

Board of Directors

Item 4.1




Subject: Trust Review - SOF, Regulatory & Operational Performance Month 3
Date of meeting: Tuesday 30th July 2019
Prepared by: Hayley Kendall, Chief Operating Officer
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Presented by: Hayley Kendall, Chief Operating Officer

1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period ending 30th June 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 2019 for routine monitoring on delivery.
- Section 3 - Operational and Financial Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2019 for routine monitoring on delivery.

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

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none"> • MSSA Bacteraemias
Finance and use of resources		
Operational Performance		<ul style="list-style-type: none"> • Maximum 6 week wait for diagnostics
Strategic Change		
Leadership and Improvement		<ul style="list-style-type: none"> • Staff Sickness • Staff Turnover
Segmentation		

2.1.1 Single Oversight Framework - Exceptions

2.1.2 Indicator: MSSA Bacteraemias

Accountable executive Officer: Raph Perry

Issue: 5 Cases in June (6 Cases YTD against an annual target of 7).

Actions: All cases of MSSA have been through case review. Three patients were septic or had endocarditis two of which were considered unavoidable infections. Only one case was secondary to a sternal wound infection and this patient did not receive decolonisation. Two cases were related to cannulas. An action plan was discussed at the IPC and further education on both pre-operative routine decolonisation and cannula care is being undertaken.

Anticipated Delivery: Q3 19/20

2.1.3 Indicator: Maximum 6 week wait for diagnostic procedures

Accountable executive Officer: Sue Pemberton

Operational Lead: Steve Colfar

Issue: Below target for June 2019 at 75.05% against a target of 99%.

Actions: Overall 6 week diagnostic performance is below the 80% trajectory for June 2019 which has previously been agreed with NHSE. There has been further downtime with the MRI Scanner and increased difficulty in covering weekend additional sessions, mainly due to securing specialist Radiographer cover. The estimate for CT go live is now 27th August and from 18th September for MRI. A locum consultant has been appointed for 6 months from 10th June to help with reducing the backlog for CT and MRI scans. An additional consultant is also due to start employment 1st October 2019 with a third awaiting a start date due to GMC registration issues. The Trust will re-submit a compliance trajectory to NHSE/I which will show only slight improvements until September 2019 with a plan to achieve close to 99% compliance by March 2020.

Anticipated Delivery: March 2020.

2.1.4 Indicator: Staff Sickness

Accountable executive Officer: Jo Twist

Operational Lead: Katie Toner, Fiona Ross

Issue: Staff sickness is 4.91% for June against a target of 3.4%.

Actions: Rolling 12 months to June shows an increase in sickness across all divisions with the exception of corporate services, which reduced by 0.72%. An action plan to review attendance management is in development. Audit has been undertaken to review compliance with management of attendance in high reporting, individual actions will be addressed throughout the organisation. This will be complemented with the implementation of key Health & Well Being interventions.

Anticipated Delivery: Ongoing monitoring.

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

Accountable executive Officer: Jo Twist


Operational Lead: Katie Toner, Fiona Ross

Issue: Turnover is 13.90% against a target of 10% (rolling 12 months).

Actions: Turnover for all leavers including all fixed terms staff slightly increased for June 2019, with voluntary turnover at 10.71%. 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. Overall turnover rate includes medical staff leaver, end of fixed term contract, retirement etc

Anticipated Delivery: 2019/20.

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

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none">• % of deaths screened for review within 7 days• Number of Adverse Events (Red Alerts), Serious Incidents and Never Events

2.1.6 **Quality of Care - Exceptions**

2.1.7 **Indicator: Mortality screening within 7 days**

Accountable Executive Officer: Raph Perry

Issue: Screening of deaths within 7-days is 72% in month (66% YTD) against a target of 95%.

Actions: Work continues to improve the screening times. Complex screens take longer than seven days but then do not necessarily require formal mortality review so improve the overall target. It is difficult to recruit more screeners and efforts are also being made to even out the numbers per consultant.

