Public Board Meeting Report

Subject:	**Single Oversight Framework Integrated Performance Report**
Date:	**22nd February 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:

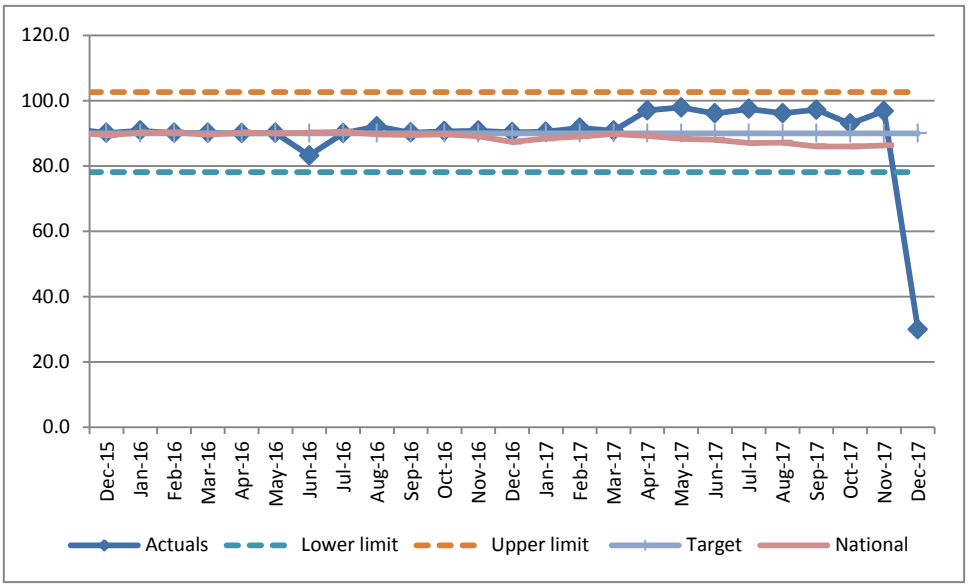
- Dementia
- Response Rate: Friends and Family Accident and Emergency
- Recommended Rate: Friends and Family Maternity
- Recommended Rate: Friends and Family Outpatients
- Emergency Access within four hours
- % of Ambulance handover >30 minutes and > 60 minutes
- 18 weeks referral to treatment time
- Specialties exceeding 18 wk referral
- Number of cases exceeding 52 weeks referral to treatment
- Diagnostic waiters, 6 weeks and over – DM01
- Breaches of the 28 day guarantee following a last minute (on the day) non clinical cancelled elective operation
- % of fractured neck of femur achieving Best Practice Tariff

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

Exception Report

Indicator: Dementia – Find, Assess, Investigate and Refer [3 aspects]
Month: February 2018 [Reporting on data collected in December 2017]
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

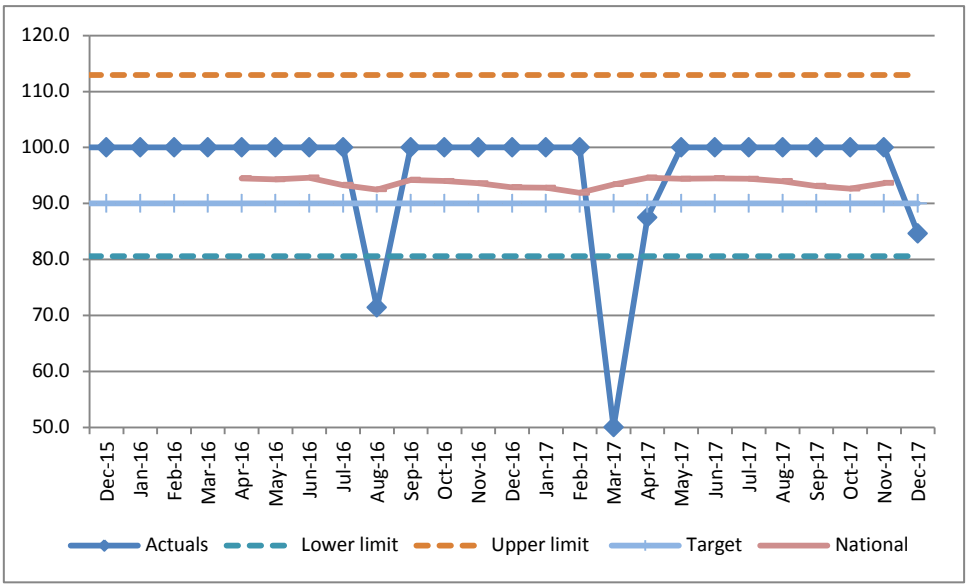
During December, 30.0% of eligible patients were identified; this represents a significant reduction from previous performance on this indicator.

Causes of underperformance - Find

The data collection and analysis moved from the Governance Support Unit to Safeguarding in December 2017, coinciding with the drop in performance. Analysis of the 'Find' component of the dementia return was previously done by GSU and a further meeting is being held on February 16th to fully determine the causes behind this fall in performance.

There were 261 cases where the old documentation (without the case-finding question) appears to have been used. There were also 57 cases where the question was in the documentation but the response was left blank without explanation.

Current position – Assess and Investigate



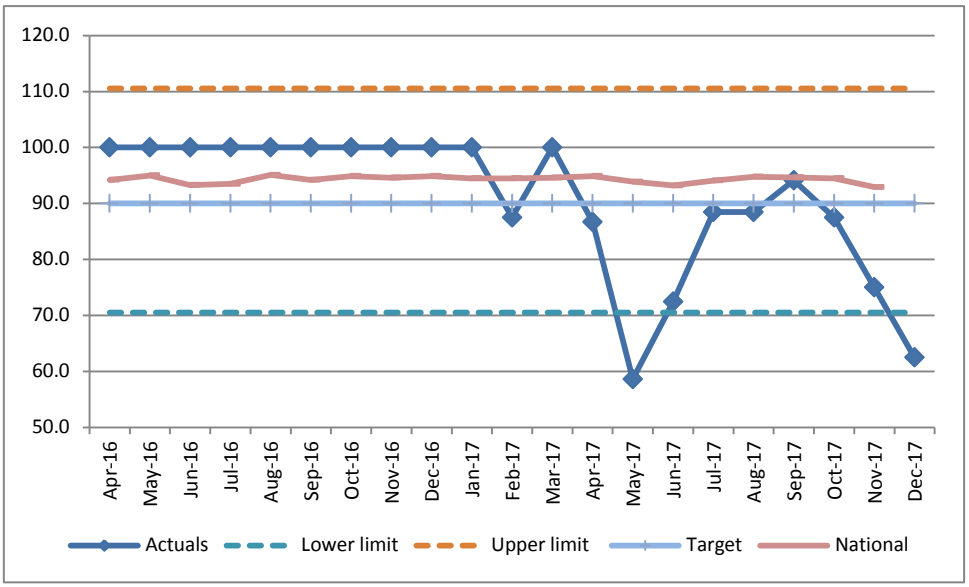
Current position – Assess and Investigate

During December 2017, 11 of the 13 eligible patients who scored positively on the case-finding question or had a clinical diagnosis of delirium were reported as having had a dementia diagnostic assessment [84.6%].

Causes of underperformance - Assess and Investigate

There are a small number of people responding positively to the case-finding question or being identified as having delirium. It is likely that this is an under-representation of people who should be assessed and investigated further for dementia because of omissions in the documentation.

The current data collection process means that people may be identified if they present with delirium on admission; however, there is currently no reliable way of identifying who receives the diagnosis after the admission documentation has been completed. In December 2017, no patients were identified on admission as presenting with delirium; however, this is due to an issue with data collection. Now the administrator checks case notes for mention of delirium in the presenting complaints.

Current position – Refer


Current position – Refer
There were 8 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 5 of these patients were referred for further diagnostic advice in line with local pathways [62.5%].
Causes of underperformance – Refer Where patients are suspected of having dementia, with no previous diagnosis, it is not always consistently recorded on the discharge letter.

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 report will be prepared in conjunction with the Lead Clinician for consideration by the Quality Committee on March 21st.	Fiona McCandless-Sugg	March 9th 2018
The Lead Clinician has made some amendments to the screening section of ED and medical clerking documentation.	Dr Steve Rutter	TBC
The process of data collection, recording and analysis requires a major overhaul to ensure	Fiona McCandless-	March 31st 2018

we are collecting meaningful data. During February, the Specialist Nurse and Data Collection Administrator will work on this and it should be reflected in the March data return.	Sugg / Owen Hufton	
Moving forward, Nervecentre would be the most appropriate way to collect the required data. At the Safeguarding Steering Group it was decided that this should be moved forward.	Adam Hayward	TBC

Improvement trajectory
The CCG are aware of the current issues and GPs have been notified. Between February 1st and 12th, there have been 428 emergency admissions of people over the age of 75, data is available for 188 people who stayed for longer than 72 hours. Of these, 9 were known to have dementia, 5 were unable to answer due to clinical condition, 39 forms did not have the case-finding question on the form, the form was missing in 3 cases, 50 people gave a negative reply, 7 people gave a positive reply, in 58 cases the question was there but the response was blank and we are awaiting data from 17 patients. Moving forward, all 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. A spot check on 15th February in ED showed that all documentation in use contains the case finding question. Refinements identified and implemented in February should be evident in the data collected and reported for March.

Lead: Tina Hymas-Taylor, Head of Safeguarding

Executive Lead: Suzanne Banks, Chief Nurse

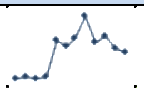
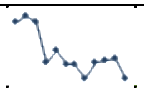
Exception Report

Indicator: Friends and Family Test

Month: Month 10 January 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%	Jan-18	9.6%	9.2%		R
Recommended Rate: Friends and Family Maternity	96%	Jan-18	95.5%	95.2%		R
Recommended Rate: Friends and Family Outpatients	96%	Jan-18	93.7%	92.5%		R

Causes of underperformance

1. **The FFT in relation to ED** – the response rate 3.6% below plan January 2018.

