Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of directors Meeting Report

Subject: Integrated Performance Report - Exception Summary Report
Date: 26th June 2014
Author: Simon Evans/Rebecca Stevens
Lead Director: Jacqui Tuffnell, Director of Operations

Executive Summary
Performance Summary: May 2014

Monitor Compliance

The Trusts performance for May 2014 is currently at 3 Monitor compliance points these are due to underachievement against RTT Non-Admitted, A&E 4 hour wait and C-Difficile. For Quarter 1 2014/15 performance is projected at 3 Monitor compliance points.

As a consequence of the Trusts financial and governance risk ratings the Trust remains in breach of its authorisation with automatic over-ride applying a red governance risk rating.

Acute Contract

RTT

The Trust has failed to achieve the bottom-line position for the Non Admitted standard in May 2014 with all three standards having failing individual specialties; these are detailed in the table below:

RTT Specialty	General Surgery	Urology	T&O	ENT	Ophthalmology	MaxFax	Plastic Surgery	Cardiothoracic	Gastroenterology	Cardiology	Dermatology	Respiratory Medicine	Neurology	Rheumatology	Geriatrics	Gynaecology	Others	Total
Incomplete	88.16%	92.87%	91.20%	92.84%	96.17%	80.31%	92.04%	100%	93.71%	94.39%	96.27%	88.81%	94.59%	95.07%	95.22%	92.46%	91.87%	92.13%
Admitted	89.87%	94.64%	83.69%	91.76%	93.06%	85.27%	100%	-	100%	87.50%	98.95%	-	-	-	-	92.89%	93.50%	91.13%
Non-Admitted	92.12%	92.31%	88.69%	96.62%	98.32%	96.36%	96.15%	-	88.04%	87.05%	98.54%	93.60%	96.13%	93.65%	99.67%	95.42%	94.82%	94.10%

The Trust has reported 4 patients on an Incomplete Pathway waiting over 52 weeks at May 2014 month end, these relate to 1 Max fax patient, 1 Cardiology patient, 1 Trauma and Orthopaedic patient and 1 Vascular patient. The Trauma and Orthopaedic patient will remain as an over 52 week patient in June as we are unable to take off PTL until patient treated in July despite this being patient choice.

A significant emphasis is being placed on Trust's reviewing their longest waiters, it is therefore intended to provide the board with the longest waiting patients and total number of patients who have not been treated within 18 weeks. The longest waiting patients at May 14 month end reporting were as follows:

Patient	Weeks Waiting	Specialty	Key Information
1	52 Weeks+	T&O	Treatment due to commence 22/07/2014, Patient paused - will be adjusted on admisson - not a 52 week breach once treatment commenced
2	52 Weeks+	Vascular Surgery	Patient commenced treatment 05/06/2014
3	52 Weeks +	Cardiology	Patient commenced treatment 10/06/2014 – clinician pathway - NUH
4	52 Weeks +	Max fax	Patient commenced treatment 09/06/2014 - Parents changed appointment and unable to treat before breach
5	50 Weeks	General Surgery	Treatment due to commence 19/06/2014
6	50 Weeks	ENT	Patient commenced treatment 16/06/2014
7	49 Weeks	T&O	Patient Clock Stopped 13/06/2014
8	48 Weeks	T&O	Patient commenced treatment 04/06/2014
9	48 weeks	Oral Surgery	Patient commenced treatment 07/06/2014
10	47 Weeks	Oral Surgery	Patient declined treatment 18/06/2014 - discharged
11	47 Weeks	Oral Surgery	Treatment due to commence 19/06/2014

The total number of patients in May 2014 who were over 18 weeks was 1291 (+55) from previous month. This increase is mainly attributable to patients that have just tipped over into the 18 Weeks reporting group. Patients waiting over 40 weeks has decreased by 11 from the previous month.

Medical specialties

Gastroenterology and Cardiology specialities in medicine continue to fail the non-admitted 18 week standard.
Gastroenterology continue to underperform on their intended trajectory. The specialty continue to reduce the backlog and in May have slightly exceeded (positively) the trajectory by clearing more patients than anticipated above 18 weeks with the resulting performance. In addition to this specialist diagnostic services previously undertaken only at other tertiary hospitals is now being undertaken at Kings Mill hospital again reducing waits and unnecessary transfers.

This positive move forward does have risks however we have had a consultant resignation, in order to pursue a more specialist role at Derby Hospitals. The overall cacpacity of the service is now greater risk than before and short term locum cover will be required until a substantive replacement can be found.

Cardiology performance on the non-admitted and incomplete standard has deteriorated as the service remains under capacity to deliver the 18 week capacity. The loss of two substantive consultants and a short period of no locum cover for one of these consultants

has inevitably increased waiting times. The head of service continues to utilise wider professional networks to attract high calibre suitable replacements and early discussions are extremely positive in sourcing replacements. This does still carry risk as the lead time for recruitment into these posts and two further posts required when two additional consultants retire is substantial.

In the interim for both Gastroenterology and Cardiology demand management and review strategies are being undertaken to ensure that all referrals into the service are appropriately going to specilaists and where alternative services can be provided in and outside of the trust they are being used.

