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SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO THE BOARD OF DIRECTORS

HELD ON 16 APRIL 2014

Subject:	Performance Management Framework Review
Supporting TEG Member:	Kirsten Major, Director of Strategy and Operations
Authors:	Paul Buckley, Deputy Director of Strategy and Planning
Status[1]	A

PURPOSE OF THE REPORT:

This paper describes review the current Performance Management Framework (PMF) arrangements and proposes a revised way forward, describes a number of next steps and includes a timetable for the completion of the review.

KEY POINTS:

The revised Performance Management arrangements are based on 5 overriding key principles:

a) The Board of Directors should establish clear KPIs and targets which should be balanced across clinical, operational, financial and staff dimensions.
b) Individual service lines should develop their own KPIs and targets within this context which are usually agreed as part of the annual planning cycle.
c) KPIs and targets should be tracked and monitored regularly with regular performance reviews at all levels to drive performance improvement.
d) Performance conversations should focus on identifying root causes rather than symptoms, and participants should be focused on how performance can be improved.
e) It is important to reinforce desirable behaviours with rewards and consequences for performance.

There are a number of key actions required to take forward the proposed changes which include a new Integrated Performance Report for the Board of Directors and new arrangements for working closely with Directorates.

IMPLICATIONS[2]**:**

AIM OF THE STHFT CORPORATE STRATEGY 2012-2017		TICK AS APPROPRIATE
1	Deliver the Best Clinical Outcomes	✓
2	Provide Patient Centred Services	✓
3	Employ Caring and Cared for Staff	
4	Spend Public Money Wisely	✓
5	Deliver Excellent Research, Education & Innovation	

RECOMMENDATION(S):

The Board is asked to:

a) Debate the proposed indicators for 2014/15
b) Agree to the key actions required to take forward the proposed changes to performance management within STH.

APPROVAL PROCESS:

Meeting	Date	Approved Y/N
TEG	26 March 2014	Y
Board	16 April 2014	

SHEFFIELD TEACHING HOSPITAL NHS FOUNDATION TRUST

Performance Management Framework Review

1. Introduction

This paper describes the work carried out to date to review the Sheffield Teaching Hospitals NHS Foundation Trust (STH) Performance Management Framework (PMF). It proposes a revised way forward, describes a number of next steps and includes a timetable for the completion of the review.

1.1 Scope

The scope of this work included a review performance reporting at the Board of Directors and performance management of Clinical Directorates. The review has been carried out by the Deputy Director of Strategy and Planning through a number of defined steps.

- Review of performance related documentation including the existing STH PMF document, guidance from Monitor, NHS Foundation Trust performance reports, FTN best practice, Price Waterhouse Coopers (PWC) report (July 2009) and Internal Audit Report (June 2013)
- Observation of the Board of Directors and review of STH Board reports
- Participation in the existing PMF approach through attendance at TEG and Directorate PMF meetings, attendance at Healthcare Governance Committee, Finance, Performance & Workforce Committee
- Review of the STH online performance monitoring tool
- Participation in the 2014/15 Business Planning meetings and preparation for the 2013/14 Annual Care Group Reviews
- Initial discussions with key internal stakeholders including Directorates, Healthcare Governance, Finance, Workforce, Information and Corporate colleagues

1.2 Background

In 2009 STH agreed a new PMF based on Monitor's Service Line Management approach which focussed on performance at a Directorate level. In June 2013 Internal Audit was asked to provide assurance that the PMF was meeting the needs of STH and a useful tool for Directorate management. The final report gave a C grading of moderate assurance which indicated the presence of medium risks/internal control weaknesses and highlighted the following key points.

- The purpose of the PMF is unclear and is not sufficiently well defined
- No clear timetable for when each data source is available in the online performance tool
- Concerns with the availability, accuracy & timeliness of some indicators/data
- The limited use of locally relevant indicators in assessing performance
- The low level of clinical engagement with the system

These identified points are addressed within this paper.

2. Proposed Way Forward

2.1 Performance Management Process

In its simplest form the PMF includes the performance management processes which collectively help deliver the strategic objectives and ultimately the vision of STH. Performance management

within STH will continue to be based on aspects of Monitor's Service Line Management approach in which the following are described.

