Public Board Meeting Report

Subject: **Single Oversight Framework Integrated Performance Report**

Date: **28th June 2018**

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Lead Directors: Andy Haynes – Medical Director, Paul Robinson – Chief Financial Officer, Julie Bacon – Executive Director of HR & OD, Simon Barton – Chief Operating Officer, Suzanne Banks – Chief Nurse, Paul Moore – Director of Governance and Quality Improvement

Overview

QUALITY

During May the trust continued to maintain compliance with providing single sex accommodation to its patients and reported no breaches, recognising the importance placed in maintaining the privacy and dignity of our patients. The trusts privacy and dignity policy was updated and ratified at Nursing and Midwifery board in June and this positively supports our ongoing delivery of this agenda

All healthcare associated infections were monitored and managed in line with national and local guidance. During this period there were two cases of Clostridium Difficile Infection (CDI). This is within our monthly trajectory and brings the year to date total to 4 cases. In addition there remains ZERO MRSA bacteraemia identified in May 2018, and only two Escherichia Coli bacteraemia none of which were related to the presence of a urinary catheter. May 2018 saw a sharp decline of influenza infections with zero individuals testing positive.

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Reducing harm from pressure ulcers (PUs) has been identified as a supplementary quality priority in line with the Quality Account that will be implemented during 2018/9. In May there was 1 avoidable pressure ulcer and a further reduction in total to 5 pressure ulcers for this period. To support these positive improvements in care a new process for wound photography is under review aimed at improving timely access to photography and consent. Improved skin care and continence products are also going to be implemented alongside education this coming month which should improve pressure damage caused by moisture.

In May there was a positive reduction in falls in line with the agreed trajectory for improvement and remains below the national average. The falls lead nurse continues to drive the reduction in falls with good multidisciplinary engagement and building of a culture where falls are treated as unacceptable with everyone actively engaged in reducing these. There are a number of positive development examples including a project group of Matrons and senior AHPs who are initiating a "*Colour me Safe*" coloured wristbands project aimed at identifying patients at risk of falls by the colour of their wrist band. A further project is trialling a personalised falls dashboard which on a monthly basis gives the area their own personal falls information to raise awareness of the themes and trends with actions to take forward. Falls alert stickers for use on patient's notes to visually highlight to staff a falls risk will also be introduced.

Within the Safety Thermometer the Trust reported 95.38% harm free care during April against a standard of 95%. The standard includes 'new' harms that are acquired during that admission and 'old' harms which are present on admission, the total of all harms was 4.62% n = 25 and the new harms total is 3 (0.5%)

The Trust compliance with VTE assessment again met the standard for the month of March (95.8% against a standard of 95%). The Governance Support Unit continues to review a random sample of medical notes to ensure that all eligible patients have had appropriate VTE prophylaxis in accordance with Trust guidance. The findings from this audit continue to be feedback through the Governance forums and where deficits in care are established an incident is logged on Datix. It was agreed through PSQG to establish a working group to look at Divisional and clinical ownership and devise an ongoing improvement plan and increased compliance.

Ward staffing information continues to be submitted monthly as part of the national safer staffing UNIFY and is detailed in the monthly board staffing report. All areas were appropriately staffed during May with no reported breaches of the minimal staffing levels with no areas identifying harms relating to staffing. Annual establishment reviews were carried out by the Chief Nurse with all division and following final review should be signed off by July.

The reporting of Dementia will be covered via exception reports as remain off track for the month of May but with continued improvement as per agreed trajectory.

OPERATIONAL PERFORMANCE

Performance on emergency access has been positive during May 2018 with 95.7% of patients discharged or admitted within 4 hours. This was the 15th best performance out of 137 Acute Trusts in the NHS and is above trajectory.

Attendances to ED were the highest they have been for over 2 years. Admissions to Medicine for patients aged 75 and over remain above normal levels and have not materially fallen since winter, although some of the variation has reduced, but bed availability to ED has improved mainly due to reduced length of stay on EAU (down by 4 hours) and increases in discharges from the short stay unit. There was 1 patient, however, who waited 12 hours from decision to admit, a patient awaiting a mental bed and a full investigation is underway with the local mental health provider, Nottinghamshire Healthcare Trust.

