Public Board Meeting Report

Subject:	**Single Oversight Framework Integrated Performance Report**
Date:	**26th April 2018**
Authors:	**Phil Bolton – Deputy Chief Nurse, Yvonne Simpson- Head of Corporate Nursing, Denise Smith – Deputy Chief Operating Officer, Helen Hendley, Deputy Chief Operating Officer Elective Care, Jonathan Clements – Financial Planning and Strategy Manager, Helen Cowley and Michelle Smith – Workforce Information Officers, Elaine Jeffers – Deputy Director Governance and Quality Improvement**
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, for each of the standards rated as red an exception report is provided as below.

These are:

Quality

- Clostridium difficile Hospital acquired cases
- Falls per 1000 OBDs resulting in Low or No Harm
- Eligible patients asked case finding question, or diagnosis of dementia or delirium
- Patients where the dementia outcome was positive or inconclusive, are referred for further diagnostic advice.

Patient Experience

- % complaint responses dispatched within appropriate number of days
- Recommended Rate: Friends and Family - Inpatients
- Recommended Rate: Friends and Family – Accident and Emergency
- Recommended Rate: Friends and Family Maternity
- Recommended Rate: Friends and Family Outpatients

Emergency Access

- Emergency Access within four hours total Trust
- Emergency Access within four hours Kings Mill Hospital
- % of Ambulance handover >30 minutes and > 60 minutes

Referral to Treatment

- Specialties exceeding 18 week referral to treatment time (incomplete pathways)
- 18 weeks referral to treatment time – incomplete pathways
- Number of cases exceeding 52 weeks referral to treatment

Cancelled Operations

- Breaches of the 28 day guarantee following a last minute (on the day) non clinical cancelled elective operation

Cancer Access

- 62 day referral to treatment

Within the Patient Safety Section one indicator is rated as Amber, SHMI

The YTD Actuals for SHMI during the period July 2016 – June 17 is 102.21 against a plan/standard of 100. This continues to be within the expected range. Over the last 2 reporting quarters (Q4 16/17 and Q1 17/18) the number has gone up compared to the previous 3 quarters but again within the expected range. This is regularly reviewed by the Trust's Mortality Surveillance Group.

Actions with regard to achievement of quality standards not rated as red are included in the reading room.

Safer staffing in the period is described below with a more detailed report in the reading room.

Ward staffing information is submitted monthly as part of the national safer staffing UNIFY. The monthly UNIFY submission does not include all ward and department areas within the Trust.
The number of areas with **red** ratings (actual staffing level is below the accepted 80% level and highlights a potential significant risk) and there was 1 **red** rating. The number of areas with **amber** ratings (staffing fill rate is less than the accepted 90%, but above 80%) and there were 1 **amber** ratings. March 2018 saw 13 wards of the 27 monitored recording as **blue** rating (actual staffing figures are greater than 110% fill rate) and the remaining 12 wards were **green** rating.
The Unify data for March 2018 in wards which were reported as **red** and **amber** does not have any correlation to patient harms.
Graph 1 below, displays over a 12 month period, where the Trust has not staffed to its expected planned level (**red** below 80% and **amber** between 80% & 90%) and the staffing fill rates above planned (greater than 110% **blue**).

For Organisational health all standards are achieving and rag rated green, a detailed report is provided in the reading room.

Financial Summary

At year end the Trust is £5.94m ahead of its control total excluding STF, this reflects the additional Tranche 1 monies of £0.91m following the autumn budget and a change in accounting treatment of the Trust's PFI scheme of £5.00m

The Trust is £9.64m ahead of its control total including STF, reflecting £ for £ matched STF incentive funding of £5.94m received for being ahead of control total excluding STF and the loss of £2.24m of A+E performance STF for quarters 2,3 and 4.

	March In-Month			Outturn			Annual Plan
	Plan	Actual	Variance	Plan	Actual	Variance	
	£m	£m	£m	£m	£m	£m	£m
Surplus/(Deficit) - Control Total Basis Exc STF and Impairment	(4.63)	1.76	6.39	(46.44)	(40.50)	5.94	(46.44)
Surplus/(Deficit) - Control Total Basis Inc STF and Exc Impairment	(3.60)	8.42	12.02	(37.62)	(27.99)	9.64	(37.62)
Finance and Use of Resources Metric YTD				3	3		3
CIPs	1.68	1.51	(0.17)	16.26	16.35	0.09	16.26
Capex (including donated)	(0.79)	(6.87)	(6.08)	(9.67)	(10.29)	(0.62)	(9.67)
Closing Cash	1.45	8.91	7.46	1.45	8.91	7.46	1.45
NHSI Agency Ceiling - Total	(1.49)	(1.56)	(0.07)	(17.91)	(16.74)	1.17	(17.91)
NHSI Agency Target - Medical	(1.11)	(0.99)	0.13	(13.37)	(10.70)	2.67	(13.37)

- The finance element of the Single Oversight Framework is a score of 3 against a plan of 3.
- CIP outturn delivery is above plan by £0.09m.
- Outturn capex expenditure is £0.62m ahead of plan, as a result of additional PDC received for specific projects not reflected in the plan.
- Closing cash at 31st March was £7.46m ahead of plan reflecting timing differences between receipt of capital loan cash and payments of creditors.
- Outturn agency spend totalled £16.74m against the NHSI ceiling of £17.91m. In month expenditure is marginally above ceiling by £0.07m.
- Outturn medical agency spend totalled £10.70m against the NHSI target of £13.37m.

