

## Board of Directors (in Public) Item 4.1

**Subject:** Board Dashboards - Regulatory, Operational and Strategic Performance  
**Date of meeting:** Tuesday 30<sup>th</sup> January 2018  
**Prepared by:** Lucinda Tennent - Information and Performance Manager  
**Presented by:** Tony Wilding - Director of Strategic Partnerships & Chief Operating Officer

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

### 1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period to 31<sup>st</sup> December 2017/18. The report is divided into the following three sections:

- Section 1 - Single Oversight Framework: This section provides details on our 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 - Operational Dashboard: These are our internal indicators which were agreed with the Board in April 2017 for routine monitoring on delivery.
- Section 3 - Strategic Dashboard: This reports on the indicators agreed by the Board of Directors (BoD) in April 2017 which monitor the in-year milestones toward each of our 5 Strategic Objectives.

### **Section 1 - Single Oversight Framework (SOF)**

NHS Improvement updated the Single Oversight Framework in November 2017. The key changes to the metrics are as follows:

- The following 3 indicators have been removed from the framework and have therefore been removed from the Trusts SOF dashboard.
  - HSMR ratio (weekend) from quality indicators
  - Aggressive cost reduction plans indicator
  - Emergency readmission rates
- The following 3 indicators have been added to the framework and are now included in the dashboard.
  - E-Coli bloodstream infections
  - MSSA bacteraemias
  - Dementia assessment and referral standards







Refer to Appendix 1 - SOF.

The following indicators, which were under performing against the in-month or year to date target last month, are now achieving target:

- Written Complaints – Rate

The following indicators are new exceptions this month:

- 18 Weeks Referral to Treatment - Incomplete Pathways
- Maximum 6 week wait for diagnostic procedures

Framework	Rating	Exception
Segmentation		Segment 1: Maximum autonomy; universal support
Leadership and Improvement Capability		
Strategic Change		
Operational Performance		18 Weeks Referral to Treatment - Incomplete Pathways (in-month) Maximum 6 week wait for diagnostic procedures (In month)
Quality - Safe, Effective & Caring		Mixed Sex Accommodation (YTD) MRSA Bactremia (YTD)
Quality - Organisational Health		Staff sickness (in-month & YTD)

### 1.1 Segmentation

Nothing to report.

### 1.2 Leadership & Improvement Capability

Nothing to report.

### 1.3 Strategic Change

Nothing to report.

### 1.4 Operational Performance

#### 1.4.1 Indicator: 18 Weeks Referral to Treatment - Incomplete Pathways

**Accountable Executive Officer:** Tony Wilding

**Issues:** Non-Compliance at 91.09% against a target of 92%, 181 patient backlog.

The trust failed to achieve compliance with the incomplete RTT target for December. This was caused by a very high number of cancellations due to the lack of POCCU beds driven by a high level of acuity on the unit that has continued into January 2018. In addition, the backlog in Medicine has increased and an action plan is in place to support a reduction in the this backlog.

**Actions:** Action Plans have been submitted by the divisions to the executives.

**Anticipated delivery:** Target will be back on track in February 2018

#### 1.4.2 **Indicator: Maximum 6-week wait for diagnostic procedures**

**Accountable executive Officer:** Tony Wilding

**Issue:** Currently below target for December at 98.63% against a target of 99% with a total of 16 breaches. 6 sleep studies, 1 echocardiography and 9 CT breaches.

**Actions:** There are currently business cases being produced for an additional CT and MRI scanners. There is an action plan in place in medicine to reduce the sleep backlog again probably into quarter one next year.

**Anticipated Delivery:** Q1 2018/19

### 1.5 Quality - Safe, Effective and Caring

#### 1.5.1 **Indicator: Mixed Sex Accommodation breaches**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** The Trust has reported 1 breach in August 2017.

**Actions:** The Trust has achieved much in ensuring prompt discharge following assessment as fit to leave critical care. Effort continues.

**Anticipated Delivery:** not applicable as target is nil and has already been exceeded.

#### 1.5.2 **Indicator: MRSA Bacteraemia**

**Accountable Executive Officer:** Raphael Perry

**Issue:** The single case to date arose in a gentleman who was a known MRSA carrier, but this information was not made available to us on his transfer for definitive intervention. A poorly inserted venflon almost certainly contributed.

**Actions:** Improved transfer information across the health economy, and developed policy in line with best practice for venflon insertion.

**Anticipated Delivery:** not applicable as target is nil and has already been exceeded.

### 1.6 Quality - Organisational Health

#### 1.6.1 **Indicator: Staff Sickness**

**Accountable Executive Officer:** Jo Twist

**Issue:** Sickness is 3.94% YTD and 4.15% in month against a target of 3.4%.

**Actions:** All staff triggering the sickness policy are reviewed by the Division with HR support; all are being managed as per the policy. Sickness levels are being driven by long term rather than short term sickness.

**Anticipated Delivery:** Ongoing monitoring and management.

## **Section 2 - Operational Dashboard**

Refer to Appendix 2 - Operational Performance Dashboard.


