Meeting:	**Brighton and Sussex University Hospitals NHS Trust** **Board of Directors**
Date:	**4th November 2015**
Board Sponsor:	**Chief Operating Officer**
Paper Author:	**Gareth Hall, Associate Director - Business Support**
Subject:	**Trust Board Performance Scorecard – Month 6**

Executive Summary – Introduction:

The aim of this paper is to report monthly performance to the Board against the set of measures aligned to the Trust's annual objectives and the composite metrics and national standards used by the TDA and Monitor to measure our operational performance.

The Performance report has been refreshed further to enable a more comprehensive view of performance.

Board members should note that where validated data is unavailable for the period, indicative numbers may be used and that the reporting of some indicators is subject to a time lag and may be reported some months in arrears. This is highlighted where necessary in the report itself.

Recent Context: Board members have been regularly advised of the continuing challenges and failure to deliver the National Standards for A&E, RTT and Cancer Waiting Times (CWT). The Board has previously been informed of 'recovery plans' and associated trajectories agreed with the NHS Trust Development Authority (TDA) and our local commissioners in addition to the associated 'Contract Performance Notes' received by the Trust.

The revised trajectories are currently as follows:

- **A&E 4-hour standard** – delivery of 95% compliance by March 31st 2015 (subject to the ECIST programme) to reflect the expected impact of a number of significant planned service changes affecting clinical pathways, the *Right Care, Right Place, Each Time* programme and available capacity at both PRH and the RSCH including community beds planned for Newhaven. This work and the associated detailed project plans are being coordinated by the reconfigured Urgent Care Transformation Board in conjunction with other external partners across the local health system and this multi-agency delivery plan is overseen by the Local Health Economy (LHE) 'System Resilience Group.

- **18 week (RTT**) – The Trust has agreed revised recovery plans to comply with the new nationally reported standard associated with 'incomplete' pathways. As previously reported, we do not anticipate aggregate compliance before October 2016 due to the extensive backlog of long waiters. This is subject to review pending completion of the detailed validation exercise concerning the 'unknown clock status' which is currently underway. 2 specialties; General surgery and Spinal Surgery are expected to take much longer to comply as there is a significant mismatch between capacity and demand. The extensive specialty level plans are propagated on a re-alignment of capacity and demand (where that

is possible without the use of external capacity), forensic pathway and waiting list management and improvements in operational data quality.

- **Cancer Access –** As previously reported, The Trusts performance in relation to the key cancer waiting times has been consistent with a deteriorating national picture and we are one of a number of Acute Trusts who have been requested to identify progress, against the 8 high impact changes for Cancer. The Trust extensive recovery plan is designed to deliver compliance from November 2015.

Highlights from the month 6 Board report: In terms of Month 6 performance, the Trust continues to report a 'failed' position against aggregate performance for the 18 Week RTT 'incomplete' pathway standards with an 81.4% performance against the 92% standard. The Trust continued to breach the '6 week wait for diagnostic test standard' in September as patients breached the 6 week target across a range of modalities including; Echo, MRI, CT, Ultrasound, Endoscopy & Neurophysiology – further detail is in section 1 of the paper.

Trust delivery of the 4 hour A&E wait standard deteriorated in September with an 85.1% performance, giving a year to date (YTD) position of 82.5% and is below with the recovery trajectory. Performance remains particularly challenged on the Brighton site within the main ED and remains very high risk as winter approaches.

A total of 2 patients experienced waits of over 12 hour in our Emergency Department from decision to admit during September. Such lengthy waits are as a result of major challenges regarding patient flow and largely due to a significant mismatch between discharges and admissions. All breaches are reviewed and lessons learned to help prevent recurrence.

The Trust breached 2 of the national cancer standards in August – performance is reported 1 month in arrears and is evaluated quarterly. The associated recovery plan is referenced in the narrative above and is explored in more detail elsewhere in this report.

5 cases of C. Difficile were reported in September giving the YTD total of 27 cases (end of September) with the year-end threshold of 46, as set by the Department of Health.

