

Council of Governors (in Public)

Item 7.1

Subject: Board Dashboards - Regulatory, Operational and Strategic Performance
Date of meeting: 4th December 2017
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 30th September 2017. The report is divided into the following three sections:

- Section 1 - Single Oversight Framework (SOF): This section comprises 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 - Strategic Dashboard: These are our internal indicators which were agreed with the Board in April 2017 for routine monitoring of performance.
- Section 3 - Operational Dashboard: This reports on the indicators agreed by the Board of Directors (BoD) in April 2017 which monitor the in-year milestones for each of our 5 Strategic Objectives.

2. Regulatory Performance

2.1 Section one – Single Oversight Framework








Refer to Appendix one – Single Oversight Framework.

Executive Summary

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

- Complaints

There are no new exceptions this month.

Framework	Rating	Exception
Segmentation		Segment 1: Maximum autonomy; universal support
Leadership and Improvement Capability		
Strategic Change		
Operational Performance		
Quality - Safe, Effective & Caring		Mixed Sex Accommodation (YTD) MRSA Bactremia (YTD) Potential under reporting of patient safety incidents (in-month and YTD)
Quality - Organisational Health		Staff sickness (in-month & YTD)
Finance		Refer to Finance Report

2.2 Segmentation

Nothing to report.

2.3 Leadership & Improvement Capability

Nothing to report.

2.4 Strategic Change

Nothing to report.

2.5 Operational Performance

Nothing to report.

2.6 Quality - Safe, Effective and Caring

2.6.1 Indicator: Mixed Sex Accommodation breaches

Accountable Executive Officer: Sue Pemberton

Issue: The Trust has reported 1 breach in August 2017, there were no breaches reported in September 2017.

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

Anticipated Delivery: Ongoing through the year.

2.6.2 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.

2.6.3 Indicator: Potential Under Reporting of Patient Safety Incidents

Accountable Executive Officer: Mark Jackson

Issue: The latest available NRLS Report covering the period April to September 2016 has rated the Trust as level 3 (poor) for potential under reporting of patient safety incidents.

Actions: Continued focus on the importance of incident reporting in safety huddle and at team brief. The Risk and Safety Lead has met with lower reporting departments to discuss the importance of incident/near miss reporting by all staff and the definitions of what constitutes an incident/near miss. These meetings will continue in order to encourage staff to report. In addition, the Information team are developing a dashboard so that wards can easily see the rate of incident reporting vs near miss reporting. Meetings are taking place with the Managers in the corporate division to highlight the need for better incident reporting. Although, staff in the corporate division will often report incidents and it will be managed in the area where the incident has happened, which gives the impression that teams in the corporate division are not reporting as highly as other teams. The Learning from Deaths initiative is being implemented across Trusts which should provide a platform for increased reporting. LHCH has a policy to support the actioning and closing of incidents in a 28 day timeframe. This is monitored via Divisional Governance meetings monthly, with all staff that have incidents open being reported within the committee. To assist the Divisions in the closure of incidents, the Risk Team now provide a weekly report to the Divisional Heads of Operations which details the incident handlers who have incidents open over 28 days. This is resulting in improvement. The Executive Team, along with the Divisions have developed an incentivised accountability framework which will include incident reporting as a KPI.

Anticipated Delivery: End of Q3 2017/18.

2.7 Quality - Organisational Health

2.7.1 Indicator: Staff Sickness

Accountable Executive Officer: Jo Twist

Issue: Sickness is 3.94% 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.

2.8 Finance

Refer to Finance report for exceptions.

3. Section two – Strategic Dashboard


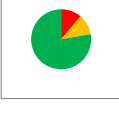

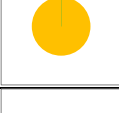
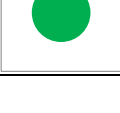
Refer to appendix two.

Executive Summary

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

- Recruitment to 100k genome project

There are no new exceptions this month.

