

## Council of Governors (in public) Item 8.1

**Subject:** Trust Review-SOF, Regulatory and Operational Performance up and including month 9 (end of December 2018)  
**Date of meeting:** Tuesday 12<sup>th</sup> March 2019  
**Prepared by:** Gary White, Information Business Partner - Corporate  
**Presented by:** Sue Pemberton, Director of Nursing & Operations  
**Purpose of Paper** To note

### 1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period ending the 31st December 2018. The report is divided into the following three sections:




- Section 1-Single Oversight Framework (SOF): This section provides details on the 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:

- Occurrence of any Never Events

Framework	Rating	Exception
Quality of Care		Occurance of any Never Events (In-month & YTD)
Finance and use of resources		
Operational Performance		Maximum 6 week wait for diagnostic procedures (In-month and YTD)

Strategic Change		
Leadership and Improvement		Staff Sickness (In-month)
Segmentation		

## 1.1 Quality of Care

### 1.1.1 Indicator: Occurrence of Never Events

**Accountable Executive Officer:** Mark Jackson

**Issue:** One breach occurred in December 2018. The plan for the entirety of the financial year is zero breaches.

**Actions:** A Trust wide alert was sent out on the day of the incident. The incident was reported in the weekly Trust Bulletin.

**Anticipated Delivery:** An online training package has been developed which is ready for roll out.

## 1.2 Operational Performance

### 1.2.1 Indicator: Maximum 6-week wait for diagnostic procedures

**Accountable executive Officer:** Sue Pemberton

**Issue:** Currently below target for December 2018 at 82.35% against a target of 99%, there were a total of 222 breaches for December.

**Actions:** Performance has remained above 80% as was predicted against the improvement trajectory submitted to NHSE. Monthly updates to NHSE provided.

Two new consultant appointments are likely to start between April 2019 and June 2019 when specialist registration with the GMC is achieved. The CT scanner is now expected to be operational May 2019 and the MRI scanner July 2019. A full capacity and demand assessment has been completed for the scanning and reporting of CT and MR images. The Trust is completing a review process to outsource additional scanning to a third party that will utilise the Trusts current CT and MRI scanner at weekends. On completion of a full governance review, it is anticipated this activity can start in early February.

**Anticipated Delivery:** There will be a significant improvement in performance from May 2019 when the new CT scanner is installed and the new consultants will have commenced. A further increase in performance will then be effective from August 2019 when the new MRI scanner will be installed. The Radiology Department is also working on a backup recovery plan with aims to use our current scanners over a 7 day week including some evenings by using a third party (Radiology Management Solutions) to work in the out of hours period. Governance and due diligence processes are currently in progress. RMS have been into the Trust and are being inducted and trained and will commence March/April 2019.

## 1.3 Leadership and Improvement Capability

### 1.3.1 Indicator: Staff sickness

**Accountable executive Officer:** Jo Twist

**Issue:** Sickness is 3.85% YTD and 4.06% 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:** On-going monitoring and management.

## **Section 2 – Quality of Care Dashboard**

Refer to Appendix 2.

There are no new exceptions this month.

Framework	Rating	Exception
Quality of Care		<ul style="list-style-type: none"><li>• Mortality screening within 7 days (In-month &amp; YTD)</li><li>• HSMR Weekend (in-month)</li><li>• Number of adverse events, Serious Incidents &amp; Never Events (in-month &amp; YTD)</li><li>• % blood cultures taken within 24 hours preceding first antibiotic taken</li></ul>

## **2. Exceptions**

### **2.1 Indicator: Mortality screening within 7 days**

**Accountable Executive Officer:** Raphael Perry

**Issue:** Screening of deaths within 7-days is 77% in month and 74% YTD against a target of 95%.

**Actions:** The new mortality review policy was introduced in September 2017 and was updated further in February 2019. There is new national guidance on Learning from Deaths which has implications for how organisational learning is identified and implemented. Deaths are currently at 132 YTD.

