

Board of Directors (in Public)

Item 4.1

Subject: Strategic and Operational Dashboards 2018/19
Date of meeting: 1 May 2018
Prepared by: Claire Wilson, Chief Finance Officer
Presented by: Claire Wilson, Chief Finance Officer
Purpose of Report: For approval

| BAF Ref | Impact on BAF |
|---------|--|
| 1 - 5 | The BAF has been revised to reflect the risk associated with the 2018/19 strategic objectives. |

1. Executive Summary

This paper sets out a proposed approach for monitoring against the Trusts strategic and operational performance during 2018/19.

2. Introduction

The Board of Directors is responsible for setting the overall strategic direction of the Trust and to monitor performance against its objectives. The indicators reported to the Board of Directors have been reviewed for 2018/19 in line with its statutory duties and operational objectives. This paper sets out the proposed framework for 2018/19 together with the delivery targets for each indicator where appropriate.

3. Strategic Objectives

The Board of Directors have agreed the following strategic objectives for 2018/19.

i) Quality and Patient Experience

- Improve safety culture and reduce harm;
- Embed organisational learning such that there is clear evidence of observable changes in practice;
- Retain CQC rating of 'outstanding'
- Deliver an improvement plan in response to GIRFT Report.

ii) Research and Innovation

- Implement robotics programme
- Deliver transition plan for Congenital Heart Disease
- Deliver informatics review action plan and establish assurance mechanism for data quality;

- Raise the Trust's academic profile and increase the number of academic appointments
- Deliver Research and innovation Strategy milestones including attraction of research grants
- Develop a strategy for good corporate citizenship

iii) Finance and Value

- Retain Segmentation 1 under NHS Improvement's Single Oversight Framework
- Develop business partner model and improve business intelligence
- Operate Use of Resources Framework in shadow form
- Embed Accountability Framework
- Deliver 2018/19 targets set out in private patient strategy
- Develop 10 new international business models for future exploration with at least one contract signed in 2018/19

iv) Best NHS Employer

- Listen, involve and develop Team LHCH through delivery of an effective staff engagement plan
- Build capability for outstanding leadership at all levels

v) Partnerships

- Lead and deliver the CVD programme and specifically
- Implement single cardiology pathway
- Improve the visibility and external promotion of surgical work
- Maintain stakeholder engagement across the wider health and care partnership

Appendix 1 sets out the proposed deliverables for each objective. The risks associated with each has been reflected in the Board Assurance Framework (BAF) for 2018/19. It is proposed that the Board of Directors receives a quarterly update on the delivery against each objective which will then also align with the timetable for BAF reporting.

4. Operational Objectives

4.1 Single Oversight Framework Reporting

The Trust is monitored externally by NHS Improvement in accordance with the Single Oversight Framework (SOF). The framework has five themes with the aim of supporting Trusts to work alongside their local partners, maintain Care Quality Commission ratings of 'Good' or 'Outstanding', meet NHS constitution standards and manage their resources effectively. The themes are:

- i. Quality of care
- ii. Finance and use of resources
- iii. Operational performance
- iv. Strategic change
- v. Leadership and improvement capability

The standards within each theme are set out in Appendix 2 together with proposed RAG rating thresholds for internal reporting purposes. The Board of Directors will continue to monitor performance against the standards contained within the SOF on a monthly basis. Indicators reported as 'red' will be flagged for exception reporting.

4.2 Quality Reporting

The quality strategy is currently being reviewed and a revised draft will be considered by the Board of Directors in quarter 1 2018/19. Appendix 3 sets out the current quality performance dashboard which will continue to be used until the new strategy is implemented. The dashboard will be revised alongside the new strategy.

4.3 Performance Reporting

In addition to the SOF, the Board set and monitor other financial and operational performance targets to ensure delivery against key Trust priorities. Appendix 4 sets out the proposed Performance dashboard for 2018/19 for those targets not already reflected in the SOF report. The Board will monitor performance on a monthly basis and Indicators reported as 'red' will be flagged for exception reporting.

