Sheffield Teaching Hospitals NHS
NHS Foundation Trust

Council of Governors

2 December 2014

Chief Executive's Report

1. PERFORMANCE

At the end of quarter 2, the Trust has continued to make good progress in meeting its operational targets. At the end of quarter 2, all targets were met with the exception of the Referral to Treatment (RTT) time target for admitted and non-admitted patients. This target (more commonly known as the 18 weeks target) has been challenging for some time in particular in view of a 4.5% increase in referrals which has occurred in the first 6 months of 2014/15. The dashboard is attached at Appendix 1.

As a result, the Trust has not been able to meet the target for non-admitted and admitted patients for some months. The predicted November position is:

- 94.6% for non-admitted patients against target of 95%.
- 87.2% for admitted patients against target of 90%

This reflects the improved performance over recent months and a relatively small gap between the target and the current performance. A more detailed paper on this matter is attached at Appendix 2.

The performance against the C.Diff target is now within the Monitor target due to the decision to only consider cases which arise from a lapse in care against the target. A more detailed explanation is set out below in the section of my report concerning infection, prevention and control.

In financial terms, the month 6 position shows a deficit against plan of £336k which is 0.1% of the budget to date. The operating position deteriorated by a further £500k in September 2014 to £4.3m (0.9%) but the release of uncommitted contingencies (£8m full year and £4m year to date) from month 6 has had a significant impact on the overall position.

The key ongoing financial management actions remain to drive the efficiency programme, to progress the work with financially challenged directorates and secure good general directorate financial performance, to contain operational and cost pressures, to manage contractual issues and deliver contract targets, to deliver CQUINS schemes, and to maximise contingencies. Maintaining activity levels through winter and industrial action, minimising contract penalties and securing an "infrastructure payment" from NHS England to compensate for inadequate tariffs for the Trust's most complex work will be crucial to the ultimate out-turn position.

Looking ahead to 2015/16, internal financial planning is now well underway, it is likely that the Trust will need around £30m of further efficiency savings in 2015/16 if financial balance is to be achieved. This will be a significant challenge. The Trust will also need a fair national settlement in terms of tariffs and other business rules, a reasonable outcome to contract negotiations and robust internal financial and business planning.

The expected publication of 2015/16 national tariff and other information at the end of October 2014 has been delayed and this probably reflects the difficulty of framing a settlement which is deliverable to both Commissioners and Providers.

In terms of current performance, the challenges of maintaining the flow for patients attending as emergencies have become evident in early November 2014 and the Winter Preparedness report elsewhere on the agenda addresses this issue and how it has been managed in more detail.

2. RIGHT FIRST TIME

Programme highlights for the last three months
The key developments across the various workstreams are listed below:

Integrated Care:
- Further developments with input of Social Workers, Community Nursing Services and GPs to co-ordinate care planning and management for patients at high risk of admission.
- Over 3000 patients at high risk of admission in the city now have multi-disciplinary care plans agreed to help them stay well supported at home.
- The medicines optimisation scheme for patients on multiple prescriptions will be expanded.

Intermediate care:
- Active Recovery (home based rehabilitation for step up and step down care) is now taking 97% of its referrals within 24 hours, significantly reducing delays.
- The extension of Discharge to Assess continues and is now drawing interest nationally. Sheffield hosted a Webinar for approximately 100 health and social care staff around the country on the model developed in STHFT.
- The Single Point of Access now has Social Workers in the service 8am – 10pm, 7 days a week and this is enhancing the ability to find alternatives to admission where appropriate.

The Right First Time partners commissioned the Office for Public Management to evaluate the key areas of intermediate care and associated services that have received investment over the last two years. The detailed report was received by the RFT Board in October 2014. It highlighted many positives for the progress made including:

- Improvements in the transitional care arrangements and integration of teams (less people 'going round the cycle').
- Increased use of services all round and more timely access to services.
- Admissions have been avoided due to the work of the programme.
- Fewer permanent care home admissions.
- Decreasing lengths of stay and decreased waits for intermediate care beds and Active Recovery.
- Good service user experiences across all services.
- Frailty Unit has reduced length of stay and mortality rates of the patient group they see.
- NRP limits the number of moves for vulnerable patients.
- The King's Fund: Making our health and care systems fit for an ageing population (Oliver et al) identifies nine care components with goals for best practice - RFT compares well and has implemented most of the key attributes.

It also highlighted some key recommendations including:

- Need to increase awareness in primary care of the services being developed.
- Need to improve engagement with carers, Housing Services and Yorkshire Ambulance Service in the workstreams.
- Need improved linkages with mental health assessments and provision across services, especially dementia services.
- Assessment for long term care needs in an acute setting is not ideal – need to consider Discharge to Assess process and more prevention of hospitalisation.
- Need equity of services in and out of hours (e.g. SCELS)
- Transfer of information by paper based records and use of different electronic systems impedes efficiency of services / staff.
- There have been financial savings to the system but no cash released to the wider system.

Challenges Ahead

This focuses mostly on the changing nature of the partnership model for Sheffield. The emergence of the Integrated Commissioning Programme (Better Care Fund) demonstrates the Commissioners' (CCG and SCC) determination to develop integrated models of care in the city and this will build on the work started within Right First Time. It has already resulted in the development of a strategic commitment between the three Foundation Trusts and the newly established GP Provider Board to collaborate further on the development of integrated care.

3. WORKING TOGETHER

The Working Together Programme (WTP) is a partnership between seven hospital Trusts in South Yorkshire, Mid Yorkshire and North Derbyshire. Its aim is to work together on a number of common issues and deliver benefits that each Trust would not achieve by working on their own.

Since January 2014 a number of projects, both clinical and non-clinical, have been established and are making good progress achieving some real benefits for patient care, use of resources and sharing good practice. The first collective procurement of examination gloves achieved significant savings with a number of other joint procurements on medical and consumable products in the pipeline.

An innovative agreement to share information through OpenNet ICE has been implemented and is enabling clinicians to access test results much quicker across the seven Trusts.

Several reviews of services, led by clinicians, are also underway which are focused on delivering safe and sustainable services across the patch by sharing expertise, out of hours cover and addressing workforce constraints through future collaborative recruitment and training approaches.

4. INFECTION, PREVENTION AND CONTROL

This report provides information on the year to date performance against the MRSA bacteraemia plan for 2014/15, the *C.diff* plan for 2014/15 and also the MSSA bacteraemia plan for 2014/15. Information is also included on the number of cases of E.Coli bacteraemia. In addition, attention is drawn to a number of key IPC issues.

2014/15 MRSA PERFORMANCE

MRSA thresholds for 2014/15

Bacteraemia are either classified as Trust attributable or community acquired. Each case of MRSA bacteraemia is subject to a Post Infection Review (PIR). The responsibility for conducting the PIR is determined by when the bacteraemia is identified; for any bacteraemia identified on day 0 or day 1, the patient's Clinical Commissioning Group (CCG) organise the PIR, for any case identified after that the Trust organise the PIR.

NHS England adopted a zero tolerance approach to MRSA bacteraemia from 2013/14 and as such the Trust national target remains zero. Any cases attributed to the Trust will be subject to a contractual penalty of £10k.

Monitor no longer use MRSA bacteraemia as an indicator.

MRSA performance for October 2014

There has been 1 case of MRSA bacteraemia recorded for the month of October. A PIR meeting has been held the outcome was that this case should be classified as "third party – intractable". This is because the most plausible cause of the bacteraemia was thought to be from the gastro-intestinal tract. The host CCG, NHS Barnsley, agree with this conclusion and the case will now be considered by an arbitrator at NHS England for them to either ratify or challenge this view. If this was agreed to be intractable then this case would not count as a Trust attributable case.

