	43.3%	50.2%	71.6%	35.7%	28.7%	42.7%	30.7%	37.2%	14.2%	24.5%	85.8%	120.1%	1212.2%	335.2%	46.6%

2.4 Performance trajectories

The annual planning process for 2016/17 required organisations to submit performance trajectories for the 18 week referral to treatment target, A&E 4 hour wait target, cancer 62 day target and the 6 week diagnostic target. The trajectories forecast a complaint position across the year for RTT, A&E (non-compliant in January and February but compliant for Q4 at an aggregate level).. The trust is compliant with all four measures in April 16. See appendix 2 for further detail.

Discussions are ongoing with commissioners and NHS England to understand how payment is triggered and paid.

2.5 18 Week incomplete pathways

Current position

The trust achieved 92.5% against a target of 92%, however three specialities continue to be non-compliant – Orthopaedics, Ophthalmology and Neurology.

Forecast position

It is forecast that compliance will be maintained however recent bed pressures are resulting in cancellations which may impact on overall performance. Work is continuing to finalise the IMAS models to determine the right size waiting list for each specialty, this is dependent on confirmation of expected activity levels from the current capacity and demand review.

2.6 Cancer Targets

Current position

In Quarter 4, the trust was non-compliant with the 62 day first definitive treatment and the 62 day screening target, with a compliance rate of 77.8% against the 85% national target. Across the NESCN compliance was 83.4% and nationally compliance was 81.7%. Quarter 4 benchmarking across the NESCN in relation to the 62 day first definitive treatment target is available for information on page 6 of the supplementary pack.

Trend analysis of the breach reasons demonstrates that breached due to slow diagnostic pathways have increased in March. On investigation this was due to delays to PET, CT, MRIs and biopsies. This has been identified previously and is a key element of the cancer action plan and the transforming clinical support programme. The draft framework for the cancer action plan can be found in appendix 3, the cancer action plan working group meet on the 6th of June and the completed plan will be presented to Board in June.

A KPI dashboard has been developed to track critical process measures particularly waiting times for diagnostics. The dashboard can be found in Appendix 3.

Indicative figures for April suggest that 62 day first definitive and the 2ww first seen target will be non-compliant. The main reason for non-compliance with 2ww first seen target is patient choice. Information is being sent to GPs to highlight these patients so that they can ensure they are providing patients with enough information and the Trust is in discussion with the CCGs about further actions that can be taken

Forecast position

Indicative information for April suggests that performance on the 62 day standard was 80.6% which is within the improvement trajectory

2.7 A & E 4 hour wait target

Current position

The trust achieved this measure in April with a performance of 95.5% against the target of 95%

Forecast Position

Early indications suggest that the trust will remain compliant in May. A number of the transformation work streams will support future compliance with this measure.

2.8 Delayed Transfers of care

Current Position

Delayed transfers of care as a percentage of occupied beds were 5.4% in March, which is above the 4.0% threshold and demonstrates ongoing issues operational issues.

Forecast Position

The Transforming Inpatients workstream has the reduction of delayed transfers of care as one of its measures of success.

2.9 Appraisals

Current position

The position at the end of the April 2016 was 66%, which is a slight deterioration compared to the previous month.

Forecast Position

As last month it is expected that through the revised approach to appraisal a significant improvement in annual appraisal rates will be seen. The impact will be seen over the course of the year as the new process requires the performance objectives to be cascaded through the management teams during quarter 1 and followed through from this point.

2.10 Monthly Nursing and Staffing Report

Fill rate data is summarised by Clinical Centre at organisational level. Whilst RAG rating thresholds have not yet been decided nationally and will not appear on the NHS Choices website, within this report we have rated our results by applying the following thresholds:

Red	≤ 80%
Amber	80 – 95%
Green	≥ 95%

Ward level detail is available in the supplementary performance report.

