

Board of Directors (in Public) Item 4.1

Subject: Performance Assessment using the Strategic and Operational Dashboards
Date of meeting: 25th April 2017
Prepared by: Tony Grayson, Head of Information Services
Presented by: Tony Wilding, Chief Operating Officer







1. Executive Summary

Given this is month 12, it is useful to remind the Board of Directors about some of the highlights of 2016/17:






- Inspected and rated outstanding by the Care Quality Commission
- No significant concerns from the recently concluded Well Led Review
- Achievement of all NHS constitution access targets
- Delivery of the financial plan
- Zero MRSA and CDiff (due to lapses in care)
- No. 1 for patient experience of overall quality of care
- Trust remains in Segment 1; Maximum Autonomy, Universal Support

The purpose of the remainder of this paper is to present an update on Trust performance for the period to 31st March 2016/17.

1.1 Single Oversight Framework

Framework	Rating
Leadership and Improvement Capability	
Strategic Change	
Operational Performance	
Quality - Safe, Effective & Caring	
Quality - Organisational Health	
Finance	
Segmentation	Segment 1: Maximum autonomy; universal support

1.2 Strategic Objectives – Our Vision ‘To be the Best’

Objective	Rating
Quality & Experience	
Service & Innovation	
Value	
Workforce	
Working together	

2. Background

The Trust uses three dashboards to review performance:

- A Single Oversight Framework, which focuses on key metrics put forward by NHS Improvement
- A strategic dashboard, where measures reported track implementation of the Trust’s strategy.
- An integrated operational dashboard, which reports all of the measures of operational performance in the month and cumulatively tracks progress across core objectives.

3. Single Oversight Framework – Exceptions and Actions

3.1 Leadership and Improvement Capability



Nothing to report.

3.2 Strategic Change



Nothing to report.

3.3 Operational Performance



Nothing to report.

3.4 Quality – Safe, Effective and Caring



3.4.1 Indicator: Occurrence of never events

Issue: ‘No harm’ never event reported March 2017

Actions: A full root cause analysis is underway.

Anticipated delivery: April 2017

3.4.2 Indicator: Mixed sex accommodation breaches


Issue: Breaches on critical care with 21 for the year 2016/17. Up until February, there had been a marked improvement in the Mixed Sex accommodation breaches within Critical Care. During February and March there have been significant MSA breaches. Each breach has been due to ward bed capacity or the unavailability of enhanced levels of care provision in the ward environment.

Actions: Each breach is escalated to a Head of Nursing and a risk assessment undertaken. Each case is assessed on an individual basis and when deemed in the patients best interest with regard to safety, the patients were kept on critical care. Where possible patients are moved to a side room on ITU to eliminate further breaches. To aid further delayed discharges, patient flow and MSA breaches, extra ward bed capacity has been achieved, with Cedar opening an extra 4 beds. There is a Patient Flow working group, led by the Deputy Director of Nursing to provide solutions and an action plan which will enable further improvements.

Anticipated delivery: April 2017

3.5 Quality – Organisational Health

3.5.1 Indicator: NHS staff survey – recommendation as a place to work

Issue: The latest figures from internal surveys on Recommendation as a Place to Work are below target at 64%, however,  was against a low response rate of only 16%. The most recent National Staff Survey reported that 73% of staff would recommend LHCH as a place to work, against a response rate of 69%.

Actions: Comments have been analysed and no recurring theme has been identified, however, the low response rate is under review.

Anticipated delivery: Q1 2017/18

3.6 Finance



Refer to Finance Report.

4. Strategic Objectives – Exceptions and Actions

4.1 Quality & Experience



4.1.1 Indicator: Mortality reviews within 30 days

Issue: Doctors are reviewing 40% year to date (43% in month). Nurses are reviewing 60% year to date (17% in month). Both against a target of 95%

Actions: A new screening process has been introduced from October which has new cases being screened by one of a team of six (on rotation) and if the potential for learning is

identified, the case will progress to full review. This method will still see all cases reviewed and should significantly shorten the overall process with a reduced number of cases requiring in depth review. The requirements of 'Learning from Deaths' will improve timeliness of the process and reporting to MRG (please note that an update on these requirements will be brought to the May Board meeting).

Anticipated delivery: Q1 2017/18.

4.1.2 Indicator: Number of falls (20% reduction)

Issue: The 4 top areas experiencing falls are Elm, Oak, Cedar and Birch Wards. The Trust is above the target with 99 for the year against a target of 65. In 2015/16, the Trust had a total of 89 falls, with 81 of these occurring in Elm, Oak, Cedar and Birch Wards; with a 20% reduction set for these Wards at 65 for the year ending March 2017.

