Paper 6.2

Ashford and St. Peter's Hospitals
NHS Foundation Trust

Council of Governors
Date: 8th December 2021

TITLE	Performance Report - October 2021
EXECUTIVE SUMMARY	**Trust Performance Scorecard Report** There has been an extensive and progressive update to the Trust Performance Scorecard Report aiming to align to both the NHSE/I best practice document in reporting and analysing performance data, and ensuring harmonisation within Surrey Heartlands ICS. There is considerable variation in the reporting of performance data, trends and analysis across the NHS, whereby we have enhanced our basic Statistical Process Control charting included in previous report updates, and aligned it with both NHSE/I best practice and through extensive benchmarking other Trust's reports. This is expected to be a two-step process whereby once this reporting format is familiarised we will enhance upon this best practice to dovetail our key performance metrics with the CQC quality domains. Page 5 of the report provides a summarised definition of the Statistical Process Control (SPC) and Icons, explaining the charts and what the symbols mean and the benefits of displaying the data in this way. An extensive range of resources to support Boards and Councils using the Making Data Count methodology can be found on the NHS England website, which includes a number of videos explaining the approach (with case studies) and can be accessed here: https://www.england.nhs.uk/publication/making-data-count/ **Covid Position** The number of Covid patients within the hospital averaged 21 per day during October (rising from avg 10 per day at the beginning of the month to 30 at the end of the month), with demand for non-Covid urgent care services also remaining very high. **Elective Activity** The Trust recorded a non-compliant performance for RTT Incomplete Pathways at 80.6%, although remained considerably above the NHSE England Average recorded at 66.5% for September (latest data published on 11th Nov 21). Constitutional RTT standards have been temporarily shifted to national Phase 4 post-Covid recovery and H2 Planning priorities where an update is included within this reporting pack. *Assurance: The Trust has Acceptable assurance at this stage that plans are developing to achieve the required levels of activity. Optimising elective facilities at Ashford is essential which will allow increased uninterrupted elective operating through the autumn and winter months. Pressure on acute beds in extremis could affect this.*

Urgent Care

The Trust's reportable NHSI (SPH site inc. Ashford & Woking WiC activity) performance for October 2021 was 80.5%, a 1.5% reduction on September 2021 (82.1%). Attendance levels in October 21 remained above average pre-Covid levels, which were also reflected in a proportional increase in non-elective admissions. The Trust has comprehensive actions to improve performance which are detailed within the pack.

Emergency Department (ED) and Urgent Treatment Centre (UTC) remains under sustained pressure, although the Trust's regional and national ranking continued to increase for the month. ED Performance compared nationally using the NHSI metric (including Ashford and Woking WiCs), the Trust was positioned 18th of 112 Trusts. When comparing the Trust for SPH site only for October the Trust was positioned 31st of 112 Trusts.

Assurance: We continue to have partial assurance around delivery of the 4 hour standard in the current environment. Whilst we have a live improvement program both within ED and supporting flow, the impact of increased attendances post-Covid, unpredictable surges in demand, and potential for growing Covid related presentations is affecting delivery of the 4 hour standard.

Diagnostics (DM01)

The Trust recorded a non-compliant performance for the DM01 diagnostic standard in October with performance recorded at 88.2%. Challenges have arisen in Non-Obstetric Ultrasound (NOUS) due to staff sickness, staff vacancies and requiring to isolate due to Covid. The Trust has seen NOUS demand increase by 12% compared to 2019, in addition, recruiting agency staff to help with the increasing demand in ultrasound remains challenging and therefore the Trust is seeking insourcing and outsourcing to support NOUS backlog reduction.

Endoscopy continues to experience significant challenge due to 1) availability and consistency of scheduling staff, 2) a rise in diagnostic internal referrals due to deliberate increase in outpatient activity as part of restoration and due to the upstream impact of the outpatient booking backlog in the summer (circa 300 patients), and a considerable increase in urgent inpatient endoscopy referrals. Workforce challenges contributed to the fact that a number of endoscopy referrals from August and September not being added to the appropriate waiting list.

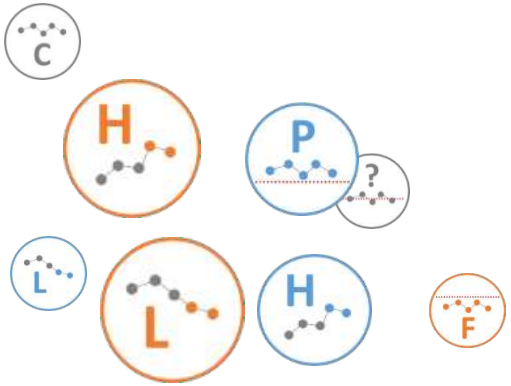
Endoscopy DM01 backlog has additionally seen an increase due to the changing composition of approach to ensure clinically urgent patients are prioritised for inpatients, cancer and surveillance, and then routine DM01 cohort. We also continued to experience resource issues to support booking and validation, with the Trust holding a number of recruitment days to resolve this.

Despite significant improvement in endoscopy lists utilisation, the challenge of supporting the additional priority demand will temporarily increase the DM01 backlog position.

Assurance: We have partial level of assurance regarding ongoing delivery of

	diagnostic activity similar to or above pre-Covid levels. Unforeseen changes in demand profile, staff availability and Covid trend could affect this. **Cancer** For September (latest national upload) the Trust reported compliance for 6 of 8 Cancer Standards; these were the 62 Day Urgent GP Referral to Treatment (88.2%), 28 Day Faster Diagnosis Standard (76.5%), 31 Day Diagnosis to Treatment (99.2%), 31 Day Subsequent Drug Treatments (100%), Breast Symptomatic (95.7%) and 62 Cancer Screening Performance (90%). During the same period the Trust reported non-compliance for the Two Week Rule (91.0%), driven by an under performance in Colorectal, Lung, Skin and UGI (two of which are related to Endoscopy). The Trust also reported non-compliance for 31 Day Subsequent Surgery Treatments (92.3%) due to 1 patient breach. The Trust is provisionally reporting non-compliance for the Two Week Rule, 62 Day Urgent GP Referral to Treatment and 31 Day Subsequent Surgery Treatment Standards for October. This position is currently undergoing validation. October currently compliant for all other cancer standards. The number of cancer patients waiting greater than 62 and 104 days has increased due to a rule change requiring patients to be notified before their cancer pathway can be closed. Divisional teams are implementing revised processes to expedite notification to patients. *Assurance: We have partial assurance that the Trust will continue to deliver against the key cancer waiting times standards.*
The Council is asked to:	Review the paper and discuss the contents seeking additional assurance as necessary.
Author:	Julian Ruse, Associate Director of Performance
Submitted by:	James Thomas, Chief Operating Officer
Decision:	For Discussion

Ashford & St Peter's Hospitals NHS FT



Trust Board Performance Scorecard

Reporting Month: Oct 2021
Board Month: Nov 2021

The NHS England website has a range of resources to support Boards using the Making Data Count methodology.
This includes a number of videos explaining the approach (with case studies) and can be accessed here > https://www.england.nhs.uk/publication/making-data-count/

Statistical Process Control (SPC) & Icons

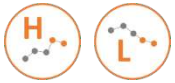
This scorecard incorporates Statistical Process Control (SPC) graphs.

On each graph, data is plotted against a centre line (the average). The Upper Control Limit (UCL) and Lower Control Limit (LCL) are defined by the variability of the data.
It is expected that 99% of data points will fall within the process limits (probability) and SPC are therefore useful to identify and consider how likely it is that the target will be achieved.

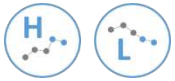
Variation Icons

> Are we improving, declining or staying the same?

Common cause variation – No significant change



Special cause of concerning nature or higher pressure due to Higher or Lower values



Special cause of improving nature or lower pressure due to Higher or Lower values

CC - Common cause variation describes variation that is expected & predictable.
SC - Special cause variation describes variation that is unusual or unexpected.

Assurance Icons

> Can we reliably hit the target?

Variation indicates 'hit and miss' variation, inconsistency passing and failing the target

Variation indicates consistently Passing the target

Variation indicates consistently Falling short of the target

Assurance Level Icons

> A level of assurance has been assigned to each of the key metrics in this report, the 4 levels are;

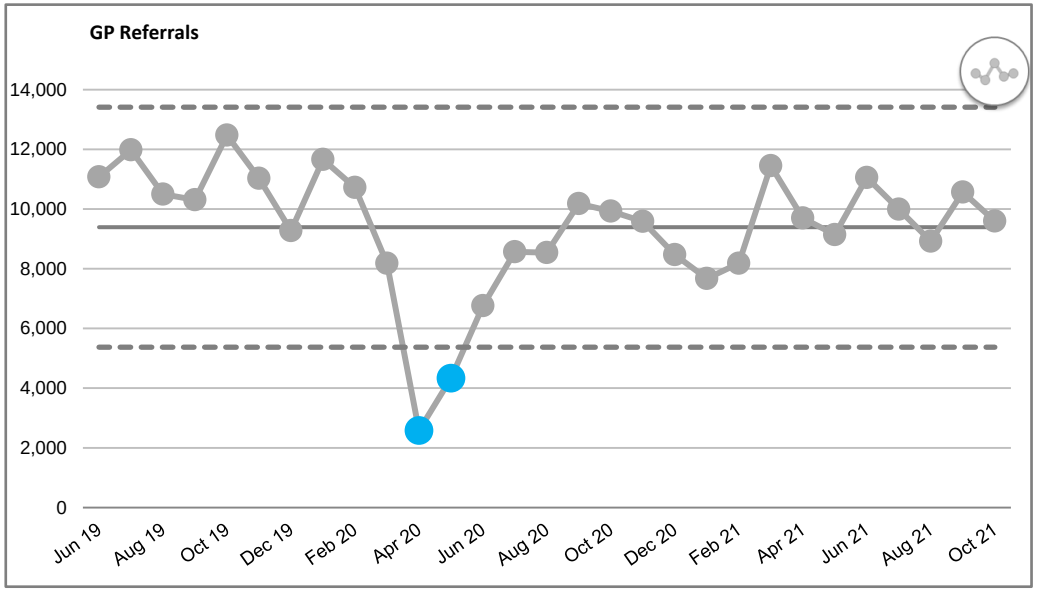
Assurance Levels			
No Assurance	**Partial**	**Acceptable**	**Significant**
No confidence or evidence in delivery	Some confidence and evidence in delivery of existing mechanisms and objectives	General confidence and evidence in delivery of existing mechanisms and objectives	High level of confidence and evidence in delivery of existing mechanisms and objectives

Activity

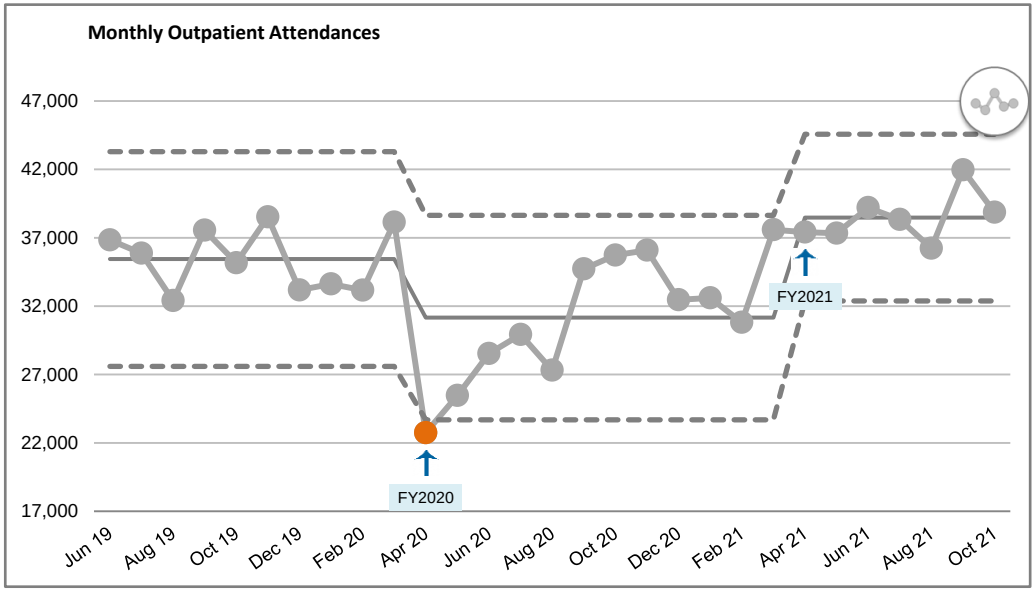
Reporting Period: Monthly | October 2021

Overview

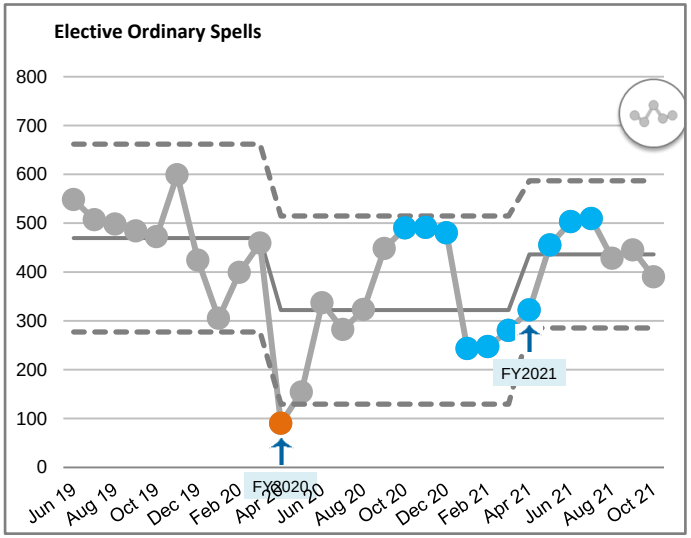
GP Referrals



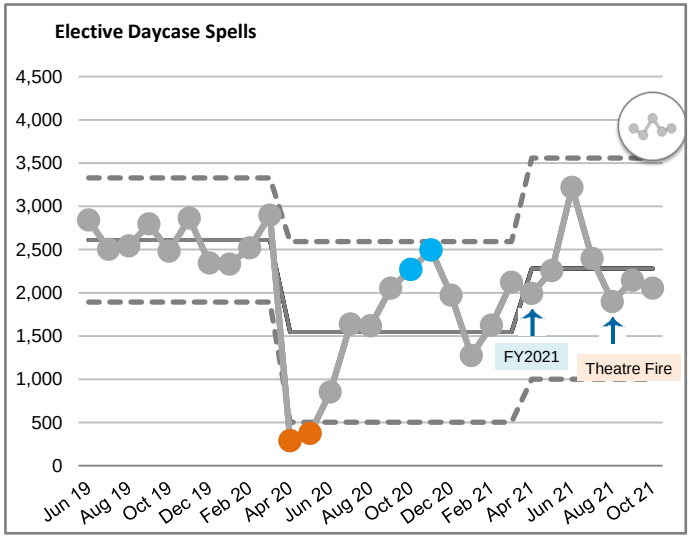
Monthly Outpatient Attendances



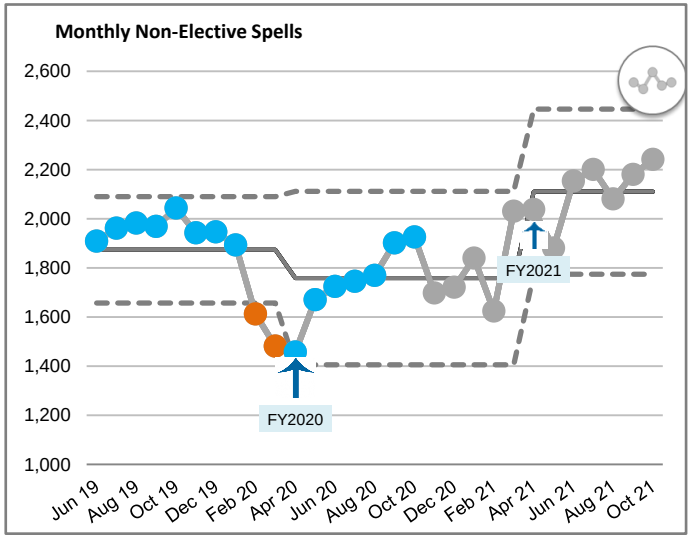
Elective Ordinary Spells



Elective Daycase Spells



Monthly Non-Elective Spells



RTT Clock Stops (Admitted & Non-Admitted) inc. H2 Plan & Actual

Admitted	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	1354	1606	1542	1502	1290	1378	1561	1571	1229	1532	1395	1483
19/20	1426	1515	1447	1502	1412	1502	1548	1545	1164	1336	1329	1005
20/21	91	187	612	878	884	1127	1163	1114	917	347	411	597
21/22	930	1072	1245	1391	1081	1227	1134	*1311*	*1238*	*1202*	*1152*	*1217*

