

## Board of Directors (In Public) Item 4.1

**Subject:** Trust Review - SOF, Regulatory and Operational Performance  
**Month 10**  
**Date of meeting:** 5<sup>th</sup> March 2019  
**Prepared by:** Gary White, Senior Information Business Partner - Corporate  
**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 31st January 2019. The report is divided into the following three sections:


- 1 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.
- 2 Section 2 - Quality of Care Dashboard: internal quality indicators agreed by the Board in April 2018 for routine monitoring on delivery.
- 3 Section 3 - Operational & Financial Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2018 for routine monitoring on delivery.

#### 1.1. Section 1 - Single Oversight Framework (SOF)

Refer to Appendix 1.

The following indicators are new exceptions this month:

- Written Complaints – Rate
- Staff Sickness
- Proportion of temporary staff

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none"> <li>Written Complaints – Rate (in-month)</li> <li>Occurance of any Never Events (YTD)</li> </ul>
Finance and use of resources		
Operational Performance		<ul style="list-style-type: none"> <li>Maximum 6 week wait for diagnostic procedures (YTD &amp; in-month)</li> </ul>
Strategic Change		
Leadership and Improvement		<ul style="list-style-type: none"> <li>Staff Sickness (in-month)</li> <li>Proportion of temporary staff (in-month)</li> </ul>
Segmentation		

### In-month Exceptions

#### 1.1.1 Indicator: Written Complaints- Rate

**Accountable executive Officer:** Sue Pemberton

**Issue:** In month the indicator has failed expected performance (target of 5 Vs actual of 6)

**Actions:** Year to date the indicator is performing well and will achieve the target at the end of the financial year. Month on month it is difficult to anticipate the number of incoming complaints.

**Anticipated Delivery:** March 2019

#### 1.1.2 Indicator: Maximum 6-week wait for diagnostic procedures

**Accountable executive Officer:** Sue Pemberton

**Issue:** Currently below target for January 2019 at 77.32% against a target of 99%, there were a total of 267 breaches for January. There was an increase in referrals in November & December 2018 which, due to loss of working days in December over the Christmas period, caused an increased backlog. Referrals were subsequently carried over to January 2019. This resulted in an in-month fall in compliance which is expected to improve back to over 80% from February 2019.

**Actions:** The Board of Directors signed off the business case on Tuesday 3<sup>rd</sup> 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. A revised trajectory has been developed for 2019 which is awaiting submission to NHSI and Trust Board for approval.

#### 1.1.3 Indicator: Staff Sickness

**Accountable executive Officer:** Joanne Twist

**Issue:** Sickness rate is above Trust target of 3.4%, currently 4.68% (3.94% YTD)

**Actions:** HR continues to support divisions in the management of sickness. There was a spike in Medicine in January 2019. Noticeable increase in sickness related to chest/respiratory and cough/cold/flu sickness for January in some areas.

**Anticipated Delivery:** Ongoing


- 1.1.4 **Indicator:** Proportion of temporary staff  
**Accountable executive Officer:** Joanne Twist  
**Issue:** Staff employed on Fixed Term appointments exceeds Trust target of 5% (currently 6%).  
**Actions:** Initial review of temporary appointments on ESR has been undertaken. Some staff who are currently in secondment roles are showing on the temporary staff report. Data cleanse exercise to be undertaken. Trust level doctors make up nearly 30% of the temporary staffing workforce. Work to be undertaken within individual departments regarding high numbers of employees on fixed term contracts and the long term planning of these employees.  
**Anticipated Delivery:** April 2019

## 1.2. Section 2 - Quality of Care

Refer to Appendix 2.