Timeliness of access to Cancer care remains positive with standards being achieved above trajectory. There remains work to do to make this sustainable with the reduction in the backlog and this is acute within Urology where a 25% increase in referrals has been seen since March which is pressurising the backlog reduction and it is still expected, as per the trajectory to see some months below the standard as the backlog reduces.

Diagnostics performance is better than trajectory during May and achieved the standard. This standard is expected to be achieved from herein but risks do remain with Cardiac CT and with the scheduled CT replacement in September.

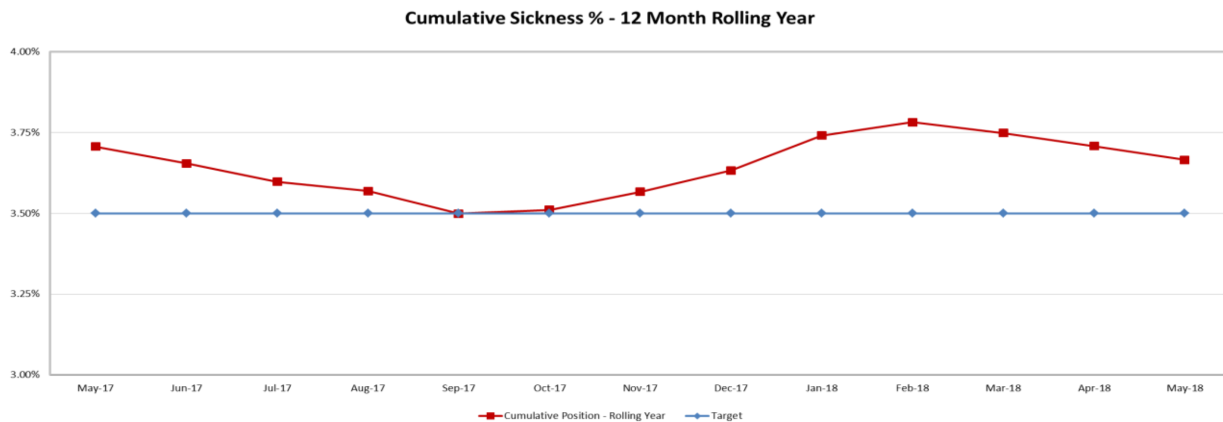
18 weeks RTT is below trajectory and the standard (90% v 91% trajectory) but has shown the second consecutive month of improvement. The waiting list size has stabilized and this is a positive sign for the future RTT position in the long term. However, the forecast of delivery of the 92% standard has changed for July. The improvement actions to recover this position are shown within the exception report. There is also an exception report for patients who have waited over 52 weeks for which there were 40. The final exception report related to the best practice standards for timeliness of care for patients awaiting treatment for hip fractures

WORKFORCE

Sickness Absence - GREEN
Sickness absence decreased in May by 0.02% to 3.20% (April 2018, 3.22%). This is now three consecutive months below the 3.5% threshold.

Sickness absence for May 2018 is 0.50% lower than May 2017.

The 12 month rolling year (sickness averaged for the previous 12 month period for each month), was indicating a sustained improvement as the winter upturn has now been reversed.



Appraisal - Green

Trust wide appraisal compliance for May 2018 decreased to 95% (April 2018, 96%) however is still within the target of 95%.

Training and Education - Green

Mandatory training has remained the same at 92%* against a 90% target. Divisional compliance ranking information shows all Divisions are at or exceeding the target.

**This rate refers to the number of competencies completed and not the number of staff compliant.*

Staffing and Turnover
The overall turnover rate decreased to 0.50% (April, 1.19%), this is inside of the threshold of 1% and is GREEN.

There were 3.55 FTE more starters than leavers in May 2018 (23.50 FTE starters v 19.95 FTE leavers). The highest FTE leaving reason is Voluntary Resignation – Promotion at 5.00 FTE.

All Registered Nurse (RN) vacancies increased in May to 13.84%, 186.34 FTE. Band 5 RN vacancies increased to 20.34%, 150.64 FTE. Medical vacancies decreased slightly to 10.96%.