The following indicators, which were under performing against the in-month or year to date target last month, are now achieving target:

- NHS Activity
- Friends and Family Test Response Rate – Inpatients
- Cancelled Operations

- 62 day wait for first treatment from urgent GP referral to treatment – consultant upgrade (adjusted)

The following indicators are new exceptions this month:

- Cancer-14 day wait from referral to date first seen

Framework	Rating	Exception
Performance Summary		<p>Quality: Number of Adverse Events (red alerts), SIs &amp; Never Events (YTD)</p> <p>Performance: Cancelled operations (In month and YTD) Cancelled operations seen in 28-days (YTD) Urgent operations cancelled 2nd time (YTD) Delayed Transfers of Care (In month and YTD) GP Referrals (in month and YTD) Private Activity (YTD) Cancer-14 day wait from referral to date first seen</p> <p>Local Target: Welsh waiting times (in month &amp; YTD)</p> <p>Workforce: Turnover Rate between 1-2 yrs service (voluntary, FTC excluded)</p> <p>Finance: Cash Balance (In month and YTD) Total Bank Cost £000's (In month and YTD)</p>

## 1.7 Exceptions

### 1.7.1 Indicator: Number of Adverse Events (red alerts), Serious Incidents & Never Events

**Accountable Executive Officer:** Mark Jackson

**Issue:** 2 YTD

**Actions:** The RCA for the SI that occurred in August has been sent to the CCG and we are awaiting a response. The action plan is being progressed through Surgery Division. The two adverse events have now been investigated and determined not to be SI's.

**Anticipated Delivery:** Quarter 4 2017/18.

### 1.7.2 Indicator: Cancelled Operations

**Accountable Executive Officer:** Tony Wilding

**Issue:** There were a total of 28 reportable cancellations for Cardiac Surgery in December 2017 meaning the service line was non-compliant at 4.4% against a 1.5% (internal) stretch target. This was a 150% increase compared to the same time period for the last financial year.

The top 3 cancellation themes for December are as follows:

1. Elective bed shortage POCCU
2. Emergency taking priority – consultant covering emergency

### 3. List overrun

Elective bed shortage on POCCU was a particular area of concern between the 13th and 22nd December, prior to the Christmas period. The unit experienced a higher than normal volume of Level 3 patients that could not be moved from the POCCU unit, resulting in a total of 14 reportable cancellations and 4 non-reportable cancellations.

**Actions:** The Surgical Division continues to monitor the cancellation rate for the Cardiac service line and identifies (where possible) cancellations that may have been avoided. This information is shared frequently at monthly business meetings with the consultants so that any learning can be shared amongst the group to avoid repeats in the future. Furthermore scheduling takes into consideration case mix when listing patients in an attempt to reduce cancellations due to list overruns which is having an impact on the number of cancelled operations for this reason which is starting to reduce.

**Anticipated Delivery:** ongoing

#### 1.7.3 **Indicator: Cancelled operations for non clinical reasons seen in 28-days**

**Accountable Executive Officer:** Tony Wilding

**Issue:** A TAVI patient cancelled for an operation on the 23/03/2017 due to no POCCU beds.

**Actions:** On occasion it is difficult to schedule some procedures due to the nature of the case. TAVI cases can sometimes fall into this category due to the complexity and team required to deliver the service.

**Anticipated Delivery:** March 2018

#### 1.7.4 **Indicator: Delayed Transfers of Care**

**Accountable Executive Officer:** Tony Wilding

**Issue:** Delayed transfers of care are above target for YTD, however, we are currently showing as compliant for December.

**Actions:** The Trust continues to work with other organisations to ensure patient discharges are managed as efficiently as possible. A flagging system is in place to identify patients with complex discharge needs which are subsequently managed by the care support team. In addition, the Surgical Division have actioned a new service initiative, Consultant ward round week in July 2017, which will support the management of patient discharges in an efficient and timely manner.

**Anticipated Delivery:** Work ongoing across the system to improve performance.

#### 1.7.5 **Indicator: GP Referrals**

**Accountable Executive Officer:** Tony Wilding

**Issue:** GP referrals YTD is 20,611 against a target of 21,258 – the variation is more than 200 below the current plan. Performance for this indicator was below target for the month of April by 520 compared to the same period last year and when compared to 16/17 average, however, when adjusted for working days, the number of referrals was constant.

**Actions:** Monthly figures fluctuate between 3500 – 4400. Active monitoring to continue.

**Anticipated Delivery:** Not applicable.

#### 1.7.6 **Indicator: Private Activity**

**Accountable Executive Officer:** Tony Wilding

**Issue:** YTD = -4.1% and month 16.7%

**Actions:** Continued focus on delivery.

**Anticipated Delivery:** Not applicable.

#### 1.7.7 **Indicator: Cancer-14 day wait from referral to date first seen**

**Accountable Executive Officer:** Tony Wilding

**Issue:** Non-compliant for December at 83.33% against a 93% target. Suspected Lung Cancer coded from CT – LLCU team arranged first appointment within 14 days however, were unable to contact the patient. Patient finally contacted team to inform currently on holiday and could not attend within the 14 day target.

**Actions:** Performance for the 14 day (GP referral 1<sup>st</sup> OPA) was at risk due to the low denominator and patient choice – breach was unavoidable.

**Anticipated Delivery:** The 14 day (GP referral 1<sup>st</sup> OPA) is anticipated to be compliant for January 2018.

**1.7.8 Indicator: Welsh 26 weeks**

**Accountable Executive Officer:** Tony Wilding

**Issue:** All Welsh RTT patients waiting over 26-weeks for treatment.

**Actions:** The Trust continues to work with Welsh commissioners to improve waiting times for patients and is focused on ensuring any patients that do breach 26-weeks are seen before 36-weeks. The majority of Welsh pathways are complex and only get referred to the Trust late in the pathway. The Trust is assisting commissioners in identifying ways of improving the referral process to enable delivery of this target. Additional monitoring of waiting times has also been introduced by Commissioners to identify bottlenecks in the patient pathway; an initiative the Trust is actively participating in.