**Anticipated Delivery:** Q4 2018/19

### **2.2 Indicator: HSMR Weekend (in-month)**

**Accountable Executive Officer:** Mark Jackson

**Issue:** In-month ratio of 164.998 against a plan of 100

**Actions:** We are currently refreshing our mortality improvement strategy. This indicator is not reliable given the size of the dataset and therefore it is proposed to omit the routine monitoring of mortality occurring following a weekend admission. As a specialist, relatively low volume trust, our mortality rates are low. This is the product of low numbers of deaths and relatively low volumes of activity. As a consequence, when a number of deaths occur together, mortality rates can elevate considerably. The Trust routinely reviews the confidence limits associated with such rates to ensure action is taken based upon statistical significance – i.e. when the lower bound confidence limit excludes a risk adjusted rate of 100. To focus resource on reviewing a subset (2/7ths) of mortality would create a lot of false positives – occasions where the data suggests we have a problem when in fact we do not, simply as a consequence of low volumes with high variability.

**Anticipated Delivery:** March 2019

### **2.3 Indicator: Number of Adverse Events, Serious Incidents & Never Events**

**Accountable Executive Officer:** Mark Jackson

**Issue:** One Never Event in Surgical Division.

**Actions:** An alert was sent out Trust wide on the day of the incident advising what had happened and the immediate learning that needed to be actioned. The incident was reported on Steis.

**Anticipated Delivery:** An online training package has been developed in relation to medical gases awareness which is ready for roll out.

### **2.4 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, the Trust remains under target. 71% in month and 74% YTD. The target is 95%


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

**Anticipated Delivery:** Q1 2019/20.

### **Section 3 - Operational & Financial Performance**

Refer to Appendix 3.

There are no new exceptions this month.

Framework	Rating	Exception
Operational Performance		<ul style="list-style-type: none"> <li>• Improve PET scanning turnaround times at 5-days (YTD &amp; Month)</li> <li>• Cancelled Operations (YTD &amp; Month)</li> <li>• Plain Film Inpatient (YTD &amp; Month)</li> <li>• CT Outpatient (YTD &amp; Month)</li> <li>• MRI Outpatient (YTD &amp; Month)</li> <li>• 26 Weeks Referral to Treatment in aggregate- Admitted Pathways (YTD &amp; Month)</li> <li>• 26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways (YTD &amp; Month)</li> <li>• 26 Weeks Referral to Treatment in aggregate - Incomplete Pathways (YTD &amp; Month)</li> <li>• Capital Expenditure (YTD &amp; Month)</li> <li>• Total Bank Cost (YTD &amp; Month)</li> <li>• Deliver the recurrent cost savings (YTD &amp; Month)</li> </ul>

### **3. Exceptions**

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

**Accountable Executive Officer:** Sue Pemberton

**Issue:** December is currently 31.3% against a 75% target.

**Actions:** There are on-going 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. To ensure that patient care is not compromised the surgical division are micro managing all patients to ensure they receive the pet scan with the 31 day pathway.

**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.

### 3.2 Indicator: Cancelled Operations

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Total number of reportable cancellations for December 2018 was 13. This has dropped significantly from last month (28).

Top three leading cancellation themes were as follows:

1. Elective list overrun – resulted in 5 cancellations
2. Elective bed shortage POCCU/CCA – resulted in 3 cancellations
3. Elective Emergency Took Priority – resulted in 3 cancellations

Elective list overruns are a common cause of cancellations. The Division has taken steps to reduce the number of cancellations attributed to this theme including improved theatre scheduling project. The list overruns in November where as a direct result of complications in theatre that could not have been avoided/factored into scheduling.

#### **Actions:**

The Division has a robust cancellation action plan in place which is reviewed on a monthly basis and updated when required. Regular clinical engagement takes place at monthly Divisional Performance and at consultant business meetings.

A review of cancellation data is to be presented at Audit day in January 2019.

The Division have commenced reviewing all clinical cancellations at business meetings to identify learning from the cancellation if deemed avoidable and sharing the learning amongst the consultant body.

