To:	**Trust Board**
From:	Andrew Brown, CBU Medical Lead Jason Braybrooke, Head of Service Nicola Grant, Lead Nurse Sarah Taylor, CBU Manager
Date:	**30 August 2012**
CQC regulation:	As applicable

Title:	Fracture Neck of Femur – Best Practice Tariff Indicators (BPT)

Author/Responsible Director:
Andrew Brown, CBU Medical Lead.

Purpose of the Report:
Provide an update on the current performance and actions in relation to Fractured Neck of Femur patients

The Report is provided to the Board for:

Decision		Discussion	X
Assurance	X	Endorsement	

Summary / Key Points:
Current Performance and update on actions implemented, specifically in relation to:-
Additional Theatre Capacity
Dedicated NOF Ward
Orthogeriatrician Cover

Recommendations:
Please see section 5 of the report

Previously considered at another corporate UHL Committee ? YES - GRMC

Strategic Risk Register YES	**Performance KPIs year to date** Included in the report

Resource Implications (eg Financial, HR)
Already identified and agreed

Assurance Implications
Yes

Patient and Public Involvement (PPI) Implications
Yes full patient experience being planned

Equality Impact
None

Information exempt from Disclosure
No

Requirement for further review ?
Regular updates are provided to GRMC, CQRG and Contract Performance

UNIVERSITY HOSPITALS OF LEICESTER NHS TRUST

PLANNED CARE DIVISION

Musculoskeletal Clinical Business Unit

REPORT

TO: Trust Board

REPORT BY: Andrew Brown, CBU Medical Lead
Jason Braybrooke, Head of Service
Nicola Grant, Lead Nurse
Sarah Taylor, CBU Manager

Date 30 August 2012

SUBJECT: Fracture Neck of Femur – Best Practice Tariff Indicators (BPT)

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1. Introduction

The BPT for Fractured Neck of Femurs were introduced in April 2011 to enhance this pathway for patients, this applied across 6 indicators and to all patients 65 and over.

These indicators are:-

- Time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia
- Admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon
- Admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia
- Assessed by a geriatrician in the peri-operative period (within 72 hours of admission)
- Postoperative geriatrician-directed multi-professional rehabilitation team
- Fracture Prevention Assessments (specialist falls and bone health)

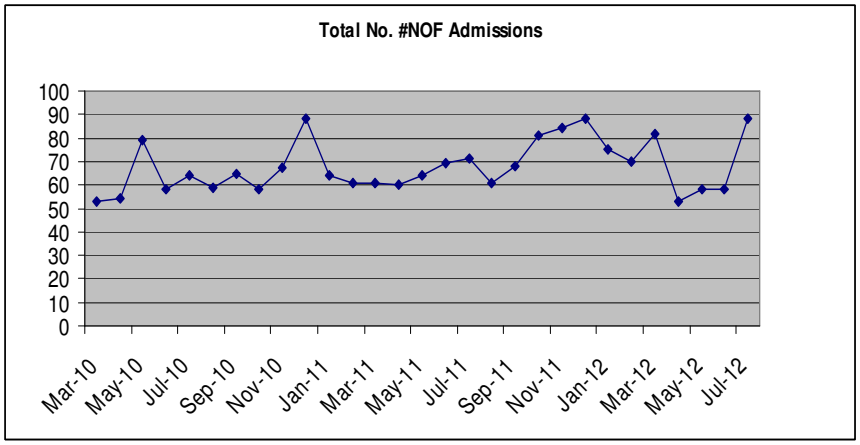
From April 2012 a further criteria was added of two Abbreviated mental tests (AMT) performed and all scores recorded with the first test carried out prior to surgery and the second post-surgery but within the same spell. The age criteria was also lowered from 65 to 60 or above and the Tariff was increased to £1,335 per patient that meets all 7 criteria.

