Sherwood Forest Hospitals
NHS Foundation Trust

Public Board Meeting Report

Subject: Single Oversight Framework Integrated Performance Report
Date: 30th November 2017
Authors: Phil Bolton – Deputy Chief Nurse, Yvonne Simpson- Head of Corporate Nursing, 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, Denise Smith – 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 guidance has been revised in November 2017; the Board will receive an update with regard to the implications of the revision in December 2017.

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:

- Never Event
- Falls
- 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 - Cardiology
- Number of cases exceeding 52 weeks referral to treatment
- % of fractured neck of femur achieving Best Practice Tariff

Exception Report

Indicator: NEVER EVENT

Month: October 2017

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

Current position
During the month of October, 1 wrong implant/prosthesis Incident met the reporting criteria of a Never Event. The patient has a functioning knee joint and to date there is no requirement to perform further surgery.

Causes of underperformance
The Investigation to determine the root cause is still in progress. An initial panel meeting was held and actions agreed, as described below.

Actions to address		
Action	**Owner**	**Deadline**
Checking procedures for every type of implant to be immediately implemented, relevant to all theatres, Doctor and scrub nurse check and document. Division to provide assurance report to PSQB 8th November.	Sharon Baxter	8.11.2017

Interrogation of data submitted to National Joint Registry (NJR), was this a failed opportunity to identify the error sooner. Process for flagging anomalies at the submission stage, prospective process to be implemented.	Cheryl Snell	31.11.2017
Radiologist to carryout review on all post-operative joint xrays.	Mr Desai	31.11.2017
Patient to be offered an apology and explain the missed opportunity to identify the error earlier. Surgeon to notify the GMC of the Never Event.	Mr Badhe	31.10.2017 - completed
Communication of incident and immediate learning in Theatre using Communication Cells.	Sharon Baxter	01.11.2017 - completed
A review of practice undertaken and implants within the store room were already segregated. Implants have been checked and all correct.	Sharon Baxter	01.11.2017 - completed
Clinical Lead for safety in theatre introducing additional Stop moments.	Theatres Clinical Lead for safety	1.11.2017 - introduced

Improvement trajectory

Risks	
Risk	**Mitigation**
The error could be repeated if the reasons why this occurred are not fully understood.	To reduce the risk of describing the events and not exploring the reasons WHY the Investigation team is being supported by a member of the GSU and will be encouraged to fully explore the underpinning cause/s

Lead: Head of Governance

Executive Lead: Director of Governance and Quality Improvement.

