

Board of Directors (in Public) Item 4.1

Subject: Board Dashboards - Regulatory, Operational and Strategic Performance
Date of meeting: Tuesday 27th March 2018
Prepared by: Lucinda Tennent - Information and Performance Manager
Presented by: Tony Wilding - Director of Strategic Partnerships and Chief Operating Officer
Purpose of the Report: To Note

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

1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period to the 28th February 2018. 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:

The following indicators are new exceptions this month:

Framework	Rating	Exception
Segmentation		Segment 1: Maximum autonomy; universal support
Leadership and Improvement Capability		
Strategic Change		
Operational Performance		Maximum 6 week wait for diagnostic procedures (In month and YTD)
Quality - Safe, Effective & Caring		Mixed Sex Accommodation (YTD) MRSA Bactremia (YTD) HSMR For 56 diagnosis groups (supplied from Dr Foster – Hospital Guide)(In month)
Quality - Organisational Health		Staff sickness (in-month & YTD)

1.1 Quality - Safe, Effective and Caring

1.1.1 Indicator: Maximum 6-week wait for diagnostic procedures

Accountable executive Officer: Tony Wilding

Issue: Currently below target for February 2018 at 95.54% against a target of 99% with a total of 65 breaches; 44 for CT, 19 for MRI and 2 Echocardiography.

Actions: There are currently business cases being produced for an additional CT and MRI scanners at the Trust to be presented to the Board in May 2018. We are mitigating the pressures by using mobile scanners where available but this is limited and does not meet our needs to achieve the target.

Anticipated Delivery: We will not achieve compliance at year end.

1.1.2 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 this has already been exceeded.

1.1.3 Indicator: HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide)

Accountable Executive Officer: Raphael Perry
Data not currently available.

1.1.4 Indicator: MRSA Bacteraemia

Accountable Executive Officer: Raphael Perry

Issue: Referral of MRSA carrying patient from another hospital.

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 this has already been exceeded.

1.2 Quality - Organisational Health

1.2.1 Indicator: Staff Sickness

Accountable Executive Officer: Jo Twist

Issue: Sickness is 4.04% YTD and 3.98% 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: Q1 2018/19

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:

- Friends & Family Test response rate - inpatients

The following indicators are new exceptions this month:

- Private Activity

Framework	Rating	Exception
Performance Summary		<p>Quality: Number of Adverse Events (red alerts), SIs & Never Events (YTD)</p> <p>Performance: Cancelled operations (In month and YTD) Cancelled operations seen in 28-days (YTD) Urgent operations cancelled for a 2nd time (YTD and In month) Delayed Transfers of Care (YTD) GP Referrals (YTD) Private Activity (In month and YTD) NHS Activity (In month and YTD) 18 weeks referral to treatment incomplete pathways 52 week+ (in month and YTD) 62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj)(In month)</p> <p>Local Target: Welsh waiting times (in month & YTD)</p> <p>Finance:</p>

		Cash Balance (In month and YTD) Total Bank Cost £000's (In month and YTD)
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1.3 Exceptions

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

Accountable Executive Officer: Mark Jackson

Issue: No new SIs or adverse events in the reporting period.

1.3.2 Indicator: Cancelled Operations

Accountable Executive Officer: Tony Wilding

Issue: There were a total of 29 reportable cancellations for Cardiac Surgery in February 2018 meaning the service line was non-compliant at 4.5% against a 1.5% (internal) stretch target. Top three cancellation themes for February 2018 are as follows:

1. Elective bed shortage POCCU
2. Impact of overnight emergencies
3. Elective other and Elective staff shortage POCC (resulted in an equal number of reportable cancellations)

As seen in December and January elective bed shortage on POCCU was the top reason for cancellations. In February as with previous months the POCCU unit experienced a higher than normal volume of Level 3 patients that could not be moved from the unit to the ward. This resulted in 10 reportable cancellations (decrease from December 17 and January 18).