FINANCIAL SUMMARY

At month 2 the Trust is reporting a deficit of £9.83m before Provider Sustainability Funding (PSF), £0.24m adverse to plan. Achievement of PSF is based on delivery of the 4 hour access target and delivery of the control total. £3.58m of the annual PSF amount is dependent on delivery of control totals across the system. All PSF measures are assessed at quarter end. At this stage £1.24m of PSF has been reflected in the position in line with plan. The reported control total deficit is therefore £8.59m, £0.24m adverse to plan.

Key areas of note in the position year to date (YTD) are:-

- The Financial Improvement Plan (FIP) is delivering in line with target, an improvement of £0.22m in month. However, the monthly target increases throughout the year and considerable further work is needed to mitigate the risk of non-delivery.

- Non elective (NEL) activity and therefore income remains at levels seen in quarter 4. The planning assumption was that activity would fall in quarter 1 of 2018/19. At the end of month 2 NEL activity is £1.3m over plan. Correspondingly, costs to deliver this activity including capacity costs and non pay, continue to be incurred. Income is sufficient to offset costs.

- Medical pay spend is £0.96m adverse to plan at month 2. This has worsened compared to month 1 as spend has increased by £0.32m, most significantly in Medicine and W&C. Significant overspends reflect cover for sickness and vacancies mostly in Medicine and W&C of £0.37m, costs of additional capacity covered by income of £0.25m, unmet FIP of £0.22m.

- Elective activity is below plan by £0.35m with no reduction in cost. This is within Gynaecology (£0.11m) and most specialties within the Surgical division (£0.24m). Elective activity has recovered in part in May with an adverse variance to plan of £0.08m in month.

- Births are £0.21m below plan YTD and levels of lower activity have been seen for a number of months. Costs have not changed. A full forecast is underway using antenatal activity as a leading indicator.

- Agency spend rose in May by £0.17m to £1.57m. This is in excess of the ceiling by £0.25m YTD.]

- Cash balances remain ahead of plan reflecting timing of payment of 2017/18 capital creditors.

- Capital spend is behind plan but is expected to return to plan now it has been agreed with NHSI that 1718 Sustainability and Transformation bonus monies can be used to support the plan, removing the need for borrowing.

At the end of May the Trust is £0.24m behind the control total including and excluding Provider Sustainability Funding (PSF).

	May In-Month			YTD			Annual Plan	Forecast	Forecast Variance
	Plan	Actual	Variance	Plan	Actual	Variance			
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Surplus/(Deficit) - Control Total Basis Exc PSF	(4.49)	(4.57)	(0.09)	(9.59)	(9.83)	(0.24)	(46.34)	(46.34)	0.00
Surplus/(Deficit) - Control Total Basis Inc PSF	(3.87)	(3.95)	(0.09)	(8.35)	(8.59)	(0.24)	(33.94)	(33.94)	0.00
Finance and Use of Resources Metric YTD				3	3		3	3	
Financial Improvement Programme (FIP)	0.67	0.90	0.23	1.28	1.27	(0.01)	17.30	17.30	0.00
Capex (including donated)	(0.32)	(0.46)	(0.13)	(0.57)	(0.64)	(0.07)	(9.75)	(9.75)	0.00
Closing Cash	2.62	4.55	1.93	2.62	4.55	1.93	1.76	1.76	0.00
NHSI Agency Ceiling - Total	(1.32)	(1.57)	(0.25)	(2.72)	(2.97)	(0.25)	(16.66)	(16.66)	0.00

- PSF has been assumed to be received; first assessment is at the end of Q1.
- FIP delivery is marginally under plan at £0.01m.
- Capital expenditure is £0.07m behind plan in May.
- Closing cash at 31st May was £1.93m ahead of plan reflecting timing of payment of 2017/18 capital creditors.
- Agency spend is above NHSI ceiling level in May, spend has risen in month by £0.17m.

Exception Report

Indicator: **Exposure to Serious Incidents**
Month: Month 5, May 2018
Standard: To not exceed more than 2 Serious Incidents including Never Events per month

Current position

During the month of May a total of 4 serious incidents were reported in accordance with NHS England's Serious Incident Framework (May 2015). Of the 4 incidents, none met the reporting criteria for a Never Event.

