

Board of Directors (in Public)

Item 4.3

Subject: Strategic & Operational Dashboard
Performance Assignment Thresholds

Date of meeting: Tuesday 25th April 2017

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Presented by: Dr Mark Jackson, Director of Research & Informatics

1. Executive Summary

The purpose of this paper is to provide clarity around the levels of performance necessary to assign a green, amber or red status for each metric in the Strategic & Operational Dashboard.

2. Introduction

Indicators reported to the Board of Directors each year are revised accordingly to meet the strategic and operational needs of the organisation. These needs will be influenced by both external and internal priorities.

Clarity around targets set against these indicators is set to ensure the Board are clearly sighted on performance across the Trust. This document sets out the indicators covering Strategic and Operational Reporting, including the Single Oversight Framework, to the Board for 2017/18 and the associated targets relevant to each indicator.

3. Indicators & Targets

Appendix 1 shows all indicators for 2017/18 to be reported to the Board. The relevant targets and RAG ratings for each are shown, with indicators split into reporting sections directly aligned to the Single Oversight Framework (leadership and improvement capability, strategic change, operational performance, quality – safe, effective & caring, quality – organisational health, and finance), Trust's strategic objectives (quality & experience, service & innovation, value, workforce, stakeholders), and operational indicators (quality, performance, workforce and finance). This paper makes these thresholds transparent and explicit.

Red, Amber, Green Allocation and Exception Reporting

Indicators shown as red rated in-month, in-quarter, year to date or end year forecast based on the ratings given in Appendix 1 will be flagged for exception reporting. Relevant Senior Managers (Divisional Heads of Operations, Heads of Nursing and Heads of Departments) will receive an exception report template to complete (Appendix 2). In the absence of a response from a relevant Senior Manager, exception report templates will be escalated to Executive Leads for comment.

4. Recommendation

The Board of Directors are asked to approve the contents of the paper for implementation alongside the revised Strategic & Operational Dashboard which will commence in May 2017.

Appendix 1: Strategic & Operational Dashboard Indicators 2017/18

	Target	Red	Amber	Green	Trend Change
Single Oversight Framework – Leadership and Improvement Capability					
Comments given					
Single Oversight Framework – Strategic Change					
Comments given					
Single Oversight Framework: Operational Performance					
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	>=92%	<92%	-	>=92%	>1%
All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	<85%	-	>=85%	>1%
Maximum 6-week wait for diagnostic procedures	>=99%	<99%	-	>=99%	>0.1%
Single Oversight Framework: Quality – Safe, Effective & Caring					
Written complaints – rate (national definition to be determined; shown as number)	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	>0
Occurrence of any Never Events	0	>0	-	0	>0
NHS England/NHS Improvement Patient Safety Alerts outstanding	0	>0	-	0	>0
Mixed Sex Accommodation breaches	0	>0	-	0	>0
VTE Risk Assessment	>=95%	<90%	>=90% <95%	>=95%	>1%
Clostridium Difficile	Sliding Scale	Above target and above previous year performance	Above target but below previous year performance	Equal to or less than target	>0
Clostridium Difficile infection rate (per 1000 beddays)	<=0.16	>0.16	-	<=0.16	>0
MRSA bacteraemia	0	>0	-	0	>0
HSMR for all diagnoses and procedures (supplied from Dr Foster)	<=100	>150	<100 >=150	<=100	>10
HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide)	<=100	>150	<100 >=150	<=100	>10

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	>20
Potential under reporting of patient safety incidents	<3	3	-	<3	>0
Emergency readmissions following elective admission	<=100	>150	<100 >=150	<=100	>10
Emergency readmissions following non-elective admission	<=100	>150	<100 >=150	<=100	>10
Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (arrival)	>=90%	<85%	>=85% <90%	>=90%	>2%
Std 2: 7-day Services: First Consultant review - seen/assess <14 hrs (admission)	>=90%	<85%	>=85% <90%	>=90%	>2%
Std 5: 7-day Services: CT scan within 1 hr for critical care need	>=70%	<65%	>=65% <70%	>=70%	>2%
Std 5: 7-day Services: Echocardiography within 12 hrs for urgent care need	>=80%	<75%	>=75% <80%	>=80%	>2%
Std 5: 7-day Services: Microbiology tests within 12 hrs for urgent care need	>=85%	<80%	>=80% <85%	>=85%	>2%
Std 6: 7-day Services: Access to interventions	>=80%	<75%	>=75% <80%	>=80%	>2%
Std 8: 7-day Services: Ongoing review twice daily in high dependency area	>=80%	<75%	>=75% <80%	>=80%	>2%
Std 8: 7-day Services: Ongoing review every 24 hours on general wards	>=80%	<75%	>=75% <80%	>=80%	>2%
Staff Friends and Family - recommend as a place of treatment	>=96%	<86%	>=86% <96%	>=96%	>1%
Inpatient scores from Friends & Family Test - % positive	>=95%	<90%	>=90% <95%	>=95%	>1%
Community scores from Friends & Family Test - % positive	>=95%	<90%	>=90% <95%	>=95%	>1%

