**Paper 6.2**

Ashford and St. Peter's Hospitals
NHS Foundation Trust

# Council of Governors
# Date: 2nd March 2022

| TITLE | Performance Report - January 2022 |
|---|---|
| **EXECUTIVE SUMMARY** | **Covid Position**<br>The number of Covid patients within the hospital averaged 69 per day during January with demand for non-Covid urgent care services also very high. The impact of the high number of Covid infections in the community created challenges within the hospital causing an increase in the number of inpatients with Covid and staffing difficulties due to infection.<br><br>**Elective Activity**<br>The Trust recorded a non-compliant performance for RTT Incomplete Pathways at 78.7%, although remains substantially above the NHSE England Average recorded at 63.8% for December (latest data published on 10th Feb 22).<br><br>Routine surgery was postponed between Christmas to 30th January to provide clinical resource and ward beds to support the Trust's Urgent Care demand due to Covid Omicron and Winter pressures. However, the number of Priority (P2) patients waiting urgent surgery over 4 weeks not yet booked has remained at a low level due to maintaining cancer and P2 surgeries during the current Covid Omicron wave.<br><br>Staff Covid sickness also reduced capacity, coupled with considerable last minute patient cancellations due to the very high levels of Omicron infection within the local community reduced full utilisation of outpatient, diagnostic and elective activity.<br><br>*Assurance: The Trust has Acceptable assurance at this stage that plans are underway to achieve the required levels of activity once the current Omicron surge subsides. Optimising elective facilities at Ashford is essential which will allow increased elective operating, although continued pressure on acute beds in extremis could affect this.*<br><br>**Urgent Care**<br>The Trust's reportable NHSI (SPH site inc. Ashford & Woking WiC activity) performance for January 2022 was 78.2%, an improvement from 77.4% recorded during December 2021.<br><br>Daily attendance levels during January 22 were similar to December 21 although the Emergency Department (ED) and Urgent Treatment Centre (UTC) remained under sustained pressure due to surges in attendances, the very high occupancy of the hospital creating exit block from the Emergency Department, and the impact of Covid affecting staffing levels.<br><br>The Trust experienced significant issues with inpatient flow out of ED, this was due to a largely bedded assessment unit, as a result of poor flow out of the organisation. A lack of placement capacity across social care, who faced similar |

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| | infection control and staffing pressures as the acute Trust was also a factor. These challenges were amplified by the need to manage separate red and green pathways and coping with outbreaks of Covid across multiple wards encompassing empty beds that can't be used.<br><br>However, the Trust's regional and national ranking remained in the 2nd quartile (locally and nationally). ED Performance compared nationally using the NHSI metric (including Ashford and Woking WiCs), the Trust was positioned 30th of 112 Trusts. When comparing the Trust for SPH site only for January the Trust was positioned 43rd of 112 Trusts.<br><br>*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, unpredictable surges in demand, and potential for Covid surge related presentations is affecting delivery of the 4 hour standard.*<br><br>**Diagnostics (DM01)**<br>The Trust recorded a non-compliant DM01 performance of 84.8% for January 2022, with the endoscopy cohort recorded at 56.3%.<br><br>The Trust saw a reduction in elective diagnostic capacity and activity during the New Year although comparably high community referrals and very high emergency demand leading to higher waiting list sizes, mainly in Non-Obstetric Ultrasound, MRI and Endoscopy.<br><br>The Trust's internal diagnostic services, including In-health and Alliance Medical were also affected by staff sickness and requiring to isolate due to Covid. Patient choice delays were higher than usual during the month which included considerable cancellations and non-attendances. These were primarily related to patients isolating due to Covid infection.<br><br>Demand for endoscopy for urgent TWR and inpatient endoscopy remained considerably high although utilisation rates of the available capacity have remained high.<br><br>The Trust is creating additional capacity to meet the demand and recovery of Non-Obstetric Ultrasound and Endoscopy through additional weekend / evening lists, and both internal and outsourcing solutions. Our partner, Alliance Medical also has plans to increase activity to support the demand and recovery of MRI.<br><br>*Assurance: We have partial level of assurance regarding ongoing delivery of diagnostic activity similar to or above pre-Covid levels once the Omicron surge subsides to regain delivery of the DM01 diagnostic performance target. Unforeseen changes in demand profile, staff availability and future Covid waves could affect this.*<br><br>**Cancer**<br>For **December** (latest national upload) the Trust reported compliance for 3 of 8 Cancer Standards; these were; 31 Day Diagnosis to Treatment (97.6%), 31 Day Subsequent Drug Treatments (100%) , 31 Day Subsequent Surgery |

| | |
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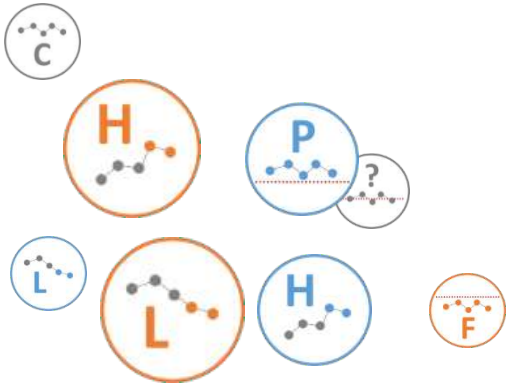
| | Treatments (100%).<br><br>During the same period the Trust reported non-compliance for; Two Week Rule (87.1%), Breast Symptomatic TWR (89.4%), 62 Day Urgent GP Referral to Treatment (83.7%) and 62 Cancer Screening Performance (80%) and 28 Day Faster Diagnosis Standard (71.9%).<br><br>For **January**, the Trust is provisionally reporting non-compliance for the Two Week Rule, TWR Breast Symptomatic [due to 25% increase in referrals and covid sickness within the team], 62 Day Urgent GP Referral to Treatment, and 62 Cancer Screening Performance (2 breaches) which has been due to a combination of patient cancellations, patient choice and staff sickness. This position is currently undergoing validation.<br><br>Capacity has been under immense pressure across the majority of tumour sites due to the ongoing increased levels of referrals, the reduction in activity over the winter period, and considerable impact of Covid with an increase in patient cancellations and staff sickness.<br><br>A revised capacity and demand exercise across all specialities has taken place which identified opportunities to increase capacity, resilience and to develop more agile response processes which has immediately been put in place. Other acute providers are facing similar demand and ASPH performance remains good against national performance benchmarks.<br><br>*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: Jan 2021**
**Board Month: Feb 2022**

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

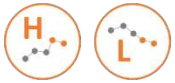
This scorecard incorporates Statistical Process Control (SPC) graphs.

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.

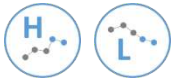
## Variation Icons

> Are we improving, declining or staying the same?

Common cause variation – No significant change




Special cause of concerning nature or higher pressure due to **H**igher or **L**ower values




Special cause of improving nature or lower pressure due to **H**igher or **L**ower 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 **P**assing the target

Variation indicates consistently **F**alling short of the target

## Assurance Level Icons

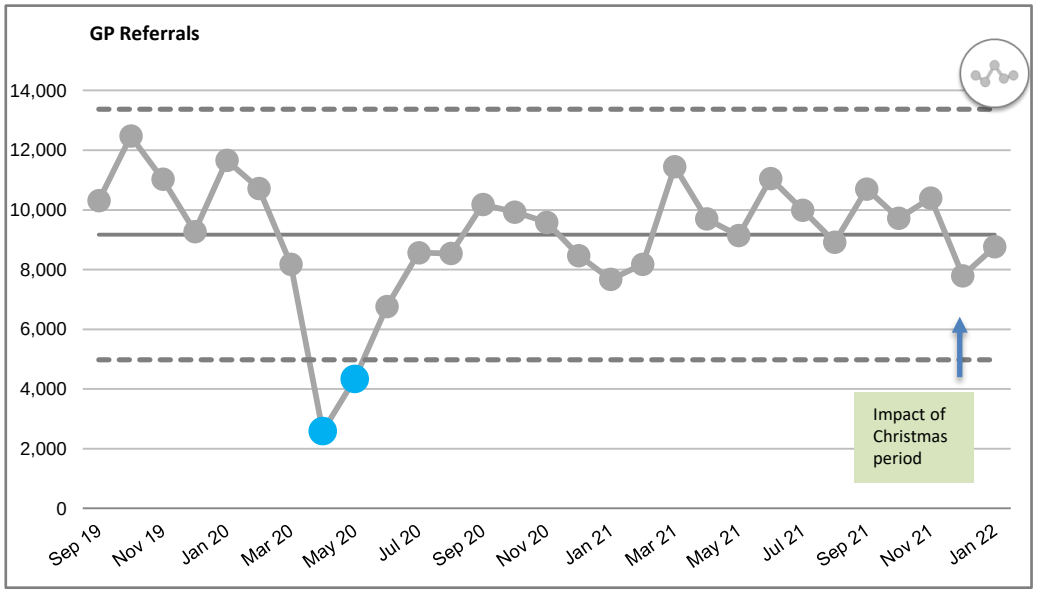
> A level of assurance has been assigned to each of the key metrics in this report, the 4 levels are;

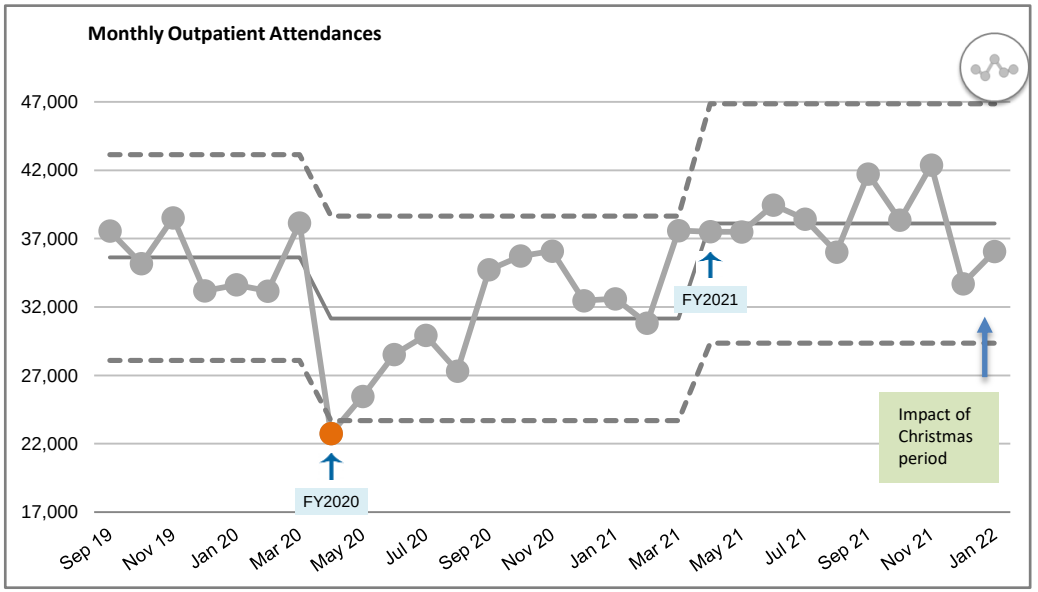
| Assurance Levels | | | |
|---|---|---|---|
| **No Assurance** | **Partial** | **Acceptable** | **Significant** |
| No confidence or evidence in delivery | Some confidence and evidence in delivery of existing mechanisms and objectives | General confidence and evidence in delivery of existing mechanisms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

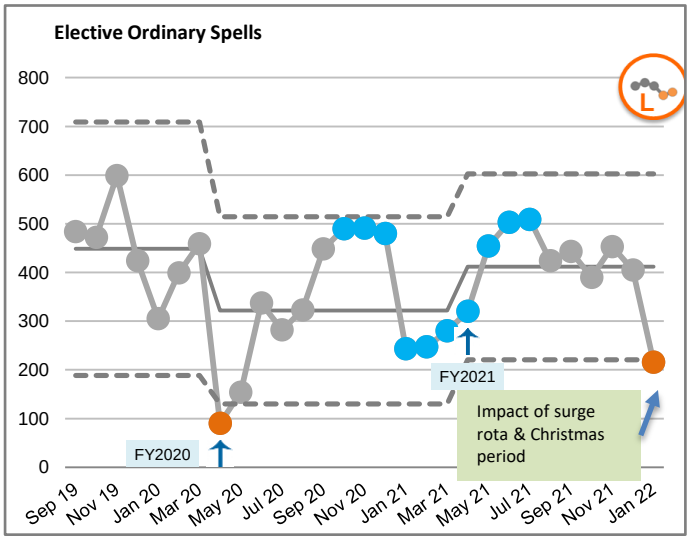
# Activity

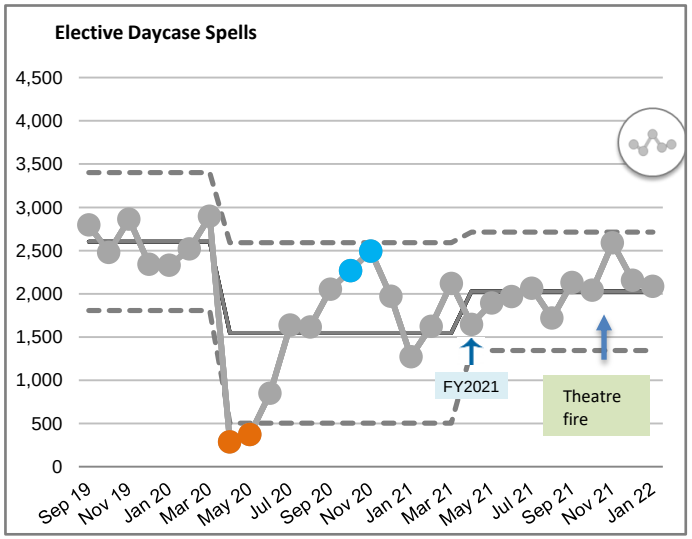
Reporting Period: Monthly | January 2022

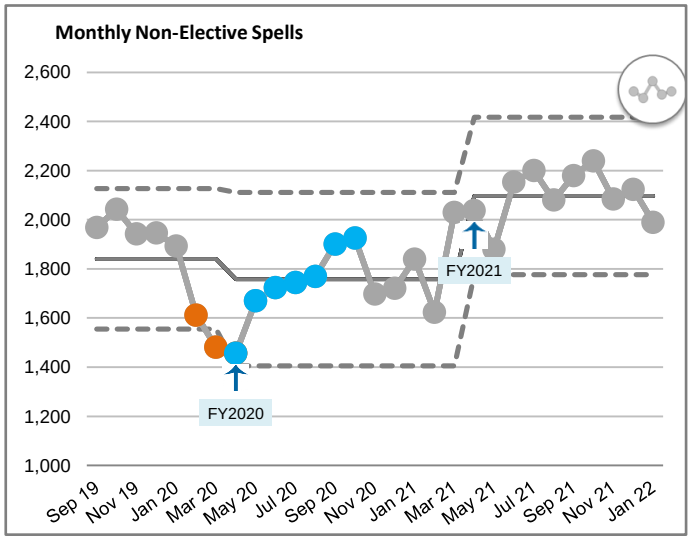
Overview



## 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 (Baseline) | 1426 | 1515 | 1447 | 1502 | 1412 | 1502 | 1548 | 1564 | 1164 | 1336 | 1329 | 1005 |
| 20/21 | 91 | 187 | 612 | 878 | 884 | 1127 | 1163 | 1114 | 917 | 347 | 411 | 597 |
| *ERF (H2) >89%* | | | | | | | *1378* | *1392* | *1036* | *1189* | *1183* | *894* |
| ASPH Plan | | | | | | | *1252* | *1311* | *1238* | *1202* | *1152* | *1217* |
| **21/22 Delivery** | 942 | 1071 | 1250 | 1402 | 1081 | 1234 | 1134 | 1486 | *1148* | 952 | | |
| 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 (Baseline) | 7550 | 8126 | 7824 | 8656 | 7780 | 7953 | 9096 | 8622 | 7063 | 8341 | 7904 | 6829 |
| 20/21 | 3980 | 4533 | 5056 | 5338 | 4653 | 6288 | 6445 | 6844 | 5746 | 6253 | 5866 | 7486 |
| *ERF (H2) >89%* | | | | | | | *8095* | *7674* | *6286* | *7423* | *7035* | *6078* |
| ASPH Plan | | | | | | | *7893* | *8401* | *7935* | *7418* | *7278* | *7725* |
| **21/22 Delivery** | 7107 | 7087 | 7537 | 7413 | 6743 | 8077 | 8312 | 8697 | *6872* | 7299 | | |
| 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 (Baseline) | 8976 | 9641 | 9271 | 10158 | 9192 | 9455 | 10644 | 10186 | 8227 | 9677 | 9233 | 7834 |
| 20/21 | 4071 | 4720 | 5668 | 6216 | 5537 | 7415 | 7608 | 7958 | 6663 | 6600 | 6277 | 8083 |
| *ERF (H2) >89%* | | | | | | | *9473* | *9066* | *7322* | *8613* | *8217* | *6972* |
| ASPH Plan | | | | | | | *9145* | *9712* | *9173* | *8620* | *8430* | *8942* |
| **21/22 Delivery** | 8049 | 8158 | 8787 | 8815 | 7824 | 9311 | 9446 | 10183 | 8020 | 8251 | | |
| | | | | | | Plan | 86% | 95% | 111% | 89% | 91% | 114% |
| | | | | | | Actual | 89% | 100% | 97% | 85% | | |
| | | | | | | Actual (adjusted for working days) | 97.2% | 95.4% | 92.8% | 93.8% | | |

**H2 PLANNING & ACTIVITY**

NHSE H2 Planning 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 modelled plan was based on national NHSE expectations of low impact from further Covid waves**, and therefore the recent Omicron wave has impacted the Trust's ability to deliver the plan due to clinical rota changes required to support the increased demands for Urgent Care, including higher rates of staff sickness and staff requiring to isolate due to Covid. Furthermore, last minute patient cancellations for outpatient, diagnostic and elective activity increased considerably due to very high levels of Omicron infection within the local community.