It has been 127 days (up to 31 October 2014) since the last case of MRSA bacteraemia was attributed to the Trust, with one case pending the outcome of a PIR.

The year to date performance is 1 case of MRSA bacteraemia attributed to the Trust (1 case pending the outcome of a PIR) against the threshold of zero.

For 2014/15 the target for MRSA is zero.

MRSA Screening

October MRSA screening figures were 112%.

The MRSA screening figures are calculated using the number of screens processed by the laboratory for the month divided by the number of admissions for the month. This is used as a proxy measure as the Trust information systems are not able to reconcile individual screens with individual patients. A figure of over 100% may indicate that the volume of screens being undertaken is in line with all patients being screened for MRSA as per Trust policy.

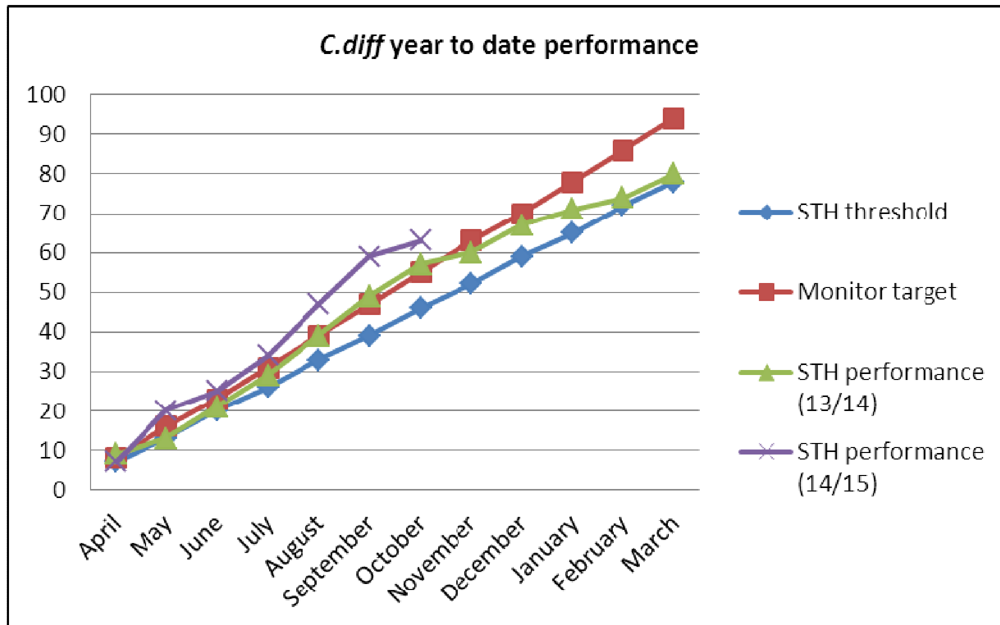
To ensure that MRSA screening protocols are being followed at ward and department level, the Infection Control Programme specifies how the IPC team will undertake MRSA screening compliance audits in each area each year.

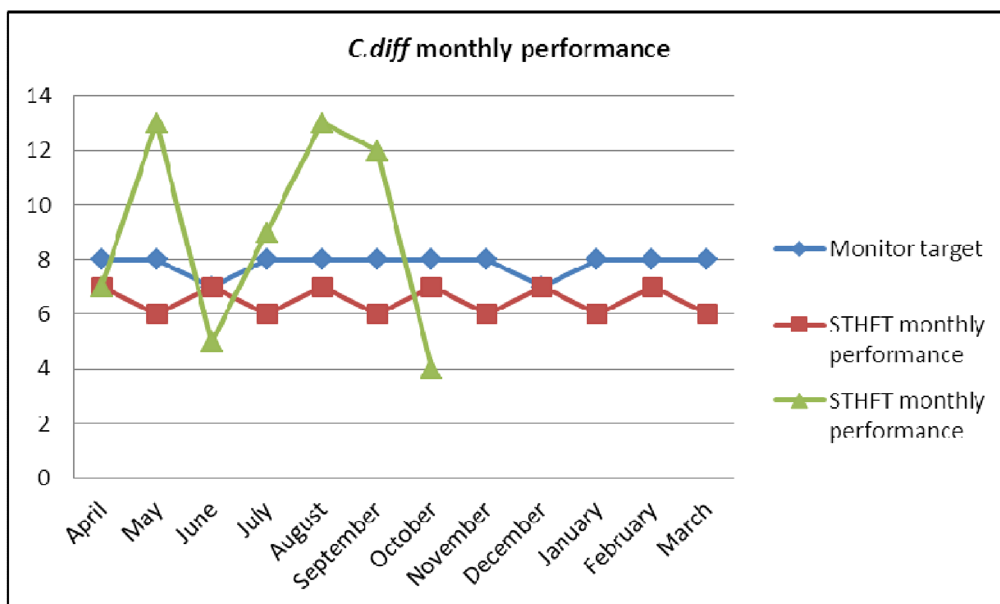
2014/15 *C.DIFF* PERFORMANCE

STHFT has recorded 4 positive samples for October. The year to date performance is 63 cases of *C.diff* against an internal threshold of 46 and a Monitor threshold of 55.

The Trust has been set a contract threshold of 94 cases, but to ensure that we aim to maintain a year on year improvement on the number of cases of *C.diff* attributable to the Trust an internal target of 78 has been set.

Monitor has retained *C.diff* as a target in the Risk Assessment Framework.





As indicated in the performance section above, discussions with Monitor have highlighted that although they continue to note the total number of cases attributable to the Trust; they are only considering those cases which were associated with a lapse in care against the target of 94.

The types of issues which would result in the infection being considered to be associated with a lapse in care could be any case where there was evidence of transmission of *C. difficile* in hospital such as via ribotyping of the infection indicating the same strain is involved, where there

were breakdowns in cleaning or hand hygiene, or where there were problems identified with choice, duration, or documentation of antibiotic prescribing. It must be noted that none of these would indicate that the infection was definitely caused by the provider organisation, only that it cannot be stated that best practice was followed at all times.

The Infection Control Doctors (ICD) have considered which of the 25 cases of *C.difficile* attributed to the Trust in quarter 1 they believed to have been associated with lapses in care. Review of the root cause analyses from these cases led to the ICDs concluding that 8 cases were and 17 cases were not associated with lapses in care. These cases have subsequently been reviewed by NHS Sheffield Clinical Commissioning Group which agrees with these findings. The root cause analyses from quarter 2 are currently being reviewed by the ICDs prior to review by NHS Sheffield.

There were 34 cases of *C.diff* in quarter 2, and 8 cases of *C.diff* associated with lapses in care in quarter 1. Even if all the quarter 2 cases were associated with lapses in care the Trust would still be under the Monitor trajectory target of 47 by the end of quarter 2, as the maximum number of cases it would have recorded would be 42.

Discussions are beginning with NHS Sheffield Clinical Commissioning Group about the Contract Penalties and how they will be applied if the Trust breaches its contract target.

As the Trust is now above the contract and internal threshold, the Infection Control Operational Group has devised an action plan based on the Trust *C.diff* plan for 2014/15. Monthly review of the *C.diff* Action Plan commenced at the Healthcare Governance Committee in July 2014.

