Public Board Meeting Report

Subject:	**Single Oversight Framework Integrated Performance Report**
Date:	**29th March 2018**
Authors:	**Phil Bolton – Deputy Chief Nurse, Yvonne Simpson- Head of Corporate Nursing, Denise Smith – Deputy Chief Operating Officer 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 below.

These are:

Patient Safety

- Serious Incidents including Never Events (STEIS reportable) by reported date

Quality

- E.Coli bacteremia blood stream infection – 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

- 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

Fractured Neck of Femur

- % of fractured neck of femur achieving Best Practice Tariff

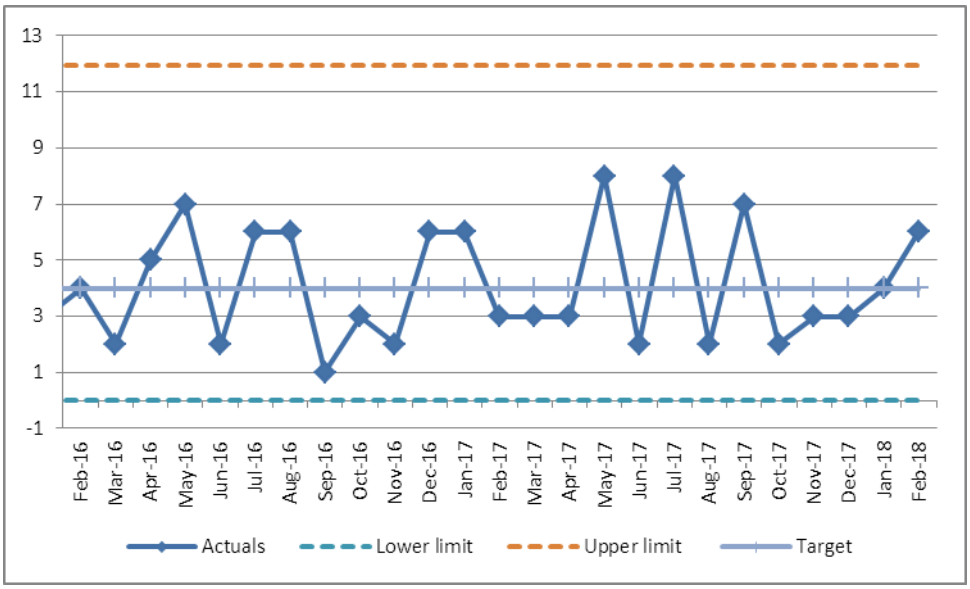
Cancer Access

- 31 day second or subsequent treatment (Surgery)
- 62 day referral to treatment from screening

The sickness absence exception report is included in the Organisational Health section of the report

Exception Report

Indicator: Post 48 hours *Escherichia Coli* bacteraemia
Month: February data 2018
Standard: <4

Current position
There were six *Escherichia Coli* bacteraemia in February, bringing the cumulative total to 48, at present there is no objective attached to this, however there is an aspiration for a reduction of 10% on the previous years. A review of the six E.coli infections identified that three were related to the urinary tract, and two have been attributed to the presence of a catheter. The Root Cause Analysis process is in progress to identify whether there was any learning to be identified; initial indications suggest that one catheter could have been removed in a more timely manner.    The remaining four were likely to be caused as a result of endogenous infection due to their underlying conditions.

Causes of underperformance
For this type of organism, patient factors are a major aspect of any bacteraemia. Every patient has E.coli within their bodies which makes the possibility of an endogenous source of infection more likely, and was the likely reason for 4 of the 6 infections. 2 patients had underlying liver and biliary disease, 1 had gastrointestinal disease and the final one was admitted with an established urinary tract infection. In addition the need for invasive devices due to patient condition was also a factor, though the potential for early removal is being investigated as part of the root cause analysis.

Actions to address		
Action	**Owner**	**Deadline**
Collection of risk factor data to monitor for themes	Infection Prevention and Control Team	31/03/2018

Increase in training for insertion of invasive devices	Infection Prevention and Control Team	31/03/2018

Improvement trajectory
To bring number under four a month

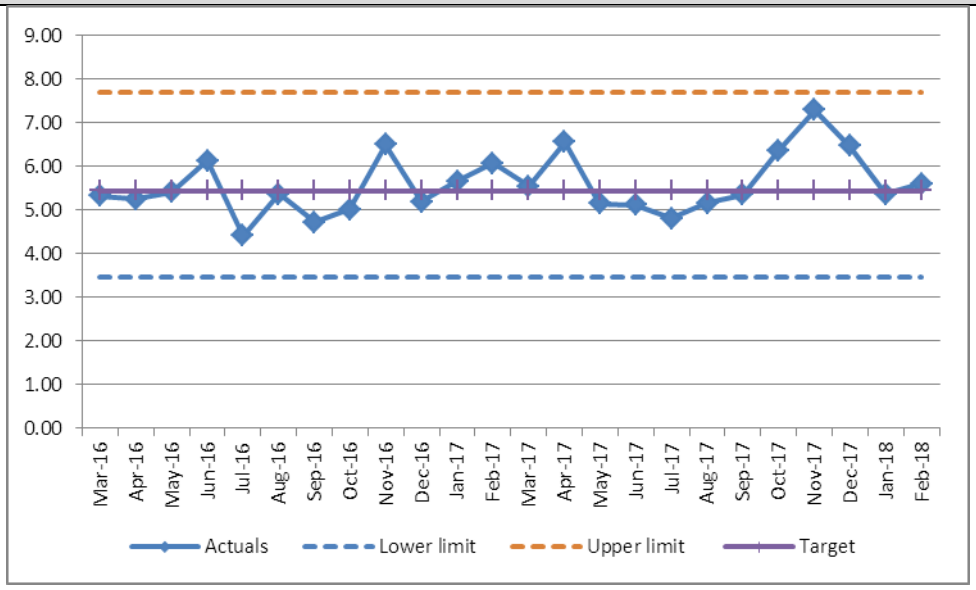
Risks	
Risk	**Mitigation**
Patient factors – early identification of primary infection and appropriate treatment	Timely microbiology samples to ensure appropriate treatment is given early

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

Current position



Falls in 1000 bed days resulting in low or no harm is currently at 5.6, against an internal target of 5.5. A falls deep dive was presented to March Quality Committee.

Causes of underperformance
The Falls Lead Nurse continues to work with the ward teams on identification of risks and falls prevention, and there has been a significant reduction in falls over the last four months.

Actions to address		
Action	**Owner**	**Deadline**
• The Falls Lead Nurse continues to analyse each fall related Datix for possible themes and trends taking actions accordingly.	Falls Lead Nurse	Ongoing
• The patient falls resulting in fractured femurs will be initially investigated for immediate concerns requiring actions, pending the full reports and subsequent actions to take forward for learning.	Falls Lead Nurse/ Divisional rep	Ongoing
• The gap analysis following the results of the National Audit of Inpatient falls was discussed in the Falls meeting this month and actions taken forward in relation to recommended	Falls Lead Nurse	31 March 2018

improvements. • Royal College of Physicians visual assessment of inpatient recommendations is being rolled out. • The physiotherapists have carried out significant work around mobility aid access and a staff teaching programme that will help staff choose the correct mobility aid in out of hours for example. • Discussions also held around how audits in relation to falls prevention can be further developed and implemented. • The Falls Nurse is in the process of arranging visits to other Trusts • The Falls prevention strategy for 2018/19, falls steering group and terms of references associated with the group will be updated in line to reflect the National Audit guidelines together with SFHT themes and trends incorporating best practise with Nice guidelines. A launch is then proposed.	Falls Lead Nurse Therapy Services Falls Lead Nurse Falls Steering Group	TBC Ongoing Ongoing Ongoing
Improvement trajectory		
Below Trust Indicator of 5.5 for falls causing low or no harm		

