Public Board Meeting Report

Subject:	**Single Oversight Framework Integrated Performance Report**
Date:	**25th January 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:

- Falls
- Serious Incidents
- Patients where the dementia outcome was positive or inconclusive, are referred on to specialist services
- 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
- % of fractured neck of femur achieving Best Practice Tariff
- 62 days urgent referral to treatment

Exception Report

Indicator: Serious Incidents.
Month: Month 1, January 2018.
Standard: To not exceed more than 2 Serious Incidents including Never Events per month

Current position
During the month of December 2017 a total of 3 serious incidents were reported in accordance with NHS England's Serious Incident Framework (May 2015). Of the 3 incidents, 1 was declared a Never Event.

Causes of underperformance
The Serious Incidents reported included two patients who fell sustaining a neck of femur fracture on wards 14 and 42. The Trust also reported one wrong site surgery Never Event which occurred in the Dermatology service. A separate exception report details the Never Event and the Immediate actions.

Actions to address		
Action	**Owner**	**Deadline**
To conclude a thorough root cause analysis in accordance with NHS England's Serious Incident Framework into each matter highlighted above	Head of Governance	Investigation timeline expires 13/03/18
A review of the Root Cause Classification will be repeated to help inform the underpinning causes and contributory factors of the serious incidents Investigated from April 2017 to date.	Head of Governance	To be presented to February 2018 PSQB
Continue to monitor the Datix system (Risks, Incidents, Complaints, Legal and Safeguarding concerns) for any emerging themes and feed these through the Governance Structures and Improvement Groups for example Deteriorating Patient Group.	Head of Governance	Quarterly report presented to PSQB.
Improvement trajectory		
The Trust is working to reduce exposure to serious incidents.		

Risks	
Risk	**Mitigation**
Human factors have the potential to lead to patient harm during periods of sustained increase in capacity.	Delivery and assurance of the agreed actions in the incident action plan.

Lead: Denise Berry - Head of Governance

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

Exception Report

Indicator: NEVER EVENT

Month: Month 1, January 2018.

Standard: To have no Never Events as defined by the NHS England, Never Events policy (March 2015)

Current position
During the month of December, 1 Wrong site surgery incident met the criteria for reporting as a Never Event.

Causes of underperformance
Dermatology procedure at Kings Mill Hospital. The operator had difficulty identifying the correct lesion to be excised, from amongst a number of lesions in close proximity to the index lesion, and the wrong lesion was biopsied. The Patient raised a concern at the time which did not prompt a stop moment. The incident was detected through a complaint. It was confirmed that a Never Event had occurred during the final of responding to the complaint. An investigation has commenced and shall include, as part of that investigation, the findings and actions from a similar Never Event in 2015. The Medical Division called a Dermatology safety review meeting on the 12th December 2017 and actions were agreed to mitigate the risk of future events.

Actions to address		
Action	**Owner**	**Deadline**
Procedure to be updated and give directive regarding the use of photographs as this is currently optional. Must be taken for more than one lesion site and where the patient lacks capacity.	Head of Service	Implemented. Booking form has been updated to include this directive
Change the marking process to use consecutive letters with surgical marker pens.	Head of Service	Implemented.
Reinstate colour printers into the department to ensure that the photographs are included as part of the medical record.	Dermatology Business Manager	On order, in the meantime interim arrangements are in place.

If photograph not required then to measure from a fixed point and document on the body map which is part of the booking form.	Head of Service	Implemented
Audit the current practice against the procedure and add this to Meridian audit programme	Head of Service	February 2018
WHO compliance audit data to be reviewed and action where compliance is below standard.	Head of Service	Completed
Relaunch the revised procedure and formally write to all permanent staff and visiting consultants outlining the expected changes to practice.	Head of Service	Completed

Improvement trajectory
No further Never Events.

Risks	
Risk	**Mitigation**
The actions as described above are not fully embedded across the whole team.	The requirements are embed within the documents that Dermatology use for each patient. Head of Service is reinforcing the requirements with the team.

Lead: Denise Berry - Head of Governance

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

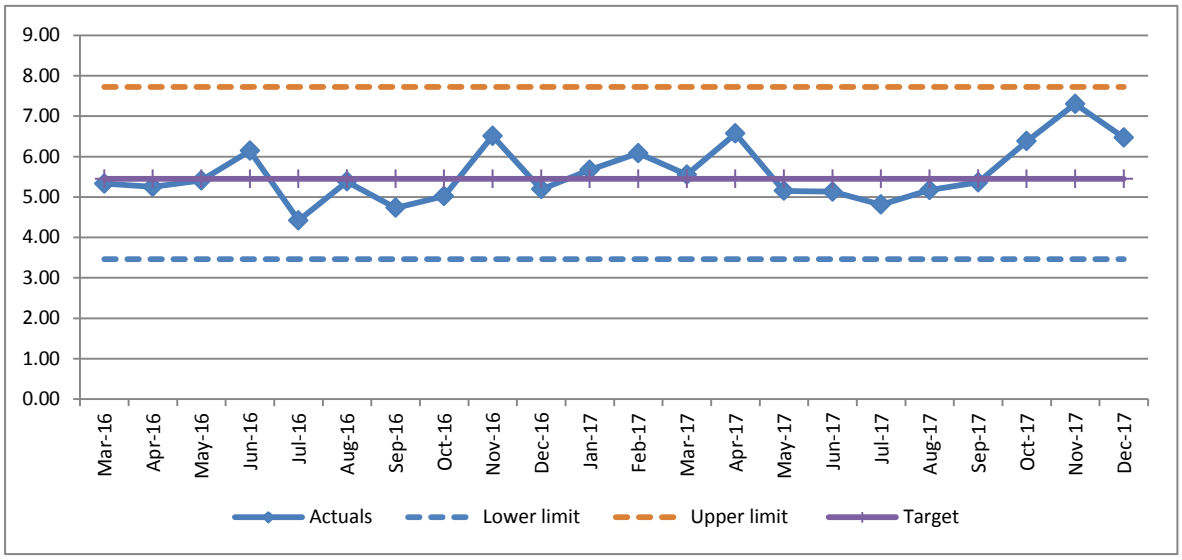
Exception Report

Indicator: Falls

Month: January 2018

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

Current position



Causes of underperformance

There is no single theme or trend analysed via Datix system. There have been at least three Datix Incident reports about staff unavailable to cover enhanced observation shifts.

There has been difficulty filling shifts for those at risk patients especially over the bank holiday period.

Patients isolated with flu who are at risk of falls and are nursed in a cubicle requiring constant care rather than cohorting.

Staff sickness and shift cancellations over bank holiday periods.

Acuity and dependencies on the inpatient wards.

Current winter pressures do not allow staff to leave the clinical areas to attend falls e-learning/ drop in session or attend individual area educational sessions by the Falls Lead Nurse.

Actions to address		
Action	**Owner**	**Deadline**
• 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. • Audit of a sample of falls in December to ensure that lying and standing blood pressure measurements are being taken. This is in response to the November Ward Metric results along with the rise in falls. Education around this measurement will be part of this work. • Falls e-learning sessions incorporating a falls drop-in clinic for all staff have been arranged by the Falls Lead Nurse commencing in January 2018. • Analysis of each fall related Datix for possible themes and trends taking actions accordingly. • The Falls Lead Nurse will also be prioritising work around communication of a patient's risk of falling when a patient moves from one area to another. • A summary of the National Inpatient Falls Audit 2017 published in November, has been presented to the Nursing, Midwifery & AHP Board and the recommendations will help guide the Falls Prevention Strategy. The Falls NICE Guidance has recently been published, and these two documents will be developed an action plan.	Falls Lead Nurse	On-going monthly On–going monthly December 2017 – update to the Nursing & Midwifery Board in February 2018 On-going monthly On-going monthly January 2018 Action plan – January 2018

Improvement trajectory
SFH has remained below national average for all falls 6.63 on a monthly basis, since May 2017, until September 2017. The aim is to reduce falls below the national average of 6.63, by January 2018.

Risks	
Risk	**Mitigation**
The Virtual Ward Healthcare Assistant team recruitment event took place on the w/c 13	Ensure all shifts are put out to Nurse Bank to ensure there is a full complement of Virtual

November 2017, and there will be an 8 – 10 week period before the new recruits are in place.	Ward staff 24/7.
The unfilled Healthcare Assistant shifts will continue to rise.	Further recruitment to the Nurse Bank for Healthcare Assistants and all inpatient vacancies to be identified and recruited to undertaken in December 2017.
The Enhanced Patient Observation policy is not being adhered to and Healthcare Assistants on the Nurse Bank are not choosing these shifts.	HoN to review the wards and ensure that Healthcare Assistants are rotated as per policy to ensure safety, and improve the uptake of the Nurse Bank shifts for Healthcare Assistant.
Due to winter pressures an increase likelihood of opening additional capacity, which could potentially increase the number of falls	Winter plan is to not open additional capacity but to utilise current inpatient facilities, and reduce elective activity

Lead: Joanne Lewis-Hodgkinson – Lead Falls Nurse
Executive Lead: Suzanne Banks, Chief Nurse

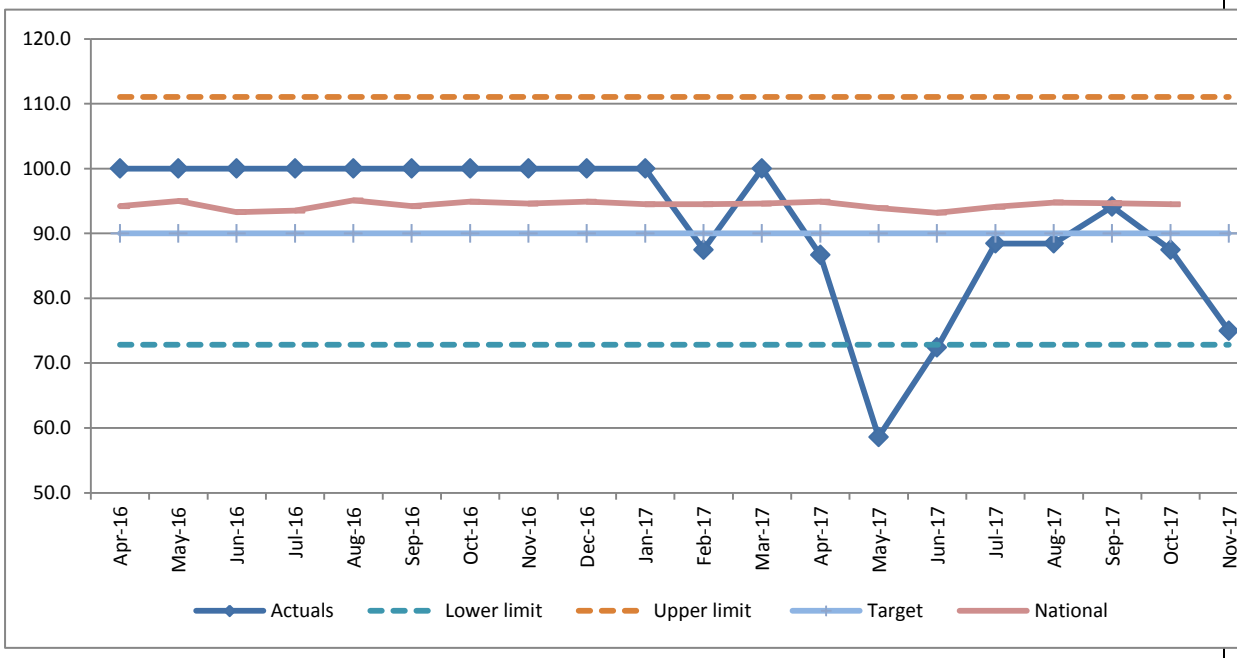
Exception Report

Indicator: Dementia

Month: January 2018

Standard: Patients where the dementia outcome was positive or inconclusive, are referred onto a Specialist service

Current position



Causes of underperformance

- In the absence of the Dementia Specialist Nurse support has been accessed from a number of areas to ensure the data is uploaded in a timely manner. Whilst this was undertaken it was identified that the initial case finding question usually undertaken in Emergency Department (ED) has been omitted from the re-print of the ED assessment booklets from October to mid-December 2017. This has meant that a large number of patients have not received the required screening assessments.
- The UNIFY data has been uploaded for December and January figures are being a collated. To ensure all the patients who were not fully assessed in October receive the screening they may require , we are in the process of writing to each patients GP identifying the omission and asking them to consider whether it is clinically indicated to assess the patient and sign post them for further support.
- An additional quality check has been implemented during the specialist nurses absence to ensure the data reflects the service provision accurately, this has involved a review and sign off by the Dementia Lead Clinician, who has reviewed any

case notes pertaining to patients where the assessment provision is unclear. He has also been responsible for signing off the data before submission.

