

Board of Directors (Public)

Item 4.1

Subject:	Strategic & Operational Dashboard Performance Assignment Thresholds
Date of meeting:	26th July 2016
Prepared by:	Gail Jones, Information Manager Tony Grayson, Head of Information Services Dr Mark Jackson, Director of Research & Informatics
Presented by:	Dr Mark Jackson, Director of Research & Informatics

BAF Ref	Impact on BAF
1 - 9	None

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 and Operational Dashboard.

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. Alongside these requirements is the need to be assured of robust data quality underpinning the information reported (refer to the Trust's Data Quality Strategy approved by the Board in July 2015 and update paper provided this month).

This document sets out the indicators covering Strategic and Operational Reporting to the Board for 2016/17 and the associated targets relevant to each indicator. New for 2016/17 is a self-assessment section that covers Strategic Objectives that cannot be measured quantitatively.

Quantitative and Qualitative Indicators & Targets

Appendix 1 shows all strategic and operational indicators for 2016/17 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 Trust's strategic objectives: quality & experience, service & innovation, value, workforce, stakeholders, together with Operational indicators for Quality, Performance, Workforce and Finance. This paper makes these thresholds transparent and explicit.

As a consequence of the extent of changes made to the 16/17 dashboard, not every quantitative indicator has yet received a data quality assessment. These will be complete by September 2016.

The qualitative indicators sit outside the normal data quality process. The acid test of quality of these ratings will be whether assessments running up to delivery matches the final “delivered” assessment.

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.

Self-assessments will be rated as below:

- | | |
|--------|--|
| Green: | On track to deliver the objective on the planned date. |
| Amber: | Not completely on track, but issues are felt to be recoverable and the delivery of the objective planned date is still achievable. |
| Red: | Significant issues have occurred that threaten achievement of the objective by the planned date. |

In Year Revisions

Ideally, in year revisions to the strategic, operational and performance dashboards should not need to occur. However, the NHS is in a significant state of flux at present. NHS Improvement has recently been formed, and a consultation on the establishment of a single oversight framework for Foundation and NHS Trusts is being proposed. This could see the introduction of new metrics that are not part of our current suite (e.g. change in cost/weighted activity unit, 7 day services, sustainability & transformation planning, strategic change, leadership & improvement capability). Our dashboards will need to change as and when the need arises.

Recommendation

The Board of Directors are asked to review and approve the definitions of indicators together with thresholds for RAG ratings.

Appendix 1: Strategic and Operational Indicators 2016/17

Table 1: Strategic Objective Quantitative Indicators RAG Ratings

	Target	Red	Amber	Green	Trend Change
Quality and Experience Indicators					
Mortality Reviews - Nurses	>=95%	<75%	>=75% <95%	>=95%	>5%
Mortality Reviews - Doctors	>=95%	<75%	>=75% <95%	>=95%	>5%
Number of falls (4 key locations)	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 falls	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 pressure ulcers	Sliding scale	Above target and above previous year performance	Above target but below previous year performance	Equal to or less than target	>0
Sepsis bundle compliance	>=95%	<75%	>=75% <95%	>=95%	>5%
Pathology bundle compliance	>=80%	<70%	>=70% <80%	>=80%	>5%
Dementia case finding	>=90%	<85%	>=85% <90%	>=90%	>1%
Patients discharged by 12pm	>=20%	<10%	>=10% <20%	>=20%	>2%
Service and Innovation					
18 weeks Referral To Treatment (RTT) waiting times - Incomplete patients	>=92%	<92%	-	>=92%	>1%
Number of 18-week Pathways Waiting 52-weeks+	0	>0	-	0	>0
26 weeks Referral To Treatment (Welsh) waiting times - Admitted patients	>=95%	<95%	-	>=95%	>1%
26 weeks Referral To Treatment (Welsh) waiting times - Non-admitted patients	>=98%	<98%	-	>=98%	>1%
26 weeks Referral To Treatment (Welsh) waiting times - Incomplete patients	>=95%	<95%	-	>=95%	>1%
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 Urgent GP referral	>=85%	<85%	-	>=85%	>1%
Cancer: 62 day Consultant Upgrade	>=85%	<85%	-	>=85%	>1%
Incidence of Clostridium	<=12	>12	-	<=12	>0