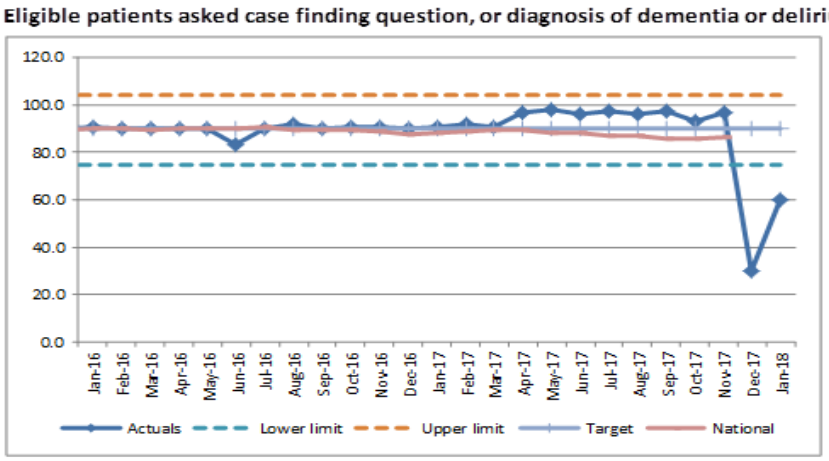
Risks	
Risk	**Mitigation**
Unfilled shifts to provide Enhanced patient care for those patients who are at risk of falls.	100 Healthcare Assistants have been appointed over the last 6 months, vacancies on the inpatient wards have been filled, and Nurse Bank has been successfully recruited to. There is a task to finish group looking at the Enhanced patient observations SOF which will link into the national workstream.
Unfunded capacity is open on Ward 14 and Short Stay Unit which could increase the risk of falls	Falls have continued to decrease over the last four months, and there has been no increase in harms in these areas.

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: March 2018 [Reporting on data collected in January 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



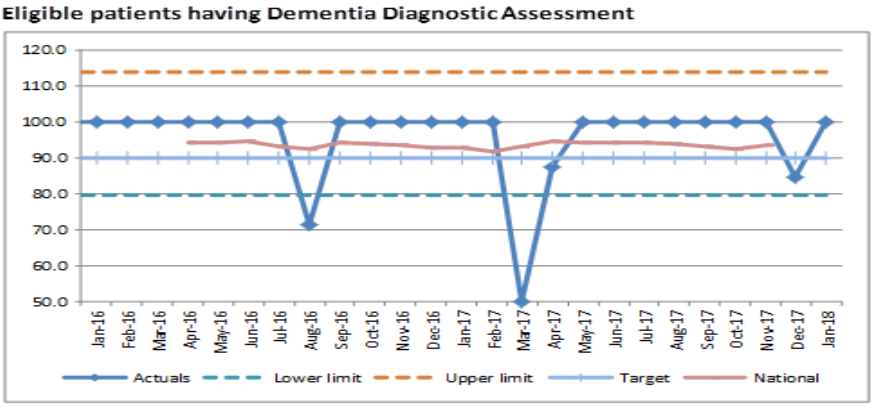
Current position – Find

During January 2018, 60.1% of eligible patients were identified;this has increased from the February return (December data - 29.9%), but performance is still below the required 90%.

Causes of underperformance - Find

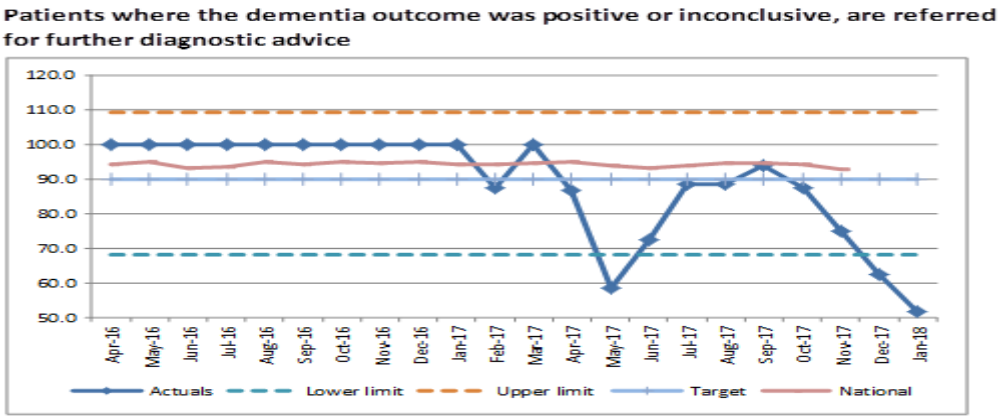
There were 89 cases where the old documentation (without the case-finding question) appears to have been used. There were also 193 cases where the question was in the documentation but the response was left blank without explanation. Forms were missing in 7 cases. Specialist Nurse will be monitoring this given the 72 hour target for completion of initial screen there will be times when the patient will not be asked the case-finding question in time to meet the dementia return criteria.

Current position – Assess and Investigate



Current position – Assess and Investigate

During January 2018, 42 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

Current position – Refer
There were 27 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 14 of these patients were referred for further diagnostic advice in line with local pathways [51.9%].
Causes of underperformance – Refer
There were 7 patients who appear to have required RRLP input, but referrals were not made. Where patients are suspected of having dementia, with no previous diagnosis, it is not always consistently recorded on the discharge letter so that the GP can consider referral to the memory clinic. These patients were only identified post discharge; we were therefore unable to follow them up. Our initial strategy to address any deficit was discontinued due to the responses from GP's. Although we have been assured that all patients over 75 do receive screening in the community.

Actions to address		
Action	**Owner**	**Deadline**
The Specialist Dementia Nurse is undertaking a deep dive in order to understand the issues that impact on the Dementia and Delirium return. A deep dive was reviewed by the March Quality Committee .	Fiona McCandless-Sugg	Completed
Dementia Nurse to explore options to address the 72 hour criteria issue	Fiona McCandless-Sugg	31st April 2018
The Lead Clinician has made some amendments to the screening section of ED and medical clerking documentation. This is an on-going piece of work	Dr Steve Rutter	TBC
The process of data collection, recording and analysis requires a major overhaul to ensure we are collecting meaningful data. During	Fiona McCandless-Sugg / Owen	March 31st 2018

February, the Specialist Nurse and Data Collection Administrator have worked on this and a new spreadsheet is being piloted for data collected in March.	Hufton	
Moving forward, Nervecentre would be the most appropriate way to consistently collect the required data. The Specialist Dementia Nurse will be working with the Nervecentre lead to explore the feasibility of this resolution option.	Fiona McCandless-Sugg	4th April 2018

Improvement trajectory
ED and medical clerking forms should include the case-finding question in a format that means data is collected where possible, but it is clearly identified if the patient is unable to answer the question. The forms also specify that patients must be referred to RRLP if: • AMTS total score is less than 7 and the patient is not known to have dementia • SQiD answer is 'yes' • Response to dementia awareness question is 'yes' This is a short-term solution to the current difficulties, and should help to address the issues that have been identified with the FIND component of the Dementia Return. The most effective solution is for the Dementia data to be collected on Nervecentre. The Specialist Dementia Nurse will be reviewing how this works at NUH and then discuss and agree next steps with the Nervecentre lead.

Lead: Tina Hymas-Taylor, Head of Safeguarding
Executive Lead: Suzanne Banks, Chief Nurse

Exception Report

Indicator: Friends and Family Test

Month: Month 11 February 2018

Standard: Friends and Family Test (FFT)

Current position

Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG
Response Rate: Friends and Family Accident and Emergency	≥12.8%	Feb-18	9.6%	9.8%		R
Recommended Rate: Friends and Family Maternity	96%	Feb-18	95.3%	92.1%		R
Recommended Rate: Friends and Family Outpatients	96%	Feb-18	93.8%	94.5%		R

Causes of underperformance

1. **The FFT in relation to ED** – the response rate 3.0% below plan for February 2018.

   ED continue to experience high attendances, with high clinical acuity, which may be a contributory factor relating to the response rate not meeting the trajectory, the department have introduced. The use of iPad supported by volunteers is in place, however this has not increased the February response arte.

   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 March 2018.