Surveillance

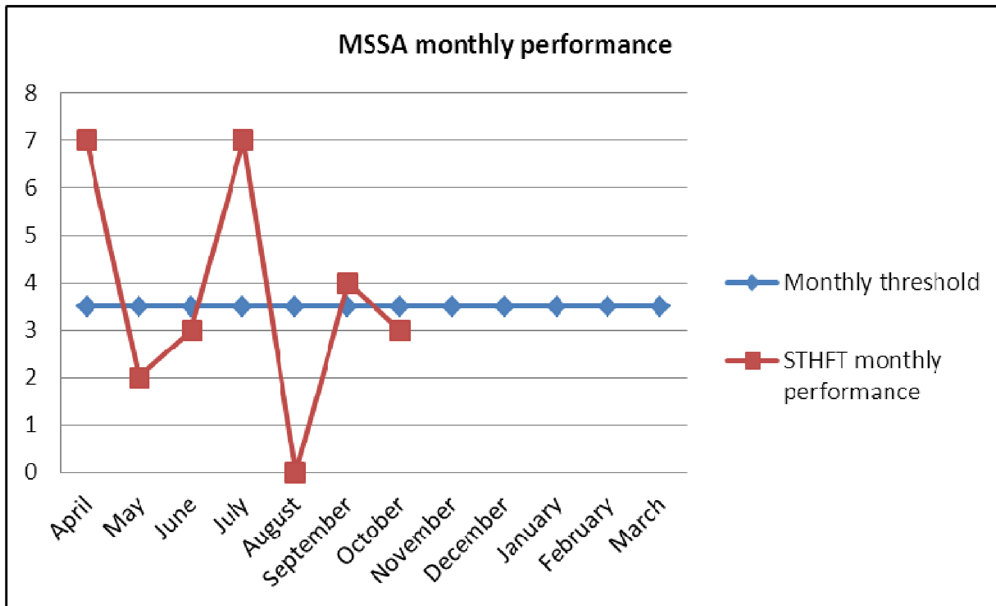
No clinical areas on either campus are currently under surveillance for *C.diff* having had at least 2 episodes of *C.diff* within a 28 day period.

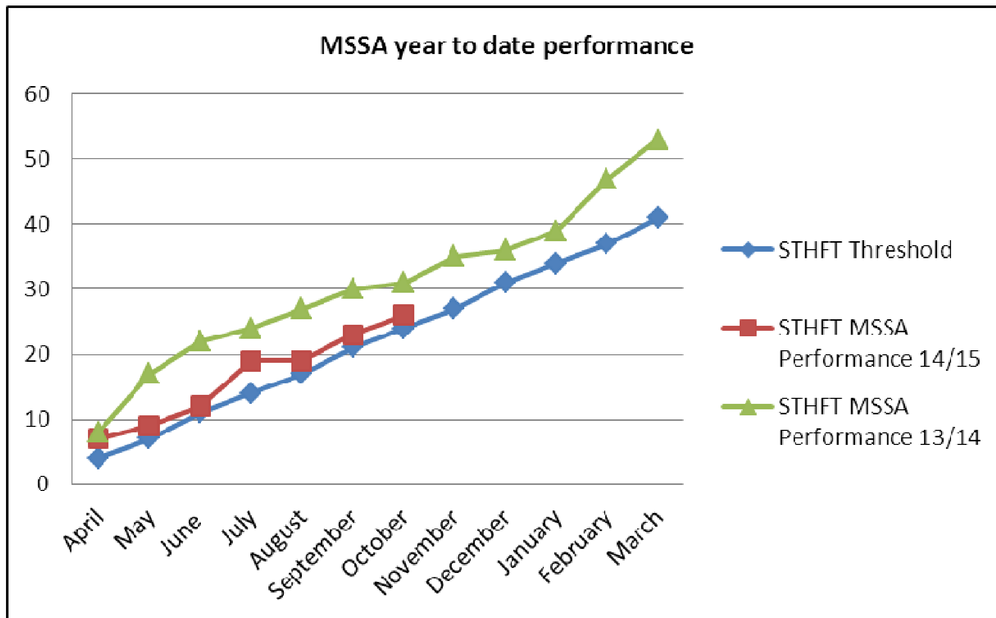
It is good practice to consider carefully any areas which experience more than 1 episode of *C.diff* within a 28 day period. The positive samples are tested to see if they are the same ribotype which may indicate that cross infection has taken place. A series of audits are undertaken by the IPC team to check performance on essential infection control standards such as commode cleanliness and hand hygiene regardless of whether the episodes of *C.diff* are thought to be linked or not.

MSSA

The Trust continues to return data on the number of cases of MSSA bacteraemia to Public Health England. Cases are labelled as either Trust attributable or community acquired. For October, 3 Trust attributable cases of MSSA bacteraemia were recorded; this is better than the monthly trajectory that the Trust has set itself.

The year to date performance is 26 cases against an internal threshold of 25. There is no threshold set for MSSA bacteraemia in 2014/15 however, alongside the MSSA improvement plan; the Trust set itself a target of having 42 or less cases for 2014/15.





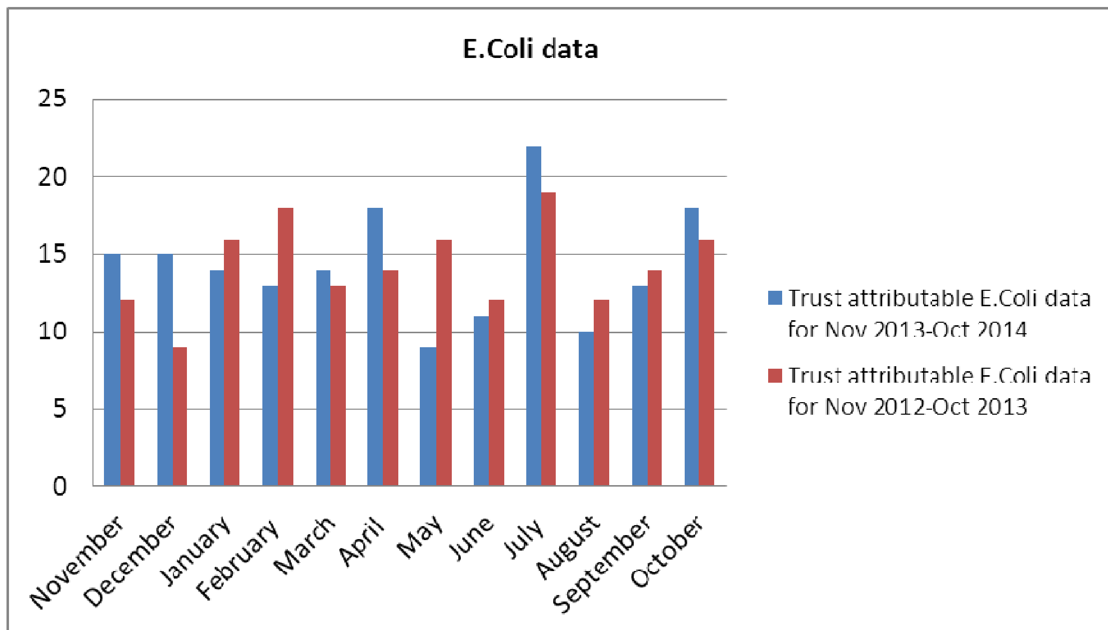
E.COLI

The Trust commenced returning data on the number of cases of E.Coli bacteraemia to Public Health England in June 2011. Cases are labelled as either Trust attributable or community acquired. For October, 18 Trust attributable cases of E.Coli bacteraemia were recorded.

Currently, it is not expected that the Trust will be set a reduction target for E.Coli bacteraemia as E.Coli bacteraemia is often not directly associated with healthcare.

For the last 12 months (November 2013 – October 2014) the total Trust attributable cases of E.Coli bacteraemia stands at 172 cases.

