Imperial College Healthcare NHS Trust

Trust board - public

Agenda Item	2.3
Title	Operational Report and Scorecard
Report for	For noting
Report Author	Steve McManus, Chief Operating Officer
Responsible Executive Director	Steve McManus, Chief Operating Officer

Executive Summary: This is a regular report to the Trust Board and outlines the key operational headlines that relate to the reporting month of June 2015. This report has been updated to reflect feedback from both Executive and Non-Executive Board members.

Recommendation(s) to the Trust board:

The Trust board is asked to note the contents of this report.

Trust strategic objectives supported by this paper:

- To achieve excellent patient experience and outcomes, delivered efficiently and with compassion;
- To educate and engage skilled and diverse people committed to continual learning and improvement;
- As an Academic Health Science Centre, to generate world leading research that is translated rapidly into exceptional clinical care; &
- To pioneer integrated models of care with our partners to improve the health of the communities we serve.

Imperial College Healthcare NHS Trust

Trust Board Performance Report

Report Period Month 3 (to end June 2015)

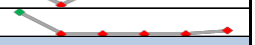
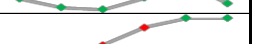
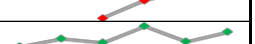
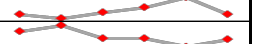
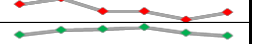
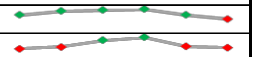
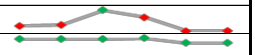
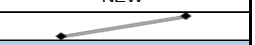
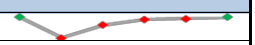
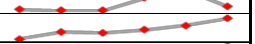
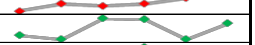
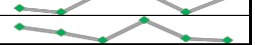
Trust Board, Wednesday 29th July 2015

Imperial College Healthcare NHS
NHS Trust

1 Table of Contents

Imperial College Healthcare NHS Trust

2 Scorecard Summary

Pg	Metric	Period	Standard	Performance	Direction of Travel
	Safe				
5	Serious Incidents (S.I.s)	Jun-15	0	14	
6	Staffing fill rates		tbc	96.75%	
7	MRSA		0	0	
7	Clostridium difficile		5	7	
	Effective				
8	Hospital Standardised Mortality Ratio (HSMR)	Qtr 3 14/15	100	67.06	
8	Percentage of interventional studies which recruited 1st patient within 70 days of Valid Research Application	Qtr 3 14/15	70%	71.20%	
9	Harm Free Care (Safety Thermometer)	Jun-15	90%	97.0%	
9	30 day readmissions		tbc	6.43%	
10	Average length of Stay (elective)		3.4	3.66	
11	Average length of stay (non-elective)		4.5	4.8	
11	Activity: First Outpatient	May-15	27,337	27,776	
11	Activity: Follow-up Outpatient		45,300	44,830	
12	Activity: Daycase		6,433	6,001	
12	Activity: Elective Inpatient		1,752	1,335	
12	Activity: Non-elective Inpatient		8,286	8,895	
12	Activity: Adult Critical Care		3,561	3,227	
12	Activity: Regular Day Attender		270	1,099	
	Caring				
14	Mixed-Sex Accommodation	Jun-15	0	0	
15	Friends and Family Test - Inpatients		95%	97.00%	
15	Friends and Family Test - A&E		85%	91.00%	
16	Complaints (total number received)		100	106	
	Well Led				
16	Vacancy rate (%)	Jun-15	10.0%	11.6%	
16	Sickness absence rate (%)		3.4%	3.0%	
17	Statutory and mandatory training excl. doctors in training / Trust grades (%)		95.0%	82.0%	
17	Statutory and mandatory training - doctors in training / Trust grades (%)		95.0%	63.0%	
18	Consultant appraisal rate (%)		95.0%	86.0%	
18	Band 2-9 & VSM PDR rate		95.0%	27.0%	
19	Health and Safety RIDDOR		0	3	
19	Open actions relating to GMC surveys, quality and monitoring visits		tbc	No Data	NEW
20	Staff engagement score		tbc	44	
	Responsive		0		
22	18 Weeks Incomplete (%)	Jun-15	92.0%	92.1%	
22	18 weeks Incomplete (number)		tbc	4,367	
22	52 Weeks Waits (Number)		0	2	
23	Number of diagnostic tests waiting longer than 6 weeks (%)		1.0%	2.0%	
24	A&E Type 1 Performance (%)		95.0%	89.0%	
24	A&E All Types Performance (%)		95.0%	95.4%	
25	Two week GP referral to 1st outpatient, cancer (%)	May-15	93.0%	94.1%	
25	Two week GP referral to 1st outpatient – breast symptoms (%)		93.0%	93.1%	
25	31 day wait from diagnosis to first treatment (%)		96.0%	97.4%	
25	31 day second or subsequent treatment (surgery) (%)		94.0%	97.3%	
25	31 day second or subsequent treatment (drug) (%)		98.0%	98.8%	
25	31 day second or subsequent treatment (radiotherapy) (%)		94.0%	98.7%	
25	62 day urgent GP referral to treatment for all cancers (%)		85.0%	76.4%	
25	62 day urgent GP referral to treatment from screening (%)		90.0%	88.0%	
26	New Outpatient DNA rate (%)	Jun-15	12.3%	13.9%	
26	Follow-up Outpatient DNA rate (%)		11.3%	12.6%	
27	Hospital initiated outpatient cancellation rate (%)		tbc	6.7%	

3 Indicator Overviews

3.1 Safety

3.1.1 Safety: Serious Incidents (SIs)

14 serious incidents were reported in June 2015. The year to date total is 24, compared to 18 for Q1 last year. The average number of SIs per month in 2014/15 was 12. We continue to review each case.

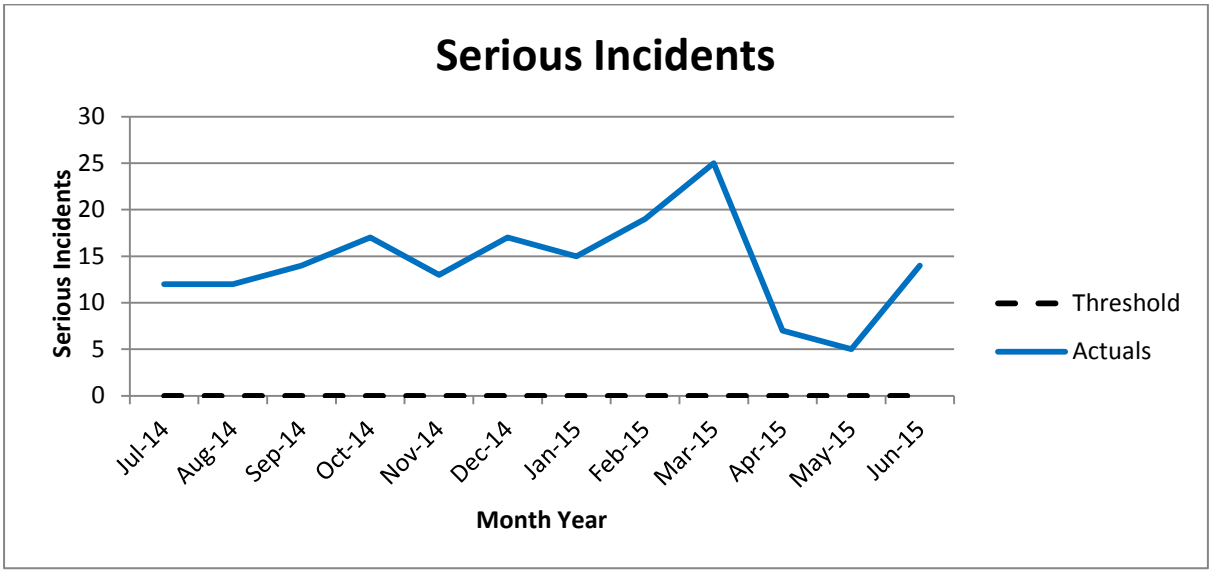


Figure 1 - Number of Serious Incidents (SIs) by month for the period July 2014 – June 2015

3.1.2 Safety: Nurse / Midwife staffing levels

In June the Trust reported the following for the average staffing fill rate:

- Above 95 per cent for registered nursing/midwifery and care staff during the day and night.

Please refer to Appendix 1 for ward level detail.

The month of June saw a sustained improvement in performance. This is due to a reduction in vacancies and an increase in the bank fill rate. There were a very small number of ward areas where the fill rate was below 85 per cent for care staff. Key reasons for this are:

- Small numbers of unfilled shifts in some areas e.g. A8 and Douglas ward which has shown a bigger impact on the overall fill rate for that area; &
- The acuity of patients particularly on medical wards such as AMU which has resulted in requesting additional staff for patients who require specialling. Where additional shifts have not been filled, this has impacted on the fill rates for these areas

On these occasions senior nurses have made decisions to mitigate any risk to patient safety by undertaking the following:

- The ward manager/sister working clinically within the numbers;
- Increasing the compliment of registered staff where there has been a reduced fill rate for care staff;
- Monitoring progress against recruitment and vacancy reduction plans
- Reviewing staffing on a daily basis;
- Adjusting the occupancy to ensure patient needs are met by the staff that are available; &
- Redeploying staff from other areas, where possible.

Divisional Directors of Nursing have confirmed that the levels of care provided during June were safe.

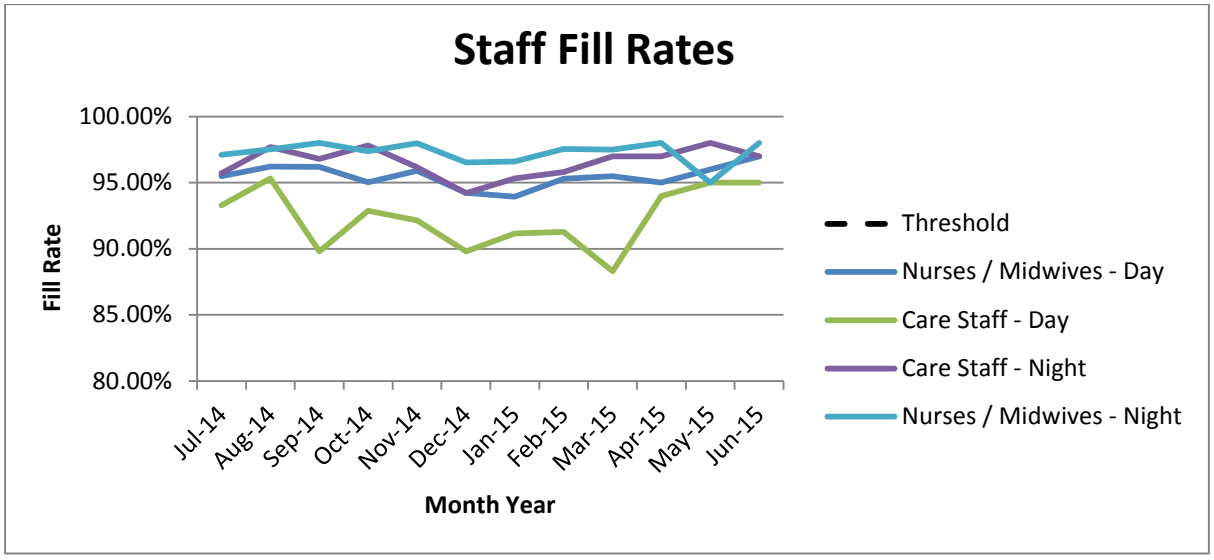


Figure 2 – Staff fill rates by month for the period July 2014 – June 2015

3.1.3 Safety: Meticillin resistant Staphylococcus aureus bloodstream infections (MRSA BSI)

No Trust-attributable cases of MRSA BSI occurred in June 2015.