Trust Averages

	< 80	80-95	> 95	
	DAYS Average fill rate - RN/RMs (%)	DAYS Average fill rate - HCA (%)	NIGHTS Average fill rate - RN/RMs (%)	NIGHTS Average fill rate - HCA (%)
Trust Average				
Integrated Medical Care Centre	91.7%	101.7%	94.4%	118.7%
Surgical service Centre	92.3%	107.8%	95.8%	117.2%
Tertiary services Centre	96.5%	114.9%	98.5%	186.1%
Women & Children centre	93.4%	85.6%	101.6%	106.4%
Trauma, anaes & Theatre	87.6%	90.6%	94.4%	132.7%
Specialty Services Centre	98.4%	102.5%	94.0%	112.2%
Trust Average	93.3%	100.5%	96.5%	128.9%

The fill rate for unregistered staff overnight across the organisation remains above 100% in March 2016. This is due to two factors, firstly a demand for staff to provide enhanced observations and secondly where rota templates have been increased to 3 RN's but inconsistent fill rate has occurred.

Associate Directors of Nursing / Midwifery within the Clinical Centres are assured that safe care is delivered and systems and processes are in place should staffing levels fall short of those planned and this includes reducing capacity if safe staffing cannot be maintained. A number of centres reduced bed capacity during March on a temporary basis due to a combination of sickness and vacancies (average of beds 31 closed).

There are a number of wards with RN fill rates below 80% including wards 7, 9 and 34 at JCUH, Romanby at FHN and Zetland ward RCH. All have maintained a maximum 1:8 RN to patient ratio supported by assistant practitioners and the therapeutic care team.

The number of unregistered staff in the women and children's centre and critical care is small with a predominantly registered nurse / midwife workforce, therefore percentages are significantly affected if even a small number of staff have unplanned leave.

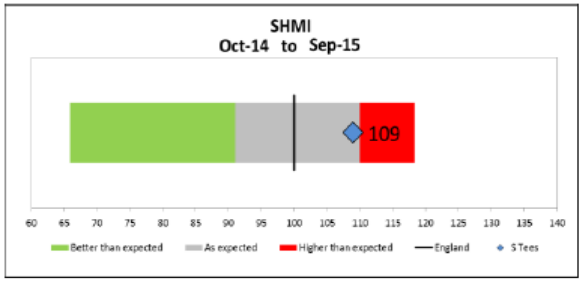
The revised process for Band 5 recruitment has been implemented with the outcome of 21st March interviews resulting in the appointment of 22.48 (WTE). The final 7 Romanian nurses recruited in January have now arrived and are undertaking induction ready to start on the wards on 18th April. These nurses will be working at band 3 until their NMC registration arrives and have been placed in surgery (wards 5, 6 and 7) and orthopaedics (ward 34) at JCUH and two wards at FHN (Ainderby and Romanby).

Appendix 1 – Mortality Report

Mortality Report for Board May 2016

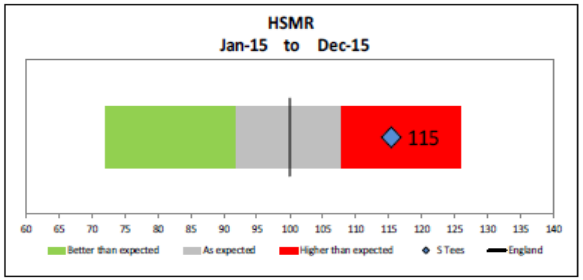
Agenda Item

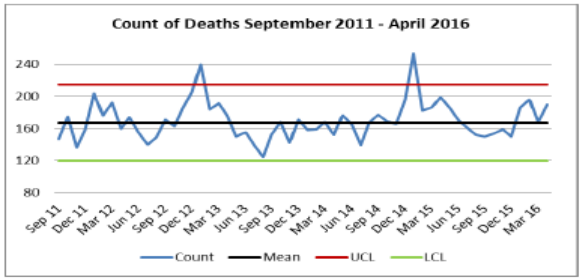
South Tees Hospitals NHS
NHS Foundation Trust



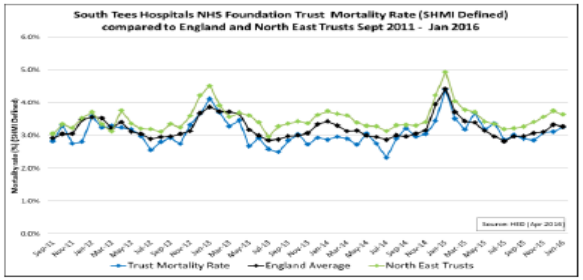
SHMI for the period Oct 2014 – Sep 2015 is 109 which is "As Expected".