**Anticipated Delivery:** Q4 2017/18.

**1.7.9 Indicator: Turnover Rate between 1-2 yrs service (voluntary, FTC excluded)**

**Accountable Executive Officer:** Joanne Twist

**Issue:** Turnover Rate is 1.64% against a 1.4% target

**Actions:** Currently analysing exit interview data, responses rate increased from 18% to 38% for exit interviews. Intention to Leave Focus Groups being held in February with staff approaching 12-18 months service and First Impressions Focus Groups to try and capture any issues early on and introduce new interventions where appropriate. 6 monthly thematic reports going to the Divisions Performance meetings this month.

**Anticipated Delivery:** On-Going monitoring and management

**1.7.10 Indicator: Cash Balance**

**Accountable Executive Officer:** Claire Wilson

**Issue:** Cashflow is currently behind the YTD position due to a) the opening cash balances being £1.4m behind plan, and b) the non-payment of the HRG4+ increase by Wales Health Specialised Services Committee (WHSSC).

**Actions:** CFO has raised and is continuing to press Welsh HRG4+ issue with NHSI who are raising issue as part of a wider debate around funding flows between the English and Welsh Health services.

**Anticipated Delivery:** March 2018.

**1.7.11 Indicator: Total Bank Cost £000's**

**Accountable Executive Officer:** Jo Twist

**Issue:** Bank Costs have increased due to a reduction in the use of Agency and the increased pay rate used compared to Agenda for Change.

**Actions:** The Workforce utilisation group chaired by the Director of HR reviews the level of Bank staff used within the trust and looks at other options available.






**Anticipated Delivery:** On-going – Monthly meeting

**Section 3 - Strategic Dashboard**

Refer to Appendix 3 to 7 – Strategic Dashboard

The following indicators, which were under performing against the in-month or year to date target last month, are now achieving target:

The following indicators are new exceptions this month:

Framework	Rating	Exception
Quality & Experience		Mortality screening within 7 days (in month & YTD) Number of Falls - 4 key locations: Birch, Cedar, Elm and Oak (YTD) Sepsis - Blood cultures taken within 24hrs preceding first antibiotic given (in month) Outpatient scores from Friends & Family Test (In Month and YTD) % of radiological alerts with a response document (in month & YTD)
Service Delivery, Research & Innovation		RTT (in-month) 6 week diagnostic (in-month) Achieve recruitment on 100K genome project - rare diseases (In month) Number of patients recruited into CRN trials (In Month and YTD)
Financial Sustainability - Value for Money		Deliver the recurrent cost improvement savings (YTD)
Be the Best NHS Employer		
Partnership & Collaborative Working		

## 2.1 Quality & Experience

The strategic objective measures for Quality and Experience are provided in Appendix 3.

### 2.1.1 Indicator: Mortality screening within 7 days

**Accountable Executive Officer:** Raphael Perry

**Issue:** Screening of deaths within 7-days is 79% in month and 67% YTD against a target of 95%.

**Actions:** The new mortality review policy has been introduced in September 2017. There is new national guidance on Learning from Deaths which has implications for how organisational learning is identified and implemented. There have been more deaths this year since the target was set. Currently at 150 YTD against a comparison of 183 for the whole of 2016/17.

**Anticipated Delivery:** Q2 2018/19

### 2.1.2 Indicator: Number of Falls

**Accountable Executive Officer:** Sue Pemberton

**Issue:** The Trust has reported 7 falls in month against target of 7 however, 65 YTD against a target of 63.

**Actions:** The past few months have been challenging in preventing falls within the identified ward areas. Clinical teams are seeing an increased number of confused patients and those patients requiring enhanced levels of care from registered and unregistered staff. Unavoidable falls remain higher than avoidable, with some examples of falls pertaining to mobility aids, medication effects, and haemodynamic changes. Preventing falls remains the focus for all staff within the clinical areas, with the lead for falls, matrons and ward managers

providing the leadership and support to ward staff which includes awareness and training for falls prevention. Two Ward's are now trailing an early movement device that will advise nursing staff the movement of patients to enable a rapid response to prevent patients falling. This has shown a reduction in falls on Birch Ward.

**Anticipated Delivery:** End of 2017/18.

**2.1.3 Indicator: Sepsis - blood cultures taken within 24 hours**

**Accountable Executive Officer:** Raphael Perry

**Issue:** Work continues to improve compliance with the new sepsis screening process and results are improving; however, we remain under target.

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

**Anticipated Delivery:** Q1 2018/19.

**2.1.4 Indicator: Outpatient scores from Friends & Family Test**

**Accountable Executive Officer:** Sue Pemberton

**Issue:** 92.96% YTD against a target of 95%. The negative responses are linked to OPD waiting times.

**Actions:** Training is now completed for automated room calling using the Ipad system and the system will go live in February. This will allow Consultants/Leads to check each patient's journey through OPD, thus only calling patients when all diagnostic tests have been completed. Flexible starting times have now been implemented in Cardiac Diagnostics and Pulmonary Function from 8am and this will be constantly reviewed depending on actual patient flow requirements. A new Senior Nurse for OPD has been appointed who is accountable for patient and family experience. Patients and families are kept fully informed of any potential delays to clinics.

**Anticipated Delivery:** February 2018

**2.1.5 Indicator: % of radiological alerts with a response document**

**Accountable Executive Officer:** Raphael Perry

**Issue:** This is a new indicator introduced to provide visibility on a key organisational risk. It measures completion of the actions in response to a secure health messaging alert raised against a suspicious radiological finding.

**Actions:** Divisions have been provided with the information at individual requester level which identifies non-compliance with the process. They are supporting colleagues to create the radiological alert document that provides the assurance that the alert has been responded to. Performance has improved but we are still not achieving the standards for the year and so this is being given priority focus within the divisions.

