Kingston Hospital NHS
NHS Foundation Trust

Operational Performance Report for August 2015

Trust Board Meeting	**Item: 9**
Date: 13th October 2015	**Enclosure: E**
Purpose of the Report: To provide an update on monthly performance for all of the key operational indicators, background issues and remedial actions where necessary. Quality, Workforce and Finance reports form separate reports this month.	
For: Information ☒ Assurance ☒ Discussion and input ☐ Decision/approval ☐	
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Board Assurance Framework
Legal / Regulatory / Reputation Implications:	Monitor CQC compliance
Link to Relevant CQC Domain: **Safe ☒ Effective ☒ Caring ☒ Responsive ☒ Well Led ☒**	
Link to Relevant Corporate Objective:	
Document Previously Considered By:	
Recommendations: The Trust Board is asked to **note** the contents of this report.	

Month 5 – August Operational Performance Report

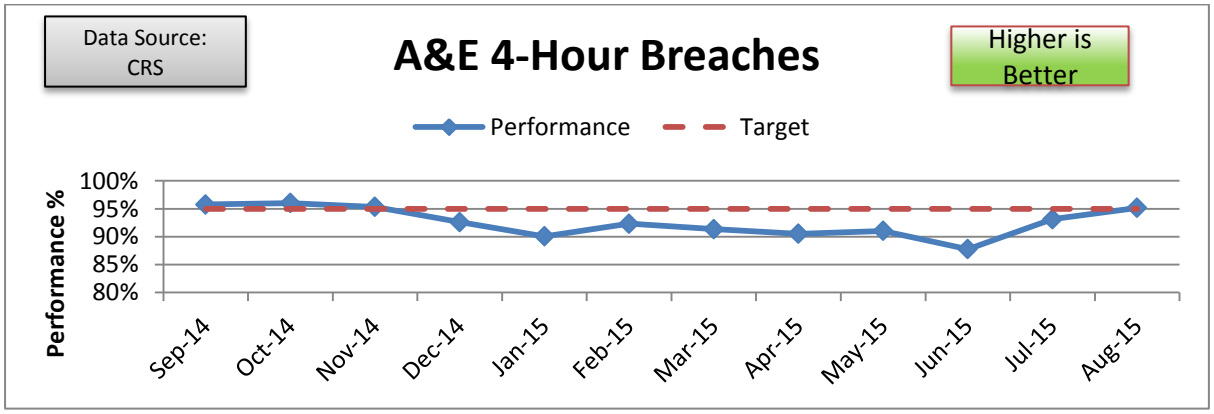
M5 was relatively strong in terms of operational performance across the Trust in all key indicators. The following areas are particularly worthy of note:

Emergency Access Standard

The month end position for all types of attendances was 95.3% which represented a significant improvement from previous months. Reasons for this positive movement was in part all of the efforts of the management and clinical teams putting in more support to the Emergency Department particularly out of hours and at weekends but was also due to slightly lower numbers coming through the department and less surges and spikes in activity which allowed the department to maintain a better rhythm each day which in turn reflected in the performance.

The position remains extremely fragile with staffing featuring as a really big issue. Work is being done to look at overall numbers of senior clinicians (both doctors and nurses) in the department. This is across the whole 24 hour period as unusually for an Emergency Department is busy first thing in the morning and at weekends to ensure that there are enough staff to deal with not only the average flow of patients booking in, but also with some flexibility to manage peaks.

A daily dashboard for the emergency department has been developed and will be launched 12 October so that the team have visibility on their flows, overall numbers and tolerances each day with both a weekly look back and a forecast position based on actual performance.



18 Weeks Referral to Treatment

The Trust is on track to deliver aggregate compliance across all 3 measures for the month of August.

RTT measure	Standard (%)	August (%)	August Breaches (completed pathways)
Non-Admitted	95	97.18	119
Admitted	90	90.89	93

RTT measure	Standard (%)	August (%)	Total waiting list size	Backlog
Incomplete	92	95.86	16,358	678

Non-compliant specialties

Admitted

T&O 88.03% (18 weeks> 17)
Impact of reduced operating capacity in month largely due to annual leave which was significant for a large part of the month.

Gynae 78.42% (18 weeks> 30)
A RAP was instigated to deliver backlog clearance work by September, however despite very good progress, pressures including securing additional lists in month will likely see slippage against the recovery into November (NB this service hasn't been compliant for its admitted position since early 2014).

Pain 89.55% (18 weeks> 7)
Capacity pressures have seen a dip in performance likely to continue into September and October with additional capacity being secured and the Service Line looking to appoint a locum Consultant.

Vascular 75.00% (18 weeks> 1)
This low elective volume specialty is now reaching the conclusion of a programme of backlog reduction with an expectation of compliance to be reflected in the September position.

Non-Admitted

Plastics 92.16% (18 weeks> 8)
The Service Line are seeking to address a return to compliance with additional clinic capacity.