Actions to address		
Action	**Owner**	**Deadline**
The Safeguarding team through additional hours are reviewing the December data (ED), so that there is assurance that the patient's received the right pathway of care.	Tina Hymas-Taylor, Head of Safeguarding	End of January 2018
To provide an additional layer of assurance the Lead Clinician has reviewed the December data prior to submission	Jayne Revill – Matron Urgent & Emergency Care	End of January 2018

Improvement trajectory
To maintain 90% or over of patients where dementia outcome was positive or inconclusive, have been referred to specialist services, by February 2018.

Lead: Tina Hymas-Taylor, Head of Safeguarding

Executive Lead: Suzanne Banks, Chief Nurse

Exception Report

Indicator: Friends and Family Test

Month: Month 9 December 2017

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%	Dec-17	9.7%	10.0%		R
Recommended Rate: Friends and Family Maternity	96%	Dec-17	95.5%	95.8%		R
Recommended Rate: Friends and Family Outpatients	96%	Dec-17	93.9%	94.2%		R

Causes of underperformance

1. **The FFT in relation to ED** – the response rate has decreased by 2% during December 2017; national FFT data for this period is yet to be published to provide comparison with other trusts. As we are aware of the increased volume of patients attending the Emergency Department in December, it is realistic to assume there may have been limited engagement with patients in relation to the FFT survey due to the increased demands and delays patient were experiencing in the department.
   The recommendation rate for December continues to increase exceeding the internal trust target, which should provide assurances that patients are satisfied with the care and treatment provided.
   Following a review of the negative experiences related to:
   - Waiting times
   - Car Parking charges
   - Additional reception staff required

The Head of Department continues to work to achieve the national target of 12.8%, and is exploring the introduction of iPads within the department, however due to the current pressures this work remains ongoing.

2. **The FFT relation to recommending Maternity Services** increased by 6%, almost achieving the trust target, the areas where patients made a negative comment are highlighted below:

2.1 Antenatal Clinic (7 comments in total)

- Waiting times in clinic
- Member of staff was rude and abrupt

2.2 Maternity Ward (3 comments in total)

- Midwife didn't introduce herself and lack of information
- Discharge was a slow process
- Lack of support when attempting to breast feed

2.3 Community Midwifery - (2 comments in total)

- Length of time to be discharged from hospital

2.4 Sherwood Women's Centre – (2 comments in total)

- Unprofessional midwife
- Waiting times – felt this was due to consultants travelling from Newark

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

- Layout of the EPU, following a scan, parent's took to bereavement room which is situated in front of waiting area for patient
- Shorter waiting times

3. The FFT response rate in Outpatient Services – this has remained static for December 2017 – themes continue to be consistent, these are listed below relating to areas and themes:

- Clinic 1 – Waiting times in Orthopaedic Outpatient Clinics, including the Fracture Clinic
- Newark Outpatient Department – Waiting times
  Car parking spaces and charges
  Access to vending machines for refreshments
- Physiotherapy Services - Increased hydrotherapy sessions
  More equipment for amputee patients
  Improved signage to therapy services
- Car Parking Charges
- Smoking in the front entrance

All Divisional Triumvirate Management teams receive their comment reports directly from Optimum Meridian. This allows them to understand where both positive and negative feedback has been reported and identify any areas of good practice or required areas for improvement, this includes whether the patient would recommend the Trust.
The D&O Division are well sighted on these issues and continue to work with all outpatient clinics to ensure a positive patient experience, to reduce unnecessary waiting times and importantly ensure patients are advised and comfortable during any unexpected delays.
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.

4. Resourcing FFT in 2018/19

Historically the Trust have no allocated budget to support FFT operationally, currently the Patient Experience Team budget is bridging this shortfall. A business case is currently being drafted to executives for consideration to detail the resource and finance required to continue to support the FFT trust wide, including text messaging response collection and inputting the paper surveys which is managed internally by the Patient Experience Team.

5. Number of complaints received in January 2018

The number of complaints received in January 2018 to date forecasts an increase in the number of complaints compared to recent months, a theme has been identified relating to communication and discharge which has been escalated and discussed with senior managers and further analysis is being undertaken triangulating complaints, incidents and safeguarding concerns. Given the pressures we are experiencing relating to patient flow, this may be expected therefore the analyst will provide detailed information to agree any necessary steps to improve this experience. The Patient Experience Team are ensuring wherever possible, when concerns/complaints are received regarding patients during admissions, actions are taken to resolve the issues and ensure a safe discharge and positive experience.

Complaints data from January 2017 did not indicate an increase in complaints during the winter period, however a sharp increase occurred later in March 2017, following a review of this data there are no significant themes relating to discharge or communication.

6. Alerts to poor experience

During November 2017, training was provided to ward and department leaders to ensure relevant staff are able to respond to the FFT alerts that will be switched on in February 2018. All negative feedback will generate an alert to the nursing, medical and business managers and will require an acknowledgement within 3 working days, a response is then agreed with the patient, carer or relative. The system will then require updating to reflect the action taken as a result of the feedback and provides evidence demonstrating You Said, We Did. Training is due to be provided to Outpatients teams in January 2018 prior to the launch.

This will provide a clear audit trail and report to the board relating to the improvements attempted and how effective this has been in specific areas.

7. Update from Meridian relating to comment analysis

The Trust has received a letter from Meridian on 18 December 2017 in relation to the concerns raised regarding the false negative comment reporting. The letter explained major enhancements were rolled out in November 2017 following bespoke in-house developments to improve the accuracy of applying sentiments to comments made by patients, which determines the positive/or negative outcome.

The number of false negative comments has decreased which is demonstrated by the information above, and the Patient Experience Team continue to review all weekly reports and highlight any false negatives comments to Meridian which are amended real-time.

Please note the false negatives comments do not affect the recommendation rate.

Meridian will continue to release enhancements to the sentiment functionality which will continue to be monitored throughout 2018 via the quarterly meetings with Head of Patient Experience.

Action	**Owner**	**Deadline**
KK to draft business case for executive consideration	Kim Kirk	20 January 2018
Improvement trajectory		
Monitoring required remedial actions to continue via Divisional Performance meetings, including the identification of false negatives to ensure the system is updated to reflect		

accurate real-time data.
Risks Establish and agree funding to support FFT in 2018/19 to maintain FFT completion
Mitigation Business Case being drafted

Lead: Kim Kirk – Head of Patient Experience

Executive Lead: Paul Moore – Director of Quality Governance

Exception Report

Indicator: Emergency access within 4 hours

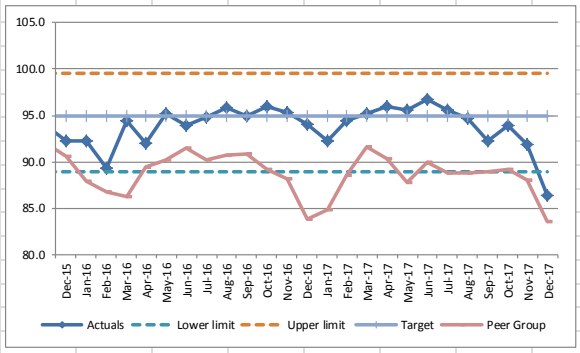
Month: Month 9 December 2017

Standard: A&E maximum waiting time of four hours from arrival to admission / transfer / discharge (95%)

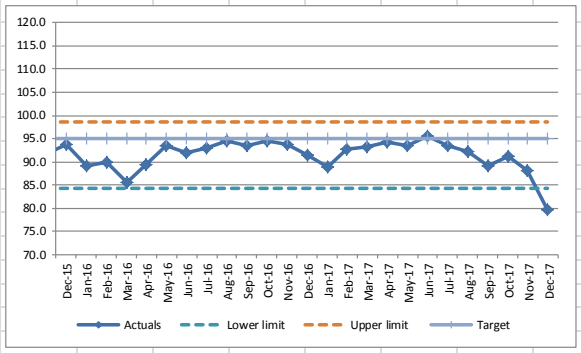
Current position

Overall, 86.4% 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 79.8% and at Newark Hospital performance was 98.2%. Year to date the target is at 93.94% for the Trust.

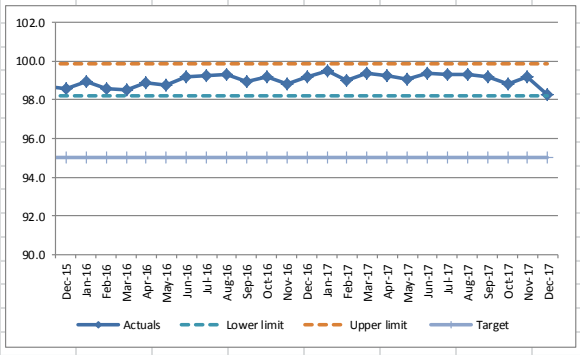
Emergency access within four hours Total Trust



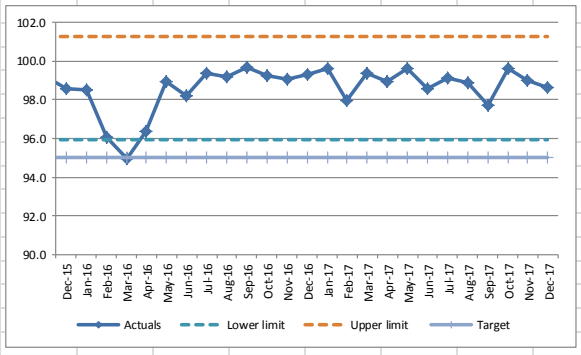
Emergency access within four hours Kings Mill



Emergency access within four hours Newark



Emergency access within four hours Primary Care *(included in total trust performance not SFH activity)*



2017/18

Sherwood Forest Hospitals Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Attendances	1247	1325	1251	1320	1222	1214	1253	1243	1314
Over 4 hours	5	2	3	0	5	7	9	9	9
	509	590	415	590	655	938	759	1004	1783
% within 4 hours	95.92%	95.55%	96.68%	95.53%	94.64%	92.28%	93.95%	91.93%	86.44%

2016/17

Sherwood Forest Hospitals Trust	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Total Attendances	1189	1320	1238	1337	1217	1231	1261	1204	1266
Over 4 hours	2	6	9	5	6	4	6	9	0
	953	639	753	697	506	628	504	572	753
% within 4 hours	91.99%	95.16%	93.92%	94.79%	95.84%	94.90%	96.01%	95.25%	94.05%

2017/18

Kings Mill Hospital	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Attendances	8129	8676	8168	8535	8012	8105	8280	8147	8479
Over 4 hours	470	561	369	555	617	874	726	965	1712
	94.22%	93.53%	95.48%	93.50%	92.30%	89.22%	91.23%	88.15%	79.81%
% within 4 hours									

2016/17

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

2017/18

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

2016/17

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

2017/18

Primary Care 24	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17
Total Attendances	2323	2397	2273	2394	2157	2129	2254	2459	2676
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%**

2016/17

Primary Care 24	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Total Attendances	2052	1980	1603	1682	1383	1294	2193	1928	2388
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%**

Causes of underperformance

In month, there were 12,660 attendances with 753 breaches (all sites).

