

Council of Governors (in Public) Item 8.1

Subject: Regulatory, Operational and Strategic Performance Dashboard
Date of meeting: Tuesday 5th June 2018
Prepared by: Lucinda Tennent, Information and Performance Manager
Presented by: Tony Wilding, Director of Strategic Partnerships and Chief Operating Officer

1. Executive Summary

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




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




Section 1 - Single Oversight Framework (SOF)

Refer to Appendix 1 - SOF.

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

The following indicators are new exceptions this month:

| Framework | Rating | Exception |
|---------------------------------------|---|--|
| Segmentation |  | Segment 1: Maximum autonomy; universal support |
| Leadership and Improvement Capability |  | |
| Strategic Change |  | |

| | | |
|------------------------------------|---|--|
| Operational Performance |  | Maximum 6 week wait for diagnostic procedures (In month and YTD) |
| Quality - Safe, Effective & Caring |  | Mixed Sex Accommodation (YTD) MRSA Bactremia (YTD) |
| Quality - Organisational Health |  | Staff sickness (in-month & YTD) |

1.1 Operational Performance

1.1.1 Indicator: Maximum 6-week wait for diagnostic procedures

Accountable executive Officer: Tony Wilding

Issue: Currently below target for March 2018 at 84.98% against a target of 99% with a total of 233 breaches; 136 for CT, 95 for MRI, 1 for Sleep Studies and 1 Echocardiography.

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

Anticipated Delivery: We will not achieve compliance at year end. This is because whilst there will be a reduction in CT breaches once the second scanner opens we won't have the MRI capacity until late 2019. We are trying to mitigate this with additional mobile vans and are currently looking at options for long term lease.

1.2 Quality-Safe, Effective and Caring

1.2.1 Indicator: Mixed Sex Accommodation breaches

Accountable Executive Officer: Sue Pemberton

Issue: The Trust has reported 1 breach in August 2017.

Actions: The Trust has achieved much in ensuring prompt discharge following assessment as fit to leave critical care. Effort continues.

Anticipated Delivery: Not applicable as target is nil and this has already been exceeded.

1.2.2 Indicator: MRSA Bacteraemia

Accountable Executive Officer: Raphael Perry

Issue: Referral of MRSA carrying patient from another hospital.

Actions: Improved transfer information across the health economy, and developed policy in line with best practice for venflon insertion.

Anticipated Delivery: Not applicable as target is nil and this has already been exceeded.

1.3 Quality - Organisational Health

1.3.1 Indicator: Staff Sickness

Accountable Executive Officer: Jo Twist

Issue: Sickness is 4.04% YTD and 4.13% in month against a target of 3.4%.

Actions: All staff triggering the sickness policy are reviewed by the Division with HR support; all are being managed as per the policy. Sickness levels are being driven by long term rather than short term sickness.

Anticipated Delivery: Q1 2018/19


Section 2 - Operational Dashboard

Refer to Appendix 2 - Operational Performance Dashboard.

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

- 62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj)

The following indicators are new exceptions this month:

| Framework | Rating | Exception |
|---------------------|---|--|
| Performance Summary |  | <p>Quality: Number of Adverse Events (red alerts), SIs & Never Events (YTD)</p> <p>Performance: Cancelled operations (In month and YTD) Cancelled operations seen in 28-days (YTD) Urgent operations cancelled for a 2nd time (YTD and In month) Delayed Transfers of Care (In month and YTD) NHS Activity (In month and YTD) Private Activity (YTD) NHS Activity (In month and YTD) 18 weeks referral to treatment incomplete pathways 52 week+ (YTD)</p> <p>Local Target: Welsh waiting times: Admitted and incomplete pathways (in month & YTD)</p> <p>Finance: Cash Balance (In month and YTD) Total Bank Cost £000's (In month and YTD)</p> |

1.4 Exceptions

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

Accountable Executive Officer: Mark Jackson

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

1.4.2 Indicator: Cancelled Operations

Accountable Executive Officer: Tony Wilding

Issue: There were a total of 14 reportable cancellations for cardiac surgery in March 2018 meaning the service line was non-compliant at 2.1% against an internal stretch target of 1.5%.

Top three cancellation themes for March 2018 are as follow:

1. Emergencies taking priority
2. Elective list overrun
3. POCCU bed shortage

Number of reportable cancellations has reduced in March compared to previous months. The leading theme for cancellations in March was a high number of emergencies taking priority in which the consultant had to provide surgical cover for the emergency resulting in the cancellation of a scheduled patient.

Elective list overrun has emerged as a second leading theme for cancellations in March. This is due to an increased number of complex procedures being performed e.g. Aortic and complex mitral procedures.

All cancellations have been dated with no 28 day breaches.

Actions: The Surgical Division has implemented a cancellation action plan with aim of reducing the number of reportable cancellations. Furthermore the date and time of scheduling has been moved to enable clinician presence at the meeting. This will support review of listing complex procedures which is aimed at reducing cancellations for list overrun.

As with previous months the Surgical Division continues to share information relating to cancellations with clinicians at monthly business meetings and in other forums such as Divisional Performance to identify methods to reduce cancellations.

Anticipated Delivery: Ongoing

1.4.3 **Indicator: Cancelled operations for non clinical reasons seen in 28-days**

Accountable Executive Officer: Tony Wilding

Issue: A TAVI patient cancelled for an operation on the 23/03/2017 due to no POCCU beds.

