Performance Report December 2014 – key national indicators

1. Introduction

This report summarises the Trust's performance and position for the following key national targets:

- A&E indicators
- 12+ hour wait from decision to admit to admission (trolley waits)
- Ambulance handover time > 1 hour
- Referral to Treatment waiting times for admitted care, non-admitted care and incomplete pathways
- 52+ week
- Cancellation of an urgent operation for the second time
- 6 week standard for diagnostics
- Cancer Waiting Time Standards

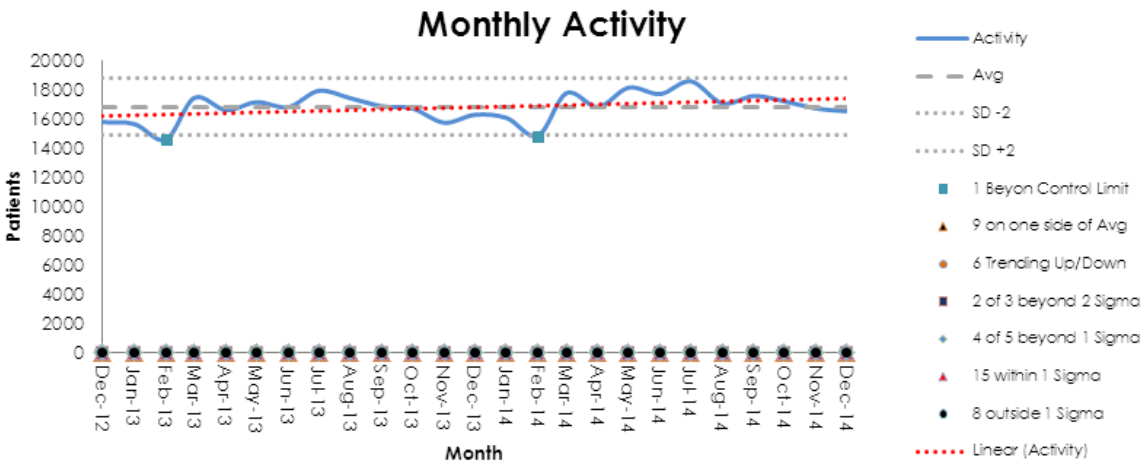
2. A&E Indicators

The National Operating Framework, 'Everyone Counts' outlines 3 main indicators for A&E performance;

- **total time in department**
- **trolley waits**
- **ambulance handover compliance**

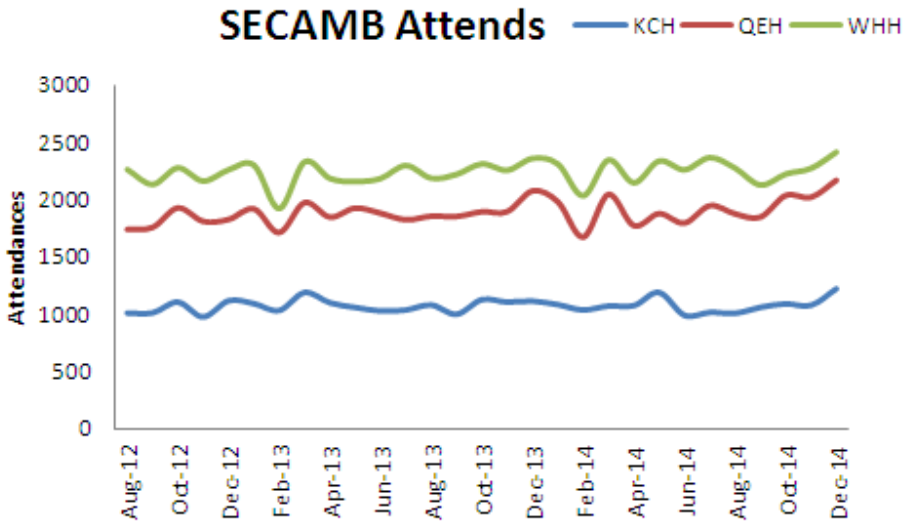
(Due to consistent poor performance throughout 2013/14 we will continue to monitor unplanned re-attenders throughout this financial year).

The Trust was non-compliant with the 4 hour A&E standard in December 2014 at 88.5% and for quarter 3 performance was at 90.7%. As seen from the graph below activity levels were above last year (+1.48%) which is a lower increase than that seen in the past 6 months. There is variation between sites with KCH seeing around the same number as last year (+0.56%). QEH and WHH have seen a larger increase (1.4% and 2.26% respectively).