Framework	Rating	Exception
Quality & Experience		Mortality screening within 7 days (in month & YTD) Number of Falls - 4 key locations: Birch, Cedar, Elm and Oak (in month and YTD) Sepsis - Blood cultures taken within 24hrs preceding first antibiotic given (in month) Outpatient scores from Friends & Family Test (in Month and YTD) % of radiological alerts with a response document (in month & YTD)
Service Delivery, Research & Innovation		PET scanning turnaround times at 5-days (in month) Number of patients recruited into CRN trials (YTD)
Financial Sustainability - Value for Money		Refer to Finance Report
Be the Best NHS Employer		
Partnership & Collaborative Working		

3.1 Quality & Experience

The strategic objective measures for quality and experience are provided in Appendix two.

3.1.1 Indicator: Mortality screening within 7 days

Accountable Executive Officer: Raphael Perry

Issue: Screening of deaths within 7-days is 53% in month and 63% 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.

3.1.2 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 increase number in 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.

Anticipated Delivery: End of 2017/18.

3.1.3 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, compliance remains 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.

3.1.4 Indicator: Outpatient scores from Friends & Family Test

Accountable Executive Officer: Sue Pemberton

Issue: 88% 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.

3.1.5 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.

3.2 Service Delivery, Research & Innovation

The strategic objective measures for Service Delivery, Research & Innovation are provided in Appendix 2a.

3.2.1 Indicator: PET scanning turnaround times at 5-days

Accountable Executive Officer: Hayley Kendall

Issue: September is currently 62% against a 75% target and 65% YTD.

Actions: There are ongoing discussions across Cheshire and Merseyside with regards to the current provide of PET scans, a contract that was placed regionally. Current waiting

times are higher than required and the trust is working with NHS Specialised Commissioning and CCG to negotiate with the provider for improved access times.

Anticipated Delivery: Review in Q3 2017/18

3.2.2 **Indicator: Number of patients recruited into CRN trials**

Accountable Executive Officer: Mark Jackson

Issue: Recruitment into CRN trials is 12 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 improved the trend.

Anticipated Delivery: Q3 2017/18.

3.3 **Financial Sustainability - Delivering Value for Money**

Refer to Finance Report and Appendix 2b.

3.4 **Be the Best NHS Employer**

The strategic objective measures are provided in Appendix 2c.

3.5 **Partnership & Collaborative Working**

The strategic objective measures are provided in Appendix 2d.

4. **Section 3 – Operational Dashboard**

Refer to Appendix three - Operational Performance Summary.


Executive Summary

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

- VTE Prophylaxis;
- DGH Referrals;
- 62 day wait for treatment from urgent GP referral – Consultant upgrade (adjusted); and
- Appraisals

The following indicators are new exceptions this month:

- Friends & Family Test response rate - inpatients;
- Private Activity; and
- Turnover rate between 1-2 years service

Framework	Rating	Exception
Performance Summary		<p>Quality: Friends & Family Test response rate - inpatients (in month) Number of Adverse Events (red alerts), SIs & Never Events (YTD)</p> <p>Performance: Cancelled operations (in month) Cancelled operations seen in 28-days (YTD) Delayed Transfers of Care (YTD) GP Referrals (in month and YTD) NHS Activity (in month and YTD) Private Activity (in month and YTD)</p> <p>Local Target: Welsh waiting times (in month & YTD)</p> <p>Workforce: Turnover Rate between 1-2 yrs service (voluntary, FTC excluded)</p> <p>Finance: Refer to Finance Report</p>

4.1 Exceptions

4.1.1 Indicator: Friends & Family Test response rate - inpatients

Accountable Executive Officer: Sue Pemberton

Issue: For September 2017 the friends and family test response for inpatients has decreased to 38.94% against a target of 50%.

Actions: There has 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.

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

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

Accountable Executive Officer: Mark Jackson

Issue: Serious incidents reported in April and August 2017.

Actions: The incident investigations are underway with Divisional Heads of Operations in Medicine, Clinical Services and Surgery.

Anticipated Delivery: End of Quarter 3 2017/18.