Actions: On occasion it is difficult to schedule some procedures due to the nature of the case. TAVI cases can sometimes fall into this category due to the complexity and team required to deliver the service.

Anticipated Delivery: March 2018

1.4.4 **Indicator: Urgent operations cancelled 2nd time**

Accountable Executive Officer: Tony Wilding

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

Actions: The surgical Division continues to monitor the cancellation rate for the cardiac service line and identifies (where possible) cancellations that may have been avoided. The information is shared with consultants and the wider clinical surgical team. Work is also on-going cross-divisionally to address issues relating to the POCCU unit. The patient received surgery on the 23rd February 2018 and was prioritised.

Anticipated Delivery: On-going

1.4.5 **Indicator: Delayed Transfers of Care**

Accountable Executive Officer: Tony Wilding

Issue: Delayed transfers of care are above target for YTD and also for March with a performance of 7.02% against a target of 4.5%. The Trust took an active decision to keep patients longer at LHCH rather than transfer to other hospitals in order support the local health economy over the winter period.

Actions: The Trust continues to work with other organisations to ensure patient discharges are managed as efficiently as possible. A flagging system is in place to identify patients with complex discharge needs which are subsequently managed by the care support team. In addition, the Surgical Division have actioned a new service initiative, Consultant ward round week in July 2017, which will support the management of patient discharges in an efficient and timely manner.

Anticipated Delivery: Ongoing

1.4.6 **Indicator: NHS Activity**

Accountable Executive Officer: Tony Wilding

Issue: YTD = -1.27% and in month -9.9%

Actions: Continued focus on delivery.

Anticipated Delivery: Not applicable.

- 1.4.7 **Indicator: Private Activity**
Accountable Executive Officer: Tony Wilding
Issue: YTD = -0.5% and month 25%
Actions: Continue focus on delivery.
Anticipated Delivery: Not applicable.
- 1.4.8 **Indicator: 18 weeks Referral to Treatment incomplete pathways 52 week+**
Accountable Executive Officer: Tony Wilding
Issue: Email received from Knowsley Community Admin Manager on 27/02/2018 with referral attached dated 14/10/2016, was never previously sent.
Actions: Escalated to divisional managers and consultant 28/02/2018, patient attended outpatient clinic and pathway was closed. Admin error identified and results and referrals tracker are now checked on a daily basis (was previously weekly) and are now emailed to community team for registry on PAS.
Anticipated Delivery: Patient seen in clinic 7th March 2018 and pathway closed.
- 1.4.9 **Indicator: Welsh 26 weeks: Admitted and Incomplete Pathways**
Accountable Executive Officer: Tony Wilding
Issue: 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: Currently working with Welsh commissioners on actions required to deliver compliance.
- 1.4.10 **Indicator: Cash Balance**
Accountable Executive Officer: Claire Wilson
Issue: Cashflow is currently behind the YTD position largely due to the non-payment of the HRG4+ increase by Wales Health Specialised Services Committee (WHSSC).
Actions: CFO has raised and is continuing to press Welsh HRG4+ issue with NHSI who are raising issue as part of a wider debate around funding flows between the English and Welsh Health services. The Trust is expecting an additional allocation of STF funding at the end of the year which will support the current cash position, however, the value of this is unknown at the time of writing the report.
Anticipated Delivery: The Financial year deadline / delivery date is 31/3/18.
- 1.4.11 **Indicator: Total Bank Cost £000's**
Accountable Executive Officer: Claire Wilson
Issue: Bank used across the Trust due to Maternity leave and sickness, mainly in admin and nursing. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets.
Actions: The Workforce utilisation group chaired by the Director of HR reviews the level of Bank staff used within the trust and looks at other options available.
Anticipated Delivery: On-going – Monthly meeting






Section 3 - Strategic Dashboard

Refer to Appendix 3 to 7 – Strategic Dashboard

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

- Observed Mortality Rate

The following indicators are new exceptions this month:

| Framework | Rating | Exception |
|--|---|---|
| Quality & Experience |  | Mortality screening within 7 days (in month & YTD). Observed mortality rate % Blood Cultures taken within 24 hours preceding first antibiotic given (In month) % of radiological alerts with a response document (in month & YTD) |
| Service Delivery, Research & Innovation |  | Maximum 6-week wait for diagnostic procedures(In month and YTD) Achieve recruitment on 100K genome project - rare diseases (In month) Number of patients recruited into CRN trials (In Month and YTD) |
| Financial Sustainability - Value for Money |  | Deliver the recurrent cost improvement savings (YTD) |
| Be the Best NHS Employer |  | |
| Partnership & Collaborative Working |  | |

2.1 Quality & Experience

The strategic objective measures for Quality and Experience are provided in Appendix 3.

2.1.1 Indicator: Mortality screening within 7 days

Accountable Executive Officer: Raphael Perry

Issue: Screening of deaths within 7-days is 67% in month and within range, however, and YTD is still below target at 67% against 95%.

Actions: The new mortality review policy has been introduced in September 2017. There is new national guidance on Learning from Deaths which has implications for how organisational learning is identified and implemented. There have been more deaths this year since the target was set. Currently at 215 YTD against a comparison of 184 for the whole of 2016/17.