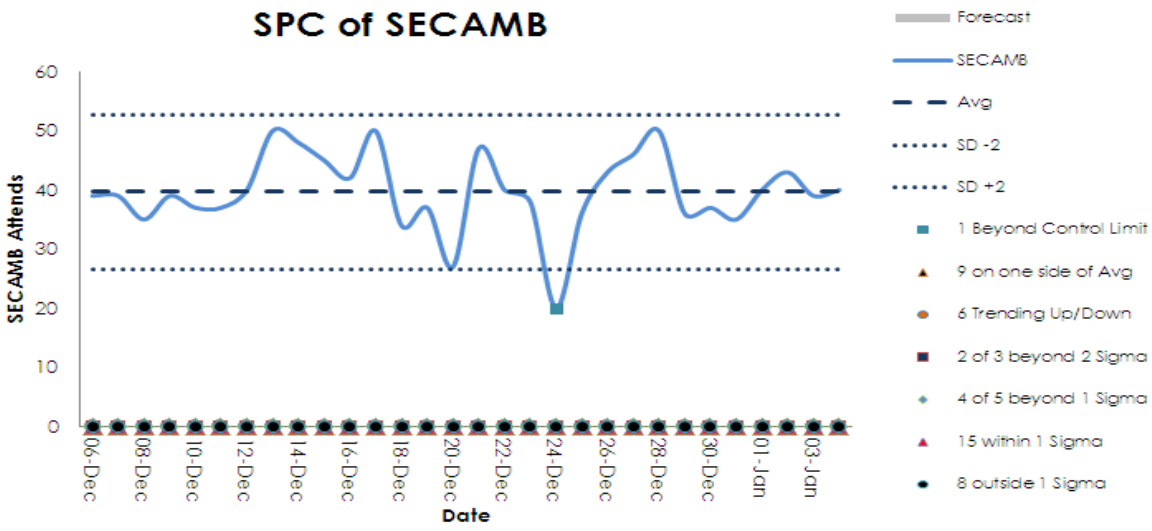
Graph 1 – A&E attendances

Ambulance attendances have increased to the highest recorded level for the Trust at 5806. This is up +4.56% on last year. It is important to note this number may differ from numbers issued by SECAMB as it includes patients who are not booked into A&E e.g. pPCI. Once again, this varies between sites with KCH seeing +9.69% up on last year, QEH +4.48% and WHH 2.37%.



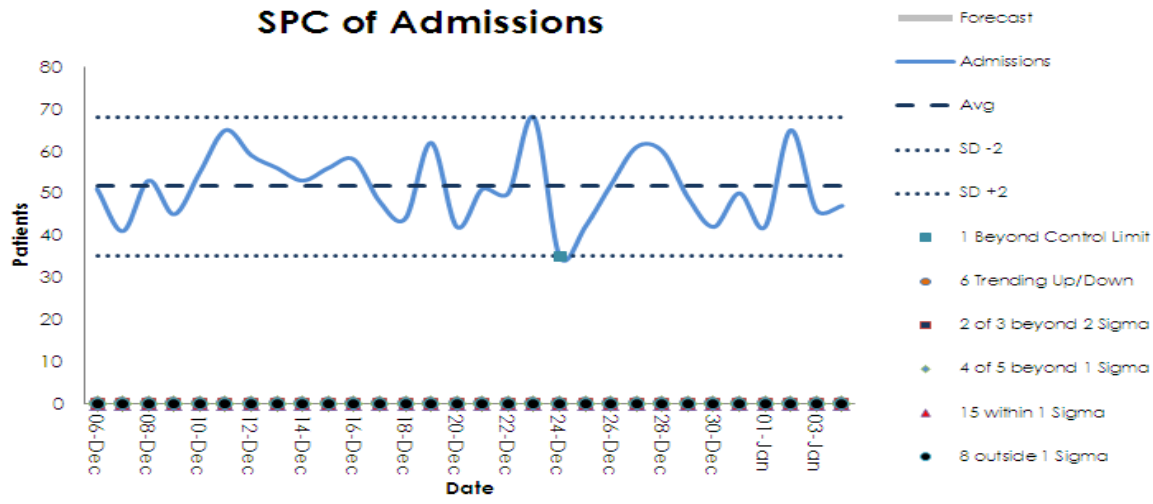
Graph 2 – Ambulance attendances

In addition to the overall growth in self presenters and SECAMB conveyances there continues to be a significant variability in attendances on a daily basis. The graph below illustrates the daily SECAMB attendances at KCH. Excluding the activity Christmas day, the variation can be seen in that on one day we had a low of 26 but on several other days the attendances have been at the upper confidence levels indicating special cause variation.