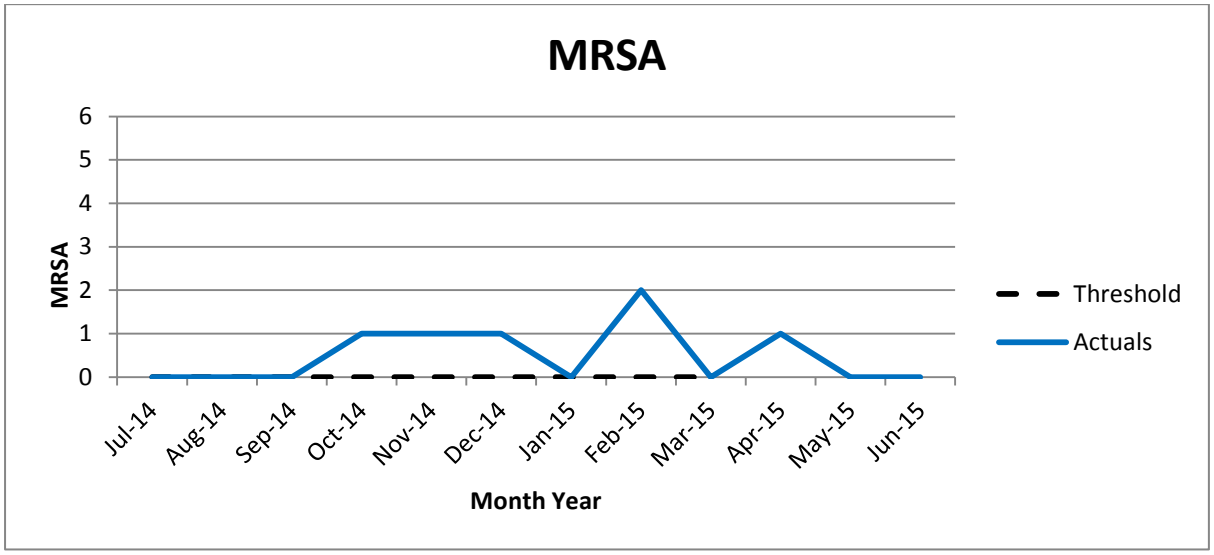


Figure 3 - Number of MRSA (b) infections by month for the period July 2014 – June 2015

3.1.4 Safety: Clostridium difficile

Seven cases of C. Difficile were allocated to the Trust for June 2015. One of these has been identified as a potential lapse of care because two cases had crossing pathways. In another one the ribotype was untypable so we are unable to determine whether transmission took place.

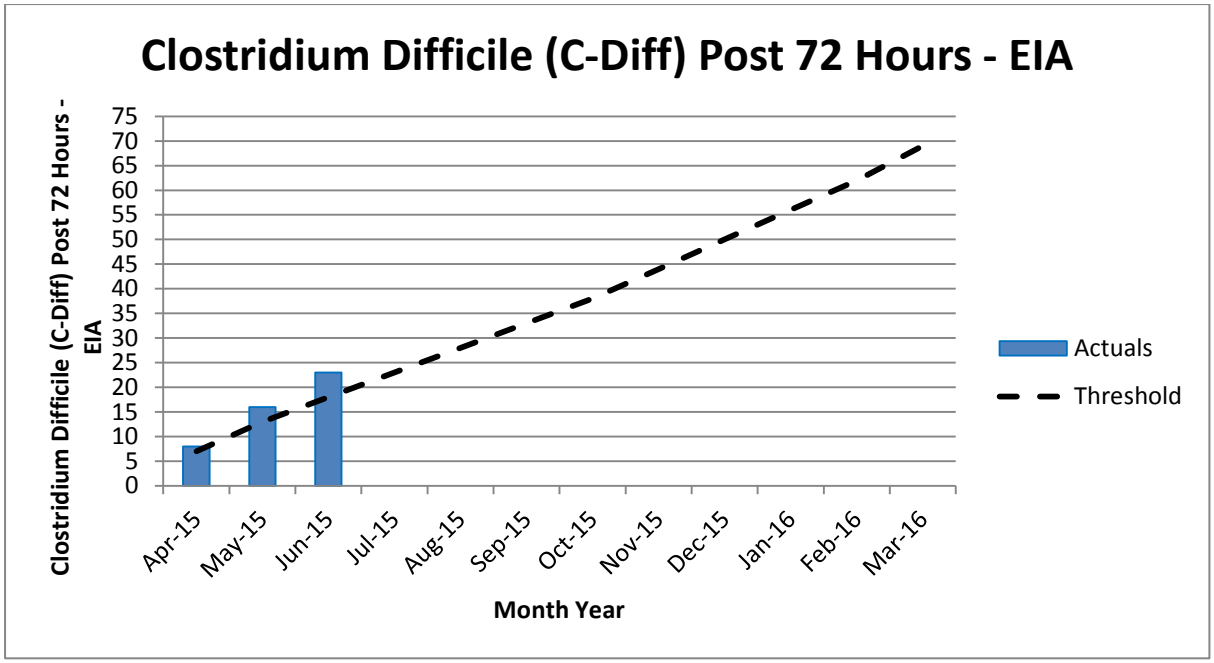


Figure 4 - Number of Clostridium Difficile infections above cumulative plan by month for the period April 2015 – March 2016

3.2 Effectiveness

3.2.1 Effectiveness: Mortality Data

As described in our quality strategy, we are introducing a standardised system to ensure a multi-disciplinary review of all deaths that occur in our hospitals. This will be reported on Datix and will be reviewed at the Medical Director's Incident Review panel. We anticipate that the process will be in place by December 2015; however, we will begin to report initial baseline data relating to the percentage of deaths currently reviewed by a multi-disciplinary team from next month.

The Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures the number of deaths in the Trust, that occur during the patients' stay at the Trust, and is adjusted for a variety of factors (i.e. age, poverty, treatments offered).

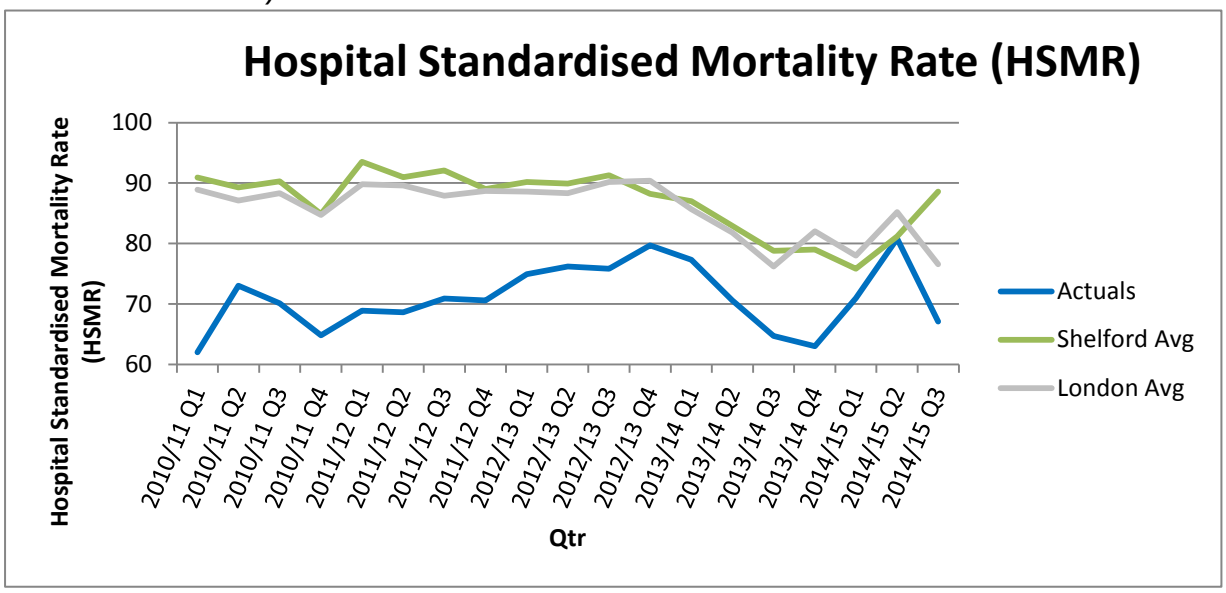


Figure 5 - Hospital Standardised Mortality Ratios for the period Q1 2010/11 to Q3 2014/15

3.2.2 Effectiveness: Recruitment of patients into interventional studies

Finalised data for Q4 will be available in August 2015. Preview data suggests that the Trust performance agains the 70-day benchmark is close to 80 per cent.

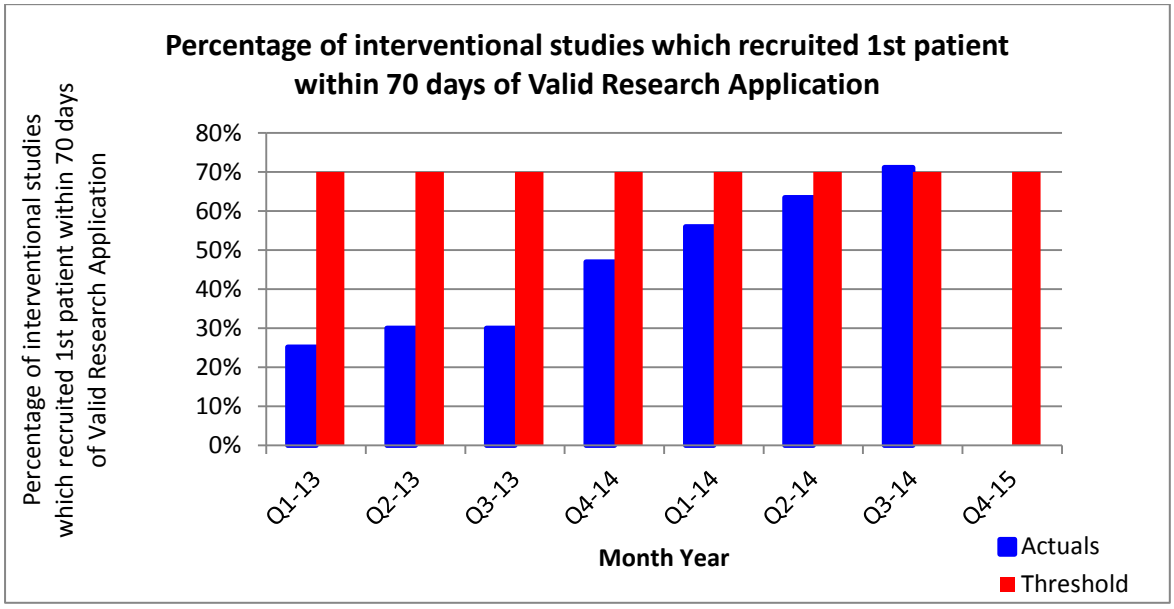


Figure 6 - Interventional studies which recruited First patient within 70 days of Valid Application Q1 2013/14 – Q4 2014/15

3.2.3 Effectiveness: Harm Free Care (Safety Thermometer)

The Trust continues to excel in ensuring our patients experience Harm Free Care during their inpatient stays, with uninterruptedly higher scores than both the London and Shelford average.