Exception Report

Indicator: Post 72 hours *Clostridium Difficile I*nfection

Month: March 2018

Standard: <4

Current position
There were 6 *Clostridium Difficile* Infections (CDI) in March, bringing the cumulative total to 39, the annual objective is 48 A review of the 6 CDI identified that 3 were linked, the others were sporadic cases. An initial meeting was held to review the period of increased incidence and several learning points and actions were taken as a result. The Joint monitoring audit process targeted the stroke unit and identified multiple actions to improve cleanliness across the department these included: • Medirest tasked with ensuring stroke unit have adequate cleaning staff • Medirest tasked with bringing the department up to specification; • all the nursing team were re-educated in cleaning methodology to ensure medical equipment was cleaned correctly to a high standard; • all patients antibiotic regimes were reviewed • Improved communication between cleaning and nursing staff to improve understanding on the need for isolation precautions. After results confirmed that there were 3 CDI with the same ribotype an outbreak meeting was held and the Consultant in Communicable Disease Control (CCDC) attended to provide input from Public Health England (PHE). It was deemed that the actions already in place were appropriate and timely to halt further incidence of CDI

Causes of underperformance
For this type of organism, patient factors are a major contributor to the increased risk of infection. Where antibiotics are required to treat a primary infection there is an increased risk that this will drive incidence of CDI occurring. It was identified that the standards of cleaning on the Stroke Unit had fallen below an acceptable standard, due, in part, to a shortage of cleaning staff and a lack of appreciation of the unintended consequences related to staff being redistributed..

Actions to address

Action	Owner	Deadline
For the in situ deep clean process to be completed and all affected areas 'fogged'	Medirest	31/04/2018
For the stroke unit cleaning schedule to be increased to 'high risk'	Soft facilities and Medirest	31/10/2018
Mattresses to progress through Trust decontamination route	Stroke Unit/ Tissue Viability	

Improvement trajectory
To achieve reduced nationally set objective for 2018/2019 of 47 cases.

Risks	
Risk	**Mitigation**
Patient factors – early identification of primary infection and appropriate treatment	Timely microbiology samples to ensure appropriate treatment is given early
High levels of flow reduces ward ability to clean to high enough specification (fogging)	To increase frequency of 'Amber cleaning' to minimise risk of environmental contamination
Mattresses routinely kept on ward to enable quick allocation to severely ill patients	For mattress decontamination team to ensure a clean mattress is available at all times.

Lead: Rosie Dixon, Nurse Consultant - IPC

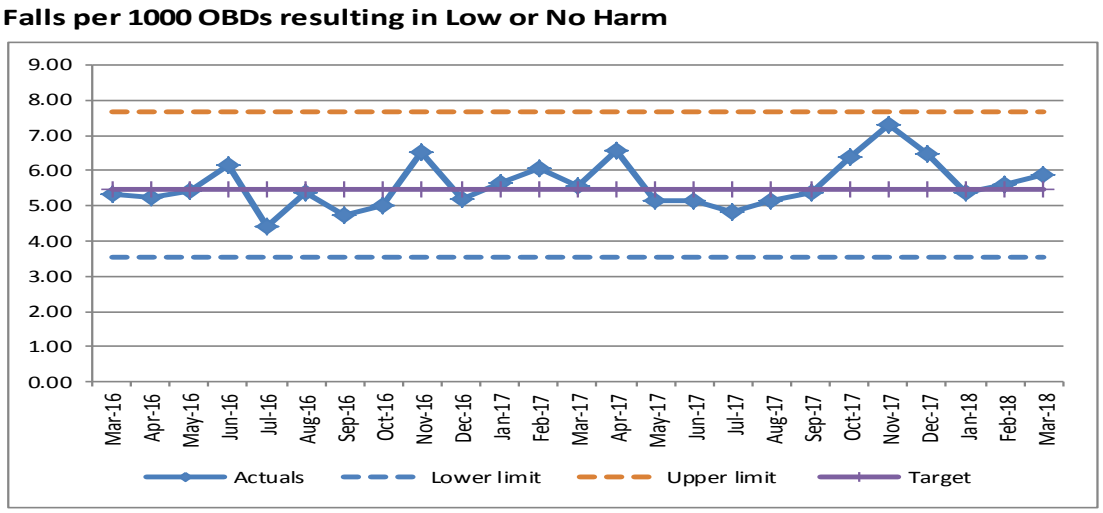
Executive Lead: Dr Andrew Haynes, Executive Medical Director

Exception Report

Indicator: Falls

Month: March 2018

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



Causes of underperformance
There was no single theme or trend analysed via Datix system. Current pressures do not allow staff to leave clinical area to attend falls e-learning /drop in session or attend individual area educational sessions by Falls Lead.