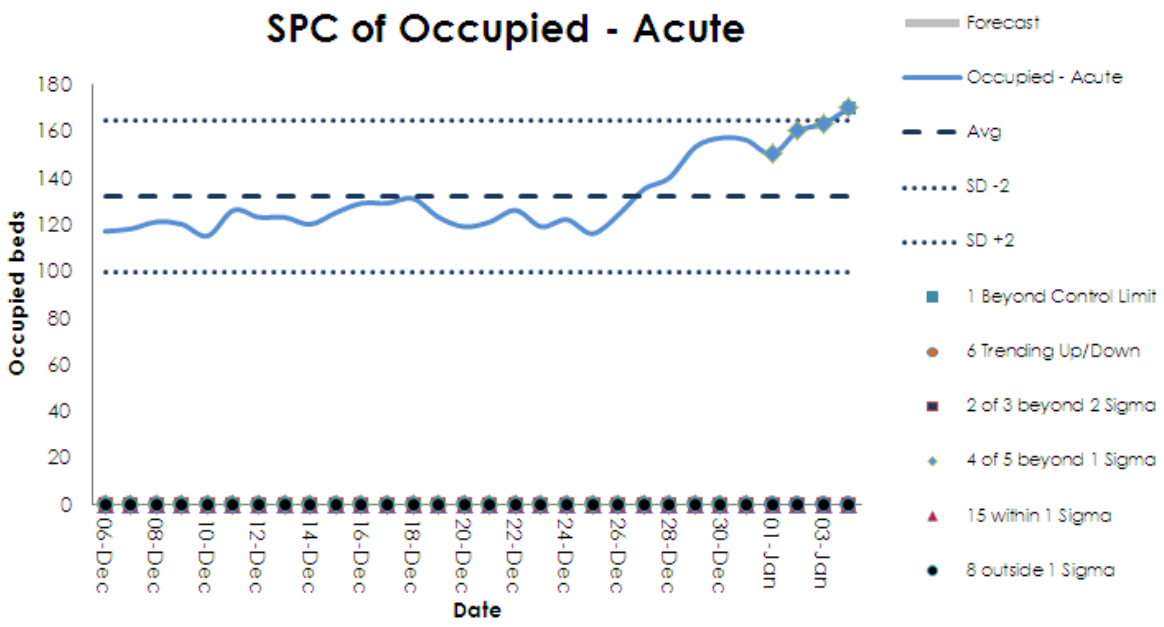
Graph 3 – Daily Ambulance attendances at KCH

The increase in attendances was also compounded by an increase in emergency admissions. As we can see from the graph 4, admissions at KCH in mid-December were higher than expected and followed by a high number of admissions (68) on 23rd December. In the week leading up to Christmas there has historically been a rise in discharges which reduces the overall bed occupancy. In contrast this year in the same period before Christmas we saw high levels of attendances and admissions resulting in increased occupancy levels, opening of extra beds and occupation of medical patients in surgical beds as a consequence.

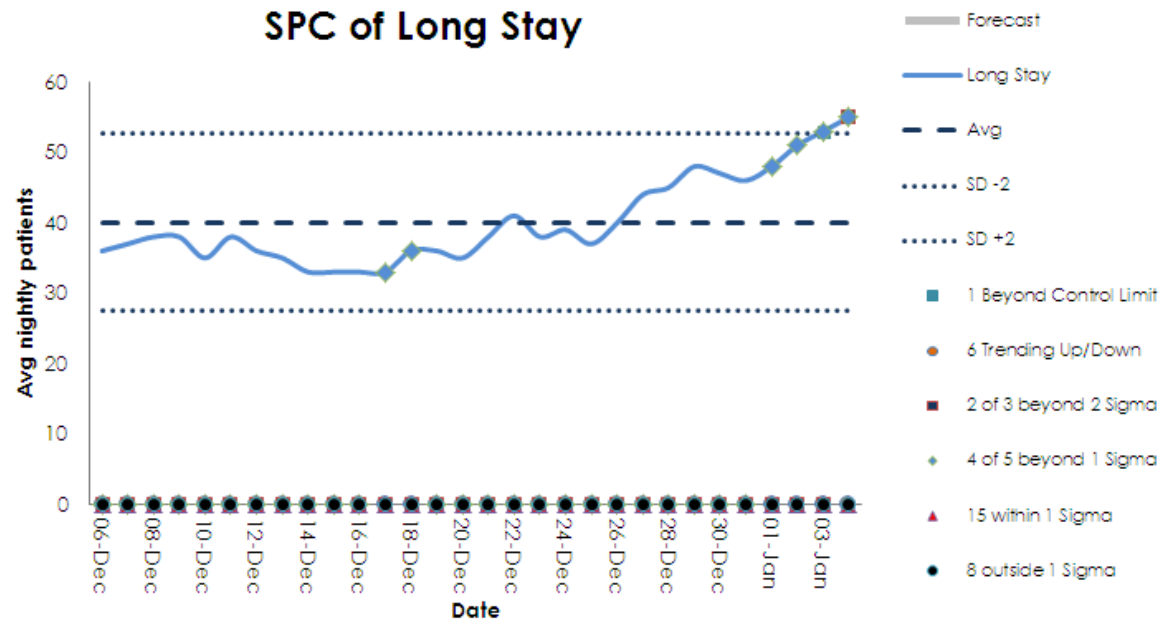


Graph 4 – Admissions at KCH

Graph 5 below illustrates the midnight occupancy of acute wards at QEH; we can see that this dramatically increased towards the end of December. This is partly due to the increment in long stay (14+ days) patients. Although this is usually seen around extended bank holiday periods such as Christmas and Easter it has been sustained throughout the year, with an average of 45 patients at QEH over 14 days and a peak of 56 just after Christmas. This was also noted At WHH where there was an average of 40 patients with a peak of 55.



