The Office *of the* Committee *for* Health & Social Care

THE MEDICAL SPECIALIST GROUP LLP

Secondary Healthcare Contract: 2018 Key Performance Indicators Supporting Information:

The purpose of this document is to provide additional information to support the publication of the Key Performance Indicators (KPIs) in relation to the first year of the Secondary Healthcare contract (SHC).

Although data was kept on various elements of activity within Health & Social Care (HSC) and the Medical Specialist Group (MSG) prior to 2018, it was not reported on or monitored in the same way. During 2018, and following the launch of a new SHC, a considerable amount of work has been undertaken by both HSC and MSG to allow us to report on the KPIs detailed within the contract. As part of this process, some KPIs have required changes to systems and ways of working to allow the data to be collected and some only became reportable later on within the year. The teams within HSC and MSG continue to work closely together to ensure that data is as accurate and of the best quality possible to ensure that it continues to assist decision making.

The KPIs have been set to reflect the highest standards of practice and patient care and they encourage a culture of continual development, learning and improvement towards excellence. Where targets have not been met during this first year of monitoring, we have a good understanding of why and thus a platform from which to make further improvements over the coming year.

The KPI measures are reported over six 'themes' which collectively provide a detailed overview of the quality of services provided.

Professional Compliance Measures

Up to Date Job Plans & Job Descriptions

Target: 100%

Job Plans describe how our Doctors and Consultants spend their working days whilst Job Descriptions contain the list of skills and competencies required from each professional. They are reviewed periodically to ensure that they reflect current working arrangements.

All job plans and job descriptions were in place and up to date for HSC and MSG Doctors / Consultants for the year 2018.

Completion of Annual Appraisals

Target: 100%

Annual appraisals are formal peer reviews undertaken with Doctors and Consultants. They ensure professional standards and can highlight personal development objectives to assist the individual in meeting their professional obligations.

This indicator is measured in April of each year with a view to the previous calendar year. Information available as at the end of January 2019 confirms that 96.1% of annual appraisals

had been completed with the remaining Doctors / Consultants having been granted an extension by the Responsible Officer.

Analysis of those not completed has identified that long term unavoidable absences have meant that a very small number of appraisals have been deferred.

Attendance in the Cancer Multidisciplinary Team (MDT) Meetings

Target: 70%

It is recognised as best practice that patient care pathways are discussed and agreed at MDT meetings. These meetings bring together the blend of healthcare professionals with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care for patients.

In 2018, the median percentage of attendance achieved over the year was 76.5%.

Attendance of Academic Half Days

Target: 7 out of 12 AHDs

Academic Half Days (AHDs) are an ongoing programme of presentations, training and continuing professional development (CPD) for both HSC and MSG Doctors and Consultants. CPD is crucial to healthcare providers as it allows a medical practitioner to learn and discover ways to improve on the patient care they deliver. It also enables medical practitioners to stay current with the latest developments within their specialty, addresses real-world challenges that medical practitioners face day to day and meets the regulator's revalidation requirements.

During 2018, 50% of HSC and MSG Consultants and Doctors attended seven out of the 12 AHDs which were provided. Analysis of this result has indicated that those who were unable to meet this target were generally dealing with emergencies or unscheduled events, or may have been on leave.

Attendance at Contractual Meetings

Target: 70%

There are three main contractual meetings attended by a number of professionals from multiple groups within all areas of both primary and secondary healthcare. These meetings cover contract management, governance and clinical services.

All meetings across 2018, apart from one Clinical Reference Group meeting scheduled on the 28 December 2018, were quorate. The median percentage of attendance at the meetings was 59.7%. The achievement of the KPI was affected by the contractual definition of the membership of the Clinical Reference Group which included some representatives from primary care as well as HSC and MSG who realistically were only required to attend for specific agenda items and their attendance of all meetings would not have been the most efficient use of their time.

Compliance with Inpatient Discharge Summaries Process

Target: 100%

Once a patient is discharged from the inpatient care of either an MSG Consultant, HSC Doctor, or a visiting Consultant, HSC aims to send a discharge note to the patient's GP within 24 hours. This is then followed by a full discharge summary, care plan, details of investigations and findings. This KPI measures the percentage of overall discharge summaries that are sent within the 24 hour target.

