

Board of Directors (in Public)

Item 3.1

Subject: Trust Review - SOF, Regulatory and Operational Performance Month 9
Date of meeting: Tuesday 28th January 2020
Prepared by: Hayley Kendall, Chief Operating Officer
Martin Curry, Senior Information Analyst - Interim
Presented by: Hayley Kendall, Chief Operating Officer
Purpose of Report: To Note

1. Executive Summary

The purpose of this paper is to present an update on the Trust performance for the period ending 31st December 2019. The exceptions to note for this month are:

- The Trust continues to have significant pressures in delivering against the six week diagnostic target with performance at 71.5%, hindered by ongoing scanner failure, although performance is in line with the NHSI trajectory the Trust is monitored against.
- Delivering the surgical activity plan remains a challenge but activity in December was in line with the revised financial forecast position. In addition there was a significant under performance in month within the Medicine Division, mainly related to inpatient activity being behind plan.
- Patients waiting longer than 18 weeks on Incomplete Pathways continues to increase. The Divisions continue to work on capacity to reduce patient delays, but the Trust failed the 92% Target in December with specific challenges from the diagnostic waiting times and longer waiting times in Cardiology.
- Sickness remains a significant pressure for the Trust with performance still being far from plan.

The Board is asked to note the content of the paper and associated actions detailed.

2. Introduction

The report is divided into three sections as follows:

- Section 1 - Single Oversight Framework (SOF): This section provides details on the mandated regulatory indicators from NHS Improvement; these inform NHSI's risk assessment (segmentation) which determines the level of autonomy afforded to the Trust.
- Section 2 - Quality of Care Dashboard: internal quality indicators agreed by the Board in April 2019 for routine monitoring on delivery.
- Section 3 - Operational and Financial Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2019 for routine monitoring on delivery.

Section 1 - Single Oversight Framework (Refer to Appendix 1)

1.1.1 Single Oversight Framework – Exceptions

1.1.2 Indicator: Clostridium Difficile

Accountable Officer: Raph Perry

Issue: 1 Case in December and 6 YTD against an annual target of 4.

Actions: All cases reviewed and fed back to wards and consultant. Continued education and training on bare below elbows and deep cleaning.

Anticipated Delivery: Individual action plan in place for each case.

1.1.3 Indicator: Gram Negative Bacteremia

Accountable Officer: Raph Perry

Issue: 2 Cases in December and 11 cases YTD against an annual target of 9.

Actions: All cases of Gram Negative Bacteraemias have been through case review. Continued education on infection prevention processes.

Anticipated Delivery: Individual action plan in place for each case.

1.1.4 Indicator: Maximum time of 18 weeks RTT - incomplete pathways

Accountable Officer: Hayley Kendall

Issue: Below target for December 2019 at 89.73% against a target of 92%.

Actions: Full understanding of where waiting time pressures are, mainly related to significant waiting times within diagnostics and a growing backlog of patients waiting longer than 18 weeks in Cardiology. Additional short term capacity added into the system in January 2020 to reduce breaches whilst understanding the recurrent capacity required by sub specialty. There has been minimal uptake of the pension options agreed by the Board due to uncertainty of the position post March 2020. Engagement with clinical staff to follow rules within the access policy regarding chronological booking of patients through the pathway.

Anticipated Delivery: Month End January 2020.

1.1.5 Indicator: Maximum 6 week wait for Diagnostic Tests

Accountable Officer: Hayley Kendall

Issue: Below target for December 2019 at 71.5% against a target of 99%.

Actions: Performance is slightly below the 72.71% target for December 2019 which was agreed in the trajectory shared with NHSE/I and local commissioners. The new scanners have been installed and they were operational late October 2019. The backlog recovery plan commenced in both CT and MR in November and performance started to improve, however subsequent ongoing scanner failure with the older MRI machine has hindered progress. This has resulted in downtime from 9th December 2019 to the 24th January 2020 (expected) whilst the scanner awaits replacement of a significant part which has been unavailable. Escalated at executive level, date provided to the Trust of the 24th January 2020 when the scanner will be back in action.

Anticipated Delivery: June 2020.

