

## Board of Directors (in Public) Item 4.1

**Subject:** Trust Review-SOF, Regulatory and Operational Performance  
**Date of meeting:** 4<sup>th</sup> September 2018  
**Prepared by:** Lucinda Tennent-Information and Performance Manager  
**Presented by:** Tony Wilding-Director of Strategic Partnerships and Chief Operating Officer  
**Purpose of Report:** To Note

BAF Ref	Impact on BAF
1.1, 1.2, 2.1, 3.7	None

### 1. Executive Summary






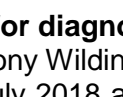
The purpose of this paper is to present an update on Trust performance for the period to the 31<sup>st</sup> July 2018. The report is divided into the following three sections:

- Section 1-Single Oversight Framework (SOF): 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-Quality of Care Dashboard: internal quality indicators agreed by the Board in April 2018 for routine monitoring on delivery.
- Section 3-Operational & Financial Performance Dashboard: internal performance, workforce and financial indicators agreed by the Board in April 2018 for routine monitoring on delivery.

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

Refer to Appendix 1.

The following indicators are new exceptions this month:

Framework	Rating	Exception
Quality of Care		
Finance and use of resources		
Operational Performance		Maximum 6 week wait for diagnostic procedures (In month and YTD)
Strategic Change		
Leadership and Improvement		
Segmentation		Segment 1: Maximum autonomy; universal support

## 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 July 2018 at 80.72% against a target of 99% with a total of 229 breaches; 26 Sleep Studies, 23 Echocardiography, 88 CT and 92 MRI.

**Actions:** The Board of Directors signed off the business case on Tuesday 3<sup>rd</sup> July 2018 and we are now working at pace to implement the two additional scanners.


**Anticipated Delivery:** We will not achieve compliance at year end; however we expect improved performance in Q4 when the new CT scanner will be operational.

## Section 2 – Quality of Care Dashboard

Refer to Appendix 2.

The following indicators are new exceptions this month:

- Number of Adverse Events (Red Alerts), Serious Incidents and Never Events (In month and YTD)
- % Blood Cultures taken within 24 hours preceding first antibiotic given
- Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)

Framework	Rating	Exception
Quality of Care		Mortality screening within 7 days (in month & YTD) % Blood Cultures taken within 24 hours preceding first antibiotic given (In month) Number of Adverse Events (Red Alerts), Serious Incidents and Never Events (In month and YTD) Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)

## 2. Exceptions

### 2.1 Indicator: Number of Adverse Events (Red Alerts), Serious Incidents and Never Events

**Accountable Executive Officer:** Mark Jackson

**Issue:** There has been one serious incident reported to STEIS in July for a patient that took more than was required of a drug and required observation within another hospital overnight. It is unclear at this time if this is a SI and on completion of the investigation this will be confirmed.

**Actions:** Awaiting the investigation to be started

**Anticipated Delivery:** Completed by 12<sup>th</sup> September – CCG by 26<sup>th</sup> October 2018

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

**Accountable Executive Officer:** Raphael Perry

**Issue:** Work continues to improve compliance with the new sepsis screening process and results are improving; however, we remain under target. 22 out of 31 bundles (72%) in month and 67 out of 86 (78%) for YTD.

**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:** Q2 2018/19

### 2.3 Indicator: Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)

**Accountable Executive Officer:** Susan Pemberton

**Issues:** Grade 2 Pressure ulcers that have been LHCH acquired due to lapses in care is currently at 2 YTD with 1 been reported for July. On review learning points have been identified and additional actions will be implemented.

**Actions:** Discussion to identify root cause and plan actions to prevent future incidents.

**Anticipated Delivery:** Completed and closed end of July

### 2.4 Indicator: Mortality screening within 7 days

**Accountable Executive Officer:** Raphael Perry

**Issue:** Screening of deaths within 7-days is 64% in month and 71% 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. Deaths are currently at 41 YTD against a comparison of 42 for June 2017/18. (Reported a month behind)




**Anticipated Delivery:** Q3 2018/19

## Section 3-Operational & Financial Performance

Refer to Appendix 3.