4.1.3 Indicator: Cancelled operations

Accountable Executive Officer: Tony Wilding

Issue: For September 2017 the Surgical Division had a significant increase in the number of reportable cancellations, 17 in total compared to the same time period in the last financial year 2016/17, 4 reportable cancellations in total. The main cancellation theme apparent for September was emergencies taking priority. LHCH received a higher than normal number of emergencies specific to the Aortic Team – Dissections that were required surgery overnight and involved the emergency on-call team. The knock on effect of this was the loss of anaesthetic cover the following day resulting in reportable cancellations. List overruns were largely due to complications with the first patient listed resulting in the second case not being able to proceed. For surgeon unavailable one cancellation was due to a surgeon being unwell and the following two cancellations were due to the fact that the same surgeon had to

cancel his list for the following day in the event that they were still not fit to work. All reportable cancellations have been dated to avoid breaching the 28 day cancellation standard.

Four urgent patients were cancelled in September for the following reasons in order of leading cause:

1. Urgent emergency took priority
2. Urgent other – delayed transfer
3. Urgent bed shortage CCA

No urgent patients were cancelled for a second time in September and all patients have now had surgery.

There were a total of ten non-reportable cancellations for September for the following reasons in order of leading cause:

1. Six were due to clinical cancellations i.e. patients not fit for surgery.
2. Three were due to emergencies taking priority
3. Elective bed shortage on CCA was responsible for on non-reportable cancellation.

Actions: This failure is historical and the learning from the incident has now been embedded into operational policy.

Anticipated Delivery: May 2017 - Delivered.

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

Accountable Executive Officer: Tony Wilding

Issue: A TAVI patient cancelled for 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.

4.1.5 **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.

4.1.6 **Indicator: GP Referrals**

Accountable Executive Officer: Tony Wilding

Issue: GP referrals YTD is 13,242 against target of 14,172 – 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.

4.1.7 **Indicator: NHS Activity**

Accountable Executive Officer: Tony Wilding

Issue: YTD = -0.86%.

Actions: Continued focus on delivery.

Anticipated Delivery: Not applicable.

4.1.8 Indicator: Private Activity

Accountable Executive Officer: Tony Wilding

Issue: YTD = -5.60%.

Actions: Continued focus on delivery.

Anticipated Delivery: Not applicable.

4.1.9 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.

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

Accountable Executive Officer: Joanne Twist

Issue: Turnover Rate is 1.88% 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 arranged with staff approaching 12-18 months service and First Impressions Focus Groups to try and capture any issues early on.

Anticipated Delivery: On-Going monitoring and management

5. 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.