Breaches by Primary Breach Reason and Day

Most breaches occurred (based on attendance day) mainly on a Tuesday. The majority of breaches were due to: waiting for bed, waiting for assessment by an ED doctor and awaiting clinical decision making.

Breach Reason	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Sat
Awaiting clinical decision making	45	34	43	35	26	66	
Delay in referral from PC24	1	2				1	
Exception - True Clinical Exception	14	12	10	12	14	22	
Multiple clinical handovers		2				1	
Waiting for Assessment - Waiting to be examined by an ED Doctor	34	23	40	14	48	37	
Waiting for Bed - Direct Surgical Referral			1				
Waiting for Bed - ED Referral waiting for bed	132	132	167	128	121	112	
Waiting for Diagnostic - Pathology	3	5	3	4	5	5	
Waiting for Diagnostic - Xray	3	3	2	1	1	8	
Waiting for internal transfer	2	1	5	2	3	2	
Waiting for Specialist - ENT			1		1		
Waiting for Specialist - Gynae			1		1		
Waiting for Specialist - Orthopaedic		1	1		1	4	
Waiting for Specialist - Paediatrics	3						
Waiting for Specialist - Psychiatric			1	4			
Waiting for Specialist - Social Services			1				
Waiting for Specialist - Surgical	1	2	3		2	3	
Waiting for Transport - Waiting for Ambulance Transport	10	10	26	15	8	15	
Waiting for Treatment - Waiting for ED Treatment	8	3	15	7	8	11	
Waiting For Urgent GP Review							
Grand Total	**256**	**230**	**320**	**222**	**239**	**287**	

Actions to address		
Action	**Owner**	**Deadline**
Undertaking a review of the ED escalation policy	UEC Division	31st January
AECU (CDU) review looking at nursing establishment and capacity of unit	Tracey Wall	31st January
Continue recruitment for medical staff vacancies	Richard Clarkson	Ongoing recruitment continues until all posts are filled
Weekly workforce meetings in place to update recruitment plans and review medical staff rota to minimise gaps and ensure good / safe skill mix is in place.	Richard Clarkson	Weekly – ongoing
Standard Operating Procedure in place to standardise expectations medical leadership on every shift	Richard Clarkson	Complete – ongoing review to ensure standards are embedded
Implementation and embedding of Senior streaming to ensure senior review of all patients with investigations ordered within 30 minutes of arrival	Richard Clarkson	Implemented, ongoing embedding of the process
Revised junior doctor rota to commence 6 December 2017	Richard Clarkson	Complete.
Weekly review of stranded patients	Division of Medicine	Weekly – ongoing
Continued focus on achievement of a third of daily discharges by noon	Division of Medicine	Daily – ongoing

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

Risks	
Risk	**Mitigation**
Failure to fill medical staff vacancies	Long term locums requested and internal locums sourced
Number of stranded patients increases	Internal and escalation following weekly review meeting
Failure to achieve third of discharges by noon	Maintain operational focus through daily flow meetings with escalation through Division where not achieved

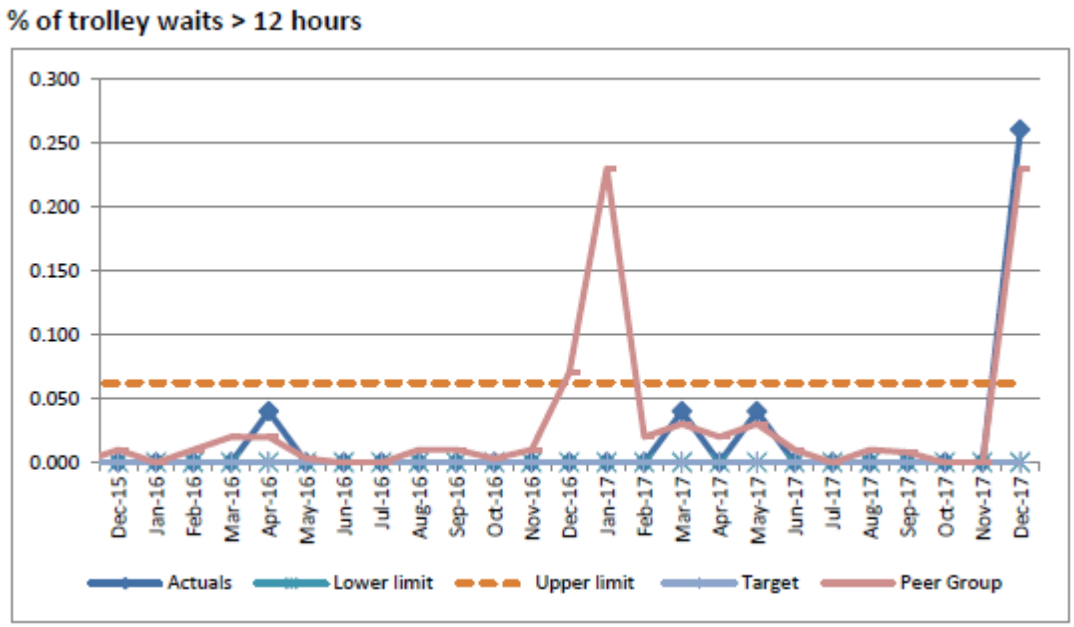
Divisional Lead: Siobhan McKenna, Divisional General Manager Urgent and Emergency Care

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: % of 12 all trolley waits > 12 hours
Month: Month 9 December 2017
Standard: 0 patients waiting longer than 12 hours from decision to admit

Current position
In December there were 7 12 hour trolley waits from decision to admit to admission.



Causes of underperformance
Three 12 hour trolley waits occurred on the 3rd December, one occurred on the evening of the 26th with a further three occurring on the 27th December. RCAs were completed for each 12 hour breach which showed the root cause to be a lack of admitting capacity within the Trust. Decision to admit for each patient was within three hours of arrival.

Actions to address		
Action	**Owner**	**Deadline**
Revised escalation process 24/7 - Silver to Gold for any patient in ED 8 hours from DTA and Gold to Chief Executive for any patient in ED for 10 hours from DTA	COO	Complete
Balance the safety and quality risk of long patient waits in ED with mixed sex accommodation breaches (in line with current NHSE guidance)	COO / Gold	Ongoing
Standard Operating Procedure in place to standardise expectations medical leadership on every shift	Richard Clarkson	Complete – ongoing review to ensure standards are embedded
Implementation and embedding of Senior	Richard Clarkson	Implemented, ongoing

streaming to ensure senior review of all patients with investigations ordered within 30 minutes of arrival		embedding of the process
Weekly review of stranded patients	Division of Medicine	Weekly – ongoing
Continued focus on achievement of a third of daily discharges by noon	Division of Medicine	Daily – ongoing
Reviewing and encouraging discharge lounge usage from the base wards	Clinical Chairs/Divisional General Managers	Daily – ongoing
Improve focus and quality of plans for the weekends and holiday periods	Simon Barton	Complete- ongoing
Reinvigorating 'Red to Green'. This will focus on: Stranded patients, EDD accuracy, TTOs prescribed the day before discharge, Discharge lounge usage, discharges before 1200, and median discharge time.	Simon Barton/Yvonne Simpson	19/1/18

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

Risks	
Risk	**Mitigation**
Continued exit block from the Emergency Department	Maintaining focus on patient flow through daily capacity and flow meetings and weekly patient flow group

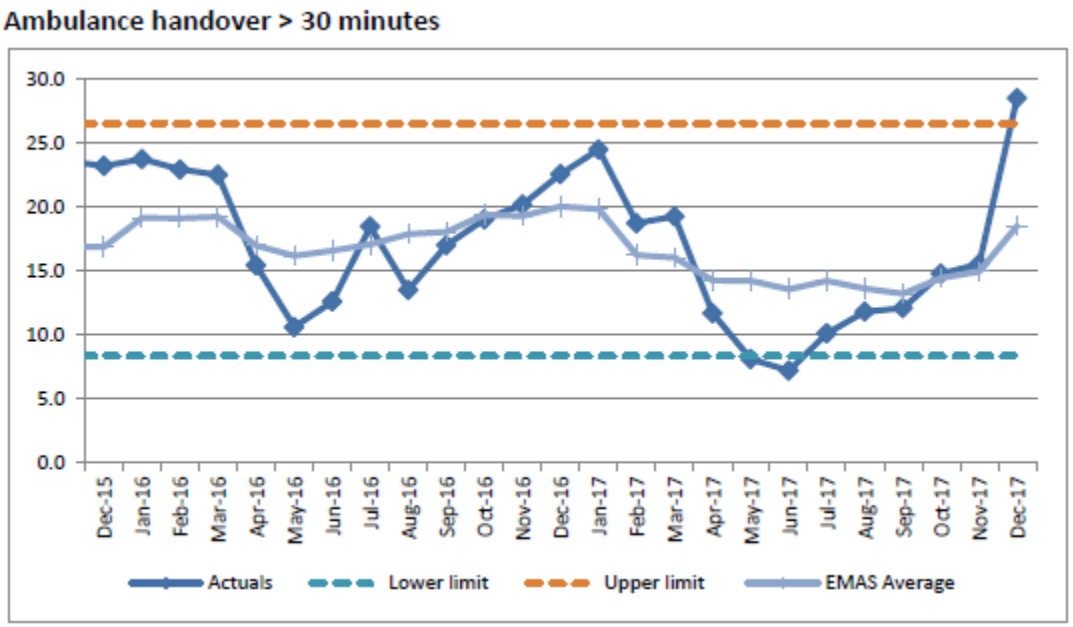
Divisional Lead: Siobhan McKenna, Divisional General Manager Urgent and Emergency Care

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: % of Ambulance handover >30 minutes
Month: Month 9 December 2017
Standard: 0 patients delayed more than 30 mins from arrival to handover

Current position
In December, 28.5% of ambulance handovers took longer than 30 minutes.



Causes of underperformance
At times, the Trust is experiencing a higher number of ambulance arrivals than predicted per day. This increase in the number of ambulance arrivals falls predominately between 22:00 and 02:00. This increase, together with potential batching of ambulance arrivals, can lead to delay in taking handovers due to space constraints within the Emergency Department.

