

Integrated Performance Report

May 2006

Trust Board Meeting

6th July 2006

Integrated Performance Report (IPR) – May 2006

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The Leeds Teaching Hospitals NHS Trust

Overview

- This month, a new style of Trust Board reporting has been adopted. It is intended to highlight the Trust's performance against a much wider set of indicators but will also continue to summarise progress towards national targets as these will be used to compile the Trust's "Annual Health Check".
- The new indicators are grouped under the broad headings of: Access & Activity, Finance, Workforce, Patient Experience and Productivity & Efficiency. As the report develops, the data and supporting information within it (peer benchmarking and local context) should provide an opportunity for the Trust Board to consider and take decisions to improve the Trust's overall performance.
- The late agreement on Service Level Agreement income and the consequential impact on workforce and activity have resulted in insufficient time to fully develop the data for this month's report. However, the enclosed report "Focus on: Performance, Productivity and Efficiency" should give a clear indication of the future style of reporting.

2006/07: Progress to date:

- **Activity:** In the first two months of 2006/07, activity is below the corresponding period last year in all areas except Accident and Emergency. This is due to the low month in April (which included the Easter break) but has been largely offset by a busier than anticipated May.
- **Access:** Performance against the identified key commitments is generally improving. A&E has made progress against the 4 hour target and the agreed action plans continue to be implemented within cancer in order to bring the Trust up to national standards. However, the number of last minute, non-clinical cancelled operations and waiting times for an MRI or CT scan worsened in May.
- Progress against the local trajectory set for meeting the national target of 20 weeks for inpatients and day cases by March 2007 is encouraging but LTHT is already behind profile for outpatients against both the local target of 6 weeks by December 2006 and the national target of 11 weeks by March 2007. Ensuring that balanced and sustainable progress is made in both the inpatient and outpatient settings is necessary to provide the impetus towards the 18 week waiting times target.
- **Workforce:** The levels of sickness absence for the first two months of the year were higher than the England average for 2005 of 4.5%; this suggests that improvements can be made in this area. Contrary to the current LTHT workforce strategy to reduce staff numbers through turnover in order to avoid redundancies, the turnover rate is lower than planned. The number of people starting with the Trust just outnumbered those leaving in the first two months of 2006/07.
- **Patient Experience:** The Trust lags behind its peers for its response time to complaints and needs to improve. Initial data shows that the Trust compares well with its peers for incident reporting but could strengthen the quality and timeliness of data in order to learn from these incidents. The number of risk management claims for the year to date is lower than the same period last year.
- **Productivity and Efficiency:** The Trust's Change Management Programme will lead its drive for increased productivity and efficiency. A number of task forces have already been set up to focus on procurement, medical productivity and the specialties of General Surgery and Trauma & Orthopaedics. National benchmarking data shows that LTHT performed better than its peer group in terms of short stay emergency admissions, sickness absence and spending on agency staff but worse than its peers for medical productivity, unnecessary outpatient appointments and day case rates.

Key commitments:

Existing Standards & New National Targets (Healthcare Commission)	May Data	YTD	YTD position
Maintain the 4 hour maximum wait in A&E from arrival to admission, transfer or discharge (<i>% less than 4 hours</i>)	98.2%	97.5%	Amber
Thrombolysis: 60min call to needle: deliver a 10% increase per yr	<i>Pilot of alternative treatment ongoing</i>		
Maintain a maximum two week wait from urgent GP referral to 1 st outpatient appointment for all urgent suspected cancer referrals. (<i>% seen within 2 weeks</i>)*	100%	99.9%	Green
Ensure a maximum waiting time of one month from diagnosis to treatment for all cancers (<i>% within 1 month</i>)*	89.9%	91.4%	Red
Achieve a maximum waiting time of two months from urgent referral to treatment for all cancers (<i>% within 2 months</i>)*	75.1%	71.3%	Red
Maintain a two week maximum wait standard for Rapid Access Chest Pain Clinics (RACPC) (<i>% less than 2wks</i>)	100%	100%	Green
Maintain a 3 month maximum wait for revascularisation (<i>reported breaches of 3 months</i>)	0	0	Green
Maintain a maximum wait of 13 weeks for an outpatient appt. (<i>no. waiting over 13 weeks</i>)	0	0	Green
Maintain a maximum wait of 26 weeks for inpatients (<i>number waiting over 26 weeks</i>)	1	3	Green
Every hospital appointment to be booked for the convenience of the patient, making it easier for patients and their GPs to choose the hospital and consultant that best meets their needs.	98.6% IP/DC	98.7% IP/DC	Amber
	98.4% OP	98.5% OP	Amber
Delayed transfers of care to reduce to a minimal level by 2006 (<i>% delayed, weekly data</i>)	1.7%	1.5%	Green
From April 2002, all patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days or fund the patient's treatment at the time and hospital of the patient's choice (<i>no. of breaches declared</i>)	22	36	Red
Number of operations cancelled, by the hospital, for non-clinical reasons, on the day of or after admission (<i>no. declared</i>)	112	168	Red
Reduce emergency bed days by 5% by 2008 (from the expected 2003/04 baseline) (<i>% change in number of occupied bed days for emergency admissions from same point in 2003/04</i>)	-12.5%	-13.6%	Green
Achieve year on year reductions in MRSA levels, expanding to cover other health care associated infections as data from mandatory surveillance becomes available (<i>number per quarter</i>)	42 (Q4, 05/06)	n/a	Green
To ensure that by 2008, nobody waits more than 18 weeks from GP referral to hospital treatment; no patient to wait longer than 26 weeks for an MRI or CT scan (<i>number 26+ as at month end</i>)	31	48	Red
Slot utilisation: The availability of clinic slots within 13 weeks as shown on the Choose and Book slot utilisation reports (<i>definition tbc</i>)	n/a	n/a	-
To ensure that by 2008, nobody waits more than 18 weeks from GP referral to hospital treatment; no patient to wait longer than 13 weeks for a diagnostic test by 31st March 2007 (<i>number 13+</i>) (<i>to be confirmed</i>)	n/a	n/a	-
Data quality on ethnic group: Percentage of FCEs with a valid 2001 census coding for ethnic category (<i>excluding not stated and not known</i>)	54.1%	54.5%	Red
Percentage of patients attending GUM services seen within 48 hours of contacting the service (<i>quarterly survey data</i>)	30% (Feb 06)	n/a	-
Percentage of maternities where breastfeeding data was collected (<i>quarterly - available after end of quarter 1</i>)	n/a	n/a	-
Percentage of maternities where smoking at delivery data was collected (<i>quarterly - available after end of quarter 1</i>)	n/a	n/a	-

Note: The year to date position is based on both the current position and progress to date. If the target can be met based on performance continuing at the same rate, the position is green. *Cancer monthly data is incomplete & subject to change following validation.

Focus on: Performance, Productivity and Efficiency

- Each month, this section will provide an overview of the performance, productivity and efficiency indicators identified by the Trust looking at plans, trends and benchmarking data to assess the impact of changes in performance on the strategic direction of the Trust.

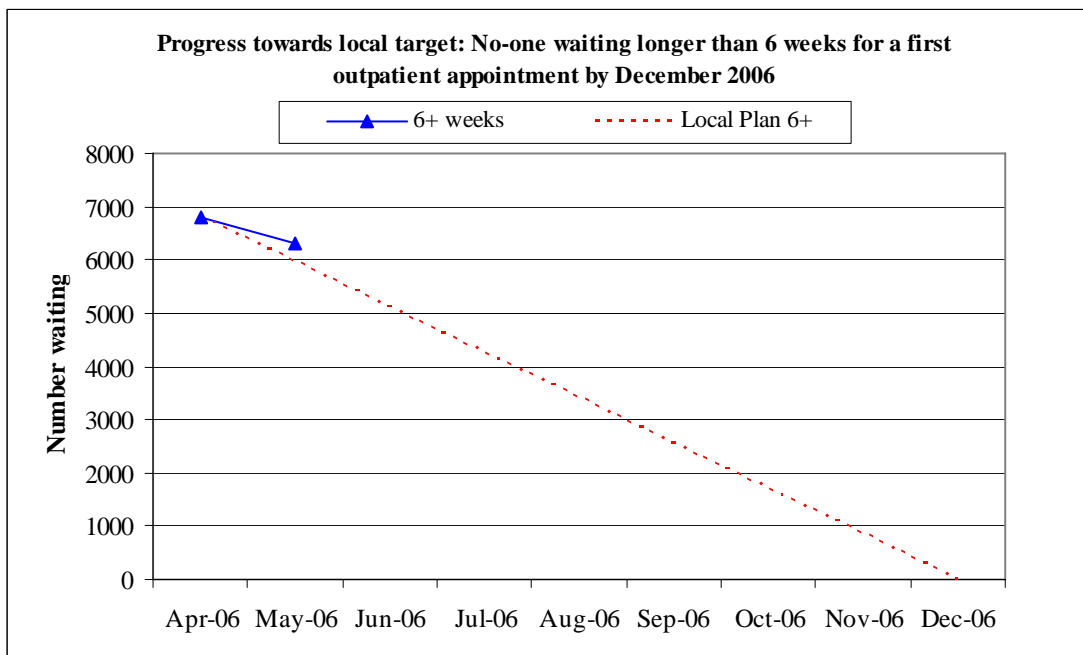
Access and Activity:

- In order for the Trust to thrive in an environment of patient choice and increasing pressure from the private sector, hitting and maintaining access and activity targets will be imperative. Developing a robust service strategy to implement these targets and maintain service levels is also part of the Trust's action plan for achieving Foundation Trust status.

Access:

- Last year, the main areas of concern for the Trust were A&E (4 hour target), cancer (31 and 62 day targets) and cancelled operations (last minute, non-clinical). The plan, agreed in March, for A&E is already bringing results and further plans are being developed around improving the specialist assessment areas at St James'.
- Whilst the first couple of months of 2006/07 have shown mixed results against the two cancer targets (1 month diagnosis to treatment and 2 months urgent referral to treatment), plans remain in place to meet and maintain the targets from July and September respectively. However, internal analysis of breaches for the year to date against the 31 day target has shown that due to the number of breaches in April to June, even with no further breaches from July onwards, LTHT will not be able to achieve the national standard of 98% for the year 2006/07.
- Cancelled operations remains a key issue for the Trust in 2006/07 (*see patient experience, below*).
- With the 18 week waiting time target to be achieved by 2008, interim national targets have been set for March 2007 of 11 weeks for first outpatient appointment and 20 weeks for inpatients and day cases. LTHT has also set an ambitious local target of 6 weeks for a first outpatient appointment by December 2006 in order to support direct booking within the Choose and Book programme.
- As figure 1 shows, although it is early in the year, the Trust has fallen behind plan (by 6%) for this local target. Numerous specialties saw an increase in the number waiting longer than 6 weeks and whilst it is difficult to make assessments at this early stage, specialties such as General Surgery and Neurology will need to show improvement.

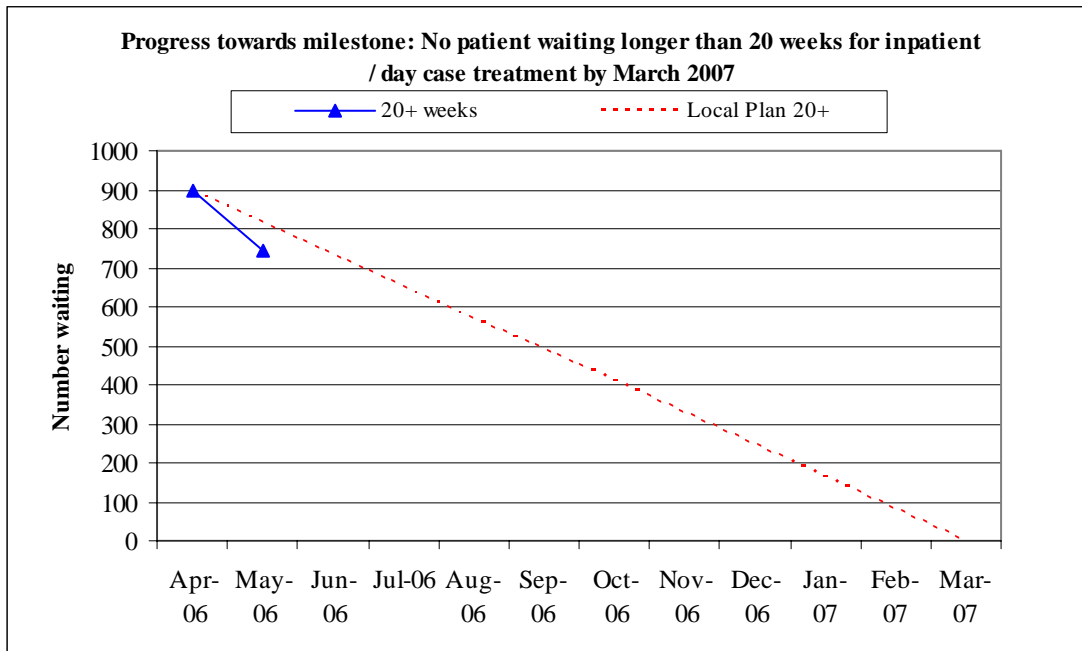
Figure 1:



- Within inpatients and day cases, maintaining the 6 month waiting times standard is still proving difficult for Cardiothoracic Surgery due to ongoing issues with capacity in Paediatric Cardiothoracic Surgery. In the longer term, this should be resolved once the newly appointed consultant has completed the necessary training.

- However, as figure 2 shows, the Trust is currently ahead of schedule to meet the 20 week inpatient target by March 2007. Whilst this suggests good progress, it is possible that, as waiting times within outpatients are shortened in order to meet the local 6 week target, this could impact on the numbers being added to the inpatient waiting list and affect progress here.

Figure 2:



Activity:

- Activity plans for this year have been based on the average outturn activity levels of 2005/06 and developments within Cardiology and Renal Services.
- Following lower than expected activity levels in both outpatients and inpatients in April, activity rose significantly in May to bring the Trust closer to its planned levels for the year to date. When compared with May last year, the number of outpatient attendances were up by almost 10% and the number of Finished Consultant Episodes (inpatients and day cases) were up by almost 6%. However, the year to date activity is still behind plan in all areas except A&E attendances.
- For the year to date there is currently no sign of PCT demand deflection schemes (intended to decommission around £8m) having an impact on activity levels.

Finance:

- See separate finance paper.

Workforce:

- In 2006/07, the Trust needs to achieve more than twice the level of savings ever achieved previously (£25m / 3.5% of the total budget). The implications of this on staff, including the change management and additional savings target initiatives, are explained in more detail in the revised business plan.
- Reductions in spending on bank and agency staff and expenditure on overtime are intended to go some way towards achieving these savings. In 2005/06, LTHT spent over £13.5m on bank and agency staffing, approximately 3% of its staffing costs. Data from the NHS Institute of Innovation and Improvement suggests that LTHT is already below the average trust spend on agency staff of 4.2% of staffing costs¹.
- In order to facilitate these reductions, the Trust needs to minimise sickness absence. In 2005, the average rate of sickness absence for an acute trust was 4.4%. Over the first two months of 2006/07, the rate at LTHT has been 5.2% and 5.6% respectively. LTHT has set the nationally accepted benchmark of 4% as its target for the year.

- More detailed analysis of sickness levels in May shows that it has been much higher than the Trust average in the following CMTs: Facilities (10.4%), Theatres and Anaesthetics (7.9%), Womens Services (6.8%) and Non-Surgical Oncology (6.3%). Further work will need to be undertaken in these areas to investigate the reasons for these high levels.
- Although the percentage of sickness absence is currently above the target set for 2006/07, the Trust has developed an additional savings plan on management of attendance that should reduce this by the end of the year.
- In addition to the reductions in the use of bank and agency staff and overtime, the Trust also aims to avoid the need for compulsory redundancies this year through staff turnover. The anticipated turnover for 2006/07 is 12% and is based on the expected annual turnover for a large acute teaching hospitals trust. Currently, the Trust is behind the planned level set in the workforce strategy of 2% for April & May at 1.6%.
- During the course of 2006/07, work will also be done to try and improve productivity (*see productivity and efficiency, below*). In the short term, the restrictions on vacancies put in place last year will continue, however, for the first two months of the year, new 'starters' to the organisation just outnumbered 'leavers'.
- Already, there are indications that staff are feeling the pressure of meeting financial savings. In the 2005 Staff Survey, 67% of staff at the trust said that in an average week, they work longer than their contracted hours due to pressure and demands of the job; this is both above the average for acute trusts and a significant increase from the 2004 survey where 59% of staff gave this response².
- In terms of staff development during 2006/07, LTHT is committed to the national requirement of providing all staff with a Knowledge and Skills Framework (KSF) as part of the implementation of Agenda for Change. KSFs are a framework upon which to base review and development and outline the knowledge and skill levels expected of each staff group. Latest data submitted to the Department of Health shows 77% of staff with a KSF and plans are being drawn up to ensure that the 100% target is met. KSFs will be used as part of the existing performance development planning and appraisal meetings undertaken by staff.
- The Trust also continues to monitor trends in the number of disciplinary cases and grievances including Trust Board appeals and employment tribunals. Any large variances from expected levels are then investigated further. Figure 3 (*below*) shows a rise in disciplinary cases (10%) in May but these remain within expected levels.