Cancellations due to the impact of overnight emergencies has emerged as the second leading cause of reportable cancellations for February. This resulted in a total of 4 reportable cancellations due to anaesthetists, perfusionists and surgeons covering emergencies overnight. Cancellations arising from elective staff shortages on POCCU and elective other reasons (listed patients displaced to accommodate previously cancelled patients) resulted in an equal number of reportable cancellation for February and emerged as the third leading theme for cancellations.

All cancellations have been dated with no 28 day breaches

Actions: The Surgical Division continues to monitor the cancellation rate for the cardiac service line and identifies (where possible) cancellation that may have been avoided. This information is shared frequently with amongst the consultants and wider surgical team. A piece of work is currently on-going involving the clinical leads for cardiac and aortic surgery to devise an action plan that focuses on reducing avoidable cancellations. The action plan will be presented at the next Divisional Performance Meeting – 23rd March 2018. Heads of Nursing and Divisional Head of Operations, Surgery will be focusing on reducing cancellations as a result of POCCU bed shortages.

Anticipated Delivery: Ongoing

1.3.3 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

1.3.4 Indicator: Urgent operations cancelled 2nd time

Accountable Executive Officer: Tony Wilding

Issue: Patient was cancelled initially due to POCCU staff shortage and a second time in-month due to POCCU bed shortages.

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. The information is shared with consultants and the wider clinical surgical team. Work is also on-going cross-divisionally to address issues relating to the POCCU unit. The patient received surgery on the 23rd February 2018 and was prioritised.

Anticipated Delivery: On-going

1.3.5 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 amber for February 2018. The Trust took an active decision to keep patients longer at LHCH rather than transfer to other hospitals in order support the local health economy over the winter period.

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: Ongoing

1.3.6 Indicator: GP Referrals

Accountable Executive Officer: Tony Wilding

Issue: GP referrals YTD is 25,665 against a target of 25,982 – the variation is more than 300 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.

1.3.7 Indicator: NHS Activity

Accountable Executive Officer: Tony Wilding

Issue: YTD = -0.41% and in month -10.7%

Actions: Continued focus on delivery.

Anticipated Delivery: Not applicable.

1.3.8 Indicator: Private Activity

Accountable Executive Officer: Tony Wilding

Issue: YTD = -2.8% and month -6.1%

Actions: Continue focus on delivery.

Anticipated Delivery: Not applicable.

1.3.9 Indicator: 18 weeks Referral to Treatment incomplete pathways 52 week+

Accountable Executive Officer: Tony Wilding

Issue: Email received from Knowsley Community Admin Manager on 27/02/2018 with referral attached dated 14/10/2016, was never previously sent.

Actions: Escalated to Divisional Managers and consultant 28/02/2018, Consultant requested OPA 07/03/2018, Patient attended and pathway was closed, Admin error identified in Knowsley Community – member of staff has since left the trust, Results and referrals tracker are checked on a daily basis (was previously weekly), are now emailed across and Knowsley Community register it on PAS with an active RTT clock start for the receiving secretary to be able to monitor.

Anticipated Delivery: Treatment options discussed with patient in clinic on 07/03/2018 and it was decided she is happy to stay on medical therapy, Letter typed 07/03/2018, Pathway closed 07/03/2018.

- 1.3.10 **Indicator: 62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj)**
Accountable Executive Officer: Tony Wilding
Issue: 62 day wait for first treatment from GP for consultant upgrade for February is currently 83.33% against the target of 85% due to the low denominator and one late referral. The patient could not be treated within 24 days of referral as they were receiving radiotherapy.
Actions: On-going pathway work with referring trust and RCA to be completed.
Anticipated Delivery: On-going
- 1.3.11 **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: 2018/19 subject to discussions in relation to HRG4+
- 1.3.12 **Indicator: Cash Balance**
Accountable Executive Officer: Claire Wilson
Issue: Cashflow is currently behind the YTD position largely due to 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. We are not anticipating any resolution before M12.
Anticipated Delivery: The Financial year deadline / delivery date is 31/3/18.
- 1.3.13 **Indicator: Total Bank Cost £000's**
Accountable Executive Officer: Jo Twist
Issue: Bank used across the Trust due to Maternity leave and sickness, mainly in admin and nursing. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets.
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:

