

Board of Directors (in Public)

Item 4.1

Subject: Trust Review-SOF, Regulatory and Operational Performance
Date of meeting: Tuesday 6th November 2018
Prepared by: Lucinda Tennent-Information and Performance Manager
Presented by: Tony Wilding-Director of Strategic Partnerships & COO
Purpose of Report: To note

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 the 30th September 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, 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 of Care		

Finance and use of resources		There are non-recurring schemes of £139k to offset the recurrent CIP underachievement.
Operational Performance		Maximum 6 week wait for diagnostic procedures (In month and YTD)
Strategic Change		
Leadership and Improvement		Staff Sickness
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 September 2018 at 86.12% against a target of 99% with a total of 160 breaches; 3 Echocardiography, 95 CT and 62 MRI.

Actions: The Board of Directors signed off the business case on Tuesday 3rd 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.

1.2 Leadership and Improvement : Organisational Health

1.2.1 Indicator: Staff Sickness

Accountable Executive Officer: Jo Twist

Issue: Sickness is 3.64% YTD and 4.49% 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 – Quality of Care Dashboard


Refer to Appendix 2.

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

- Number of LHCH acquired grade 2 pressure ulcers (due to lapses in care)
- % Blood Cultures taken within 24 hours preceding first antibiotic given (In month)

The following indicators are new exceptions this month:

Framework	Rating	Exception
Quality of Care		Mortality screening within 7 days (in month & YTD) 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.
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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. Root cause analysis has confirmed a medication labelling error and its classification as a serious incident.

Actions: A comprehensive action plan is currently being implemented.

Anticipated Delivery: End of December 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. 17 out of 24 bundles (71%) in month and 114 out of 148 (77%) 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: Q4 2018/19

2.3 Indicator: Mortality screening within 7 days

Accountable Executive Officer: Raphael Perry

Issue: Screening of deaths within 7-days is 83% in month and 74% 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 88 YTD against a comparison of 99 for September 2017/18.

Anticipated Delivery: Q4 2018/19


Section 3-Operational & Financial Performance



Refer to Appendix 3.

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

Two new indicators have been added to the performance report; 104 day cancer breaches and radiology reporting times. Both have been added due to guidance from national bodies.

The following indicators are new exceptions this month:

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 Bed Occupancy Local Target: Welsh waiting times for All Pathways (In month & YTD) 104 Day Cancer (YTD)
Financial Sustainability - Value for Money		Deliver the recurrent cost improvement savings (YTD)
Organisational Health		

3. Exceptions

3.1 Indicator: Cancelled Operations

Accountable Executive Officer: Tony Wilding

Issue: There were a total of 17 cancellations for cardiac surgery in September 2018

Top 3 cancellation themes for September 2018 where:

1. Elective impact of overnight emergencies resulting in the loss of different staff groups e.g. anaesthetists
2. List overrun
3. Anaesthetist unavailable

The number of reportable cancellations in September 2018 has decreased compared to August 2018 and also lower than September 2017.

Elective impact of overnight emergencies has emerged as the leading cancellation reason in September; this has been a combination of different staff groups; 4 anaesthetists and 2 surgeons. Similarly elective list overruns and no anaesthetic cover have emerged as the second and third leading theme for cancellations in September 2018.

Actions: The Surgical Division has implemented a cancellation action plan with aim of reducing the number of reportable cancellations; scheduling work is on-going with clinical representation at weekly scheduling meetings. This supports 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.

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.

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 undergone surgery on the 7th August 2018. TA TAVI lists are routinely operated 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 = -2.7% and Month = -2.7 %

Actions: Continued focus on delivery. Activity data is discussed at the weekly operational performance meeting.

Anticipated Delivery: Monthly review.

3.4 Indicator: Overall Referrals

Accountable Executive Officer: Tony Wilding

Issue: Overall referrals are below target YTD at the end of month 06 with 19,259 referrals against a target of 20,118. This is driven by Medicine referrals currently being below target by 972 at a total of 16,702 against a target of 17,674 YTD. Surgery is also below target but has shown improvement from last month being below target by 67 referrals at a total of 2,213 YTD against a target of 2,280.

Actions: There are no obvious issues regarding referrals into the Trust and the trend is being monitored and reviewed as well as a review of market share data.

Anticipated Delivery: To be reviewed in Q2.

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

Accountable Executive Officer: Tony Wilding

Issue: Due to admin issue which has now been resolved. Patient was cross-referred to other surgeon in 2017 as needed to be seen after completing a separate course of medication but no referral was made; patients GP contacted secretary confirming patient still needed procedure.

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 September with a performance of 7.23% 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: Bed Occupancy

Accountable Executive Officer: Tony Wilding

Issue: September is currently at 78.4% with Surgery and Medicine being below target for the month. This is due to the occupancy on Birch Ward being low due to the summer months. The labs are currently profiled for lower activity.

Actions: A full review of the Trust bed model has been carried out.

Anticipated Delivery: We have reduced our bedstock by 12 beds due to the closure of Mulberry ward for refurbishment, which will see our occupancy increase in coming months.