The following indicators are new exceptions this month:

- Cancelled operations seen in 28 days
- NHS Activity

Framework	Rating	Exception
Operational Performance		Performance: Cancelled operations (YTD) Cancelled operations seen in 28 days PET Scanning turnaround times at 5-days 18 weeks referral to treatment incomplete pathways 52 week + (YTD) Delayed Transfers Of Care (In month and YTD) NHS Activity Referrals (GP/Other) – YTD  Local Target: Welsh waiting times (in month & YTD)
Financial Sustainability - Value for Money		Deliver the recurrent cost improvement savings (YTD)
Organisational Health		Appraisals Turnover Rate between 1-2 yrs service (voluntary, FTC excluded)

### 3. Exceptions

#### 3.1 Indicator: Cancelled Operations

**Accountable Executive Officer:** Tony Wilding

**Issue:** There were a total of 12 non-clinical cancellations for cardiac surgery in July 2018

Top 3 cancellation themes for June 2018 where:

1. Emergencies taking priority and Elective impact of overnight emergencies resulting in the non availability of key staff
2. No POCCU beds
3. List overrun

The number of reportable cancellations in July 2018 has decreased compared to June 2018 and is the same number reported for July 2017.

Both emergencies taking priority and elective impact of overnight emergencies have emerged as the leading cancellation reason in July. Similarly POCCU beds and list overruns have emerged as the second and third leading theme for cancellations in July 2018.

**Actions:** The Surgical Division has implemented a cancellation action plan with aim of reducing the number of reportable cancellations. Furthermore the date and time of the scheduling meeting has been moved to enable clinician presence at the meeting. This will support review of listing complex procedures which is aimed at reducing cancellations for list overrun. As with previous months the Surgical Division continues to share information relating to cancellations with clinicians at monthly business meetings and in other forums such as Divisional Performance to identify methods to reduce cancellations. The Surgical Division now review a cancellation theme on a bi-monthly basis with clinicians at monthly business meetings with the view of reducing cancellations attributed to certain themes.

**Anticipated Delivery:** We are reviewing the bench marking data for cancelled operations with the aim of reviewing our internal target and will propose a new target to the Board of Directors in September 2018.

### 3.2 Indicator: Cancelled Operations seen in 28 days

**Accountable Executive Officer:** Tony Wilding

**Issue:** Patient cancelled on 03/07/2018 – cancelled operations seen in 28 days.

There has been one patient who breached the 28 day standard reported for July 2018.

The patient was a TA TAVI patient who was cancelled for surgery on the 03/07/2018 due to a list overrun. The patient was provided with a new date for surgery within 28 days however was unfortunately cancelled on the 24/07/2018 due to the impact of an overnight emergency resulting in the loss of anaesthetic cover the following day. This resulted in a 28 day breach.

**Actions:** The patient has underwent surgery on the 7th August 2018. TA TAVI lists are routinely delivered once per month. This results in significant pressures for the Division when rescheduling surgery for patients requiring this procedure in the event of a cancellation. The Division has now allocated additional TAVI lists from September 2018 onwards to reduce the risk of 28 day breaches for TAVI patients.

**Anticipated Delivery:** September 2018

### 3.3 Indicator: NHS Activity

**Accountable Executive Officer:** Tony Wilding

**Issue:** YTD = -2.8% and Month = -5.9%

**Actions:** Activity is monitored on a monthly basis and whilst activity is lower than plan there are no current trends which are a cause for concern and activity is forecast to increase.

**Anticipated Delivery:** Not Applicable

### 3.4 Indicator: Overall Referrals

**Accountable Executive Officer:** Tony Wilding

**Issue:** Overall referrals are below target YTD at the end of month 03 with 13,006 referrals against a target of 13,412. This is driven by Medicine referrals currently being below target by 442 at a total of 11,342 against a target of 11,784 YTD. Surgery is also below target by 84 referrals at a total of 1,436 YTD against a target of 1,520.