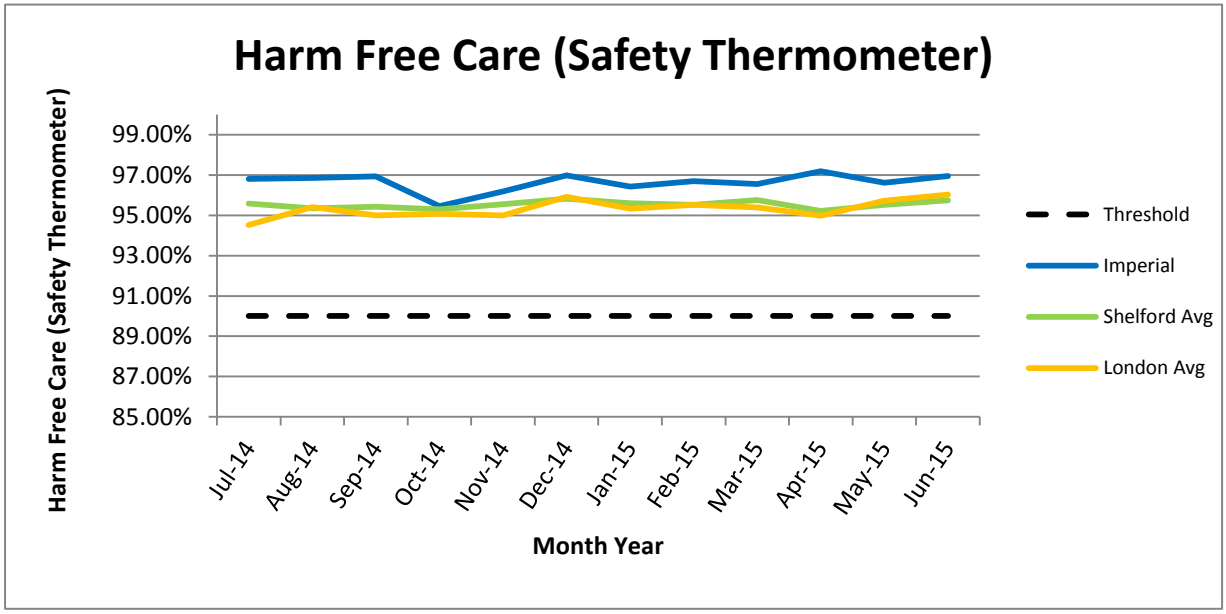


Figure 7 – Harm Free Care (Safety Thermometer) July 2014 – June 2015

3.2.4 Effectiveness: 30 Day Readmissions

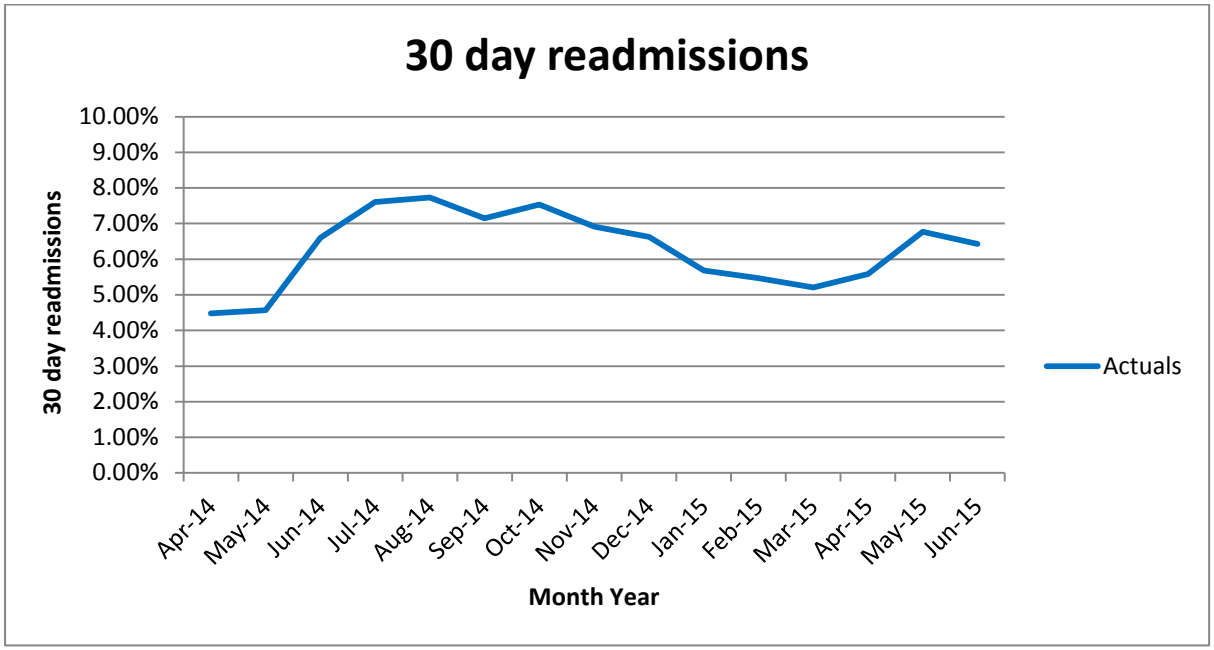


Figure 8 - 30 day readmissions for the period April 2014 - June 2015

3.2.5 Effectiveness: Average Length of Stay

An initial analysis into the increase in the length stay for patients on an elective pathway has highlighted various data quality issues that were artificially inflating the reported position. For example:

i) Historic incorrect entry of day case activity as zero day length of stay. Improvements in reporting has decreased the denominator for this indicator, which is thus reflected as an increase in the overall length of stay;

ii) Focus on correcting data regarding extreme outliers (e.g. a 290 day stay within Endoscopy). The Discharge team is leading this work and working with the Divisions to rectify this information on a live basis;

iii) A number of patients' admission date were recorded with the previous year. It is proving difficult to retrospectively amend this data, although options are currently being explored; &

iv) The split of the length of stay data into elective and non-elective has contributed to the increase in the reported position for the elective length of stay. This has now improved.

A working collective has been formed between the site, information, and performance teams in order to rectify these issues.

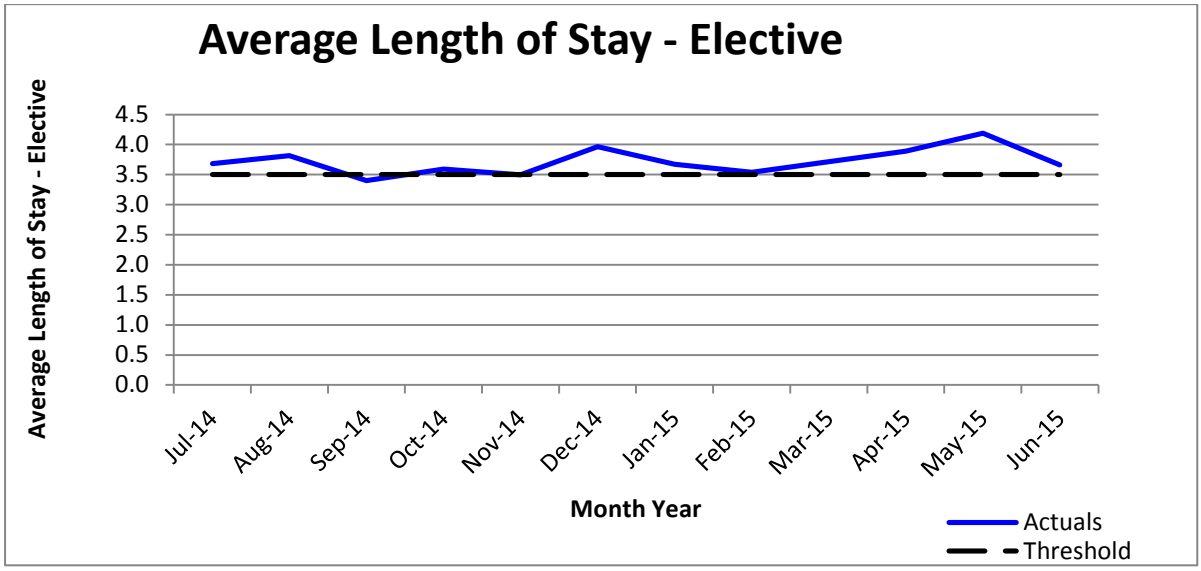


Figure 9 – Average Length of Stay – Elective for the period July 2014 – June 2015

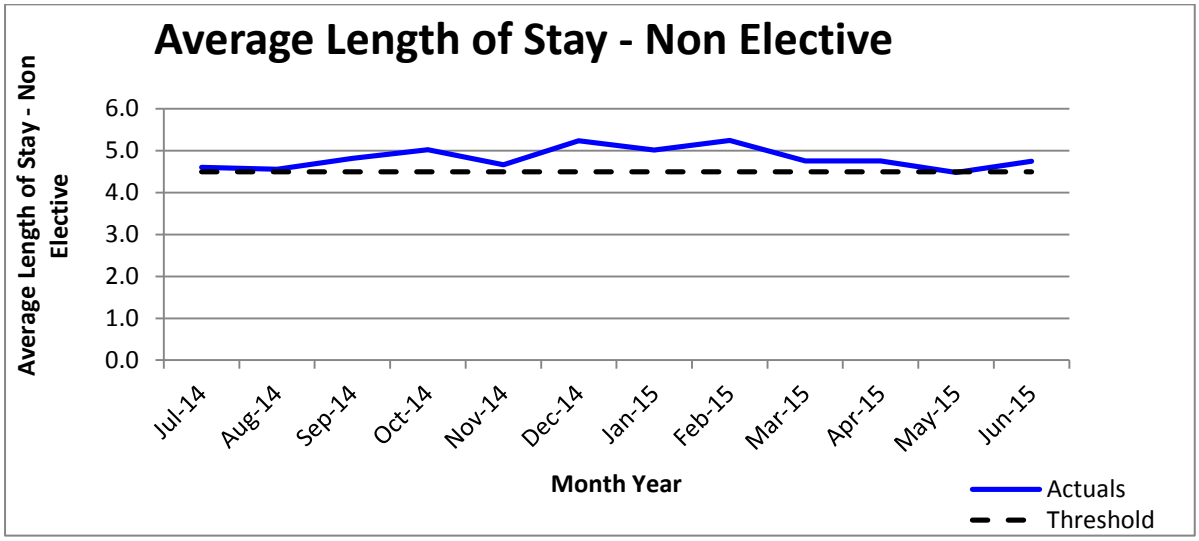


Figure 10 – Average Length of Stay – Non-Elective for the period July 2014 – June 2015

3.2.6 Effectiveness: Activity data

This is the first time that this activity data has been presented in the Operational Report to the Trust Board. Plans are in place to operationalise a regular review with the Finance, Operational, and Corporate teams. The analysis of these indicators will drive data quality improvement to ensure the correct depth of coding.

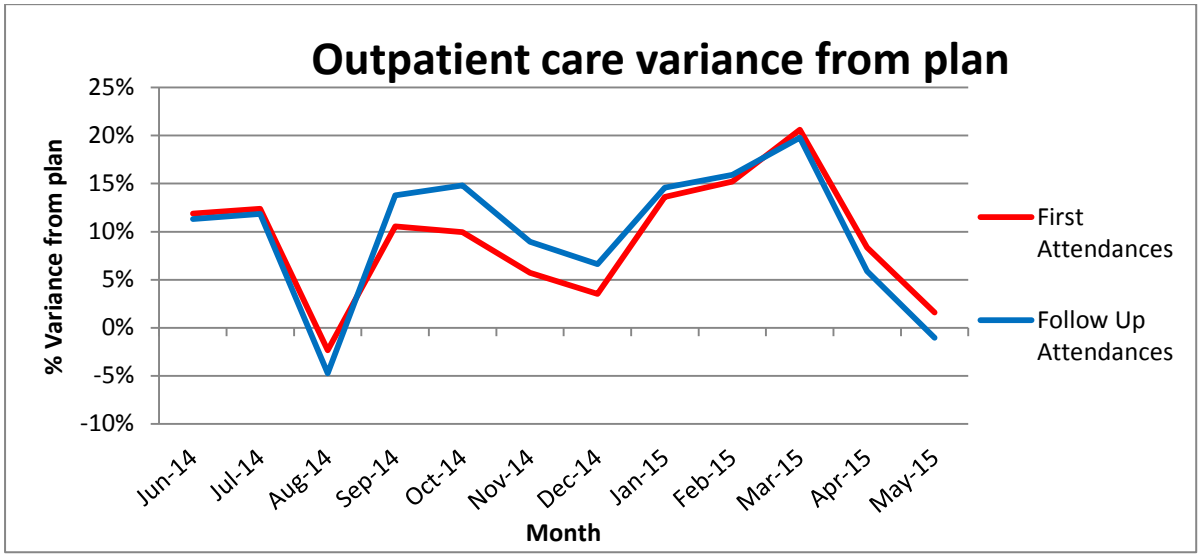


Figure 11 – Outpatient Care Variance from Plan for the period June 2014 – May 2015

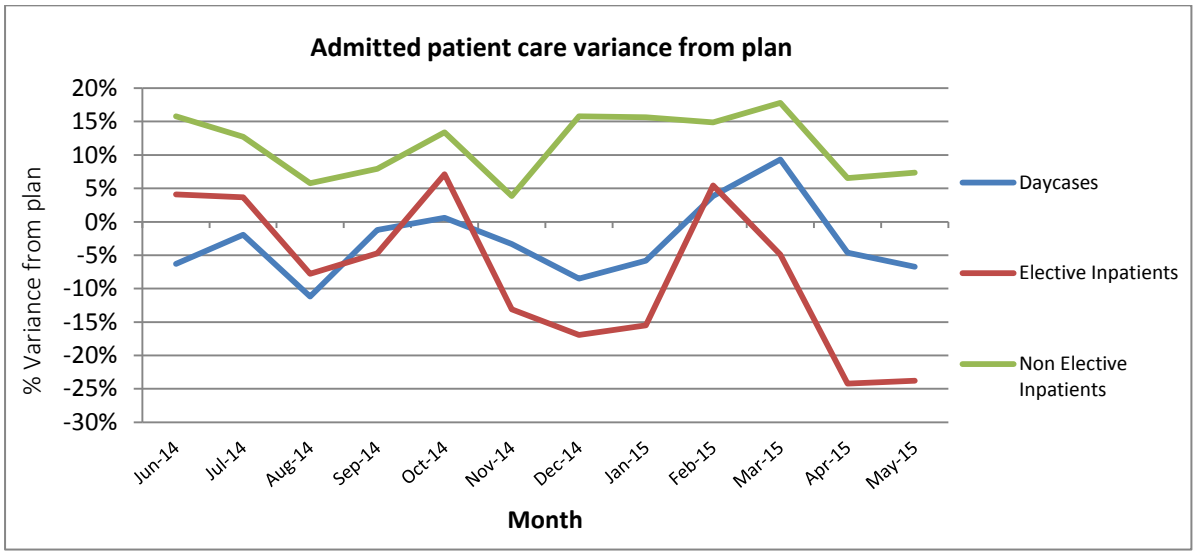


Figure 12 – Admitted Patient Care Variance from Plan for the period June 2014 – May 2015