Anticipated Delivery: Q2 2018/19

2.1.2 Indicator: Observed Mortality Rate

Accountable Executive Officer: Raphael Perry

Issue: Observed mortality rate is above the target of 1.3% at 1.95% for March and 1.62% for YTD. There have been an increased number of deaths through 2017/18 and the spike in November has persisted though January. This is as a result of a change in policy for managing OHCA patients through the PPCI pathway and increasing acuity of surgical patients. There is close scrutiny of all deaths and no increase of avoidable deaths.

Actions: A deep dive into mortality is underway.

Anticipated Delivery: Q2 2018/19

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

Accountable Executive Officer: Raphael Perry

Issue: For March there has been 6 out of 11 bundles completed resulting in 55% against a 95% target. Work continues to improve compliance with the new sepsis screening process and results are improving; however, we remain under target. Additionally, since the introduction of screening, not all patients are managed via the sepsis bundle, as some are treated within other pathways.

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

Anticipated Delivery: Q4 2017/18.

2.1.4 **Indicator: % of radiological alerts with a response document**

Accountable Executive Officer: Raphael Perry

Issue: This is a new indicator introduced to provide visibility on a key organisational risk. It measures completion of the actions in response to a secure health messaging alert raised against a suspicious radiological finding.

Actions: Divisions have been provided with the information at individual requester level which identifies non-compliance with the process. They are supporting colleagues to create the radiological alert document that provides the assurance that the alert has been responded to. Performance has improved but we are still not achieving the standards for the year and so this is being given priority focus within the divisions.

Anticipated Delivery: March 2018.

2.2 **Service Delivery, Research & Innovation**

The strategic objective measures for Service Delivery, Research & Innovation are provided in Appendix 4.

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

Accountable Executive Officer: Mark Jackson

Issue: Rare Diseases is currently at 6 for March 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 108 behind target YTD.

Actions: The Trust has negotiated a transfer of 900 for 2018/19 which fits better with anticipated recruitment from our portfolio of intervention trials.

Anticipated Delivery: Q1 2018/19.

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 £449k to offset the recurrent CIP underachievement.

Actions: Operational delivery of the CIP plan is being overseen through the Business Transformation Steering Group, chaired by the Chief Finance Officer. The Directorates have been tasked to reduce or mitigate this gap.

Anticipated Delivery: The Financial year deadline / delivery date is 31/3/18.

2.4 **Be the Best NHS Employer**

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

2.5 Partnership & Collaborative Working

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

3 Conclusion

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

4 Recommendations

The Council of Governors are asked to note Trust performance and associated exception and action reports.

