WOLVERHAMPTON CCG

GOVERNING BODY
11th July 2017

Agenda item 13

Title of Report:	**Summary – Wolverhampton Clinical Commissioning Group (WCCG) Finance and Performance Committee- 30th May 2017**
Report of:	Tony Gallagher – Chief Finance Officer
Contact:	Tony Gallagher – Chief Finance Officer
Governing Body Action Required:	☐ **Decision** ☒ **Assurance**
Purpose of Report:	To provide an update of the WCCG Finance and Performance Committee to the Governing Body of the WCCG.
Key Points:	• The CCG has submitted its draft accounts for 2016/17. All key national metrics have been met. • Performance information to Month 12 is enclosed. Exceptions are highlighted in the body of the report.
Recommendations:	• **Receive** and **note** the information provided in this report.
Public or Private:	This Report is intended for the public domain.
LINK TO BOARD ASSURANCE FRAMEWORK AIMS & OBJECTIVES:	

• Improving the quality and safety of the services we commission	Ensure on-going safety and performance in the system Continually check, monitor and encourage providers to improve the value for money of patient services ensuring that patients are always at the centre of all our commissioning decisions to ensure the right care is provided at the right time in the right place
• Reducing Health Inequalities in Wolverhampton	Improve and develop primary care in Wolverhampton – Delivering a robust financial management service to support our Primary Care Strategy to innovate, lead and transform the way local health care is delivered, supporting emerging clinical groupings and fostering strong local partnerships to achieve this Support the delivery new models of care that support care closer to home and improve management of Long Term Conditions by developing robust financial modelling and monitoring in a flexible way to meet the needs of the emerging New Models of Care.
• System effectiveness delivered within our financial envelope	Proactively drive our contribution to the Black Country STP by playing a leading role in the development and delivery of the Black Country STP Financial model to support material improvement in health and wellbeing for both Wolverhampton residents and the wider Black Country footprint. Greater integration of health and social care services across Wolverhampton Work closely with partners finance departments across the City to support the development and delivery of the emerging vision for transformation; including exploring the potential for an 'Accountable Care System.' Continue to meet our Statutory Duties and responsibilities Providing assurance that we are delivering our core purpose of commissioning high quality health and care for our patients that meet the duties of the NHS Constitution, the Mandate to the NHS and the CCG Improvement and Assessment Framework Deliver improvements in the infrastructure for health and care across Wolverhampton The CCG will work with our members and other key partners to encourage innovation in the use of technology, effective utilisation of the estate across the public sector and the development of a modern up skilled workforce across Wolverhampton.

1. FINANCE POSITION

The Committee noted that the final accounts had been submitted and the details of the surplus reported.

2. PERFORMANCE

The following tables are a summary of the performance information presented to the Committee;

Executive Summary - Overview

Mar-17

Performance Measures	Previous Mth	Green	Previous Mth	Red	Previous Mth	No Submission (blank)	Previous Mth	Target TBC *	Total
NHS Constitution	11	11	12	13	1	0	0	0	**24**
Outcomes Framework	7	11	10	8	18	16	2	2	**37**
Mental Health	22	24	7	7	4	2	0	0	**33**
Totals	**40**	**46**	**29**	**28**	**23**	**18**	**2**	**2**	**94**

Performance Measures	Previous Mth:	Green	Previous Mth:	Red	Previous Mth:	No Submission (blank)	Previous Mth:	Target TBC *
NHS Constitution	46%	46%	50%	54%	4%	0%	0%	0%
Outcomes Framework	19%	30%	27%	22%	49%	43%	5%	5%
Mental Health	67%	73%	21%	21%	12%	6%	0%	0%
Totals	**43%**	**49%**	**31%**	**30%**	**24%**	**19%**	**2%**	**2%**

* figures for Target TBC can vary month to month as the number of indicators not submitted (blank) for the month count will take priority. There are currently 4 indicators with targets yet to be agreed (2 of which had no data submitted for March 17)

Exception highlights were as follows;

Indicator Ref:	Title and Narrative	Yr End Target / Threshol

Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
91.50%	90.95%	91.04%	91.18%	90.45%	91.22%	90.30%	91.08%	90.11%	90.59%		91.00%	90.86%	92.00%