Graph 5 – Midnight occupied beds on Acute wards at QEH



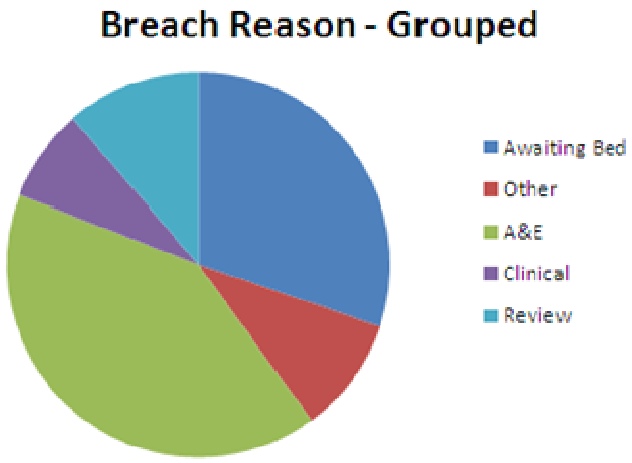
Graph 6 – Long stay patients midnight occupied beds at QEH

In addition to the increase in admissions and occupied beds, length of stay has also increased by half a day on both the QEH and WHH site (from 4.07 to 4.59 at QEH and 4.23 to 4.78 at WHH). This was seen on the short stay and acute wards.

Breaches of the 4 hour Access Standard

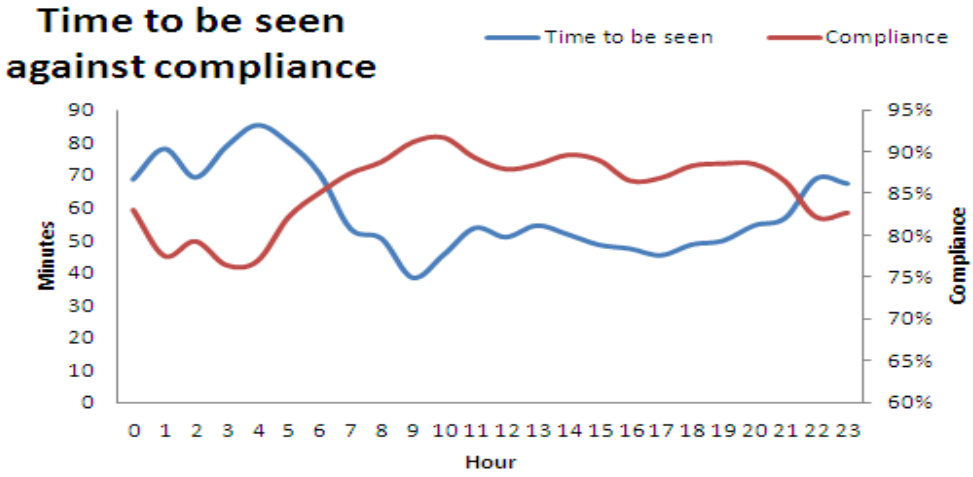
The chart below demonstrates that there are a number of breaches that are attributable to A&E (41%) and that the number of breaches for patients waiting for an inpatient bed has increased overall to 30%. The issue here is that patients awaiting bed allocation in ED occupy cubicles within the department. This then results in delays in the pathway for

patients waiting to be seen by a clinician in the waiting room which contributes to the number of breaches with a reason of ***'delay to be seen'***. Patients who wait for a bed spend, on average, 30 minutes longer in A&E than patients who have a different reason for breaching the 4 hour standard.



As with several of the metrics discussed, there is significant site variation but especially with the percentage of patients who breach awaiting a bed. Although for the Trust this is at 30%, at the WHH this has peaked at 41% of breaches and QEH 52%. This is due to the aforementioned uplift in admissions following on from the rise in attendances and length of stay all of which contributed to an increase in bed occupancy.

Another important factor is the *variation* in time from attendance to first assessment by a clinical decision maker. The national standard is that 55% of patients should be seen within 60 minutes. Graph 7 below demonstrates that although performance in this regard is good between the 8am to 8pm, outside these hours performance deteriorates. The impact is that the longer the patient waits to be seen, the higher the likelihood of a 4 hour breach. Although this is influenced by the length of time patients are waiting for a bed there are other factors such as doctor productivity and efficient tracking of the patients' journey that also impact.

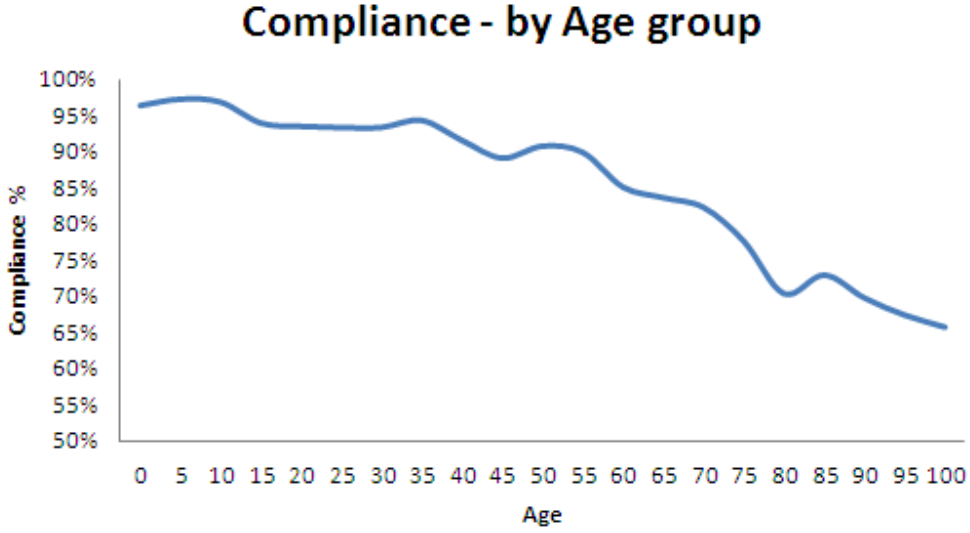


Graph 7 – Trust average time to be seen against compliance profile

Action
The Trust Clinical Lead for Emergency Care has taken the following actions to address this;