**Anticipated Delivery:** The surgical division are working hard to reduce cancelled ops. The target for cancelled operations is going to be reviewed as part of the annual planning process for next year. A visit will be scheduled to review the theatre scheduling software the Trust is planning to implement in Q4 at the Trust. A report will be presented to the integrated performance committee in April 2019 detailing further improvements that are required to reduce cancellations in surgery.

### 3.1 Indicator: Plain Film Inpatient

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Current performance is at 65%. Routine inpatient plain films are primarily reviewed and actioned by the admitting clinical consultant caring for the patient, which allows for any urgent intervention to take place. Further review by the Consultant Radiologist acts as a safety check to pick up more discrete changes that may not be identified by the admitting consultant's team and which do not require immediate action. Requests for urgent reporting are actioned immediately.

**Actions:** Reporting performance is being closely monitored and risk assessed during the current identified shortage in the Radiology workforce. Two new consultants have an anticipated start dates for April 2019 to June 2019 which will ease the current pressures. For reporting radiologists to prioritise inpatient radiographs during their reporting sessions

**Anticipated Delivery:** June 2019

### 3.2 Indicator: CT Outpatient

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Current performance is at 72% against a 90% compliance target

**Actions:** The Radiology department is working closely with the medical and surgical divisions to ensure that any scans required prior to admission or outpatient review for treatment are prioritised and expedited. An improved contract management process with Medica was implemented in October 2018 to ensure timely reporting of outsourced scans against set KPIs. A report was submitted to the executive team in December 2018 which highlighted a plan to increase the level of reporting by 20% in Q4 to ensure there is a significant improvement in reporting turnaround times. This will be achieved by increasing the level of outsourced scans for reporting as well as the planned increase when new consultants are in post.

**Anticipated Delivery:** June 2019

### 3.3 Indicator: MRI Outpatient

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Current performance is 67% against a 90% compliance target.

**Actions:** There are minimal requests for urgent MRI scans. The Radiology Department is working closely with the medical and surgical divisions to ensure that any scans required prior to admission or outpatient review for treatment are prioritised and expedited. Further communication with Medica and another provider to assess if cardiac MRI and aorta scans are able to be outsourced. Medica have increased the level of Consultant Radiologists assigned to review scans for LHCH thereby increasing reporting turnaround times and potentially offer aortic MRI reports. Full compliance expected to be achieved when new consultant capacity is in place.

**Anticipated Delivery:** June 2019

### 3.4 Indicator: Welsh 26 weeks (Admitted, Non Admitted & Incomplete)

**Accountable Executive Officer:** Sue Pemberton

**Issue:** Patients waiting over 26-weeks for treatment.

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

**Anticipated Delivery:** 2018/19 subject to discussions in relation to HRG4+

### 3.5 Finance Indicators:

**Indicator:** Capital Expenditure £000's

**Indicator:** Total Bank Cost £000's

**Indicator:** Deliver the recurrent Cost Improvement savings

Please refer to Finance report.

