

BOARD OF GOVERNORS

PERFORMANCE REPORT – 2 MONTHS TO MAY 2010

Report of the Director of Information Systems & Analysis and the Head of Performance Intelligence

1. Introduction

This paper sets out the performance position for the period ending 31 May 2010.

2. Executive Summary of Performance Position to 31 May 2010

<u>2. Performance against priority targets</u>	2010/11 Target	FYtD Performance Apr – May 10 [Trend in period since last report]	Risk / Commentary
2.1 4 hour maximum wait in A&E (incl. partnered Cambs MIU activity)	98%	98.3% [↑ improvement]	Medium. Live action plan in place to sustain.
2.2 18 weeks from GP referral to hospital treatment - admitted patients	90%	95.2% [↑ improvement]	Low. Although the individual Orthopaedic specialty is at risk.
2.3 18 weeks from GP referral to hospital treatment - non-admitted patients	95%	98.4% [↑ improvement]	Low
2.4 Cancer 2 week wait from urgent referral to first seen	93%	96.0% - All cancers 98.0% - Breast symptoms (Apr 10) [↑ improvement]	Low
2.5 Cancer 31 day wait for first treatment from diagnosis	96%	97.2% (to Apr 10) [← no real change]	Low
2.6 Cancer 31 day wait for subsequent treatment - (excluding Radiotherapy until Dec 2010)	Drug 98% Surgery 94%	100.0% (Apr 10) [← no real change] 99.0% (Apr 10) [↑ improvement]	Low
2.7 Cancer 62 day wait for first treatment from urgent referral	Standard 85% Screening 90%	88.5% (Apr 10) [↑ improvement] 96.4% (Apr 10) [↑ improvement]	Medium. Action plan in place to address.
2.8 Reduction in MRSA bacteraemias	10	1 (on trajectory) [↑ improvement]	Medium. Risk due to small numbers. Detailed action plan ongoing and reviewed monthly.
2.9 Clostridium difficile infection in the 2 and over age group	108	18 (on trajectory) [↑ improvement]	Medium. Detailed action plan ongoing and reviewed monthly.
2.10 Cancelled operations and patients not re-booked within 28 days of an operation cancelled	0	1 patient not re-booked within 28 days; and 94 (0.72%) cancelled operations [↑ improvement]	Medium

<u>2. Performance against priority targets – cont.</u>	2010/11 Target	FYtD Performance Apr – May 10 [Trend in period since last report]	Risk / Commentary
2.11 Delayed transfers of care (DTC)	< 09/10 Nat Ave	7.1% [↑ improvement]	High. Up on 09/10 levels.
2.12 Access to GUM clinic within 48 hours	100%	100.0% [← no real change]	Low
2.13 % of outpatients waiting 13 weeks or more at the end of each month	0%	0.00% [↑ improvement]	Low
2.14 % of inpatients waiting 26 weeks or more at the end of each month	0%	0.00% [← no real change]	Low
<u>2. Performance against productivity measures</u>	2010/11 Target	Rolling year Performance - 12 months end Apr 10 [Trend in period since last report]	Risk / Commentary
2.15 Overall Non-Elective Spell Length of Stay (LoS) - days	4.0	5.7 [← no real change]	High. Significantly adverse to trajectory.
2.16 Overall Elective Spell LoS - days	2.6	3.8 [↑ improvement]	High. Significantly adverse to trajectory.
2.17 Day Case rate	79.8%	76.6% [↑ improvement]	Medium
2.18 Day of Surgery Admission (DOSA) rate	80.9%	69.6% [↑ improvement]	Medium
2.19 Day Case Basket rate	83.0%	75.1% [↑ improvement]	Medium
2.20 New outpatient did not attend (DNA) rate	na	6.1% (to May 10) [← no real change]	Medium

3. Performance for the period ending 31 May 2010

This report relates to performance against key targets and productivity measures. The summary given above outlines a number of areas of higher or growing risk. Actions being taken to address these areas are as follows:

- [Ref 2.7] Cancer 62-day wait standard target – further improvement has been made since the last Board of Governors meeting, and non-adjusted performance for April is 88.5% and favourable to the target of 85%. However an element of risk remains due to the nature of inter-trust referrals.