Non-Admitted	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	6878	7613	7356	7462	7131	7513	8506	8181	6851	8808	7188	7829
19/20	7550	8126	7824	8656	7780	7953	9096	8171	7063	8341	7904	6829
20/21	3980	4533	5056	5338	4653	6288	6445	6844	5746	6253	5866	7486
21/22	6997	7042	7086	7237	6740	7513	8314	*8401*	*7935*	*7418*	*7278*	*7725*

ASPH	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	8232	9219	8898	8964	8421	8891	10067	9752	8080	10340	8583	9312
19/20	8976	9641	9271	10158	9192	9455	10644	9716	8227	9677	9233	7834
20/21	4071	4720	5668	6216	5537	7415	7608	7958	6663	6600	6277	8083
21/22	7927	8114	8331	8628	7821	8740	9448	*9712*	*9173*	*8620*	*8430*	*8942*
						Plan	86%	100%	111%	89%	91%	114%
				Actual (adjusted for working days)			97%					

H2 PLANNING & ACTIVITY

NHSE H2 Planning has been revised (from H1 ERF) which now incentivises Providers to achieve targets based on Referral to Treatment (RTT) clock stop activity which align to first definitive treatment for patients, and therefore incentivises wait list reductions. The national ambition is to deliver minimum 'clock stops' treatments between October and March in comparison to the equivalent months during FY2019.

The Trust in agreement with Surrey Heartland ICS commissioners have submitted the above plan which considers the Trust's capacity to deliver equivalent 'clock stop' treatments with consideration of available capacity and resilience during winter, different monthly working days FY21 vs FY19, the exclusion of waiting list initiatives that occurred during FY19, and the estimated reduction in activity required to support the clinical training and implementation of Cerner (the Trust's new Patient Administration System').
The Trust is using a mixture of insourcing and outsourcing in collaboration with other health providers to provide the necessary additional capacity, whilst addressing process and staffing issues within services, in-house additional capacity and in-house productivity to deliver and exceed the submitted monthly targets.

Recovery

Reporting Period: Monthly | October 2021

Elective Care

RECOVERY DASHBOARD - ASPH											
Measure	Target	Deadline	Trend	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21
Cancer > 104 day waits	0	Jun-21		25	18	14	21	21	19	32	49
Cancer > 62 day waits	<89	Jun-21		72	75	71	83	86	127	161	281
RTT P2 > 4wk waits (All)	tbc	Jun-21		176	167	150	65	47	37	39	41
RTT P2 > 4wk waits (no TCI)	0	Jun-21		127	121	65	12	25	13	19	22
RTT Total > 90wk waits (All)	0	Jun-21		1	5	3	2	2	2	2	2
RTT Total > 90wk waits (exc. TCIs)	0	Jun-21		1	3	1	0	1	2	0	1
RTT Total > 78wk waits (All)	0	Jun-21		43	69	48	11	13	12	8	8
RTT Total > 78wk waits (exc. TCIs)	0	Jun-21		22	35	24	9	11	12	6	2
RTT Total > 52wk waits (All)	0	Mar-22		466	291	175	115	94	89	111	74
RTT Total > 52wk waits (exc. TCIs)	0	Mar-22		430	210	139	49	76	71	86	38
Urgent 1st OPA Total > 6wk waits	0	tbc		1178	1425	1375	1561	1720	1620	1442	1181
Routine 1st OPA Total > 18wk waits	0	tbc		1047	1208	1137	1287	1519	1338	1700	1640
Diagnostics > 6wks waits %	<1%	Aug-21		16.4%	13.8%	8.7%	5.4%	2.5%	6.7%	5.8%	11.8%
Diagnostics > 6wks waits actual	<50	Aug-21		1081	966	596	396	184	475	439	988
Diagnostics > 13wks waits actual	0	Aug-21		743	565	270	118	41	17	10	8
Endoscopy > 6wks waits %	<1%	Jun-21		56.3%	52.0%	40.4%	24.6%	9.8%	15.8%	11.8%	31.5%
Endoscopy > 6wks waits actual	<17	Jun-21		957	860	505	259	86	117	78	343
Endoscopy > 13wks waits %	0%	Jun-21		41.9%	33.8%	21.3%	9.6%	3.8%	1.6%	0.6%	0.6%
Endoscopy > 13wks waits actual	0	Jun-21		712	559	266	101	33	12	4	6
Advice & Guidance	>80%	May-21		78%	79%	86%	78%	80%	79%	75%	76%
Pre-Covid OPA Activity	110%	Jul-21		94%	113%	115%	107%	107%	112%	112%	97%
Pre-Covid Elective Activity	110%	Jul-21		60%	93%	97%	86%	89%	83%	79%	
Virtual - 1st OPA	40%	Jul-21		44%	43%	39%	37%	37%	35%	34%	33%
Virtual - Follow Up	40%	Jul-21		42%	38%	33%	32%	32%	30%	31%	28%

Recovery

Reporting Period	
Monthly	October 2021

Elective Care

Assurance Level: **Acceptable**

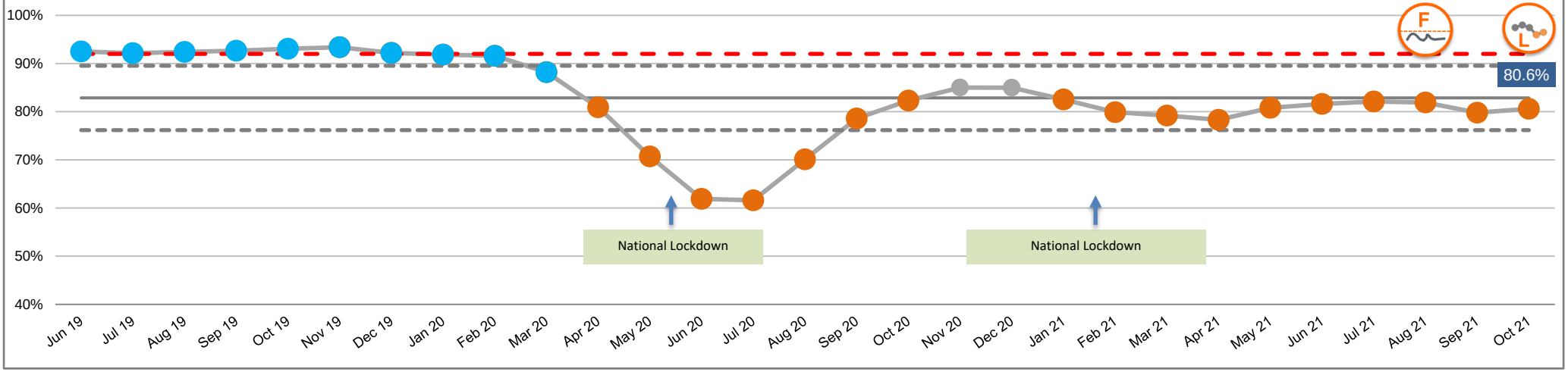
What is impacting current performance?	Key drivers affecting recent underperformance have been Covid sickness/isolation and: **Inpatients:** Loss of theatre due to fire (orthopaedics, general surgery), and on the day cancellations due to SPH bed pressures **Day cases:** Patient DNAs and booking processes resulting in increased DNAs (endoscopy), loss of theatre due to fire (orthopaedics, general surgery), delay in realignment to new theatre timetable (oral and maxillofacial surgery), drop in non-elective related demand for IV therapy (medicine), **Outpatients:** implementation of PIFU (physiotherapy), consultant retirement/job plan redesign (orthopaedics/neurology/cardiology), slot utilisation **Outpatient procedures:** Pathway redesign/improvement (audiology), annual leave/sickness/redirection of resources (iMSK Ultrasound injections)
What actions are being undertaken to improve performance?	A dedicated resource has been secured to liaise between the providers and the divisional areas to ensure that agreed outsourcing and insourcing contracts are delivering the volumes agreed. Locums have been recruited in a number of areas to support capacity. Weekend ad-hoc operating lists are providing additional theatre sessions across specialties. **Outsourcing**: Runnymede (Orthopaedics), Nuffield (Orthopaedics, Respiratory), Cobham (Ophthalmology, MaxFacs, Orthopaedics and General Surgery). **Insourcing:** ENT, Colorectal, Vascular, Gastroenterology, additional cataract and endoscopy capacity through additional theatre facilities, this programme has delivered in excess of 3000 additional appointments including surgical procedures and diagnostics. **Projects** – additional oral dental lab in process of being built, reduction of on-the-day cancellations through the implementation of perioperative pathway, additional locum cover to provide additional capacity. 4eyes consultancy supporting theatre utilisation assessment. PTL validation to remove duplicated referrals and ensure lists accurately reflect the position. Provision of additional theatre equipment to support increased activity. **Divisional Support programme -** Weekly meetings led by the COO and core team with each Divisional area are in place to review the activity and planning data to highlight areas of concern and support in the identification of causes of underperformance and opportunities for improvement. Insourced fixed term support for insourcing/outsourcing programme. Recruitment of ADO for Recovery and Restoration now complete
When will the position be recovered?	Recovery trajectories are individual to each speciality area and are under continuous review. Current activity shows an increase in the monthly outpatient attendances performance and additional work has been undertaken that has allowed a more detailed understanding of the areas that are impacting performance leading to projects to resolve areas of concern. The Trust's recovery metrics continues to considerably outperform other providers.
What are the key risks?	There is a risk to additional sessions and weekend lists which are voluntary for staff and come after a period of much pressure already for some of these staff. This risk will be closely monitored ,including use of locums/insourcing/outsourcing where appropriate to complement in house additional activities. As the Elective Recovery Fund monitoring has now changed to clock stop measurements and produces a risk of areas such as over-due follow-ups increasing as they will not impact achievement, however these areas will be included in the restoration and recovery programme to monitor and ensure that these areas do not increase. A key risk in achievement is the clinical office vacancy rate, this has been mitigated by a recruitment day to recruit a pool of additional clerical staff, this is also supported by recruited validators.
What are the Quality implications for the Trust?	Outpatient backlogs and increasing waiting times have the potential to increase clinical risk for patients, plans are in place to reduce waiting times. Risk of impact on staff well-being and quality of care through increased additional work that some clinicians and staff are undertaking to ensure capacity is meeting the demand.

Referral to Treatment (RTT)

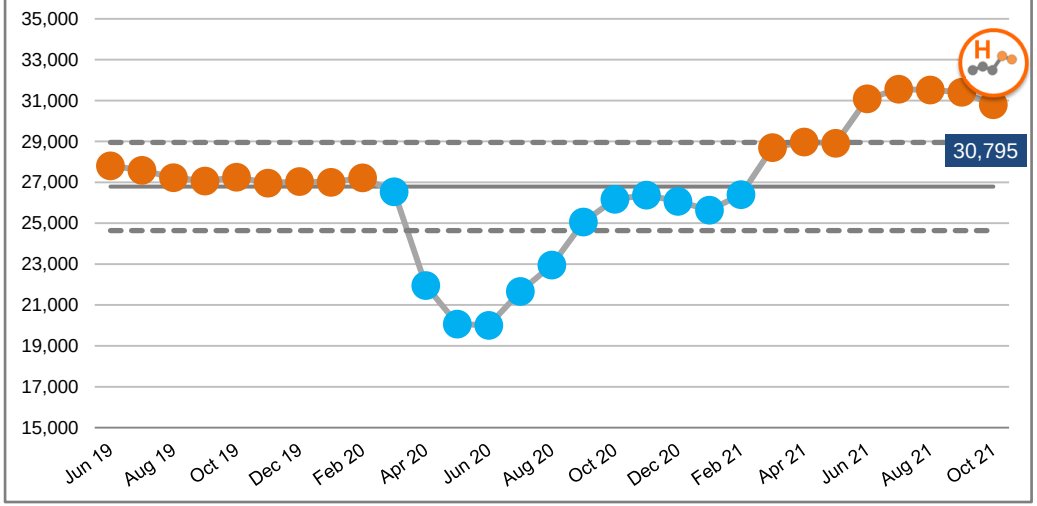
Reporting Period: Monthly | October 2021

Elective Care

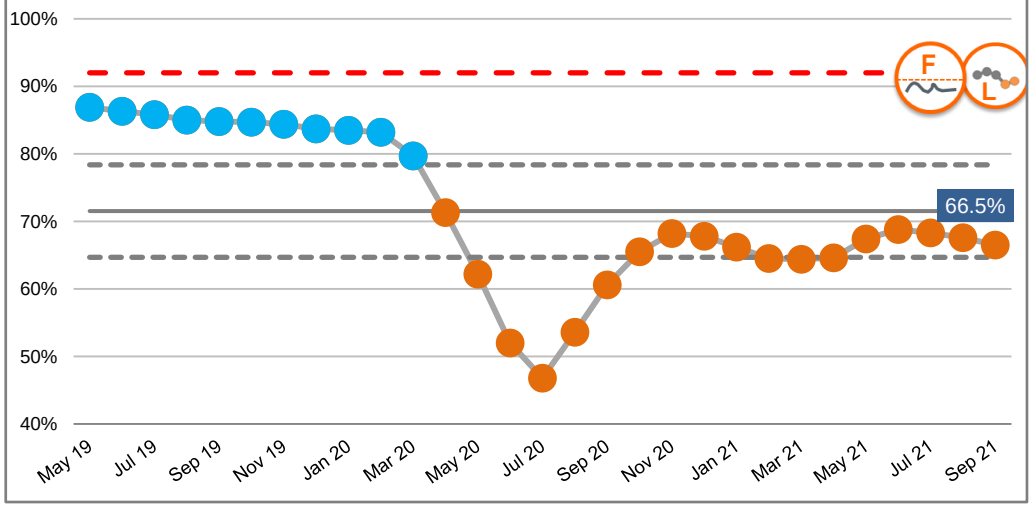
RTT Monthly Performance (ASPH) [Target = 92%]



