

Board of Directors (in Public) Item 4.1

Subject: Board Dashboard: Period Ended 30th November 2018
Date of meeting: 8th January 2019
Prepared by: Lucinda Tennent/Information and Performance Manager
Presented by: Sue Pemberton/Director of Nursing & Operations
Purpose of Report: To Note

BAF Ref	Impact on BAF
1.1, 1.2, 2.1, 3.2	None

1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period ending the 30th November 2018. The report is divided into the following three sections:



- 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 2018 for routine monitoring on delivery.
- Section 3-Operational & Financial Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2018 for routine monitoring on delivery.

Section 1 - Single Oversight Framework (SOF)

Refer to Appendix 1.

There are no new exceptions this month.

Framework	Rating	Exception
Quality of Care		
Finance and use of resources		

Operational Performance		Maximum 6 week wait for diagnostic procedures (In-month and YTD)
Strategic Change		
Leadership and Improvement		Staff Sickness (In-month)
Segmentation		

1.1 Quality - Safe, Effective and Caring

1.1.1 Indicator: Maximum 6-week wait for diagnostic procedures

Accountable executive Officer: Sue Pemberton

Issue: Currently below target for November 2018 at 82.83% against a target of 99%, there were a total of 212 breaches for November.

Actions: The Board of Directors signed off the business case on Tuesday 3rd July 2018 and staff are now working at pace to implement the two additional scanners.

Anticipated Delivery: Compliance will not be achieved at year end; however an improved performance in Q1/2 2019/20 is expected when the new CT scanner is operational.

1.2 Leadership and Improvement : Organisational Health

1.2.1 Indicator: Staff Sickness

Accountable Executive Officer: Jo Twist

Issue: Sickness is 3.83% YTD and 4.30% in month against a target of 3.4%.

Actions: All staff triggering the sickness policy are reviewed by the Division with HR support; All are being managed as per the policy. Sickness levels are in the main being driven by long term absence; however there has been a spike in short term sickness in M8 and moving into early M9


Anticipated Delivery: On-going monitoring and management

Section 2 – Quality of Care Dashboard

Refer to Appendix 2.

The following indicators are new exceptions this month:

- HSMR Weekend (in-month);
- Number of falls (in-month).

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none"> • Mortality screening within 7 days (In-month & YTD) • HSMR Weekend (in-month) • Number of falls (in-month) • Number of Adverse Events (Red Alerts), Serious Incidents and Never Events (In-month and YTD) • % blood cultures taken within 24 hours preceding first antibiotic taken

2. Exceptions

2.1 Indicator: Mortality screening within 7 days

Accountable Executive Officer: Raphael Perry

Issue: Screening of deaths within 7-days is 73% in month and 74% YTD against a target of 95%.

Actions: The mortality review policy was introduced in September 2017. There is new national guidance on Learning from Deaths which has implications for how organisational learning is identified and implemented. Deaths are currently at 116 YTD.

Anticipated Delivery: Q3 2018/19

2.2 Indicator: HSMR Weekend (in-month) Accountable

Executive Officer: Mark Jackson **Issue:** In-month

ratio of 165 against a plan of 100

Actions: We are currently refreshing our mortality improvement strategy.

Anticipated Delivery: March 2019

2.3 Indicator: Number of falls (in-month)

Accountable Executive Officer: Sue Pemberton

Issue: There have been 8 falls in November against a target of 6.

Actions: The majority of these were unavoidable falls. All corrective measures are in place.

Anticipated Delivery: Ongoing

2.4 Indicator: Number of Adverse Events (Red Alerts), Serious Incidents and Never Events

Accountable Executive Officer: Mark Jackson

Issue: There has been 1 serious incident reported in November relating to a delay in cancer diagnosis.

Actions: A root cause analysis is currently underway.

Anticipated Delivery: February 2019

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

Accountable Executive Officer: Raphael Perry


Issue: Work continues to improve compliance with the new sepsis screening process and results are improving; however, the Trust remains under target. 74% in month and YTD. The target is 95%

Actions: Increased contribution of outreach nurses and ANPs in sepsis management. Reinforcement of performance by Division and continued education in the use of the sepsis bundle.