- Outpatient scores from Friends & Family Test

The following indicators are new exceptions this month:

- Mortality Reviews to be completed within 30 days of allocation – Doctors
- % Blood Cultures taken within 24 hours preceding first antibiotic given

Framework	Rating	Exception
Quality & Experience		Mortality screening within 7 days (in month & YTD) HSMR for 56 diagnosis groups (In month)

		Observed Mortality Rate % Blood Cultures taken within 24 hours preceding first antibiotic given (In month) % of radiological alerts with a response document (in month & YTD)
Service Delivery, Research & Innovation		62 day wait for first treatment from urgent GP referral to treatment (adj)(In month) Maximum 6-week wait for diagnostic procedures(In month and YTD) 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 87% in month and within range, however, and YTD is still below target at 68% against 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: Observed Mortality Rate

Accountable Executive Officer: Raphael Perry

Issue: Observed mortality rate is above the target of 1.3% at 2.14% for January and 1.59% for YTD. There have been an increased number of deaths through 2017/18 as the spike in November has persisted through January. The reason appears to be a change in policy for managing OHCA patients through the PPCI pathway and increasing acuity of surgical patients. There is close scrutiny of all deaths and no increase of avoidable deaths.

Actions: A deep dive into mortality is underway.

Anticipated Delivery: Q2 2018/19

2.1.3 Indicator: % Blood Cultures taken within 24 hours preceding first antibiotic given

Accountable Executive Officer: Raphael Perry

Issue: For February there has been 9 out of 13 bundles completed resulting in 69% against a 95% target. Work continues to improve compliance with the new sepsis screening process and results are improving; however, we remain under target. Additionally, since the introduction of screening, not all patients are managed via the sepsis bundle, as some are treated within other pathways.

Actions: Reinforcement of performance by Division and continued education in the use of the sepsis bundle.

Anticipated Delivery: Q4 2017/18.

2.1.4 **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: Achieve recruitment on 100k genome project – rare diseases**

Accountable Executive Officer: Mark Jackson

Issue: Rare Diseases is currently at 1 for February 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.

2.2.2 **Indicator: Number of patients recruited into CRN trials**

Accountable Executive Officer: Mark Jackson

Issue: Recruitment into CRN trials is 97 behind target YTD.

Actions: A number of new trials are opening over the coming couple of months and there has been a change nationally to permit inclusion of recruitment to the 100,000 genome project 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 £354k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £632k, with £417k 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: The Financial year deadline / delivery date is 31/3/18.

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 to improve delivery and these are actively monitored.