- The Board of Directors should establish clear KPIs and targets that are balanced across clinical, operational, financial and staff dimensions
- Individual service lines should develop their own KPIs and targets within this context which are usually agreed as part of the annual planning cycle.
- KPIs and targets should be tracked and monitored regularly with regular performance reviews at all levels to drive performance improvement.
- Performance conversations should focus on identifying root causes rather than symptoms, and participants should be focused on how performance can be improved
- It is important to reinforce desirable behaviours with rewards and consequences for performance.

The Board of Directors continues to drive towards the levels of performance expected of a first class Foundation Trust. Directorates operate within a devolved clinical structure remaining directly accountable for the quality of services delivered to patients within an agreed financial envelope.

The performance management of productivity and efficiency (P&E) targets will be included in the revised performance arrangements. However, the detailed process of ensuring delivery of individual P&E schemes should continue to be led by the STH Programme Management Office (PMO) under the defined governance structure which is in place.

2.2 Board of Directors

Performance Indicators

The Board should establish the key performance indicators and targets for the organisation aligned to those set out by Monitor, NHS England, Care Quality Commission and those identified locally. **Appendix 1** brings together a range of indicators and targets which are presented to the Board for initial consideration.

Board Reporting

To ensure good governance **Appendix 2** contains a number of references to Monitor's Board Governance Assurance Framework and Quality Governance Framework. To meet these and best practice requirements and those set out in Monitor's Governance Reviews (consultation) and Code of Governance, an Integrated Performance Report will be developed for the Board and consist of a front end dashboard, a Directorate level heatmap and detailed exception reports where adverse performance is observed. An example is provided at **Appendix 3.** The report will be presented with variances, trends and where possible benchmarking information to illustrate areas of good and adverse performance. The Directorate level heatmap sets out at a high level the relative performance against the agreed performance indicators. An example is included in **Appendix 4.**

The Integrated Performance Report will be reported on a monthly basis at the Board of Directors and be collectively delivered by each of the functional Executive Directors – the Director of Strategy & Operations, Chief Nurse, Medical Director, Director of Finance and Director of Human Resources & OD. TEG members should review the Integrated Performance Report and the Directorate level heatmap prior to every Board meeting.

Soft Performance Measurement

The Board of Directors should also consider what is described in the Quality Governance Framework as the use of 'soft' performance measurement, such as visits to services and patient

stories, which are supported by formal mechanisms for capturing, reporting and reacting to this information.

The Board currently visit services after each formal monthly meeting and Executive Directors spend time either visiting or working within a department or service. Non-Executive Director visits to services outside of the formal Board and other intelligence obtained from their work (such as appointments panels) for the Trust may add to this. The use of patient stories at Board meetings can be an effective mechanism to draw the Board's attention to the experience of patients cared for by STH.

2.3 Directorates

Responsibilities

The key responsibilities for performance management at a Directorate level remain the same as those described by PWC.

- The service line consists of a Clinical Director (CD) who is accountable for the performance of the service line in all areas and a General Manager (GM) and Nurse Director (ND) who have this responsibility delegated to them
- These leaders should exhibit competencies across quality, finance, people and collaborative service leadership
- There should be a single line of accountability for delivering tasks

Performance Indicators & Measurement

Directorate key performance indicators will be aligned to those which are agreed by the Board and include other specific indicators which are determined by the leadership team to reflect the nature of their business. All agreed performance indicators should have a target and where performance is met then a Green rating is given for that indicator where it is not either Amber or Red is apportioned depending on the extent to which it is not met. Each Directorate is then rated overall based on the performance against the agreed key performance indicators (**Figure 1).**

Figure 1 - Directorate Ratings

Rating	Description
Green	Meeting or exceeding KPIs
Amber	Not meeting more than one KPIs for more than one month
Red	Failure to meet more than one KPIs for three consecutive months Significant adverse performance on any KPI

For some Directorates, particularly those which are non-admitting, there will be more locally agreed performance measures compared to those set out nationally. Where this is the case locally agreed measures should be benchmarked and upper quartile performance should be the target. An example Dashboard is included in **Appendix 5**.