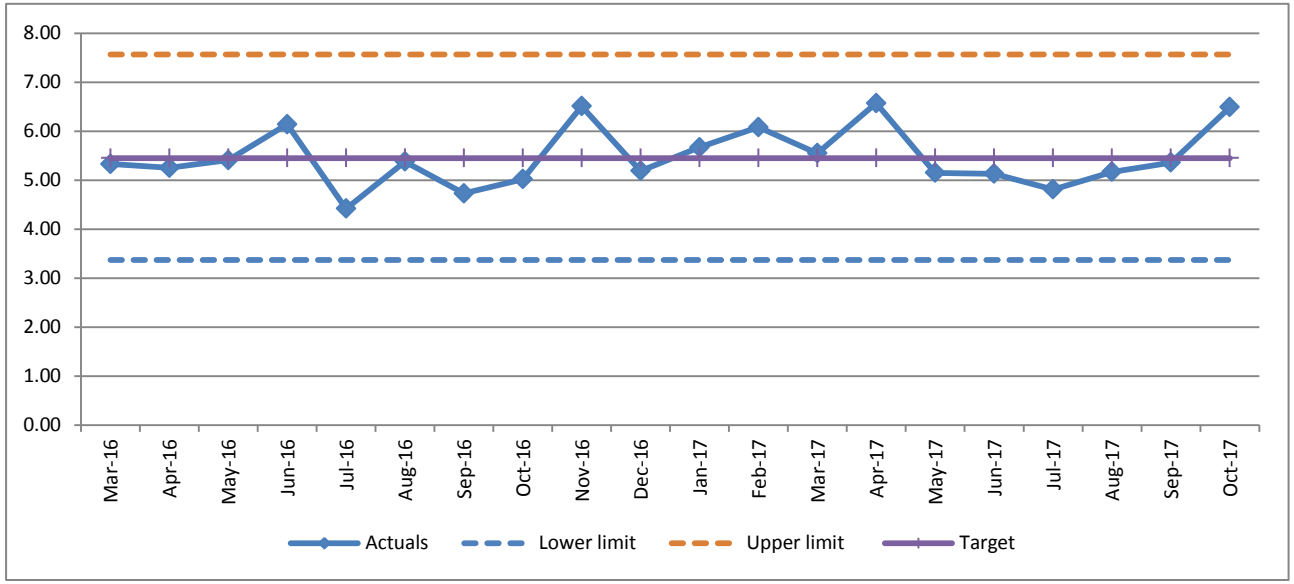
Exception Report

Indicator: Falls

Month: October 2017

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

Current position



The graph demonstrates the current position for falls across Sherwood Forest Hospitals NHS FT (SFH), from November 2016 to October 2016.

Causes of underperformance

The following issues have been raised with the Heads of Nursing (HoN) via e mail and at a Specialist Nurse meeting with the HoN when the Falls Nurse discussed the rise in falls for October 2017.

- There has been a rise in the number of unfilled Nurse Bank Healthcare shifts (3% in October 2017), of which there is a portion that is Enhanced Patient Observations (EPO) shifts for the week ending 8 October 2017.
- There has been a decrease in the availability of the Virtual Ward team as some have moved to substantive inpatient wards.
- There are significant Healthcare Assistant vacancies across the inpatient wards.

Actions to address

Action	**Owner**	**Deadline**
• The Falls Lead Nurse has discussed with various staff groups to possible reasons for the current rise in falls. One of the themes was around filling of shifts for enhanced patient care.	Joanne Lewis-Hodgkinson	Completed 1 November 2017
• Ongoing weekend visits and a night shift are currently rostered by the Falls Lead Nurse for assurance and educational visits.		On going
• A deep dive has been carried out by the Falls Nurse for the October falls in relation to time of day, location and day of the week. This will be presented in various forums for discussion.		Completed November 2017
• The Falls lead Nurse will review EPO documentation over the weekend of 26th November 2017.		26th November 2017

• Falls Lead Nurse has arranged for a Falls champion session on 1st December and the Falls Group meeting in November to concentrate on October /November falls to ask the question- **What is different? What are your ideas around falls prevention?**		1 December meetings
• The Falls Lead Nurse has reviewed all incident forms in relation to falls and no particular themes or trends have been identified.		Daily/weekly on going
• The Nursing Taskforce Steering Group has reviewed the EPO policy and audit undertaken by the Lead Nurse for Practice Development, and further education is to be provided by the Practice Development Matrons.	Yvonne Simpson – Corporate Head of Nursing	Completed October 2017
• Further recruitment to the Virtual Ward, inpatient wards and Nurse Bank Healthcare Assistants.		Completed 17th November 2017

Improvement trajectory
SFH has remained below national average for all falls 6.63 on a monthly basis, since May 2017. The team's 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 November 2017, and there will be a 8 – 10 week period before the new recruits are in place.	Ensure all shifts are put out to Nurse Bank to ensure there is a full complement of Virtual Ward staff 24/7.
The unfilled Healthcare Assistant will continue to rise.	Further recruitment to the Nurse Bank for Healthcare Assistants to be 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.

Lead: Joanne Lewis-Hodgkinson RN – Falls Lead Nurse

Executive Lead: Suzanne Banks – Chief Nurse

Exception Report

Indicator: Friends and Family Test

Month: Month 6 September 2017

Standard: [descriptor]

Current position

Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG
Response Rate: Friends and Family Accident and Emergency	≥12.8%	Oct-17	9.3%	11.2%		R
Recommended Rate: Friends and Family Maternity	≤96	Oct-17	96.3%	95.1%		R
Recommended Rate: Friends and Family Outpatients	≤96	Oct-17	93.8%	93.9%		R

Causes of underperformance

ED Response Rate – the response rate has fluctuated around 11% for the past months compared to the national average 12.8%. The ED Team continue to work hard to maintain the increase seen during 2017, and using paper and SMS texting will continue to support this approach.