**Anticipated Delivery:** March 2018.

**2.2 Service Delivery, Research & Innovation**

The strategic objective measures for Service Delivery, Research & Innovation are provided in Appendix 4.

**2.2.1 Indicator: 18 Weeks Referral to Treatment - Incomplete Pathways**

**Accountable Executive Officer:** Tony Wilding

**Issues:** Non-Compliance at 91.09% against a target of 92%, 181 patient backlog.

The trust failed to achieve compliance with the incomplete RTT target for December. This was caused by a very high number of cancellations due to the lack of POCCU beds driven by a high level of acuity on the unit that has continued into January 2018. In addition, the backlog in Medicine has increased and an action plan is in place to support a reduction in the this backlog.

**Anticipated delivery:** February 2018

**2.2.2 Indicator: Maximum 6-week wait for diagnostic procedures**



**Accountable executive Officer:** Tony Wilding

**Issue:** Currently below target for December at 98.63% against a target of 99% with a total of 16 breaches. 6 sleep studies, 1 echocardiography and 9 CT breaches.

**Actions:** There are currently business cases being produced for an additional CT and MRI scanners. There is an action plan in place in medicine to reduce the sleep backlog again probably into quarter one next year.

**Anticipated Delivery:** Q1 2018/19

#### 2.2.3 **Indicator: Achieve recruitment on 100k genome project – rare diseases**

**Accountable Executive Officer:** Mark Jackson

**Issue:** Rare Diseases is currently at 1 for December against a target of 15.

**Actions:** This is a national issue and is a reflection of narrow inclusion and exclusion criteria which are under constant review by the central team.

**Anticipated Delivery:** The timeframe for recruitment has been extended into 2018.

#### 2.2.4 **Indicator: Number of patients recruited into CRN trials**

**Accountable Executive Officer:** Mark Jackson

**Issue:** Recruitment into CRN trials is 64 behind target YTD.

**Actions:** A number of new trials are opening over the coming couple of months which will reverse this underperformance somewhat, although we anticipate the possibility of some under-delivery at year end.

**Anticipated Delivery:** Q4 2017/18.

### 2.3 **Financial Sustainability - Delivering Value for Money**

The strategic objective measures for Financial Sustainability are provided in Appendix 5.

#### 2.3.1 **Indicator: Deliver the recurrent cost improvement savings**

**Accountable Executive Officer:** Claire Wilson

**Issue:** There are non-recurring schemes of £319k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £502k, with £396k of non-recurrent CIP to offset this position.

**Actions:** Operational delivery of the CIP plan is being overseen through the Business Transformation Steering Group, chaired by the Chief Finance Officer. The Directorates have been tasked to reduce or mitigate this gap.

**Anticipated Delivery:** March 2018.

### 2.4 **Be the Best NHS Employer**

The strategic objective measures for being the best employer are provided in Appendix 6. There are no exceptions to report.

### 2.5 **Partnership & Collaborative Working**

The strategic objective measures for being the best employer are provided in Appendix 7. There are no exceptions to report.

## 3. **Conclusion**

The Trust is facing a number of challenges and underperformance in a number of indicators. Managers and clinicians are well sighted on the issues and action plans have been produced and are actively monitored.