Performance Management Review Meetings

There will be a clear and consistent schedule of performance management review meetings. The Chief Operating Officer (COO) is responsible for organising and leading the review meetings. The frequency of meetings will be based on the Directorate rating and any concerns highlighted by TEG.

Figure 2 – Performance Review Meeting Requirements

Rating	Frequency	Minimum Attendance
Green	Quarterly meetings Directorate to identify and lead items for discussion	COO, GM, CD and ND
Amber	Monthly meetings Provide a monthly performance report with action plans to address areas of concern	COO, GM, CD and ND
Red	Monthly meetings Provide monthly performance reports with actions plans to address the areas of concern Enforcement action may be taken to remedy the adverse performance	TEG members, COO, GM, CD and ND

Meetings with Directorates rated Amber or Red will have clear terms of reference and agendas set by the COO with information available 3-5 working days ahead of the meeting. It is expected that the CD, GM and ND attend the meetings where discussions should aim to understand the issues preventing good performance and the actions in place to address the variance. All review meetings should not replace the ongoing performance conversations which take place between the Directorate and the COO. The COO will require dedicated performance and information support to ensure robust and timely data is available that allow meetings to progress effectively. This support will take a lead on producing the Board reports and Directorate dashboards.

Appendix 6 includes a high level timeline for the meetings to take place. The meeting timetable includes the forward looking Business Planning Review meetings in November/December and an Annual Directorate Review meeting in May/June led by the Chief Executive. These meetings will be integrated into the timetable as they are a key part of agreeing future objectives and reviewing the delivery of performance for the previous year. Both meetings involve members of TEG with the latter involving the Chief Executive.

Escalation and De-Escalation

The STH performance management process should help develop the devolved clinical directorate structure. Leadership teams will continue to be held to account for delivering high quality, efficient and financially sustainable service lines. Within Care Groups, Clinical Directors will be expected to work together to help maintain an overall Green rating for the Care Group including, where possible over-performing to meet the under-performance in other Directorates. Across STH Care Groups should be expected to work together to maximise opportunities for success.

A robust escalation process will be established to ensure swift action can be taken to support Directorates where possible changes in performance are identified or anticipated. Ongoing performance conversations should take place with the COO at every opportunity to share this intelligence. All Directorates will on an agreed basis be offered additional support should any the delivery of the required standards of performance be at risk. This may include Service Improvement support, additional short term capacity to maintain performance or specific resources to implement remedial measures.

Where Directorates fail to achieve the required improvements after support they will be subject to increased monitoring required to produce detailed actions plans and discuss the recovery plans with TEG members. Should Red Directorates fail to act appropriately to deliver the agreed recovery plans, TEG may consider instigating the STH Capability Procedure and enforcement action within the Directorate to remedy the adverse performance.

Where performance improves and is sustained the Directorate will be returned on an agreed basis to less frequent monitoring.

3. Analytical Performance Management Tools

STH should have in place a robust performance management system includes high quality, timely and efficient data. There continue to be examples across the NHS where outdated, often manual systems are used to drive and monitor performance from which the Board are unable to gain assurance. The Internal Audit report highlighted concerns with the availability, accuracy and timeliness of some indicators/data currently used at STH.

There are a range of business analysis/intelligence tools which may assist the Trust in developing a more robust performance management system. It is proposed that in progressing revised arrangements for performance management within STH, an appraisal of the available tools and resources will be considered. This would then allow the Integrated Performance Report to include an assessment of the quality of data which is contained within the report.

4. Next steps

There are a number of key actions required to take forward the proposed changes described within this paper (**Table 1**).