Recommendation Rate – All divisions and specialities Leads and Managers receive weekly comment reports to highlight where negative feedback has been reported to identify improvements.

All wards/departments receive weekly and monthly reports providing detailed information of all feedback, this includes recommendation rate

and positive/negative comments which are then actioned locally. Due to the software used, dependent upon the language used, a positive recommendations can be reported as a negative experience which results in a false/negative comment. Due to Outpatient responses received largely via SMS texting, we can receive a number of these which are reviewed and amended centrally on the meridian system by the Patient Experience Team, which provides a revised recommendation rate. In other areas within the Trust paper surveys are the most popular method of feedback which are inputted by the Patient Experience Team therefore this prevents false/negative reporting.

Currently we provide FFT data at different periods within the month to different groups, therefore this data is affected by the false/negative reporting, hence the 93.9% reported as red above..

We are currently working with Meridian to provide a solution to this issue.

Following a review of the false negatives, the recommendation rate for Outpatient is **96.4%** for October 2017.

Action	Owner	Deadline
Continue to identify and update false negatives to ensure meridian dashboard reflects real-time data	Kim Kirk	Ongoing
Further work with Optimum Meridian to develop mechanism to reduce false negatives	Kim Kirk	1 Dec 2017

Improvement trajectory
Monitoring to continue via Divisional Performance meetings and identifying false negatives to ensure system is updated to reflect accurate real-time data.

Risk	Mitigation
Providing inaccurate data at different periods in the month will provide conflicting information	Agree cut-off date with divisions for false negative amendments to ensure one version of monthly data provided to all relevant areas.

Lead: Kim Kirk – Head of Patient Experience

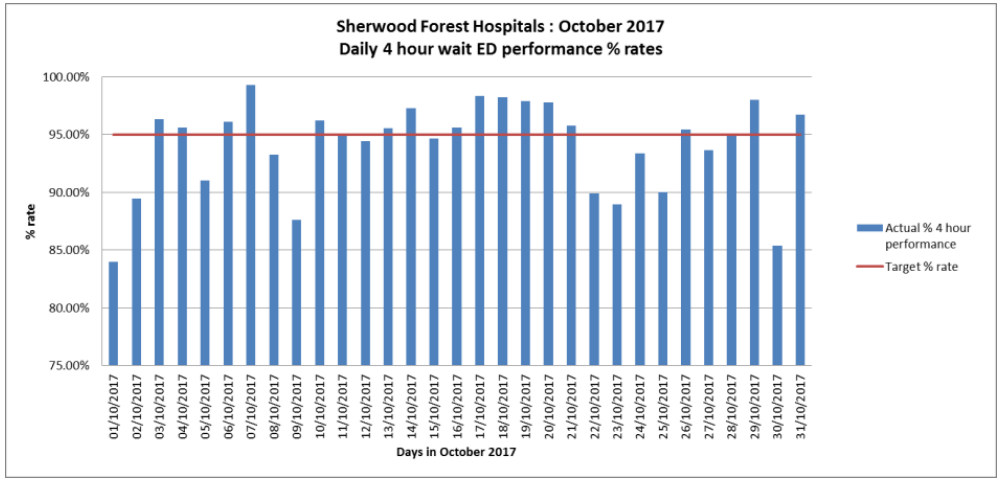
Executive Lead: Paul Moore – Director of Quality Governance

Exception Report

Indicator: Emergency access within 4 hours
Month: Month 7 October 2017
Standard: A&E maximum waiting time of four hours from arrival to admission / transfer / discharge (95%)

Current position

94% of patients had a maximum waiting time of four hours from arrival to admission / transfer / discharge in October 2017.