Difficile	Monitor				
Clostridium Difficile - lapses in care	<=4 Commissioner	>4	-	<=4	>0
Community data completeness - Referrals	>=50%	<50%	-	>=50%	>1%
Community data completeness - Treatments	>=50%	<50%	-	>=50%	>1%
Value					
NHS activity (inpatients)	Sliding scale	Below target and decrease from previous year	Below target but increase from previous year	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	>1%
PP activity (inpatients)	Sliding scale	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	>1%
Reduce Premium session Spend	<last year	Above the previous year	Above target but less than the previous year	Less than the previous year	>£0
Cost reduction strategy delivered £m's	Sliding scale	Below target by more than 10%	Below target between >0% to 10%	Equal to or above target	>£0
Workforce					
Time to Hire	<=42	>60	>42 <=60	<=42	2 days
Turnover Rate between 1-2 years' service (voluntary)	<=1.4%	>2%	>1.4% - <=2%	<=1.4%	>0.1%
Bank Spend 2016/17 £K	Sliding scale	Above plan >10%	Above plan <=10%	Below plan	>£0
Total Agency spend Vs. profile 2016/17 £K	Sliding scale	Above profile >10%	Above plan <=10%	Below profile	>£0
Qualified Nurse Agency Spend Vs. profile £K	Sliding scale	Above profile >10%	Above plan <=10%	Below profile	>£0
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%
Recommendation as a place to work	>=76%	<66%	>=66% <76%	>=76%	>2.5%
Recommendation as a place for treatment	>=94%	<84%	>=84% <94%	>=94%	>0%
I am able to make suggestions to improve the work in my team	>=82%	<72%	>=72% <82%	>=82%	>0%
I am able to make improvements happen in my area of work	>=65%	<55%	>=55% <65%	>=65%	>0%
The team I work in has a set of shared objectives	>=85%	<75%	>=75% <85%	>=85%	>0%

Table 2: Strategic Objective Qualitative Indicators and RAG Ratings

The below indicators are qualitatively assessed. A conventional approach to measuring data quality in these indicators cannot be taken. However, consistency across time can be assessed by examining how the RAG rating changes over time. An indicator historically rated as green for delivery sometime in the future that turns red immediately prior to the due date would suggest a lack of oversight in delivering this particular objective.

RAG ratings for qualitative indicators are assessed thus:

- Green: On track to deliver the objective on the planned date.
- Amber: Not completely on track, but issues are felt to be recoverable and the delivery of the objective planned date is still achievable.
- Red: Significant issues have occurred that threaten achievement of the objective by the planned date.

Division Routine Reports - implementation
Consultant Dashboard – CUSUM automation
Reduce missed/omitted/delayed medications
Reduce the number of alerts in EPR
Implement improvement plan to improve antimicrobial prescribing to reduce antimicrobial resistance
Implement a human factors improvement plan
Meet the requirements of patients with additional needs
Implement the organisational learning policy
Implement cardiology strategy
Develop service line specific strategies informed by KPMG
Implement service line specific strategies
Implement world class cancer outcomes strategy
Develop & implement a genomics strategy
Develop & implement an integrated IM&T strategy
Embed the community respiratory service
Embed the community respiratory service
Robotic surgery -business case submission
Implement a seven day ACS service (24/7 service)
Develop & deliver innovations that keep us at the cutting edge
Deliver SLR self-service to management
Improve adoption of SLR as a reliable information source
Develop & embed leadership behaviors and management skills
Implement talent management & succession planning
Provide appropriate education for all
Develop sustainable partnership working
Improve education and experience of all trainee's
Develop an open culture where people are encouraged to be involved
Develop and implement an integrated health & wellbeing strategy
Improve education and experience of all trainee's
Implement the equity and inclusion strategy
Deliver stakeholder improvement plan
Engage in the production of the 2016-2021 sustainability and transformation plan

Table 3: Operational Performance Indicators and RAG Ratings

	Target	Red	Amber	Green	Trend Change
Quality					
Friends and family Test response rate	>=40%	<35%	>=35% <40%	>=40%	>1%
Cumulative average patient derived FFT	>=95%	<90%	>=90% <95%	>=95%	>1%
Cumulative average family derived FFT	>=90%	<85%	>=85% <90%	>=90%	>1%
Number of complaints	Sliding scale	Above target and above previous year performance	Above target but below previous year performance	Equal to or less than target	>0
Mixed sex accommodation	0	>0	-	0	>0
Incidence of MRSA Bacteremia	0	>0	-	0	>0
VTE risk assessment	>=95%	<90%	>=90% <95%	>=95%	>1%
VTE Prophylaxis	>=95%	<90%	>=90% <95%	>=95%	>1%
Number of in-hospital deaths	Sliding scale	Above target and above previous year performance	Above target but below previous year performance	Equal to or less than target	>1
Observed mortality	<=1.35% (different in month – see sliding scale)	>1.85%	>1.35% <=1.85%	<=1.35%	>0.1%
HSMR (all diagnosis)	<=100	Above upper 95% CI	Above 100 but below upper 95% CI	<=100	>10
HSMR (56 diagnostic groups)	<=100	Above upper 95% CI	Above 100 but below upper 95% CI	<=100	>10
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 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
Medication Errors	Sliding scale	Equal to or greater than target	Below target but above previous year performance	Below target and below previous year performance	>1
PPCI 90 minute 'door to balloon'	>=95%	<90%	>=90% <95%	>=95%	>1%
PPCI 120 minute 'call to balloon'	>=90%	<85%	>=85% <90%	>=90%	>1%