**Actions:** There are no obvious issues regarding referrals into the Trust and the trend is being monitored.

**Anticipated Delivery:** To be reviewed in Q3.

### 3.5 Indicator: 18 Weeks Referral to Treatment Incomplete Pathways 52 Week +

**Accountable Executive Officer:** Tony Wilding

**Issue:** The patient attended the Trust for urgent cardiology treatment and was subsequently cross referred to the cardiac surgeons for consideration for coronary artery bypass graft (CABG) surgery. The patient was seen and listed for surgery; however, it was recommended that the surgery be delayed to allow the patient to undergo anti-platelet therapy for ideally 6 months. Therefore, the patient was placed on watchful waiting as part of the Trust's waiting list management procedures with the aim of going onto the live waiting list after a 6 month period. Due to human error, the patient was not moved onto the active waiting list and the Trust was only alerted to this when they were contacted by the patients GP. The patient was brought into the Trust as a priority, the consultant explained the issue with the delay and the patient has subsequently had their surgery and is recovering well. As part of the learning from this breach additional training is being provided to the patient administration staff.

**Actions:** Given to consultant with shortest waiting time, OPD escalated to next available clinic. Patient came in for surgery on 6th June 2018.

**Anticipated Delivery:** Complete

### 3.6 Indicator: Delayed Transfers Of Care

**Accountable Executive Officer:** Tony Wilding

**Issue:** Delayed transfers of care are above target for YTD and also for July with a performance of 5.47% against a target of 4.5%.

**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. As part of the

Trust's CUR Programme, we are going to share our data of the top 5 external delays in the transfer of care of our patients with colleagues at the North Mersey A&E Delivery Board. The aim is then to review data across the system and look at how we can improve patient flow across all providers.

**Anticipated Delivery:** On-going

### **3.7 Indicator: Improve PET Scanning turnaround times at 5-days**

**Accountable Executive Officer:** Tony Wilding

**Issue:** July is currently 41.7% against a 75% target.

**Actions:** There are ongoing discussions across Cheshire and Merseyside with regards to the current provision of PET scans, a contract that was placed regionally. Current waiting times are higher than required and the Trust is working with NHS Specialised Commissioning and CCG to negotiate with the provider for improved access times.

**Anticipated Delivery:** This issue has been raised with the NHS England national team as they have negotiated a 10 year contract which is currently only in year 3. This is a standing item on the local commissioning meeting agenda.

### **3.8 Indicator: Welsh 26 weeks**

**Accountable Executive Officer:** Tony Wilding

**Issue:** All pathways for 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:** We are currently working with the Welsh commissioners regarding late referrals which impact on our performance.

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

**Accountable Executive Officer:** Joanne Twist

**Issue:** Turnover Rate is 1.9% against a 1.4% target

**Actions:** Retention Strategy going to Operations Board in September 2018

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

### **3.10 Indicator: Appraisals**

**Accountable Executive Officer:** Joanne Twist

**Issue:** Appraisals are currently below the 90% target at 29%, this is due to the appraisal window being reset in May 2018.

**Actions:** Trajectories being set by all Divisions to meet target by the end of August 2018.

**Anticipated Delivery:** 31<sup>st</sup> August 2018.

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

**Accountable Executive Officer:** Claire Wilson

**Issue:** Month 3 recurring CIP achieved £970k against a plan of £1,177k, a shortfall of £207k. There are non-recurring schemes of £82k to offset the recurrent CIP underachievement.

**Actions:** Divisions are working on additional schemes to bridge the recurrent gap and a fully identified plan is expected to be reported to the Board of Directors in September 2018. Operational delivery of the CIP plan is being overseen through the Business Transformation Steering Group, chaired by the Chief Finance Officer. The Divisions have been tasked to reduce or mitigate this gap.