Causes of underperformance

The nature of the Serious Incidents reported included the following:

- Delay in undertaking endoscopy, when undertaken the following day, untreatable bowel ischaemia was identified
- Patient alleged physical assaulted by staff member
- Delay resulted in permanent deterioration in vision
- Delay resulted in permanent deterioration in vision

Action	Owner	Deadline
Ophthalmology Consultants and Operational Manager met with CCG to review and evaluate external provider ophthalmology referral processes.	Surgical Division / CCG	11th June 2018
Matters concerning allegations of assault have been reported to the police and subject to police and HR investigation. Staff involved are being managed under appropriate HR policies. Allegations of assault were subsequently withdrawn by the Patient, but the matter remains subject to ongoing investigations at time of report.	Medical Division	Dependent upon conclusion of police and HR investigations.

Improvement trajectory

At time of report there is 1 serious incident in June 2018. However, it is not possible to forecast reliably. Typically, the risk of serious incidents intensifies during winter, and also to a lesser extent during quarter 1 (Apr-Jun).

Risk	Mitigation
Lack of capacity to meet need for Ophthalmology Outpatients.	Recovery Plan produced

Lead: Denise Berry - Head of Governance
Executive Lead: Paul Moore – Director of Governance and Quality Improvement.

Exception Report

Indicator: Dementia – Find, Assess, Investigate and Refer [there are three parts]

Month: June 2018 [Reporting on data collected in April 2018]

Standard: Maintain identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia. Desired performance is 90% on each part of the indicator.

Current position

FIND - During April 2018, 82.2% of eligible patients were identified; this has increased from the March return (March data – 66.5%) but performance is still below the required 90%.

ASSESS AND INVESTIGATE - During April 2018, 60 patients were identified as scoring positive on the case-finding question or having a clinical diagnosis of delirium and they were all reported as having had a dementia diagnostic assessment [100%].

REFER - There were 47 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 37 of these patients were referred for further diagnostic advice in line with local pathways [78.7%].

Causes of underperformance

FIND -91 of the eligible 511 who were not screened; the reasons being:

- 84 – blanks
- 7 – missing forms

REFER -There were 10 people who do not appear to have been referred:

- 6 – positive to the case-finding question
- 3 – delirium but no evidence of referral
- 1 – AMT score suggested referral required

Actions to address	Owner	Deadline
A Dementia Assessment Nurse will commence in post after Trust induction; she will be ensuring that all eligible patients are on the appropriate pathway.	Debbie King	4th June 2018
The other Dementia Assessment Nurse post has been re-advertised. When this person is in post, this will ensure that assessments are carried out seven days a week.	Tina Hymas-Taylor	10th June 2018

Improvement trajectory

Work by the Data Collection Administrator has led to an increase in FIND and the performance for the May return is now over the desired 90%.

It is anticipated that the REFER performance will demonstrate the minimum 90% performance when the September figures are collated.

Exception Report

Indicator: Friends and Family Test

Month: Month 2 May 2018

Standard: Friends and Family Test (FFT)

Current position

Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG
Recommended Rate: Friends and Family Maternity	96%	May-18	94.5%	93.8%		R
Recommended Rate: Friends and Family Outpatients	96%	May-18	93.5%	93.7%		R

Causes of underperformance

The FFT recommendation rate in Maternity Services – recommendation ratings is 2.2% below plan for May 2018.

Patient feedback related to following services:

Antenatal – Waiting times

Maternity Ward – Extra support in the night

Gynaecology Clinic – Waiting

Ward 25 – More staff, continuity of care

The Women and Childrens Division will share the feedback for discussion with medical colleagues at the forthcoming consultant meeting. The business team have reviewed booking rules and reviewed capacity.

We are holding a bespoke Women and Children's recruitment event to cover outstanding Vacancies.

The FFT recommendation rate in Outpatient Services – recommendation rating is 2.3% off plan for May 2018.

Sexual Health – Sites in community – MCH, KMH, Ollerton, Warsop, Newark and Oates Hill Surgery

- Waiting times, Car park fees and rude reception and Doctors

Orthopaedic, Ophthalmology, and Diabetics Clinics

- Waiting times, Correct appointment paperwork and car parking costs
- Weekly OPD Matron and Clinical Lead review all Friends and Family responses and shares the negative comments with the relevant staff.
- Any staff attitude comments are dealt with individually.
- Waiting times in clinics. Patients waiting times over 20 minutes are shared with the relevant division. Waits are displayed in clinics and nursing staff update patients of delays, car parking vouchers and beverages are offered to patients with delayed appointments. Leadership rounds are undertaken by senior team to ensure actions are being addressed.
- Therapy environmental comments are being investigated.
- Car Parking - Car parking issues escalated to Ben Widdowson, Head of Estates.