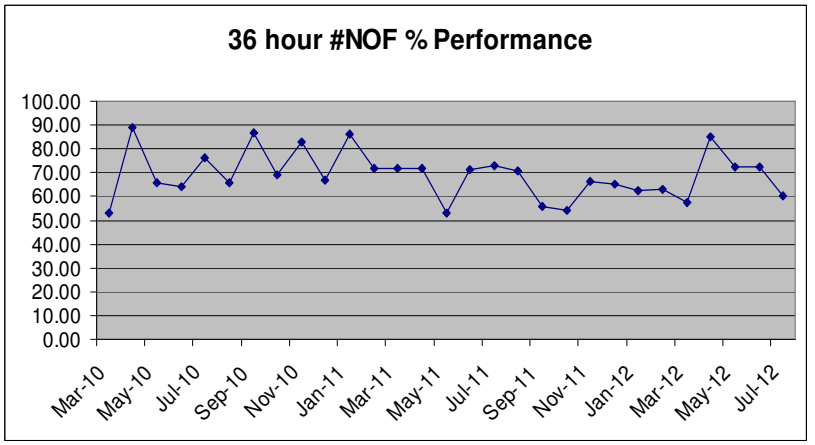
The data is uploaded into the National Hip Fracture Database (NHFD) monthly for all patients irrespective of age and the CQUIN associated with these indicators monitors compliance irrespective of age.

It is recognised that consistently achieving the indicators had proved challenging for many reasons and whilst work over the last 18 months delivered improvements the overall performance was not at the required level, the main challenges remaining to achieving the target were:-

- Patient who are medically unwell are included in the data returns therefore affect the theatre target performance.
- Insufficient capacity to meet the peaks in demand i.e. if more that 5 NOF's were admitted in a 24 hour period there was insufficient capacity to operate on all of these patients.
- Consultant Orthogeriatrician Maternity leave reduced the capacity of the team to see all patients in the time periods required
- #NOF were admitted to all 3 trauma wards therefore skills and expertise of the multi-disciplinary team were spread across these areas.

The following tables shows the trend in admissions and the performance against the 36 time to theatre from March 2010 to July 2012





2.0 Current Actions to Improve Performance/Patient Experience.

In response to a plateau in performance and a contract query being received from the PCT, the Multi Disciplinary team met and agreed that the following actions need to be put into place to improve performance, this was ratified by the GRMC:-

- Additional theatre Capacity to cope with Peaks and Troughs in Demand
- Creation of Dedicated #NOF ward
- Consultant Orthogeriatrician Cover for Maternity Leave

2.1 Additional Theatre Capacity

Due to the 11% increase in NOF admissions and increase in overall trauma, additional trauma theatre sessions are required from Monday to Thursday in the afternoons to meet this demand.

This is based on analysis undertaken into admission trends over each day of the week taking into account the need to operate within 36 hours of admission.

The following table details the average number of admissions per day and the variance due to the fluctuation in admissions. The required capacity has been modelled on the assumption that there will need to be idle capacity in the system to ensure that all patients are operated on within 36 hours of admission (where clinically appropriate).

Weekday	Average Number of Admissions	Upper Quartile of Daily admission	Variance
Monday	8.24	12.53	4.29
Tuesday	8.03	11.88	3.85
Wednesday	8.40	13.14	4.74
Thursday	8.96	15.49	6.53
Friday	7.54	11.95	4.41
Saturday	7.35	13.32	5.97
Sunday	7.35	10.93	3.58

The following table details the daily theatre capacity available prior to the service changes, which highlighted the gap in the number of operating hours required to deliver the # NOF target and an overall theatre wait for trauma patients. The final column of the table demonstrates number of lists available post changes.