5. Reporting Development and Data Quality Framework

The Trusts reporting processes and presentational formats are being reviewed as part of the Business Transformation programme and Informatics review action plan. A data quality framework is also being developed and will be introduced alongside the new report formats. This work is ongoing and it is expected to be completed in time for the new format of reporting to be introduced in quarter two 2018/19

6. Recommendation

The Board of Directors are asked to approve the proposed approach for monitoring strategic and operational performance for 2018/19.

Strategic Objectives 2018/19

| Strategic Objective | Executive Lead | Deliverables |
|---|--|---|
| [1] Quality and Patient Experience | | |
| Improve safety culture; | Director of Nursing | <ul style="list-style-type: none"> • Further embed Safety Seven • Improve incident reporting • Harms monitoring • FTSU embedded • LIA / improvement work – quarterly pulse check |
| Embed organisational learning such that there is clear evidence of observable changes in practice | Medical Director | <ul style="list-style-type: none"> • Maintain / embed Organisational Learning processes • Quarterly LFD report to BoD • Focus on evidence to support LFD in 2018/19 – divisions and OB • Triumvirates to review and refine process for review of learning |
| Retain CQC outstanding | Director of Nursing | <ul style="list-style-type: none"> • Sharpen process for communicating MRG outcomes • On-going programme of mock inspections • Continue sharing & learning |
| Deliver an improvement plan in response to GIRFT Report | Medical Director | <ul style="list-style-type: none"> • GIRFT action plan delivered from national and local reports • |
| [2] Research and Innovation | | |
| Implement robotics programme | Director of Strategic Partnerships/Chief Operating Officer | <p>To demonstrate delivery against business case objectives relating to:</p> <ul style="list-style-type: none"> • Research programme • Length of Stay savings • Outcomes • Plan for development of hybrid procedures |

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|---|---|---|
| Deliver transition plan for Congenital Heart Disease | Director of Strategic Partnerships/Chief Operating Officer | Implement safe transfer of services in line with NHS England timescales |
| Deliver informatics review action plan and establish assurance mechanism for data quality; | Chief Finance Officer | <ul style="list-style-type: none"> • Develop digital strategy • Deliver milestones in action plan including work in relation to data warehouse, reporting, staffing, governance. • Establish Data Quality Assurance Framework |
| Raise the Trust's academic profile and increase the number of academic appointments | Director of research and Innovation | No. staff with academic appointment. Includes honorary, or University person working predominantly from our site. Applies to both research and educational appointments. Target 5 for 2018/19. |
| Deliver Research and innovation Strategy milestones including attraction of research grants | Director of research and Innovation | Achieve CRN recruitment. Target 900 for 2018/19 |
| Develop a strategy for good corporate citizenship | Chief Operating Officer/Director of Workforce | <ul style="list-style-type: none"> • Plan to be considered by Board of Directors in Q2 2018/19 • Implementation in line with agreed plan |
| [3] Finance and Value | | |
| Retain Segmentation 1 for under NHS Improvement's Single Oversight Framework | Executive lead in line with Single Oversight Framework (SOF) theme. | <ul style="list-style-type: none"> • SOF indicators monitored monthly. |
| Develop business partner model and improve business intelligence | Chief Finance Officer | <ul style="list-style-type: none"> • Define role and operating model across finance, digital and HR functions. • Identify skills, capability and capacity gaps • Develop and deliver training plan. • Divisional reviews to ensure evidence of and reinforce BP model. • Deliver BI strategy and divisional dashboards |