3.8 Indicator: Improve PET Scanning turnaround times at 5-days

Accountable Executive Officer: Tony Wilding

Issue: September is currently 58.3% against a 75% target.

Actions: There are ongoing discussions across Cheshire and Merseyside with regards to the current provide 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.

3.9 Indicator: Welsh 26 weeks

Accountable Executive Officer: Tony Wilding

Issue: Non-Admitted and Incomplete 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.

3.10 Indicator: 104 Day Cancer Breaches

Accountable Executive Officer: Tony Wilding

Issue: Pertaining to May 2018 Cancer performance. Liverpool Heart and Chest Hospital are responsible for 0.5 breaches following a patient waiting more than 104 days for treatment. The patient was referred to LHCH on day 76 of a pathway – patient TCI booked outside of the 24 day parameter. The patient was not contactable via telephone to discuss a TCI date so a letter was sent allowing the patient reasonable notice; unfortunately this led to the patient breaching 104 days.

Actions: Following the aforementioned issue patient demographics was added to the Cancer Action Plan. This action is now complete and closed with a clear escalation plan for patients who the trusts are unable to contact.

3.11 Indicator: Deliver the recurrent cost improvement savings

Accountable Executive Officer: Claire Wilson

Issue: Month 6 recurring CIP achieved £1,516k against a plan of £1,797, a shortfall of £281k. There are non-recurring schemes of £139k to offset the recurrent CIP underachievement.

Actions: Divisions are working on additional schemes to bridge the recurrent gap. 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 31/3/19

3.12 Indicator: Radiology Service Reporting

Accountable Executive Officer: Tony Wilding

Issue: CQC guidance from July 2018 states that Board of Directors should receive information on radiology reporting times.

Actions: The radiology service has agreed KPIs for radiology reporting for CT, MRI, plain film and ultrasound – 90% of Inpatients should be reported within 24 working hours of image acquisition and 90% of outpatients should be reported within 120 working hours of image acquisition.

Anticipated Delivery: From December 2018 the reporting KPIs will be provided as part of the Strategic and Ops Dashboards.

4. 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.

5. Recommendations

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

Appendix 1 - Single Oversight Framework

Single Oversight Framework (SOF)												
Indicator		Type	Description	Target	YTD	Trend	Current Month		Forecast	Previous Month	Frequency	Comments
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	36	13	⬆️	7	0		2	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%	99.5%	⬆️	95%	99.74%		99.07%	M	
	Community scores from Friends & Family Test - % positive		Count of those categorised as extremely likely or likely to recommend/Count of all responders	95%	99.7%	⬇️	95%	97.4%		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%	97.1%	⬆️	95.0%	97.6%		96.4%	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	➡️	0	0		0	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	0.03	➡️	0.19	0.00		0	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		0	M	
	eColi LHCH Acquired		Rolling 12-month count of all E. coli infections/rolling 12-month average occupied bed days multiplied by 100,000	-	3	➡️	-	1		1	M	1 E.Coli LHCH Acquired on Oak
	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	108.55	⬆️	0.025	106.80		110.48	M	Current Month is May 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	Financial Sustainability		1	1	➡️	1	1		1	M	
	I&E Margin	Financial Efficiency		1	1	➡️	1	1		1	M	
	Performance against plan	Financial Controls		1	2	➡️	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%	92.31%	⬆️	92%	92.31%		92.06%	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%	94.90%	➡️	85%	100.00%		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%	80.36%	⬆️	99%	86.12%		77.85%	M	
	Dementia - Find		The number and proportion of patients aged 75 and over admitted as an emergency for more than 72 hours:	90%	98.0%	⬆️	90%	100.0%		95%	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				-	-	-		-
Leadership and Improvement Capability	Well Led Reviews - CQC Well Led Assessments	CQC Well Led Inspections				-	-	-		-		CQC Review published September 2016 rated Well-Led Domain as
	Well Led Reviews - NHSI Code of Governance					-	-	-		-		MIAA Review published March 2017 concluding the Trust is well led
	Third Party Information - Healthwatch, MP's, Whistleblowers, Coroners' Reports, CQC Warnings, Other material Concerns	Information from third parties				-	-	-		-		
	Staff Sickness	Organisational Health	Level of staff absenteeism through illness in the period Numerator = number of days sickness reporting within the month. Denominator = number of days available within the month	3.4%	3.64%	⬇️	3.4%	4.45%		3.53%	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%	13.86%	⬇️	10%	13.86%		13.40%	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%	93%	⬇️	76%	93%		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%	4.80%	⬆️	5%	4.90%		5.00%	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				1	➡️		1		1	Adhoc	Segment 1: Maximum autonomy; universal support