Table 1 – Action Plan

Action	Lead	Timescale
Report to Board of Directors on proposed performance management arrangements and indicators to Board for consideration	Kirsten Major	16 April
Wider discussion on arrangements within Directorates and Corporate Services (CMB/Ops Board/Board Committees)	Kirsten Major	April
Develop the Integrated Performance Report for the Board (Indicators, thresholds, dashboard and heatmap) and Directorate dashboards	Paul Buckley	April & May
Present draft Integrated Performance Report to Board	Kirsten Major	21 May
Establish performance review meeting schedule with Directorates & develop terms of reference for meetings	Ellen Ryabov	End May
Consider opportunities to develop online performance management tool and/or new business intelligence system	Annette Peck	End May
Publish timetable for information sources	Paul Buckley	End May
Implementation of new arrangements for 2014/15 and first round of performance meetings with Directorates	Ellen Ryabov	June

5. Conclusion

This paper describes a revised approach for performance management at STH that includes a new Integrated Performance Report for the Board of Directors and new arrangements for working closely with Directorates.

6. Recommendation

The Board is asked to:

a) Debate the proposed indicators for 2014/15
b) Agree to the key actions required to take forward the proposed changes to performance management within STH.

Appendix 1- Performance Indicators & Standards

Strategic Aim	Indicator	Standard
Deliver the best clinical outcomes	MRSA	0
	MSSA	5 or less per month
	C Difficile	6 or less per month
	Serious Untoward Incidents	N/A
	Number of patient falls per 10,000 bed nights	N/A
	Number of pressure ulcers per 10,000 bed nights	N/A
	Number of Never Events	0
	Number of days since last Never Event	N/A
	% of patients receiving harm free care	90%
	Average LOS per elective spell	0.7
	Average LOS per non elective spell	7.0
	Average LOS (excluding day cases)	3.2
	Summary Hospital-level Mortality Indicator	N/A
	Hospital Standardised Mortality Ratio	N/A
	% staff who would recommend STH to a relative for treatment	TBC
	CQC Risk Rating	N/A
	Friends and Family Test - Inpatients	TBC
	Friends and Family Test - Outpatients	TBC
	Friends and Family Test – A&E	TBC
	Friends and Family Test – Maternity	TBC
	Friends and Family Test - Community	TBC
Provide patient centred services	A&E 4-hour wait	95%
	>12 hr Trolley waits in A&E	0
	18 week waits referral to treatment time – admitted	90%
	18 week waits referral to treatment time – non-admitted	95%
	18 week waits referral to treatment time – incomplete pathways	92%
	Diagnostic waits within 6 weeks	99%
	Cancelled Operations on the day	77 or less per month
	% outpatient appointments cancelled by hospital	10%
	% outpatient appointments cancelled by patients	12.5%
	% DNA for new outpatient appointments	7%
	% DNA for follow up outpatient appointments	6.5%
	Cancer 2 week referral to date seen	93%
	Cancer 2 week wait breast referrals	93%
	31 day diagnosis to treatment	96%
	31 day second or subsequent treatment – Radiotherapy	98%
	31 day second or subsequent treatment – Drugs	94%
	31 day second or subsequent treatment – Surgery	94%
	62 day urgent referral to treatment	85%
	% appointments booked through C&B	95% by December 2014
	CQUIN Indicators	N/A
	Number of complaints	N/A
	Response to complaints within 21 days	90%
	Theatre Utilisation	95%
	Day Case percentage	78%
	Emergency re-admissions within 30 days	0%
	Delayed Transfers of Care	71
Employing caring and cared for staff	Sickness Absence	4.0%
	Appraisals	95%
	% staff who would recommend STH as a place to work	TBC
	Staff turnover (rolling 12 months)	7%
	% staff completed mandatory training	90%

Strategic Aim	Indicator	Standard
Spend public money wisely	I & E	On plan
	Net surplus	On plan
	Liquidity ratio (days)	15 days
	Capex	Variance from plan
	Contract penalties (£)	N/A
	Quality & Efficiency	Variance from plan
	A&E attendances	On target
	Elective Inpatient activity	On target
	Non elective inpatient activity	On target
	New outpatient attendances	On target
	Follow up outpatient attendances	On target
	Monitor Governance Rating	Green
	Monitor Continuity of Services Risk Rating	3
Deliver excellent research, education and innovation	Closed trials meeting agreed recruitment to time and target	90%
	Number of participants recruited to all portfolio grant & industry studies	7100
	Number of new portfolio grant studies initiated	137
	Number of new portfolio industry studies initiated	48