- *Development of a tracking step tool to ensure that there are clear standards for recording emergency care clinical episodes across the Trust. Tracking is now also an integral part of the junior doctor induction and is being enforced by the senior ED team on a daily basis.*
- *Senior doctor in charge of the department after 1900 now has a clear responsibility to ensure tracking is up to date and is managing the junior doctors and supporting early decision making.*
- *Under-performing locums are no longer employed by the departments*
- *Employment of an additional 1500 to 00.00 specialty doctor and an additional 1400 to 2200; and 2000 to 0400 Monday to Friday using surge resilience funding*
- *These shifts have been secured based on breach analysis data including attendance profile.*
- *X2 additional locum consultants have also been employed, one each at WHH and QE using surge resilience funding . Both now in post*

The increased attendances for elderly patients has already been noted. Analysis of the compliance by age profile demonstrates that patients over the age of 60 have a much lower 4 hour compliance illustrated by graph 8. Although this is expected given that we are seen higher numbers of complex, co-morbid, frail elderly patients, further work needs to be done to improve pathways for these patients across the local health economy.



Graph 8 – Trust compliance by 5 year age groups

Action
The new acute medical model enables rapid assessment of frail elderly patients using an ambulatory care approach coupled with support from the Integrated Discharge Team (IDT) to facilitate discharges from ED and CDU. The division is planning to take this a step further by piloting designated Comprehensive Geriatric Assessment clinics in conjunction with the IDT.

Update from A&E Recovery Action Plan

1. A&E Processes

Email alert – has now been implemented which means that the ED Matrons, Consultants and divisional management team are alerted when the number of patients in the department reaches a level which puts the department at risk of multiple breaches.

Observation Bay - at WHH it has not been possible to implement an Observation Bay due to the bed pressures the site has experienced over December. And lack of staffing. It is a priority to implement an Observation Bay using the Blue Bay using a PDSA methodology. Currently recruiting substantively rather than using temporary staffing which is unreliable and will result in an inconsistent service.

SAU WHH - SAU has been successfully established. A dedicated clinical environment for the SAU at QEQMH has been identified within the current Ambulatory Care Bay and CDU footprint. In order to release this clinical area to Surgery negotiations with the Therapy Department have enabled the Ambulatory Care area to expand into part of the Therapies footprint. Gary Upton is supporting this work.

Radiology Breaches - At QEQMH delays in accessing ultra sound and CT are being managed through joint monitoring with Radiology and ED.

ED Refurbishment WHH - Strategic Development have supported the ED Clinical Leads and Managers to develop options for the ED to be expanded and redesigned to improve the department, which will include a much improved waiting area, new minor injuries and paediatric areas both with designated waiting rooms, and a redesigned majors area. The majors refurbishment will include a new clinical workstation which will improve patient visibility and patient flow.

2. Pathways

Ambulatory care - x2 Locum Acute Physicians now at QEQMH and WHH using surge resilience funding. The Acute Physicians have been successfully leading the implementation of hot ambulatory clinics working closely with the ED staff to identify patients who may be suitable for management on an ambulatory or short stay pathway. They have become a valued member of the emergency floor clinical teams. The implementation of 7 day working has been restricted due to the number of Acute Physicians currently in post, ideally there would be a minimum of 3 Consultants in post to support extended working day rotas, with 5 to achieve a 7 day rota.

Discharge - The IDT team is becoming established with the implementation of a named discharge manager link to each ward with a dedicated caseload of patients. Full 7 day working across the IDT team was implemented in December and improved the focus on weekend discharge planning. There has been very positive feedback regarding the impact in ED and across the emergency floor where the team are focussing on admission avoidance, rapid assessment and supportive discharge. The medical teams are reporting improvements in supported discharge but there is still some work to be done to improve multidisciplinary working.

Top 10 Pathways - The Emergency Care Board is to be reinstated with an executive level chair to provide senior clinical leadership to drive the development and implementation of the pathways.

3. Workforce

ED Medical Staffing - There are now 3.5 substantive ED Consultants at QEQMH and 4.5 at WHH, with one additional Consultant on a year-long sabbatical which ends in March 2015. Using surge resilience funding, the Consultants have been working additional shifts in the evenings and weekends to increase the consultant presence in the department up to 22:00 weekdays and extended cover at weekends on an ad hoc basis and supported by locum ED Consultants who are employed either on a Trust locum

contract or via Agency. As a result we are seeing an improvement in the 60 minute performance standard, in particular at WHH and improved clinical supervision of middle grade and junior doctors.

ED middle grade locums - the ED Consultants have put in place robust monitoring arrangements to review clinical competency, productivity, leadership and engagement with the local department team. There is now a small group of regular locums being employed whilst substantive recruitment is being progressed. This has resulted in improved productivity and better team working.

