

REPORT TO:	BOARD OF DIRECTORS (BoD)
DATE:	11 FEBRUARY 2021
REPORT TITLE:	INTEGRATED PERFORMANCE REPORT (IPR)
BOARD SPONSOR:	CHIEF OPERATING OFFICER
PAPER AUTHOR:	DEPUTY CHIEF OPERATING OFFICER
PURPOSE:	DISCUSSION
APPENDICES:	APPENDIX 1: INTEGRATED PERFORMANCE REPORT (IPR) DECEMBER 2020

INTRODUCTION

This report provides highlights on the IPR (Appendix 1) which covers performance and activity during December 2020 and also reports on the Trust response to Wave 2 of the Covid-19 pandemic.

COVID-19 PANDEMIC RESPONSE

The safety of patients and staff has been the highest priority during December as Covid-19 second wave increased both the number of patients presenting to the Hospitals and due to the number of staff who were also diagnosed with Covid-19. During December bed base capacity was also restricted as measures to reduce nosocomial infections were rigorously adhered to. This involved the occasional closure of beds and the cohorting of patients based on their Covid-19 status.

There was a daily average of 450 members of staff reported off sick due to Covid-19. The increased patient acuity and staff risk were managed via the Trust GOLD response.

GOLD meetings chaired by the Chief Operating Officer were stepped up again to daily on the 16 November 2020 as Covid related activity began to increase and required a daily response. A revised terms of reference and membership to improve communication, together with a structured agenda and action log with specified focussed weekly updates for key priorities have been included.

Daily management of GOLD response:

- Tactical Silver reports with escalation and documented agreed decisions relating to the effective function and delivery of services on the Hospital sites.
- Documented decisions through Bronze via the Operational Control Centres and Tactical Silver.
- Incident response discussed and decisions ratified these included:
 - Suspension of elective activity;
 - Redeployment of staff and volunteers;
 - Reconfiguration of bed base;
 - Extension of O2 therapy across the bed base;
 - Mortuary capacity.

- Infection Prevention and Control (IPC) and Personal Protective Equipment (PPE) management took place.
- Independent Sector activity plans.
- Workforce management, including escalation to Kent & Medway (K&M) Incident Control Centre (ICC) for support via Military; Helping Hands scheme and redeployment of clinical workforce to support Intensive Therapy Unit (ITU) and wards.
- Daily updates from the Regional K&M ICC calls, which involved all Acute Trusts, South East Coast Ambulance Service (SECAMB) and external partners. The agenda for the calls includes a (Situation Report\0 SITREP from each Hospital and to give and receive escalations and requests for mutual aid.

RESTORE & RECOVERY PROGRAMME

The Trust is now reporting against the NHS England/NHS Improvement (NHSE/I) K&M agreed Recovery plan which was agreed September 2020. However, due to the increased Covid-19 demand in December and following Regional guidance, a decision was made to restrict and then suspend all routine elective work. This decision focussed on reducing the risk to patients whilst the levels of Covid-19 were high in the Community and Hospital setting and also to release clinical staff to be redeployed into the ITU and ward environments. Therefore, the current Restore and Recovery plans have been paused. The plan continues to be monitored weekly by the Chief Operating Officer's Office and Care Group Operations Directors through their wider teams.

The Trust has continued to focus on the booking and treatment of Priority 1 (Cancer), Priority 2 (Clinically Urgent) and diagnostics such as Endoscopy or Radiology which support cancer pathways or any low risk surgery working with the Independent Sector. For those patients who require high risk surgery or High Dependency Unit (HDU)/ITU post operatively we are continuing to treat these patients within the Trust.

Activity levels in December have deteriorated across all points of delivery; with MRI being the only service which has delivered above plan in month, this has been due to additional lists being provided in this modality.

Performance against the Plan has also deteriorated with the exception of New Out Patients' which has delivered 40% against a plan of 25% and also Flexi Sigmoidoscopy which has delivered 131% against a plan of 100%. The Flexi Sigmoidoscopy patients will be predominantly cancer pathway or clinically urgent patients and there is a priority to reduce the waiting times which developed in Wave 1.

Any reduction in elective work and subsequent redeployment of staff has been seen and supported by GOLD. This includes a reduction in Radiology.

