North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 23/10/2012	**Agenda Item No:** 5.2	**Enclosure:** 4
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 six 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. The 18 week Intensive Support Team (IST) have visited the organisation on 10th, 16th and 19th October. We expect their report by 31st October 2012. The recovery plans requires sign-off by the IST on Friday 19th October 2012. 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 Six (September)
Performance reported in
October 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 1 September 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 has failed to meet the standard for the past two weeks. Actions are in place and detailed below. This will require significant attention and monitoring of progress over the coming weeks and will require a step up in performance to achieve Q2 performance.
- **Unplanned Re-attendance rate**
  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. This issue is specifically picked up in the Health Economy wide Patient Access Group on a weekly basis.

- **Total time in the A&E Department**
- **Time to Initial Assessment**
- **Time to Treatment**

Patient flow issues are being addressed through the Emergency Flow Project, specifically around the introduction 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.

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.

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
    - Should this rota be supported by a 2nd person working as "POW" to review core wards to "pull" patients through the system to create capacity for EMU?
    - Should this rota work until 10pm to ensure a senior person is working during the peak times?
- Xx% 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.

1.2 Delayed 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.

1.3 Thrombolysis: 60 Minute Call to Needle Time

6 patients treated, 4 breached. All patients who breached were extended call to door times.

2. REFERRAL TO TREATMENT ANALYSIS BY SPECIALTY

The key strategic improvement over the next few months is that every patient should experience a maximum 18 week wait at the Cumberland Infirmary and the West Cumberland Hospital, a transformational plan has now been agreed, will be presented at the November Board and will be monitored weekly at PTL.

3. CANCER BREACHES

In July 2012 there were 13 breaches of the 62 day treatment target for patients referred on the suspected cancer pathway.

A case note audit was undertaken to establish the root cause of these breaches. The audit established the following themes.

- Inter trust referral issues
- Access to diagnostics
- Use of the 2 week wait alert system

In order to address these issues additional management support has been identified to assist in reviewing pathways and proactively managing patient pathways.

Communication with the Newcastle Cancer Manager has been established to improve early information sharing and validation of pathways.

Patients are discussed at a weekly PTL meeting.

Further case note audits will be undertaken for any August and September breaches.

Work has commenced with radiology to review access for diagnostics for patients on the 2 week wait pathway.

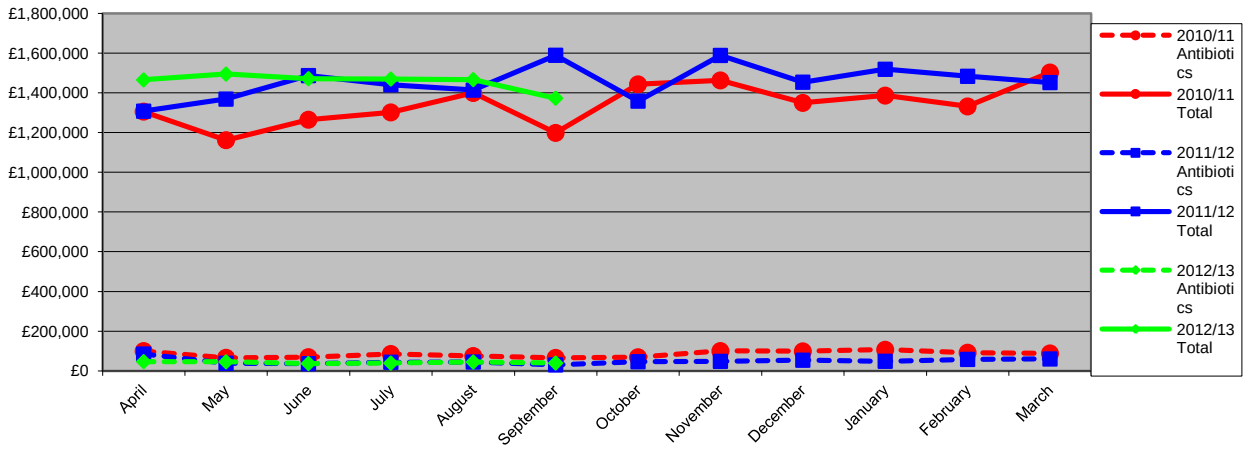
4. PHARMACY METRICS

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.