Figure 3: LTHT Disciplinary and Grievances

	Disciplinary cases (new and ongoing)	Grievances* (ongoing)
April 2006	61	11
May 2006	67	13

NB: Grievances includes Trust Board appeals and Employment Tribunals

Patient Experience:

- In acknowledgement of the impracticality of providing a thorough analysis of the whole patient experience on a monthly basis, a small number of key indicators have been selected that should provide either an early warning of any deterioration in the general experience of patients or provide evidence of improvement.
- The indicators currently being developed cover cancelled operations, complaints, hospital acquired infections, incident reporting and risk management claims and are intended to act as indicators of quality.

Cancelled operations:

- Due to both the upset caused to patients and the possible health implications when an operation is cancelled, it is important to reduce the number of cancelled operations to a minimum. During 2005/06, peer comparison showed this to be an area of weakness at the Trust. With the advent of patient choice, it will be difficult for the Trust to market the quality of its services if this is overshadowed by issues such as high numbers of cancelled operations.
- Whilst the April data appeared to show improvement with only 56 last minute, non-clinical cancellations, the figure for May is back at the average level for last year at 112. Over half the cancellations related to only two specialties: Cardiothoracic Surgery and Urology. The main reasons given were the lack of ICU/HDU beds (Cardiothoracic Surgery) and unavailability of ward beds (Urology). Availability of beds

has been an issue in both April and May (*see figure 4, below*). The Trust has now agreed developments in cardiac critical care beds; this should reduce the number of last minute cancellations.

Figure 4: Cancelled operations: last minute, non-clinical, by reason, 2006/07

	April 2006	May 2006
Unavailability of beds: Ward beds	26	43
List overrun	17	12
Unavailability of beds: ICU/HDU beds	0	16
Emergencies / trauma	0	14
Unavailability of staff: Anaesthetist	0	8
Unavailability of staff: Theatre staff	6	1
Unavailability of staff: Surgeon	2	4
Equipment: failure / unavailable	2	3
Administrative error	0	3
Other	3	8
All	56	112

- Although the number of breaches of 28 days following a last minute, non clinical cancellation also rose in May, it remains well below the monthly average seen in 2005/06.

Complaints:

- Through the DATIX system, which collates information relating to complaints, the Trust can “flag” any element of service provision that needs to be reviewed following a complaint and register this review or any changes resulted from it. These examples are then shared in the Trust’s “Learning Points” bulletin.
- The main area for improvement at LTHT is the resolution time for complaints. The national standard allows 20 working days in which a Trust should write to the complainant with the result of the investigation of their complaint. LTHT lags behind both its peers and the national average against this standard³. Much of the responsibility for meeting this timeframe lies with the CMTs who investigate each complaint and then provide the Trust’s response.
- During 2005/06, the CMTs with the lowest percentages meeting the 20 working day deadline were: Plastic Surgery (11%), Cardiothoracic Surgery (25%), Renal (38%) and Trauma, Orthopaedics and Rheumatology (42%). In comparison with this, 11 CMTs / Corporate areas achieved over 80% last year.
- Managing complaints is a part of both clinical governance and quality improvement. As part of its action plan for achieving Foundation Trust status, LTHT has already prioritised establishing sound governance processes, including clinical performance and risk management which should include raising the percentage of complaints resolved within the allotted timeframe and an increased commitment from CMTs in dealing with complaints. Figure 5 shows the top 5 reasons for complaints in 2005/06; these account for almost two thirds of the total complaints and show little change when compared with 2004/05.