**Anticipated Delivery:** The Financial year deadline / delivery date is 31/3/19.

#### **4. Conclusion**

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

#### **5. Recommendations**

The Board of Directors is 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	Trend	Current Month Target     Jul-18		Previous Month	Frequency	Comments
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	26	11	⬆️	4	2	3	M	1 Complaint under consideration whether to investigate
	Staff Friends and Family - recommend as a place of treatment		Count of those categorised as extremely likely or likelt to recommend/count of all responders	94%	93%	➡️	94%	93%	93%	Q	Q3 2017 Staff Survey Data
	Mixed Sex Accommodation Breaches		Count of number of occasions sexes were mixed on same-sex wards	0	0	➡️	0	0	0	M	
	Inpatient scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/count of all responders	95%	99.6%	⬆️	95%	99.75%	99.74%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	100.0%	➡️	95%	100%	100%	M	
	Occurrence of any Never events	Safe	Count of Never Events in rolling six-month period	0	0	➡️	0	0	0	M	
	NHS England/NHS Improvement Patient Safety Alerts Outstanding		Number of NHS England or NHS Improvement patient safety alerts outstanding in most recent monthly snapshot	0	0	➡️	0	0	0	M	
	VTE Risk Assessment		Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95.0%	97.3%	⬇️	95.0%	96.3%	97.4%	M	
	Clostridium Difficile		Count of trust apportioned C. difficile infections in patients aged two years and over compared to the number of planned C. difficile cases	2	1	⬆️	1	0	1	M	
	Clostridium Difficile Infection rate (per 1000 beddays)		Rolling 12-month count of trust- apportioned C-difficile infections in patients aged 2 years and over/Rolling 12 Month Average Occupied bed days per 100,000 beds	0.19	0.04	⬆️	0.19	0.00	0.15	M	
	MRSA Bacteraemias		Rolling 12-month count of trust assigned MRSA infections/Rolling 12 month average occupied bed days multiplied by 100,000	0	0	➡️	0	0	0	M	
	MSSA Bacteraemias		Rolling 12-month count of trust- apportioned MSSA infections/rolling 12-month average occupied bed days multiplied by 100,000	N/a	1	⬆️	N/a	0	1	M	
	eColi		Rolling 12-month count of all E.coli infections/rolling 12-month average occupied bed days multiplied by 100,000	-	1	⬇️	-	1	0	M	1 E.Coli LHCH Acquired on CCA
	Potential Under Reporting of patient safety incidents	Count of reported incidents (no harm, low harm, moderate harm, severe harm, death)/estimated total person bed days for rolling six months shown as rate per 1000 bed days	3	2	➡️	3	2	2	6M	NRLS Report April - September 2017 (3=poor)	
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	127.44	⬆️	0.0375	100.62	164.03	M	Current Month is March 2018	
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			1	1	➡️	1	1	1	M	
	I&E Margin	Financial Efficiency		1	1	➡️	1	1	1	M	
	Performance against plan	Financial Controls		1	1	➡️	1	2	2	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	92.0%	92.05%	⬇️	92%	92.05%	92.65%	M	
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer		Proportion of patients referred for cancer treatment by: a. their GP who have currently been waiting for less than 62 days for treatment to start b. the NHS screening service who have currently been waiting for less than 62 days for treatment to start	85%	95.90%	⬇️	85%	90.00%	100%	M	Adjusted figure provided
	Maximum 6-week wait for diagnostic procedures		Proportion of patients referred for diagnostic tests who have been waiting for less than six weeks	99%	80.94%	⬆️	99%	80.72%	79.81%	M	
	Dementia - Find		The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:	90%	98.4%	⬇️	90%	96.0%	100%	M	
	Dementia - Assess			90%	100%	➡️	90%	100%	100%	M	
	Dementia - Refer		90%	100%	➡️	90%	100%	100%	M		
Strategic Change	Review of sustainability and transformation plans and other relevant matters	Strategic Change			-	-	-	-			LHCH is lead for CVD cross-cutting theme
	Well Led Reviews - CQC Well Led Assessments	CQC Well Led Inspections			-	-	-	-			CQC Review published September 2016 rated Well-Led Domain as
Leadership and Improvement Capability	Well Led Reviews - NHSI Code of Governance	Information from third parties			-	-	-	-			MAAA Review published March 2017 concluding the Trust is well led
	Third Party Information - Healthwatch, MP's, Whistleblowers, Coroners' Reports, CQC Warnings, Other material Concerns				-	-	-	-			
	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%	3.32%	⬇️	3.4%	3.89%	3.57%	M	
	Staff Turnover		Number of Staff leavers reported within the period /Average of number of Total Employees at end of the month and Total Employees at end of the month for previous 12 month period Numerator = number of leavers within the report period. Denominator = staff in post at the start of the reporting period	10%	13.59%	⬇️	10%	13.34%	13.19%	M	Turnover based on 'All' Leavers in 12 month period
	NHS Staff Survey - recommend as a place to work		Staff recommendation of the organisation as a place to work or receive treatment	76%	73%	➡️	76%	74%	74%	Q	Q3 2017 Staff Survey Data - Previous Period Q3 2016
	Proportion of temporary staff		Agency staff costs (as defined in measuring performance against the provider's cap) as a proportion of total staff costs. Calculated by dividing total agency spend over total pay bill.	5%	4.66%	⬆️	5%	4.67%	4.91%	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%	0.00%	➡️	25%	0.00%	0.00%	M	*NB excludes Raph Perry who left on Flexi Retirement but returned
Overall	Segmentation								Adhoc	Segment 1: Maximum autonomy; universal support	