PPCI 150 minute 'call to balloon'	>=95%	<90%	>=90% <95%	>=95%	>1%
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 2 nd time	0	>0	-	0	>0
Diagnostic waiting times <6 weeks	>99%	<99%	-	>=99%	>0.1%
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
Monitor Governance Risk Rating	Failing to meet at least four indicator targets at any given time, or failing the same target in three consecutive quarters.				
Workforce					
Overall staff turnover - voluntary	<=7%	>8%	>7% <=8%	<=7%	>0.25%
Mandatory Training	>=95%	<85%	>=85% or <95%	>95%	>1%
Finance					
Financial Sustainability Risk Rating	Sliding Scale	Below Target	On Target for rating, but metric below	Equal to or above target	
Capital Service Capacity Rating	Sliding Scale	Below Target	On Target for rating, but metric below	Equal to or above target	
Liquidity Rating	Sliding Scale	Below Target	On Target for rating, but metric below	Equal to or above target	
Liquidity (Days)	Sliding Scale	Below target by more than 10%	Below target between >0% to 10%	Equal to or above target	
IE Margin Metric	Sliding Scale	Below Target	On Target for rating, but metric below	Equal to or above target	
Variance in IE Margin	Sliding Scale	Below Target	On Target for rating, but metric below	Equal to or above target	
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	Above target	Equal to or	

		by more than 3%	between >0% to 3%	below target	
Total bank cost £m's	<Last year	Below Target	On Target for rating, but metric below	Equal to or above target	

Table 4: Sliding Scale Targets

These KPI's have a delivery trajectory which is profiled over the year.

	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11	M12
Number of falls (4 key locations)	6	11	17	22	27	33	38	43	49	54	59	65
Number of falls	6	12	18	24	30	36	42	48	54	60	66	72
Number of avoidable pressure ulcers	1	2	3	3	4	5	5	6	7	7	8	9
NHS activity (inpatients)	993	2108	3301	4475	5435	6644	7800	8997	9883	11019	12129	13378
PP activity (inpatients)	29	60	98	133	160	195	229	264	291	325	358	397
Cost Improvement plan £000's (YTD)	0.31	0.62	0.93	1.24	1.55	1.86	2.17	2.48	2.79	3.1	3.41	3.72
Bank Spend 2016/17 £K	£143	£123	£135	£149	£138	£123	£131	£160	£137	£115	£139	£191
Total Agency spend Vs. profile 2016/17 £K	£216	£216	£216	£175	£170	£164	£117	£117	£117	£100	£100	£100
Qualified Nurse Agency Spend Vs. profile £K	£187	£187	£187	£153	£153	£148	£102	£102	£102	£85	£85	£85
Number of complaints	9	16	22	26	29	36	40	45	50	55	61	67
Number of in-hospital deaths	13	26	40	53	66	79	92	105	119	132	145	158
Observed mortality	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
Number of incidents reported	138	276	414	552	690	828	966	1104	1242	1380	1518	1657
Medication Errors	15	29	44	58	73	87	102	116	131	145	160	174
Referrals – GP	1856	3695	5950	8198	10101	12393	14825	17018	19075	21622	24220	26511
Referrals – DGH	876	1682	2584	3550	4332	5247	6125	7012	7905	8723	9572	10448
Referrals - Other	910	1810	2835	3730	4553	5451	6382	7310	8073	8965	9919	10821
Financial Sustainability Risk Rating	2	2	2	2	2	2	2	2	2	2	2	2
Capital Service Capacity Rating	1	1	1	1	1	1	1	1	1	1	1	1

Liquidity Rating	1	1	1	1	1	1	1	1	1	1	1	1
Liquidity (Days)	(15.3)	(17.5)	(18.2)	(19.7)	(23.7)	(24.8)	(22.8)	(23.5)	(25.2)	(26.0)	(25.8)	(24.2)
IE Margin Metric	1	1	1	1	1	1	1	1	1	1	1	1
Variance in IE Margin	3	3	3	3	3	3	3	3	3	3	3	3
Net Surplus £000's (YTD)	-0.92	-1.44	-1.75	-1.94	-2.93	-3.21	-3.03	-3.41	-3.9	-4.36	-4.5	-4.35
Normalised Net Surplus £000's (YTD)	-0.92	-1.44	-1.75	-1.94	-2.93	-3.21	-3.03	-3.41	-3.9	-4.36	-4.5	-4.35
Cash Balance £m's (YTD)	5.18	3.76	3.69	3.65	2.77	1.33	2.32	2.49	2.34	2.40	2.86	2.69
Capital expenditure £m's (YTD)	0.53	1.14	1.86	2.53	3.15	3.50	3.81	4.21	4.55	4.79	5.08	5.34
Total agency cost £m's (YTD)	0.216	0.432	0.648	0.823	0.993	1.157	1.275	1.392	1.509	1.609	1.708	1.808

Appendix 2: Exception Report Template

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)