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| Operate Use of Resources Framework in shadow form | Chief Finance Officer | Shadow in place by Q2 in readiness for implementation Q3 & Q4 |
| Embed Accountability Framework | Chief Finance Officer | Simplify framework for 2018/19 and link to key deliverables |
| Private patient strategy | Chief Finance Officer | Deliver 2018/19 targets set out in private patient strategy |
| Develop new international business models | Chief Finance Officer | Develop 10 new international business models for future exploration with at least one contract signed in 2018/19 |
| [4] Best NHS Employer | | |
| Listen, involve and develop Team LHCH through delivery of an effective staff engagement plan | Director of Workforce | <ul style="list-style-type: none"> • Implementation of LIA • Quarterly updates on delivery of 'Team LHCH' strategy • Improve engagement scores / LIA pulse checks • Measures and report on staff experience • NED & Exec walkabouts |
| Build capability for outstanding leadership at all levels | Director of Workforce | <ul style="list-style-type: none"> • Learning and development plan to be developed in Q1 2018/19 • Succession planning / talent plan |
| [5] Partnerships | | |
| Lead and deliver the CVD programme | Director of Strategic Partnerships/Chief Operating Officer | Next steps programme for each of the priority areas. |
| Implement single cardiology pathway | Director of Strategic Partnerships/Chief Operating Officer | Produce proposals and implementation plans for the 6 priority areas |
| Improve the visibility and external promotion of surgical work | Director of Strategic Partnerships/Chief Operating Officer | Engagement plan to be developed by June 18 |
| Maintain active stakeholder engagement across the wider health | Director of Strategic Partnerships/Chief Operating Officer | Continue to participate in established networks and meetings |

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| and care partnership | | |
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Single Oversight Framework (SOF) Dashboard Indicators 2018/19

| | Target | Red | Amber | Green |
|---|---------------|--|--|------------------------------|
| Operational Performance | | | | |
| Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway | >=92% | <92% | - | >=92% |
| All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer | >=85% | <85% | - | >=85% |
| Maximum 6-week wait for diagnostic procedures | >=99% | <99% | - | >=99% |
| Dementia – no. patients over 75 admitted as an emergency | | | | |
| - with diagnosis | >= 90% | <80% | >=85%, <90% | >=90% |
| - with assessment | >=90% | <80% | >=85%, <90% | >=90% |
| - referred appropriately | >=90% | <80% | >=85%, <90% | >=90% |
| Quality – Safe, Effective & Caring | | | | |
| Written complaints – rate | Sliding scale | Above target and more than 5 above previous year performance | Above target but within 5 or below previous year performance | Equal to or less than target |
| Occurrence of any Never Events in a rolling 6 month period | 0 | >0 | - | 0 |
| NHS England/NHS Improvement Patient Safety Alerts outstanding | 0 | >0 | - | 0 |
| Mixed Sex Accommodation breaches | 0 | >0 | - | 0 |
| VTE Risk Assessment | >=95% | <90% | >=90% <95% | >=95% |
| Clostridium Difficile | Sliding Scale | Above target and above previous year performance | Above target but below previous year performance | Equal to or less than target |
| Clostridium Difficile infection rate (per 1000 beddays) | <=0.16 | >0.16 | - | <=0.16 |
| MRSA bacteraemia | 0 | >0 | - | 0 |
| MSSA bacteraemia | 0 | >0 | - | 0 |
| HSMR for all diagnoses and procedures (supplied from Dr Foster) | <=100 | >150 | <100 >=150 | <=100 |