   Efforts to encourage and enable service users attending ED to provide feedback have not yielded sufficient responses to meet the Board's response rate requirement. 1 in 5 patients attending ED had a mobile telephone number recorded; less than 1 in 5 of those responded to a text message to provide feedback. Continuing to experience high attendances, with high clinical acuity, may also be a factor in the Trust's ability to remind and encourage service users to provide feedback.

   Concerns raised in ED include: (i) attitude of members of staff; (ii) provision of food and drink whilst awaiting treatment; (iii) cleanliness, privacy and placement on corridors; and (iv) being kept informed about waiting times and treatment plans.

2. **The FFT relation to recommending Maternity Services** – recommendation ratings is 0.8% below plan for January. Concerns raised include:

   2.1 Antenatal Clinic

   - Waiting times in clinic
   - Smoking outside of the clinic windows
   - Staff attitude

   2.2 **Maternity Ward**

   - Attitude of staff

- Perceived lack of support when attempting to breast feed

2.3 Sherwood Birthing Unit

- Attitude of staff
- Environment – overflowing bins

2.4 Early Pregnancy Unit – (2 comments **in total)**

- Layout of the EPU, location of room – limited confidentiality
- Inadequate information

2.5 Clinic 12 – Gynaecology

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

3. The FFT recommendation rate in Outpatient Services – recommendation rating is 3.5% off plan in January 2018. Concerns raised include:

- Clinic 1
  - Waiting times in Orthopaedic Outpatient Clinics, including the Fracture Clinic
  - Booking in screens not working
- Clinic 5
  - More time with respiratory consultants
  - Appointments available to book for follow up before leaving the clinic
- Clinic 7
  - Reception open before 9am
- Pain Management
  - Attitude of Consultant
- Newark Outpatient Department
  - Waiting times
  - More seats available in waiting room
- Physiotherapy Services
  - Increase number of changing rooms for patients
  - Improved signage to therapy services
- General Concerns
  - Car Parking Charges
  - Smoking in the front entrance
  - Improved information prior to appointment which includes maps of patient car parks

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
Alert Senior Leadership Team to the nature of concerns and comments received from the	Paul Moore (Director of	Completed 15/02/18

Friends and Family Test for January 2018.	Governance & Quality Improvement)	
From February 2018, the volunteers will be supporting the Emergency Department with the collection of FFT feedback to understand how patients rate their experience, this will be recorded via iPads. This data will then be uploaded daily to provide real-time feedback on the meridian dashboards.	Kim Kirk (Head of Patient Experience)	From 01/02/2018
The D&O Division to report to the Patient Safety & Quality Board (March 2018) setting out agreed actions to address intractable concerns relating to car parking and waiting times in outpatient department. *To also include an update on proposed action from Estates to address car parking and smoking in close proximity to hospital entrances.*	Dr Gill (Clinical Chair Diagnostics & Outpatients Division)	7th March 2018
Alert Action to roll out to OPD and training to be provided	Mandy Toplis	28.02.2018
Improvement trajectory		
In ED we anticipate a boost to response rates in February following the input of volunteers. In Maternity we anticipate a return to a recommendation rating at or above plan by the end of February. In Outpatients & Diagnostics, this may be more difficult to resolve in the short term. The concerns service users express about car parking (spaces and cost) may continue to affect FFT recommendation ratings as they have done for the previous 9 months. Forecast improvements are subject to what actions (which are currently under review by the Estates Department) the Trust could reasonably take to increase the number of car parking spaces available, explore access by public transport Kings Mill and Newark hospitals and any decision that may affect the cost of car parking going forward.		
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 10 January 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 Emergency Access and ambulance handover have been combined as the indicators are inter-related.

Overall, 87.2% of patients had a maximum waiting time of four hours from arrival to admission / transfer / discharge in December 2017. At Kings Mill Hospital performance was 81% and at Newark Hospital performance was 98%. Year to date the target is at 92.8% for the Trust. There is further detail on specific pressures outlined in the winter pressures paper to Board.

January 2018 – Emergency Care System performance		
All Type Performance: **87.2%** (previous month – 86.4%) (year to date – 92.8%)	% of attends to Majors/Resus **54%** (previous month – 52%) (year to date – 49%)	Bed Occupancy **94%**
Discharges pre-noon **22%** (best practice 30%)	Ave Daily Patients with an LOS >10 days (n/i MCH & Newark) **145** (previous month – 133) (year to date – 120)	Admissions via ED **2517** (previous month – 2552) (year to date ave – 2471)

Figure 1 – January 2018 Emergency Access position

25.6% of ambulances had a delay over 30 minutes on the EMAS (non-CAD extra) data, this showed an improvement of just under 3% on December, but requires further improvement.

January 2018 – Ambulance handover performance		
Ambulance Arrivals **3247** (previous month - 3293) (rolling average – 2926)	Handover >30 minutes **25.6%** (previous month – 28.5%)	Handover >60 minutes **2.6%** (previous month – 4.3%)

Figure 2 – January 2018 Emergency Access position

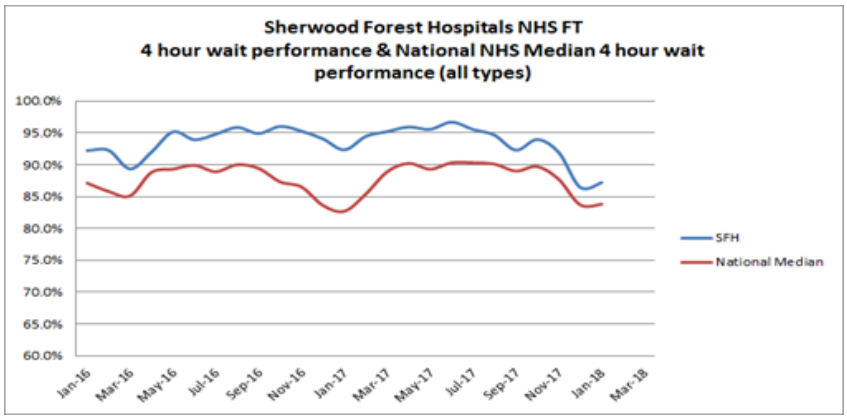


Figure 3 – 4 hour wait trend against NHS national median

2017/18										
Sherwood Forest Hospitals Trust	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Ja**
Total Attendances	12475	13252	12513	13200	12225	12147	12539	12439	13153	12
Over 4 hours	509	590	415	590	655	938	759	1004	1783	1
% within 4 hours	**95.92%**	**95.55%**	**96.68%**	**95.53%**	**94.64%**	**92.28%**	**93.95%**	**91.93%**	**86.44%**	**87.**
2016/17										
Sherwood Forest Hospitals Trust	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Ja**
Total Attendances	11892	13206	12389	13375	12176	12314	12616	12049	12660	12
Over 4 hours	953	639	753	697	506	628	504	572	753	9
% within 4 hours	**91.99%**	**95.16%**	**93.92%**	**94.79%**	**95.84%**	**94.90%**	**96.01%**	**95.25%**	**94.05%**	**92.**
2017/18										
Kings Mill Hospital	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Ja**
Total Attendances	8129	8676	8168	8535	8012	8105	8280	8147	8479	8
Over 4 hours	470	561	369	555	617	874	726	965	1712	1
% within 4 hours	**94.22%**	**93.53%**	**95.48%**	**93.50%**	**92.30%**	**89.22%**	**91.23%**	**88.16%**	**79.81%**	**81.**
2016/17										
Kings Mill Hospital	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Ja**
Total Attendances	8139	9247	8907	9563	8894	9138	8612	8493	8466	8
Over 4 hours	859	593	709	670	482	604	473	535	722	9
% within 4 hours	**89.45%**	**93.59%**	**92.04%**	**92.99%**	**94.58%**	**93.39%**	**94.51%**	**93.70%**	**91.47%**	**88.**
2017/18										
Newark Hospital	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Ja**
Total Attendances	2023	2179	2072	2271	2056	1913	2005	1833	1994	1
Over 4 hours	15	20	13	15	14	15	24	15	34	
% within 4 hours	**99.26%**	**99.08%**	**99.37%**	**99.34%**	**99.32%**	**99.22%**	**98.80%**	**99.18%**	**98.29%**	**98.**
2016/17										
Newark Hospital	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Ja**
Total Attendances	1701	1979	1879	2130	1899	1882	1811	1628	1806	1
Over 4 hours	19	25	15	16	13	20	15	19	14	
% within 4 hours	**98.88%**	**98.74%**	**99.20%**	**99.25%**	**99.32%**	**98.94%**	**99.17%**	**98.83%**	**99.22%**	**99.**
2017/18										
Primary Care 24	**Apr-17**	**May-17**	**Jun-17**	**Jul-17**	**Aug-17**	**Sep-17**	**Oct-17**	**Nov-17**	**Dec-17**	**Ja**
Total Attendances	2323	2397	2273	2394	2157	2129	2254	2459	2680	2
Over 4 hours	24	9	33	20	24	49	9	24	37	
% within 4 hours	**98.97%**	**99.62%**	**98.55%**	**99.16%**	**98.89%**	**97.70%**	**99.60%**	**99.02%**	**98.62%**	**99.**
2016/17										
Primary Care 24	**Apr-16**	**May-16**	**Jun-16**	**Jul-16**	**Aug-16**	**Sep-16**	**Oct-16**	**Nov-16**	**Dec-16**	**Ja**
Total Attendances	2052	1980	1603	1682	1383	1294	2193	1928	2388	2
Over 4 hours	75	21	29	11	11	4	16	18	17	
% within 4 hours	**96.35%**	**98.94%**	**98.19%**	**99.35%**	**99.20%**	**99.69%**	**99.27%**	**99.07%**	**99.29%**	**99.**

Causes of underperformance

In month, there were 12,743 attendances with 1,636 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

