







Board of Directors (in Public) Item 8.1

Subject: Performance Assessment using the Strategic and Operational Dashboards
Date of meeting: 25th July 2017
Prepared by: Lucinda Tennent, Information & Performance Manager & Mark Jackson, Director of Research & Informatics
Presented by: Tony Wilding, Chief Operating Officer


1. Executive Summary

The purpose of this paper is to present an update on Trust performance for the period to 30th June 2017/18.

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 Delivery, Research & Innovation	
Financial Sustainability Delivering Value for Money	
Be the Best NHS Employer	
Partnership & Collaborative Working	

1.3 Operational Performance

Performance Summary	
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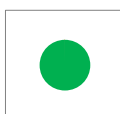
2. Background

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

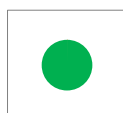
3. Single Oversight Framework – Exceptions and Actions

3.1 Leadership and Improvement Capability



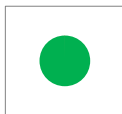
Nothing to report.

3.2 Strategic Change



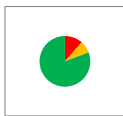
Nothing to report.

3.3 Operational Performance



Nothing to report.

3.4 Quality – Safe, Effective and Caring



3.4.1 Indicator: MRSA Bacteraemia

Accountable Executive Officer: Raph Perry

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 Quarter 4 2017/18.

3.4.2 Indicator: eColi

Accountable Executive Officer: Raph Perry

This is a new indicator for the dashboard, mandated by NHS Improvement. The aim is to reduce Gram-negative blood stream infections by 50% by March 2021, beginning with eColi. This translates to a 10% in year reduction (one less case).

These infections are mainly contained to abdominal operations, of which we do very few. That said, a reduction be a challenge given our small numbers.

Actions: Reinforce infection prevention best practices.

Anticipated delivery: End of Quarter 4 2017/18.

3.4.3 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 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 v 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 (see separate paper by the Medical Director on this Board of Directors agenda) 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. The NRLS report shows that the organisation submitted closed incidents on average 57 days after the incident occurred which is deterioration on the previous count of 42 days. More timely closure of incidents would see learning from investigating the incident being achieved closer to the incident date. Moreover, timely incident closure would see the organisation move up in the league table of reporting for the cluster.

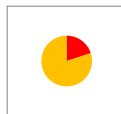
To assist the Divisions in the closure of incidents, the Risk Team now provide a weekly report to the Divisional Heads of Operations which details the incident handlers who have incidents open over 28 days. This is resulting in improvement.

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 Quarter 2 2017/18.

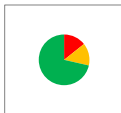
3.5 Quality – Organisational Health

Nothing to report.



3.6 Finance

Refer to Finance Report.



4. Strategic Objectives – Exceptions and Actions

4.1 Quality & Experience



4.1.1 Indicator: Mortality screening within 7 days and reviews within 30 days

Accountable Executive Officer: Raphael Perry / Sue Pemberton

Issue: Screening of deaths within 7-days has improved in June compared to May, but not to target. Year to date performance for full reviews is close to target and over for Nursing reviews. Please note these data are one month behind to allow the 30 days of follow up to expire.

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 (please see Medical Directors Q1 report on agenda).

Anticipated delivery: Q2 2017/18.

4.1.2 Indicator: Sepsis (blood cultures within 24h and antibiotics 1h)

Accountable Executive Officer: Raph Perry

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 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.

4.1.3 Indicator: Radiological alerts with a response document

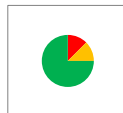
Accountable Executive Officer: Raph Perry

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.

Anticipated delivery: March 2018.

4.2 Service Delivery, Research & Innovation



4.2.1 Indicator: Number of patients recruited into CRN trials

Accountable Executive Officer: Mark Jackson

Issue: Recruitment into CRN trials is 58 behind target.

Actions: A number of new trials are opening over the coming couple of months which will reverse this underperformance.

Anticipated delivery: Q3 2017/18.

4.3 Financial Sustainability Delivering Value for Money



Refer to Finance Report.

4.4 Be the Best NHS Employer



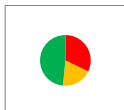
Nothing to report.

4.5 Partnership & Collaborative Working



Nothing to report.

5. Operational Performance



5.1 Indicator: Number of serious incidents

Accountable Executive Officer: Mark Jackson

Issue: Serious incident reported in April 2017.

Actions: Incident investigation is underway with Divisional Head of Operations for Medicine.

Anticipated delivery: July 2017.

5.2 Indicator: Cancelled operations for non clinical reasons

Accountable Executive Officer: Tony Wilding

Issue: Cancelled operations internal target is 1.5%. Performance in June was 2.5%. The principal driver of this elevated rate was emergency cases taking priority.

Actions: A new project aimed at reducing cancellations is being led by the Service Line Manager for cardiac and aortic surgery.

Anticipated delivery: Q3 of 2017/18.

5.3 Indicator: Cancelled operations for non clinical reasons seen within 28-days

Accountable Executive Officer: Tony Wilding

Issue: A TAVI patient cancelled for operation on the 23/03/2017 due to no POCCU beds. This failure is historical and the learning from the incident has now been embedded into operational policy.

Anticipated delivery: May 2017. Delivered.

5.4 Indicator: Delayed transfers of care

Accountable Executive Officer: Tony Wilding

Issue: Delayed transfers of care are above target due to capacity issues across the local health economy.

Action: 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: July 2017

5.5 Indicator: GP Referrals

Accountable Executive Officer: Tony Wilding

Issue: GP referrals YTD is 6,465 against target of 7,086 – 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.

Action: Monthly figures fluctuate between 3500 – 4400. Active monitoring to continue.

Anticipated delivery: Not applicable.

5.6 Indicator: 31 day Cancer (diagnosis to treatment & subsequent treatment)

Issue: 31 day cancer performance is below target in month.

31 day wait decision to treat to treatment – x2 breaches:

- X1 Patient complex case needed joint procedure. RCA complete discussed with clinical team best for patient care.
- X1 Patient – Patient TCI rescheduled without notification to tracking team.

31 day subsequent decision to treatment – x 1 breach:

- X1 Patient TCI rescheduled without notification to tracking team.

Actions: Two patients were rescheduled outside of the 31 day target without notification being sent out. Learning and awareness has been discussed within the Thoracic Consultant team and the secretarial team. Unfortunately due to the low denominator of subsequent treatments this resulted in a fail across two key indicators.

Anticipated delivery: Delivered.

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

Accountable Executive Officer: Tony Wilding

Issue: Performance for quarter shows non-compliance at 84.62%. This is primarily due to the low denominator and accepting one full breach in April due to upgrade flag missing from Somerset Cancer Register.

Action: Continuous work and improvements within the Cancer Tracking Team and Clinical Team to manage upgraded patients.

Anticipated delivery: On-going throughout 2017.

5.8 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.

5.9 Indicator: Appraisals

Accountable Executive Officer: Joanne Twist

Issue: Appraisals performance has fallen commensurate with the re-starting of the new year. We remain in the appraisal window which is open until the end of August.

Actions: Departmental Managers are undertaking appraisals and regular feedback on performance is available via My PACT and via corporate reports.

Anticipated delivery: September 2017.

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.