TRUST BOARD

Date of Meeting: 27/11/2012	**Agenda Item No:** 6.3	**Enclosure:** 5
Intended Outcome:		
For noting ✓	**For information**	**For decision**

Title of Report: Service Performance Report

Aims:
To update the Trust Board on the operational performance.

Executive Summary:
The service performance report summarises Trust performance against a range of operating indicators for month seven of 2012/13.

Operational performance against key targets remains broadly strong with some pressures within specific specialities on access targets.

As reported at the last Board a concern has been raised with respect to our 18 week backlog of patients. An action plan has been prepared and agreed with NHS North of England and our commissioners. A full briefing report, including the operational delivery detail of the plan will be presented to Board on 27th November 2012.

Overview of key areas for consideration or noting:

As above.

Specific implications and links to the Trust's Strategic Aims:	
Ensure we provide high quality, safe and effective care for all our patients including meeting essential standards of safety and quality as set out by the CQC	✓
Develop a viable integrated clinical strategy for secondary care services which is sustainable and affordable	
Develop a new healthcare facility in West Cumbria that is fit for the 21st century	
Achieve sustainable financial balance through the delivery of the Trust's internal Cost Improvement Programme, securing a viable contract income from our GP commissioners and contributing to the system wide cost reductions	
To develop and implement a successful merger or acquisition plan that enables the Trust to become part of an existing NHS Foundation Trust	

Recommendations:
The Trust Board is asked to note the content of the report.

Prepared by:	**Presented by:**
Corinne Siddall Director of Operations	Corinne Siddall Director of Operations

TRUST BOARD PERFORMANCE REPORT Month Seven (October) Performance reported in November 2012

INTRODUCTION

This report provides the Trust Board with a summary of the organisations service performance against a range of key performance indicators as at October 2012.

OPERATING PERFORMANCE

The full Performance Dashboard is located at Appendix 1. The Performance Dashboard structure has eleven distinct sections and these are identified below:

1. Quality: headline measures
2. Resources: headline measures
3. Quality: supporting measures
4. Resources: supporting measures
5. Local monitoring
6. Local productivity metrics
7. Local workforce metrics
8. Local quality metrics
9. Estates metrics
10. Facilities metrics
11. Referral to Treatment analysis by speciality

In addition to national requirements local targets have also been maintained, particularly around productivity metrics.

1. QUALITY: HEADLINE MEASURES

1.1 A&E Clinical Indicators

- **95% treated within 4 hours**

  The Trust has experienced significant pressure managing the A&E access target. Although managing to achieve the target consistently, previously this was predominantly due to the high performance at WCH which masked performance below the expected standard week on week at CIC. The Trust achieved Q2 performance standard – 95.32% – against required standard of 95%.

  However, in October 2012 the Trust failed this standard, achieving 93.51%. Trust Board are asked to note that performance to date for November 2012 (as at 20/11/12) is 97.55% with both CIC and WCH achieving > 95%. Performance to date for Q3 is 95.05%.

  Actions are in place and detailed below. This will require significant attention and monitoring of progress over the coming weeks and will require a consistent step up in performance to achieve Q3 performance.

- **Unplanned Re-attendance rate**

The national target is 5% this indicator measures all unplanned re-attendances within a 7 day period including those who re-attend for an unrelated condition to the original.

<u>CIC – October</u>
Target – 5%
Achieved – 6% (7 patients had multiple re-attendances)
- 3 attributable to mental health and social problems or alcohol and substance misuse
- 1 attributable to persistent abdominal pain and nausea who was subsequently referred to gastroenterology
- 1 attributable to on-going palpitations and was referred to their GP
- 1 attributable to on-going plaster cast issues
- 1 attributable to a left shoulder injury with verbal advice given

<u>WCH - October</u>
Target – 5%
Achieved – 5.1% (5 patients had multiple re-attendances)
- 3 attributable to mental health and social problems or alcohol and substance misuse
- 1 attributable to a persistent dislocation of jaw who was referred to the specialty
- 1 attributable to on-going chest pain who was referred to the GP

Both secondary and primary care clinicians continue working closely to address these issues to ensure that specific patients who frequently attend A&E within 7 days are directed to, and supported by, appropriate community and social care services.

- **Total time in the A&E Department**

Admitted
Patient flow issues are being addressed through the Emergency Flow Project, specifically around the on-going improvements of the acute physician role on the Emergency Assessment Unit, and the redesign of the Emergency Assessment and Short Stay Unit. Other specific

projects in relation to the EAU plan include Early Morning Discharge, Nurse-Led Discharge and the introduction of a Discharge Lounge, which was launched in October 2012.

The Emergency Department project has a significant focus on the streaming of patients through the department using a Rapid Assessment Model. This will allow the department to continue to assess and treat a greater number of patients in the system simultaneously, and minimises a 'log jam' effect which impacts on this target.