Single Oversight Framework: Quality – Organisational Health					
Staff Sickness	<=3.6%	>3.8%	>3.6% <=3.8%	<=3.6%	>0.25%
Proportion of temporary Staff	<=5%	>6%	>5% <=6%	<=5%	>0.25%
Staff Turnover	<=10%	>12%	>10% <=12%	<=10%	>0.25%
Executive Team Turnover	<=25%	>30%	>25% <=30%	<=25%	>5%
NHS Staff Survey - recommend as a place to work	>=75%	<65%	>=65% <75%	>=75%	>1%
Single Oversight Framework: Quality – Finance					
Capital Service Cover	1	>=3	2	1	
Liquidity	2	4	3	<=2	
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	2	4	3	<=2	
Value for money information	Comments given				
Aggressive cost reduction plans	£3.72m				
Control total acceptance	Yes or No				
Single Oversight Framework - Segmentation					
1 Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.					
2 Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.					
3 Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.					
4 Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.					
Strategic Objectives – Quality & Experience					
Number of Falls - 4 key locations (Birch, Cedar, Elm & Oak)	Sliding scale	Above target and above previous year performance	Above target but below previous year performance	Equal to or less than target	>1
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	>0
Number of avoidable LHCH-Acquired	0	>0	-	0	>0

Pressure Ulcers Grade 3+					
HSMR for all diagnoses and procedures (supplied from Dr Foster)	<=100	>150	<100 >=150	<=100	>10
HSMR for 56 diagnosis groups (supplied from Dr Foster - Hospital Guide)	<=100	>150	<100 >=150	<=100	>10
Observed mortality Rate	<=1.3%	>2%	<=2% >1.3%	<=1.3%	>0.1%
% mortality reviews screened within 7 days	>=95%	<85%	>=85% <95%	>=95%	>5%
Mortality reviews completed within 30 days of screening allocation (Doctors)	>=80%	<70%	>=70% <80%	>=80%	>5%
Mortality reviews completed within 30 days of allocation (Nurses)	>=80%	<70%	>=70% <80%	>=80%	>5%
Blood cultures taken within 24hrs preceding first antibiotic given	>=95%	<75%	>=75% <95%	>=95%	>5%
Delivery of at least one sepsis antibiotic within one hour of prescription (LHCH target)	>=70%	<50%	>=50% <70%	>=70%	>5%
Delivery of a sepsis antibiotic within three hours of prescription (National Standard)	>=96%	<75%	>=75% <96%	>=96%	>5%
Inpatient scores from Friends & Family Test - % positive	>=95%	<90%	>=90% <95%	>=95%	>1%
Outpatient scores from Friends & Family Test - % positive	>=95%	<90%	>=90% <95%	>=95%	>1%
Community scores from Friends & Family Test - % positive	>=95%	<90%	>=90% <95%	>=95%	>1%
All re-inspected KLOE's rated as 'Outstanding'	Yes or No				
% of radiological alerts with a response document	>=95%	<85%	>=85% <95%	>=95%	>1%
Share best practice and learning from complaints and incidents	Follow-up audit of SUI reveals improvement embedded and delivering within 1-year - Yes or No				
Strategic Objectives – Service Delivery, Research & Innovation					
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate -	>=92%	<92%	-	>=92%	>1%