The level of reported Delayed Transfers of Care (DTOC) remains very high at 3.9% and continues to represent a significant and unresolved problem in terms of limiting Trust capacity for acutely ill patients thereby compounding patient flow problems within the hospital. The numbers of bed days in September occupied by patients who are considered medically fit for discharge but not a reportable DTOC continue to be very high at an average of 40 occupied beds per day.

Links to Corporate objectives	The report monitors progress against the objectives of ***excellent outcomes; great experience; empowered skilled staff; high productivity***
Identified risks and risk management actions	Risk 1. Adverse patient experience of and impaired access to Trust services. Risk 2. Adverse impact on Trust reputation with patients, staff and external bodies. Risk 3. Non-Compliance with national standards and the potential adverse impact on national performance ratings published by the

	TDA and the CQC. Risk 4. Adverse financial consequences associated with contractual fines, penalties and associated financial adjustments for performance below agreed standards. The value of performance related contractual fines (subject to re-investment) such as those associated with RTT, A&E and Ambulance Handover is estimated to be approximately £3.2m at month 6 (subject to a cap of 2.5% contract value). The expectation is that most will be re-invested in the Trust by our commissioners. Risk 5. Adverse impact on future Foundation Trust authorisation. **Management actions** Specific risk management actions will depend on the specific KPI and performance measure concerned. Measures are reviewed regularly at the relevant Board sub-committee or the Hospital Management Board and associated actions are agreed and monitored by exception.
Resource implications	See above – risk 4
Appendices	Appendix 1 – Month 6 Trust Board performance Report.

Action required by the Board:
The Board is asked to note month 6 performance as detailed in the scorecard and the associated narrative and to agree any further actions to address adverse variances as required.

Report to the Board of Directors, September 2015
Trust Board Performance Report – Month 6

Particular themes or areas of concern for the Board to note are described below:

1. Patient Access – Waiting Times/Referral to Treatment /RTT (KPIs 1 - 5):
As previously reported, the Trust has submitted revised recovery plans to comply with the new nationally reported standard associated with 'incomplete' pathways which is now the sole measure of the constitutional right of patients to start treatment within 18 weeks. Due to the extensive backlog of long waiters we do not anticipate aggregate compliance before October 2016. The extensive specialty level plans are propagated on a re-alignment of capacity and demand, forensic pathway and waiting list management and associated improvements in operational data quality.

Of the circa 7200 patients currently waiting over 18 weeks, one third are waiting for surgery, the balance are on outpatient pathways. Digestive Diseases (surgical), Oral Surgery, Orthopaedic and Neurosciences (including Spinal) continue to make up over half of the total number of patients waiting longer than 18 weeks.

In addition, some cases that would previously have been excluded from the RTT return are now being added as part of our work on patients with 'unknown clock status' which is expected to be concluded within the next 4 weeks and may impact on the trajectory.

Delivery of the recovery programme remains high risk and is highly susceptible to escalating unscheduled care demand which impacts on available theatre and bed capacity for planned care on a daily basis.

September performance is as follows:

	National Standard	Actual Performance
Incomplete backlog	92%	81.4%

As referenced previously, the Trust was inappropriately excluding echocardiograms from the monthly return on diagnostics and September is the first month of full reporting. There is a recovery plan but the volume of work is such that we will not be compliant with the operating standard (<1% of patients to wait over 6 weeks) until March 2016. We have reported 512 breaches of the standard for September and therefore a 10.13% performance against the 1% target. Both TDA and commissioners are fully briefed and we are in discussion with the National PMO to see whether they can help us reduce the overall number of patients who are currently waiting.

It is worth noting that there have been significant problems with the new 'Referral Management' service used by GPs in Brighton and Hove. The new contractor engaged by the CCG, Optum Health Solutions has taken over from BICS and provides referral management services for all elective services with the exception of patients referred under the two week wait cancer rule who come direct and musculoskeletal patients who come via the Sussex MSK Partnership triage service.

The new service provider was initially unable to access the E referral system for BSUH slots (previously known as Choose and Book) and was affected by an IT problem. A backlog of patients quickly developed and patients have now been passed to BSUH in large batches. Discussions are continuing to both ensure we get things back onto a stable platform and can quantify the impact on unexpected spend within the centralised booking hub as the team catches up on a backlog of over 2500 patients.