Weekday	Daily Number of Theatre Sessions	Theatre Capacity Hours @ 95.5%	Required Theatre Time Based on Average no of admissions	Required Theatre Time Based Upper Quartile of Daily Admissions	**AVERAGE ADMISSIONS** Variance From Theatre Capacity to Average	**Service Required** Variance From Theatre Capacity to Upper limit of Daily Admissions	**Number of Sessions post service development**
Monday	4.5	13.18	12.99	16.79	-0.78	-4.86	5.5
Tuesday	4.5	13.18	12.66	15.92	-0.42	-3.93	5.5
Wednesday	4.5	13.18	13.24	17.61	-1.05	-5.74	5.5
Thursday	5.5	17.25	14.13	20.76	2.07	-5.06	6.5
Friday	5.5	17.25	11.89	16.01	4.48	0.04	5.5
Saturday	3	9.97	11.59	17.85	-2.48	-9.21	3
Sunday	2	6.65	11.59	14.65	-5.80	-9.09	3

(Assumptions data includes 5% return to theatre rate within the current patient episode and assumes an average theatre time per patient of 1hour 44 minutes)

All 4 additional sessions have been in place since the 2nd July 2012.

2.2 Creation of a Fracture Neck of Femur Ward

The MSK CBU set a target of having a fractured neck of femur ward in place by the end of June 2012 which has been achieved. The number of beds on this ward has been reduced whilst the nursing and therapy staffing levels have remained the same, this is to ensure that staff can maintain caring at its best standards and keep sickness levels to a minimum due to the heavy workload that this group of patients create. It was felt that by creating a dedicated ward, this will enable both Surgical and Ortho geriatric care to be concentrated into one area, therefore allowing greater cover and improvement in processes.

Early feedback from this area is that the workload is heavy with the number of elderly confused patients with dementia requiring all care, staff moral though is high. Patient flow has been an issue during July due to the number of admissions which has meant transferring post NOF patients to another trauma ward.

2.3 Appointment of Locum Ortho geriatrician

6 of the criteria are dependent on Ortho geriatrician input. Due to Maternity Leave and the delays in recruitment, performance has deteriorated in the last 3 months of 2011/12. It has been agreed with the Acute Division that this will be addressed to ensure consistent cover is in place for the Maternity leave. It is important that this level of input is maintained and a transformation bid has been submitted for the whole project but to include 3 additional PAs of Orthogeriatrican time.

3.0 Current Performance against CQUIN indicators

The following table highlights the % performance for each quarter during 2011/2012 and the monthly performance for April, May and June 2012.

CQUIN	Indicator	Threshold 2011/12	Q1	Q2	Q3	Q4	FYE	Threshold from Q2	April	May	June
	Number of Admissions		193	200	256	227	876		53	58	58
CE1 a i)	time to surgery within 36 hours from arrival in an emergency department, or time of diagnosis if an inpatient, to the start of anaesthesia	**Monthly >=70% FYE 75%**	65.3	66.5	63.7	60.8	63.9	**Monthly > 72%**	84.9	72.4	72.4
CE1 a ii)	time to surgery within 48 hours (where went to theatre)	**>= 90%**	84.2	91.7	84.0	87.3	86.6	**Monthly > 90%**	92.5	85.7	89.7
CE1 b)	admitted under the joint care of a consultant geriatrician and a consultant orthopaedic surgeon	**>=95%**	100	92.5	95.7	94.7	95.7	**Monthly > 95%**	96.2	94.8	89.7
CE1 c)	admitted using an assessment protocol agreed by geriatric medicine, orthopaedic surgery and anaesthesia	**% # Admitted under Assess Protocol**	100	92.5	95.7	94.7	95.7	**Monthly > 95%**	94.3	98.3	94.8
CE1 d)	assessed by a geriatrician in the perioperative period (within 72 hours of admission)	**Monthly >=70% Q4 75%**	66.8	69.0	84.0	75.8	74.7	**Monthly > 75%**	77.4	82.8	77.6
CE1 e)	postoperative geriatrician-directed multi-professional rehabilitation team	**Monthly >=80% Q4 85%**	85.5	80.0	84.8	70.9	80.3	**Monthly > 85% 2**	86.8	82.8	70.7

CE1 f i)	specialist falls assessment	**Monthly >=80% Q4 85%**	83.9	76.0	87.9	88.1	84.4	**Monthly > 85%**	94.3	96.6	72.4
CE1 f ii)	bone protection treatment	**Monthly >=70% Q4 75%**	70.5	79.0	84.8	77.5	78.4	**Monthly > 85%**	79.2	87.9	94.8
CE1 f iii)	Abbreviated mental test score on admission and post admission	**N/A**	N/A	N/A	N/A	N/A	N/A	**Monthly > 85%**	77.7	67.2	63.8

Please note June's data is not yet finalised due to annual leave, recruitment of an additional audit clerk is in progress to address this.