2. **The FFT relating to recommending Maternity Services** – recommendation ratings is 3.9% below plan for February 2018. Concerns raised include:

2.1 **Community Midwifery**

- Different midwives throughout pregnancy
- Delays in visits taking place

2.2 Clinic 12 – Gynaecology

- Longer time in appointments with Consultant
- Waiting time in clinics
- More reception staff available
- Water dispenser to be available
- Appointments to be confirmed with more notice

3. **The FFT recommendation rate in Outpatient Services** – recommendation rating is 1.5% off plan in February 2018. Concerns raised include:

- Clinic 1
  - Waiting times in Orthopaedic Outpatient Clinics, including the Fracture Clinic
- Clinic 3
  - Waiting times
- Newark Outpatient Department
  - Waiting times
  - More seats available in waiting room
- Physiotherapy Services
  - Waiting times
- Sexual Health – Warsop
  - Directions to Clinic
  - Attitude of receptionist
- General Concerns
  - Car Parking Charges
  - Smoking in the front entrance

Car parking charges remain a concern for our population but out-with the responsibility of the Outpatient Department. All feedback is shared with the Estates Department to enable views to be considered with future planning.

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.
Alert Action to roll out to OPD and training to be provided – training date confirmed	Mandy Toplis	27.03.2018
Improvement trajectory		
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 11 February 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

The exception reports for all the emergency access standards have been combined as the indicators are inter-related. This report should be read in conjunction with the winter pressures paper which is more comprehensive.

Overall, 89% of patients had a maximum waiting time of four hours from arrival to admission / transfer / discharge in February 2018. At Kings Mill Hospital performance was 83.6%% and at Newark Hospital performance was 98.7%. Year to date the target is at 92.7% for the Trust. There is further detail on specific pressures outlined in the winter pressures paper to Board.

February 2018 – Emergency Care System performance		
All Type Performance: **89%** (Previous month – 87.2%) (Year to date – 92.7%)	% of attends to Majors/Resus **54%** (Previous month – 54%) (Year to date – 49%)	Bed Occupancy **98%** (Medical beds, all sites)
Discharges pre-noon **23.2%** (Best practice 30%)	Ave Daily Patients with an LOS > 7days (excl MCH & Newark) **211** (previous month – 206) (3 month average – 207)	Daily admissions via ED **81** (previous month – 81) (year to date ave – 78)

Figure 1 – February 2018 Emergency Access position

18.7% of ambulances had a delay over 30 minutes on the EMAS (non-CAD extra) data, this shows an improvement of 6.7% on January, but requires further improvement.

January 2018 – Ambulance handover performance		
Ambulance Arrivals **2592** (previous month - 2978) (YTD average – 2694)	Handover >30 minutes **18.7%** (Previous month – 25.4%)	Handover >60 minutes **1.2%** (Previous month – 2.7%)

Figure 2 – February 2018 Emergency Access position

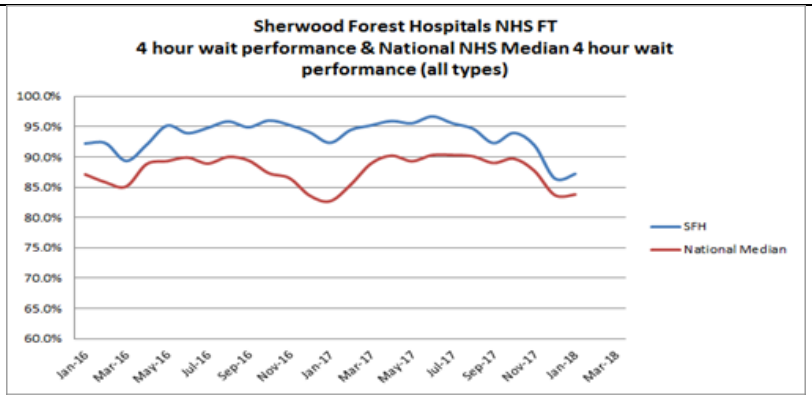


Figure 3 – 4 hour wait trend against NHS national median

2017/18

Sherwood Forest Hospitals Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Total Attendances	12475	13252	12513	13200	12225	12147	12539	12439	13153	12743	11380
Over 4 hours	509	590	415	590	655	938	759	1004	1783	1636	1256
% within 4 hours	95.92%	95.55%	96.68%	95.53%	94.64%	92.28%	93.95%	91.93%	86.44%	87.16%	88.96%

2016/17

Sherwood Forest Hospitals Trust	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Attendances	11892	13206	12389	13375	12176	12314	12616	12049	12660	12202	11140
Over 4 hours	953	639	753	697	506	628	504	572	753	936	619
% within 4 hours	91.99%	95.16%	93.92%	94.79%	95.84%	94.90%	96.01%	95.25%	94.05%	92.33%	94.44%

2017/18

Kings Mill Hospital	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Total Attendances	8129	8676	8168	8535	8012	8105	8280	8147	8479	8315	7423
Over 4 hours	470	561	369	555	617	874	726	965	1712	1577	1217
% within 4 hours	94.22%	93.53%	95.48%	93.50%	92.30%	89.22%	91.23%	88.16%	79.81%	81.03%	83.61%

2016/17

Kings Mill Hospital	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Attendances	8139	9247	8907	9563	8894	9138	8612	8493	8466	8295	7642
Over 4 hours	859	593	709	670	482	604	473	535	722	919	565
% within 4 hours	89.45%	93.59%	92.04%	92.99%	94.58%	93.39%	94.51%	93.70%	91.47%	88.92%	92.61%

2017/18

Newark Hospital	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Total Attendances	2023	2179	2072	2271	2056	1913	2005	1833	1994	1887	1708
Over 4 hours	15	20	13	15	14	15	24	15	34	35	22
% within 4 hours	99.26%	99.08%	99.37%	99.34%	99.32%	99.22%	98.80%	99.18%	98.29%	98.15%	98.71%

2016/17

Newark Hospital	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Attendances	1701	1979	1879	2130	1899	1882	1811	1628	1806	1724	1642
Over 4 hours	19	25	15	16	13	20	15	19	14	9	16
% within 4 hours	98.88%	98.74%	99.20%	99.25%	99.32%	98.94%	99.17%	98.83%	99.22%	99.48%	99.03%

2017/18

Primary Care 24	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Total Attendances	2323	2397	2273	2394	2157	2129	2254	2459	2680	2541	2249
Over 4 hours	24	9	33	20	24	49	9	24	37	24	17
% within 4 hours	98.97%	99.62%	98.55%	99.16%	98.89%	97.70%	99.60%	99.02%	98.62%	99.06%	99.24%

2016/17

Primary Care 24	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
Total Attendances	2052	1980	1603	1682	1383	1294	2193	1928	2388	2183	1856
Over 4 hours	75	21	29	11	11	4	16	18	17	8	38
% within 4 hours	96.35%	98.94%	98.19%	99.35%	99.20%	99.69%	99.27%	99.07%	99.29%	99.63%	97.95%

Causes of underperformance

In month, there were 11,380 attendances with 1,256 breaches (all sites).

Breaches root causes

There are two key root causes of performance below the standard:

- The ability to move a patient out of ED to a bed in a timely manner (i.e. within an hour of decision to admit) is the key root cause of the vast majority of patients who have to wait over 4 hours. This is due to the fact that most days start without a bed on the Emergency Assessment Unit (EAU) due to the high occupancy of the base ward beds
- Medical staffing rota gaps within the Emergency department leading to delays in clinical assessment and decision making

Actions to address		
Action	**Owner**	**Deadline**
Following the Board of Directors time out that was dedicated to emergency care on the 18/1/18, the improvement action plan is being developed with the Divisions focussing on 4 themes in the clinically led improvement plan.	**Simon Barton**	In progress
Development of new key performance indicator pack for urgent and emergency care (also to inform Board of Directors deep dive)	**Simon Barton**	In progress
'Start Right'	**Dr Ben Owens**	
Programme of work to reduce EAU bottlenecks		In progress
Ensuring ED medical rota's that consistently achieve a maximum 2 hour waiting time to be seen – particularly overnight – Middle Grade recruitment in place		April 2018
Maximisation of 'Ambulatory Emergency Care' and use of AECU and a reduction in process variation of its use		April 2018
Embedding of Senior streaming to ensure senior review of all patients with investigations ordered within 30 minutes of arrival		In progress
ED Focus on ambulance handover times ensuring all patients handed over <30 minutes including the introduction of the additional trolleys and work with EMAS regarding conveyance		In progress
'Todays Work Today'	**Dr Anne-Louise Schokker**	
Implementation of best practice board rounds and reduction in variation of those rounds		July 2018
Daily use of 'Predicted dates of discharge' within medicine – including the identification of patients for morning discharge		Complete
Development and introduction of criteria led discharge		In progress
Clear inter-professional standards for response to inpatient wards for requests such as imaging, specialist review, therapy support		In progress
Escalation processes for internal delays on the wards		Complete
Improvement on the usage of the discharge		In progress

lounge for patients awaiting transport – particularly in medicine		
Discharge medication process review		June 2018
'Length of Stay'	**Dr Steve Rutter**	
Daily review of all patients within medicine who have been inpatients >7 days		In place
Improved visibility of patients delays for external capacity		April 2018
Development of community alternatives for inpatients with external partners (such as home IV)		June 2018
Development of a capacity plan for Mid-Notts		June 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
Robust weekend planning		In progress

