

Board of Directors (in Public)

Item 4.1







Subject: Trust Review - SOF, Regulatory & Operational Performance Month 5
Date of meeting: Tuesday 24th September 2019
Prepared by: Hayley Kendall, Chief Operating Officer
 Martin Curry, Senior Information Analyst - Interim
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 31st August 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"> • C-Difficile • MSSA Bacteraemias • Gram Negative Bacteraemias
Finance and use of resources		
Operational Performance		<ul style="list-style-type: none"> • Maximum 6 week wait for diagnostics
Strategic Change		
Organisational Health		<ul style="list-style-type: none"> • Staff Sickness
Segmentation		

2.1.1 **Single Oversight Framework - Exceptions**

2.1.2 **Indicator: Clostridium-Difficile**

Accountable Officer: Raph Perry

Issue: 1 Case in August (4 Cases YTD, against an Annual Target of 4).

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

Anticipated Delivery: Q3 2019/20

2.1.3 **Indicator: MSSA Bacteraemias**

Accountable Officer: Raph Perry

Issue: 1 Case in August (8 Cases YTD, against an Annual Target of 7).

Actions: All cases of MSSA have been through case review. 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: Ongoing

2.1.4 **Indicator: Gram Negative Bacteraemias**

Accountable Officer: Raph Perry

Issue: 1 Case in August (7 Cases YTD, against an Annual Target of 9).

Actions: All cases of Gram Negative Bacteraemias have been through case review. No themes identified. Continued education on infection prevention processes.

Anticipated Delivery: Ongoing

2.1.5 **Indicator: Maximum 6 week wait for Diagnostic Tests**

Accountable Officer: Hayley Kendall

Issue: Below target for August 2019 at 69.8% against a target of 99%.

Actions: Overall 6 week diagnostic performance is below the 80% trajectory for August 2019 which has previously been agreed with NHSE. There has been further downtime of the CT scanner in the month as well as a continued increase in demand. In addition demand for CT guided biopsies for cancer patients has continued to be a pressure, displacing routine CT scans. As capacity is static until the new scanners are live performance will remain at the current position.

Anticipated Delivery: March 2020

2.1.6 **Indicator: Staff Sickness**


Accountable Officer: Sue Pemberton

Issue: Staff sickness is 4.50% for August against a target of 3.4% (4.82% YTD).

Actions: Rolling 12 months to August shows an overall increase in sickness. An action plan to review attendance management is in development. An audit has been undertaken to review compliance with management of attendance in high reporting areas, individual actions will be addressed throughout the organisation. This will be complemented with the implementation of key Health and Well Being interventions. A further in depth review and action plan will be presented at the September 2019 Board meeting.

Anticipated Delivery: Ongoing monitoring.

3. **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• Adverse Incidents, Serious Incidents or Never Events

3.1.1 Quality of Care - Exceptions

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

Accountable Officer: Raph Perry

Issue: Screening of deaths within 7-days is 63% in month (68% 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: Q 2/3 2019/20.


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

Accountable Officer: Marga Perez-Casal

Issues: 2 Serious Incidents in August against a target of 0.

Actions: A separate report will be presented under the Board agenda.

4. 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• Bed Occupancy• Activity NHS• 18 Weeks RTT – Incomplete Pathway 52+ Weeks• Radiology - Plain Film Inpatient• Radiology - CT Outpatient• Radiology - MRI Outpatient• 26 Weeks Welsh RTT - Admitted• 26 Weeks Welsh RTT - Non Admitted• 26 Weeks Welsh RTT - Incomplete• Agency Cost• Deliver the recurrent cost improvement savings

4.1.1 Operational - Exceptions

4.1.2 **Indicator: Improve histopathology turnaround times at 7 days**

Accountable Officer: Hayley Kendall

Issue: Latest data shows 39% (10 day turnaround) against a target of 70% at 7 days.

There is a particular challenge with the external provider of laboratory services for LHCH. The current service provided does not meet the required timescales for the management of our patient pathways. There are negotiations underway across the network to develop a solution for the provision of cancer laboratory services for LHCH which was presented to the July 2019 Operational Board.

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

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

Accountable Officer: Hayley Kendall

Issue: August performance at 47.6% (50% YTD) against a target of 75%

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

Anticipated Delivery: Spring 2020.

