Sherwood Forest Hospitals NHS
NHS Foundation Trust

Board of directors Meeting Report

Subject: Integrated Performance Report - Exception Summary Report
Date: 29th May 2014
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Lead Director: Jacqui Tuffnell, Director of Operations

Executive Summary
Performance Summary: April 2014

Monitor Compliance

The Trusts performance for April 2014 is currently at 2 Monitor compliance points these are due to underachievement against RTT Non-Admitted and A&E 4 hour wait. For Quarter 1 2014/15 performance is projected at 4 Monitor compliance points with RTT Admitted and C-Difficile being a risk of sustained achievement. The Trust did formally identify risks to achieving RTT and 4 hours within the narrative of the annual plan however only identified that it was likely to fail Cdiff. To give the Board a fuller view of the challenges being experienced, the April 2014 exception report is at a more granular detail level.

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 April 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	**89.31%**	94.32%	**85.59%**	92.79%	96.63%	**77.32%**	95.58%	100%	92.61%	**90.82%**	97.05%	92.25%	95.45%	92.59%	96.80%	92.43%	92.34%	**92.06%**
Admitted	**87.80%**	93.13%	**83.20%**	92.77%	**88.06%**	**83.23%**	90.48%	-	100%	95.00%	99.48%	-	-	-	-	94.44%	94.49%	**90.03%**
Non-Admitted	**92.68%**	**93.72%**	**88.60%**	96.60%	97.71%	**90.23%**	**92.86%**	-	**86.28%**	95.88%	98.46%	95.29%	95.88%	98.48%	99.02%	96.54%	**94.00%**	**94.49%**

The Trust has reported 4 patients on an Incomplete Pathway waiting over 52 weeks at April 2014 month end, these relate to 2 Orthodontic patients and 2 General Surgery patients, both general surgery patients were patients referred to tertiary centres for treatment and discharged back to us at Week 52 and end of April so no scope to stop the breach from occuring. This issue has been escalated with the Director of Operations at respective organisations.

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 April 14 month end reporting were as follows:

Patient	Weeks Waiting	Specialty	Key Information
1	52 Weeks+	Orthodontics	Patient commenced treatment 9/05/14
2	52 Weeks+	Orthodontics	Patient pathway stop 12/05/14
3	52 Weeks +	General Surgery	Patient referred back to SFH 52Wks
4	52 Weeks +	Vascular Surgery	Patient referred back to SFH 52Wks
5	51 Weeks	Oral Surgery	Patient commenced treatment 6/05/14
6	50 Weeks	Orthodontics	Commenced watchful wait 9/05/14
7	49 Weeks	Vascular Surgery	Patient declined treatment 7/05/14
8	48 Weeks	Cardiology	Patient attended OPD 20/05/14, consultant to discuss with patient Ablation Procedure. Potential 52 Week Risk at May 2014 month end
9	48 weeks	Orthodontics	OPD booked for 22/05/14, patient will require surgery. Waiting List team aware of requirement
10	47 Weeks	Vascular Surgery	Patient commenced treatment 14/05/14
11	47 Weeks	T&O	Patient on Waiting List for shoulder surgery, no TCI. Patient will be 52 weeks at May 2014 month end.
12	47 Weeks	ENT	Patient has TCI for 30/05/14
13	47 Weeks	Vascular Surgery	OPD 20/05/14 outcome of add to Waiting List for treatment. Potential 52 week risk.
14	47 Weeks	Vascular Surgery	Patient declined treatment 01/05/14
15	47 Weeks	Paediatrics	Patient commenced treatment 6/05/14
16	47 Weeks	Paediatrics	Confirmation being chased that treatment has commenced at alternative provider

The total number of patients in April 2014 who were over 18 weeks was 1236.

Following a significant issue in relation to incomplete pathways in 2012, the Trust achieved bottom line RTT performance from January 2013 which it sustained until November 2013 when the Trust failed bottom-line achievement for non-admitted patients. The Trust then failed to achieve admitted bottom-line in January 2014. A decision was made at that stage, given that the quarter was breached for both pathways, to increase the volume of breach patients being treated to provide a more sustainable position and achieve for all specialties. The Trust has worked hard to improve the position by April 2014 however a number of factors have detrimentally impacted achievement of the standards.