Point of Delivery	Sep-20	Oct-20	Nov-20	Dec-20
Total Outpatient Attendances (face to face or virtually)	Plan 56,266	60,264	67,374	61,106
	Actual 58,091	61,617	60,136	50,297
Consultant Led Outpatients Attendances Conducted by telephone / video	Plan 22,940	23,001	28,817	26,087
	Actual 23,842	24,013	23,192	19,984
Consultant Led Follow Up Attendances Conducted by telephone / video	Plan 17,269	17,649	22,893	20,871
	Actual 17,826	18,317	17,976	15,386
Daycase Electives	Plan 4,138	4,928	5,012	4,834
	Actual 4,117	4,641	4,218	3,311
Ordinary Electives	Plan 789	886	867	807
	Actual 721	907	879	458
Magnetic Resonance Imaging (MRI)	Plan 4,896	5,528	5,656	4,777
	Actual 4,669	4,918	6,012	5,233
Computed Tomography (CT)	Plan 7,060	7,080	7,653	7,125
	Actual 6,548	6,247	6,418	6,061
Non-Obstetric Ultrasound	Plan 4,749	4,391	4,510	4,792
	Actual 3,712	4,239	4,033	3,505
Colonoscopy	Plan 512	662	616	629
	Actual 401	521	588	414
Flexi Sigmoidoscopy	Plan 180	234	216	222
	Actual 170	198	222	146
Gastroscopy	Plan 595	766	716	729
	Actual 469	580	462	408

Point of Delivery	Sep-20	Oct-20	Nov-20	Dec-20
Total Outpatient Attendances (face to face or virtually)	Target 100%	100%	100%	100%
	Performance 94%	90%	93%	88%
Consultant Led Outpatients Attendances Conducted by	Plan 25%	25%	25%	25%
	Performance 41%	39%	39%	40%
Consultant Led Follow Up Attendances Conducted by	Plan 60%	60%	60%	60%
	Performance 49%	49%	48%	50%
Daycase Electives	Plan 80%	90%	90%	90%
	Performance 86%	84%	79%	69%
Ordinary Electives	Plan 80%	90%	90%	90%
	Performance 74%	81%	86%	53%
Magnetic Resonance Imaging (MRI)	Plan 90%	100%	100%	100%
	Performance 74%	79%	96%	87%
Computed Tomography (CT)	Plan 90%	100%	100%	100%
	Performance 97%	90%	88%	85%
Non-Obstetric Ultrasound	Plan 90%	100%	100%	100%
	Performance 89%	93%	90%	85%
Colonoscopy	Plan 90%	100%	100%	100%
	Performance 104%	93%	112%	89%
Flexi Sigmoidoscopy	Plan 90%	100%	100%	100%
	Performance 79%	88%	93%	131%
Gastroscopy	Plan 90%	100%	100%	100%
	Performance 92%	90%	82%	73%

PERFORMANCE

In December, the Trust performance against the agreed constitutional standards is:

- Accident & Emergency (A&E) 4 hour access standard 71.07% and 73.59% including Kent Community Health NHS Foundation Trust (KCHFT) Urgent Treatment Centres;
- 18 Week Referral to Treatment (RTT) 69.02%;
- 62 day Cancer Standard 81.32%;
- 6 week diagnostic standard 77.64%.

A&E 4 Hour Compliance

December performance for the 4 hour standard was 71.07%, which is a deterioration of 4.32% on the previous month (75.39%) and the previous year (73.9%).

There were 186 x 12 Hour Trolley Waits. This is the first time the Trust has ever reported above 20 x 12 hour breaches. The high number of breaches reflects the significant increase in Covid-19 patients who required admission and will be further discussed in the report below.

- The number of patients who received initial assessment within 15 minutes of arrival dropped significantly from 43.4% to 36.5% and reflects the increased Covid-19 presentations who have to be streamed into a dedicated area for initial assessment.
- The proportion of patients who left the department without being seen is compliant at 2.00%.
- The unplanned re-attendance position has improved to 10.48%.
- Time to treatment within 60 minutes deteriorated to 40%.

The number of patients attending the Emergency Department (ED) has been at pre-pandemic levels since August 2020. December saw a significant increase in patient acuity with an increasingly greater number of patients attending with Covid-19 symptoms

and requiring admission. The EDs at both acute sites have expanded their physical footprints into adjoining clinical areas to support social distancing and to provide additional consulting rooms. The Observation Wards have also been converted into an additional dedicated Covid respiratory areas.

All patients requiring admission have to be admitted into a specific stream, i.e. pre-identified covid or non covid wards. Balancing the bed capacity, within the strict infection control requirements is a daily challenge. It is important that there are always sufficient covid positive, pending, and non covid beds available to accommodate emergency presentations and this requires proactive and constant review of side rooms and infections on site.