RWT_EB3

The performance data for headline level Referral To Treatment (RTT) Incompletes has been reported below the 92% target (91.00%) for March. The data for February was not submitted via the deadline, however has since been confirmed as 90.81%, this confirms the Year End performance as 90.85% and below target. When compared to the previous years performance, there has been a decrease in compliance (Mar 15/16 = 92.00% - 2,595 breaches out of 32,455, Mar16/17 = 91.00% - 2,927 breaches out of 32,512) with an overall increase in the number of patients on the waiting list of 57 (0.18% increase). The March data has since been validated via the National Unify2 submission as 91.00% seen within 18 weeks. Failing specialties include : Cardiology, ENT, T&O, General Surgery, Ophthalmology, Plastic Surgery, Oral Surgery and Urology. The Trust have confirmed that the March performance has seen a marginal improvement however has remained under threshold primarily as a result of the Easter period. There has been an increase in the number of Ophthalmology referrals due to capacity issues at Shrewsbury and Telford NHS Trust. This issue has been raised with NHSE as is impacting on the Royal Wolverhampton Trusts capacity and could impact on performance over the next few months. The Dermatology specialty is current achieving standard, however, multiple Dermatologists have submitted resignations which will impact the capacity of the service. Dermatology capacity has been logged on the CRM Action Log and the Trust is discussing options with the Commissioner. Close working with Directorate Managers continues regarding priority bookings for inpatients at 14-17 weeks on the waiting lists. Additional Orthodontic sessions continued throughout April to reduce the 52 week waiters backlog. A proposed staggered STF trajectory for 2017/18 (compliance by end of quarter 1) has been submitted and awaits NHSI signoff. The Trust has significantly reduced the backlog of incompletes within threshold (to prevent further patients breaching), however those that remain over threshold continue to impact on monthly performance. RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The Incompletes headline performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 92% with increased focus for RTT in three areas : Referral Diversion, Peer-to-Peer reviews and Musculoskeletal (MSK) Pathway Re-design.

Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
99.08%	99.19%	99.18%	99.01%	99.20%	99.00%	99.23%	97.59%	98.65%	98.67%	98.56%	98.65%	98.84%	99.00%

RWT_EB4

The performance for Diagnostic Tests has failed to meet the 99% target for the fifth consecutive month with March reporting at 98.65% (76 breaches out of 5650) with the YTD also failing target at 98.84%. The Trust sole Cardiac Consultant commenced Maternity leave in November and a locum consultant recruited, however has been unable to maintain the substantive consultants workload. The Trust attempted further recruitment but this has so far been unsuccessful. All diagnostic test areas were at 100% with the exception of Computed Tomography (CT) and Magnetic Resonance Imaging (MRI) scans which remain under target. The Trust confirmed at the Clinical Quality Review Meeting (CQRM) meeting held in April that they have seen an increased rate of referrals to the specialised CT and MRI Heart investigations due to a change in NICE guidance which has adversely impacted on overall performance. The Radiology Department continues to work closely with the Cardiac Directorate to utilise scan capacity. The Radiographers are aware of reporting issues and will flag any cases if they are deemed clinically more urgent - categories are : Inpatient (same day), Routine (within 6 weeks), Urgent (within 5 days), 62 Day Target (within 5 days) and Soon (within 2 weeks). Outsourcing of scans has been investigated, however as specialised scans require a consultant to be present during consultations this is not an option for all referrals. A mobile CT scanner is on site and routine scans are being displaced in order to create specialist capacity within the Radiology Department. The National verified figures have confirmed that breaches occurred in March for both MRI (27 breaches out of 1,211 - 97.77%) and CT scans (49 breaches out of 685 - 92.85%) and these were the only two test areas which performed below target during the reporting period. The Trust are confident that the backlog of diagnostic tests will be cleared by the end of May 2017 and compliant by the end of June 2017. As a Commissioner, the March performance calculates at 98.62% and below target with five patients waiting longer than 6 weeks :

MRI - 1 x Nuffield Health Wolverhampton (9wks), 1 x University Hospitals of Leicester (13wks).

Urodynamics - 1 x University Hospitals of Birmingham (7wks).

Echocardiography - 1 x Oxford University Hospitals (6wks), 1 x Sandwell and West Birmingham (6 wks).

The Diagnostic waiting list continues to be discussed at the monthly CQRM and CRM meetings, as part of the CCG Assurance Call Agenda with NHS England and as part of the Quality Requirements Operational Standards contract for 2017/18 (maintaining the 99% target).

Discussion Point : Escalation of Wolverhampton patients at other Trusts.

Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
85.08%	88.03%	91.61%	88.63%	90.32%	93.86%	92.33%	92.08%	91.47%	86.36%	89.71%	91.24%	90.06%	95.00%

RWT_EB5

The Month 12 performance has failed to achieve both the National target (Type 1 and All Types) and STF Trajectory of 95%, however has seen a 1.02% increase from the previous month's performance to 91.24% (90.06% YTD). The headline performance can be split into the following: Emergency Department New Cross - 85.65%, Walk In Centre - 100%, Cannock Minor Injury Unit (MIU) - 100% and Vocare - 91.24%. When compared to the previous year's performance, there has been an increase in compliance (Mar 15/16 - 90.32%, Mar 16/17 - 91.24%). Initial comparisons of attendance numbers between 15/16 and 16/17, show an 18.03% in-month increase for March and 16.23% for the full year, however, due to multiple changes (including opening of new Emergency Department, changes to GP Referral Pathways to A&E and commencement of the Vocare Urgent Care Centre) a direct comparison is not possible. Using the Type 1 attendances as an activity baseline, data shows that there has been a -3.15% decrease in attendances (Mar16 and Mar17) but a 3.31% increase YTD. The following graph below highlights changes to systems and pathways and the attendance numbers for 15/16 (Blue), 16/17 (Red) for All Types (solid line) and Type 1 (dashed line). The Graph shows the increase in all Type attendances following the commencement of Vocare and a direct correlation between increased A&E (from Nov 15) with reduction in AMU and EAU activity figures. The Trust and CCG continue to hold Urgent Care teleconferences (Exec to Exec) three times a week and the A&E Delivery Board meetings to review progress and manage performance. A revised trajectory has been submitted and is awaiting approval from NHS Improvement (NHSI) which would provide a staggered recovery to meet national recovery trajectory of 91% by September 2017 and full compliance of the 95% target by March 2018. The March A&E performance was raised at the April Clinical Quality Review Meeting (CQRM) and the Trust confirmed issues with 1st assessments have been linked to on-going staffing issues and reliance on locum staffing. The A&E performance continues to be discussed at the monthly CQRM and CRM meetings, as part of the CCG Assurance Call Agenda with NHS England, the A&E Delivery Boards and as part of the Quality Requirements and National Operational Standards contract for 2017/18. Early indications are that the April performance (2017/18) has seen an increase to 92.5%, however, this is awaiting validation by the Trust.

Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
79.88%	72.02%	81.36%	79.77%	75.63%	80.13%	70.00%	70.76%	80.41%	72.97%	77.98%	81.18%	76.84%	85.00%

RWT_EB12

The performance for March 2017 has seen a 3.21% increase and achieved 81.18% in-month which is the highest reported performance since June 2016, however this still remains below both the Sustainability and Transformation Fund (STF) trajectory and National target of 85%. The Trust have since confirmed via the Integrated Quality and Performance Report that there were 21 patients that breached target during March (7 x tertiary referrals - all received on or after day 42 of the pathway, 6 x capacity issues, 3 x patient initiated and 5 x complex pathways). Analysis by Cancer site confirms the breaches are relating to : Urology (5 breaches out of 20.5 - 75.61%), Colorectal (3 breaches out of 8 - 62.50%), Head & Neck (2.5 breaches out of 7 - 64.29%), Upper GI (2.5 breach out of 7 - 64.29%), Gynaecology (1.5 breaches out of 5.5 - 72.73% and Haematology (3 out of 6.5 - 53.85%). Other cancer site performance reported as follows : Skin (0 breaches out of 11.5 - 100%), Lung (0 breaches out of 7 - 100%) and Breast (0 out of 20 - 100%). The Trust have confirmed that excluding tertiary referrals performance for March reports at 83.72%. Weekly escalation meetings with Divisional Managers continue to review performance with the aim to identify bottlenecks. Recruitment within the service is on-going and an experienced CT and MRI Cardiology Consultant has been recruited which should provide a positive impact on the Diagnostics performance. A revised recovery trajectory has been submitted to NHSI which includes a commitment to achieve an 80% standard throughout 17/18 however this has been rejected and discussions are on-going. Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and March performance has been confirmed as 82.72% (16.5 patient breaching target out of 95.5) and therefore remains RED. The Month 12 performance was discussed at the March CQRM and CRM meetings with the Trust confirming that they have been in discussions with NHSI regarding the recovery trajectory. Early indications are that the April performance has seen a decrease to 77.40% and remains below target (RED).

The 62 Day Cancer waits continues to be a National issue and is to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 85%.

Discussion Point : Tertiary referrals received after day 42 of the pathway (or already breached standard).

Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers*

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
80.77%	96.88%	82.35%	84.00%	95.83%	76.92%	80.00%	95.65%	89.47%	85.71%	66.67%	90.00%	85.36%	90.00%