There are a number of factors which have led to our failure to achieve:

In October 2013, our incomplete pathways increased by 30%, predominantly as we were using capacity elsewhere e.g. addressing the ‘backlog’ of review patients, increasing capacity to avoid ASI penalties and the divisions were under pressure to reduce variable pay so did reduce the number of WLIs and staff were unprepared to work at Agenda for Change rates. But also as a result of growth in referrals, significantly in excess of the activity plan agreed with commissioners, overall for the organisation this was 20%. We had also declared, in June 2013 that the Trust would have a shortfall of bed capacity during winter and requested additional bed capacity at Ashfield. This request was rejected and the commissioner’s utilised winter funding to commission 10 beds in residential homes for

discharge to assess, this being despite of being involved in the placement criteria. The Trust has seen an overall increase of external referrals into the Trust of 20% compared to 2012/13 adding additional challenge into the system.

The reality was simply insufficient capacity to eradicate the review backlog, avoid ASIs and achieve the remedial action plan for RTT. To clarify, the capacity not only relates to medical teams but involves the theatre and outpatient teams.

In March, when the Trust had pulled out all stops for achieving from April (use of external, WLIs,) we identified an issue with delays in referrals. After discussion with commissioning colleagues, it was identified to the Trust that the 'Gateway' used by commissioners had a backlog of over 1250 and their position as at 30 April was 857 patients in backlog. Clearly this backlog position has a significant impact for the Trust and will impact RTT performance. The Trust had not been having appointment slot issues however during April as the backlog started to be processed we started to face ASIs of over 13%. Given we are already now in this position, the trust is having to react given the significant detrimental effect the lack of capacity will have.

Activity outturn overall for 2013/14 was good:

Electives	Plan 36,659	Actual 36,311
Non-electives	Plan 49,004	Actual 50,108
Outpatients	Plan 304,981	Actual 314,197

Therefore in relation to activity per say the Trust should be in a better position particularly in relation to first outpatients, this will be linked to the 20% external referral increase during this financial year. I did attempt in February 2013 dialogue with commissioners in relation to a 12 week pathway, 4 weeks (first), 4 weeks (diagnostics), 4 weeks (treatment). However this was not agreed. I attempted in commissioning round this year for 15 weeks,5/5/5 and the divisions produced capacity plans to achieve this however this was not agreed by commissioners. The commissioners are still stating as at today that they will not commission anything other than 6/6/6 despite significant pressure to achieve all specialties.

The elective intensive support team has been working with the Trust for over 2 years and signed the Trust off in April as all required actions had been completed and there was no further work to improve the position which could be offered to the Trust.

In order to provide a sustainable change the Trust is working on revised capacity and demand (given the gateway backlog issue) and trajectories for achievement of all specialties. Once complete, the divisions will be weekly performance managed against the trajectory. Until this work is concluded (timeline 21 May 2014), we are unable to provide a definitive position in relation to achievement however achievement of all specialties remains high risk, sustainably until Q3. The Trust will increase the number of breach patients treated in May and June with the aim to achieve bottom-line achievement again from Q2 however if this endangers all specialty position by Q3, I recommend that we continue with ensuring we treat the breaches in order to sustain in the long term with the ultimate outcome of bottom-line not achieving until Q3.

In April, the incomplete position improved and we reduced the number of patients waiting in the 14-17 week category showing good direction of travel that patients will not continue tipping over into 18 weeks. We do however have issues with patients referred to the tertiary centre and are improving escalation processes to resolve much earlier in the process.

Capacity was agreed (but prior to awareness of the gateway backlog) as part of budget

setting and progress has been made in this area however the divisions will backfill all gaps with locums which we had not due to funding constraints.

We have 6 consistently failing specialties in relation to RTT:

General surgery – capacity and processes
Urology – capacity and processes
Trauma & Orthopaedics – back pain capacity, processes
Cardiology – capacity (significant issues with consultants)
Gastroenterology – capacity (Clinical Fellow about to commence)
Maxillofacial – capacity (sickness absence)

Efficiency improvements are now in place in both outpatients and theatres however clinician management is vital to ensure lists and outpatient clinics are fully utilised and as productive as feasible.

