

## Board of Directors Item 4.1

**Subject:** Trust Review - SOF, Regulatory and Operational Performance  
Month 12  
**Date of meeting:** 30<sup>th</sup> April 2019  
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Hayley Kendall – Chief Operating Officer  
**Presented by:** Sue Pemberton - Director of Nursing & Operations

### 1. Executive Summary







The purpose of this paper is to present an update on Trust performance for the period ending the 31st March 2019. 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		Occurance of any Never Events (YTD)
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 and YTD))
Segmentation		

### 1.1 Quality of Care

No exceptions.

### 1.2 Operational Performance

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

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Currently below target for March 2019 at 82.16% against a target of 99%.

**Actions:** Overall 6 week diagnostic performance remains above the 80% trajectory for March 2019 and this was achieved due to the continued additional activity performed using mobile vans and additional consultant supervised sessions. The Clinical Lead for Radiology continues to vet all requests for scans to assess their level of clinical urgency. Cross divisional work on expediting scans to support 18 week RTT planning is also working well. The revised building work for the new CT and MRI scanners remains on plan to be completed by July 2019 with the scanners becoming operational in August 2019. Due to the level of increased activity and clearing of backlog, The trust has submitted an improvement trajectory as part of the annual planning process showing that full compliance against the six week target is expected to be achieved by March 2020

**Anticipated Delivery:** March 2020

### 1.3 Leadership and Improvement Capability

#### 1.3.1 Indicator: Staff sickness

**Accountable Executive Officer:** Jo Twist

**Issue:** Sickness is 4.03% YTD and 4.94% in month against a target of 3.4%.

**Actions:** Sickness has increased across all divisions within Trust. 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 being driven by long term rather than short term sickness in Medicine and Clinical services. Surgery sickness is an almost equal split of long term and short term. HR are developing an action plan to address high sickness to be disseminated throughout key hot spots.

**Anticipated Delivery:** On-going monitoring and management.

## **Section 2 – Quality of Care Dashboard**

Refer to Appendix 2.

There are no new exceptions this month.

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none"><li>• Mortality screening within 7 days (In-month &amp; YTD)</li><li>• % blood cultures taken within 24 hours preceding first antibiotic taken</li></ul>

## **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 76% YTD against a target of 95%.

**Actions:** The new mortality review policy, introduced in September 2017 has been updated in February 2019. The targets completion times for mortality review have been extended. The national guidance on Learning from Deaths has been implemented and there are several developments in terms of organisational learning. These include monthly presentations by the divisions to the Operational 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:** Quarter 1 2019/20

### **2.2 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 74% 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:** Quarter 1 2019/20.

## **Section 3 - Operational & Financial Performance**

Refer to Appendix 3.

There is one new exception this month – bed occupancy.

Framework	Rating	Exception
Operational Performance		<ul style="list-style-type: none"> <li>• Histopathology Turnaround Times</li> <li>• PET Scans (YTD &amp; Month)</li> <li>• Cancelled Operations (YTD &amp; Month)</li> <li>• Bed occupancy (In-month)</li> <li>• Activity – NHS</li> <li>• 18 week RTT 52 week waits</li> <li>• Plain Film Inpatient (YTD &amp; Month)</li> <li>• CT Outpatient (YTD &amp; Month)</li> <li>• MRI Outpatient (YTD &amp; Month)</li> <li>• 104 Day Cancer (YTD)</li> <li>• 26 Weeks Referral to Treatment in aggregate- Admitted Pathways (YTD &amp; Month)</li> <li>• 26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways (YTD &amp; Month)</li> <li>• 26 Weeks Referral to Treatment in aggregate - Incomplete Pathways (YTD &amp; 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; Month)</li> <li>• Capital Expenditure (YTD)</li> <li>• Total Bank Cost (YTD &amp; Month)</li> <li>• Deliver the recurrent cost savings (YTD &amp; Month)</li> </ul>

