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Dear Dale

Elective Care Expectations

In response to Ian Dalton's letter dated 22nd August 2018 and on behalf of the CEO and Chair, the actions and assurance requested for Sherwood Hospitals NHS FT is outlined in the letter below. In summary, I can confirm:

- The Trust is committed to delivering elective care performance and activity levels alongside safe emergency care and the financial control total.
- All aspects are reviewed, challenged and agreed by the Trusts Senior Leadership Team and is discussed and triangulated at Board on a monthly basis.
- There is an appropriate monthly trajectory in place for reducing the volume of avoidable 52+ waits by March 2019
- The Trust has reviewed the 2018/19 elective activity plan and will continue to update and refine actual activity forecasts as appropriate.

Table 1 overleaf summarises the year end activity and performance forecast. Please note, the review of the elective activity plan has highlighted a difference in the SUS Day case activity plan (as shown in appendix 1 of the letter) when compared to the Trust SLAM plan due to the inclusion of OP Procedures.

A more detailed explanation can be found in section 1.4.

To ensure a clear and sensible assessment of plan vs activity, OP procedures have been stripped out of the DC and OP FA plan and shown separately grouped as OP procedure FA and FUP. This confirms the Trust is forecast to be within a +/- 4% tolerance to plan in these PODs.

For elective inpatient activity the Trust is forecasting to be below plan due to the impact of a sustained increase in NEL/Trauma activity, a reduced take up of WLI's and the movement of elective activity to DC and OP procedures.

The Trust will continue to work closely internally and with commissioners and local private providers to close appropriate gaps.

Table 1 - Summary activity plan vs forecast		March 18 Actual	June 18 Actual	Mar 19 Forecast
RTT Waiting List	Total waiting list size	24,196	24,793	23,205
Performance	Incomplete Standard	88.78%	90.04%	92%
52 Week Waits	52 + waits	28	21	0
Demand	Variance in referrals (GP) received YTD (percentage variance from provider plan)		2.76%	
New Outpatients	Total first outpatient activity YTD variance from plan (percentage variance from plan) *__Exclude OP procedures FA__ To reconcile to SUS use OPFA SP / OPFA MP / OP Procedures FA		+0.44%	-0.16%
Outpatient Procedures	OP Procedures / OP Procedures FA OP Procedures FUP		+3.9%	+3.75%
Day Case	Day case elective volume (spells) YTD variance from plan (percentage variance from plan) * __Exclude OP procedures - see note 1.4__ To reconcile to SUS include OP procedures		-1.02%	-0.62%
Elective Ordinary	Elective ordinary admissions YTD (percentage variance from plan)		-4.32%	-6.93%

1.1 RTT waiting list:

The 2018/19 incomplete plan is based on 3 years of historical data and confirms a reduction in the overall waiting list size to 23,205 by March 2019. The actual size of the PTL has grown since March 2018 however this is in line with trajectory.

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July Trajectory	July Final	Aug Trajectory	August Forecast	September to March 2019 Trajectory
Total Incomplete	24,976	24,274	26,001	24,585	25,461	24,794	25,512	25,698	25,920	25,958	25,920 - 23,205

Risk to delivery:

- Overdue Follow up Community Paediatric activity will transfer onto the live Incomplete PTL from September onwards. This is a change from the planning assumption. The expected increase in denominator is 1,000.

Mitigation:

- Focus on dating follow up activity before it becomes overdue (it is at this point that the activity is transferred to the live Incomplete PTL).
- Working with commissioners to maintain funding for the second locum consultant – CCG decision has been delayed by a further month.

1.2 RTT performance:

April 2018 to July 2018 has seen a month on month improvement on the March 2018 position.

Currently forecasting a small reduction in August due to non- delivery of actions in Cardiology, Urology and Ophthalmology (August position yet to be finalised). The Trust is committed to delivering the standard before winter 2018 and as a minimum will continue to deliver >90%.

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July Trajectory	July Final	Aug Trajectory	August Forecast	September to March 2019 Trajectory
%	89.59%	89.15%	90.96%	90.01%	91.75%	90.04%	92.00%	90.60%	92.01%	90.31%	92.00%

A number of actions including use of the private sector and GPWSI underpin recovery. Activity has already transferred to the Private sector for Orthopaedics to support RTT recovery (45 in August). Oral surgery activity (c20) will be sent in September. Private sector contracts are in place and can be mobilised immediately.

