

Board of Directors (in Public) Item 4.1

Subject: Board Dashboards - Regulatory, Operational and Strategic Performance
Date of meeting: 28th November 2018
Prepared by: Lucinda Tennent - Information and Performance Manager
Presented by: Tony Wilding - Director of Strategic Partnerships & Chief Operating Officer

1. Introduction

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

- Section 1 - Single Oversight Framework: This section provides details on our mandated regulatory indicators from NHS Improvement; these inform NHSI's risk assessment (segmentation) which determines the level of autonomy afforded to the Trust.
- Section 2 - Operational Dashboard: These are our internal indicators which were agreed with the Board in April 2017 for routine monitoring on delivery.
- Section 3 - Strategic Dashboard: This reports on the indicators agreed by the Board of Directors (BoD) in April 2017 which monitor the in-year milestones toward each of our 5 Strategic Objectives.

Section 1 - Single Oversight Framework (SOF)








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:

- Potential Under Reporting of patient safety incidents

The following indicators are new exceptions this month:

- Written Complaints – Rate

| Framework | Rating | Exception |
|---------------------------------------|---|---|
| Segmentation |  | Segment 1: Maximum autonomy; universal support |
| Leadership and Improvement Capability |  | |
| Strategic Change |  | |
| Operational Performance |  | |
| Quality - Safe, Effective & Caring |  | Written Complaints – Rate (In Month) Mixed Sex Accommodation (YTD) MRSA Bactremia (YTD) |
| Quality - Organisational Health |  | Staff sickness (in-month & YTD) |
| Finance |  | Aggressive Cost Reduction Plans – Cost reduction strategy delivered £m (YTD) |

1.1 Segmentation

Nothing to report.

1.2 Leadership & Improvement Capability

Nothing to report.

1.3 Strategic Change

Nothing to report.

1.4 Operational Performance

Nothing to report.

1.5 Quality - Safe, Effective and Caring

1.5.1 Indicator: Written Complaints – Rate

Accountable Executive Officer: Sue Pemberton

Issues: 38 YTD, 9 within Month against a target of 4

Actions: There was no trend in operator, area or service. It was unusual for clinical services to receive a higher number of complaints, the subject of which was all different, one related to end of life care, another to a patient who raised concerns after attending an appointment after

multiple DNAs and was rude towards staff, and the other related to the delay incurred when a patient was awaiting transfer to another trust for renal dialysis.

Anticipated Delivery: End of Quarter 4 2017/18

1.5.2 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: September 2017.

1.5.3 Indicator: MRSA Bacteraemia

Accountable Executive Officer: Raphael Perry

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

Actions: Improve transfer information across the health economy, and adhere to best practice for venflon insertion.

Anticipated Delivery: End of Q4 2017/18.

1.6 Quality - Organisational Health

1.6.1 Indicator: Staff Sickness

Accountable Executive Officer: Jo Twist

Issue: Sickness is 3.88% YTD 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.

1.7 Finance

1.7.1 Indicator: Aggressive Cost Reduction Plans – Cost reduction strategy delivered £m

Accountable Executive Officer: Claire Wilson

Issue: There are non-recurring schemes of £98k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £599k, with £166k 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 31/3/17.

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:

- Cancelled Operations

The following indicators are new exceptions this month:

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

| Framework | Rating | Exception |
|---------------------|---|---|
| Performance Summary |  | <p>Quality:</p> <p>Friends & Family Test response rate - inpatients (in month)</p> <p>Number of Adverse Events (red alerts), SIs & Never Events (In month and YTD)</p> <p>Performance:</p> <p>Cancelled operations seen in 28-days (YTD)</p> <p>Urgent operations cancelled 2nd time (YTD)</p> <p>Delayed Transfers of Care (In month and YTD)</p> <p>GP Referrals (in month and YTD)</p> <p>NHS Activity (in month and YTD)</p> <p>Private Activity (in month and YTD)</p> <p>62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj) (In month)</p> <p>Local Target:</p> <p>Welsh waiting times (in month & YTD)</p> <p>Workforce:</p> <p>Turnover Rate between 1-2 yrs service (voluntary, FTC excluded)</p> <p>Finance:</p> <p>Cash Balance (In month and YTD)</p> <p>Total Bank Cost £000's (In month and YTD)</p> |

1.8 Exceptions

1.8.1 Indicator: Friends & Family Test response rate - inpatients

Accountable Executive Officer: Sue Pemberton

Issue: For October 2017 the friends and family test response for inpatients is currently 48.40% against a target of 50%.

Actions: There have been some technical issues with the hand held devices used to capture the FFT data within some of the ward areas. The IT leads are working with the matrons for medicine and surgery to overcome this issue. The information team are currently sending an e-mail prompt to staff informing them of the percentage of numbers completed for their areas.

Anticipated Delivery: Awaiting a solution from IT for the devices – October/November 2017.

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

Accountable Executive Officer: Mark Jackson

Issue: Serious incidents reported in April, August and 2 Adverse Events in October.

Actions: The root cause analysis (RCA) for the serious incident (SI) in April is complete and the action plan is being progressed through the Medicine Division. The RCA for the SI in August is in the final review stages before being managed through the Division of Surgery. The two recent adverse events are both currently being investigated by RCA to determine if they are a SI.

Anticipated Delivery: Quarter 4 2017/18.