Action	Owner	Deadline
Divisional Management teams to receive and review FFT comment reports. This will enable Divisional teams to develop and implement changes that can respond to the concerns and improve the experience for service users.	Kim Kirk (Head of Patient Experience)	Completed and ongoing- weekly and monthly reported provided.
Improvement trajectory		
All divisions to review and share feedback in team meetings.		
Risks: Continued decrease in recommendation rate for OPD and Maternity services		
Mitigation: Actions agreed and this will be monitored monthly		

Lead: Kim Kirk – Head of Patient Experience

Executive Lead: Paul Moore – Director of Quality Governance

Sherwood Forest Hospitals
NHS Foundation Trust

Exception Report

Indicator: 18 weeks referral to treatment time – incomplete pathways

Month: Month 02 May 2018

Standard: Maximum time of 18 weeks from referral to treatment – RTT (92%)

Current position

The volume of patients on an Incomplete RTT pathway at the end of May was 24,585 of which 2,457 were waiting >18 weeks. This position delivered a 1% improvement on April with performance of 90% against a trajectory of 91%. This is the second consecutive month of improvement. The number of specialties failing the standard has reduced from 12 to 9.

The 2018/19 RTT trajectory is shown in table 1 below. This includes a performance range based on a 5% positive or negative deviation from the forecast volume of patients waiting >18weeks. The May position is considered outside of range but continues to show improvement on both March and April.

Table 1: 2018/19 Trajectory

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	Jul Trajectory	Aug Trajectory	Sept Trajectory	Oct Trajectory	Nov Trajectory	Dec Trajectory	Jan Trajectory	Feb Trajectory	Mar Trajectory
Total Incomplete	24,976	24,274	26,001	24,585	25,461	25,512	25,920	25,189	24,819	24,915	25,041	24,155	23,535	23,205
>18	2,600	2,633	2,350	2,457	2,100	2,040	2,070	2,010	1,970	1,970	1,980	1,930	1,880	1,850
<18	22,376	21,641	23,651	22,128	23,361	23,472	23,850	23,179	22,849	22,945	23,061	22,225	21,655	21,355
%	89.59%	89.15%	90.96%	90.01%	91.75%	92.00%	92.01%	92.02%	92.06%	92.09%	92.09%	92.01%	92.01%	92.01%
Performance range	90.11-89.07%	In range	91.41-90.51%	Outside of range	92.16-91.34%	92.4-91.6%	92.41-91.61%	92.42-91.62%	92.46-91.67%	92.49-91.70%	92.49-91.7%	92.41-91.61%	92.41-91.61%	92.41-91.61%

The size of the waiting list has remained relatively stable and is lower than trajectory which is positive for the future position.

Causes of underperformance

The main drivers for underperformance can be summarised into four themes:
1 - Workforce gaps resulting in capacity issues across a range of specialties
2 - Overdue review patients who have a RTT clock start
3 - Pathway management
4 - Patient choice or medical reason to delay pathway.

Actions to address	Owner	Deadline
Specialties are covering gaps with regard to theatre and OP capacity via waiting list initiatives with regular sessions in place or planned over the next 6-8 weeks within T&O, Oral Surgery, Pain, Dermatology and ENT. The impact of these actions on the volume of patients waiting >18 weeks is expected to be a reduction of 170 (7%) by the end of July.	DGM's	Ongoing
Additional clinic capacity has been secured for Gastroenterology and Urology. The impact of this capacity is expected to be a further reduction of 190 (7.7%) by the end of July.	DGM's	Ongoing
A review of outpatient demand and capacity has commenced, this will drive internal forward planning to ensure alignment between demand and capacity at specialty level.	Dep. COO	End of July 2018

In terms of pathway management specialty teams and DQ continuously validate and work with staff to ensure all are recording the correct outcome at each stage of a patient pathway. 1-2-1 support is in place where required. This will be supported by a roll out of RTT e-learning to all appropriate staff from September 2018.	DQ Dep. COO	In place September 2018
Patient choice and delays for medical reasons are appropriately reviewed and managed at the weekly RTT Meeting.	Dep. COO	In place
Works continues with partners as part of the QIPP Elective care work stream to reduce demand on outpatient services that will support patients to the right service but will also improve the RTT position	Dep. COO	September 2018

Improvement trajectory

All specialties not achieving the standard are required to submit and update a recovery action plan which is monitored weekly at the RTT meeting chaired by the Deputy COO (Elective Care). The plans underpin the recovery bridge to reduce the volume of patients waiting >18 weeks by at least 800 from mid-April to the end of July and deliver the 92% standard.