Thresholds		
Green	Amber	Red
On target	Within 5% of target	> 5% from target (except for Cancer, A&E, CDiff, Never Events, MRSA, 18 weeks

Appendix 2 – Board Governance Assurance Framework (BGAF) & Quality Governance Framework (QGF)

BGAF

1. The Board has debated and agreed a set of quality and financial metrics outside the nationally and regionally agreed metrics that are relevant to the Board given the context within which it is operating and what it is trying to achieve

2. The Board receives a performance report which includes;

- A fully integrated performance dashboard which enables the Board to consider the performance of the Trust against a range of metrics including quality, performance, activity and finance and enables links to be made
- Variances from plan are clearly highlighted and explained
- Key trends and findings are outlined and commented on
- Future performance is projected with associated risks and mitigations provided where appropriate
- Key quality information is triangulated so that Board members can accurately describe where problematic service lines are
- Benchmarking of performance to comparable organisations is included where possible
- Supporting performance detail is broken down by service line so members can understand which services are high and low performing from a financial and quality perspective

QGF

A strategic integrated performance dashboard

- This would allow comparison and triangulation across quality, performance, workforce, productivity and finance metrics.
- An analysis of Trusts demonstrating good practice indicates that there is a generic range of useful information that can be triangulated to give a comprehensive picture of performance of a trust, for example: Hospital Episode Statistics (HES) data; patient experience surveys; complaints, claims and patient safety incident reporting; Patient Reported Outcome Measures (PROMS); national and local clinical audit findings; and post-investigation complaints and staff surveys. Trusts have also found it helpful to include an overview summary matrix of their quality performance by division or service so that they are better able to see any adverse performance within the overall aggregate level.

Detailed performance scorecards

- These are aligned to main strategic goals and provide monthly historical representation of data and benchmark positions. Trusts are increasingly using standardised scorecards at the board, which are then expanded and used by divisions and service lines to measure trust-wide and local goals. Ward-based dashboards should be aggregated to allow better benchmarking between services. Some trust leaders have electronic access to real-time dashboards that allow them to see on any one day how the trust is performing against its priorities.

Board assurance

- The Trust board can gain assurance through the use of a strategic integrated performance dashboard that includes quality, performance, activity and finance targets aligned to strategic goals, which visibly cascades down to ward and service level dashboards;

- The use of ‘soft’ performance measurement, such as board visits and patient stories, which are supported by formal mechanisms for capturing, reporting and reacting to this information
- A formalised strategic approach to data quality improvement aligned to quality governance. This should be supported by regular data quality metrics and a data quality assurance, process mapping and audit programme will allow the board to receive assurance that this is effective
- Actively benchmarking performance with comparable organisations based on risk assessing areas of greatest need; internal benchmarking and ‘peer reviews’; and a robust analysis of historical data.
- The board uses a strategic integrated performance dashboard which includes:
  - quality, performance, activity and finance;
  - aligning performance scorecards to strategic goals;
  - expanding to ward- and service-level dashboards;
  - explanation for variances;
  - analyses and comments;
  - performance projection and trends;
  - risk analysis on achieving trajectory; and
  - overview summary of the impact on quality by division or service.

Appendix 3 – Integrated Board Report Dashboard (Template Example)

Indicator	Measure	Current Data Month	Month Actual	YTD	Trend	Data Quality
Deliver the best clinical outcomes						
MRSA						
C Diff						
Serious Untoward Incidents						
Pressure Sores						
Average Length of Stay						
Patient Falls						
Never Events						
Staff satisfaction Survey						

Indicator	Measure	Current Data Month	Month Actual	YTD	Trend	Data Quality
Employing Caring & Cared for Staff						
Sickness Absence						
Appraisals						
Staff satisfaction Survey						

Indicator	Measure	Current Data Month	Month Actual	YTD	Trend	Data Quality
Spend Public Money Wisely						
I & E						
Net surplus						
Quality & Efficiency						
Elective Inpatient activity						
Non elective inpatient activity						
New outpatient attendances						
Follow up outpatient attendances						