There has been a recognised increase in the demand for patients to be admitted direct to the dedicated Covid-19 positive respiratory wards, which have the highly skilled staff who can manage patients with non-invasive ventilation (NIV). These patients are the most acutely unwell outside of ITU. Patients who require NIV have been delayed in ED whilst the most clinically appropriate bed is identified and due to ED being the most clinically safe and appropriate area to wait as the nursing staff are able to manage this cohort of patients' clinical needs.

Patients who have presented with Covid-19 symptoms will be admitted into a 'Pending' bay whilst we await the results of a Covid Swab. This is to reduce the risk of cross infection by patients. Patients who have a positive swab result from the Community can be admitted directly into a covid positive ward. For those patients who are emergency admissions, but have no covid symptoms, i.e. may be attending for another medical or surgical emergency may be admitted into a non covid ward.

Balancing the IPC requirements and to ensure appropriate bed availability has resulted in some patients being delayed in ED. There are most often empty beds in the Hospital, however, they may not be the correct bed (covid or non covid) and therefore patients will remain in ED whilst a series of moves will be made to accommodate clinically appropriate patients. The decisions around ward moves are made by the senior clinical team in each Hospital and supported by the operational teams on a daily basis; with very detailed plans overseen by the Hospital Medical Directors and with any significant changes of ward designation agreed at the daily GOLD meetings. This issue is not unique to this Trust and has been regularly discussed on the K&M Regional calls as all Hospitals have struggled with the availability of the 'appropriate' bed capacity and the impact on overcrowding in ED and patient flow.

Medically fit for discharge (MFFD) patients continue to have an impact on the hospitals overall bed capacity. Barriers to discharge can be due to infection control requirements for patients with suspected or confirmed Covid-19 having a negative swab 48 hours prior to transfer to a nursing or residential home. Daily Local Health Economy (LHE) calls, chaired by Clinical Commissioning Group (CCG) colleagues are in place to confirm system capacity, all provider discharges and escalate challenges with capacity or workforce. External colleagues, particularly in the Community Trust have also seen high levels of staff sickness.

The national Discharge Guidance, which identifies MFFD patients where a decision has been made and documented in the patients' medical notes that the patient has completed all medical intervention and is ready to transfer to home or their next care location. On the daily board or ward rounds the multi-disciplinary team are identifying MFFD patients through a series of 'Criteria to Reside' questions. During December there has been a focus on restating and implementing the new Discharge Guidance, which is also supported by the Academy of Royal Colleges.

A protocol for the Clinical Management and Agreed Definition of MFFD patients was agreed and implemented in December, which will also support the identification of MFFD patients and support discussion with external Partners to facilitate early discharge from Hospital.

Ambulance Handover delays of over 60 minutes have also increased in month. This has been due to the increased activity and predominantly due to a lack of space within the EDs to off load the patients safely into the appropriate clinically designated area of ED. The Trust staff have a very interdependent working relationship with SECAmb and have worked tirelessly to reduce the number of ambulance delays and release the crews as quickly as possible.

In the middle of December, the EDs went live with Point of Care testing for Covid-19. This was a significant improvement as ED staff are now able to obtain a result within 30 minutes. The service is available 5/7 days a week for 24 hours a day and at weekends the service is 12 hours a day. Recruitment is ongoing and there will be a 7/7 will be extended to a 24-hour service in January 2021.

18 Weeks Referral to Treatment (RTT) Standard

The 18 week performance has deteriorated very slightly from 69.54% to 69.02%. The backlog size has increased for the first time in six months to 14,702 and waiting list has increased slightly to 47,450. The decision to pause non urgent elective activity has resulted in a deterioration in performance.

The number of patients waiting over 52 weeks has increased from 2,172 to 2,544. The number of patients waiting over 52 weeks has increased since April 2020 due to the new national categorisation framework. Consultants continue to review, and where necessary, contact patients to minimise any risk of potential harm. Harm reviews are in place with patients being reported on Datix.

Urgent patients who are choosing not to proceed with their procedure or treatment are being referred back to the GP in accordance with the Access Policy. Clinical discussions to reassure and support patients with their decisions are regularly taking place. Some patients are now declining to accept appointments as they were unwilling to isolate pre-procedure or attend the Hospital whilst Covid-19 continues to be a risk.

Urgent and Cancer outpatient clinics are continuing to be managed through a range of mediums such as virtual or telephone. Face to face clinics are being reviewed and reduced to minimise the risk to patients through attending the Hospital sites. Virtual clinics continue to be very successful with 50% of all Follow Up appointments and 41% of all first New appointments being managed this way.

Due to increased levels of Covid-19 in the community and hospital environment, out patient clinics have been reviewed to reduce all non-urgent activity to enable clinical staff to be released to support nursing gaps on the wards, ED, ITU and the vaccination programme. Clinically Urgent and Cancer clinics have continued.

