North Cumbria University Hospitals NHS
NHS Trust

TRUST BOARD

Date of Meeting: 09/10/2012	**Agenda Item No:** 6.2	**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 five of 2012/13.

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

There are some on-going concerns relating to 18 week performance which are currently being discussed with NHS North of England. This is in relation to incomplete pathways. A plan is being developed which will be formally presented to the November Board with a verbal report to October Board.

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

North Cumbria University Hospitals NHS
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TRUST BOARD
PERFORMANCE REPORT
Month Five (August)
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 August 2012.

1. 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

1.4 Mixed Sex Accommodation Breaches

Following the introduction in August 2012 of new protocols and the increased monitoring of patients requiring transfer from intensive care to a general ward significant improvements have been made. This has resulted in two mixed sex accommodation breach in August 2012 at the Cumberland Infirmary relating to a patient not being transferred within a four hour period from intensive care to a general ward. This is a significant improvement however close monitoring will continue to ensure this improvement is maintained.

1.5 A&E Clinical Indicators

- **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.

CIC
Target – 5%
Achieved – 5.9% (9 patients had multiple re-attendances)
7 attributable to mental health and social problems or alcohol and substance misuse
1 attributable to on-going abdominal pain and was referred to gastro
1 was a patient who returned with a leg injury

WCH
Target – 5%
Achieved – 5.3% (2 patients had multiple re-attendances)
2 attributable to mental health and social problems or alcohol and substance misuse

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
The 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, which will be 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
WCH

95th percentile and median both achieved

Longest wait – 6 hours 50 minutes
- Due to Transport
- Escalation implemented
- Tripartite monthly meeting has now been established between NCUHT, NWAS and the Commissioners to address transport issues

CIC

95th percentile and median both achieved

Longest wait – 8 hours 45 minutes
- Due to initially awaiting a specialist opinion from the RVI (2 hour 15 minutes delay)
- Further delay awaiting transport (delay of 3 hours 15 minutes)
- Escalation implemented
- Tripartite monthly meeting has now been established between NCUHT, NWAS and the Commissioners to address transport issues

- **Time to initial assessment**

  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. This model will have an initial pilot in September/October.

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

1.6/1.7 Cancer 2 week waits and Cancer 62 days waits

All 2 week waits and 62 day waits were compliant for the month of August.

We are preparing for Cancer Peer Review in November.

Some risks have been highlighted and an appropriate action plan is in place.

We have undertaken a root cause analysis of all the breaches up until the end of July and this has identified areas for enhanced flow of patients. Discussions are taking place with clinical teams and the expectation is that they improved pathways will be agreed and this will be reported further to the Board next month.

3.5 Strokes: Patients with 90% of their admission on a Stroke ward

Weekly monitoring of performance indicators are in place on both sites, through weekly meetings. At CIC they are now holding a daily MDT data collection meeting to ensure that all evidence is collated. In addition to this there are a ring fenced beds purely for stroke patients on both sites to ensure that beds are available for patients coming in through the A&E Department. A case note review of patients who did not have any stay on an acute stroke unit is undertaken for every patient who does not reach the ward within 4 hours.

A new performance pack is being developed to highlight the key areas of the performance metrics, these will be by site and as a whole, and this will be available for the next Divisional performance meeting.
The performance report highlights that the Trust is now achieving the target of 80% of stroke patients are spending 90% of their inpatient stay on the ward. The performance report should highlight the figure 81.6% in green, as we are now achieving and the current figure highlight that we should be on target to attain 80% in September.

4.3 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.

4.10 Staff Absences (Sickness absence rate)

The sickness amber absence rate for the Trust is just under 4.8% against the regional QIPP target of 3.5% although the financial year to date total (4.7%) is

broadly similar to last year's overall performance. Only 5 acute trusts in the North West region are currently meeting this ambitious target. Overall sickness rates have reduced for each of the last 3 consecutive years.

4.11 Temporary Staffing Costs (including agency costs)

Overtime rates have reduced considerably from the July figure of 6.9% to a figure of 6.5%. This downward momentum needs to be maintained. Agency locum expenditure remains a priority for reducing costs in the clinical divisions and there are plans agreed with PMO to achieve this. The replacement of vacant consultant positions is now a key performance indicator and will be monitored through SMT.

5.5 Infant Health: Breastfeeding Initiation

Current performance reported – August 58%

Current performance for August is 58%. This will be fully validated for next Trust Board Performance Paper once all the information has been collected and validated, which takes place after the board papers are issued.
(This is a long standing information timing issue).