- 1.8.3 **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: This failure is historical and the learning from the incident has now been embedded into operational policy.
Anticipated Delivery: May 2017 - Delivered.
- 1.8.4 **Indicator: Delayed Transfers of Care**
Accountable Executive Officer: Tony Wilding
Issue: Delayed transfers of care are above target for YTD due to capacity issues across the local health economy.
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: September 2017.
- 1.8.5 **Indicator: GP Referrals**
Accountable Executive Officer: Tony Wilding
Issue: GP referrals YTD is 15,760 against target of 16,534– more than 200 below 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.
- 1.8.6 **Indicator: NHS Activity**
Accountable Executive Officer: Tony Wilding
Issue: YTD = -1.34% and month -4.2%
Actions: Continued focus on delivery.
Anticipated Delivery: Not applicable.
- 1.8.7 **Indicator: Private Activity**
Accountable Executive Officer: Tony Wilding
Issue: YTD = -6.50% and month -11.1%
Actions: Continued focus on delivery.
Anticipated Delivery: Not applicable.
- 1.8.8 **Indicator: 62 day wait for first treatment from urgent GP referral to treatment – consultant upgrade (adjusted)**
Accountable Executive Officer: Tony Wilding
Issue: Performance for October is non-compliant at 80%. The patient that is showing as a breach is complex and was previously under the care of Arrowe Park and upgraded to a possible lung cancer. The patient requires a complex work up as the cancer could either be colorectal mets or lung cancer. The histology has been sent on for further testing and is likely to be a colorectal met rather than lung cancer. The patient will be removed off a lung pathway if this is the case there we will be 100% for 62 day wait consultant upgrade. The outcome is due to reporting timescales.
Actions: To pro-actively manage complex patients alongside the clinician.
Anticipated Delivery: Continuously on-going
- 1.8.9 **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: Q2 2017/18.

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

Accountable Executive Officer: Joanne Twist

Issue: Turnover Rate is 2.02% against a 1.4% target

Actions: Currently analysing exit interview data, responses rate increased from 18% to 38% for exit interviews. Intention to Leave Focus Groups being held in November with staff approaching 12-18 months service and First Impressions Focus Groups to try and capture any issues early on and introduce new interventions where appropriate.

Anticipated Delivery: On-Going monitoring and management

1.8.11 Indicator: Cash Balance

Accountable Executive Officer: Claire Wilson

Issue: Cashflow is currently behind the YTD position due to a) the opening cash balances being £1.4m behind plan, and b) the non-payment of the HRG4+ increase by Wales Health Specialised Services Committee (WHSSC). The improvement in the in-month position is driven by the resolution of some outstanding debt with RLUBHT.

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 Q4.

The finance team is currently running a debt reduction programme and has had significant success in resolving some long running disputes (eg radiology services) which will improve cash position in Q3.

Anticipated Delivery: The Financial year deadline / delivery date is 31/3/17.

1.8.12 Indicator: Total Bank Cost £000's

Accountable Executive Officer: Claire Wilson

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

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

Anticipated Delivery: On-going – Monthly meeting

Section 3 - Strategic Dashboard


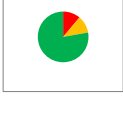

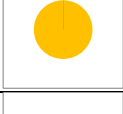
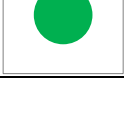
Refer to Appendix 3 to 7 – Strategic Dashboard

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

- Improve PET scanning turnaround times at 5 days

The following indicators are new exceptions this month:

- Achieve recruitment on 100k genome project – rare diseases

| Framework | Rating | Exception |
|--|--|--|
| Quality & Experience |  | Mortality screening within 7 days (in month & YTD) Number of Falls - 4 key locations: Birch, Cedar, Elm and Oak (YTD) Sepsis - Blood cultures taken within 24hrs preceding first antibiotic given (in month) Outpatient scores from Friends & Family Test (YTD) % of radiological alerts with a response document (in month & YTD) |
| Service Delivery, Research & Innovation |  | Achieve recruitment on 100K genome project - rare diseases (In month) Number of patients recruited into CRN trials (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 67% in month and 64% YTD against a target of 95%.

Actions: The new mortality review policy will be introduced in September. There is new national guidance on Learning from Deaths which has implications for how organisational learning is identified and implemented. We are actively recruiting 2-3 additional screeners to improve numbers. There have been more deaths this year since the target was set. Currently at 104 YTD against a comparison of 183 for the whole of 2016/17.

Anticipated Delivery: Q2 2017/18.

2.1.2 Indicator: Number of Falls

Accountable Executive Officer: Sue Pemberton

Issue: The Trust has reported 10 falls in month against target of 7 and 47 YTD against a target of 42.

Actions: The past few months have been challenging in preventing falls within the identified ward areas. Clinical teams are seeing an increased number of confused patients and those patients requiring enhanced levels of care from registered and unregistered staff. Unavoidable falls remain higher than avoidable, with some examples of falls pertaining to mobility aids, medication effects, and haemodynamic changes. Preventing falls remains the focus for all staff within the clinical areas, with the lead for falls, matrons and ward managers providing the leadership and support to ward staff which includes awareness and training for falls prevention. One Ward is trialing an early movement device that will advise nursing staff the movement of patients to enable a rapid response to prevent patients falling.

Anticipated Delivery: End of 2017/18.

2.1.3 Indicator: Sepsis - blood cultures taken within 24 hours

Accountable Executive Officer: Raphael Perry

Issue: Work continues to improve compliance with the new sepsis screening process and results are improving; however, we remain under target. Additionally, since the introduction of screening, not all sepsis patients are managed via the sepsis bundle, meaning that the Trust is unable to account for the totality of its sepsis care.

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

Anticipated Delivery: Q3 2017/18.

2.1.4 Indicator: Outpatient scores from Friends & Family Test

Accountable Executive Officer: Sue Pemberton

Issue: 91% YTD against a target of 95%. The negative responses are linked to OPD waiting times.