2017/18

Sherwood Forest Hospitals Trust	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17
Total Attendances	12475	13252	12513	13200	12225	12147	12539
Over 4 hours	509	590	415	590	655	938	759
% within 4 hours	95.92%	95.55%	96.68%	95.53%	94.64%	92.28%	93.95%

2016/17

Sherwood Forest Hospitals Trust	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16
Total Attendances	11892	13206	12389	13375	12176	12314	12616
Over 4 hours	953	639	753	697	506	628	504
% within 4 hours	91.99%	95.16%	93.92%	94.79%	95.84%	94.90%	96.01%

Causes of underperformance

The breaches by patient category were as follows:

Major	600
Resus	102
Minor	20
Primary Care	17
AECU	11
Children	6
Minor Injury	3
Total	**759**

The primary breach reasons were as follows:

Waiting for Bed - ED Referral waiting for bed	236
Waiting for Assessment - Waiting to be examined by an ED Doctor	153
Awaiting clinical decision making	136
Exception - True Clinical Exception	71
Waiting for Transport - Waiting for Ambulance Transport	62
Waiting for Diagnostic - Pathology	28
Waiting for Treatment - Waiting for ED Treatment	17
Delay in referral from PC24	10
Waiting for Diagnostic - X-ray	10
Waiting for Specialist - Orthopaedic	9
Waiting for Specialist - Surgical	8
Waiting for Specialist - Psychiatric	6
Multiple clinical handovers	5
Waiting for internal transfer	5
Waiting for Bed - Direct Surgical Referral	1

Waiting for Specialist - Gynae	1
Waiting for Specialist - Paediatrics	1
Total	**759**

The key factors impacting on performance are:
1. Emergency Medicine medical staffing
2. Medical bed pressures

Emergency Medicine medical staffing
There are currently 4.00 wte Consultant vacancies, 8.00 wte specialty doctor vacancies, this leads to a reliance on locum doctors and reduced skill mix as specialty doctor gaps may be need to be filled with junior doctors.
Overnight, medical leadership is provided by middle grade doctors, whereas during the daytime this is provided by Consultant staff.

Medical bed pressures
There has been an increase in the number of patients with a length of stay of 7 days or longer and less than a third of discharges by noon each day, leading to reduced patient flow through medical beds.

Actions to address		
Action	**Owner**	**Deadline**
2.00 wte Locum Consultants appointed, one due to start in December 2017, the other start date is to be confirmed. This will reduce the Consultant vacancies to 2.00 wte.	Richard Clarkson	Ongoing recruitment continues until all posts are filled
1.00 wte specialty doctor commenced in post November 2017, 5.00 wte specialty doctors appointed. This will reduce the specialty doctor vacancies to 2.00 wte	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	6 December 2017
Revised ANP bank rates and weekly pay	Richard Clarkson	November 2017

Weekly review of stranded patients	Division of Medicine	Weekly – ongoing
Continued focus on achieved a third of daily discharges by noon	Division of Medicine	Daily – ongoing

Improvement trajectory
The standard is expected to be achieved by March 2018.

Risks	
Risk	**Mitigation**
Non appointment of roles	Long term locums requested
Delays to start date	Weekly monitoring meetings
Retraction of appointment	Weekly monitoring meetings
Inability to attract consultants	Currently using agency locums

Divisional Lead: Divisional General Manager, Urgent and Emergency Care
Executive Lead: Denise Smith, Acting Chief Operating Officer

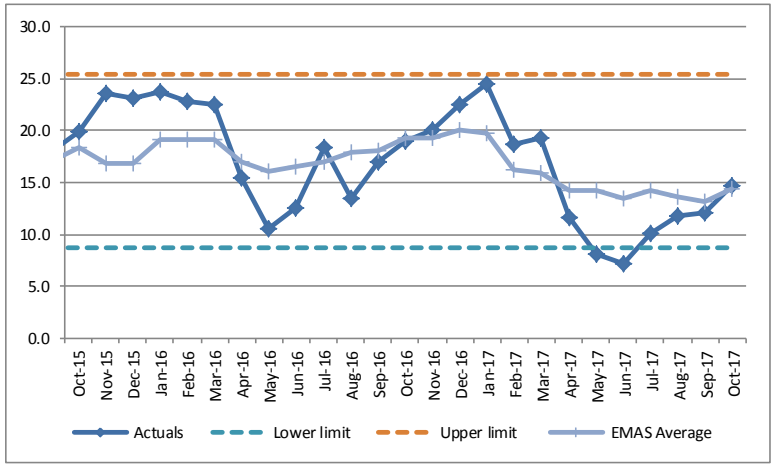
Exception Report

Indicator: % of Ambulance handover >30 minutes and >60 minutes
Month: Month 7 October 2017
Standard: 0 patients delayed more than 30 mins from arrival to handover
0 patients delayed more than 60 mins from arrival to handover