The following indicators are new exceptions this month:

- Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)
- Number of Adverse Events, Serious Untoward Incidents and Never Events

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none"> <li>• Mortality screening within 7 days (YTD &amp; in-month)</li> <li>• HSMR Weekend (in-month)</li> <li>• Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care) (in-month)</li> <li>• Number of Adverse Events, Serious Untoward Incidents and Never Events (YTD &amp; in-month)</li> <li>• % blood cultures taken within 24 hours preceding first antibiotic taken (YTD)</li> </ul>

### In-month Exceptions

- 1.2.1 **Indicator:** Mortality screening within 7 days  
**Accountable executive Officer:** Raphael Perry  
**Issue:** Screening of deaths within 7-days is 63% in month and 73% YTD against a target of 95%.  
**Actions:** The new mortality review policy, introduced in September 2017 has been updated in February 2019. The national guidance on Learning from Deaths has been implemented and there are several developments in terms of organised learning. These include monthly presentations by the divisions to the operations board; divisional governance action plans and RCAs as appropriate; contributions to the fortnightly sharing and learning sessions; learning presented at divisional audit days and a quarterly report to the Board of Directors.  
**Anticipated Delivery:** Q4 2018/19
- 1.2.2 **Indicator:** HSMR Weekend  
**Accountable executive Officer:** Raphael Perry  
**Issue:** The HSMR Weekend ratio is 164.99 for July 2018. However, this indicator is not reliable given the size of the dataset and therefore it is proposed to omit the routine

monitoring of mortality occurring following a weekend admission. As a specialist, relatively low volume trust, our mortality rates are low. This is the product of low numbers of deaths and relatively low volumes of activity. As a consequence, when a number of deaths occur together, mortality rates can elevate considerably. The Trust routinely reviews the confidence limits associated with such rates to ensure action is taken based upon statistical significance – i.e. when the lower bound confidence limit excludes a risk adjusted rate of 100. To focus resource on reviewing a subset (2/7ths) of mortality would create a lot of false positives – occasions where the data suggests we have a problem when in fact we do not, simply as a consequence of low volumes with high variability.

**Actions:** Proposal to remove routine monitoring of this indicator from the dashboard.

**Anticipated Delivery:** March 2019

1.2.3 **Indicator:** Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)

**Accountable executive Officer:** Sue Pemberton

**Issue:** There were 5 hospital acquired pressure ulcers last year (2017-18). A target was set to reduce pressure ulcers by 20% this year (2018-19), in reality this was 1 pressure ulcer due to our low incidence of pressure ulcers. So far, 5 pressure ulcers have developed where lapses in care have been identified (and 1 x pressure ulcer with outstanding review). 1 x pressure ulcer (blister) assessed as likely friction injury only – current debate within Tissue Viability whether these should be assessed as pressure ulcers in future.

**Actions:** Each new pressure ulcer incident prompts a full Root Cause Analysis, where actions are planned to assist the prevention of similar occurrences in the future.

Actions have included changing the physical location of pressure reducing aids, changes to documentation on EPR, raising awareness of moisture damage and how this can pre-empt pressure damage.

**Anticipated Delivery:** April 2019. Actions above completed. Close working with critical care (highest risk area), regular training/high visibility is on-going.

1.2.4 **Indicator:** Number of Adverse Events, Serious Untoward Instances & Never Events

**Accountable executive Officer:** Sue Pemberton

**Issue:** One STEISS report in relation to a breach of IT policy which has been investigated and an action plan in place.

**Actions:** Deliver action plan


**Anticipated Delivery:** March 2019

### 1.3 Section 3 - Operational & Financial Performance

Refer to Appendix 3.

The following indicators are new exceptions this month:

- Referrals - GP
- MRI - Inpatient
- Turnover Rate between 1-2 yrs service (Voluntary (FTC excluded))

Framework	Rating	Exception
Operational Performance		<ul style="list-style-type: none"> <li>• Improve PET scanning turnaround times at 5-days (YTD &amp; in-month)</li> <li>• Cancelled Ops (YTD)</li> <li>• Referrals – GP (YTD &amp; in-month)</li> <li>• 18 Week RTT Incomplete Pathways 52 week+ (YTD)</li> </ul>