Actions: The next phase of self-check in is due to be trialled by November. This will enable future work to a linked appointment system where diagnostic test appointments will be more effectively managed around the main OPD consultant review. This streamlining work will significantly reduce OPD waiting times. Work is on-going with the divisions to review the working times of cardiac diagnostics and pulmonary function to reduce risk of delays in morning clinics. There are now two patient information screens live in the department which aim to keep patients updated with information. Other screens will be able to go live when the next phase of self-check in is completed. Patients and their families/carers are regularly briefed in the wait area about expected wait times.

Anticipated Delivery: On-going throughout 2017.

2.1.5 Indicator: % of radiological alerts with a response document

Accountable Executive Officer: Raphael Perry

Issue: This is a new indicator introduced to provide visibility on a key organisational risk which is slow to improve. 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 that 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. A deep dive within each Division has been agreed to provide interim assurance that SHM's are being managed effectively.

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 5 for October 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 10 behind target YTD.

Actions: A number of new trials are opening over the coming couple of months which will reverse this underperformance. Recruitment in August was excellent which has closed the gap somewhat.

Anticipated Delivery: Q3 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 £98k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £599k, with £166k 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 31/3/17.

2.4 Be the Best NHS Employer

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

2.5 Partnership & Collaborative Working

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

3. Conclusion

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

4. Recommendations

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

Appendix 1 - Single Oversight Framework

| Single Oversight Framework (SOF) | | | | | | | | | | | | | | | | | | | |
|--|---|----------|---|-------------------|---------------|--------|----------------|--------------|-----------|----------|--|--|--|---------------|---|--|--|--|--|
| | Reviews | Rating | Comment | | | | | | | | | | | Concern | | | | | |
| Leadership and Improvement Capability | Well Led Reviews - CQC Well Led Assessments | | CQC review published September 2016 rated Well-led Domain as 'Outstanding' | | | | | | | | | | | | | | | | |
| | Well Led Reviews - NHSI Code of Governance | | MIAA review published March 2017 concluding the Trust is well led with no significant concerns. | | | | | | | | | | | | | | | | |
| | Third Party Information - Healthwatch, MP's, Whistleblowers, Coroners' Reports, CQC Warnings, Other Material Concerns | | | | | | | | | | | | | | | | | | |
| Strategic Change | Review of sustainability and transformation plans and other relevant matters | | UHCH is lead for CVD cross-cutting theme | | | | | | | | | | | | | | | | |
| | Indicator | Target | YTD | Performance Trend | Current month | | Previous Month | Data Quality | Frequency | Comments | | | | Red Indicator | | | | | |
| | | | | | Target | Oct 17 | | | | | | | | | | | | | |
| Operational Performance | Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway | >=92% | 93.46% | ↑ | >=92% | 93.46% | 92.19% | | | M | | | | | | | | | |
| | All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer | >=85% | 97.81% | ↓ | >=85% | 91.30% | 100.00% | | | M | Adjusted figure provided | | | | | | | | |
| | Maximum 6-week wait for diagnostic procedures | >=99% | 99.87% | ↓ | >=99% | 99.62% | 99.92% | | | M | | | | | | | | | |
| Quality - Safe, Effective & Caring | Written Complaints - rate | 40 | 37 | ↓ | 4 | 9 | 4 | | | M | Awaiting national technical guidance | | | | Y | | | | |
| | Occurrence of any Never Events | 0 | 0 | → | 0 | 0 | 0 | | | M | | | | | | | | | |
| | NHS England/NHS Improvement Patient Safety Alerts outstanding | 0 | 0 | → | 0 | 0 | 0 | | | M | | | | | | | | | |
| | Mixed Sex Accommodation breaches | 0 | 1 | ↑ | 0 | 0 | 0 | | | M | | | | | Y | | | | |
| | VTE Risk Assessment | >=95% | 97.3% | ↑ | >=95% | 97.7% | 97.4% | | | M | | | | | | | | | |
| | Clostridium Difficile | 2 | 1 | → | 0 | 0 | 0 | | | M | Due to lapses in care | | | | | | | | |
| | Clostridium Difficile infection rate (per 1000 beddays) | <=0.19 | 0.03 | → | <=0.19 | 0.00 | 0.00 | | | M | | | | | | | | | |
| | MRSA bacteraemias | 0 | 1 | → | 0 | 0 | 0 | | | M | | | | | Y | | | | |
| | eColi | 4 | 4 | → | 1 | 0 | 0 | | | | Plan based on 2016/17 | | | | | | | | |
| | HSMR for all diagnosis (supplied from Dr Foster) | <=100 | 117.10 | ↑ | <=100 | 62.14 | 118.12 | | | M | Current month is July 17 | | | | | | | | |
| | HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide) | <=100 | 135.03 | ↑ | <=100 | 85.98 | 128.71 | | | M | Current month is July 17 | | | | Y | | | | |
| | Hospital Standardised Mortality Ratio - Weekend (DFI) | <=100 | 137.08 | ↑ | <=100 | 0 | 106.55 | | | M | Current month is July 17 | | | | Y | | | | |
| | Potential under reporting of patient safety incidents | <3 | 2 | ↑ | <3 | 2 | 3 | | | 6M | NRLS Report April - September 2017 (3 = poor) | | | | Y | | | | |
| | Emergency readmissions following elective admission | <=100 | 85.49 | ↑ | <=100 | 85.49 | 96.31 | | | M | Current month is April 2017 | | | | | | | | |
| | Emergency readmissions following non-elective admission | <=100 | 69.81 | ↑ | <=100 | 69.81 | 79.74 | | | M | Current month is April 2017 | | | | | | | | |
| | 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 dependancy area | >=80% | 96% | → | >=80% | | | | | 6M | September 2016 Survey | | | | | | | | |
| | Std 8: 7-day Services: Ongoing review every 24 hours on general wards | >=80% | 98% | → | >=80% | | | | | 6M | September 2016 Survey | | | | | | | | |
| | Staff Friends and Family - recommend as a place of treatment | >=94% | 95% | → | >=94% | 95% | 95% | | | Q | Q3 2016 Staff Survey Data | | | | | | | | |
| | Inpatient scores from Friends & Family Test - % positive | >=95% | 99.1% | ↓ | >=95% | 98.7% | 99.6% | | | M | | | | | | | | | |
| | Community scores from Friends & Family Test - % positive | >=95% | 100% | ↓ | >=95% | 99.0% | 99.5% | | | M | | | | | | | | | |
| Quality - Organisational Health | Staff Sickness | <=3.4% | 3.88% | ↓ | <=3.4% | 3.82% | 3.75% | | | M | | | | | Y | | | | |
| | Proportion of temporary Staff | <=5% | 5.21% | ↓ | <=5% | 5.72% | 5.31% | | | M | | | | | | | | | |
| | Staff Turnover | <=10% | 12.0% | ↑ | <=10% | 12.0% | 12.1% | | | M | Turnover based on 'All' Leavers in 12 month period | | | | | | | | |
| | Executive Team Turnover | <=25% | 14.3% | → | <=25% | 14.3% | 14.3% | | | M | Calculation: Leavers in 12 month period / Average Staff in Post in 12 month period x 100 //// *NB excludes Raph Perry who left on Flexi Retirement but returned | | | | | | | | |
| | NHS Staff Survey - recommend as a place to work | >=76% | 73% | → | >=76% | 73% | 73% | | | Q | Q3 2016 Staff Survey Data - Previous Period Q3 2015 | | | | | | | | |
| Finance | Capital service cover | 1 | 1 | → | 1 | 1 | 1 | | | M | Trigger: Poor levels of overall financial performance (average score of 3 or 4) very poor performance (score of 4) in any individual metric Potential value for money concerns | | | | | | | | |
| | liquidity | 3 | 3 | → | 3 | 3 | 3 | | | M | | | | | | | | | |
| | Efficiency | | | | | | | | | | | | | | | | | | |
| | I&E margin | 1 | 1 | → | 1 | 1 | 1 | | | M | | | | | | | | | |
| | Controls | | | | | | | | | | | | | | | | | | |
| | Performance against plan | 1 | 1 | → | 1 | 1 | 1 | | | M | | | | | | | | | |
| | Agency spend | 2 | 1 | → | 2 | 1 | 1 | | | M | | | | | | | | | |
| | Overall Financial Performance | | | | | | | | | | | | | | | | | | |
| | Overall use of resources rating | 3 | 1 | → | 3 | 1 | 1 | | | M | | | | | | | | | |
| | Value for money information | | | | | | | | | | | | | | | | | | |
| | NCBC Benchmarking Data, Meridian Review, Back Office Review, Pathology Review | | Comment: Back office review underway as part of STP | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| Aggressive cost reduction plans - Cost reduction strategy delivered Em | | 2,103.00 | 1,745 | ↑ | 323 | 357 | 234 | | | M | There are non-recurring schemes of £98k to offset the recurrent CIP underachievement. The Trust is forecast to underachieve its CIP by £599k, with £166k of non-recurrent CIP to offset this position. | | | | Y | | | | |
| Control total acceptance | | Yes | | | | | | | | | | | | | | | | | |
| Overall | Segmentation | | | | | | | | | Adhoc | Segment 1: Maximum autonomy; universal support | | | | | | | | |