For the previous 12 months (November 2012 – October 2013) the total Trust attributable cases of E.Coli bacteraemia stood at 171 cases.



There are currently no national benchmarks available to allow the Trust to compare its performance with that of other Trusts.

INFECTION PREVENTION AND CONTROL

Norovirus

The Trust had fewer cases of Norovirus during October than in September which has resulted in minimal disruption to service delivery.

Quarterly Infection Prevention and Control feedback from Groups / Departments to the Board of Directors

As part of the Trust's Infection Control Programme, wards and departments have the opportunity to raise issues which they feel the Board of Directors should be aware of. The returns for quarter 2 identified the following new issue:

- The Respiratory Directorate have highlighted that work is currently underway to refurbish the side rooms on Brearley 2 to enable the management of Cystic Fibrosis patients with Cepacia and Mycobacterium Abcessus, who need to be cared for on a different ward to the Cystic Fibrosis Ward.

5. NURSE STAFFING

Governors will be aware that nurse staffing levels are now reported to the Board of Directors in public each month. Generally the Trust is doing well in ensuring a high correlation between planned and actual staffing levels but on those small number of occasions when the gap between

planned and actual staffing levels is greater than 15% the reasons are set out in full in the monthly Board report.

6. APPOINTMENTS

Following a number of retirements and secondments from the posts of Operations Director (previously known as General Managers), a recent round of interviews have taken place with the following appointments being made to the Groups as set out below:

- Operating Services, Critical Care and Anaesthesia – Lisa Walton (currently on a national fast-track executive stream placement with the organisation leading the programme on surgical flow).
- Head and Neck – Carolyn Wilkie (current substantive post as Deputy General Manager in Head and Neck, Obstetrics and Gynaecology and Neonatology).
- LEGION (Labs, Engineering, Gynaecology, Imaging, Obstetrics and Neonatology) – covering maternity leave for the current Operations Director for a period of 12 months – Sue Gregory (current substantive post of Deputy General Manager in Head and Neck, Obstetrics and Gynaecology and Neonatology).
- Surgical Services – Vickie Leckie (current substantive post as Deputy General Manager in Surgical Services).

7. COMMUNICATIONS

The Trust's work continues to be highlighted at key national and regional health award ceremonies, including the Health Service Journal Awards, the Yorkshire and Humber Medipex NHS Innovation Awards and the NHS Leadership Recognition Awards. Two teams were recognised at the Health Service Journal Awards, which is widely recognised as one of the most coveted awards in healthcare. This included the electronic check-in and workflow system (Improving Care with Technology category) and the Front Door Response Team (Secondary Care Redesign).

We also had four finalists in the Yorkshire and Humber Medipex NHS Innovation Awards, which highlight hospital innovations that point to the future. Among the shortlisted teams were the Jessop Wing's regional MRI scanning service allowing safer management of serious pregnancy complications, and a new way of diagnosing digestive disorder bile acid malabsorption developed by our nuclear medicine department.

Dr Diana Greenfield, a consultant nurse leading the way in cancer care and Steve Harrison, a manager inspiring a generation of NHS professionals to improve the quality, safety and value of care they provide through the Microsystems Coaching Academy have both been nominated in the NHS Leadership Recognition Awards. Dr Greenfield has been shortlisted in the 'Inspirational NHS Leader of the Year' category and Steve in the 'NHS Coach/Mentor of the Year' category.

Last month saw the successful launch of a £580,000 fundraising campaign for a new helipad at the Northern General Hospital. The appeal, called Saving Time, Saving Lives, has been launched by the Sheffield Hospitals Charity to raise funds to build a new helipad close to the hospital's A&E department, and was featured widely in the local media, including the Sheffield Star and ITV Calendar.

Yet again Sheffield was the host for a major international conference, which saw thirty leading consultant urologists, professors and their students from across the world gather to celebrate a multi-million pound project which has been training the next generation of urology scientists over the past four years.

The €3.2 million Training Urology Scientists to Develop Treatments (TRUST) project, which was funded by the European Union and led by Sheffield Teaching Hospitals NHS Foundation Trust, showcased best urological practice and is an excellent example of the leading international role the Trust is taking in urological care and research.

Andrew Cash
Chief Executive
26 November 2014

Appendix 1

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

SUMMARY OF OVERALL PERFORMANCE

OCTOBER 2014

	Target	Monitor Weightings	Oct	Q2	Q1	YTD 14/15	Last Year 13/14
FINANCIAL POSITION	In financial balance		↓			↓	
CANCER WAITS							
2 WEEK WAITS	93% seen within 2 weeks	1.0	↔				
31 DAY DECISION TO TREAT TO TREATMENT	96% treated within 31 days	1.0	↔				
62 DAY REFERRAL TO TREATMENT	85% treated within 62 days	1.0	↓				
31 DAY SUBSEQUENT TREATMENT	98% treated within 31 days	1.0	↔				
18 WEEK REFERRAL T0 TREATMENT							
ADMITTED PATHWAYS	90% seen within 18 weeks	1.0	↑				
NON ADMITTED PATHWAYS	95% seen within 18 weeks	1.0	↑				
INCOMPLETE PATHWAYS	92% waiting less than 18 weeks	1.0	↑				
ACTIVITY							
ELECTIVE INPATIENTS	On target	n/a	↓			↓	
NON ELECTIVE INPATIENTS	On target	n/a					
NEW OUTPATIENTS	On target	n/a	↑			↓	
FOLLOW UP ATTENDANCES	On target	n/a	↓			↓	
A&E ATTENDANCES	On target	n/a	↓			↑	
A&E STANDARDS							
WAITING TIME	95% seen within 4 hours	1.0	↓			↓	
PATIENT EXPERIENCE							
MRSA*	No more than 1 case in 2 months	1.0	↔				
CLOSTRIDIUM DIFFICILE	7 cases or less per month	1.0	↑			↑	
NEVER EVENTS	No never events	n/a					
MIXED SEX ACCOMMODATION	No breaches	n/a					
OPERATIONS CANCELLED ON THE DAY	Less than 75 operations per month cancelled on the day	n/a	↓			↓	
CQUINS INDICATORS	On target for CQUINS indicators	n/a					

	On target
	<= 5% from target - activity only
	> 5% from target for activity. Worse than target for other indicators.
↑	improving from previous month
↓	deteriorating from previous month
↔	no change from previous month

Appendix 2

SHEFFIELD TEACHING HOSPITALS NHS FOUNDATION TRUST

EXECUTIVE SUMMARY

REPORT TO TRUST BOARD OF DIRECTORS

HELD ON 19 NOVEMBER 2014

Subject:	Update on 18 Week Wait Performance
Supporting Director:	Kirsten Major – Director of Strategy & Operations
Author:	Annette Peck – Head of Information
Status (see footnote):	A & D

PURPOSE OF THE REPORT:

This paper provides an update on the performance against the 18 week referral to treatment targets and describes the factors influencing that performance.

KEY POINTS:

The average waiting time for care at the Trust is 8 weeks.

The Trust continues to meet all the cancer treatment waiting time standards – the prioritisation of these urgent pathways inevitably sometimes impacts on our 18 week performance in non-cancer, non-urgent diagnoses.

The number of non-admitted and admitted patients treated within 18 weeks in September was below the required national waiting time standards. The figures were 82.0% (target 90% admitted patients) and 92.3% (target 95% non-admitted patients). The Trust has met the target for incomplete pathways (92%) every month so far this year apart from August when the performance was just below target at 91.9%. The position improved in September to be at 92.4%. When considered together these performance data demonstrate that Directorates are implementing their recovery plans and that the future position in relation to waiting times is considerably more robust and sustainable.