Cancer 62 day Standard

December 62 day performance is non-compliant at 81.32%. The total number of patients on an active cancer pathway at the end of the month has decreased to 3,179 and is compliant.

There were 5 patients waiting 104 days or more for treatment or potential diagnosis, with all patients now having received their treatment at the time of writing this report:

2 week wait (2ww) and 31-day performance are compliant across all standards with the exception of 62-day upgrades at 70.59%. Although the 62-day performance standards have not been achieved this month staff have continued to monitor each patient to try to progress patients' pathways and strive to return to compliance next month.

The Wave 2 increase in Covid-19 patients has continued to create a risk to the delivery of the Cancer standards. Patients are now choosing to delay their treatment plans in order to wait for the Covid vaccination before attending Hospital. The K&M Cancer Network are escalating this risk in order to try and facilitate this small group of patients receiving vaccination as a priority.

It has also been a challenge to maintain Cancer surgery for the most complex patients who may require HDU/ITU post operatively due to the increasing demand for ITU capacity for covid positive patients. Low risk Cancer surgery has continued to be managed through the Independent Sector, who are able to offer a 'Green' covid secure environment.

The specialities who have not achieved 62 day compliance are Breast, Lung, Upper GI and Gynaecology, although Gynaecology have improved from 62.5% to 80% in month. Haematology, Lower GI and Skin are all compliant. With Lower GI achieving 85.7% and compliance for the first time in a year.

Cancer Operations Director led meetings have continued with radiology, endoscopy and all 2ww tumour sites, together with, as required, escalations to partner Trusts in order to expedite patient pathways.

6 Week Referral to Diagnostic Standard

Compliance has deteriorated to 77.64% and there were 3,738 patients who had waited over 6 weeks for their diagnostic procedure.

Due to the greatly increased demand for CT capacity for emergency admission patients both in ED, ITU and on the wards a decision was taken in conjunction with the Local Medical Committee (LMC), which has senior medical membership from both the Trust and Primary Care, to suspend all routine referrals. There was also a high level of clinical staff sickness within the Radiology departments which placed an additional pressure on the Departments to respond to the increased CT demand. To reduce the risk a plan was put in place which included stopping direct access CT; referring non-obstetric ultra sound direct to Any Qualified Providers; a consultant Radiologist is available for advice 24/7; ED referrals have to be approved by a Consultant or the senior ED Doctor out of hours.

In Cardiology, echocardiography capacity has been reduced to allow 60 minutes per echo in accordance with College guidance to meet IPC guidance and also to provide additional inpatient echos.

There has been an increase in colonoscopy breaches due to a focus on reducing the waiting time for cancer referrals. There has also been some reluctance by patients to accept an appointment, particularly in endoscopy due to concerns regarding pre-procedure isolation and concerns regarding Covid-19 overall. Booking staff are continuing to assure patients and a clinical discussion is also available as required. No patient is removed from a waiting list without a clinical discussion and referral back to the patients GP.

Radiology have sent 400 non-obstetric ultra sound referrals to the Independent Sector in month to reduce waiting times and all specialities are continuing to work with the Independent Sector providers to increase capacity.

Audiology continue to deliver 100% compliance in both the complete and incomplete pathways. To achieve this the service has increased their virtual consultations and through pathway redesign with ENT and Primary Care.

IDENTIFIED RISKS AND MANAGEMENT ACTIONS:	Failure to deliver Constitutional Standards resulting in delays in patient care and experience. Links to Corporate Risks as stated below.
LINKS TO STRATEGIC OBJECTIVES:	We care about... <ul style="list-style-type: none"> • Our patients • Our people • Our future • Our sustainability • Our quality and safety
LINKS TO STRATEGIC OR CORPORATE RISK REGISTER	SRR19: Patients may decline a date within breach and choose to delay their treatment until after their 52 week breach date. SRR21: Due to lack of capacity in tertiary centre patients may breach the 62 day standard waiting on diagnostic or treatment. SRR22: Urgent Treatment Centre may not become established and result in increased demand to ED CRR68: Risk to delivery of the operational constitutional standards and undertakings.
RESOURCE IMPLICATIONS:	No
COMMITTEES WHO HAVE CONSIDERED THIS REPORT	None
SUBSIDIARY IMPLICATIONS	No
PRIVACY IMPACT ASSESSMENT: No	EQUALITY IMPACT ASSESSMENT: No

RECOMMENDATIONS AND ACTION REQUIRED:

The Board of Directors is asked to discuss and **NOTE** the IPR.