The Cancer Services division has continued in actively approaching trusts who have made late referrals to us and request that they take responsibility for the entire breach. The Trust has sought the support of the Anglia Cancer Network to standardise how the breach reallocation policy is applied across the Network and negate the need for local negotiation. Actions also continue in four key areas of focus to improve patient administration; expedite patient pathways; increase capacity; and reallocate appropriate inter-provider trust breaches. These ongoing actions are monitored weekly at Executive Director level, and the Cancer Target action plan is updated monthly.
- [Ref 2.8] The 2010/11 target is set at 10 MRSA bacteraemias and focuses on post-48hr infections only (so reflects what the Trust can influence); there were 12 post-48 hour infection cases in 2009/10. Although the Trust is currently on trajectory with only 1 case so far in May, there is risk in achieving target because of the small numbers involved. Root cause analysis is carried out on every confirmed case. Senior Clinical Nurses undertake weekly audits of high impact interventions and patient experience audits. The roll out of the Healthcare Acquired Infection (HCAI) assurance ward accreditation programme continues Trust-wide. There are new learning points each month (from any MRSA bacteraemias recorded). The Infection Control priorities and action plan continues to be implemented as planned.

- [Ref 2.9] The 2010/11 target is set at 108 Clostridium difficile cases – no more than 9 per month. The Trust is currently on trajectory with 18 cases recorded so far to the end of May, but the target represents a further improvement on the already significant 57% reduction seen in 2009/10.

Robust actions are in place, including the continued analysis of time to isolation data including reports and action plans from wards where non-compliance is identified; the deep clean programme - 4 wards have been deep cleaned since 1 April 2010; and an equipment cleaning pilot to provide an audit trail at ward level continues.
- [Ref 2.10] 94 patients have been cancelled on or after the day of admission for surgery this financial year to date, and as a proportion of elective activity (0.72%) represents slight improvement on performance last year. Cancellation breakdown by reason: 55 – no operating time available, 20 – medical/equipment shortage, 10 – bed shortage, 3 – by consultant, 3 ITU bed shortage, 2 – no anaesthetist, and 1 - by ward.

Operational managers continue to review year to date cancellations and analyse weekly cancelled operations reports to ensure that correct reasons are being captured and that clinical cancellations are being excluded.

Many cancellations due to no operating time are actually being caused as beds have not been available in the morning for day of surgery admissions (DOSA). Consequently theatres lists are running late. A further 10 trolleys for DOSA were opened in June to help minimise this, and the Trust DOSA unit is due to open in September later this year. An escalation policy is followed and all cancelled operations are reported to the Duty Director of Operations in order that all alternatives to cancellation are considered before this action is taken as a last resort.
- [Ref 2.11] The proportion of inpatients whose transfer of care was delayed remains high and has risen compared to last year (7.1% vs 4.1%).

CEOs, Chief Operating Officers (COOs) and other key stakeholders have continued to meet regularly to drive a reduction in delayed transfers of care (DTC). In May, the CEOs decided to separate this forum into a strategic group and an operational group to support delivery.

The number of DTC fell during April and May compared to previous months (February and March). However this mirrors last year's performance and may not be significant. The whole health economy action plan is being refreshed and rationalised by the new operational group of COOs to ensure that resources are channelled to the priority actions. The recent analysis by the Department of Health is being used to support revision of the action plan.

The focus on discharge planning within the Trust continues, remaining pivotal to our success and running alongside the EP3 Effectiveness Programme.
- [Ref 2.15 & 2.16] Overall non-elective and elective spell length of stay (LoS) for the 12 months ending April 2010 are 5.7 and 3.8 days respectively; both are considerably adverse to trajectory to meet the 2011 target. The Effective Patient Care (EPC) programme has delivered 74 cumulative beds against the 2008 baseline since April 2009. Each Division has a phased delivery plan (starting from April) for bed closures agreed for 2010/11. Significant progress has been made against this plan, with over 50 beds closed in the Medicine Division in April and May.

The Joint Clinical & Corporate Executive (JCCE) has approved capital funding to enable the next phase of hospital reconfiguration, including work to enable an enlarged day of surgery admission (DOSA) facility by September 2010.

Divisions are continuing to update their action plans each month. Plans are reviewed by the Executive and discussed with divisions at the bi-monthly divisional meetings and at the Clinical Executive on a monthly basis - best practice is identified and being shared with other divisions at the latter.

4. Recommendation

The Board is asked to note the Trust's performance position for the period ending 31 May 2010 and the actions being taken to address areas of risk.