The Trust has received more referrals than expected throughout the year so far but has consistently delivered more inpatient and outpatient activity than contracted for by commissioners.

The number of 18 week pathways that have been closed in the second quarter of the year is higher than in the first quarter.

RECOMMENDATIONS:

The Board is asked:

a) To receive the more detailed description of 18 week RTT performance as requested previously by the Board of Directors.
b) To be assured that all actions are being progressed.
c) To identify any further actions the Board would want to pursue or progress.

IMPLICATIONS:

		TICK AS APPROPRIATE
1	Deliver the best clinical outcomes	✓
2	Provide patient centred services	✓
3	Employ caring and cared for staff	
4	Spend public money wisely	✓
5	Deliver excellent research, education & innovation	

APPROVAL PROCESS:

Meeting	Presented	Approved	Date
Board of Directors	DSO		19 November 2014

1Status: A = Approval
A* = Approval & Requiring Board Approval
D = Debate
N = Note

2 Against the five aims of the STHFT Corporate Strategy 2012-2017

1. Introduction

This paper provides an update on performance against the 18 week referral to treatment targets for the first six months of the year.

Until recent months, the Trust has always met the waiting times for patients receiving treatment within 18 weeks from the time they are referred by their GP. The average waiting time for patients having care at the Trust is 8 weeks and has remained at this level throughout the first six months. The Trust continues to meet all the cancer treatment waiting time standards

However, growing numbers of patients and their doctors are choosing Sheffield Teaching Hospital NHS Foundation Trust for their care and this has resulted in a significant increase in referrals. This has in turn made meeting the 18 week timeframes for treatment much more challenging as the number of patients waiting longer increased.

The need to reduce the number of long waiting patients was recognised and an action plan put in place to do this. As a consequence the Trust has not met the targets for admitted and non admitted pathways in recent months.

The performance across the 3 targets to date in 2014/15 is summarised in the table below.

Target	April	May	June	July	August	Sept
Non-admitted	×	×	×	×	×	×
Admitted	×	×	×	×	×	×
Incomplete	✓	✓	✓	✓	×	✓

The specialities that continue to be particularly challenged are Cardiac Services, Orthopaedics, Urology, Dental Specialities and Dermatology.

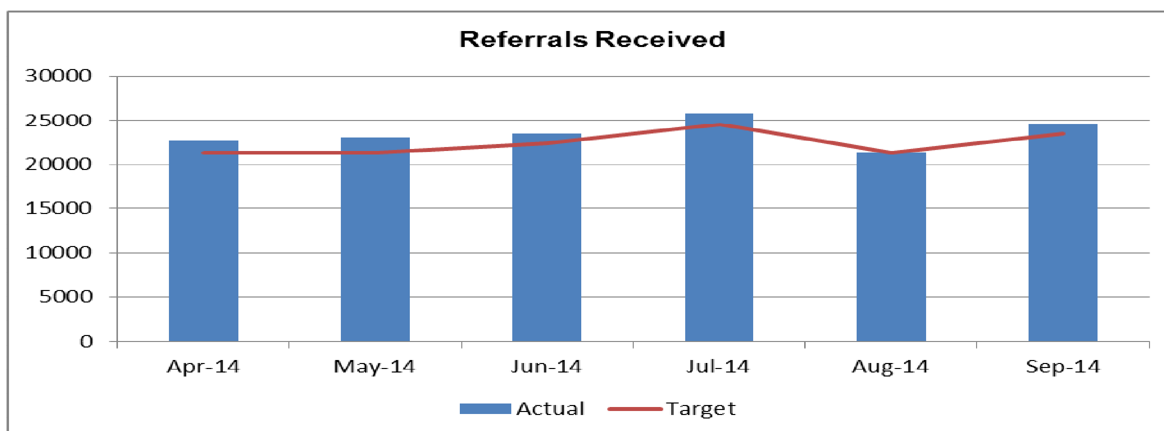
Appendix 1 provides further by specialty detail regarding waiting times and activity levels.

The factors influencing this position are analysed in more detail below.

2. Referrals to the Trust

At the start of the year the Trust agreed with its commissioners the level of referrals the Trust could expect to receive during the year. In the first six months there have been over 6,600 more referrals than the expected level; an over performance of 4.9%. Of these, over 4,500 have been from primary care.

Figure 1 Referrals Received

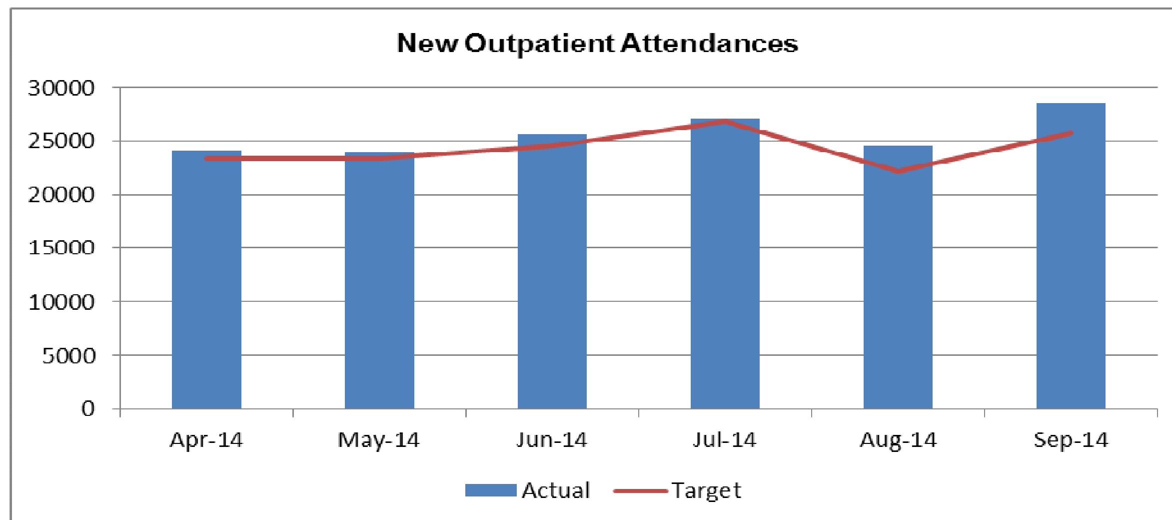


The increase has been across all specialities but has been particularly noticeable in those where achieving 18 weeks is proving difficult.

3. New Outpatient Attendances

The number of new outpatients seen has been has been above the target for every month so far this year. The cumulative position is nearly 9,000 attendances above the target; an over performance of 5.2%.