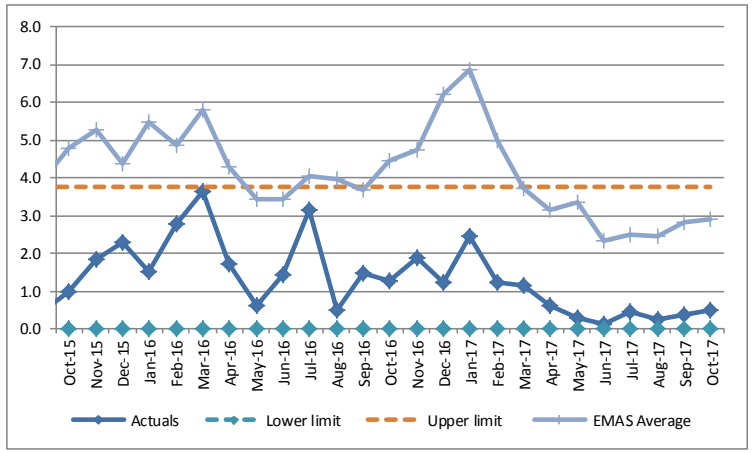
Current position

In October, 14.8% of ambulance handovers took longer than 30 minutes. In October, 0.5% of ambulance handovers took 60 minutes or longer

Ambulance handover > 30 minutes



Ambulance handover > 60 minutes



Causes of underperformance

At times, the Trust is experiencing a higher number of ambulance arrivals than predicted per day. This increase, together with potential batching of ambulance arrivals, can lead to delay in taking handovers due to space constraints within the Emergency Department. In addition, there has been a shortage of trolleys to transfer patients on to.

Actions to address		
Action	**Owner**	**Deadline**
Develop case of need for investment in additional trolleys	Richard Clarkson	December 2017
Agree operational handover policy and escalation process with EMAS	Richard Clarkson	December 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

Improvement trajectory
To be agreed

Risks	
Risk	**Mitigation**
Case of need not supported	Review existing trolley capacity across the Trust

Lead: Divisional General Manager, Urgent and Emergency Care

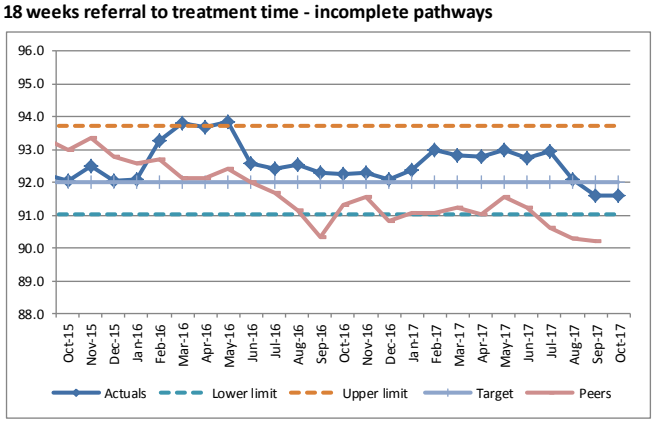
Executive Lead: Denise Smith, Acting Chief Operating Officer

Exception Report

Indicator: 18 weeks referral to treatment time – incomplete pathways

Month: Month 6 October 2017

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

Current position
In October, 8 specialties failed to achieve the standard and overall the Trust failed the standard, achieving 91.6%    The specialties failing the standard were:

	With in 18 Wks	Total	% < 18
General Surgery (grouped)	1,494	1,625	91.94%
Urology	1,856	2,042	90.89%
Oral Surgery	491	557	88.15%
Plastic Surgery	72	81	88.89%
Cardiology	1,321	1,656	79.77%
Dermatology	924	1,014	91.12%
Respiratory	787	858	91.72%
Neurology	1,033	1,192	86.66%

Causes of underperformance

General Surgery
Loss of theatre lists due to anaesthetic staffing gaps, shortage of specialty doctors has reduced activity,

Urology
Lack of capacity, compounded by short notice reduction in capacity from tertiary provider.