The Divisional Management team in surgery has been overhauled. The new General Manager commenced on 28 April 2014 and has significant experience in 18 weeks and is already grasping the specialty issues which require addressing. Additional business unit support has been put in place and the Interim General Manager is remaining in post until July to ensure delivery of the action plan with particular emphasis on capacity.

There will clearly be significant financial consequences of utilising external support and undertaking additional sessions to achievable a sustainable position. The finance impact is being worked through as part of the non-recurrent capacity plan.

Doncaster and Bassetlaw have agreed to review the capacity and demand model to ensure long term stability and independent overview of our work.

Whilst we are not expecting anything further which could impact on our position, for example we couldn't anticipate that the referrals were going to be delayed at the gateway, it is important that I identify that this assessment is on the basis of no further gateway or external issues. We received, on 20 May a Department of Health request for our capacity plans and trajectories to achieve, this request has been sent to all organisations as Q4 admitted was breached nationally and Dame Hakin has formally announced that organisations must treat long waiting patients with the consequence that RTT targets will not be achieved.

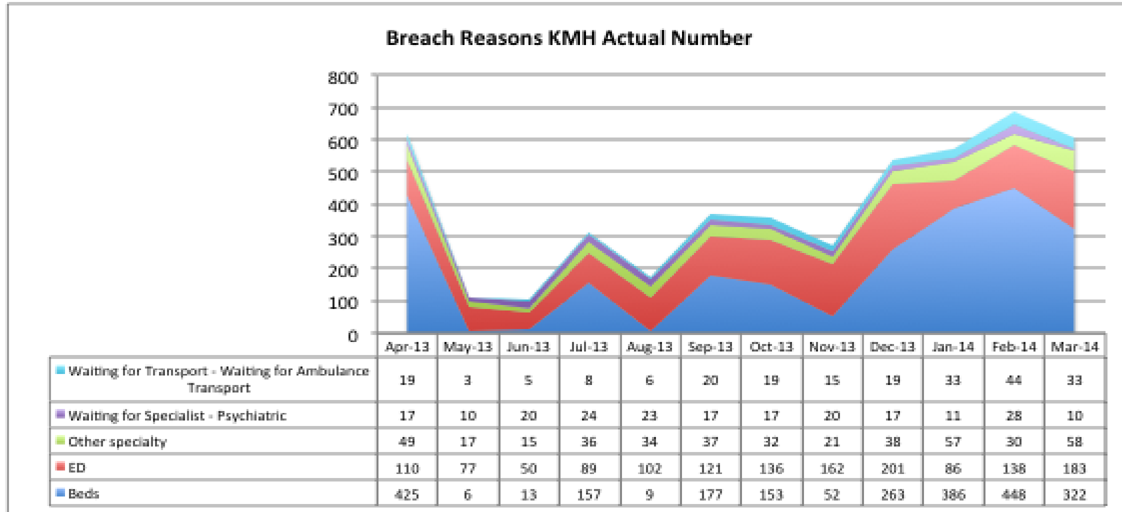
ED

For the month of April 2014 the Trust reported performance of 93.48%. In 2013/2014 as previously reported the trust exceeded the annual 95% 4 hour standard. Achieving 95.66%.

Over the period 1st April – 19th May 2014 compared to the same time in 2013 the Trust has seen an increase in the volume of patient attending ED. The summary table below demonstrates the variances.