		<ul style="list-style-type: none"> <li>• Plain Film - Inpatient (YTD &amp; Month)</li> <li>• CT - Outpatient (YTD &amp; in-month)</li> <li>• MRI - Inpatient (Month)</li> <li>• MRI - Outpatient (YTD &amp; in-month)</li> <li>• 104 Day Cancer (YTD)</li> <li>• 26 Weeks Referral to Treatment in aggregate- Admitted Pathways (YTD &amp; in-month)</li> <li>• 26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways (YTD &amp; in-month)</li> <li>• 26 Weeks Referral to Treatment in aggregate - Incomplete Pathways (YTD &amp; in-month)</li> <li>• Std 6: 7 day Services: Access to interventions (YTD)</li> <li>• Turnover Rate between 1-2 yrs service(Voluntary(FTC excluded)) (YTD &amp; in-month)</li> <li>• Capital expenditure (YTD &amp; in-month)</li> <li>• Total bank cost (YTD &amp; in-month)</li> <li>• Deliver the recurrent cost improvement savings (YTD &amp; in-month)</li> </ul>
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### In-month Exceptions

#### 1.3.1 **Indicator:** Improve PET Scanning turnaround times at 5-days

**Accountable executive Officer:** Sue Pemberton

**Issue:** January is currently 52.4% 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.

#### 1.3.2 **Indicator:** Referrals - GP

**Accountable executive Officer:** Sue Pemberton

**Issue:** GP referrals are under the agreed target both year to date and in-month. This is due to a review of the reporting process.

**Actions:** The administrative/system processes currently in place in the Trust require the addition of an OP referral to the Trust's PAS when we receive an emergency admission or an inpatient transfer. The Information Team is progressing a piece of work, supported by the Trust's PAS Programme Board, to review the business rules used to identify and remove these records from the Trust's OP referrals dataset. The Information Team is also progressing the work required to identify all referrals to the Trust's community services.

**Anticipated Delivery:** April 2019

- 1.3.3 **Indicator:** Plain Film - Inpatient  
**Accountable executive Officer:** Sue Pemberton  
**Issue:** Current performance is at 76.99% against a target of 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 April 2019 which will ease the current pressures and see performance increase to the expected compliance rate.  
**Anticipated Delivery:** May 2019
- 1.3.4 **Indicator:** CT - Outpatient  
**Accountable executive Officer:** Sue Pemberton  
**Issue:** Current performance is at 73% against a target of 90%.  
**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. Two new consultants have an anticipated start date for April 2019 which will ease the current pressures and see performance increase to the expected compliance rate.  
**Anticipated Delivery:** May 2019
- 1.3.5 **Indicator:** MRI – Inpatient & Outpatient  
**Accountable executive Officer:** Sue Pemberton  
**Issue:** Current performance is 67%% 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. Two new consultants have an anticipated start date for April 2019 which will ease the current pressures and see performance increase to the expected compliance rate.  
**Anticipated Delivery:** May 2019
- 1.3.6 **Indicator:** Welsh 26 weeks RTT (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:** 2018/19 subject to discussions in relation to HRG4+

- 1.3.7 **Indicator:** Turnover Rate between 1-2 years service (voluntary (FTC excluded))  
**Accountable executive Officer:** Joanne Twist  
**Issue:** Turnover rate for staff employed between 1-2 years exceeds target of 1.4%, currently at 2.02% YTD.  
**Actions:** Initial analysis of data identifies that majority of leavers within this period are due to career progression. However, on further analysis there is a need to undertake a data cleanse, as there appears to be a coding issue for some posts who are showing as voluntary leavers rather than fixed term. 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:** 2019-2021
- 1.3.8 **Indicator:** Capital expenditure  
**Accountable executive Officer:** Claire Wilson  
**Issue:** Capital Expenditure is £4.7m YTD, £2.8m behind plan of £7.5m YTD.  
**Actions:** Delays in CT/MR and Cath lab projects have lead to expenditure slippage in 2019/20. Weekly meetings being held with key departmental heads in order to track orders and delivery dates to ensure that forecast is delivered by the year end.  
**Anticipated Delivery:** March 2019
- 1.3.9 **Indicator:** Total bank cost  
**Accountable executive Officer:** Claire Wilson  
**Issue:** Bank costs are £1.913m YTD, £283k above the plan of £1.630m.  
**Actions:** Bank costs are £1,913k YTD, which is £285k above plan. However, agency costs are £397k below plan for the same period, equating to an overall underspend on temporary staffing of £112k YTD. Staffing budgets continue to be closely monitored by divisional teams with support from business partners to ensure delivery in line with approved budgets by the end of the year.  
**Anticipated Delivery:** April 2019
- 1.3.10 **Indicator:** Deliver the recurrent cost improvement savings  
**Accountable executive Officer:** Claire Wilson  
**Issue:** The position to month 10 shows recurrent CIP delivery of £2,741k against a target of £3,065k, providing a shortfall of £325k (89% achievement) this is offset by £251k of non-recurrent schemes, leaving a gap of £74k.  
**Actions:** The forecast CIP position shows a projected recurrent shortfall of £413k in year with £307k of non-recurrent mitigations identified to bridge this gap where there are delays to a recurrent scheme being implemented, bringing the forecasted in-year gap to £106k. The full year effect of CIPs commenced in 2018/19 that will be fully realised by 2019/20 is £3,560k (94%). The divisions continue to work on schemes to bridge the final recurrent gap.  
**Anticipated Delivery:** April 2019