### 3. Exceptions

#### 3.1 Indicator: Histopathology Turnaround times

**Issue:** February 2019 (latest available information) actual position is 10% below the target of 70%

**Actions:** LHCH have a service level agreement (SLA) with Liverpool Clinical Labs (LCL) to manage pathology services. There is a particular challenge with histopathology services. LCL has an agreed NHSI improvement plan in place which is monitoring their performance against a ten day turnaround. LHCH have not formally accepted the 10 day target as it is not supportive of running an effective service but acknowledge the plan that has been agreed with NHSI. The set improvement trajectory planned for an improvement in compliance to 70% by January 2019 but this has not been achieved by LCL. Current performance has fallen back to 60%. There are a number of contributing factors which have led to this position. There has been an increased workload from across the Liverpool hospitals, an increased level of sickness absence in the team, and the additional requirements for upcoming UKAS inspection and this has impacted on staff capacity. A meeting was held in January with the Clinical Director of LCL to review key prioritisation areas for improvement such as samples arising from the EBUS service. All requests could not be accommodated by LCL. LHCH's concerns have formally been raised to the cancer network and we are currently awaiting their response. It should be noted that LHCH will be exploring alternative options for histopathology service provision.

**Anticipated Delivery:** June 2019

#### 3.2 Indicator: Improve PET Scanning turnaround times at seven business days

**Accountable Executive Officer:** Sue Pemberton

**Issue:** In month actual performance significantly below 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. Where patients are exceeding the waiting time target, patients are escalated via the Cancer manager to expedite the scan as required.

**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:** In month performance (1.9%) is above the 1.50% target. The trust had performed well during Quarter 4 2018/19 in achieving an overall performance position of 1.5%. In March 2019 cancellations were slightly above the target, mainly due to a batch of emergency aortic dissections admitted in one week, leading to a high level of cancellations. The Surgical Division has developed a more rigorous plan for focussing on reducing cancellations during 2019/20 that is being presented to the Integrated Performance Committee on the 29<sup>th</sup> April 2019. It should be noted that the national benchmarking data shows LHCH as the best performing cardiac unit in the country for % of elective cancellations.

**Actions:** Revised improvement plan developed and implemented. Ongoing review of each cancellation and escalation to Surgical Clinical Leads where improvements are identified.

**Anticipated Delivery:** Quarter 2 2019/20

### **3.4 Indicator: Bed Occupancy**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** In month performance (77.5%) is significantly below the 85% target

**Actions:** A full review of inpatient activity, throughput and flow has been undertaken across the Trust to review any specific changes in relation to length of stay, ward activity etc. Whilst there have been no statistical variations in the main inpatient indicators the lower bed occupancy can be directly linked to the lower levels of activity delivered in March 2019. As part of the productivity agenda all Divisions are undertaking a utilisation of asset review to identify any areas for reduction. This will be the subject of a larger piece of work and would have the relevant risk assessments undertaken if there are any planned changes to trust capacity

**Anticipated Delivery:** Quarter1 2019/20

### **3.5 Indicator: Activity - NHS**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** In month March 2019 underperformance against plan is -8.3%. Year to date underperformance against plan is -3.8%. On investigation it is apparent that patient complexity has changed over the last quarter with more complex patients being treated through the planned capacity. The overall cases are lower than expected but there is a higher level of income attracted per case and this reconciliation is being undertaken on a monthly basis. It was predicted that the March activity against plan position would be lower than expected due to a reduced level of activity in surgery

**Actions:** Divisional focus on achieving the activity plan for quarter one of 2019/20. All divisional activity is reviewed at the Trust Performance Meeting on a weekly basis

**Anticipated Delivery:** Quarter 1 2019/20

### **3.6 Indicator: Plain Film Inpatient**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Current YTD performance is at 66.99%. March position is 68.76% (against a target of 90%). 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 June 2019 which will ease the current pressures

**Anticipated Delivery:** July 2019

### **3.7 Indicator: CT Outpatient**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Current performance is at 86.10% against a target of 90%.

**Actions:** The request for CT scans is experiencing an annual growth of 8% and currently there are capacity issues within the consultant workforce to achieve the set KPI of 90% of scans reported within a five day turnaround. March 2019 has shown the highest level of compliance for over 12 months and is now just 3.9% off the trust's KPI. As a result this has been reduced to a score of 12 on the risk register. 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. A full vetting procedure is also undertaken 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 consultant capacity is in place. An improved contract management process with Medica to whom we outsource reporting of CT scans. This was implemented in October 2018 to ensure timely reporting of outsourced scans against set KPIs. Outsourcing performance is currently at 90% against set KPI

**Anticipated Delivery:** July 2019

### **3.8 Indicator: MRI Outpatient**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Current performance is at 67.77% against a target of 90%.