Actions to address		
Action	**Owner**	**Deadline**
Develop case of need for investment in additional trolleys	Richard Clarkson	Complete. Trolleys being ordered.
Agree operational handover policy and escalation process with EMAS	Richard Clarkson	January 2017
Review the potential to increase 'see and treat' by ambulance crews and thereby reduce the number of patients conveyed to ED	Richard Clarkson	December 2017- discussed with EMAS and on-going
Develop Outline Business Case for a receptionist on majors to release capacity of flow co-ordinators and improve enabling more robust/accurate booking in process	Louise Mcmenemy	January 2017

Improvement trajectory
To consistently deliver performance of a maximum of 10% of ambulance handovers taking over 30 minutes (but less than 60 minutes)

Risks	
Risk	**Mitigation**
Outline business case not supported	Review booking in process and operational handover policy

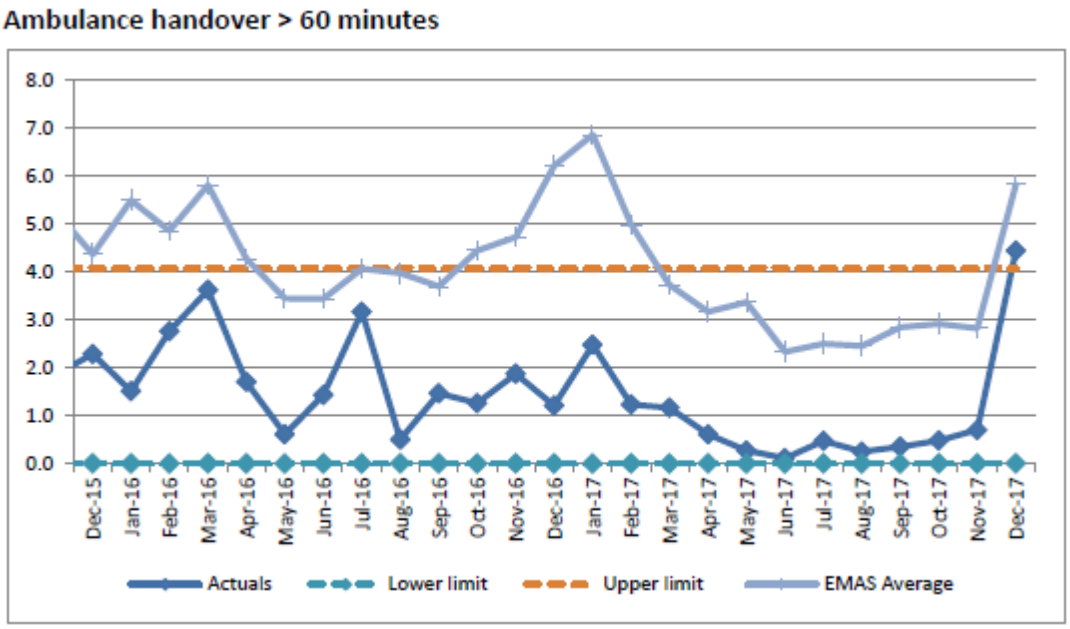
Divisional Lead: Siobhan McKenna, Divisional General Manager Urgent and Emergency Care

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: % of Ambulance handover >60 minutes
Month: Month 9 December 2017
Standard: 0 patients delayed more than 60 mins handover from EMAS

Current position
In December, 4.4% of ambulance handovers took 60 minutes or longer.



Causes of underperformance
At times, the Trust is experiencing a higher number of ambulance arrivals than predicted per day. This increase in the number of ambulance arrivals falls predominately between 22:00 and 02:00. This increase, together with potential batching of ambulance arrivals, can lead to delay in taking handovers due to space constraints within the Emergency Department.

Actions to address		
Action	**Owner**	**Deadline**
Develop case of need for investment in additional trolleys	Richard Clarkson	Complete. Trolleys being ordered.
Agree operational handover policy and escalation process with EMAS	Richard Clarkson	January 2017
Review the potential to increase 'see and treat' by ambulance crews and thereby reduce the number of patients conveyed to ED	Richard Clarkson	December 2017- discussed with EMAS and on-going
Develop Outline Business Case for a receptionist on majors to release capacity of	Louise Mcmenemy	January 2017

flow co-ordinators and improve enabling more robust/accurate booking in process		

Improvement trajectory
The Trust expects to deliver the standard every month.

Risks	
Risk	**Mitigation**
Outline business case not supported	Further review booking in process.

Divisional Lead: Siobhan McKenna, Divisional General Manager Urgent and Emergency Care

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

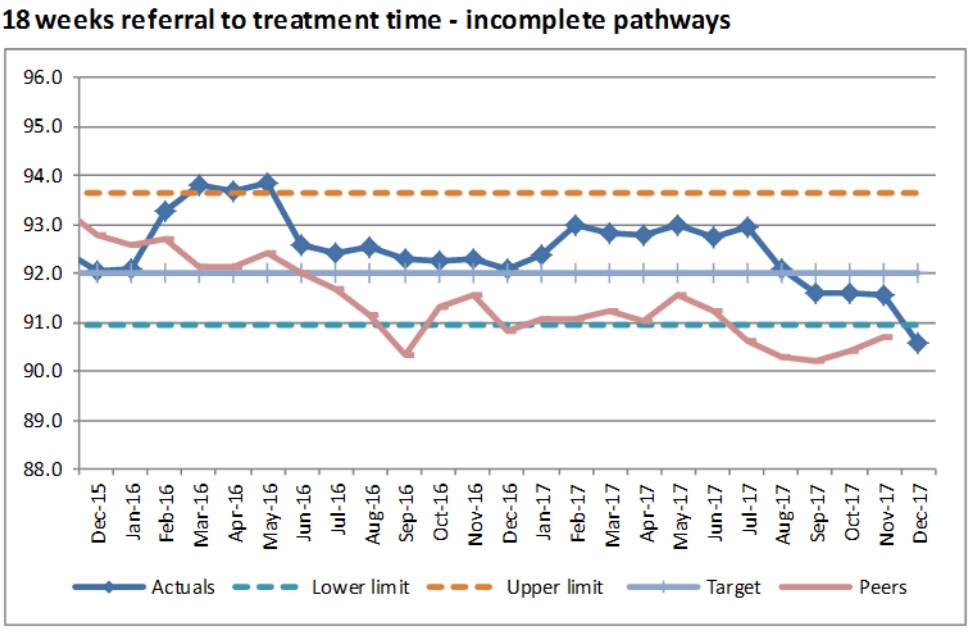
Indicator: 18 weeks referral to treatment time – incomplete pathways

Month: Month 9 December 2017

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

Current position

In December 2017, 9 specialties failed to achieve the standard and overall the Trust failed the standard, achieving 90.6%%



The specialties failing the standard are shown in red below:

RTT Reporting Specialty	<18 Weeks	>18 Weeks	Grand Total	
100 - General Surgery	1405	156	1561	90.01%
101 - Urology	1859	238	2097	88.65%
110 - Trauma & Orthopaedics	1874	199	2073	90.40%
120 - Ear, Nose & Throat	2075	167	2242	92.55%
130 - Ophthalmology	3386	272	3658	92.56%
140 - Maxillofacial Surgery	401	86	487	82.34%
160 - Plastic Surgery	34	4	38	89.47%
301 - Gastroenterology	1796	121	1917	93.69%
320 - Cardiology	1404	258	1662	84.48%
330 - Dermatology	912	66	978	93.25%
340 - Respiratory	735	72	807	91.08%
400 - Neurology	954	228	1182	80.71%
410 - Rheumatology	676	38	714	94.68%
430 - Geriatrics	259	18	277	93.50%
502 - Gynaecology	1006	61	1067	94.28%
X01 - Other	2446	221	2667	91.71%
Grand Total	**21222**	**2205**	**23427**	90.59%

Causes of underperformance
General Surgery Lack of capacity due to medical staff vacancies, backfill arrangements do not create the same level of theatre capacity Urology Lack of medical staff capacity due to short notice absences and underutilisation of theatre capacity Trauma & Orthopaedics Cancellation of routine, non-urgent elective inpatient activity to manage winter pressures, in line with national guidance Maxillofacial Surgery Planned additional capacity has been prioritised for patients on a cancer pathway. Shortfall in capacity to manage the additional demand. Plastic Surgery Very small patient numbers, standard failed due to two patients breaching. Cancellation of minor ops lists over the Christmas period has reduced capacity and available capacity has been prioritised for patients on a cancer pathway. Cardiology Lack of outpatient capacity, particularly to manage patients overdue for review appointments. Respiratory Lack of follow up capacity and lack of auto CPAP capacity. 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	Steve Jenkins	In progress – ongoing
Urology – medical staff recruitment, joint arrangements in place with NUH, maximising all theatre capacity at Kings Mill and Newark Hospitals	Steve Jenkins	In progress – ongoing
Trauma & Orthopaedics – maximising day case surgery during the winter period	Steve Jenkins	In progress – ongoing
Maxillofacial Surgery – new Consultant from NUH will support longer term recovery	Steve Jenkins	In progress – ongoing
Plastic Surgery – review minor ops booking process and source additional capacity to clear the backlog	Dale Travis	In progress – ongoing
Cardiology – outpatient recovery programme in place	Dale	In progress –

	Travis	ongoing
Respiratory – securing additional capacity	Dale Travis	In progress – ongoing
Neurology – longer term plan to transfer the service to NUH during 18/19 and securing additional capacity in the interim	Dale Travis	In progress - ongoing
Other (Diabetes & Endocrinology) – create additional specialist nurse follow up capacity	Dale Travis	In progress – ongoing

Improvement trajectory	
General Surgery	To be confirmed
Urology	To be confirmed
Trauma & Orthopaedics	Dependent on elective surgery re-commencing
Oral Surgery	March 2018
Plastic Surgery	To be confirmed
Cardiology	Q1 2018/19
Respiratory	January 2018
Neurology	To be confirmed
Other (Diabetes & Endocrinology)	To be confirmed

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

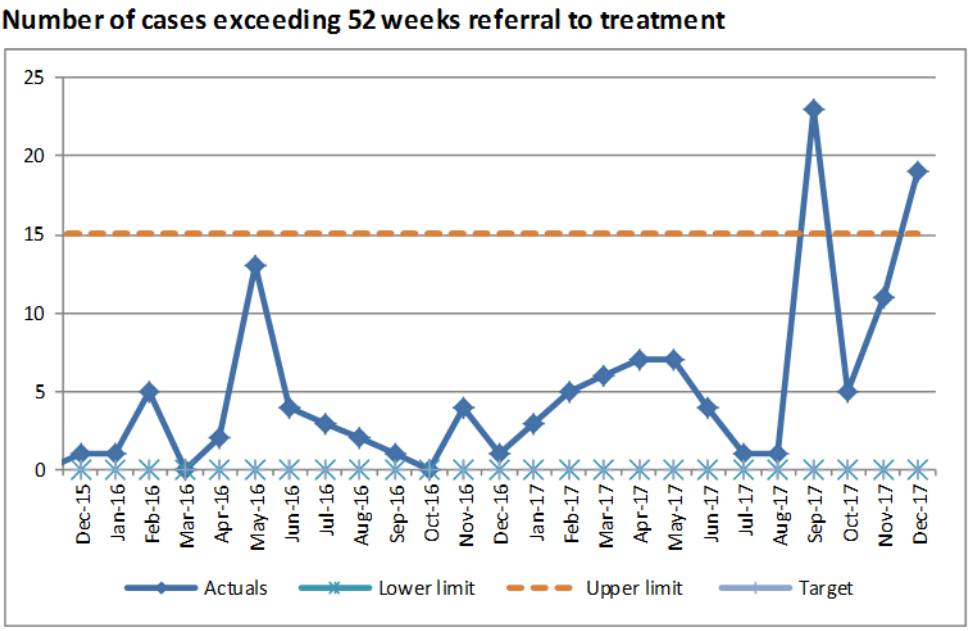
Indicator: Number of cases exceeding 52 weeks referral to treatment

Month: Month 9 December 2017

Standard: 0

Current position

In December 2017, 19 patients waited longer than 52 weeks from referral to treatment.