## 4. **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)														
	Reviews	Rating	Comment										Concern	
Leadership and Improvement Capability	Well Led Reviews - CQC Well Led Assessments		CQC review published September 2016 rated Well-led Domain as 'Outstanding'											
	Well Led Reviews - NHSI Code of Governance		MIAA 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													
Strategic Change	Review of sustainability and transformation plans and other relevant matters		LHCH is lead for CVD cross-cutting theme											
	Indicator	Target	YTD	Performance Trend	Current month		Previous Month	Data Quality	Frequency	Comments			Red Indicator	
					Target	Dec 17								
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	>=92%	91.09%	↓	>=92%	91.09%	92.44%		M					
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	97.78%	→	>=85%	100%	100%		M	Adjusted figure provided				
	Maximum 6-week wait for diagnostic procedures	>=99%	99.59%	↓	>=99%	98.63%	99.00%		M					
	Dementia - Find	90%	98.90%	↑	90%	100%	97.60%		M					
	Dementia - Assess	90%	100%	→	90%	100%	100.00%		M					
	Dementia - Refer	90%	100%	→	90%	100%	100.00%		M					
Quality - Safe, Effective & Caring	Written Complaints - rate	50	44	↑	5	1	6		M	Awaiting national technical guidance			Y	
	Occurrence of any Never Events	0	0	→	0	0	0		M					
	NHS England/NHS Improvement Patient Safety Alerts outstanding	0	0	→	0	0	0		M					
	Mixed Sex Accommodation breaches	0	1	→	0	0	0		M				Y	
	VTE Risk Assessment	>=95%	97.3%	↓	>=95%	96.8%	97.6%		M					
	Clostridium Difficile	2	1	→	0	0	0		M	Due to lapses in care				
	Clostridium Difficile infection rate (per 1000 beddays)	<=0.19	0.02	→	<=0.19	0.00	0.00		M					
	MRSA bacteraemias	0	1	→	0	0	0		M				Y	
	eColi	8	5	→	1	1	1		M	Plan based on 2016/17				
	MSSA Bacteraemias	N/A	7	→	N/A	0	0		M					
	HSMR for all diagnosis (supplied from Dr Foster)	<=100	113.89	↑	<=100	99.18	124.49		M	Current month is September 2017				
	HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide)	<=100	127.01	↑	<=100	89.81	135.46		M	Current month is September 2017			Y	
	Potential under reporting of patient safety incidents	<3	2	→	<3	2	2		6M	NRLS Report April - September 2017 (3 = poor)			Y	
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	>=90%	100%	→	>=90%				6M	September 2016 Survey				
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission)	>=90%	100%	→	>=90%				6M	September 2016 Survey				
	Std 5: 7-day Services: CT scan within 1 hr for critical care need	>=70%	100%	→	>70%				6M	September 2016 Survey				
	Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need	>=80%	100%	→	>=80%				6M	September 2016 Survey				
	Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need	>=85%	100%	→	>=85%				6M	September 2016 Survey				
	Std 6: 7-day Services: Access to interventions	>=80%	100%	→	>=80%				6M	September 2016 Survey				
	Std 8: 7-day Services: Ongoing review twice daily in high dependency area	>=80%	96%	→	>=80%				6M	September 2016 Survey				
	Std 8: 7-day Services: Ongoing review every 24 hours on general wards	>=80%	98%	→	>=80%				6M	September 2016 Survey				
	Staff Friends and Family - recommend as a place of treatment	>=94%	95%	↑	>=94%	95%	93%		Q	Q3 2016 Staff Survey Data				
	Inpatient scores from Friends & Family Test - % positive	>=95%	99.2%	→	>=95%	99.5%	99.5%		M					
	Community scores from Friends & Family Test - % positive	>=95%	99.5%	→	>=95%	99.0%	99.0%		M					
Quality - Organisational Health	Staff Sickness	<=3.4%	3.94%	↓	<=3.4%	4.15%	4.09%		M				Y	
	Proportion of temporary Staff	<=5%	5.31%	↑	<=5%	5.58%	5.67%		M					
	Staff Turnover	<=10%	12.0%	↓	<=10%	12.0%	11.7%		M	Turnover based on 'All' Leavers in 12 month period				
	Executive Team Turnover	<=25%	14.3%*	→	<=25%	14.3%	14.3%*		M	Calculation: Leavers in 12 month period / Average Staff in Post in 12 month period x 100 // **NB excludes Raph Perry who left on Flexi Retirement but returned				
	NHS Staff Survey - recommend as a place to work	>=76%	73%	→	>=76%	73%	73%		Q	Q3 2016 Staff Survey Data - Previous Period Q3 2015				
Finance	Capital service cover	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	3	2	→	3	2	2		M					
	Efficiency													
	I&E margin	1	1	→	1	1	1		M					
	Controls													
	Performance against plan	2	2	→	2	2	2		M					
	Agency spend	2	1	→	2	1	1		M					
	Overall Financial Performance													
	Overall use of resources rating	2	1	→	2	1	1		M					
	Value for money information													
NCBC Benchmarking Data, Meridian Review, Back Office Review, Pathology Review		Comment: NCBC Benchmarking undertaken and review of results being carried out, GIRFT results under review, Back office review underway as part of STP.												
Control total acceptance		Yes												
Overall	Segmentation								Adhoc	Segment 1: Maximum autonomy; universal support				

