Public Board Meeting Report

Subject:	**Single Oversight Framework Integrated Performance Report**
Date:	**31st May 2018**
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Lead Directors:	**Andy Haynes – Medical Director, Paul Robinson – Chief Financial Officer, Julie Bacon – Director of HR & OD, Simon Barton – Chief Operating Officer, Suzanne Banks – Chief Nurse, Paul Moore – Director of Governance and Quality Improvement**

Overview

The report provides detail of how the Trust is performing against the NHS constitutional standards and the performance indicators suggested in the Single Oversight Framework guidance issued in September 2016 by NHSI.

The attached dashboard shows how the Trust has performed against these standards in the period. If there is no national standard then last year's performance is indicated, these are shaded grey, in order to provide context and ensure a focus on continuous improvement.

The Trust is performing well against the majority of the standards, however in some area's the standard is not being achieved, an exception report is provided as below.

These are:

- Serious Incidents
- Falls
- Dementia
- % complaint responses dispatched within appropriate number of days
- Friends and Family, Response and Recommended
- Emergency Access
- Referral to Treatment
- Diagnostics
- Cancelled Operations
- Best Practice Tariff for fractured neck of femur
- Cancer Access

Quality

During April 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.

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 objective, and there were no further cases identified within

the Stroke Unit, suggesting that the measures put in place following last month's outbreak have been effective. This year's annual objective from 2018/19 has reduced to no more than 47 cases in a year. In addition to this there were again ZERO MRSA bacteraemia identified in April 2018, and only two Escherichia Coli bacteraemia none of which were related to the presence of a urinary catheter. April 2018 saw a sharp decline of influenza infections with only 13 individuals testing positive.

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 April there were zero avoidable pressure ulcers, an outstanding achievement. The newly formed Harms group continues to support this work and the implementation of the new fundamentals of care programme for all Registered Nurses and Health Care Assistants has already evaluated well.

Within the Safety Thermometer the Trust reported 95.77% harm free care during April against a standard of 95%. The standard includes 'new' harms which are acquired during that admission and 'old' harms which are present on admission, the total of all harms was 4.23% n = 24 and the new harms total is 6 (1.06%)

The Trust compliance with VTE assessment again met the standard for the month of March (95.4% against a standard of 95%). The Governance Support Unit continues to review a random sample of medical notes to ensure 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.
Ward staffing information is 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 April with no reported breaches of the minimal staffing levels and no areas identifying harms relating to staffing. Annual establishment reviews were carried out by the Chief Nurse with all divisions and were agreed pending final sign off.

The reporting of falls and Dementia are covered via exception reports as remain off track for the month of April

Performance

Performance against all the emergency access standards improved in April, including a 3.6% improvement in performance against the 4 hour standard to 92.4%. An improvement programme is in place, reporting weekly to the Executive Team; this programme is clinically led and is run through three key work streams.

Elective access performance for referral to treatment times and diagnostics has improved in April and the cancer 62 day access performance was achieved in March.

The Trust continues to see 52+ patients and is likely to do so until December 2018 when the historical validation of open pathways is due to be completed.

Recovery action plans are in place for the elective access standards with weekly monitoring and reporting. Key risks to delivery include unforeseen diagnostic equipment breakdown,

additional demands on capacity, such as breast screening, and the ability to cross cover existing capacity due vacancies in medical, nursing and administrative staff.