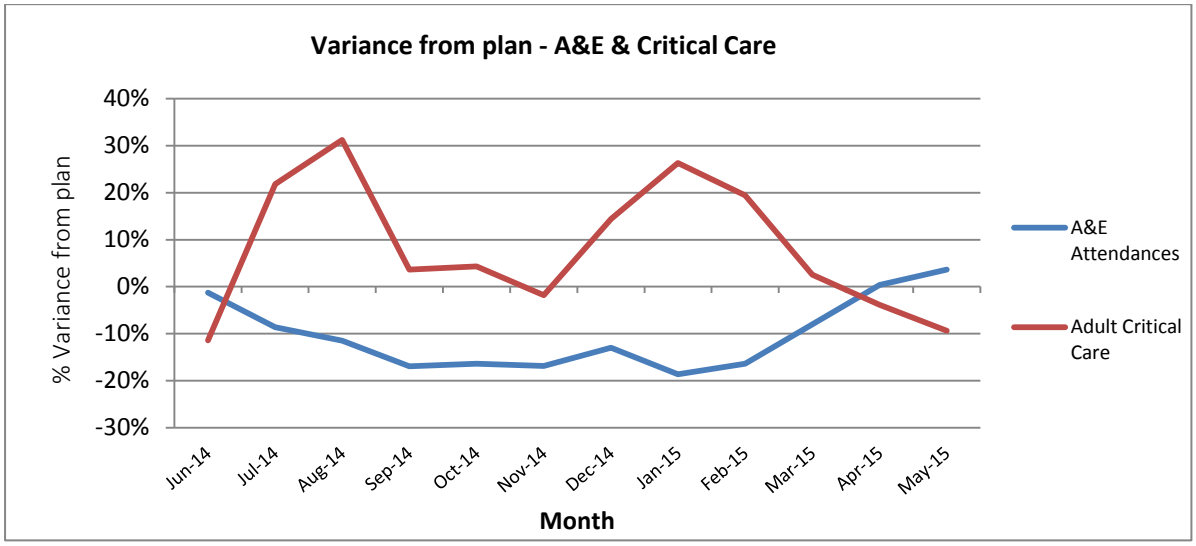


Figure 13 – A&E and Critical Care Variance from Plan for the period June 2014 – May 2015

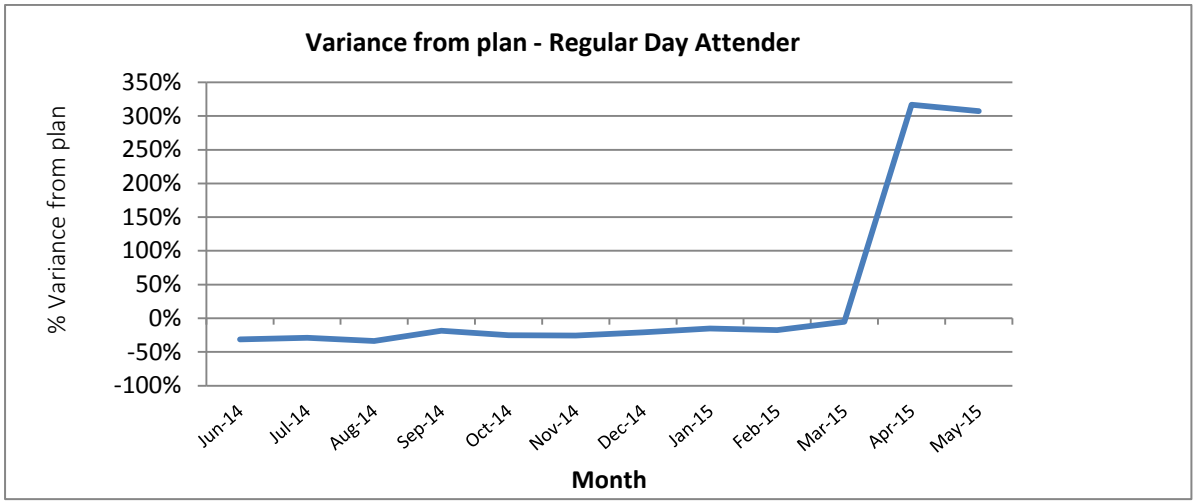


Figure 14 – Regular Day Attender (RDA) Variance from Plan for the period June 2014 – May 2015

3.3 Caring

3.3.1 Caring: Eliminating mixed sex accommodation

No mixed-sex accommodation breaches were reported during June 2015.

Being in mixed-sex accommodation can be difficult for some patients for a variety of personal and cultural reasons. Therefore, all providers of NHS-funded care are expected to eliminate all mixed-sex accommodation (except where it is in the overall best interest of the patient or reflects their personal choice). Hospitals can face a fine of up to £250 for breaching same-sex accommodation guidance.

This rating highlights the total number of times that the same-sex accommodation guidance was breached during the reporting period.

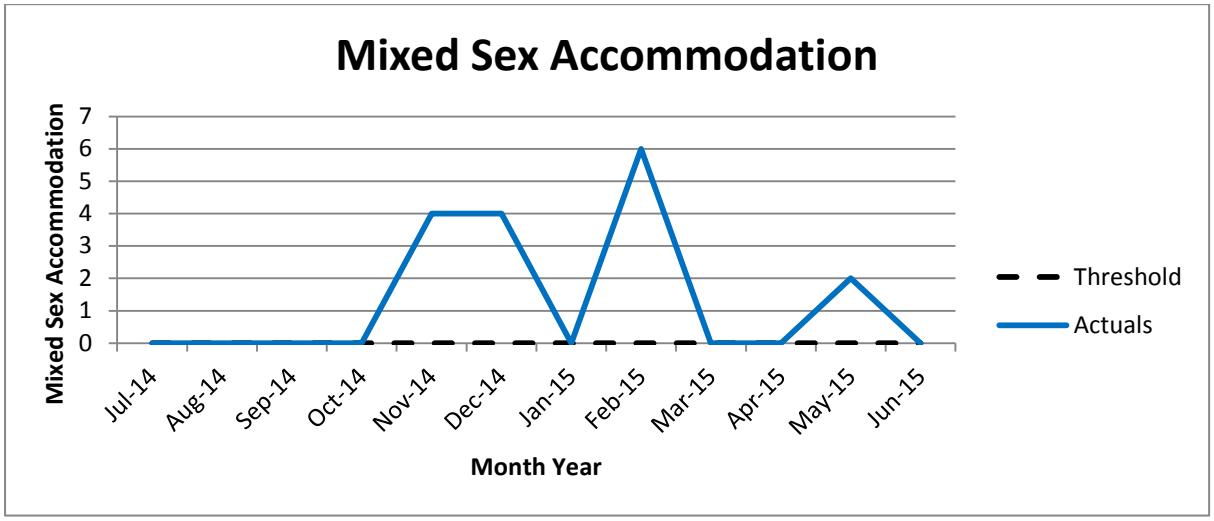


Figure 15 - Mixed Sex Accommodation breaches by month for the period July 2014 – June 2015

3.3.2 Caring: Friends and Family Test

Following the introduction of the new real-time collection system in April, there has been a month on month improvement in the response rates. With levels now approaching those achieved at the end of 14/15. The percentage of patients who would recommend is also increasing. Overall, the trust FFT scores are good and in line with national levels.

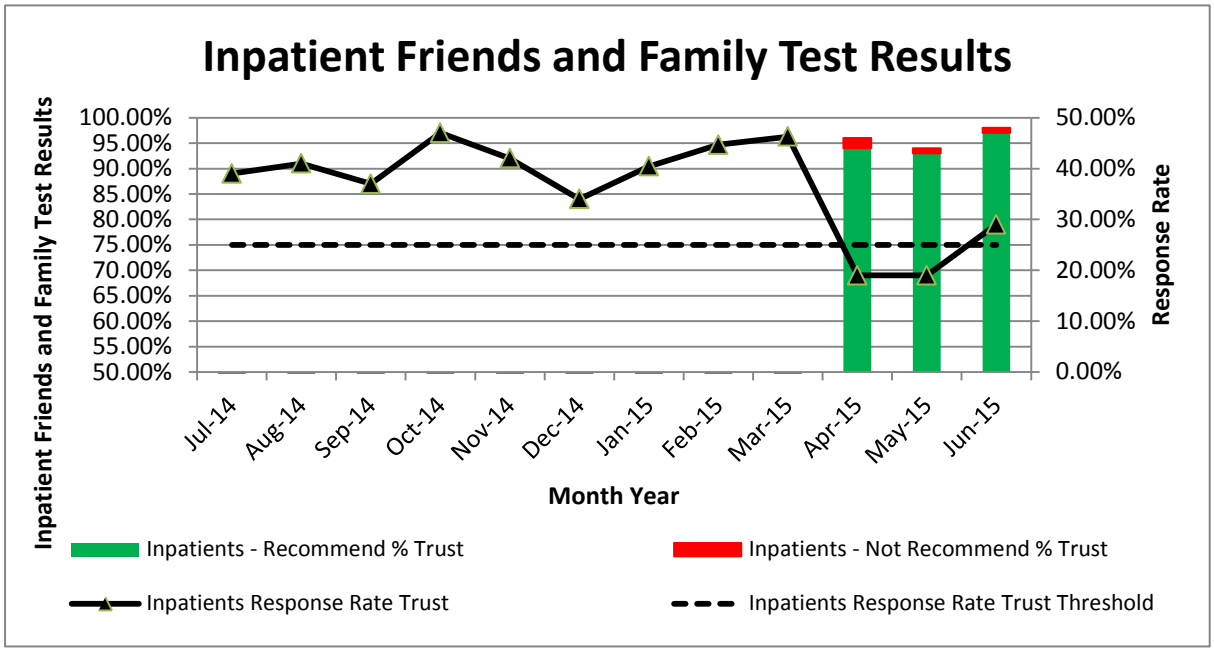


Figure 16 - Friends and Family: Percentage who would recommend ICHT Inpatients for the period April 2015 – June 2015

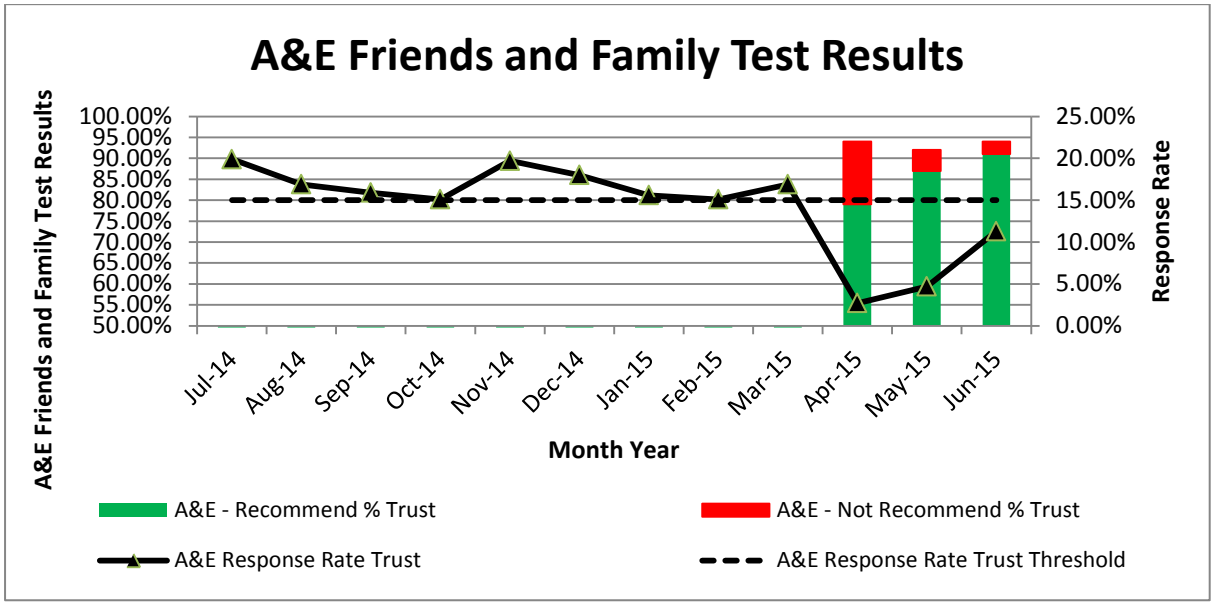


Figure 17 - Friends and Family: Percentage who would recommend ICHT Accident and Emergency for the period April 2015 – June 2015

3.3.3 Caring: Complaints

There has been an increase in the number of complaints in June although there is no obvious reason for this. It was noted last month that the volume of complaints in May was particularly low which may have been related to the two bank holidays. The June volume is more consistent with previous months. The response rate to complaints remains lower than it should be, but this will be addressed by the centralisation of the complaints function. The consultation process for this is well underway and the majority of changes should be in place by the end of August.