## Appendix 2 – Operational Performance Dashboard

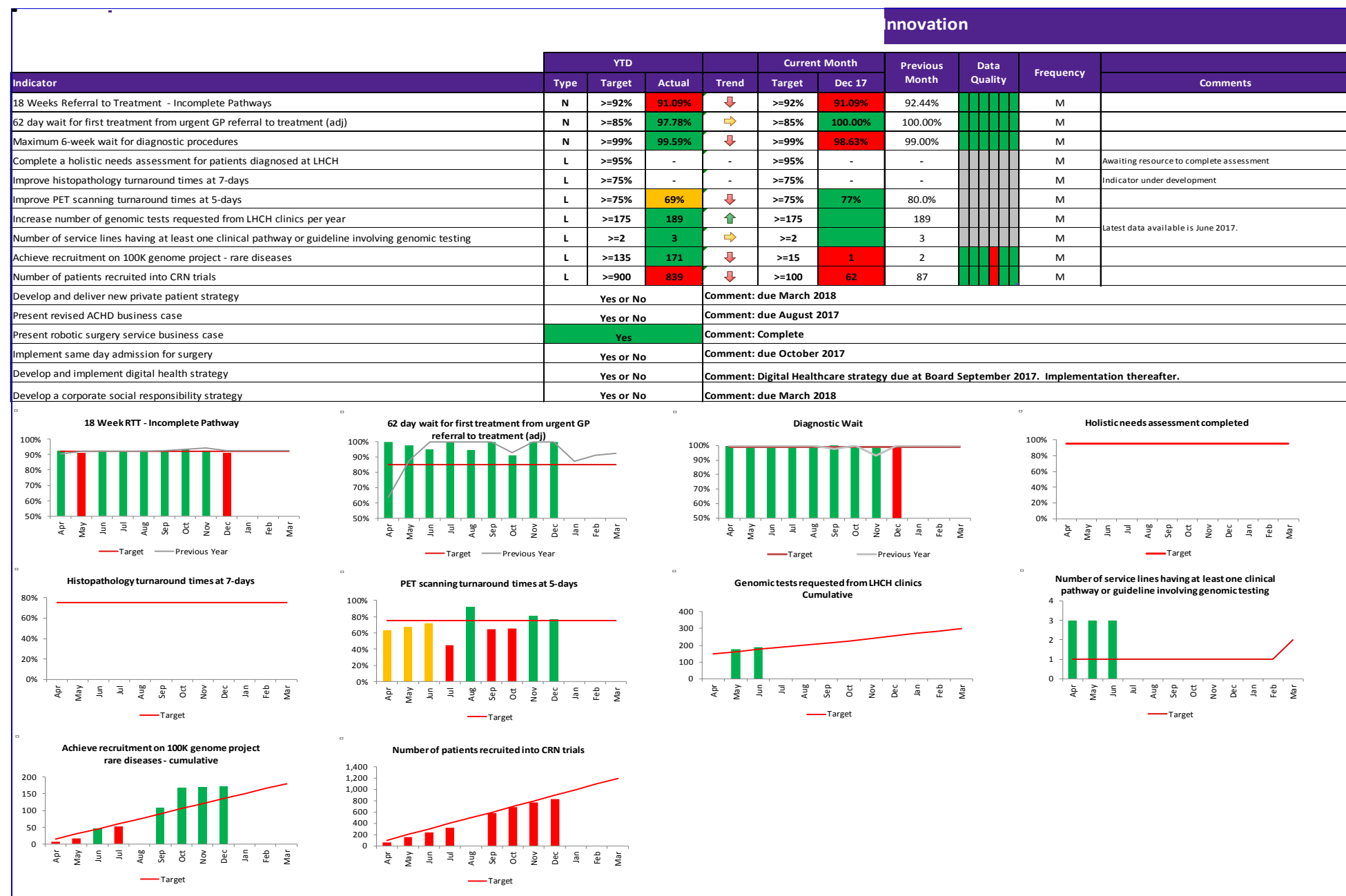
Performance Report Summary 2017/18												
	Indicator	Target	Actual	Performance Trend	Current month		Previous Month	Data Quality	Frequency	Comments	Exception	
			YTD		Target	Dec 17						
Quality	Friends and family Test response rate - Inpatients	>=50%	50%	↑	>=50%	55.74%	52.95%	✓	M			
	VTE Prophylaxis	>=95%	98.32%	↓	>=95%	98.10%	98.88%	✓	M			
	Number of in-hospital deaths	N/A	150	↑	N/A	16	21	✓	M			
	Risk adjusted CABG mortality	<=1	0.95	↑	<=1	0.93	1.00	✓	M	6-month rolling averages; latest due up to September 2017		
	Risk adjusted non-primary PCI MACE	<=1	0.55	↓	<=1	0.55	0.55	✓	M	6-month rolling averages; latest data up to September 2017		
	Number of Adverse Events (red alerts), SIs & Never Events	0	2	↓	0	0	0	✓	M	2 SI Reported (April and August)	Y	
	Number of Reported Patient Safety Incidents (6-month rolling avg)	>=1257	1251	↓	>=139	147	153	✓	M			
Performance	Cancelled operations	<=1.5%	2.2%	↓	<=1.5%	4.3%	2.0%	✓	M	Internal Target		
	Cancelled operations seen in 28-days	100%	97.3%	↓	100%	100%	100%	✓	M	1 Operation not re-booked within 28 days of cancellation	Y	
	Urgent operations cancelled 2nd time	0	1	↓	0	0	0	✓	M			
	Delayed transfers of care	<=4.5%	5.91%	↑	<=4.5%	4.50%	6.96%	✓	M		Y	
	Bed occupancy	>=85%	83.02%	↓	>=85%	82.12%	88.14%	✓	M			
	Referrals - GP	21,258	20,611	↓	2,362	2,230	2,506	✓	M		Y	
	Referrals - DGH	7,596	7,867	↓	844	803	860	✓	M			
	Referrals - Other	1,296	1,557	↓	144	149	177	✓	M			
	Activity - NHS	0%	1.37%	↑	0%	24.7%	2.2%	✓	M		Y	
	Activity - Private	0%	-4.10%	↑	0%	16.7%	-5.9%	✓	M			
	18 Weeks Referral to Treatment Incomplete Pathways 52 week +	0	0	↓	0	0	0	✓	M			
	14 day wait from referral to date first seen	>=93%	99.34%	↓	>=93%	88.89%	100.00%	✓	M	Patient could not attend within the 14 day target due to being on holiday.		
	31 day wait from diagnosis to first treatment	>=96%	99.47%	↑	>=96%	100.00%	98.33%	✓	M			
	31 day wait for second or subsequent treatment (surgery)	>=94%	98.41%	↓	>=94%	100.00%	100.00%	✓	M			
	62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj)	>=85%	88.14%	↓	>=85%	100.00%	100.00%	✓	M		Y	
Local Target	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	>=95%	89.36%	↓	>=95%	89.36%	90.32%	✓	M		Y	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways	>=98%	82.76%	↓	>=98%	82.76%	84.21%	✓	M		Y	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways	>=95%	94.65%	↑	>=95%	94.65%	93.31%	✓	M		Y	
Workforce	Appraisals	>=90%	90%	↓	>=90%	90%	90%	✓	M	Data shown is for Sept 17 end of Appraisal Window	Y	
	Mandatory training	>=95%	95%	↓	>=95%	95%	95%	✓	M			
	Turnover Rate between 1-2 yrs service (voluntary)(FTC excluded))	<=1.4%	1.64%	↓	<=1.4%	1.64%	1.90%	✓	M	YTD is 12 month period		
Finance	Net Surplus £000's	3,619	3,671	↑	-242	-296	904	✓	M			
	Normalised Net Surplus £000's	3,619	3,671	↑	-242	904	904	✓	M			
	Cash Balance	8,018	6,135	↓	-266	928	-411	✓	M	Cashflow is currently behind the YTD position largely due to the non-payment of the HRG+ increase by Wales Health Specialised Services Committee (WHSSC).	Y	
	Capital expenditure £000's	-4,284	-3,496	↓	-376	-395	19	✓	M	Expenditure in month slightly over plan. Current forecast of £5801k is an overspend on plan of approximately £390k		
	Total agency cost £000's	-1,688	-1,448	↑	-188	-159	-170	✓	M	Agency costs in month are close to the NHS Ceiling. There has been an increase in the use of Medical and Nursing agency compared to the previous month		
	Total bank cost £000's	-508	-1,567	↑	-45	-180	-193	✓	M	Increasing levels of Bank staff being used across the Trust. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets	Y	