1.1.6 Indicator: Staff Sickness

Accountable Officer: Sue Hodgkinson

Issue: Staff sickness is 4.73% for December against a target of 3.40% (4.66% YTD).

Actions: An action plan to review attendance management is in development. An audit has been undertaken to review compliance with management of attendance in high reporting areas, individual actions will be addressed throughout the organisation. This will be complemented with the implementation of key health and well being interventions. See HR Report.

Anticipated Delivery: Ongoing monitoring with deep dives being undertaken in the high sickness areas.

2. Section 2 - Quality of Care Dashboard (Refer to Appendix 2)

2.1.1 Quality of Care - Exceptions

2.1.2 Indicator: Number of Falls (all areas, avoidable and unavoidable).

Accountable Officer: Sue Pemberton

Issue: 12 Falls during December and 59 YTD against an annual target of 72.

Actions: There were a high number of falls during the month of December, 10 of the 12 falls have been categorised as unavoidable as patients were independent in their mobility. Mini investigations are now taking place for each patient fall to ensure all mitigation actions are considered and implemented.

Anticipated Delivery: Ongoing

2.1.3 Indicator: % Blood Cultures taken within 24 hours preceding first antibiotic given

Accountable Officer: Raph Perry

Issue: 73.1% in December against a target of 95%

Actions: No progress with PR as enabler of accurate timing. Falls reviewed weekly and suggest timing satisfactory.

Anticipated Delivery: n/a

3. Section 3 - Operational and Financial Performance (Refer to Appendix 3)

3.1.1 Operational - Exceptions

3.1.2 Indicator: Improve PET Scanning Turnaround times at 5 days

Accountable Officer: Hayley Kendall

Issue: 33.3% for December and 42.5% YTD (target 75%).

Actions: All LHCH requests for PET scans are managed by another NHS organisation. There is currently a supply issue with the consumables utilised in such scans causing longer than required waiting times. Waiting times are unlikely to be resolved before Spring 2020. LHCH escalate to the service provider any areas of concern in delays for patients.

Anticipated Delivery: Spring 2020.

3.1.3 Indicator: Cancelled Operations

Accountable Officer: Hayley Kendall

Issue: December performance is 2.0% against plan of 1.5%.

Actions: A review of each cancellation is performed and discussed monthly at the consultant business meetings. Performance is improved compared to last year but the Surgical Division strive to improve the position each month. A clinical RCA is carried out on each cancellation within surgery to understand areas for improvement and ways of avoiding future cancellations.

Anticipated Delivery: Ongoing

3.1.4 Indicator: Activity (Spells) – NHS

Accountable Officer: Hayley Kendall

Issue: December underperformance against plan of -13.09%.

Actions: Surgery performance in month was in line with the revised financial forecast and is forecast to achieve the revised plan for the quarter four period. The Medicine Division under performed in month against the inpatient plan mainly due to the reduced number of Cath Labs utilised over the holidays. There are active discussions to recover and improve the forecast position in Medicine which will be reflected in the February and March 2020 activity positions.

Anticipated Delivery: Quarter 4 2019/20.

3.1.5 Indicator: Radiology - Plain Film – Inpatient

Accountable Officer: Hayley Kendall

Issue: December performance is 55.9% (YTD 45.3%) against a target of 90%.

Actions: The main reason for underperformance against the plan is consultant capacity. One Radiology Consultant has commenced in post as well as two clinical fellows which increases capacity for reporting. The risk of low compliance against plain film reporting is mitigated as all plain film x rays are primarily reviewed by the lead clinician of the inpatient team that requests the scan.

Anticipated Delivery: Quarter 1 2020/21

3.1.6 Indicator: Radiology - CT - Outpatient

Accountable Officer: Hayley Kendall

Issue: December performance is 64.6% (YTD 75.7%) against a target of 90%

Actions: Compliance has been challenging due to the increase in amount of healthy lung screening CTs. LHCH is significantly over the plan that has been agreed with the commissioners. All requests for scans are screened by the Clinical lead for Radiology. Requests for rapid turnaround for reports are managed cross divisionally on a prioritisation process.