4. Recommendations

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

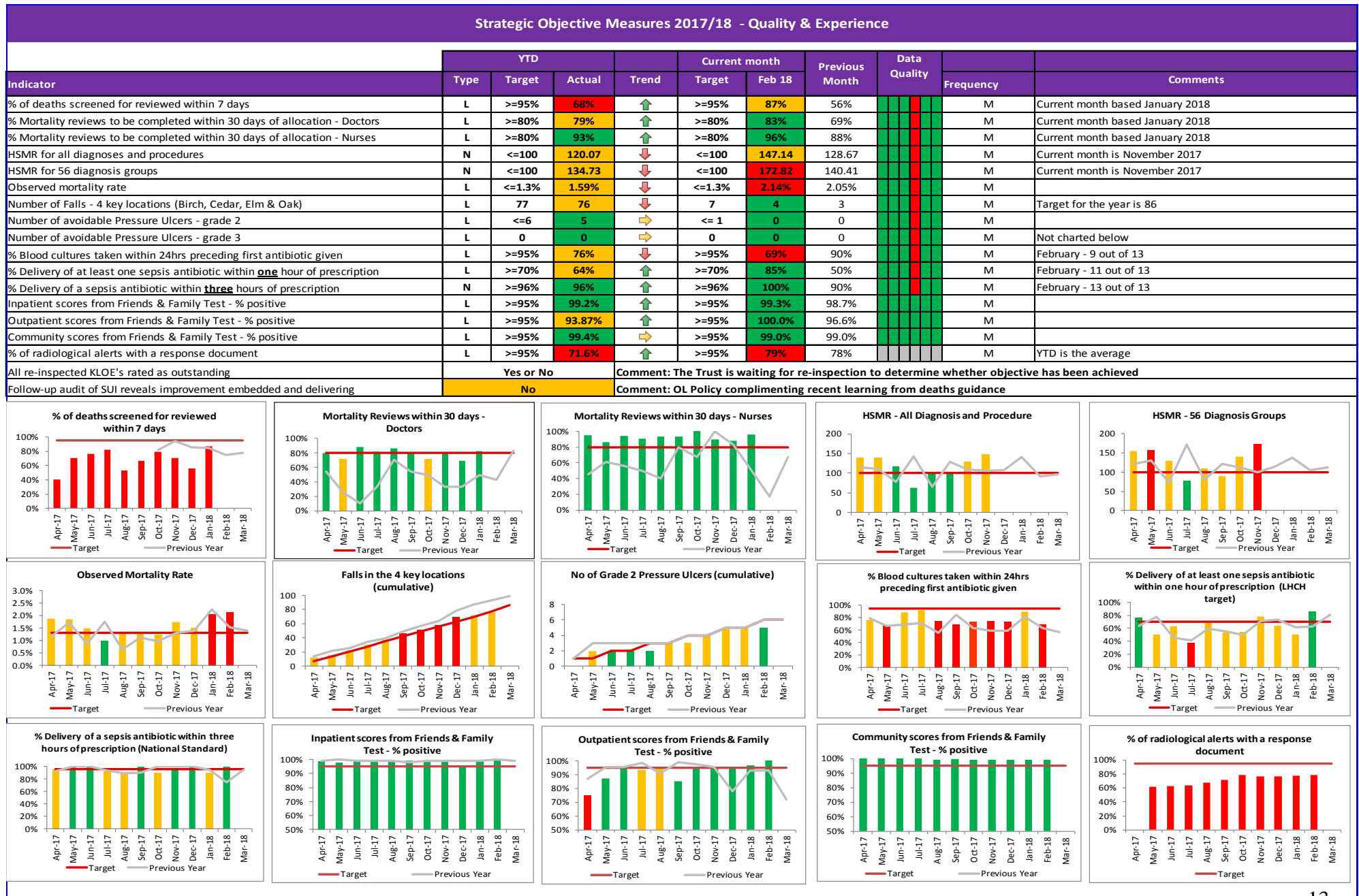
Appendix 1 - Single Oversight Framework

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	Feb 18								
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	>=92%	92.04%	↓	>=92%	92.04%	92.11%		M					
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	97.64%	↓	>=85%	92.86%	93%		M	Adjusted figure provided				
	Maximum 6-week wait for diagnostic procedures	>=99%	98.55%	↑	>=99%	95.54%	94.08%		M					
	Dementia - Find	90%	98.12%	↓	90%	92.59%	96.83%		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	55	46	→	5	1	1		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%	97.1%	↓	>=95%	96.38%	96.83%		M					
	Clostridium Difficile	4	1	→	1	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 (LHCH Acquired)	8	7	↑	1	0	1		M	Plan based on 2016/17				
	MSSA Bacteraemias (LHCH Attributable)	N/A	8	↑	N/A	0	1		M	MSSA reported on Elm Ward				
	HSMR for all diagnosis (supplied from Dr Foster)	<=100	120.07	↓	<=100	147.14	128.67		M	Current month is November 2017				
	HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide)	<=100	134.73	↓	<=100		140.41		M	Data is currently unavailable			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%	93%	↓	>=94%	93%	95%		Q	Q3 2016 Staff Survey Data				
	Inpatient scores from Friends & Family Test - % positive	>=95%	99.2%	↑	>=95%	99.3%	98.7%		M					
	Community scores from Friends & Family Test - % positive	>=95%	99.4%	→	>=95%	99.0%	99.0%		M					
Quality - Organisational Health	Staff Sickness	<=3.4%	4.04%	↑	<=3.4%	3.98%	5.05%		M				Y	
	Proportion of temporary Staff	<=5%	5.30%	↓	<=5%	5.38%	5.20%		M					
	Staff Turnover	<=10%	12.6%	↓	<=10%	12.6%	12.2%		M	Turnover based on 'All' Leavers in 12 month period				
	Executive Team Turnover	<=25%	0.0%	→	<=25%	0.0%	0.0%		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 "Feb and Mar data is Quarterly for "NHS Staff Survey - recommend as a place to work" and "Staff Friends and Family - recommend as a place of treatment " and therefore same for Mar and Feb				
	NHS Staff Survey - recommend as a place to work	>=76%	74%	↑	>=76%	74%	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	1	2	→	2	2	2		M					
	Agency spend	1	1	→	2	1	1		M					
	Overall Financial Performance													
	Overall use of resources rating	1	1	→	1	1	1		M					
	Value for money information													
NCBC Benchmarking Data, Meridian Review, Back Office Review, Pathology Review		Comment: NCBC Benchmarking undertaken and conference held on 26/17th February, GIRFT results under review, Corporate Benchmarking complete and reported separately to BTSG												
Aggressive cost reduction plans - Cost reduction strategy delivered Em		3,073.00	2,829	↓	323	288	208		M	There are non-recurring schemes of £354k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £632k, with £417k of non-recurrent CIP to offset this position.			Y	
Control total acceptance		Yes												
Overall	Segmentation								Adhoc	Segment 1: Maximum autonomy; universal support				

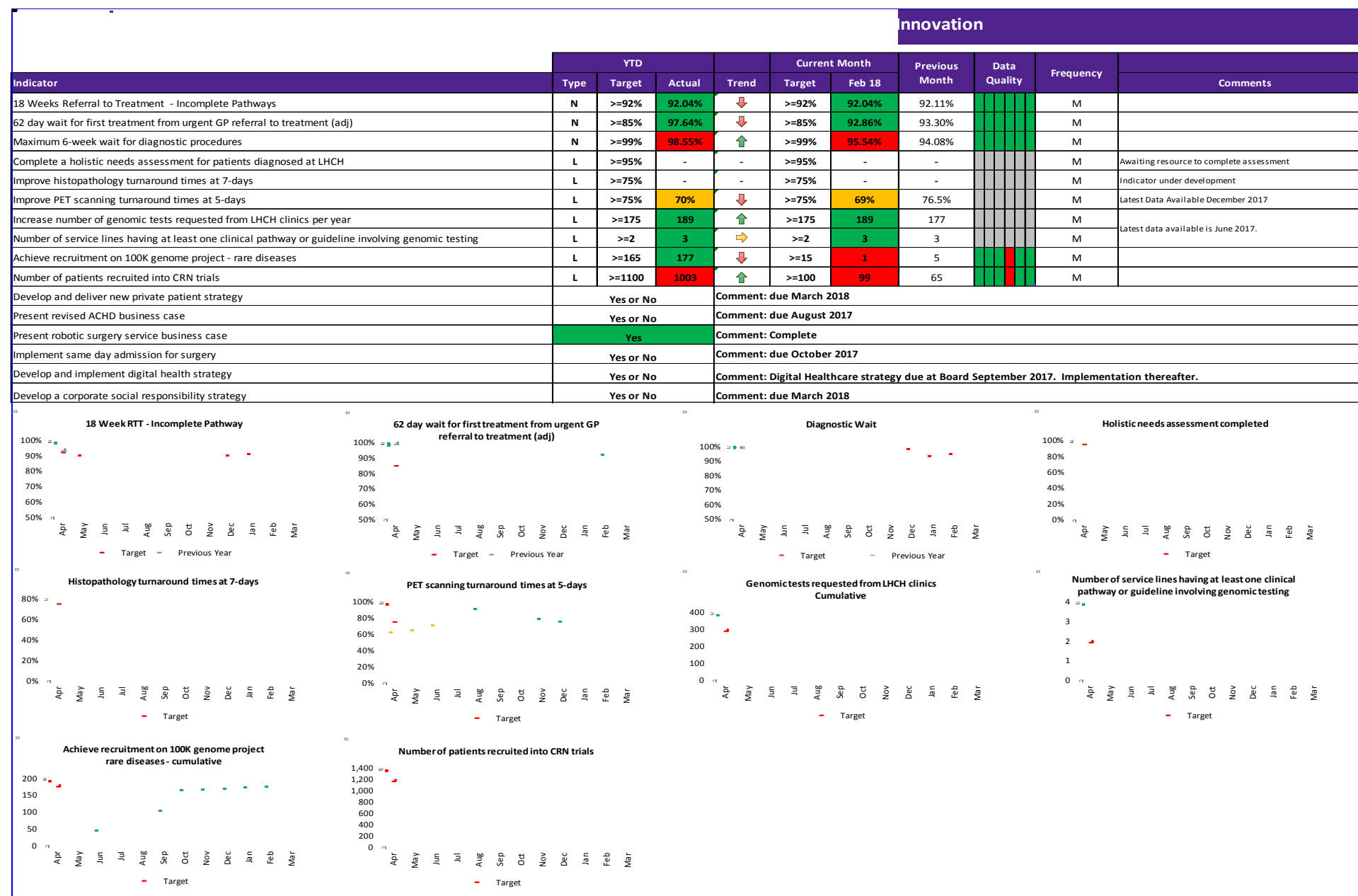
Appendix 2 – Operational Performance Dashboard