In 2018, this KPI recorded a compliance rate of 63.2%. This KPI has been impacted by an increase in clinics delivered whilst the medical records team did not operate at full staff complement. Plans are underway to improve performance against the target.

Meet Expected Timings for Operating Theatres

Target: 85%

This measures the percentage of operating theatre sessions that start at the scheduled time. The measure assists with the identification of any recurring issues that might be preventing the theatre team from consistently meeting their schedule.

The monthly figure has been improving since reporting commenced in July 2018, with the average at the end of 2018 standing at 70.8%. Scheduled times can be impacted greatly by emergencies that a Consultant/Doctor may have to attend given that Guernsey does not have Junior Doctors. Over-runs are also possible if cases are more complex than originally planned.

Please note that the Day Patient Unit (DPU) does not currently record start and finish times and therefore are not included within this report at this time.

Patient Safety & Experience Measures

Venous Thromboembolism (VTE) Risk Assessment Rate

Target: >95%

Venous Thromboembolism is a condition in which a blood clot forms, most often in the deep veins of the leg, groin or arm and travels in the circulation, lodging in the lungs. VTE is preventable in the hospital setting and this KPI measures, through monthly audits, the percentage of patients aged 18+ who have had a VTE risk assessment completed within 24 hours of their admission to hospital. This assessment allows the appropriate prophylaxis to be administered to patients who require it.

There has been continuous improvement of this KPI during 2018, with the last quarter showing 84.8% of patients assessed within 24 hours of their admission. The median average for 2018 was 67.5%. The audits we undertake are also fed into the National Audits.

Never Events

Never Events are serious incidents that are preventable because national guidance or safety measures are available and should have been implemented to stop the incident from happening. They are an important part of an open (just) culture and reporting them is associated with better patient outcomes. They are fully investigated so we can learn from them to help improve the care we provide.

To protect patient confidentiality (owing to their very small incidence rate in Guernsey), Never Events will be reported every three years.

Hospital Acquired Infections Rate

This KPI measures the number of infections for E.coli, C. Diff., MRSA and MSSA which patients have acquired in a hospital stay exceeding 48 hours. Infections recorded within 48 hours are deemed to have been acquired in the community.

In 2018, there were 6 hospital acquired infections from a total of 3,456 admissions of which 5 were categorised as 'unavoidable' in accordance with our Infection Control Policy.

Waiting Time Measures

Waiting Times – Emergency Department

Target: 95%

This measure looks at the time from checking in at the Emergency Department (ED) to the time a patient is either admitted or discharged. The achievement of this KPI can therefore involve professionals beyond the ED service itself.

The average for 2018 was 91.2% and performance has improved steadily throughout 2018.

Patients in Guernsey are seen very quickly by a healthcare professional when they attend ED but they may need to see a specialist Consultant before a decision can be made about how to progress that patient's care. If that Consultant is already undertaking surgery or occupied with patients elsewhere, there may be a delay in decision making. Such unavoidable waits can impact upon closing an episode of care for an individual which impacts on the achievement of the target.

This is also a UK measured target with 88.1% of NHS service users being admitted and discharged within 4 hours between January and September 2018. The average over that same period in Guernsey was 90.1%.

Radiology Waiting Times

Target: 95%

This KPI measures the three timeframes for radiology examinations:

- referral to examinations within 6 weeks (where patients attend their appointment within six weeks of their referral for a radiology examination)

- 8 week referral to report (where the first verified report is available within eight weeks of the patients referral for examination)
- cancer two week wait (where the first verified report for a patient following a cancer pathway is available within two weeks of the patients referral for examination)

In addition, there is a requirement for inpatient reports to be turned around within 24 hours.

Guernsey does not have a wide pool of professional clinical staff available to deliver these services, which means that when key individuals within a service such as Radiology become unavoidably absent for personal reasons, delays can sometimes occur. Despite this happening earlier in 2018, this KPI has improved over the year from 63.7% in April 2018 to 83% by year end. The average for the year was 76.8%.