- 4.1.4 **Indicator: Cancelled Operations**
Accountable Officer: Hayley Kendall
Issue: 2.2% in August against a target of 1.5% (2.3% YTD)
Actions: Medicine had no reportable cancellations for August. Surgery had 12 reportable cancellations, due primarily to emergency cases taking priority, list overrun and impact of overnight emergencies. A review of each cancellation is performed and discussed monthly at the consultant business meetings.
Anticipated Delivery: Ongoing.
- 4.1.5 **Indicator: Bed Occupancy**
Accountable Officer: Hayley Kendall
Issue: Overall 76.5% in August against a target of 85%
Actions: A full review of inpatient activity and throughput through wards is underway as part of operational planning. The clinical divisions have agreed a reduced bed base on an interim basis as a result of the improved inpatient pathway in surgery. A longer term plan for the inpatient wards will be presented to Operational Board in November 2019, linked to demand and activity plans.
Anticipated Delivery: Q4 2019/20
- 4.1.6 **Indicator: Activity - NHS**
Accountable Officer: Hayley Kendall
Issue: August underperformance against plan of -1.55%.
Actions: A separate paper detailing the surgical activity plan and recovery is presented under a separate item on the agenda. The Medicine Division were slightly under plan in activity terms in month but over achieved on income due to casemix.
Anticipated Delivery: Q4 2019/20
- 4.1.7 **Indicator: 18 Weeks RTT - Incomplete Pathways 52+ weeks**
Accountable Officer: Hayley Kendall
Issue: 1 Medical (Cardiology) Breach in August (2 YTD)
Actions: The Cardiology breach in August was a late referral at 51 weeks from Countess of Chester Hospital which is formally under review. The specialty are attempting to treat the patient in month.
Anticipated Delivery: Ongoing
- 4.1.8 **Indicator: Radiology - Plain Film - Inpatient**
Accountable Officer: Hayley Kendall
Issue: August performance is 54.4% (YTD 38.1%) against a target of 90%.
Actions: The main reason for underperformance against the plan is consultant capacity. Two new substantive Radiology Consultants are due to start in position. A locum radiologist has been appointed for a six month period from 10th June 2019. In addition, two clinical fellows were appointed in May 2019 and the division expect to see an improvement in performance from Quarter 3 2019/20.
Anticipated Delivery: November 2019.
- 4.1.9 **Indicator: Radiology - CT - Outpatient**
Accountable Officer: Hayley Kendall
Issue: August performance is 63.9% (YTD 72.3%) 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. Full compliance against this KPI is expected to be achieved shortly after the new consultant capacity is in place.
Anticipated Delivery: Q3 2019/20
- 4.1.10 **Indicator: Radiology - MRI - Outpatient**
Accountable Officer: Hayley Kendall
Issue: August performance is 70.8% (YTD 60.7%) against a target of 90%
Actions: Significant improvement in performance in recent months. This is mainly due to the

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

Anticipated Delivery: Q3 2019/20

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

Accountable Officer: Hayley Kendall

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

- Admitted - 88.10% against a 95% target
- Non-Admitted - 86.67% against a 98% target
- Incomplete - 93.77% against a 95% target