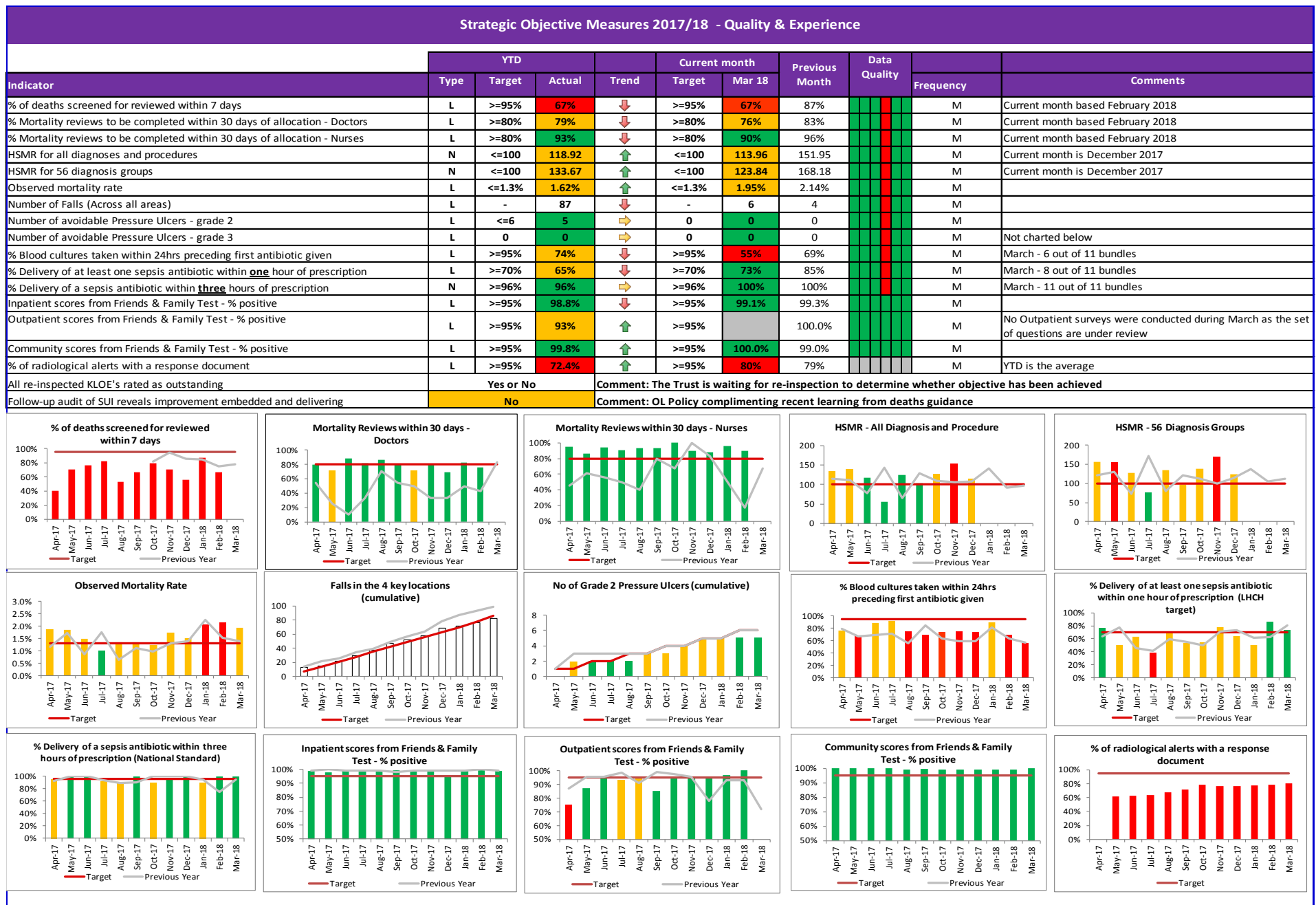
Appendix 1 - Single Oversight Framework

| Single Oversight Framework (SOF) | | | | | | | | | | | | | |
|---|---|--|---|-------------------|---------------|---------|----------------|--------------|-----------|--|--|---------------|---------|
| | Reviews | Rating | Comment | | | | | | | | | | Concern |
| Leadership and Improvement Capability | Well Led Reviews - CQC Well Led Assessments | | CQC review published September 2016 rated Well-led Domain as 'Outstanding' | | | | | | | | | | |
| | Well Led Reviews - NHSI Code of Governance | | MIAA review published March 2017 concluding the Trust is well led with no significant concerns. | | | | | | | | | | |
| | Third Party Information - Healthwatch, MP's, Whistleblowers, Coroners' Reports, CQC Warnings, Other Material Concerns | | | | | | | | | | | | |
| Strategic Change | Review of sustainability and transformation plans and other relevant matters | | LHCH is lead for CVD cross-cutting theme | | | | | | | | | | |
| | Indicator | Target | YTD | Performance Trend | Current month | | Previous Month | Data Quality | Frequency | Comments | | Red Indicator | |
| | | | | | Target | Mar 18 | | | | | | | |
| Operational Performance | Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway | >=92% | 92.08% | ↑ | >=92% | 92.08% | 92.04% | | M | | | | |
| | All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer | >=85% | 96.94% | ↑ | >=85% | 100.00% | 93% | | M | Adjusted figure provided | | | |
| | Maximum 6-week wait for diagnostic procedures | >=99% | 98.55% | ↓ | >=99% | 84.98% | 95.54% | | M | | | | |
| | Dementia - Find | 90% | 98.12% | ↑ | 90% | 96.67% | 92.59% | | M | Awaiting validations | | | |
| | Dementia - Assess | 90% | 99% | ↓ | 90% | 85.71% | 100.00% | | M | Awaiting validations | | | |
| | Dementia - Refer | 90% | 100% | ↑ | 90% | 100% | 100.00% | | M | | | | |
| Quality - Safe, Effective & Caring | Written Complaints - rate | 67 | 46 | ↓ | 6 | 3 | 1 | | M | Awaiting national technical guidance | | Y | |
| | Occurrence of any Never Events | 0 | 0 | ↑ | 0 | 0 | 0 | | M | | | | |
| | NHS England/NHS Improvement Patient Safety Alerts outstanding | 0 | 0 | ↑ | 0 | 0 | 0 | | M | | | | |
| | Mixed Sex Accommodation breaches | 0 | 1 | ↑ | 0 | 0 | 0 | | M | | | Y | |
| | VTE Risk Assessment | >=95% | 97.1% | ↑ | >=95% | 96.83% | 96.38% | | M | | | | |
| | Clostridium Difficile | 4 | 1 | ↑ | 1 | 0 | 0 | | M | Due to lapses in care | | | |
| | Clostridium Difficile infection rate (per 1000 beddays) | <=0.19 | 0.02 | ↑ | <=0.19 | 0.00 | 0.00 | | M | | | | |
| | MRSA bacteraemias | 0 | 1 | ↑ | 0 | 0 | 0 | | M | | | Y | |
| | eColi (LHCH Acquired) | 8 | 7 | ↑ | 1 | 0 | 0 | | M | Plan based on 2016/17 | | | |
| | MSSA Bacteraemias (LHCH Attributable) | N/A | 8 | ↑ | N/A | 0 | 0 | | M | MSSA reported on Elm Ward | | | |
| | HSMR for all diagnosis (supplied from Dr Foster) | <=100 | 118.92 | ↑ | <=100 | 113.96 | 151.95 | | M | Current month is December 2017 | | | |
| | HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide) | <=100 | 133.67 | ↑ | <=100 | 123.84 | 168.18 | | M | Current month is December 2017 | | Y | |
| | Potential under reporting of patient safety incidents | <3 | 2 | ↑ | <3 | 2 | 2 | | 6M | NRLS Report April - September 2017 (3 = poor) | | Y | |
| | Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival) | >=90% | 100% | ↑ | >=90% | | | | 6M | September 2016 Survey | | | |
| | Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission) | >=90% | 100% | ↑ | >=90% | | | | 6M | September 2016 Survey | | | |