Waiting Times – Inpatients and Outpatients

Target: 95%

This KPI measures the percentage of patients referred to an MSG Consultant, HSC Doctor or visiting Consultant who were seen within the agreed waiting time based on their referral priority. The KPI includes both referrals from primary care for outpatient episodes and from the date of the decision to admit a patient until they are admitted as an inpatient.

The SHC sets out expectations for patient elective waiting times as:

- 8-week Routine for Outpatients (following referral by GP)
- 8-week Routine for Inpatients (following outpatient appointment)
- 7 Days Urgent
- 24 Hours Emergency
- 2 Weeks Cancer Referral

For inpatient episodes, 83.7% were seen within the contractual waiting times. 76.5% of patients were seen within the contractual waiting times for outpatient episodes. The percentage when taking into account both measures was 81.5% across 2018.

Although waiting times for orthopaedic outpatients exceeded the target waiting time during the first half of the year, a successful initiative over the summer ensured that Consultants were booking orthopaedic outpatient appointments within contractual waiting times by September 2018. This successful action has had an adverse effect on the waiting times for orthopaedic inpatients however, which currently exceed the target waiting time by a considerable margin. As such, a specific project is underway jointly between HSC and MSG to improve the waiting times in this area of increasing demand.

Outpatient Measures

Organisation Cancelled Outpatient Appointment Rate

Target: <10%

This is the percentage of outpatient appointments which are cancelled or rearranged by HSC or MSG. It does not include appointments which are cancelled due to an administrative error if the patient was not aware of the error but it does include changing of appointment times.

It should be noted that a cancelled appointment can include changes made in the best interests of the patient, such as changing an appointment to an earlier time/date.

The 2018 average was 13.5%.

Failure to Attend and Short Notice Patient Cancellation Paediatric Outpatient Rate- Paediatrics.

Target: <11%

This KPI measures when patients did not attend (DNA) their appointment or when the patient has cancelled their appointment with less than 24 hours notice. It is very difficult to fill an appointment slot if someone cancels their appointment at short notice and as such, DNAs increase the costs incurred by HSC and MSG.

Children have a different target from adults due to the reliance on parents/guardians to assist them in meeting the appointment.

During 2018, 10.2% of paediatric patients failed to attend or cancelled at short notice.

This KPI seems to be affected by seasonal changes with higher DNA rates around school holiday times. Both HSC and MSG are considering whether any system or process changes can be made to help improve this situation.

Organisation Initiated Radiology Cancellation Rates

Target: <10%

This KPI measures the percentage of booked attendances for Radiology investigations which were cancelled prior to the patient attendance but does not include referrals to walk in services.

Data on this KPI has only been reported since August and has consistently been at or below 1%.

Failure to Attend and Short Notice Patient Cancellation Outpatient Rate –Adults

Target: <6%

This KPI measures when patients have failed to attend their outpatient appointment or when the patient has cancelled their outpatient appointment with less than 24 hours notice.

It is very difficult to fill an appointment slot if anyone cancels their appointment at short notice and as such, DNAs increase the costs incurred by HSC and MSG.

The median average for 2018 was 6.1%.

Inpatient Measures

Delayed Transfer of Care Days

Target: <100 days per month

This KPI measures the number of days in aggregate that patients stay in hospital after they are considered fit for discharge. In some cases, a patient may need further help at home or admittance to a nursing / care home, but they do not need the level of care given by an acute care hospital ward. Delayed transfers of care reduce the number of beds available to other patients who need them, as well as causing unnecessarily long stays in hospital for patients. Delays may be caused by the inability to secure a nursing / care home bed or due to the patient still awaiting a review by the Needs Assessment Panel to assess further care needs.

We have only been reporting on this KPI since July 2018, in which time the median average was 91 days per month across all patients whose discharge from hospital was delayed.

Emergency Readmission Rate Within 28 Days of Discharge

Target: <10%

This KPI measures the percentage of incidences where the same person is admitted to the Princess Elizabeth Hospital as an emergency within 28 days of the last time they left following a stay at hospital. It should be noted that if a person is readmitted for an issue unrelated to their previous episode of care, they would still be counted within this KPI and so detailed analysis is needed to understand whether anything can be learned from the readmission which would improve the overall quality of patient care.