RTT Incomplete Pathways (ASPH)



RTT Monthly Performance - England Average [Target = 92%]

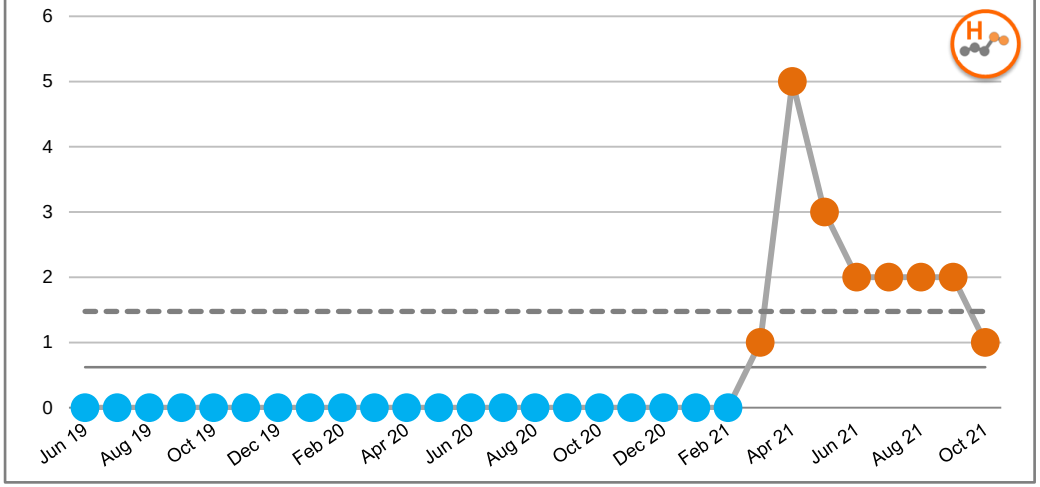


Referral to Treatment (RTT)

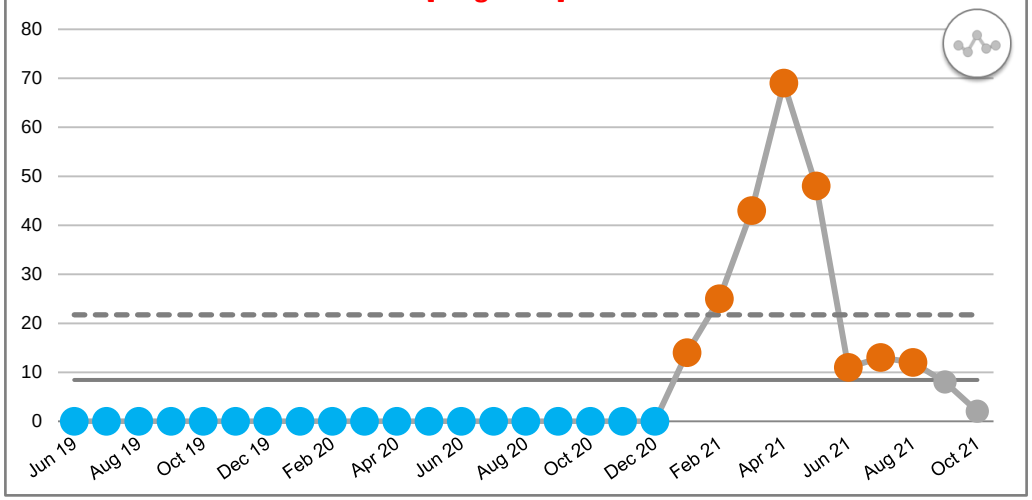
Reporting Period: Monthly | October 2021

Elective Care

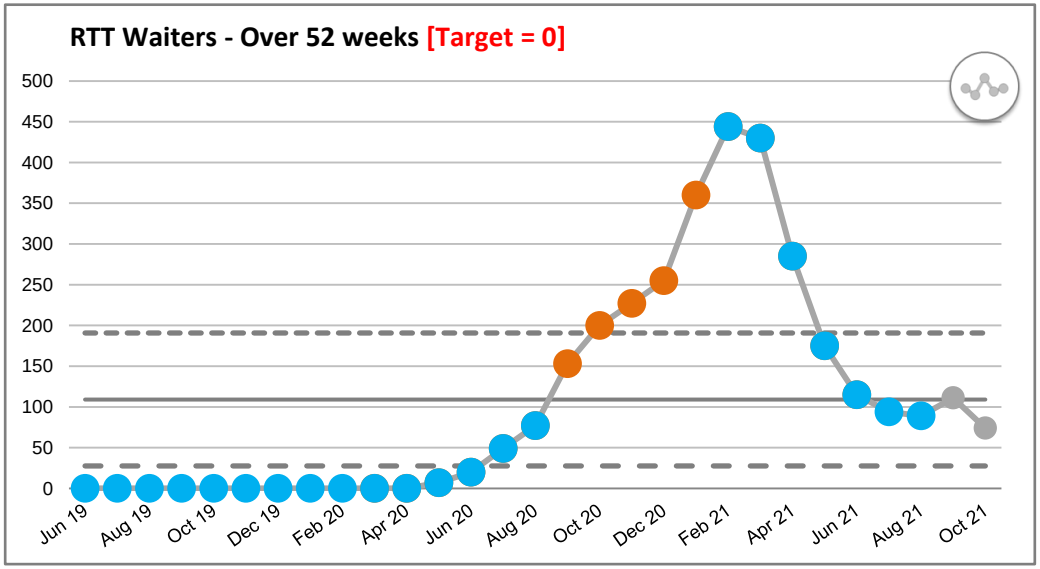
RTT Waiters - Over 90 weeks [Target = 0]



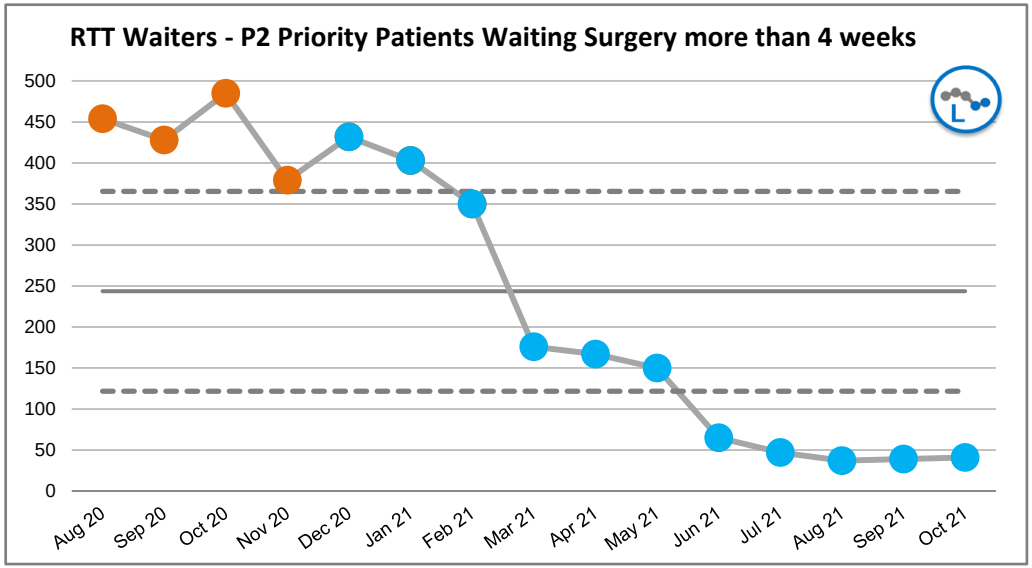
RTT Waiters - Over 78 weeks [Target = 0]



RTT Waiters - Over 52 weeks [Target = 0]



RTT Waiters - P2 Priority Patients Waiting Surgery more than 4 weeks

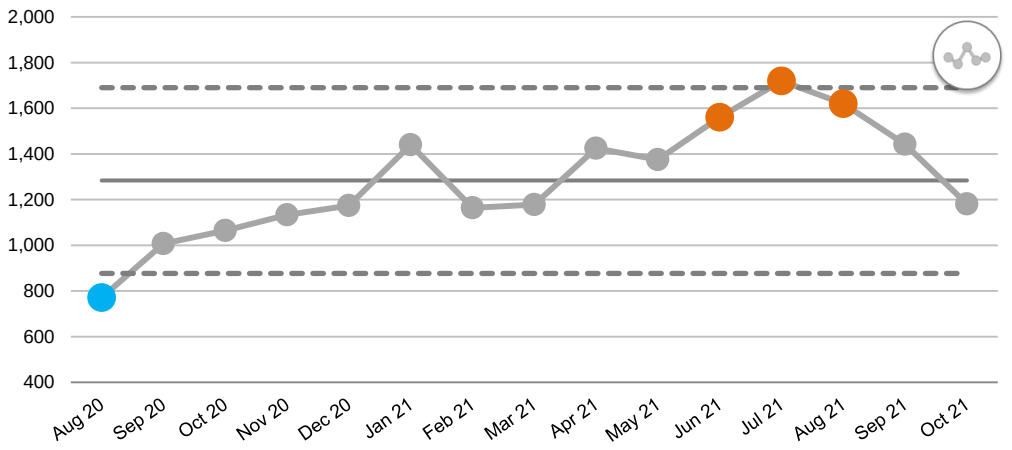


Referral to Treatment (RTT)

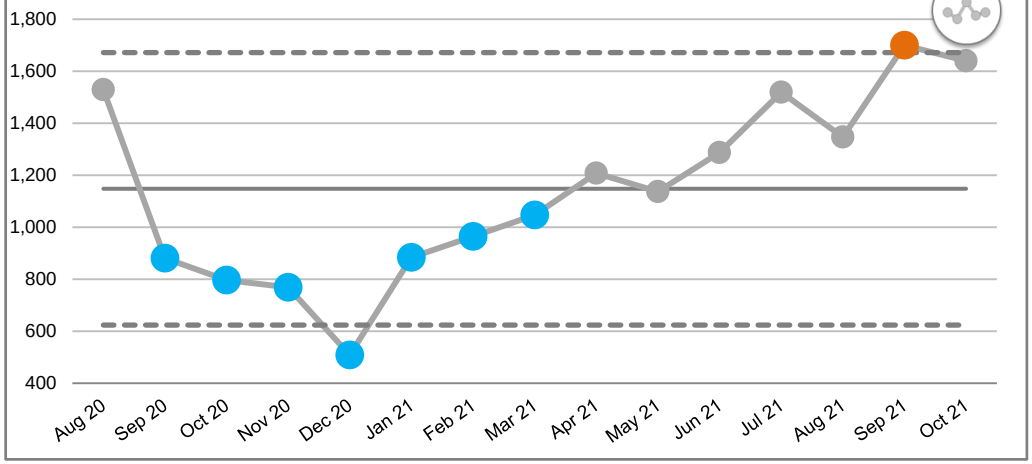
Reporting Period: Monthly | October 2021

Elective Care

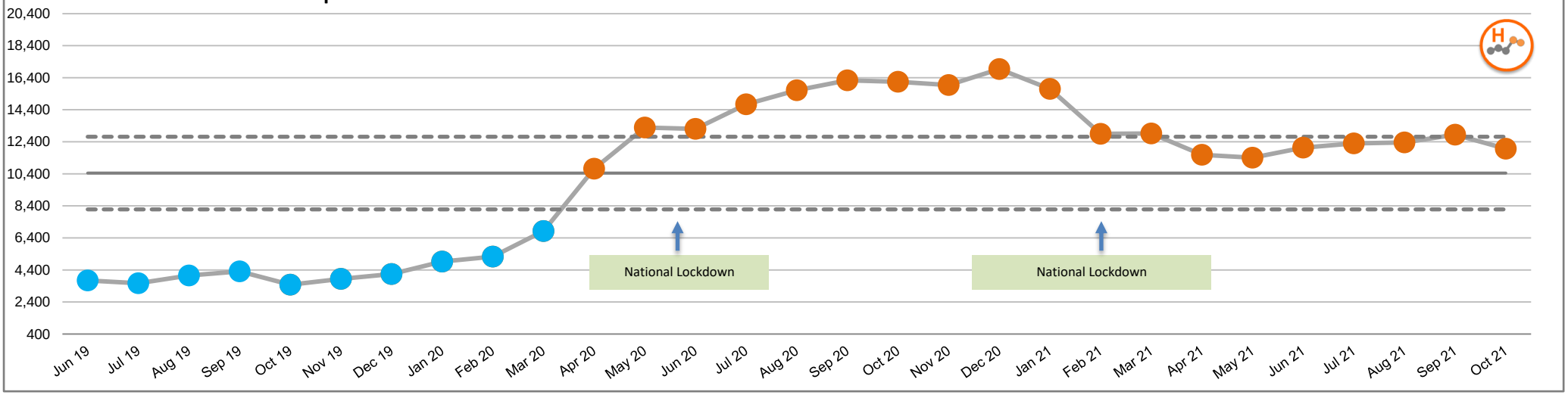
Urgent 1st OPA Total > 6wk waits



Routine 1st OPA Total > 18wk waits



Overdue Planned Follow Ups



Referral to Treatment (RTT)

Reporting Period: Monthly | October 2021

Elective Care

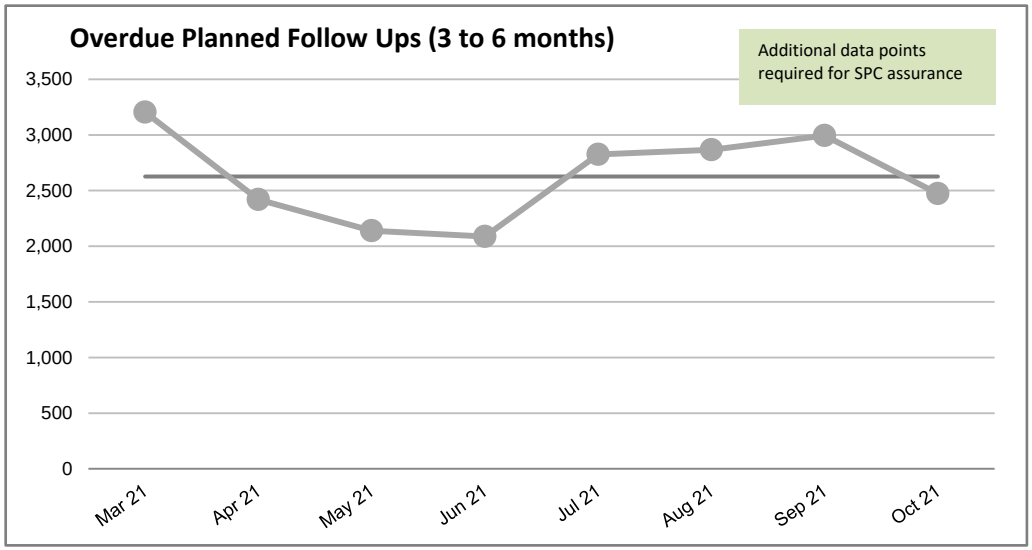
RTT Performance (inc. & Overdue Follow Ups)

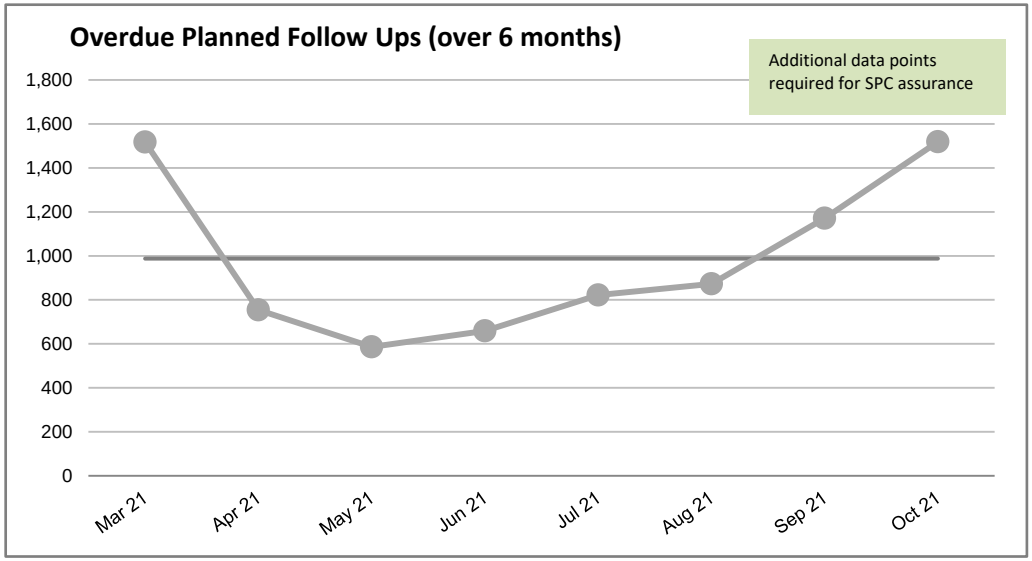
The Trust recorded a non-compliant performance for RTT Incomplete Pathways at 80.6%, although remains considerably above the NHSE England Average recorded at 66.5% for September (latest data published on 11th Nov 21).