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|---|--------|-------|-----------------|--------|
| HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide) | <=100 | >150 | <100 >=150 | <=100 |
| Potential under reporting of patient safety incidents | <3 | 3 | - | <3 |
| Staff Friends and Family - recommend as a place of treatment | >=96% | <86% | >=86% <96% | >=96% |
| Inpatient scores from Friends & Family Test - % positive | >=95% | <90% | >=90% <95% | >=95% |
| Community scores from Friends & Family Test - % positive | >=95% | <90% | >=90% <95% | >=95% |
| Outpatient scores from Friends & Family Test - % positive | >=95% | <90% | >=90% <95% | >=95% |
| Organisational Health | | | | |
| Staff Sickness | <=3.6% | >3.8% | >3.6% <=3.8% | <=3.6% |
| Proportion of temporary Staff | <=5% | >6% | >5% <=6% | <=5% |
| Staff Turnover | <=10% | >12% | >10% <=12% | <=10% |
| Executive Team Turnover | <=25% | >30% | >25% <=30% | <=25% |
| NHS Staff Survey - recommend as a place to work | >=75% | <65% | >=65% <75% | >=75% |
| Finance and Use of Resources | | | | |
| Capital Service Cover | 1 | >=3 | >=2 | 1 |
| Liquidity | 1 | >=3 | >=2 | 1 |
| I&E Margin | 1 | >=3 | >=2 | 1 |
| Performance against plan | 1 | >=3 | >=2 | 1 |
| Agency spend | 1 | >=3 | >=2 | 1 |
| Overall use of resources rating | 1 | >=3 | >=2 | 1 |
| Control total acceptance | Yes/No | No | n/a | Yes |

Quality dashboard

Additional priority indicators not covered by the Standard Operating Framework (SOF).

| | Target | Red | Amber | Green |
|---|---------------|--|--|------------------------------|
| Number of avoidable LHCH-Acquired Pressure Ulcers Grade 2 | Sliding scale | Above target and above previous year performance | Above target but below previous year performance | Equal to or less than target |
| Number of avoidable LHCH-Acquired Pressure Ulcers Grade 3+ | 0 | >0 | - | 0 |
| Observed mortality Rate | <=1.3% | >2% | <=2% >1.3% | <=1.3% |
| % mortality reviews screened within 7 days | >=95% | <85% | >=85% <95% | >=95% |
| Mortality reviews completed within 30 days of screening allocation (Doctors) | >=80% | <70% | >=70% <80% | >=80% |
| Mortality reviews completed within 30 days of allocation (Nurses) | >=80% | <70% | >=70% <80% | >=80% |
| Blood cultures taken within 24hrs preceding first antibiotic given | >=95% | <75% | >=75% <95% | >=95% |
| Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target) | >=70% | <50% | >=50% <70% | >=70% |
| Delivery of a sepsis antibiotic within three hours of prescription (National Standard) | >=96% | <75% | >=75% <96% | >=96% |
| % of radiological alerts with a response document | >=95% | <85% | >=85% <95% | >=95% |
| Complete a holistic needs assessment for patients diagnosed at LHCH | >=95% | <85% | >=85% <95% | >=95% |
| Friends and family Test response rate | >=50% | <45% | >=45% <50% | >=50% |
| VTE Prophylaxis | >=95% | <90% | >=90% <95% | >=95% |
| Mortality CABG - Continuous improvement (Maintain observed to expected ratio at 1 or below) | <=1 | >1.5 | >1 <=1.5 | <=1 |
| Mace PCI - Continuous improvement (Maintain observed to expected ratio at 1 or below) | <=1 | >1.5 | >1 <=1.5 | <=1 |
| Number of adverse events | 0 | >0 | - | 0 |

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|---|---------------|--|--|---------------------------------|
| (red alerts), SI and never events | | | | |
| Number of patient related safety incidents reported | Sliding scale | Below target and below previous year performance | Below target but above previous year performance | Equal to or greater than target |
| Hospital Standardised Mortality Ratio - Weekend (DFI) | ≤ 100 | Small sample size - statistical significance determined by breach of upper confidence interval | Small sample size – above 100 but within the upper confidence interval | ≤ 100 |

Performance dashboard

Additional priority indicators not covered by the Standard Operating Framework (SOF).