Workforce

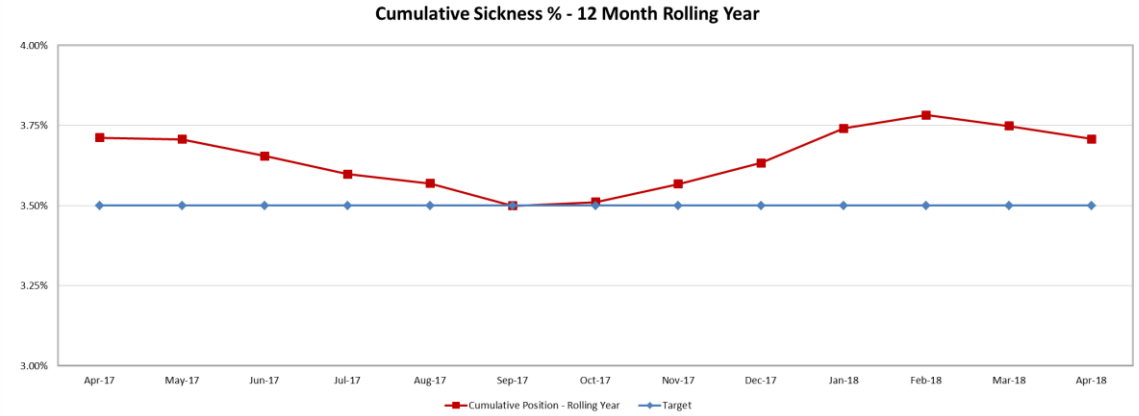
Sickness Absence

Sickness absence decreased in April by 0.17% to 3.22% (March 2018, 3.39%). Both of the last two months were back below the 3.5% threshold.

Corporate and Diagnostics & Outpatients are the two Divisions which have a sickness absence average less than 3.5% for a rolling 12 month period (May 2017 to April 2018).

Sickness absence for April 2018 is 0.49% lower than April 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

Trust wide appraisal compliance for April 2018 increased to 96% (March 2018, 95%). This is the first time that the 95% target has been exceeded.

Training and Education

Mandatory training has decreased by 2% in month to 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 increased to 1.19% (March, 0.88%), this is outside of the threshold of 1% and is rated as Amber on the dashboard.

There were 2.59 FTE more leavers than starters in April 2018 (44.44 FTE starters v 47.03 FTE leavers). A number of retirements in April may link with staff retiring after Easter and it is expected that turnover will be green again in May.

All Registered Nurse (RN) vacancies increased in April to 13.76%, 185.51 FTE. Band 5 RN vacancies increased to 19.61%, 145.94 FTE. Medical vacancies increased slightly to 11%.

At the latest Assessment Centres 9 RNs and 25 HCSWs were offered roles. There are 18 RNs booked in for the next Assessment Centre.

This table below shows the net position with staff in post against establishment in April 2018:

	Apr-18								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Total Trust									
Admin & Clerical	1140.83	1067.31	1306	73.52	6.44%	13.77	23.21	2.17%	40
Allied Health Professionals	223.86	214.94	268	8.92	3.99%	0.40	4.00	1.86%	8
Ancillary	40.42	36.84	44	3.58	8.85%	0.43	1.00	2.71%	0
Medical & Dental	503.65	447.82	471	55.83	11.09%	5.00	3.00	0.67%	13
Registered Nurse Operating Line * - ALL Bands	1347.72	1162.21	1376	185.51	13.76%	10.19	10.49	0.90%	30
Scientific & Professional	217.32	196.47	214	20.85	9.60%	2.00	1.00	0.51%	4
Technical & Other	277.29	259.99	321	17.30	6.24%	2.43	1.59	0.61%	1
Unregistered Nurse	601.70	580.88	678	20.82	3.46%	10.23	2.73	0.47%	3
Total - Trust	**4391.95**	**3966.44**	**4678**	**425.51**	**9.69%**	**44.44**	**47.03**	**1.19%**	**99**
Band 5 Registered Nurse Only operating line *	744.13	598.18	721	145.94	19.61%	7.11	8.49	1.42%	-

Note: Starters and Leavers excludes Rotational Doctors

**Establishment and thereby vacancies in the Band 5 RN category have been reduced by 5% of establishment in order to reflect the margin that would usually be left unfilled to fund the cover for unplanned absences such as sickness with bank and agency. This margin is never filled with substantive staff. This impacts both the band 5 RN figure and the total RN figure.*

Financial Summary

At month 1 the Trust is reporting a deficit of £5.26m before Provider Sustainability Funding (PSF), £0.16m 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 £0.62m of PSF has been reflected in the position in line with plan. The reported control total deficit is therefore £4.64m, £0.16m adverse to plan.

Two divisions, Surgery (£0.23m adverse to plan) and Women's and Children's (£0.16m adverse to plan), are the main drivers of this position, with underspends within the remaining 3 divisions and Corporate offsetting these in part.