Anticipated Delivery: Q1 2019/20.

Section 3 - Operational & Financial Performance

Refer to Appendix 3.

Framework	Rating	Exception
Operational Performance		<ul style="list-style-type: none"> • Improve histopathology (YTD & Month) • Improve PET scanning turnaround times at 5-days (YTD & Month) • Cancelled Operations (YTD & Month) • Delayed Transfers of Care (YTD & Month) • Plain Film Inpatient (YTD & Month) • CT Outpatient (YTD & Month) • MRI Outpatient (YTD & Month) • 26 Weeks Referral to Treatment in aggregate- Admitted Pathways (YTD & Month) • 26 Weeks Referral to Treatment In aggregate - Non Admitted Pathways (YTD & Month) • 26 Weeks Referral to Treatment in aggregate - Incomplete Pathways (YTD & Month) • Std 6: 7 Day Services: Access to interventions (YTD) • Capital expenditure £000's (YTD) • Total bank cost £000's (YTD & Month) • Deliver the recurrent cost improvement savings £000s (YTD)

3. Exceptions

3.1 Indicator: Improve histopathology turnaround times at 7-days

Accountable Executive Officer: Sue Pemberton

Issue: Current performance has dropped to 58% against a target of 60% from the improvement trajectory set by LCL. The target is set to increase to 70% by December 2018

Actions: The SLA with LCL is closely monitored by the clinical services division. A review of resource utilisation to increase throughput and reduce internal processing delays based on current capacity and equipment is being undertaken by SVL. There is also a plan to increase 4 new Consultant Histopathologists. The Trust is continuing to work with LCL to reduce the average turnaround time of 10 days to at least 7 days.

Anticipated Delivery: Compliance with the set improvement trajectory by LCL is expected by December 2018. Full compliance is expected by September 2019.

3.2 Indicator: Improve PET Scanning turnaround times at 5-days

Accountable Executive Officer: Sue Pemberton

Issue: November is currently 30.4% against a 75% target.

Actions: There are ongoing discussions across Cheshire and Merseyside with regards to the current provide of PET scans, a contract that was placed regionally. Current waiting times are higher than required and the Trust is working with NHS Specialised Commissioning and CCG to negotiate with the provider for improved access times.

Anticipated Delivery: This issue has been raised with the NHS England national team as they have negotiated a 10 year contract which is currently only in year 3. This is a standing item on the local commissioning meeting agenda.

3.3 Indicator: Cancelled Operations

Accountable Executive Officer: Sue Pemberton

Issue: Total number of reportable cancellations for November 2018 was 28. This is the highest volume of reportable cancellations the Division has reported in the current financial year.

Top three leading cancellation themes were as follows:

1. Emergency substitution – resulted in 6 cancellations
2. Elective anaesthetist unavailable – resulted in 5 cancellations
3. Elective list overrun – resulted in 4 cancellations

The Division experienced a high volume of aortic emergencies in November, displacing planned elective cases resulting in their cancellations.

There has been an on-going issue with a shortage of anaesthetists to cover surgical activity. Actions have been taken to address this issue including the recruitment of two locum anaesthetists.

Elective list overruns are a common cause of cancellations. The Division has taken steps to reduce the number of cancellations attributed to this theme including improved theatre scheduling project. The list overruns in November were as a direct result of complications in theatre that could not have been avoided or factored into scheduling.

Actions:

The Division has a robust cancellation action plan in place which is reviewed on a monthly basis and updated when required.

Regular clinical engagement takes place at monthly Divisional Performance meetings and at consultant business meetings.

A review of cancellation data is to be presented at Audit day in January 2019.

The Division have commenced reviewing all clinical cancellations at business meetings to identify learning from the cancellation if deemed avoidable and sharing the learning amongst the consultant body.

Anticipated Delivery: The surgical division are working hard to reduce cancelled ops. The target for cancelled operations is going to be reviewed as part of the annual planning process for next year. A visit to another provider Trust will be scheduled to review the theatre scheduling software the Trust are planning to implement in Q4 as part of the service development project.