Actions to address		
Action	**Owner**	**Deadline**

• Take forward for comments the RCP vision assessment document in a simple format for staff to use as part of falls assessments. • Queens Medical visit arranged as part of sharing good practice • Individual ward education –Stroke Unit and Ward 32 • E-learning session/falls drop-in session for staff – 18 April 2018 • New 2108/2021 Falls Strategy to be launched towards April/ May 2018. • Sign off new falls TOR and membership at Falls Steering Group • Attending Woodland ward dementia café as part of dementia care and advice in relation to falls. This will also provide an opportunity for community relationships with carers/relatives . • Attending Dementia steering group to discuss the Dementia strategy being related to falls prevention as per 2017 RCP falls audit. • Communications re **Lets TALK** about falls in the form of an acronym –which highlights the importance of wards and depts passing on information and discussing about a patients falls risk so staff can be more prepared for the persons transfer .	Falls Lead Nurse	End May 2018 April 2018 April/May 2018 April 2018 End April /Beginning May 2018 April 2018 End April 2018 End April 2018

Improvement trajectory
Below national average for all falls 6.63 on a monthly basis. Below Trust Indictor of 5.5 low or no harm and 0.8 moderate /severe falls

Risks	
Risk	**Mitigation**
Enhanced Patient Observations for those patients who are at risk of falls, some shifts are not covered by Nurse Bank.	Virtual Ward Healthcare Assistants are recruited and in post to reduce patient harm. All patients requiring enhanced observations have the appropriate level of observation.
There is additional capacity open to support the Trust through the Winter Pressures	Plans in place to commence the closing of additional capacity. All areas have met the Trust's minimal safe staffing.

Lead: Joanne Lewis-Hodgkinson – Falls Lead Nurse

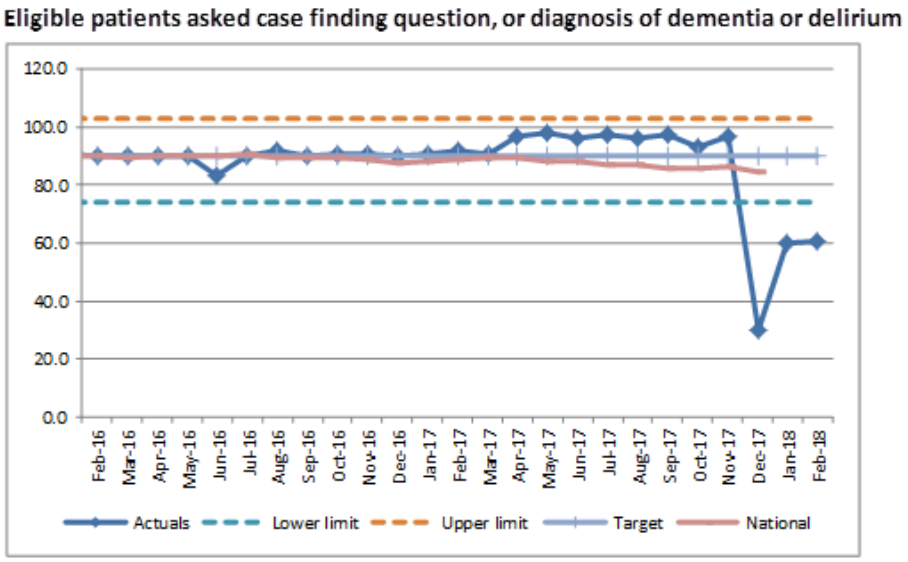
Executive Lead: Suzanne Banks, Chief Nurse

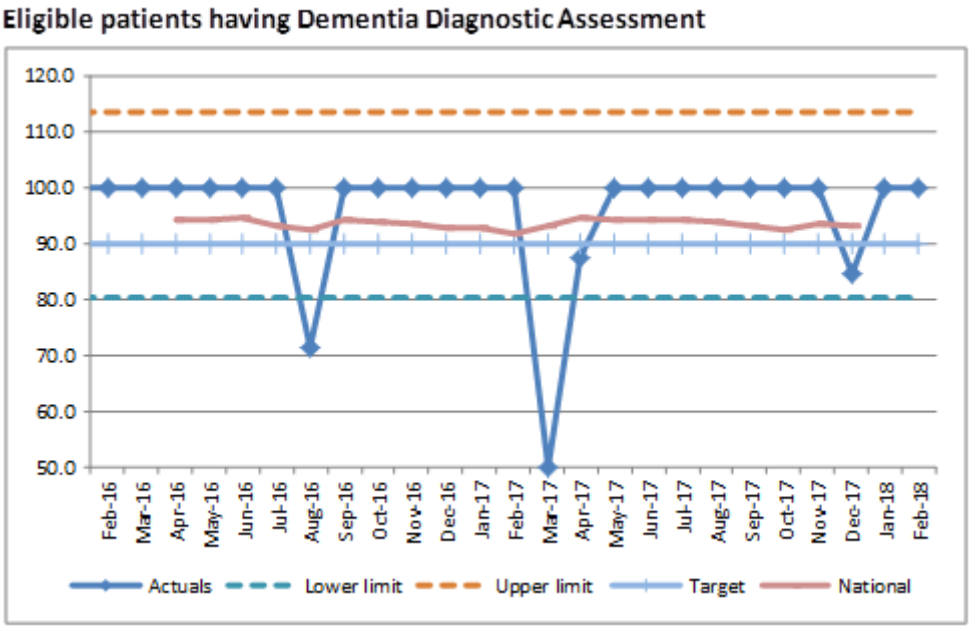
Exception Report :