2. Patient Access – Emergency Care (KPI 6 – 12):

At month 6 the Trust continues to face significant operational challenges on a day to day basis notably at the Royal Sussex County Hospital (RSCH) but also on occasion at Princess Royal Hospital (PRH). The reasons for this have previously been reported extensively to the Board.

Trust delivery of the 4 hour A&E wait standard deteriorated in September with an 85.1% performance, giving a year to date (YTD) position of 82.5% and is below with the recovery trajectory. Performance remains particularly challenged on the Brighton site within the main ED and remains very high risk as winter approaches. This issue is covered elsewhere in this Board agenda.

Regrettably, a total of 2 patients have experienced waits of over 12 hour in our Emergency Department from decision to admit during September. Such lengthy waits are as a result of major challenges regarding patient flow and largely due to a significant mismatch between discharges and admissions. All breaches are reviewed and lessons learned to help prevent recurrence.

At month 6, the ratio of admissions to attendances was 24.6% and is largely unchanged from the previous period. A&E attendances across the Trust overall were 1.6% (-1,087) lower than 14/15 levels to month 5, with Non-Elective admissions 3.2% (- 709) lower than the comparator for the same time period. Such reported activity reductions need to be considered within the context of pathway and currency changes such as those connected with RACOP and SAU etc.

Ambulance handover delays monitor the time it takes for clinical handover between Trust and SECAMB for patients brought into the emergency department by ambulance. The standard is a 15 minute handover. Year to date data continues to require validation with the ambulance Trust but remains a major operational challenge with significant delays reported during periods of high pressure. We continue to work with SECAMB on this as a priority and are in the process of agreeing a recovery plan in conjunction with them.

3. Patient Access – Cancer: (KPI 13 – 21):

Cancer access targets are evaluated quarterly and are reported 1 month in arrears.

As previously reported, The Trusts performance in relation to the key cancer waiting times has been consistent with a deteriorating national picture and we are one of a number of Acute Trusts who have been requested to identify progress, against the 8 high impact changes for Cancer. This involved establishing sub-speciality trajectories by tumour group and a recovery plan to deliver cancer wait compliance by November 2015.

The Trust breached 2 of the national cancer standards in August across the following pathways:

- 62 day wait for first treatment from urgent GP referral;
- 31 day wait for second or subsequent treatment - surgery

The continued high level of cancellations for surgery, resulting from the ongoing emergency flow related pressures is continuing to impact on performance against the trajectory.

4. Clinical Quality – Infection Control and Prevention (KPI 22 – 23):
5 cases of C.Difficile were reported in September giving the YTD total of 27 cases (end of September) which is 4 in excess of the trajectory to achieve the year end threshold of 46 set by the Department of Health. There were zero cases of MRSA in September with the YTD total remaining on 1.

5. Clinical Quality - Mortality (KPI 24 – 27):
This suite of indicators reflects a number of indicators that the CQC and the TDA use to monitor Trust performance in addition to the HSMR and SHMI previously reported. The indicators are reported internally using HED data (data is several months in arrears) and report performance against risk adjusted thresholds. Reported data now shows a rolling 12 month figure rather than performance in month as this is considered to be a more representative measure.

A threshold of below 100 is considered to be acceptable. Variation between months is not unexpected because of the relatively small numbers of patients associated with the measure and variances between weekend and Monday-Saturday rates are broadly in keeping with the national norm. Overall mortality continues to be lower than expected. Crude mortality (non-risk adjusted) for Non- Elective admissions has been added to this suite of indicators at the request of the TDA to enable a more up to date trend/early warning prompt prior to publication of the risk adjusted data**.** May data is largely unchanged from previous months.

6. Clinical Quality – Patient Safety (KPI 29 - 42):
The number of 'new Serious Incidents' reported in month was 1 in September. New incidents are those reported in the month although this may not be the month in which the incident actually occurred and are subject to a detailed investigation.

The in-year reduction in VTE assessment performance reported in KPI 38 reflects a change in counting methodology which now includes a broader cohort of patients across the Trust. Performance management is now being taken forward by the Trust Thrombosis Committee.