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**	
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 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 process
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 process
'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		March 2018
Escalation processes for internal delays on the wards		March 2018

Improvement on the usage of the discharge lounge for patients awaiting transport – particularly in medicine		March 2018
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
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 potholders 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

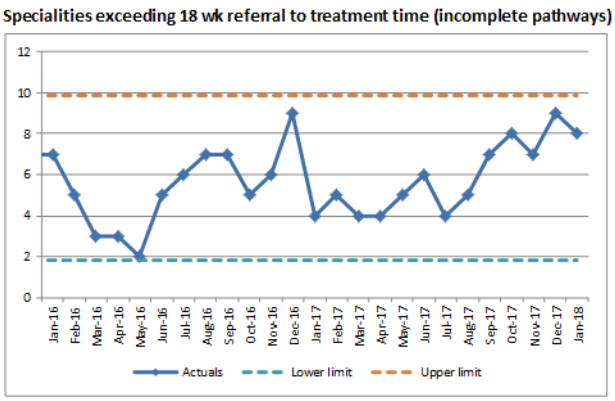
Indicator: 18 weeks referral to treatment time – incomplete pathways

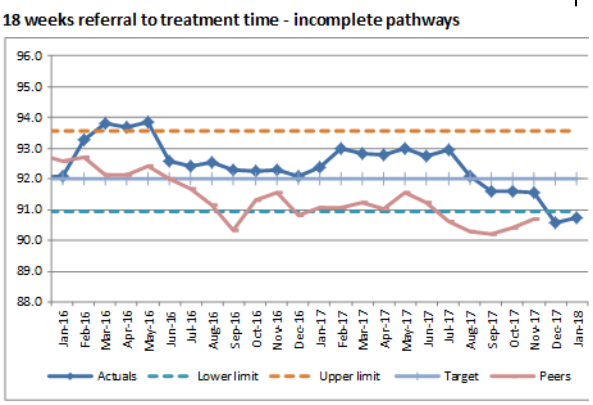
Month: Month 10 January 2018

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

Current position

In January 2018, 8 specialties failed to achieve the standard and overall the Trust failed the standard, achieving 90.7%





The specialties failing the standard are shown in red below:

RTT Reporting Specialty	<18 Weeks	>18 Weeks	Grand Total	% Performance
100 - General Surgery	1535	153	1688	90.94%
101 - Urology	1869	251	2120	88.16%
110 - Trauma & Orthopaedics	1850	228	2078	89.03%
120 - Ear, Nose & Throat	2038	174	2212	92.13%
130 - Ophthalmology	3744	250	3994	93.74%
140 - Maxillofacial Surgery	360	93	453	79.47%
160 - Plastic Surgery	53	10	63	84.13%
301 - Gastroenterology	1856	121	1977	93.88%
320 - Cardiology	1365	246	1611	84.73%
330 - Dermatology	951	49	1000	95.10%
340 - Respiratory	702	61	763	92.01%
400 - Neurology	793	221	1014	78.21%
410 - Rheumatology	797	59	856	93.11%
430 - Geriatrics	225	17	242	92.98%
502 - Gynaecology	1013	58	1071	94.58%
X01 - Other	2253	201	2454	91.81%
Grand Total	**21404**	**2192**	**23596**	**90.71%**

Causes of underperformance

General Surgery

Lack of capacity due cessation of routine, elective inpatient surgery and medical staff gaps.

Urology

Lack of capacity within the service, cessation of routine, elective inpatient surgery and prioritisation of cancer surgery

Trauma & Orthopaedics
Cancellation of routine, elective inpatient activity to manage winter pressures, in line with national guidance

Maxillofacial Surgery
Planned additional capacity continues to be prioritised for patients on a cancer pathway. Shortfall in capacity to manage the additional demand.

Plastic Surgery
Relatively few patient number overall within this service. Backlog of patients awaiting minor ops procedures.

Cardiology
Lack of outpatient capacity, particularly to manage patients overdue for review appointments. In addition, there has been an increase in waiting times for elective angiograms due to prioritisation of inpatient and urgent procedures over the winter period. Medical staff gaps due to Interventional Cardiologist vacancy.

Neurology
No substantive workforce in place and the service has been closed to new referrals since 3 December 2017.

Other (Diabetes & Endocrinology)
Lack of capacity due to due to the implementation of a 'hot week' Consultant rota.

Actions to address		
Action	**Owner**	**Deadline**
General Surgery – recruitment in progress and forward planning of theatre lists to maximise available capacity	DGM	In 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 – maximising day case surgery during the winter period	DGM	In progress
Maxillofacial Surgery – additional capacity planned, conversion of clinic sessions to theatre sessions, utilise NH where appropriate	DGM	In progress
Plastic Surgery – continued focus on management of PTL to ensure plastic surgery patients and dermatology patients are treated in order	DGM	In progress
Cardiology – outpatient recovery programme in place which includes recruitment plan	DGM	In progress
Neurology – longer term plan to transfer the service to NUH during 18/19 and securing additional capacity in the interim	DGM	In progress
Other (Diabetes & Endocrinology) – create additional specialist nurse follow up capacity and review patient pathways	DGM	In progress

Improvement trajectory
The standard is forecast to be achieved from Q1 2018/19

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

Lead: Divisional General Managers

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

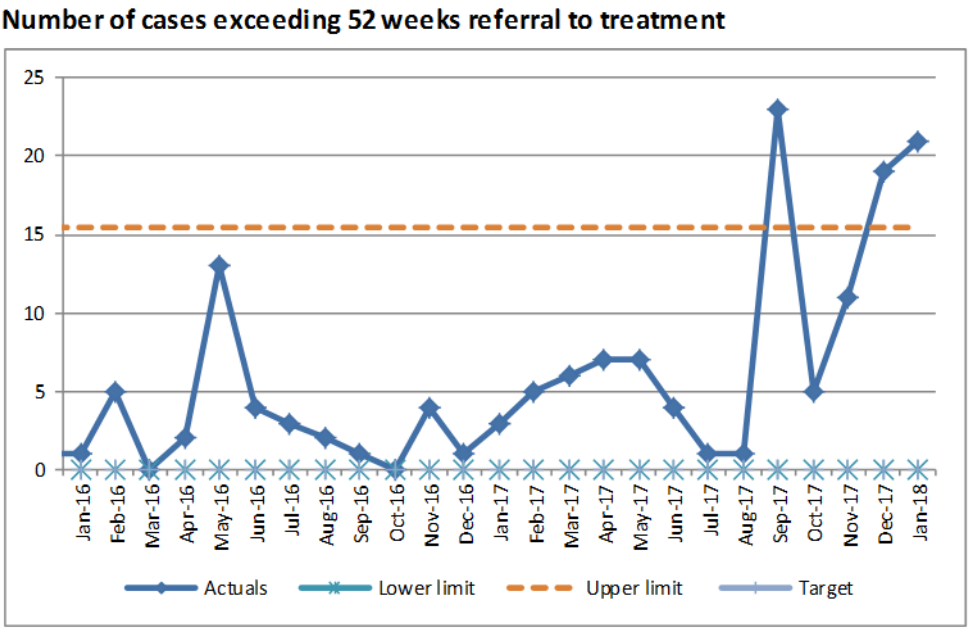
Indicator: Number of cases exceeding 52 weeks referral to treatment

Month: Month 10 January 2018

Standard: 0

Current position

In January 2018, 21 patients waited longer than 52 weeks from referral to treatment.



Division	Specialty Code	Number
Surgery	100 - General Surgery	2
Surgery	101 - Urology	1
Surgery	120 - ENT	2
Surgery	130 - Ophthalmology	1
Medicine	320 - Cardiology	1
Medicine	410 - Rheumatology	14
Trust Total	**Trust Total**	**21**

Causes of underperformance

The pathway for each of these patients is detailed below:

Specialty	Patient ID	Pathway	No. weeks
100 - General Surgery	D0266461	DQ validation – ref to NUH – EUS now complete awaiting outcome - once Report is reviewed TCI for appointment/treatment can be confirmed	56
100 - General Surgery	D0472419	DQ validation – pathway stopped discharged in month - OPA 16/1	54
101 - Urology	D0077020	DQ validation – pathway stopped treated TCI 10/1	66
120 - Ear, Nose & Throat	D0762397	DQ validation – pathway stopped treated TCI 8/1	54
120 - Ear, Nose & Throat	D0971272	DQ validation – pathway stopped treated TCI 15/1	53
130 - Ophthalmology	D0615689	DQ validation - pathway stopped discharged in month, decision 22/1	72
320 – Cardiology	D0390474	Overdue review patient – waiting diagnostics pt. cancelled multiple appointments. OP Booked 19/02/2018 for diagnostic	55
410 – Rheumatology	D0369381	Rheumatology Lost to Follow up – Attended 13/02/2018 pathway stopped	100
410 – Rheumatology	D0722868	Rheumatology Lost to Follow up – cancelled x 3 OP appointment Consultant to decide on next step	98
410 – Rheumatology	D0779321	Rheumatology Lost to Follow up – OP Booked 20/02/2018	113
410 – Rheumatology	D0910729	Rheumatology Lost to Follow up – appointment booked 07/02/2018 pt. cancelled and requested discharge pathway stopped 01/02	147
410 – Rheumatology	D0939640	Rheumatology Lost to Follow up – OP Booked 20/02/2018	183
410 – Rheumatology	D0005946	Rheumatology Lost to Follow up – Attended 07/02/2018 pathway stopped	90
410 – Rheumatology	D0025047	Rheumatology Lost to Follow up – OP Booked 27/02/2018	84
410 – Rheumatology	D0026495	Rheumatology Lost to Follow up – OP Booked 13/03/2018	175
410 – Rheumatology	D0303431	Rheumatology Lost to Follow up – OP Booked 23/04/2018	130
410 – Rheumatology	D0757412	Rheumatology Lost to Follow up – OP Booked 24/04/2018	58
410 – Rheumatology	D0494896	Rheumatology Lost to Follow up – OP Booked 07/03/2018	93
410 – Rheumatology	D0757038	Rheumatology Lost to Follow up – OP Booked 20/03/2018	179
410 – Rheumatology	D0241418	Rheumatology Lost to Follow up – OP Booked 17/04/2018	54
410 – Rheumatology	D0331376	Rheumatology Lost to Follow up – OP Booked 10/04/2018	98