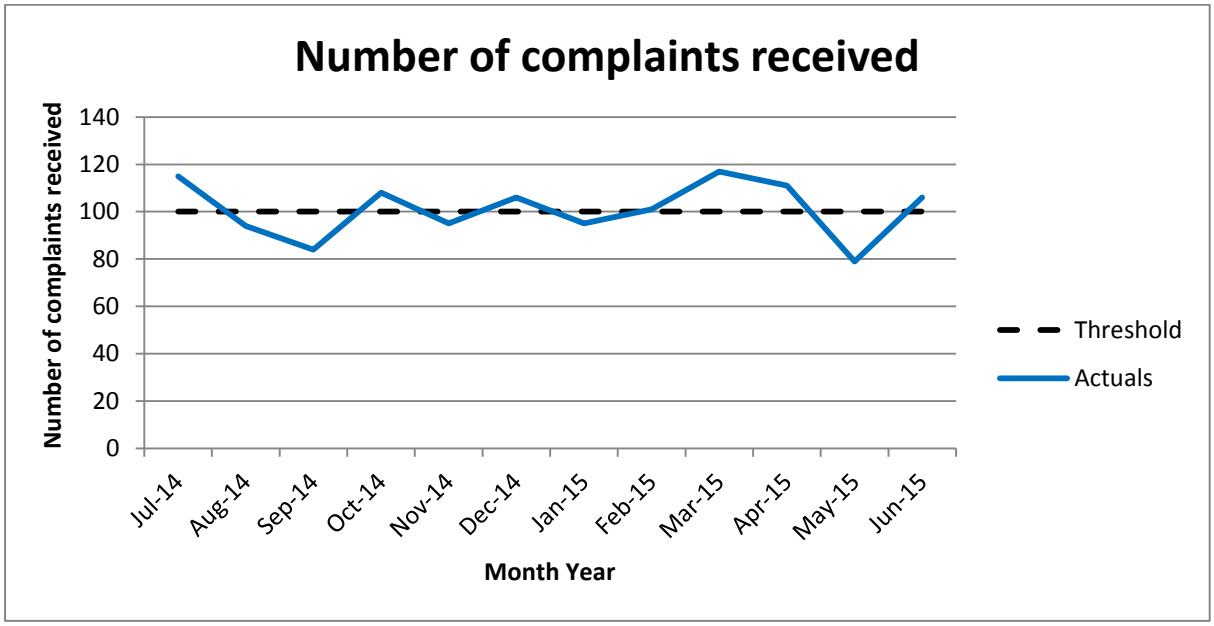


Figure 18 – Number of complaints received for the period July 2014 – June 2015

3.4 Well-Led

3.4.1 Well-Led: Vacancy Rate

- **All roles**

At the end of June, we directly employed 9,231 WTE (37 WTE greater than end of May) with a further 1,257 WTE worked through bank and agency staffing. This reflects the 11.64 per cent vacancy rate (1,216 WTE vacant) and was 41 WTE over the ESR post establishment. The 15/16 plan has been input into ESR for the five Divisions and the Corporate Directorates are in the process of being aligned through partnership working with the Finance and People Planning Teams.

There are 531 WTE pipeline candidates waiting to join (46 WTE more than at the end of May) giving a non-recruited to vacancy rate of 6.55 per cent. Monitoring of vacancies across all departments is supported through monthly reporting, performance reviews and bespoke KPI meetings within the Divisions. Hard to recruit specialties and staffing groups are discussed and targeted recruitment plans agreed at the monthly strategic people planning meetings with the Divisional and Resourcing leads.

- **Bands 2~6 Nursing & Midwifery on Wards**

Within the wards, the band 2-6 vacancy rate was 13.44 per cent (325 WTE vacant) marginally lower than the 13.64 per cent seen at the end of May; A further 166 WTE are waiting to fill these ward vacancies, giving a non-recruited vacancy rate of 6.55 per cent.

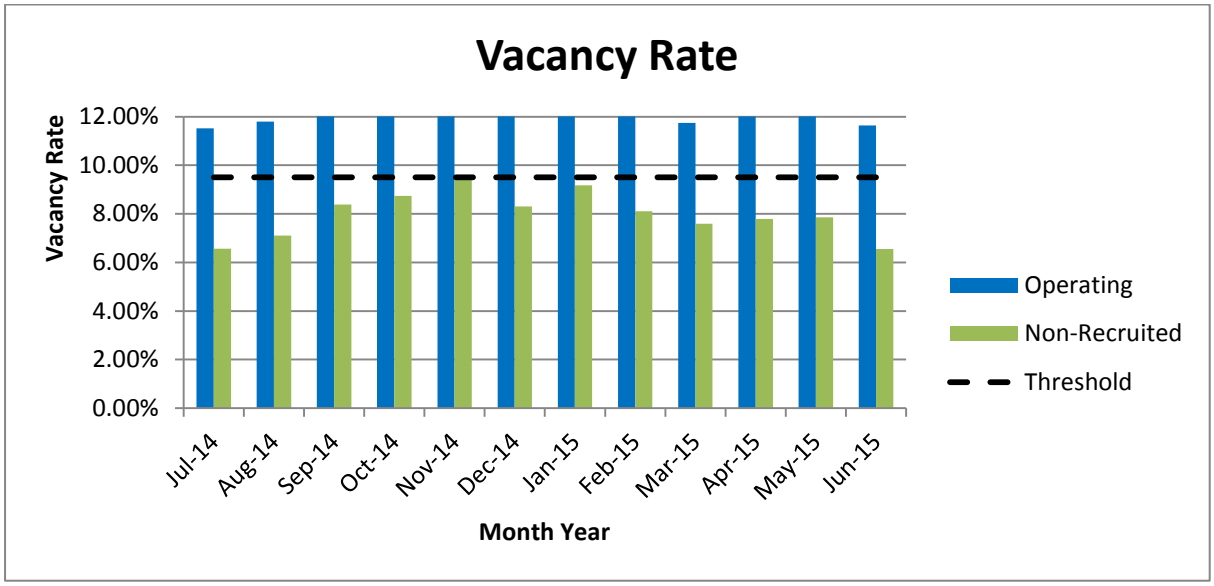


Figure 19 - Vacancy rates for the period July 2014 – June 2015

3.4.2 Well-Led: Sickness absence rate

Recorded sickness absence reduced by 2 per cent in month from 3.08 per cent to 3.01 per cent and is significantly lower than the 3.47 per cent recorded in June 2014

(13 per cent less). Overall, this brings the rolling 12-month position to 3.39 per cent which is now below the 15/16 target of 3.40 per cent.

New managers continue to attend the Understanding Workforce Policies training, as well as refresher training for existing managers, ensuring they are confident and supported in the pro-active management of sickness absence. Absence levels are monitored via daily reviews with GMs and the Site team, as well as monthly divisional and corporate meetings to ensure proactive management.

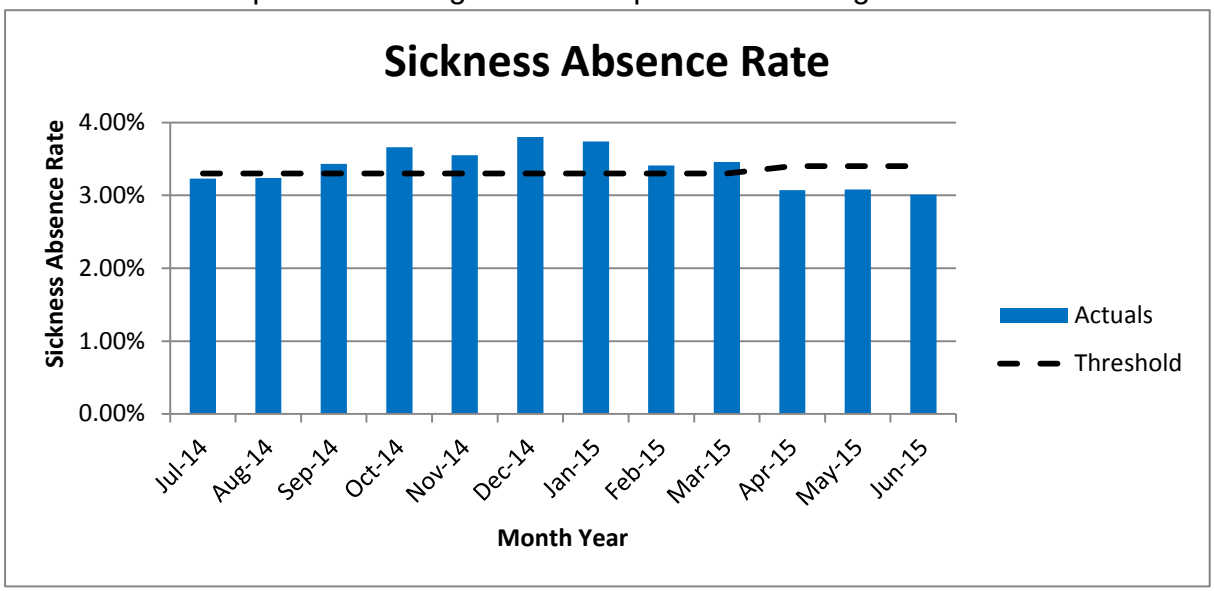


Figure 20 - Sickness absence rates for the period July 2014 – June 2015

3.4.3 Well-Led: Statutory and mandatory training

- **Excl. doctors in training / trust grade**

WIRED 2 was launched on 13 March 2015 to enhance our ability to report on topic level compliance rates for the Trust's ten core skills training topics. Compliance rates have improved significantly from 69 per cent in April 2014 to 82 per cent currently.

A campaign has been launched to increase compliance in Fire Training, with Loop day sessions and targeted communications across the Trust. Compliance has increased from 45 per cent in March to 65 per cent to date with further campaigns in August.

- **Doctors in training / trust grade**

Reports for doctors in training mirror those of other staff groups and shows an overall compliance rate of 63 per cent. Individualised training profiles produced by WIRED are prompting the steady increase in compliance as the group have clarity around which courses they are required to complete from induction onwards.

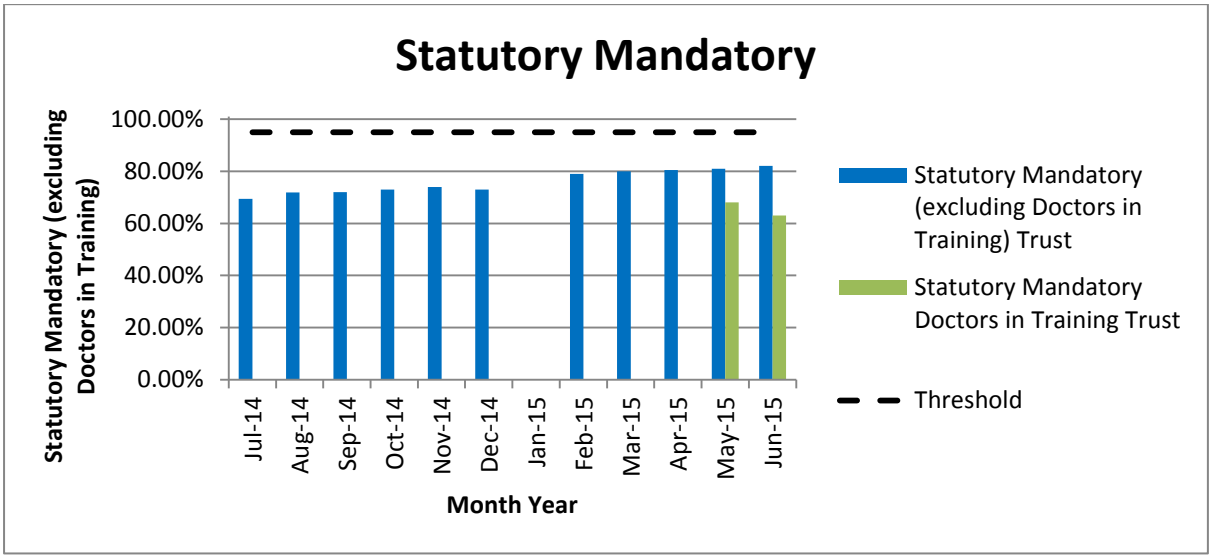


Figure 21 - Statutory and mandatory training for the period July 2014 – June 2015

3.4.4 Well-Led: Non-training Grade Doctor Appraisals

We have changed the way we report doctor appraisal rates this month to ensure we review a more complete measure of compliance. This includes incorporation of career grade doctor appraisal rates, rather than just consultant appraisal rates, and reporting by completed sign off or 'output' of appraisal rather than date of appraisal meeting. Both of these factors have contributed to a lower rate of 85.6 per cent this month; however this does not represent a decline in individual compliance.