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

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

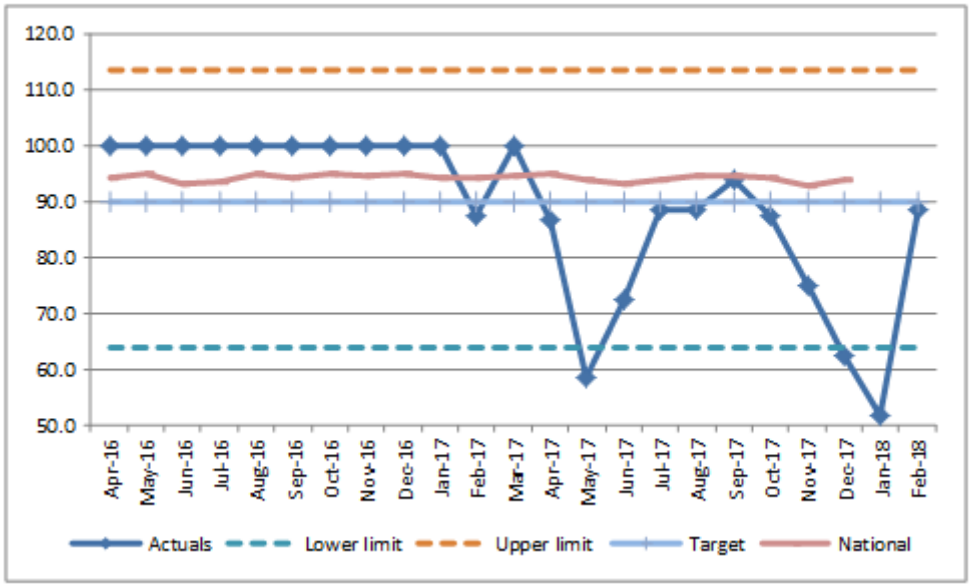
Standard: Maintain identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia. Desired performance is 90% on each part of the indicator.

Current position – Find

Current position – Find
During February 2018, 60.5% of eligible patients were identified; this has increased from the February return (January data – 60.1%), but performance is still below the required 90%.
Causes of underperformance - Find
212 of the eligible 537 patients were not screened for the following reasons: 139 question blank 10 missing documentation 48 old documentation 14 unable to answer for clinical reasons (not included in the analysis) 1 refused to answer question
Current position – Assess and Investigate



Current position – Assess and Investigate

During February 2018, 66 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%].

Current position – Refer
Patients where the dementia outcome was positive or inconclusive, are referred for further diagnostic advice 
Current position – Refer
There were 62 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 55 of these patients were referred for further diagnostic advice in line with local pathways [88.7%].
Causes of underperformance – Refer
The following exceptions were found: 4 answered positive to case-finding but there was no evidence of referral 1 AMT score suggested referral was needed but no evidence this happened 2 no evidence of referral for delirium

Actions to address		
Action	**Owner**	**Deadline**
Case for Dementia Assessment in Nervecentre to be presented to the Digital Strategy Implementation Board.	Tina Hymas-Taylor	April 10th 2018
Six-month secondment for Dementia Assessment Nurse to improve performance on FIND	Tina Hymas-Taylor	April 30th 2018
Improvement trajectory		

Following appointment to the Dementia Assessment Nurse secondment it is expected that the performance on FIND will improve; this will ensure that patients who require further assessment are appropriately identified.

The ability to collect dementia screening information on Nervecentre is completely dependent on the assessment module being made available at SFH. Over the next weeks and months the time-scale for implementation should become in clearer. How the dementia return is completed at NUH is also being investigated.

Lead: Tina Hymas-Taylor, Head of Safeguarding

Executive Lead: Suzanne Banks, Chief Nurse

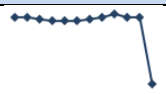
Exception Report

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

Month: Month 12 March 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%	Mar-18	94.3%	60.0%		

Causes of underperformance

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

This progress of all complaints are tracked by the Patient Experience Team and shared with the Executive on a weekly basis, due to a need to improve the quality of some of the complaint responses, additional time was taken to enhance and expand upon the responses provided.

We explained the delay to all complainants concerned and a letter of apology for the delay was also given by the Chief Executive as part of our response to them.

Discussions have taken place between the Director of Governance and Quality Improvement, Deputy Director of Governance and Quality Improvement, Chief Executive and Head of Patient Experience to further develop the complaints process in order to avoid delays in the future.

The Trust aims to achieve a standard wherein complaints are responded to within 25 working days or an agreed timescales negotiated with the complainant.