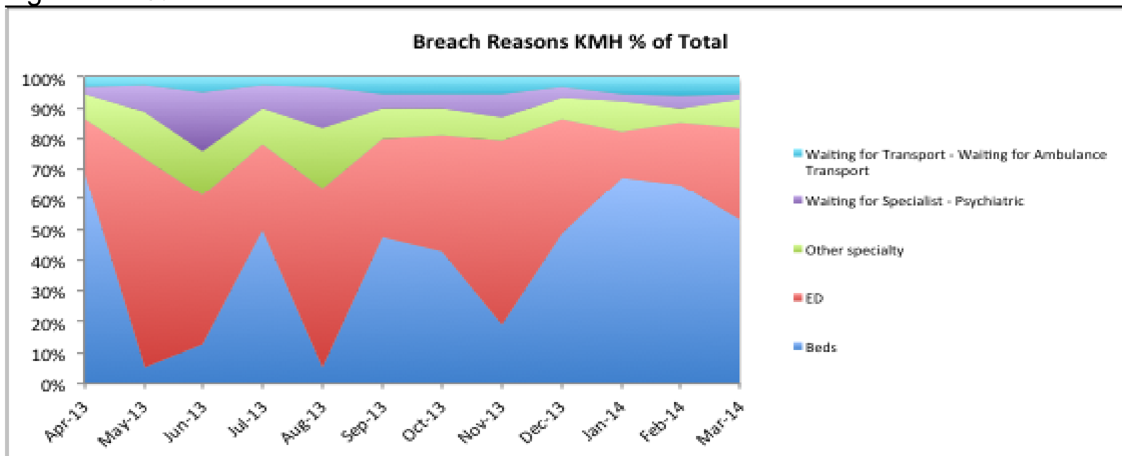
	Daily Average Attendances	Total Attendances	Highest Daily Attendance	Lowest Daily Attendance
SFH 2013	369	18,097	447	296
SFH 2014	409	20,047	473	341
Difference	40 (+10.8%)	1950 (+10.7%)	26	45
KMH 2013	260	12,755	327	190
KMH 2013	272	13,322	340	229
Difference	12 (4.6%)	567 (4.4%)	13	39

The analysis below indicates the challenges and patient acuity changes seen within ED. A breakdown of the breaches is charted below, with the single most significant breach reason being for flow and bed capacity. This is magnified in Q4 where at times more than 60% of all breaches were due to poor flow and unavailability of bed.



	Apr-13	May-13	Jun-13	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14
Waiting for Transport - Waiting for Ambulance Transport	19	3	5	8	6	20	19	15	19	33	44	33
Waiting for Specialist - Psychiatric	17	10	20	24	23	17	17	20	17	11	28	10
Other specialty	49	17	15	36	34	37	32	21	38	57	30	58
ED	110	77	50	89	102	121	136	162	201	86	138	183
Beds	425	6	13	157	9	177	153	52	263	386	448	322

The breach reason distribution as a % of all breaches shows that although bed breaches accounted numerically for a substantial element of the poor performance it was not the only significant % cause.



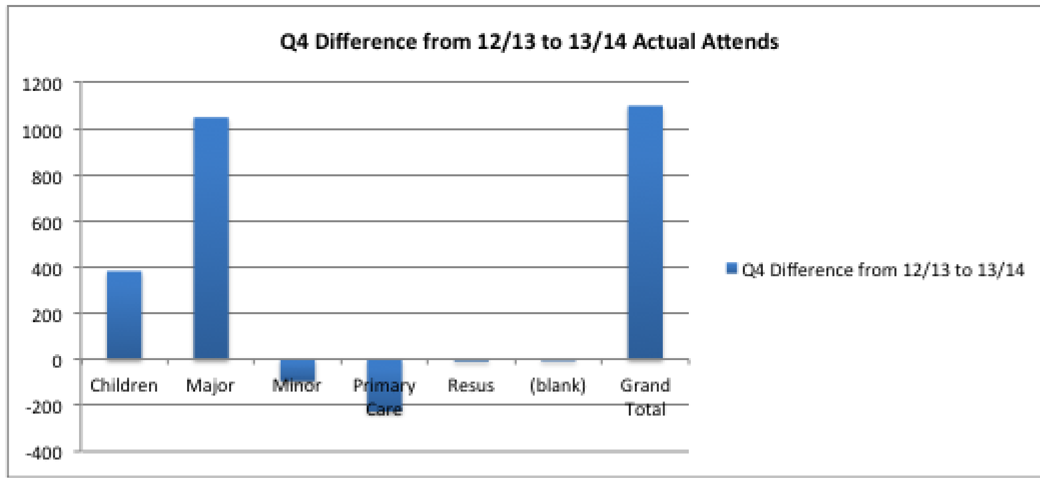
ED delays in decision making and waiting to be seen by a senior clinician is the next most significant reason for breaching. *Please note: it has not been possible to extract ED waits that happen as a direct result of overcrowding in ED for the prime reason of poor flow.*

