

Meeting:	Brighton and Sussex University Hospitals NHS Trust Board of Directors
Date:	30 March 2015
Board Sponsor:	Chief Executive, Chief Financial Officer and Director of Strategy and Change / Deputy CEO
Paper Author:	Gareth Hall, Associate Director - Business Support
Subject:	Trust Board Performance Scorecard – Month 11

Executive Summary

The aim of this paper is to report monthly performance to the Board against the set of measures aligned to the Hospital's strategic goals and the composite metrics used to measure our operational performance externally.

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. This is highlighted where necessary in the report itself.

Highlights from the month 11 Board report:

The Trust continues to submit a 'managed fail' position against aggregate performance for the 18 Week RTT 'admitted', 'non-admitted' and incomplete pathway standards. The Trust delivered the February backlog reduction target agreed with the TDA in January ahead of time and exceeded the target by 178, reducing the overall number of patients waiting longer than 18 weeks by 732. Good progress has been made in a number of specialties but the Trust remains with significant waits in spinal services and digestive diseases (surgical).

Trust delivery of the 4 hour A&E wait standard remains extremely challenged with 78.9% performance in February giving a year to date position of 84.5% against the 95% standard. This means that performance continues to be below expectations and the focus on improving this as a real priority remains. The reasons for this remain complex and are covered elsewhere in this Board agenda.

The level of reported Delayed Transfers of Care (DTC) remains very high with a February performance of 5.33% against a target of 3.5% and continues to represent a significant, material problem in terms of limiting Trust capacity for acute patients. The numbers of bed days in February occupied by patients who are considered medically fit for discharge but not a reportable DTC continue to be very high at an average of 46 occupied beds per day. This does not include all patients who could be cared for out of the hospital and we are developing further information to highlight this overall position.

Regrettably, the Trust breached one national cancer standard in January; the '62 day wait for first treatment from urgent GP referral' due to the unavoidable cancellation of a number of elective surgical cases.

2 cases of C. Difficile were reported in February and the Trust is currently on trajectory to be within the year-end threshold of 50 cases for C.Difficile. There were zero cases of MRSA in February.

Links to strategic objectives	Best and Safest Care ✓ High Performing ✓
Identified risks and risk management actions	<p>Risk 1. Adverse patient experience of and impaired access to Trust services.</p> <p>Risk 2. Adverse impact on Trust reputation with patients, staff and external bodies.</p> <p>Risk 3. Non-Compliance with national standards and the potential adverse impact on national performance ratings published by the TDA and the CQC.</p> <p>Risk 4. Adverse financial consequences associated with contractual fines, penalties and associated financial adjustments for performance below agreed standards. It is estimated that the value of performance related contractual fines such as those associated with RTT, A&E and Ambulance Handover will be circa £5.8m at month 11. Discussions are on-going with our commissioners about the scale and scope of reinvestment of such fines and penalties.</p> <p>Risk 5. Adverse impact on future Foundation Trust authorisation.</p> <p>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.</p>
Resource implications	See above – risk 4
Legal implications	None specifically identified
Report history	Executive Management Board March 2015
Appendices	Appendix 1 – Month 11 Trust Board performance Report

Action required by the Board:

The Board is asked to note month 11 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 – March 2015 Trust Board Performance Report - Month 11

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

1. Referral to Treatment - 18 Week Pathway (KPIs 1 - 5):

The Trust delivered the February backlog reduction target agreed with the TDA in January ahead of time and exceeded the target by 178, reducing the overall number of patients waiting longer than 18 weeks by 732. Good progress was made in a number of specialties but the Trust remains with significant waits in spinal services and digestive diseases (surgical).

Board members have previously been advised that achieving RTT trajectories is extremely 'high risk' due, in part, to the ongoing pressures within unscheduled care that continue to reduce capacity available to deliver service level recovery plans.

As previously reported, considerable volumes of activity continue to be outsourced to available capacity in the independent sector and work to establish achievable trajectories in order to achieve future aggregate compliance is on-going at specialty level.

February performance is as follows due to the agreed focus on the longest waiting patients:

	National Standard	Actual Performance
Admitted Care	90%	71.6%
Non-admitted Care	95%	86.4%
Incomplete backlog	8%	11.9%

The trust reported one Orthopaedic patient waiting over 52 weeks at month end – the patient has subsequently been treated.

2. Referral to Treatment – 6 week wait for diagnostic tests (KPI 6):

The Trust was compliant in February.

3. Cancelled Operations (KPI 7 – 9):

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 increase. All cancellations are assessed clinically and re-scheduled as quickly as possible.

4. A&E standards (KPI 10 – 11):

At month 11 the Trust continues to face significant operational challenges on a day to day basis particularly at the Royal Sussex County Hospital (RSCH) but increasingly so at Princess Royal Hospital (PRH). The RSCH was in the highest level of escalation (level 4) for 7 days and at level 3 for 18 days during February with a similar picture reported at PRH. Trust performance with regard to the 4 hour A&E wait standard remains extremely challenged with a 78.9% performance in February giving a worsening year to date position of 84.5% against the 95% standard. Regrettably, 7 patients waited for longer than 12 hours for a hospital bed following a decision to admit during several periods of exceptional pressure which were, in part, linked to the outbreak of Norovirus at PRH which resulted in the re-direction of cases to the RSCH. A full review of each case is in hand so that lessons for the whole system can be identified and actioned.

In keeping with the national media reports, the Trust has experienced a 4% increase in A&E attendances year to date and the recent surge in emergency admissions reported to the Board for December continued in February – see section 6 for further narrative.

Ambulance conveyance rates to BSUH have increased by around 2.6% which equates to around an additional 100 journeys to hospital per month in comparison to the previous year.