Anticipated Delivery: Quarter 4 2019/20

3.1.7 Indicator: Radiology - MRI - Outpatient

Accountable Officer: Hayley Kendall

Issue: December performance is 80.1% (YTD 67.8%) against a target of 90%

Actions: Significant improvement in performance in recent months. This was mainly due to the appointment of a locum radiologist who was appointed and thereby increasing reporting capacity. As with CT, all MRI requests are vetted by the Clinical Lead for Radiology to ensure urgent scan requests are expedited. Full compliance against this KPI is expected to be achieved shortly after the new substantive consultant capacity is in place.

Anticipated Delivery: Quarter 4 2019/20

3.1.8 Indicator: Welsh 26 weeks RTT (Admitted, Non Admitted and Incomplete)

Accountable Officer: Hayley Kendall

Issue: Patients waiting over 26 weeks for treatment. December Performance is:

- Admitted - 78.65% against a 95% target
- Non-Admitted - 65.12% against a 98% target
- Incomplete - 91.72% against a 95% target

Actions: The Trust continues to work with Welsh commissioners to improve waiting times for patients and is focused on ensuring any patients that do breach 26 weeks are seen before 36 weeks. The main area driving the under performance is late and incomplete referrals from organisations and extended waiting times for diagnostic tests in Wales. At a recent meeting with the Welsh Commissioners LHCH highlighted the delays being experienced with referring Trust's and requested support in improving the position. This work will continue.

Anticipated Delivery: 2020/21

3.1.9 Indicator: Turnover Rate between 1-2 yrs service (voluntary (FTC excluded))

Accountable Officer: Sue Hodgkinson

Issue: 2.76% against a target of 1.40%.

Actions: A Retention Strategy and Action Plan have been developed for 2019-2021, which will review current data captured and develop initiatives to improve turnover. The Trust is also part of NHSI Cohort 4 Retention Improvement Programme supporting Nursing turnover, but any good practice will be shared to include all staff.

Anticipated Delivery: Ongoing

3.1.10 Indicators: Capital Expenditure, Agency Cost, Bank Cost & Deliver the recurrent CIP

Accountable Officer: Frankie Morris

Issue, Actions & Anticipated Delivery: Refer to the finance report.

4. Conclusion

The Trust is facing a number of challenges including underperformance in a number of indicators. Managers and clinicians are well sighted on the issues and action plans have been produced to improve delivery and these are actively monitored. The Trust continues to work with the external agencies involved in the underperforming service areas to explore all system wide opportunities for improving performance. The IPC are sighted on the operational performance pressures and will receive quarterly updates on the statutory target compliance.

5. Recommendations

The Board is asked to note Trust performance and associated exception and action reports.