ED delays in decision making and waiting to be seen by a senior clinician is something that has grown worse numbers wise although not as a % of overall breaches.
In order to understand why performance has started to deteriorate the charts below compare previous years activity on a number of levels.

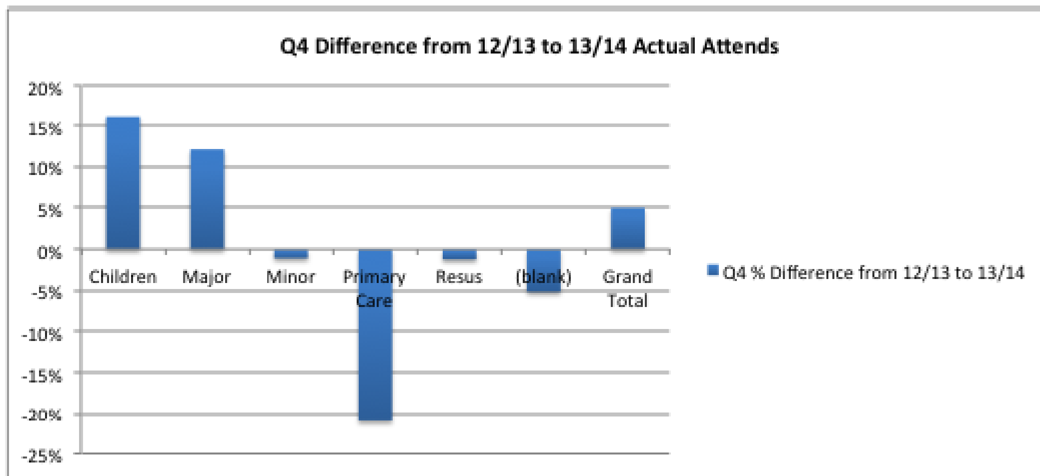
Change in Attendance Types

In Q4 13/14 1100 more patients attended the KMH emergency department compared to 12/13. This on its own would not necessarily lead to the failure against 95% standard.

However the patient type distribution suggests that patients were of a more complex nature and had poorer health with a significant increase in majors patients. i.e. patients with major injury or illness and a large proportion therefore requiring admission.



Proportionately comparing the two years there was a reduction in minors patients and resus but a disproportionate increase in majors and paediatric patients attending the department. Both categories require significantly more time with senior clinical teams, greater on-going care need and increased chance of specialist review.



Changes in Attendance Arrival Time
The increase in presentations to the Emergency Department would not necessarily lead to failure in the 95% target. Even with increased numbers of majors patients evenly distributed, or following existing presentation patterns the Emergency Department should be able to respond. However the table "heat map" below shows that whilst numbers and casemix have increased the time at which patients arrive has changed.

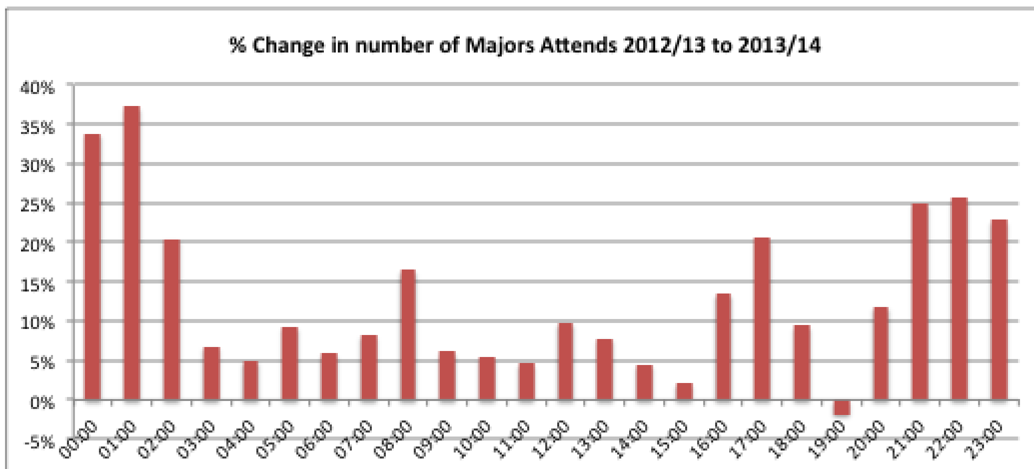
The table and charts below show that patients are now arriving later into the evening and overnight, at a time when staffing reduces and the most senior medical team (consultants) move onto an on-call system.