Non-Admitted

CIC - September

Longest wait – 9 hours 55 minutes

- Due to initially awaiting an assessment from the Crisis team (3 hour 29 minutes delay)
- Further delay awaiting transport (delay of 2 hours 41 minutes)
- Escalation implemented
- Tripartite monthly meeting has now been established between NCUHT, NWAS and the Commissioners to address transport issues

WCH - September

Longest wait – 11 hours 14 minutes

- Due initially to Clinical need, patient involved in a high impact RTC
- Required a number of CT scans and in-depth discussions with the RVI
- Further delay awaiting transport (delay of 2 hours 09 minutes) for transfer to the RVI
- Escalation implemented
- Tripartite monthly meeting has now been established between NCUHT, NWAS and the Commissioners to address transport issues

CIC - October

Longest wait – 9 hours 10 minutes

- Patient at 14:20 with abdominal pain.
- Under a DNR order
- Remained in Resus and died at 21:57
- Remained in department and moved into a side room with the family
- Moved out of the department at 23:30 (9 hours 10 minutes)

WCH - October

Longest wait – 8 hours 48 minutes

- Due to Transport (Booked when patient had been in the department for 1 hour 29 minutes, took a further of 7 hours 18 minutes)
- Significant escalation implemented
- Tripartite monthly meeting has now been established between NCUHT, NWAS and the Commissioners to address transport issues

- **Left without being seen**

Performance indicator achieved

- **Time to initial assessment**

  CIC – October

  Longest wait – 1 hour 46 minutes
  - Patient attended at 16:32
  - 21 patients arrived in the space of 1 hour (15:30 – 16:30)
  - Initially assessed at 18:18 by which time a further 22 patients had arrived in the department (16:30 – 18:18) – 43 arrivals in total in this time frame.
  - Escalation of limited capacity in the department implemented

  WCH - October

  Longest wait – 1 hour 27 minutes
  - Patient attended at 19:03
  - Remained in the ambulance and monitored by ambulance staff until a trolley was available in the department
  - Transferred into the department at 20:13
  - Initial assessed in the department at 20:30
  - Escalation of limited capacity in the department implemented

  At the beginning of November the department at CIC commenced a new triage process, utilising the PCAS service to lead on the initial assessment of ambulance patients. Every day during the month of November the department has met the target of Initial Assessment in < 15 minutes.

  The Emergency Flow project for the Emergency Department has a significant focus on the streaming of patients through the department using a Rapid Assessment Model. This model allows the department to initially assess and treat a greater number of patients in the system simultaneously, minimising the amount of time the patient has to wait for an initial assessment.

- **Time to treatment**

  Performance indicator achieved

All the A&E clinical quality indicators are monitored by the directorate team daily and weekly.

Key issues are being addressed by the emergency flow project and implementation on the integrated emergency floor are as follows:-

- New ways of working in A&E
- Increased rigour around escalation and bed management processes
- Presence of consultants at an early stage in patient pathway. New medical model implemented in August 2012.
- Reduction in GP referred patients in A&E
- Resolving transport issues
- Reducing emergency admissions
- Resolving DTOC issues

There is also a weekly meeting, chaired by the Medical Division, with the Chief Executive, Director of Operations and Director of Clinical Transformation to closely track a set of agreed Emergency Care Standards.

These are as follows:-

- 95% of patients admitted/discharged from A&E within 4 hours
- 100% of patients admitted/discharged from A&E within 6 hours
- Ambulatory care, where appropriate
- Senior clinical assessment in EMU (aim for one hour)
- 7 day review by a senior clinician
    - Monday to Friday: ACP working 8-2 and 2nd ACP working 12.30-6
    - Saturday and Sunday: ACP working 8-2 and 2nd ACP working 12-8
    - This rota should be supported by a 2nd person working as "POW" to review core wards to "pull" patients through the system to create capacity for EMU
    - This rota should ideally work until 10pm to ensure a senior person is working during the peak times
- 20% of patients discharge with a 0 day LoS
- 60% of patients discharged with a 1 day LoS
- ALoS on EMU (assessment) is a maximum of 24 hours
- ALoS on EMU (admission) is a maximum of 48 hours
- Zero tolerance of patients transferred between wards after 10pm
- Zero tolerance of patients treated on the ward that is not their main specialty

A weekly KPI report will be produced and areas for action agreed and progressed.

2. CANCER BREACHES

- Cancer PTL's tracked weekly at PTL
- All breaches have RCA to identify trends and issues requiring management action
- Cancer improvement plan monitored weekly at PTL.