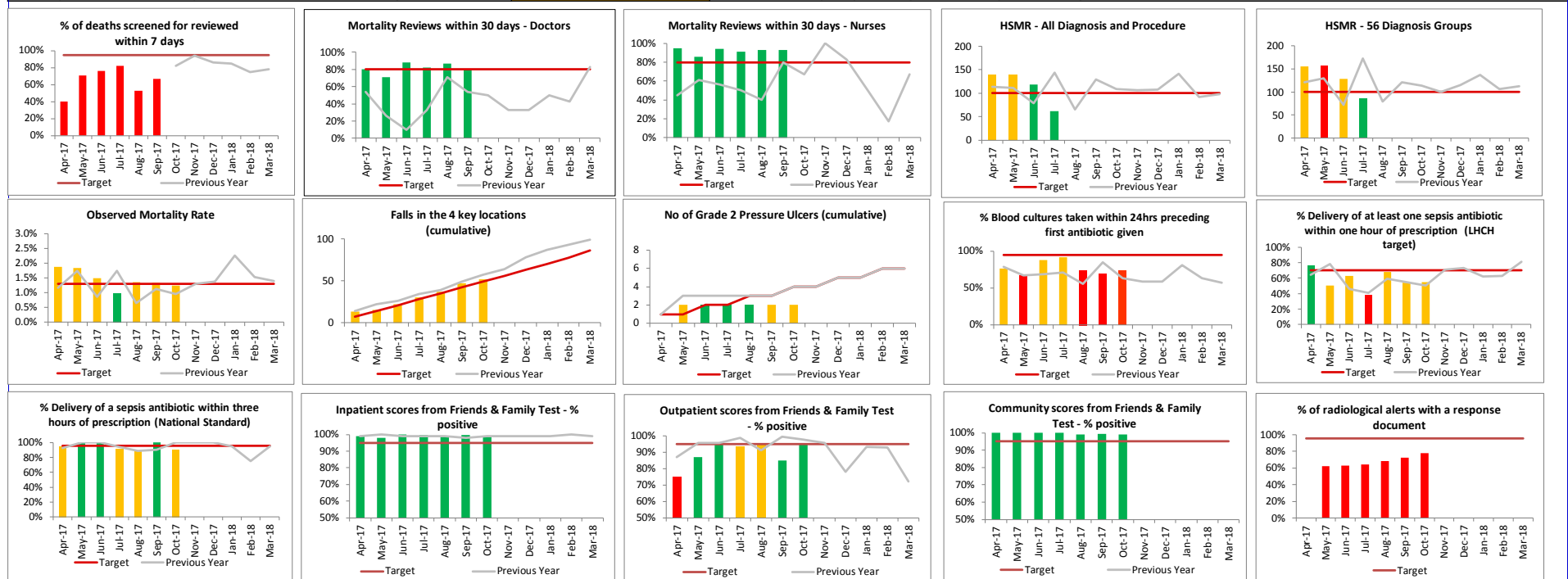
Appendix 2 – Operational Performance Dashboard