Total clinical income is £0.36m better than plan at month end, of which £0.22m relates to high cost drugs and devices for which there is offsetting expenditure. The Trust plan is based on levels of activity seen in 2017/18 and activity in April has seen a continuation of winter levels of activity. Non Elective activity remained high as was Critical Care activity. Elective activity was below planned levels in month 1.

Other operating income was in line with plan.

Expenditure is £0.53m adverse to plan. Overall Financial Improvement Plan (FIP) delivery is £0.22m adverse to plan.

Pay expenditure is £0.45m adverse to plan in month. Non delivery of FIP within pay is £0.17m with the remainder of spend representing costs being incurred in maintaining

capacity for continuing winter levels of activity Agency spend in April decreased by £0.16m compared to March to £1.40m. This is in line with the NHSI ceiling.

Non pay (including non-operating expenses) is £0.08m adverse to plan in month 1. High cost drug and devices overspends of £0.22m and FIP non delivery of £0.06m are offset by Corporate and Central underspends.

Cash balances remain ahead of plan reflecting timing of payment of 2017/18 capital creditors. Capital spend is behind plan reflecting the need for cash borrowing to support the programme, discussions regarding which are underway with NHSI.
At the end of April the Trust is £0.16m behind its control total including and excluding Provider Sustainability Funding (PSF).

This reflects the ongoing winter costs incurred in April and slippage on the Financial Improvement Programme (FIP).

	April 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	(5.10)	(5.26)	(0.16)	(5.10)	(5.26)	(0.16)	(46.34)	(46.34)	0.00
Surplus/(Deficit) - Control Total Basis Inc PSF	(4.48)	(4.64)	(0.16)	(4.48)	(4.64)	(0.16)	(33.94)	(33.94)	0.00
Financial Improvement Programme (FIP)	0.60	0.38	(0.22)	0.60	0.38	(0.22)	17.30	17.30	0.00
Capex (including donated)	(0.25)	(0.19)	0.06	(0.25)	(0.19)	0.06	(9.75)	(9.75)	0.00
Closing Cash	5.76	6.72	0.96	5.76	6.72	0.96	1.76	1.76	0.00
NHSI Agency Ceiling - Total	(1.40)	(1.40)	(0.00)	(1.40)	(1.40)	(0.00)	(16.66)	(16.66)	0.00

- FIP delivery is below plan by £0.22m.
- Capital expenditure is £0.06m behind plan in April.
- Closing cash at 30th April was £0.96m ahead of plan reflecting timing of payment of 2017/18 capital creditors.
- Agency spend is at NHSI ceiling level in April.

Exception Report

Indicator: Serious Incidents.

Month: Month 4, April 2018.

Standard: To not exceed more than 2 Serious Incidents including Never Events per month

Current position		
During the month of April a total of 3 serious incidents were reported in accordance with NHS England's Serious Incident Framework (May 2015). Of the 3 incidents, none met the reporting criteria for a Never Event.		
Causes of underperformance		
The nature of the Serious Incidents reported included the following: • Care was not optimal, missed opportunity to treat spinal abscess. • Failure to act upon results following a biopsy within Dermatology clinic. • Medication Incident, failure to administer critical medication.		
Actions to address		
Action	**Owner**	**Deadline**
The Director of Governance and Quality Improvement has commissioned a Medical Division Safety Summit.	Medical Division	30th June 2018
The Medical Division are currently reviewing the last 12 months positive results for all patients within Dermatology to cross check all have been followed through.	Medical Division	30th June 2018
Immediate action taken was to change the medication administration times and provide support to the ward by the Practice Development Team.	Alison Whitham	Completed.
Improvement trajectory		
It is likely that the current number of serious incidents reported during quarter 1 (2018/19) will exceed quarter 4 (2017/18)		
Risk	**Mitigation**	
Human factors have the potential to lead to patient harm during periods of sustained increase in capacity.		