Appendix 2 – Quality of Care

Regulatory and Operational Performance - Quality of Care

Indicator	Type	Description	Target	YTD	Trend	Current Month		Previous Month	Frequency	Comments	Type
						Target	Sep-18				
% of deaths screened for review within 7 days	Mortality		95%	74%	↑	95%	83%	74%	M	Current month based August 2018	L
% mortality reviews to be completed within 30 days of allocation - Doctors			80%	76%	↑	80%	83%	68%	M	Current month based August 2018	L
% mortality reviews to be completed within 30 days of allocation - Nurses			80%	93%	↓	80%	92%	95%	M	Current month based August 2018	L
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.32%	↓	1.3%	1.53%	1.15%	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	114.61	↑	100	61.96	174.36	M	Current Month is May 2018	L
HSMR for all diagnosis (supplied from Dr Foster)			100	99.68	↑	100	94.69	105.69	M	Current Month is May 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	36	28	↑	6	4	7	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	3	2	→	0	0	0	M		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	0	0	M		
Number of reported patient safety incidents (6 month rolling avg)			N/a	750	↑	N/a	118	110	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%	77%	↓	95%	71%	79%	M	September - 17 out of 24 bundles	L
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	66%	↓	70%	54%	71%	M	September - 13 out of 24 bundles	L
% Delivery of a sepsis antibiotic within three hours of prescription			96%	92%	↓	96%	88%	97%	M	September - 21 out of 24 bundles	N
% of radiological alerts with a response document			95%	92.1%	↑	95%	96.5%	95.8%	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%	62.6%	69.3%	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%	98.48%	97.82%	M		
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.21%	↑	95%	99.16%	96.85%	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		Previous Month	Frequency	Comments
							Target	Sep-18			
Peer/Finance	Number of in-hospital deaths	Mortality	Count of Hospital deaths across the trust for the month/YTD	N/a	72	↓	N/a	16	12	M	
	Improve histopathology turnaround times at 7-days			75%			75%			M	Indicator under development
	Improve PET scanning turnaround times at 5-days			75%	54.2%	↑	75%	58.3%	42.1%	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%	2.8%	3.8%	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%	100%	100%	M	
	Urgent operations cancelled 2nd time		Count of those urgent operations that have already been cancelled on one or more occasions before.	0	0	→	0	0	0	M	
	Delayed Transfers of Care	Performance	A delayed transfer of care occurs when a patient is ready to depart from such care and is still occupying a bed.	4.5%	5.42%	↓	4.5%	7.23%	6.79%	M	
	Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	81.2%	↑	>=85%	78.4%	76.2%	M	
	Referrals GP	Referrals	Count of referrals received into the trust from GP organisations (Community referrals removed)	9696	8947	↓	1616	1370	1535	M	Community Referrals Removed
	Referrals DGH (External)		Count of referrals received into the trust from external sources (Community referrals removed)	4986	5631	↓	831	927	1042	M	Community Referrals Removed
	Referrals Other		Count of referrals received internally and all other sources (Community referrals removed)	5436	4681	↓	906	528	698	M	Updated to include Internal Referrals (Community Referrals Removed)
	Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	-2.7%	↓	0.0%	-2.7%	-1.7%	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%	99.3%	↓	96%	98%	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%	95%	↑	85%	100%	88%	M	
	104 Day Cancer		Cancer 62 day pathway patients 104 day RCA 62 target	0	0.5	→	0	0	0	M	This indicator has been included for the first time this month.
	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%	77.11%	↓	95%	77.11%	96.8%	M	
	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	81.48%	↑	98%	81.48%	81.3%	M	
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	91.58%	↑	95%	91.58%	91.0%	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	102.28	↓	100	107.47	99.04	M	Current Month is March 2018
	Emergency readmissions following non-elective admission			100	99.83	↓	100	123.97	116.59	M	Current Month is March 2018
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	7 Day services		90%	100%	→	90%			6M	March 2018 Survey results.
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission)			90%	100%	→	90%			6M	March 2018 Survey results.
	Std 5: 7-day Services: CT scan within 1 hr for critical care need			70%	100%	→	70%			6M	March 2018 Survey results.
	Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need			80%	100%	→	80%			6M	March 2018 Survey results.
	Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need			85%	100%	→	85%			6M	March 2018 Survey results.
	Std 6: 7-day Services: Access to interventions			80%	97%	→	80%			6M	March 2017 Survey results. September 2017 survey never covered Standard 6. March 2018 Survey (Not yet available)
	Std 8: 7-day Services: Ongoing review twice daily in high dependency area			80%	100%	→	80%			6M	March 2018 Survey results.
	Std 8: 7-day Services: Ongoing review every 24 hours on general wards			80%	94%	→	80%			6M	March 2018 Survey results.
	Mandatory training	Organisational Health		95%	91%	→	95%	91%	91%	M	
	Appraisals			90%	83%	↑	90%	92%	83%	M	
	Turnover Rate between 1-2 yrs service (voluntary(FTC excluded))			1.4%	1.64%	↓	1.4%	1.83%	1.64%	M	
Finance	Net Surplus £000's	Finance		3631	3640	↑	1034	1035	319	M	
	Cash Balance			11708	13896	↑	11708	13896	12525	M	
	Capital expenditure £000's			3081	2458	↓	538	121	425	M	YTD capital spend is £208k behind plan. Orders for equipment have been placed but had not been received as at 31.08.18
	Deliver the recurrent cost improvement savings			£ 1,797	£ 1,516	↑	£ 335	£ 267	£ 279	M	There are non-recurring schemes of £139k to offset the recurrent CIP underachievement.