RWT_EB13

Performance in Month 12 has seen a significant positive increase from the previous month and has achieved the 90% target in-month (90.00%) for the first time since November. The YTD however remains below target at 85.36%. The SQPR submission indicated that there was 1 breach (out of 10 patients). Analysis of the Year on Year performance shows that the M12 performance is below that of 2015/16 for the same month (15/16 - 91.30%). The Trust have confirmed that this indicator is impacted by a small cohort of patients and is directly impacted by 62 Day urgent GP Referral to 1st definitive treatment performance issues. The Trust continue to schedule additional Saturday clinics for Urology. Weekly escalation meetings with Divisional Managers continue to review performance with the aim to identify bottlenecks. Recruitment within the service is on-going and an experienced CT and MRI Cardiology Consultant has been recruited which should provide a positive impact on the Diagnostics performance. Following the Cancer Review report (June17) the Trust have requested any further recommendations for service improvement from the Intensive Support Team (IST). Validated figures are received after the SQPR submission deadline as the final cancer figures are uploaded nationally 6 weeks after month end and March performance has been confirmed as 90.91% (1 patient breaching target out of 11) and therefore remains RED. The Month 12 performance was discussed at the March CQRM and CRM meetings with the Trust. Early indications are that the April performance has seen a positive increase to 94.74% and is therefore rated GREEN.

The 62 Day Cancer waits continues to be a National issue and is to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The performance remains as part of the Quality requirements National Operational Standards for 2017/18 with the threshold remaining at 90%.

Zero tolerance RTT waits over 52 weeks for incomplete pathways

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Threshold
0	0	100	64	53	51	49	23	23	25	24	10	422	0

RWT_EBS4

This indicator has breached the zero threshold for 52 week waiters as it continues to manage the outstanding long waiting Orthodontic patients following an in-depth review of waiting list practices. At the end of March, 10 patients were recorded as waiting over 52 weeks and the National Unify2 data has since confirmed that all the over 52 week waiters are Orthodontic patients. RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The Trust have confirmed that the original Orthodontic long waiters back log is nearing completion with the exception of 1 complex case who has been scheduled to be seen in May. The Trust recovery trajectory is set to clear all remaining long waiters by the end of June and they are confident that this will be achieved. At the CQRM meeting held in May, the April 2017 total remaining 52 week waiters was confirmed as 7, with the expectation that May will report 5 remaining patients. Validated National Data confirms the March total as 10 waiters over 52 weeks, all Orthodontics. As a commissioner, the CCG have 1 Trauma & Orthopaedic patient waiting over 52 weeks at the Royal Orthopaedic Hospital (Birmingham). RTT performance (including 52 Week Waiters and Referral Diversions) continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. The 52 week waiters performance remains as part of the Quality requirements Operational Standards for 2017/18 with the threshold remaining at zero per month.

Delayed Transfers - % occupied bed days - to exclude social care delays

2.54%	3.52%	2.43%	1.29%	2.46%	2.17%	1.13%	2.13%	2.18%	1.80%	2.61%	1.68%	2.16%

RWT_LQR3

The Delayed Transfers of Care (DToC) indicator is based on the proportion of delays by occupied bed days (excluding Social Care) and has achieved the 2.5% threshold both in-month (1.68%) and Year End (2.16%). The Trust have confirmed via the Integrated Quality and Performance Report (published and available from the Trust Public website) the total performance (including social care) is 5.26%. The National verified data (based on a monthly snapshot) indicates that the Trust Delayed Transfer rankings (where 1 = worst) as 121st (out of 230 organisations) for all delay types (a total of 30 patients delayed on the snapshot survey date), 183rd for NHS responsible delays (8 patients on the snapshot) and 88th (18 patients on the snapshot) for Social Care responsible delays (plus 4 patients on the snapshot responsible to both NHS and Social Care). The issue of delays was discussed at the April CQRM meeting with Staffordshire delays continuing to have significant impact on performance. As at the March 2017 National statistics submission, there were 8 Staffordshire (Local Authority responsible) patients classified as delayed (midnight snapshot only) at the Royal Wolverhampton Hospital, which equates to 26% of the Trusts delays, the full month delay days for all Staffordshire patients was 338 (27% of the Trust delay days). The Trust have indicated the following delay reasons for March:

39.5% - Delay Awaiting Assessment (prev 21.6% - Increase)
18.4% - Delay awaiting further NHS Care (prev 22.4% - decrease)
21.1% - Delay awaiting domiciliary package (prev 25.0% - decrease)
6.4% - Delay awaiting family choice (prev 12.9% - decrease)
1.8% - Delay awaiting equipment/adaptations (prev 7.8% - decrease)
0.9% - Delay awaiting public funding (prev 5.2% - decrease)

Delayed Transfers of Care continues to be discussed at the monthly CQRM and CRM meetings and as part of CCG Assurance Call Agenda with NHS England. Delays remain as part of the Local Quality Requirements Standard Contract for 2017/18 with the threshold reduced further and stretched from 2.5% to 2.0% by the end of Quarter 4. A threshold of 3.5% by September 2017 (combined NHS and Social Care related delays) has been agreed between the Royal Wolverhampton Hospital and Local Authority (stretched from 4.9% to 3.5%). A set of actions have been agreed to support this work and to achieve the threshold by September 2017.