**New Cancer Performance Target: Faster Diagnosis Standard**

A new cancer diagnosis standard, designed to ensure that patients find out within 28 days whether or not they have cancer, will be introduced in 2020. To prepare for the future 28-day standard, the Surgical Division have implemented the new data collection requirements and associated data quality measures from February 2019. Full national data collection for all patients will start in April 2019 with full monitoring against the standard from April 2020.

## **2 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.

## **3 Recommendations**

The Board of Directors are asked to:

- 1 Note Trust performance and associated exception and action reports; and
- 2 Approve the removal of HSMR Weekend indicator from future dashboards as described in section 1.2.2 above.



## Appendix 1 - Single Oversight Framework

Single Oversight Framework (SOF)											
Indicator	Type	Description	Target	YTD	Trend	Current Month Target	Jan-19	Forecast	Previous Month	Frequency	Comments
Quality of Care	Written Complaints - Count	Count of written complaints/Count of whole time equivalent staff	55	29	↓	5	6		2	M	1 Complaint under consideration whether to investigate
	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%	93%	→	94%	93%		93%	Q	Q3 2017 Staff Survey Data
	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%	99.4%	↓	95%	99.00%		99.40%	M	
	Community scores from Friends & Family Test - % positive	Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	99.7%	↓	95%	99.0%		100%	M	
	Occurrence of any Never events	Count of Never Events in rolling six-month period	0	1	↑	0	0		1	M	to be updated
	NHS England/NHS Improvement Patient Safety Alerts Outstanding	Number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot	0	0	→	0	0		0	M	to be updated
	VTE Risk Assessment	Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95.0%	97.0%	↑	95.0%	97.0%		96.4%	M	
	Clostridium Difficile	Count of trust apportioned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	4	2	→	1	0		0	M	
	Clostridium Difficile Infection rate (per 1000 beddays)	Rolling 12-month count of trust- apportioned C-difficile infections in patients aged 2 years and over/Rolling 12 Month Average Occupied bed days per 100,000 beds	0.19	0.02	→	0.19	0.00		0	M	
	MRSA Bacteraemias	Rolling 12-month count of trust assigned MRSA infections/Rolling 12 month average occupied bed days multiplied by 100,000	0	0	→	0	0		0	M	
	MSSA Bacteraemias	Rolling 12-month count of trust- apportioned MSSA infections/rolling 12-month average occupied bed days multiplied by 100,000	N/a	5	↑	N/a	0		2	M	
	eColi LHCH Acquired	Rolling 12-month count of all E. coli infections/rolling 12-month average occupied bed days multiplied by 100,000	-	5	→	-	0		0	M	
Finance	HSMR for 56 diagnosis groups (supplied from Dr Foster; hospital guide)	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	108.55	↓	0.015	140.98		80.75	M	Oct-18
	Capital Service Cover	Financial Sustainability	1	1	→	1	1		1	M	
	Liquidity	Financial Efficiency	1	1	→	1	1		1	M	
	I&E Margin	Financial Controls	1	1	→	1	1		1	M	
	Performance against plan	Overall Financial Performance	1	2	→	1	2		2	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
	Agency Spend		1	1	→	1	1		1	M	
Operational Performance	Overall use of resources (UoR) rating		1	1	→	1	1		1	M	
	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	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	92.0%	92.23%	↓	92%	92.23%		92.33%	M	
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	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%	95.90%	→	85%	100.00%		100%	M	Adjusted figure provided
	Maximum 6-week wait for diagnostic procedures	Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	99%	91.45%	↓	99%	77.52%		82.35%	M	
	Dementia - Find	The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:	90%	87.0%	↓	90%	81.1%		86%	M	awaiting validation
	Dementia - Assess		90%	99%	→	90%	100%		100%	M	awaiting validation
Strategic Change	Dementia - Refer		90%	97%	→	90%	100%		100%	M	awaiting validation
	Review of sustainability and transformation plans and other relevant matters	Strategic Change			-	-	-		-		LHCH is lead for CVD cross-cutting theme
Leadership and Improvement Capability	Well Led Reviews - CQC Well Led Assessments	CQC Well Led Inspections			-	-	-		-		CQC Review published September 2016 rated Well-Led Domain as
	Well Led Reviews - NHS Code of Governance				-	-	-		-		MIAA Review published March 2017 concluding the Trust is well led with
	Third Party Information - Healthwatch, MP's, Whistleblowers, Coroners' Reports, CQC Warnings, Other material Concerns	Information from third parties			-	-	-		-		
	Staff Sickness	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%	3.94%	↓	3.4%	4.68%		4.06%	M	
	Staff Turnover	Number of 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 leavers within the report period. Denominator = staff in post at the start of the reporting period	10%	13.31%	↑	10%	13.31%		13.91%	M	Turnover based on 'All 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%	74%	→	76%	74%		74%	Q	Q3 2017 Staff Survey Data - Previous Period Q3 2016
	Proportion of temporary staff	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.	5%	5.17%	↓	5%	6.06%		5.72%	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%	13.30%	↓	25%	13.30%		0.00%	M	*NB excludes Ragh Perry who left on Flexi Retirement but returned
	Segmentation			1	→		1		1	Adhoc	Segment 1: Maximum autonomy; universal support