4.0 Performance against Best Practice Tariff

In order to qualify for the Best Practice Tariff top up, patients must be over 60 years old, fall into a specific HRG grouper and achieve all of the 6 criteria for the last financial year.

From April 2011 – March 2012, there were 756 patients who have been identified via the HRG grouper as Hip Fragility Patients, of which we have identified 313 that qualified for the top-up tariff. The following table demonstrates performance against each criteria.

Criteria's Past	# Passed Criteria	% Compliance
Surgery within 36 hours of admission	**496**	**66%**
Admitted under joint care of Geriatrician & ortho surgeon	**703**	**93%**
Admitted under Assessment Protocol	**720**	**95%**
Geriatrician Assessment?	**593**	**78%**
Multidisciplinary Team Assessment	**625**	**83%**
Specialist Falls Assessment	**652**	**86%**
All 6 BPT Criterion Passed?	**313**	**41%**

Maximum Potential Best Practice Tariff amount available	**£672,840**
Potential Best Practice Tariff at 85% of Maximum (to account for Unfits etc)	**£571,914**
Current Best Practice Tariff amount achieved	**£278,570**
FYE – April 2011 to March 2012 is	**41%**

From April 2012 the top up amount received increases to £1,335 with the addition of the 7th criteria, performance against the criteria for this financial year is shown below.

Criterias Past	Unique Count of Criterea Passes in April 2012	April % Compliance	Unique Count of Criterea Passes in May 2012	May % Compliance	Unique Count of Criterea Passes in June 2012	June % Compliance
# to Theatre 0-35Hrs	44	75%	32	62%	39	71%
# Admitted under joint care of Geriatrician and ortho surgeon	59	100%	50	96%	52	95%
# Admitted under Assessment Protocol	59	100%	49	94%	54	98%
# Geriatrician Assessment	56	95%	46	88%	50	91%
# Multiprof Rehab Review	54	92%	43	83%	46	84%
# Specialist Falls Assessment	59	100%	50	96%	52	95%
# AMTS	36	61%	35	67%	42	76%

	April 2012	May 2012	June 2012	**Q1 2012**
# Patients	59	52	55	**166**
# Compliance for all 7 criterea	22	22	21	**65**
% Compliance for all 7 criterea	37.3%	42.3%	38.2%	**39.2%**
Best Practice Tariff Achieved	£29,370	£29,370	£28,035	**£86,775**

5.0 Next Steps/Recommendations

- Changes have only recently been implemented with additional theatre lists and the NOF ward, we therefore need to monitor these changes over the next few months to assess their full impact.

- Continue the Operational NOF group which is a multi disciplinary meeting held monthly. This group will continue to look at ways of enhancing the current services provided and deal with the daily issues.

- We will be undertaking a full patient satisfaction survey to gain users feedback on their experiences of our NOF service.

- We will implement a team debrief at the end of each NOF theatre list to review and discuss performance with a view to improving future performance.

- 6 of the 7 indicators rely on Orthogeriatrician input into the service. If the transformation bid submitted is not successful we would recommend investment in an additional 3 PAs of Orthogeriatrician time.

6.0 Conclusion

Care of the Elderly neck of femur patient constituents a large and important part of the Trauma service and can be used as a surrogate marker for the quality of the service as a whole. Implementation of best practice Tariff's has been a driver to improve service delivery with significant additional resources put into the neck of femur service. Work thus far has led to improvements in time to theatre but has not yet realised its full potential.

Latest service changes need to be monitored to ensure continuing improvement and timely actions to address issues as they arise.