Lead: Denise Berry - Head of Governance

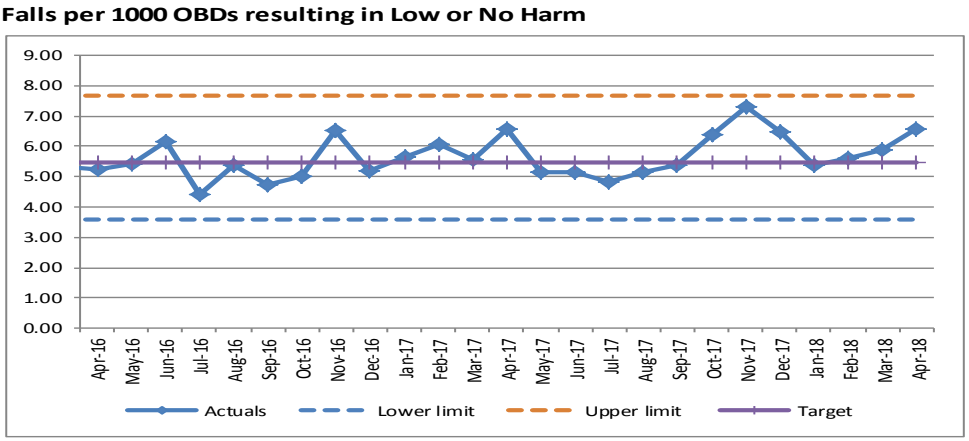
Executive Lead: Paul Moore – Director of Governance and Quality Improvement.

Exception Report

Indicator: Falls

Month: April 2018

Standard: **Falls in 1000 bed days resulting in low or no harm**



From May the reporting of falls in SFHT will follow the new Standard Operating Procedure which provides clarity around the reporting structure and management of falls data.

Separate data will now be available for the following:

- Outpatients /RIDDOR/assist to floor and falls from low beds/seizures or fits/falls on corridor/falls in car parks.

Causes of underperformance:
No theme or pattern noted to monthly rise in falls and no increase seen in falls with harm. Staff are required to communicate in more detail regarding a patients falls risk and history when a patient is transferred to another area of care .This will allow the receiving area to be more prepared and aware of the patients risk.

Risks	
Risk	**Mitigation**
Unfilled shifts to provide Enhanced patient care for those patients who are at risk of falls.	Significant recruitment to the Nurse Bank over the last 6 months. Utilisation of Virtual ward

Lead: Joanne Lewis-Hodgkinson RN

Executive Lead: Suzanne Banks – Chief Nurse

Exception Report

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

Month: May 2018 [Reporting on data collected in March 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 March 2018, 66.5% of eligible patients were identified; this has increased from the February return (February data – 60.5% %), but performance is still below the required 90%.

Causes of underperformance – Find

203 of the eligible 606 patients were not screened for the following reasons:
182 – Question not asked / blank, 10 – missing form, 11 – question missing / old documentation

Current position – Refer

There were 79 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 62 of these patients were referred for further diagnostic advice in line with local pathways [78.5%].

Causes of underperformance – Refer
There were 17 people who do not appear to have been referred:
15 Needed referral to RRLP or back to GP for delirium or memory clinic referral
1 Nothing on discharge letter even though RRLP suggested that the GP would need to review (negative to case-finding)
1 Positive reply to case-finding but nothing on discharge letter

Actions to address		
Action	**Owner**	**Deadline**
Two nurses have been appointed to the six-month secondment for Dementia Assessment Nurses to improve performance on FIND	Tina Hymas-Taylor	Start date to be confirmed
When blanks are identified in assessment documentation, the Data Collection Administrator is asking staff to complete the case-finding question	Owen Hufton	On-going

Improvement trajectory

A month on month improvement is expected with full compliance projected by September 2018

Lead: Tina Hymas-Taylor, Head of Safeguarding

Executive Lead: Suzanne Banks, Chief Nurse

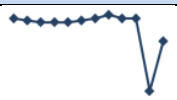
Exception Report

Indicator: % of complaint responses dispatched within appropriate number of days

Month: Month 1 April 2018

Standard: Complaint Response Rates

Current position

Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RA
% complaint responses dispatched within appropriate number of days	≥90%	Apr-18	86%	86%		

Causes of underperformance

The Trust has not met the target of 90% of complaints signed off within 25 working days due to delays in the quality assurance stage of the complaints procedure.

The progress of all complaints are tracked by the Patient Experience Team and shared with the executive team on a weekly basis Due to queries relating to the complaint responses, additional time was required for clarification.

The revised process for the final authorisation of complaints by the executive has seen an increase in the complaint response rate of 26%, almost achieving the internal target of 90%.