## Appendix 2 – Quality of Care

### Quality of Care

Indicator	Type	Description	Target	YTD	Trend	Current Month		Previous Month	Frequency	Comments	Type
						Target	Jan-19				
% of deaths screened for review within 7 days	Mortality		95%	73%	↓	95%	63%	77%	M	Current month based October 2018	L
% mortality reviews to be completed within 30 days - Doctors			80%	76%	↑	80%	94%	77%	M	Current month based October 2018	L
% mortality reviews to be completed within 30 days - Nurses			80%	92%	↑	80%	100%	92%	M	Current month based October 2018	L
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.34%	↑	1.3%	1.41%	1.56%	M		L
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	0.00	M	Current Month is July 2018. See note in section 1.2.2 of narrative report.	L
HSMR for all diagnosis (supplied from Dr Foster)			100	99.68	↓	100	123.59	75.57	M	Current Month is July 2018	L
Cardiac Surgery observed:expected mortality ratio			1.00	0.95	↑	1.00	0.99	1.29	M	6-month rolling averages; latest Apr-Sep 2018	
Non-primary PCI observed:expected MACE ratio			1.00	0.00	↑	1.00	0.09	0.20	M	6-month rolling averages; latest Apr-Sep 2018	
Number of Falls (Birch, Cedar, Elm and Oak)	Incidents	Count of Falls recorded across all areas	60	48	↑	6	3	6	M		L
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	5	5	→	0	1	1	M		L
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		L
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	5	→	0	1	1	M		
Number of reported patient safety incidents (6 month rolling avg)			N/a	1274	-	N/a	111	110	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	Sepsis		95%	75%	↑	95%	83%	71%	M		L
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	68%	↓	70%	69%	79%	M		L
% Delivery of a sepsis antibiotic within three hours of prescription			96%	93%	↓	96%	93%	96%	M		N
% of radiological alerts with a response document			95%	93.8%	↑	95%	96.5%	95.5%	M	YTD is Average	L
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment	L
Friends and Family Test Response Rate - Inpatients	Patient Experience	Count of patients responding to the friends and family test in inpatients / count of eligible patients	50%	66%	↑	50%	99.1%	60.4%	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%	98.6%	↓	95.0%	99.00%	99.13%	M		
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.97%	#DIV/0!	95%	#DIV/0!	98.10%	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