| | Target | Red | Amber | Green |
|---|---------------|--|--|----------------|
| Performance | | | | |
| Cancelled Operations for non-clinical reasons | 1.5% | >2% | >1.5% <2% | <=1.5% |
| Improve histopathology turnaround times at 7-days | >=75% | <65% | >=65% <75% | >=75% |
| Improve PET scanning turnaround times at 5-days | >=75% | <65% | >=65% <75% | >=75% |
| Cancelled operations for non-clinical reasons readmitted with 28 days | 100% | <100% | - | 100% |
| Urgent operations cancelled for 2nd time | 0 | >0 | - | 0 |
| Delayed Transfers of care | <=4.5% | >5% | >4.5% <=5% | <=4.5% |
| Bed Occupancy | >=85% | <80% or >90% | >=80% <85% | >=85% <=90% |
| Referrals – GP | Sliding scale | Below target greater than 200 away from plan | Below target but within 200 of plan | Above target |
| Referrals – DGH | Sliding scale | Below target greater than 200 | Below target but within 200 | Above target |
| Referrals – Other | Sliding scale | Below target greater than 200 | Below target but within 200 | Above target |
| NHS activity percentage variance from plan | >0% | Below target and decrease from previous year | Below target but increase from previous year | Above target |
| PP activity percentage variance from plan | >0% | Below target and decrease from previous year | Below target but increase from previous year | Above target |
| Number of 18-week Pathways Waiting 52-weeks+ | 0 | >0 | - | 0 |
| Cancer: 14 day GP referral to 1st Outpatient Appointment | >=93% | <93% | - | >=93% |
| Cancer: 31 day diagnosis to 1st treatment for all cancers | >=96% | <96% | - | >=96% |
| Cancer: 31 day Second or subsequent treatment (surgery & drug) | >=94% | <94% | - | >=94% |
| Cancer: 62 day Consultant Upgrade | >=85% | <85% | - | >=85% |
| Welsh patients: 26 weeks Referral To Treatment waiting times - Admitted | >=95% | <95% | - | >=95% |

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|--|----------------|-------------------------------|---------------------------------|--------------------------|
| patients | | | | |
| Welsh Patients: 26 weeks Referral To Treatment waiting times - Non-admitted | >=98% | <98% | - | >=98% |
| Welsh Patients: 26 weeks Referral To Treatment waiting times - Incomplete | >=95% | <95% | - | >=95% |
| Emergency readmissions following elective admission | <=100 | >150 | <100 >=150 | <=100 |
| Emergency readmissions following non-elective admission | <=100 | >150 | <100 >=150 | <=100 |
| Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival) | >=90% | <85% | >=85% <90% | >=90% |
| Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission) | >=90% | <85% | >=85% <90% | >=90% |
| Std 5: 7-day Services: CT scan within 1 hr for critical care need | >=70% | <65% | >=65% <70% | >=70% |
| Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need | >=80% | <75% | >=75% <80% | >=80% |
| Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need | >=85% | <80% | >=80% <85% | >=85% |
| Std 6: 7-day Services: Access to interventions | >=80% | <75% | >=75% <80% | >=80% |
| Std 8: 7-day Services: Ongoing review twice daily in high dependancy area | >=80% | <75% | >=75% <80% | >=80% |
| Std 8: 7-day Services: Ongoing review every 24 hours on general wards | >=80% | <75% | >=75% <80% | >=80% |
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| | | | | |
| Workforce | | | | |
| Mandatory Training Compliance | >=95% | <85% | >=85% <95% | >=95% |
| Appraisals Compliance | >=90% | <80% | >=80% <90% | >=90% |
| Turnover Rate between 1-2 years' service (voluntary) | <=1.4% | >2% | >1.4% - <=2% | <=1.4% |
| Finance | | | | |
| Net Surplus £m's | Financial plan | Below target by more than 5% | Below target between >0% to 5% | Equal to or above target |
| Capital expenditure | Financial plan | Below target by more than 10% | Below target between >0% to 10% | Equal to or above target |
| Cash balance | Financial plan | Below target by more than 10% | Below target between >0% | Equal to or above |

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|---|----------------|------------------------------|--------------------------------|--------------------------|
| | | | to 10% | target |
| Deliver the target recurrent cost improvement savings | Financial plan | Below target by more than 5% | Below target between >0% to 5% | Equal to or above target |