








## Board of Directors (in Public) Item 4

**Subject:** Performance Assessment using the Strategic and Operational Dashboards  
**Date of meeting:** 26<sup>th</sup> September 2017  
**Prepared by:** Mark Jackson, Director of Research & Informatics & Lucinda Tennent, Information & Performance Manager  
**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 31<sup>st</sup> August 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	
---------------------	---

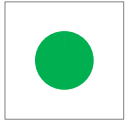
## 2. Background

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; and
- An integrated operational dashboard, which reports all of the measures of operational performance in the month and cumulatively tracks progress across core objectives.

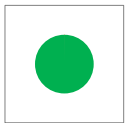
### 3. Single Oversight Framework – Exceptions and Actions

#### 3.1 Leadership and Improvement Capability



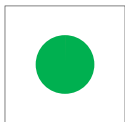
Nothing to report.

#### 3.2 Strategic Change



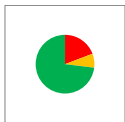
Nothing to report.

#### 3.3 Operational Performance



Nothing to report.

#### 3.4 Quality – Safe, Effective and Caring



##### 3.4.1 Indicator: Written Complaints – Rate

Accountable Executive Officer: Sue Pemberton

Issue: August 2017 – 25 YTD against a target of 29.

There is no trend in subject, area, operator or the time relating to the subject of the complaint. Complainants have 12 months to make a complaint following their experience or subject of complaint. There is no trend in the timing of this either.

Actions: None.

Anticipated delivery: End of Quarter 4 2017/18.

##### 3.4.2 Indicator: Mixed Sex Accommodation breaches

Accountable Executive Officer: Sue Pemberton

Issue: The Trust has reported 1 breach in August 2017.

Actions: The Trust has achieved much in ensuring prompt discharge following assessment as fit to leave critical care. Effort continues.

Anticipated delivery: September 2017.

#### **3.4.3 Indicator: MRSA Bacteraemia**

Accountable Executive Officer: Raphael Perry

Issue: 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.

#### **3.4.4 Indicator: HSMR – basket of 56 diagnosis groups**

Accountable Executive Officer: Raphael Perry

Issue: HSMR for May 2017 = 150.81, 95% CI: 86.70 – 238.25.

Actions: Consider revision of reporting tolerances based upon confidence limits issued by Dr Foster.

Anticipated delivery: September 2017.

#### **3.4.5 Indicator: HSMR – weekend**

Accountable Executive Officer: Raphael Perry

Issue: HSMR for May 2017 = 248.51, 95% CI: 80.10 – 432.43.

Actions: Consider revision of reporting tolerances based upon confidence limits issued by Dr Foster.

Anticipated delivery: September 2017.

#### **3.4.6 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 vs 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.

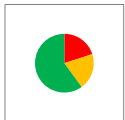
The Learning from Deaths initiative is being implemented across Trusts which should provide a platform for increased reporting.

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. 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 3 2017/18.

### **3.5 Quality – Organisational Health**



#### **3.5.1 Indicator: Staff Sickness**

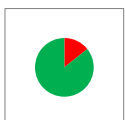
Accountable Executive Officer: Jo Twist

Issue: There has been a small improvement in monthly sickness although it remains above target, as does year to date.

Actions: All staff triggering the sickness policy are reviewed by the Division with HR support; all are being managed as per the policy. Sickness levels are being driven by long term rather than short term sickness.

Anticipated delivery: Ongoing monitoring and management.

### **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 but not to target (76% in month and 62% YTD against a target of 95%).

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.

Anticipated delivery: Q2 2017/18.

#### **4.1.2 Indicator: HSMR – basket of 56 diagnosis groups**

See section 3.4.4 above.

#### **4.1.3 Indicator: Sepsis - blood cultures within 24 hours**

Accountable Executive Officer: Raphael Perry

Issue: 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.

Anticipated delivery: Q3 2017/18.

#### **4.1.4 Indicator: Outpatient scores from Friends & Family Test**

Accountable Executive Officer: Steven Colfar

Issue: 89% YTD against a target of 95%. The negative responses are linked to OPD waiting times.

Actions: The next phase of self-check in is due to be trialled by November. This will enable future work to a linked appointment system where diagnostic test appointments will be more effectively managed around the main OPD consultant review. This streamlining work will significantly reduce OPD waiting times.

Work is on-going with the divisions to review the working times of cardiac diagnostics and pulmonary function to reduce risk of delays in morning clinics.

There are now two patient information screens live in the department which aim to keep patients updated with information. Other screens will be able to go live when the next phase of self-check in is completed.

Patients and their families/carers are regularly briefed in the wait area about expected wait times.

Anticipated delivery: On-going throughout 2017.

#### **4.1.5 Radiological alerts with a response document**

Accountable Executive Officer: Raphael Perry

Issue: 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. A deep dive within each Division has been agreed to provide interim assurance that SHM's are being managed effectively.

Anticipated delivery: March 2018.

### **4.2 Service Delivery, Research & Innovation**



#### **4.2.1 Indicator: Achieve Recruitment on 100k Genome Project – rare diseases**

Accountable Executive Officer: Mark Jackson

Issue: Recruitment into the 100k Genome Project – rare diseases is 7 behind target YTD.

Actions: This is a National issue; there has been a revision in inclusion and exclusion criteria which may improve recruitment.

Anticipated delivery: Q4 2017/18.

#### **4.2.2 Number of patients recruited into CRN trials**

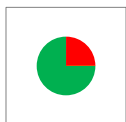
Accountable Executive Officer: Mark Jackson

Issue: Recruitment into CRN trials is 72 behind target YTD.

Actions: A number of new trials are opening over the coming couple of months which will reverse this underperformance. Recruitment in August was excellent which has closed the gap somewhat.

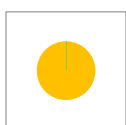
Anticipated delivery: Q3 2017/18.

#### **4.3 Financial Sustainability Delivering Value for Money**



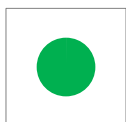
Refer to Finance Report.

#### **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 adverse events, serious incidents and never events**

Accountable Executive Officer: Mark Jackson

Issue: Serious incidents reported in April and August 2017.

Actions: The incident investigations are underway with Divisional Heads of Operations in Medicine and Surgery.

Anticipated delivery: September & November 2017.

#### **5.2 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.

Action: This failure is historical and the learning from the incident has now been embedded into operational policy.

Anticipated delivery: May 2017 - Delivered.

### **5.3 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: September 2017

### **5.4 Indicator: GP Referrals**

Accountable Executive Officer: Tony Wilding

Issue: GP referrals YTD is 11,110 against target of 11,810 – 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.

### **5.5 Indicator: NHS Activity**

Accountable Executive Officer: Tony Wilding

Issue: YTD = -0.36%

Action: Position significantly improved in month. Continued focus on delivery.

Anticipated delivery: September 2017.

### **5.6 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 80.56% YTD. This is primarily due to the low denominator and a number of late referrals into LHCH.

Action: Clinical Input to proactively manage upgraded patients through diagnostic to treatment.

Anticipated delivery: On-going throughout 2017.

#### **5.7 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.

#### **5.8 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.

Results from September suggest achievement of target.

Anticipated delivery: September 2017.

#### **5.9 Indicator: Finance Indicators**

Refer to Finance Report.

### **6. 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.

### **7. Recommendations**

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