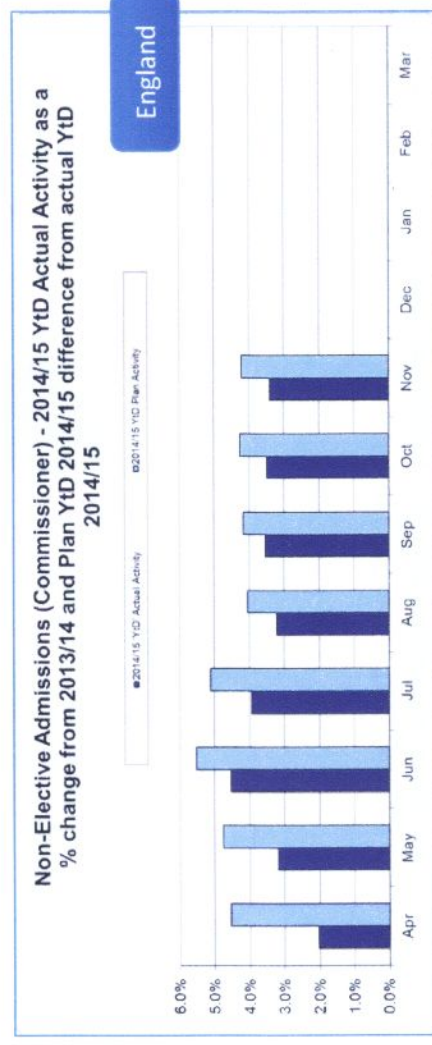


Winter Pressures Performance – Dudley CCG (2014-15)

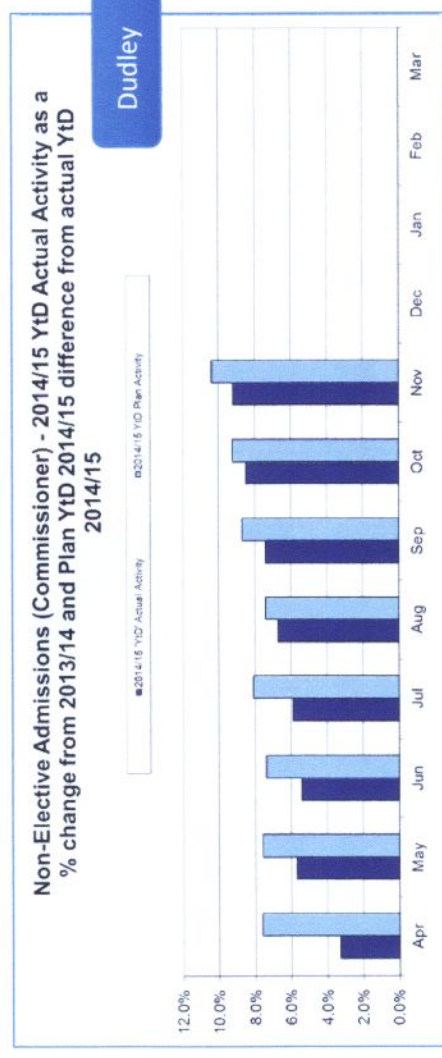
Emergency Admissions

Context

In England, non-elective admissions have exceeded plans in 2013/14 and 14/15 to date. The graph (top) shows that 14/15 YTD activity has over plan to a greater extent than the previous year. The monthly pattern of over performance was similar for both years.