| Performance Report Summary 2017/18 | | | | | | | | | | | | |
|------------------------------------|---|--------|---------|-------------------|---------------|---------|----------------|--------------|-----------|---|---|-----------|
| | Indicator | Target | Actual | | Current month | | Previous Month | Data Quality | Frequency | Comments | | Exception |
| | | | YTD | Performance trend | Target | Oct 17 | | | | | | |
| Quality | Friends and family Test response rate - Inpatients | >=50% | 50% | ↑ | >=50% | 48.40% | 39% | ✓ | M | | | |
| | VTE Prophylaxis | >=95% | 98.27% | ↑ | >=95% | 99.57% | 98.8% | ✓ | M | | | |
| | Number of in-hospital deaths | N/A | 113 | ↓ | N/A | 14 | 15 | ✓ | M | | | |
| | Risk adjusted CABG mortality | <=1 | 0.88 | ↓ | <=1 | 0.99 | 0.90 | ✓ | M | 6-month rolling averages; latest due up to July 2017 | | |
| | Risk adjusted non-primary PCI MACE | <=1 | 0.98 | ↓ | <=1 | 0.65 | 0.51 | ✓ | M | 6-month rolling averages; latest data up to July 2017 | | |
| | Number of Adverse Events (red alerts), SIs & Never Events | 0 | 4 | ↓ | 0 | 2 | 0 | ✓ | M | 2 SI Reported (April and August), 2 adverse events (October) | Y | |
| | Number of Reported Patient Safety Incidents (6-month rolling avg) | >=973 | 1000 | ↑ | >=139 | 154 | 146 | ✓ | M | | | |
| Performance | Cancelled operations | <=1.5% | 2.0% | ↑ | <=1.5% | 1.3% | 2.3% | ✓ | M | Internal Target | | |
| | Cancelled operations seen in 28-days | 100% | 97.3% | ↑ | 100% | 100% | 100% | ✓ | M | 1 Operation not re-booked within 28 days of cancellation | Y | |
| | Urgent operations cancelled 2nd time | 0 | 1 | ↑ | 0 | 0 | 0 | ✓ | M | | | |
| | Delayed transfers of care | <=4.5% | 5.95% | ↓ | <=4.5% | 6.53% | 9.22% | ✓ | M | | Y | |
| | Bed occupancy | >=85% | 82.50% | ↑ | >=85% | 84.33% | 81.95% | ✓ | M | | | |
| | Referrals - GP | 16,534 | 15,760 | ↑ | 2,362 | 2,463 | 2,155 | ✓ | M | | Y | |
| | Referrals - DGH | 5,908 | 6,127 | ↑ | 844 | 940 | 841 | ✓ | M | | | |
| | Referrals - Other | 1,008 | 1,224 | ↑ | 144 | 188 | 153 | ✓ | M | | | |
| | Activity - NHS | 0% | -1.34% | ↓ | 0% | -4.2% | -3.2% | ✓ | M | | Y | |
| | Activity - Private | 0% | -6.50% | ↑ | 0% | -11.1% | -34.9% | ✓ | M | | | |
| | 18 Weeks Referral to Treatment Incomplete Pathways 52 week + | 0 | 0 | ↑ | 0 | 0 | 0 | ✓ | M | | | |
| | 14 day wait from referral to date first seen | >=93% | 100.00% | ↑ | >=93% | 100.00% | 100.00% | ✓ | M | | | |
| | 31 day wait from diagnosis to first treatment | >=96% | 99.34% | ↑ | >=96% | 100.00% | 100.00% | ✓ | M | | | |
| | 31 day wait for second or subsequent treatment (surgery) | >=94% | 97.56% | ↑ | >=94% | 100.00% | 100.00% | ✓ | M | | | |
| | 62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj) | >=85% | 86.36% | ↓ | >=85% | 80.00% | 100.00% | ✓ | M | | Y | |
| Local Target | 26 Weeks Referral to Treatment in aggregate - Admitted Pathways | >=95% | 65.91% | ↓ | >=95% | 65.91% | 79.37% | ✓ | M | | Y | |
| | 26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways | >=98% | 86.84% | ↓ | >=98% | 86.84% | 87.10% | ✓ | M | | Y | |
| | 26 Weeks Referral to Treatment in aggregate - Incomplete Pathways | >=95% | 91.96% | ↑ | >=95% | 91.96% | 86.68% | ✓ | M | | Y | |
| Workforce | Appraisals | >=90% | 90% | ↑ | >=90% | 90% | 90% | ✓ | M | Appraisal window reset | Y | |
| | Mandatory training | >=95% | 94% | ↑ | >=95% | 94% | 94% | ✓ | M | | | |
| | Turnover Rate between 1-2 yrs service (voluntary)(FTC excluded) | <=1.4% | 2.02% | ↓ | <=1.4% | 2.02% | 1.88% | ✓ | M | | | |
| Finance | Net Surplus £000's | 2,974 | 3,063 | ↑ | 830 | 942 | 663 | ✓ | M | | | |
| | Normalised Net Surplus £000's | 2,974 | 3,063 | ↑ | 830 | 943 | 663 | ✓ | M | | | |
| | Cash Balance | 7,467 | 5,792 | ↑ | 1,071 | 956 | -1,404 | ✓ | M | Cashflow is currently behind the YTD position due to a) the opening cash balances being £1.4m behind plan, and b) the non-payment of the HRCA+ increase by Wales Health Specialised Services Committee (WHSKC). The improvement in the in-month position is driven by the resolution of some outstanding debt with RUSHF. | Y | |
| | Capital expenditure £000's | -3,532 | -2,949 | ↑ | -375 | -302 | -1,541 | ✓ | M | Expenditure in month is broadly in line with plan, with the Surgical Robot expenditure recognised last month. Current forecasts would indicate an overspend on capital of approximately £400k. | | |
| | Total agency cost £000's | -1,313 | -1,118 | ↑ | -188 | -184 | -178 | ✓ | M | Agency costs in month are close to the NHS Ceiling. There has been an increase in the use of Medical and Nursing agency compared to the previous month. | | |
| | Total bank cost £000's | -406 | -1,193 | ↓ | -60 | -224 | -183 | ✓ | M | Increasing levels of Bank staff being used across the Trust. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets. | Y | |