Surgical Specialties

Summary

T+O, General Surgery and Urology specialties failed to meet 95% target for non admitted pathways with improvement and achievement seen in Max fax. T+O, Max fax and general surgery failed 90% target on the admitted pathway with achievement seen in Urology. The number of patients waiting over 18 weeks on an incomplete pathway has improved in T+O and General Surgery.

Service Line

T & O – both the admitted (83.7%) and non admitted performance (88.9%) has remained under target but this is due to the impact of treating the increase in the number of backlog patients. The total number of patients being treated remains under trajectory. Backfilling of vacant theatre lists is being undertaken to improve this but is restricted due to job plans and sub specialty being undertaken. There has also been an increase in cancelled electives to manage trauma capacity. As identified below in 4 hour performance, a review of trauma is currently underway to understand the changes since April. Exploration of capacity at NUH was fruitful but patients would not accept having their procedure there.

General Surgery – Admitted (89.9%) and non admitted performance (92.1%) is still being impacted by the high number of over 18 week patients in Vascular surgery. The number of patients treated on an ongoing clock in May was under trajectory but the % of over 18 week patients was on plan. Therefore the admitted target was marginally missed. Additional clinic capacity for NUH consultants is now in place and therefore the impact on backlog will be significant to aid recovery. There is significant admin process change to avoid the volume of missed clock stop opportunities and inter hospital transfer issues. The impact of non admitted onto admitted pathways has been minimal.

Max fax – Non admitted performance was back on track in May (96.4%) and expected to maintain achievement of 95%. Admitted performance continues to be below target (85.3%) but is expected due to backlog of 18 week + patients. Plans are in place with other providers across July to clear the minor ops this is disappointing as the original plans with The Park have now changed and they cannot deliver what they had committed to. Subsequent capacity is now being sought. This will pose a risk to admitted bottom line in Q2.

Urology – The non admitted performance is below target (92.3%) due to treating less patients than trajectory and the number of incomplete patients waiting over 18 weeks is increasing (from 94.3% in April to 92.9% in May). An action plan is in place to recover the position. The specialty achieved the admitted target at 94.6%.The issues pertaining to diagnostic capacity is impacting on overall 18 week performance. A plan is in place to pull this back with scheduled evening sessions. Further work is underway to scope future

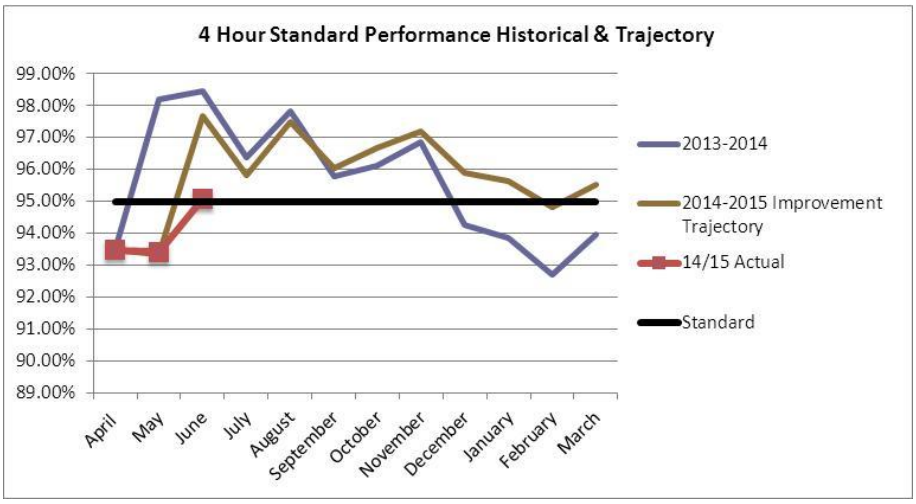
capacity requirements as a result of the “Blood in pee” campaign.

The above specialties have had a full demand and capacity review undertaken in order to collate short and long term strategies. All options are being identified such as pooled lists for simpler surgical procedures, outsourcing activity to other providers, flexing of current capacity to address backlog issues and engagement with the Achieving Best Care Team for relaunching of the Elective Pathway Programme.

Cancelled ops we breached guarantee of readmission within 28 days in May, this was due to 2 patients cancelled, 1 cancellation due to consultant sickness on day and 1 x cancellation due to bed pressure. It is difficult to completely prevent this reoccurring due to the nature of the events but anb improved escalation process has been implemented within theatres to prevent any on day cancellations being enacted without Divisonal Management approval.

ED

The Emergency Department Standard of 95% was not achieved in May. Building on the deep dive narrative described in Aprils performance report there is now a comprehensive recovery plan describing all areas of underperformance with associated actions. Accompanying this improvement plan is an anticipated trajectory shown below. The Trajectory shows step improvements for June and December when key programmes of work are expected to take impact.



This recovery plan was reviewed at the mid Nottinghamshire urgent care working group and all those actions that relate to flow and external impact on our services were appropriately supported and directed to external agencies. This will remain a key element of urgent care working group agenda going forward.