Nursing staff - An 8B Senior Matron and additional 8A Matron in ED at QEQMH has enabled an extended working day and weekend cover rota to be implemented. This has proved to be very successful in ensuring there is senior nursing leadership available out of hours, particularly during the period of extremely high pressure post-Christmas.

Using surge resilience funding, additional nursing shifts have been requested via NHSP and Agency to increase the numbers of nurses available on each shift at peak hours throughout the day. Due to the high demand for ED nurses in neighbouring economies these shifts have not always been filled. QEQMH is the most challenging site to secure agency nursing cover for due to its physical location from London.

Operational and management cover - senior staff have been working extended working day hours on an ad hoc basis to support the site operational teams with capacity and flow issues. At the WHH we are piloting additional management support in ED to strengthen the overall leadership of the department and assist with streamlining of the emergency pathway. The pilot will be evaluated prior to its conclusion on March 31st.

New Year's Resolution – perfect week- 13th -20th January a week of action learning that had a large part of the organisation focussed on emergency care and in particular effective discharge. Early indications are that a lot of useful information was gathered and performance did improve in the week. Evaluation will be competed after the de-brief session held on 26th January.

3. Referral to Treatment waiting time performance

The 2014/15 National Operating Framework, 'Everyone Counts' measures the following RTT standards;

- **non-admitted patients = 95%**
- **admitted patients = 90%**
- **incomplete pathways = 92%**
- **52 week waiters = zero tolerance**

(Incomplete pathways are a measure of all patients still waiting for their first definitive treatment regardless of where they are on their pathway, i.e. this measure combines both admitted and non-admitted patients waiting for treatment.)

December performance against the 2014/15 standards was; non-admitted care 96.0%, admitted care 82.4%, incomplete pathways 91.7% and there were nine patients who were waiting 52+ weeks as at the end of December.

Pathway	< 18 Weeks	>18 Weeks	Total	% Compliance	52 Week waiters	Backlog Position
Non-Admitted Pathway	8,239	345	8,584	96.0%		
Admitted Pathway	2,568	548	3,116	82.4%		1629
Incomplete Pathways	30,174	2,737	32,911	91.7%	9	

Table 3.1 – RTT Position Compliance by Pathway (December 2014)

December performance shows the Trust remains compliant with the non-admitted standard however as has been raised as a risk for several months the incomplete pathways standard has now moved to a non-compliant position along with continued non-compliance in the admitted standard. The deterioration of the incomplete pathways position is as a direct result of significant growth in the admitted backlog, particularly in Dermatology which has grown by 90 in month and Orthopaedics which grew by 89 in month. Exceptions to compliance are detailed in the below table.

Pathway	Specialty	< 18 Weeks	>18 Weeks	Total	% Compliance
Admitted	Gen Surg	332	74	406	81.8%
Admitted	Urology	221	29	250	88.4%
Admitted	T&O	490	210	700	70.0%
Admitted	ENT	181	28	209	86.6%
Admitted	Ophthalmology	423	57	480	88.1%
Admitted	Max Fax	92	25	117	78.6%
Admitted	Dermatology	222	62	284	78.2%
Admitted	Gynae	242	43	285	84.9%
Admitted	Other Specs	134	15	149	89.9%
Non-Admitted	T&O	701	41	742	94.5%
Incompletes	Gen Surg	3,045	288	3,333	91.4%
Incompletes	T&O	4,669	961	5,630	82.9%
Incompletes	Ophthalmology	3,983	392	4,375	91.0%
Incompletes	Dermatology	2,331	363	2,694	86.5%

* Where total clock stops are 20 or less this does not count as failure of the standard as it is below the deminimis limit.

Table 3.2 – Exception report for non-compliant specialties (December 2014)

The Trust backlog position grew significantly during December by 134 patients ending the month at 1,629. Orthopaedics grew by 89 and Dermatology grew by 90. It remains the case in both of these specialties that whilst they continue to treat a higher number of breaches in month, the rate at which patients are being added to the backlog is greater than the amount we are able to treat resulting in a net growth. The only other specialty area that experienced growth in December is ENT which grew by 8 patients.

The chart below shows the backlog position by week over a rolling 12 month period.