SLR Specialty	>18 Weeks	Grand Total
100 - General Surgery	2	2
101 - Urology	2	2
130 - Ophthalmology	1	1
320 - Cardiology	1	1
340 - Respiratory	1	1
410 - Rheumatology	12	12
Grand Total	**19**	**19**

Causes of underperformance
The pathways for each of the patients is detailed below, all breaches were identified through as a result of ongoing validation work: 1. General Surgery, 74 weeks, found through validation, TCI 16 Jan 2018 2. General Surgery, 55 weeks, found through validation, TCI 16 Jan 2018 3. Urology, 67 weeks, found through validation, TCI 10 Jan 2018 4. Urology, 63 weeks, found through validation, TCI 22 Jan 2018 (patient on holiday) 5. Ophthalmology, 69 weeks, found through validation, TCI for Jan 2018 to be confirmed 6. Cardiology, 61 weeks, delay UHL referral to bi-monthly SFH clinic, diagnostic PFTs expedited 15 Jan 2018. UHL Consultant to review results. Await clinical outcome, escalated to UHL 7. Respiratory, 57 weeks, complex ICR from Neurology, CPAP treatment 15 Jan 2018 8. Rheumatology, 157 weeks, lost to follow-up, appointment 23 Jan 2018 9. Rheumatology, 152 weeks, lost to follow-up, appointment 17 Jan 2018 patient DNA, further and last appointment booked 07 Feb 2018 10. Rheumatology, 144 weeks, lost to follow-up, appointment 30 Jan 2018 11. Rheumatology, 141 weeks, lost to follow-up, appointment 30 Jan 2018 12. Rheumatology, 135 weeks, lost to follow-up, appointment 31 Jan 2018 13. Rheumatology, 119 weeks, lost to follow-up, appointment 23 Jan 2018 14. Rheumatology, 106 weeks, lost to follow-up, appointment 22 Jan 2018, changed by patient to 13 Feb 2018 15. Rheumatology, 106 weeks, lost to follow-up, appointment 22 Jan 2018 16. Rheumatology, 104 weeks, lost to follow-up, appointment 31 Jan 2018 17. Rheumatology, 94 weeks, lost to follow-up, appointment 26/01/2018 18. Rheumatology, 74 weeks, lost to follow-up, appointment 31 Jan 2018 19. Rheumatology, 65 weeks, lost to follow-up, appointment 23 Jan 2018

Actions to address		
Action	**Owner**	**Deadline**
Continue validation work	Data Quality Manager / Divisional General Managers	In progress – ongoing

Improvement trajectory
Until the validation programme is complete further 52 week breaches may continue to be identified – this is due for completion by the 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

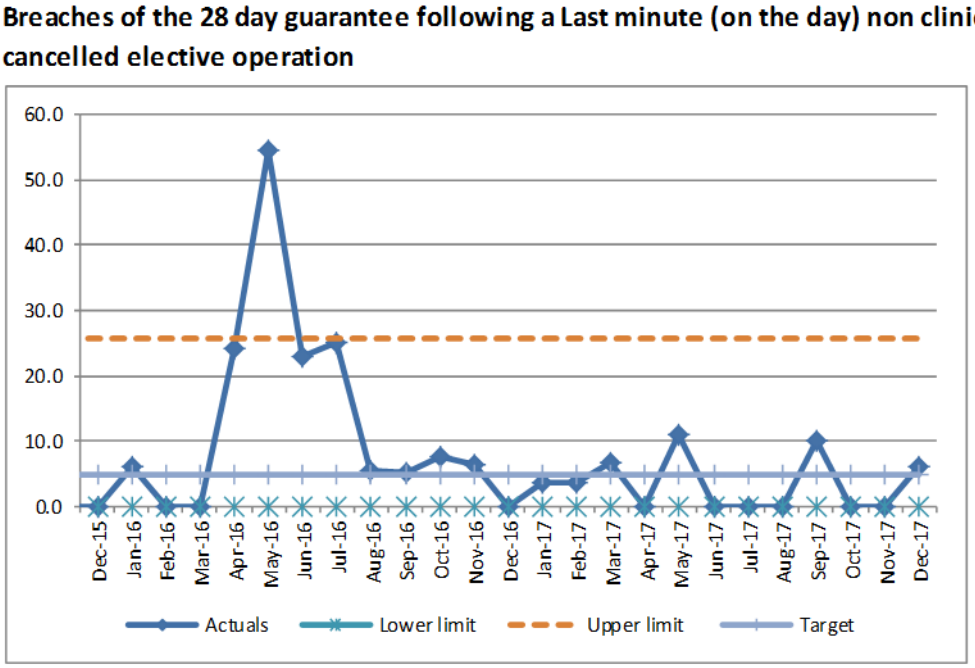
Exception Report

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

Month: Month 9 December 2017

Standard: ≤ 5.0%

Current position
In December 6.3% of patients breached the 28 day guarantee.



Causes of underperformance
This related to one patient cancellation on 15 December 2017 due to a lack of ITU / HDU bed following orthopaedic surgery. The patient was not offered a further date within 28 days due to the cessation of routine, non-urgent elective operations during the winter pressures period.

Actions to address

Action	Owner	Deadline
Escalate through division when this is possible to occur	Service	On-going
Discussion with DGM around decision and priority	DGM/Deputy	On-going
Discussion with flow teams to establish risk level	Division	On-going

Improvement trajectory
Expected recovery in February 2018 providing routine elective activity is resumed.

Risks	
Risk	**Mitigation**
Emergency flow requirement from ITU is not predictable and can fluctuate in winter months	Continue to manage on a patient by patient basis

Lead: Steve Jenkins, Divisional General Manager Surgery

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

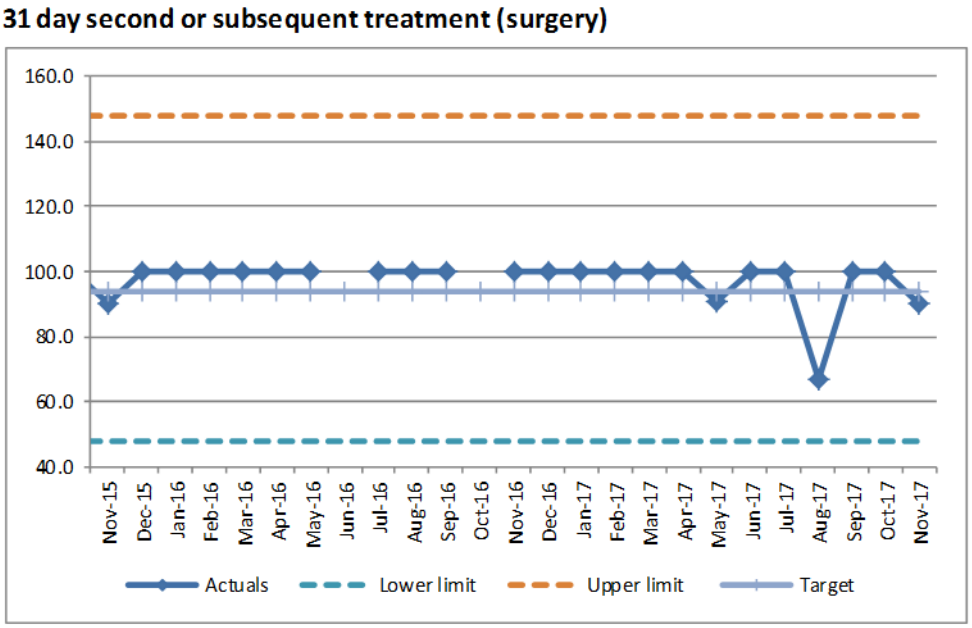
Indicator: 31 day second or subsequent treatment (surgery)

Month: Month 8 November 2017

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

Current position

Trust performance in November 2017 (subsequent surgery) was 90% against the national target of 94%



Causes of underperformance

There was 1 breach which related to 1 patient, the reasons for the breaches are detailed below:

Tumour Site	Breach reason	Accountable Breach
Urology	1. Delay due to capacity issues	1
Total		**1**

Actions to address

Action	Owner	Deadline
Working towards 7 day diagnostic standards for radiology (except CT colon which has reduced from 21 days to 14 days)	Elaine Torr	Q4
Working toward 7 day diagnostic standards for Endoscopy	Dale Travis	To be

		confirmed
Working towards booking of 2ww referrals by day 7	Divisional General Managers	To be confirmed
Implementation of optimal pathways	Divisional General Managers	To be confirmed
Diagnosis by day 28	Divisional General Managers	To be confirmed
Tertiary referrals by day 38	Divisional General Managers	To be confirmed
Reduction of 62 day backlog	Divisional General Managers	Ongoing since July 2017
Weekly PTL escalation meeting and weekly Chief Executive oversight meeting	Cancer Services Manager & Chief Executive	In place – ongoing

Improvement trajectory
January 2018 94% February 201894% March 2018 94%

Risks	
Risk	**Mitigation**
Outpatient capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Diagnostic	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Surgical capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Tertiary delays	Escalation process in place with tertiary providers
Oncology	Review Oncology SLA – for SFHT and tertiary patients

Lead: Divisional General Managers

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

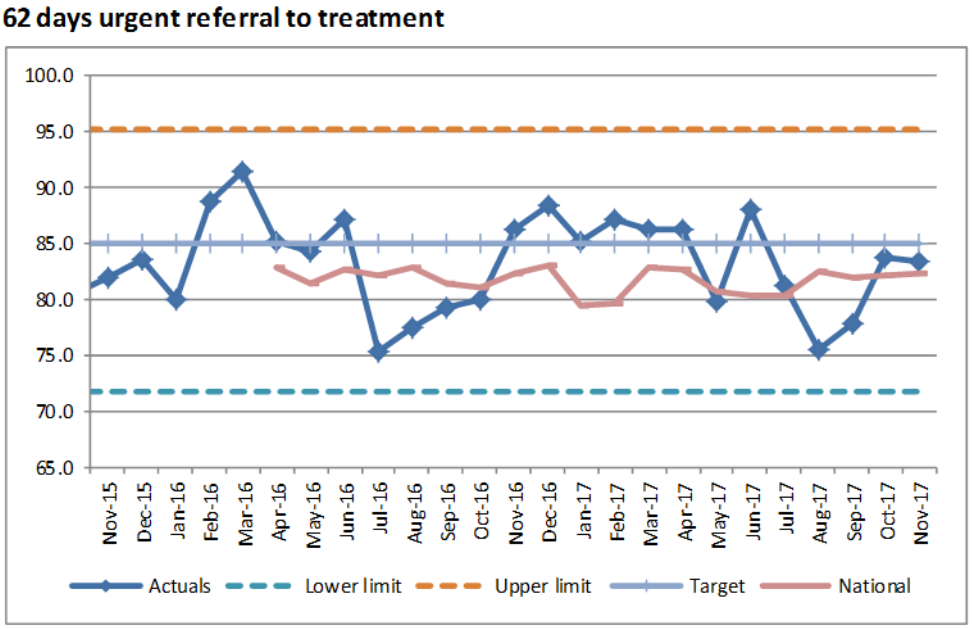
Indicator: 62 days urgent referral to treatment

Month: Month 8 November 2017

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

Current position

Trust performance in November 2017 was 83.4 % against the standard of 85%.