Anticipated Delivery: Q2/3 19/20.

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

Accountable Executive Officer: Sue Pemberton


Operational Lead: Helen Martin

Issue: 1 in June against a target of 0 in month and 3 YTD against a target of 0.

Actions: Major IT downtime – Trust PCs started to display intermittent loss of access for approximately 10 minutes across all areas with access failing to many users on the system whilst some had sustained access. The system came back on line but not in a seamless way. At this time it was reported that the Drager system was not working, hence telemetry brick monitoring by nursing staff, as per the BCP, was implemented. Reviews as to how this could be resolved were ongoing from Tuesday 18th June 2019 until Thursday 20th June 2019 with involvement from external partners (ANS, Dragger, Informatics Merseyside). The problem remained unresolved by Thursday 20th June, therefore, the Executive Team convened a meeting to discuss plans to ensure system correction and stability of the telemetry system. In consultation with clinicians and senior management, it was agreed to go ahead with a controlled shut down of the two main 4500x appliances at 14:00 on Thursday in order to restart the system, with appropriate patches applied. The restart was conducted but triggered other issues and it took approximately 8 hours to get back all affected systems. Telemetry came back on after the restart with just a boost of the system at CCU being required. A decision was made to cancel a number of outpatient appointments and TCI's.

Anticipated Delivery: Resolved; the SI report is due at Liverpool CCG on 12th September 2019.

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

Framework	Rating	Exception
Operational Performance		<ul style="list-style-type: none"> • Improve histopathology turnaround times at 7-days • Improve PET scanning turnaround times at 5-days • Cancelled Operations • Activity NHS • Radiology - Plain Film Inpatient • Radiology - MRI Outpatient • 26 Weeks RTT - Admitted • 26 Weeks RTT - Non Admitted • 26 Weeks RTT - Incomplete • Cash Balance • Agency Cost • Bank Cost • Deliver the Recurrent Cost Improvement Savings

3.1.1 **Operational - Exceptions**

3.1.2 **Indicator: Improve histopathology turnaround times at 7-days**

Accountable Executive Officer: Sue Pemberton

Operational Lead: Steve Colfar

Issue: June performance at 39% (10 day turnaround) against a target of 70% at 7 days.

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 have an agreed NHSI improvement plan in place which is monitoring their performance against a ten day turnaround. This does not meet service requirements for LHCH and is having a significant impact on patient pathways to the level where some patients (EBUS referrals from Whiston) have had treatment diverted to Manchester. Negotiations at a network level are taking place between LHCH, LCL, Arrowe Park, Whiston Hospital and the Cancer Network to review how the service can be improved. This may include a working solution to transfer routine histopathology to Whiston, maintain some resection/ frozen section samples at LCL and transfer EBUS samples to Whiston. The viability of such a solution is currently being reviewed including the logistical challenges this would bring. An options appraisal will be submitted to July 2019 Operational Board for review and action.

Anticipated Delivery: Dependant on solution but likely to be early 2020.

3.1.3 **Indicator: Improve PET Scanning Turnaround times at 5 days**

Accountable Executive Officer: Sue Pemberton

Operational Lead: Steve Colfar

Issue: June performance at 29.4% and 50.8% YTD against a target of 75%

Actions: All LHCH requests for PET scans are managed by RLBUHT. There are significant issues with the production of radio isotopes which are produced by the RLBUHT radio-pharmacy department and this is having a region wide impact. Full production of the isotopes is still planned from September 2019. Liverpool CCG are closely monitoring the situation with fortnightly meetings in place which DHOO for Clinical Services attends. Until this situation has eased all requests for scans are managed on a prioritisation process. Normal service is unlikely before spring 2020.

Anticipated Delivery: Spring 2020.

3.1.4 **Indicator: Cancelled Operations**

Accountable Executive Officer: Sue Pemberton

Operational Lead: Fiona Altintas, Karen Wafer

Issue: June performance at 2.3% and 2.7% YTD against a target of 1.5%.