## Appendix 2 – Quality of Care

### Regulatory and Operational Performance - Quality of Care

Indicator	Type	Description	Target	YTD	Trend	Current Month Target	Jul-18	Previous Month	Frequency	Comments	Type
% of deaths screened for review within 7 days	Mortality		95%	71%	↓	95%	64%	81%	M	Current month based June 2018	L
% mortality reviews to be completed within 30 days of allocation - Doctors			80%	78%	↓	80%	73%	81%	M	Current month based June 2018	L
% mortality reviews to be completed within 30 days of allocation - Nurses			80%	88%	↓	80%	82%	88%	M	Current month based June 2018	L
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.43%	↓	1.3%	1.77%	1.06%	M		L
HSMR Weekend (DFI)		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	137.97	↑	100	118.5057	210.65	M	Current Month is March 2018	L
HSMR for all diagnosis (supplied from Dr Foster)			100	117.68	↑	100	118.5809	147.80906	M	Current Month is March 2018	L
Risk adjusted CABG mortality			1.00	0.95	↑	1.00	0.93	1.00	M	6-month rolling averages; latest due up to September 2017	
Risk adjusted non-primary PCI Mace			1.00	0.55	→	1.00	0.55	0.55	M	6-month rolling averages; latest due up to September 2017	
Number of Falls (Birch, Cedar, Elm and Oak)	Incidents	Count of Falls recorded across all areas	24	18	→	6	4	4	M		L
Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)		Count of Pressure Ulcers that were due to lapses in care and reported as grade 2	2	2	↓	0	1	0	M	1 Acquired on Elm Ward	L
Number of LHCH acquired grade 3+ pressure ulcers (due to lapses in care)		Count of Pressure Ulcers that were due to lapses in care and reported as grade 3	0	0	→	0	0	0	M		L
Number of Adverse Events (Red Alerts), Serious Incidents and Never Events		Number of events that were reported as a red alert, serious incident or never event	0	1	↓	0	1	0	M	Clinical Services Division - awaiting investigation	
Number of reported patient safety incidents (6 month rolling avg)			N/a	508	↓	N/a	123	132	M		
Follow-up audit of SUI reveals improvement embedded and delivering			No			Comment: OL Policy complimenting recent learning from deaths guidance					
% Blood Cultures taken within 24 hours preceding first antibiotic given	Sepsis		95%	78%	↓	95%	71%	75%	M	July - 22 out of 31 bundles	L
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	66%	↑	70%	77%	50%	M	July - 24 out of 31 bundles	L
% Delivery of a sepsis antibiotic within three hours of prescription			96%	91%	↑	96%	97%	85%	M	July - 30 out of 31 bundles	N
% of radiological alerts with a response document			95%	90%	↑	95%	94.0%	92.5%	M	YTD is Average	L
Complete a holistic needs assessment for patients diagnosed at LHCH			95%			95%			M	Awaiting Resource to complete assessment	L
Friends and Family Test Response Rate - Inpatients	Patient Experience	Count of patients responding to the friends and family test in inpatients / count of eligible patients	50%	66%	↑	50%	66%	60.4%	M		
Outpatient scores from Friends & Family Test - % positive		Count of outpatient friends and family test responses that are rated as positive / Count of friends and family tests taken within outpatients	95.0%	98.0%	↓	95.0%	98.73%	98.99%	M		
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.30%	↑	95%	97.25%	96.81%	M		
All re-inspected KLOE's rated as outstanding			Yes or No			Comment: The Trust is waiting for re-inspection to determine whether objective has been achieved					