## 4. Conclusion

The Trust is facing a number of challenges including 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 Council of Governors 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 Target	Dec-18	Forecast	Previous Month	Frequency	Comments
Quality of Care	Written Complaints - Rate	Caring	Count of written complaints/Count of whole time equivalent staff	50	23	↑	5	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 likely 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%	99.4%	↓	95%	99.40%		99.72%	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%	100.0%		100%	M	
	Occurrence of any Never events	Safe	Count of Never Events in rolling six-month period	0	1	↓	0	1		0	M	to be updated
	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	to be updated
	VTE Risk Assessment		Number of patients admitted who have a VTE risk assessment/number of patients admitted in most recently published quarter	95.0%	97.0%	↑	95.0%	96.4%		93.6%	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	3	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	0.02	→	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	5	↓	N/a	2		1	M	
	eColi LHCH Acquired		Rolling 12-month count of all E. coli infections/rolling 12-month average occupied bed days multiplied by 100,000	-	5	↑	-	0		1	M	1 E.Coli LHCH Acquired on Birch
	HSMR for 56 diagnosis groups (supplied from Dr Foster; hospital guide)		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	104.89	→	0.016667	140.98		140.98	M	Current Month is July 2018
	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 Efficiency		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	
Operational Performance	Overall use of resources (UoR) rating	Overall Financial Performance		1	1	→	1	1		1	M	
	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%	92.33%	↑	92%	92.33%		92.25%	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%	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%	82.35%		82.83%	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%	96.0%		95%	M	awaiting validation
Strategic Change	Dementia - Assess			90%	100%	↑	90%	100%		89%	M	awaiting validation
	Dementia - Refer			90%	100%	↑	90%	100%		67%	M	awaiting validation
Leadership and Improvement Capability	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				-	-	-		-		CQC Review published September 2016 rated Well-Led Domain as
	Well Led Reviews - NHS Code of Governance	Inspections				-	-	-		-		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%	3.85%	↑	3.4%	4.00%		4.30%	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%	13.91%	↓	10%	13.91%		13.61%	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%	74%	→	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%	5.07%	↓	5%	5.72%		5.61%	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	Dec-18				
% of deaths screened for review within 7 days	Mortality		95%	74%	↑	95%	77%	73%	M	Current month based October 2018	L
% mortality reviews to be completed within 30 days - Doctors			80%	76%	↑	80%	77%	73%	M	Current month based October 2018	L
% mortality reviews to be completed within 30 days - Nurses			80%	90%	↓	80%	92%	100%	M	Current month based October 2018	L
Observed mortality rate		Total number of deaths in month or YTD / Total number of discharges in month or YTD	1.3%	1.33%	↓	1.3%	1.56%	1.12%	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	110.82	→	100	164.998	165.00	M	Current Month is July 2018	L
HSMR for all diagnosis (supplied from Dr Foster)			100	97.42	→	100	123.59	123.59	M	Current Month is July 2018	L
Cardiac Surgery observed:expected mortality ratio			1.00	0.95	↑	1.00	1.29	1.42	M	6-month rolling averages; latest due up to June 2018	
Non-primary PCI observed:expected MACE ratio			1.00	0.00	↑	1.00	0.20	0.34	M	6-month rolling averages; latest due up to June 2018	
Number of Falls (Birch, Cedar, Elm and Oak)	Incidents	Count of Falls recorded across all areas	54	45	↑	6	6	8	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	5	3	↓	1	1	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	4	→	0	1	1	M		
Number of reported patient safety incidents (6 month rolling avg)			N/a	1163	-	N/a	110	141	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%	74%	↓	95%	71%	74%	M		L
% Delivery of at least one sepsis antibiotic within one hour of prescription			70%	68%	↑	70%	79%	65%	M		L
% Delivery of a sepsis antibiotic within three hours of prescription			96%	96%	↑	96%	96%	94%	M		N
% of radiological alerts with a response document			95%	93.5%	↓	95%	95.5%	97.0%	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%	64%	↑	50%	60.4%	53.4%	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%	98.6%	↓	95.0%	99.13%	100.00%	M		