In accordance with NHS Complaints Legislation, complaints are required to be responded to within 25 working days or an agreed timescales negotiated with the complainant.

Please note all complainants were made aware of the delays. It is expected that the response rate will meet the required 90% standard in the next reporting period

Action	Owner	Deadline
Communication and escalation of complaint responses awaiting sign off with Trust HQ agreed with all relevant executives.	Kim Kirk (Head of Patient Experience), Paul Moore and Richard Mitchell	Ongoing

Improvement trajectory

Achieve 90% target in April 2018 and future months.

Risks: Complainants will not receive timely responses

Mitigation: Actions agreed and this will be monitored weekly

Lead: Kim Kirk – Head of Patient Experience

Executive Lead: Paul Moore – Director of Quality Governance

Exception Report

Indicator: Friends and Family Test

Month: Month 1 April 2018

Standard: Friends and Family Test (FFT)

Current position

Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RA
Response Rate: Friends and Family Accident and Emergency	≥12.8%	Apr-18	12.5%	12.5%		
Recommended Rate: Friends and Family Maternity	96%	Apr-18	95.4%	95.4%		
Recommended Rate: Friends and Family Outpatients	96%	Apr-18	93.3%	93.3%		

Causes of underperformance

Overall the FFT recommendation rates for the Emergency Department and Maternity service are improving. A scoping exercise has been undertaken to look at organisations where recommendation rates are higher than Sherwood Forest. Findings from this scoping exercise have been included within the actions taken in month and are a contributory factor to the improved performce.

1. **The FFT recommendation rate in ED** – the response rate is 3.2% below plan for March 2018.

An action has been taken to increase the use of mobile phone technology to improve the performance.

2. **The FFT recommendation rate in Maternity Services** – recommendation ratings is 1.4% below plan for March 2018.

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. A number of pathways have also changed to reduce the need for consultant appointments which the Division hope will improve patient experiences.

3. **The FFT recommendation rate in Outpatient Services** – recommendation rating is 2% off plan for March 2018.

In March 2018, FFT was rolled out to Sexual Health services, which are based within KMH and the wider community settings via the SMS texting survey. This has received a good response and provided a number of negative patient experiences which have impacted on the March recommendation rate. These have been reported to the Division and action is being taken to address a number of the concerns raised.

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. ED to ensure reception staff are following the correct clerking procedure to include mobile telephone numbers for all eligible patients.		
Risks: Continued decrease in recommendation rate for OPD and response rate in ED		
Mitigation: Actions agreed and this will be monitored monthly		

Lead: Kim Kirk – Head of Patient Experience

Executive Lead: Paul Moore – Director of Quality Governance

Exception Report

Indicators: Emergency access within 4 hours
% of Ambulance handover >30 minutes % of Ambulance handover >60 minutes

Month: Month 1 April 2018

Standard: A&E max waiting time of 4 hours from arrival to admission / transfer / discharge (95%)
0 patients delayed more than 30 mins from arrival to handover
0 patients delayed more than 60 mins handover from EMAS

Current position

Performance in April was 92.4%, a 3.6% improvement from March. National ranking for April was 28 out of 137 Trusts. 15.9% of ambulance handovers took over 30 minutes and 0.8% took over 60 minutes, an improvement of 5.4% and 3.6% respectively on March.

18/19 Monthly & Quarterly trajectory

2018/19	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Trajectory % within 4 hours	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	93.6%	90.5%	90.0%	90.5%
Quarterly trajectory			95.0%			95.0%			93.0%		
Quarterly requirement for PSF			95.0%			95.0%			92.0%		
Actual Monthly	92.4%										
Actual Quarterly	92.4%										

Causes of underperformance

- **Admissions in the >75's to medicine** – 824 during April 2018 compared to 667 during April 2017.
- **EAU Demand & Capacity** – closure of 12 beds in June 2017 has impacted on EAU ability to meet daily demand.
- **Weekend discharges in medicine** – admissions via ED to EAU have not materially reduced at weekends, yet discharges do materially reduce with about 50-60% of the weekday discharge rate. This leads to 'roll over' demand that has to be managed on Mondays, impacting on performance.
- **Internal Base ward bed capacity & flow** – the winter plan for 17/18 was compromised by ensuring safe nurse staffing levels and had both less acute beds than the 16/17 winter plan.
- **External capacity** – the decommissioning of 'Transfer to Assess' beds, has created delays along some external pathways. The Trust is now seeing a more material increase in the DTOC levels.
- **Operations control systems** – day to day capacity and flow planning and monitoring needed to be reviewed to ensure effective and consistent capacity and flow meetings are in place throughout each day with robust escalation arrangements for long waiting patients.