All doctors who are 6 months overdue from their appraisal date are being escalated to the Responsible Officer. Non-compliance continues to be managed against the Revalidation & Appraisal Policy. Appraisal compliance is also reviewed at the Divisional Performance Reviews.

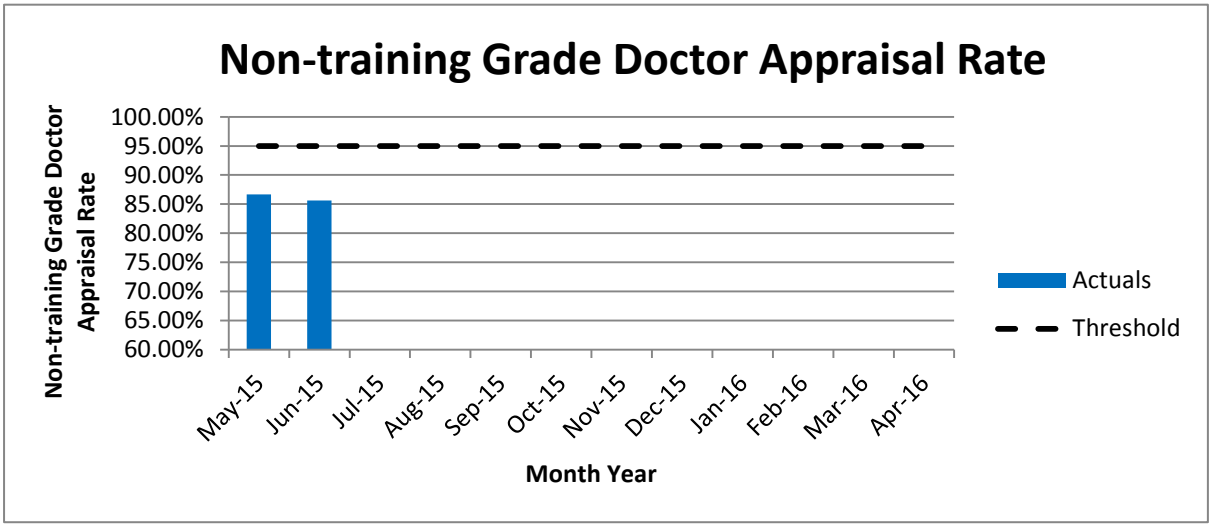


Figure 22 - Non-training Grade Doctor Appraisal Raterates for the period May 2015 – April 2016

3.4.5 Well-Led: Performance Development Reviews (band 2 – 9)

The end of June saw the first PDR completion window close with the expectation that all of our people at bands 7-9 will have had a completed PDR by the end of the first quarter. The PDR compliance rate for staff at bands 7 ~ 9, at the end of June was 85.59 per cent with 257 members of staff within this group still requiring a PDR with their line manager. The Divisional and Corporate leads, with the support of the HR Business Partners, are working to ensure that these remaining PDR's are scheduled and completed as soon as possible.

Our staff, within the band 2-6 group (6,255 headcount), are required to have had a PDR with their line Manager by the end of September and the PDR compliance rate for this group of staff is currently at 10.81 per cent. Overall, at the end of June, the Trust PDR compliance rate for all bands of staff was 27 per cent. Monitoring of all PDR's is supported by weekly reports detailing PDR completion progress to all Divisions and Corporate Directorates. Managers can also monitor PDR compliance at line manager and employee level within the Your People application on Qlikview.

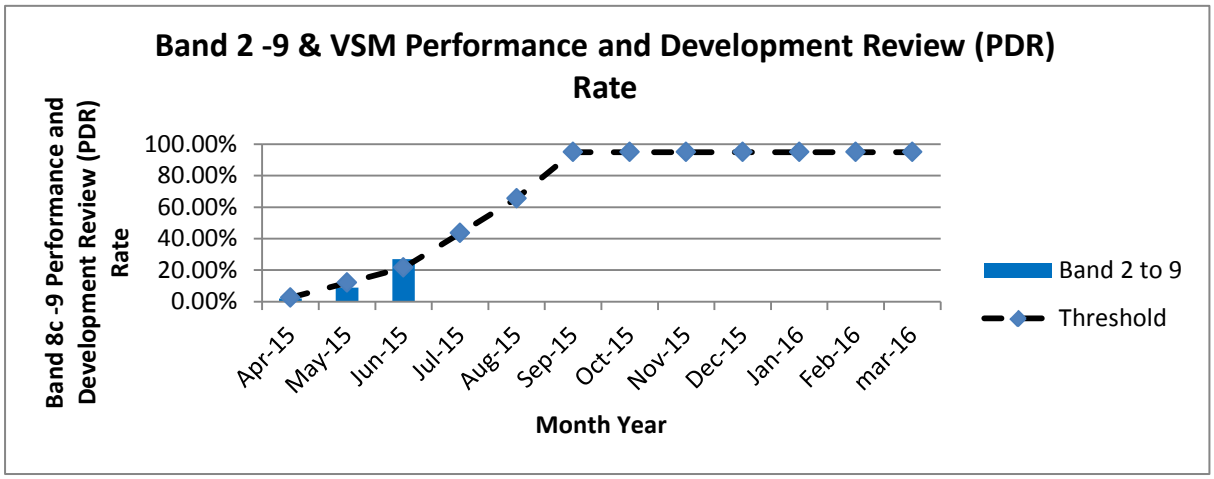


Figure 23 - Band 2 - 9 performance development review rates for the period April 2015 to June 2015

3.4.6 Well-Led: Health and Safety RIDDOR

Three RIDDOR reportable accidents took place during June 2015. Firstly, a member of staff had a 'slip, trip and fall' on a wet floor in Charing Cross Hospital CT Scanning Unit, which resulted in a fractured ankle, leading to an absence of more than seven days from work. Secondly, a member of staff was assisting a fainting patient to the floor but got trapped between the patient and wall and was unable to stand. Whilst being assisted up by another member of staff, the member of staff sustained an injury to her left shoulder. She was off for more than 7 days. Thirdly, a member of staff was struck by a tea trolley at Hammersmith Hospital, leading to right knee injury. The member of staff was off work for more than 7 days.

There were 19 RIDDOR reportable accidents in the 12 months to 30 June 2015. There were no RIDDOR reportable dangerous occurrences during June with a

total of four reportable dangerous occurrences in the 12 months to 30 June 2015. The majority of RIDDOR accidents relate to slips, trips and falls. The health and safety service has introduced a more robust quarterly workplace inspection form to enable DSCs/Managers to report slip/trip hazards and controls.

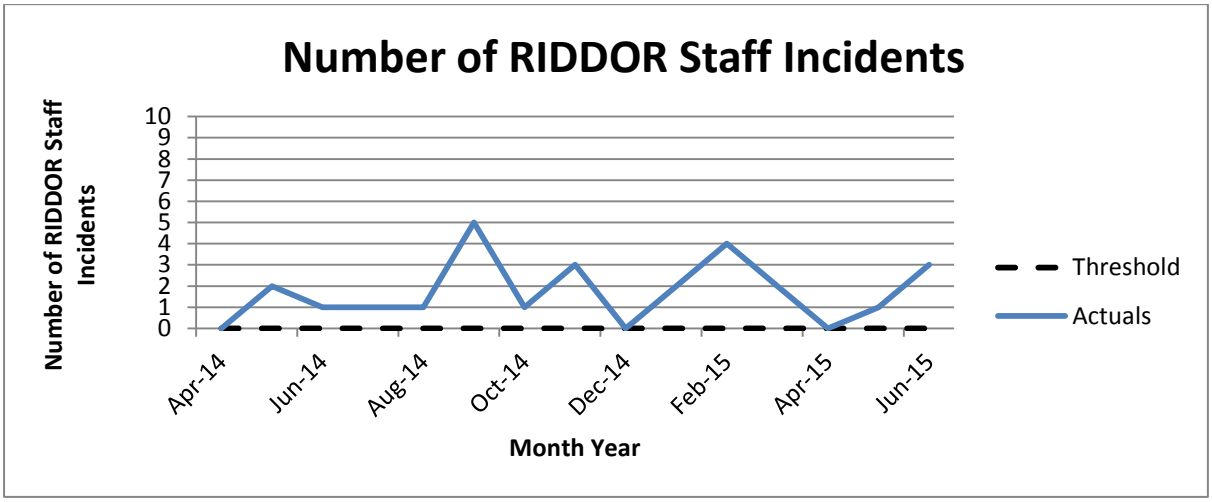


Figure 24 – RIDDOR Staff Incidents for the period July 2014 – Apr 2015 (May and June data whilst the Health and Safety dashboard is revised)

3.4.7 Well-Led: GMC NTS Actions

The GMC National Training survey was published in June 2015. 24 of our programmes have at least one red flag (negative outliers), with the total number of red flags being 50. We are required to produce an action plan by 31st July in response to 46 of these red flags. The actions are currently being drawn up by the Directors of Medical Education with the service in question for submission to HENWL. Once the plan is submitted, we will report the numbers of open and completed actions each month through the scorecard.

The full results of the GMC Survey will be reported to the Board Quality Committee in September.

3.4.8 Well-Led: Staff Engagement

The results of the 7th Quarterly Engagement Survey are being communicated across the Trust. The Survey was open between March and April 2015 and the results show the best results to date.

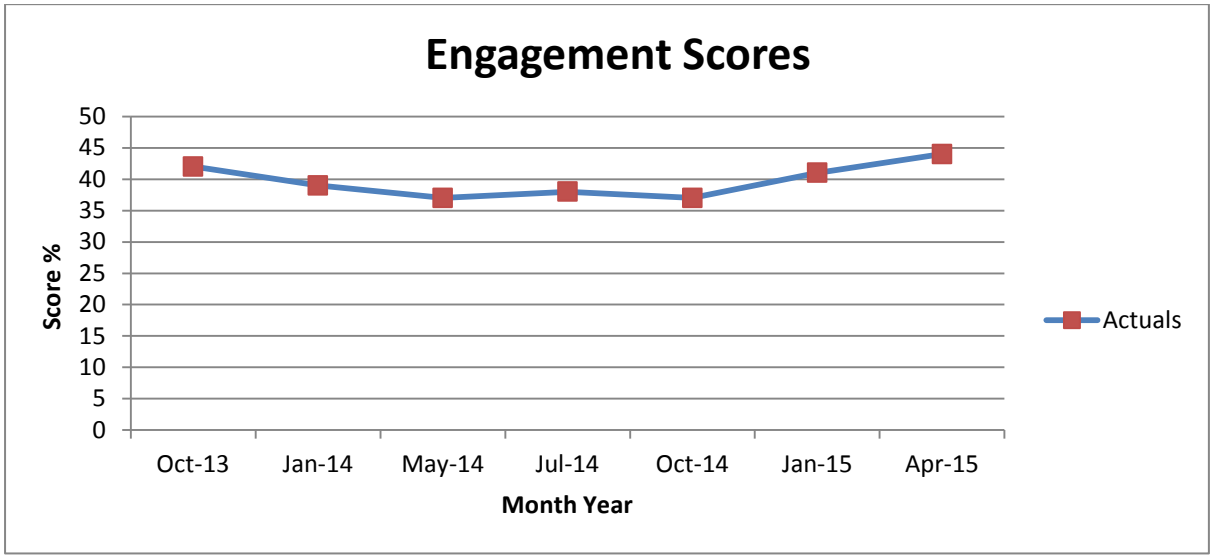


Figure 25 – Engagement scores for the period October 2013 – April 2015

- The total response rate was the highest to date at 57 per cent having increased from 27 per cent in Survey 1;
- The Trust Engagement Score rose by 3 per cent to 44 per cent, again the highest score to date;
- All individual questions show slight improvements since Survey 6; &
- The Friends and Family test questions have both increased since Survey 6. 77 per cent would recommend the Trust for care and treatment, an increase of 1 per cent and 60 per cent would recommend the Trust as a place to work, an increase of 4 per cent since Survey 6.

The next Survey launches on 20th July.

Senior nurses and General Managers helped facilitate a variety of sessions all with the aim of listening to this key frontline group of staff. The question as to "how can we make your working life better?" produced some genuinely interesting responses, for example a simple "hello" in the morning appears not be as common as we might expect; indeed "thank you" still appears thin on the ground. These responses, amongst others, were presented to the Divisional Management Committee and a plan to address these is being worked up.