Improvement trajectory
The emergency care access standard is expected to be achieved consistently from the end of April 2018. This will include consistently delivering a performance of a maximum of 10% of ambulance handovers taking over 30 minutes (but less than 60 minutes)

Risks	
Risk	**Mitigation**
Failure to fill medical staff vacancies within ED	A medium term plan is in place with regard to middle grades for ED – these post holders will be operational from April 2018
Appropriately skilled service improvement capacity to support the Divisions with change management	Plan being developed with the Programme Management Office
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 11 February 2018

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

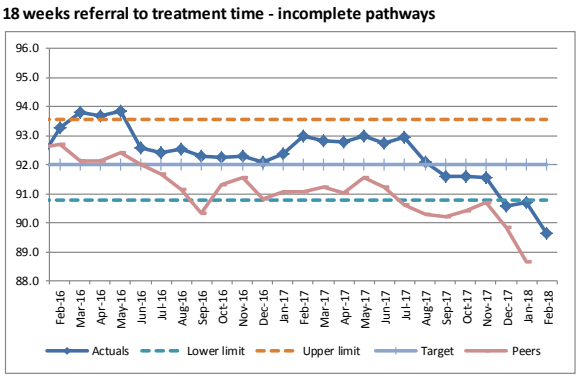
Current position

There are currently 22,725 patients on an Incomplete RTT pathway (both inpatient and outpatient) at SFHFT. This number has risen since April 2017 by 4,700 in the main due to the drive to re-start overdue review pathways in July 2017 which accounts for 4,100 of the increase.
From June to July 2017 the total incomplete list rose by c25% of which 6% were patients with a pathway >18 weeks (known as the backlog); the biggest change in specialty backlog was seen within Cardiology.

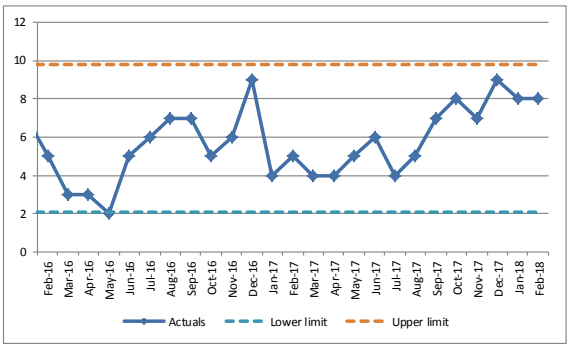
The Trust reached its tipping point in terms of non-delivery of the standard in September 2017. During this period, and in addition to the growth in Cardiology there was a significant increase in the volume of patients waiting >18weeks within Ophthalmology. Whilst performance remained below the standard and relatively static for October and November at 90.6%, the volume of Neurology backlog patients grew due to limited medical capacity .

From December onwards a further rise in backlog patients has been predominantly within the surgical division (Ophthalmology, Urology, T&O and ENT) due to the planned cancellation of elective activity to support winter pressures.

For February 2018 there were 8 specialties which failed to deliver the national standard, this led to the Trust, achieving 89.65%.



Specialities exceeding 18 wk referral to treatment time (incomplete pathways)



The specialties failing the standard are shown in red below:

18 Week National Specialty	Actual		
	With in 18 Wks	Total	% < 18
General Surgery (grouped)	1,527	1,681	90.84%
Urology	1,689	1,948	86.70%
T&O	1,749	2,046	85.48%
ENT	1,947	2,116	92.01%
Ophthalmology	3,648	3,938	92.64%
Oral Surgery	356	421	84.56%
Plastic Surgery	65	67	97.01%
Gastroenterology	1,729	1,885	91.72%
Cardiology	1,221	1,483	82.33%
Dermatology	885	962	92.00%
Respiratory	701	755	92.85%
Neurology	600	847	70.84%
Rheumatology	698	757	92.21%
Geriatrics	222	238	93.28%
Gynaecology	1,069	1,125	95.02%
Other	2,264	2,456	92.18%
Grand Total	**20,370**	**22,725**	**89.64%**

Causes of underperformance

Across the Surgical division there are four over-arching drivers to underperformance in General Surgery, Urology, T&O and Oral Surgery:

1. Planned cessation of routine elective operating due to emergency pathway pressures
2. Cancellations due to adverse weather resulting in backlogs higher than expected
3. Availability of medical staff due to vacancies
4. Prioritisation of capacity for Cancer patients

For Medicine, the Neurology service remains in a period of transition to a new model of care with NUH. The current model at SFHT has no substantive workforce and is dependent on NUH consultants supporting clinical activity. Note: The service has been closed to new referrals since 3 December 2017, with a plan to re-open with a new service model from May 2018.

For Cardiology, insufficient outpatient capacity, increased waiting time for an elective angiogram due to prioritisation of inpatient and urgent procedures over the winter period and medical and technician staffing gaps are the key drivers for underperformance.

Actions to address

Action	Owner	Deadline
General Surgery – Locum recruitment completed. Forward planning of	DGM	In

theatre lists to maximise available capacity, including sessions at NH.		progress
Urology – medical staff recruitment in progress, joint arrangements in place with NUH, maximising all theatre capacity at KMH and NH	DGM	In progress
Trauma & Orthopaedics – Utilising in week theatre sessions and weekend theatres for joint replacements	DGM	In progress
Oral Surgery – additional capacity planned, conversion of clinic sessions to theatre sessions, utilise NH where appropriate	DGM	March 2018
Cardiology – outpatient recovery programme in place which includes recruitment plan, source weekend diagnostic capacity	DGM	In progress
Gastroenterology - additional locum in place	DGM	Complete
Neurology – NUH consultants are supporting and providing more clinical activity from 5th February 2018 up until end of April during which there is an expectation that the transfer date of the NUH @ SFH model is confirmed.	DGM	April 2018

Improvement trajectory
The standard is forecast to be achieved from June 2018/19.

Risks	
Risk	**Mitigation**
Prior to and on the day cancellations due to Emergency pathway pressure and/or adverse weather	Planned reduction in Elective activity as per Winter plan. Patients escalated and decision made to cancel at Gold command meeting
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

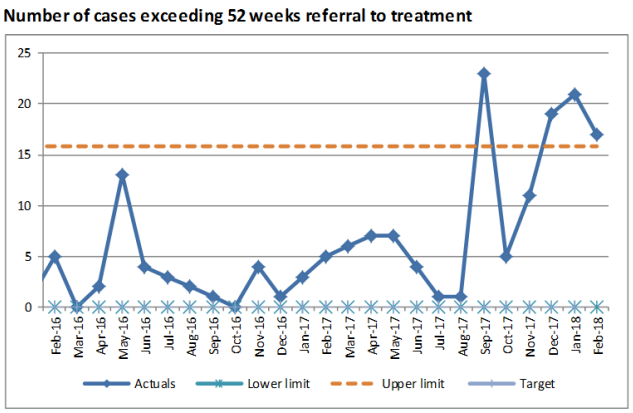
Month: Month 11 February 2018

Standard: 0

Current position

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.

Regionally, SFHT were one of 27 Trusts with a combined reported total of 385 52+ week waits for the month of January (February not available at time of writing).