Performance Report Summary 2017/18											
	Indicator	Target	Actual		Current month		Previous Month	Data Quality	Frequency	Comments	Exception
			YTD	Performance Trend	Target	Feb 18					
Quality	Friends and family Test response rate - Inpatients	>=50%	50%	↑	>=50%	72.12%	46.69%	✓	M		
	VTE Prophylaxis	>=95%	98.11%	↑	>=95%	97.62%	96.43%	✓	M		
	Number of in-hospital deaths	N/A	173	↑	N/A	21	23	✓	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	3	↓	0	0	1	✓	M	2 SI (April and August) and 1 adverse Event (January) reported	Y
	Number of Reported Patient Safety Incidents (6-month rolling avg)	>=1399	1466	↑	>=142	113	99	✓	M		
Performance	Cancelled operations	<=1.5%	2.4%	↓	<=1.5%	4.5%	3.8%	✓	M	Internal Target	
	Cancelled operations seen in 28-days	100%	98.9%	↓	100%	100%	100%	✓	M	2 Operation not re-booked within 28 days of cancellation	Y
	Urgent operations cancelled 2nd time	0	3	↓	0	1	1	✓	M		
	Delayed transfers of care	<=4.5%	5.68%	↓	<=4.5%	4.96%	4.38%	✓	M		Y
	Bed occupancy	>=85%	83.26%	↓	>=85%	82.39%	86.32%	✓	M		
	Referrals - GP	18,502	18,955	↓	1,682	1,718	2,048	✓	M	Community Referrals removed	Y
	Referrals - DGH (External)	9,185	9,141	↓	835	802	930	✓	M	Community Referrals removed	
	Referrals - Other	8,294	10,135	↓	754	987	1,715	✓	M	Updated to include Internal Referrals (community referrals removed)	
	Activity - NHS	0%	-0.41%	↓	0%	-10.7%	-4.2%	✓	M		Y
	Activity - Private	0%	-2.80%	↓	0%	-6.1%	12.9%	✓	M		
	18 Weeks Referral to Treatment Incomplete Pathways 52 week +	0	1	↓	0	1	0	✓	M		
	14 day wait from referral to date first seen	>=93%	99.36%	↓	>=93%	100.00%	100.00%	✓	M		
	31 day wait from diagnosis to first treatment	>=96%	99.11%	↓	>=96%	96.67%	97.80%	✓	M		
	31 day wait for second or subsequent treatment (surgery)	>=94%	98.68%	↑	>=94%	100.00%	85.70%	✓	M		
Local Target	62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj)	>=85%	87.50%	↓	>=85%	83.33%	85.71%	✓	M		Y
	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	>=95%	89.16%	↑	>=95%	89.16%	70.59%	✓	M		Y
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways	>=98%	92.75%	↑	>=98%	92.75%	85.25%	✓	M		Y
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways	>=95%	93.65%	↑	>=95%	93.65%	92.22%	✓	M		Y
Workforce	Appraisals	>=90%	90%	↑	>=90%	90%	88%	✓	M	Data shown is for Sept 17 end of Appraisal Window	Y
	Mandatory training	>=95%	94%	↓	>=95%	94%	94%	✓	M		
	Turnover Rate between 1-2 yrs service (voluntary/FTC excluded)	<=1.4%	1.28%	↑	<=1.4%	1.28%	1.31%	✓	M	YTD is 12 month period	
Finance	Net Surplus £000's	4,562	5,546	↓	943	908	966	✓	M		
	Normalised Net Surplus £000's	4,562	5,546	↓	943	908	966	✓	M		
	Cash Balance	9,230	6,871	↓	547	-710	736	✓	M	Cashflow is currently behind the YTD position largely due to the non-payment of the MRG4+ increase by Wales Health Specialised Services Committee (WHSSC).	Y
	Capital expenditure £000's	-4,660	-4,547	↓	-376	-953	-168	✓	M	Current forecast of 6,306k is an overspend on plan of approximately £895k, due to award of £767k from DH for Cybersecurity	
	Total agency cost £000's	-1,875	-1,672	↑	-188	-129	-96	✓	M	Agency Costs have reduced significantly due to no use of Junior Medical Agency in January & February. Radiography, Nursing and Admin remain the highest users of Agency.	
	Total bank cost £000's	-580	-1,952	↓	-58	-217	-168	✓	M	Bank used across the Trust due to Maternity leave and sickness, mainly in admin and nursing. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets	Y