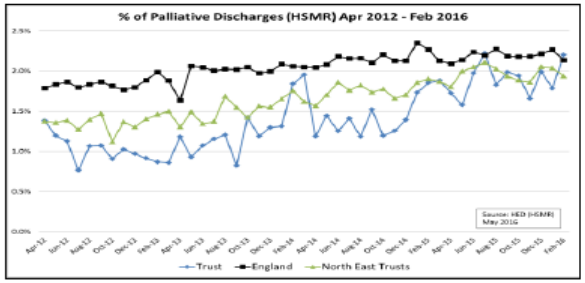
HSMR for the period Jan 2015 – Dec 2015 is 115 which is 'Higher than Expected".
(Source: HED)





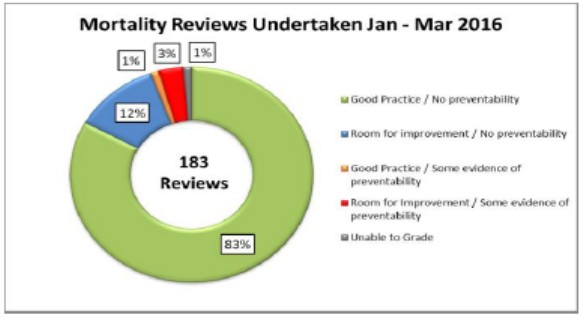
The count of deaths shows that the winter 2015/2016 has seen fewer deaths in hospital than winter 2014/2015. The Trust is currently averaging 169 deaths per month.
Trust unadjusted mortality rates have returned to levels lower than both regional and national rates
(Source: CBiS/HED)





Specialist palliative care coding spells remains under review as coded cases have not risen as much as anticipated though have moved closer to the regional figures.
(Source: HED)

183 mortality surveillance reviews in Jan – Mar 2016, 152 cases (83%) were graded as "good practice with no preventability". There was some evidence for preventability in ~ 4% with > 50:50 chance of preventability in ~0.5%
(Source: Mortality Surveillance database)



Appendix 2 – Performance trajectories

RTT - Incomplete %	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
52 Week trajectory	0	0	0	0	0	0	0	0	0	0	0	0
Actual 52 week	**0**											
Improvement Plan	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%	92.6%
Actual RTT	**92.5%**											

A&E - 4 hour %	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Improvement Plan	95.1%	95.6%	96.3%	96.4%	97.0%	97.3%	96.4%	96.1%	95.9%	94.9%	94.7%	95.4%
Actual Performance	**95.5%**											

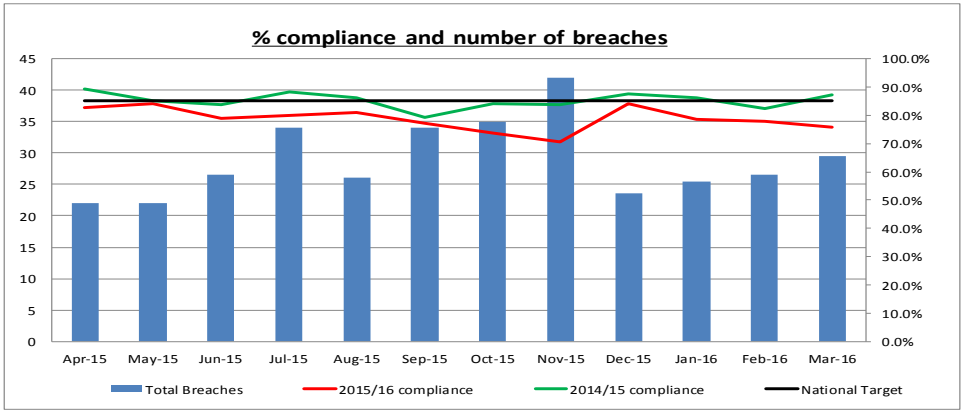
Cancer - 62 day first treatment	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Improvement Plan	79.8%	81.5%	80.3%	81.6%	83.3%	83.6%	84.4%	86.3%	86.1%	85.4%	85.7%	85.6%
Actual Performance	**80.6%***											