3.5 Responsive

3.5.1 Responsive: Referral to Treatment (RTT)

The NHS Constitution enshrines the right of patients to be treated within 18 weeks of referral to a consultant-led service. Performance is assessed against two primary performance standards;

- Incomplete Pathways (92 per cent)
- Number of over 52 week waits (zero tolerance).

Referral to treatment performance has considerably improved over recent months. The primary measure of RTT performance is that 92 per cent of patients should be waiting under 18 weeks at the end of each month. In June the Trust met this standard and submitted a performance of 92.12 per cent of patients waiting under 18 weeks. This was the first time since May 2014 that the Trust had achieved the standard.

Further work over the coming months in increasing capacity, particularly in surgical specialities, will result in patient waiting times reducing further and a reduced number of patients waiting over 18 weeks.

Two patients were reported as having waited over 52 weeks in June's submission, which represents a month-on-month decrease of 9 patients.

There are a number of on-going initiatives to further reduce the number of patients on the Trust waiting lists for treatment. These include:

- Clinical validation of referrals
    - Will support referral back to GP earlier for those patients who do not need hospital treatment and support application of access policy for patients who DNA
- Additional outpatient activity
    - Will reduce time to first outpatient appointment to support shorter pathway time for admitted and non-admitted pathways
- Outsourcing of diagnostic work
    - Trust has capacity constraints in several diagnostic modalities
    - Reducing waiting times will support delivery of 6 week standard as well as reducing overall pathway times for RTT and cancer patients
- Additional inpatient activity
    - This will support clearance of a backlog of admitted activity in challenged specialties

Underperformance in activity during the first three months of 2015/16 is a risk to RTT delivery and this is being managed directly with divisional teams.

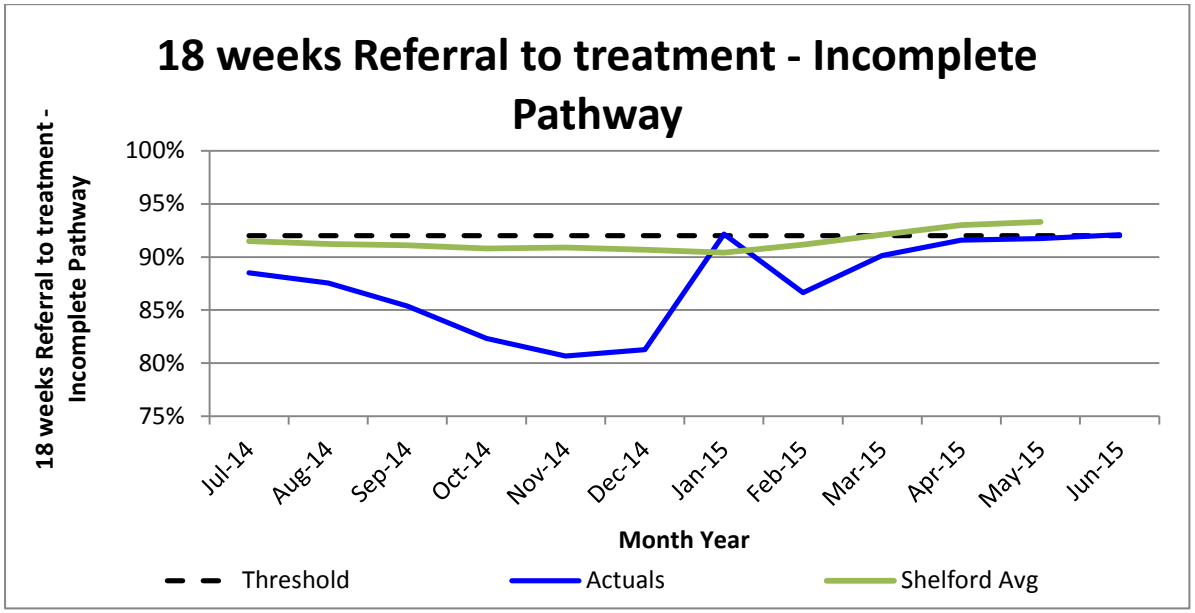


Figure 26 - RTT Incomplete Pathways for the period July 2014 – June 2015

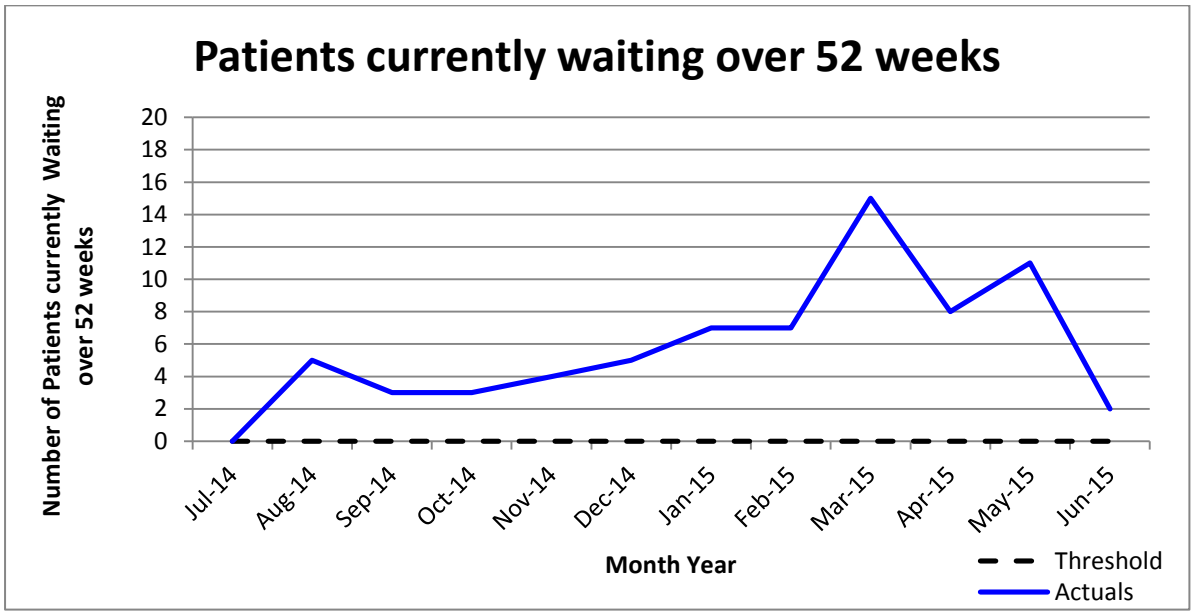


Figure 27 - Number of patients waiting over 52 weeks for the period July 2014 – June 2015

3.5.2 Responsive: Diagnostics

The Trust has had significant challenges with diagnostic capacity in recent months. This is particularly affecting our imaging services and is as a result of insufficient staff and high staff turnover, break down of old diagnostic equipment, and additional equipment needed to increase capacity. The Trust has not met the 6-week diagnostic standard since May 2014 and does not expect to achieve until the third quarter of 2015/16.

There is a recovery plan in place for improving imaging capacity and reducing the time that patients wait for their diagnostic test. This includes recruitment of additional staff to accommodate longer working hours and access to additional scanning machines.

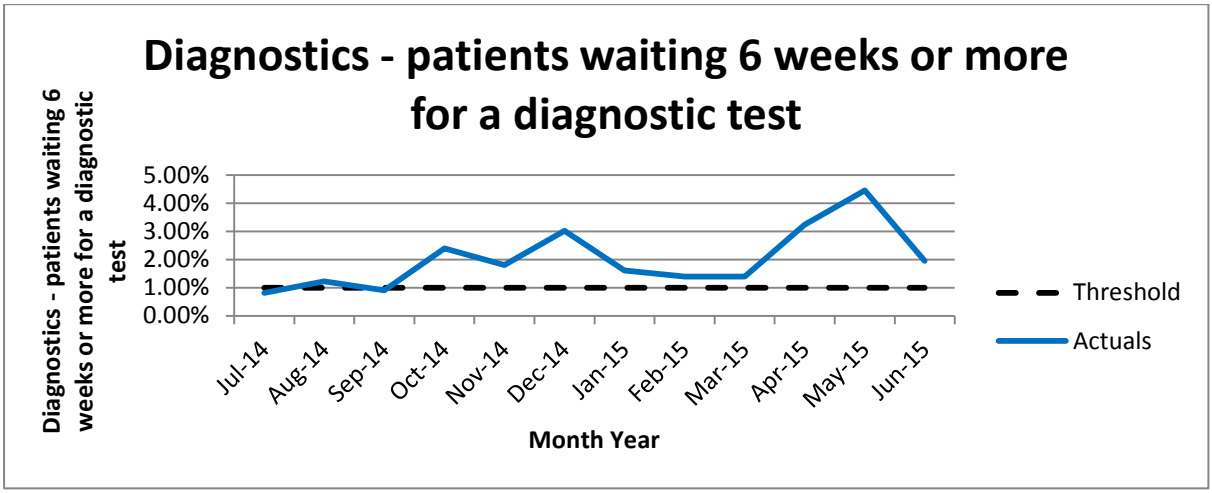


Figure 28 - Percentage of patients waiting over 6 weeks for a diagnostic test by month for the period July 2014 – June 2015

3.5.3 Responsive: Accident and Emergency

The Trust achieved the four hour access standard for patients attending Accident and Emergency in June. This was the first time the Trust had achieved the standard in a number of months and was as the result of a number of initiatives to improve flow within the organisation. For patients who are discharged, there has been an increased focus on discharging before noon, to allow increased capacity for any new emergency admissions and free up capacity within the Emergency Department.

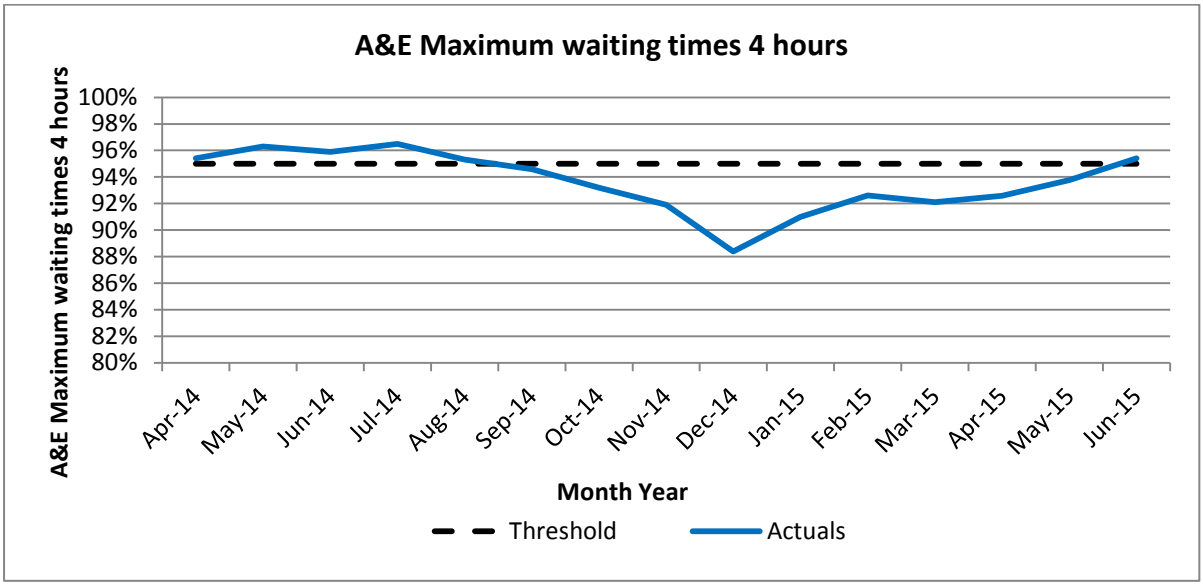


Figure 29 – A&E Maximum waiting times 4 hours for the period April 2014 – June 2015

3.5.4 Responsive: Cancer

In July, performance is reported for the cancer waiting times standards in May. In May the Trust achieved six of the eight cancer standards. The Trust failed to meet the 62-day GP referral to treatment standard in May. This was due to:

- Delays in access to diagnostic services, specifically in imaging and endoscopy; &
- Late referrals from other NWL trusts with insufficient time remaining on the pathway to treat patients within target.

The Cancer Performance Team has agreed a revised escalation process with the Imaging department to prioritise the diagnostic investigations for patients on open cancer pathways in the context of wider capacity challenges within the department. Additional tracking resource has been allocated to the diagnostic phase of the cancer pathways in response to this to support the work of the diagnostics teams. The Trust has also invited the IST to review the colorectal diagnostic pathway in order to establish a more efficient patient flow from GP referral to treatment. The CWHHE commissioning team has continued to support the Trust in the development of improved referral routes into our treating services from local DGHs. A quality schedule has been included in the 2015/16 contract which formally monitors the transfer point between trusts on shared patient pathways to allow the commissioners to drive improvements in local hospitals to ensure that patients are referred to us earlier for treatment.