Risk to delivery:

- Orthopaedic Trauma and Cancer demand continues to exceed planning assumptions.
- Number of specialties reliant on locum medical staff incl. Cardiology and Gastroenterology

Mitigation:

- Use of the Private Sector for routine Orthopaedic work. In place
- Additional Trauma capacity secured to reduce impact on Elective capacity
- Use of the Private sector for routine Urology and General Surgery activity – c20-40 cases
- GPWSI in place to support Cardiology. In place
- ENT convert 2 OP DCC's to DC DCC's from the end of October 2018
- Offer WLI's as required. In place

Further Assurance:

- Patients are booked in chronological order and in line with Access policy.
- The Trust is actively validating live RTT records. This should be undertaken weekly and does require strengthening. A roll out of the Elective Access training new and refresher in Q3 and Q4 will support this.
- The Trust monitor clock stops vs clock starts on a weekly basis adjusting for any nullified pathways.

1.3 52 Week Waiters:

The 2018/19 plan shows a reduction in the volume of avoidable waits to zero by the end of March 2019. The trajectory was based on an agreed programme of work across all specialties to validate and review a backlog of open referrals due to historic issues following PAS migration and other technical and process issues. The validation will continue until December 2018. Regional NHSI colleagues are updated on a monthly basis at the PRM.

For context, the vast majority of 52+ waits are due to a historic data quality issues and not due to long waits for surgery, etc. The nature of the 52+ will be non-admitted activity as most patients require a face to face follow up and are discharged. To date no harm has been identified.

An exception report is submitted to Board on a monthly basis and provides an update on the volume of 52+ due to validation and those considered "real" 52+.

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July Trajectory	July Final	Aug Trajectory	August Forecast	September to December Trajectory	January to February Trajectory	March Trajectory
52+	20	29	17	40	15	21	12	18	12	14	12	6	0

Risk to delivery:

- Whilst the historic validation project and clinical review is ongoing, additional 52+ week waiters can be added straight onto the waiting list at any time.
- The conversion rate from notes review to confirming 52+ is difficult to predict, therefore a weekly trajectory would not add any value in terms of additional actions required either by the CCG or Trust. Most patients simply require a face to face follow up and are discharged.

Mitigation:

- The Executive team have committed to offering (where appropriate) a follow up appointment within 2 weeks of identification
- All 30+ long wait patients are actively progressed at the weekly RTT PTL meeting chaired by the Deputy COO for Elective Care.
- There is a number of "safety net" reports such as "awaiting reports" and "not added to waiting list" that are reviewed at the Weekly RTT meeting
- The number of patients waiting 40 and 52 weeks by specialty admitted/non admitted with and without a TCI is shared with the CCG and NHSI on a weekly basis.

1.4 Activity Summary

Table 2: Reconciliation SLAM to SUS (Activity plan submission):

POD	Activity Plan	Forecast as at M04	Year-end Variance
Elective	6,196 (as per SUS plan)	5,767	-429
Day case (incl OP procedure plan)	40,433 (as per SUS plan)	37,598	-2,835
Day case (excl OP procedures)	31,842 (SLAM only)	31,646	-196
OP New (incl OP procedures FA)	102,475 (as per SUS plan)	103,874	+1,402
OP New FA SP/MP	87,121 (SLAM only)	86,981	-139
OP procedures OP procedures FA OP procedures Fup	51,407 (SLAM only)	53,335	+1,928

Table 2 aims to clarify the position in terms of the activity plan and actual in SUS vs the activity plan and actual in SLAM. The Trust did include (as part of the DC plan) a volume of OP Procedures. The actual activity for OP procedures is recorded (in the main) against the OP FA and FUP Procedure PODS. Table 2 shows that if the actual activity is matched correctly against plan that there is no significant under-delivery against DC.

1.4.1 Demand

In your letter (appendix 1 current performance as at Q1) the table shows demand exceeding plan by 2.76%. The CCG and Trust joint 18/19 Elective Transformation Programme, has several key components which will free up capacity for patients on the waiting list, these include an increase in utilisation of Advice & Guidance pathways and the implementation of a MSK Hub.