The above plan is comparing clock stop activity compared to plan, further adjusted for working days. This differs from the financial plan which is calculated using NHSE Treatment Function Code weighted clock stop values to derive ERF/ERF+/TIF financial incentivisation payments.

# Recovery

Reporting Period: Monthly | January 2022

Elective Care

| RECOVERY DASHBOARD - ASPH | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Measure | Target | Trend | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 |
| **Cancer** > 104 day waits | 0 | | 14 | 21 | 21 | 19 | 32 | 49 | 34 | 36 | 48 |
| **Cancer** > 62 day waits | <89 | | 71 | 83 | 86 | 127 | 161 | 281 | 170 | 176 | 183 |
| **RTT P2** > 4wk waits (All) | tbc | | 150 | 65 | 47 | 37 | 39 | 41 | 69 | 99 | 108 |
| **RTT P2** > 4wk waits (no TCI) | 0 | | 65 | 12 | 25 | 13 | 19 | 22 | 29 | 43 | 51 |
| **RTT Total** > 90wk waits (All) | 0 | | 3 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 0 |
| **RTT Total** > 90wk waits (exc. TCIs) | 0 | | 1 | 0 | 1 | 2 | 0 | 1 | 1 | 1 | 0 |
| **RTT Total** > 78wk waits (All) | 0 | | 48 | 11 | 13 | 12 | 8 | 8 | 2 | 2 | 3 |
| **RTT Total** > 78wk waits (exc. TCIs) | 0 | | 24 | 9 | 11 | 12 | 6 | 2 | 2 | 2 | 1 |
| **RTT Total** > 52wk waits (All) | 0 | | 175 | 115 | 94 | 89 | 111 | 74 | 90 | 90 | 105 |
| **RTT Total** > 52wk waits (exc. TCIs) | 0 | | 139 | 49 | 76 | 71 | 86 | 38 | 77 | 80 | 93 |
| **Urgent 1st OPA Total** > 6wk waits | 0 | | 1375 | 1561 | 1720 | 1620 | 1442 | 1181 | 1040 | 985 | 1102 |
| **Routine 1st OPA Total** > 18wk waits | 0 | | 1137 | 1287 | 1519 | 1338 | 1700 | 1640 | 1668 | 1571 | 1897 |
| **Diagnostics** > 6wks waits % | <1% | | 8.7% | 5.4% | 2.5% | 6.7% | 5.8% | 10.8% | 10.5% | 16.5% | 14.6% |
| **Diagnostics** > 6wks waits actual | <50 | | 596 | 396 | 184 | 475 | 439 | 988 | 889 | 1334 | 1251 |
| **Diagnostics** > 13wks waits actual | 0 | | 270 | 118 | 41 | 17 | 10 | 8 | 21 | 118 | 81 |
| **Endoscopy** > 6wks waits % | <1% | | 40.4% | 24.6% | 9.8% | 15.8% | 11.8% | 31.5% | 38.5% | 44.4% | 43.8% |
| **Endoscopy** > 6wks waits actual | <17 | | 505 | 259 | 86 | 117 | 78 | 343 | 616 | 661 | 588 |
| **Endoscopy** > 13wks waits % | 0% | | 21.3% | 9.6% | 3.8% | 1.6% | 0.6% | 0.6% | 1.2% | 7.9% | 5.9% |
| **Endoscopy** > 13wks waits actual | 0 | | 266 | 101 | 33 | 12 | 4 | 6 | 19 | 117 | 79 |
| **Advice & Guidance** | >80% | | 86% | 78% | 80% | 79% | 76% | 76% | 76% | 76% | 78% |
| **Pre-Covid OPA Activity** | 110% | | 115% | 107% | 107% | 112% | 112% | 97% | 95% | 93% | 94% |
| **Pre-Covid Elective Activity** | 110% | | 97% | 86% | 89% | 83% | 79% | | | | |
| **Virtual** - 1st OPA | 25% | | 39% | 37% | 37% | 35% | 34% | 33% | 33% | 31% | 28% |
| **Virtual** - Follow Up | 25% | | 33% | 32% | 32% | 30% | 31% | 28% | 28% | 30% | 28% |

# Recovery

Reporting Period: Monthly | January 2022

Elective Care

**Assurance Level:** **Acceptable**

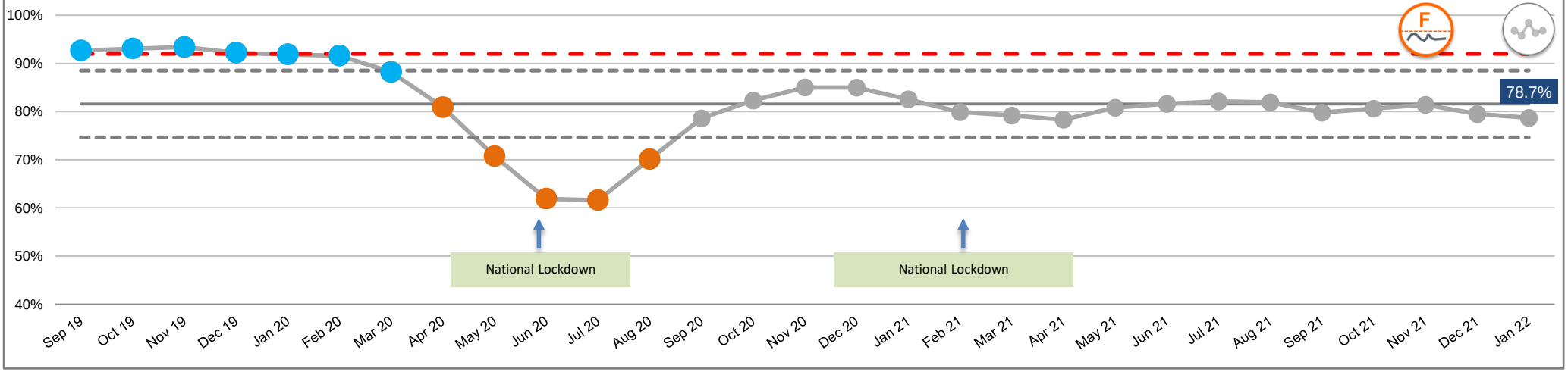
| | |
|---|---|
| Current performance | We have achieved above plan despite severe operational challenge. Theatre activity was affected by redeployment of much of the theatre staff from the last week in December until the third week of January. Bed pressures subsequently have only allowed opening of one of our two elective Ashford wards since the Christmas break.<br>Divisions have been strong for a number of reasons in outpatient activity;<br>1. Better resilience baked in through recovery planning using insourcing, outsourcing & locums<br>2. GSCAT - higher activity in GS and Colo due to reduced electives and therefore resource was diverted to outpatients. Super weekend in Urology created additional capacity.<br>3. iMSK & SS - higher activity in breast due to surge in TWR referrals, ENT & Ophthalmology insourcing, also buoyed by swabs (vs. FY19)<br>4. GSM Division - good activity levels. A number of specialties delivered higher activity vs. plan.<br>5. Considerable focus on clinic productivity & reducing DNAs/Canc's; and a strong clock stop caching-up regime. |
| 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. To date this has provided 5,400 (up until week ending 16th Jan) episodes including outpatients, diagnostics and surgical interventions. Some clinical limitations in the patients that can be accepted.<br>**Outsourcing**: Runnymede (Orthopaedics, general surgery), Nuffield (Orthopaedics, Respiratory), Cobham (Ophthalmology, MaxFacs, Orthopaedics, and General Surgery), Xyla Healthcare (Respiratory), colorectal under development to commence in February **Insourcing:** ENT, Colorectal, Vascular, Gastroenterology, Ophthalmology , To be commenced - Dermatology<br>**Workforce** -Locums have been recruited in a number of areas to support capacity (colorectal, urology, neurology, dermatology) and two are being recruited into gastroenterology. A small number of weekend ad-hoc operating lists are providing additional theatre sessions across specialties. Focused fundamental demand and capacity analysis and associated business cases are being developed to ensure that services will meet ongoing increased demand and manage backlogs.<br>**Projects** – Additional oral dental lab providing 3 treatment rooms opening in February , reduction of on-the-day cancellations through the implementation of new perioperative pathway. 4eyes consultancy supporting theatre utilisation has now been handed back to Trust teams and workstreams remain in place. Additional patient pathway validation team is enabling RTT wait list validation to ensure 'clean' lists accurately reflect the position. We continue to use fully staff modular endoscopy facility and ophthalmology modular theatres. Ophthalmology modular recovery unit is being installed during February which will enable increased number of patients per list through these theatres. PIFU implementation programme under development commencing with rheumatology, pain management, urology - dedicated project support funded through the ICS and working collaboratively with RSCH and SASH.<br>**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. |
| When will the position be recovered? | Recovery trajectories are individual to each speciality area and are under continuous review. Current progress has been delayed by the Omicron surge, which through December saw about 70 staff redeployed from theatre to others areas of the hospital. Despite recalling these staff back from the third week of January, much activity continues to be restricted due to acute bed pressures overflowing into the elective wards. Services have continued where possible with the aim of maintaining recovery, in particular using in/outsourcing capacity. The Trust's recovery metrics continues to considerably outperform other providers in the region. |
| What are the key risks? | There is an ongoing risk to additional sessions and weekend lists which are voluntary, and come after a period of much pressure already for some of these staff. This risk will be closely monitored , and being mitigated through the use of locums/insourcing/outsourcing where appropriate to complement in house additional activities. This is also being supported through demand and workforce analysis to 'right-size' services by recruiting clinical and non-clinical staff to ensure sustainable services<br>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.<br>Unlike previous covid waves current modelling suggests that the residual requirement for a significant number of dedicated covid beds will continue for well into the next financial year – this remains to be confirmed however could cause impact. Further waves and new variants are not modelled for – if that happens recovery trajectories will be affected. |
| 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 and in key areas clinical risk assessment of those waiting is being undertaken. Ongoing use of locums risks increase in clinical variation.<br>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)

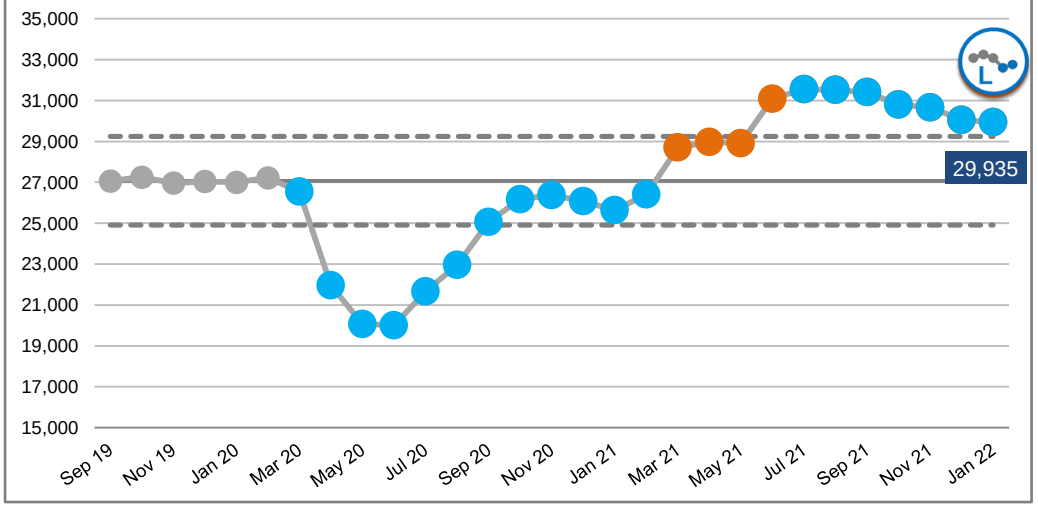
| Reporting Period | |
|---|---|
| Monthly | January 2022 |

Elective Care

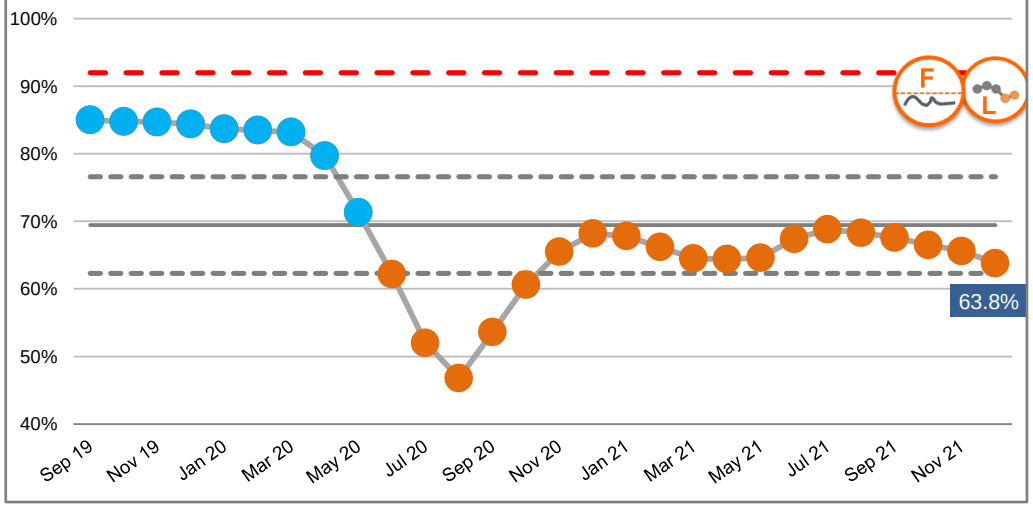
## RTT Monthly Performance (ASPH) [Target = 92%]