The Trust has made significant headway in reducing the number of RTT long waiting patients with the number over 90 weeks (2 patients waiting due to patient choice) and 52 weeks (74 patients) remaining low compared with other providers nationally. Of the 74 patients, almost half require surgery (the majority with a date for this confirmed), whilst others require their booked diagnostic and/or an outpatient appointment to occur to conclude their treatment.
The number of Priority (P2) patients waiting urgent surgery for more than 4 weeks has remained at a very low level. We have a number of patients who are exercising choice to delay their treatment which is permitted by NHSE although these patients must remain on the waiting list. We continue to engage with these patients and will ensure treatment options are available when they are ready and fit to do so.

Urgent waits over 6 weeks have shown a good trending reduction with Routine waits over 18 weeks also now showing a reduction. We are putting on additional capacity using insourcing and outsourcing although we balance this activity across new GP referral and Planned Follow Ups.

Specialty teams have comprehensive action plans to address the above capacity shortfalls although many have experienced lag whilst recruitment, transfer and contracting processes conclude. Therefore higher capacity is scheduled to commence (or has already) in many specialties using additional substantive, locum and agency staff, including collaboration with insourcing and outsourcing healthcare providers. Administrative and Clinical reviews of long waiting patients remain ongoing to reduce potential clinical harm risks.





Referral to Treatment (RTT)

Reporting Period: Monthly | October 2021

Elective Care

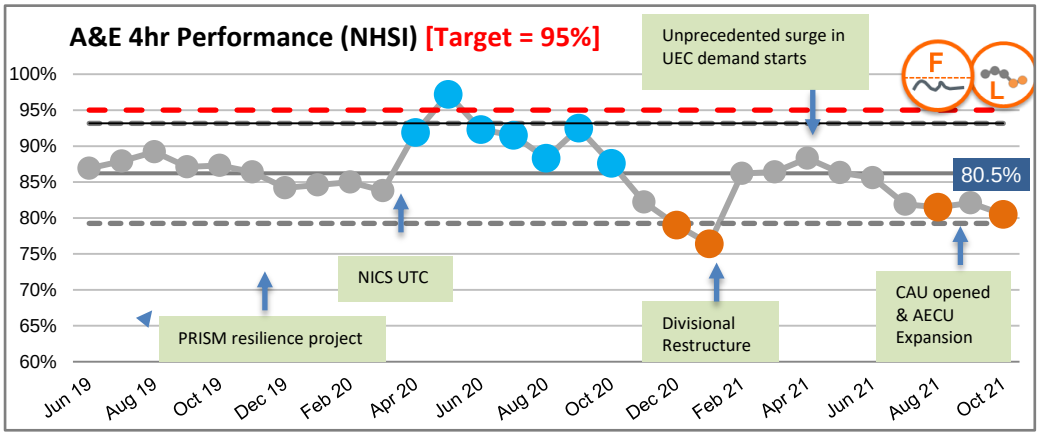
Assurance Level: **Partial**

What is impacting current performance?	All services have been maximising outpatient and inpatient activities, however annual leave and other staffing pressures, including short term staff sickness and Covid isolation, Infection Protection Control (IPC) regimes and the fire at Ashford Theatres have reduced activity lower than planned. Specialty teams have comprehensive action plans to address the above capacity shortfalls although many have experienced lag whilst recruitment, transfer and contracting processes conclude. The Trust has also seen an increase in last minute patient cancellations and non-attendance which have been difficult to backfill due to patient Covid swabbing and isolation (IPC) requirements .
What actions are being undertaken to improve performance?	Through a carefully controlled plan we have put in place an expansion of internal theatre and outpatient capacity; • Maximising the benefits of moving elective activity to Ashford, additional theatres (3), ECU (4 beds) & a ring fenced ward • All services maximising outpatient and inpatient activities, however annual leave and other resource pressures (sickness) require us to increase resilience , hence additional staffing, including insourcing and outsourcing • The use of locums across many surgical and medical specialties • Weekend and evening clinics and theatre lists • Increasing our use of local independent sector providers • Transformation opportunities • Streamlining pre-operative processes to reduce cancellations and improve patient experience Weekly meetings with Divisional areas reviewing the activity and planning data to highlight areas of concern and support in the identification of causes of underperformance and opportunities for improvement.
When will the position be recovered?	In accordance with NHSE H1 and H2 planning, the Trust has made considerable progress in reducing long waiting patients and has plans to deliver the national ambition minimum 'clock stops' treatments between October 21 and March 22 in comparison to the equivalent months during FY2019.
What are the key risks?	Key staff are undertaking additional work on an ongoing basis and there is a risk this is not sustainable and therefore a number of services have a risk of being able to deliver long term resilience. This risk will be closely monitored including use of locums/insourcing/outsourcing where appropriate.
What are the Quality implications for the Trust?	The Trust pays close attention to the management of the new national P2 patients who wait greater than 4 weeks. Demonstrable monthly reduction in the number of patients in this cohort can be seen. As a result of concerns of outpatient booking process an Outpatient Patient Safety Group was formed. This group consisting of Divisional Directors, ADOs, Chief of Patient Safety and Chief Operating Officer meets fortnightly to oversee plans to mitigate and reduce risk and ensure safety. The Divisions of SS & iMSK, GS-ACT, and SSM have all been individually assessed with a risk rating of 12 in relation to outpatient safety. This outpatient safety group has now widened its remit to consider all patients waiting greater than 6 weeks for urgent first outpatient consultation.

A&E 4 Hour Performance

Reporting Period: Monthly | October 2021

Emergency Care

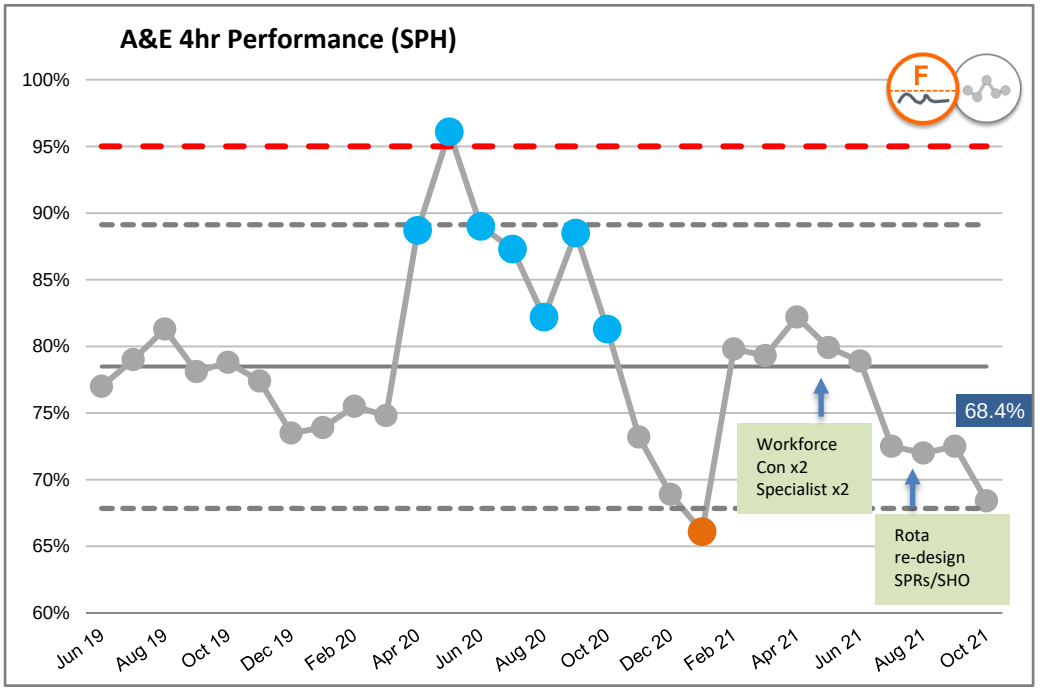


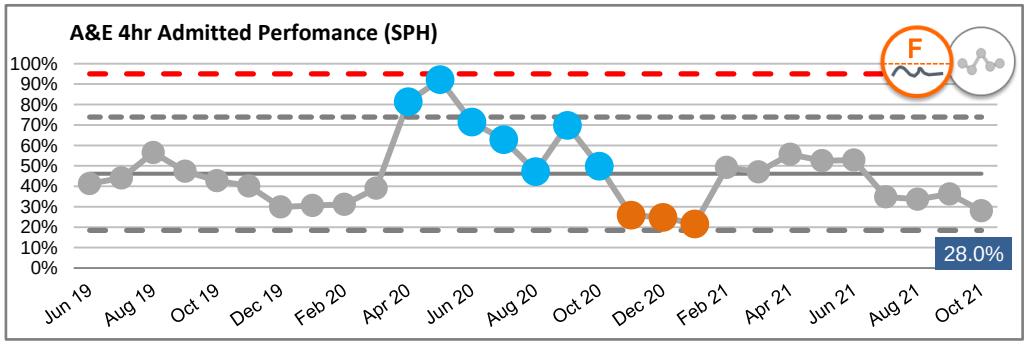
A&E Performance

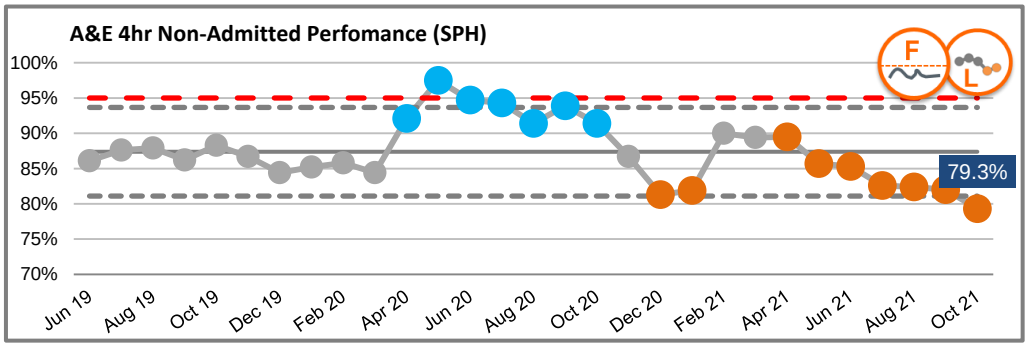
Overall NHSI performance was 80.5% in October 2021, a slight reduction from 82.1% recorded during September 2021.

The ED as well as the local Walk in Centres and UTC were adversely impacted by the continued high attendances. This led to diversion of patients from other areas of the community to the UTC and SPH ED due to capacity challenges. It also led to capacity challenges within the hospital, which meant that CAU was not always able to operate as an assessment area as it became blocked with inpatients waiting for beds on wards. Work continues to embed the clinical pathway changes which will further benefit patient care and performance.

SAUV co-located with AECU on 11th October 2021. This was to enable provision of multi-specialty SDEC space adjacent to ED, CAU (UTC will also moving there shortly).





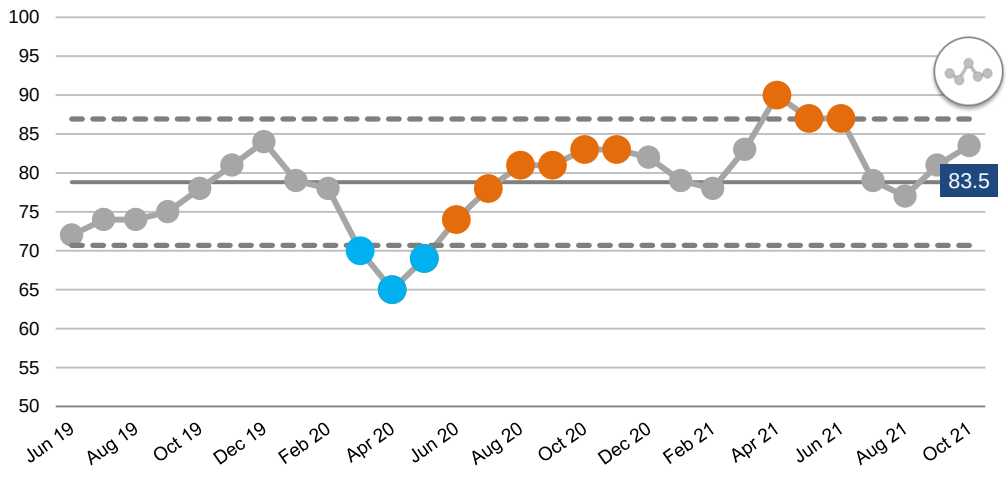


A&E 4 Hour Performance

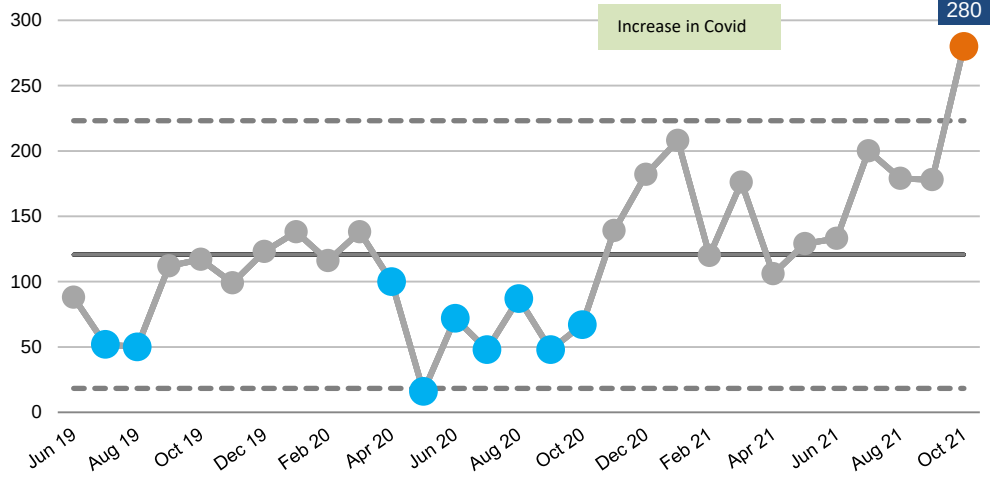
Reporting Period: Monthly | October 2021