Actions to address		
Action	**Owner**	**Deadline**
Continue validation work	Data Quality Manager / Divisional General Managers	Dec 2018

Improvement trajectory
Further 52 week breaches may continue to be identified until validation work is complete (end of December 2018)

Risks	
Risk	**Mitigation**
Further breaches identified	Progress validation programme and appoint patients as soon as any breaches are identified

Lead: Divisional General Managers

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

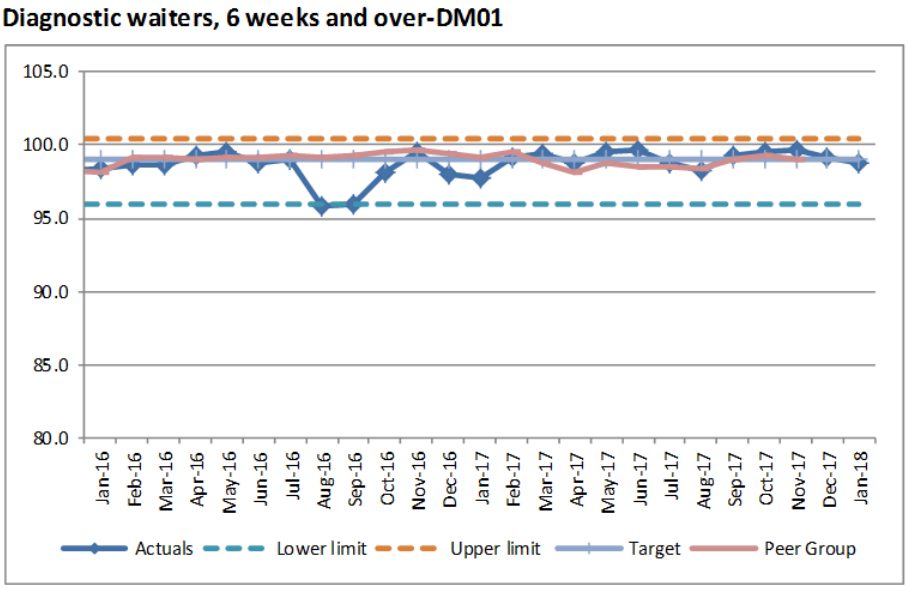
Indicator: Maximum 6 week wait for diagnostic procedures

Month: Month 10 January 2018

Standard: ≥ 99%

Current position

In January 2018, the Trust delivered 98.8% against the standard of 99%.



	Jan-18			
	Under 6 wks	6 weeks and over	Grand Total	%
Magnetic Resonance Imaging	1170	15	1185	98.73%
Computed Tomography	671	6	677	99.11%
Non-obstetric ultrasound	1329	9	1338	99.33%
Barium Enema	0	0	0	#DIV/0!
DEXA Scan	206	2	208	99.04%
Audiology - Audiology Assessments	400	4	404	99.01%
Cardiology - echocardiography	896	15	911	98.35%
Cardiology - electrophysiology	0	0	0	
Neurophysiology - peripheral neurophysiology	0	0	0	
Respiratory physiology - sleep studies	147	7	154	95.45%
Urodynamics - pressures & flows	45	3	48	93.75%
Colonoscopy	167	3	170	98.24%
Flexi sigmoidoscopy	59	0	59	100.00%
Cystoscopy	121	1	122	99.18%
Gastroscopy	198	2	200	99.00%
Total	**5409**	**67**	**5476**	98.78%

Causes of underperformance
MRI Shortfall in capacity due to unforeseen absence, further compounded by sickness absence of locum cover. **Echocardiography** Lack of capacity to meet demand during the month due to sickness absence and reduction in activity over bank holiday periods. **Sleep studies** Inpatient sleep studies postponed during the winter period in order to maximise capacity for non-elective medical inpatient demand. One patient cancellation was not re-booked before month end. **Urodynamics** Lack of capacity to meet demand during the month due to annual leave. **Colonoscopy** Planned surveillance clock re-starts

Actions to address		
Action	**Owner**	**Deadline**
Echocardiography: Explore all options to secure locum cover for sickness absence, review local workforce agreement to attract internal additional sessions, draft business case for additional echo machine	DGM	Complete
Sleep studies: Re-provision of sleep studies at KMH in March 2018 and review service provision at NH	DGM	Mar 2018
Urodynamics: Increase numbers on each list from 4 to 5, weekly capacity planning process in place, backfill lists lost through annual leave	DGM	In progress
Colonoscopy: Review capacity and demand in line with revised planned surveillance clock re-start change in guidance	DGM	In progress

Improvement trajectory
The Trust forecasting to deliver this standard during Q4 of 2017/18

Risks	
Risk	**Mitigation**
National shortage of MSK special interest Radiologists	Proactive demand and capacity management to minimise risk of non-delivery in month
Lack of sleep studies service provision at NH	Consider alternative locations on the NH site
NUH hot week cover does not include BPS sessions	Rearrange activity within other job plans to ensure BPS sessions are covered

Lead: Divisional General Managers

Executive Lead: Simon Barton, Chief Operating Officer

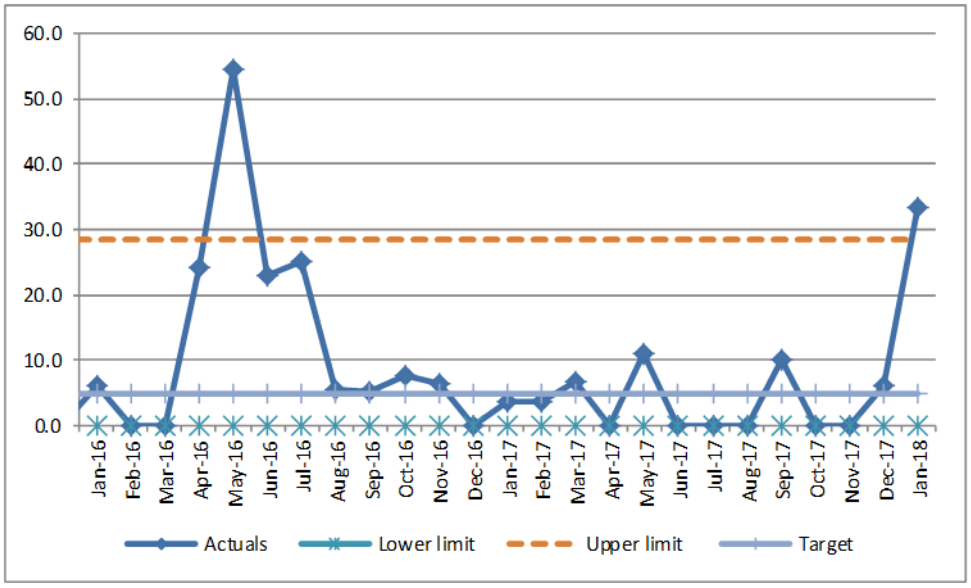
Exception Report

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

Month: Month 10 January 2018

Standard: ≤ 5.0%

Current position
In December 33.3% of patients breached the 28 day guarantee.



Causes of underperformance
6 patients breached this standard in January 2018 due to the cessation of all routine, elective inpatient surgery to support patient flow during the winter period.

Actions to address

Action	**Owner**	**Deadline**
Prioritise cancelled patients for re-booking on recommencement of routine, elective surgery	DGM / Deputy DGM	Feb 2018

Improvement trajectory
The standard is forecast to deliver within 2 weeks of recommencement of routine, elective surgery

Risks

Risk	**Mitigation**
Continued cessation of routine, non-elective surgery	Plans in place to undertake additional theatre sessions once routine, elective surgery recommences

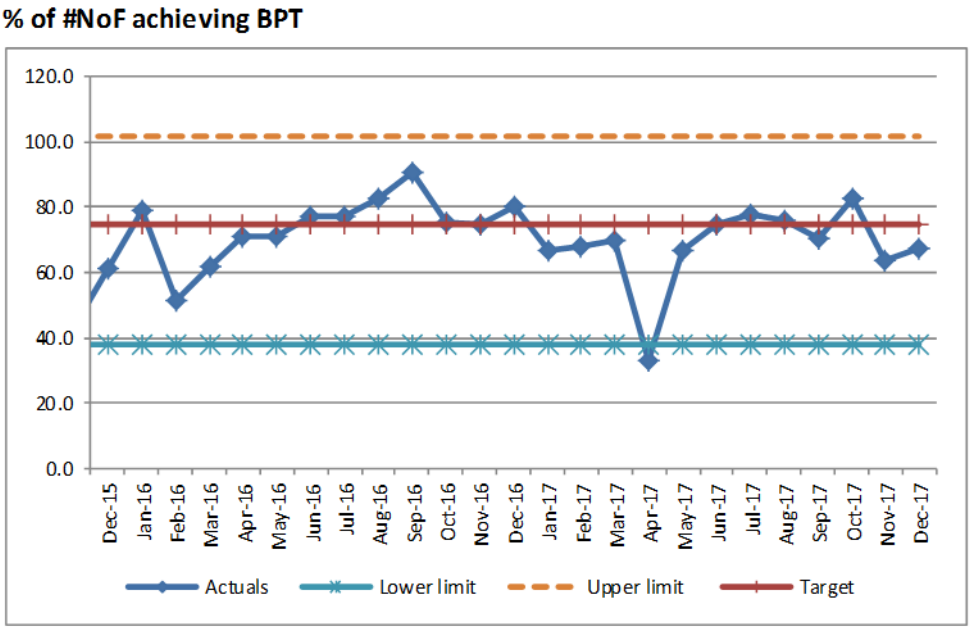
Lead: Steve Jenkins, Divisional General Manager Surgery

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: Fractured neck of femur achieving best practice tariff
Month: Month 9 December 2017
Standard: 75%

Current position
Performance in December 2017 was 67.6% against the standard of 75%



Causes of underperformance

- Increased presentations – expected demand is 1-2 #NOF per day, at present the Trust is experiencing demand of up to 5 #NOF per day
- Delays in ortho-geriatrician review – these should take place within 72 hours however, the increased number of medical outliers has had a detrimental impact on the ability of the Consultant Physician to achieve these timescales. At present the average time to review is 84 hours.
- Time to surgery – this should take place within 36 hours however, due to the increased number of #NOF over the Christmas period over and above predicted demand, there have been delays in surgery taking place.