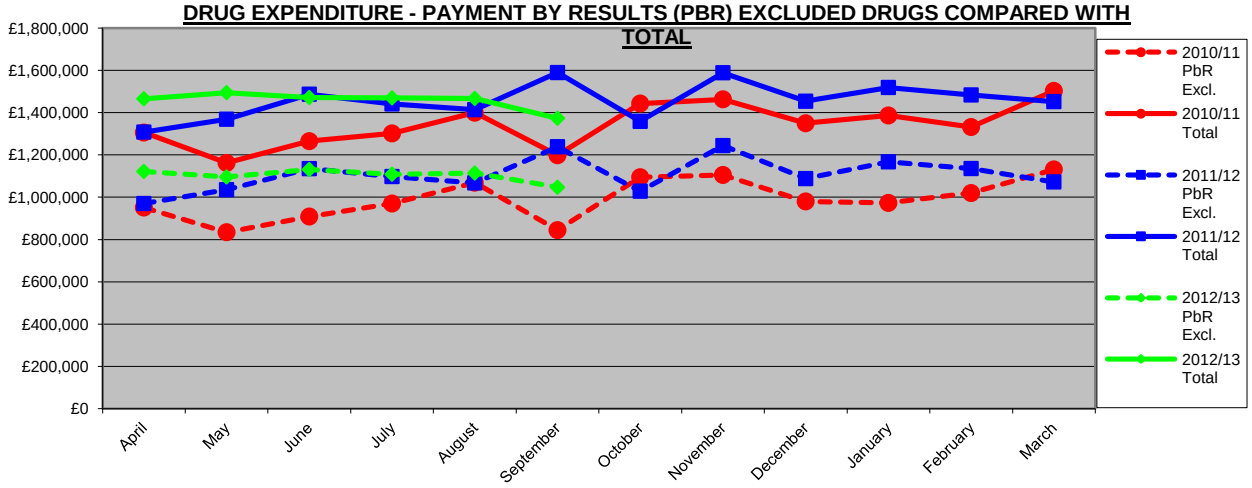
Expenditure up to the end of month 6 of 2012/13 on antibiotic drugs accounts for 2.9% of total expenditure comparable to the same period in 2011/12 which was 3.2%.

The expenditure for PbR excluded drugs is 76% of the total drugs spend, and PbR included drugs account for 24%, which is the same as the corresponding period in 2011/12.

EXPENDITURE ON ANTIBIOTICS COMPARED WITH TOTAL EXPENDITURE



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



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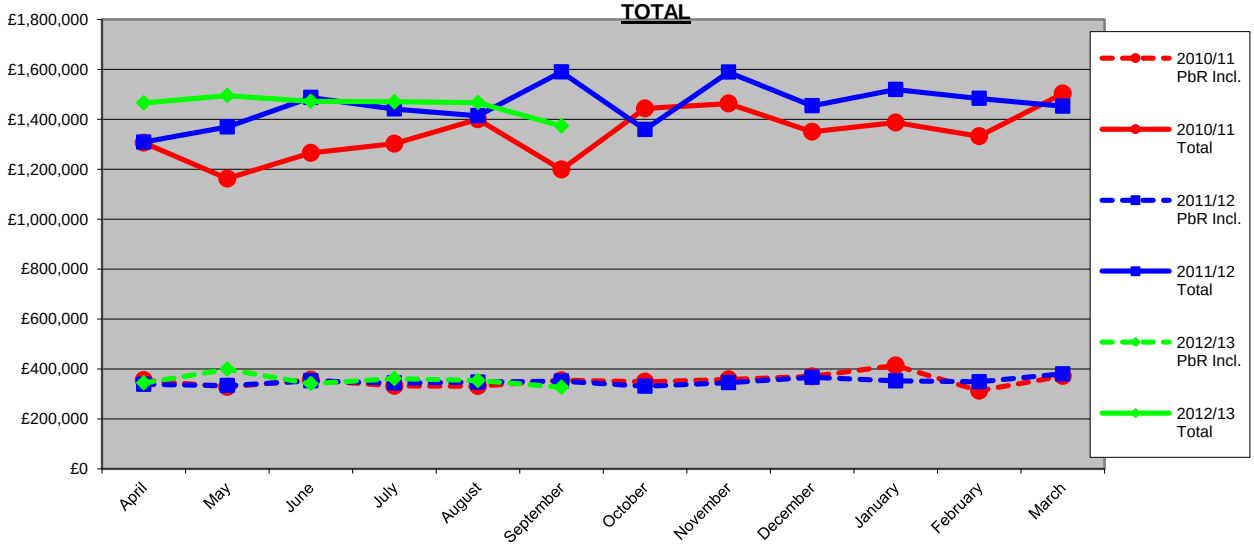

APPENDIX 1

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.