Emergency Care

A&E Monthly Average Daily Ambulance Attendances (SPH)



Ambulance Handovers (30-60 mins)

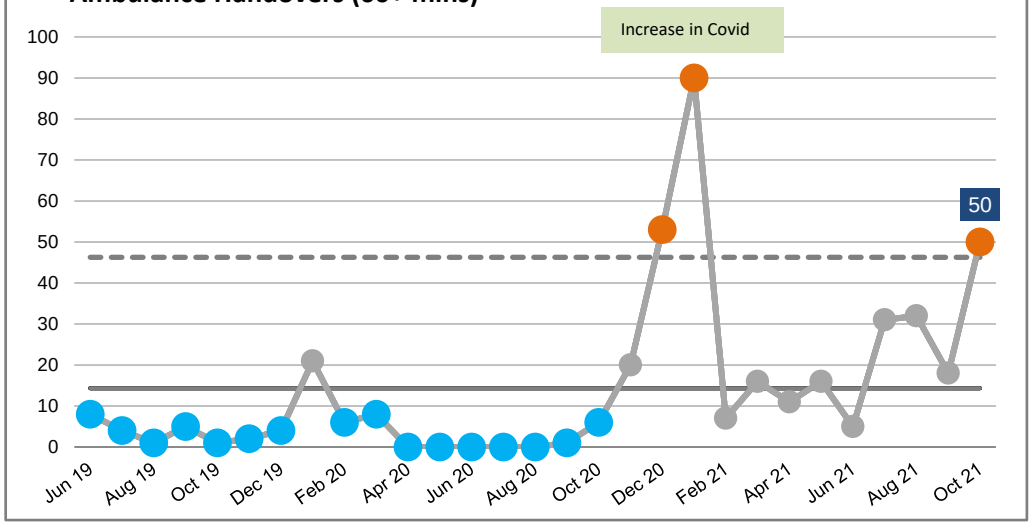


A&E Performance and Flow

Ambulance attendances since May 2021 have on average been consistently higher than pre-Covid. The Trust recorded 280 Ambulance handover delays (30-60 mins delay), and 50 Ambulance handover delays (60+ mins delay) throughout October 2021.

Ambulance handover delays are a reflection of the level of ED escalation, as they occur when the department has to balance risk to the patients who are already transferred and those who are queuing to be seen.
As per NHSE/I request, protocols and escalation processes within ED and across the site to minimise handover delays have been fully reviewed. This will include exception reporting for 60+ minute delays. Review of early November data suggests there have been improvements in all ambulance waits including <15 minutes as a result of this increased focus. When in high escalation, ED works closely with South East Central Ambulance Service with the aim to support management and mitigation of risks across the system. Attendance levels in October 21 remained exceptionally high (and above average pre-Covid levels). This was also reflected in a proportional increase in non-elective admissions. Average length of stay rose in October to an average of 7.1 days.

Ambulance Handovers (60+ mins)

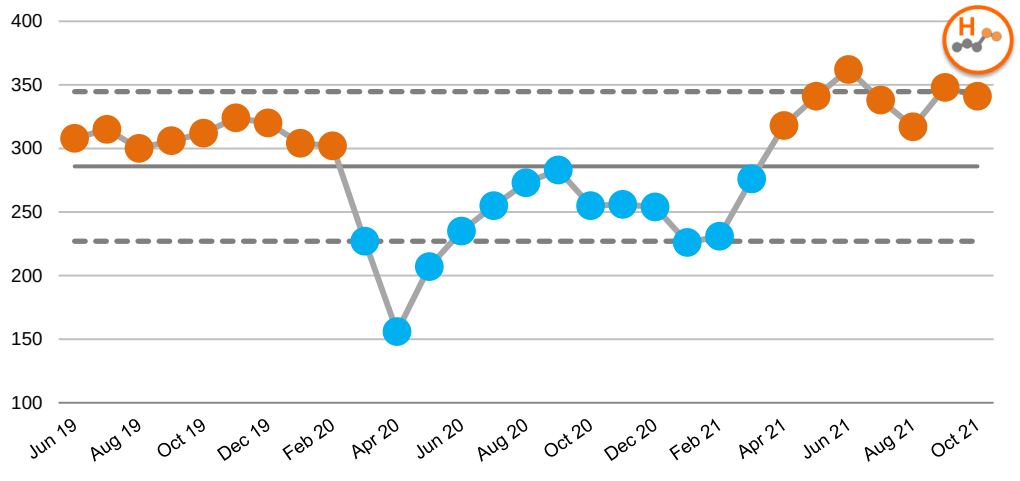


Hospital Flow

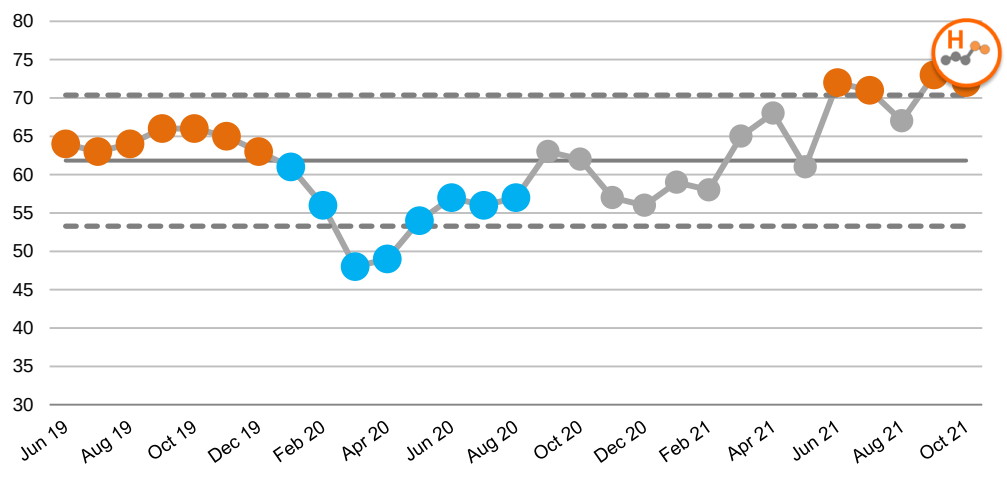
Reporting Period: Monthly | October 2021

Emergency Care

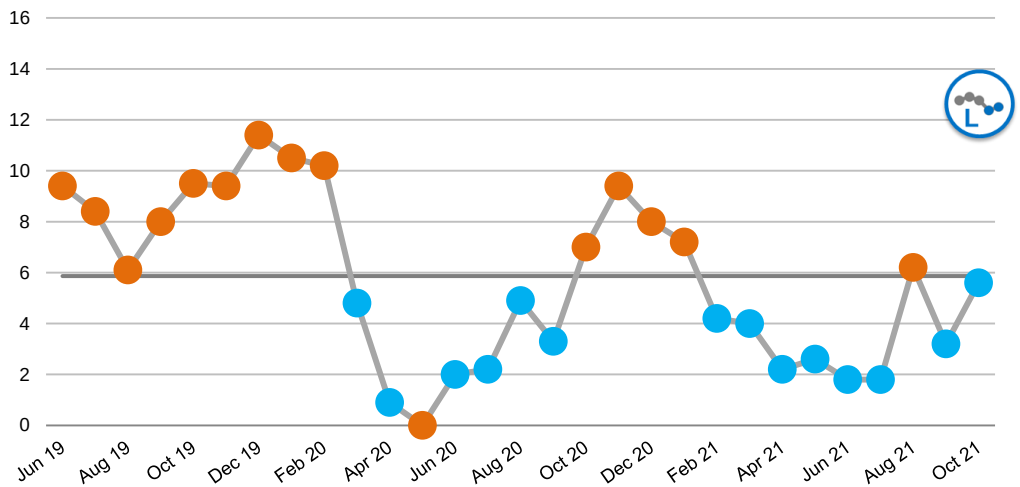
A&E Monthly Average Daily Attendances (SPH)



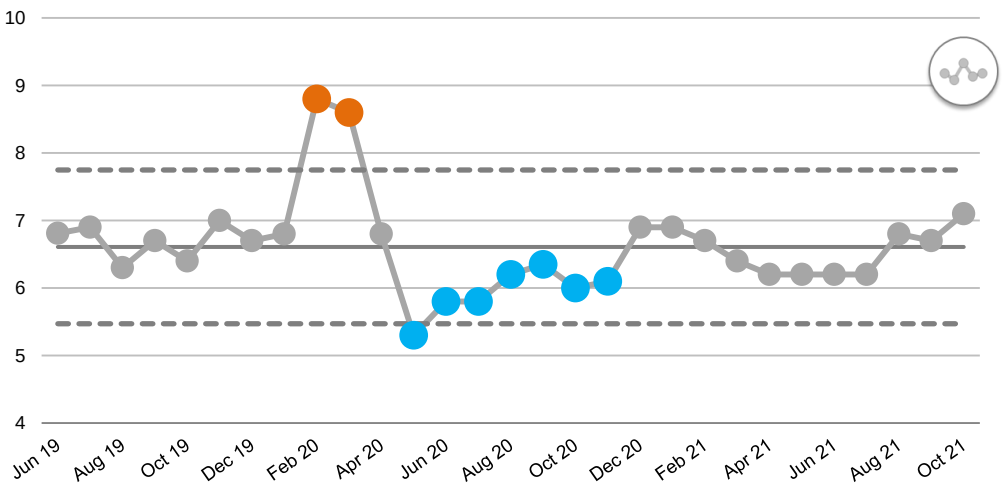
A&E Monthly Average Daily Admissions (SPH)



Overnight Waits in A&E [Avg DTA's]



Average Length of Stay

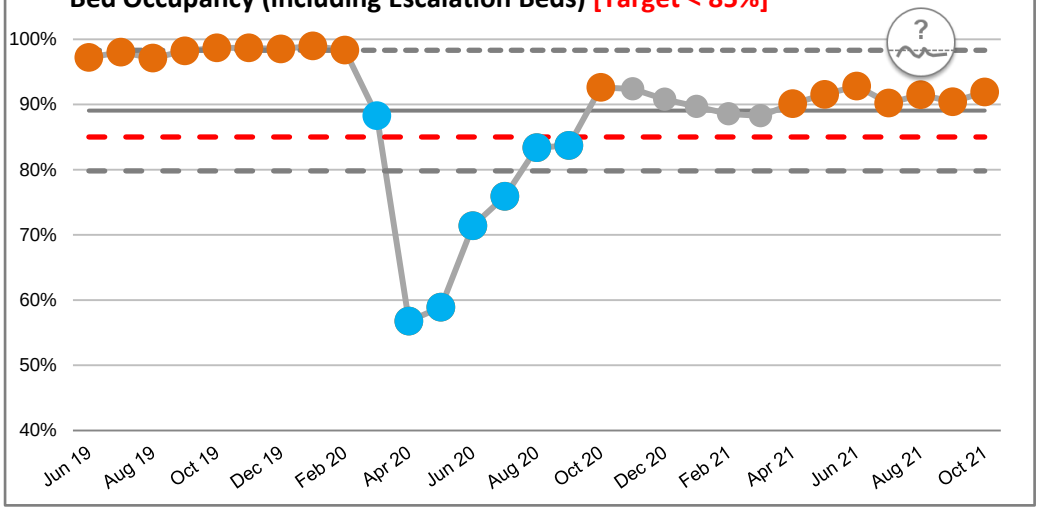


Hospital Flow

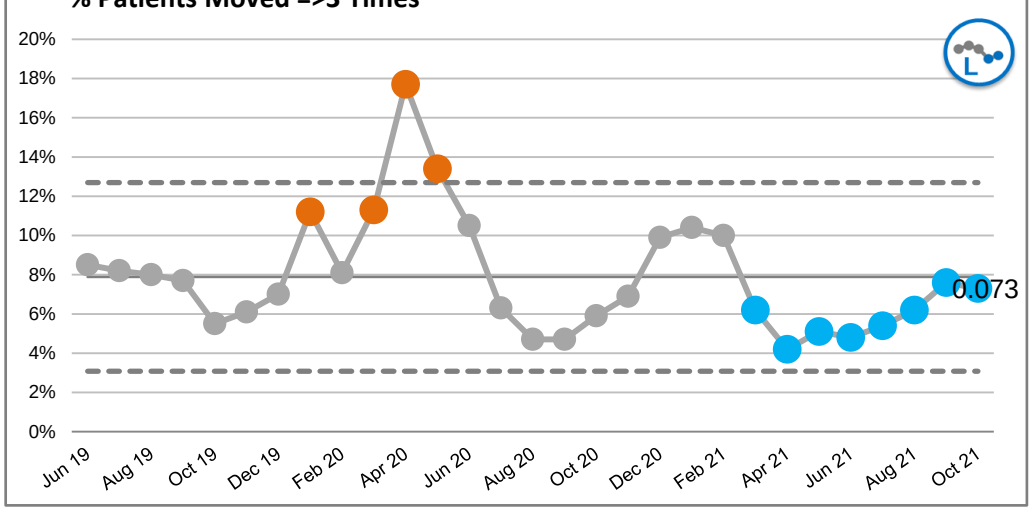
Reporting Period: Monthly | October 2021

Emergency Care

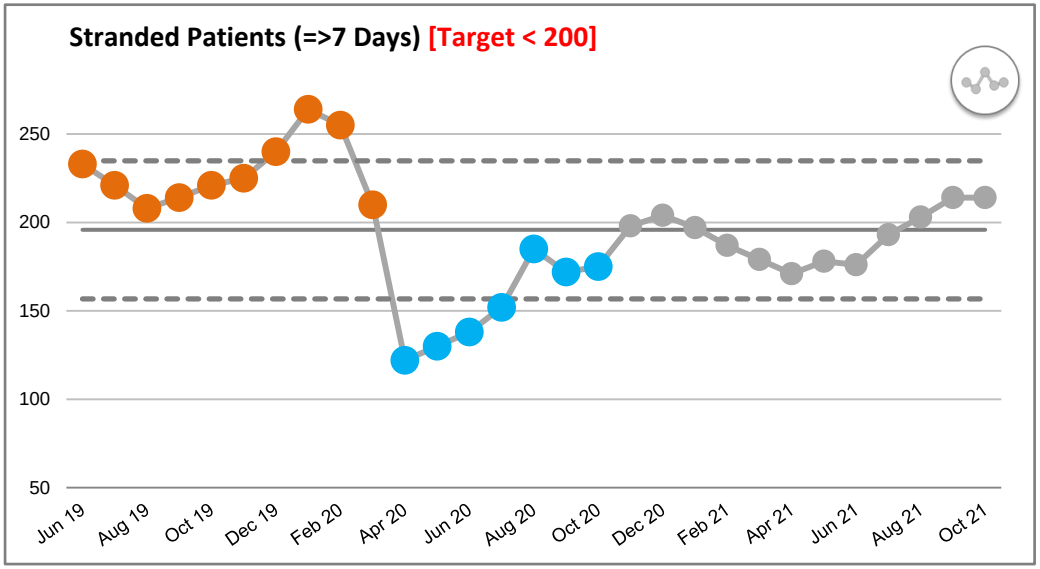
Bed Occupancy (including Escalation Beds) [Target < 85%]