Performance in August has dipped due to a reduction in the numbers and availability of breast feeding peer supporters. The department are currently experiencing a delay in receiving CRB checks and once this information is returned the service will have recruited an additional 13 peer supporters to replace the peer supporters who have resigned or reduced their availability.

5.7 No of patients waiting longer than 6 weeks for diagnostic tests

One patient was booked for a flexible sigmoidoscopy had to be cancelled on the day due to endoscopy reprocessing equipment (washer) failure. They were then rebooked past the 6 week diagnostic window due to an administrative error. The process around cancellations on the day and the rebooking of these cancellations has now been reconfirmed with all staff across both endoscopy units.

Nil to report

11. REFERRAL TO TREATMENT ANALYSIS BY SPECIALTY

The Dashboard contains the details of the month five position. Section 11 shows the speciality performance levels as follows:

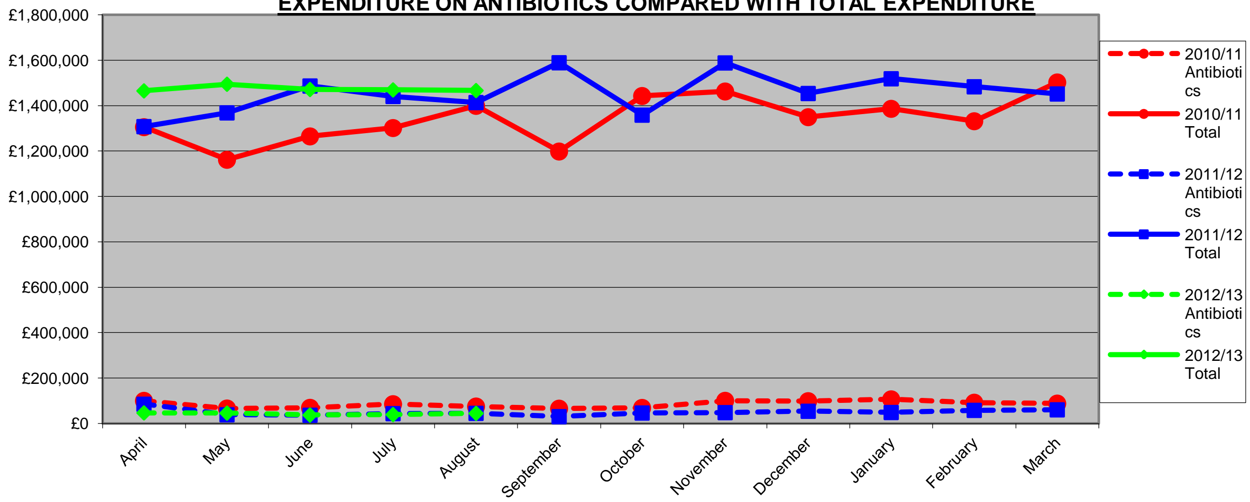
a) Admitted and non-admitted - percentage treated within 18 weeks
b) Admitted patient care 95th percentile
c) Non admitted patient care 95th percentile
d) Admitted patient care median wait
e) Non admitted patient care median wait
f) Incomplete pathways 95th percentile
g) Incomplete pathways median wait
h) Incomplete pathways – number of incomplete pathways (this is shown for trending analysis purposes)