Discussion Point : The Trust have identified the issue of Staffordshire patients as the predominant issue.

Percentage of all routine EIS referrals, receive initial assessment within 10 working days

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD	Target
50.00%	87.50%	100.00%	100.00%	92.86%	83.33%	90.00%	100.00%	90.00%	53.33%	100.00%	92.31%	86.61%	95.00%

BCPFT_LQGE05

This indicator has seen fluctuations in performance over the financial year and has failed to achieve the 95% target both in-month (92.31%) and YTD (86.61%). Performance relates to the proportion of Early Intervention Service (EIS) clients receiving an initial assessment within 10 working days and the March data refers to 13 clients in total, of which 1 client breached standard. The details of the breach have been shared with the CCG and confirms that the client cancelled initial appointments, and subsequently DNA'd (Did Not Attend) a further two appointments before being seen. The Trust have previously submitted a Remedial Action Plan (RAP), however this has yet to be agreed with the CCG. A review of the DNA policy for this service (in line with the Trusts Access Policy) has been requested by the CCG with a view to set out an action plan to help reduce the number of DNAs. The Trust have confirmed that the ability to meet this deadline is dependent on client choice and the team continue to offer 100% of referrals an appointment for assessment within the 10 day standard. This indicator is currently not part of the 2017/18 Local Quality Requirements schedule, however the 17/18 actions are to be agreed and discussed at the Clinical Quality Review Meeting (CQRM).

Delayed transfers of care to be maintained at a minimum level

Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
9.67%	13.22%	13.62%	14.00%	18.45%	18.55%	18.87%	23.09%	26.73%	10.38%	5.74%	5.57%	14.82%

BCPFT_LQGE11

The Delayed Transfers of Care (DTOCs) has been an on-going issue throughout the year, however the performance since January has seen a significant improvement with March reporting 5.57% against the 7.5% monthly threshold . The performance relates to the total number of delay days for the month (76) over the total number of occupied bed days excluding leave for the month (1324) and is based on the Provider total (all Commissioners) and currently cannot be split by individual commissioner. When compared to the previous years performance, there has been an increase in compliance (Mar 15/16 = 9.85%, Mar 16/17 = 5.57%). Following previous attendance requests from the Wolverhampton CCG Head of Quality & Risk , the Local Authority have attended the CQRM meeting for a dedicated discussion of actions to address the DTOC issues since January 2017. Difficulties have included the acknowledgment of differences between Social Care and Health DTOC definitions and processes, and the discussions and subsequent actions via the joint meeting has shown an immediate improvement in performance. As delayed discharges remain a National issue, performance will monitored via the 2017/18 Local Quality Requirements contract and remain an agenda item on both the CCG's monthly performance call with NHS England (NHSE) and the Trusts CQRM meetings. The graph below shows the Year End proportion of delays by delay category (category sections identified by Grey labelled columns) and responsibility (stacked columns). The graph identifies highest areas of delays YTD : NHS responsible = Housing delays (16 out of 57 delays), Social Care = Nursing Home (29 out of 97 delays).

3. Contract and Procurement Report

The Committee received the latest overview of contracts and procurement activities. The draft proposal setting out the CCG's expectation for MRET/readmissions/fines business cases was considered and approved.

4. Risks

Breaches in performance and increases in activity will result in an increase in costs to the CCG. Performance must be monitored and managed effectively to ensure providers are meeting the local and national agreed targets and are being managed to operate within the CCG's financial constraints. Activity and Finance performance is discussed monthly through the Finance and Performance Committee Meetings to provide members with updates and assurance of delivery against plans.

A decline in performance can directly affect patient care across the local healthcare economy. It is therefore imperative to ensure that quality of care is maintained and risks mitigated to ensure patient care is not impacted. Performance is monitored monthly through the Finance and Performance Committee and through the following committees; including Clinical Quality Review Meetings, Contract Review Meetings and Quality and Safety Committee.

The CCG continues to have a challenging financial position for 17/18 with a number of factors outside of its direct control that could impact on its ability to deliver its financial targets. The QIPP programme for the year is substantial and the management team will continue to closely manage the delivery agenda.

5. RECOMMENDATIONS

Receive and **note** the information provided in this report.