Operational and Finance Performance											
Indicator	Type	Description	Target	YTD	Trend	Current Month Target	Previous Month	Frequency	Comments		
Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	145	👉	N/a	15	M			
Improve histopathology turnaround times at 7-days			60%	66%	👉	60%	68%	M	Data as reported by Liverpool labs (December 2018)		
Improve PET scanning turnaround times at 5-days			75%	44.5%	👈	75%	52.4%	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%	2.7%	👈	1.50%	1.3%	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%	99.4%	👉	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	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.	5.40%	5.33%	👈	5.4%	4.73%	M			
Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	82.2%	👈	>=85%	83.5%	M			
Referrals GP	Referrals	Count of referrals received into the trust from GP organisations (Community referrals removed)	16160	13700	👈	1616	1242	M	Updated to include External GP Referrals (Community Referrals removed). Ongoing work to identify DQ Flags		
Referrals DGH (External)		Count of referrals received into the trust from external sources (Community referrals removed)	8310	12296	👈	831	1603	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)	9060	11316	👈	906	1941	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%	9.7%	👈	0.0%	9.7%	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	M	May-18		
Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Repts within Std	90%	65.55%	👈	90%	75.99%	M	tbc		
Plain Film Outpatient		Total Plain Film Outpatient Repts within Std	90%	98.82%	👉	90%	100.00%	M	tbc		
CT Inpatient		Total CT Inpatient Repts within Std	90%	99.65%	👈	90%	100.00%	M			
CT Outpatient		Total CT Outpatient Repts within Std	90%	73.58%	👈	90%	84.95%	M			
MRI Inpatient		Total MRI Inpatient Repts within Std	90%	93.83%	👈	90%	80.95%	M			
MRI Outpatient		Total MRI Outpatient Repts within Std	90%	68.17%	👈	90%	74.92%	M			
Ultrasound Inpatient		Total Ultrasound Inpatient Repts within Std	90%	97.66%	👈	90%	93.10%	M			
Ultrasound Outpatient		Total Ultrasound Outpatient Repts within Std	90%	98.14%	👉	90%	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%	M			
31 day wait from diagnosis to first treatment		Patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	99.5%	👈	96%	98%	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%	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%	96%	👈	85%	91%	M			
104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0.5	👉	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%	85.71%	👈	95%	85.71%	M			
26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	80.70%	👈	98%	80.70%	M			
26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	89.63%	👈	95%	89.63%	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	96.85	👈	100	106.30	M	Current Month is July 2018		
Emergency readmissions following non-elective admission			100	86.60	👈	100	97.60	M	Current Month is July 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.		
Mandatory training	Workforce	Organisational Health	95%	93%	👈	95%	93%	M			
Appraisals			90%	93%	👉	90%	93%	M			
Turnover Rate between 1-2 yrs service (voluntary)(FTC excluded)			1.4%	2.02%	👈	1.4%	1.02%	M			
Net Surplus £000's	Finance	Finance	£7,723	£7,727	👈	£1,035	£1,030	M			
Normalised Net Surplus £000's			£7,723	£7,727	👈	£1,035	£1,030	M			
Cash Balance			£12,988	£16,973	👈	£12,988	£16,973	M			
Capital expenditure £000's			£7,572	£4,787	👈	£1,347	£365	M	YTD capital spend is £2.4M behind plan. Mainly due to Scanners not yet received.		
Total agency cost £000's			£1,615	£1,219	👈	£167	£321	M			
Total bank cost £000's			£1,630	£1,913	👈	£163	£173	M	Bank used across the Trust due to Maternity leave and sickness, mainly 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			£ 3,065	£2,741	👈	£ 349	£305	M	There are non-recurring schemes of £142k to offset the recurrent CIP underachievement.		