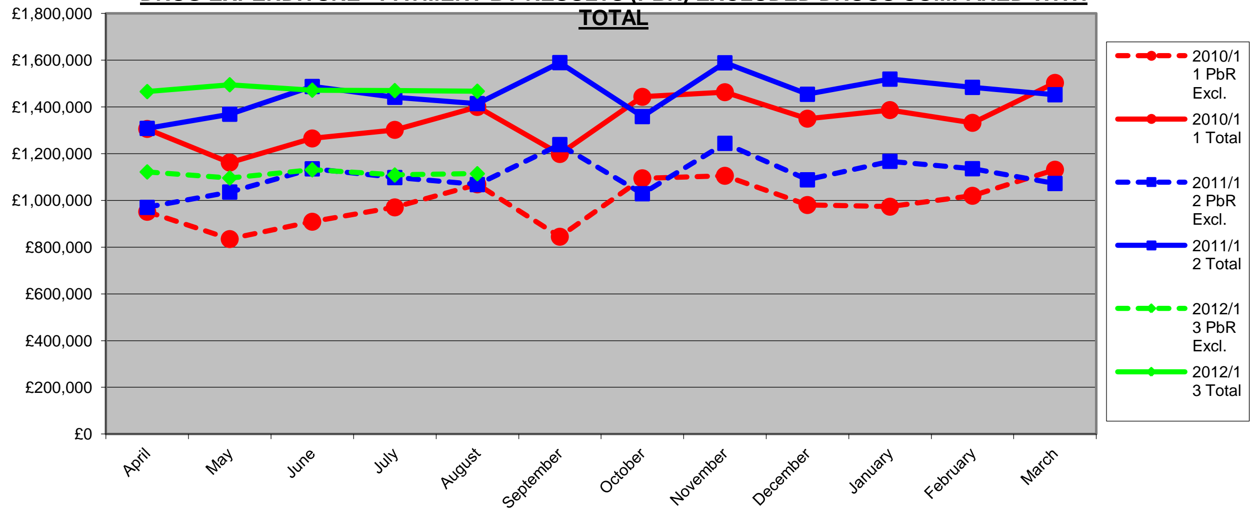
12. PHARMACY METRICS

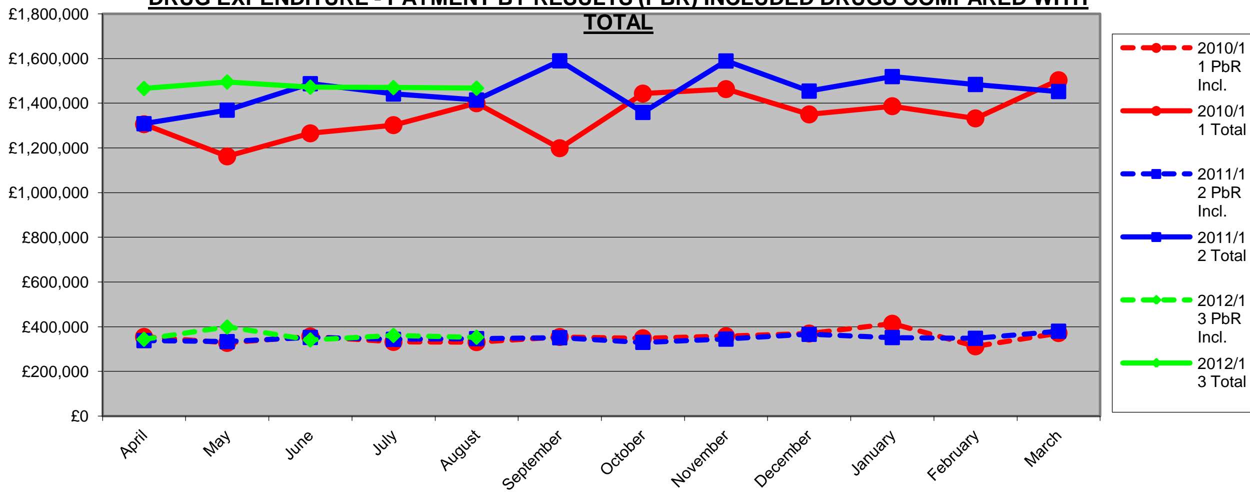
The charts below highlight expenditure for three key areas comparing expenditure against total drug spend and also comparing the current year and the previous two years.

Expenditure up to the end of month 5 of 2012/13 on antibiotic drugs accounts for 2.9% of total expenditure comparable to the same period in 2011/12 which was 3.5%.

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
£1,800,000
£1,600,000
£1,400,000
£1,200,000
£1,000,000
£800,000
£600,000
£400,000
£200,000
£0
April
May
June
July
August
September
October
November
December
January
February
March
2010/11 Antibiotics
2010/11 Total
2011/12 Antibiotics
2011/12 Total
2012/13 Antibiotics
2012/13 Total


DRUG EXPENDITURE - PAYMENT BY RESULTS (PBR) EXCLUDED DRUGS COMPARED WITH TOTAL
£1,800,000
£1,600,000
£1,400,000
£1,200,000
£1,000,000
£800,000
£600,000
£400,000
£200,000
£0
April
May
June
July
August
September
October
November
December
January
February
March
2010/11 PbR Excl.
2010/11 Total
2011/12 PbR Excl.
2011/12 Total
2012/13 PbR Excl.
2012/13 Total


DRUG EXPENDITURE - PAYMENT BY RESULTS (PBR) INCLUDED DRUGS COMPARED WITH TOTAL
£1,800,000
£1,600,000
£1,400,000
£1,200,000
£1,000,000
£800,000
£600,000
£400,000
£200,000
£0
April
May
June
July
August
September
October
November
December
January
February
March
2010/11 PbR Incl.
2010/11 Total
2011/12 PbR Incl.
2011/12 Total
2012/13 PbR Incl.
2012/13 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.