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), Paulk 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

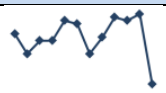
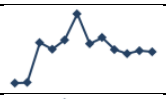
Exception Report

Indicator: Friends and Family Test

Month: Month 12 March 2018

Standard: Friends and Family Test (FFT)

Current position

Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RA
Recommended Rate: Friends and Family Inpatients	97%	Mar-18	98.3%	96.9%		
Response Rate: Friends and Family Accident and Emergency	≥12.8%	Mar-18	9.6%	9.6%		
Recommended Rate: Friends and Family Maternity	96%	Mar-18	95.3%	94.6%		
Recommended Rate: Friends and Family Outpatients	96%	Mar-18	93.8%	94.0%		

Causes of underperformance

1. **The FFT in relation to ED** – the response rate 3.2.0% below plan for March 2018.

   Following further review of the ED response rate and the method of data collection, when patients are booking into the Emergency Department, reception staff are capturing 40% of mobile telephone number for patients, with a slight decrease during the weekend.

   Whilst not all patients will have a mobile telephone number, we know from Outpatient patient information that approximately 65% of SFH patients use a mobile telephone, therefore this conversion rate could be significantly increased if numbers are obtained.

   This issue has been escalated to the divisional team to ensure all reception staff are clerking patients into the department correctly and asking if the FFT survey can be sent following the attendance.

   The weekly and monthly reports are shared with division to ensure they are aware of the figures to formulate a plan to increase FFT response rates for April 2018.

2. **The FFT relating to recommending Maternity Services** – recommendation ratings is 1.4% below plan for March 2018. Concerns raised include:

2.1 Clinic 12 – Gynaecology

- Longer time in appointments with Consultant
- Waiting time in clinics
- More reception staff available

- **Sherwood Birthing Unit**
  - More birthing pools
- **Antenatal Clinic**
  - Waiting times

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 in March 2018.

In March 2018, FFT was rolled out to the Sexual Health services which are based within KMH and 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.

The other concerns related to:, this has receive

4. Concerns raised include:

- Sexual Health Services – KMH and community settings
  - Reception staff rude
  - Felt rushed during appointment
  - Better signage
  - Clearer advice to be given
  - More responsive reception staff
  - Waiting times
- Clinic 1
  - Free coffee
  - Waiting times in Orthopaedic Outpatient Clinics, including the Fracture Clinic
- Clinic 5
  - Waiting times
- Newark Outpatient Department
  - Waiting times
- Physiotherapy Services
  - Waiting times
  - Longer session
  - More chairs available
- General Concerns
  - Car Parking Charges
  - Smoking in the front entrance

The Diagnostic and Outpatient division have completed the following actions:

• Weekly OPD Matron and Clinical Lead reviews all Friends and Family responses and shares the negative comments with the relevant area including issues such as car parking and smoking.

• Waiting times in clinics- Patients waiting times over 20 mins 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 undertaken by senior team to ensure actions are being undertaken.

• Attitude of reception staff- Issues addressed with individual areas and improvement notices given for consistent underperformance. Attitude of nurse- Specialist Nurse shared with responsible

Division. • Car Parking- Car parking issues escalated to Ben Widdowson and Wes Burton.		
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 12 March 2018

Standard: A&E maximum waiting time of four 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
Overall, 88.8% of patients had a maximum waiting time of four hours from arrival to admission / transfer / discharge in March 2018. At Kings Mill Hospital performance was 83.8%% and at Newark Hospital performance was 98%. Performance for 2017/18 was 92.3% for the Trust. National ranking for March was 30 out of 137 Trusts. 21.3% of ambulances had a delay over 30 minutes on the EMAS (non-CAD extra) data, this shows a deterioration of 2.6% on February and requires further improvement. This report should be read in conjunction with the winter pressures paper.

Causes of underperformance
• **EAU Demand & Capacity** – following the closure of 12 (52 to 40) beds on EAU in June 2017, the unit has not been able to meet demand on a daily basis as it is the outlet from ED for the medical admissions. This has been grossly exacerbated in winter as admissions have increased. • **Weekend discharges in medicine** – this winter 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, leading to lower performance on Mondays. Best practice suggests that weekend discharges should be 80% of the weekday discharge rate. • **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 that the 16/17 winter plan, but also used an outlier approach to additional medical bed capacity which it is known increases the average length of stay of patients. • **External capacity** – the decommissioning of 'Transfer to Assess' beds, which closed completely at the end of March, has created delays along a number of external pathways, most notably for 'non-weight bearing' patients. The Trust is now seeing a more material increase in the DTOC levels but with an overall high level of occupancy this cannot be coped with as well as it previously has. • **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		
Action	**Owner**	**Deadline**
Clinically led improvement plan in place, monitored weekly through Patient Flow Group	**Simon Barton**	In progress
Development of key performance indicator pack	**Simon Barton**	31 May 2018
'Start Right'	**Dr Ben Owens**	
Reduce EAU bottlenecks including maximisation of AEC and development of a new frailty assessment unit		In progress
Ensuring ED medical rota's that consistently achieve a maximum 2 hour wait to be seen – particularly overnight		April 2018
Embedding of Senior streaming to ensure senior review with investigations ordered within 30 minutes of arrival		In progress
Focus on ambulance handover within 30 minutes		30 June 2018
'Todays Work Today'	**Dr Anne-Louise Schokker**	
Deliver 33% of daily discharges by noon		July 2018
Delivery 80% of weekday discharge rate at the weekend		In progress
Implementation of criteria led discharge, starting with a pilot on ward 44 before wider roll out		31 Aug 2018
Clear inter-professional standards for response to inpatient wards for requests		In progress
Increase discharge lounge utilisation and pre booking of patient discharge transport		In progress
'Length of Stay'	**Dr Steve Rutter**	
Daily review of all patients within medicine who have been inpatients >7 days		In place
Development of community alternatives for inpatients with external partners (such as home IV)		June 2018
Development of a capacity plan for Mid-Notts		July 2018
Work with external partners to reduce DToCs		In progress
Hospital Operational control systems	**Denise Smith**	
Revised escalation process for long waiting patients		Complete
Revised standard operating procedure for Capacity & Flow meetings		Complete
Development of live bed management systems		August 2018
Development of an internal bed capacity plan		July 2018