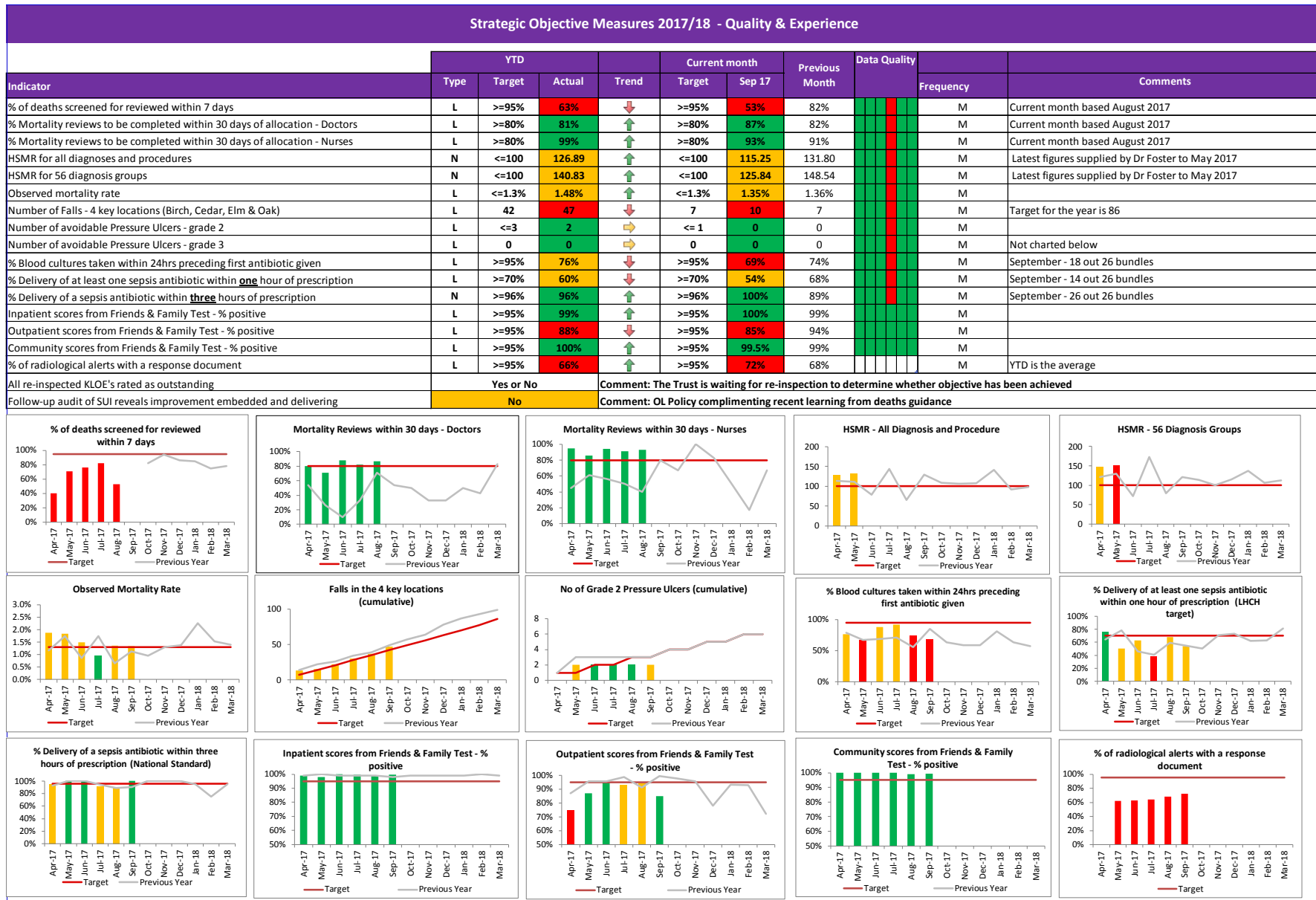
6. Recommendations

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

Section 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	Sep 17									
Operational Performance	Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	>=92%	92.19%	↓	>=92%	92.19%	92.37%			M					
	All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	98.70%	↑	>=85%	100.00%	94.44%			M	Adjusted figure provided				
	Maximum 6-week wait for diagnostic procedures	>=99%	99.87%	↑	>=99%	99.92%	99.74%			M					
Quality - Safe, Effective & Caring	Written Complaints - rate	36	29	↑	7	4	11			M	Awaiting national technical guidance	Y			
	Occurrence of any Never Events	0	1	→	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	1			M		Y			
	VTE Risk Assessment	>=95%	97.2%	↓	>=95%	97.4%	97.7%			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	126.89	↑	<=100	115.25	131.80			M	Current month is June 17				
	HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide)	<=100	140.83	↑	<=100	125.84	148.54			M	Current month is June 17	Y			
	Hospital Standardised Mortality Ratio - Weekend (DFI)	<=100	149.63	↑	<=100	107.38	218.94			M	Current month is June 17	Y			
	Potential under reporting of patient safety incidents	<3	3	→	<3	3	3			6M	NRLS Report April - September 2016 (3 = poor)	Y			
	Emergency readmissions following elective admission	<=100	97.75	↓	<=100	96.17	88.08			M	Current month is March 2017				
	Emergency readmissions following non-elective admission	<=100	96.77	↑	<=100	79.71	110.18			M	Current month is March 2017				
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	>=90%	100%	→	>=90%		100%			6M	September 2016 Survey				
	Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission)	>=90%	100%	↑	>=90%		100%			6M	September 2016 Survey				
	Std 5: 7-day Services: CT scan within 1 hr for critical care need	>=70%	100%	→	>70%		100%			6M	September 2016 Survey				
	Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need	>=80%	100%	→	>=80%		100%			6M	September 2016 Survey				
	Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need	>=85%	100%	→	>=85%		100%			6M	September 2016 Survey				
	Std 6: 7-day Services: Access to interventions	>=80%	100%	→	>=80%		100%			6M	September 2016 Survey				
	Std 8: 7-day Services: Ongoing review twice daily in high dependency area	>=80%	96%	↑	>=80%		96%			6M	September 2016 Survey				
	Std 8: 7-day Services: Ongoing review every 24 hours on general wards	>=80%	98%	↑	>=80%		98%			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%	↑	>=95%	100%	99%			M					
	Community scores from Friends & Family Test - % positive	>=95%	100%	↑	>=95%	99.5%	99%			M					
Quality - Organisational Health	Staff Sickness	<=3.4%	3.94%	↑	<=3.4%	3.86%	4.17%			M		Y			
	Proportion of temporary Staff	<=5%	5.09%	↓	<=5%	5.31%	4.90%			M					
	Staff Turnover	<=10%	12.1%	↓	<=10%	12.1%	11.5%			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 £m		1,474.00	1,154	↓	306		249			M	Recurring CIP's only	Y			
Control total acceptance		Yes													
Overall										Adhoc	Segment 1: Maximum autonomy; universal support				
	Segmentation														