Appendix 3 – Strategic Dashboard: Quality & Experience



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



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	Feb 18					
Overall use of resources rating	1	1	➡	1	1	1	<div><div></div><div></div><div></div><div></div><div></div></div>	M		
Deliver the recurrent cost improvement savings	£3,397	£2,829	⬇	£323	£288	£208	<div><div></div><div></div><div></div><div></div><div></div></div>	M	There are non-recurring schemes of £354k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £632k, with £417k of non-recurrent CIP to offset this position.	
Agency rating	1	1	➡	2	1	1	<div><div></div><div></div><div></div><div></div><div></div></div>	M	Continued use of Agency; £1.672m against a ceiling of £2.063m (Full year ceiling - £2.251m)	
Liquidity rating	3	2	➡	2	2	2	<div><div></div><div></div><div></div><div></div><div></div></div>	M		
Implement model hospital dashboard	Yes or No		Comment: March 18							
Develop Service Line Reporting	Yes or No		Comment: SLR for 2016/17 is available on Qlikview, Reference Costs 2016/17 submitted. Meetings held during October and November with DHOs, Finance Business Partners and Clinical Leads to discuss outputs and action plans for improvement.							
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
Jan	2000
Feb	2200

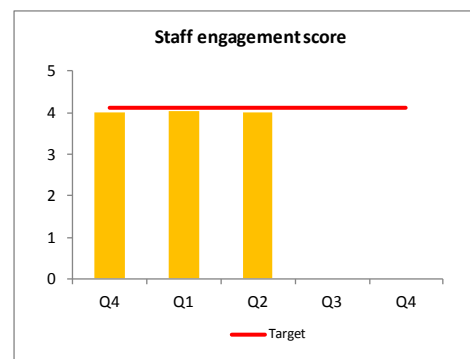
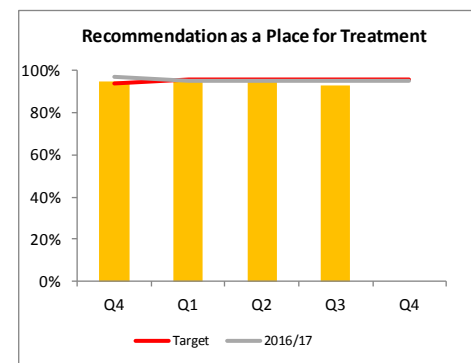
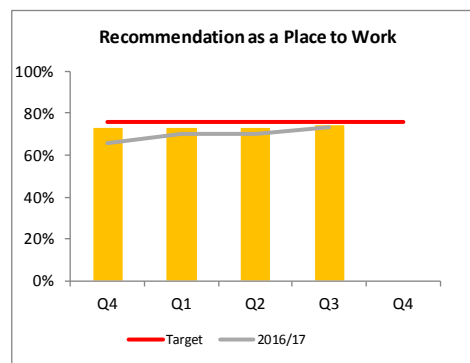
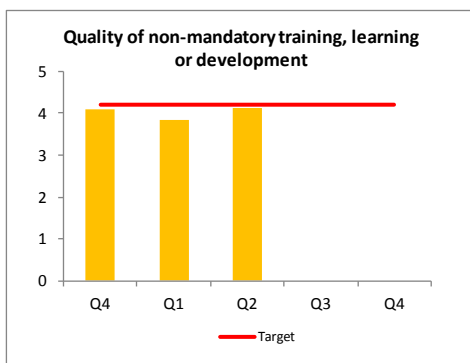
Overall Financial Performance:

The year to date (YTD) overall financial position for M11 is a surplus of £5.546m, against a planned surplus of £5.005m, showing a favourable variance of £40k. The variance is partially related to additional income received for donated assets, which does not affect the STF monies. However in M11, £1.005m of reserves have been used to secure the £2.256m STF monies. However, a significant risk to the forecast position is the ongoing 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

Strategic Objective Measures 2017/18 - Be the Best NHS Employer

Indicator	YTD			Trend	Current month		Previous Avail. Quarter	Data		Comments
	Type	Target	Actual		Target	Feb 18		Quality	Frequency	
Quality of non-mandatory training, learning or development	L	>=4.2	4.11%	↑	>=4.2	4.11%	3.85%		Q	Q3 17/18 taken from Q3 2017 Staff Survey. Q1 from FFT Survey. Q3 Information from 'NHS_staff_survey_2016_RBQ_full' (Q3 2016) > KEY FINDING 13 - see Notes tab for Questions
Recommendation as a Place to Work	L	>=76%	74%	↑	>=76%	74%	73%		Y	Q3 17/18 taken from Q3 2017 Staff Survey Q4, Q1 + Q2 Data for all taken from Q3 2016 Staff Survey*
Recommendation as a Place for Treatment	L	>=96%	93%	↓	>=96%	93%	95%		Y	Q3 17/18 taken from Q3 2017 Staff Survey Q4, Q1 + Q2 Data for all taken from Q3 2016 Staff Survey*
My organisation takes positive action on health & well-being	L	>=45%	43%	↑	>=45%	43%	41.0%		Q	Q3 17/18 taken from Q3 2017 Staff Survey. Q1 from FFT Survey. Q3 from Q9a Staff Survey. (only response 'Yes, Definitely')
Staff engagement score	L	>=4.1	4.01	↓	>=4.1	4.01	4.02		Q	Q3 17/18 taken from Q3 2017 Staff Survey. Q1 from FFT Survey. Q3 Data from Staff Survey Engagement report". Previous Avail. Quarter from Staff Survey 2015. See Notes tab for Questions



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"> • 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. • AF prevention and management workshop – with colleagues from primary care, secondary care and commissioning. • Two cases for change presented to the CVD Programme Board: Primary Pacing Pathway, and Aortic Dissection Pathway – to be shared with the C&M Acute Sustainability Programme (Urgent and Emergency care). • ACS working group established and monthly meetings planned up to March 2018. – group will define the priorities for the best ACS model in C&M. • Engagement with Healthwatch and setting criteria for a CVD Patient Reference Group. 						