2018/19 trajectory				
	Q1	**Q2**	**Q3**	**Q4**
	95%	95%	92%	90.5%

Risks	
Risk	**Mitigation**
Appropriately skilled service improvement capacity to support the Divisions with change management	Plan being developed with the Programme Management Office, to be in place during Q1.
Changes in external capacity	Working in partnership with external partners and A&E Delivery Board

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 12 March 2018

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

The RTT waiting times measures the proportion of patients waiting under 18 weeks as a snapshot at month end (target of 92% under 18 weeks).

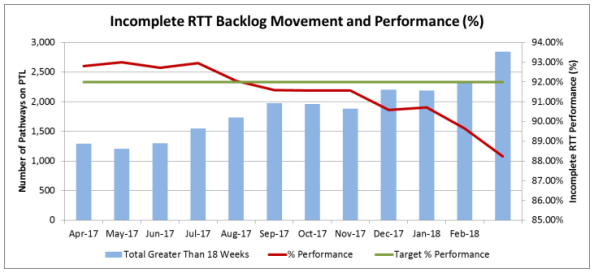
Current position

The volume of patients on an Incomplete RTT pathway at the end of March is 24,195 of which 2,485 are waiting >18 weeks. This position delivers performance of 88.23% against the 92% standard.
The Trust were ranked 112th out of 185 Trusts for the month of February at 89.6%, (March position unpublished). Trusts ranked 91st or above achieved the standard.

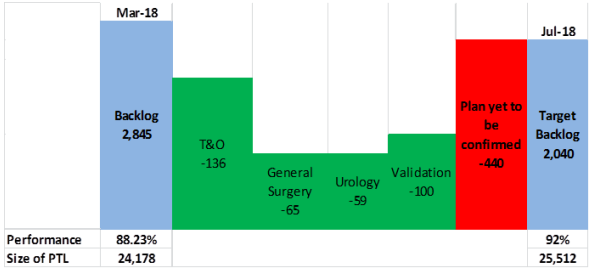
Causes of underperformance

The graph below shows that the volume of patients waiting >18 weeks has been growing throughout 2017/18 (small dip in November), this is seen across a number of specialties notably Ophthalmology, Cardiology and Neurology. The drivers for growth are currently under review and will be linked to any improvement actions. For March, 11 specialties failed the standard.

Backlog movement:



Recovery bridge:



SFHFT have submitted a trajectory to NHSI and CCG colleagues to deliver the 92% standard for the month of July onwards. In order to do this the volume of patients waiting >18 weeks would need to reduce by c800.
The Surgical and Medical divisions have a backlog reduction target and are currently refocussing their action plans to deliver the reduction between now and the end of July 2018. The bridge will be underpinned by a set of quantifiable actions with progress tracked at the weekly RTT meeting.

Actions to address

Action	Owner	Deadline
General Surgery – Staff identified to undertake additional theatre and outpatient clinics. Focus on validation with 1-2-1 support to PPC's. Impact of actions on backlog over the next 12 weeks is c65 patients	DGM	July 2018
Urology – Three additional lists booked (1 April / 2 May) further lists and outpatient capacity will be secured for June with new appointees and changes in the Urology timetable.	DGM	June 2018

Impact on backlog c60 patients		
Trauma & Orthopaedics – Additional weekend sessions planned every 2 weeks, specialty team undertaking in-depth validation to ensure the PTL is clean. Impact on backlog c140 patients	DGM	July 2018
Oral Surgery – 3 additional theatre sessions agreed with NUH 1 per month May – July. Evening clinics agreed every Thursday. Impact on backlog c16	DGM	Complete
Cardiology – outpatient recovery programme in place which includes recruitment plan, source weekend diagnostic capacity, recovery expected July 2018	DGM	In progress
Gastroenterology – New locum picking up follow up activity in addition to WLI clinics	DGM	Complete
Develop capacity plan to align and underpin actions to consistently deliver the standard	Deputy Coo (Elective Care)	May 2018

Improvement trajectory
The standard is currently forecast to be achieved from July 2018/19

Risks	
Risk	**Mitigation**
Medical staff availability to fulfil existing and additional sessions	Continue recruitment and secure locums where required
NUH @ SFHT services – Neurology and Vascular, activity is due to transfer to NUH in 2018/19. Both services were due to transfer in 2017/18 but timelines have slipped.	Divisional General Manager discussion with NUH to agree a cut-off date to transfer the service to @NUH model.