3.4 Indicator: Delayed Transfers Of Care

Accountable Executive Officer: Sue Pemberton

Issue: Delayed transfers of care are above target for YTD with a performance of 5.17% against a target of 4.5%.

Actions: The Trust continues to work with other organisations to ensure patient discharges are managed as efficiently as possible. A flagging system is in place to identify patients with complex discharge needs which are subsequently managed by the care support team.

Anticipated Delivery: On-going

3.5 Indicator: Plain Film Inpatient

Accountable Executive Officer: Sue Pemberton

Issue: Current performance is at 72.99%. Routine inpatient plain films are primarily reviewed and actioned by the admitting clinical consultant caring for the patient, which allows for any urgent intervention to take place. Further review by the Consultant Radiologist acts as a safety check to pick up more discrete changes that may not be identified by the admitting consultant's team and which do not require immediate action. Requests for urgent reporting are actioned immediately.

Actions: Reporting performance is being closely monitored and risk assessed during the current identified shortage in the Radiology workforce. Two new consultants have an anticipated start date for February and April 2019 which will ease the current pressures. For reporting radiologists to prioritise inpatient radiographs during their reporting sessions

Anticipated Delivery: Q4

3.6 Indicator: CT Outpatient

Accountable Executive Officer: Sue Pemberton

Issue: Current performance is at 84.69% against a 90% compliance target

Actions: The Radiology department is working closely with the medical and surgical divisions to ensure that any scans required prior to admission or outpatient review for treatment are prioritised and expedited. An improved contract management process with Medica was

implemented in October 2018 to ensure timely reporting of outsourced scans against set KPIs. A full re-tendering exercise is underway to review if any other companies can provide an improved service. Full compliance is expected to be achieved when new LHCH consultant capacity is in place.

Anticipated Delivery: Q4

3.7 Indicator: MRI Outpatient

Accountable Executive Officer: Sue Pemberton

Issue: Current performance is 74.65% against a 90% compliance target.

Actions: There are minimal requests for urgent MRI scans. The Radiology Department is working closely with the medical and surgical divisions to ensure that any scans required prior to admission or outpatient review for treatment are prioritised and expedited. Further communication with Medica is taking place to assess if MRI aorta scans are able to be outsourced. Medica have increased the level of Consultant Radiologists assigned to review scans for LHCH thereby increasing reporting turnaround times and potentially offer aortic MRI reports. In addition, a full re-tendering exercise is underway to review if any other companies can provide this service. Full compliance expected to be achieved when new consultant capacity is in place.

Anticipated Delivery: Q4

3.8 Indicator: Welsh 26 weeks (Admitted, Non Admitted & Incomplete)

Accountable Executive Officer: Sue Pemberton

Issue: Patients waiting over 26-weeks for treatment.

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 majority of Welsh pathways are complex and only get referred to the Trust late in the pathway. The Trust is assisting commissioners in identifying ways of improving the referral process to enable delivery of this target. Additional monitoring of waiting times has also been introduced by Commissioners to identify bottlenecks in the patient pathway; an initiative the Trust is actively participating in.

Anticipated Delivery: This is challenging due to late referrals which have been raised with the Welsh Commissioning teams.

3.9 Indicator: Total bank cost £000's (YTD & Month)

Accountable Executive Officer: Claire Wilson

Issue: The YTD overspend is (£1,541) against a target of (£1,304)

Actions: Bank staff are supporting flexible staffing requirements in preference to using agency staff. Increases have been seen in administration and nursing staff but overall staffing levels are within budget. Continued focus by divisional teams on ensuring that staffing levels are delivered safely whilst ensuring value for money is delivered.

Anticipated Delivery: March 2019

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.

5. Recommendations

The Board of Directors are asked to note Trust performance and associated exception and action reports.