Oral Surgery
Additional capacity identified has been utilised for patients on a cancer pathway.

Plastic Surgery
To be confirmed

Cardiology
See separate exception report

Dermatology
The service has been closed to new referrals in recent months, this opened again in October 2017. There are 1.86 wte Consultant vacancies and this gap was not filled with locum cover during August and September.

Respiratory
Delays associated with patients on a sleep studies pathway

Neurology
The service has no substantive workforce and the long term locum has recently left the Trust.

Actions to address		
Action	**Owner**	**Deadline**
General Surgery – additional capacity to be sourced to clear the admitted backlog	Steve Jenkins	In progress – ongoing
Urology – medical staff recruitment, joint arrangements in place with NUH, maximising Newark Hospital capacity, additional capacity to be sourced	Steve Jenkins	In progress – ongoing
Oral Surgery – further additional capacity to be sourced to address the backlog and Consultant from NUH will resolve capacity pressures longer term	Steve Jenkins	In progress – ongoing
Plastic Surgery	Dale Travis	
Cardiology – see separate exception report	Dale Travis	
Dermatology – create additional capacity at Newark Hospital, undertake additional minor ops lists to clear backlog and secure additional locum support.	Dale Travis	In progress - ongoing
Respiratory – additional sleep study clinics being sourced	Dale Travis	In progress – ongoing
Neurology – joint working with NUH on future service provision and proposal to close to new referrals in the interim	Dale Travis	In progress - ongoing

Improvement trajectory	
General Surgery	To be confirmed
Urology	To be confirmed
Oral Surgery	January 2018
Plastic Surgery	To be confirmed

Cardiology	To be confirmed
Dermatology	To be confirmed
Respiratory	November 2017
Neurology	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: Denise Smith, Acting Chief Operating Officer

Exception Report

Indicator: Referral to Treatment: Cardiology

Month: Month 7 October 2017

Standard: Referral to Treatment incomplete pathways >92%

Current position

Performance in October 2017 was 77.35% against the standard of 92%.

18 Week National Specialty	30th October 2017 (Backlog)			
	Actual @ 29/10/2017 (including ASI's)			
	<18 wks	>18 wks	Total	% <18
Cardiology	1253	367	1620	77.35%

Causes of underperformance

The root cause of the underperformance relates predominantly to outpatient delays, with a number of breached pathways as a result of overdue review appointments.

There is a shortfall in capacity required to deliver the activity plan, an increase in Consultant and Specialist Nurse workforce was agreed for 2017/18, until recently only 1 Locum Consultant had been secured with the remainder of the shortfall being covered on an ad hoc basis through waiting list initiatives.

A further two Locum Consultants are now in place and nurse clinics are being established to manage post-procedure follow up activity as well as some of the chest pain and arrhythmia referrals.

Actions to address		
Action	**Owner**	**Deadline**
Recruit locums to consultant vacancies	M Bulgin	Complete
Recruit to Specialist Nurse vacancies	M Bulgin	Complete
Set up Specialist Nurse clinics	J Davies	November 17
Explore options to backfill medical staff vacancy	S Doughty	Weekly
Creation of outpatient capacity (WLI and locum clinics)	S Doughty	December 2017
Explore weekend lab working	M Bulgin, S Doughty	December 2017

Improvement trajectory
To be confirmed

Risks	
Risk	**Mitigation**
Consultant availability	Locums approached to undertake additional evening sessions at standard agency rates

Named consultant backlogs	Cross cover to be arranged between Consultants
Radiographer availability for weekend working in the lab	Explore bank and locum rates
Medical staff vacancy (Dr Jan)	Exploring options for backfill
Inability to contact long wait patients	Issue appointments with sufficient notice. Subsequent notes review with consultant if DNA.
Chronological appointment booking particularly for short notice clinics	Divisional team to proactively manage with the clinic admin staff