As at the end of February 2018, 17 patients waited longer than 52 weeks from referral to treatment; 13 were Rheumatology patients, 1 General surgery, 1 Maxillofacial, 1 Oral Surgery and 1 Cardiology. 14 of the 17 patients have a confirmed TCI in March or April, 2 patients require a date and 1 patient pathway has subsequently been stopped.

Causes of underperformance

1 patient chose to delay their pathway.

16 of the 17 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, a full harm review will be undertaken at the OP appointment.

Actions to address

Action	Owner	Deadline
Validation team in place undertaking a methodical review of 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, any delays are reviewed at the weekly RTT meeting	Divisional General Managers	In place
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	Data Quality Manager / Clinician	In place

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
Cancellation of Elective activity to support Emergency pathway pressure	Review status of patients at weekly RTT PTL meeting

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)

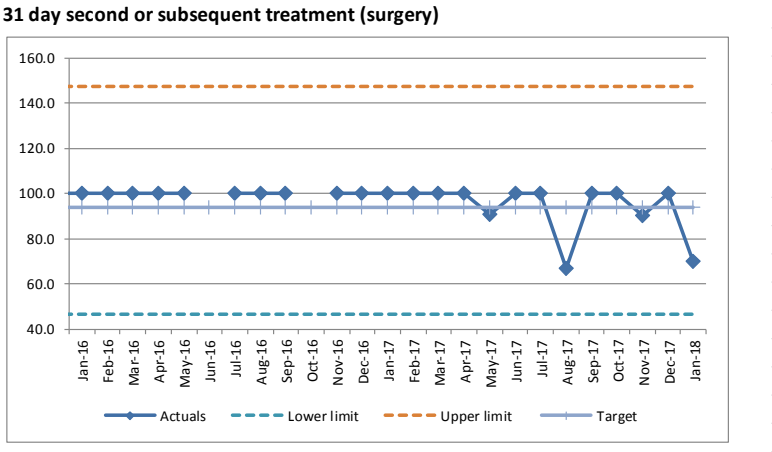
Month: Month 10 January 2018

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

Current position

Trust performance in January 2018 (subsequent surgery) against the national target of 94%:

Trust	70%	3 breaches /10 treatments
Regionally	91.5%	16/45 Trusts failed the standard
Nationally	93.6%	Trust ranked 144/146



Causes of underperformance

2 Skin patients breached the standard, the first due to reduced plastic surgeon capacity over the Christmas period. The second patient was originally booked in target, but was cancelled due to the consultant taking compassionate leave. The patient was rebooked the following week.

1 Urology breach, the patient did not stop their medication prior to surgery.

Actions to address

Action	Owner	Deadline
Elective capacity prioritised for cancer and urgent patients	Divisional General Managers	In place

Weekly PTL escalation meeting – extend to include 31 day patients	Cancer Services Manager	Q1 2018/19

Improvement trajectory
February 2018 94% (on track to deliver) March 2018 94% (on track to deliver)

Risks	
Risk	**Mitigation**
Surgical capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Tertiary delays	Escalation process in place with tertiary providers

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

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: 62 days referral to treatment from screening

Month: Month 10 January 2018

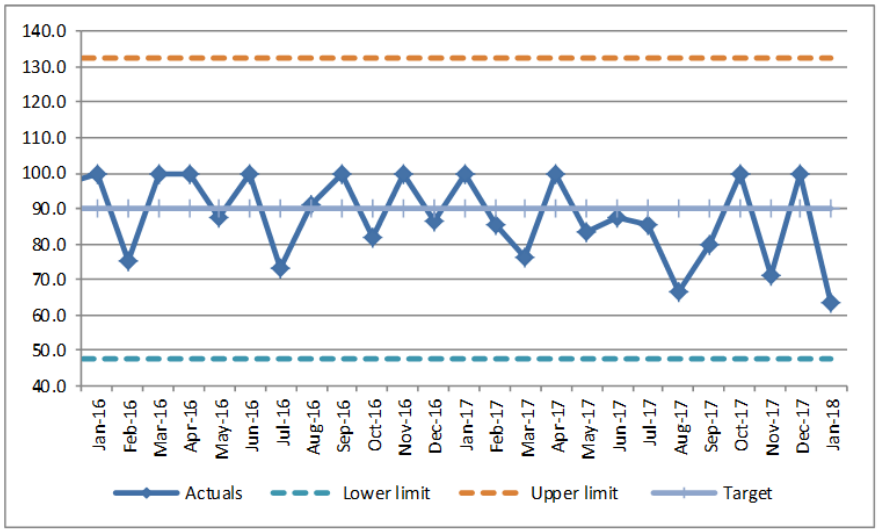
Standard: Maximum 62 day wait for first treatment from NHS cancer screening service (90%)

Current position

Trust performance in January 2018 against the national target of 90%:

Trust	63.3%	2 breaches / 5.5 treatments
Regionally	84.6%	24/38 Trusts failed the standard
Nationally	87.7%	Trust ranked 119/130

62 day referral to treatment from screening



Causes of underperformance

The total volume of treatments apportioned to SFHFT per month is relatively small with an average of 6 per month for the last 10 months.

For January, there were 2 breaches which related to 3 patients from a total of 5.5 treatments. The reasons for the breaches were 2 patient choice to delay diagnostics and 1 delay to oncology clinic appointment.

Actions to address		
Action	**Owner**	**Deadline**
Cancer capacity plans now required to cover holiday period	Deputy COO (Elective Care)	Easter completed March 2018
Meeting to review Oncology capacity both at KMH and NUH	Deputy COO (Elective Care)	6th April 2018

Improvement trajectory
February 90%

Risks	
Risk	**Mitigation**
Divisions not sighted on delays in screening pathway	Screening patients to be reviewed at the Weekly PTL meeting with any delays escalated as appropriate

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

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

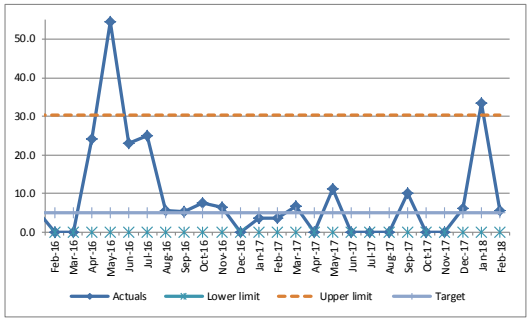
Indicator: Breaches of the 28 day guarantee following a last minute (on the day) non-clinical cancelled elective operation

Month: Month 11 February 2018

Standard: ≤ 5.0%

Current position
In February 2018 5.6% 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



Causes of underperformance
18 patients were cancelled on the day in February, 17 patients were given a revised TCI within 28 days of cancellation. 1 patient breached this standard due to lack of HDU capacity.

Actions to address		
Action	**Owner**	**Deadline**
Prioritise cancelled patients for re-booking on full recommencement of routine, elective surgery	DGM / Deputy DGM	In place

Improvement trajectory
Capacity pressures have continued throughout March, compounded by severe. The recovery profile has moved to April 2018.

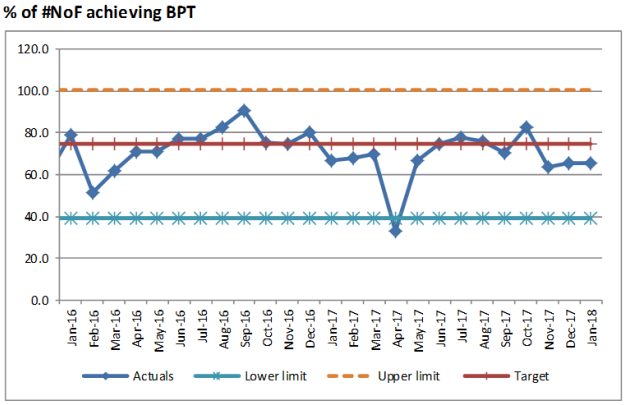
Risks	
Risk	**Mitigation**
Continued cessation of routine, non-elective surgery	Plans in place to undertake additional theatre sessions once routine, elective surgery fully recommences
Patients are not offered a date within 28 days	Cancelled patients to be reviewed at the weekly RTT PTL meeting chaired 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: Fractured neck of femur achieving best practice tariff
Month: Month 10 January 2018
Standard: 75%

Current position
For patients with a fragility hip fracture, care needs to be quickly and carefully organised. By quickly stabilising patients and ensuring that expert clinical teams respond to their complex frail conditions, the most positive outcomes can be achieved. For January 2018 the Trust achieved 65.4% of best practice tariff measures, against the standard of 75%.   