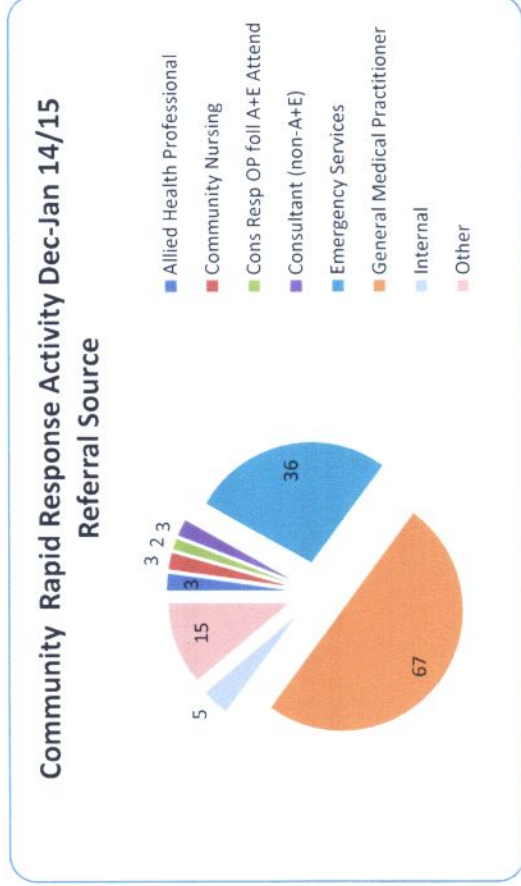


The Dudley position is similar to the national picture for non-elective admissions. However the monthly pattern is noticeably different with non-elective admissions rising into the winter months.

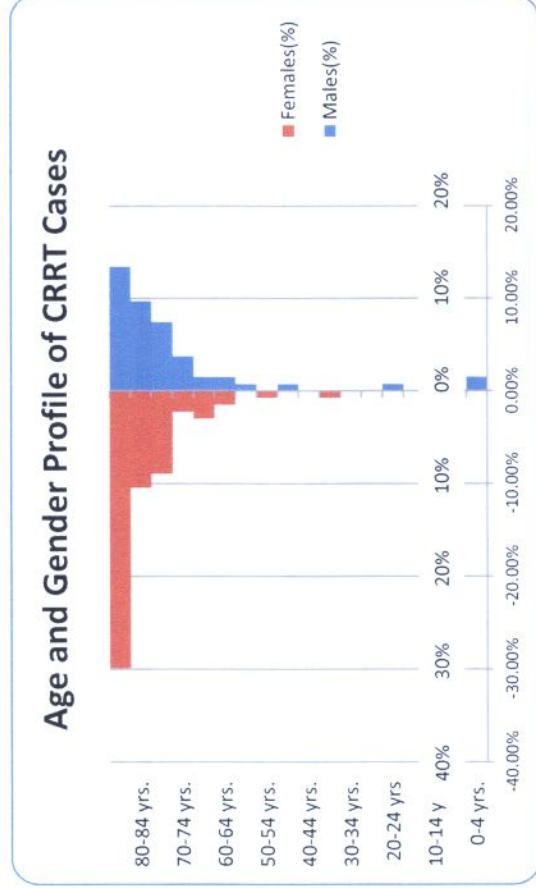


Community Rapid Response Team

In the December to January period dealt with 134 cases 36 were ambulance calls (see graph below). However, the disposition data for these calls is not yet available. Therefore it is difficult to assess the impact of this intervention on both Emergency Admissions and A&E attendances.



The chart below shows the age and gender profile of CRRT cases. The 70yrs and above age groups constitute the greater proportion of CRRT activity. The graph shows that age groups outside the service specification have been included. This is because once an ANP is aboard the ambulance, the next 999 response by that vehicle may need to attend before returning to base.