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 12 March 2018

Standard: 0

The referral to treatment standard has a zero tolerance to patients waiting longer than 52 weeks – there is no adjustment for patient choice, with no limit on the length of time a patient may delay their treatment as long as it is clinically appropriate

Current position
SFHFT have reported 52+ wait patients throughout 2017/18 and whilst we do experience genuine patient choice and capacity issues, in the main they are due to data quality issues which can be summarised as: 1. Historic issues (for which the underlying cause of the issue has been addressed) 2. Live issues, for which resolutions (to prevent the issues recurring) are underway Regionally, SFHFT were one of 28 Trusts with a combined reported total of 436 52+ week waits for the month of February (March not yet published). Nationally 2,236 patients were waiting more than 52 weeks. At the end of March 2018, The Trust reported 28 patients waiting >52 weeks of which; 16 were Rheumatology patients, 7 ENT, 1 General surgery, 1 Oral Surgery, 1 Ophthalmology, 1 Urology and 1 Cardiology. 16 of the 28 patients have a confirmed TCI in April, 3 in May due to capacity, 3 patients were discharged and 1 clock stop in month. 5 remain without a TCI, (4 Rheumatology and 1 Cardiology); the Medical division are actively identifying additional capacity.

Causes of underperformance
25 of the 28 patients are as a result of the on-going work to validate open pathways that were historically migrated onto the Medway PAS system. The vast majority of open pathways can usually be closed as no longer required; these tend to be patients who no longer require any form of follow-up. However, some patient pathways will need a review within an outpatient setting to decide if their pathway needs to remain open or is appropriate to close. As the DQ team identify such pathways, the divisional teams are tasked with creating sufficient and timely capacity to offer a patient a review appointment within 2 weeks of identification a full harm review will be undertaken at the OP appointment and a formal written apology sent.

Actions to address		
Action	**Owner**	**Deadline**
Validation team in place undertaking a methodical review of historic open pathways	Data Quality Manager / Divisional General Managers	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, any delays are reviewed at the	Divisional General Managers	In place

weekly RTT meeting		
Patient found to require a review will trigger the harm review process immediately. The clinician will be notified and undertake a full harm review at OP. A formal apology will be sent to the patient	Data Quality Manager / Clinician	In place
Strengthening the oversight and ownership of live validation issues via 3 work streams focussing on: 1. Training for staff 2. Standard operating procedures 3. Patient management reports	Deputy COO (Elective Care)	May 2018

Improvement trajectory
Further 52 week breaches may continue to be identified until validation work is complete (end of December 2018). The 2018/19 planning guidance states that numbers nationally of patients waiting more than 52 weeks for treatment should be halved by March 2019, and locally eliminated wherever possible. Trust trajectory is to be at zero by the end of March 2019.

Risks	
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	Programme of training, supported by standard operating procedures and robust management of “safety net” reports to be in place over the next quarter.

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

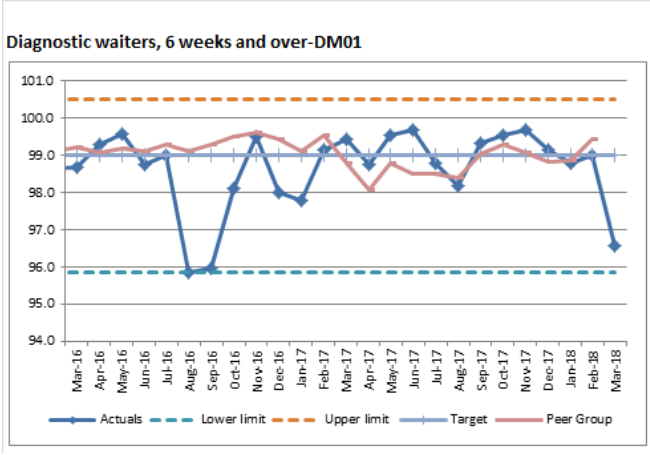
Month: Month 12 March 2018

Standard: ≥ 99%

Current position

In March 2018, the Trust delivered 96.59% against the standard of 99%.

	Mar-18			
	Under 6 wks	6 weeks and over	Grand Total	%
Magnetic Resonance Imaging	1342	3	1345	99.78%
Computed Tomography	583	16	599	97.33%
Non-obstetric ultrasound	1174	0	1174	100.00%
DEXA Scan	241	2	243	99.18%
Audiology - Audiology Assessments	431	7	438	98.40%
Cardiology - echocardiography	901	158	1059	85.08%
Respiratory physiology - sleep studies	187	2	189	98.94%
Urodynamics - pressures & flows	26	0	26	100.00%
Colonoscopy	168	2	170	98.82%
Flexi sigmoidoscopy	72	0	72	100.00%
Cystoscopy	60	0	60	100.00%
Gastroscopy	218	1	219	99.54%
Total	**5403**	**191**	**5594**	96.59%



Causes of underperformance

CT - One of the CT scanners at KMH had a tube failure at month end. Priority had to be given to urgent, ED and in-patients therefore some outpatients were cancelled, all patients were scanned the following week, this was then into April.