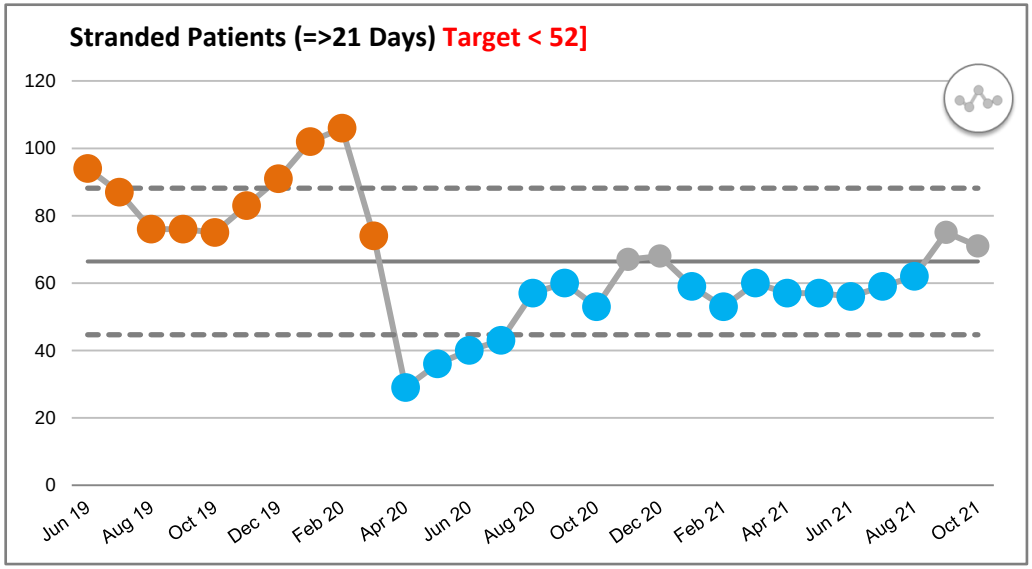
% Patients Moved =>3 Times



Stranded Patients (=>7 Days) [Target < 200]



Stranded Patients (=>21 Days) Target < 52]



A&E 4 Hour Performance / Flow

Reporting Period: Monthly | October 2021

Emergency Care

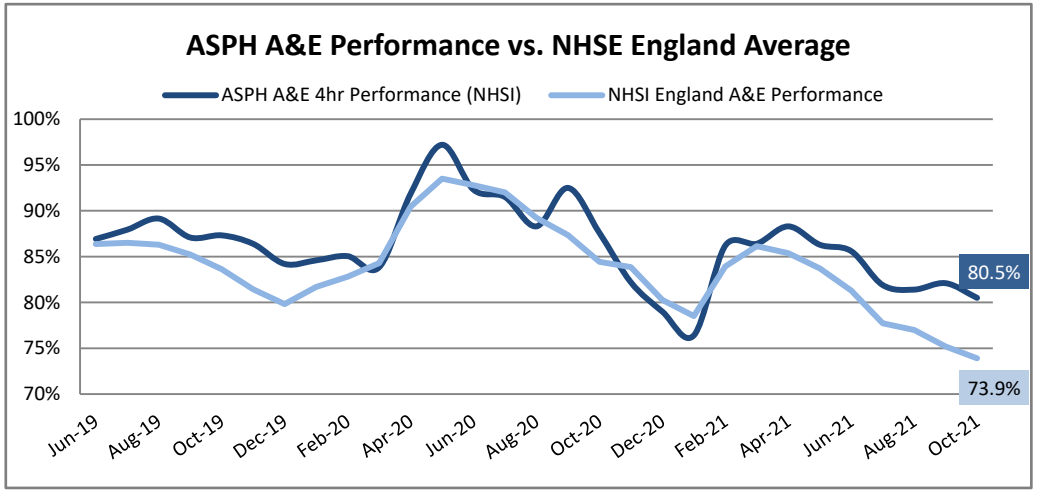
ASPH 4hr Performance (NHSI and SPH)

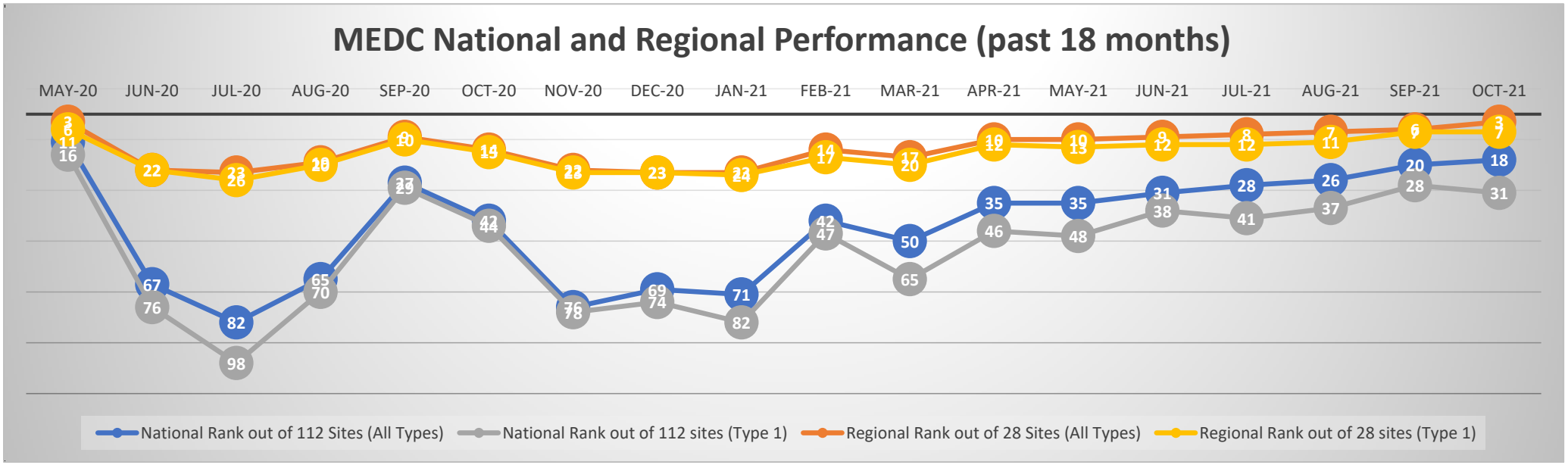
The Trust's reportable NHSI (SPH site inc. Ashford & Woking WiC activity) performance for October 2021 was 80.5%, a 1.6% reduction on September 2021 (82.1%). However the Trust's regional and national ranking continued to increase for the month.

A&E Regional & National Ranking

During October 2021 the Trust's NHSI (all types) performance position regionally was 3rd (of 28), and nationally 18th (of 112).

ASPH performance of 80.5% was higher than the NHSE England Average of 73.9% for the same month. The Trust has consistently reported higher performance than NHSE England Average since May 2021, showing significant resilience during recent pressures compared to peers.





A&E 4 Hour Performance / Flow

Reporting Period		Emergency Care
Monthly	October 2021	

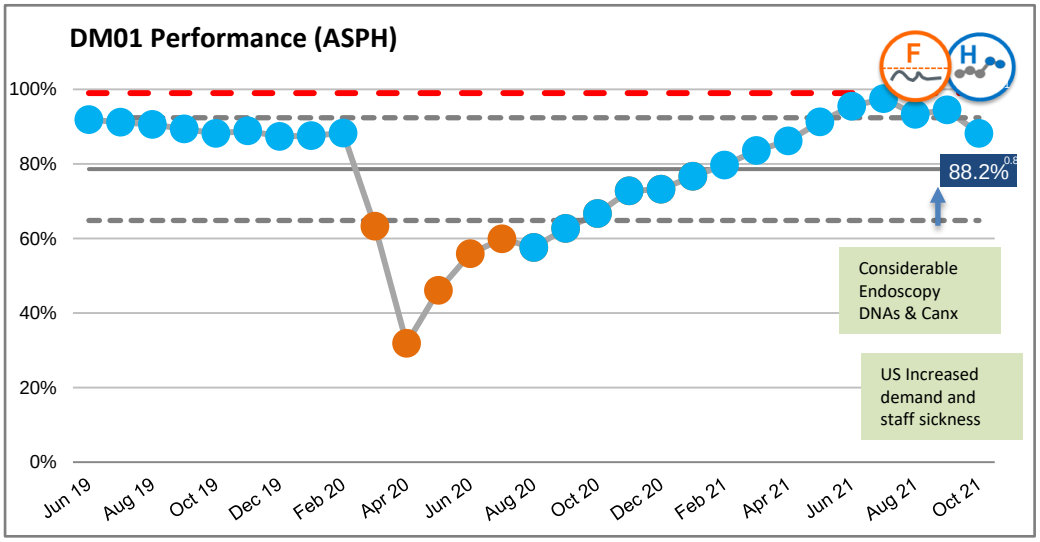
Assurance Level: **Partial**

What is impacting current performance?	• Very high volumes of patients (both walk-in and ambulance conveyances) attending for urgent and emergency care, including a significant increase in paediatrics. Paediatric ED has moved into remit of the ED to support paediatrics team to redeploy resources to manage RSV surge. • Walk in Centre and UTC demand exceeding capacity, leading to redirection of patients/closures which then impact on ED. • Reduced assessment space due to requirement to adhere to strict IPC guidance to maintain patient safety. • Physical space constraints within the ED department especially within ambulatory majors and Fit to Sit. • Not yet embedded processes to reduce intrinsic ED delays for non-admitted patients • Limited speciality assessment capacity: due to fledgling Same Day Emergency Care, reduced availability of speciality ward beds and discharge delays.
What actions are being undertaken to improve performance?	1. Clinical Assessment Unit (CAU) opened 26th August, creating assessment space for all specialties with the aim to improve flow from ED. 2. Home First team (multi-partner including therapies, rapid response, social services) commenced on 26th August with the aim to facilitate same day discharge for medically fit patients. 3. AECU and SAUV have relocated together from 10th October, increasing the floor print and capacity for direct referral into SDEC services. 4. New Older Person's Assessment Unit planned to open in December (delayed from November due to consultant staffing) within the ED footprint 5. Implementation of RAT from 11th October – 12pm-7pm Mon-Fri initially, supported by the relaunch of core clinical standards 6. Implementation of new ways of working in ED to facilitate equalising waiting times across ambulatory and non-ambulatory patients, including children. 7. Embedding new ways of working on CAU, including focused QI support to improve clinical pathways. This includes the roll out of Criteria to Admit, which aims to support clinical teams to consider alternative options prior to patient admission. 8. Workforce planning. Capacity and demand analysis underway for ED and UTC. Plans are progressing to complete ED Consultant job planning. Acute medicine workforce planning is also underway, and a new consultant post has recently been advertised. 9. Strengthening Trust and system performance framework for UEC including development of new metrics to monitor performance delivery. 10. Three separate multi-system meetings in place weekly to promote discharge of patients ready to leave hospital. 11. A Beautiful Information Inpatient PTL went live during the summer which has brought together datasets to provide greater oversight of the discharge processes and support improved pathway management
When will the position be recovered?	Over the past 6 months the Trust has consistently recorded better A&E performance than the NHSE England average. Improvement, investment and process changes are underway although recovery to deliver the national 95% standard will remain challenging. A key enabler will be the ED capital refurbishment.
What are the key risks?	- Recruitment, retention and engagement of the current workforce to work differently. - Increasing volume of activity, and surges in activity due to demand/IPC leading to imbalance in demand and capacity - Potential surges including RSV and Covid-19 - Capacity in the wider system including social care provision, community hospital capacity - Need to refurbish ED estate to ensure it is fit for purpose for modern healthcare
What are the Quality implications for the Trust?	Delays in ED can have negative implications to quality in terms of patient experience and outcomes, staff experience and IPC risk due to overcrowding. The Division has implemented new governance processes including daily quality checks by Matrons and a new pilot of RAT/complex streaming to provide earlier senior decision making. The risk register entry relating to clinical harm is currently identified as moderate (15).

Diagnostics (DM01)

Reporting Period: Monthly | October 2021

Elective Care



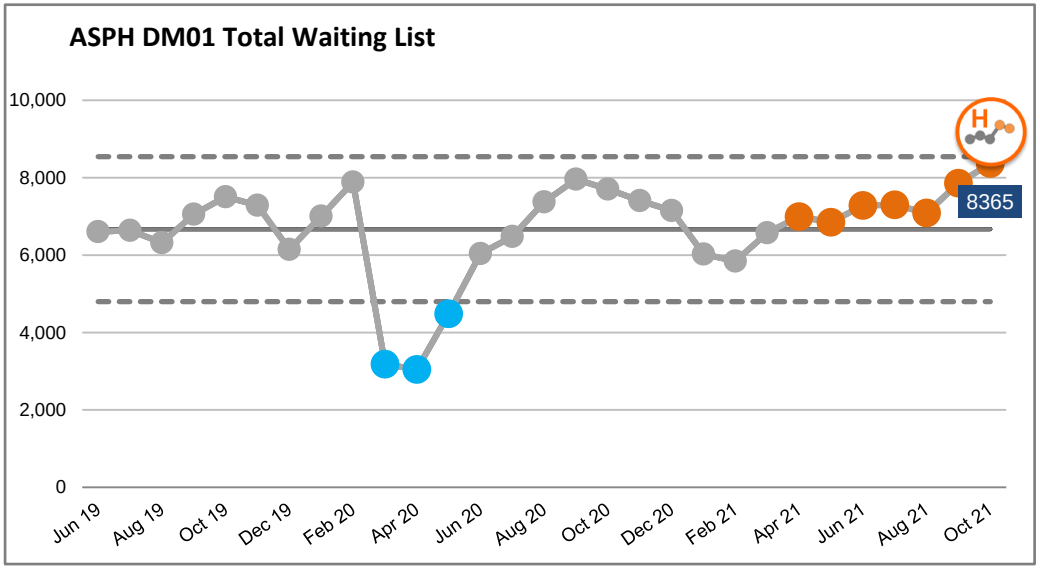
DM01 Performance

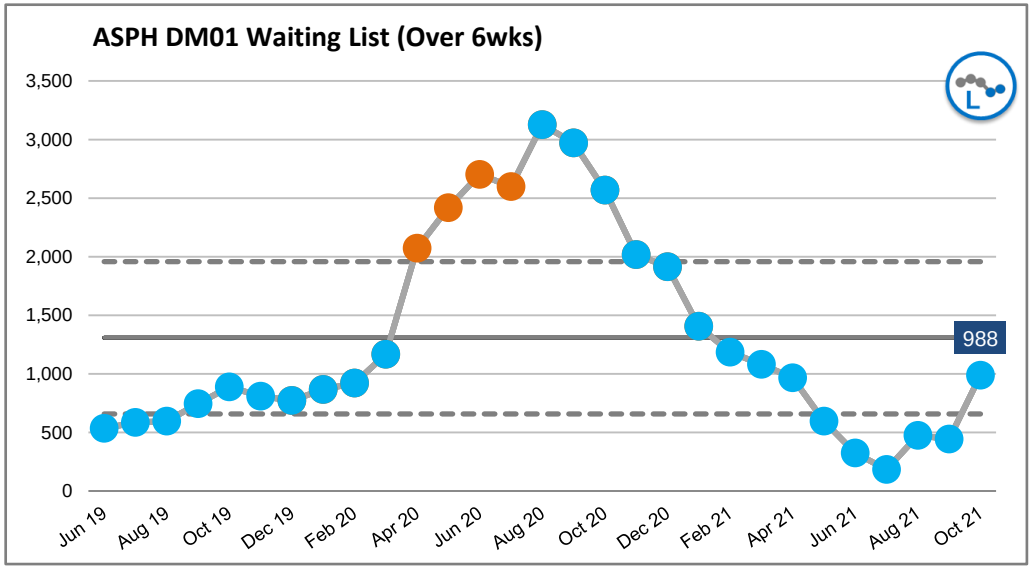
The Trust recorded a non-compliant DM01 Diagnostics performance for October at 89.2% which was a reduction on the performance recorded in September (94.5%).