Name: **Lesley Sawrey**
Job Title: **Deputy Chief Finance Officer**
Date: **31.5.17**

Performance Indicators 16/17

Current Month: Mar

Key:

(based on if indicator required to be either Higher or Lower than target/threshold)

- Improved Performance from previous month
- Decline in Performance from previous month
- Performance has remained the same

16-17 Reference	Description - Indicators with exception reporting highlighted for info	Provider	Target	Latest Month Performance	In Mth RAG	YTD Performance	YTD RAG	Variance between Mth	Trend (null submissions will be blank) per Month A M J J A S O N D J F M Yr End
RWT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	RWT	92%	91.00%	R	90.86%	R		
RWT_EB4	Percentage of Service Users waiting 6 weeks or more from Referral for a diagnostic test*	RWT	99%	98.65%	R	98.84%	R	↑	
RWT_EB5	Percentage of A & E attendances where the Service User was admitted, transferred or discharged within 4 hours of their arrival at an A&E department*	RWT	95%	91.24%	R	90.06%	R	↑	
RWT_EB6	Percentage of Service Users referred urgently with suspected cancer by a GP waiting no more than two weeks for first outpatient appointment*	RWT	93%	95.83%	G	93.89%	G	↑	
RWT_EB7	Percentage of Service Users referred urgently with breast symptoms (where cancer was not initially suspected) waiting no more than two weeks for first outpatient appointment*	RWT	93%	95.35%	G	95.62%	G	↑	
RWT_EB8	Percentage of Service Users waiting no more than one month (31 days) from diagnosis to first definitive treatment for all cancers*	RWT	96%	96.02%	G	95.99%	R	↓	
RWT_EB9	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is surgery*	RWT	94%	82.50%	R	83.58%	R	↑	
RWT_EB10	Percentage of Service Users waiting no more than 31 days for subsequent treatment where that treatment is an anti-cancer drug regimen*	RWT	98%	98.11%	G	99.59%	G	↓	
RWT_EB11	Percentage of Service Users waiting no more than 31 days for subsequent treatment where the treatment is a course of radiotherapy	RWT	94%	94.29%	G	97.38%	G	↓	
RWT_EB12	Percentage of Service Users waiting no more than two months (62 days) from urgent GP referral to first definitive treatment for cancer*	RWT	85%	81.18%	R	76.84%	R	↑	
RWT_EB13	Percentage of Service Users waiting no more than 62 days from referral from an NHS screening service to first definitive treatment for all cancers*	RWT	90%	90.00%	G	85.36%	R	↑	
RWT_EBS1	Mixed sex accommodation breach	RWT	0	0.00	G	4.00	R	→	
RWT_EBS2	All Service Users who have operations cancelled, on or after the day of admission (including the day of surgery), for non-clinical reasons to be offered another binding date within 28 days, or the Service User's treatment to be funded at the time and hospital of the Service User's choice*	RWT	0	0.00	G	0.00	G	→	
RWT_EAS4	Zero tolerance methicillin-resistant Staphylococcus aureus*	RWT	0	0.00	G	0.00	G	→	
RWT_EAS5	Minimise rates of Clostridium difficile	RWT	3 (11 mths) 2 (mth 12) 35 (Yr End)	3.00	R	45.00	R	↓	
RWT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	RWT	0	10.00	R	422.00	R	↑	
RWT_EBS7a	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 30 minutes	RWT	0	86.00	R	985.00	R	↑	
RWT_EBS7b	All handovers between ambulance and A & E must take place within 15 minutes with none waiting more than 60 minutes	RWT	0	7.00	R	178.00	R	↑	
RWT_EBS5	Trolley waits in A&E not longer than 12 hours	RWT	0	0.00	G	0.00	G	→	
RWT_EBS6	No urgent operation should be cancelled for a second time*	RWT	0	0.00	G	0.00	G	→	
RWTCB_S10C	VTE risk assessment: all inpatient Service Users undergoing risk assessment for VTE, as defined in Contract Technical Guidance	RWT	95%	96.49%	G	95.92%	G	↓	
RWTCB_S10B	Duty of candour	RWT	Yes	Yes	G	-	R	↓	
RWTCB_S10D	Completion of a valid NHS Number field in mental health and acute commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	99.00%	99.87%	G	99.74%	G	↓	
RWTCB_S10E	Completion of a valid NHS Number field in A&E commissioning data sets submitted via SUS, as defined in Contract Technical Guidance	RWT	95.00%	98.90%	G	97.97%	G	↑	
RWT_LQR1	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all wards excluding assessment units.	RWT	95.00%	93.28%	R	93.33%	R	↑	
RWT_LQR2	Electronic discharge summary to be fully completed and dispatched within 24 hours of discharge for all assessment units [e.g. PAU, SAU, AMU, AAA, GAU etc.]	RWT	95.00%	81.20%	R	82.21%	R	↑	
RWT_LQR3	Delayed Transfers - % occupied bed days - to exclude social care delays	RWT	Q1 - 3.5% Q2 - 3.2% Q3 - 2.8% Q4 - 2.5%	1.68%	G	2.16%	G	↑	
RWT_LQR4	Serious incident (SI) reporting – SIs to be reported no later than 2 working days after the incident is identified.	RWT	0	0.00	G	8.00	R	→	
RWT_LQR5	Serious incident (SI) reporting – 72 hour review to be undertaken and uploaded onto the STEIS system by the provider (offline submission may be required where online submission is not possible).	RWT	0	0.00	G	7.00	R	→	
RWT_LQR6	Serious incident reporting - Share investigation report and action plan, all grades within timescales set out in NHS Serious Incident Framework. 60 working days of the incident being identified unless an independent investigation is required, in which case the deadline is 6 months from the date the investigation commenced.	RWT	0	1.00	R	15.00	R	↑	
RWT_LQR7	Number of cancelled operations - % of electives	RWT	0.80%	0.35%	G	0.42%	G	↓	
RWT_LQR8	Hospital GSF - % patients recognised as end of life are on the GSF register within the hospital.	RWT	95.00%	100.00%	G	100.00%	G	→	
RWT_LQR11	Completion of electronic CHC Checklist	RWT	TBC	95.45%		91.13%	Awaiting Target	↑	
RWT_LQR13	Maternity - Antenatal - % of women booked by 12 weeks and 6 days	RWT	90.00%	90.90%	G	90.45%	G	↑	