Causes of underperformance
The main drivers for underperformance are: • Sustained increased in presentations up to 5 #NOF per day compared to an average of 1-2 per day. • Insufficient Ortho-geriatrician capacity leading to delayed patient review. • Demand outstripping capacity in terms of time to surgery.

Actions to address		
Action	**Owner**	**Deadline**
Utilisation of elective capacity to support increased demand during trauma surges	Deputy DGM/Service Manager	Complete
Escalation process in place to ensure the trauma lead is made aware if plans are not in place to achieve BPT timescales	Trauma Coordinator	Complete
Patient tracking process in place which is reviewed at the daily trauma meeting	Deputy DGM / Trauma lead	Complete

Review risk of patients not being seen in 72hrs – potential impact on LOS on ward	DGM's & HoS	Mar 2018

Improvement trajectory
Plan to deliver this standard from February 2018. Risk for March due to staffing gaps caused by the adverse weather at the start of the month.

Risks	
Risk	**Mitigation**
Trauma surge – increased demand over predicted levels would continue impact on the ability to operate within 36 hours	Flex utilisation of emergency and elective theatre lists to manage overall demand
Continued 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: Steve Jenkins, Divisional General Manager Surgery
Executive Lead: Simon Barton, Chief Operating Officer

QUALITY AND SAFETY

1. Safe Staffing

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 information within **Appendix 1** details the summary of planned and actual staffing for all ward areas in the Trust for February 2018.

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 0 **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.

February 2018 saw 17 wards of the 29 monitored recording as **blue** rating (actual staffing figures are greater than 110% fill rate) and the remaining 11 wards were **green** rating.

The rationale for each ward is captured in the **Appendix 1** narrative, and demonstrates a predominantly typical monthly picture.

The Unify data for February 2018 in wards which were reported as **red** and **amber** does not have any correlation to patient harms. Patient experience through the Friends & Family test remains below the recommended level in 10 wards **Appendix 2.**

Graph 1 and **table 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**).

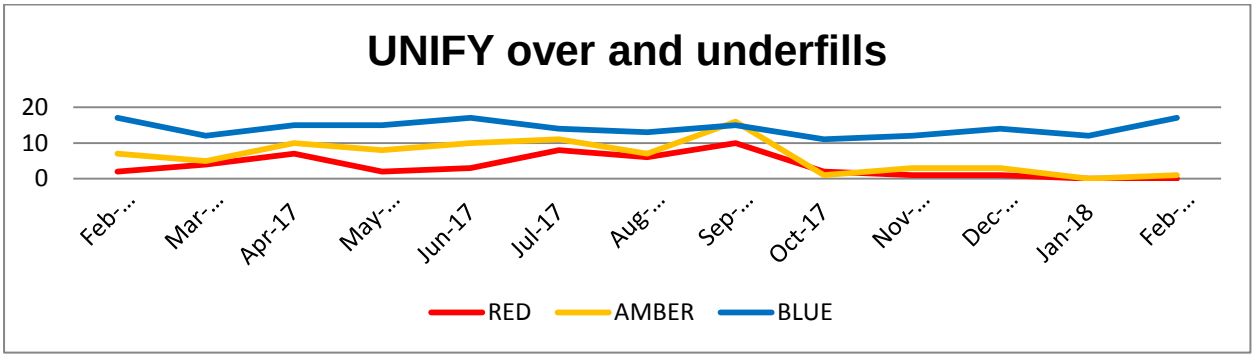


Table 1 Volume of wards identifying under and over-fill staffing levels.

	RED	AMBER	BLUE
Feb-17	2	7	17
Mar-17	4	5	12
April-17	7	10	15
May-17	2	8	15
June-17	3	10	17
July-17	8	11	14
Aug-17	6	7	13
Sept 17	10	16	15
Oct 17	2	1	11
Nov 17	1	3	12
Dec 17	1	3	14
Jan 18	0	0	12
Feb 18	0	2	16

2. Same sex accommodation

There were no single sex accommodation breaches to report in February 2018.

3. Infection Prevention and Control

All healthcare associated infections are carefully monitored and managed in line with national and local guidance. There were three cases of Clostridium Difficile Infection (CDI) in February 2018. This was within our monthly objective, and brought our total to 33 cases which remain within the annual objective to date. The threshold for 2018/19 has been set at 48 for SFH. There were ZERO MRSA bacteraemia were identified in February 2018.

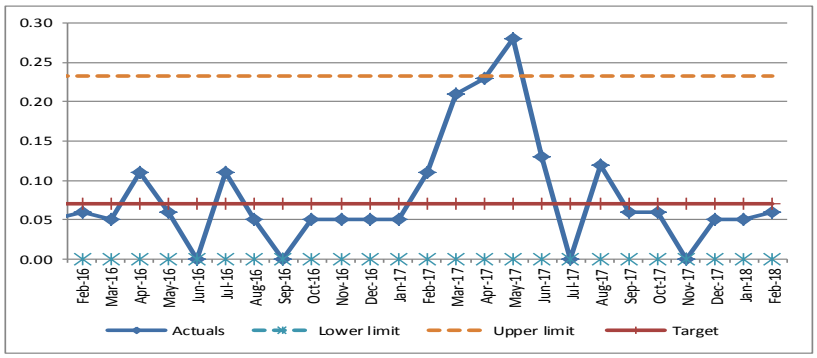
A review of the 6 E.coli infections identified that 3 were related to the urinary tract, and 2 have been attributed to the presence of a catheter. The RCA process is in progress to identify whether there was any learning to be identified; initial indications suggest that one catheter could have been removed in a more timely manner. The IPC team continue to audit and provide ward based education around invasive devices. The other 3 infections were endogenous infections related to the gastro intestinal tract and biliary tract, at present these are not considered to be avoidable due to the nature of the patients underlying illness. There were ZERO confirmed outbreaks during February 2018.

February 2018 saw the continuation of influenza infections, during the month of February 115 individuals tested positive, this is less than half the numbers identified the previous month. As already seen in January most were Flu B although the numbers identified and the majority were diagnosed either on admission in ED or on EAU. Although these numbers were substantially lower they continue to put pressure on both isolation rooms and the equipment required to protect staff and diagnose cases. The regular reviews of stock and attendance at capacity and flow meetings continued through February. The increased numbers of Flu also led to an increase in antibiotic consumption due to many patients suffering from a secondary bacterial chest infection. There is a possibility that the heightened levels of antibiotic use throughout the whole health economy may give rise to an increase in antibiotic associated diarrhoea.

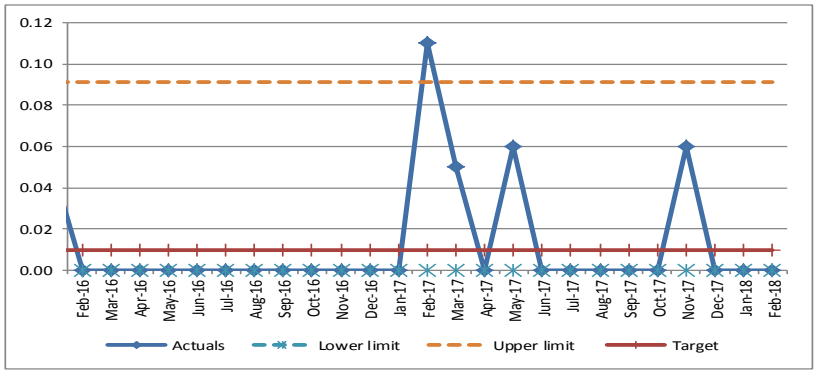
4. Tissue Viability

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 2017/8.
The graphs below shows the percentage of pressure ulcers by grade 2-4 calculated by the occupied bed days (OBDs). There was one avoidable grade 2 PU in February 2018.