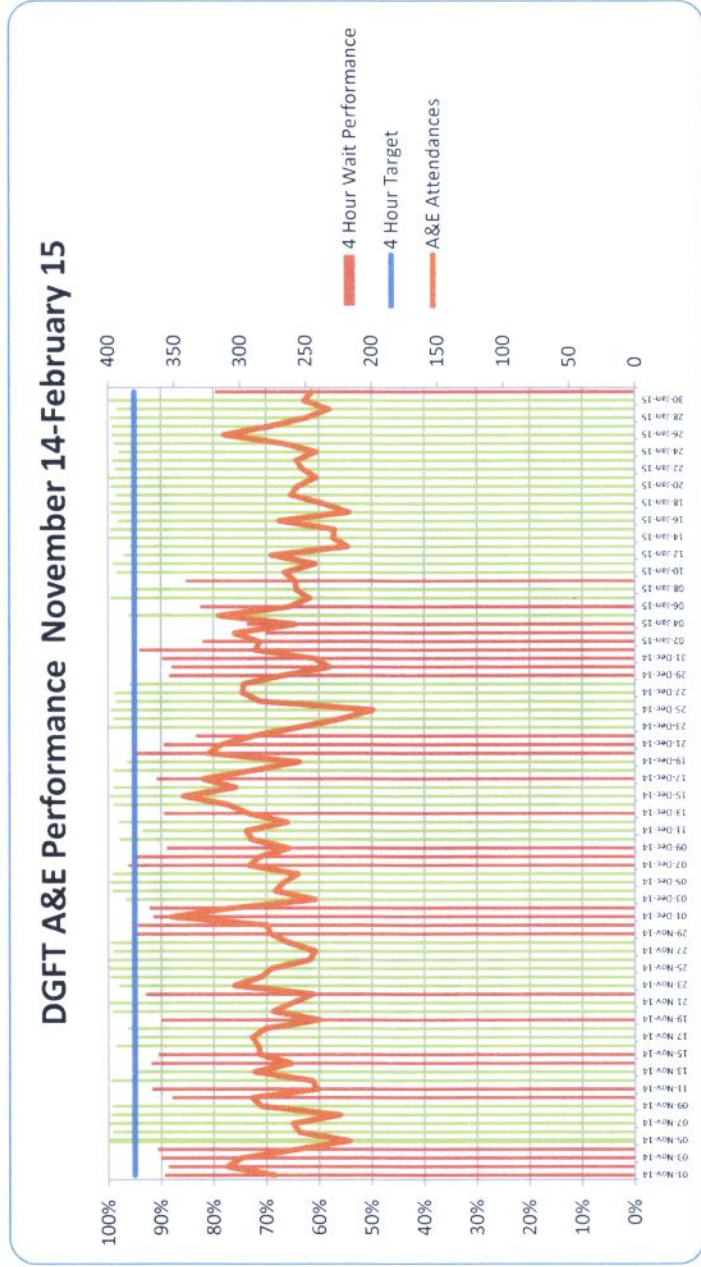


Accident & Emergency 4 Hour Waits

A&E Performance

The 4 hour wait performance continues to improve at DGFT with high levels of achievement against the target for many days throughout the winter period thus far.

The graph below shows daily performance from November through to February. The most challenging period was the 30th of December through to the 4th of January when all days failed to meet the standard. However there has been a marked improvement since then with performance throughout most of January comfortably meeting the standard.



Correlation tests on this data failed to meet the reliability requirement to confirm a relationship between attendance figures and 4 hour wait performance. Therefore a statistically significant relationship between attendance figures and 4 hour wait performance was not evident.

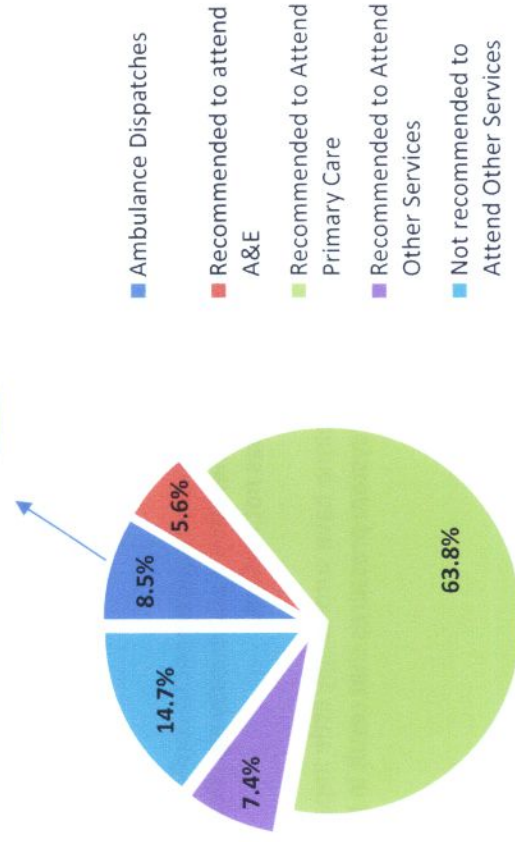
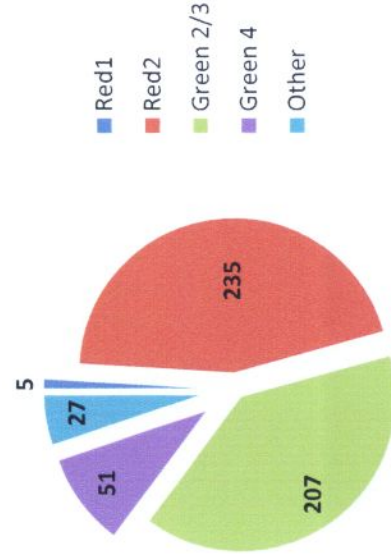
It therefore seems likely that attendance figures alone have surprisingly little impact on performance. It would appear that it is particular combinations of system pressures that result in the A&E not meeting the wait standard.