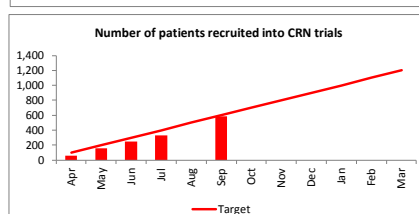
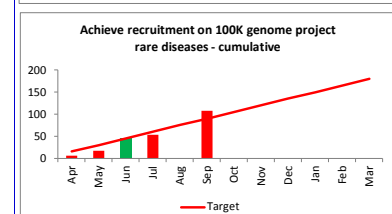
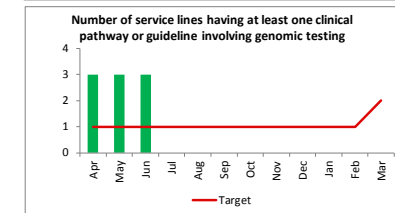
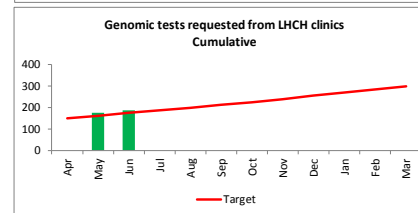
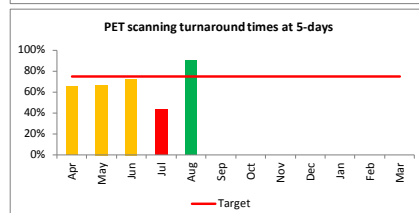
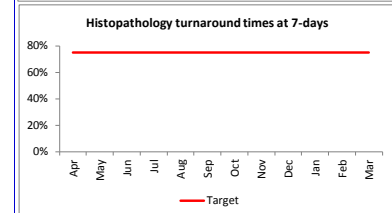
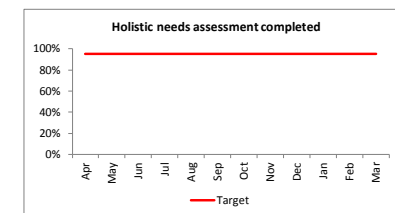
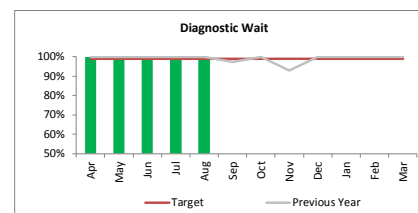
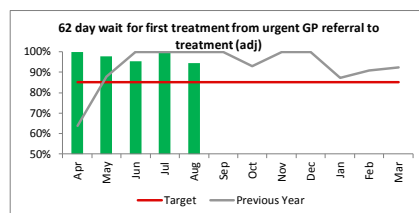
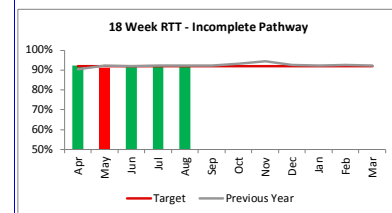
Section 2 - Strategic Dashboard