Actions to address:	Deadline	Progress
Clinically led improvement plan in place, monitored weekly through Patient Flow Group	In progress	Good clinical engagement across all work streams maintained
Development of key performance indicator pack & weekly reporting to EDs/NEDs	Complete	
EAU Demand & Capacity		
Maximisation of Ambulatory Emergency Care (AECU) avoiding admissions to EAU	In progress	Increase in AEC weekly activity (ave. 88 in March, 93 in April). Estates options appraisal for AECU complete.
Embedding of Senior streaming to ensure senior review with investigations ordered within 30 minutes of arrival	In progress	1:1 discussions taking place with all ED senior doctors
Focus on ambulance handover within	30 June 2018	5.4% improvement in

30 minutes		performance (March 21.3%, April 15.9%)
Weekend discharges in medicine		
Delivery of 70-80% of weekday discharge rate at the weekend through improved planning	In progress	54% in March and 61% in April, with 15 more discharges per weekend in April from medicine
Implementation of criteria led discharge, starting with a pilot on ward 43 before wider roll out	31 Aug 2018	Roll out planned for the 4th floor by 31 May 2018
Internal Base ward bed capacity & flow		
Deliver 30% of daily discharges by noon through more effective discharge planning	July 2018	Performance at 25% and is stable during April and against the YTD average
Clear inter-professional standards for response to inpatient wards for requests	In progress	Response times to be formalised and monitored – in place for radiology and achieving 80%-90% of scans same day
Increase discharge lounge utilisation and pre booking of patient discharge transport	In progress	Discharge lounge usage was 321 in April, a slight reduction on March which was 354 but an improvement on the YTD average of 311
Daily review of all patients within medicine who have been inpatients >7 days	In place	Daily hub meetings in place with input from community services partners – Reduction in number of patients with LoS >7 days (8% reduction during April)
External capacity		
Development of community alternatives for inpatients with external partners	June 2018	Discussions with external providers taking place
Development of a system capacity plan for Mid-Notts	July 2018	In progress, being led by the Mid-Notts A&E Delivery Board
Work with external partners to reduce DToCs	In progress	DToC action plan in place across the local health community
Operations control systems		
Revised escalation process for long waiting patients	Complete	Process well embedded
Revised standard operating procedure for Capacity & Flow meetings	Complete	Implemented May 2018
Development of live bed management systems	August 2018	Project meetings commence 11 June 2018
Development of an internal bed capacity plan	June 2018	First draft complete. Final draft for submission to June BoD.

Risk	**Mitigation**
System capacity plan not yet in place to determine capacity across the health and social care system	SFH internal bed capacity plan under development for July Board meeting
Further reductions in external bed capacity	Working in partnership with external partners through A&E Delivery Board and the Urgent Care Programme Board to ensure community capacity is in place prior to any changes

Divisional Leads: Dr Ben Owens, Dr Anne-Louise Schokker

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: 18 weeks referral to treatment time – incomplete pathways

Month: Month 01 April 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 April was 24,274 of which 2,633 were waiting >18 weeks. This position delivered performance of 89.15% against a trajectory of 89.59% and the national standard of 92%.

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 April position of 89.15% is therefore considered within range.

Table 1: 2018/19 Trajectory

Incomplete	April 18 Trajectory	April Final	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Ma
Total Incomplete	24,976	24,274	25,461	25,512	25,920	25,189	24,819	24,915	25,041	24,155	23,535	23
>18	2,600	2,633	2,100	2,040	2,070	2,010	1,970	1,970	1,980	1,930	1,880	1,
<18	22,376	21,641	23,361	23,472	23,850	23,179	22,849	22,945	23,061	22,225	21,655	21
%	89.59%	89.15%	91.75%	92.00%	92.01%	92.02%	92.06%	92.09%	92.09%	92.01%	92.01%	92
Performance range	90.11-89.07%	In 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

In terms of National context, the Trust were ranked 112th out of 185 Trusts for the month of March at 88.78%, Trusts ranked 81st or above achieved the standard. The April National position is currently unpublished.