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

Anticipated Delivery: Ongoing

4.1.12 Indicator: Total Agency Cost and Deliver the recurrent CIP

Accountable Officer: Claire Wilson

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

5. Conclusion

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

6. 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	Aug-19			
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	29	14	↓	3	3	2	M	
	Staff Friends and Family - recommend as a place of treatment		Count of those categorised as extremely likely or likely to recommend/count of all responders	94%	95.0%	→	94%	95.0%	95.0%	Q	
	Mixed Sex Accommodation Breaches		Count of number of occasions sexes were mixed on same-sex wards	0	0	→	0	0	0	M	
	inpatient scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	99.8%	↑	95%	100%	99.8%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	97.5%	↓	95%	96%	100%	M	
	Occurrence of any Never events	Safe	Count of Never Events	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 recent month	95%	96.6%	↓	95%	96.3%	96.5%	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	1.7	4	↓	0.33	1	0	M	
	MRSA Bacteraemias		Count of trust assigned MRSA infections	0	0	→	0.00	0	0	M	
	MSSA Bacteraemias		Count of trust assigned MSSA infections	2.9	8	→	0.58	1	1	M	
	Gram Negative Bacteraemias		Count of trust assigned Gram Negative Bacteraemias infections	3.8	7	↑	0.75	1	3	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	124.12	↑	100	115.17	132.45	M	Current month: May 2019; YTD: Apr 2019 - May 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		1	2	↓	1	2	1	M	
	Performance against plan	Financial Controls		1	2	↓	1	2	1	M	
	Agency Spend	Financial Controls		1	1	→	1	1	1	M	
	Overall use of resources (UoR) rating	Overall Financial Performance		1	1	→	1	1	1	M	
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	Operational Performance	Count of the number of patients whose clock period is less than 18 weeks during the calendar months of the return/Count of number of patients whose clock has not stopped during the calendar months of the return	92%	93.03%	↑	92%	93.03%	92.73%	M	
	All cancers - maximum 62-day wait for first treatment from (a) their GP who have currently been waiting for less than 62 days for treatment to start from (b) the NHS screening service who have currently been waiting for less than 62 days for treatment to start		Proportion of patients referred for cancer treatment by: a. their GP who have currently been waiting for less than 62 days for treatment to start b. the NHS screening service who have currently been waiting for less than 62 days for treatment to start	85%	91.30%	↑	85%	100%	75%	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%	69.8%	↓	99%	69.6%	73.8%	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%	93.8%	↓	90%	92.9%	100%	M	Latest Dementia figures are July 19 (Aug being validated)
	Dementia - Assess			90%	100%	→	90%	100%	100%	M	Latest Dementia figures are July 19 (Aug being validated)
	Dementia - Refer			90%	100%	→	90%	100%	100%	M	Latest Dementia figures are July 19 (Aug being validated)
	Review of sustainability and transformation plans and other relevant matters	Strategic Change				-	-	-	-		LHCH is lead for CVD cross-cutting theme
Organisational Health	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%	4.62%	↑	3.4%	4.50%	4.61%	M	
	Staff Turnover (Voluntary)		Number of Voluntary Staff leavers reported within the period /Average of number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period. Numerator = number of voluntary leavers within the report period. Denominator = staff in post at the start of the reporting period	10%	10.80%	↓	10%	10.80%	10.33%	M	Turnover based on 'Voluntary' Leavers in 12 month period
	NHS Staff Survey - recommend as a place to work		Staff recommendation of the organisation as a place to work or receive treatment	76%	76%	↑	76%	76%	74%	Q	Q3 2018 Staff Survey Data - Previous Period Q3 2017
	Proportion of Agency Staff Costs		Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	1.90%	1.99%	↑	1.90%	2.37%	2.47%	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%	10.50%	↑	25%	10.50%	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	Aug-19			
% of deaths screened for review within 7 days	Mortality		95%	68%	↓	95%	63%	80%	M	Current month: June 2019 (1 month lag for this measure)
% mortality reviews to be completed within 30 days - Doctors			80%	71%	↑	80%	75%	67%	M	Current month: June 2019 (1 month lag for this measure)
% mortality reviews to be completed within 30 days - Nurses			80%	97%	↑	80%	100%	93%	M	Current month: June 2019 (1 month lag for this measure)
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.5%	↑	1.3%	1.4%	1.4%	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	161.03	↑	100	115.52	200.54	M	Current month: May 2019; YTD: Apr 2019 - May 2019
HSMR for all diagnosis (supplied from Dr Foster)			100	121.69	↓	100	123.97	119.49	M	Current month: May 2019; YTD: Apr 2019 - May 2019
Cardiac Surgery observed: expected mortality ratio			1.00	1.11	↓	1.00	1.11	0.87	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	30	29	↑	6	6	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	2.5	5	↑	0.50	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	5	↓	0	2	0	M	5 x Serious Incidents YTD
Number of reported patient safety incidents (6 month rolling avg)			N/a	654	↑	N/a	131	138	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%	84.9%	↑	95%	90.3%	76%	M	
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	73.6%	↑	70%	80.7%	68%	M	
% Delivery of a sepsis antibiotic within three hours of prescription			96%	97.3%	↓	96%	94%	100%	M	
% of radiological alerts with a response document			95%	100%	→	95%	100%	100%	M	
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment
Friends and Family Test Response Rate - Inpatients	Patient Experience	Count of patients responding to the friends and family test in inpatients / count of eligible patients	95%	99.8%	↑	95%	100%	100%	M	
Friends and Family Test Response Rate - Outpatient scores % positive		Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients	95%	98.5%	↑	95%	99.7%	93%	M	
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.4%	↑	95%	98.8%	96.6%	M	
All re-inspected KLOE's rated as outstanding			Yes or No							The Trust is waiting for re-inspection to determine whether objective has been achieved