The Trust recorded a trending improvement in performance since the initial impact of the pandemic although has been challenged recently and speciality during October due to considerably higher demand across a number of diagnostic modalities, especially in Non-Obstetric Ultrasound.

This additional demand including staff sickness, vacancy factor and requiring to isolate due to Covid, has driven the issues in Non-Obstetric Ultrasound (NOUS). Plans to support meeting demand and recovery of the position include, additional weekend / evening lists, additional radiologist session and both internal and outsourcing solutions. These solution gain particular speed during January, once confirmed a recovery trajectory will be provided.

Challenged modalities (patient waiting greater than 6 weeks) are ultrasound (585), Endoscopy (249), MRI (30), and Sleep Studies (14).

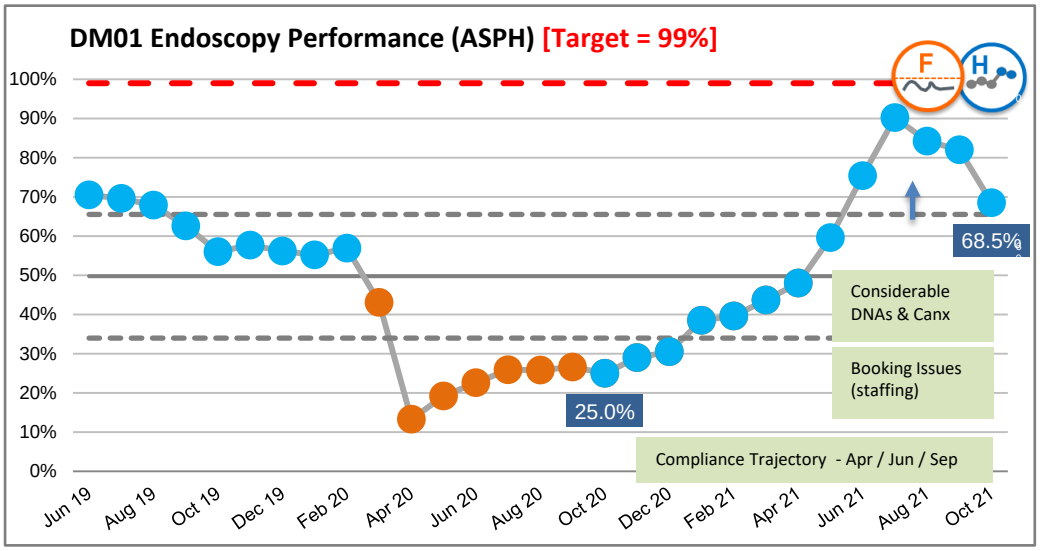




Endoscopy (DM01)

Reporting Period: Monthly | October 2021

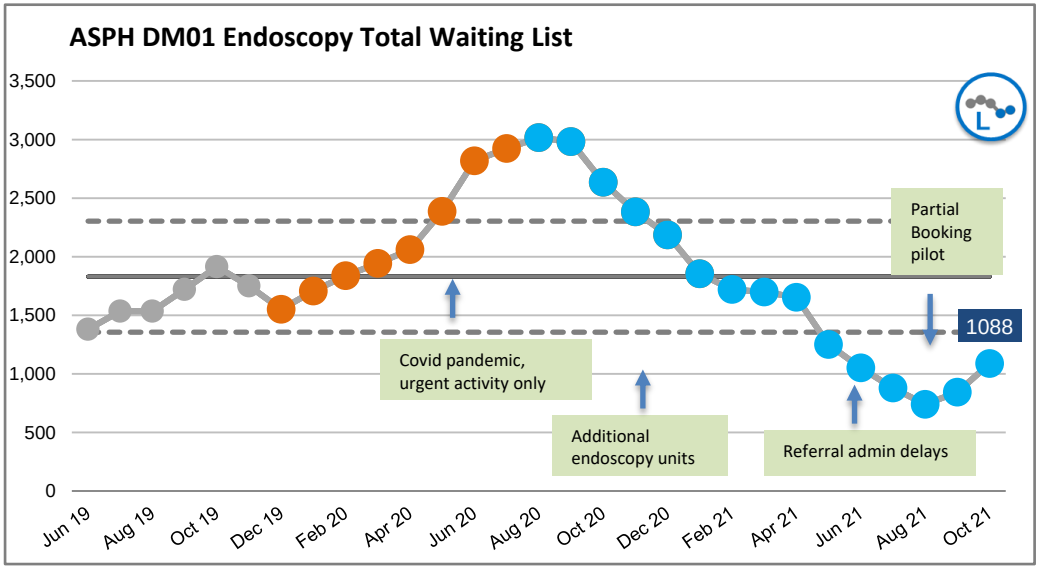
Elective Care

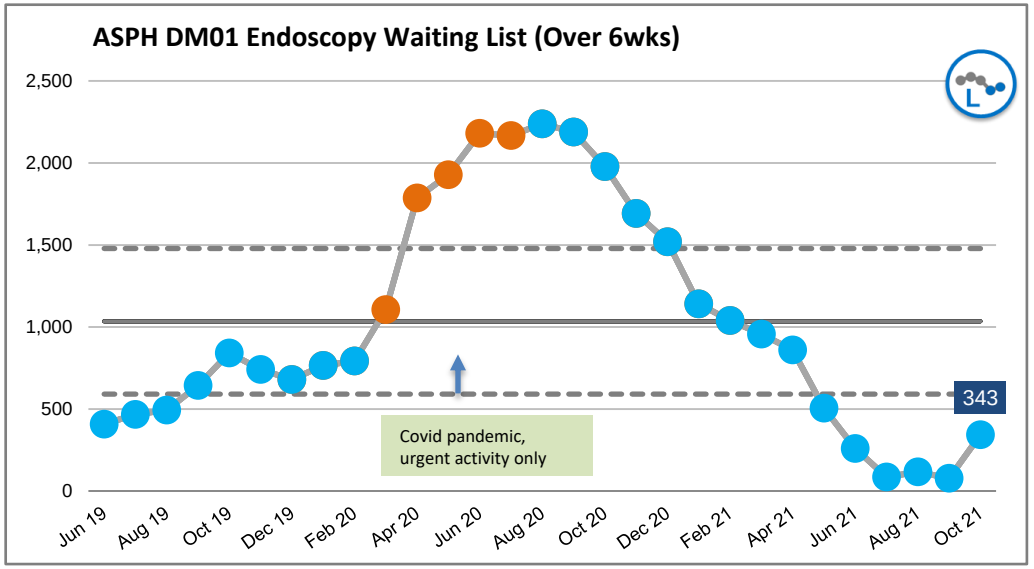


DM01 Endoscopy Performance

During October it came to light that due to issues retaining to workforce challenge a number of patients were not added to the visible waiting list pertaining to August and September. From 1st October an experienced endoscopy manager started which in part uncovered these issues. During October, the team have focused on a new comprehensive plan which now covers workforce, booking processes, and clear booking priorities for inpatients, cancer, surveillance and routine referrals.

Immediate impact of this new grip and approach is being seen in utilisation: 61% for last 2 weeks of Oct compared to 104% for the first 2 weeks of Nov. Immediate changes include; calling all patients (not communicating given dates via letter), direction of more resource to incoming calls, nurse pre-assessment earlier in the pathway, improved process for pre-procedure bowel prep and changes to pre-admission isolation and covid screening to reduce pre-admission burden to patients. The Team are making productivity and recovery of the endoscopy situation an absolute priority, which is supported by daily meetings with the new leadership team with COO, deputy COO and Director of Finance. A specialist endoscopy recovery team from the cancer alliance at request of the COO have also now commenced a programme supporting the Trust which will ramp up during November.





Diagnostics (DM01)

Reporting Period	
Monthly	October 2021

Elective Care

Assurance Level: **Partial**

What is impacting current performance?	The Trust recorded a non-compliant DM01 performance of 89.2% for October 2021, with the endoscopy cohort recorded at 74.9%. Challenges have arisen in MRI and Ultrasound (US) due to staff sickness and requiring to isolate due to Covid, compounded by increases being seen in demand across both modalities. The Trust has seen MRI demand increase by 16% and NOUS by 12% compared to 2019. In addition, recruiting agency staff to help with the increasing demand in ultrasound has been challenging over the past 2 months. Endoscopy continues to experience significant challenge due to 1) availability and consistency of scheduling staff, 2) a rise in diagnostic internal referrals due to deliberate increase in outpatient activity as part of restoration and due to the upstream impact of the outpatient booking backlog in the summer. 3) 734 patients who had not been recorded on the waiting list dating back to August who have now been recorded, & 4) an increase in inpatient referrals. Inpatient referrals are prioritised daily ahead of routine referrals due to urgency which has increased the DM01 backlog position.
What actions are being undertaken to improve performance?	Endoscopy: • Recruitment to scheduling staff is still underway, some of the new appointments will start in November. • Additional admin staff working evenings and weekends to support with scheduling and wait list additions. • The recruitment day did not result in appointment to all vacancies within Endoscopy. A second recruitment day is planned for 1st December 2021. • Endoscopy nursing team working additional hours to support further booking and pre-assessment. • Daily review of inpatient referrals with operational lead and nursing lead. • Daily Exec reviews, new leadership team in place, 2-3 days onsite support per week from endoscopy specialist team from KSS cancer alliance. MRI (MRI) and Ultrasound (US) - Our MRI provider increased our mobile MRI capacity during October from 4 days a week to 7 days to help manage increased demand. The Trust has secured agency staff to provide additional capacity for ultrasound and additional outsourced capacity to provide additional capacity. In addition, our sonographers have increased the number of weekend and out of hours lists to increase capacity during November.
When will the position be recovered?	Endoscopy - The challenges in scheduling and administration of patients through the endoscopy service does mean that the original trajectory of compliance from September will need to be recalculated once productivity expectations due to revised processes and training are sustained, initial projections suggest this could be within Q2/Q3 FY22. Recovery trajectories for MRI and US will be developed once workforce challenges are resolved or additional outsourcing is confirmed to maintain resilience considering the increases being seen in demand.
What are the key risks?	- Workforce - Increasing demand - Competing pressure from urgent care, inpatients and cancer pathways - A further Covid surge
What are the Quality implications for the Trust?	The risk of harm due to delays in endoscopy is currently recorded on the Trust's risk register as 15. Despite recent challenges the department still has minimal patients waiting greater than 13 weeks. The endoscopy team have strengthened the links with the Trust cancer team to ensure closer monitoring of patients on cancer pathways. Inpatient endoscopy capacity is also reviewed at a daily clinical and admin team huddle to ensure appropriate utilisation of lists. Recent challenges in endoscopy have affected staff morale. The division's outpatient matron now supports the endoscopy nursing team with quality rounds and staffing.

Cancer

Reporting Period: Monthly | October 2021

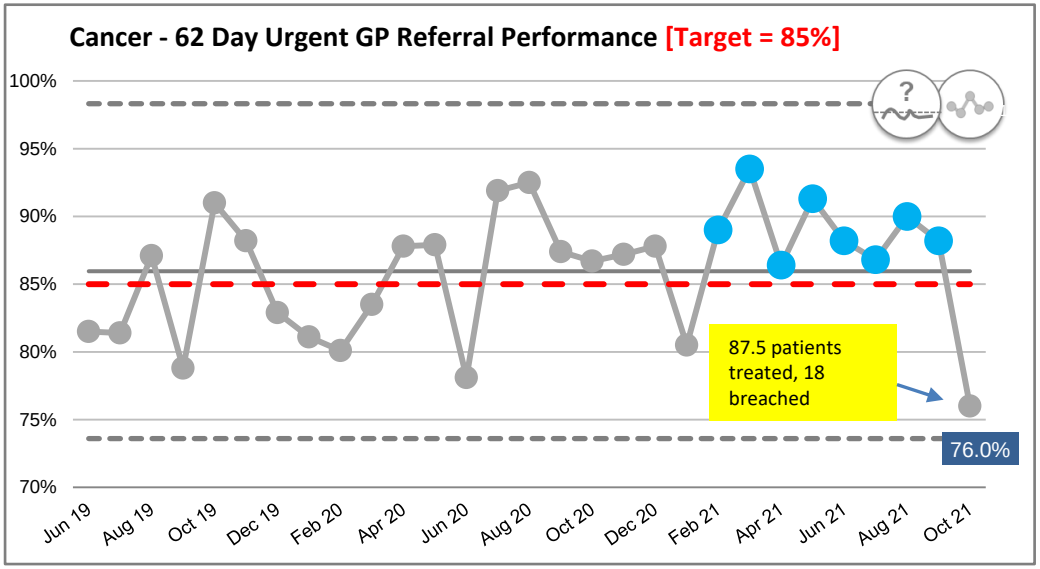
Elective Care

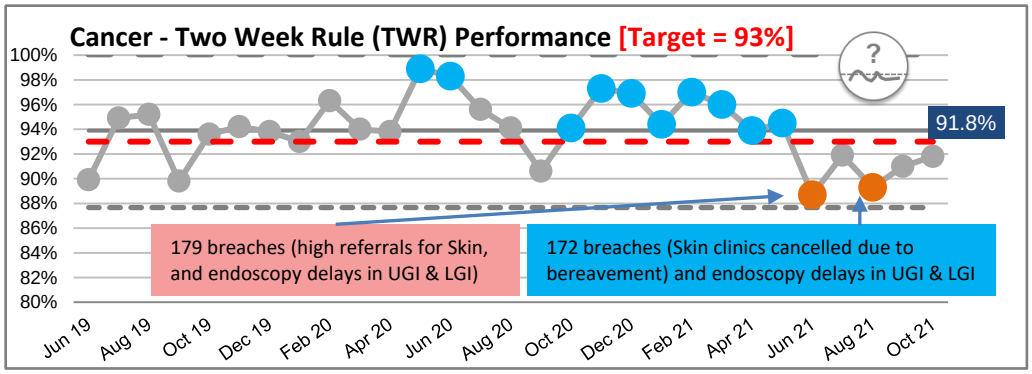
TWR
The Trust recorded a non-compliant TWR performance for October at 91.8%. Of the 138 breaches, 61 breaches were due to patient choice (44%) with 77 due to hospital operational reasons (56%).