Lead: Dale Travis, Divisional General Manager Medicine

Executive Lead: Denise Smith, Acting Chief Operating Officer

Exception Report

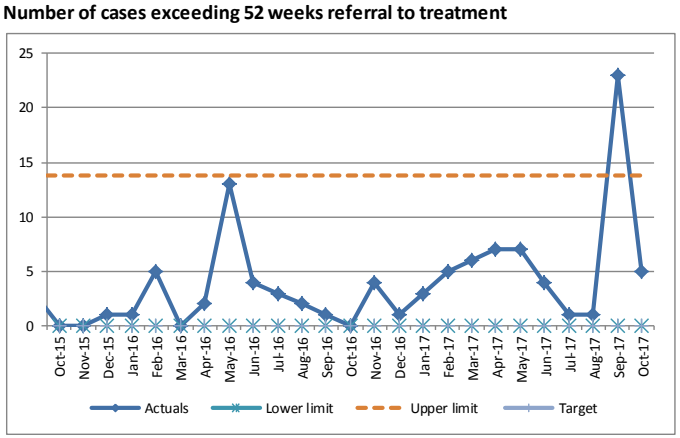
Indicator: Number of cases exceeding 52 weeks referral to treatment

Month: Month 7 October 2017

Standard: 0%

Current position

In October 2017 5 patients waited longer than 52 weeks from referral to treatment.



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. Ear, Nose & Throat 85 weeks – Found through validation. Patient has now been treated and removed from the PTL.

2. Ear, Nose & Throat 87 weeks – Found through validation. Patient has an appointment 30 November 2017.
3. General Surgery 66 weeks – Found through validation, incorrect stop. Seen in clinic 20 November, listed for Hernia repair, pre-operative assessment 28 November 2017, looking to bring forward and treat 28 November 2017, theatre slot reserved.
4. Trauma and Orthopaedic Patient at 107 weeks – Found through validation of overdue reviews. Patient has appointment 30 November 2017.
5. General Surgery 102 weeks – Found through validation, incorrect stop. Patient has now been treated and removed from PTL.

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.

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

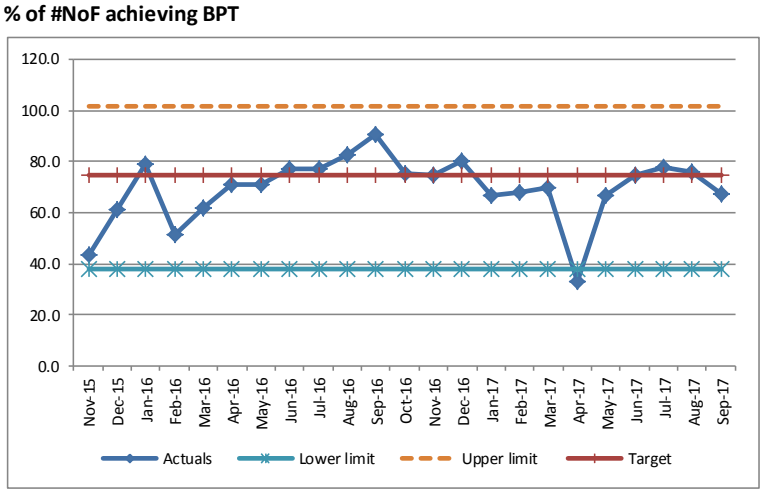
Lead: Divisional General Managers

Executive Lead: Denise Smith, Acting Chief Operating Officer

Exception Report

Indicator: Fractured neck of femur achieving best practice tariff
Month: Month 6 September 2017
Standard: 75%

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



Causes of underperformance
Best practice tariff as not achieved for 14 patients, the main causes are that the patients did not have surgery within 36 hours and patients being unfit for surgery within this timescale.