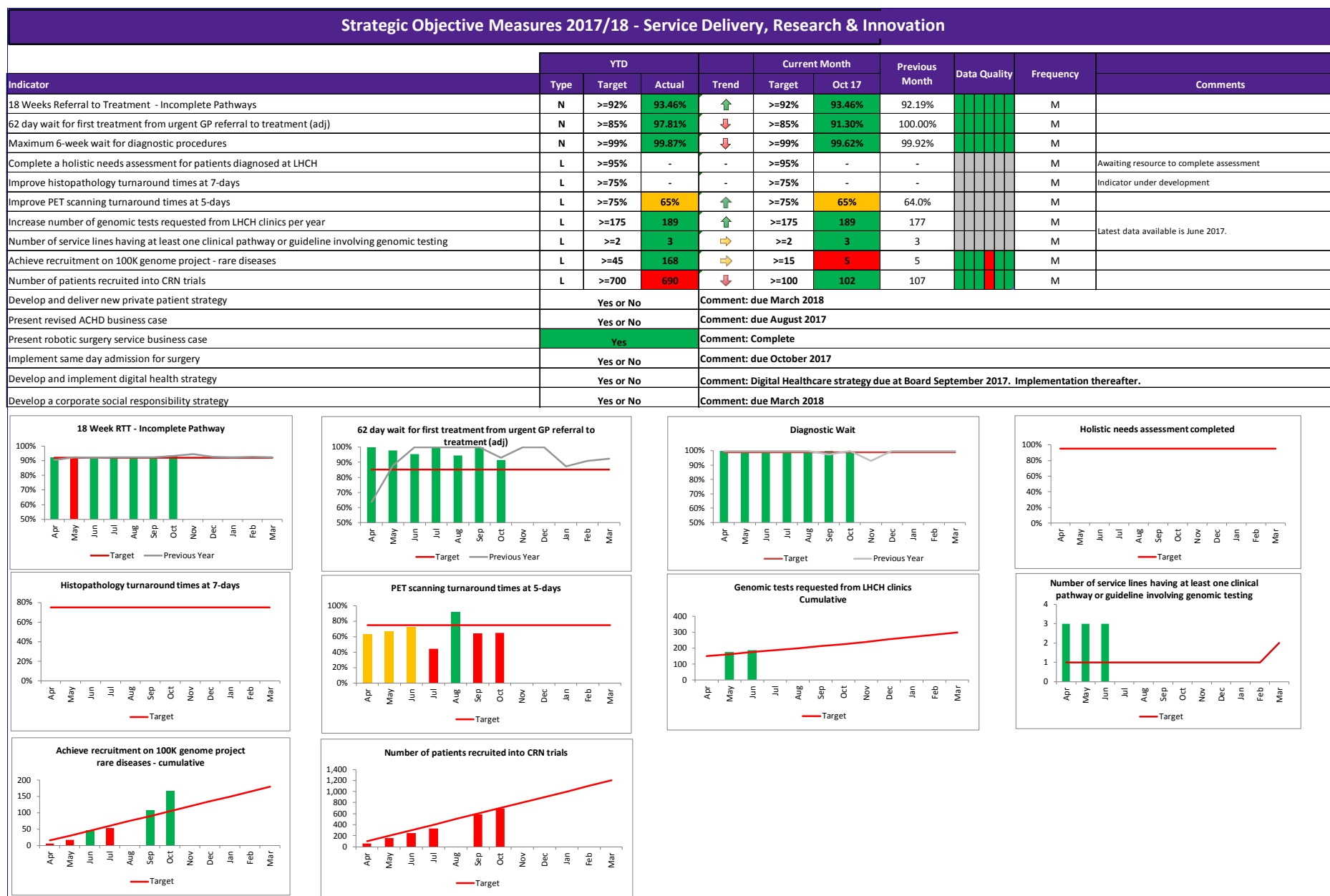
Appendix 3 – Strategic Dashboard: Quality & Experience