Figure 2 New Outpatient Attendances

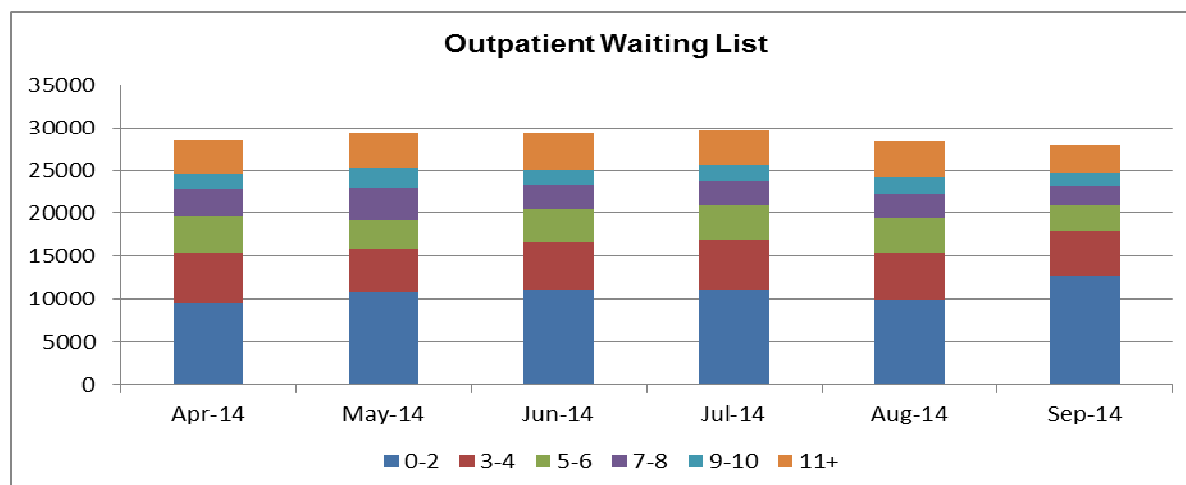


The majority of the specialities that are not delivering the 18 week performance have seen more outpatients than their target.

4. Outpatient Waiting List

The number of patients waiting for their first outpatient appointment increased during the first four months of the year but has now reduced again and is lower than it was in April. In April 20% of patients were waiting over 8 weeks for their first appointment but this has now fallen to 17%.

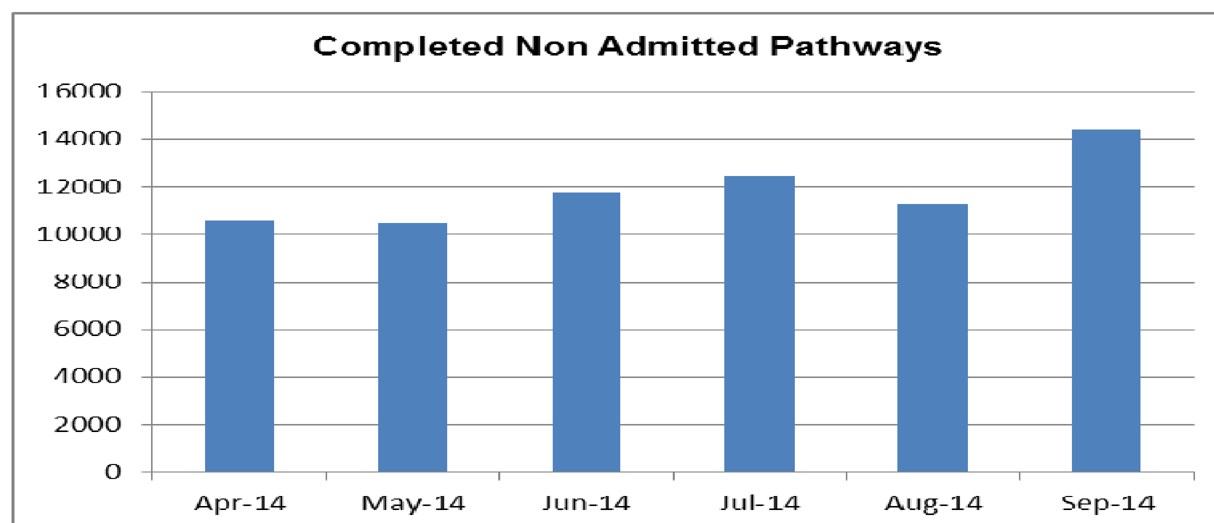
Figure 3 Outpatient Waiting List



5. Completed Non Admitted Pathways

Patients that do not require admission for their treatment are classified as being on non admitted pathways. These are patients who receive their first definitive treatment as an outpatient or who do not require treatment. The number of patients whose pathways have stopped in this way has increased significantly in the second quarter of this financial year from an average of 10,930 per month to an average of 12,720.

Figure 4 Number of Completed Non Admitted Pathways



As part of the recovery plan each directorate agreed a trajectory for the number of non admitted pathways that they would close between June and September.

The performance overall has been above trajectory but the balance between under and over 18 weeks has not been as anticipated, and this aspect of waiting times planning is notoriously difficult to predict as it reflects the balance between patients' length of wait and the clinical urgency of conditions.

Figure 5 Non admitted Pathways for period June to September

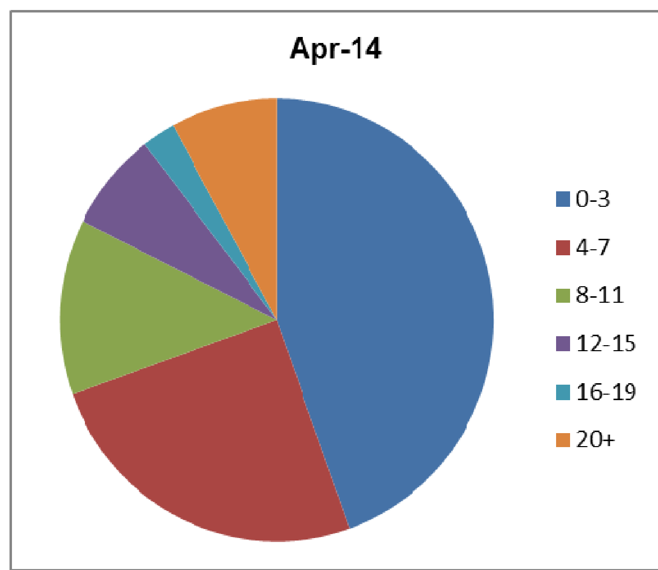
	Actual			Trajectory			Variance		
	Under 18 weeks	Over 18 weeks	Total	Under 18 weeks	Over 18 weeks	Total	Under 18 weeks	Over 18 weeks	Total
Cardiology	1152	144	1296	1308	400	1708	-156	-256	-412
Cardiothor Surg	207	0	207	324	0	324	-117	0	-117
Dermatology	3274	201	3475	3080	140	3220	194	61	255
ENT	2070	503	2573	1773	96	1869	297	407	704
Gastroenterology	1823	68	1891	1897	26	1923	-74	42	-32
General Surgery	798	29	827	909	32	941	-111	-3	-114
Geriatrics	206	7	213	219	0	219	-13	7	-6
Gynaecology	3319	125	3444	2851	118	2969	468	7	475
Neurology	2749	649	3398	2389	726	3115	360	-77	283
Neurosurgery	1195	112	1307	1093	107	1200	102	5	107
Ophthalmology	3226	28	3254	2734	85	2819	492	-57	435
Oral Surgery	1063	77	1140	873	75	948	190	2	192
Other	17629	907	18536	16319	960	17279	1310	-53	1257
Plastic Surgery	1743	94	1837	1802	181	1983	-59	-87	-146
Rheumatology	1186	26	1212	1019	32	1051	167	-6	161
Thoracic Medicine	634	22	656	910	11	921	-276	11	-265
Orthopaedics	2599	207	2806	2225	186	2411	374	21	395
Urology	1603	156	1759	1500	320	1820	103	-164	-61
Total	46,476	3,355	49,831	43,225	3,495	46,720	3,251	-140	3,111

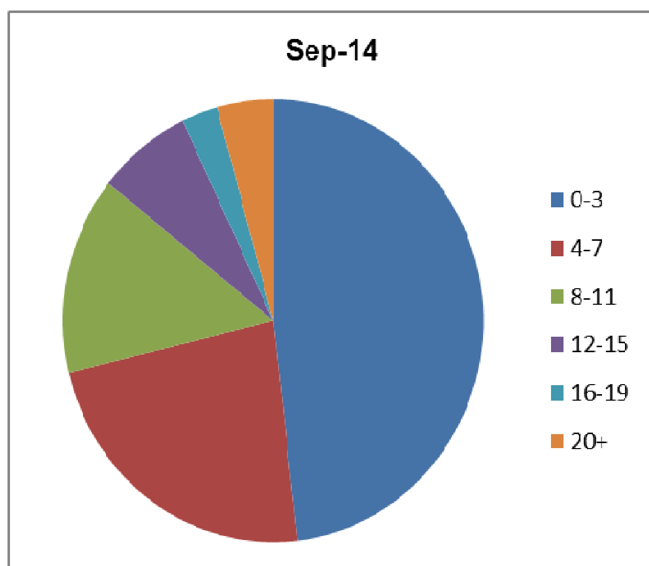
Directorates have now developed trajectories for the period October to December and work is underway to extend this to cover the last quarter of the year.