The May trajectory aimed to have no more than 2,350 patient waiting >18 weeks. The month-end April position (2,633) to the month-end May trajectory required a reduction of 283 (10.7%). The actual reduction is 180 (6.8%) across T&O, General surgery, Neurology and Rheumatology.

Plans are in place and continue to be developed to reduce the volume of patients waiting >18 weeks in June and July, however there is significant risk to delivery due to the use of elective Orthopaedic capacity for Trauma, the prioritisation of Urology capacity for cancer patients and additional actions required for Cardiology.

Based on actions plans in place the current forecast for the end of June is c90.3% and end of July 91%.

Risk	Mitigation
Medical staff availability to fulfil existing and additional sessions	Continue recruitment and secure locums where required

Lead: Helen Hendley, Deputy Chief Operating Officer (Elective Care)

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: Number of cases exceeding 52 weeks referral to treatment

Month: Month 02 May 2018

Standard: 0

Current position
Regionally, SFHT were one of 27 Trusts with a combined total of 540 52+ week waits reported for the month of April. Nationally 2,882 patients were waiting more than 52 weeks. At the end of May, the Trust reported 40 patients waiting 52+ weeks of which; 11 were Urology, 4 T&O, 14 ENT, 1 Oral Surgery, 1 Ophthalmology, 11 Urology, 4 Cardiology, 1 Neurology, 1 Rheumatology and 2 Paediatric. 25/40 patients have an appointment in June, 4 in July, 2 patients have declined an appointment. Contact has been attempted with 9 patients via telephone or letter who are yet to respond.

Causes of underperformance
38/40 patients were identified as part of the historic validation of open pathways. Of the remaining 2/40 one patient has cancelled multiple appointments and is now re-booked for July. The second patient was identified as having an incorrect clock stop through routine validation and is dated in June. The root causes of the position are subject to a number of papers to both Board and NHSI.

Actions to address	Owner	Deadline
Validation team in place with the ongoing methodical review of open pathways	Data Quality Manager / DGM	Dec 2018
Patient pathways found to require a review are escalated to the divisional teams to identify immediate capacity to offer an OP appointment within 2 weeks	DGM	In place
Patient found to require a review will trigger the harm review process immediately. A formal apology will be sent to the patient	Data Quality Manager	In place

Improvement trajectory

Further 52 week breaches may continue to be identified until validation work is complete (end of December 2018). The Trust trajectory is to be at zero by the end of March 2019.

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	Jul Trajectory	Aug Trajectory	Sept Trajectory	Oct Trajectory	Nov Trajectory	Dec Trajectory	Jan Trajectory	Feb Trajectory	Mar Trajectory
52+	20	29	17	40	15	12	12	12	12	12	12	6	6	0

Risk	Mitigation
Further breaches identified due to ongoing validation programme	Appoint patients as soon as any breaches are identified
On-going live errors recorded on Medway PAS	Patient management reports to be reviewed on at the weekly RTT meeting

Lead: Helen Hendley, Deputy Chief Operating Officer (Elective Care)

Executive Lead: Simon Barton, Chief Operating Officer

Sherwood Forest Hospitals
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Exception Report

Indicator: % of 12 all trolley waits > 12 hours
Month: Month 2 May 2017
Standard: 0 patients waiting longer than 12 hours from decision to admit

Current position
The Trust reported a 12 hour wait on 26 May for a patient awaiting a mental health bed.

Causes of underperformance
There was an initial delay in the patient being assessed by the mental health team as the Rapid Response Liaison Psychiatry (RRLP) team (run by Nottinghamshire Healthcare NHS Trust - NHT) was delayed in responding. On assessment a decision to admit was made, but NHT were not able to provide a bed within 12 hours. The case went to SI scoping that week and a joint (with NHT) root cause analysis will be completed by the end of June.