The Trust also failed to meet the 62-day screening standard in May. This was due to:

- Significant patient choice delays (over 100 days); &
- Delays in scheduling treatment at other NWL sites after patients have been repatriated from the screening service.

Screening guidelines do not correlate neatly with CWT guidelines as patients are given a 6 month window to attend their first assessment clinic after the identification of a screen-detected lesion. This results in very large patient choice breaches against the standard. To counter-balance this, the west London screening team have agreed to increase the level of clinical contact with patients who are not attending, and the point of escalation has been brought forward from two months to day 31. We will be reviewing progress against this in late July.

There are three scenarios in which screening activity can be attributed to ICHT in CWT reporting:

- **Patients screened in the West London Screening Service, hosted at CXH, who are treated at ICHT**. Because CXH hosts the screening service the CWT clock starts for patients screened there are all attributed to ICHT. If screen detected cancers are referred into the surgery or oncology services at ICHT for treatment, a full treatment is reflected in our reported CWT position

as we are responsible for both the clock start and the clock stop. If these patients breach the 62-day screening standard we report a full breach against the Trust. In some scenarios patients are repatriated from the screening service to other local trusts for simple surgery, before returning to us after later opting for more complex surgery instead. In these scenarios ICHT still report a full treatment or breach as the clock start and clock stop are still both recorded against an ICHT site.

- **Patients screened in the West London Screening Service who are treated at another trust**. As above, the clock start for these pathways is attributed to ICHT because we host the screening service. When patients are repatriated to other trusts for treatment, half a treatment is reflected in our reported CWT position because the clock starts and clock stops are at different trusts. If these patients breach the standard, even where any delays are the fault of the recipient trust, we also incur half a breach in our reported CWT position.
- **Patients screened in other screening services treated at ICHT**. Patients screened in other screening services will have their clock starts attributed to the hospital site that hosts that service. When we receive those patients for treatment, we record ICHT as the treating site which means half a treatment is reflected in our reported CWT position because the clock starts and clock stops are at different trusts. As above, if these patients breach the standard, even where any delays are the fault of the referring trust or screening service, we also incur half a breach in our reported CWT position.

Indicator	Standard	May-15	Q4 14/15
Two week GP referral to 1st outpatient, cancer (%)	93.0%	94.1%	93.9%
Two week GP referral to 1st outpatient – breast symptoms (%)	93.0%	93.1%	94.4%
31 day wait from diagnosis to first treatment (%)	96.0%	97.4%	96.7%
31 day second or subsequent treatment (surgery) (%)	94.0%	97.3%	100.0%
31 day second or subsequent treatment (drug) (%)	98.0%	98.8%	99.6%
31 day second or subsequent treatment (radiotherapy) (%)	94.0%	98.7%	96.8%
62 day urgent GP referral to treatment for all cancers (%)	85.0%	76.4%	79.1%
62 day urgent GP referral to treatment from screening (%)	90.0%	88.0%	92.5%

Table 1 - Performance against national cancer standards for the period 1st May to 31st May 2015

3.5.5 Responsive: Outpatient DNA rates

A DNA (Did Not Attend) occurs where a patient fails to attend an arranged appointment without cancelling it beforehand. DNAs cost the NHS an average of £108 per appointment. When a patient DNAs their first appointment, or two follow-up appointments, they may be discharged back to their GP.

DNA rates have reduced since September following increased rates of use of text messaging reminders to patients prior to their outpatient appointment.

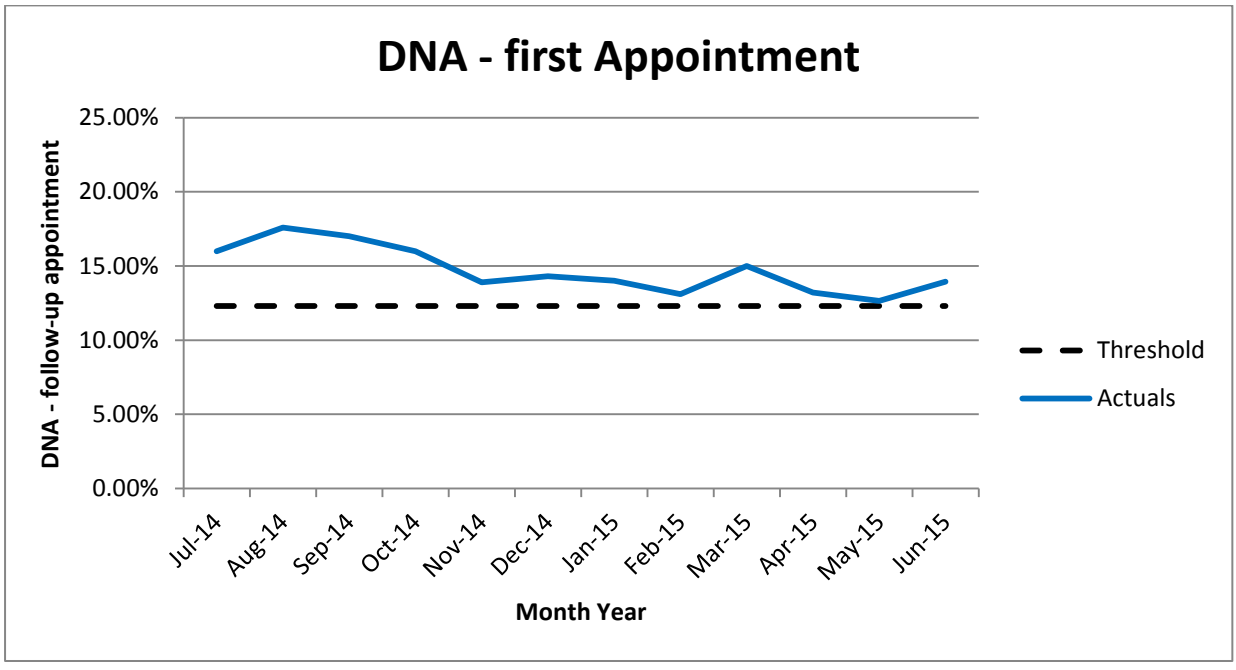


Figure 30 – First outpatient DNA rate for the period July 2014 – June 2015

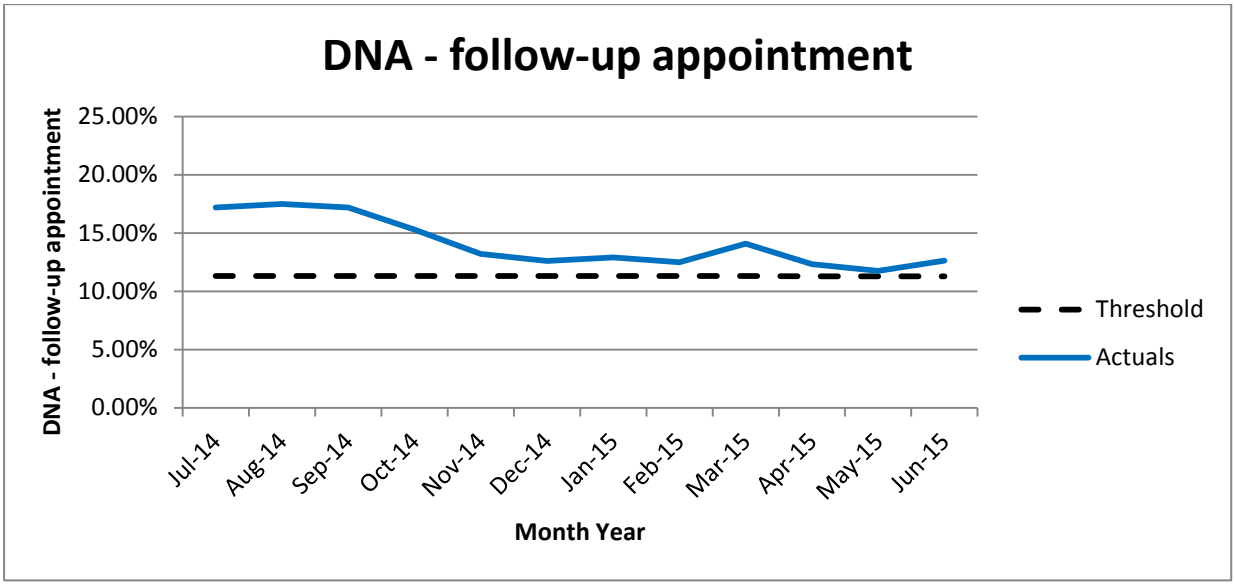


Figure 31 – Follow up outpatient DNA rate for the period July 2014 – June 2015

3.5.6 Responsive: Hospital Appointment Cancellations (hospital instigated)

Appointments are sometimes cancelled by a service within the hospital. This should only occur in very limited circumstances – such as in an emergency or when a member of staff is ill. Hospital instigated cancellations impact on the hospital's efficiency and potentially delays treatment for our patients.

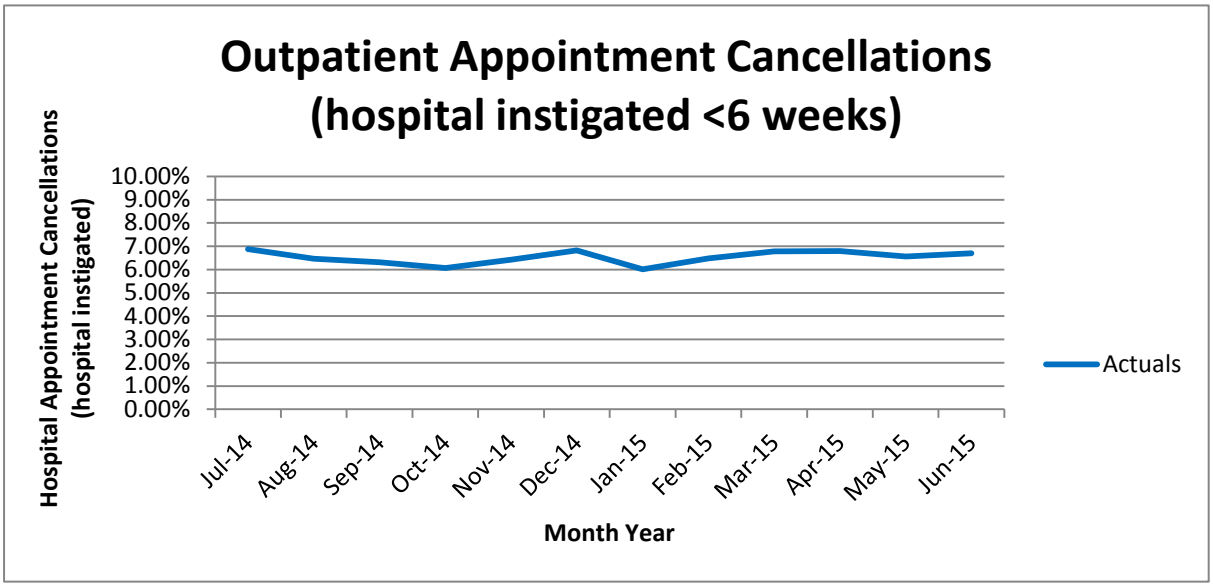


Figure 32 – Outpatient Hospital instigated cancellation rate for the period July 2014 – June 2015

4 Finance

Please refer to the Monthly Finance Report for the Finance narrative.

Imperial College Healthcare NHS
NHS Trust

Page 10 - CONTINUITY OF SERVICES RISK RATING (CoSRR)

Continuity of Service Risk Rating (CoSRR)	Weight	2015/16 Actual M1	Actual M2	Actual Q1	Forecast Q2	Forecast Q3	Forecast Q4	Trend (Actuals)
Liquidity	50%	(1.3)	(2.7)	(4.0)	(6.0)	(9.9)	(13.4)	
Liquidity Risk Rating		3	3	3	3	2	2	YTD
Capital Servicing Capacity	50%	0.39	(0.01)	0.40	1.54	1.96	1.87	
Capital Servicing Capacity Risk Rating		1	1	1	2	3	3	YTD
Overall CoSRR		2	2	2	3	3	3	

Monitor's continuity service risk rating was red due the Trust's deteriorating liquidity position.
Overall this is in line with plan.

Continuity of Services Risk Ratings (CoSRR)	Risk:	R

Table 2 - Continuity of Service Risk Rating (CoSrr) actual and forecast 2015/16