**Actions:** MRI referrals are growing at an annual rate of 16%. Reporting turnaround times for MRI is currently lower than times for CT as these scan cannot be outsourced to a third party at present. Testing work is currently being undertaken with both Medica and another provider to assess the quality of reporting and to see if this will be a possibility in the near future. 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 consultant capacity is in place

**Anticipated Delivery:** July 2019

### **3.9 Indicator: 18 Weeks RTT incomplete pathways 52 week+**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** 1 patient breached target. The target is to have zero breaches over 52 weeks

**Actions:** The Trust breached the target in March 2019 due to one Welsh patient that was referred to LHCH at 50 weeks. Unfortunately the patient requires complex investigations and thus is unlikely to be treated in April 2019.

**Anticipated Delivery:** May 2019

### **3.10 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. Over 50% of the patients breaching the target are due to late or incomplete referrals. 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:** Uncertain at present due to the Welsh systems response to LHCH and the ongoing financial discussions.

### **3.11 Indicator: Turnover Rate between 1-2 yrs service**

**Accountable Executive Officer:** Jo Twist

**Issue:** Indicator exceeds target of 1.4%, currently at 2.16%

**Actions:** : Initial analysis of data identifies that majority of leavers within this period are due to "other/unknown". Data cleanse of coding has been undertaken, medical staff leavers who resigned from post in March 2019 terminated their fixed term contracts early. Further work required to establish the actual reasons for all staff coded as "other/unknown"

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:** Q3 2019-2021

### **3.12 Finance Indicators:**

**Indicator:** Total Bank Cost £000's

**Indicator:** Deliver the recurrent Cost Improvement savings

Please refer to 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.