## Appendix 3 – Operational & Financial Performance

Regulatory and Operational Performance - Operational Performance											
	Indicator	Type	Description	Target	YTD	Trend	Current Month Target	Previous Month	Frequency	Comments	
							Jul-18				
Performance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	60	↓	N/a	19	11	M	
	Improve histopathology turnaround times at 7-days			75%			75%			M	Indicator under development
	Improve PET scanning turnaround times at 5-days			75%	55.2%	↓	75%	41.7%	60.0%	M	
	Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	3.0%	↑	1.50%	2.3%	2.0%	M	Internal Target
	Cancelled operations seen in 28 days		Count of operations cancelled for non-clinical reasons and not offered a new date within 28 days	100%	98.0%	↓	100%	94%	100%	M	
	Urgent operations cancelled 2nd time		Count of those urgent operations that have already been cancelled on one or more occasions before.	0	0	→	0	0	0	M	
	Delayed Transfers of Care	Performance	A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed.	4.5%	5.49%	↓	4.5%	5.47%	5.35%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	82.6%	↑	>=85%	82.9%	81.8%	M	
	Referrals GP		Count of referrals received into the trust from GP organisations (Community referrals removed)	6464	6160	↑	1616	1540	1504	M	Community Referrals Removed
	Referrals DGH (External)	Referrals	Count of referrals received into the trust from external sources (Community referrals removed)	3324	3586	↑	831	936	862	M	Community Referrals Removed
	Referrals Other		Count of referrals received internally and all other sources (Community referrals removed)	3624	3260	↓	906	782	854	M	Updated to include Internal Referrals (Community Referrals Removed)
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	-2.8%	↑	0.0%	-5.3%	-8.6%	M	
	Activity Private		Count of Total spells - Activity Plan for Private Patients	-			-			M	This indicator is currently under review, however, figures should be available for next month's dashboard.
	18 Weeks Referral to treatment Incomplete Pathways 52 week +	RTT	Count of patients on an incomplete pathway waiting over 52 weeks	0	1	→	0	0	0	M	May-18
	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%	93%	→	85%	100%	100%	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%	77.85%	↓	95%	77.85%	88.7%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	80.48%	↑	98%	80.48%	80.0%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	82.78%	↑	95%	82.78%	89.4%	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	102.17	↑	100	89.01	97.84	M	Current Month is December 2017
	Emergency readmissions following non-elective admission			100	95.16	↓	100	97.93	78.49	M	Current Month is December 2017
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	7 Day services		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%	96%	→	80%			6M	September 2016 Survey
	Std 8: 7-day Services: Ongoing review twice daily in high dependency area			80%	98%	→	80%			6M	September 2016 Survey
	Std 8: 7-day Services: Ongoing review every 24 hours on general wards			80%	95%	→	80%			6M	September 2016 Survey
Mandatory training	Organisational Health		95%	93%	↓	95%	93%	94%	M		
Appraisals			90%	29%	↑	90%	29%	17%	M		
Turnover Rate between 1-2 yrs service (voluntary(FTC excluded))			1.4%	1.72%	↓	1.4%	1.72%	1.68%	M		
Net Surplus £000's	Finance			2280	2286	↑	787	788	651	M	
			11906	12388	↑	11906	12388	8973	M	The YTD cash position of £12.4m is £0.475m above the plan of £11.9m. This is due mainly to the receipt of the revenue pump priming funding from NHSI (£652k not included in the original plan) and also the postponement of a Salix loan receipt (£421k) planned for in June but now expected to be received in quarter 3. There is also a small lag in the expected timing of payment for capital items.	
Cash Balance			1843	1909	↑	399	499	475	M	YTD capital spend is £66k ahead plan.	
Capital expenditure £000's											
Deliver the recurrent cost improvement savings				£ 1,177	£ 970	↑	£ 315	£ 330	£ 241	M	There are non-recurring schemes of £82k to offset the recurrent CIP underachievement.