Q4 % Change 12/13 to 13/14

	Children	Major	Minor	Primary Care	Resus	(blank)	Grand Total
00:00	0%	34%	-58%	-21%	-19%	0%	9%
01:00	0%	37%	-71%	-29%	46%	100%	18%
02:00	-100%	20%	-87%	-9%	-35%	-50%	1%
03:00	-100%	7%	-32%	-33%	-25%	-100%	-1%
04:00	0%	5%	-43%	-33%	-36%	-100%	-2%
05:00	0%	9%	-36%	-62%	73%	0%	5%
06:00	0%	6%	-16%	-29%	-25%	0%	-3%
07:00	-80%	8%	-6%	71%	-20%	-100%	3%
08:00	-14%	17%	-1%	-27%	-8%	-100%	2%
09:00	29%	6%	1%	-17%	-36%	0%	4%
10:00	14%	5%	-10%	-2%	38%	-100%	0%
11:00	-1%	5%	4%	-12%	-9%	0%	2%
12:00	15%	10%	-10%	16%	-13%	100%	1%
13:00	41%	8%	-3%	0%	16%	50%	8%
14:00	8%	4%	11%	-41%	49%	0%	7%
15:00	4%	2%	-6%	-10%	-11%	-50%	-2%
16:00	19%	13%	13%	-6%	-19%	400%	13%
17:00	41%	21%	10%	-16%	-18%	-100%	16%
18:00	6%	9%	3%	-38%	-37%	100%	2%
19:00	32%	-2%	5%	-44%	-8%	0%	2%
20:00	-78%	12%	11%	-37%	-8%	0%	7%
21:00	0%	25%	1%	-36%	42%	-80%	9%
22:00	-100%	26%	-11%	-49%	39%	-33%	5%
23:00	0%	23%	-20%	-14%	83%	0%	11%
Total	16%	12%	-1%	-21%	-1%	-5%	5%

The reduction in minors patients both in numbers and proportionately will have freed up resource in the emergency department, together with the shift in timing where minors patients are arriving earlier in the day.

Unfortunately the resources required to care for and treat minors patients (largely emergency nurse practitioners and junior doctors) would not have the necessary skills and experience to be able to see and treat majors patients. Majors patients require senior medical and advanced nurse practitioner level experience and expertise.



The overall increase in majors presentations between 21:00 and 02:59 is an average of 27% and in resus 21:00-00:00 38% increase. This is in a context of the Emergency Department senior registrar rota experiencing one of the worst years for rotational placements with no substantive registrars able to work overnight and only 50% of placements being filled.

In response to these challenges the Trust has begun from 12th May 2014increased the registrar cover overnight by 100%. This is not a sustainable solution but it is one that will have impact quickly. Reconfigured some of our daytime nursing and medical decision makers to support earlier in the morning and late at night, again boosting capacity where it is needed. Recruiting additional ANPs this is expected to initially be small numbers but they will help unlock some medical capacity to redistribute to key areas in the evening.