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 (c20% of the overall volume of patients waiting > 18 weeks).
3 – Pathway management
4 - Patient choice or medical reason to delay pathway.

Actions to address	Owner	Deadline
Recruitment at both middle grade and consultant level is ongoing across a number of specialties. Recent successful appointments made in General Surgery and Urology have start dates in May and June. The Pain service has secured a locum to commence early June. 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 8 weeks within T&O, Oral Surgery, Pain, Dermatology and ENT The impact of these actions on the volume of patients waiting >18 weeks will be a reduction of c350 through May and June.	DGM's	Ongoing
The volume of patients with an overdue review is being addressed in two ways. Additional clinic capacity has been secured in May and June for Gastroenterology, Urology and Neurology. Cardiology, expect	DGM's	Ongoing

to have additional sessions agreed for June. In addition to this a number of specialties such as ENT are undertaking a clinical desk top review of notes to determine if a review is required. The impact of these actions on the volume of patients waiting >18 weeks will be a reduction by c150 over the next 8 weeks.		
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

Improvement trajectory

The standard is forecast to be delivered from July 2018 onwards.

All failing specialties 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 recovery 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.

As at the end of April, the actions in place exceeded the expected reduction in the volume of patients waiting >18 weeks by delivering a reduction of 212 against a target of 160. Tangible plans are in place to continue the reduction in May and June with plans for July in development.

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 01 April 2018

Standard: 0

Current position

Regionally, SFHT were one of 25 Trusts with a combined total of 537 52+ week waits reported for the month of March. Nationally 2,755 patients were waiting more than 52 weeks.

At the end of April 2018, the Trust reported 29 patients waiting >52 weeks of which; 14 were ENT, 5 Rheumatology, 2 General surgery, 1 Oral Surgery, 2 Ophthalmology, 4 Urology and 1 Gastroenterology. 23/29 patients have a confirmed TCI in May, 4 in June, 1 in July, 1 remains without a TCI; this has been delayed due to difficulties in contacting the patient.

Causes of underperformance

23/29 patients were identified as part of the historic validation of open pathways. As the DQ team continue to work through the historical validation cohorts, the process in terms of supporting Divisions to have early sight of potential breaches in order to plan capacity accordingly is improving.

Of the remaining 6/29 two are complex patients requiring multiple surgeons and who had long diagnostic pathways, one patient choice following multiple cancellations, one patient unfit, and two patients identified as having an incorrect clock stop identified through routine validation of which one patient pathway was stopped incorrectly awaiting diagnostics and the second was admitted for treatment which was not performed.

Actions to address	Owner	Deadline
Validation team in place undertaking a 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.

			Trajectory											
Incomplete	April 18 Trajectory	April 18 Actual	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19
52+	20	29	17	25	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

Exception Report

Indicator: Maximum 6 week wait for diagnostic procedures

Month: Month 01 April 2018

Standard: ≥ 99%

Current position

In April 2018, the Trust delivered 98.59% against a trajectory of 98.73% and the national standard of ≥ 99%. The 2018/19 Diagnostic performance trajectory is shown in table 1 below. This now includes a performance range based on a 5% positive or negative deviation from the forecast volume of patients waiting >6 weeks. The April position of 98.59% is considered outside of range.

Table 1: Diagnostic trajectory 2018/19

DM01	April	April Final	May	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	M
Total waiting list	5,513	5,889	5,556	6,010	5,659	5,063	5,432	5,600	5,540	5,347	5,562	5,335	5
Number of patients waiting > 6 weeks	70	83	65	59	56	50	54	55	55	53	55	53	
Percentage patients waiting <6 weeks	98.73%	98.59%	98.83%	99.02%	99.01%	99.01%	99.01%	99.02%	99.01%	99.01%	99.01%	99.01%	99
Performance range	98.67-98.79%	Outside of range	98.77-98.89%	98.97-99.07%	98.96-99.06%	98.96-99.06%	98.96-99.06%	98.97-99.07%	98.96-99.06%	98.96-99.06%	98.96-99.06%	98.96-99.06%	98.96

Causes of underperformance

66/83 breaches were within Echo, CT and MRI and in the main were due to capacity issues.