Strategic Objective Measures 2017/18 - Quality & Experience

| Indicator | YTD | | | Trend | Current month | | Previous Month | Data Quality | Frequency | Comments |
|---|-----------|--------|--------|--|---------------|--------|----------------|--------------|-----------|---|
| | Type | Target | Actual | | Target | Oct 17 | | | | |
| % of deaths screened for reviewed within 7 days | L | >=95% | 64% | ↑ | >=95% | 67% | 53% | | M | Current month based September 2017 |
| % Mortality reviews to be completed within 30 days of allocation - Doctors | L | >=80% | 81% | ↓ | >=80% | 80% | 87% | | M | Current month based September 2017 |
| % Mortality reviews to be completed within 30 days of allocation - Nurses | L | >=80% | 92% | → | >=80% | 93% | 93% | | M | Current month based September 2017 |
| HSMR for all diagnoses and procedures | N | <=100 | 117.10 | ↑ | <=100 | 62.14 | 118.12 | | M | Latest figures supplied by Dr Foster to July 2017 |
| HSMR for 56 diagnosis groups | N | <=100 | 135.03 | ↑ | <=100 | 85.98 | 128.71 | | M | Latest figures supplied by Dr Foster to July 2017 |
| Observed mortality rate | L | <=1.3% | 1.45% | ↑ | <=1.3% | 1.24% | 1.35% | | M | |
| Number of Falls - 4 key locations (Birch, Cedar, Elm & Oak) | L | 49 | 52 | ↑ | 7 | 5 | 10 | | M | Target for the year is 86 |
| Number of avoidable Pressure Ulcers - grade 2 | L | <=3 | 2 | ↑ | <= 1 | 0 | 1 | | M | |
| Number of avoidable Pressure Ulcers - grade 3 | L | 0 | 0 | → | 0 | 0 | 0 | | M | Not charted below |
| % Blood cultures taken within 24hrs preceding first antibiotic given | L | >=95% | 76% | ↑ | >=95% | 73% | 69% | | M | October - 8 out of 11 bundles |
| % Delivery of at least one sepsis antibiotic within <u>one</u> hour of prescription | L | >=70% | 60% | ↑ | >=70% | 55% | 54% | | M | October - 6 out of 11 bundles |
| % Delivery of a sepsis antibiotic within <u>three</u> hours of prescription | N | >=96% | 95% | ↓ | >=96% | 90% | 100% | | M | October - 10 out of 11 bundles |
| Inpatient scores from Friends & Family Test - % positive | L | >=95% | 99% | ↓ | >=95% | 98.7% | 99.60% | | M | |
| Outpatient scores from Friends & Family Test - % positive | L | >=95% | 91% | ↑ | >=95% | 95% | 85% | | M | |
| Community scores from Friends & Family Test - % positive | L | >=95% | 99.6% | ↓ | >=95% | 99.0% | 99.5% | | M | |
| % of radiological alerts with a response document | L | >=95% | 68% | ↑ | >=95% | 78% | 72% | | M | YTD is the average |
| All re-inspected KLOE's rated as outstanding | Yes or No | | | Comment: The Trust is waiting for re-inspection to determine whether objective has been achieved | | | | | | |
| Follow-up audit of SUI reveals improvement embedded and delivering | No | | | Comment: OL Policy complimenting recent learning from deaths guidance | | | | | | |

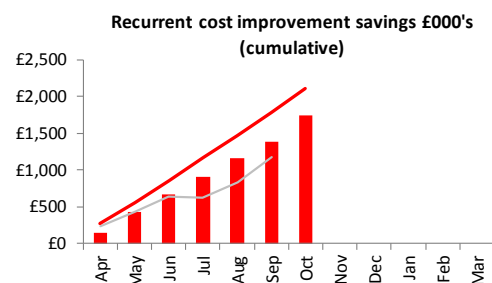


Appendix 4 – Strategic Dashboard - Service Delivery, Research & Innovation



Strategic Objective Measures 2017/18 - Financial Sustainability Delivering Value for Money