Appendix 3 – Operational & Financial Performance

Regulatory and Operational Performance - Operational Performance

	Indicator	Type	Description	Target YTD	Actual YTD	Trend	Current Month Target	Previous Month	Frequency	Comments	
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	81	⬆️	N/a	15	16	M	
	Improve histopathology turnaround times at 7-days	Turnaround Times	Improve histopathology turnaround times at 7-days	70%	39.0%	⬆️	70%	39.0%	66.0%	M	Data reported by Liverpool labs (latest data June-2019)
	Improve PET scanning turnaround times at 5-days		Improve PET scanning turnaround times at 5-days	75%	50.0%	⬆️	75%	47.6%	51.9%	M	Request to scan (does not include reporting time)
	Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	2.3%	⬆️	1.50%	2.2%	1.2%	M	Internal Target
	Cancelled Operations <u>NOT</u> seen in 28 days		Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days	0	1	⬆️	0	0	1	M	
	Cancelled Urgent Operations cancelled for 2nd+ time		Count of those urgent operations that have already been cancelled on one or more occasions before.	0	0	⬆️	0	0	0	M	
	Delayed Transfers of Care	Performance	A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed.	4.50%	4.03%	⬆️	4.5%	4.78%	5.78%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	82.3%	⬆️	>=85%	76.5%	83.3%	M	
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	-1.55%	⬆️	0.0%	-1.50%	-2.2%	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	2	⬆️	0	1	0	M	1 Welsh Patient breach in April, treated 20th May. 1 Breach in August.
	Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Reports within Std	90%	38.1%	⬆️	90.0%	54.4%	23.91%	M	
	Plain Film Outpatient		Total Plain Film Outpatient Reports within Std	90%	86.1%	⬆️	90.0%	93.4%	61.89%	M	
	CT Inpatient		Total CT Inpatient Reports within Std	90%	99.1%	⬆️	90.0%	98.6%	98%	M	
	CT Outpatient		Total CT Outpatient Reports within Std	90%	72.3%	⬆️	90.0%	63.9%	77.35%	M	
	MRI Inpatient		Total MRI Inpatient Reports within Std	90%	93.8%	⬆️	90.0%	92.3%	82%	M	
	MRI Outpatient		Total MRI Outpatient Reports within Std	90%	60.7%	⬆️	90.0%	70.8%	80.20%	M	
	Ultrasound Inpatient		Total Ultrasound Inpatient Reports within Std	90%	93.8%	⬆️	90.0%	100%	96.77%	M	
	Ultrasound Outpatient		Total Ultrasound Outpatient Reports within Std	90%	95.2%	⬆️	90.0%	100%	100%	M	
	14 day wait from referral to date first seen	Cancer	Patients waiting a maximum of two weeks from an urgent GP referral for suspected cancer to date first seen by specialist	93%	100%	⬆️	93%	100%	100%	M	
	31 day wait from diagnosis to first treatment		Patients waiting a maximum of 31 days from diagnosis to first definitive treatment	96%	100%	⬆️	96%	100%	100%	M	
	31 day wait for second or subsequent treatment (surgery)		Patients waiting a maximum of 31 days for all subsequent treatments	94%	100%	⬆️	94%	100%	100%	M	
	62 day wait for first treatment from urgent GP referral to treatment - consultant upgrade (Adj)		Patients waiting a maximum of 62 day's from a consultant decision to upgrade the urgency of a patient they suspect to have cancer to first treatment	85%	97.7%	⬆️	85%	85.7%	100%	M	
	104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0	⬆️	0	0	0	M	
	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	Welsh	Count of the number of Welsh patients whose clock period is less than 26 weeks during the calendar months of the return/Count of number of Welsh patients whose clock has not stopped during the calendar months of the return	95%	88.21%	⬆️	95%	88.10%	86.54%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	85.59%	⬆️	98%	86.67%	93.33%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	94.24%	⬆️	95%	93.77%	94.36%	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	106.60	⬆️	100	106.03	101.12	M	Current month: Feb 2019; YTD: Apr 2018 - Feb 2019
	Emergency readmissions following non-elective admission			100	94.42	⬆️	100	78.76	75.63	M	Current month: Feb 2019; YTD: Apr 2018 - Feb 2019
Workforce	Mandatory training	Organisational Health		95%	94.4%	⬆️	95%	94.4%	94%	M	
	Appraisals			90%	48.8%	⬆️	90%	48.8%	25%	M	Appraisal window reset May 2019
	Turnover Rate between 1-2 yrs service (voluntary (FTC excluded))			1.40%	2.65%	⬆️	1.40%	2.60%	1.95%	M	
Finance	Net Surplus £000's	Finance		£553	£722	⬆️	(£22)	£66	£661	M	
	Normalised Net Surplus £000's			£553	£557	⬆️	(£22)	£110	£496	M	
	Cash Balance £000's			£16,375	£28,485	⬆️	£16,375	£26,485	£25,913	M	Cash balances of £28.4m are £12m ahead of the planned position of £16.4m. This is primarily due to phasing of the Original Capital Plan and 18/19 PSF bonus monies
	Capital Expenditure £000's			£7,176	£3,130	⬆️	£665	£1,138	£519	M	Capital is £1,098k behind plan due to a change in the phasing of schemes.
	Total Agency cost £000's			£581	£679	⬆️	£116	£160	£167	M	Agency costs are £43k over in month due to Surgery Jr Drs £48k over in month. YTD Agency is £98k over plan. However we are £176k below cap YTD
	Total Bank cost £000's			£1,015	£986	⬆️	£201	£198	£179	M	Bank Costs are under plan in Month (£3k) and YTD (£30k)
	Deliver the recurrent cost improvement savings			£1,495	£1,148	⬆️	£308	£227	£390	M	Falling recurring CIP's are partially offset YTD by £40k of non recurring CIP's. There has been a significant increase in Recurring CIP's.