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	Feb 2018

Patient tracking process in place which is reviewed at the daily trauma meeting	Deputy DGM / Trauma lead	Feb 2018
Review risk of patients not being seen in 72hrs – potential impact on LOS on ward	DGM's & HoS	Feb 2018

Improvement trajectory
The initial forecast was to deliver this standard from February 2018. However, due to a sustained increase in medical outliers and trauma presentations above predicted levels, this has not been achieved. The revised forecast is to deliver in March 2018 assuming the number of medical outliers returns to planned levels, thereby releasing Consultant Physician time, and trauma demand returning to predicted levels.

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. Same sex accommodation

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

2. Infection Prevention and Control

All healthcare associated infections are carefully monitored and managed in line with national and local guidance. There were two cases of *Clostridium Difficile* Infection (CDI) in January 2018. This was within our monthly objective, and brought our total to 30 cases which also remain within the annual threshold to date.

Zero MRSA bacteraemia were identified in January

There were 4 *Escherichia Coli* bacteraemia in January, bringing the cumulative total to 42, at present there is no objective attached to this, however there is an aspiration for a reduction of 10% on the previous years. This dovetails with the CCG aspirations.

There was one ward fully closed due to a norovirus outbreak in January, this was managed proactively and reopened within 6 days, 2 other areas had bays closed to admissions for a period.

January 2018 saw the continuation and escalation of influenza infections, during January 251 individuals tested positive for a type of Flu of which 73% were Flu B; the age range was between 0 and 98, unusually 39% were under the age of 65. Most were diagnosed either on admission in ED or on EAU. This placed an enormous pressure on both isolation rooms and the equipment required to protect staff and diagnose cases. This was managed through regular reviews of stock and attendance at capacity and flow meetings. The pressure on the organisation was compounded by the number of residential and nursing homes being closed to admissions and transfers due to both respiratory and norovirus infections.

3. Falls

Reducing harm from falls has been identified as a supplementary quality priority in line with the Quality Account that will be implemented during 2017/8.

Graph 1 (below) shows the percentage of falls calculated by the occupied bed days (OBD) as per the National Audit of Inpatient Falls 2015 criteria. Noting the fluctuations with this, the Trust is focused on embedding improvements to see another step change in reducing the amount of falls. The current Trust figure for January 2018 showed a reduction to 5.4 per 1000 OBDs against the National average of 6.63 and internal target of 5.5. The Falls Nurse continues to drive reduction in falls in respect of multi –disciplinary involvement and to maintain the culture where falls are treated as unacceptable and everyone is actively engaged in reducing falls.

Graph 1- Falls per 1000 OBDs resulting in Low or No Harm

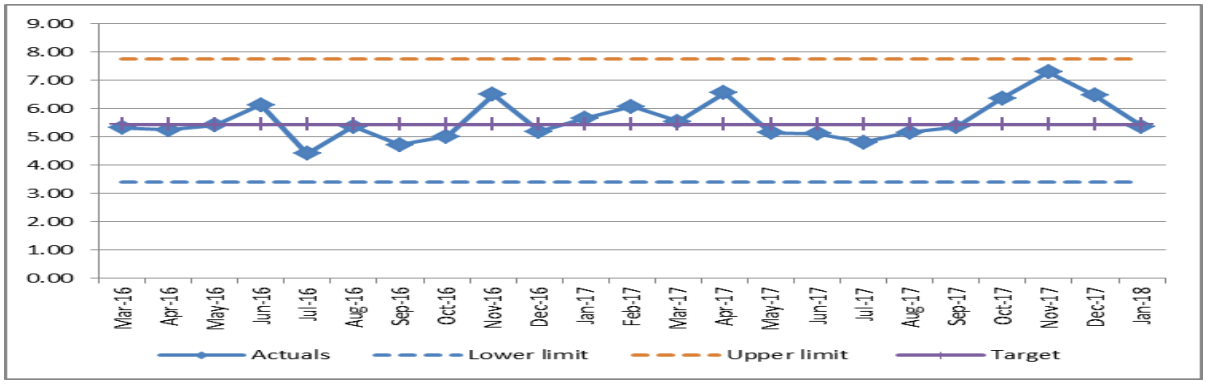


Table 2 (below) shows the number of falls by severity of harm over a 21 month period.

In January 2018 the **total amount** of reported falls was 107.This shows a slight decrease compared to the previous months.

In line with current National guidance **from January 2018 all fractured neck of femurs are now reported as severe harm.**

- There were 2 severe harms reported in January 2018 .Both patients fell and sustained a fracture to their femur. The incidents were initially scoped and are subject to further investigation. One of the incidents was deemed to be STEIS reportable. The second incident highlighted good practise in relation to falls prevention.
- In January 2018 there were 11 low harms reported which shows a noticeable reduction when compared to the previous months.

Table 2

In-patient Falls by severity of harm	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18
No harm Falls	83	89	64	73	72	73	106	82	94	89	90	98	79	70	69	67	76	98	111	110	94
Low harm Falls	13	21	18	26	12	19	15	17	20	18	14	14	12	12	11	18	15	17	21	10	11
Moderate harm Falls	0	0	0	1	0	0	1	2	0	1	0	2	2	1	1	0	1	0	0	0	0
Severe harm Falls	1	1	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	0	3	2
Total	97	111	82	100	84	92	122	102	114	108	104	114	93	83	81	85	92	115	132	123	107

Mitigation plans and actions going forward

- In January the Falls Nurse started attending ward board rounds to ensure that those patients who are at risk of falls or who have already fallen are discussed in regard to their appropriate management and safety and has fed back findings to Divisions.
- ***Post fall safety huddles*** are recommended as good practice and these have been implemented across a number of wards with a further roll out planned.
- A Professional and Practice Development Physiotherapist now works one day a week with the Falls Nurse to help to Improve the multidisciplinary approach to falls management.
- Pharmacy has produced a medication review sheet and guidelines that will now include a review of medications in relation to falls.
- There is a follow up workshop in relation to the National falls Audit planned which SFHT will attend. There will be further networking opportunities at the conference.
- The Falls steering group is producing a gap analysis report against the Trust results from the National Falls Audit 2017. This will be presented back to PSQB.
- There has been a focus of support from the Falls Lead Nurse within inpatient areas of additional bed capacity that have been opened over the winter period to offer additional support and education to these teams.
- Ongoing weekend visits are currently rostered by the Falls Lead Nurse for both assurance and educational visits. Bespoke education and visits to those areas with the highest falls rates will be continued.
- Falls E-Learning sessions incorporating a falls drop in clinic for all staff have been arranged and commenced in January

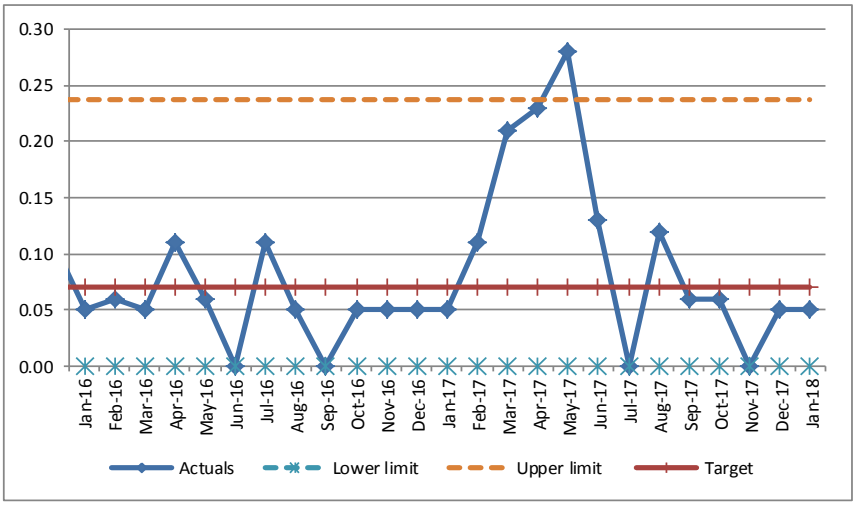
4. Tissue Viability

Pressure Ulcers- December 2017

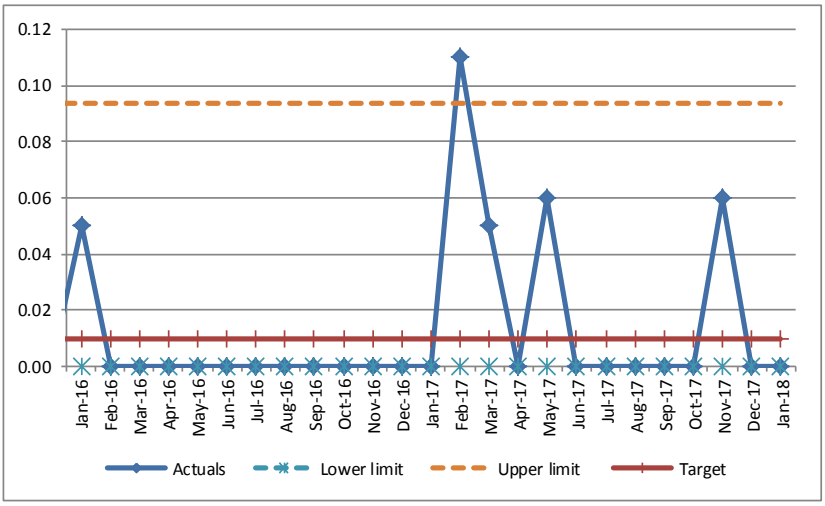
Reducing harm from pressure ulcers (PUs) has been identified as a supplementary quality priority in line with the Quality Account that will be implemented during 2017/8.