NHS 111 – impact on A&E 4 hour waits

The graph below shows NHS 111 dispositions for Dudley residents in December 2014. There were 6,182 calls triaged from Dudley residents in December. For comparison the number of calls in October was just below 4,000 , therefore December showed a marked increase in NHS 111 activity. 525 of the December calls were given a 999 disposition (8.5% of all dispositions). The breakdown of the 999 categories for these calls is shown in the top right pie chart. The percentage of NHS 111 consultations that resulted in an ambulance disposition has decreased from the October point which was 11%.

Despite the decreasing proportion of NHS 111 calls receiving an ambulance disposition, 525 ambulances in December was 17.5% of all ambulances dispatched for Dudley residents. This would still appear to be an unwarrantedly high number and a review of the sensitivity (false positive rate) of ambulance conveyances generated by the NHS 111 service is recommended.

Ambulance Dispatches - December 2014



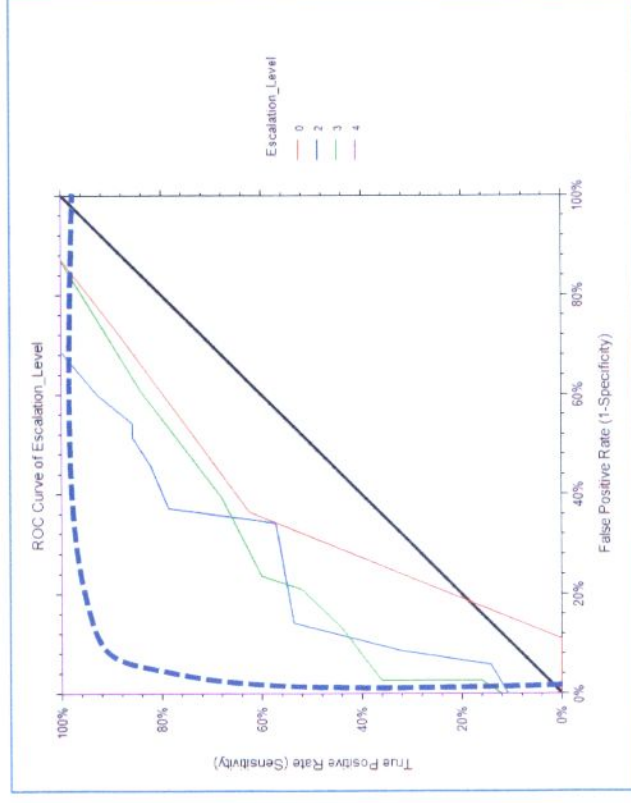
NHS 111 Outcome of Calls Triaged

Escalation levels and predictive factors

It seems reasonable that a combination of deteriorating A&E performance, high levels of delayed transfers of care and poor 4 hour wait performance should theoretically provide a strong predictor model for DGFT escalation levels.

However, the evidence does not strongly support this assumption. Logistic regression using these factors to build a model has determined that these factors account for 21% of the variance in escalation levels. Leaving 79% of the variance unexplained by these factors.