Appendix 1 - Single Oversight Framework

Single Oversight Framework (SOF)											
Indicator		Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
								Target	Dec-19		
Quality of Care	Quantity of Complaints	Caring	Quantity of complaints	50	29	↑	5	0	2	M	
	Staff Friends and Family - recommend as a place of treatment		Count of those categorised as extremely likely or likely to recommend/count of all responders	94%	95.0%	→	94%	95.0%	95.0%	Q	
	Mixed Sex Accommodation Breaches		Count of number of occasions sexes were mixed on same-sex wards	0	0	→	0	0	0	M	
	Inpatient scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	99.7%	↑	95%	99.2%	99.2%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	99.3%	↓	95%	99%	100%	M	
	Occurrence of any Never events	Safe	Count of Never Events	0	1	→	0	0	0	M	
	VTE Risk Assessment		Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recent month	95%	96.2%	↑	95%	96.3%	96.1%	M	
	Clostridium Difficile		Count of trust assigned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	3.0	6	↓	0.33	1	0	M	
	MRSA Bacteraemias		Count of trust assigned MRSA infections	0	1	↑	0	0	1	M	
	MSSA Bacteraemias		Count of trust assigned MSSA infections	5.2	9	→	0.58	0	0	M	
	Gram Negative Bacteraemias		Count of trust assigned Gram Negative Bacteraemias infections	6.8	11	↓	0.75	2	1	M	
	HSMR for 56 diagnosis groups (supplied from Dr Foster; hospital guide)	Effective	The ratio of observed deaths that occurred following admission in a provider to a modelled expectation of deaths (multiplied by 100) on the basis of the average England death rates for 56 specific clinical groups given a selected set of patient characteristics for those treated there.	100	127.01	↑	100	112.32	131.62	M	Current month: Sep 2019; YTD: Apr 2019 - Sep 2019.
Finance	Capital Service Cover	Financial Sustainability		1	1	→	1	1	1	M	Trigger: Poor levels of overall financial performance (average score of 3 or 4) very poor performance (score of 4) in any individual metric Potential value for money concerns
	Liquidity			1	1	→	1	1	1	M	
	I&E Margin	Financial Efficiency		1	1	→	1	1	1	M	
	Performance against plan	Financial Controls		1	1	→	1	1	1	M	
	Agency Spend			1	1	→	1	1	1	M	
	Overall use of resources (UoR) rating	Overall Financial Performance		1	1	→	1	1	1	M	
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Operational Performance	Count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	92%	92.06%	↓	92%	89.73%	90.57%	M	
	All cancers - maximum 62-day wait for first treatment from (a) their GP who have currently been waiting for less than 62 days for treatment to start from (b) the NHS screening service who have currently been waiting for less than 62 days for treatment to start		Proportion of patients referred for cancer treatment by: a. their GP who have currently been waiting for less than 62 days for treatment to start b. the NHS screening service who have currently been waiting for less than 62 days for treatment to start	85%	95.14%	↓	85%	95.80%	100%	M	
	Maximum 6-week wait for diagnostic procedures		Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	99%	73.3%	↓	99%	71.5%	76.9%	M	
	Dementia - Find		The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied; b. who, if identified as potentially having dementia or delirium, are appropriately assessed; and, c. where the outcome was positive or inconclusive, are referred on to specialist services.	90%	95.0%	↑	90%	92%	90%	M	
	Dementia - Assess			90%	100%	→	90%	100%	100%	M	
	Dementia - Refer			90%	100%	→	90%	100%	100%	M	
	Review of sustainability and transformation plans and other relevant matters	Strategic Change				-	-	-	-		LHCH is lead for CVD cross-cutting theme
Organisational Health	Staff Sickness (All Staff)	Organisational Health	Level of staff absenteeism through illness in the period Numerator = number of days sickness reporting within the month. Denominator = number of days available within the month	3.4%	4.66%	↓	3.4%	4.73%	4.66%	M	
	Staff Turnover (Voluntary)		Number of Voluntary Staff leavers reported within the period / Average of number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period. Numerator = number of voluntary leavers within the report period. Denominator = staff in post at the start of the reporting period	10%	10.87%	↓	10%	10.87%	10.81%	M	Turnover based on 'Voluntary' Leavers in 12 month period
	NHS Staff Survey - recommend as a place to work		Staff recommendation of the organisation as a place to work or receive treatment	76%	76%	↑	76%	76%	74%	Q	Q3 2018/19 Staff Survey Data - Previous Period Q3 2017
	Proportion of Agency Staff Costs		Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	1.90%	2.10%	↓	1.90%	2.06%	1.43%	M	
	Executive Team Turnover	Level of Senior Executive Turnover	Calculation: Leavers in 12 month period / Average Staff in Post in 12 month period x 100	25%	21.10%	↓	25%	21.10%	10.53%	M	
Overall	Segmentation				1	→		1	1	Adhoc	Segment 1: Maximum autonomy; universal support