Section 2a - Service Delivery: Strategic Dashboard

Strategic Objective Measures 2017/18 - Service Delivery, Research & Innovation

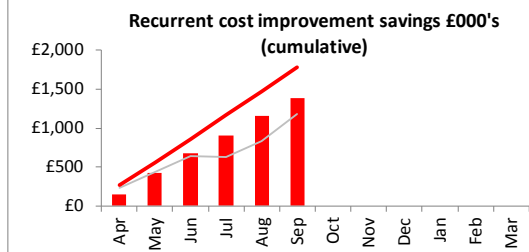
Indicator	Type	YTD		Trend	Current Month		Previous Month	Data Quality	Frequency	Comments
		Target	Actual		Target	Sep 17				
18 Weeks Referral to Treatment - Incomplete Pathways	N	>=92%	92.19%	↓	>=92%	92.19%	92.37%		M	
62 day wait for first treatment from urgent GP referral to treatment (adj)	N	>=85%	98.70%	↑	>=85%	100.00%	94.44%		M	
Maximum 6-week wait for diagnostic procedures	N	>=99%	99.87%	↑	>=99%	99.92%	99.74%		M	
Complete a holistic needs assessment for patients diagnosed at LHCH	L	>=95%	-	-	>=95%	-	-		M	Awaiting resource to complete assessment
Improve histopathology turnaround times at 7-days	L	>=75%	-	-	>=75%	-	-		M	Indicator under development
Improve PET scanning turnaround times at 5-days	L	>=75%	65.0%	↓	>=75%	62.0%	90.0%		M	
Increase number of genomic tests requested from LHCH clinics per year	L	>=175	189	↓	>=175	189	189		M	Latest data available is June 2017.
Number of service lines having at least one clinical pathway or guideline involving genomic testing	L	>=2	3	→	>=2	3	3		M	
Achieve recruitment on 100K genome project - rare diseases	L	>=45	163	↓	>=15	5	7		M	Latest data available is September 2017
Number of patients recruited into CRN trials	L	>=600	588	↑	>=100	107	83		M	
Develop and deliver new private patient strategy	Yes or No		Comment: due March 2018							
Present revised ACHD business case	Yes or No		Comment: due August 2017							
Present robotic surgery service business case	Yes		Comment: Complete							
Implement same day admission for surgery	Yes or No		Comment: due October 2017							
Develop and implement digital health strategy	Yes or No		Comment: Digital Healthcare strategy due at Board September 2017. Implementation thereafter.							
Develop a corporate social responsibility strategy	Yes or No		Comment: due March 2018							