The Transformation of Outpatient Services programme includes the development of virtual clinics which are led by either a GPwSI or Consultant which will review all GP referrals ensuring that the patient receives as much care and treatment within a primary/community care setting and only those patients that require a face to face Outpatient appointment attend secondary care. Current specialties where this model is in operation are Dermatology and Gynaecology with Cardiology being rolled out during September.

The Trust continues to work with partners across the ICS to review QIPP opportunities, using comparative data to identify variation in referral volumes and referral management opportunities.

Note: A refresh of the Trust-wide Demand and Capacity modelling commenced in August 2018**.**

1.4.2 First Outpatient Activity

First Outpatient Single/Multi Practitioner for months 1 to 4 is marginally ahead of plan (+130). Forecast year end position is marginally behind plan (-139). This is well within 4% tolerance.

First Outpatient activity will not be affected over the winter period. The Trust has committed to focus on reducing unnecessary follow up activity in 2018/19.

1.4.3 Day Case Activity

As described in table 2, the assessment of under-recovery as at month 3 SUS DC activity plan is distorted by an anomaly during the planning submission whereby DC and OP procedure plans were submitted as a single DC plan, much of the actual activity (particularly in Gynaecology) is recorded in New OP (procedure) and Follow up (procedure).

Drivers

- Day case under-recovery is predominantly due to staffing gaps in Gastroenterology (Endoscopy) in Q1 and an error in the DC plan for Gynaecology.

- Recovery plans in Gastroenterology are focussed on additional (sub-contracted) Endoscopy activity in the private sector. This will be c 2 sessions per week from October and is likely to focus on surveillance patients (c80-100) to support releasing capacity for 2WW and RTT activity.

- Gynaecology under-recovery is due to activity recorded as First and Follow up Outpatient procedure attendances and the initiation of a QIPP scheme in April 2018 identified using GIRFT and the Model Hospital to reduce the volume of unnecessary diagnostic hysteroscopies. The latter will be adjusted in the activity plan for 2019/20

- All surgical specialities are forecasting to over-deliver against the DC plan in the main this is due to a shift from Elective to DC but also a focus on DC activity in January and February 2019 when routine inpatient elective operating will cease to support delivery of the Trust winter plan.

1.4.4 Elective activity

Drivers

- Impact of NEL demand, notably a sustained increase in orthopaedic trauma on elective orthopaedic capacity

- Seeing a reduced take up of additional WLI's

- ENT – Surgeon off sick for 2 months. Unlikely to recover underperformance as at M05 but forecast to be on monthly plan as a specialty from M06 onwards.

- General Surgery – Converted 1 elective list per week for "hot" Laproscopic Chole's which is recorded as NEL activity.

- Following a review of a series of benchmarking information available from Model Hospital, BADS and GIRFT visits, there was a consistent theme of day case surgery rates being below national expected levels for the following procedures:

    - Tonsillectomy
    - Septoplasty
    - Circumcisions
    - Transurethral Resection of Bladder Tumour
    - Orchidopexy

- Upon investigation, these were predominantly coding and counting issues, where patients were admitted to an inpatient ward, with a LOS of 0 days and coded as an Elective. The Trust has changed its practice to record all these procedures as an intended management status of Day Case, regardless of the ward they are admitted to.

- Within the Theatre Workstream there are a number of initiatives to drive improved Day Case Rates for a number of procedures such as:
    - Anterior Cruciate Ligament repairs by extending the hours of Physiotherapy input on our Day Case Ward
    - Urology Outreach for TWOC in Community for Transurethral Resection of Bladder Tumour

Assumptions in DC and Elective forecast:

- Routine Inpatient elective surgical activity will cease in January and February 2019
- September to December Trust will continue to maximise theatre productivity gains
- Day case activity will continue as no impact on IP beds
- Outpatient and diagnostic activity will continue
- Any surgical outsourcing of activity to deliver performance will be over and above current activity forecast and will be IPT'd at no cost to SFHFT
- Any diagnostic (Endoscopy / Angio) outsourcing of activity to deliver performance is planned to be sub-contracted meaning SFHFT will record the activity and income and offset against cost (to be agreed at no greater than tariff).

Should you require any further information, clarity or assurance please do not hesitate to contact me.

Yours sincerely

Andy Haynes
Medical Director & Deputy Chief Executive