Surgery: Slight improvement on previous month. Main reasons for cancellations were impact of overnight emergency, surgeon sickness and the impact of perfusionist cover due to patient on ECMO. A planned change to scheduling to convert the number of urgent patients on a Monday to elective patients and to increase in the number of days pre-operatively, urgent patients are to be transferred is to commence in July. This should continue to support the reduction of clinical cancellations

Medicine: In June there was one medicine cancellation of a research patient. This was done in advance whilst learning was identified from the previous case.

Anticipated Delivery: Ongoing.

3.1.5 **Indicator: Activity – NHS**

Accountable Executive Officer: Sue Pemberton

Operational Lead: Fiona Altintas, Karen Wafer, Steve Colfar

Issue: June underperformance against plan of -7.8%.

Surgery Actions: Surgery activity was underplan in June. A higher than normal rate of clinical cancellations, sessions lost for surgeon cover, impact of ECMO patient and IT incident have all contributed to the underperformance. In July the division will present a year end forecast to the Executive Team with regard to surgical activity. Issues with loss of activity have resulted in a negative contribution of £700,000 YTD. We have witnessed a reduction in clinical cancellations in July and the division has made scheduling changes to continue this trend.

Medicine Actions: Medicine's position was on plan for elective activity in June but overall under plan following an IT incident and low non-elective activity.

Clinical Services Actions: Critical Care income is now £213,000 above plan YTD due to a £335,000 over performance in June 2019. Radiology activity was over plan in June 2019 but income remains £130,000 below plan YTD. Overall the division is currently holding a £256,000 positive contribution for the end of June 2019.

Anticipated Delivery: Plans for all three divisional positions in Quarter 2 were presented to the Executive Team in July 2019.

3.1.6 **Indicator: Radiology - Plain Film – Inpatient**

Accountable executive Officer: Sue Pemberton

Operational Lead: Steve Colfar

Issue: June performance is 47.20% (YTD 39.08%) against a target of 90%.

Actions: 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. Reporting performance is being closely monitored and risk assessed during the current identified shortage in the radiology workforce. Two new substantive Radiology Consultants are due to start in position but there continues to be challenges with achieving full GMC registration for one consultant. A locum Radiologist has been appointed for a 6 month period from 10th June. In addition, two clinical fellows were appointed in May 2019 with a likely start date for August 2019.

Anticipated Delivery: November 2019.

3.1.7 **Indicator: Radiology - MRI – Outpatient**

Accountable executive Officer: Sue Pemberton

Operational Lead: Steve Colfar

Issue: June performance is 83.90% (YTD 75.23%) against a target of 90%

Actions: Significant improvement in performance in June 2019 with compliance now increased to 83.9% - the highest level in over 12 months. This is mainly due to the appointment of a locum Radiologist who was appointed and thereby increasing reporting capacity. However there is some concern that performance will be unable to maintained when this temporary appointment is completed. Work is still ongoing to see if MRI scans can be outsourced to Medica as currently

they do not have the consultant body with experience in Cardiac MRI. 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 substantive consultant capacity is in place.

Anticipated Delivery: October 2019

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

Accountable Executive Officer: Sue Pemberton

Operational Lead: Fiona Altintas, Karen Wafer

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

- Admitted - 91.30% against a 95% target
- Non-Admitted - 81.25% against a 98% target
- Incomplete - 94.52% against a 95% target

Actions: The Trust continues to work with Welsh commissioners to improve waiting times for patients and is focused on ensuring any patients that do breach 26-weeks are seen before 36-weeks. There has been an improvement in Junes performance in all areas, - admitted, non-admitted and incomplete pathways. 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, however the operational team from LHCH met with the welsh commissioners In May and it was agreed to step down the formal meeting process. The main issues remain patients breached at referral, referral on or after week 15 and a delay in diagnostics.

Anticipated Delivery: Uncertain at present due to the issue of late and incomplete referrals from welsh hospitals.