Actions: Further improvement works for falls prevention:

- Deep dive into falls for 2016-2017 analysis of results expected May 2017
- A3 for improvements nearly completed end of April - falls leads identified
- Frailty assessments occurring by Occupational Therapy (OT) colleagues
- Information for patients before admission and throughout their pathway – highlighting falls post-procedure
- Delirium policy completed – risk assessments to be added to EPR following communication to staff end of April 17
- Working with OT and Physiotherapy colleagues “ending PJ Paralysis” early mobilisation for patients who have potential for early discharge – this initiative should also be seen as fall prevention.

Anticipated delivery: Q1 2017/18 and ongoing.

4.1.3 Indicator: % Blood cultures taken within 24hrs preceding first antibiotic given

Issue: The Blood cultures taken within 24hrs preceding first antibiotic is currently not meeting the target with performance at 67% for the year 2016/17, 57% in month against a 95% target.

Actions: Improvement work is currently under way:

- Full adoption of the new national screening tool for sepsis.
- Continued training on early MEWS identification of sepsis.
- Screening tool incorporated into EPR and focusses on the appropriate diagnosis of severe sepsis. Only patients satisfying the screening criteria will start the sepsis bundle.
- Continued work with the EPR team and the analysts to explore the barriers to describing the data appropriately.
- Non EPR audits consistently show a better performance in the KPIs than the data routinely produced through the EPR query so data will be gathered directly for individual patients for a two month period to eliminate automatic search errors.
- Some simple refinements to the timing of data entry will facilitate an improvement in blood culture KPI.
- The focus on severe sepsis should lead to an improvement in the timing of blood cultures.
- A working group has been set up to address approach to sepsis.

Anticipated delivery: Q1 of 2017/18.

4.2 Service & Innovation



4.2.1 Indicator: 62 day wait for first treatment from urgent GP referral to treatment - Consultant upgrade (adjusted)

Issue: Performance for this indicator was 71.4% for the month of March against a target of 85%. This is due to one patient breach caused by the cancellation of surgery as the patient was medical unfit for treatment.

Action: The Trust continues to work with other providers to ensure that the best and most efficient pathway is in place for lung cancer patients.

Anticipated delivery: April 2017

4.2.3 Indicator: Welsh 26-weeks

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: Q1 2017/18.

4.2.4 Indicator: 100,000k genome project - rare diseases

Issue: Recruitment below trajectory both YTD and in month for rare diseases only; performance for lung cancer is excellent and above trajectory.

Actions: Action Plan in place. Expect 6 samples per week. Further support from Audit team in screening for suitable patients. We are targeting opportunities in ACHD to address the shortfall in recruitment.

Anticipated delivery: Ongoing monitoring

4.3 Value



4.3.1 Indicator: Private patient activity

Issue: Private patient activity was below target for March 2017, but remained above plan for the full year.

Actions: The Trust is working to implement the recommendations of the MIAA report alongside a review of private patients.

Anticipated delivery: ongoing work during 2017/18

4.3.2 Indicator: Improve adoption of SLR as a reliable information source

Issue: Service line reporting to be enhanced.

Actions: The finance and information departments are reviewing current processes and have been liaising with system suppliers and other NHS Trusts to ensure best practice is put in place. A new costing group is in the process of being established to deliver key objectives for self-service, engagement and continuous cycle of improvements.

Anticipated delivery: Updates to SLR data expected Q1 2017/18 with ongoing engagement work to improve outputs.

4.4 Workforce and Working Together

Nothing additional to report (see Single Oversight Framework regarding Recommendation as a place to work).

5. Operational Performance

5.1 Indicator: VTE prophylaxis

Issue: VTE prophylaxis remains just below target YTD at 91.2% compared to 95%. March 2017 performance was at 84.4%.

Actions: A regular review of patients recorded is underway to identify improvements.

Anticipated delivery: Q1 of 2017/18

5.2 Indicator: Cancelled operations for non clinical reasons

Issue: Cancelled operations internal target is 1.5%. Both the yearly and in-month performance are above target.

Actions: The surgeon of the day will review each cancellation as it occurs and proactively seek a substitute. The escalation protocol is now embedded.

Anticipated delivery: Q1 of 2017/18.

5.3 Indicator: Delayed transfers of care

Issue: Delayed transfers of care are above target 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 parallel the Director of Nursing is reviewing the CQUIN in conjunction with Commissioners.

Anticipated delivery: Linked to community based plan.

6. Finance Indicators

Refer to Finance Report.

7. 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.

8. Recommendations

The Board of Directors are asked to note Trust performance and associated exception and action reports.