[illegible]

Appendix 2 – Quality of Care

Regulatory and Operational Performance- Quality of Care

Indicator		Description	Target	YTD	Trend	Current Month		Previous Month	Frequency	Comments		
						Target	Nov-18					
% of deaths screened for review within 7 days			95%	74%	↓	95%	73%	75%	M	Current month based October 2018		
% mortality reviews to be completed within 30 days of allocation - Doctors			80%	76%	↓	80%	73%	75%	M	Current month based October 2018		
% mortality reviews to be completed within 30 days of allocation - Nurses			80%	90%	↑	80%	93%	88%	M	Current month based October 2018		
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.31%	↑	1.3%	1.12%	1.25%	M			
HSMR Weekend (DFI)		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	110.82	↓	100	164.998	53.69	M	Current Month is July 2018		
HSMR for all diagnosis (supplied from Dr Foster)			100	97.42	↓	100	123.59	73.59	M	Current Month is July 2018		
Cardiac Surgery observed:expected mortality ratio			1.00	0.95	↑	1.00	1.29	1.42	M	6-month rolling averages; latest due up to June 2018		
Non-primary PCI observed:expected MACE ratio			1.00	0.00	↑	1.00	0.20	0.34	M	6-month rolling averages; latest due up to June 2018		
Number of Falls (Birch, Cedar, Elm and Oak)		Count of Falls recorded across all areas	48	39	↓	6	8	3	M			
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	2	→	0	0	0	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	3	→	0	1	1	M			
Number of reported patient safety incidents (6 month rolling avg)			N/a	1053	↓	N/a	141	139	M			
Follow-up audit of SUI reveals improvement embedded and delivering			No		Comment: OL Policy complimenting recent learning from deaths guidance							
% Blood Cultures taken within 24 hours preceding first antibiotic given			95%	74%	↑	95%	74%	59%	M			
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	66%	↓	70%	65%	72%	M			
% Delivery of a sepsis antibiotic within three hours of prescription			96%	93%	↓	96%	94%	97%	M			
% of radiological alerts with a response document			95%	93.2%	↑	95%	97.0%	95.8%	M	YTD is Average		
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment		
Friends and Family Test Response Rate - Inpatients		Count of patients responding to the friends and family test in inpatients / count of eligible patients	50%	65%	↓	50%	53.4%	69.5%	M			
Outpatient scores from Friends & Family Test - % positive		Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients	95.0%	98.0%	↑	95.0%	100.00%	99.15%	M			
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.96%	↓	95%	98.79%	99.61%	M			
All re-inspected KLOE's rated as outstanding			Yes or No		Comment: 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	Trend	Current Month Target	Nov-18	Previous Month	Frequency	Comments
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	115	↑	N/a	13	14	M	
	Improve histopathology turnaround times at 7-days			60%	58%	→	60%	58%		M	This indicator has been included for the first time this month.
	Improve PET scanning turnaround times at 5-days			75%	49.3%	↓	75%	30.4%	33.3%	M	
	Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	2.9%	↓	1.50%	3.6%	2.2%	M	Internal Target
	Cancelled operations seen in 28 days		Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days	100%	98.0%	→	100%	100%	100%	M	
	Urgent operations cancelled 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.	4.5%	5.58%	↓	4.5%	5.17%	3.82%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	82.4%	↑	>=85%	85.4%	85.2%	M	
	Referrals GP		Count of referrals received into the trust from GP organisations (Community referrals removed)	12928	13713	↑	1616	2451	2406	M	Updated to include External GP Referrals (Community Referrals Removed)
	Referrals DGH (External)	Referrals	Count of referrals received into the trust from external sources (Community referrals removed)	6648	7768	↑	831	1077	1055	M	Updated to include External Self referrals and External Tertiary (Community Referrals Removed)
	Referrals Other		Count of referrals received internally and all other sources (Community referrals removed)	7248	6603	↓	906	941	1033	M	Updated to include Internal Referrals and Ref Org Unknown (Community Referrals Removed)