Figure 5: The 5 main reasons for complaints made in 2005/06

Rank	Reason
1	Treatment - Clinical
2	Problems with outpatient waiting lists
3	Treatment - Non-clinical
4	Communication issues
5	Attitude/verbal aggression

Incidents:

- As with the management of complaints, the monitoring of and actions taken as result of reported incidents are a key part of clinical governance and patient safety. Nationally, the percentage of incidents that go unreported is estimated at as much as 80%. As part of the Trust’s aim to promote an open learning culture, the reporting of any incident is to be encouraged. Therefore, during 2006/07, LTHT is aiming to increase the number of incidents reported by 5%.
- LTHT will also continue to use the newly available comparative data from the National Patient Safety Agency (NPSA) in 2006/07. This should provide some indication of how LTHT compares with its peers for clinical, near miss and patient incidents. However, this data should be interpreted with caution as a high number of incidents reported could indicate either good reporting or a high incident rate. To date,

this data has provided some evidence of the success of the Trust's approach to incident reporting, although, internal analysis has shown that there is still much room for improvement in this area⁴.

- The delays in the input of incident reports by CMTs are well documented and continue to impact on the Trust's ability to analyse the data. For example, analysis of the CMT level data for April shows that by the time the second snapshot was taken in mid-June, over 400 incidents occurring in April had been added including over 100 incidents relating to Facilities & Estates and over 50 for Obstetrics.
- In order to try and reach the Trust standard of incidents being input within 5 days, the Risk Management team will continue to provide training not only on the input side but also in utilising the reports produced through the DATIX system. Courses have also been set up to run on a six monthly basis covering root cause analysis investigation techniques and managing an incident. There is currently a waiting list of staff wishing to attend these.

Risk Management Claims:

- The Trust is currently developing indicators to show progress with closing claims and to reflect the financial impact of these claims.
- Based on last years monthly average of 11 clinical negligence, 4 employer's liability and 2 public liability claims, the data for the first two months of the year shows less than expected numbers of claims being made.

Productivity and Efficiency:

- With the expected losses on national tariffs under Payment by Results totalling £20m over the next three years, increasing activity alone will not be enough to meet the tight savings requirements. Improving efficiency as well as productivity will be needed in order to bring the costs incurred by the Trust into line with national tariffs.
- The Trust has already set up a Change Management Programme through which task forces have been set up to lead on efficiency projects. The Programme aims to achieve expenditure reduction through improving efficiency and productivity whilst maintaining (or improving) clinical quality.

Productivity:

- Medical Productivity has been identified as one of the areas in which the potential for improved efficiency is greatest at the Trust and a task force has already been set up to look at this. This has also been highlighted within the recent national publication "Delivering Quality and Value. Focus on: Productivity and Efficiency"⁵. This document outlines a number of indicators that Trusts could use to assess their performance (*see Efficiency, below*).
- As figure 6 shows, LTHT did not compare well with its peer group for these productivity indicators.

Figure 6: Productivity, 2004-05

	Average of selected acute teaching hospitals peer group	LTHT
FCEs (total): Per Consultant WTE	475	439
FCEs (total): Per Medical Staff WTE	171	148
Average admissions: Per Consultant	412	381

Source: HSMC, Birmingham; 11 acute teaching hospitals

- As part of the new Consultant Contract, consultants should be agreeing their Programmed Activities with the Trust as part of their job planning processes. Programmed Activities outline a consultant's commitments to clinical care, research, teaching etc. By monitoring adherence to the Programmed Activities and actual activity data held on PAS, the Trust would have a clearer picture of the workloads of each consultant that could inform the ongoing productivity project. However, this information is not yet maintained centrally.