3.1.9 Indicator: Cash Balance, Total Agency Cost, Total Bank Cost and Deliver the recurrent CIP

Accountable Executive Officer: Claire Wilson

Issue, Actions & Anticipated Delivery: 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 reports.

Appendix 1 - Single Oversight Framework

Single Oversight Framework (SOF)											
Indicator		Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
							Target	Jun-19			
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	22	9	↓	6	4	3	M	
	Staff Friends and Family - recommend as a place of treatment		Count of those categorised as extremely likely or likely to recommend/count of all responders	94%	95.0%	→	94%	95.0%	95.0%	Q	
	Mixed Sex Accommodation Breaches		Count of number of occasions sexes were mixed on same-sex wards	0	0	→	0	0	0	M	
	Inpatient scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	100%	↓	95%	99.7%	100%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	97.6%	↑	95%	100%	94.4%	M	
	Occurrence of any Never events		Count of Never Events	0	0	→	0	0	0	M	
	VTE Risk Assessment	Safe	Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95%	96.4%	↑	95%	96.6%	96.0%	M	
	Clostridium Difficile		Count of trust assigned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	0	3	↑	0	0	3	M	
	MRSA Bacteraemias		Count of trust assigned MRSA infections	0	0	→	0	0	0	M	
	MSSA Bacteraemias		Count of trust assigned MSSA infections	1.17	6	↓	0.58	5	0	M	
	Gram Negative Bacteraemias		Count of trust assigned Gram Negative Bacteraemias infections	1.50	3	↑	0.75	0	1	M	
	HSMR for 56 diagnosis groups (supplied from Dr Foster; hospital guide)	Effective	The ratio of observed deaths that occurred following admission in a provider to a modelled expectation of deaths (multiplied by 100) on the basis of the average England death rates for 56 specific clinical groups given a selected set of patient characteristics for those treated there.	100	105.31	↓	100	96.68	94.75	M	Current month: Mar 2019; YTD: Apr 2018 - Mar 2019
Finance	Capital Service Cover	Financial Sustainability		1	1	→	1	1	1	M	Trigger: Poor levels of overall financial performance (average score of 3 or 4) Very poor performance (score of 4) in any individual metric Potential value for money concerns
	Liquidity	Financial Sustainability		1	1	→	1	1	1	M	
	I&E Margin	Financial Efficiency		2	2	→	2	2	2	M	
	Performance against plan	Financial Controls		1	1	→	1	1	1	M	
	Agency Spend	Financial Controls		1	1	→	1	1	1	M	
	Overall use of resources (UoR) rating	Overall Financial Performance		2	1	↑	2	1	2	M	
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Operational Performance	Count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	92%	92.02%	↓	92%	92.02%	93.04%	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%	95.40%	→	85%	100%	100%	M	
	Maximum 6-week wait for diagnostic procedures		Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	99%	75.05%	↓	99%	75.05%	79.93%	M	
	Dementia - Find		The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours: a. who have a diagnosis of dementia or delirium or to whom case finding is applied; b. who, if identified as potentially having dementia or delirium, are appropriately assessed; and, c. where the outcome was positive or inconclusive, are referred on to specialist services.	90%	93.75%	↑	90%	100%	90.91%	M	
	Dementia - Assess			90%	100%	→	90%	100%	100%	M	
	Dementia - Refer			90%	100%	→	90%	100%	100%	M	
Strategic Change	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 2019 rated Well-Led Domain as 'Outstanding'	
	Well Led Reviews - NHS Code of Governance				-	-	-	-		MAA Review published March 2017 concluding the Trust is well led with no significant concerns	
	Third Party Information - Healthwatch, MP's, Whistleblowers, Coroners' Reports, CQC 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%	4.97%	↓	3.4%	4.91%	4.42%	M	
	Staff Turnover (All Leavers)		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%	13.90%	↓	10%	13.90%	13.30%	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 2018 Staff Survey Data - Previous Period Q3 2017
	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%	5.72%	↑	5%	5.72%	5.92%	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%	11.10%	→	25%	11.10%	11.10%	M	
Overall	Segmentation			1	→		1	1	Adhoc	Segment 1: Maximum autonomy; universal support	