Causes of underperformance

There were 12 breaches which related to 14 patients, the reasons for the breaches are detailed below:

Tumour Site	Breach Reason	Accountable Breach
Gynaecology	1. Patient required multiple diagnostic and staging tests under two clinical teams prior to treatment planning.	1
Head and Neck	1. Tertiary from RK5BC on day 42. Not scheduled to be treated within 24 days of receipt. Unable to schedule treatment in target due to surgical capacity.	0.5
Lower GI	1. Patient choice to delay diagnostic test then further delays to diagnostics due to capacity issues. 2. Delay to diagnostic test due to capacity issues	2
Lung	1. Patient required multiple diagnostic tests to confirm diagnostics. Patient choice to delay diagnostic test and oncology clinic appointment.	2

	2. Patient choice to delay oncology clinic appointment.	
Other	1. Patient required multiple diagnostic and staging tests under two clinical teams prior to treatment planning	1
Skin	1. Delay to diagnostic test due to capacity issues 2. Patient choice delay to treatment date	2
UGI	1. Tertiary referral from SFHT on day 60 of pathway. Patient required multiple diagnostic and staging tests prior to treatment planning. Treated within 24 days of receipt. 2. Tertiary referral from SFHFT on day 31 of patient. Patient choice to delay staging test and clinic appointment. Not treated within 24 days of receipt	1
Urology (excluding testicular)	1. Tertiary referral from SFHFT on day 84 of pathway. Patient choice to delay clinic appointment. Patient required complex planning for trial so not treated within 24 days of receipt. 2. Delay to oncology clinic appointments due to capacity issues. 3. Patient choice delay to diagnostic tests.	2.5
		12

Actions to address		
Action	**Owner**	**Deadline**
Working towards 7 day diagnostic standards for radiology (except CT colon which has reduced from 21 days to 14 days)	Elaine Torr	Q4
Working toward 7 day diagnostic standards for Endoscopy	Dale Travis	To be confirmed
Working towards booking of 2ww referrals by day 7	Divisional General Managers	To be confirmed
Implementation of optimal pathways	Divisional General Managers	To be confirmed
Diagnosis by day 28	Divisional General Managers	To be confirmed
Tertiary referrals by day 38	Divisional General Managers	To be confirmed
Reduction of 62 day backlog	Divisional General Managers	Ongoing since July 2017
Weekly PTL escalation meeting and weekly Chief Executive oversight meeting	Cancer Services Manager & Chief Executive	In place – ongoing

Improvement trajectory
January 2018 85.7 February 201885.7% March 2018 85%

Risks	
Risk	**Mitigation**
Outpatient capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Diagnostic	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Surgical capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Tertiary delays	Escalation process in place with tertiary providers
Oncology	Review Oncology SLA – for SFHT and tertiary patients

Lead: Divisional General Managers

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

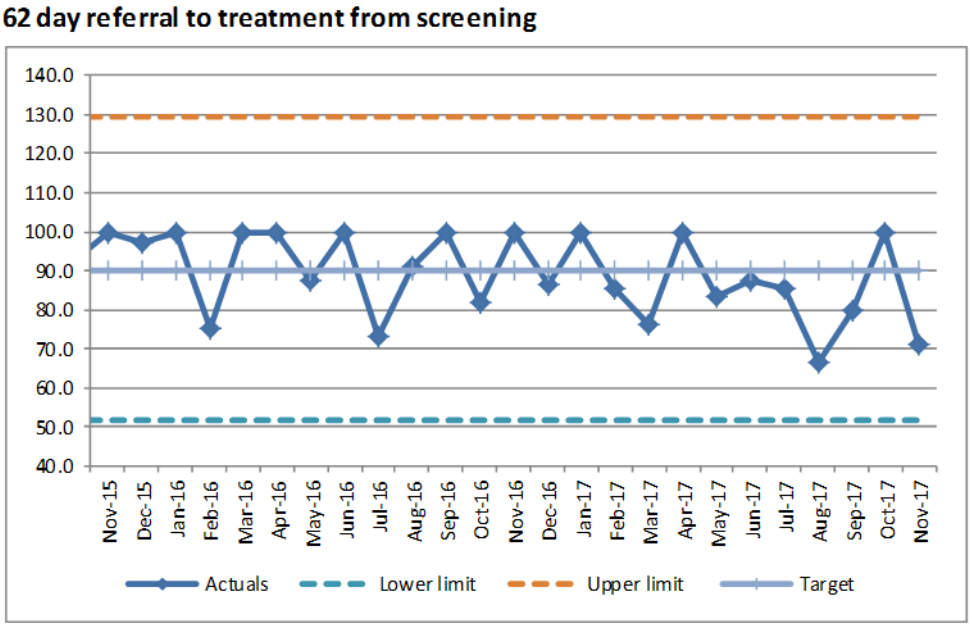
Indicator: 62 days referral to treatment from screening

Month: Month 8 November 2017

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

Current position

Trust performance in November 2017 was 71.4 % against the standard of 90%.



Causes of underperformance

There were 2 breaches which related to 2 patients, the reasons for the breaches are detailed below:

Tumour Site	Breach reason	Accountable Breach
Breast	1. Delay to staging test due to medical reasons.	1
LGI	1. Patient choice to delay diagnostic and staging tests. Delay to treatment due to capacity issues.	1
Total		**2**

Actions to address		
Action	**Owner**	**Deadline**
Working towards 7 day diagnostic standards for radiology (except CT colon which has reduced from 21 days to 14 days)	Elaine Torr	Q4
Working toward 7 day diagnostic standards for Endoscopy	Dale Travis	To be confirmed
Diagnosis by day 28	Divisional General Managers	To be confirmed
Tertiary referrals by day 38	Divisional General Managers	To be confirmed
Reduction of 62 day backlog	Divisional General Managers	Ongoing since July 2017
Weekly PTL escalation meeting and weekly Chief Executive oversight meeting	Cancer Services Manager & Chief Executive	In place – ongoing
Reviewing SLA with newly appointed Bowel Screening Manager	Divisional General Managers	Q4

Improvement trajectory
January 80.9% February 87.1% March 85.5%

Risks	
Risk	**Mitigation**
Outpatient capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Diagnostic	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Surgical capacity	Review capacity and demand and monitor weekly, prioritising patients on a cancer pathway
Tertiary delays	Escalation process in place with tertiary providers
Oncology	Review Oncology SLA – for SFHT and tertiary patients

Lead: Divisional General Managers

Executive Lead: Simon Barton, Chief Operating Officer

QUALITY AND SAFETY

1. Same sex accommodation

There were no single sex accommodation breaches to report in December 2017.

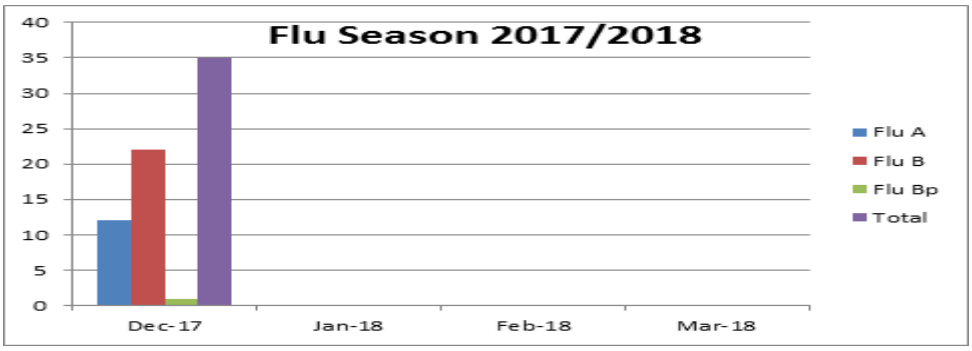
2. Infection Prevention and Control

All healthcare associated infections are carefully monitored and managed in line with national and local guidance. There was one case of Clostridium Difficile Infection (CDI) in December 2017. This was within our monthly trajectory, and brought our total to 28 cases which remain within the annual threshold to date.

There were no cases MRSA bacteraemia identified in December 2017.

There were two Escherichia Coli bacteraemia in December 2017, bringing the cumulative total to 37, at present there is no trajectory attached to this, however there is an aspiration for a reduction of 10% on the previous years. This dovetails with the Clinical Commissioning Groups intentions.

December 2017 witnessed the start of the influenza season, during December 2017, there were 35 individuals tested positive for a type of Flu (Graph 1) most were diagnosed either on admission in Emergency Department or on the Emergency Assessment Unit. When compared to the entire 2016/17 season where there were 26 cases it is evident that as predicted by Public Health England, this is going to be a challenging year for Flu. It is anticipated that this pressure will continue for some time.

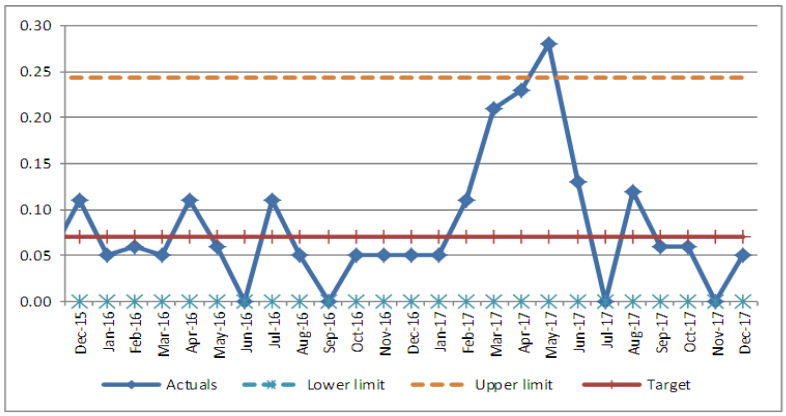


3. Tissue Viability

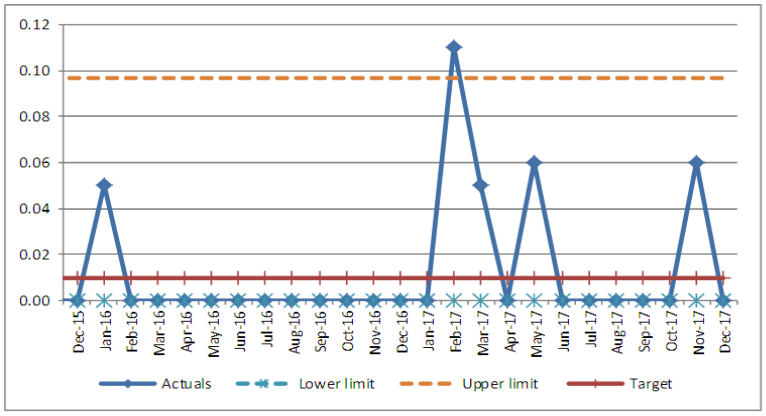
Reducing harm from pressure ulcers (PUs) has been identified as a supplementary quality priority in line with the Quality Account implemented during 2017/8.

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 December 2017. One suspected deep tissue injury from November 2017 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

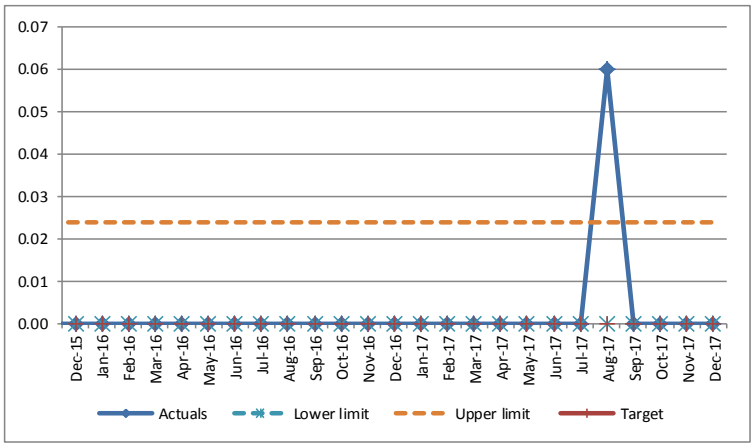


Table 1 below shows the total number hospital acquired PUs, both avoidable and unavoidable by grade over a 17 month period

Table 1

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

*validated suspected deep tissue injury from November 2017

Mitigation plans and actions going forward:

- A review of Emergency Department (ED) following the pressure ulcer prevention work completed during December 2017. Further strengthening of processes and communication with Tissue Viability Nurse Consultant, Divisional Heads of Nursing (HoNs) and the ED team to ensure PU NICE guidelines are followed consistently.
- 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 Tissue Viability Nurse Consultant to Divisional HoNs monthly which includes supporting and performance monitoring of both the Tissue Viability Team and the Matrons to ensure Key Performance Indicators (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 Emergency Admissions Unit (EAU) staff. Ongoing communications Trustwide.
- TV report presented to the Patient Safety Quality Board quarterly – starting in February.
- Fundamentals Study Day for all nurses across the Trust to include, Patient Safety, TV, Infection Prevention & Control, deteriorating patients, pain. Accountability of Registered Nurses will be the focus throughout the day.
- Consultant Nurses commenced monthly meeting with HoNs to discuss preventing harms and accountability.