## Appendix 3 – Strategic Dashboard: Quality & Experience

Strategic Objective Measures 2017/18 - Quality & Experience												
	YTD				Current month		Previous Month	Data Quality	Frequency	Comments		
Indicator	Type	Target	Actual	Trend	Target	Dec 17						
% of deaths screened for reviewed within 7 days	L	>=95%	67%	➡	>=95%	79%	79%	■	■	■	M	Current month based November 2017
% Mortality reviews to be completed within 30 days of allocation - Doctors	L	>=80%	80%	⬆	>=80%	81%	71%	■	■	■	M	Current month based November 2017
% Mortality reviews to be completed within 30 days of allocation - Nurses	L	>=80%	93%	⬇	>=80%	90%	100%	■	■	■	M	Current month based November 2017
HSMR for all diagnoses and procedures	N	<=100	113.89	⬆	<=100	99.18	124.49	■	■	■	M	Latest figures supplied by Dr Foster to September 2017
HSMR for 56 diagnosis groups	N	<=100	127.01	⬆	<=100	89.81	135.46	■	■	■	M	Latest figures supplied by Dr Foster to September 2017
Observed mortality rate	L	<=1.3%	1.49%	⬆	<=1.3%	1.51%	1.73%	■	■	■	M	
Number of Falls - 4 key locations (Birch, Cedar, Elm & Oak)	L	63	69	⬇	7	11	6	■	■	■	M	Target for the year is 86
Number of avoidable Pressure Ulcers - grade 2	L	<=5	5	➡	<= 1	1	1	■	■	■	M	
Number of avoidable Pressure Ulcers - grade 3	L	0	0	➡	0	0	0	■	■	■	M	Not charted below
% Blood cultures taken within 24hrs preceding first antibiotic given	L	>=95%	76%	⬇	>=95%	73%	74%	■	■	■	M	December - 8 out of 11 bundles
% Delivery of at least one sepsis antibiotic within <u>one</u> hour of prescription	L	>=70%	63%	⬇	>=70%	64%	78%	■	■	■	M	December - 7 out 11 bundles
% Delivery of a sepsis antibiotic within <u>three</u> hours of prescription	N	>=96%	96%	⬆	>=96%	100%	96%	■	■	■	M	December - 11 out of 11 bundles
Inpatient scores from Friends & Family Test - % positive	L	>=95%	99.2%	➡	>=95%	99.5%	99.5%	■	■	■	M	
Outpatient scores from Friends & Family Test - % positive	L	>=95%	92.96%	⬆	>=95%	95.5%	94.6%	■	■	■	M	
Community scores from Friends & Family Test - % positive	L	>=95%	99.5%	➡	>=95%	99.0%	99.0%	■	■	■	M	
% of radiological alerts with a response document	L	>=95%	70.0%	➡	>=95%	77%	77%	■	■	■	M	YTD is the average
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								
Follow-up audit of SUI reveals improvement embedded and delivering	No			Comment: OL Policy complementing recent learning from deaths guidance								



## Appendix 4 – Strategic Dashboard - Service Delivery, Research & Innovation



## Appendix 5 – Strategic Dashboard: Financial Sustainability / Delivering Value for Money

Strategic Objective Measures 2017/18 - Financial Sustainability Delivering Value for Money										
	YTD		Trend	Current month		Previous Month	Data Quality	Frequency	Comments	
Indicator	Plan	Actual		Plan	Dec 17					
Overall use of resources rating	2	1	➡	2	1	1		M		
Deliver the recurrent cost improvement savings	£2,750	£2,333	⬇	£320	£276	£312		M	There are non-recurring schemes of £319k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £502k, with £396k of non-recurrent CIP to offset this position.	
Agency rating	2	1	➡	2	1	1		M	Continued use of Agency; £1.288m against a ceiling of £1.502m (Full year ceiling - £2.251m)	
Liquidity rating	3	2	➡	3	2	2		M		
Implement model hospital dashboard	Yes or No		Comment: March 18							
Develop Service Line Reporting	Yes or No		Comment: SLR for 2016/17 is complete, Reference Costs 2016/17 submitted. Meetings held during October and November with DHOs, Finance Business Partners and Clinical Leads to discuss outputs of the in-year 2017/18 model. Areas for improvement are being developed alongside necessary development of data and systems covered within the Business Informatics Transformation programme.							
Implement service line reporting plan	Yes or No		Comment: March 2018 (key milestone reference costs August 2017)							