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 January. One suspected deep tissue injury from December has been validated as a grade 3 PU (avoidable) and has been included in the charts below.

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

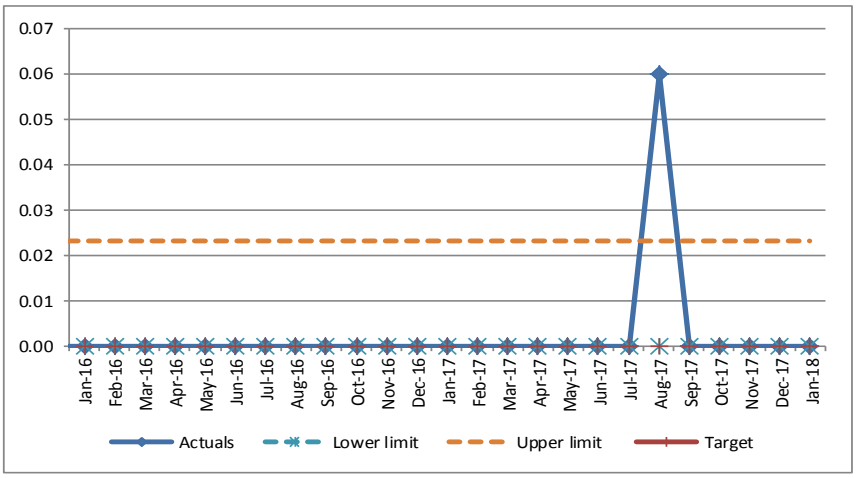


Table 1 below shows the total number hospital acquired PUs, both avoidable and unavoidable by grade over a 17 month period

Table 1

PUs by Grade	Sep	Oct	Nov	Dec	Jan 17	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan
Grade 2																	
Avoidable	0	1	1	1	1	2	4	4	5	2	0	2	1	1	0	1	1
Unavoidable	1	3	4	3	4	0	1	3	6	2	5	7	6	10	3	4	4
Grade 3																	
Avoidable	0	0	0	0	0	2	1	0	1	0	0	0	0	0	0	1*	1*
Unavoidable	1	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	0
Grade 4																	
Avoidable	0	0	0	0	0	0	0	0	0	0	0	1	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	2	4	5	4	5	4	6	8	12	4	5	11	7	9	3	6	6

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

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

Mitigation plans and actions going forward

- TV care embedded within ED following a deep dive and support
- Additional focus with operational harms group to start March 2018
- Individual TVN to focus on allocated wards where TV audit results not achieved and support
- Matron and the TVNC to complete audit and deep dive on the Stroke unit, and plan goals to achieve TV audit moving forward
- Tissue Viability team complete monthly ward audits, with support to the ward staff. Matrons confirm and challenge with Ward Sister/Charge Nurses. Report presented by the TVNC to Divisional HONs monthly which includes supporting and performance monitoring of both the TVT and the Matrons to ensure KPIs are achieved
- Tissue Viability (TV) Flash Report (includes KPIs and risks) presented to the Nursing and Midwifery Board as part of the Harms free Care Agenda

- Further development of the dynamic mattresses service including quick access for ED and EAU staff. Ongoing communications Trust wide
- Fundamentals Study Day (to start March 2018) for all nurses across the Trust to include, patient safety, TV, ICP, deteriorating patients, pain. Accountability of RNs will focus throughout the day
- Review of TV Metrics Trustwide in conjunction with general metrics review to ensure all TV standards are captured

5. Harm-free Care (Safety Thermometer)

The Trust reported 95.32% harm free care during January against a standard of 95%. The standard includes 'new' harms that are acquired during that admission and 'old' harms which are present on admission, the total of all harms was 4.68% n = 27.

The new harms total is 8 (1.39%) and includes the following:-

- 4 falls with harm
- 2 catheters & UTIs
- 1 venous thromboembolism (VTE)
- 1 pressure ulcer

A 'new' harm for VTE is defined in the following way:

> *A patient may be defined as having a new VTE if they are being treated for a deep vein thrombosis (DVT), pulmonary embolism (PE) or any other recognised type of VTE with appropriate therapy such as anticoagulants. If treatment for the VTE was started after the patient was admitted to your organisation, it is counted for this measure as a new VTE. Old VTEs are not counted in this measure.*

6. VTE

The Trust met this standard for the month of December (95.32% 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.

The new VTE identified during the January Safety Thermometer audit was diagnosed and treated on the ward. This case will be reviewed as part of the audit programme to determine if it was hospital acquired or not.

7. Dementia

Screening of eligible patients (patients over the age of 75, who were admitted as emergencies and have stayed for more than 72 hours) for identification of dementia and/or delirium and subsequent referral for further assessment and investigation is national recorded information. During December 2017, 29.9% of eligible patients were identified. 11 of the 13 eligible patients who scored positively on the case-finding question or had a clinical diagnosis of delirium were reported as having had a dementia diagnostic assessment

[84.6%]; for 8 patients the outcome was positive or inconclusive and 5 of these patients were referred for further diagnostic advice in line with local pathways [62.5%]. The desired performance on each part of the indicator is 90%. Reasons why we performed lower than this is included in the accompanying exception report.

Data collection and analysis moved from the Governance Support Unit to the Safeguarding Team in December 2017 and is supported by a Band 3 Data Collection Administrator who works with the Specialist Dementia Nurse. Unfortunately the Specialist Dementia Nurse was off during December 2017 and part of January 2018 and this has had an impact on transition of data collection.

8. Safe Staffing

January saw an increase in demand for inpatient medical beds which resulted in a change in specialty and acuity of patients across a number of areas. These factors led to a change in staffing requirements against establishment within some areas.. Additionally the increase in patients admitted with influenza that required isolation contributed to the increased need in Health Care Assistants required to support the safe management of these patients who required enhanced observation.

The number of areas with **red** ratings (actual staffing level is below the accepted 80% level and highlights a potential significant risk) there was 3 Registered Nurse and 4 Health Care Assistant **red** ratings

The number of areas with **amber** ratings (staffing fill rate is less than the accepted 90%, but above 80%) there were 12 Registered Nurse and 6 Health Care assistant **amber** ratings.

January 2018 saw 31 **blue** rating (actual staffing figures are greater than 110% fill rate) and the remaining 60 ratings were **green**.

The Unify data for January 2018 in wards which were reported as **red** and **amber** does not have any correlation to patient harms

Safe staffing review and escalation occurs continuously in line with Trust guidance, data is captured and monitored in line with national requirements. This takes place twice daily.

The continued focus on the usage of temporary staffing and other initiatives to ensure safe staffing has had a positive impact without impacting on the safe care of patients related to staffing.

ORGANISATIONAL HEALTH

Sickness Absence - RED

Sickness absence increased in January by 0.55% to 4.70% (December 2017, 4.15%).

Short term sickness increased by 0.60% to 2.81%, long term decreased by 0.06% to 1.88%

All divisions are above the 3.50% target in January 2018, however, the following two Divisions did see a reduction in sickness absence in month:

- Urgent & Emergency Care – 3.55%, a decrease of 0.79%.
- Women & Childrens' – 5.23%, a decrease of 0.12%.

-

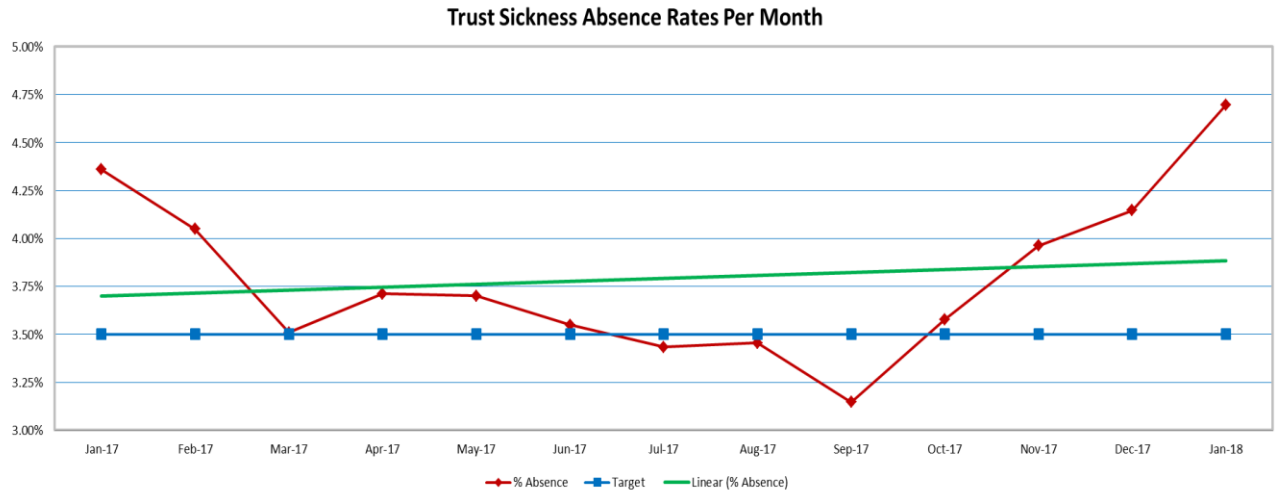
Those divisions that have seen an increase in sickness absence are;

- Medicine – 5.90%, an increase of 1.73%.
- Surgery – 4.90%, an increase of 0.52%.
- Diagnostics & Outpatients – 4.11% an increase of 0.50%.
- Corporate – 3.90% an increase of 0.25%.