Appendix 2 – Quality of Care

Regulatory and Operational Performance - Quality of Care

Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
						Target	Dec-19			
% of deaths screened for review within 7 days	Mortality		95%	69%	↑	95%	90%	76%	M	1 month data lag for this measure
% mortality reviews to be completed within 30 days - Doctors			80%	75%	↑	80%	90%	65%	M	1 month data lag for this measure
% mortality reviews to be completed within 30 days - Nurses			80%	98%	→	80%	100%	100%	M	1 month data lag for this measure
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.5%	↓	1.3%	1.8%	0.9%	M	
HSMR Weekend (supplied from Dr Foster)		HSMR is the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rate as some reference population ((Number of observed deaths/ the number of expected deaths) * 100)	100	167.03	↑	100	160.43	216.34	M	Current month: Sep2019; YTD: Apr 2019 - Sep 2019.
HSMR for all diagnosis (supplied from Dr Foster)			100	121.90	↑	100	110.84	131.48	M	Current month: Sep 2019; YTD: Apr 2019 - Sep 2019.
Cardiac Surgery observed: expected mortality ratio			1.00	1.03	↑	1.00	1.03	1.11	M	6-month rolling averages; latest to June 2019
Non-primary PCI observed: expected MACE ratio			1.00	0.16	↓	1.00	0.16	0.08	M	6-month rolling averages; latest to March 2019
Number of Falls (All Areas) - Avoidable & Unavoidable	Incidents	Count of Falls recorded across all areas	54	59	↓	6	12	6	M	All falls (avoidable & unavoidable)
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)		Count of Pressure Ulcers that were due to lapses in care and reported as grade 2	4.5	6	↑	0.50	0	1	M	
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)		Count of Pressure Ulcers that were due to lapses in care and reported as grade 3	0	0	→	0	0	0	M	
Number of Adverse Events (Red Alerts), Serious Incidents and Never Events		Number of events that were reported as a red alert, serious incident or never event	0	8	↑	0	0	2	M	2 x Adverse Events, 5 x SI's, 1 x Never events YTD
Number of reported patient safety incidents			N/a	1232	↑	N/a	143	156	M	
Follow-up audit of SUI reveals improvement embedded and delivering			No							OL Policy complimenting recent learning from deaths guidance
% Blood Cultures taken within 24 hours preceding first antibiotic given	Sepsis		95%	81.9%	↑	95%	73.1%	71%	M	
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	76.7%	↑	70%	92.3%	82%	M	
% Delivery of a sepsis antibiotic within three hours of prescription			96%	97.7%	↑	96%	100%	96%	M	
% of radiological alerts with a response document			95%	100%	→	95%	100%	100%	M	
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment
Friends and Family Test Response Rate - Outpatient scores % positive	Patient Experience	Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients	95%	98.6%	↓	95%	98.6%	100%	M	
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.2%	↑	95%	97.8%	96.6%	M	
All re-inspected KLOE's rated as outstanding			Yes or No							The Trust is waiting for re-inspection to determine whether objective has been achieved