Appendix 2 – Quality of Care

Regulatory and Operational Performance - Quality of Care

Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month		Previous Month	Frequency	Comments
						Target	Jun-19			
% of deaths screened for review within 7 days	Mortality		95%	66%	↑	95%	72%	59%	M	Current month: May 2019
% mortality reviews to be completed within 30 days - Doctors			80%	71%	↑	80%	78%	65%	M	Current month: May 2019
% mortality reviews to be completed within 30 days - Nurses			80%	97%	↓	80%	94%	100%	M	Current month: May 2019
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.5%	↑	1.3%	1.4%	1.6%	M	
HSMR Weekend (supplied from Dr Foster)		HSMR is the ratio of the number of deaths in hospital within a given time period to the number that might be expected if the hospital had the same death rate as some reference population ((Number of observed deaths/ the number of expected deaths) * 100)	100	117.74	↑	100	91.17	139.66	M	Current month: Mar 2019; YTD: Apr 2018 - Mar 2019
HSMR for all diagnosis (supplied from Dr Foster)			100	101.68	↓	100	99.60	95.20	M	Current month: Mar 2019; YTD: Apr 2018 - Mar 2019
Cardiac Surgery observed:expected mortality ratio			1.00	1.11	↑	1.00	1.11	1.13	M	6-month rolling averages; latest Oct-18 to Mar-19
Non-primary PCI observed:expected MACE ratio			1.00	0.16	↓	1.00	0.16	0.08	M	6-month rolling averages; latest Oct-18 to Mar-19
Number of Falls (All Areas)	Incidents	Count of Falls recorded across all areas	18	14	↑	6	2	10	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	2	3	↑	1	0	2	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	0	M	
Number of reported patient safety incidents (6 month rolling avg)			N/a	379	↑	N/a	125	139	M	
Follow-up audit of SUI reveals improvement embedded and delivering			No		OL Policy complimenting recent learning from deaths guidance					
% Blood Cultures taken within 24 hours preceding first antibiotic given	Sepsis		95%	85.1%	↑	95%	87.8%	86%	M	
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	82.0%	↓	70%	59.0%	84%	M	
% Delivery of a sepsis antibiotic within three hours of prescription			96%	99.0%	↓	96%	95.0%	97%	M	
% of radiological alerts with a response document			95%	100.0%	→	95%	100.0%	100.0%	M	
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment
Friends and Family Test Response Rate - Inpatients	Patient Experience	Count of patients responding to the friends and family test in inpatients / count of eligible patients	50%	100%	↓	50%	99.7%	100%	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%	98.8%	→	95%	100%	100%	M	
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.2%	↓	95%	97.0%	97.4%	M	
All re-inspected KLOE's rated as outstanding			Yes or No		The Trust is waiting for re-inspection to determine whether objective has been achieved					