## RTT Incomplete Pathways (ASPH)




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

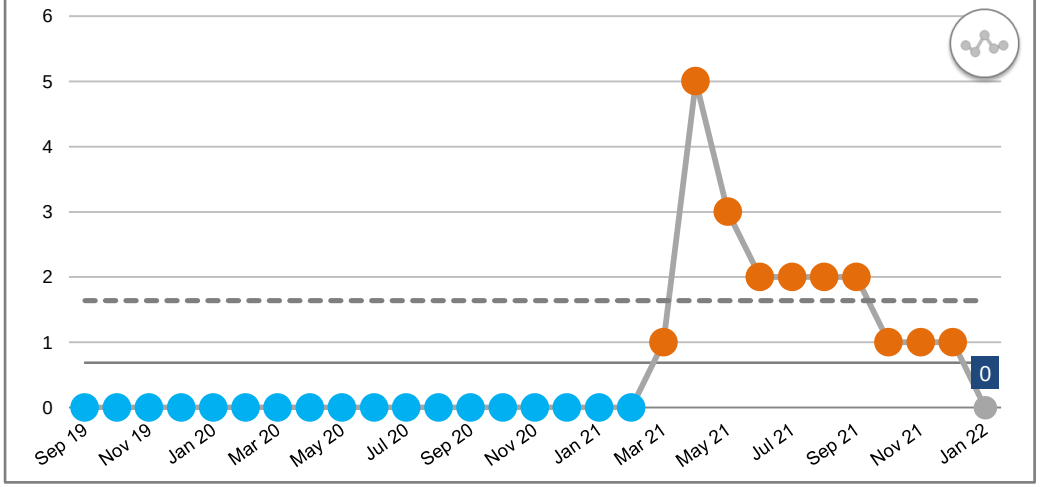


# Referral to Treatment (RTT)

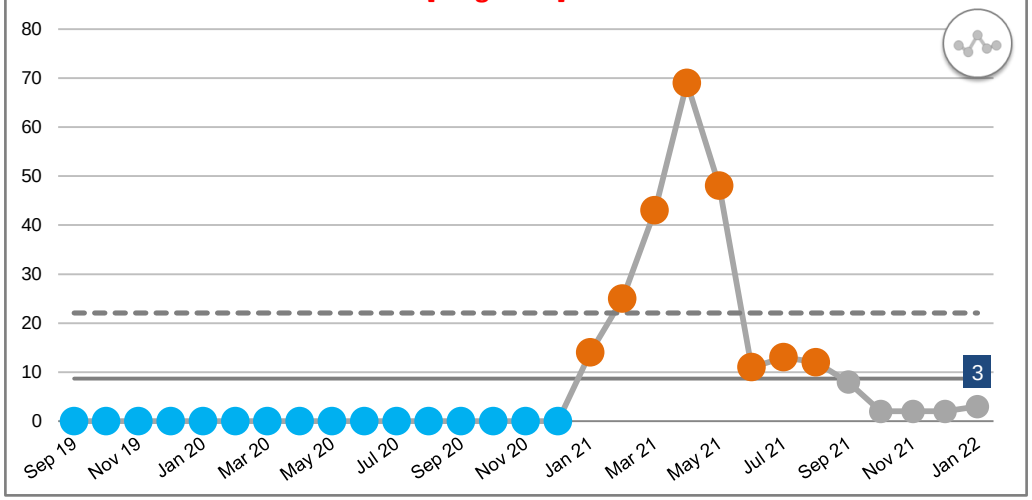
Reporting Period: Monthly | January 2022

Elective Care

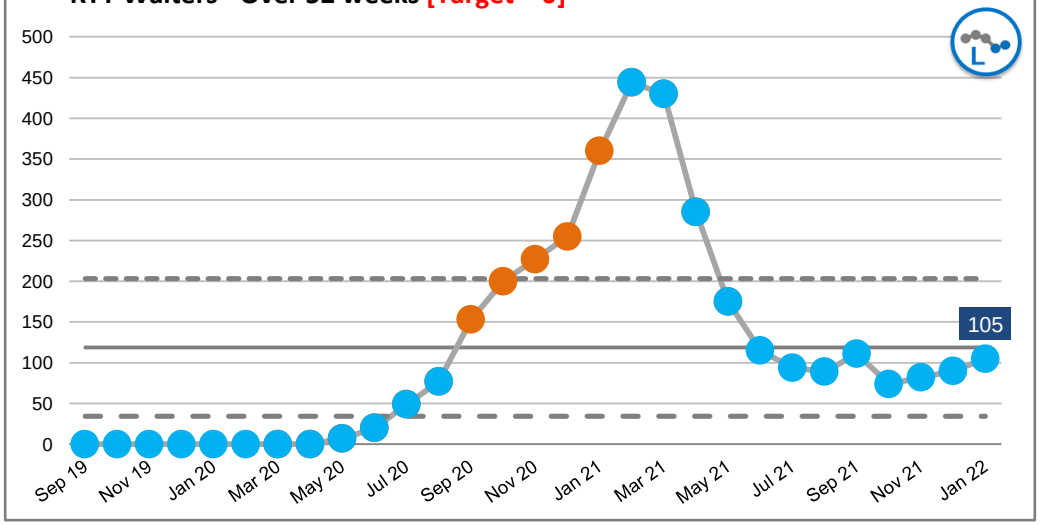
## RTT Waiters - Over 90 weeks [Target = 0]



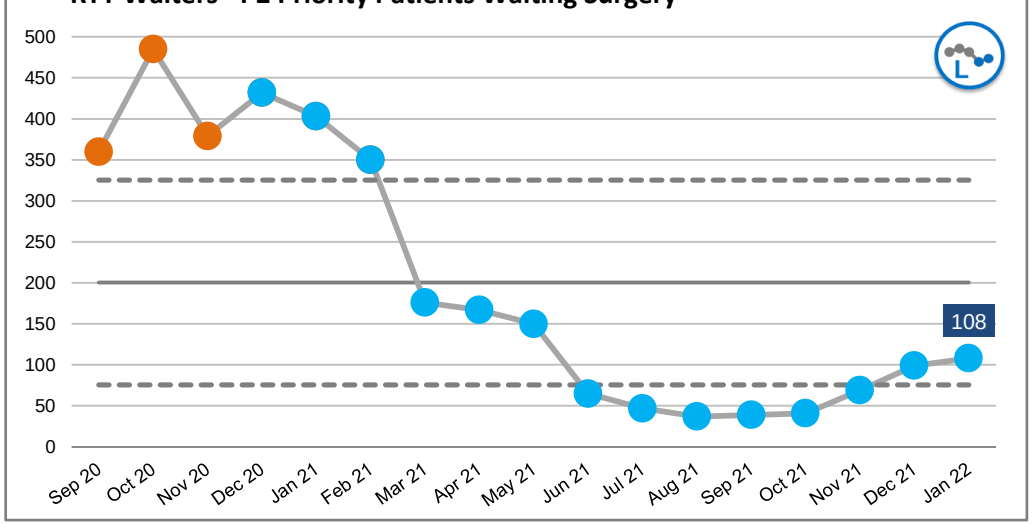

## RTT Waiters - Over 78 weeks [Target = 0]




## RTT Waiters - Over 52 weeks [Target = 0]




## RTT Waiters - P2 Priority Patients Waiting Surgery

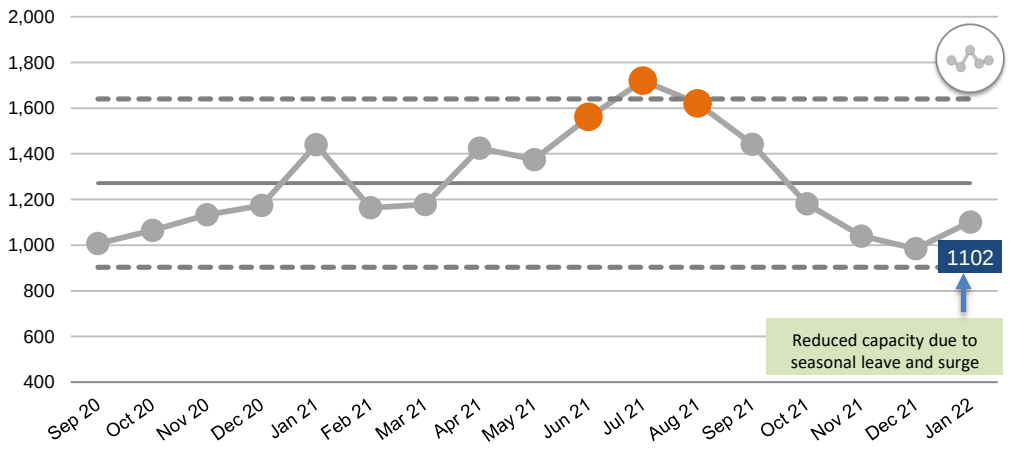


# Referral to Treatment (RTT)

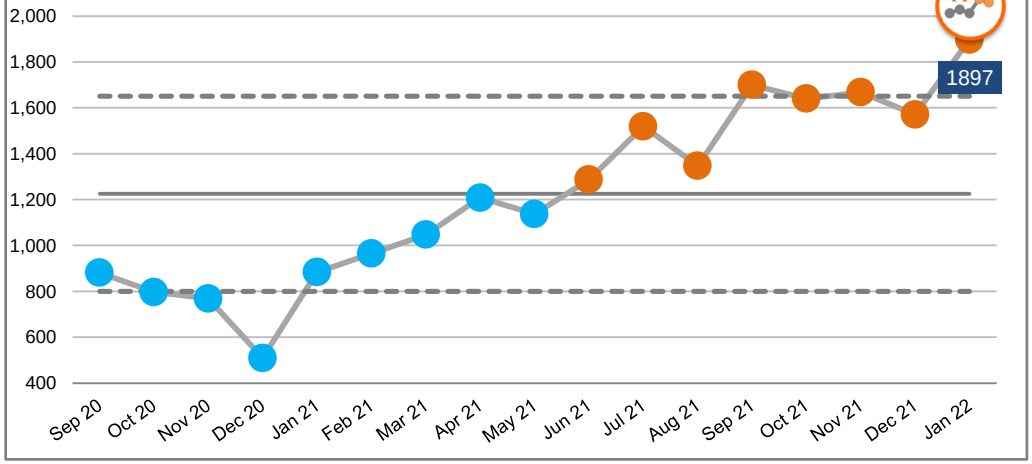
Reporting Period: Monthly | January 2022

Elective Care

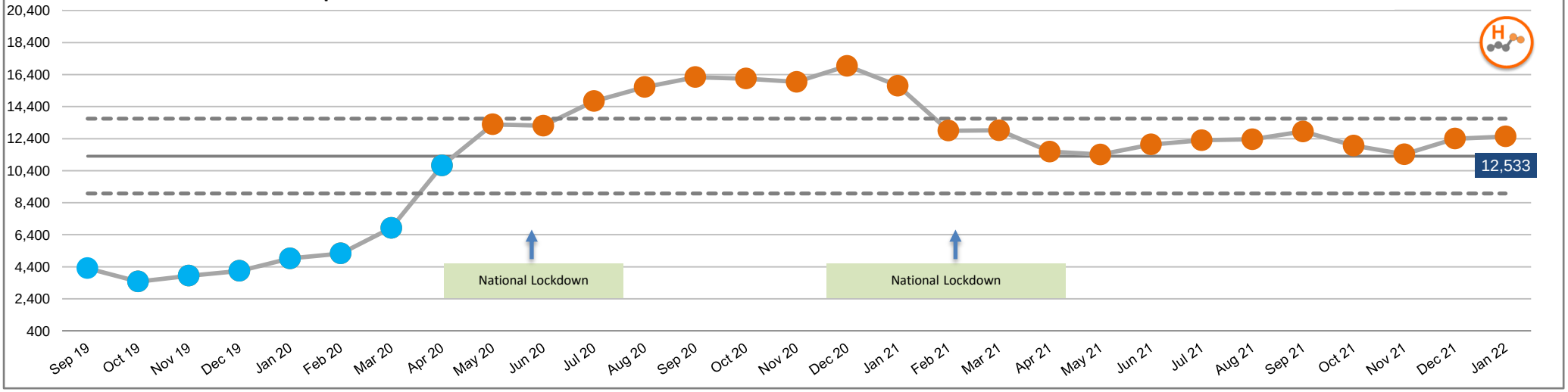
## Urgent 1st OPA Total > 6wk waits




## Routine 1st OPA Total > 18wk waits




## Overdue Planned Follow Ups



# Referral to Treatment (RTT)

Reporting Period: Monthly | January 2022

Elective Care

**RTT Performance (inc. Overdue Follow Ups)**

The Trust recorded a non-compliant performance for RTT Incomplete Pathways at 78.7%, although remains substantially above the NHSE England Average recorded at 63.8% for December (latest data published on 10th Feb 22).

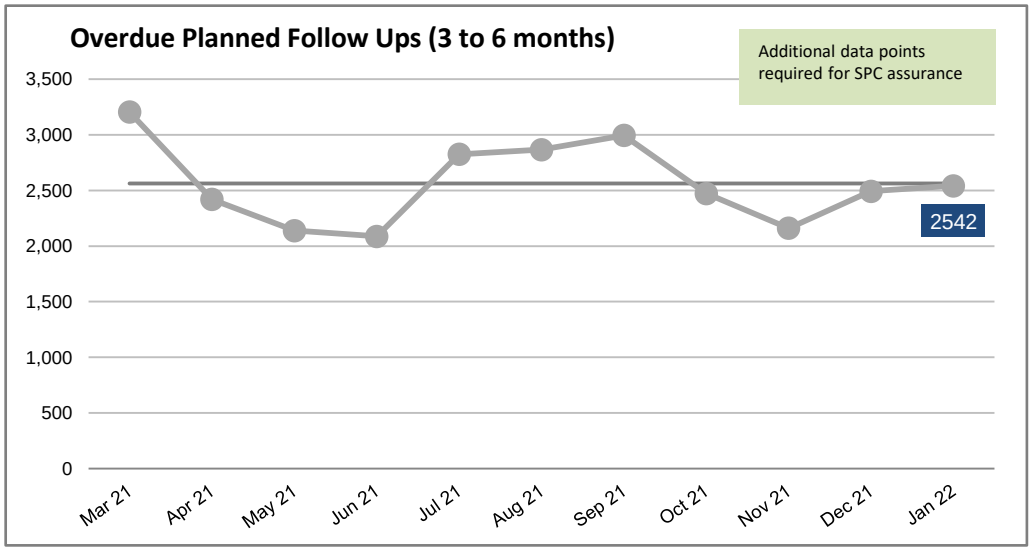
The Trust has made significant headway in reducing the number of RTT long waiting patients. We now have 0 patients waiting over 90 weeks, and only 105 patients waiting over 52 weeks, which is significantly lower when compared with other providers nationally. Of the 105 patients, almost half require surgery, whilst others require their booked diagnostic and/or an outpatient appointment to occur to conclude their treatment. These are all being arranged in line with patient availability and elective capacity.