Avoidable Hospital Acquired Grade 2 Pressure Ulcers per 1000 OBDs



Avoidable Hospital Acquired Grade 3 Pressure Ulcers per 1000 OBDs



Avoidable Hospital Acquired Grade 4 Pressure Ulcers per 1000 OBDs

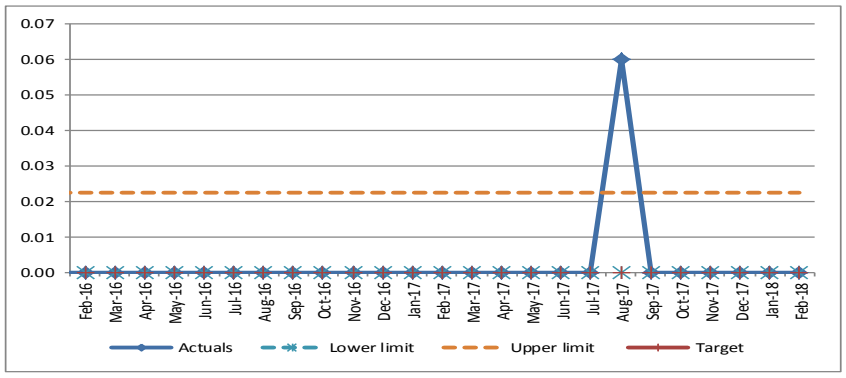


Table 1 below shows the total number hospital acquired PUs, both avoidable and unavoidable by grade over a 17 month period

Table 1

PUs by Grade	O	N	De	Ja 17	Fe	M	A	M	Ju	Ju	A	Se	O	N	De	Ja 18	Fe
Grade 2																	
Avoidable	1	1	1	1	2	4	4	5	2	0	2	1	1	0	1	1	1
Unavoidable	3	4	3	4	0	1	3	6	2	5	7	6	10	3	4	4	3
Grade 3																	

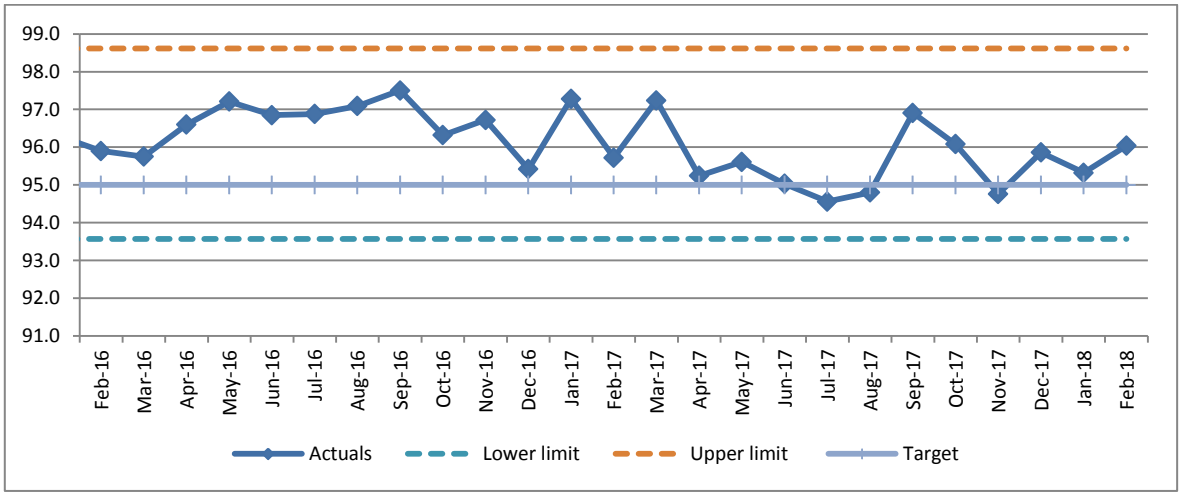
Avoidable	0	0	0	0	2	1	0	1	0	0	0	0	0	0	1*	1*	0
Unavoidable	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0	0
Grade 4																	
Avoidable	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0
Unavoidable	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total Grades 2-4 avoidable and unavoidable																	
Total	4	5	4	5	4	6	8	12	4	5	11	7	9	3	6	6	4

***validated suspected deep tissue injury from November**
*** validated suspected deep tissue injury from December**

Mitigation plans and actions going forward.

- Operational Harms Group commenced in 9 March 2018 with all matrons and AHP leads in attendance;
- Audit completed on the Stroke unit, Matron to complete action plan with TV support. To be re-audited next month;
- Maternity PU Risk Assessment and care to change from Waterlow to PURPOSE-T. Teaching and transition to start 2 April 2018;
- Wound care documentation audited in February 2018, demonstrates a significant improvements made but room for further improvement, re audit in March 2018 is planned;
- TV mandatory training for Midwives and Allied Health Care Professionals to commence when package completed May 18

5. Harm-free Care (Safety Thermometer)



The Trust reported 96.04% harm free care during February 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 3.96% n = 22.

The new harms total is 7 (1.26%) and includes the following:-

- 3 falls with harm
- 2 catheters & UTIs
- 2 pressure ulcer

There two new pressure ulcers were confirmed as unavoidable.

6. VTE

The Trust met this standard for the month of February (95.5% against a standard of 95%). Although the standard was met 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. To date this review demonstrates that appropriate VTE prophylaxis is being initiated. During this month's audit, completed risk assessment forms were in the patient records but the 24hr timeframe for completion was breached. Divisional and Specialty level data is being prepared for consideration by the divisions to improve compliance.

ORGANISATIONAL HEALTH

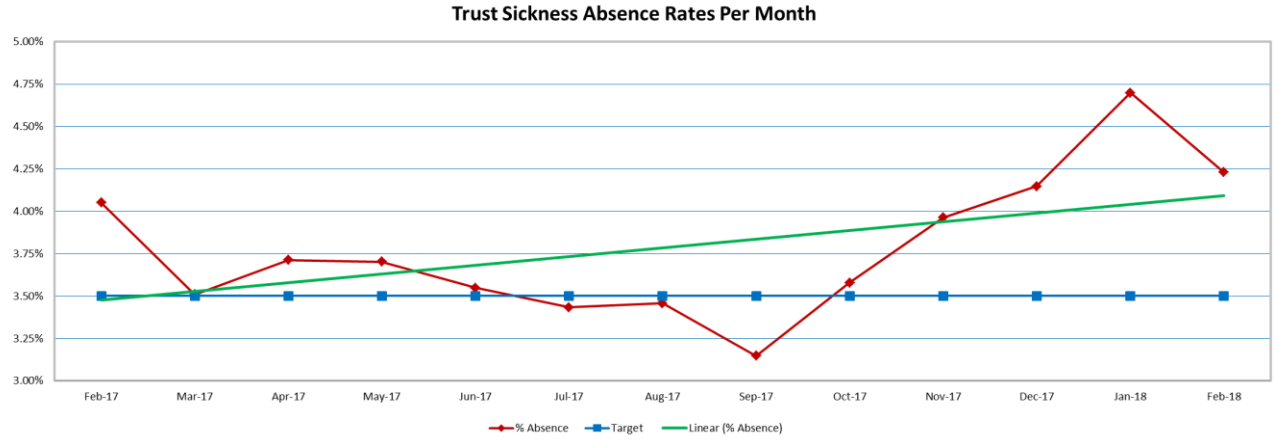
Sickness Absence - RED

Sickness absence decreased in February by 0.47% to 4.23% (January 2018, 4.70%). Short term sickness decreased by 0.45% to 2.36%, long term decreased by 0.01% to 1.87%

Urgent and Emergency Care are the only division below the 3.50% target in February 2018 at 3.41%. However, three other Divisions also saw a reduction in sickness absence in month.

The top reason for short term sickness was colds, coughs and flu with 585.23 FTE days lost. The top reason for long term sickness was anxiety/stress/depression with 699.53 FTE days lost.

As can be seen from the chart below, sickness absence for February 2018 is 0.18% higher than February 2017, which is of concern but is affected by flu this year.



Divisional management and HR Business Partner teams will continue to strive to bring sickness rates back below the 3.5% target. As the winter period does tend to exacerbate

sickness levels, Trust performance on this may not be back below the 3.5% threshold again until later this Spring.