* indicative position

Diagnostic - 6 week %	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17
Improvement Plan	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%	99.1%
Actual Performance	**99.0%**											

Appendix 3 – Cancer Action plan

62 Day Cancer KPI Dashboard



	2015/16												Trend
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	
Complex Diagnostics	12	8	4	4	6	3	13	13	7	3	3	2	
Patient Choice	3	1	7	10	2	4	2	9	4	3	2	2	
Elective Capacity	2	4	4	6	3	8	4	6	7	8	5	0	
Slow Diagnostic Pathway	0	3	5	9	8	7	9	5	2	2	2	9	
Late referrals	8	8	9	7	9	11	7	8	4	10	15	15	
Outpatient Capacity	1	1	2	0	2	0	3	4	1	2	3	5	
Medical Reason	1	2	2	4	2	3	3	3	0	0	1	2	
Admin Delay	0	0	0	0	2	1	2	0	2	1	0	2	
Other	0	0	1	1	0	4	1	1	0	3	4	2	
Total	**27**	**27**	**34**	**41**	**34**	**41**	**44**	**49**	**27**	**32**	**35**	**39**	

			Week commencing													
		Threshold	01/02/2016	08/02/2016	15/02/2016	22/02/2016	29/02/2016	07/03/2016	14/03/2016	21/03/2016	28/03/2016	04/04/2016	11/04/2016	18/04/2016	25/04/2016	02/05/2016	09/05/2016
Diagnostic Key Performance Indicators for patients referred on a 2ww pathway																	
Turnaround time from request to radiology test being appointed (within 48 hours)	All	80%	58.5%	48.6%	48.5%	56.5%	55.8%	52.8%	52.8%	62.0%	64.3%	48.0%	53.1%	64.2%	60.1%	62.3%	77.0%
	CT		71.4%	46.6%	60.4%	72.1%	59.0%	63.4%	67.9%	75.6%	70.5%	55.2%	55.6%	61.5%	62.0%	70.4%	73.6%
	MRI		28.6%	44.4%	45.0%	31.6%	75.0%	35.3%	20.0%	69.2%	44.4%	28.0%	54.2%	68.2%	53.8%	52.2%	77.8%
Turnaround time from request for radiology test to being tested (5 days)	All	80%	24.3%	28.5%	18.6%	20.5%	22.1%	22.9%	19.9%	17.2%	12.8%	24.4%	17.5%	14.6%	18.6%	16.7%	24.6%
	CT		27.7%	17.0%	17.5%	24.4%	28.9%	27.7%	23.4%	17.9%	14.1%	26.1%	16.2%	7.7%	18.5%	22.2%	23.2%
	MRI		0.0%	11.1%	5.0%	5.3%	0.0%	5.3%	0.0%	15.4%	5.3%	8.0%	4.2%	4.5%	7.7%	4.2%	33.3%
Turnaround time for radiology results following test (within 72 hours)	All	80%	30.6%	24.6%	26.9%	26.8%	29.8%	40.9%	33.5%	31.2%	27.6%	25.0%	30.4%	27.6%	30.2%	27.6%	29.7%
	CT		18.8%	13.3%	16.8%	17.7%	15.5%	23.5%	19.3%	17.3%	8.3%	14.3%	8.8%	14.0%	13.0%	16.2%	15.7%
	MRI		16.7%	0.0%	0.0%	5.6%	7.7%	11.8%	0.0%	8.3%	5.6%	4.2%	0.0%	0.0%	7.7%	16.7%	4.5%
Turnaround time for pathology reports (within 7 days)		80%	92%	96%	97%	97%	99%	95%	99%	96%	96%	94%	88%	91%	78%	92%	84%
Endoscopy 2ww to be first seen within 8 days		80%	79.66%	76.60%	94.00%	89.09%	79.37%	75.93%	82.2%	57.50%	97.67%	79.66%	82.76%	73.68%	81.13%	88.89%	85.96%
All 2ww referrals to be first seen within 8 days		60% by end of March 16 80% by end of Q1	77.17%	75.00%	83.45%	86.65%	82.16%	77.30%	80.12%	68.79%	90.52%	78.40%	70.54%	73.03%	76.94%	90.77%	87.85%