| | Std 5: 7-day Services: CT scan within 1 hr for critical care need | >=70% | 100% | ↑ | >=70% | | | | 6M | September 2016 Survey | | | |
| | Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need | >=80% | 100% | ↑ | >=80% | | | | 6M | September 2016 Survey | | | |
| | Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need | >=85% | 100% | ↑ | >=85% | | | | 6M | September 2016 Survey | | | |
| | Std 6: 7-day Services: Access to interventions | >=80% | 100% | ↑ | >=80% | | | | 6M | September 2016 Survey | | | |
| | Std 8: 7-day Services: Ongoing review twice daily in high dependency area | >=80% | 96% | ↑ | >=80% | | | | 6M | September 2016 Survey | | | |
| | Std 8: 7-day Services: Ongoing review every 24 hours on general wards | >=80% | 98% | ↑ | >=80% | | | | 6M | September 2016 Survey | | | |
| | Staff Friends and Family - recommend as a place of treatment | >=94% | 93% | ↓ | >=94% | 93% | 95% | | Q | Q3 2016 Staff Survey Data | | | |
| | Inpatient scores from Friends & Family Test - % positive | >=95% | 98.8% | ↓ | >=95% | 99.1% | 99.3% | | M | | | | |
| | Community scores from Friends & Family Test - % positive | >=95% | 99.8% | ↑ | >=95% | 100.0% | 99.0% | | M | | | | |
| Quality - Organisational Health | Staff Sickness | <=3.4% | 4.04% | ↓ | <=3.4% | 4.13% | 3.96% | | M | | | Y | |
| | Proportion of temporary Staff | <=5% | 5.27% | ↑ | <=5% | 4.96% | 5.38% | | M | | | | |
| | Staff Turnover | <=10% | 13.4% | ↓ | <=10% | 13.4% | 12.6% | | M | Turnover based on 'All' Leavers in 12 month period | | | |
| | Executive Team Turnover | <=25% | 0.0% | ↑ | <=25% | 0.0% | 0.0% | | M | Calculation: Leavers in 12 month period / Average Staff in Post in 12 month period x 100 // NB excludes Raph Perry who left on Flexi Retirement but returned Feb and Mar data is Quarterly for "NHS Staff Survey - recommend as a place to work" and "Staff Friends and Family - recommend as a place of treatment" and therefore same for Mar and Feb | | | |
| | NHS Staff Survey - recommend as a place to work | >=76% | 74% | ↑ | >=76% | 74% | 73% | | Q | Q3 2016 Staff Survey Data - Previous Period Q3 2015 | | | |
| Finance | Capital service cover | 1 | 1 | ↑ | 1 | 1 | 1 | | M | Trigger: Poor levels of overall financial performance (average score of 3 or 4) very poor performance (score of 4) in any individual metric Potential value for money concerns | | | |
| | liquidity | 3 | 2 | ↑ | 1 | 2 | 2 | | M | | | | |
| | Efficiency | | | | | | | | | | | | |
| | I&E margin | 1 | 1 | ↑ | 1 | 1 | 1 | | M | | | | |
| | Controls | | | | | | | | | | | | |
| | Performance against plan | 1 | 2 | ↑ | 1 | 2 | 2 | | M | | | | |
| | Agency spend | 1 | 1 | ↑ | 1 | 1 | 1 | | M | | | | |
| | Overall Financial Performance | | | | | | | | | | | | |
| | Overall use of resources rating | 1 | 1 | ↑ | 1 | 1 | 1 | | M | | | | |
| | Value for money information | | | | | | | | | | | | |
| NCBC Benchmarking Data, Meridian Review, Back Office Review, Pathology Review | | Comment: NCBC Benchmarking undertaken and conference held on 26/17th February, GIRFT results under review, Corporate Benchmarking complete and reported separately to BTSG | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| Aggressive cost reduction plans - Cost reduction strategy delivered £m | | 3,720 | 3,061 | ↓ | 323 | 232 | 288 | | M | There are non-recurring schemes of £449k to offset the recurrent CIP underachievement. | | Y | |
| Control total acceptance | | Yes | | | | | | | | | | | |
| Overall | Segmentation | | | | | | | | Adhoc | Segment 1: Maximum autonomy; universal support | | | |