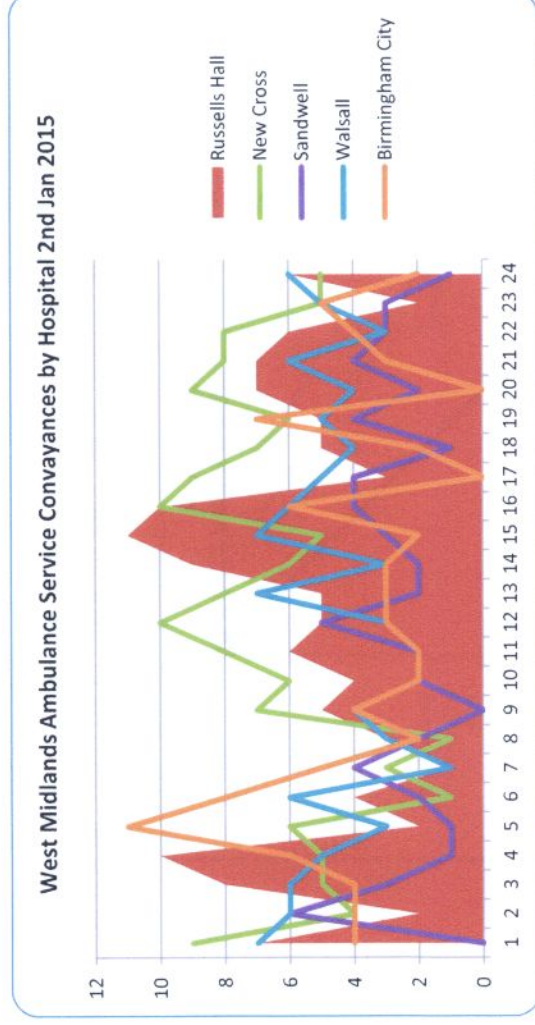
The ROC Curve graph below shows that all escalation levels deviate markedly from the ideal sensitivity of the dotted line. Again highlighting the poor reliability of escalation level predictability using these factors.



Ambulance Handovers

The graph below shows the ambulance conveyances to 5 hospitals on the 2nd January 2015 (one of the busiest days for ambulance conveyances during the winter). Russell's Hall and New Cross hospitals experiences the more severe clustering of ambulances by hour with Birmingham City having 11 ambulance conveyances between 5am and 6am.

Russell's hall hospital had 133 ambulance conveyances over the 24 hour period with New Cross having the highest figure of 154.

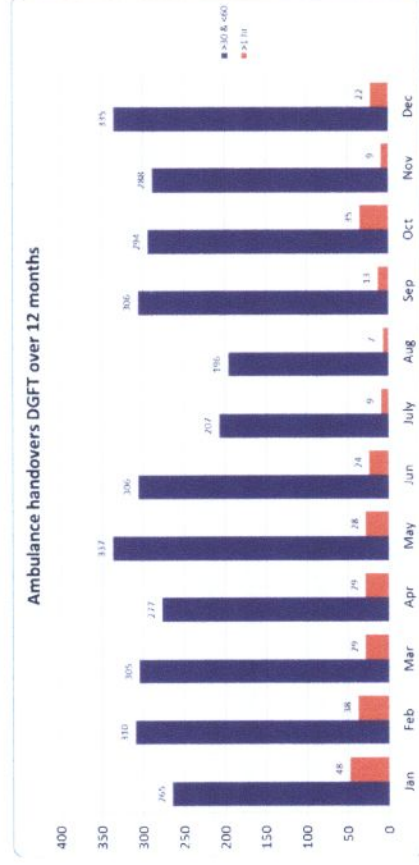


Analysis of daily conveyances by hour over the winter period did not reveal any unusual distributions or inequities in ambulance clustering by hospital.