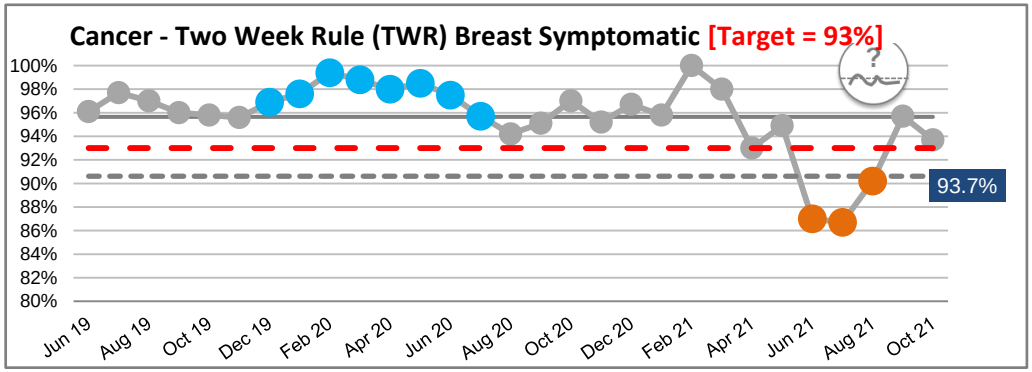
62 Day GP Referral to Treatment
The Trust recorded a compliant 62 Day GP Referral to Treatment performance for October at 76.0%. Delays have been recorded due to complex pathways (12 patients), capacity (7 patients), patient fitness (3 patients), and patient choice (2 patients).

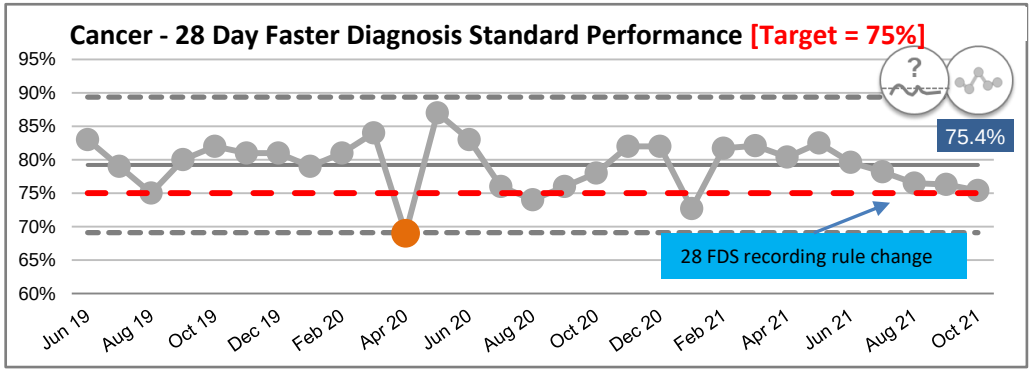
28 Day Faster Diagnosis Standard and Patients Waiting Greater than 62 Days
Due to a rule change in the reporting of patients for the 28 Day Faster Diagnosis Standard the Trust's compliance has fallen although remains above the 75% minimum target.

Patients Waiting Greater than 62 and 104 Days
The Trust has seen an increase in the number of patients in these categories due to the rule change identified above. Divisional teams are implementing revised processes to expedite notification to patients.







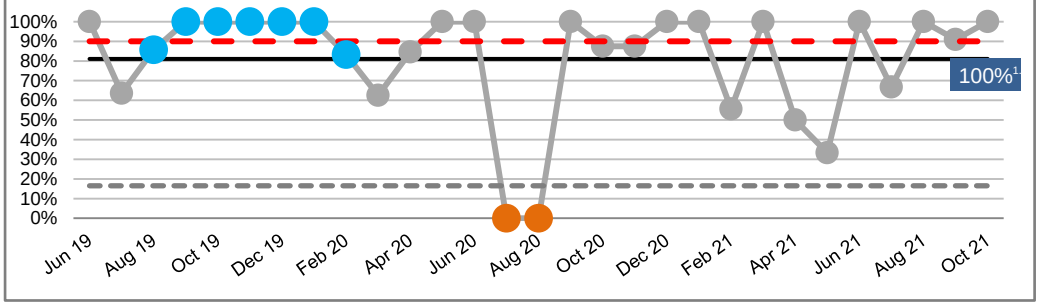


Cancer

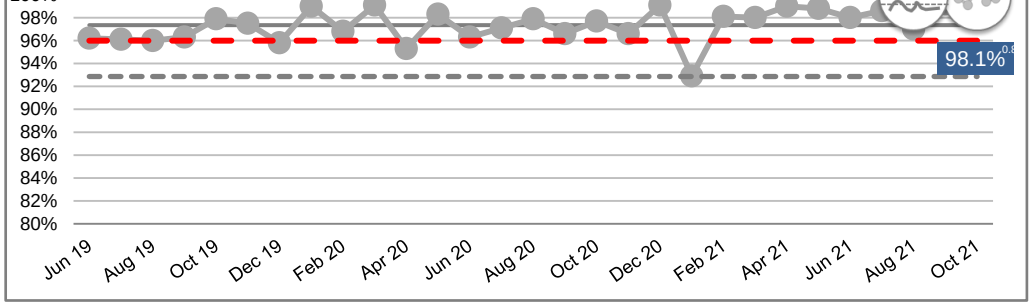
Reporting Period: Monthly | October 2021

Elective Care

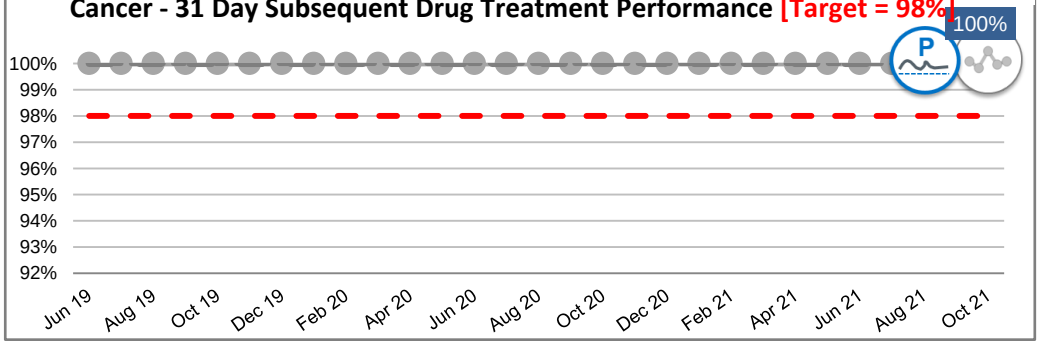
Cancer - 62 Day NHS Cancer Screening Performance [Target = 90%]



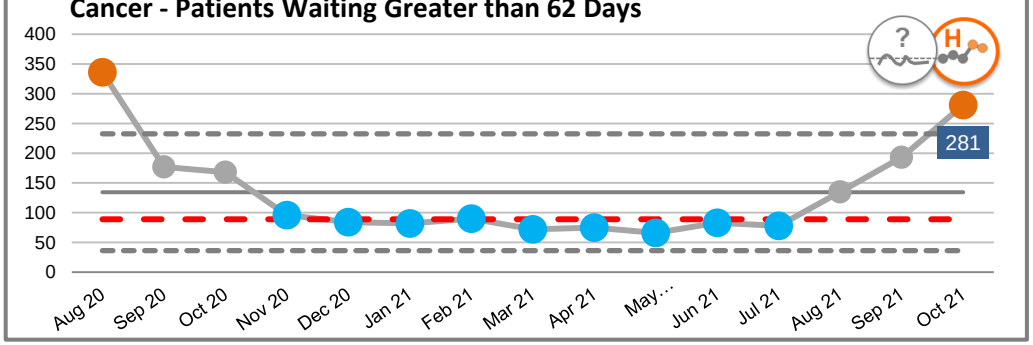
Cancer - 31 Day Diagnosis to First Treatment Performance [Target = 96%]



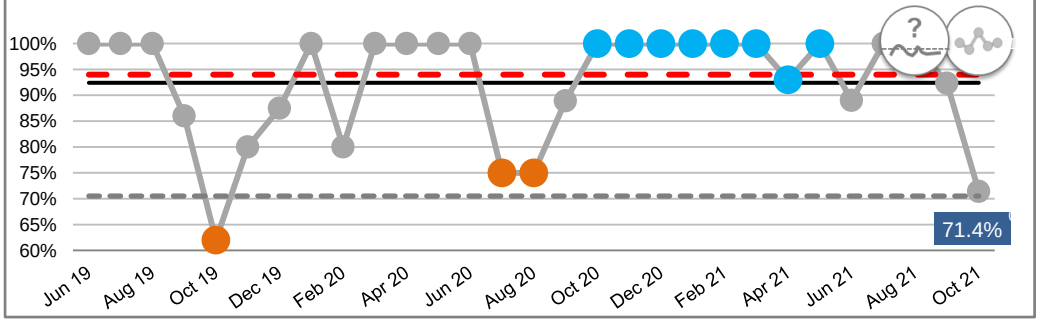
Cancer - 31 Day Subsequent Drug Treatment Performance [Target = 98%]



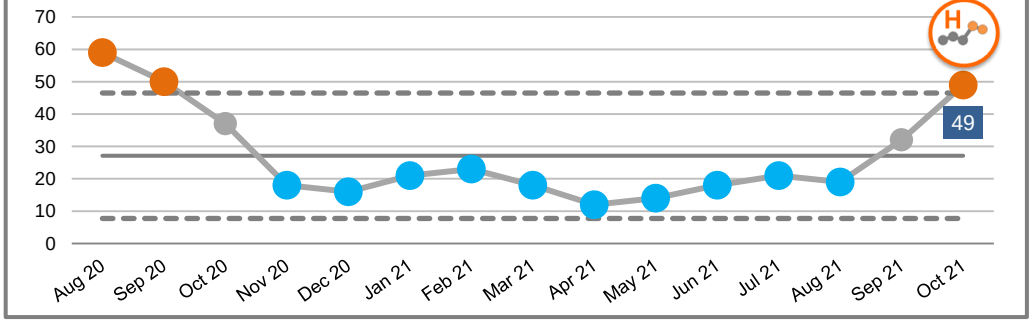
Cancer - Patients Waiting Greater than 62 Days



Cancer - 31 Day Subsequent Surgery Treatment Performance [Target = 94%]



Cancer - Patients Waiting Greater than 104 Days



Cancer

Reporting Period: Monthly | October 2021

Elective Care

Assurance Level: **Partial**

What is impacting current performance?	For September (latest national upload) the Trust reported compliance for 6 of 8 Cancer Standards; these were the 62 Day Urgent GP Referral to Treatment (88.2%), 28 Day Faster Diagnosis Standard (76.5%), 31 Day Diagnosis to Treatment (99.2%), 31 Day Subsequent Drug Treatments (100%), Breast Symptomatic (95.7%) and 62 Cancer Screening Performance (90%). During the same period the Trust reported non-compliance for the Two Week Rule (91.0%), driven by an under performance in Colorectal, Lung, Skin and UGI (two of which are related to Endoscopy). The Trust also reported non-compliance for 31 Day Subsequent Surgery Treatments (92.3%) due to 1 patient breach. Capacity is under pressure across the majority of tumour sites due to the increased levels of referrals. A revised capacity and demand exercise is underway across the specialities to identify shortfalls and develop more agile response processes. The TWR for Breast symptomatic was achieved despite the increase in referrals. Other acute providers are facing similar demand and ASPH performance is good against national performance benchmarks. The Trust is provisionally reporting non-compliance for the Two Week Rule, 62 Day Urgent GP Referral to Treatment and 31 Day Subsequent Surgery Treatment Standards for October. This position is currently undergoing validation. October currently compliant for all other cancer standards.
What actions are being undertaken to improve performance?	There is ongoing work to reset the capacity across all tumour sites, as well as ensure the agility of service level response to respond flexibly to referral surges. A revised capacity and demand exercise.
When will the position be recovered?	Demand continues to be challenging, with all teams working on the ambition to ensure Two Week Rule appointments are available and booked within the first 7 days from referral. As a result of this work all tumour sites, apart from Colorectal (driven by Endoscopy) are achieving TWR performance.
What are the key risks?	- Capacity due to increase and surges in demand - Availability of workforce - Endoscopy
What are the Quality implications for the Trust?	Delays in the care for cancer patients can cause harm. Patients are monitored individually at weekly performance meeting and locally at divisional cancer performance meetings. Bi-monthly Cancer Clinical Harm Review meeting in place with acute consultants, GPs and patient safety team where long waiting patients and those delay are considered in detail. The risk of harm due to cancer patients due to delay is currently rated as 12 on the Division's risk register.

Appendix A

Ashford and St. Peter's Hospitals
NHS Foundation Trust

The following query was raised by Governors;

We are aware of the increase in patient dissatisfaction about appointments, their cancellations or rearrangement, sometimes multiple times. Also, the timing of letters and/or cancellations which sometimes arrive after the scheduled appointment. What is being done to rationalise the outpatient appointment system and why can't Medical Secretaries make / reschedule appointments for their own departments? Why is the return address for undelivered appointment letters directed to Bristol?

Letters are sent from various administrative offices from within the organisation. Recent improvements have focused on the main Appointment Centre although we plan to extend this across the Trust during Phase 2 of the Outpatient Transformation Programme which will cover all offices that send appointment letters. [The Outpatient Transformation Programme is discussed in more detail in the Trust's Patient Experience Group]. With the Trust's imminent implementation of Cerner, a future module the Trust will adopt will allow direct booking of appointments via the patient portal.

The main Appointment Centre currently distributes letters at least 3 weeks before an appointment. If there is a cancellation during the three-week period and an appointment is re-booked for a new patient, or additional capacity is put on, then the letter will be sent immediately and will obviously no longer be sent with the 3 week minimum lead time.

Some clinical services request that we book late notice clinics (e.g. 5 working days in advance). In this situation, the team will call patients and in our pilot areas, also text patients with the appointment date, time and location information. In this scenario, letters will likely arrive after the appointment; therefore we are encouraging clinical services to provide as much notice to book patient appointments where able to do so as letters can take up to 7 days to reach their location when sent through our Synertec postal service.

Synertec is our letter distribution company, who have their return address for letters listed as Bristol which allows a central location for advising the Trust when a letter has not been successfully delivered.

All patients who have experienced issues regarding late or incorrect appointment letters are encouraged to raise this direct with the Specialty Team who has sent the letter and raise a PALS enquiry as this will enable the outpatient transformation group to understand the scale of the problem.

Rachael Strauss
DTC Clinical Professional Lead