## **5. Recommendations**

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

## Appendix 1 - Single Oversight Framework

Single Oversight Framework (SOF)												
	Indicator	Type	Description	Target	YTD	Trend	Current Month Target	Mar-19	Forecast	Previous Month	Frequency	Comments
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	67	96	↑	6	2		5	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%	95%	↑	94%	95%		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%	95.5%	↓	95%	95.74%		100.00%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	95.7%	↑	95%	100.0%		96%	M	
	Occurrence of any Never events	Safe	Count of Never Events in rolling six-month period	0	1	→	0	0		0	M	
	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	
	VTE Risk Assessment		Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95.0%	96.9%	↓	95.0%	96.4%		96.5%	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	→	0	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	0.01	→	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		1	M	
	eColi LHCH Acquired		Rolling 12-month count of all E. coli infections/rolling 12-month average occupied bed days multiplied by 100,000	-	7	↓	-	2		0	M	
	HSMk 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	99.002	↑	100	84.01		103.98	M	Nov-18
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	Financial Sustainability		1	1	→	1	1		1	M	
	IdE Margin	Financial Efficiency		1	1	→	1	1		1	M	
	Performance against plan	Financial Controls		1	2	→	1	2		2	M	
	Agency Spend	Financial Controls		1	1	→	1	1		1	M	
	Overall use of resources (Lor) 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	92.0%	92.52%	↑	92%	92.52%		92.30%	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%	96.60%		93%	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%	82.16%	↓	99%	82.16%		84.71%	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	90%	96.7%	↓	90%	90.9%		100%	M	awaiting validation
	Dementia - Assess			90%	99%	→	90%	100%		100%	M	awaiting validation
	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 - COC Well Led Assessments	COC Well Led Inspections			-	-	-	-		-		COC Review published September 2016 rated Well-Led Domain as
	Well Led Reviews - NHS Code of Governance				-	-	-	-		-		MAAA Review published March 2017 concluding the Trust is well led
	Third Party Information - Healthwatch, MPs, Whistleblowers, Coroners' Reports, COC Warnings, Other material Concerns	Information from third parties			-	-	-	-		-		
	Staff Sickness	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%	4.02%	↓	3.4%	4.94%		4.17%	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%	13.77%	↓	10%	13.77%		13.28%	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%	76%	↑	76%	76%		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%	5.28%	↑	5%	5.52%		6.10%	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%	12.50%	↑	25%	12.50%		13.30%	M	*NB excludes Ralph Perry who left on Flex Retirement but returned
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	Trend	Current Month		Previous Month	Frequency	Comments	Type	
						Target	Mar-19					
% of deaths screened for review within 7 days	Mortality		95%	72%	↓	95%	60%	73%	M	Current month based January 2019	L	
% mortality reviews to be completed within 30 days - Doctors			80%	76%	↑	80%	73%	60%	M	Current month based January 2019	L	
% mortality reviews to be completed within 30 days - Nurses			80%	93%	→	80%	93%	93%	M	Current month based January 2019	L	
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.37%	↓	1.3%	1.70%	1.40%	M		L	
HSMR Weekend (DFI)		HSMR is the ratio of the number of deaths in hospital within a given time perious 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	114.6727	↓	100	135.270	85.58	M	Current Month is November 2018	L	
HSMR for all diagnosis (supplied from Dr Foster)			100	91.91	↑	100	81.54	92.3	M	Current Month is November 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	72	55	↑	6	1	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	6	5	→	0	0	0	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	0	0	M			
Number of reported patient safety incidents (6 month rolling avg)			N/a	0	-	N/a	0	127	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%	74%	↑	95%	74%	70%	M		L	
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	68%	↑	70%	71%	63%	M		L	
% Delivery of a sepsis antibiotic within three hours of prescription			96%	94%	↑	96%	100%	93%	M		N	
% of radiological alerts with a response document			95%	94.2%	↑	95%	96.8%	96.5%	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%	70%	→	50%	100.0%	100.0%	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%	98.8%	↑	95.0%	100.00%	99.68%	M			
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.87%	↓	95%	97.80%	97.95%	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	Current Month Mar-19	Previous Month	Frequency	Comments
Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	178	↓	N/a	19	15	M	
Improve histopathology turnaround times at 7-days			70%	66%	↓	70%	60%		M	Data as reported by Liverpool labs (February 2019)
Improve PET scanning turnaround times at 5-days			75%	42.5%	↑	75%	29.2%	27.8%	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%	2.5%	↓	1.50%	1.8%	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%	99.5%	↑	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.	5.40%	5.11%	↑	5.4%	3.36%	4.56%	M	
Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	81.7%	↓	>=85%	77.5%	81.2%	M	
Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	3.8%	↓	0.0%	3.3%	-1.0%	M	Excludes ACHD activity
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	3	↑	0	1	1	M	
Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Repts within Std	90%	66.99%	↓	90%	68.76%	82.38%	M	tbc
Plain Film Outpatient		Total Plain Film Outpatient Repts within Std	90%	98.90%	↓	90%	98.71%	100.00%	M	tbc
CT Inpatient		Total CT Inpatient Repts within Std	90%	99.64%	↓	90%	99.16%	100.00%	M	
CT Outpatient		Total CT Outpatient Repts within Std	90%	75.09%	↑	90%	86.30%	83.13%	M	
MRI Inpatient		Total MRI Inpatient Repts within Std	90%	94.30%	↓	90%	92.31%	100.00%	M	
MRI Outpatient		Total MRI Outpatient Repts within Std	90%	69.61%	↓	90%	67.77%	90.00%	M	
Ultrasound Inpatient		Total Ultrasound Inpatient Repts within Std	90%	97.98%	↑	90%	100.00%	100.00%	M	
Ultrasound Outpatient		Total Ultrasound Outpatient Repts within Std	90%	98.34%	↑	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%	99.6%	↑	96%	100%	98%	M	Awaiting validation
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%	91%	M	Awaiting validation
104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0.5	↑	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%	89.47%	↑	95%	89.47%	84.2%	M	
26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	88.00%	↑	98%	88.00%	66.7%	M	
26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	93.67%	↓	95%	93.67%	94.2%	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	0.00	0.00	M	Current Month is July 2018
Emergency readmissions following non-elective admission			100	86.60	↑	100	0.00	0.00	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%	92%	↓	95%	92%	93%	M	
Appraisals			90%	93%	↑	90%	93%	93%	M	
Turnover Rate between 1-2 yrs service (voluntary(FTC excluded))			1.4%	2.16%	↓	1.4%	2.98%	2.02%	M	
Net Surplus £000's	Finance	Finance	£9,584	£9,676	↑	£1,258	£1,348	£603	M	
Normalised Net Surplus £000's			£9,584	£11,258	↑	£1,258	£2,930	£603	M	
Cash Balance			£15,115	£17,725	↓	£15,115	£17,725	£18,577	M	
Capital expenditure £000's			£10,611	£9,879	↓	£1,856	£2,460	£2,632	M	
Total agency cost £000's			£1,951	£1,427	↓	£170	£113	£96	M	
Total bank cost £000's			£1,953	£2,347	↓	£175	£230		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			£3,800	£3,368	↑	£393	£131	£ 296	M	There are non-recurring schemes of £142k to offset the recurrent CIP underachievement.