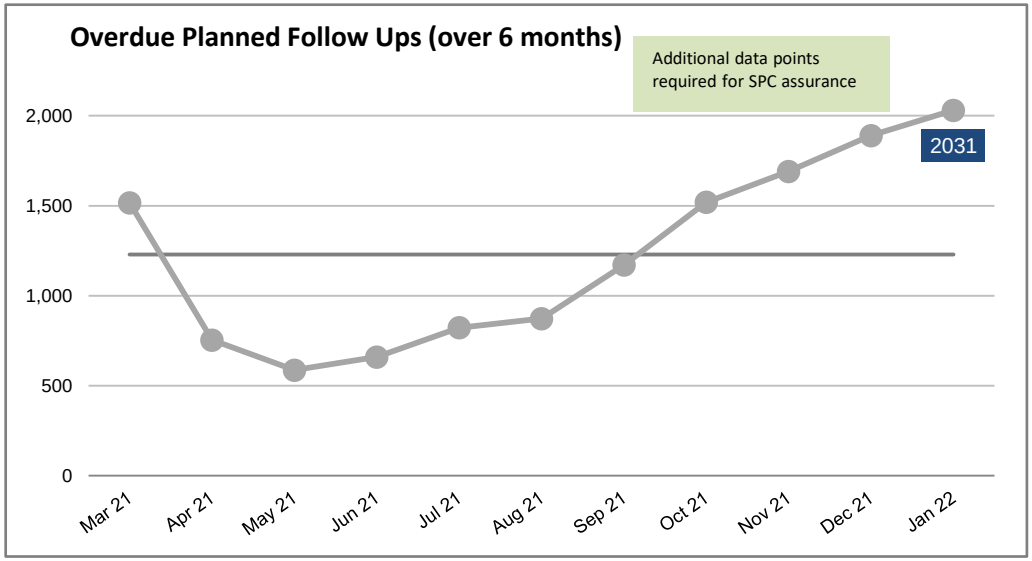
Routine surgery was postponed from Christmas throughout January to provide clinical resource and ward beds to support the Trust's Urgent Care demand due to Covid Omicron and Winter pressures. However, the number of Priority (P2) patients waiting urgent surgery over 4 weeks not yet booked has remained at a low level due to maintaining cancer and P2 surgeries during the current Covid Omicron wave.

Urgent waits over 6 weeks and Routine waits over 18 weeks have risen, whilst the Trust's overdue Follow Ups have also increased. To support the reduction in overdue follow ups, the Trust has agreed to increase the capacity for follow-ups to reduce the number of overdue appointments (and the potential associated clinical risk) through the following two initiatives;

(1) Immediate permanent clinic changes to create additional follow up capacity ongoing,
(2) The reduction of 1st Outpatient capacity (based on specialty demand) for a short period between March and May to address the specialty follow up backlogs. This will leave approximately 8,000 overdue follow ups (in Ophthalmology, Dermatology, Gastroenterology and Neurology) which will be addressed through business planning and the release of capacity using Patient Initiated Follow Ups (PIFU).

We are also putting on additional capacity using insourcing and outsourcing although we balance this activity across new GP referral and Planned Follow Ups. The above initiatives are in agreement with our ICS commissioners.



# Referral to Treatment (RTT)

| Reporting Period | |
|---|---|
| Monthly | January 2022 |

Elective Care

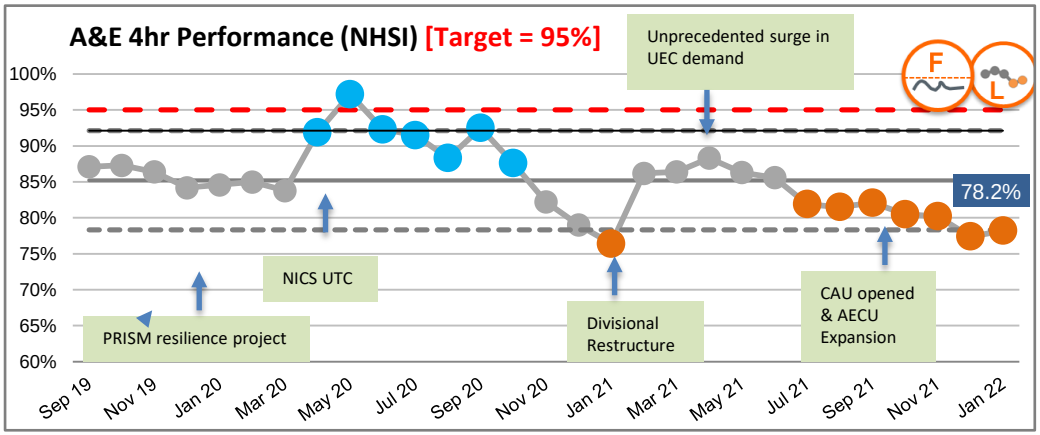
**Assurance Level:** **Acceptable**

| | |
|---|---|
| What is impacting current performance? | The Trust was required to re-introduce surge rotas from mid-December and throughout January to provide additional clinical support for the increased demands of Urgent Care due to the Covid Omicron wave, including releasing elective beds for urgent and emergency inpatient activity.<br>Routine surgery (other than Ophthalmology) was postponed during this time although emergency, cancer and P2 patients continued to be treated.<br>However, staff Covid sickness reduced capacity, coupled with considerable last minute patient cancellations due to the very high levels of Omicron infection within the local community reduced full utilisation of outpatient, diagnostic and elective activity. |
| What actions are being undertaken to improve performance? | Although Covid infection remains high in the community, the Trust will implement the plans we have in place to expand internal theatre and outpatient capacity through;<br>• Maximising the benefits of moving elective activity to Ashford, additional theatres (3), ECU (4 beds) & a ring fenced ward<br>• The use of locums across many surgical and medical specialties<br>• Weekend and evening outpatient and diagnostic clinics and theatre lists<br>• Increasing our use of local independent sector providers<br>• Transformation opportunities<br>• Streamlining pre-operative processes to reduce cancellations and improve patient experience<br><br>Weekly meetings with Divisional areas continue reviewing the activity and planning to highlight areas of concern and support in the identification of causes of underperformance and opportunities for further improvement. The development of business cases for introducing substantive resource and capacity are continuing to introduce resilience going forward. |
| When will the position be recovered? | In accordance with NHSE H2 planning, the Trust has made considerable progress in reducing long waiting patients and has plans to continue to deliver the national ambition minimum 'clock stops' treatments towards March 22 although disruption will continue whilst Covid infection remains high affecting patient and staff availability. The Trust remains substantially above the England Average RTT performance. |
| 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 with the number of patients waiting longer than 4 weeks remaining low. 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 for overdue follow ups. This outpatient safety group also widened its remit to consider patients waiting greater than 6 weeks for urgent 1st outpatient consultation. |

# A&E 4 Hour Performance

Reporting Period: Monthly | January 2022

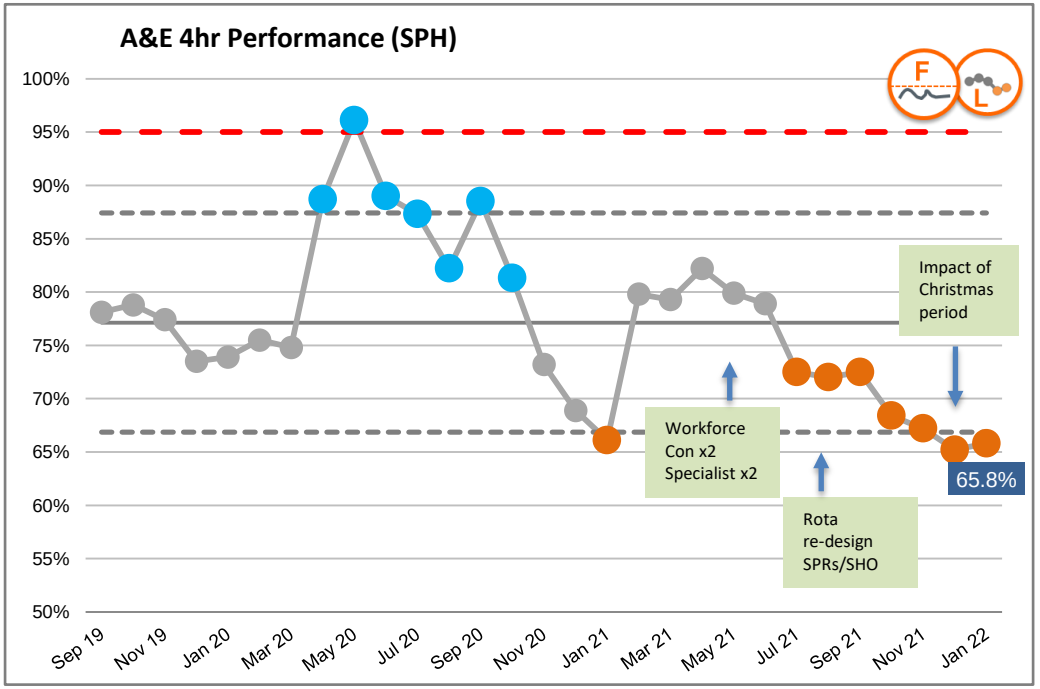
Emergency Care

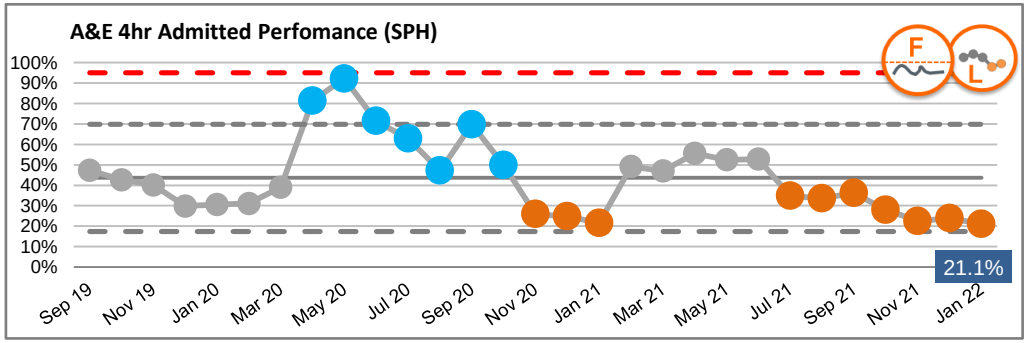


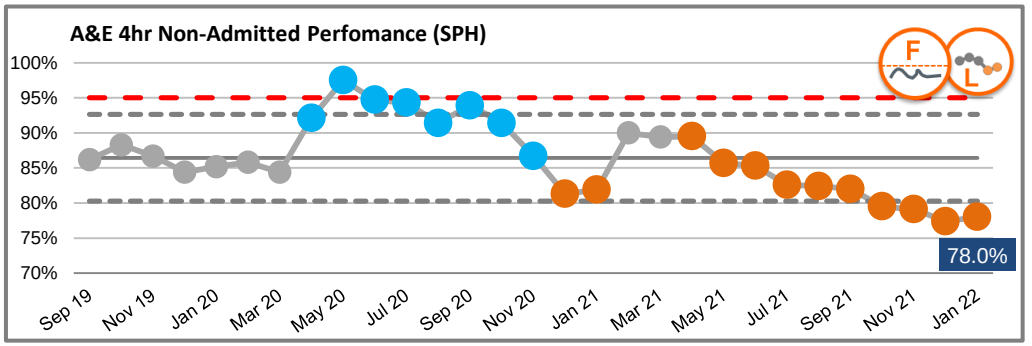

## A&E Performance

Overall NHSI performance was recorded at 78.2% in January 2022, a small improvement from 77.4% recorded during December 2021. Patient flow was very challenging in month, with a significant increase in patients waiting for in A&E overnight waiting for a bed compared to December and bed occupancy higher than during any month recorded since March 2020. The Trust recorded high levels of patients with a length of stay of 7 days and over during the month. The Clinical Assessment Unit continued to be unable to operate as an assessment area as it became blocked with inpatients waiting for beds.

Priority actions underway to improve performance include those linked to the Trust Main Effort to ensure that the only patients who reside with us will benefit from our care; to improve the non-admitted pathway within ED; to finalise plans for frailty; to finalise the new build business case to fund the extension in hours for AECU and other supporting front door pathways i.e. navigation, frailty, along with work to resolve historic workforce planning issues and focus on recruitment and retention in key risk areas.



# A&E 4 Hour Performance / Flow

Reporting Period: Monthly | January 2022

Emergency Care

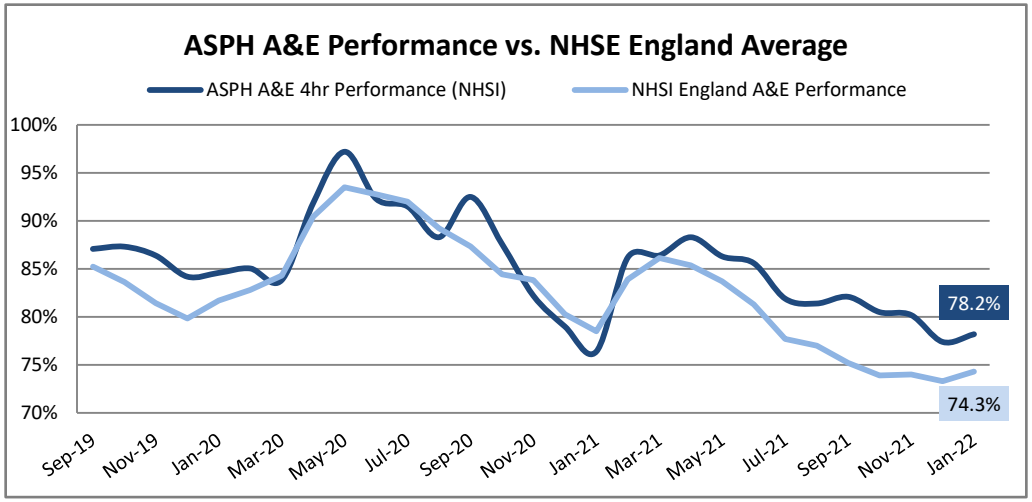
**ASPH 4hr Performance** (NHSI and SPH)

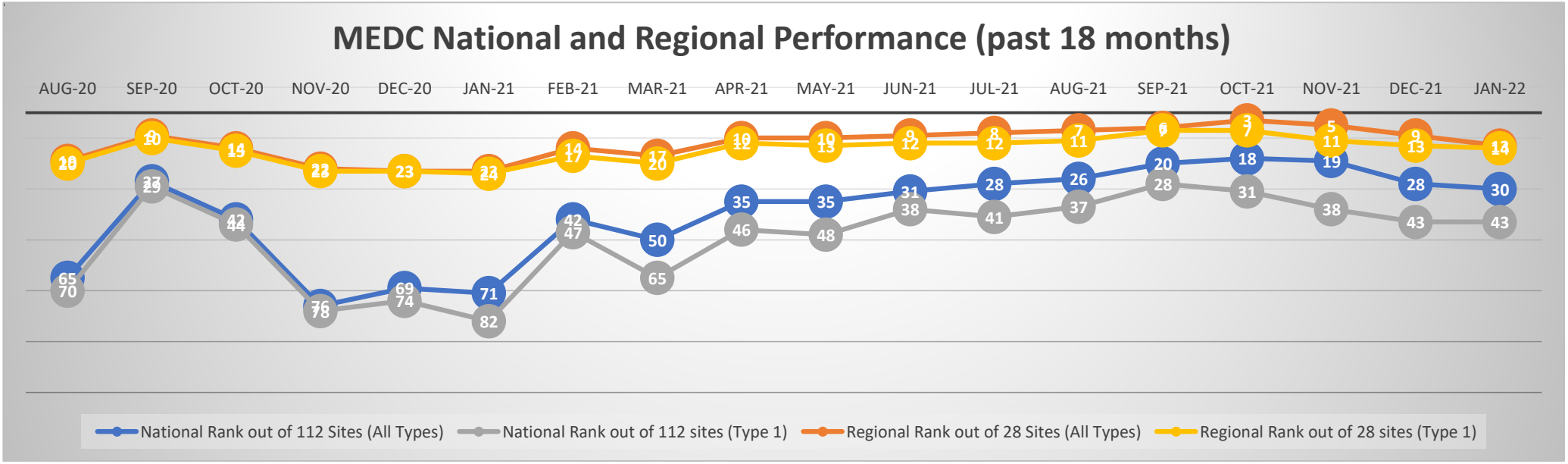
The Trust's reportable NHSI (SPH site inc. Ashford & Woking WiC activity) performance for January 2022 was 78.2%, a 0.8% increase on December 2021 (77.4%).

**A&E Regional & National Ranking**

During January 2022 the Trust's NHSI (all types) performance position regionally was 13th (of 28), and nationally 30th (of 112).