RWT_LQR14	Stroke - Percentage of patients who spend at least 90% of their time on a stroke unit	RWT	80.00%	87.50%	G	89.40%	G	↓	
RWT_LQR15	Stroke - Percentage of higher risk TIA cases are assessed and treated within 24 hours	RWT	60.00%	78.26%	G	71.16%	G	↑	
RWT_LQR17	Best practice in Day Surgery - outpatient procedures - % of Day case procedures that are undertaken in an Outpatient setting	RWT	90.00%	94.00%	G	94.37%	G	↓	
RWT_LQR18ai	Optimising Outpatient Follow-Ups - 2015/16 - Prostate cancer patients receiving telephone follow up clinic: Prostate Biopsy Follow up ≥ 4 patients per month	RWT	4	2.00	R	67.00	G	→	
RWT_LQR18aii	Optimising Outpatient Follow-Ups - 2015/16 - Prostate cancer patients receiving telephone follow up clinic: Prostate Cancer Follow up ≥ 17 patients per month	RWT	17	23.00	G	438.00	G	↓	
RWT_LQR18c	Optimising Outpatient Follow-Ups - Gynaecology Nurse Led Clinic – patients followed up in nurse led clinics for the management and implantation of pessaries instead of in a consultant clinic ≥ 50 per month	RWT	50	8.00	G	90.00	R	↓	
RWT_LQR19a	Dressings - % formulary and exception compliance	RWT	98.00%	99.37%	G	99.44%	G		
RWT_LQR19b	Dressings - % spend via non FP10 supply route	RWT	98.00%	99.51%	G	99.49%	G		
RWT_LQR20	% Patients in receipt of TTOs within 4hours from the pharmacy receiving order	RWT	TBC	96.17%		96.92%	Awaiting Target	↓	
RWT_LQR24a	Dementia – FAIR - Percentage of patients aged 75 years and over to whom case finding is applied following an episode of emergency, unplanned care to hospital.	RWT	90.00%	76.24%	R	92.17%	G	↓	
RWT_LQR24b	Dementia – FAIR - Percentage of patients aged 75 years and over admitted as emergency inpatients identified as potentially having dementia or delirium who are appropriately assessed.	RWT	90.00%	100.00%	G	100.00%	G	→	
BCPFT_EB3	Percentage of Service Users on incomplete RTT pathways (yet to start treatment) waiting no more than 18 weeks from Referral*	BCP	92.00%	98.31%	G	98.44%	G	↓	
BCPFT_EBS1	Mixed sex accommodation breach	BCP	0.00	0.00	G	0.00	G	→	
BCPFT_EBS3	Care Programme Approach (CPA): The percentage of Service Users under adult mental illness specialties on CPA who were followed up within 7 days of discharge from psychiatric in-patient care*	BCP	95.00%	96.67%	G	96.64%	G	↑	
BCPFT_EBS4	Zero tolerance RTT waits over 52 weeks for incomplete pathways	BCP	0.00	0.00	G	0.00	G	→	
BCPFT_DC1	Duty of Candour	BCP	Yes	Yes	G	-	G		
BCPFT_IAPT1	Completion of IAPT Minimum Data Set outcome data for all appropriate Service Users, as defined in Contract Technical Guidance	BCP	90.00%	100.00%	G	100.00%	G	→	
BCPFT_EH4	Early Intervention in Psychosis programmes: the percentage of Service Users experiencing a first episode of psychosis who commenced a NICE-concordant package of care within two weeks of referral	BCP	50.00%	50.00%	G	62.36%	G	↓	
BCPFT_EH1	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within six weeks of referral	BCP	75.00%	91.77%	G	92.32%	G	↓	
BCPFT_EH2	Improving Access to Psychological Therapies (IAPT) programmes: the percentage of Service Users referred to an IAPT programme who are treated within 18 weeks of referral	BCP	95.00%	100.00%	G	99.60%	G	→	
BCPFT_LQGE01a	Proportion of Patients accessing MH services who are on CPA who have a crisis management plan (people on CPA within 4 weeks of initiation of their CPA)	BCP	90.00%	100.00%	G	100.00%	G	→	
BCPFT_LQGE01b	Percentage of inpatients with a Crisis Management plan on discharge.	BCP	100.00%	100.00%	G	99.51%	R	→	