Appendix 3 – Operational & Financial Performance

Regulatory and Operational Performance - Operational Performance

	Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month Target	Previous Month	Frequency	Comments	
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	144	🔴	N/a	18	10	M	
	Improve histopathology turnaround times at 7-days	Turnaround Times	Improve histopathology turnaround times at 7-days	70%	60.2%	🟡	70%	74.9%	61.0%	M	Data reported by Liverpool labs (latest data August-2019)
	Improve PET scanning turnaround times at 5-days		Improve PET scanning turnaround times at 5-days	75%	42.5%	🔴	75%	33.3%	55.0%	M	Request to scan (does not include reporting time)
	Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	2.3%	🟡	1.50%	2.0%	2.4%	M	Internal Target
	Cancelled Operations <u>NOT</u> seen in 28 days		Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days	0	1	🟡	0	0	0	M	
	Cancelled Urgent Operations cancelled for 2nd+ time		Count of those urgent operations that have already been cancelled on one or more occasions before.	0	0	🟡	0	0	0	M	
	Delayed Transfers of Care	Performance	A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed.	4.50%	4.14%	🟡	4.5%	3.90%	4.58%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	81.5%	🔴	>=85%	75.1%	79.0%	M	
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	-5.58%	🔴	0.0%	-13.00%	-7.1%	M	
	Referral to treatment - Incomplete Pathways 52+ weeks	RTT	Count of all patients on an incomplete pathway waiting over 52 weeks (English & Non-English)	0	3	🟡	0	0	0	M	1 Welsh Patient breach in April, treated 20th May, 1 Breach in August (Cardiology) and 1 Breach in September (Cardiothoracic Surgery).
	Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Reports within Std	90%	45.3%	🔴	90.0%	55.9%	67.51%	M	
	Plain Film Outpatient		Total Plain Film Outpatient Reports within Std	90%	90.8%	🔴	90.0%	90.6%	100%	M	
	CT Inpatient		Total CT Inpatient Reports within Std	90%	99.1%	🟡	90.0%	100%	99%	M	
	CT Outpatient		Total CT Outpatient Reports within Std	90%	75.7%	🔴	90.0%	64.6%	85.45%	M	
	MRI Inpatient		Total MRI Inpatient Reports within Std	90%	92.4%	🟡	90.0%	100%	83%	M	
	MRI Outpatient		Total MRI Outpatient Reports within Std	90%	67.8%	🟡	90.0%	80.1%	74.85%	M	
	Ultrasound Inpatient		Total Ultrasound Inpatient Reports within Std	90%	95.9%	🟡	90.0%	100%	100%	M	
	Ultrasound Outpatient		Total Ultrasound Outpatient Reports within Std	90%	96.0%	🟡	90.0%	100%	100%	M	
	14 day wait from referral to date first seen	Cancer	Patients waiting a maximum of two weeks from an urgent GP referral for suspected cancer to date first seen by specialist	93%	100%	🟡	93%	100%	100%	M	
	31 day wait from diagnosis to first treatment		Patients witing a maximum of 31 days from diagnosis to first definitive treatment	96%	100%	🔴	96%	98%	100%	M	
	31 day wait for second or subsequent treatment (surgery)		Patients waiting a maximum of 31 days for all subsequent treatments	94%	100%	🟡	94%	100%	100%	M	
	62 day wait for first treatment from urgent GP referral to treatment - consultant upgrade (Adj)		Patients waiting a maximum of 62 day's from a consultant decision to upgrade the urgency of a patient they suspect to have cancer to first treatment	85%	99%	🟡	85%	100%	100%	M	
	104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0	🟡	0	0	0	M	
	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	Welsh	Count of the number of Welsh patients whose clock period is less than 26 weeks during the calendar months of the return/Count of number of Welsh patients whose clock has not stopped during the calendar months of the return	95%	85.68%	🔴	95%	78.65%	82.00%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	85.71%	🔴	98%	65.12%	91.53%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	93.10%	🟡	95%	91.72%	90.39%	M	
	Emergency readmissions following elective admission	Readmissions	Occurs when the next admission to any English NHS hospital is an emergency within 28 days of live discharge.	100	107.59	🟡	100	115.63	130.25	M	Current month: Jun 2019; YTD: Apr 2019 - Jun 2019.
	Emergency readmissions following non-elective admission			100	84.67	🔴	100	89.98	75.31	M	Current month: Jun 2019; YTD: Apr 2019 - Jun 2019.
Workforce	Mandatory training	Organisational Health		95%	93.8%	🟡	95%	93.8%	94%	M	
	Appraisals			90%	90.1%	🟡	90%	90.1%	90%	M	Appraisal window reset May 2019
	Turnover Rate between 1-2 yrs service (voluntary (FTC excluded))			1.40%	2.76%	🔴	1.40%	2.76%	2.50%	M	
Finance	Net Surplus £000's	Finance		£1,709	£1,879	🔴	£49	£49	£384	M	
	Normalised Net Surplus £000's			£1,709	£1,714	🔴	£49	£49	£384	M	
	Cash Balance £000's			£15,177	£28,082	🟡	£15,177	£28,082	£26,251	M	Cash balances of £28.1m are £12.9m ahead of the planned position of £15.2m. This is primarily due to phasing of the Original Capital Plan and 18/19 PSF bonus monies
	Capital Expenditure £000's			£9,958	£8,074	🔴	£537	£197	£601	M	Capital is £1.9m behind plan due to a change in the phasing of schemes.
	Total Agency cost £000's			£1,049	£1,301	🔴	£116	£145	£99	M	Agency costs are £29k above plan in month, YTD is £252k over plan - due to Surgery Medical Agency costs are £242k above plan.
	Total Bank cost £000's			£1,820	£1,998	🔴	£202	£281	£253	M	Bank Costs are over plan in Month by £80k and YTD £177k, due to SiCU £43k Adverse in month £68k YTD.
	Deliver the recurrent cost improvement savings			£2,803	£2,061	🟡	£412	£241	£204	M	Falling recurring CIP's are partially offset YTD by £168k of non recurring CIPs.