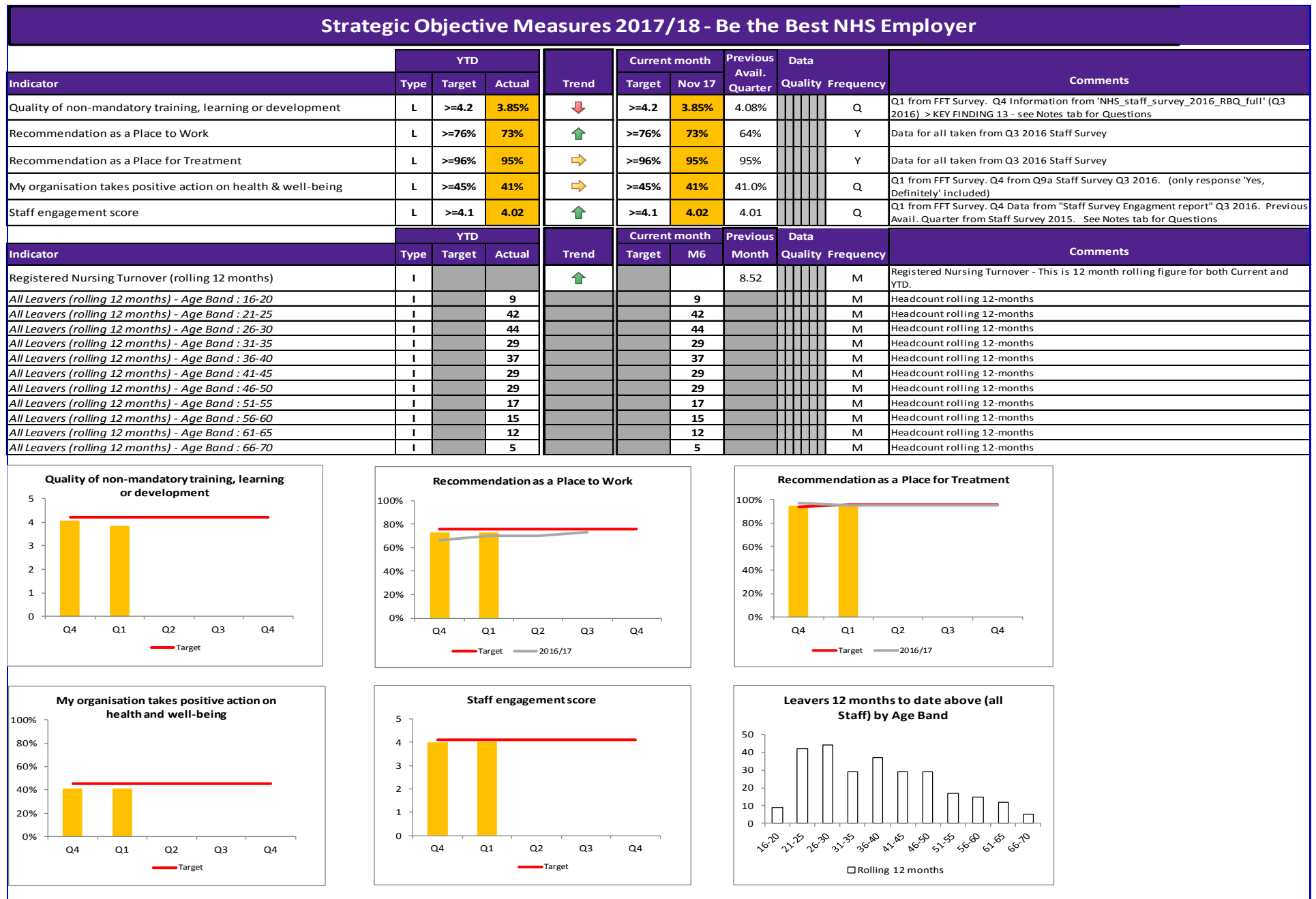
Recurrent cost improvement savings £000's (cumulative)

Month	Savings (£000's)
Apr	200
May	400
Jun	600
Jul	800
Aug	1000
Sep	1200
Oct	1400
Nov	1600
Dec	1800

Overall Financial Performance:

The year to date (YTD) overall financial position for M09 is a surplus of £3.671m, against a planned surplus of £3.619m, showing a favourable variance of £52k. The variance is partially related to additional income received for donated assets, which does not affect the STF monies. The Trusts is currently forecasting to deliver its year end control total, however, a significant risk to the forecast position is the on-going HRG4+ dispute with Welsh commissioners (£2.4m FYE) which remains unresolved and is subject to national funding discussions. The Chief Finance Officer continues to escalate this issue for resolution with NHS Improvement and NHS England.

# Appendix 6 – Strategic Dashboard: Be the Best NHS Employer



## Appendix 7 – Strategic Dashboard: Partnership & Collaborative Working

Strategic Objective Measures 2017/18 - Partnership & Collaborative Working										
Indicator	YTD			Trend	Current Quarter		Previous Quarter	Data Quality	Frequency	Comments
	Type	Target	Actual		Target	Q3				
Media impact metric	L	42	38	-	42	38	30		Q	
Fundraising impact metric	L	378	767	-	126	292	270		Q	
Address issues arising from the externally facing element of the well led review	Yes			Comment: There were no significant findings from this review.						
Implement CVD STP Plan	Yes			Comment: The CVD programme in the C&M STP has delivered in Q3: <ul style="list-style-type: none"> <li>• Clinical summits with Chester and Wirral, and with Warrington and Whiston colleagues – scenarios for primary pacing services and workforce models for sustainable on-call services were discussed.</li> <li>• AF prevention and management workshop – with colleagues from primary care, secondary care and commissioning.</li> <li>• Two cases for change presented to the CVD Programme Board: Primary Pacing Pathway, and Aortic Dissection Pathway – to be shared with the C&amp;M Acute Sustainability Programme (Urgent and Emergency care).</li> <li>• ACS working group established and monthly meetings planned up to March 2018. – group will define the priorities for the best ACS model in C&amp;M.</li> <li>• Engagement with Healthwatch and setting criteria for a CVD Patient Reference Group.</li> </ul>						

### Media impact metric

Quarter	Actual	Target
Q1	18	18
Q2	30	30
Q3	38	38
Q4	-	55

### Fundraising impact metric

Quarter	Actual	Target
Q1	200	150
Q2	480	250
Q3	767	380
Q4	-	500