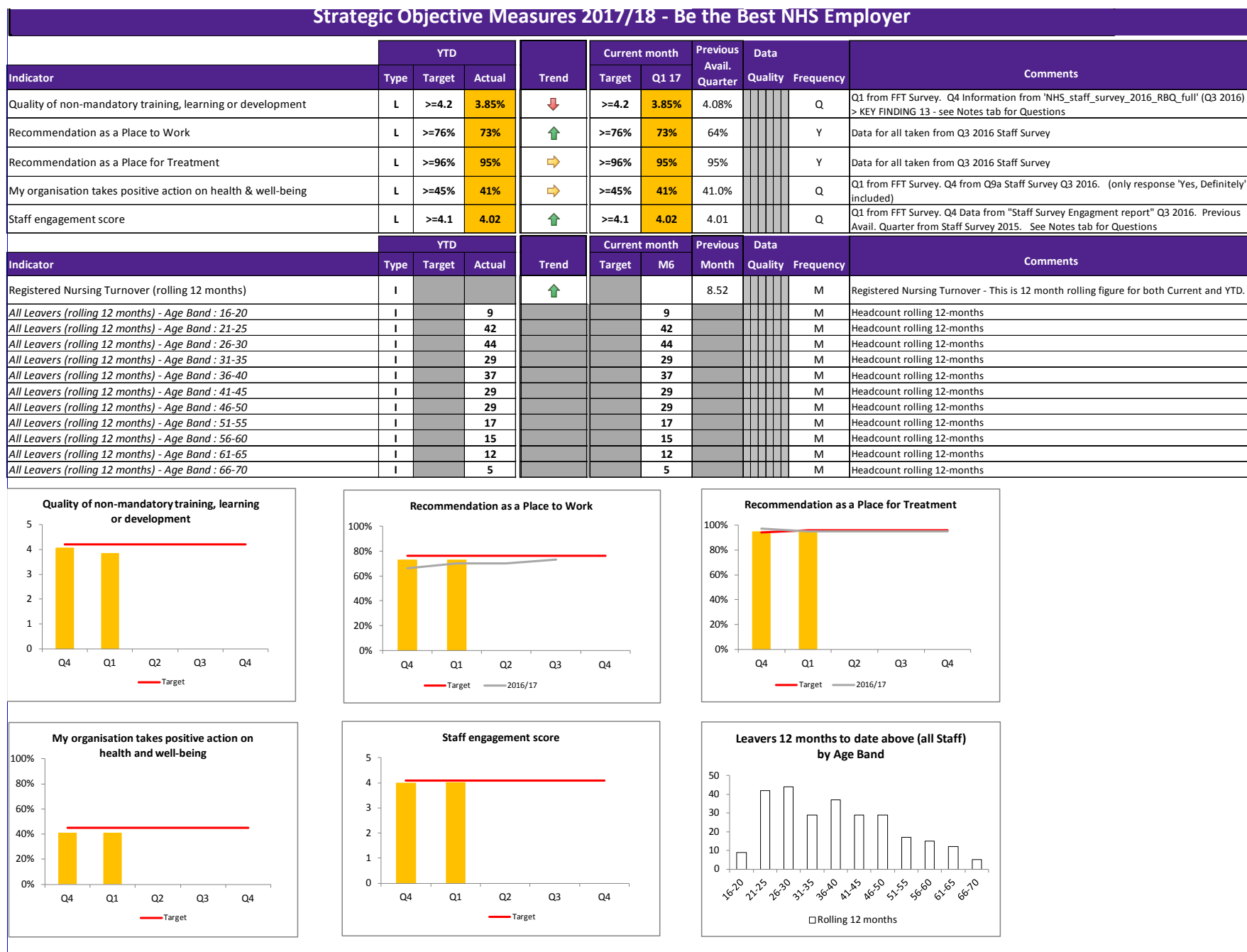
| Indicator | YTD | | Trend | Current month | | Previous Month | Data Quality | Frequency | Comments |
|--|-----------|--------|---|---------------|--------|----------------|---|-----------|--|
| | Plan | Actual | | Plan | Oct 17 | | | | |
| Overall use of resources rating | 3 | 1 | ➡ | 3 | 1 | 1 | <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> | M | |
| Deliver the recurrent cost improvement savings | £2,103 | £1,745 | ⬆ | £323 | £357 | £234 | <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> | M | Under achievement of CIP of £358k in the year to date (YTD), with a forecast recurrent shortfall of £566k. However, £270k of non-recurrent mitigation has been identified giving an in year forecast shortfall of £296k. |
| Agency rating | 2 | 1 | ➡ | 2 | 1 | 1 | <div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div><div></div></div> | M | Continued use of Agency; £1.118m against a ceiling of £1.313m (full year ceiling - £2.251m) |
| Liquidity rating | 3 | 3 | ➡ | 3 | 3 | 3 | <div><div></div><div></div><div></div><div></div><div></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. 2017/18 SLR is being completed, however, this needs to be progressed alongside recognised development work on data and systems which is ongoing. 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) | | | | | | |



Overall financial performance

The year to date (YTD) overall financial position for Month 7 is a surplus of £3,063k against a planned surplus of £2,974k, showing a favourable variance of £88k. The variance is partially related to additional income received for donated assets, which does not affect the receipt of Sustainability and Transformation Funding (STF). Forecast is to deliver in line with financial plan and therefore deliver the Trusts Control Total. However, a significant risk to the forecast position is the on-going HRG4+ dispute with Welsh commissioners (£2.4m FYE) which remains unresolved and is subject to national funding discussions. The Chief Finance Officer continues to escalate this issue for resolution with NHS Improvement and NHS England.

Appendix 6 – Strategic Dashboard: Be the Best NHS Employer



Appendix 7 – Strategic Dashboard: Partnership & Collaborative Working

| Strategic Objective Measures 2017/18 - Partnership & Collaborative Working | | | | | | | | | | |
|--|------|--------|--------|---|-----------------|-----|------------------|--------------|-----------|----------|
| Indicator | YTD | | | Trend | Current Quarter | | Previous Quarter | Data Quality | Frequency | Comments |
| | Type | Target | Actual | | Target | Q2 | | | | |
| Media impact metric | L | 28 | 30 | - | 28 | 30 | 17 | | Q | |
| Fundraising impact metric | L | 252 | 475 | - | 252 | 475 | 205 | | 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: Work continues on the cases for change for each of the 7 priority areas: prevention, cardiac rehabilitation, community HF services, imaging, pacing services, ACS pathway and stroke sustainability. We have identified clinical leads for each area at CVD board level and have also identified project support for each. A mini clinical summit is scheduled for autumn between Countess of Chester and Wirral University Teaching Hospital and work is progressing towards a mini summit between Warrington and St Helens and Knowsley. | | | | | | |

Media impact metric

| Quarter | Actual | Target |
|---------|--------|--------|
| Q1 | 18 | 18 |
| Q2 | 30 | 28 |
| Q3 | - | 40 |
| Q4 | - | 52 |

Fundraising impact metric

| Quarter | Actual | Target |
|---------|--------|--------|
| Q1 | 205 | 252 |
| Q2 | 475 | 280 |
| Q3 | - | 360 |
| Q4 | - | 500 |