7. Operational Efficiency - Cancelled Operations (KPI 43 – 47):
Capacity issues arising from the demand on unscheduled care services continue to impact on elective care and regrettably, the number of elective operations being 'cancelled on the day continues to be problematic as does the volume which could not be re-booked within 28 days. All cancellations are assessed clinically and re-scheduled as quickly as possible.

8. Operational Efficiency – Stroke and Revascularisation (KPI 48 – 53):

Time on stroke unit - In total 18 patients (out of 23) spent 90% of their IP stay on a dedicated stroke unit achieving 78% performance against target of 80%. The 5 patient that did not spend the majority of their time on the unit was admitted to other wards.

Direct Admissions - 16 patients were admitted directly to a stroke ward achieving 70% performance against the target of 90%. 7 patients were subject to delays in A&E and were subsequently admitted to other wards.

Scan Band in 1 Hour - 14 patients (of 17 eligible) were scanned within 1 hour achieving 82% performance against target of 50%

Scan Band in 24 Hours – All 17patients were scanned in 24 hours giving a 100% performance. The 1 patient who had a delayed scan was already an inpatient but required a specialty cardiac review prior to the scan and was the cause of the delay.

High Risk TIA – 13 patients (of 15) were all seen within 24 hours giving 87% performance against the standard.

Low Risk TIA – 38 patients were seen within 7 days ensuring 100% performance against the standard.

Note: the reported volume of 23 stroke patients is low as a result of a large number of stroke discharges in early October that have not yet been coded and will therefore not be included in the report until it is re-run YTD.

9. Length of Stay/Demand (KPI 54 – 68):

The Trust continues to report variable activity compared to plan, across multiple 'Points of Delivery' (EL, NEL, New OP etc) and Directorates across various commissioning groups (see dashboard for details). Although the margin of underperformance in some areas has reduced, it represents a significant risk to securing the level of income required to deliver the Trusts financial obligations.

The level of reported Delayed Transfers of Care (DTOC) reduced to 3.9% in September but still remains significantly over the 3.5% threshold. As previously reported, this represents an unresolved problem in terms of Trust bed capacity being used for non-acute cases (notably those waiting for NHS Non- Acute and other care packages) and therefore compounding the problems associated with unscheduled care and RTT related access.

The numbers of bed days occupied by patients who are considered 'medically fit for discharge' but not a reportable DTOC continue to be very high with an average of 46 beds in September. (Average of 44 over the whole previous year) which is a significant increase in comparison with the previous year.

N.B. Patients who are considered as medically fit for discharge, are those considered clinical suitable for discharge but are, for example, awaiting a formal care package assessment. Patients categorised as a 'delayed transfer' are patients who have been assessed but are waiting for that care package to be put in place i.e. transfer to a nursing home etc.

10. Patient Experience – Complaints, Friends and Family Test (KPI 69 – 79):

There has been a noted increase in complaints reported in September and this is thought to be due in part to the impact of the August holiday period where there tends to be a delay in complainants registering their issue with the Trust.

In summary, Maternity, Outpatient and A&E satisfaction rates continue to improve with maternity remaining higher than the national benchmark. The Trust is in the process of securing a new partner to assist in the management of the 'Friends and Family' process across all mandated areas and expects to see increases in response rates once this initiative becomes live before the end of the year.

11. Workforce -Training and Safety (KPI 80 - 86):

KPI 80 - Overall safe staffing fill rate has varied by 1-2% each month in recent months – September performance is 94.3%

KPI 81 – The % of **Registered Nurses** is largely unchanged but is expected to improve with the recent national and international recruitment campaigns

KPI 82 – The % of completed for **Staff Appraisals** was largely unchanged at 64.4%. The organisational target is 75%. The recently introduced Leadership Standard clearly articulates the expectations of all leaders within the organisation including the explicit objective that managers must appraise their staff annually.

KPI 85 – The **Trust vacancy rate** remains above at the 8% Trust target.

KPI 86 - **Staff Turnover** of 13% remains slightly higher than the national average of 11.5% but was largely unchanged from the previous month.

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October 2015