5.0 Inpatient Waiting List

If a patient requires treatment as an inpatient or day case then they are placed on the inpatient/day case waiting list. Although the number of patients on the list has remained more or less the same throughout the year so far, the number of patients waiting more than 3 months for their inpatient treatment has reduced from 1867 to 1521; a drop of over 3 %.

Figure 6 Inpatient Waiting List

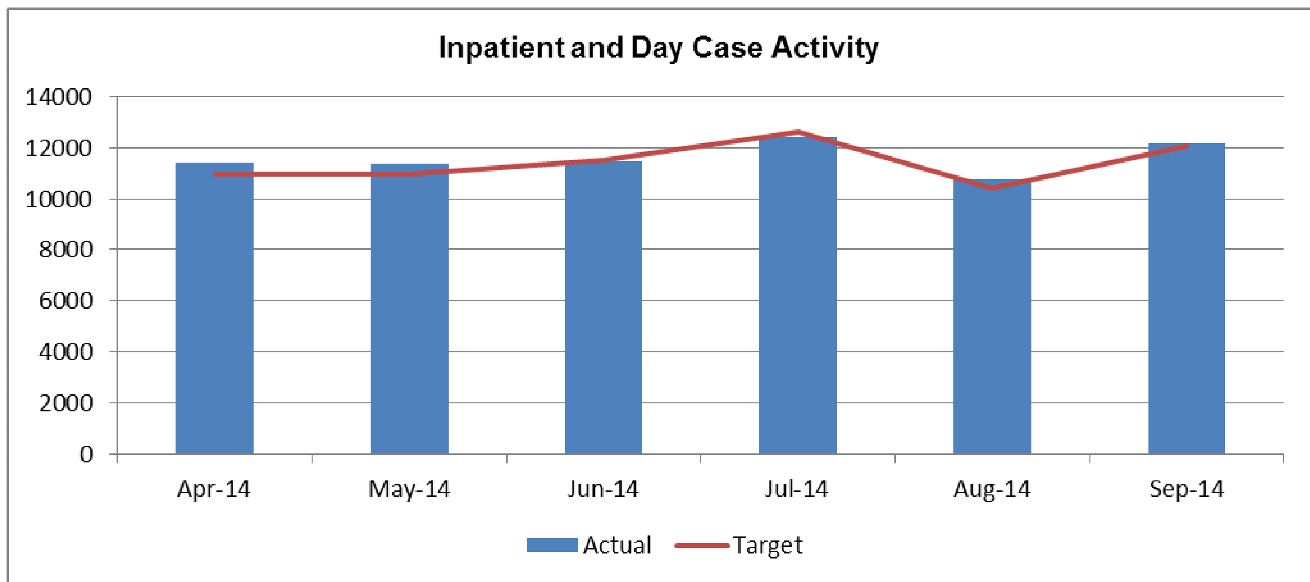




6.0 Inpatient Activity

The number of patients treated as inpatients and day cases has been at or above target for the majority of months so far this year and cumulatively is 910 spells above target.

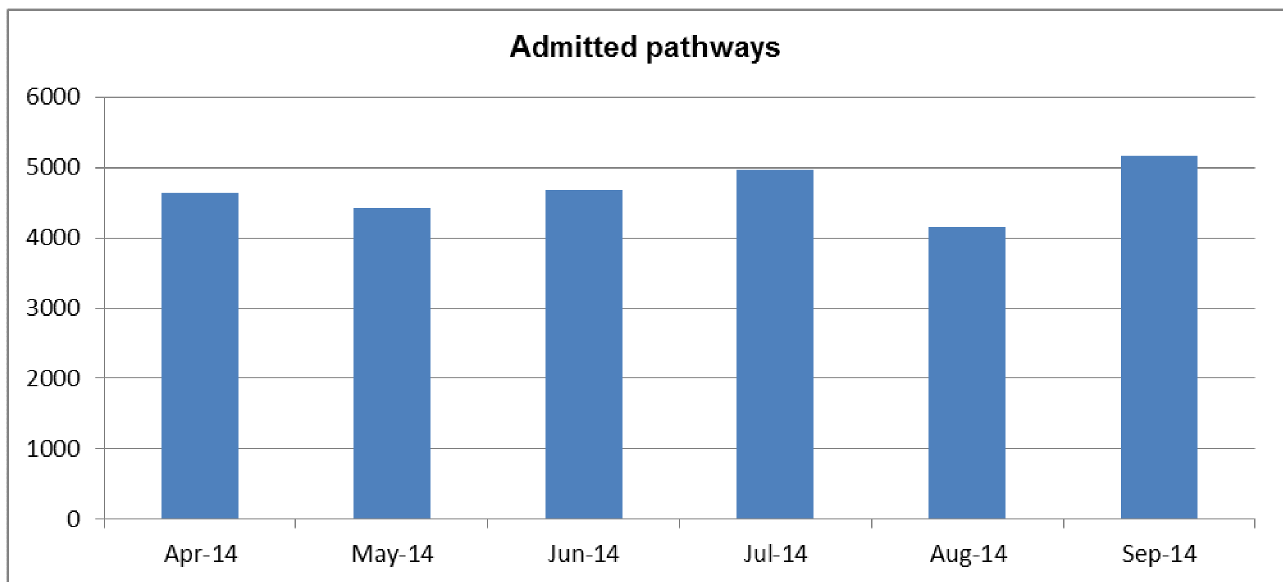
Figure 7 Inpatient and Day Case Activity



7. Completed Admitted Pathways

Patients that require admission for their treatment are classified as being on admitted pathways. The number of patients whose pathways have stopped in this way has increased significantly in the second quarter of this financial year from an average of 4578 per month to an average of 4764.

Figure 8 Completed Admitted Pathways



As part of the recovery plan each directorate agreed a trajectory for the number of non admitted pathways that they would close between June and September.

Figure 9 Admitted Pathways for period June to September

	Actual			Trajectory			Variance		
	Under 18 weeks	Over 18 weeks	Total	Under 18 weeks	Over 18 weeks	Total	Under 18 weeks	Over 18 weeks	Total
Cardiology	622	264	886	320	156	476	302	108	410
Cardiothor Surg	297	100	397	231	92	323	66	8	74
Dermatology	121	24	145	104	8	112	17	16	33
ENT	518	81	599	486	138	624	32	-57	-25
Gastroenterology	952	19	971	1055	30	1085	-103	-11	-114
General Surgery	462	52	514	653	73	726	-191	-21	-212
Geriatrics	5	0	5	0	0	0	5	0	5
Gynaecology	935	167	1102	983	116	1099	-48	51	3
Neurology	281	13	294	276	11	287	5	2	7
Neurosurgery	578	102	680	572	150	722	6	-48	-42
Ophthalmology	2197	653	2850	2435	814	3249	-238	-161	-399
Oral Surgery	1292	201	1493	1229	146	1375	63	55	118
Other	3160	222	3382	2890	147	3037	270	75	345
Plastic Surgery	1769	210	1979	1723	162	1885	46	48	94
Rheumatology	128	4	132	152	1	153	-24	3	-21
Thoracic Medicine	388	5	393	314	5	319	74	0	74
Orthopaedics	1527	597	2124	1136	1051	2187	391	-454	-63
Urology	823	157	980	830	255	1085	-7	-98	-105
Total	16,055	2,871	18,926	15,389	3,355	18,744	666	-484	182

The performance overall has been above trajectory but the balance between under and over 18 weeks has not been as anticipated in some areas, and reflects the same complexity in planning as for non-admitted pathways.