BCPFT_LQGE02	Percentage of EIS caseload have crisis / relapse prevention care plan	BCP	80.00%	89.36%	G	89.24%	G	↓	
BCPFT_LQGE03	Meeting commitment to serve new psychosis cases by early intervention teams. Quarterly performance against commissioner contract. Threshold represents a minimum level of performance against contract performance rounded down. (Monitor definition 11)	BCP	44.00	47.00	G	47.00	G	↑	
BCPFT_LQGE04	More than 50% of people experiencing a first episode of psychosis will be treated with a NICE approved care package within two weeks of referral	BCP	50.00%	50.00%	G	62.36%	G	↓	
BCPFT_LQGE05	Percentage of all routine EIS referrals, receive initial assessment within 10 working days	BCP	95.00%	92.31%	R	86.61%	R	↓	
BCPFT_LQGE06	IPC training programme adhered to as per locally agreed plan for each staff group. Compliance to agreed local plan. Quarterly confirmation of percentage of compliance	BCP	85.00%	83.38%	R	89.88%	G	↓	
BCPFT_LQGE07	Psychosis Medication Review - Percentage who have been prescribed and administered antipsychotic treatments for >12 months that have had an antipsychotic medications review in the previous 12 months.	BCP	85.00%	100.00%	G	100.00%	G	↑	
BCPFT_LQGE08	% compliance with local antibiotic prescribing formulary, including if there is evidence of justifiable clinical reasons for deviation from set formulary. Minimum of annual confirmation of % of compliance with the antibiotic formulary. To submit the EPACT antibiotic prescribing data to commissioners. Results to be presented to Health Protection Board. Adverse trends in unavoidable antibiotic consumption.	BCP	95.00%	100.00%	G	100.00%	G	↑	
BCPFT_LQGE09	Evidence of using HONOS: Proportion of patients with a HONOS score	BCP	95.00%	95.86%	G	95.75%	G	↑	
BCPFT_LQGE10	Proportion of patients referred for inpatient admission who have gatekeeping assessment (Monitor definition 10)	BCP	95.00%	100.00%	G	100.00%	G	→	
BCPFT_LQGE11	Delayed transfers of care to be maintained at a minimum level	BCP	7.50%	5.57%	G	14.82%	R	↑	
BCPFT_LQGE12	Emergency up to 4 hours. % of assessments relating to referral within period	BCP	85.00%	95.31%	G	90.47%	G	↑	
BCPFT_LQGE13	Urgent (up to 48 hours). % of assessments relating to referral within period	BCP	85.00%	91.89%	G	86.85%	G	↑	
BCPFT_LQGE14	Routine (up to 28 days). % of assessments relating to referral within period	BCP	85.00%	91.07%	G	98.05%	G	↓	
BCPFT_LQGE15	Percentage of SUIs that are reported onto STEIS within 2 working days of notification of the incident	BCP	100.00%	100.00%	G	100.00%	G	→	
BCPFT_LQGE16	Update of STEIS at 3 working days of the report. The provider will keep the CCG informed by updating STEIS following completion of 48 hour report (within 72 hours of reporting incident on STEIS). CCG will do monthly data checks to ensure sufficient information has been shared via STEIS and report back to CQRM.	BCP	100.00%	100.00%	G	98.81%	R	→	
BCPFT_LQGE17	Provide commissioners with Grade 1 and Grade 2RCA reports within 60 working days where possible, exception report provided where not met	BCP	100.00%	100.00%	G	100.00%	G	→	
BCPFT_DB01	Safeguarding – failure to achieve thresholds for specific indicators as detailed in the Safeguarding Dashboard.	BCP	Yes	Yes	G	-	R		
BCPFT_DB02	CAMHS - failure to achieve thresholds for specific indicators as detailed in the CAMHS Dashboard.	BCP	Yes	Yes	G	-	R		
BCPFT_DB03	IAPT – failure to achieve thresholds for specific indicators as detailed in the IAPT Dashboard.	BCP	Yes	Yes	G	-	G		
BCPFT_DB04	Dementia Data Set – failure to complete the Dementia Data Set	BCP	Yes	Yes	G	-	G		