4. Harm-free Care (Safety Thermometer)

The Trust reported 95.86% harm free care during December against a standard of 95%.

The standard includes 'new' harms acquired during admission and 'old' harms which are present on admission, the total of all harms was 4.14% n= 22.

The new harms total is 7 (1.32%) and includes the following:-

- 4 venous thromboembolism (VTE)
- 3 fall with harm.

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.

5. VTE

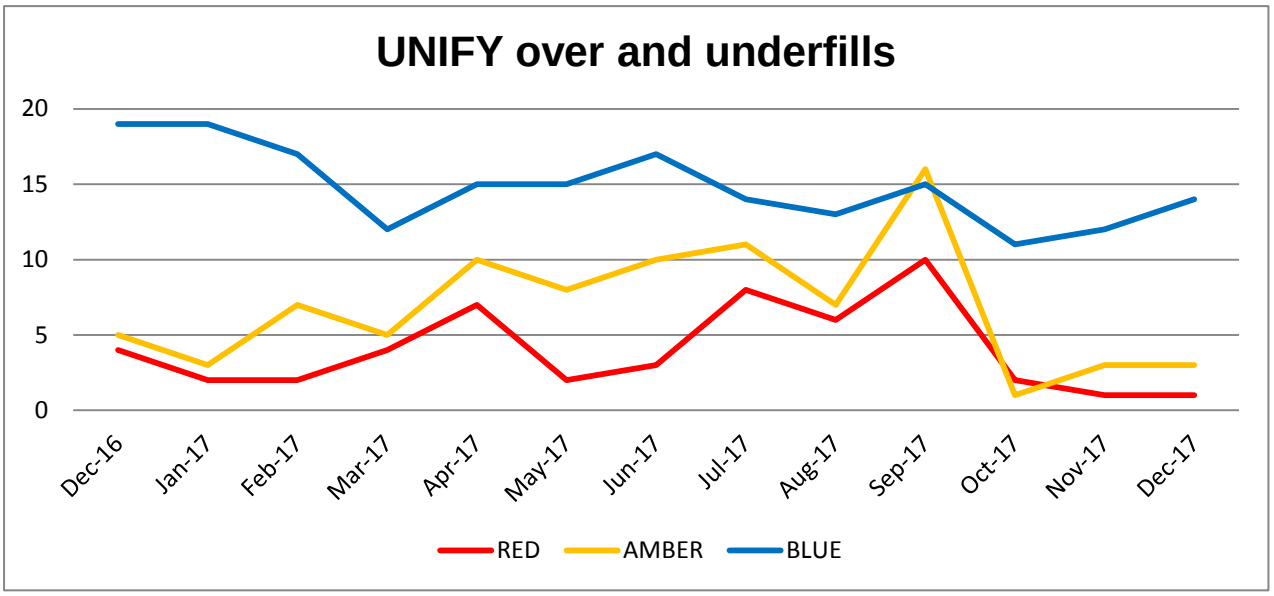
The Trust met this standard for the month of November (95.55% against a standard of 95%). Although the standard was met the Governance Support Unit continues to review a random sample of medical notes to ensure all eligible patients have had appropriate VTE prophylaxis in accordance with Trust guidance. To date this review demonstrates appropriate VTE prophylaxis is being initiated.
The 4 new VTEs identified during the December Safety Thermometer audit were diagnosed and treated on the wards. These 4 cases will be reviewed as part of the audit programme to determine if they were hospital acquired or not.

6. 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 number of areas with **red** ratings (actual staffing level is below the accepted 80% level and highlights a potential significant risk) and there was 1 **red** rating.
The number of areas with **amber** ratings (staffing fill rate is less than the accepted 90%, but above 80%) and there were 3 **amber** ratings.
December 2017 saw 14 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.
Graph 1 below, displays over a 12 month period, where the Trust has not staffed to its expected planned level (**red** below 80% and **amber** between 80% & 90%) and the staffing fill rates above planned (greater than 110% **blue**).

Graph 1: Staffing over and under-fill captured through the Unify report.



There was no correlation with safe staffing and patient harms throughout December 2017.

ORGANISATIONAL HEALTH

Sickness Absence - RED
Sickness absence increased in December 2017 by 0.19% to 4.15% (November 2017, 3.96%).

Short term sickness decreased by 0.10% to 2.21%, (November 2017, 2.31%), long term increased by 0.29% to 1.94% (November 2017, 1.65%). Normally it is expected short term sickness would increase at this time of year due to colds, coughs, flu and influenza. However, in December, the Trust saw 105.40 FTE of long term absences for this reason, whereas in November there were none.

All divisions are above the 3.50% target in December 17, Women & Childrens' and Diagnostics & Outpatients show a slight decrease;

- Women & Childrens' – 5.35% (November, 5.86%), a decrease of 0.51%. Short term sickness decreased by 1.73% to 2.01% and long term sickness increased by 1.22% to 3.34%.
- Diagnostics & Outpatients – 3.61% (November, 4.08%) a decrease of 0.47%. Short term sickness decreased by 0.30% to 2.42%, and long term sickness decreased by 0.18% to 1.19%.

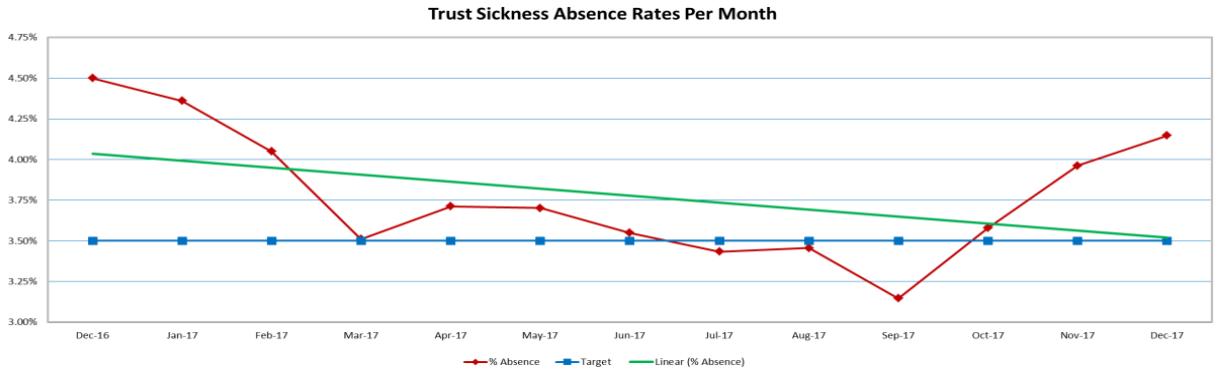
Those divisions that have seen an increase in sickness absence are;

- Surgery – 4.38% (November, 3.72%), an increase of 0.66%. Short term sickness increased by 0.04% to 2.46%, and long term sickness increased by 0.62% to 1.92%.
- Medicine – 4.17% (November, 3.56%), an increase of 0.61%. Short term sickness increased by 0.57% to 2.47%, and long term sickness increased by 0.04% to 1.70%.
- Corporate – 3.65% (November, 3.20%), an increase of 0.45%. Short term sickness increased by 0.21% to 1.57%, and long term sickness increased by 0.24% to 2.08%.
- Urgent & Emergency Care – 4.34% (November 4.31%) an increase of 0.03%. Short term sickness decreased by 0.29%, and long term sickness increased by 0.32% to 2.66%.

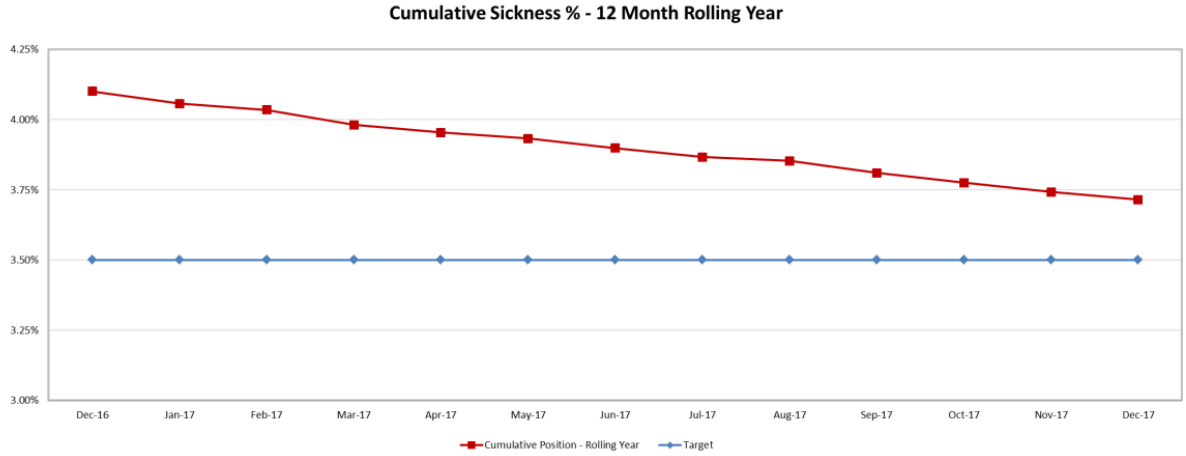
Divisionally the main reasons for long term sickness;

- Surgery – Benign and malignant tumours, cancers cases, Anxiety/stress/depression/other psychiatric illnesses and planned surgery.
- Women & Children's – Planned surgery and Anxiety/stress/depression/other psychiatric illnesses.
- Diagnostics & Rehabilitation – several staff recovering from surgery. During December the division had a number of long term Cold, Cough, Flu – Influenza cases.
- Medicine & Urgent Care – There are on-going cancer cases in Medicine and also an increase in long term Cold, Cough, Flu – Influenza cases in both divisions.

As can be seen from the chart below, although sickness absence for December 2017 has increased it is 0.35% lower than December 2016



The 12 month rolling year (sickness averaged for the previous 12 month period for each month) indicates a significant sustained improvement.



The three sickness absence reasons which have the highest increase in FTE days lost are:

- S13 Cold, cough, Flu – influenza – 615.18 FTE days - an increase of 207.11 FTE days (November, 408.07 FTE days). The staff groups with the highest FTE days lost due to this reason were:
    - Admin & Clerical – 190.21 FTE days
    - Registered Nurse 108.71 FTE days
    - Allied Health Professionals 85.35 FTE days

- S15 Chest & respiratory problems – 337.06 FTE days - an increase of 207.08 FTE days (November, 129.98 FTE days). The three staff groups with the highest FTE days lost due to this reason were:
    - Registered Nurse – 155.71 FTE days
    - Unregistered Nurse – 94.24 FTE days
    - Admin & Clerical 56.98 FTE days.

- S28 Injury, Fracture – 330.37 FTE days - an increase of 107.53 FTE days (November, 222.84 FTE days). The three staff groups with the highest FTE days lost due to this reason were:
    - Admin & Clerical – 114.53 FTE days
    - Unregistered Nurse – 103.00 FTE days
    - Registered Nurse 95.24 FTE days.

Divisional management and HR Business Partner teams will continue to strive to bring sickness rates back below the 3.5% target. However, as the winter period does tend to exacerbate sickness levels, it may not be below the 3.5% again until Spring.