Two key areas of improvement internally related to waits in the Emergency Department for doctors decisions, and for bed availability.
Since April board report the overnight registrar doctor rota has now been doubled and these waits have reduced. The output is not consistent throughout May because of the inability to fill all additional sessions. (The rota is 100% comprised of locum registrars because of the number of vacancies in the substantive employed staff.) It is anticipated that this change together with other amendments around advanced nurse practicioner rotas will reduce the number of breaches.

The second key improvement was in relation to bed availability, and although improvement

projects had not started in May they were prepared and analysed with appropriate resource ready for trials to start in June. A new process and area for discharge lounge is anticipated to improve flow by several hours each day, and although not sounding signficiant the average breach for a bed is only 1 hour past the 4 hour mark. By improving morning bed availability it is anticipated that this would improve performance significantly. The revised discharge lounge came into place on 18 June.

As part of the emergency care recovery plan, it is anticipated that the changes outlined above will support improvement in relation to the overall A & E clinical quality indicators.

Un-coded Activity

The level of un-coded admitted patient care spells at the 5th working day of the month has increased to 24.7% against the Clinical Commissioning Group target of 20%. The Trust has seen a further increase of 2% in the overall volume of finished consultant episodes creating additional workload. To ensure the coding throughput is maintained with the increase in FCEs and during the PAS implementation over the next 4 months an additional Agency Coder is being sought to work full-time within the department. The agreed start date for this position is at the beginning of July.

The volume of un-coded episodes impacts the calculated HSMR rate as any patients not fully coded will fall within residual coding and not into the actual diagnosis group creating an incorrect HSMR rate, the rate is corrected on receipt of the final SUS reconciliation date for the relevant month.

ASI Rates

ASI rate 16% against target of 5% which is attributed partly due to capacity issues within the Divisions but also due to the ongoing backlog of patients at the Gateway which as at 28.05.14 stood at 794. With the longest waiting patient being for Gynaecology with a delay of 44 days.
As at 11.06.14 the backlog at the Gateway stands at 598, with the longest wait being Gynaecology with a delay of 57 days.
Additional capacity is being arranged in order to cope with the influx in patients but this is an ongoing pressure.

At specialty level the ASI pressures are focused in Dermatology, Paedeatric ENT, Orthopaedics, Opthalmology, Lower GI (Medical), Vascular & Urology.

Cancer

Number of patients being seen outside 14 day standard still high but reduced slightly on April numbers. This is as a result of a significant increase in referrals as 2ww. Projected 843 patients in May 2014 against 730 in May 2013.
Risk of failing Q1 if June numbers sustained with priority being given to 2ww patients with additional capacity being undertaken in order to bring patients forward.

31 day -1st treatment – Decision to treat to 1st definitive treatment standard was not achieved due to 4 breaches in month, all patients were booked within protocol but deferred treatment due to illness & patient choice. Confident of Q1 achievement.

Failed to achieve subsequent drug treatment standard in May due to 1 patient breaching, not projecting any issues with achievement of Q1 performance.

We are currently projecting a performance of 77.4% for the Consultant Upgrade Standard.

There are relatively few patients reported against this standard and minimal breaches result in low performance. The majority of breaches projected are due to patient choice/unfit.

Cdiff

May performance continues to have a higher than trajectory number of patients being confirmed Trust attributable cases and the quarter will not achieve. Further information in relation to actions being taken are contained in the Quality report.

Datix Incidents

Please note that the Datix reported incidents are a provisional figure, we have a number of outstanding incidents that are still awaiting Category and severity coding due to the implementation of the new Datix reporting system, once this has been completed the figure will be refreshed to reflect this.

Q1 14/15 Forecast Risks
As detailed above the key risks identified are:

- Non-Admitted RTT achievement of 95% Monitor standard (high risk identified in narrative but not in the annual plan score template)
- A&E 4hrs Wait achievement of 95% Monitor standard (high risk identified in narrative but not in the annual plan score template
- Cdiff non-achievement of trajectory (identified as a risk at plan submission)
- ASI Rates breaching 5% Acute Contract Operational standard
- Achievement of 14 day cancer standard

Recommendation

For the Executive Board to receive this high level summary report for information and to raise any queries for clarification.

Relevant Strategic Objectives (please mark in bold)	
Achieve the best patient experience	**Achieve financial sustainability**
Improve patient safety and provide high quality care	**Build successful relationships with external organisations and regulators**
Attract, develop and motivate effective teams	

Links to the BAF and Corporate Risk Register	
Details of additional risks associated with this paper *(may include CQC Essential Standards, NHSLA, NHS Constitution)*	
Links to NHS Constitution	Key Quality and Performance Indicators provide assurances on delivery of rights of patients accessing NHS care.
Financial Implications/Impact	The financial implications associated with any performance indicators underachieving against the

	standards are identified.
Legal Implications/Impact	Failure to deliver key indicators results in Monitor placing the trust in breach of its authorisation
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	The Board receives monthly updates on the reporting areas identified with the IPR.
Monitoring and Review	
Is a QIA required/been completed? If yes provide brief details	