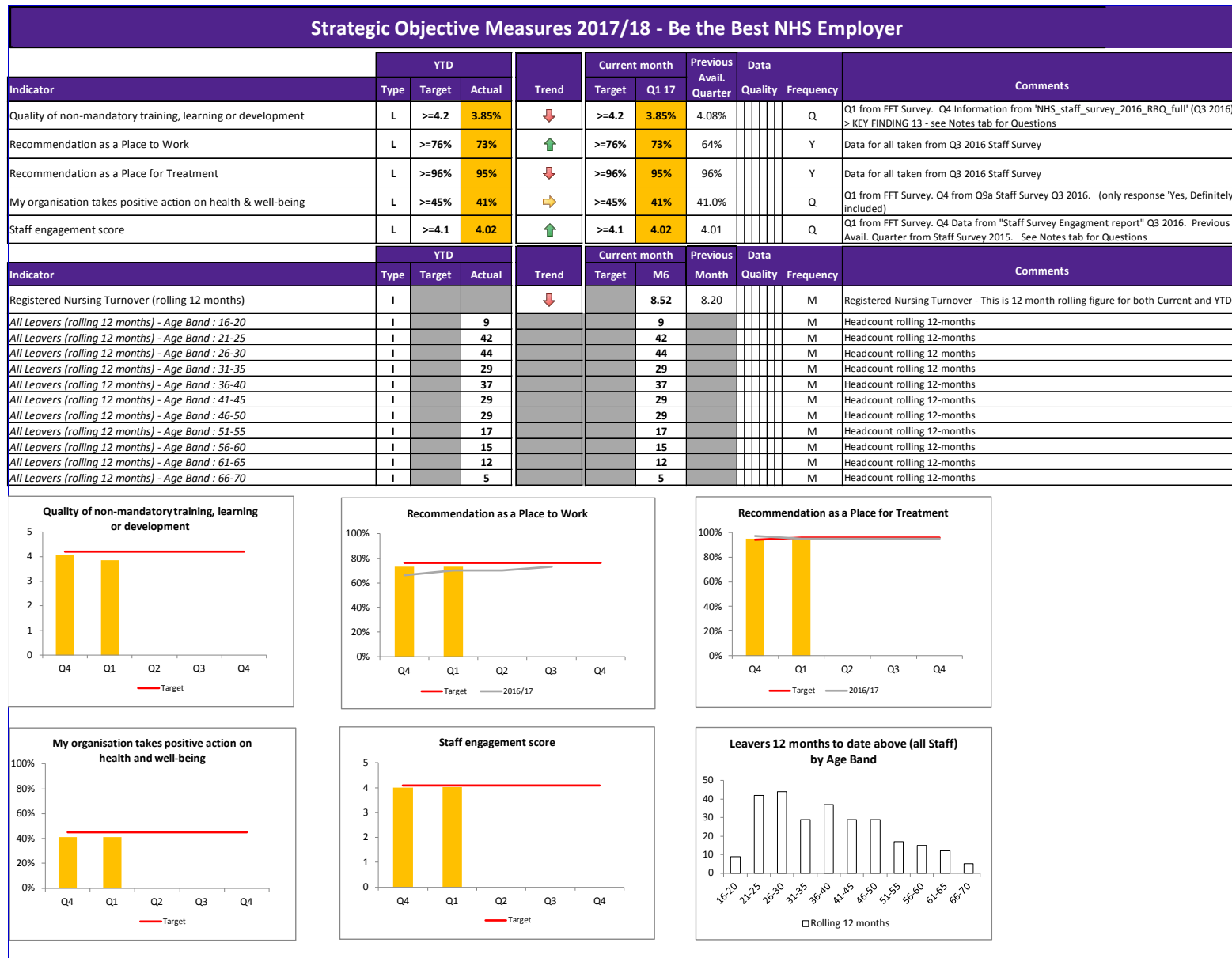
Section 2b – Financial Sustainability / Delivering Value for Money: Strategic Dashboard

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	Sep 17				
Overall use of resources rating	3	1		3	1	1		M	
Deliver the recurrent cost improvement savings	£1,474	£1,388	↓	£306	£234	£249		M	Recurring CIP only, Non Recurring CIPs are £196k YTD
Agency rating	2	1		2	1	1		M	
Liquidity rating	4	3	→	4	3	3		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 - Meetings between SLR Accountant, DHOs and Finance Business Partners have been arranged to review and identify areas for improvement.						
Implement service line reporting plan	Yes or No		Comment: March 2018 (key milestone reference costs August 2017)						



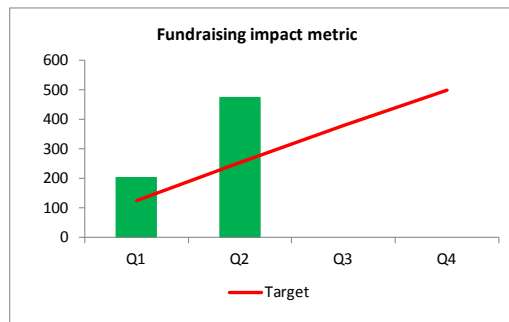
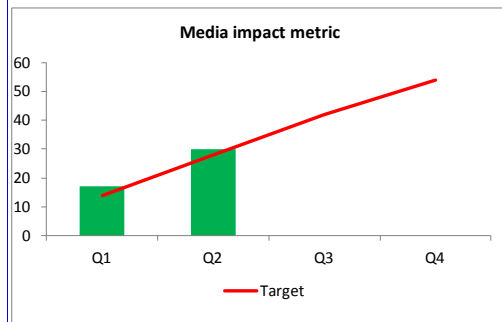
Section 2c - Be the Best NHS Employer: Strategic Dashboard



Section 2d - Partnership & collaborative Working: Strategic Dashboard

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.						