ASPH performance of 78.2% was higher than the NHSE England Average of 74.3% 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.



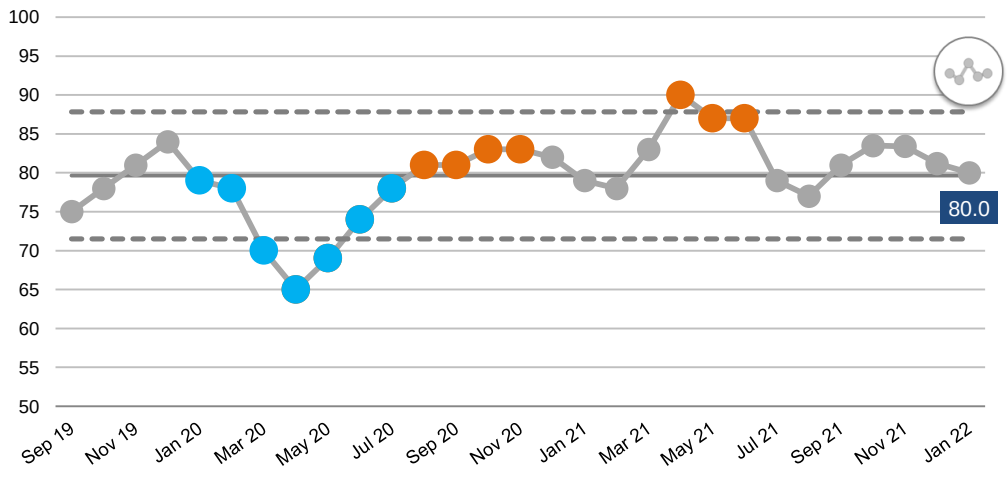



# A&E 4 Hour Performance

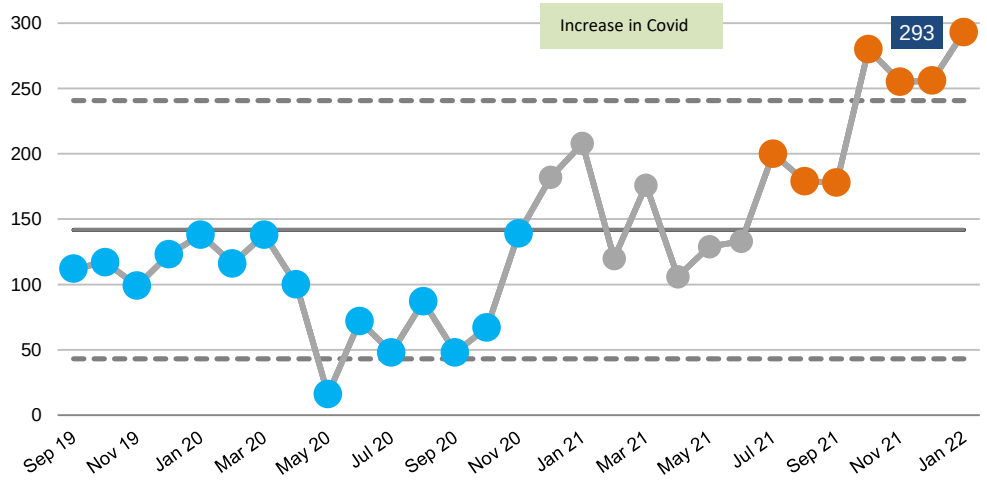
Reporting Period: Monthly | January 2022

Emergency Care

## A&E Monthly Average Daily Ambulance Attendances (SPH)




## Ambulance Handovers (30-60 mins)

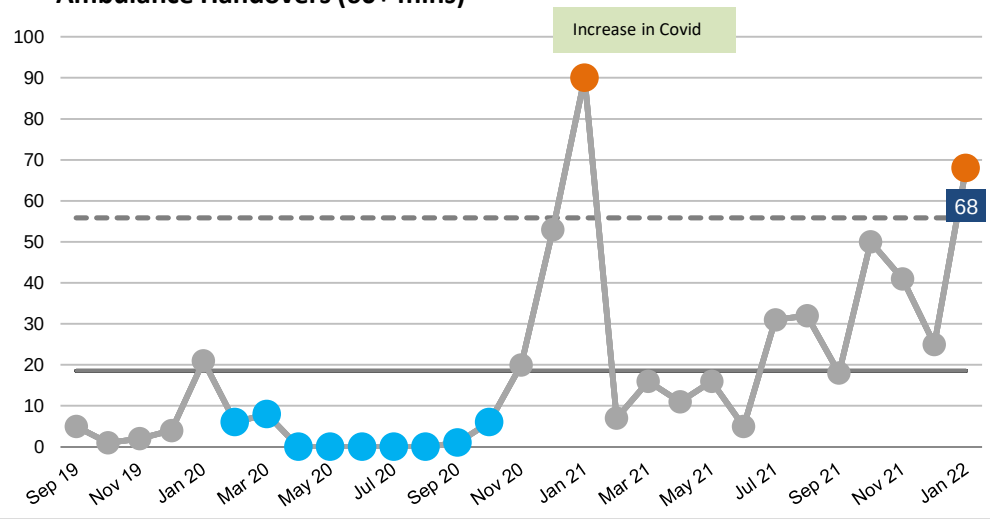



## A&E Performance and Flow

Ambulance attendances in January 2022 reduced from the exceptional peak seen earlier in the financial year, although the Trust recorded 293 Ambulance handover delays (30-60 mins delay) and 68 Ambulance handover delays (60+ mins delay). This was a significant deterioration compared to the previous months and is a reflection of two key issues in month; (1) the capacity challenges experienced by the Trust leading to exit block i.e. there were high volumes of specialty referred and DTA patients held within ED for several hours, & (2) nurse staffing levels were at times lower than usual due to high vacancies and sickness during the month which led to difficulties taking safe handover from the Ambulance second queue.

Average LOS within the Trust increased to 6.9 days, compared to a mean of 6.6 days, with stranded patients >7 days and > 14 days being a significant issue.
Protocols and escalation processes within ED and across the site to minimise handover delays have been fully reviewed. When in high escalation, ED works in partnership with South East Central Ambulance Service with the aim to support management and mitigation of risks across the system. A new pilot has been agreed with SECAMB to allow direct ambulance referral to SDEC services to reduce the demands on ED. This is currently scheduled to commence during February 2022.

## Ambulance Handovers (60+ mins)

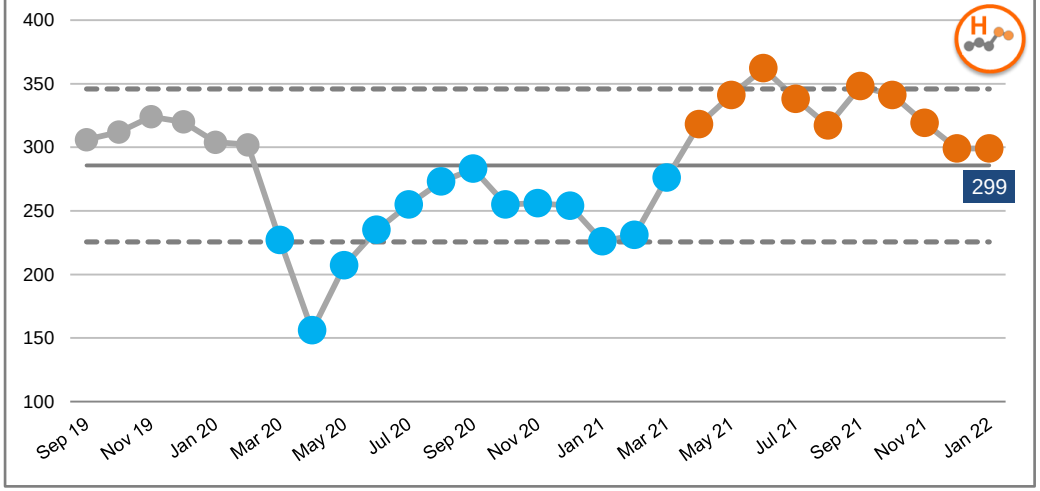


# Hospital Flow

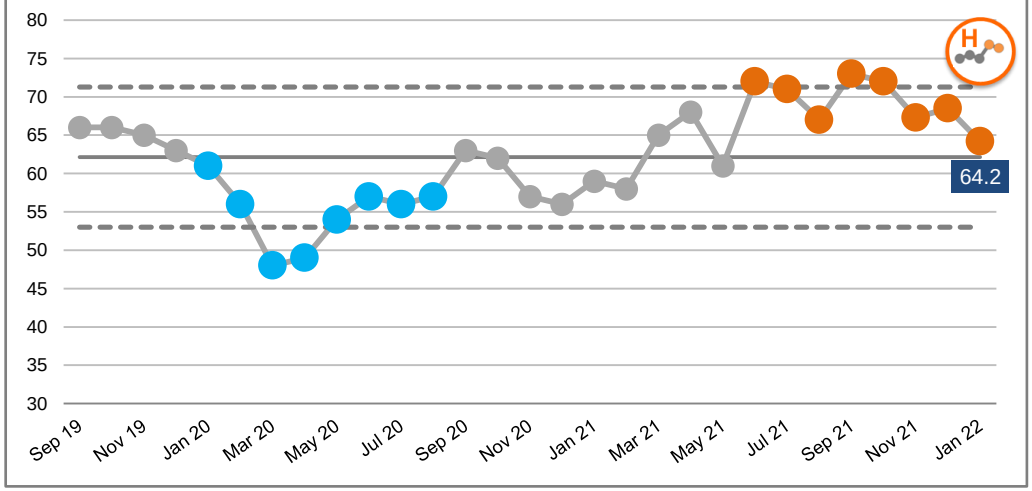
Reporting Period: Monthly | January 2022

Emergency Care

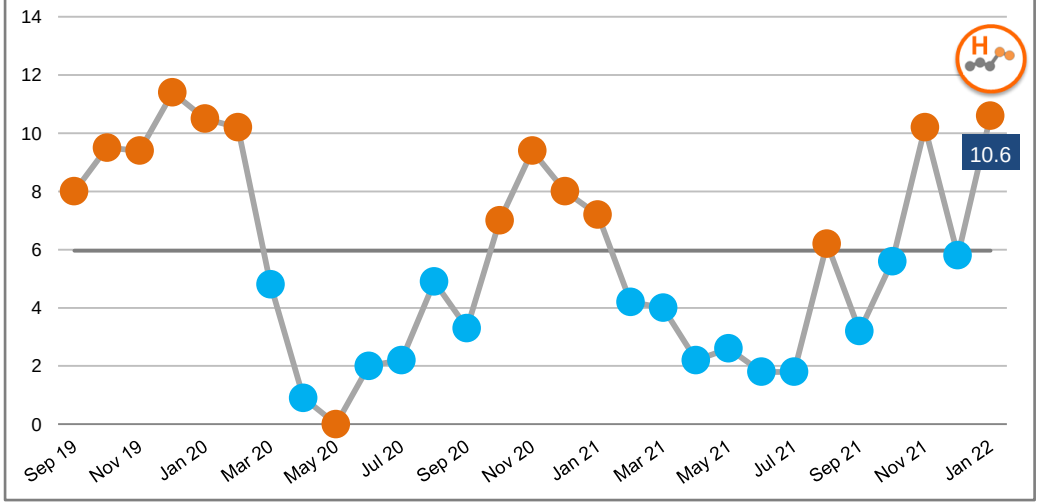
## A&E Monthly Average Daily Attendances (SPH)



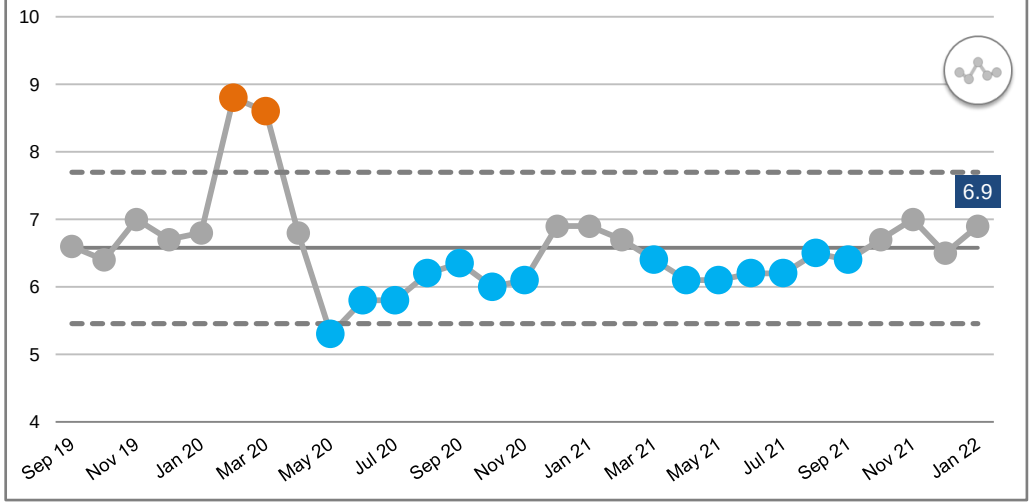

## A&E Monthly Average Daily Admissions (SPH)




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




## Average Length of Stay (Days)

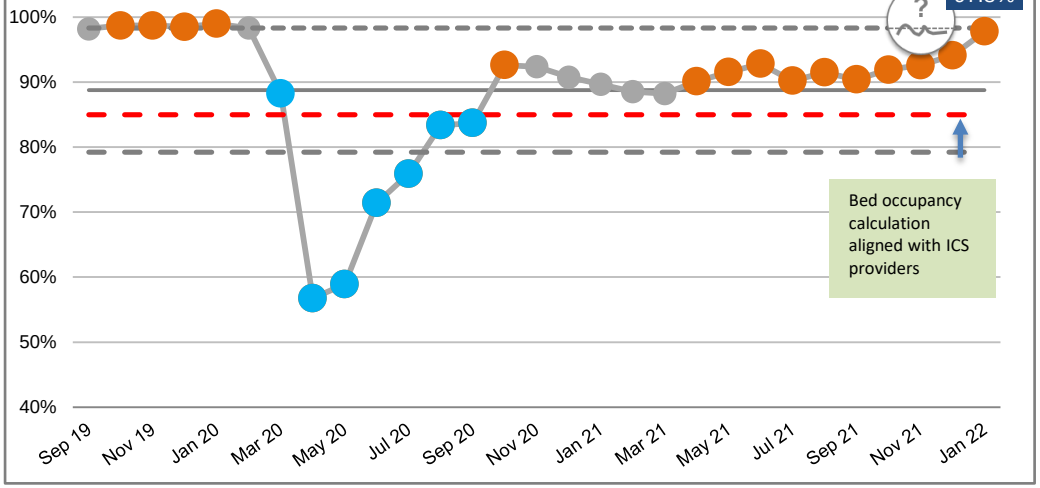


# Hospital Flow

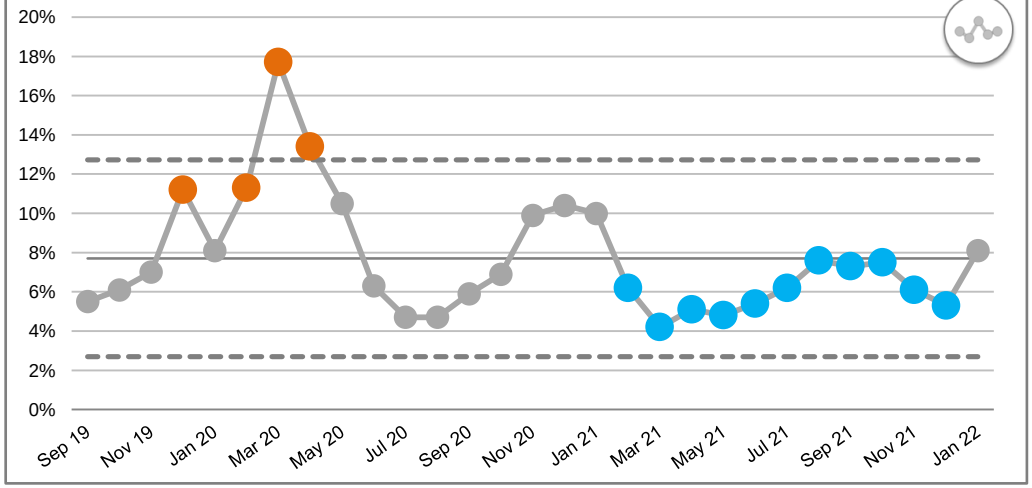
Reporting Period: Monthly | January 2022