Staffing

This table below shows the net position with staff in post against establishment in December 2017 across the Trust. There were 15.38 FTE more leavers than starters in December 2017 (20.64 FTE starters v 36.02 FTE leavers). The turnover rate increased to 0.90% (November, 0.64%), which is still below the threshold of 1%.

All Registered Nurse vacancies have increased In December 2017 to 10.64%, 148.67 FTE (November, 10.64%, 142.27 FTE). Band 5 Registered Nurse vacancies have increased to 16.83%, 126.59 FTE (November, 15.49%, 116.74 FTE). Reasons for leaving across all registered nurse leavers - were: Flexi Retirement; 3.80 FTE; Voluntary – Work Life Balance,

0.59 Retirement Age, 1.76 FTE; Voluntary – Relocation, 2.00 FTE; Voluntary Resignation - Child Dependants, 1.00 FTE; Voluntary Resignation – Health, 0.88 FTE; Voluntary Resignation - Other/Not Known, 0.60 FTE; Voluntary Resignation – Promotion, 2.00 FTE; Voluntary Resignation - To undertake further education or training, 0.61 FTE.

	Dec-17								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Total Trust									
Admin & Clerical	1151.08	1069.46	1308	81.62	7.09%	8.80	10.81	1.01%	28
Allied Health Professionals	226.17	214.89	268	11.28	4.99%	1.80	0.20	0.09%	6
Ancillary	39.80	37.03	44	2.77	6.96%	0.00	0.00	0.00%	0
Medical & Dental	497.96	445.79	469	52.17	10.48%	2.00	1.50	0.34%	7
Registered Nurse Operating Line * - ALL Bands	1336.10	1187.43	1399	148.67	11.13%	4.76	13.24	1.12%	13.00
Scientific & Professional	215.69	192.21	209	23.48	10.89%	0.00	3.00	1.56%	3
Technical & Other	273.53	260.75	324	12.78	4.67%	0.58	0.93	0.36%	2
Unregistered Nurse	594.52	573.76	668	20.76	3.49%	2.70	6.33	1.10%	7
Total - Trust	**4374.43**	**3981.32**	**4689**	**393.11**	**8.99%**	**20.64**	**36.02**	**0.90%**	**66**
Band 5 Registered Nurse Only operating line *	752.10	625.51	747	126.59	16.83%	2.76	7.04	1.13%	-

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 staff vacancy levels tracked against an August 2016 baseline.

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

There is now 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

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

The improvement in the staff in post position of band 5 Registered Nurses in the Trust has a positive impact on reducing the Trusts agency usage and expenditure. It not only assists the financial positon, but also helps to maintain safe staffing.

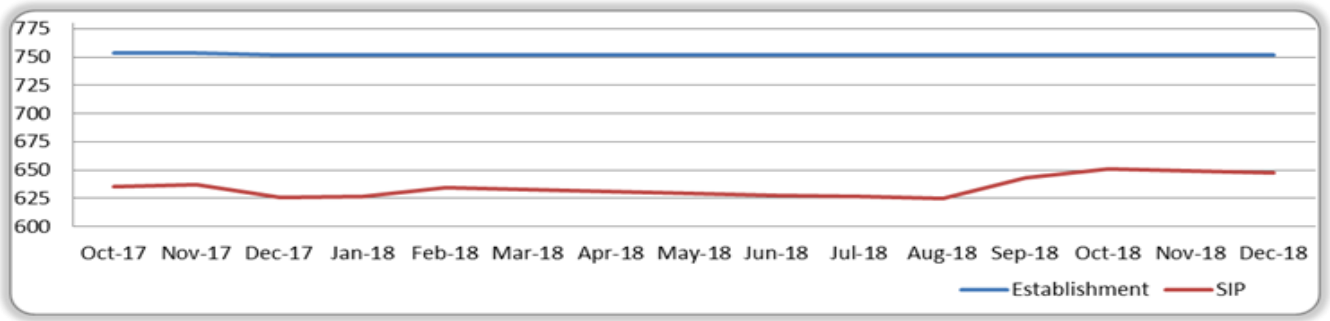
Band 5 registered nurses (RN) trajectory:

There has been a slight reduction in the establishment. However with the number of leavers and only a handful of new starters the Trajectory shows an increase in vacancies at Band 5 RNs to 126.59 WTE which is 16.8%.

December is often a month where there are more leavers than starters as year-end is often when people choose to retire or make life changes and people are reluctant to start a new job after mid-December because of Christmas; they tend to delay it to the New Year. So as predicted we had an increase to nine (7.04 WTE) Registered Nurses leaving in December. Three have retired but will possibly return on reduced hours, one has moved to a local CCG for a training post, two relocated, one left citing work life balance, one due to health and one due to childcare.

A further RN Assessment Centre was held on 17th January. Following a very successful HSCW Assessment Day in January, 31 people were offered roles. There is also a further Assessment Day for Bank HCSWs in February.

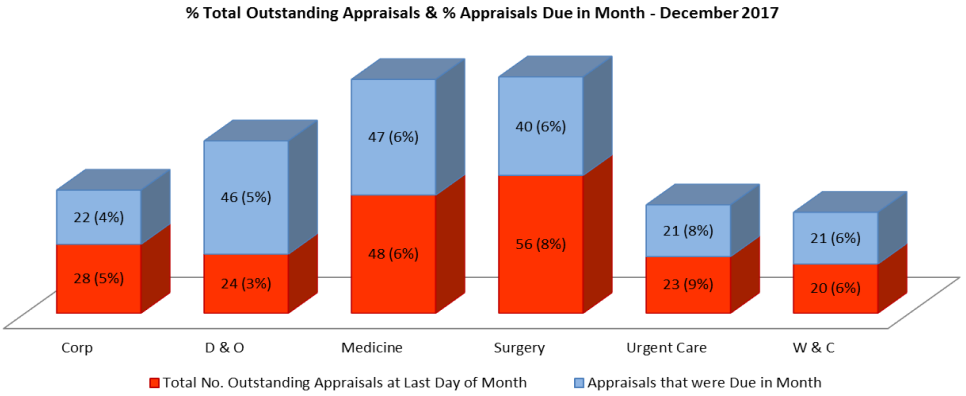
The staffing gap on wards is being mitigated by bank and agency usage. During 2017, strenuous efforts were made to strengthen the Trusts nursing bank which has resulted in around 50% of temporary staffing requirements being cover in this way.



Appraisal - Amber

Trust wide appraisal compliance was 94% for December 2017 a decrease of 1% from November 2017.

There were 201* (6%) appraisals required in December to reach 100% and an additional 197 (6%) appraisals due to be completed which expired in month, giving a total of 398. Therefore 12% of appraisals were required to be completed in December 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, Corporate, 95% (November, 93%) and one Division which remained static, Medicine, 94% (November, 94%)

Due to annual leave over Christmas and winter pressures, a small amount of slippage can be expected in December and the Divisions which decreased were:

Diagnostics & Outpatients, 97% (November, 98%)
Surgery, 92% (November, 94%)
Urgent & Emergency Care, 91% (November, 93%)
Women & Childrens, 94% (November, 96%)

Training and Education

Mandatory training has remained the same in December at 93% (November, 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% (November, 97%)
- Diagnostics & Outpatients – 96% (November, 96%)
- Medicine – 93% (November, 93%)
- Women & Children's – 93% (November, 93%)
- Surgery – 92% (November, 92%)
- Urgent & Emergency Care – 90% (November, 89%)

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

FINANCE REPORT – MONTH 9

The Trust is reporting a position year to date (YTD) that is (£1.2m) worse than control total before Sustainability and Transformation Funding (STF). This is a deterioration of (£0.2m) in month compared to plan, however this is better than was forecast by £0.2m. A loss of £3.2m of Sustainability and Transformation Funding (STF) has also been reflected YTD. This reflects non delivery of the 4 hour access target since July 17 (£1.3m) as well as the loss of control total STF of (£1.9m) as the financial position is worse than control total at the end of quarter 3. Overall the position is therefore £4.3m worse than control total post STF YTD. The Trust is measured against the control total both pre and post STF and there are no further financial penalties for not achieving the post STF control total. Bonus and incentive STF allocations will be made in 2017/18 on the pre STF control total.

The position in month is better than forecast by £0.2m, although (£0.2m) worse than plan. The adverse position to plan is within Divisions, however a reduction in pay spend in month has meant this adverse position has improved relative to previous months. Controls are in place that identify further mitigations and review all commitments, pay and non pay, to ensure that expenditure is incurred only where it contributes to delivery of the Trust's winter priorities.

Total clinical income was £0.3m better than plan in month and is £0.8m better than plan YTD. High cost drugs and devices are £0.5m worse than plan YTD offset within expenditure. ED attendances and the number of subsequent admissions is below plan. Daycase activity remains higher than planned levels. Non Elective activity remains lower than planned levels but has increased in month. Outpatient activity is under plan most notably within first attendances but offset in part by an increase in outpatient procedures.

Expenditure in month was (£0.5m) worse than plan and (£1.9m) worse than plan YTD. Overall Cost Improvement Plan (CIP) delivery is £0.4m better than plan YTD. The Sustainability and Transformation Partnership (STP) element of the CIP target YTD is £4.3m and has been offset on a non recurrent basis by SFH mitigations including the control total adjustment and interest payment benefits.

At the end of December the Trust is £1.17m behind its control total excluding STF. Q2 and Q3 non achievement of 4 hour ED access standard and non achievement of control total at the end of Q3 means that the Trust is £4.34m 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

	December 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	(5.11)	(5.36)	(0.25)	(33.64)	(34.81)	(1.17)	(46.44)	(45.53)	0.91
Surplus/(Deficit) - Control Total Basis Inc STF	(4.23)	(5.36)	(1.13)	(27.91)	(32.25)	(4.34)	(37.62)	(38.04)	(0.41)
Finance and Use of Resources Metric YTD				3	3		3	3	
CIPs	1.57	1.99	0.42	11.13	11.48	0.35	16.26	16.26	0.00
Capex (including donated)	(0.69)	(0.29)	0.40	(7.67)	(3.00)	4.67	(9.67)	(8.79)	0.88
Closing Cash	1.45	1.47	0.02	1.45	1.47	0.02	1.45	1.45	0.00
NHSI Agency Ceiling - Total	(1.48)	(1.26)	0.22	(13.52)	(12.57)	0.94	(17.91)	(17.50)	0.41
NHSI Agency Ceiling - Medical	(1.11)	(0.81)	0.30	(10.03)	(8.05)	1.98	(13.37)	(11.03)	2.34

- In month 9 against control total excluding STF the Trust was £0.25m worse than plan and cumulatively £1.17m worse than plan.
- In month 9 against control total including STF the Trust was £1.13m worse than plan and cumulatively £4.34m worse than plan, due to 4 hour access target not achieving and finances worse than the YTD control total.
- 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 £0.35m. The Trust is forecasting to achieve its overall CIP plan for 17/18. Forecast per the CIP report is £15.5m.
- YTD Capex expenditure position is £4.67m below plan, this reflects the requirement to only incur expenditure on the self funded elements of the capital programme, until approval is given by NHSI for the additional borrowing required to support the full year plan. The capital loan was approved in early January and the Trust is forecasting to underspend the capital plan by £0.88m.
- Closing cash at 31st December was in line with plan and is forecast to remain in line with plan for the next quarter.
- YTD agency spend at M9 totalled £12.57m against the profiled NHSI ceiling of £13.52m. In month performance is £0.22m below the NHSI ceiling, for the 6th month in a row. Expenditure is forecast to be within NHSI ceiling at year end by £0.41m. Medical agency spend continues to achieve the reduction required by NHSI.