VTE Prophylaxis		Count of Patients given appropriate prophylaxis / Total patients at risk	95%	97.97%	↓	95%	98.10%	98.79%	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	Current Month Dec-18	Previous Month	Frequency	Comments	
Number of in-hospital deaths	Mortality	Count of hospital deaths across the trust for the month/YTD	N/a	130	↓	N/a	15	13	M		
Improve histopathology turnaround times at 7-days			60%	58%	→	60%			M	Data as reported by Liverpool labs	
Improve PET scanning turnaround times at 5-days			75%	41.7%	↑	75%	31.3%	30.4%	M	Request to scan (does not include reporting time)	
Cancelled Operations	Cancelled Operations	Count of the number of last minute cancellations by the hospital for non clinical reasons	1.5%	2.8%	↑	1.50%	2.2%	3.6%	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%	99.3%	→	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.	4.50%	5.40%	↑	4.5%	3.84%	5.17%	M		
Bed Occupancy		Count of beds occupied over all wards/ count of bed available	>=85%	82.0%	↓	>=85%	81.6%	85.4%	M		
Referrals GP	Referrals	Count of referrals received into the trust from GP organisations (Community referrals removed)	14544	17564	↑	1616	1853	2451	M	Updated to include External GP Referrals (Community Referrals Removed)	
Referrals DGH (External)		Count of referrals received into the trust from external sources (Community referrals removed)	7479	9201	↑	831	1433	1077	M	Updated to include External Self referrals and External Tertiary (Community Referrals Removed)	
Referrals Other		Count of referrals received internally and all other sources (Community referrals removed)	8154	8234	↑	906	1541	941	M	Updated to include Internal Referrals and Ref Org Unknown (Community Referrals Removed)	
Activity NHS	Activity	Count of Total spells - Activity Plan for NHS patients	0.0%	0.4%	↑	0.0%	0.4%	0.0%	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	
Plain Film Inpatient	Radiology Reporting Turnaround Times	Total Plain Film Inpatient Repts within Std	90%	64.30%	↑	90%	87.73%	72.99%	M	tbc	
Plain Film Outpatient		Total Plain Film Outpatient Repts within Std	90%	98.69%	→	90%	100.00%	100.00%	M	tbc	
CT Inpatient		Total CT Inpatient Repts within Std	90%	99.60%	↓	90%	99.39%	100.00%	M		
CT Outpatient		Total CT Outpatient Repts within Std	90%	72.41%	↓	90%	79.34%	84.69%	M		
MRI Inpatient		Total MRI Inpatient Repts within Std	90%	95.74%	→	90%	100.00%	100.00%	M		
MRI Outpatient		Total MRI Outpatient Repts within Std	90%	67.54%	↓	90%	70.91%	74.65%	M		
Ultrasound Inpatient		Total Ultrasound Inpatient Repts within Std	90%	98.15%	→	90%	100.00%	100.00%	M		
Ultrasound Outpatient		Total Ultrasound Outpatient Repts within Std	90%	97.90%	→	90%	100.00%	100.00%	M		
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%	99.8%	→	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 days from a consultant decision to upgrade the urgency of a patient they suspect to have cancer to first treatment	85%	97%	→	85%	100%	100%	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%	90.87%	↓	95%	78.16%	91.1%	M		
26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways			98%	94.12%	↓	98%	75.00%	87.5%	M		
26 Weeks Referral to Treatment in aggregate - Incomplete Pathways			95%	88.75%	↓	95%	88.75%	90.7%	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	95.20	81.60	M	Current Month is April 2018	
Emergency readmissions following non-elective admission			100	99.83	↑	100	87.90	88.10	M	Current Month is April 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%	67%	→	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	Workforce	Organisational Health	95%	89%	→	95%	89%	89%	M		
Appraisals			90%	93%	→	90%	93%	93%	M		
Turnover Rate between 1-2 yrs service (voluntary(FTC excluded))			1.4%	1.78%	↓	1.4%	1.78%	1.77%	M		
Net Surplus £000's	Finance	Finance	£6,688	£6,697	↓	£275	£275	£1,144	M		
Normalised Net Surplus £000's			£6,688	£6,697	↓	£275	£275	£1,144	M		
Cash Balance			£13,461	£15,737	↑	£13,461	£15,737	£12,200	M		
Capital expenditure £000's			£6,225	£13,822	↓	£2,293	£334	£437	M	YTD capital spend is £2.4M behind plan. Mainly due to Scanners not yet received.	
Total agency cost £000's			£1,448	£1,098	↑	£167	£97	£100	M		
			£1,467	£1,740	↓	£163	£109	£207	M	Bank used across the Trust due to Maternity leave and sickness, mainly in admin and nursing. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets	
Total bank cost £000's											
Deliver the recurrent cost improvement savings			£ 2,717	£2,436	↓	£ 312	£258	£ 305	M	There are non-recurrent schemes of £142k to offset the recurrent GP underachievement.	