Emergency Care

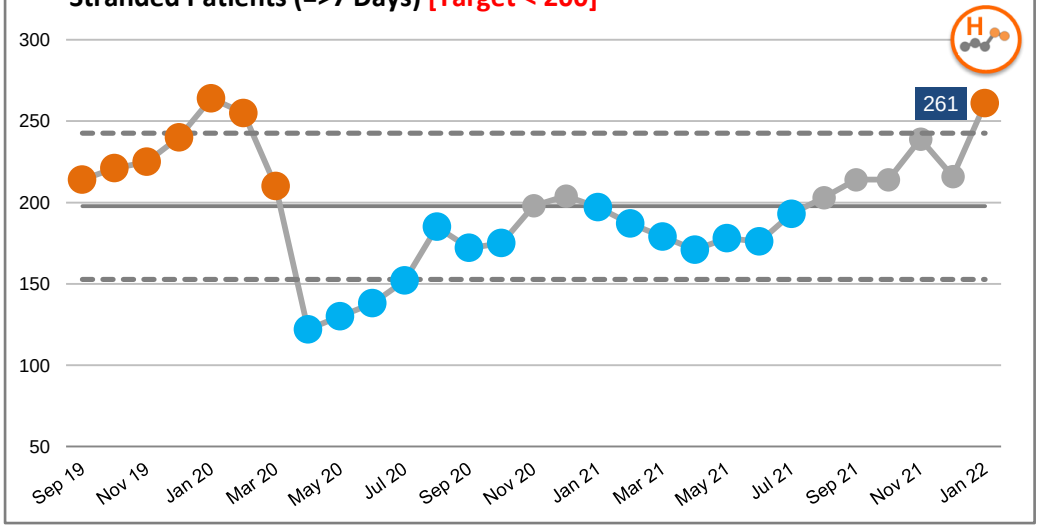
## Bed Occupancy (including Escalation Beds) [Target < 85%]



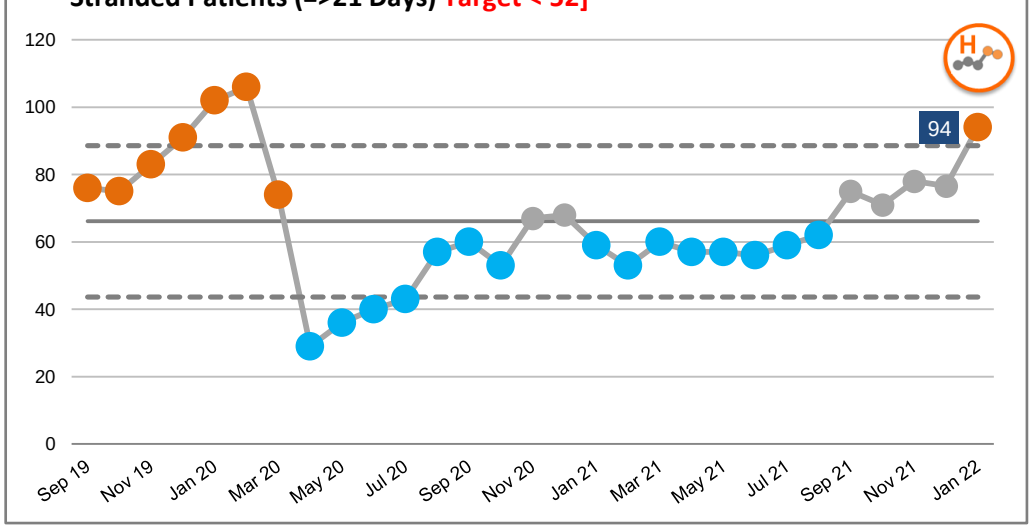

## % Patients Moved =>3 Times




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




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



# A&E 4 Hour Performance / Flow

| Reporting Period | |
|---|---|
| Monthly | January 2022 |

Emergency Care

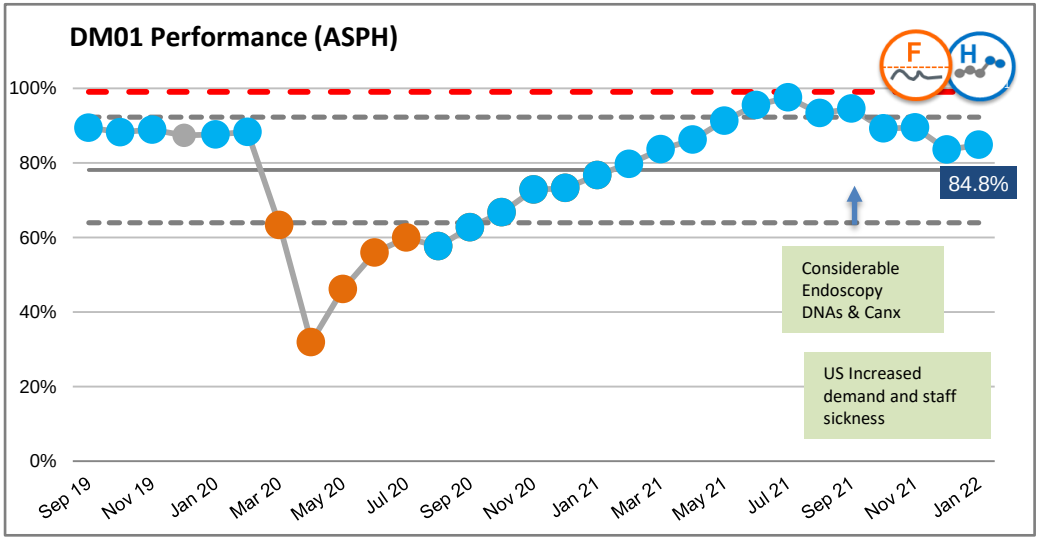
**Assurance Level:** **Partial**

| | |
|---|---|
| What is impacting current performance? | • Exit block from the ED due to lack of flow. This adds to the workload of the ED who are managing not only new attendances but also significant numbers of specialty referred and DTA patients who would normally have been transferred out.<br>• Reduced assessment capacity due to the high volume of patients in the department. This slows down the ED because there is limited examination space and in turn requires several patient moves around the department to ensure they can be properly assessed and treated whilst maintaining privacy and dignity.<br>• High bed occupancy and large numbers of stranded patients in month, along with bed closures due to IPC restrictions.<br>• Surges in demand (both in ambulances and ambulatory) which exceed capacity during peak hours of the day. This is unpredictable and can impact performance.<br>• Physical space constraints within the ED department within ambulatory majors and Fit to Sit.<br>• Not yet embedded processes to reduce intrinsic ED delays for non-admitted patients. UTC demand exceeding capacity.<br>• Limited speciality assessment capacity: need to maintain red AECU, not yet extended opening hours to 10pm pending business case approval, no frailty unit, no frailty Consultant ED in-reach in month due to implementation of Covid medical surge rotas.<br>• Need for increased senior medical leadership and oversight especially during the evening periods. |
| What actions are being undertaken to improve performance? | 1. Three separate multi-system executive meetings in place weekly to promote discharge of patients ready to leave hospital.<br>2. Embedding Beautiful Information Inpatient PTL to provide greater oversight of the discharge processes and support improved pathway management<br>3. Temporary conversion of Ashford elective bed capacity to support non-elective pathways during this period of winter pressures.<br>4. Focus on non-admitted performance, in particular a new launch of RAT in triage in ambulatory majors following the success of the January reset week trial.<br>5. Continued work to embed Criteria to Admit (now a mandatory field).<br>6. Developing plan for Frailty (Older Person's Assessment Unit) once red AECU closes.<br>7. Formal consultation on ED Consultant job planning is underway, led by the Medical Director.<br>8. Proposals to extend the hours of AECU, fund a frailty unit, implement navigation in the UTC, and increase the acute medical workforce have been developed as part of the new build business case.<br>9. Work ongoing with NICS to support alignment of UTC demand and capacity.<br>10. Plan to develop AECU PTL to increase visibility of waiting times and to support escalation of delays.<br>11. Workforce reviews underway to ensure that budgeted staffing establishments are in line with safer staffing/ capacity and demand requirements for the nursing and medical workforce to reduce the continued dependency on agency and locums who may not be as familiar with ASPH processes etc. |
| When will the position be recovered? | Over the past 8 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? | - Exit block from ED due to hospital flow<br>- Recruitment, retention and engagement of the current workforce to work differently.<br>- Increasing volume of activity, and surges in activity due to demand/IPC leading to imbalance in demand and capacity<br>- Capacity in the wider system including social care provision, community hospital capacity<br>- Inadequate ED estate which is not fit for purpose for modern healthcare or best practice pathway and staffing provision. |
| 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 implementation of RAT/complex streaming in majors 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 | January 2022

Elective Care



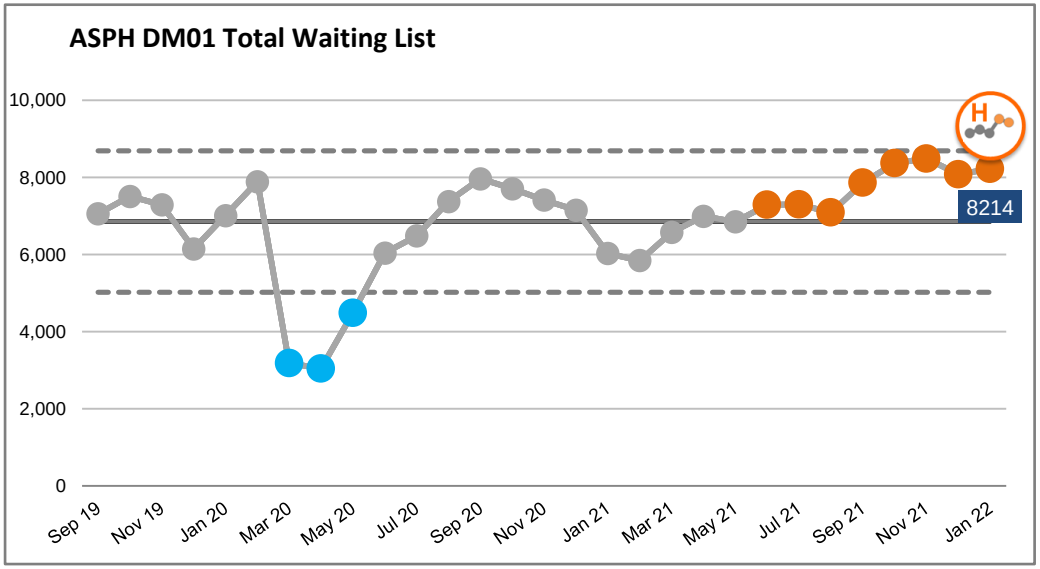

**DM01 Performance**

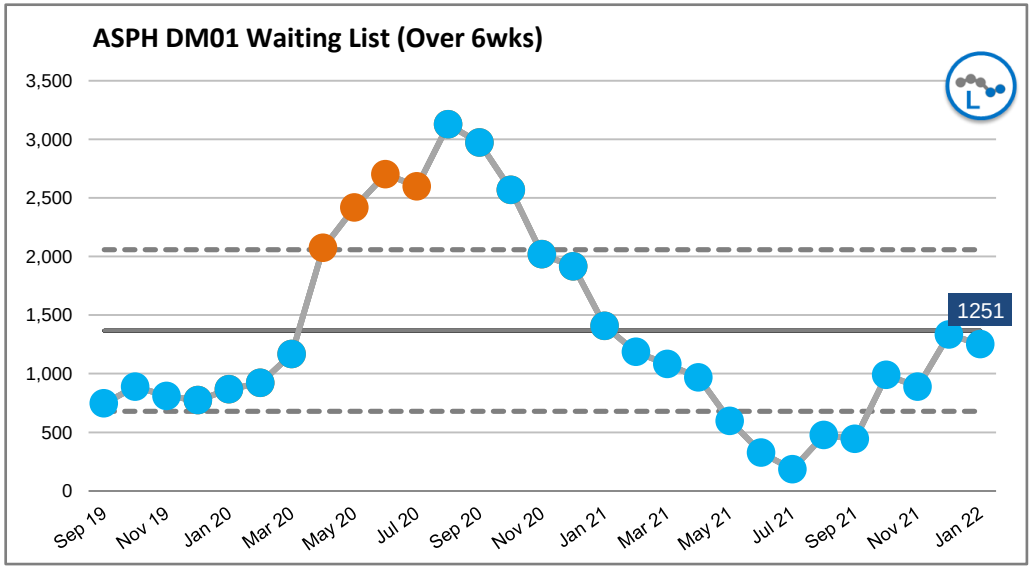
Provisional DM01 Diagnostics performance for January is recorded at 84.8% which was an improvement on the performance recorded in December (83.5%).

The Trust saw a reduction in elective diagnostic capacity and activity during the New Year although comparably high community referrals and very high emergency demand leading to higher waiting list sizes, mainly in Non-Obstetric Ultrasound, MRI and Endoscopy. The Trust's internal diagnostic services, including In-health and Alliance Medical were also affected by staff sickness and requiring to isolate due to Covid.

The Trust is creating additional capacity to meet the demand and recovery of the position including additional weekend / evening lists, additional radiologist sessions and both internal and outsourcing solutions.

Challenged modalities (patient waiting greater than 6 weeks) are Endoscopy (588), Ultrasound (458), MRI (96), and Sleep Studies (42).