	Under 6 wks	6 weeks and over	Grand Total	%
Magnetic Resonance Imaging	1,500	8	1,508	99.47%
Computed Tomography	567	30	597	94.97%
Non-obstetric ultrasound	1,388	0	1,388	100.00%
DEXA Scan	298	1	299	99.67%
Audiology - Audiology Assessments	463	1	464	99.78%
Cardiology - echocardiography	847	28	875	96.80%
Respiratory physiology - sleep studies	137	3	140	97.86%
Urodynamics - pressures & flows	29	5	34	85.29%
Colonoscopy	188	1	189	99.47%
Flexi sigmoidoscopy	76	0	76	100.00%
Cystoscopy	109	5	114	95.61%
Gastroscopy	204	1	205	99.51%
Total	**5,806**	**83**	**5,889**	98.59%

Actions to address	Owner	Deadline
Maximising Echo capacity in May through continued use of locum.	DGM	May 2018
Additional Cardiac CT sessions in May. Testing external company in terms of quality of reporting before contracting for capacity.	DGM	May 2018
Utilising MRI capacity in the private sector (5/6 scans per week) to release capacity at KMH.	DGM	May 2018

Improvement trajectory

The Trust trajectory is forecasting to fail in May, however actions in place are on track to deliver the standard and continue to do so from June onwards.

Risk	Mitigation
Equipment failure	Source additional capacity at weekends or local Trusts and private sector
Demand continues to exceed capacity	Weekly review of diagnostic waits >6 weeks with or without a TCI to date or bring forward as appropriate

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

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: Fractured neck of femur achieving best practice tariff
Month: Month 12 March 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 March 2018 the Trust achieved 68.4% of best practice tariff measures, against the standard of 75%.

2017/18 Performance:

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
33.3	66.7	75.0	78.1	75.9	70.3	82.8	63.6	65.8	65.4	82.4	68.4

Causes of underperformance

The two main drivers for underperformance for March are:

- Insufficient Ortho-Geriatrician capacity (5/12 breaches)
- Time to Theatre (4/12 breaches)

Action	Owner	Deadline
Reviewing all the notes of those patients which failed the standard to evidence the gap in Ortho-geriatrician time	DGM	June 2018
Division incorporating early intervention and review of patients by the duty anaesthetist on the day of admission to instigate earlier optimisation of patients and time to theatre.	DGM	Complete
Scope an additional trauma list Wednesday PM.	DGM	Ongoing

Improvement trajectory

Plan to deliver this standard from April 2018.

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

Exception Report

Indicator: 31 day second or subsequent treatment (surgery)

Month: Month 12 March 2018

Standard: Maximum 31 day wait for second or subsequent treatment (surgery) (94%)

Current position

Performance for March 2018 was 66.7%. This was based on 3 breaches of the standard from a total of 9 treatments.

Month	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
Standard	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%
No. of treatments	10	11	8	9	3	11	5	10	4	10	9	9
No. of breaches	0	1	0	0	1	0	0	1	0	3	0	3
% achievement	100.0%	90.9%	100.0%	100.0%	66.7%	100.0%	100.0%	90.0%	100.0%	70.0%	100.0%	66.7%

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

Three patients breached in March. One Breast treatment delayed for medical reasons, the TCI date was postponed due to the patient's medical issues.

One Skin treatment delayed due to patient choice having been offered a date within target but declined due to a planned holiday. An adjustment was applied but still dated outside of 31 days as the patient needed to be treated by a specific consultant.

One Gynaecology treatment delayed for medical reasons. Treatment date booked in target was postponed as patient was unwell.

Actions to address	Owner	Deadline
Elective capacity prioritised for cancer and urgent patients with additional theatre sessions agreed as required	Divisional General Managers	In place
Weekly PTL meeting extended to include 31 day patients	Cancer Services Manager	Q1 2018/19

Improvement trajectory

On track to deliver standard for April 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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No. of breaches	0	1	0	0	1	0	0	1	0	3	0	3
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