Indicator	Measure	Current Data Month	Month Actual	YTD	Trend	Data Quality
Provide Patient Centred Services						
A&E 4-hour wait						
>12 hr Trolley waits in A&E						
18 week waits referral to treatment time						
Cancelled Operations						
Cancelled Outpatient appointments						
DNA rate						
Cancer Waits						
C&B utilisation						
Ethnic Origin data collection						
CQUINS						
ECAT Indicators						
Complaints						

Indicator	Measure	Current Data Month	Month Actual	YTD	Trend	Data Quality
Deliver Excellent Research, Education & Innovation						
Recruitment to trials						
Number of studies						

Appendix 4 - Directorate Level Heatmap (Template – Example for Gastro)

Indicator	Measure	Gastro	Resp Med	Elderly	Diabetes / Endo	A&E	OSCCA	CDs/Spec Med	Spinal	Spec Cancer	Cardio	Vasc	Renal	PC & Comm
MRSA	Number													
C Diff	Number													
Serious Untoward Incidents	Number													
Pressure Sores	Number of pressure sores per 10,000 bed nights													
Average Length of Stay	Average LOS per elective spell													
	Average LOS per non elective spell													
Patient Falls	Number of patient falls per 10,000 bed nights													
Never Events	Number of never events													
Staff satisfaction Survey	% staff who would recommend STH to a relative for treatment													
A&E 4-hour wait	% of patients within 4 hours													
>12 hr Trolley waits in A&E	No. of patients waiting > 12 hours													
18 week waits referral to treatment time	Admitted patients													
	Non admitted patients													
	Incomplete pathways													
Cancelled Operations	Number of operations cancelled on the day for non clinical reasons													
Cancelled Outpatient appointments	% canc by hospital													
	% cancelled by patient													
DNA rate	% DNA for new outpatient appt													
	% DNA for follow up outpatient apt													
Cancer Waits	Number of months 2ww target met													
	Number of months 62 day target met													
	Number of months 31 day first treatment target met													
	Number of months 31 day subsequent treatment target met													
C&B utilisation	% appointments booked through C&B													
Ethnic Origin data collection	% valid ethnic group													
CQUINS	On target													
ECAT Indicators	% Indicated red													
	% indicated blue & green													
Complaints	Number of complaints received													
Sickness Absence	% sickness rate													
Appraisals	% appraisal rate													
Staff satisfaction Survey	% staff who would recommend STHT as a place to work													
I & E	I & E variance from plan													
Net surplus	On plan													
Quality & Efficiency	On target													
Elective Inpatient activity	On target													
Non elective inpatient activity	On target													
New outpatient attendances	On target													
Follow up outpatient attendances	On target													
Recruitment to trials	TBA Number of participants recruited to all portfolio grant & industry studies	N/A												
Number of studies	TBA Number of new portfolio grant studies initiated	N/A												

Appendix 5 – Directorate Dashboard – (Pharmacy Example)

Organisational Aim	Indicator	Measure	Target	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Deliver the best clinical outcomes	Never Events															
	Staff satisfaction Survey	% staff who would recommend STHT to a relative for treatment														
Provide Patient Centred Services	Medicines reconciliation rate	Number of reconciliations undertaken														
	Dispensing errors	Number of dispensing errors made														
	Prescription turnaround	TTOs - <60 mins, with >95% completed in 2 hours														
		OPD scripts - <30 mins, with >95% completed in 60 mins														
	Complaints	Number														
	Buildings	Profit/loss per square metre														
Employing Caring & Cared for Staff	Sickness Absence	% sickness rate														
	Appraisals	% appraisal rate														
	Staff satisfaction Survey	% staff who would recommend STHT as a place to work														
Spend Public Money Wisely	Quality & Efficiency	Variance from P&E plan														
Deliver Excellent Research, Education & Innovation	Recruitment to trials	Number of participants recruited to all portfolio grant & industry studies														
	Number of studies	Number of new portfolio grant studies initiated														
		Number of new portfolio industry studies initiated														

Appendix 6 - High Level Timeline