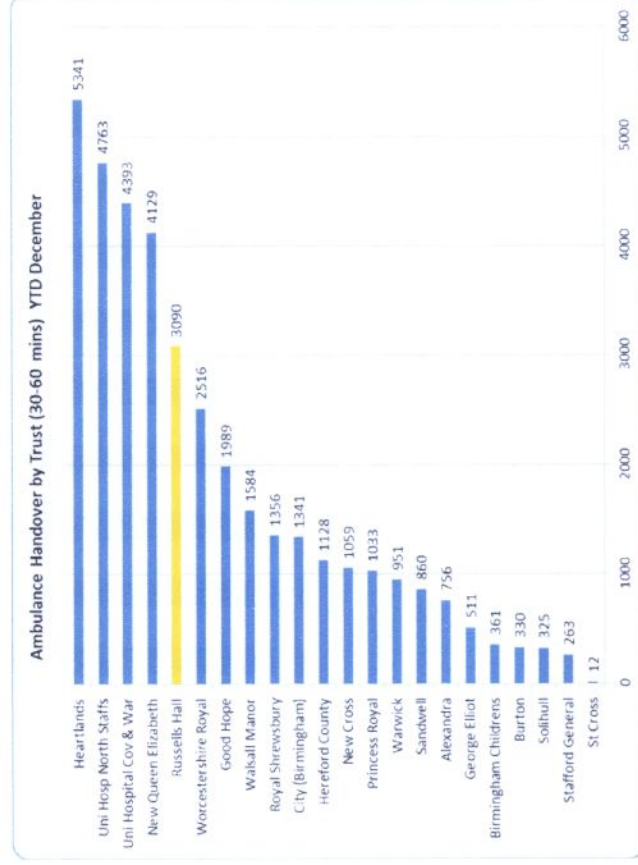
Ambulance Handovers

The graph below shows a rolling 12 months Handover performance (30 & 60min)

In September there was a marked increase in both 30min breaches which continued through December. Financial penalties for this performance breach have been applied throughout.



The graph to the left shows a comparison of the West Midlands Ambulance Service 30-60 minute handover performance at a number of A&E providers. It shows Dudley Group FT has the fifth highest level year to December.



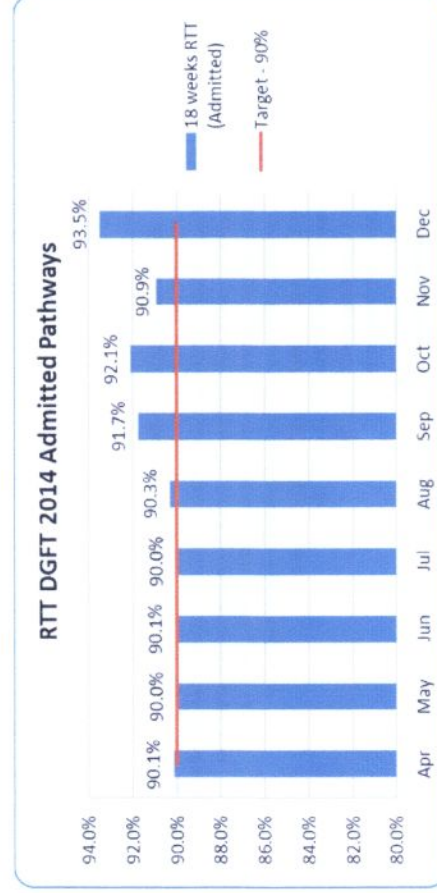
Referral to Treatment

All Headline measures for Referral to Treatment targets have been met by DGFT throughout the period. Performance for the Admitted pathways (top right) have been under pressure but September to December data confirms more sustainable headroom between performance and target.

However, 6 specialties have demonstrated difficulty in maintaining the national standard of 90% (table bottom right).

ENT and the amalgamated category of 'Other' recovered compliance by July. Trauma & Orthopaedics and Ophthalmology have shown improvement. However, Urology remains well below the target.

T&O and Ophthalmology are expected to meet target achievement in January, Urology is not expected to recover until March 2015.



The work currently undertaken to achieve recovery trajectories for these specialties does not jeopardise any of the Headline measures.