Cancer
62 Days – All patients - Urgent GP referral to Treatment
Target 85% Achieved 83.2%
86 patients treated. 70 within target - 16 breaches (unvalidated)
10 clinically complex pathways
2 patient choice
3 capacity issues

62 Days – Screening
Target 90% Achieved 76.5%
17 patients treated. 13 within target – 4 breaches (unvalidated)
1 capacity issue
1 clinically unfit
1 complex pathway
1 DNA& patient choice
RCA carried out on all breaches.
Cancer performance monitored weekly at PTL meeting
Cancer improvement plan monitored weekly at PTL

3. REFERRAL TO TREATMENT ANALYSIS BY SPECIALTY

18 Weeks

Action plan in place and monitored weekly as per October report.
Plan currently delivering on track with the exception of T&O and Ophthalmology both of which have remedial actions already in place and will be expected to be on track by end of November.

Fortnightly performance monitoring of this plan continues with CCG and NHS NoE.

IST draft report has been returned to them for final completions.
Draft Action plan will be agreed next week .
On - going support from IST has been arranged as follows :

- Capacity and Demand Workshop for managers and clinicians - *complete*
- Support to implement improved PTL reporting Q3-4
- Data Quality reports to provide enhanced assurance Q3-4#

We are currently discussing some possible amendments to this plan with IST and CEO. Further updates to Trust Board on a monthly basis.

4. TRANSFERS OF CARE

We are continuing to meet with the wider health economy about a whole system approach to Delayed Transfer of Care (DTOC). It has been agreed by all partners in the health economy (including Local Authority) that an integrated Discharge Team will be implemented and located on both acute hospital sites. Pump priming monies from commissioning will fund a 12 month management post to oversee and develop this service (due to be advertised across all health economy in the first two weeks of October). It is planned that existing staff who currently undertake a discharge function in all three organisations will come together to establish a core hospital discharge team, this will be in place late October 2012. That this initial team will clearly define and establish, (with senior guidance) appropriate function of the team over the following 6-12 months. The primary focus will be on the high volume delays in the system. This will include new operational policies shared funding streams and shared metrics. There is now a shared action plan which is reviewed weekly by senior leads from all organisations, including commissioners.

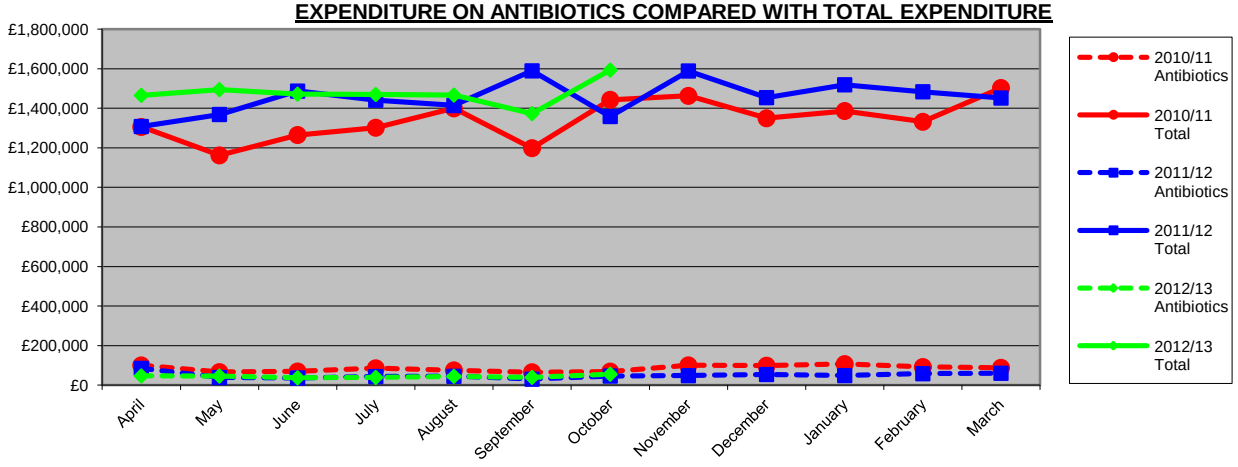
5. PHARMACY METRICS

The charts below highlight expenditure for three key areas comparing expenditure against total drug spend and also comparing the current year and the previous two years.