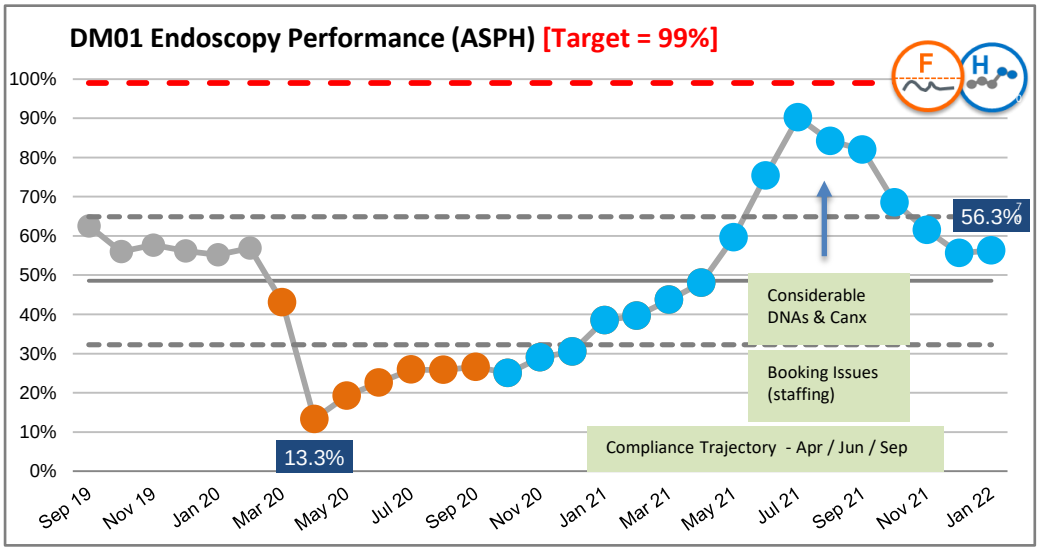


# Endoscopy (DM01)

Reporting Period: Monthly | January 2022

Elective Care

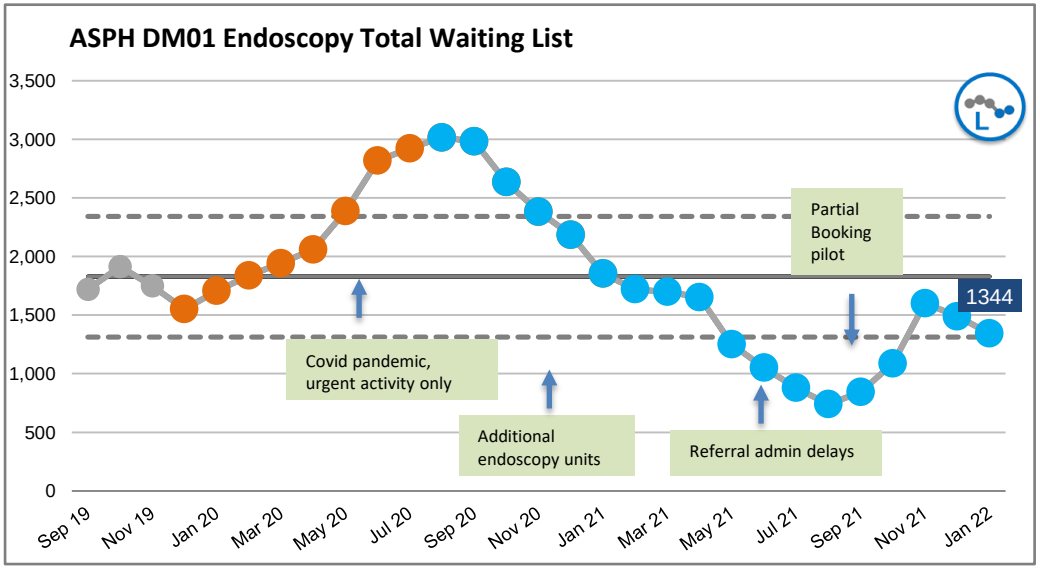


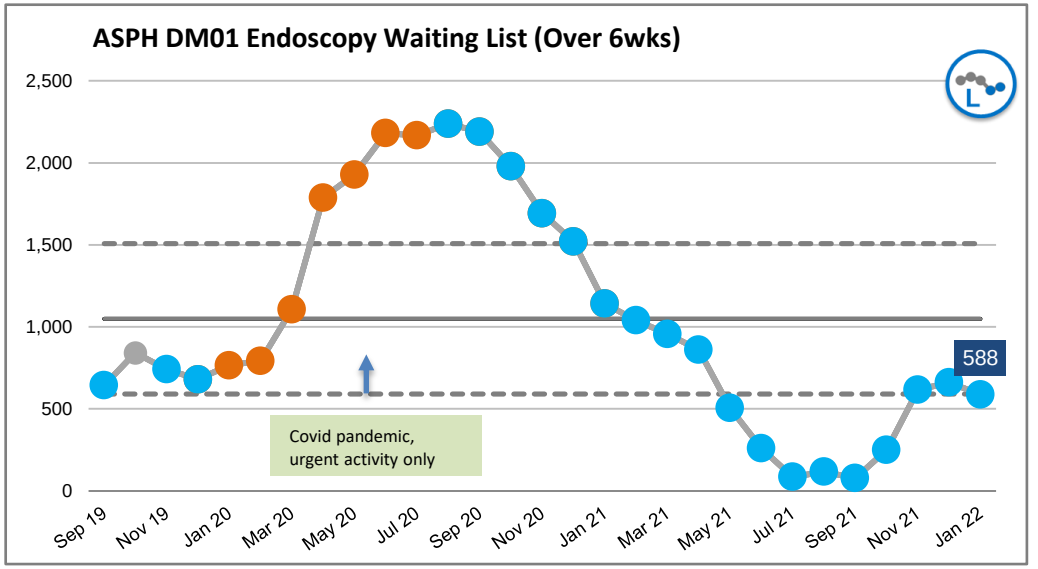

**DM01 Endoscopy Performance**

In-health capacity during December and the beginning of January was challenged due to staff shortages as a result of Covid and annual leave, reducing the Trust's endoscopy capacity.

Demand for urgent TWR and inpatient endoscopy remained very high, whilst patient choice in the New Year further reduced activity and productivity. Patient choice delays were higher than usual during the month which included considerable cancellations and non-attendances. These were primarily related to patients isolating due to Covid infection. Despite these challenges, the endoscopy team have maintained a firm grip of bookings and maximised utilisation of the unit maintaining 93% utilisation during January.

Endoscopy performance is now improving. Work to improve our call answering rate has improved from 59% in December to 88% in January. The team have been able to model the recovery trajectory and based on the past 4 months performance continue to estimate recovery by the end of Q3 2022. This position is reviewed monthly taking into consideration any changes relating to external factors.



# Diagnostics (DM01)

| Reporting Period | |
|---|---|
| Monthly | January 2022 |

Elective Care

**Assurance Level:** **Partial**

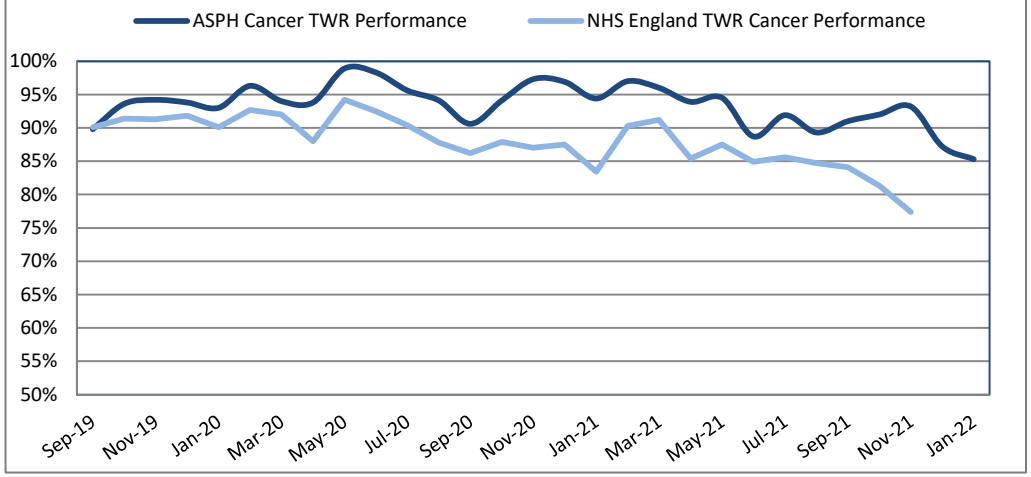
| | |
|---|---|
| What is impacting current performance? | The Trust recorded a non-compliant DM01 performance of 84.8% for January 2022, with the endoscopy cohort recorded at 56.3%.<br>The Trust saw a reduction in elective diagnostic capacity and activity during the New Year although comparably high community referrals and very high emergency demand leading to higher waiting list sizes, mainly in Non-Obstetric Ultrasound, MRI and Endoscopy. The Trust's internal diagnostic services, including In-health and Alliance Medical were also affected by staff sickness and requiring to isolate due to Covid. Patient choice delays were higher than usual during the month which included considerable cancellations and non-attendances. These were primarily related to patients isolating due to Covid infection.<br><br>The Trust is creating additional capacity to meet the demand and recovery of the position including additional weekend / evening lists, additional radiologist sessions and both internal and outsourcing solutions. |
| What actions are being undertaken to improve performance? | Endoscopy:<br>• Continue to keep a daily dashboard of performance metrics including booking rate of referrals, telephone call answer rates, booking of TWR and 62 day pathway referrals, compliments and PALs.<br>• The team received 2 written compliments in January complimenting the booking process and care during the procedure. This is a significant improvement from the 90 PALs complaints received during September 2021.<br><br>MRI - Our MRI provider has additional initiatives during Q4 to increase capacity (and reduce backlog).<br>Ultrasound (US) - The Trust has agency staff secured to provide additional capacity for ultrasound and additional insourcing and outsourcing to provide additional capacity. These providers have only been able to support with minimal capacity (~100 patients per month) although are planning to increase this in the coming months. In addition, our sonographers have increased the number of weekend and out of hours lists to increase capacity during Q4.<br>Sleep Studies - The Trust has secured a local private provider who can provide additional capacity, due to commence during Feb22.<br>The Trust is also recruiting substantive staff into the current vacancies (8 Radiologists; 4 appointed starting Mar22 through international recruitment with HEE). |
| When will the position be recovered? | Endoscopy - Expected recovery will be at the end of Q3 FY2022. We continue to take the recovery of endoscopy seriously, with daily performance meetings led by the COO or Director of Finance with all the endoscopy management team. Additional capacity is currently being secured, which once fully confirmed a trajectory can be published.<br>Recovery trajectories for MRI and US will be developed once additional outsourcing is confirmed to maintain resilience and after the Omicron surge has diminished. |
| What are the key risks? | - Continuing Covid surges<br>- Workforce<br>- Increasing demand<br>- Competing pressure from urgent care, inpatients and cancer pathways |
| 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.<br>The endoscopy team continue to work closely with the Trust cancer team to ensure closer monitoring of patients on cancer pathways.<br>The team are also now supporting the colorectal team to improve this pathway into endoscopy. Inpatient endoscopy capacity is also reviewed at daily clinical and admin team huddles to ensure appropriate utilisation of lists.<br>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 - National Comparison

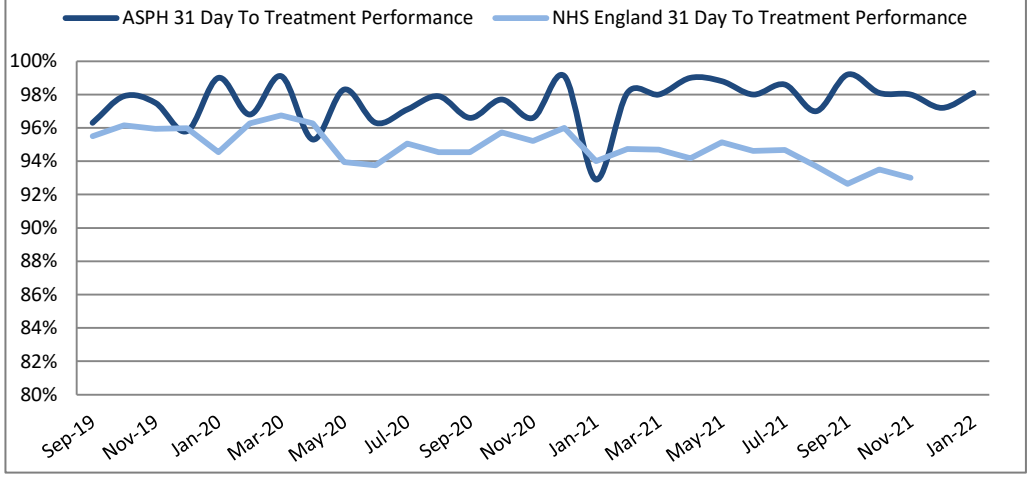
Reporting Period: Monthly | January 2022

Elective Care

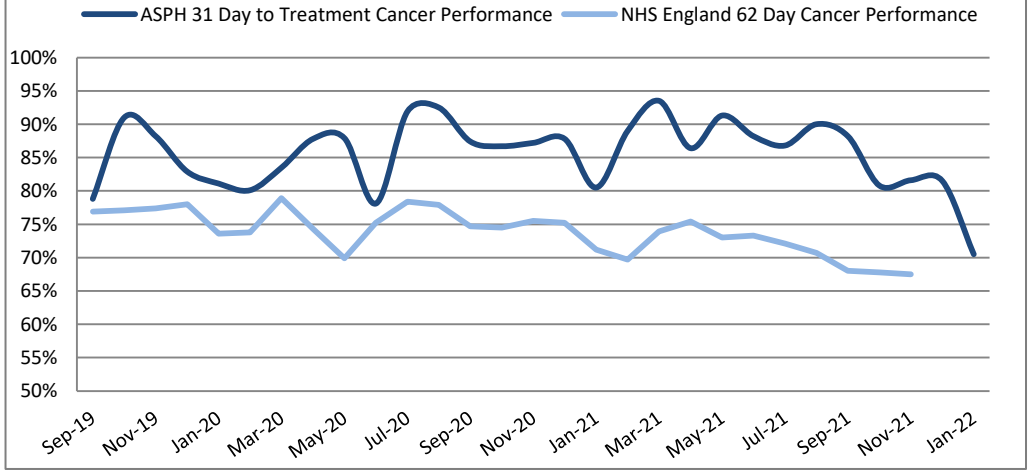
## ASPH TWR Cancer Performance vs. NHS England (Average)



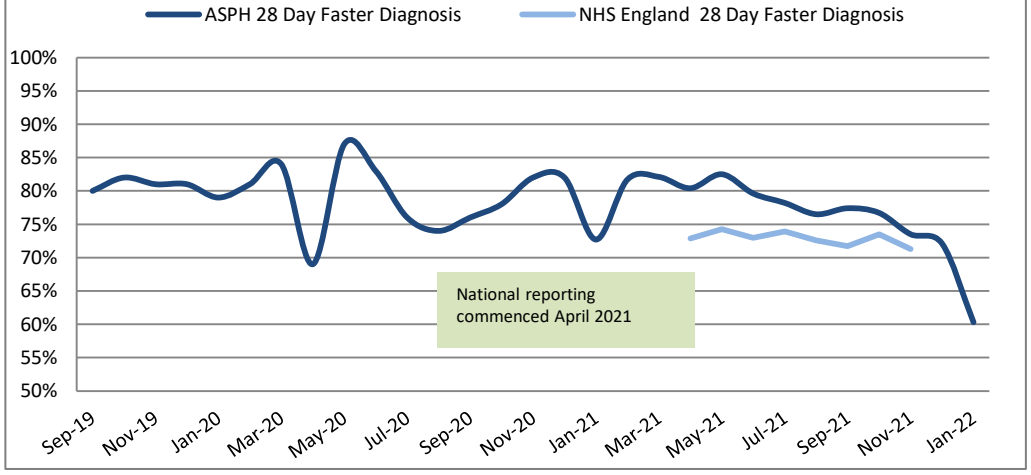

## ASPH 31 Day To Treatment vs. NHS England (Average)




## ASPH 62 Day Cancer Performance vs. NHS England (Average)




## ASPH 28 Day Faster Diagnosis vs. NHS England (Average)



# Cancer

Reporting Period: Monthly | January 2022

Elective Care

## TWR

The Trust is currently predicting a non-compliant TWR performance for January at 85.4%. Of the 205 breaches, 40% were due to Patient Choice, 50% due to surges in required demand (Colorectal / Dermatology / Breast), and 10% due to clinic cancellations due to staff Covid sickness and isolation.