The Emergency Flow Transformation Programme describes the medium and long term actions. These are summarised below:

Project / Programme Name	Description
Ward Based Discharge	Reinvigoration of Predicted Date of Discharge; ward based discharge using Jonah and the Jonah Live meeting.
Discharge Pathway	Build upon Ward Based Discharge project to embed improvements into daily treatment planning, board rounds etc. Implement robust arrangements to achieve transfer of care for patients currently being accommodated on ward 35. Redesign of pathway to integrate the discharge teams including the social work team. Workforce redesign and management of change as required. Design at interface with community care to integrate services so that patients experience seamless care. Move integrated discharge team to 7 day working.
Ambulatory Care	Development of ambulatory care pathways in line with programme agreed for CQUIN. Development of additional ambulatory care / medical day case unit capacity in line with option appraisal and business case.
Front End Decision Making	Build on progress already made on senior clinical decision making process. Increase Medical capacity overnight. (Middle Grade) Develop and implement new roles in ED and EAU to support proactive pull into speciality beds to expedite treatment plan or facilitate a safe discharge. Includes work on Paediatrics to ensure child centred efficient processes are in place.
Capacity Plan	Capacity Plan option appraisal and Capacity Plan business case. Bed reductions planned in steps enabled by improvement in discharge process, reduction in delayed transfers of care, ambulatory care etc. EAU reconfiguration in line with Capacity Plan business case.
Whole Systems Partnership working	Deliver CQUINs for development of whole system integrated services. Identify opportunities for specific support to SFHFT early discharge pathways. Ensure that appropriate evaluation and benefits realisation is undertaken to gain full impact for SFHFT and the wider health and social care economy.
Single Front Door	Work with partners to develop a service model that integrates emergency, urgent and primary care at a single front door at Kings Mill Hospital. Develop model of care and agree operational policies. Support development of a business case. Procure, build, commission and open new service

The Trust has engaged the Emergency Care Intensive Support Team (ECIST) again who attended at the beginning of May to review our discharge processes. Overall, whilst there feedback was positive in relation to ward leadership, diagnostics and junior doctor engagement, they have identified high numbers of patients without clear discharge plans and where, in their opinion we were 'over treating' with particular reference to therapy input. The recommendations from the report are being incorporated into the emergency flow transformation programme.

The Trust reported a 12 hour trolley breach in April 2014. This is extremely disappointing and was as a consequence of very little early flow in the hospital following a very busy night resulting in 8 patients moved from trolleys onto beds within a quieter section of the ED. Additional nursing support was provided to the department to provide care normally received in a ward environment however the inability to create capacity then lead to one of the patients being in ED over 12 hours from decision to admit.

Un-coded Activity

The level of un-coded admitted patient care spells at the 5th working day of the month has increased slightly to 22.8% against the Clinical Commissioning Group target of 20%. 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.

The clinical coding team are working to ensure the overall volume of un-coded FCEs at the 1st SUS submission date for April 2014 FCEs is maintaining the position for March FCEs. To ensure the coding through put is maintained during the PAS implementation over the next 4 months an additional Agency Coder is being sought to work full-time within the department.

ASI Rates

For the month of April 2014 Choose and Book Available Slot Issue (ASI) rate was 13% against a target of 5%.
As referenced within the RTT section of the IPR the extent of referral backlog at the Newark and Sherwood commissioned referral gateway has now been realised. In response to this the commissioners enforced an improvement trajectory which resulted in a considerable increase in referrals to the Trust over a short period of time.

Further investigation to ascertain the impact of these delays on the RTT standards is underway and will be combined with CCG formal investigation in discussions regarding penalties/formal compliance against standards.

Cancer

In April there was a 100% increase in patients being seen outside the 14 day standard. Whilst this is a pattern when bank holidays/school holidays occur, it is also as a consequence of a significant increase in the number of patients seen under this standard when compared to last year. There were a total of 733 patients seen in April 13 and we are projecting that 944 patients were seen in April 14. This includes an increase from 79 to 99 in Upper GI and 115 to 153 in Lower GI. The Trust is still predicting achievement and capacity for this growing demand is being factored into the full RTT recovery.

Cdiff

April performance has been disappointing and the quarter is at significant risk. Further information in relation to actions being taken are contained in the Quality report.

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

It should be noted that in the annual plan submission, Monitor were notified that we considered that we would achieve RTT and 4 hours and therefore we have failed plan in Q1.

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	