patients on an incomplete pathway					
All cancers - maximum 62-day wait for first treatment from urgent GP referral for suspected cancer	>=85%	<85%	-	>=85%	>1%
Maximum 6-week wait for diagnostic procedures	>=99%	<99%	-	>=99%	>0.1%
Complete a holistic needs assessment for patients diagnosed at LHCH	>=95%	<85%	>=85% <95%	>=95%	>1%
Improve histopathology turnaround times at 7-days	>=75%	<65%	>=65% <75%	>=75%	>1%
Improve PET scanning turnaround times at 5-days	>=75%	<65%	>=65% <75%	>=75%	>1%
Develop and deliver new private patient strategy	Timeframe: March 2018 - Yes or No				
Present revised ACHD business case	Timeframe: August 2018 - Yes or No				
Present robotic surgery service business case	Timeframe: April 2017 - Yes or No				
Implement same day admission for surgery	Timeframe: October 2017 - Yes or No				
Develop and implement digital health strategy	Timeframe: March 2018 - Yes or No				
Increase number of genomic tests requested from LHCH clinics per year	>=300	<250	>=250 <300	>=300	>0
Number of service lines having at least one clinical pathway or guideline involving genomic testing	2	0	1	2	>0
Achieve recruitment on 100K genome project – rare diseases	>=180	<160	>=160 <180	>=180	>0
Number of patients recruited into CRN trials	>=1200	<1000	>=1000 <1200	>=1200	>0
Develop a corporate social responsibility strategy	Timeframe: March 2018 - Yes or No				
Strategic Objectives – Financial Sustainability Delivering Value for Money					
Overall use of resources rating	2	4	3	<=2	
Deliver the recurrent cost improvement savings	£3.72m				
Agency rating	1	>=3	2	1	
Liquidity rating	2	4	3	<=2	

Implement model hospital dashboard	Timeframe: March 2018 - Yes or No				
Develop service line reporting	Timeframe: April 2017 - Yes or No				
Implement service line reporting plan	Timeframe: March 2018 - Yes or No (key milestone reference costs August 2017)				
Strategic Objectives – Be the Best NHS Employer					
Implement recruitment strategy	Timeframe: March 2018 - Yes or No				
Implement management development plan	Timeframe: March 2018 - Yes or No				
Quality of non-mandatory training, learning or development	>=4.2	<4	>=4 <4.2	>=4.2	>0
Recommendation as a place to work	>=75%	<65%	>=65% <75%	>=75%	>1%
Recommendation as a place for treatment	>=96%	<86%	>=86% <96%	>=96%	>1%
My organisation takes positive action on health & well-being	>=45%	<41%	>=41% <45%	>=45%	>1%
Staff engagement score	>=4.1	<4	>=4 <4.1	>=4.1	>0
Strategic Objectives – Partnership and Collaborative Working					
Address issues arising from the externally facing element of the well led review	Yes or No				
Implement CVD STP Plan	Yes or No				
Media impact metric	Sliding scale	Below target by more than 20	Below target but within 20 away of target	Equal to or greater than target	
Fundraising impact metric	Sliding scale	Below target by more than 5	Below target but within 5 away of target	Equal to or greater than target	
Operational Performance – Quality					
Friends and family Test response rate	>=50%	<45%	>=45% <50%	>=50%	>1%
VTE Prophylaxis	>=95%	<90%	>=90% <95%	>=95%	>1%
Mortality CABG - Continuous improvement (Maintain observed to expected ratio at 1 or below)	<=1	>1.5	>1 <=1.5	<=1	>0.2
Mace PCI - Continuous improvement (Maintain observed to expected ratio at 1 or below)	<=1	>1.5	>1 <=1.5	<=1	>0.2
Number of adverse events (red alerts), SI and never events	0	>0	-	0	>0

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	>10
Operational Performance - Performance					
Cancelled Operations for non-clinical reasons	1.5%	>2%	>1.5% <2%	<=1.5%	0.1%
Cancelled operations for non-clinical reasons readmitted with 28 days	100%	<100%	-	100%	0.1%
Urgent operations cancelled for 2nd time	0	>0	-	0	>0
Delayed Transfers of care	<=4.5%	>5%	>4.5% <=5%	<=4.5%	0.5%
Bed Occupancy	>=85%	<80% or >90%	>=80% <85%	>=85% <=90%	>1%
Referrals – GP	Sliding scale	Below target greater than 200 away from plan	Below target but within 200 of plan	Above target	>50
Referrals – DGH	Sliding scale	Below target greater than 200	Below target but within 200	Above target	>50
Referrals – Other	Sliding scale	Below target greater than 200	Below target but within 200	Above target	>50
NHS activity percentage variance from plan	>0%	Below target and decrease from previous year	Below target but increase from previous year	Above target	>1%
PP activity percentage variance from plan	>0%	Below target and decrease from previous year	Below target but increase from previous year	Above target	>1%
Number of 18-week Pathways Waiting 52-weeks+	0	>0	-	0	>0
Cancer: 14 day GP referral to 1st Outpatient Appointment	>=93%	<93%	-	>=93%	>1%
Cancer: 31 day diagnosis to 1st treatment for all cancers	>=96%	<96%	-	>=96%	>1%
Cancer: 31 day Second or subsequent treatment (surgery & drug)	>=94%	<94%	-	>=94%	>1%
Cancer: 62 day Consultant Upgrade	>=85%	<85%	-	>=85%	>1%
26 weeks Referral To Treatment (Welsh) waiting times - Admitted patients	>=95%	<95%	-	>=95%	>1%
26 weeks Referral To Treatment (Welsh)	>=98%	<98%	-	>=98%	>1%