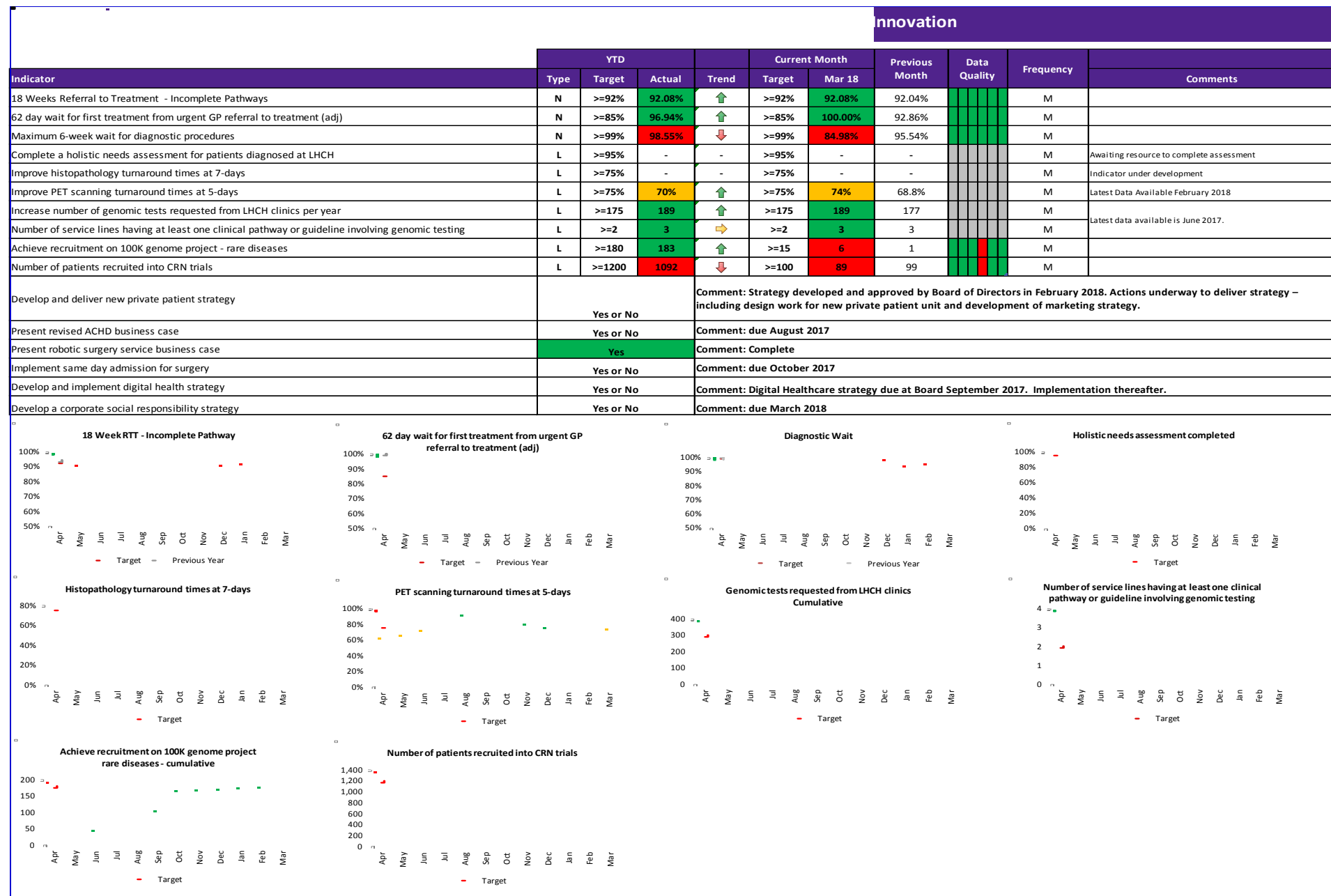
Appendix 2 – Operational Performance Dashboard