Section 3 – Operational Dashboard

Performance Report Summary 2017/18

Indicator	Target	Actual	Performance Trend	Current month		Previous Month	Data Quality	Frequency	Comments	Exception
		YTD		Target	Sep 17					
Quality	Friends and family Test response rate - Inpatients	>=50%	53%	↓	>=50%	38.94%	54%	M		
	VTE Prophylaxis	>=95%	98.04%	↑	>=95%	98.8%	97.1%	M		
	Number of in-hospital deaths	N/A	99	⇒	N/A	15	15	M		
	Risk adjusted CABG mortality	<=1	0.88	↓	<=1	0.99	0.88	M	9-month rolling averages; latest data up to July 2017	
	Risk adjusted non-primary PCI MACE	<=1	0.98	↓	<=1	0.65	0.10	M	9-month rolling averages; latest data up to July 2017	
	Number of Adverse Events (red alerts), SIs & Never Events	0	2	↑	0	0	1	M	2 SIs Reported (April and August)	Y
Performance	Number of Reported Patient Safety Incidents (6-month rolling avg)	>=391	340	↑	>=399	142	138	M		
	Cancelled operations	<=1.5%	2.0%	↓	<=1.5%	2.3%	1.1%	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%	5.84%	↑	<=4.5%	3.22%	4.93%	M		Y
	Bed occupancy	>=95%	82.39%	↓	>=95%	81.95%	82.40%	M		
	Referrals - GP	14,172	13,242	↓	2,362	2,104	2,244	M		Y
	Referrals - DGH	5,064	5,145	↓	844	804	841	M		
	Referrals - Other	864	1,025	↓	144	143	186	M		
	Activity - NHS	0%	-0.86%	↓	0%	-3.2%	7.7%	M		Y
	Activity - Private	0%	-5.60%	⇒	0%	-34.9%	0.0%	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	>=99%	100.00%	⇒	>=99%	100.00%	100.00%	M		
	31 day wait from diagnosis to first treatment	>=96%	99.33%	⇒	>=96%	100.00%	100.00%	M		
Local Target	31 day wait for second or subsequent treatment (surgery)	>=94%	97.37%	⇒	>=94%	100.00%	100.00%	M		
	62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adj)	>=95%	86.46%	↑	>=95%	100.00%	85.72%	M		Y
	26 Weeks Referral to Treatment in aggregate - Admitted Pathways	>=95%	79.37%	↓	>=95%	79.37%	81.48%	M		Y
Workforce	26 Weeks Referral to Treatment in aggregate - Non Admitted Pathways	>=96%	87.30%	↑	>=96%	87.30%	86.12%	M		Y
	26 Weeks Referral to Treatment in aggregate - Incomplete Pathways	>=95%	86.68%	↓	>=95%	86.68%	89.28%	M		Y
	Appraisals	>=90%	90%	↑	>=90%	90%	84%	M	Appraisal window reset	Y
Finance	Mandatory training	>=95%	94%	↓	>=95%	94%	98%	M		
	Turnover Rate between 1-2 yrs service (voluntary)(FTC excluded)	<=1.4%	1.88%	↓	<=1.4%	1.88%	1.52%	M		
	Net Surplus £000's	-2,145	-2,121	↑	665	665	48	M		
	Normalised Net Surplus £000's	-2,145	-2,121	↑	665	665	48	M		
	Cash Balance	6,936	4,838	↓	-540	-1,404	294	M		Y
	Capital expenditure £000's	-2,781	-2,587	⇒	-375	-1,541	-139	M		
	Total agency cost £000's	-1,125	-994	↑	-188	-178	-186	M		
Finance	Total bank cost £000's	-348	-969	↓	-58	-183	-165	M		Y