waiting times - Non-admitted patients					
26 weeks Referral To Treatment (Welsh) waiting times - Incomplete patients	>=95%	<95%	-	>=95%	>1%
Operational Performance – Workforce					
Overall staff sickness	<=3.6%	>3.8%	>3.6% <=3.8%	<=3.6%	>0.25%
Mandatory Training Compliance	>=95%	<85%	>=85% <95%	>=95%	>1%
Appraisals Compliance	>=90%	<80%	>=80% <90%	>=90%	>1%
Turnover Rate between 1-2 years service (voluntary)	<=1.4%	>2%	>1.4% - <=2%	<=1.4%	>0.1%
Operational Performance – Finance					
Net Surplus £m's	Sliding scale	Below target by more than 10%	Below target between >0% to 10%	Equal to or above target	
Normalised Net Surplus £m's	Sliding scale	Below target by more than 10%	Below target between >0% to 10%	Equal to or above target	
Cash Balance	Sliding scale	Below target by more than 10%	Below target between >0% to 10%	Equal to or above target	
Capital expenditure £000's	Sliding scale	Below target by more than 10%	Below target between >0% to 10%	Equal to or above target	
Total agency cost £m's	Sliding scale	Above target by more than 3%	Above target between >0% to 3%	Equal to or below target	
Total bank cost £m's	<Last year	Below Target	On Target for rating, but metric below	Equal to or above target	

Sliding Scale

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Written complaints (cumulative)	9	16	22	26	29	36	40	45	50	55	61	67
C Diff LHCH acquired (cumulative)	1	2	3	4	5	6	7	8	9	10	11	12
Number of falls - 4 key locations (cumulative)	7	14	21	28	35	42	49	56	63	70	77	86
Number of avoidable pressure ulcers (cumulative)	1	1	2	2	3	3	4	4	5	5	6	6
Media impact metric	Q1 = 14			Q2 = 28			Q3 = 42			Q4 = 54		
Fundraising impact metric	Q1 = 126			Q2 = 252			Q3 = 378			Q4 = 500		
Number of PSI reported	135	136	138	139	141	142	142	142	142	142	142	142
Referrals - GP	2,362	4,608	6,938	9,172	11,297	13,586	15,877	18,322	20,337	22,794	25,105	27,558
Referrals – DGH	844	1,656	2,563	3,454	4,284	5,194	6,093	7,030	7,814	8,742	9,579	10,499
Referrals - Other	894	1,801	2,805	3,779	4,645	5,590	6,434	7,417	8,178	9,130	10,009	11,165
Net Surplus £000's (YTD)	-0.37	0.16	0.8	1.53	1.50	2.14	2.97	3.86	3.62	4.56	5.50	6.86
Normalised Net Surplus £000's (YTD)	-0.37	0.16	0.8	1.53	1.50	2.14	2.97	3.86	3.62	4.56	5.50	6.86
Cash Balance £m's (YTD)	5.45	5.74	6.21	7.27	6.94	6.40	7.47	8.28	8.02	9.23	9.78	9.37
Capital expenditure £m's (YTD)	0.68	1.35	2.03	2.40	2.78	3.16	3.53	3.91	4.28	4.66	5.04	5.41
Total agency cost £m's (YTD)	0.188	0.376	0.464	0.752	0.940	1.127	1.315	1.502	1.690	1.877	2.065	2.250
Total bank cost £m's (YTD)	0.058	0.116	0.174	0.232	0.290	0.348	0.406	0.464	0.522	0.580	0.638	0.695

Appendix 2: Exception Report Template

Accountable Executive:

(Completed by Information Department)

Indicator

(Completed by Information Department)

Issue

(Completed by Information Department)

Actions Taken with Dates of Implementation

(Completed by Lead)

Estimated Timeframe for Recovery of Performance

(Completed by Lead)