Efficiency:

- LTHT continues to monitor its performance against its peers and, as a result, is clear about the areas where improvements in efficiency could be sought: increasing day cases, shortening the average length of stay (including pre-operative bed days), improving discharge planning & processes and better use of the available resources such as theatre and clinic utilisation.
- The NHS Institute for Innovation and Improvement has been working with the Department of Health's Productive Time Programme and the NHS Integrated Service Improvement Programme to support improvements in productivity and efficiency. The resulting publication "Delivering Quality and Value. Focus on: Productivity and Efficiency", issued in June, outlines a number of indicators based upon areas that currently have the highest levels of variation across the NHS suggesting that there is the potential for improvement. This information also provides some benchmarks that Trusts can use to assess their own performance.
- In summary, the published indicators show⁶:
- **Short stay emergency admissions** (2004/05): LTHT has a marginally higher admission rate than its peers from A&E but has a lower percentage admitted for 2 days or less than many of its peers. This would suggest that its admission threshold is appropriate.
- **Unnecessary outpatient appointments** (2004/05): LTHT has both a higher return to new ratio for outpatient appointments and a higher DNA rate than its peers. Further work will need to be done to assess whether the Trust is booking appointments unnecessarily as this could impact on the Trust's ability to meet its own challenging 6 week target for first outpatient waiting times.
- **Day case performance** (based on Audit Commission's Basket of 25 procedures): Over the period 2002/03 to 2005/06, the day case rate at LTHT has risen by 3%; this is a greater increase than its peers (average of 1% increase). However, the peer average for 2005/06 was 59%, 10% higher than the Trust. Improving the day case rate would help the Trust in two ways. Firstly, costs are lower than inpatient care and the throughput of patients is improved bringing financial gains⁷. Secondly, it is nationally recognised that increasing the number of procedures done as day case surgery benefits patients. Patients can recover in their own homes, the risk of hospital acquired infection is reduced, there is less disruption to their lives, cancellations due to emergency pressures are less likely in a dedicated day surgery unit and evidence also suggests that outcomes are as least as good as those for inpatient surgery⁸.
- **Wasted bed days** (% admitted on day of operation, 2004/05): Although full peer data is not available for this indicator, the available data shows that performance ranges from 35% to 70% within the peer; LTHT is within this range at 59% of patients admitted on the day of procedure
- **Reduce variation in length of stay** (weekend discharge rates, 2004/05): LTHT has a 61% drop in average daily discharges at weekends. If patients, who are ready to be discharged, are not discharged at weekends, this will impact on a trust's average length of stay. Whilst the data shows that LTHT is not an outlier for this indicator, the drop of 42% seen at one of its peers, Sheffield Teaching Hospitals NHS Foundation Trust, suggests that LTHT should look to improve (full peer data unavailable).
- **Actively manage staff** (% sickness absence, 2004): In 2004, LTHT had a lower sickness absence rate than the peer average.
- **Actively manage recruitment costs** (% of staff spend on agency staff): The data given shows LTHT to have a below average spend on agency staff when compared to its peers (the year the data refers to is not clear).
- Over the coming months, LTHT will be developing its own indicators of productivity and efficiency tailored to an acute trust but based upon those published by the NHS Institute.

Notes:

¹ *“Delivering Quality and Value. Focus on: Productivity and Efficiency”, NHS Institute of Innovation and Improvement, June 2006*

² *LTHT Staff Survey 2005, published by the Healthcare Commission*

NPSA data

³ *2004/05 Star Ratings, Healthcare Commission*

⁴ *National Patient Safety Agency (NPSA), National Reporting and Learning System*

⁵ *“Delivering Quality and Value. Focus on: Productivity and Efficiency”, NHS Institute of Innovation and Improvement, June 2006*

⁶ *Dr Foster Intelligence & The Health Services Management Centre, University of Birmingham - nb: not all the indicators within the NHS Institute report are included in this summary*

⁷ *Audit Commission Day Surgery Report, 2001 - finances*

⁸ *DOH Day Surgery: Operational Guide, August 2002 - patient exp*

Peer hospitals:

Cambridge University Hospitals NHS Foundation Trust

Central Manchester and Manchester Children's University NHS Trust

Nottingham City Hospital NHS Trust

Oxford Radcliffe Hospital NHS Trust

Queen's Medical Centre, Nottingham University Hospital NHS Trust

Royal Liverpool & Broadgreen Hospitals Universities NHS Trust

Sheffield Teaching Hospitals NHS Trust

South Manchester University Hospitals NHS Trust

The Newcastle Upon Tyne Hospitals NHS Trust

United Bristol Healthcare NHS Trust

University Hospital Birmingham NHS Trust