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	0.0%	↑	0.0%	0.0%	-7.7%	M	
	Activity Private		Count of Total spells - Activity Plan for Private Patients	-			-			M	This indicator is currently under review, however, figures should be available for next month's dashboard.
	18 Weeks Referral to treatment Incomplete Pathways 52 week +	RTT	Count of patients on an incomplete pathway waiting over 52 weeks	0	1	→	0	0	0	M	May-18
	Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Repts within Std	90%	61.85%	↑	90%	72.99%	58.24%	M	tbc
	Plain Film Outpatient		Total Plain Film Outpatient Repts within Std	90%	98.58%	↑	90%	100.00%	99.09%	M	tbc
	CT Inpatient		Total CT Inpatient Repts within Std	90%	99.64%	→	90%	100.00%	100.00%	M	
	CT Outpatient		Total CT Outpatient Repts within Std	90%	71.66%	↑	90%	84.69%	78.05%	M	
	MRI Inpatient		Total MRI Inpatient Repts within Std	90%	95.20%	↑	90%	100.00%	91.67%	M	
	MRI Outpatient		Total MRI Outpatient Repts within Std	90%	67.28%	↑	90%	74.65%	70.52%	M	
	Ultrasound Inpatient		Total Ultrasound Inpatient Repts within Std	90%	97.92%	→	90%	100.00%	100.00%	M	
	Ultrasound Outpatient		Total Ultrasound Outpatient Repts within Std	90%	97.66%	→	90%	100.00%	100.00%	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 waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	99.7%	→	96%	100%	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%	97%	→	85%	100%	100%	M	
	104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0.5	→	0	0	0	M	This indicator has been included for the first time this month.
	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%	91.59%	↑	95%	91.09%	87.6%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	94.12%	↓	98%	87.50%	94.1%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	90.68%	→	95%	80.68%	90.7%	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	102.28	#REF!	100	#REF!	104.21	M	Current Month is April 2018
	Emergency readmissions following non-elective admission			100	99.83	#REF!	100	#REF!	73.80	M	Current Month is April 2018
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	7 Day services		90%	100%	→	90%			6M	March 2018 Survey results.
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission)			90%	100%	→	90%			6M	March 2018 Survey results.
	Std 5: 7-day Services: CT scan within 1 hr for critical care need			70%	100%	→	70%			6M	March 2018 Survey results.
	Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need			80%	100%	→	80%			6M	March 2018 Survey results.
	Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need			85%	100%	→	85%			6M	March 2018 Survey results.
	Std 6: 7-day Services: Access to interventions			80%	67%	→	80%			6M	March 2017 Survey results. September 2017 survey never covered Standard 6. March 2018 Survey (Not yet available)
	Std 8: 7-day Services: Ongoing review twice daily in high dependency area			80%	100%	→	80%			6M	March 2018 Survey results.
	Std 8: 7-day Services: Ongoing review every 24 hours on general wards			80%	94%	→	80%			6M	March 2018 Survey results.
Workforce	Mandatory training	Organisational Health		95%	89%	↓	95%	89%	90%	M	
	Appraisals			90%	93%	↑	90%	93%	92%	M	
	Turnover Rate between 1-2 yrs service (voluntary)(FTC excluded)			1.4%	1.77%	↓	1.4%	1.77%	1.75%	M	
Finance	Net Surplus £000's	Finance		£6,413	£6,422	↑	£1,140	£1,144	£1,636	M	
	Normalised Net Surplus £000's			£6,413	£6,422	↑	£1,140	£1,144	£1,636	M	
	Cash Balance			£14,284	£12,200	↓	£14,284	£12,200	£13,896	M	
	Capital expenditure £000's			£3,932	£3,488	↑	£528	£437	£593	M	YTD capital spend is £623k behind plan. Orders for equipment, in particular ACHD requirements, have been placed but had not been
	Total agency cost £000's			£1,281	£1,008	↑	£167	£100	£137	M	
	Total bank cost £000's			£1,304	£1,541	↑	£163	£207	£190	M	In admin and nursing. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets
	Deliver the recurrent cost improvement savings			£ 2,458	£2,178.00	↑	£ 337	£305.00	£ 357	M	There are non-recurring schemes of £142k to offset the recurrent CIP underachievement.