| Performance Report Summary 2017/18 | | | | | | | | | | | |
|------------------------------------|---|--------|---------|-------------------|---------------|---------|----------------|--------------|-----------|---|-----------|
| | Indicator | Target | Actual | Performance Trend | Current month | | Previous Month | Data Quality | Frequency | Comments | Exception |
| | | | YTD | | Target | Mar 18 | | | | | |
| Quality | Friends and family Test response rate - Inpatients | >=50% | 50% | ↓ | >=50% | 70.32% | 72.12% | ✓ | M | | |
| | VTE Prophylaxis | >=95% | 98.17% | ↑ | >=95% | 98.76% | 97.62% | ✓ | M | | |
| | Number of in-hospital deaths | N/A | 215 | → | N/A | 21 | 21 | ✓ | M | | |
| | Risk adjusted CABG mortality | <=1 | 0.95 | ↓ | <=1 | 0.93 | 1.00 | ✓ | M | 6-month rolling averages; latest due up to September 2017 | |
| | Risk adjusted non-primary PCI MACE | <=1 | 0.55 | → | <=1 | 0.55 | 0.55 | ✓ | M | 6-month rolling averages; latest data up to September 2017 | |
| | Number of Adverse Events (red alerts), SIs & Never Events | 0 | 3 | → | 0 | 0 | 0 | ✓ | M | 2 SI (April and August) and 1 adverse Event (January) reported | Y |
| | Number of Reported Patient Safety Incidents (6-month rolling avg) | - | 1749 | ↓ | - | 120 | 113 | ✓ | M | | |
| Performance | Cancelled operations | <=1.5% | 2.4% | ↓ | <=1.5% | 2.1% | 4.5% | ✓ | M | Internal Target | |
| | Cancelled operations seen in 28-days | 100% | 98.9% | → | 100% | 100% | 100% | ✓ | M | 2 Operation not re-booked within 28 days of cancellation | Y |
| | Urgent operations cancelled 2nd time | 0 | 4 | → | 0 | 1 | 1 | ✓ | M | | |
| | Delayed transfers of care | <=4.5% | 5.79% | ↓ | <=4.5% | 7.02% | 4.96% | ✓ | M | | Y |
| | Bed occupancy | >=85% | 83.24% | ↑ | >=85% | 83.55% | 82.39% | ✓ | M | | |
| | Referrals - GP | 20,184 | 20,745 | ↑ | 1,682 | 1,734 | 1,718 | ✓ | M | Community Referrals removed | Y |
| | Referrals - DGH (External) | 10,020 | 10,053 | ↑ | 835 | 887 | 802 | ✓ | M | Community Referrals removed | |
| | Referrals - Other | 9,048 | 10,988 | ↓ | 754 | 824 | 987 | ✓ | M | Updated to include Internal Referrals (community referrals removed) | |
| | Activity - NHS | 0% | -1.27% | ↑ | 0% | -9.9% | -10.7% | ✓ | M | | Y |
| | Activity - Private | 0% | -0.50% | ↑ | 0% | 25.0% | -6.1% | ✓ | M | | |
| | 18 Weeks Referral to Treatment Incomplete Pathways 52 week + | 0 | 1 | ↑ | 0 | 0 | 1 | ✓ | M | | |
| | 14 day wait from referral to date first seen | >=93% | 99.50% | → | >=93% | 100.00% | 100.00% | ✓ | M | | |
| | 31 day wait from diagnosis to first treatment | >=96% | 99.41% | ↑ | >=96% | 100.00% | 96.67% | ✓ | M | | |
| | 31 day wait for second or subsequent treatment (surgery) | >=94% | 98.70% | → | >=94% | 100.00% | 100.00% | ✓ | M | | |
| | 62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj) | >=85% | 88.46% | ↓ | >=85% | 100.00% | 83.33% | ✓ | M | | Y |
| Local Target | 26 Weeks Referral to Treatment in aggregate - Admitted Pathways | >=95% | 89.66% | ↑ | >=95% | 89.66% | 89.16% | ✓ | M | | Y |
| | 26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways | >=98% | 100.00% | ↑ | >=98% | 100.00% | 92.75% | ✓ | M | | Y |
| | 26 Weeks Referral to Treatment in aggregate - Incomplete Pathways | >=95% | 92.48% | ↓ | >=95% | 92.48% | 93.65% | ✓ | M | | Y |
| Workforce | Appraisals | >=90% | 90% | ↑ | >=90% | 90% | 88% | ✓ | M | Data shown is for Sept 17 end of Appraisal Window | Y |
| | Mandatory training | >=95% | 94% | → | >=95% | 94% | 94% | ✓ | M | | |
| | Turnover Rate between 1-2 yrs service (voluntary/FTC excluded) | <=1.4% | 1.49% | ↓ | <=1.4% | 1.49% | 1.28% | ✓ | M | YTD is 12 month period | |
| Finance | Net Surplus £000's | 6,863 | 9,288 | ↑ | 1,358 | 3,742 | 908 | ✓ | M | Include reversal of previous years impairment of £2,367k | |
| | Normalised Net Surplus £000's | 6,863 | 6,921 | ↑ | 1,358 | 1,375 | 908 | ✓ | M | The trust also achieved the control total of £6867k, by £8k | |
| | Cash Balance | 9,368 | 7,465 | ↑ | 138 | 594 | -710 | ✓ | M | Cashflow is currently behind the YTD position largely due to the non-payment of the HRG4+ increase by Wales Health Specialised Services Committee (WHSSC). | Y |
| | Capital expenditure £000's | -5,411 | -5,979 | → | -375 | -1,362 | -1,042 | ✓ | M | Actual greater than plan due to the additional external Capital Income for Cyber security | |
| | Total agency cost £000's | -2,250 | -1,482 | ↑ | -188 | 189 | -129 | ✓ | M | Agency Costs have reduced in month due to previous years Agency Purchase Orders being finally closed down | |
| | Total bank cost £000's | -682 | -2,106 | ↓ | -58 | -155 | -217 | ✓ | M | Bank used across the Trust due to Maternity leave and sickness, mainly in admin and nursing. As the Bank rates are higher than Agenda for Change rates, this creates a financial pressure on ward budgets | Y |