## 62 Day GP Referral to Treatment

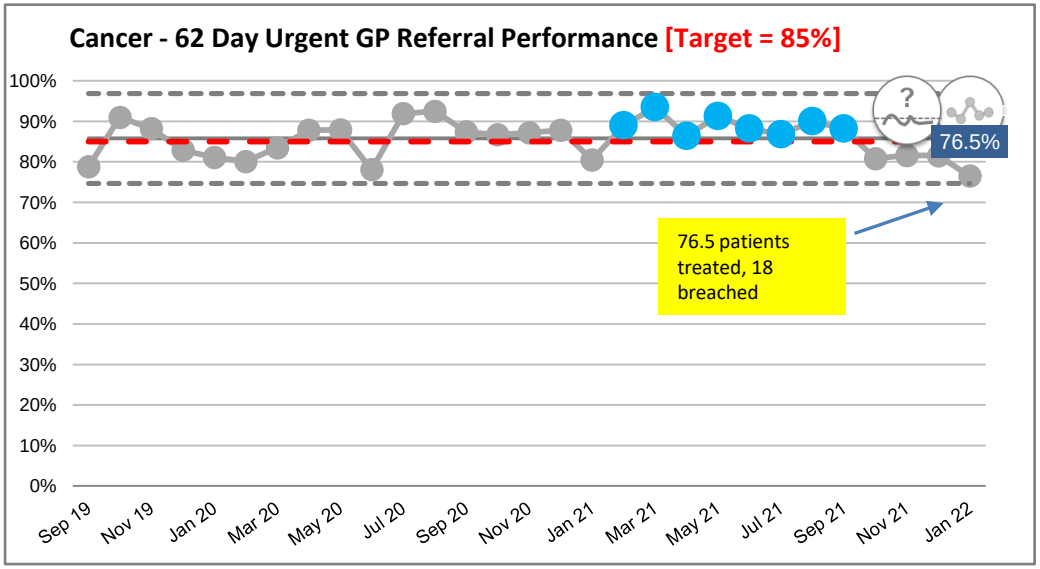
The Trust is currently predicting non-compliance against the 62 Day GP Referral to Treatment performance standard for January at 76.5% pending final validation. The delays recorded to date are; complex pathways (15 patients), capacity (4 patients), and patient choice (6 patients). The current number of treatments is expected to increase as remaining pathology reports are recorded.

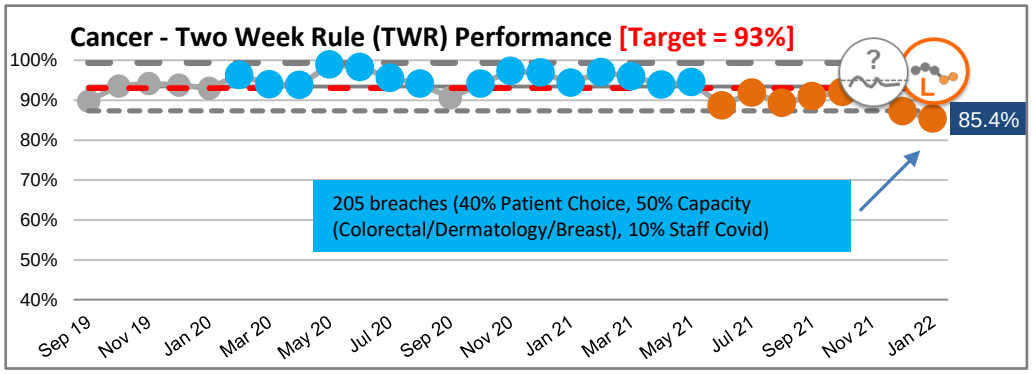
## 28 Day Faster Diagnosis Standard and Patients Waiting Greater than 62 Days

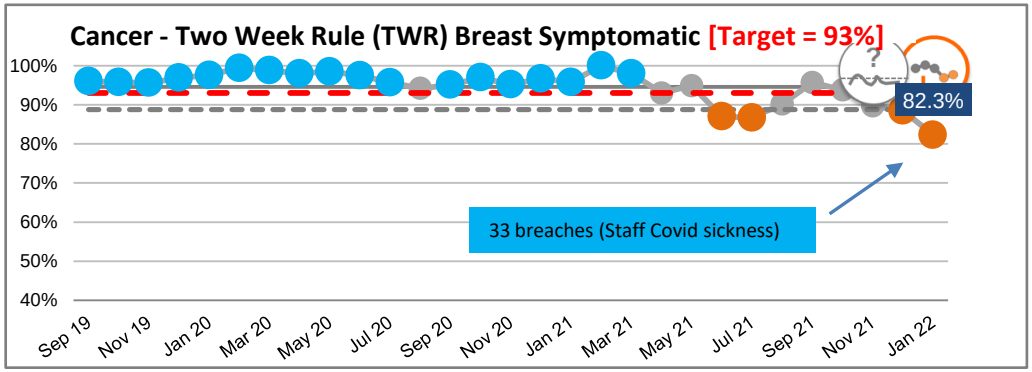
Although validation continues, the Trust is currently recording non-compliance against the 28 Day Faster Diagnosis Standard. Delay reasons are identical to TWR which has inevitably resulted in delays to informing patients of their diagnosis within 28 days.

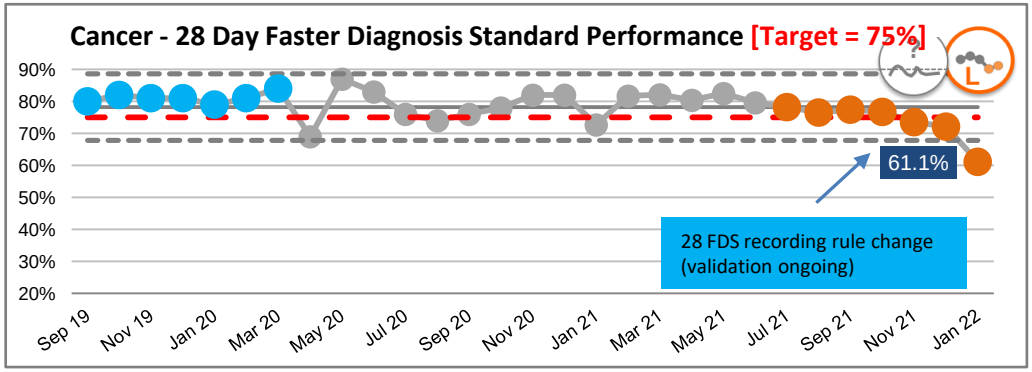
## Patients Waiting Greater than 62 and 104 Days

The Trust has seen a marginal increase compared to last month in the number of patients in these categories due the impact of Covid sickness creating patient cancellations and operational pressures due to staff sickness.



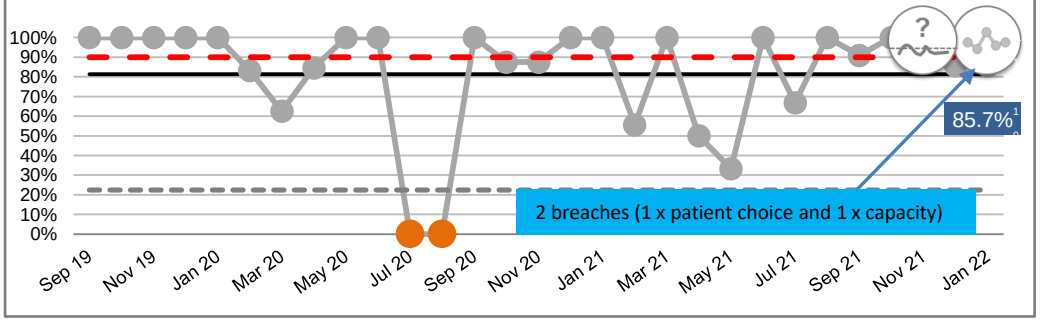



# Cancer

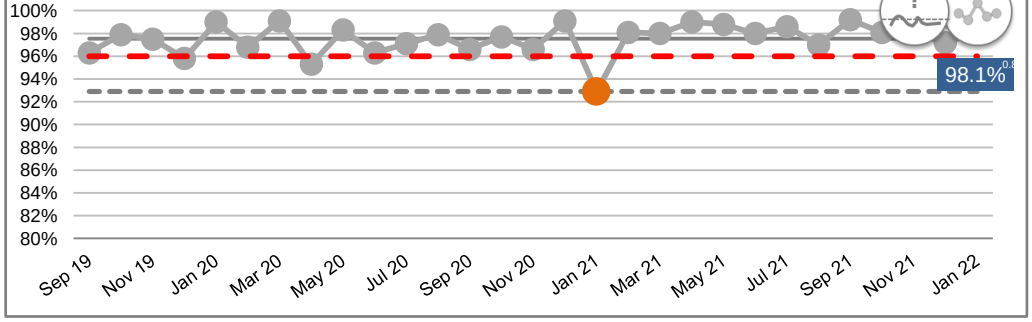
Reporting Period: Monthly | January 2022

Elective Care

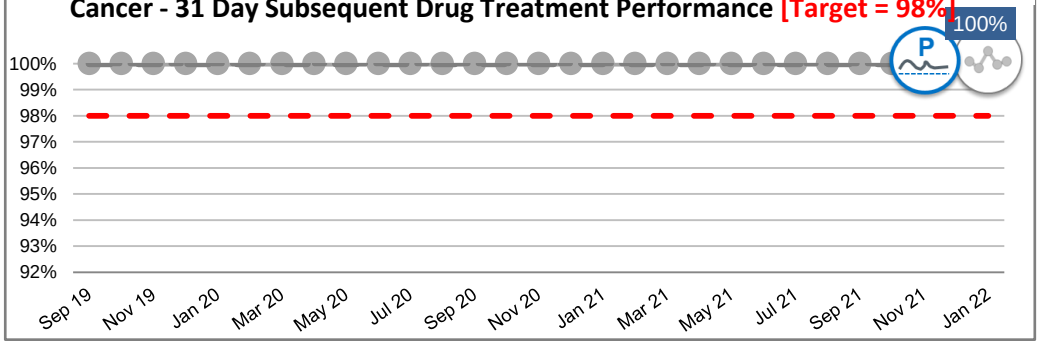
## Cancer - 62 Day NHS Cancer Screening Performance [Target = 90%]



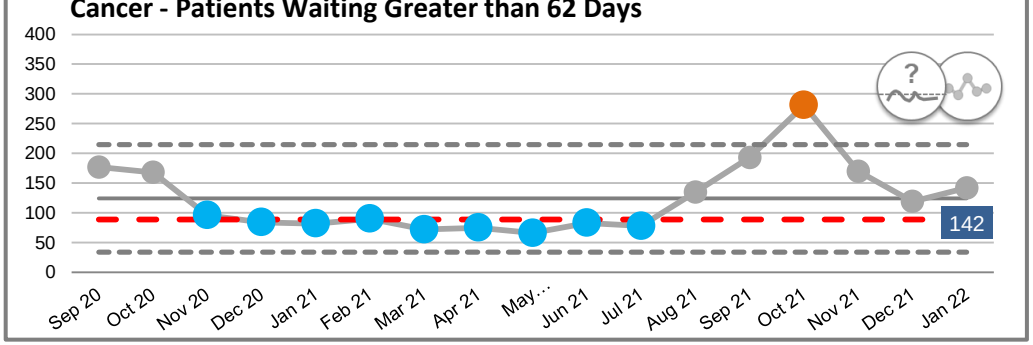

## Cancer - 31 Day Diagnosis to First Treatment Performance [Target = 96%]



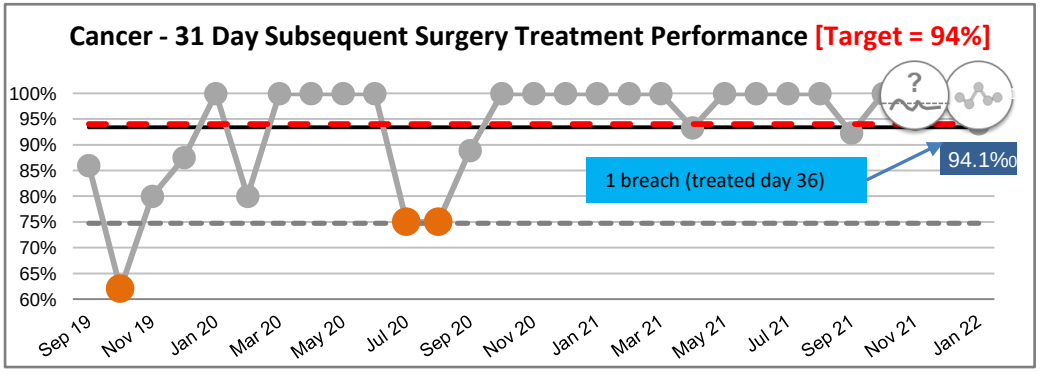

## Cancer - 31 Day Subsequent Drug Treatment Performance [Target = 98%]



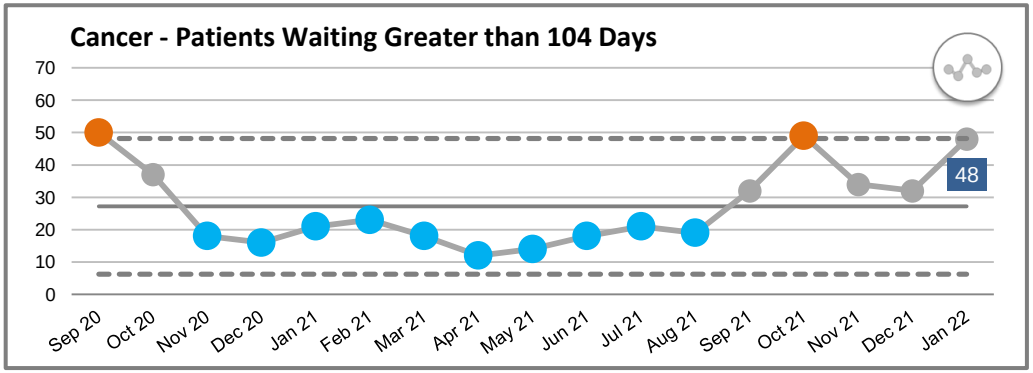

## Cancer - Patients Waiting Greater than 62 Days




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




## Cancer - Patients Waiting Greater than 104 Days



# Cancer

Reporting Period: Monthly | January 2022

Elective Care

**Assurance Level:** **Partial**

| | |
|---|---|
| What is impacting current performance? | For December (latest national upload) the Trust reported compliance for 3 of 8 Cancer Standards; these were; 31 Day Diagnosis to Treatment (97.6%), 31 Day Subsequent Drug Treatments (100%) , 31 Day Subsequent Surgery Treatments (100%).<br>During the same period the Trust reported non-compliance for; Two Week Rule (87.1%), Breast Symptomatic TWR (89.4%), 62 Day Urgent GP Referral to Treatment (83.7%) and 62 Cancer Screening Performance (80%) and 28 Day Faster Diagnosis Standard (71.9%).<br><br>Capacity has been under immense pressure across the majority of tumour sites due to the ongoing increased levels of referrals, the reduction in activity over the festive period, and considerable impact of Covid with an increase in patient cancellations and staff sickness.<br><br>A revised capacity and demand exercise across all specialities has taken place which identified opportunities to increase capacity, resilience and to develop more agile response processes which has immediately been put in place. Other acute providers are facing similar demand and ASPH performance remains good against national performance benchmarks.<br><br>For January 2022, the Trust is provisionally reporting non-compliance for the Two Week Rule, TWR Breast Symptomatic [due to 25% increase in referrals and covid sickness within the team], 62 Day Urgent GP Referral to Treatment, and 62 Cancer Screening Performance (2 breaches) which has been due to a combination of patient cancellations, patient choice and staff sickness. This position is currently undergoing validation. |
| 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. We have introduced specialty cancer daily meetings to support greater pathway recovery.<br>A revised capacity and demand exercise has led to increased capacity, resilience and more agile response processes.<br>An additional mammography unit has been ordered which will provide resilience for Breast and Breast Symptomatic TWR. |
| 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 with further pathway improvements planned to support cancer treatments within 62 days. |
| What are the key risks? | - Capacity due to increase and surges in demand<br>- Availability of workforce<br>- Endoscopy |
| What are the Quality implications for the Trust? | An issue in relation to the tracking of cancer patients to ensure they are on fast track pathways has come to light in month that affected 60 cancer patients. 13 of these patients are still on cancer tracker pending confirmation of cancer diagnosis. The issue pertains to the manual processes required to be followed when patients are registered on our systems which meant that these patients were not visible to the Cancer Team via Somerset but were visible on other systems. Appropriate clinical governance has been activated and is being picked up in detail at the Clinical Harms Oversight Group chaired by the Deputy Medical Director / Chief of Patient Safety.<br><br>Delays in the care for cancer patients can cause harm. Patients are monitored individually at weekly performance meetings 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. |