Directorates have now developed trajectories for the period October to December and work is underway to extend this to cover the last quarter of the year.

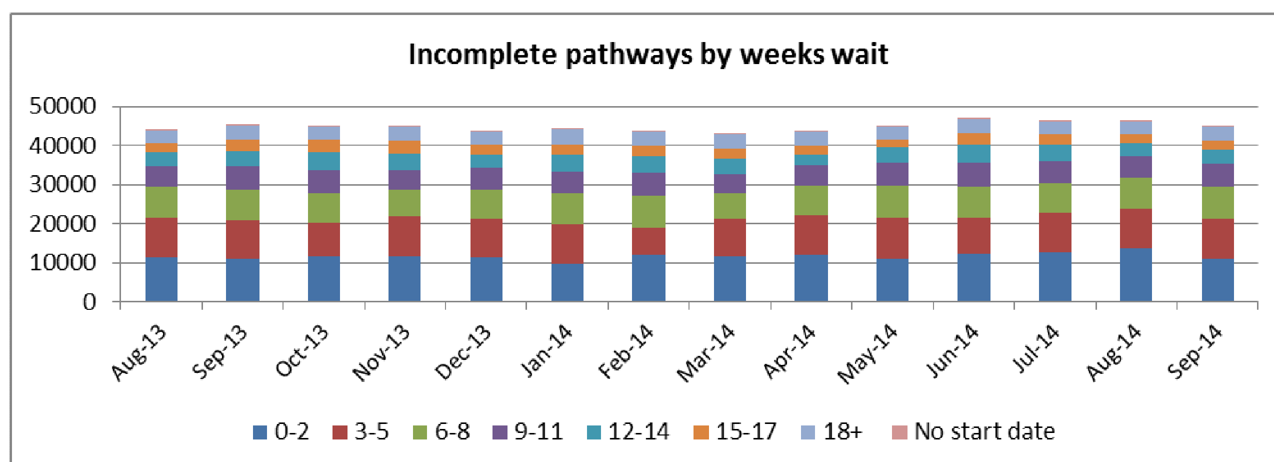
8. Incomplete Pathways

The Trust has met the target for incomplete pathways (92%) every month so far this year apart from August when the performance was just below target at 91.9%. The position improved in September to be at 92.4%.

The numbers of patients on incomplete pathways is in effect the total 'waiting list'. The total number of incomplete pathways has fallen by 3.5% since May, from 46,749 to 45,172.

The number of patients on incomplete pathways over 18 weeks had increased from 2,430 in April 2013 to 3,500 in December 2013 and has then fallen to 3,350 in March 2014. Although this rose in April to 3,529 and again in May to 3,671 it fell in July to 3,353, rose in August to 3,605 but has fallen again in September to 3,430. This is the lowest for any month since July 2013 and is a good indicator of the progress being made by implementing detailed recovery plans across the organisation.

Figure 10 Incomplete pathways by weeks waiting



9. Average Waiting Times

The average waiting times for all patients on admitted pathways fell from 70 days in March to 69 days in April to 68 in May and 67 days in July but rose again in August to 69 days. However, this has increased significantly to 78 days in September but this is a reflection of the drive to clear the backlog of long waiters. The average waiting time for all patients on non-admitted pathways fell to 50 days in March and April. It rose slightly in May to 53 days and again in July to 55 days, fell in August to 51 days but rose to 54 days in September.

10. Conclusions

The average waiting time for care at the Trust is 8 weeks.

The Trust continues to meet all the cancer treatment waiting time standards – the prioritisation of these urgent pathways inevitably sometimes impacts on our 18 week performance in non-cancer, non-urgent diagnoses.

The number of non-admitted and admitted patients treated within 18 weeks in September was below the required national waiting time standards. The figures were 82.0% (target 90% admitted patients) and 92.3% (target 95% non-admitted patients). The Trust has met the target for incomplete pathways (92%) every month so far this year apart from August when the performance was just below target at 91.9%. The position improved in September to be at 92.4%. When considered together these performance data demonstrate that Directorates are implementing their recovery plans and that the future position in relation to waiting times is considerably more robust and sustainable.

The Trust has received more referrals than expected throughout the year so far but has consistently delivered more inpatient and outpatient activity than contracted for by commissioners.

The number of 18 week pathways that have been closed in the second quarter of the year is higher than in the first quarter.

11. Recommendations

The Board is asked to:

a) To receive the more detailed description of 18 week RTT performance as requested previously by the Board of Directors.
b) To be assured that all actions are being progressed
c) To identify any further actions the Board would want to pursue

APPENDIX 1

18 WEEK RTT PERFORMANCE BY SPECIALITY

1. ADMITTED PATHWAYS – SEPTEMBER 2014

Speciality	No. within 18 weeks	Total	% Within 18 weeks	Additional patients required to be treated to achieve 18 week target
Cardiology	167	299	55.9%	102
Cardiothoracic Surgery	75	112	67.0%	26
Dermatology	33	41	80.5%	4
Ear, Nose & Throat (ENT)	144	175	82.3%	14
Gastroenterology	219	224	97.8%	n/a
General Surgery	100	113	88.5%	2
Geriatric Medicine	1	1	100.0%	n/a
Gynaecology	228	290	78.6%	33
Neurology	84	87	96.6%	n/a
Neurosurgery	154	192	80.2%	18
Ophthalmology	616	800	77.0%	104
Oral Surgery	332	391	84.9%	20
Other	875	958	91.3%	n/a
Plastic Surgery	445	512	86.9%	15
Rheumatology	25	27	92.6%	n/a
Thoracic Medicine	107	110	97.3%	n/a
Trauma & Orthopaedics	428	580	73.8%	94
Urology	206	257	80.2%	25

2. NON ADMITTED PATHWAYS – SEPTEMBER 2014

Speciality	No. within 18 weeks	Total	% Within 18 weeks	Additional patients required to be treated to achieve 18 week target
Cardiology	237	283	83.7%	32
Cardiothoracic Surgery	54	54	100.0%	n/a
Dermatology	986	1054	93.5%	16
Ear, Nose & Throat (ENT)	802	1007	79.6%	155
Gastroenterology	541	568	95.2%	n/a
General Surgery	181	187	96.8%	n/a
Geriatric Medicine	61	61	100.0%	n/a
Gynaecology	931	987	94.3%	7
Neurology	827	970	85.3%	95
Neurosurgery	333	381	87.4%	29
Ophthalmology	927	937	98.9%	n/a
Oral Surgery	305	330	92.4%	9
Other	5153	5477	94.1%	51
Plastic Surgery	458	486	94.2%	4
Rheumatology	307	310	99.0%	n/a
Thoracic Medicine	210	218	96.3%	n/a
Trauma & Orthopaedics	576	624	92.3%	17
Urology	412	470	87.7%	35