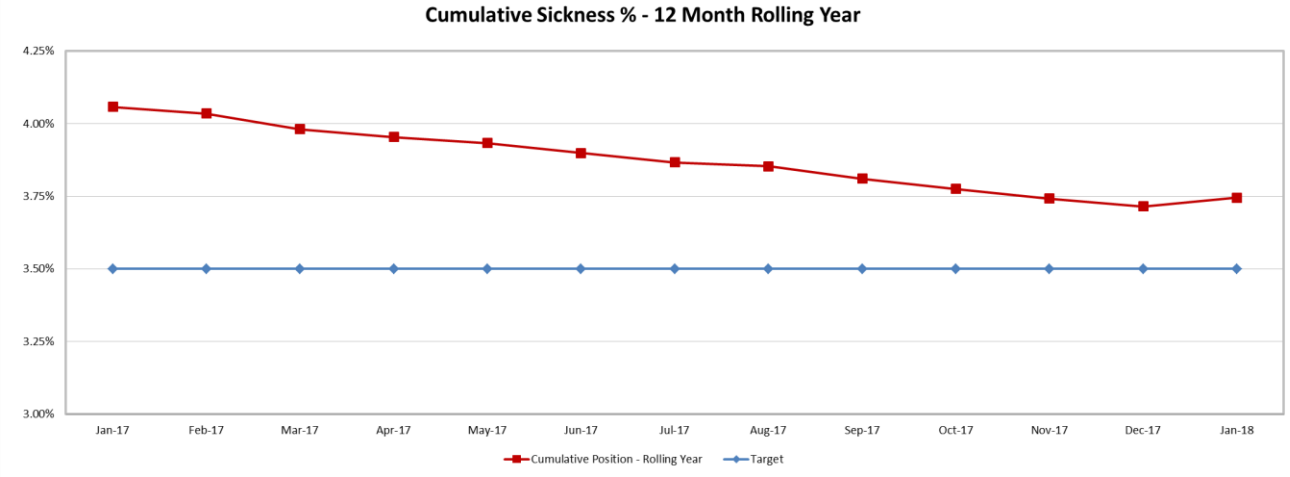
Long term sickness has decreased in month, however, short term sickness has increased with the top three reasons being: Cold, cough, flu, 1059.85 FTE days lost; Anxiety/stress/depression, 471.44 FTE days lost and Gastrointestinal problems, 390.96 FTE days lost.

For cold, cough, flu, the three Divisions with the highest FTE days lost were: Diagnostics & Outpatients 310.47 FTE; Medicine, 296.65 FTE; Surgery, 231.55 FTE.

As can be seen from the chart below, sickness absence for January 2018 is 0.34% higher than January 2017, which is of concern but is affected by flu this year.



The 12 month rolling year (sickness averaged for the previous 12 month period for each month), was indicating a sustained improvement. However, January 2018 has started an upturn.



By Staff Group, the three sickness absence reasons which have the highest increase in FTE days lost are:

- S13 Cold, cough, Flu – influenza – 1134.25 FTE days lost - an increase of 519.06 FTE days lost. This month as seasonal illnesses start to take hold.
    - Registered Nurse – 316.52 FTE days lost
    - Admin & Clerical – 294.10 FTE days lost
    - Unregistered Nurse – 208.36 FTE days lost

- S21 Ear, nose, throat (ENT) – 213.53 FTE days lost – an increase of 92.37 FTE days lost. Again, this has a seasonal aspect.
    - Registered Nurse – 68.08 FTE days lost
    - Admin & Clerical – 62.63 FTE days lost
    - Unregistered Nurse – 10.03 FTE days lost

- S28 Injury, fracture – 396.93 FTE days lost – an increase of 66.56 FTE days lost
    - Registered Nurse – 149.41 FTE days lost
    - Unregistered Nurse – 123.16 FTE days lost
    - Admin & Clerical – 117.76 FTE days lost

Divisional management and HR Business Partner teams will continue to strive to bring sickness rates back below the 3.5% target. Where they are above the target, divisions develop action plans and trajectories for bring it back on course.

For instance, Medicine Division which has the highest sickness absence for January was managing 32 long term sickness cases. Some of whom are likely to return to work in February and March. Flu has also been an issue that division and due to timescales for return to work (minimum of 5 days if treatment commenced), this has had an impact on the absence rates as they had the 2nd highest FTE days lost for short term sickness relating to Cold, cough, flu. This is not expected to continue into February

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

This table below shows the net position with staff in post against establishment in January 2018 across the Trust. Very positively, there were 22.63 FTE more starters than leavers in January 2018 (52.38 FTE starters compared to 29.75 FTE leavers).
The turnover rate decreased to 0.75% (December, 0.97%), which is within the threshold of 1% and is **GREEN.**

All Registered Nurse vacancies have increased in January to 11.76%, 157.29 FTE. Band 5 Registered Nurse vacancies have increased to 18.52%, 137.82 FTE.

Reasons for leaving across all registered nurse leavers - were: Flexi Retirement, 1.80 FTE; Voluntary – Work Life Balance, 1.67 FTE; Retirement Age, 0.40 FTE; Voluntary – Relocation, 1.00 FTE; Voluntary Resignation - Other/Not Known, 2.00 FTE; Voluntary Resignation – Promotion, 1.61 FTE; Voluntary Resignation – Better Reward Package, 1.00 FTE.

	Jan-18								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Total Trust									
Admin & Clerical	1150.83	1066.05	1303	84.78	7.37%	14.92	9.47	0.89%	26
Allied Health Professionals	226.12	215.15	266	10.97	4.85%	2.00	5.00	2.32%	5
Ancillary	39.80	37.59	44	2.21	5.55%	1.00	0.87	2.31%	0
Medical & Dental	498.96	441.67	464	57.29	11.48%	4.00	2.70	0.61%	14
Registered Nurse Operating Line * - ALL Bands	1337.02	1179.73	1393	157.29	11.76%	13.65	9.48	0.80%	18.00
Scientific & Professional	214.21	196.75	214	17.46	8.15%	5.69	0.00	0.00%	5
Technical & Other	276.93	263.46	327	13.47	4.87%	3.69	0.00	0.00%	5
Unregistered Nurse	594.35	573.69	670	20.66	3.48%	7.43	2.23	0.39%	9
Total - Trust	**4377.40**	**3974.10**	**4681**	403.30	9.21%	**52.38**	**29.75**	**0.75%**	**82**
Band 5 Registered Nurse Only operating line *	744.33	606.52	729	137.82	18.52%	7	6	1.07%	-

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.*

Below are Registered Nurse and Medical vacancy levels tracked against August 2016 baselines.

Medical Staff

Date	Budgeted establishment	Staff in Post	Vacancies	Vacancy %	Change since baseline
Aug 16	**483.57**	**413.30**	**70.27**	**14.53**	**-**
April 17	494.09	427.96	66.13	13.38	-1.15
Aug 17	493.74	430.79	62.95	12.75	-1.78
Dec 17	497.96	445.79	52.17	10.48	-4.05
Jan 18	498.96	441.67	57.29	11.48	-3.04

There is still significant improvement in the vacancy rate for medical staff when measured against a baseline of August 2016.

Registered Nurses – All bands

Date	Budgeted establishment	Staff in Post	Vacancies	Vacancy %	Change since baseline
Aug 16	**1327.51**	**1123.65**	**203.86**	**17.39**	**-**
April 17	1328.24	1164.22	164.02	12.35	-5.04
Aug 17	1332.86	1165.50	167.36	12.56	-4.83
Dec 17	1336.10	1187.43	148.67	11.13	-6.26
Jan 18	1337.02	1179.73	157.29	11.76	-5.63

There are a number of reasons that the vacancy gap has widened even though there has been more starters than leavers in January. These include RN's who haven't left but who have reduced their contracted hours and staff who have been promoted to a non-nursing position and have therefore moved category.

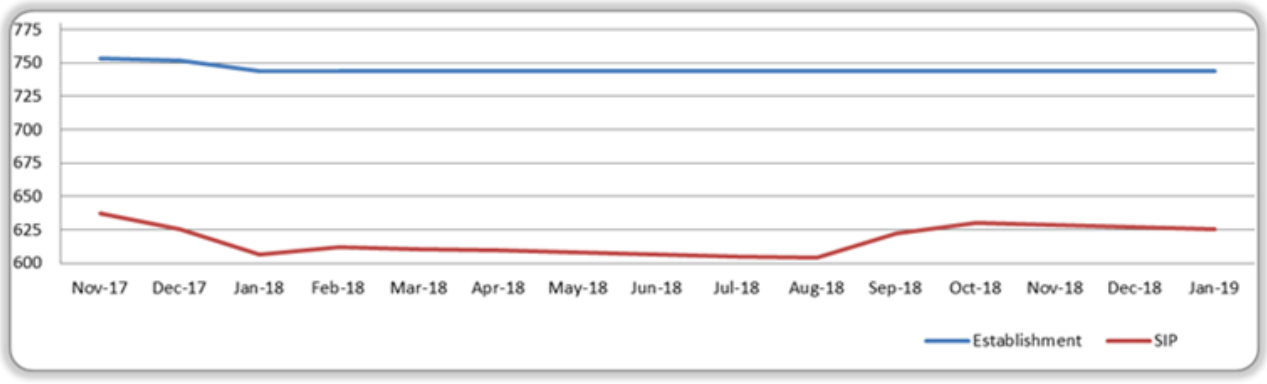
Registered Nurses – Band 5

Date	Budgeted establishment	Staff in Post	Vacancies	Vacancy %	Change since baseline
Aug 16	**773.30**	**613.58**	**159.12**	**20.65**	**-**
April 17	748.75	626.76	121.99	16.29	-4.36

Aug 17	756.87	607.22	149.65	19.77	-0.88
Dec 17	752.10	625.51	126.59	16.83	-3.82
Jan 18	744.33	606.52	137.82	18.52	-2.13

Band 5 registered nurses (RN) trajectory:

We had seven (6.47 FTE) Registered Nurses leave in January. One retired but will return, two have moved to a local community Trust, one has relocated, one has left to a local acute Trust, one to a GP practice and the other is unknown.