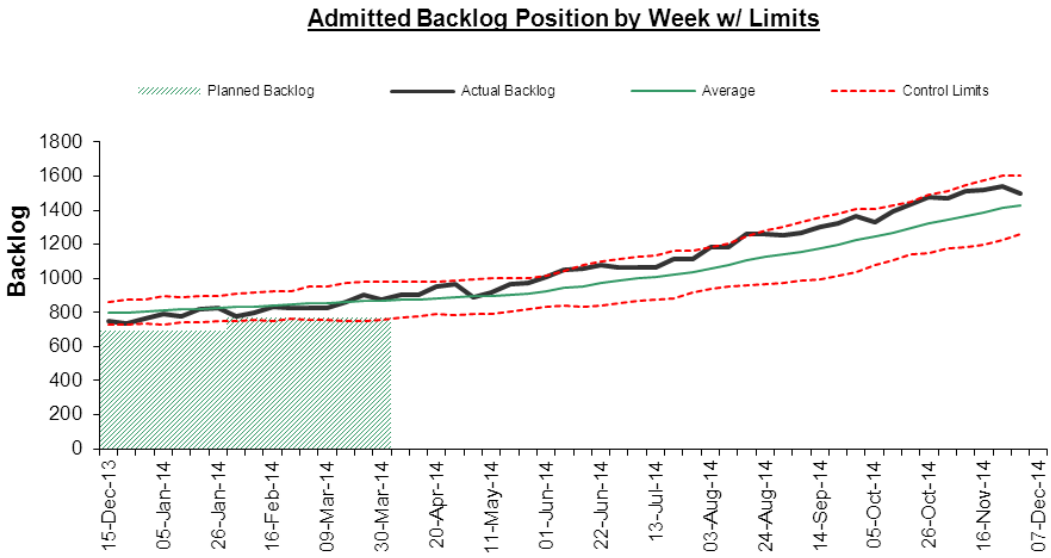


Chart 3.1 – Backlog Position by Week (rolling 12 month)

T&O, Dermatology and General Surgery remain non-compliant with the incomplete pathways standard in December with Ophthalmology also moving into non-compliant positions. As previously stated it is unlikely that these specialties will move back to a compliant position until the admitted backlog reduces to a sustainable level. The issues in Ophthalmology relate to the non-admitted pathway and capacity is being sought to treat long waiters in this area since plans to use the Independent Sector fell through in early January.

As at the end of December the Trust declared nine breaches of the 52 week wait standard. Seven of these breaches are in Orthopaedics with a further two in Ophthalmology.

Actions:

- *Further work was completed as requested by the Area Team to show the trajectory to compliance in quarter one of 2015/16. This is being further refined with scenario modelling to assess the impact of failure to reduce demand to the required levels and/or inability to secure Independent Sector capacity. It is envisaged this work will be complete by the end of the month.*

- *Specialty level action plans are being monitored on a weekly basis through the Weekly KPI Meeting chaired by the acting Chief Operating Officer.*

- *Referral management schemes began in Ashford, Canterbury and South Kent Coast CCGs during December. Early indications are that these are having a positive impact on reducing the number of referrals into the Trust. This is being closely monitored on a weekly basis to understand which scheme is having the biggest impact.*

- *An external validation team from NHS England are coming into the Trust w/c 26/01/2015 to validate all waiters over 6 weeks who currently have open*

pathways. This will give the Trust a clean base position on which to begin managing patients within 35 weeks.

4. Cancelled Operations (Non-Clinical)

The 2014/15 Operating Framework maintains the zero tolerance on urgent operations that are cancelled by the Trust for non-clinical reasons, which have already been previously cancelled once for non-clinical reasons.

The definition of 'urgent operation' is one that should be agreed locally in the light of clinical and patient need. However, it is recommended that the guidance as suggested by the National Confidential Enquiry into Peri-operative Deaths (NCEPOD) should be followed.

In December there were zero second or subsequent cancellations of any urgent operations.

5. 6 week target for diagnostics

The 2014/15 Operating Framework has retained the six week maximum wait for all diagnostic tests as outlined in the national DM01 return. The framework states that 99% of all patients should wait a maximum of six weeks for their diagnostic test. This standard is measured at aggregate Trust level and not by individual diagnostic test.

The Trust has maintained and improved upon its compliant position in November closing the month with 99.9% patients waiting six weeks or less for a diagnostic test. Surpassing the trajectory Endsocopy has achieved a compliance of 100% as at the end of December.

Table 5.1 below shows the breakdown of waiters' vs breaches by diagnostic test.

Service	Test	0 to 6 Weeks	06 < 13 plus Weeks	Total WL	% within 6wks
Imaging	Magnetic Resonance Imaging	3,347	1	3,348	99.97%
	Computed Tomography	1,858	3	1,861	99.84%
	Non-obstetric ultrasound	3,198	1	3,199	99.97%
	Barium Enema	94	0	94	100.00%
	DEXA Scan	336	0	336	100.00%
Physiological Measurement	Audiology - Audiology Assessments	200	0	200	100.00%
	Cardiology - echocardiography	1,716	0	1,716	100.00%
	Cardiology - electrophysiology	0	0	0	100.00%
	Neurophysiology - peripheral neurophysiology	368	1	369	99.73%
	Respiratory physiology - sleep studies	151	0	151	100.00%
	Urodynamics - pressures & flows	9	4	13	69.23%
Endoscopy	Colonoscopy	649	0	649	100.00%
	Flexi sigmoidoscopy	262	0	262	100.00%
	Cystoscopy	57	0	57	100.00%
	Gastroscopy	475	0	475	100.00%
Total		12,720	10	12,730	99.92%

Table 5.1 – Diagnostic DM01 (December 2014)

6. Cancer targets – December 2014

The Trust's performance for the cancer targets is given in the tables below.