Appendix 3 – Operational & Financial Performance

Regulatory and Operational Performance - Operational Performance

	Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month Target	Current Month Jun-19	Previous Month	Frequency	Comments
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	50	↑	N/a	15	18	M	
	Improve histopathology turnaround times at 7-days			70%	66.0%	↓	70%	59.0%	66.0%	M	Data as reported by Liverpool labs
	Improve PET scanning turnaround times at 5-days			75%	50.8%	↓	75%	29.4%	36.8%	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%	2.7%	↑	1.50%	2.3%	2.4%	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%	100%	→	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.	4.50%	3.20%	↑	4.5%	3.61%	3.77%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	84.8%	↓	>=85%	84.8%	85.5%	M	
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	-7.8%	↓	0.0%	-7.8%	-4.7%	M	Excludes ACHD activity
	Referral to treatment - Incomplete Pathways 52+ weeks	RTT	Count of all patients on an incomplete pathway waiting over 52 weeks (English & Non-English)	0	1	→	0	0	0	M	1 Welsh Patient breach in April, treated on 20th May.
	Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Repts within Std	90%	39.08%	↑	90%	47.20%	31.94%	M	
	Plain Film Outpatient		Total Plain Film Outpatient Repts within Std	90%	92.39%	↑	90%	99.81%	79.68%	M	
	CT Inpatient		Total CT Inpatient Repts within Std	90%	99.79%	→	90%	100%	100%	M	
	CT Outpatient		Total CT Outpatient Repts within Std	90%	79.18%	↑	90%	91.10%	79.05%	M	
	MRI Inpatient		Total MRI Inpatient Repts within Std	90%	100%	→	90%	100%	100%	M	
	MRI Outpatient		Total MRI Outpatient Repts within Std	90%	75.23%	↑	90%	83.90%	80.21%	M	
	Ultrasound Inpatient		Total Ultrasound Inpatient Repts within Std	90%	91.30%	↓	90%	96.30%	96.67%	M	
	Ultrasound Outpatient		Total Ultrasound Outpatient Repts within Std	90%	93.62%	→	90%	100%	100%	M	
	14 day wait from referral to date first seen	Cancer	Patients waiting a maximum of two weeks from an urgent GP referral for suspected cancer to date first seen by specialist	93%	100%	→	93%	100%	100%	M	
	31 day wait from diagnosis to first treatment		Patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	99.3%	→	96%	100.0%	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%	96.7%	→	85%	100%	100.0%	M	
	104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0	→	0	0	0	M	
	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	Welsh	Count of the number of Welsh patients whose clock period is less than 26 weeks during the calendar months of the return/Count of number of Welsh patients whose clock has not stopped during the calendar months of the return	95%	88.98%	↑	95%	91.30%	89.29%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	80.73%	↑	98%	81.25%	76.47%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	94.38%	↑	95%	94.52%	94.26%	M	
	Emergency readmissions following elective admission	Readmissions	Occurs when the next admission to any English NHS hospital is an emergency within 28 days of live discharge	100	107.32	↓	100	120.07	114.16	M	Current month: Dec 2018; YTD: Jan 2018- Dec 2018
	Emergency readmissions following non-elective admission			100	86.04	↑	100	82.22	96.27	M	Current month: Nov 2018; YTD: Dec 2017 - Nov 2018
Workforce	Mandatory training	Organisational Health		95%	93%	↑	95%	93%	91%	M	
	Appraisals			90%	9%	↑	90%	9%	3%	M	Appraisal window reset May 2019
	Turnover Rate between 1-2 yrs service (voluntary(FTC excluded))			1.40%	1.99%	↓	1.40%	1.99%	1.95%	M	
Finance	Net Surplus £000's	Finance		£79	£81	↓	£21	£21	£134	M	
	Normalised Net Surplus £000's			£79	£81	↓	£21	£21	£134	M	
	Cash Balance £000's			£18,183	£17,243	↑	£18,183	£17,243	£17,241	M	Cash balances of £17.3m are £1m behind the planned position of £18.3m. This is primarily due to phasing of PSF Monies now due at end quarter 1.
	Capital expenditure £000's			£869	£1,533	↑	£330	£768	£587	M	Capital is £664k above plan due to a change in the phasing of schemes.
	Total agency cost £000's			£349	£352	↓	£117	£190	£89	M	Agency costs are £74k over in month due to SICU Nursing £52k (Qtr1 catch up) and £19k over on Jr Medical - Cardiac Surgery. YTD they are £3k over plan.
	Total bank cost £000's			£611	£609	↓	£200	£233	£205	M	Bank Costs are slightly over plan in Month, but under for YTD
	Deliver the recurrent cost improvement savings			£848	£531	↓	£295	£172	£180	M	Falling recurring CIP's are partially offset YTD by £88k of non recurring CIPs.