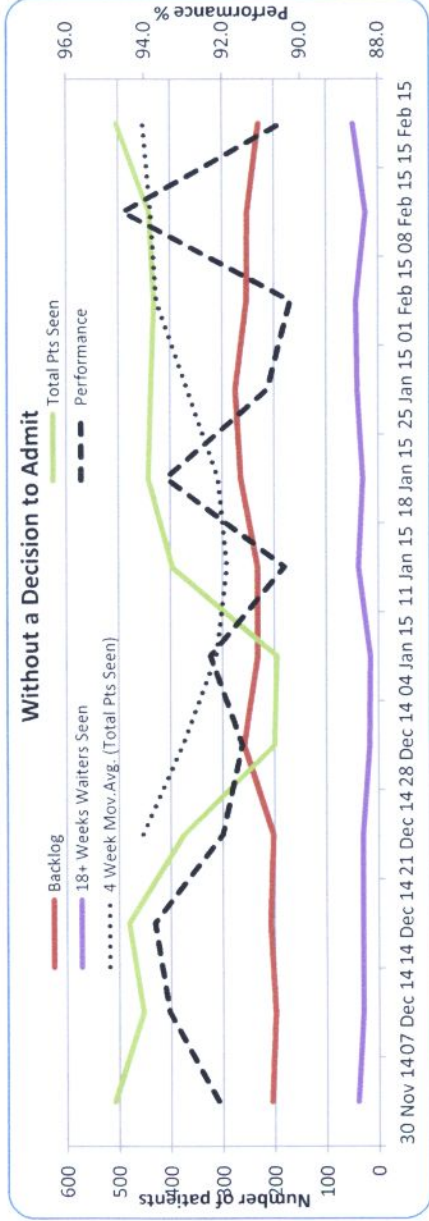
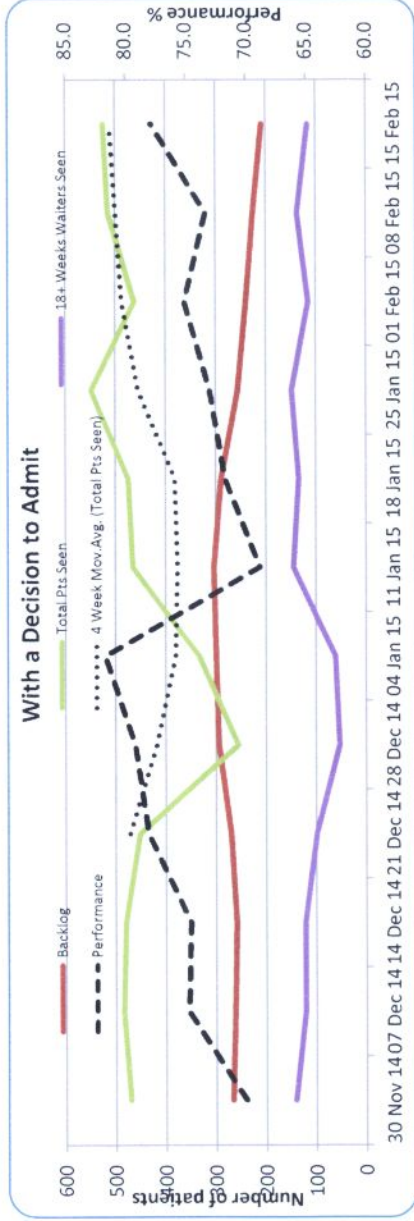
However, recovery has been affected by extra weekend and evening sessions. The question going forward is to what extent RTT target achievement will prove sustainable?

Specialty	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
ENT	82.0%	85.7%	81.3%	92.1%	97.4%	93.1%	96.6%	94.7%	94.1%
Ophthalmology	87.8%	92.3%	88.6%	85.7%	81.4%	81.9%	88.1%	82.6%	89.9%
Oral Surgery	81.9%	73.5%	73.7%	71.9%	66.7%	79.9%	74.6%	73.3%	89.4%
Other	88.0%	81.4%	89.8%	95.1%	95.6%	99.5%	96.8%	93.2%	99.3%
Trauma & Orthopaedics	81.0%	85.2%	86.7%	84.6%	88.8%	88.4%	88.2%	89.0%	89.4%
Urology	85.3%	88.2%	88.2%	80.3%	75.3%	69.5%	80.0%	76.1%	77.3%

Referral to Treatment – Wait profile over the Winter

The graphs below show various aspects of referral to treatment performance at DGFT over the winter period. The number of longer waiters grew in late December but have fallen back to previous levels in February.

The backlog of patients has fallen for in patient pathways from January onwards but out patient pathways have not seen a significant reduction over the period.



Delayed Transfers of Care

Delayed transfers of care

The graph (top) shows the number of bed days delayed overall at DGFT. This includes delays attributable to Health, Social Care and where the cause has been assigned to both parties. This graph shows that overall delayed transfers of care increased markedly in October but reduced through November and December.

The graph (bottom) shows broadly the same pattern when split by organisation attributable for the delay except for those categorised as both parties responsible which increased in the winter period.