This issue is referred to in detail in a separate report at this Board meeting.

5. Ambulance handover delays (KPI 12 – 13):

These indicators 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 and growing operational problem with significant delays reported during periods of high pressure.

This issue is referred to in detail in a separate report at this Board meeting.

6. A&E attendance to admission ratio metric (KPI 14):

At month 10, the ratio of admissions to attendances continues to rise and February's figure of 31.6% in which is a slight reduction in comparison to the previous month. Board members should be aware that the winter period has seen a 4% rise in admissions for older people aged 65-84 and an 8% rise in those aged 85 and over and that there is a rising cohort of patients spending longer in hospital - with on average around 5 additional patients per day occupying a hospital bed for longer than 14 days in comparison with last year.

This issue is referred to in detail in a separate report at this Board meeting.

7. Cancer access (KPI 19 – 27):

The Trust breached one standard in January (reporting is one month in arrears): 'the 62 day wait for first treatment from urgent GP referral' and quarterly performance for this standard remains extremely high risk.

The key issues impacting on performance principally relates to the high numbers of cancer pathway elective surgical cancellations arising from the unscheduled care pressures across a range of specialties.

8. Stroke Care Performance (KPI 28 – 33):

The total number of stroke patients admitted and discharged with a primary diagnosis of Stroke in February was 31 (the figure will change subject to final coding).

All key stroke performance standards were achieved with the exception of 2 indicators:

- 'The % of Direct Admissions to the stroke unit' where performance was 67.7% against a threshold of 90%. This was mainly due to insufficient availability of stroke bed capacity on both sites and concerned 18 patients in total
- Stroke: % of low risk TIA patients seen in 7 days - 97% against a target of 100%. This related to 1 patient who chose not to be seen within the 7 day standard.

TIA performance for both high risk and low risk strokes was 100%

9. Local performance/whole system measures (KPI 34 – 39):

Outpatient 'new to follow up' rates are subject to some variation between months but are generally higher than the LHE stretch target although the overall trend is a slight decrease. GP referral rates are largely unchanged.

10. Healthcare Acquired Infection (KPI 43 – 44):

2 cases of patients acquiring C. Difficile were reported in the month and the Trust remains within trajectory for the year end threshold. Zero cases of MRSA were reported in February.

11. Number of Serious Incidents (KPI – 49):

The number of new Serious Incidents reported in month was 6. 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.

13. Percentage of reported safety incidents that are harmful (KPI – 53):

In January there were 0.5% reported incidents that were considered harmful. This was a reduction from the previous month. All incidents are subject to a detailed investigation under the governance of the Executive Safety and Quality Committee.

14. 30 Day Emergency Readmissions (KPI 57 – 60):

Reducing the number of patients who were re-admitted has both a quality and financial implication for the Trust as a proportion of re-admissions are currently considered to be 'avoidable' and are not paid for by commissioners in accordance with the national contract. Although best evaluated over relatively long periods of time, there is some evidence to suggest that re-admissions are reducing due to the focussed work undertaken by the Trust in this area.

15. Delayed transfers of care (KPI – 61 – 62):

The level of reported Delayed Transfers of Care (DTC) reduced slightly but remains far in excess of target at 5.14% in February (against a target of 3.5%) and represents a significant problem in terms of Trust bed capacity being used for non-acute reasons 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 DTC continue to be very high with an average of 46 beds in February 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 clinically 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.

This issue is referred to in detail in a separate report at this Board meeting.

16. Hospital Mortality (KPI 63 – 66):

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.

Variation between months is not unexpected because of the relatively small numbers of patients associated with the measure. Overall mortality continues to be lower than expected.

This issue has been examined in detail by the Board Quality and Risk Committee.

17. Caesarean Section rates (KPI 68 - 69):

The reporting of this indicator has been amended to reflect the CQCs approach to risk and we now report the % of caesarean operations performed both electively and as an emergency. Variation between months is to be expected however, performance is higher than the standard for both pathways.

18. Patient Experience – Friends and Family (KPI 71 – 76):

The Board will recall note that a new national scoring methodology for the 'friends and family' test was introduced in October. The scorecard now reports the % of respondents who 'would' and who 'would not' recommend the Trust across the 3 service areas of Inpatients, A&E and maternity services.

In summary, maternity satisfaction rates remain higher than those nationally; 97.8% would recommend the service compared to 95% nationally and inpatient's satisfaction is broadly comparable with the national picture, 92.9% would recommend compared to 94% nationally. A&E satisfaction rates are 81.6% (only one month in the past 12 months has been better than this), recommending and 12% not recommending, this is below the national average of 88% recommending and 6% not recommending. The number of FFT questionnaires administered is 10.7%, which is an improvement but remains below the national average, which is 20%.

19. Workforce indicators (KPI 82 - 88):

KPI 82 - **Temporary costs over time as % of pay bill** was 11.58% and reflects, in part, the consequences of using extra capacity to manage the unscheduled care pressures.

KPI 84 – the proportion of **Temporary Staff** is slightly improved from the previous month.

KPI 85 - **Staff Turnover** of 12.1% is slightly higher than the national average of 11.5%.

KPI 86 – The % **Nurse Registered Nurses** is largely unchanged but is expected to improve with the recent national and international recruitment campaigns.

KPI 87 – The % of completed for **Staff Appraisals** increased to 45.3%. 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. A detailed action plan has been developed in response to the recommendations of a recent internal audit review of appraisals the delivery of which is to be monitored by the Clinical Management Board.

KPI 88 – The **Trust vacancy rate** remains below the 8% Trust marker at 4.7%.

Gareth Hall
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