This target was achieved throughout 2018, with a median percentage of 6.5%.

Return to Theatre within 28 Days

Target: <2.5%

This KPI measures the percentage of unplanned returns to theatre within 28 days of a procedure being performed by a Consultant or Doctor. It excludes any planned returns which are supporting a course of treatment but includes returns for surgical procedures on the same site. Returns may include occasions where there is an unexpected complication, or where a surgeon considers it to be in the best interest of the patient.

The data has been reported since July 2018 and shows the number of returns to be very low, not being more than 0.3% per month.

Day Case Unit to Inpatient Conversion Rate

Target: <5%

This KPI measures the number of patients who have been admitted as a day patient, but who have needed to stay overnight after their day patient procedure due to unforeseen circumstances. It is good practice only to offer some procedures as a day case admission, making best use of resources and allowing the patient to recover in their own home. However, medical complications may arise and a patient then needs to be admitted for an overnight stay. We will be doing further work to see if any of these admissions can be avoided.

The median average for the year was 1.7%.

Average Length of stay (Elective admissions only)

Target: <6 days

This KPI measures the (mean) average time in days that elective patients stay at the Princess Elizabeth Hospital. The length of stay is considered to be a well-accepted indicator of hospital efficiency with a shorter stay being considered to be more efficient, as it makes beds available more quickly, reducing the cost per patient and enabling more patients to be treated. However, stays that are too short may reduce the quality of care and diminish patient outcomes.

The median average in 2018 was 3.9 days per stay and, other than in January and February when the health care system generally experiences higher demand owing to winter pressures, performance in this area has achieved the KPI target.

Failure to Attend and Short Notice Patient Cancellation Inpatient Rate

Target: <2%

This KPI measures when the patient has failed to attend for an admission to hospital or has cancelled their admission with less than 24 hours notice. It is very difficult to fill an appointment slot if someone cancels their appointment at short notice and as such increases the costs incurred by HSC and MSG. It also means another patient who could have been treated earlier waits longer.

The median average for 2018 was 2.8%.

HSC and MSG are working together to investigate improvements that could be made to improve attendance rates for both inpatients and outpatients.

Organisation Initiated Inpatient Cancellation Rates

Target: <10%

This KPI measures inpatient admissions which have been cancelled by HSC or MSG and includes times when the patient came into hospital and we were unable to carry out their procedure.

This data was reported for the first time in April and May and from June onwards, this KPI has been within target, attaining a median average of 8.8% for the year.

Patient Focus Measures

Off-Island Activity

Off-island referrals are carefully monitored in order to identify opportunities to improve on-island provision and to ensure that there are no inappropriate referrals.

This measure provides information about the number of referrals made by Consultants or Doctors to HSC's Off-Island Team which required further scrutiny because:

- the agreed referral process has not been followed
- the treatment is available on island
- the referral does not comply with the HSC Commissioning Policy

The number of incorrect or inappropriate referrals have significantly reduced during 2018 with an average of 9 per month. The Off-Island Team continues to work with colleagues within both HSC and MSG to further improve this KPI.

Family & Friends Test

The Family and Friends Test is a nationally recognised feedback tool that asks the following question to service users: "How likely are you to recommend this service to friends and family if they needed similar care or treatment?" When combined with supplementary follow-up questions, this provides a mechanism to highlight both good and poor patient experience and allows us to benchmark against the UK average.

Of those respondents who chose to answer this question in 2018, the percentage of responses who were "extremely likely" to recommend our service was 75%. A further 18% responded that that they were "likely" to recommend our service.

Monitoring of these responses provides a meaningful and essential source of information for identifying gaps and developing an effective action plan for quality improvement within secondary healthcare services in Guernsey.

Complaints Procedure

This is the percentage of formal complaints that are completed within 20 operational days as set out within the Complaints Policy. 52.3% of complaints were successfully resolved within 20 days, with the balance relating to complex complaints which take longer to investigate and resolve.

This measure recognises the importance of responding to formal complaints in a timely manner. Not only can this help to put the patient's mind at rest but it can also lead to the identification of potential service problems, help identify risks, prevent them reoccurring and highlight opportunities for improvement.

Published 7 February 2019