Actions to address		
Action	**Owner**	**Deadline**
Reaffirmation of the long wait escalation process 24/7 is in place - Silver to Gold for any patient in ED 8 hours from DTA and Gold to Chief Executive for any patient in ED for 10 hours from DTA	**COO**	**Complete**
Guidance on the management of waiting times for mental health patients provided to all Bronze / Silver / Gold	**COO**	**Complete**
Meeting with Adult Mental Health Services to discuss current capacity pressures and agree actions to address	**COO**	**20 June 2018**

Improvement trajectory
The standard is expected to be achieved every month.

Risks	
Risk	**Mitigation**
Continued mental health inpatient capacity pressures	Timely escalation to ensure Silver / Gold Adult Mental Health teams are involved in resolving issues.

Divisional Lead: Siobhan McKenna, Divisional General Manager Urgent and Emergency Care
Executive Lead: Simon Barton, Chief Operating Officer

Sherwood Forest Hospitals
NHS Foundation Trust

Exception Report

Indicator: 31 day second or subsequent treatment (drug)
Month: Month 01 April 2018
Standard: Maximum 31 day wait for second or subsequent treatment - drug (98%)

Current position

Performance for April 2018 was 91.7%. This was due to 1 breach of the standard from a total of 12 treatments.

Month	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18
No. of treatments	29	12	3	12	12	12	8	14	20	17	19	12
No. of breaches	0	0	0	0	0	0	0	0	0	0	0	1
% achievement	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	91.7%

Given the relatively small volume of patients, the only acceptable reasons for breaching this standard would be patient choice or for clinical reasons.

Causes of underperformance

One Lower GI patient was treated on day 49 of their 31 day subsequent pathway; the patient requested to delay their treatment start date

Actions to address	Owner	Deadline
Weekly PTL meeting extended to include 31 day patients	Cancer Services Manager	Q1 2018/19

Improvement trajectory

On track to deliver standard for May 2018

Risk	Mitigation
Small volume of patients can lead to significant variation in performance	Robust 31 day PTL tracking and escalation of delays

Lead: Helen Hendley, Deputy Chief Operating Officer (Elective Care)
Executive Lead: Simon Barton, Chief Operating Officer

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Exception Report

Indicator: Fractured neck of femur achieving best practice tariff

Month: 1 April 2018

Standard: 75%

Current position

For patients with a fragility hip fracture, care needs to be quickly and carefully organised. By rapidly stabilising patients and ensuring that expert clinical teams respond to their complex frail conditions, the most positive outcomes can be achieved.

For April 2018 the Trust achieved 57% of best practice measures against the standard of standard of 75%. The key root cause of this performance not being at standard is the provision of an Ortho-Geriatrician assessment within 72 hours. This has been difficult to consistently achieve due to the number of vacancies within the Geriatrician workforce and this has been made even more challenging due to the Geriatricians having to see outlier patients from medicine. All other elements of best practice are being achieved where clinically appropriate.

Causes of underperformance

The two main drivers for underperformance for April were:

- Insufficient Ortho-Geriatrician capacity (8/18 breaches)
- Time to Theatre (8/18 breaches)
    - 7/8 delayed due to clinical reasons
    - 1/8 delayed due to theatre capacity

Action	Owner	Deadline
Develop escalation process for patients approaching measures with no plan in place to meet the standard.	DGM	End of June 2018
Reviewing all the notes of those patients which failed the standard to evidence the gap in Ortho-geriatrician time and further review this rota	DGM	End of June 2018
Scope an additional trauma list Wednesday PM to reduce the impact on elective work when trauma demand surges.	DGM	End of June 2018

Improvement trajectory

Expect May position to be c65%.

Risk	Mitigation
Increased demand due to a surge in Trauma would impact on the ability to operate within 36 hours	Flex utilisation of emergency and elective theatre lists to manage overall demand
Increase in medical outliers resulting in delays to Ortho-geriatric reviews	Escalation of potential safety and quality risks to the relevant Heads of Service / Clinical Chairs

Lead: Helen Hendley, Deputy Chief Operating Officer (Elective Care)

Executive Lead: Simon Barton, Chief Operating Officer