Staffing and Turnover

The turnover rate decreased to 0.52% (January, 0.75%), which is within the threshold of 1% and is **GREEN.**

The table below shows the net position with staff in post against establishment in February 2018 across the Trust. Very positively, there were 11.47 FTE more starters than leavers (31.96 FTE starters compared to 20.49 FTE leavers). Medical staff vacancies have reduce to below 10% for the first time.

	Feb-18								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Total Trust									
Admin & Clerical	1150.67	1066.77	1304	83.90	7.29%	8.83	10.60	0.99%	39
Allied Health Professionals	226.46	215.95	267	10.51	4.64%	3.00	0.00	0.00%	7
Ancillary	39.80	37.15	44	2.65	6.66%	0.43	0.00	0.00%	1
Medical & Dental	498.96	449.80	473	49.16	9.85%	9.80	2.00	0.44%	13
Registered Nurse Operating Line * - ALL Bands	1337.31	1174.59	1388	162.72	12.17%	6.67	4.89	0.42%	20
Scientific & Professional	214.07	196.60	214	17.47	8.16%	0.00	0.00	0.00%	2
Technical & Other	277.24	260.98	323	16.26	5.87%	0.00	1.47	0.56%	1
Unregistered Nurse	594.35	573.26	669	21.09	3.55%	3.24	1.53	0.27%	4
Total - Trust	**4378.00**	**3975.10**	**4682**	**402.90**	**9.20%**	**31.96**	**20.49**	**0.52%**	**87**
Band 5 Registered Nurse Only operating line *	743.68	601.13	725	142.54	19.17%	4.37	3.56	0.59%	-

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.*

Band 5 registered nurses (RN)

Four (3.56 FTE) band 5 Registered Nurses left in February. One retired, one has relocated, one left to go to a local acute Trust and the other left due to health. Although there were more new starters, February had an increase in vacancies to 142.55 WTE (19.2%). Further analysis reveals this increase is due to continued promotional activity from Band 5 to Band 6.

At the last RN Assessment Centre held on the 16th March seven nurses were offered jobs.

Temporary Staffing % - AMBER

The % temporary staff increased to 7.95% in February 2018 (from 7.82% in January 2018). The threshold is 7.50%. However, the year to date actual is 7.43%, so still below the threshold overall. The increase in temporary staffing was anticipated due to activating the winter plan.

Appraisal - GREEN

Trust wide appraisal compliance for February 2018 increased by 1% to 95% (January 2018, 94%). This is the second time that the target of 95% has been achieved across the Trust within the last 4 month period.

Training and Education - GREEN

Mandatory training has remained the same in February 2018 at 94% (January 2018, 94%), this remains above the 90% target* and has done so continuously for over a year.

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

FINANCE REPORT – MONTH 11

At the end of February the Trust position year to date (YTD) is (£0.5m) worse than control total before Sustainability and Transformation Funding (STF). This is an improvement of £0.3m in month compared to plan, which is in line with forecast. The position is (£2.4m) worse than control total post STF YTD, due to non-delivery of the 4 hour access target since July 17.

During February divisions were collectively (£0.1m) worse than forecast in month, with 4 of 5 divisions being worse than forecast, most significantly W&C driven by lower than forecast births and neonatal activity.

Total clinical income was £0.2m better than plan in month and is £2.3m better than plan YTD. Although better than plan in month, non-elective income is at its lowest since November. YTD emergency activity is £0.3m better than plan, elective activity, including daycase, is below plan by (£0.1m). Outpatients are (£0.5m) worse than plan and maternity (£0.4m) worse than plan. Other over-performance is due to commissioner QIPP plans not delivering as planned and winter monies from NHSI, a combined total of £2.5m.

Other operating income was £0.4m better than plan in month and £1.0m better than plan YTD. NHIS projects have led to £1.2m of income (for which there is corresponding expenditure) and offset by non-delivery of CIP within income of (£0.2m).

Expenditure in month was (£0.3m) worse than plan and (£3.7m) worse than plan YTD. Overall Cost Improvement Plan (CIP) delivery is £0.3m better than plan YTD and forecast to achieve in full for 2017/18.
Pay expenditure was (£0.3m) worse than plan in month and (£2.1m) worse than plan YTD. YTD overspends represent CIP delivery in non-pay of (£2.2m), costs for additional beds and support for flow of (£1.7m) and sickness cover of (£0.5m) offset by corporate underspends of £2.5m. Agency spend in February reduced by £0.1m compared to January to a total of £1.2m. The agency forecast at year end is a total spend of £16.7m, £1.2m lower than the NHSI agency ceiling. Medical agency spend is below the NHSI target by £2.5m YTD.

Non pay (including non-operating expenses) is in line with plan in month and (£1.5m) worse than plan YTD. Over delivery of non-pay CIP of £1.6m is offset by activity driven overspends of (£1.5m) and NHIS spend off set with income of (£1.2m).

The pre STF year-end forecast is a deficit of (£45.5m), £0.9m better than control total reflecting receipt of tranche 1 winter monies from NHSI. The risk range before STF has a downside of (£0.4m) worse than plan and an upside of £0.9m better than plan, a significant narrowing of the risk range compared to month 10.

The forecast outturn post STF is a (£38.0m) deficit which is (£0.4m) worse than control total. This is in line with the forecast at month 10, but with a change to assumptions. It is expected that the 4 hour access target will not be achieved in Q4 so the assumption of £0.9m STF in Q4 has been removed for this element. However, NHSI have indicated finance incentive STF will now be awarded on winter tranche 1 monies, £0.9m.

Early in January 2018, the capital loan was agreed by the Department of Health. The capital programme now progresses at pace to complete purchases and works in order that funds are spent in this year as per the loan agreement.

Cash is better than forecast at month end and forecast to be so at year end due to the receipt of capital cash.

Financial Summary

At the end of February the Trust is £0.45m behind its control total excluding STF. Q2 and Q3 non achievement of 4 hour ED access standard means that the Trust is £2.38m behind its control total including STF. The Trust is forecasting to achieve £0.91m better than its planned Control Total excluding STF, reflecting additional Tranche 1 monies following the autumn budget

	February 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 STF	(4.75)	(4.45)	0.30	(41.81)	(42.25)	(0.45)	(46.44)	(45.53)	0.91
Surplus/(Deficit) - Control Total Basis Inc STF	(3.72)	(4.03)	(0.31)	(34.02)	(36.41)	(2.38)	(37.62)	(38.06)	(0.44)
Finance and Use of Resources Metric YTD				3	3		3	3	
CIPs	1.68	1.63	(0.05)	14.58	14.84	0.26	16.26	16.26	0.00
Capex (including donated)	(0.22)	(0.13)	0.09	(8.88)	(3.43)	5.46	(9.67)	(9.95)	(0.28)
Closing Cash	1.45	3.07	1.62	1.45	3.07	1.62	1.45	6.80	5.35
NHSI Agency Ceiling - Total	(1.45)	(1.23)	0.21	(16.42)	(15.18)	1.23	(17.91)	(16.65)	1.26
NHSI Agency Ceiling - Medical	(1.11)	(0.78)	0.33	(12.26)	(9.72)	2.54	(13.37)	(10.49)	2.88

- The finance element of the Single Oversight Framework is a score of 3 against a plan of 3.
- CIP YTD delivery is above plan by £0.26m. The Trust is forecasting to achieve its overall CIP plan for 17/18.
- YTD Capex expenditure position is £5.46m below plan; this reflects the requirement to only incur expenditure on the self-funded elements of the capital programme until the capital loan was approved in early January. The Trust is forecasting to overspend the capital plan by £0.28m as a result of additional wi-fi infrastructure funded via Public Dividend Capital via the Department of Health.
- Closing cash at 28th February was £1.62m ahead of plan reflecting timing differences between receipt of capital loan cash and payments of creditors. This is forecast to continue at year end.
- YTD agency spend at M11 totaled £15.18m against the profiled NHSI ceiling of £16.42m. In month performance is below the NHSI ceiling, for the 8th month in a row. Expenditure is forecast to be better than NHSI ceiling at year end by £1.26m. Medical agency spend continues to achieve the reduction required by NHSI.