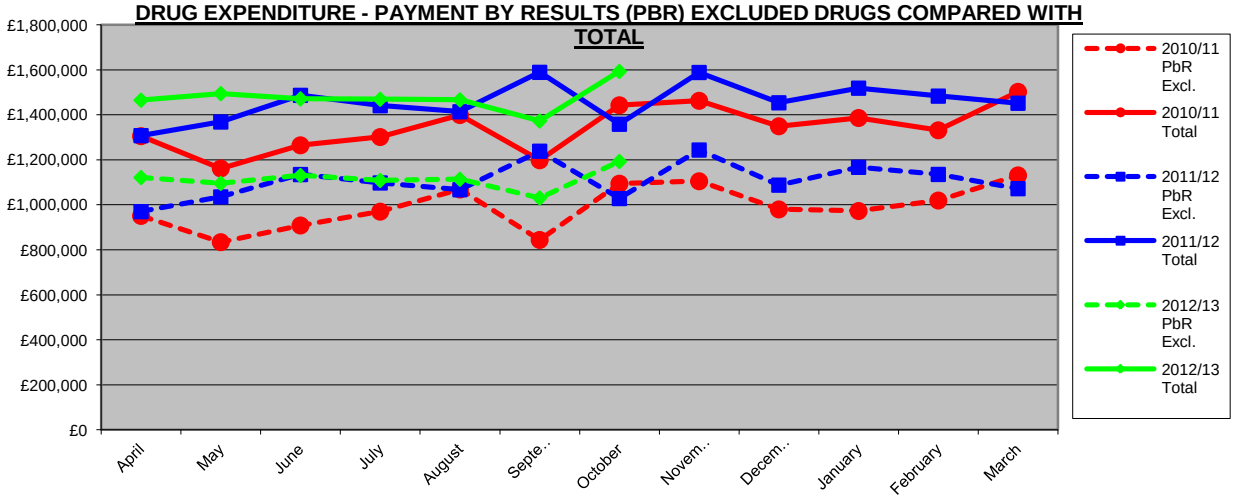
Expenditure up to the end of month 7 of 2012/13 on antibiotic drugs accounts for 3% of total expenditure comparable to the same period in 2011/12 which was 3.3%.

The expenditure for PbR excluded drugs is 75% of the total drugs spend, and PbR included drugs account for 25%.

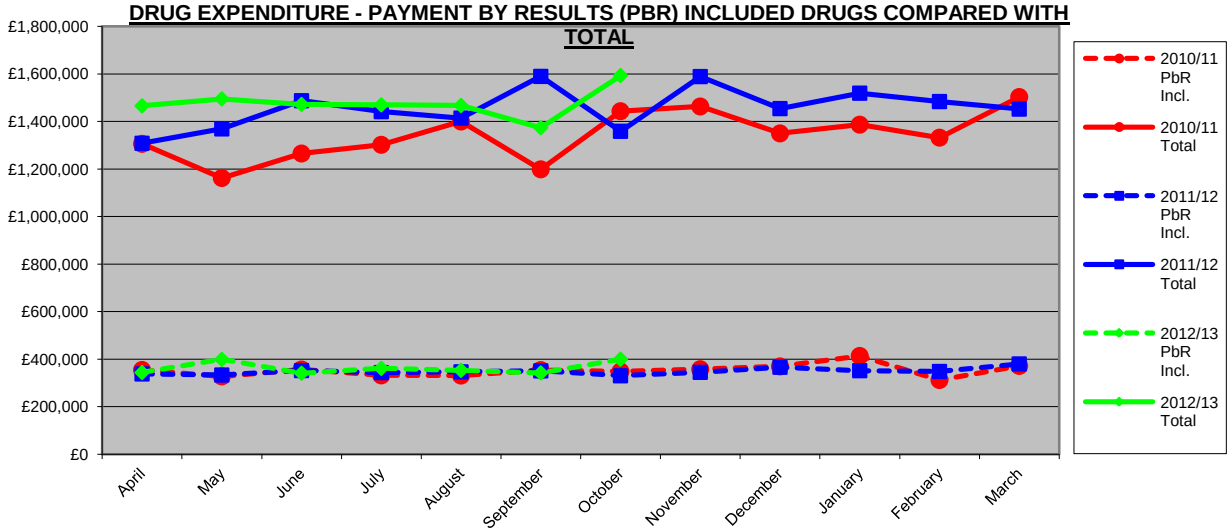
EXPENDITURE ON ANTIBIOTICS COMPARED WITH TOTAL EXPENDITURE



DRUG EXPENDITURE - PAYMENT BY RESULTS (PBR) EXCLUDED DRUGS COMPARED WITH TOTAL



DRUG EXPENDITURE - PAYMENT BY RESULTS (PBR) INCLUDED DRUGS COMPARED WITH TOTAL



APPENDIX 1

PERFORMANCE DASHBOARD

In summary the dashboard provides: -

- A profile of performance in each month of the current year, up to and including, the latest data available.
- All data items are shown using a monthly profile with the exception of a small number of indicators which use a quarterly profile.
- The criteria for traffic lighting (trajectory position) is used to assess performance for the current data period. Grey shading for the latest month indicates that data is not yet available for that period, at the time of the production of the report.
- The letters “nad” in a grey shaded box means that there was “no applicable data (nad)” for that particular period/month.
- The “Year to Date” column is also traffic lighted for those indicators where performance has to be achieved across the whole of the year.