Colorectal 89.17% (18 weeks> 17)
Improvement to a compliant position is anticipated in September.

Key observations/emergent themes that are being worked through include:

- Poor adherence to access criteria currently (e.g. multiple rebooks of DNA's, management of consultant annual leave, clear escalation of risks) and an absence of locally agreed protocols aligned to a Trust Access Policy

- Lack of an up to date and visible LHE agreed Access Policy (group established in October to write new policy) which should resolve some of the issues outlined

- Utilisation and prioritisation of capacity – clinics & theatres. The process for sign off and re-letting capacity when it is available and ensuring that emergency time is available and responsive according to the needs of the services

- Internal Service Line processes vary, we need to understand why and work in the same way regarding access agreeing any nuances

- T&O imaging reporting delays – likely to impact in October/November performance which is currently being worked through and as much mitigation as possible put in place

- **Reporting changes 1st October 2015**: As per Simon Stevens' communication in June 2015 the two RTT measures relating to completed pathways are to be abolished as soon as possible, with the performance focus in the future being solely on the incomplete pathway measure, the only measure which captures the experience of every patient waiting. Other than the removal of the provision to report patient pauses in data returns to NHS England, none of the information in this refreshed guidance is new and it does not change when each patient's waiting time start and stop must be recorded and reported.

Cancer

In August and for the third month running we have achieved all targets.

	Operational Standard	Aug-15
2-week wait seen		577
2-week wait breaches		27
compliance	**93.0%**	95.3%
2-week symptomatic seen		104
2-week symptomatic breaches		6
compliance	**93.0%**	94.2%
31-day 1st treatment		89
31-day 1st treatment breach		2
compliance	**96.0%**	97.8%
31-day 2nd treatment (surgery)		9
31-day 2nd treatment breach		
compliance	**94.0%**	100.0%
31-day 2nd treatment (drug)		4
31-day 2nd treatment		

breach		
compliance	**98.0%**	100.0%
62-day treatment (2ww)		50
62-day breach		7.5
compliance	**85%**	85.0%
62-day treatment (screening)		1
62-day breach		
compliance	**90.0%**	100.0%

Key Issues for the next three months

Staffing in AED

At present, the department is short staffed in both nursing, consultant and middle grade doctors. The nursing situation is easing on the back of recent recruitment drives so we expect to see this improvement over the coming months although there is still some way to go to ensure that we do not lose more nurses than we gain. Gaps still remain at Band 7 which will need focus as this is a key role on each shift to ensure that the department maintains flow.

Recruitment of medical staff is more problematic. We have successfully appointed a Clinical Director who is an A&E Consultant in another Trust, but we are also losing an existing member of the team to another unit. There is also maternity leave at the moment which makes cover more difficult. Balance of the department and sustainable rotas will only be achieved when we are up to 10 Consultants. It is unlikely that we will appoint to all of the vacancies at once and therefore we will need to target advertisements using intelligence from the various networks as people become available or are interested in moving. In the interim, rather like the middle grade tier, we will cover internally where possible, and where that does not happen, cover with agency staff in order to maintain safety and improve performance.

Advanced Site Practitioner Support

An urgent look at site cover is needed as the remaining numbers in the team do not allow two ASPs to be on during the day. Therefore it is very difficult to cover the site, the bed requests and the clinical aspects of their work with only one person on a shift. Cover is better at night and links in with the hospital at night team. A proposal is being drawn up which will allow more comprehensive and responsive cover to ensure that patients in AED and AAU are placed quickly and that patients are moved to the correct speciality bed wherever possible.

Phlebotomy Staffing and OPD Service

Phlebotomy has two main issues at the current time, the first is space, the waiting areas are woefully inadequate for the numbers of patients attending for bloods with only a limited number of chairs to take the patient's blood, and secondly, a shortage of phlebotomists to appoint and train to carry out this essential service not only to OPD but also the wards. We are looking at possible satellite areas which could house a second phlebotomy service for target clinics such as patients who come for warfarin levels and fasting bloods, but we have yet to find a solution. This is a priority for us and a solution which improves the experience for both our patients and the staff in those services will need to be found in the next month or so. In terms of staffing, we have recently held an open day for non clinical staff and as the second of those days is due to take place next month, we shall be looking to offer training for people to consider this as a possible career and expand the opportunities to wider than administrative roles which was the target of the first campaign.

Surge pressures and escalation responses

We now have a surge plan which articulates roles and responsibilities for those involved in escalation situations. Much work is needed both internally within the Trust and also with partners to enact a practical response to times of pressure particularly over winter. It is acknowledged and accepted that even with the various winter schemes we will be between 16-40 beds short of our needs which is based on last year's activity. We have yet to firmly agree what plans will be in place in the community which will act as a release valve for the hospital at peak times. It is always a challenge to move from plan to action, however we are working with partners and NHSE to gear up ready for those times, but it is a risk therefore we need to have as much mitigation as possible in place ready to be enabled.

ED October 2015