South Tees Hospitals NHS FT Cancer Action Plan Baseline		
Transforming Diagnostics		
	Executive Lead: Simon Kendall	**Operational Lead: Deb Thornton, OPs Director**
Baseline Position	This is an integral part of the transforming clinical support workstream. Current performance: CT and MRI request to test within 5 days - 25%. Target > 80% CT and MRI test reported within 72 hours - 30% Target > 80% Timeframes and supporting initiatives to be agreed.	
Review of cancer information		
	Executive Lead: Ruth James, Director of Quality and Risk	**Operational Lead: Allison Davis, Head of information**
Baseline position	Review of information needed to support the MDTs and core services in understanding performance against agreed targets. Currently critical information is recorded as free text. No predictive waiting list tool. Multiple systems used to produce performance management data	
Management of late referrals (ensuring treated within 24 days)		
	Executive Lead: Ruth James, Director of Quality and Risk	**Operational Lead: Lauren Farrow, Performance Manager**
Baseline position	88% of 2ww referrals seen within 8 days, target >95% Majority of 2ww referral breaches are due to patient choice - work with CCGs	
Review of MDT process		
	Executive Lead: Angela Wood, strategic lead for cancer	**Operational Lead: TBC**
Baseline position	Standardisation of practice across MDTs is required to ensure that we are delivering an equitable service for all patients. Currently there are differing practices that could be introducing unnecessary delays into the system. 19% of patients are discussed at more than 3 separate MDT meetings. (Excluding Brain and CNS) Target to be agreed	
Surgical Capacity		

	Executive Lead: Davis Chadwick	**Operational Lead: Sandra Donoghue**
Baseline position	13% of breach reasons are surgical capacity. Actions to address this are within the Transforming Surgical Pathway Workstream	
Radiotherapy Capacity		
	Executive Lead: Mike Stewart	**Operational Lead: Sue Geldart**
Baseline position	TBC	
Oncology Capacity		
	Executive Lead: Mike Stewart	**Operational Lead: Sue Gledart**
Baseline position	Delays to first outpatient appointment identified (up to 21 days)	
Management of late referrals (ensuring treated within 24 days)		
	Executive Lead: Angela Wood, strategic lead for cancer	**Operational Lead:**
Baseline position	Baseline to be established when breach reallocation policy is agreed.	
Breast MDT		
	Executive Lead: TBC	**Operation Lead: MDT Lead**
Baseline position	97.4% against 62 day target	
Lung MDT		
	Executive Lead: TBC	**Operational Lead:** Dr V Dudzevicius
Baseline position	49.4 % against 62 day target. 72% seen within 8 days of referrals. Delays with OPA with surgeons (11 - 25 days)	
Colorectal MDT		
	Executive Lead: TBC	**Operational Lead:**Dr N Wadd
Baseline position	73.7% against 62 day target	

Upper GI MDT		
	Executive Lead: TBC	**Operational Lead:** Mr P Davis
Baseline position	67.9% against 62 day target	
Brain & CNS		
	Executive Lead: TBC	**Operational Lead:** Mr A Varma
Baseline position	100% against 62 day standards	
CUP		
	Executive Lead:	**Operational Lead:** Sr N Hand
Baseline position	88.9% (other) against 62 day standard	
Gynae		
	Executive Lead: TBC	**Operational Lead:** Mr J Twigg
Baseline position	77.8% against 62 day target. 52% of patients seen within 8 days of referral	
Haematology		
	Executive Lead: TBC	**Operational Lead:** Dr M David
Baseline position	86.7% against 62 day target. 66% of patients seen within 8 days of referral	
Skin		
	Executive Lead: TBC	**Operational Lead:** Mr H Siddiqui
Baseline position	96.2% against 62 day standard	
Urology		
	Executive Lead: TBC	**Operational Lead:** Mr D Chadwick
Baseline position	74.8% of 62 day target	
Head and neck MDG		
	Executive Lead: TBC	**Operational Lead:** Col. D Bryant
Baseline position	56% against 62 day target	