Appendix 3 – Strategic Dashboard: Quality & Experience



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



Appendix 4 – Strategic Dashboard – Financial Sustainability delivering value for money

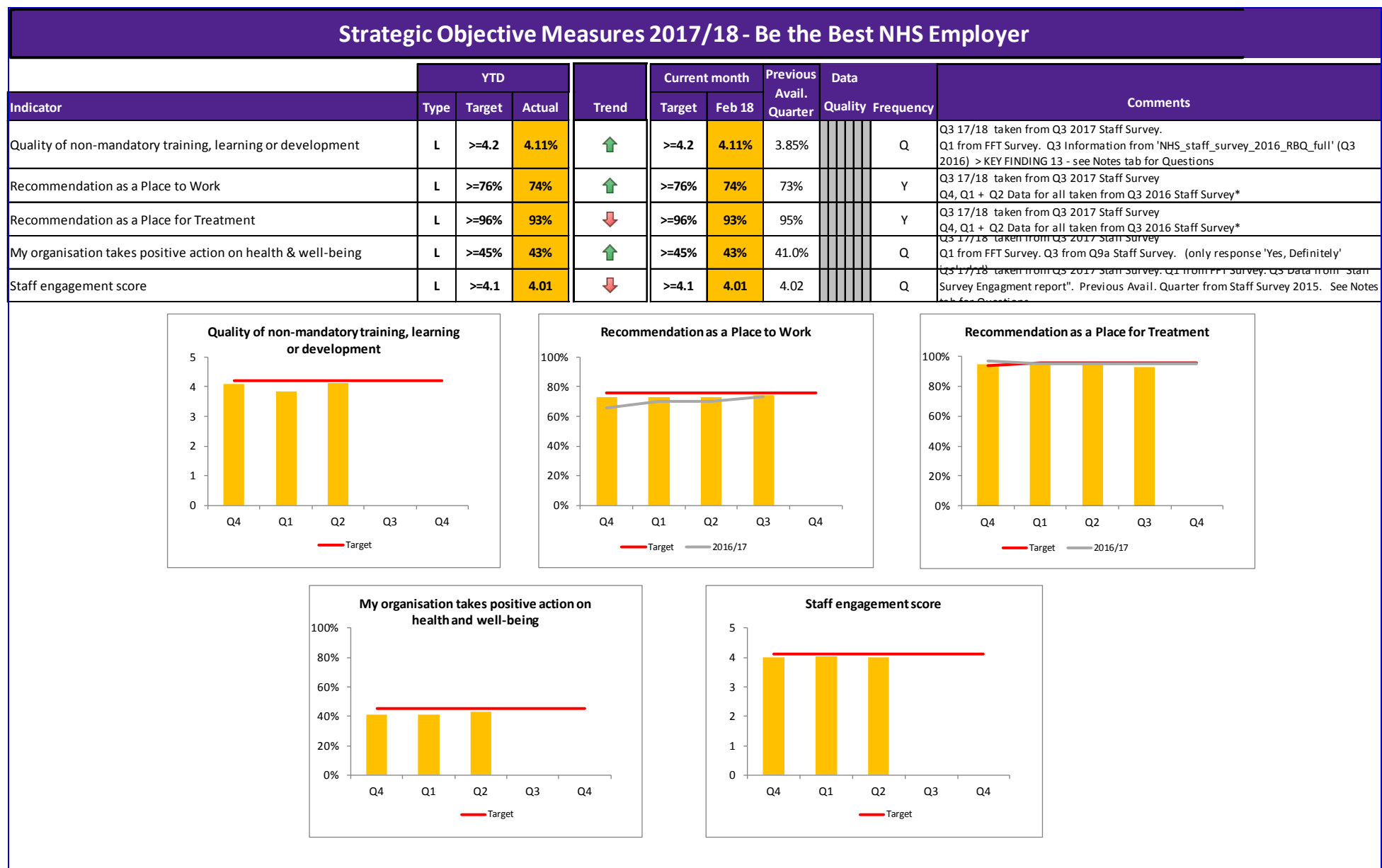
| Strategic Objective Measures 2017/18 - Financial Sustainability Delivering Value for Money | | | | | | | | | | |
|--|-----------|--------|---|---------------|--------|----------------|--|-----------|--|--|
| | YTD | | Trend | Current month | | Previous Month | Data Quality | Frequency | Comments | |
| Indicator | Plan | Actual | | Plan | Mar 18 | | | | | |
| Overall use of resources rating | 1 | 1 | ➡ | 1 | 1 | 1 | <div><div></div><div></div><div></div><div></div><div></div></div> | M | | |
| Deliver the recurrent cost improvement savings | £3,720 | £3,061 | ⬇ | £323 | £232 | £288 | <div><div></div><div></div><div></div><div></div><div></div></div> | M | There are non-recurring schemes of £449k to offset the recurrent CIP underachievement. | |
| Agency rating | 1 | 1 | ➡ | 1 | 1 | 1 | <div><div></div><div></div><div></div><div></div><div></div></div> | M | Continued use of Agency; £1.482m against a ceiling of £2.250m | |
| Liquidity rating | 1 | 2 | ➡ | 1 | 2 | 2 | <div><div></div><div></div><div></div><div></div><div></div></div> | M | | |
| Implement model hospital dashboard | Yes or No | | Comment: March 18 | | | | | | | |
| Develop Service Line Reporting | Yes or No | | Comment: SLR for 2016/17 is available on Qlikview, Reference Costs 2016/17 submitted. Meetings held during October and November with DHOs, Finance Business Partners and Clinical Leads to discuss outputs and action plans for improvement. | | | | | | | |
| Implement service line reporting plan | Yes or No | | Comment: March 2018 (key milestone reference costs August 2017) | | | | | | | |

Recurrent cost improvement savings £000's (cumulative)

| Month | Savings (£000's) |
|-------|------------------|
| Apr | 100 |
| May | 200 |
| Jun | 300 |
| Jul | 400 |
| Aug | 500 |
| Sep | 600 |
| Oct | 700 |
| Nov | 800 |
| Dec | 900 |
| Jan | 1000 |
| Feb | 1100 |
| Mar | 1200 |

Overall Financial Performance:

The overall financial position for M12 is a surplus of £6.921m, against a planned surplus of £6.863m, showing a favourable variance of £58k. The variance is partially related to additional income received for donated assets, which does not affect the STF monies. The trust achieved it's control total to recieved £2.554m STFmoney. (Planned surplus £6.867, against an actual surplus of £6.875).



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 | Q4 | | | | |
| Media impact metric | L | 54 | 69 | - | 54 | 69 | 38 | | Q | |
| Fundraising impact metric | L | 500 | 963 | - | 122 | 196 | 292 | | Q | |
| Address issues arising from the externally facing element of the well led review | Yes | | | Comment: There were no significant findings from this review. | | | | | | |
| Implement CVD STP Plan | Yes | | | Comment: The CVD programme in the C&M STP has delivered in Q4: <ul style="list-style-type: none"> • Patient Reference Group established and programme of meetings set up; first meeting of the group took place in February with the presentation of the primary pacing case. • All remaining cases for change presented to the Programme Board: Smoking, and Stroke in January; HF and Atrial Fibrillation in February; Sugar, Lipids, Cardiac Rehabilitation and ACS in March. • All prevention cases shared with the Prevention at Scale programme of the C&M Partnership led by Jon Develing. • Stroke case for change shared with the Acute Sustainability Programme Board in February. • Stroke complex rehabilitation workshop took place in March with partners from the Neuro network and other organisations from C&M. | | | | | | |