Echocardiography

In addition to the prioritisation of Inpatient referrals over the Winter period, there was insufficient capacity to meet demand during March due to sickness absence and a reduction in activity over the bank holiday period.

Actions to address

Action	Owner	Deadline
Continued use of locum physiologists, maximising existing lists and the staff member who returned from sick leave resuming full clinical duties. On track to deliver a significant reduction in the volume of breaches in April	DGM	On track

Improvement trajectory
The Trust is forecasting to fail in April and May and deliver from June onwards. Given the recovery of the Echo position it is likely we will deliver from May onwards.

Risks	
Risk	**Mitigation**
Availability of locums for weekday and weekend working	Proactive demand and capacity management to minimise risk of non-delivery in month

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

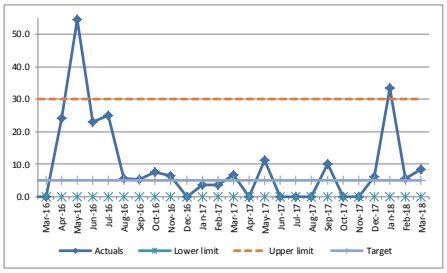
Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: Breaches of the 28 day guarantee following a last minute (on the day) non-clinical cancelled elective operation

Month: Month 12 March 2018

Standard: ≤ 5.0%

Current position
In March 2018 8.3% of patients breached the 28 day guarantee against the standard of ≤ 5.0%. **Breaches of the 28 day guarantee following a Last minute (on the day) non clinical cancelled elective operation**    1 patient breached this standard due to lack of HDU capacity. The Patient is currently on holiday and has requested a TCI in May. The Surgical division will agree a date with the patient on their return.

Actions to address		
Action	**Owner**	**Deadline**
Prioritise cancelled patients for re-booking elective surgery	DGM	In place

Risks	
Risk	**Mitigation**
Patients are not offered a date within 28 days	Cancelled patients to be reviewed at the weekly RTT PTL meeting chaired by the Deputy COO (Elective Care)

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

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: 62 days urgent referral to treatment

Month: Month 11 February 2018

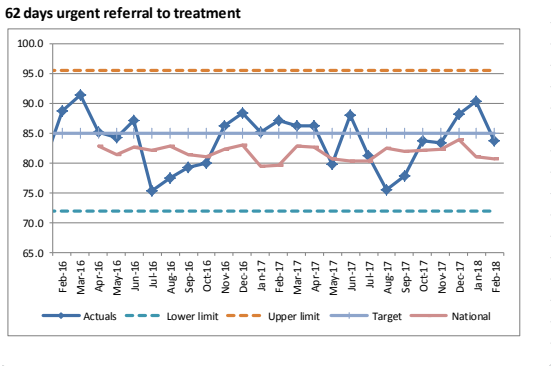
Standard: Maximum 62 day wait for first treatment from urgent GP referral for suspected cancer (85%)

Current position

The Trust delivered 83.8% for February with 65 treatments / 10.5 breaches. Breaches of the standard occurred at:

Day 63-80	Day 81-100	Day 100+
4.5	4.5	1.5

Regional performance was 79.9% with 25/43 Trusts failing the standard. The National position for February was 81%. All other Cancer targets at SFHFT were met in February 2018.



For the period 06/02/2018 to 28/02/2018 the 62 day backlog (all patients including screening and consultant upgrade) reduced by 34% from 50 to 33, this was the lowest position since March 2017.

Causes of underperformance

Breach analysis identifies a range of reasons for a delay in our patient pathways, by far the most common is delays in the diagnostic phase (including the need for multiple tests) impacting on our ability to transfer to tertiary providers in a timely manner.

We are currently working with the NHSI Intensive Support team to strengthen our understanding and actions to support unblocking delays against timed pathways.

Under the chairmanship of the Clinic lead for Cancer we are setting up a clinically led cancer task force building on the evidence for our delays to focus on improvement initiatives cross tumour site and diagnostic modality. We expect the first meeting to be in May 2018

Actions to address		
Action	**Owner**	**Deadline**
Roll out of IST analyser tool to evidence pathway delays	Janet Duffin	On track
Set up clinically led cancer task force to focus on improvement initiatives cross tumour site and modality. Expect first meeting to be in May 2018	Steve Foley	On track

Improvement trajectory
Forecast performance for March is 90.1%. April and May forecast to fail due to reallocation of treatments and breaches in line with the revised Inter-provider transfer policy. The team continue to focus on appropriate transfer by day 38 and hold a weekly call with NUH to escalate any delays or concerns.

Risks	
Risk	**Mitigation**
Re-allocation of breach and treatment due to the implementation of the Inter-provider transfer policy	Focus on appropriate transfer by day 38 Weekly call in place with NUH to escalate any delays or concerns

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

Executive Lead: Simon Barton, Chief Operating Officer