There has been a reduction in the Band 5 establishment of 8.17FTE and we had more starters than leavers, however the Trajectory still shows an increase in vacancies of Band 5 RNs to 137.82 FTE (18.5%). Further analysis of staff movement reveals this increase in vacancies is due to promotional activity from Band 5 to Band 6. This is positive as we are aiding retention and career development but does exacerbate the Band 5 gap.

The next RN Assessment Centre will be held on 23rd February. Following a very successful HSCW Assessment Day in January where 31 people were offered roles, there is also a further Assessment Day for Bank HCSWs on 22nd February.

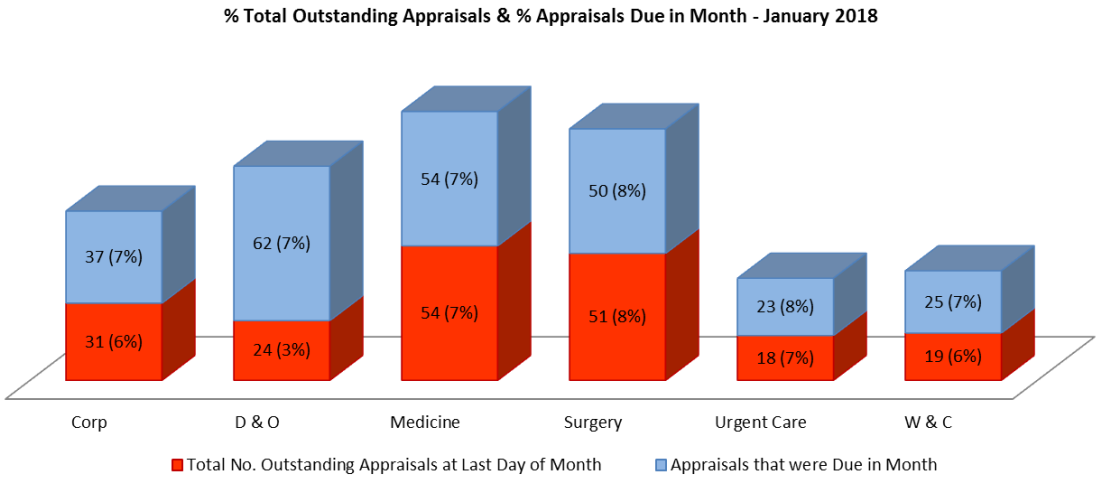
Temporary Staffing % - Amber

The % temporary staff increased to 7.82% in January 2018. The threshold is 7.50%. However, the year to date actual is 7.38%, so still below the threshold. The increase in temporary staffing is anticipated due to activating the winter plan.

Appraisal - Amber

Trust wide appraisal compliance for January 2018 remained static at 94% (December 2017, 94%). The 95% target was achieved across the Trust for one month in 2017. However, all months were in the low 90%'s. One Division, Diagnostics and Outpatients has consistently achieved the target and deliver 97% in January 2017.

199* (6%) appraisals were required in January to reach 100% and an additional 251 (7%) appraisals due to be completed which expired in month, giving a total of 448. Therefore 13% of appraisals were required to be completed in January across the Divisions below:



*Note: the figures shown in the graph differ from the above text as there are two members of staff which appear under MSK Management and do not form part of a Division

There was only one Division which increased in month, Urgent & Emergency Care, 93% (December 2017, 91%)

Three Divisions remained static in month: Diagnostics & Outpatients, 97%; Women & Childrens', 94%; Surgery, 92%.

Two Divisions decreased in month: Corporate, 94% (December 2017, 93%) and Medicine, 93% (December 2017, 94%).

Training and Education - Green

Mandatory training has remained the same in January 2018 at 94% (December 2017, 93%), this remains above the 90% target* and has done so continuously for over a year. The Divisional compliance ranking information below shows all Divisions have either hit the target or are exceeding it.

- Corporate – 97% (December, 97%)
- Diagnostics & Outpatients – 96% (December, 96%)
- Medicine – 94% (December, 93%)
- Women & Children's – 93% (December, 93%)
- Surgery – 93% (December, 93%)
- Urgent & Emergency Care – 91% (December, 90%)

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

FINANCE REPORT – MONTH 10

The Trust position year to date (YTD) is (£0.8m) worse than control total before Sustainability and Transformation Funding (STF). This is an improvement of £0.4m in month compared to plan, which is in line with forecast. The position is (£2.1m) worse than control total post STF YTD, due to non delivery of the 4 hour access target since July 17 (£1.3m).

The position in month is in line with forecast and £0.4m better than plan. All divisions in month were worse than plan, with Surgery, Urgent and Emergency Care and W&C worse than forecast. Elective cancellations have impacted on Surgery and W&C. These adverse positions have been offset by Corporate underspends.

Total clinical income was £1.2m better than plan in month and is £1.8m better than plan YTD, although (£0.2m) worse than forecast in month due to elective cancellations. Emergency activity has increased in January rather than decreased as per QIPP plans and is above the YTD plan for the first time by £1.2m. Elective activity, including daycase, remains above YTD plan by £0.1m although (£0.4m) worse than forecast in month due to cancellations to aid winter flow. Outpatients are (£0.6m) worse than plan and maternity (£0.4m) worse than plan. Other over-performance is due to commissioner QIPP plans not delivering as planned, a total of £2.5m.

Other operating income was £0.6m better than plan in month and £0.6m better than plan YTD. NHIS projects have led to £1.1m of income (for which there is corresponding expenditure) and offset by non delivery of CIP within income of (£0.5m).

Expenditure in month was (£1.5m) worse than plan and (£3.4m) worse than plan YTD. Overall Cost Improvement Plan (CIP) delivery is £0.3m better than plan YTD.

Pay expenditure was (£0.6m) worse than plan in month and (£1.8m) worse than plan YTD. YTD overspends represent CIP delivery in non-pay of (£2.0m), costs for additional beds and support for flow of (£1.7m) and sickness cover of (£0.5m) offset by corporate underspends of £2.3m. Additional capacity and sickness led to an increase in agency spend to £1.4m in month 10, as forecast and below NHS Improvement (NHSI) ceiling. Agency spend remains below the YTD NHSI ceiling and following a review of the costs of winter is forecast to be below the ceiling at year end. Medical agency spend is below the NHSI target by £2.2m YTD.

Non pay (including non-operating expenses) is (£1.6m) worse than plan YTD. This is due to NHIS costs of (£1.1m) offset with income, (£0.4m) of high cost drugs and devices costs offset with income and costs supporting increases in activity over plan.

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 (£6.0m) deficit and an upside of £0.9m, a narrowing of the risk range compared to month 9.

The forecast outturn post STF is a (£38.0m) deficit which is (£0.4m) worse than control total. This is due to non achievement of the 4 hour emergency access target in quarters 2 and 3 resulting in loss of STF of (£1.3m) offset with tranche 1 funding of £0.9m. Overall, £7.5m of

STF is expected against a plan of £8.8m. It is expected that the Trust will receive all STF monies relating to financial performance given the forecast delivery of the pre STF control total.

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 so funds are spent in this year as per the loan agreement.

Financial Summary

At the end of January the Trust is £0.75m behind its control total excluding STF. Q2 and Q3 non achievement of 4 hour ED access standard means that the Trust is £2.07m behind its control total including STF. The Trust is forecasting to achieve £0.91m better than its planned Control Total Exc. STF, reflecting additional Tranche 1 monies following the autumn budget. Cash is in line with plan.

	January 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	(3.42)	(3.00)	0.42	(37.06)	(37.81)	(0.75)	(46.44)	(45.53)	0.91
Surplus/(Deficit) - Control Total Basis Inc STF	(2.39)	(0.12)	2.27	(30.30)	(32.37)	(2.07)	(37.62)	(38.04)	(0.42)
Finance and Use of Resources Metric YTD				3	3		3	3	
CIPs	1.77	1.73	(0.04)	12.90	13.21	0.31	16.26	16.26	0.00
Capex (including donated)	(1.00)	(0.30)	0.70	(8.66)	(3.30)	5.37	(9.67)	(9.88)	(0.21)
Closing Cash	1.45	1.45	(0.00)	1.45	1.45	(0.00)	1.45	1.45	0.00
NHSI Agency Ceiling - Total	(1.46)	(1.38)	0.08	(14.97)	(13.95)	1.02	(17.91)	(17.18)	0.73
NHSI Agency Ceiling - Medical	(1.11)	(0.88)	0.23	(11.15)	(8.93)	2.21	(13.37)	(10.72)	2.65

- In month 10 against control total excluding STF the Trust was £0.42m better than plan and cumulatively £0.75m worse than plan.
- In month 10 against control total including STF the Trust was £2.27m better than plan due to forecast achievement of year end control total and cumulatively £2.07m worse than plan, due to 4 hour access target not achieving in Q2 and Q3.
- 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 £0.31m. The Trust is forecasting to achieve its overall CIP plan for 17/18. Forecast per the CIP report is £15.84m.
- YTD Capex expenditure position is £5.37m 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 £0.21m as a result of additional wi-fi infrastructure funded via Public Dividend Capital via the Department of Health.
- Closing cash at 31st January was in line with plan and is forecast to remain in line with plan for the next quarter.
- YTD agency spend at M10 totalled £13.95m against the profiled NHSI ceiling of £14.97m. In month performance is £0.08m below the NHSI ceiling, for the 7th month in a row. Expenditure is forecast to be within NHSI ceiling at year end by £0.73m. Medical agency spend continues to achieve the reduction required by NHSI.