AS AT 20-Jan-15	2 Week Wait		31 Day			62 Day	
	All Cancers	Symptomatic Breast	Diag to First Treat	Surgery	Drug	Urgent GP Referral	Screening Referral
Target 2014/15	**93%**	**93%**	**96%**	**94%**	**98%**	**85%**	**90%**
Q1 14/15	93.50%	92.37%	99.07%	95.74%	99.14%	85.65%	95.60%
Q2 14/15	93.47%	81.90%	98.69%	94.50%	100.00%	81.68%	86.03%
October	94.20%	85.14%	97.84%	90.00%	100.00%	73.64%	96.30%
*November**	93.24%	80.69%	98.41%	94.00%	100.00%	85.67%	92.00%
*December**	92.30%	93.17%	97.88%	93.94%	100.00%	85.60%	90.48%
*Q3 14/15**	93.23%	86.49%	98.04%	92.48%	100.00%	81.39%	93.15%

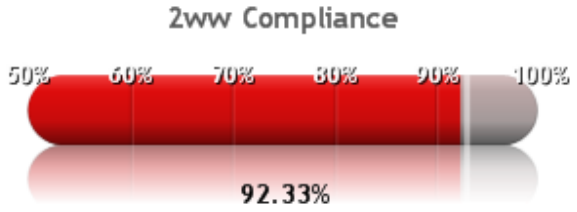
**unvalidated position*

Table 6.1 – Cancer Performance

The current un-validated position for December 2014 shows non-compliance against the 2ww standard. All other performance measures have been met. We will continue to validate the information up to the national submission date as some cancer pathways involve other providers and validation continues between organisations which can take up to 25 working days from month end.

2ww Referral Standard

The position so far for December '14 shows the Trust was non-compliant against this standard at 92.3%. Urology, Lower GI, Gynaecology and Breast tumour sites did not achieve standard. Quarter 3 14/15 has seen the largest number of 2ww patients seen so far this year (6294). There have been notable rises in surgical tumour sites which will be closely monitored by week for quarter 4. Positively the Breast Symptomatic referral standard has been met in December '14.



Tumour	Total	Breach	Comp	OK
BLANK	1	0	100.00%	
01 - Breast	401	34	91.52%	
02 - Children's	8	1	87.50%	
03 - Lung	89	1	98.88%	
04 - Haematological	3	0	100.00%	
06 - Upper GI	179	9	94.97%	
07 - Lower GI	394	32	91.88%	
08 - Skin	370	17	95.41%	
09 - Gynaecological	170	24	85.88%	
10 - Brain & Nervou...	6	0	100.00%	
11 - Urological	316	24	92.41%	
13 - Head & Neck	239	25	89.54%	
TOTAL	**2176**	**167**	**92.33%**	

62 Day Urgent GP Referral Standard

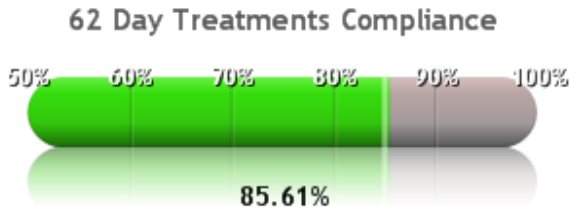
The 62 day standard has narrowly missed compliance in December. The internal position (no shared treatment or breached with other providers) the Trust achieved a compliance of 85.6% however when adding in the shared breaches from other providers the compliance falls to 84.01%, 147 treatment with 23.5 breaches. The Cancer recovery action plan remains in place and it is expected this target will be compliant for Quarter 4 14/15.

Breach numbers (Internal) for non-compliant tumour sites were as follows;

- 10 Urology
- 4 Lower GI
- 2 Gynae
- 1 Upper GI

Breaches Reasons include;

- Health care provider initiated delay to diagnostics or treatment planning
- Complex diagnostic pathways
- Elective capacity inadequate
- Patient initiated (choice) delays to diagnostic or treatment planning
- Administrative delays



Tumour	Total	Breach	Comp	OK
01 - Breast	19	1	94.74%	
03 - Lung	13	1	92.31%	
04 - Haematological	5	0	100.00%	
06 - Upper GI	4	1	75.00%	
07 - Lower GI	13	4	69.23%	
08 - Skin	26	1	96.15%	
09 - Gynaecological	7	2	71.43%	
11 - Urological	49	10	79.59%	
13 - Head & Neck	3	0	100.00%	
TOTAL	**139**	**20**	**85.61%**	

Quarter 3 position

Due to the high number of 62 day breaches in October (43.5), it has not been possible to meet the 62 day standard in quarter 3. The subsequent surgery standard will be non-compliant due to performance in October and December and the Breast Symptomatic referral standard is also non-compliant for quarters end, again due to breach numbers in October and November. All other targets are compliant.

Although at the end of quarter 3 Breast Symptomatic and 62 day standard have not been achieved there have been improvements made against these targets as the quarter progressed with Breast Symptomatic achieving in December and the 62 day standard being achieved in November and December (currently un-validated). The Cancer recovery action plan remains in place and it is expected all standards will be compliant for Quarter 4 14/15.

Performance Monitoring

The Trust has met with the Area Team and Monitor to present the plans for the four key areas for the performance standards.
Progress has been made with diagnostics, and cancer.
A&E remains challenging and the focus is now on consistent weekly and daily improvement.
RTT 18 weeks remains the most challenged and there are risks to the recovery trajectory. These are the potential failure by CCGs to deliver the demand reduction in Orthopaedics, and the lack of independent sector capacity.