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

Trial staggered start of trauma list from 9.30am to ensure sufficient time to complete post take ward round and theatre to commence on time.	Steve Jenkins	December 2017
Anaesthetist for trauma list to join the trauma meeting at 8.50am after reviewing patients and confirms golden patient fit for surgery.	Steve Jenkins	December 2017
#NOF patient to be reviewed on the day of admission by ortho-geriatrician and anaesthetist to assist in ensuring medically optimised for surgery within 36 hours.	Steve Jenkins	December 2017
Escalation process to the Divisional General Manager / Assistant General Manager for any #NOF patient not planned to have surgery within 36 hours of admission.	Steve Jenkins	Immediate

Improvement trajectory
Forecasting improvement in performance in October to achieve the 75% target at 81.8%.

Risks	
Risk	**Mitigation**
Increase in demand	Managed through theatre efficiencies with staggered starts and early appropriate escalation to Divisional Management Team

Lead: Steve Jenkins, Divisional General Manager – Surgery
Executive Lead: Denise Smith, Acting Chief Operating Officer

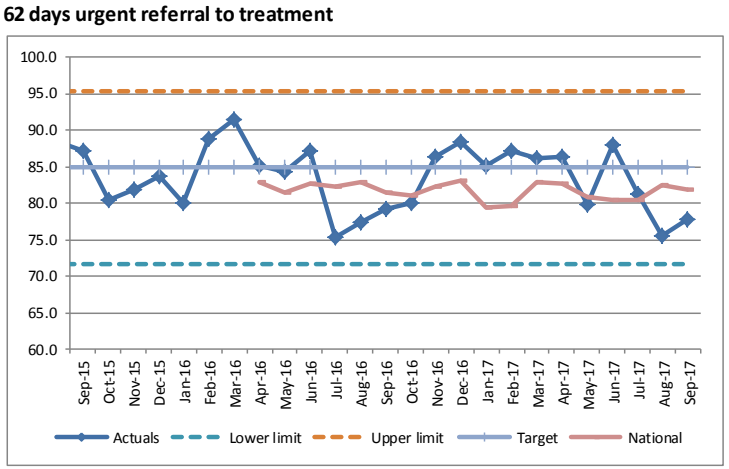
Exception Report

Indicator: 62 days urgent referral to treatment

Month: Month 6 September 2017

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

Current position
Trust performance in September 2017 was 77.8% against the standard of 85%.



Causes of underperformance
There were 17.5 breaches which related to 23 patients, the reasons for the breaches are detailed below:

Tumour Site	Breach reason	Accountable Breach
Gynae	1. Patient choice to delay staging test then delay to oncology clinic appointment due to capacity issues. 2. Patient choice to delay clinic appointment during diagnostic phase. 3. Tertiary referral from SFHFT on day 41 of pathway. Patient required multiple tests prior to treatment planning. Treated within 24 days of receipt.	2.5
Lower GI	1. Delay to diagnostic and staging tests as they were booked at extended protocol. Delay to treatment due to patient requiring assessment of fitness. 2. Patient required multiple diagnostic tests under three clinical teams to confirm diagnosis and staging. 3. Patient required multiple tests to assess fitness prior to treatment commencing. 4. Tertiary referral from ULHT on day 75 of pathway. Unable to treat within target. Treated within 24 days of receipt.	3.5
Lung	1. Tertiary referral from SFHFT on day 96 of pathway. Patient required interval test due to clinical uncertainty. Treated within 24 days of receipt. 2. Tertiary referral from SFHFT on day 90 of pathway. Patient required multiple tests under two clinical teams prior to treatment planning. Treated within 24 days of receipt. 3. Tertiary referral from SFHFT on day 70 of pathway. Patient choice to delay oncology clinic appointment. Treated within 24 days of receipt. 4. Tertiary referral from SFHFT on day 91 of pathway. Patient required multiple diagnostic tests under two clinical teams prior to treatment planning. Treated within 24 days of receipt. 5. Tertiary referral from SFHFT on day 132 of pathway. Delay to transfer of care between tumour sites. Patient choice to delay multiple diagnostic tests. Treated within 24 days of receipt. 6. Tertiary referral from SFHFT on day 58 of pathway. Patient required further histological testing prior to treatment planning. Treated within 24 days of receipt.	3
Head and Neck	1. Tertiary referral from SFHFT on day 47 of pathway. Patient choice to delay clinic appointment and treatment planning. Not treated within 24 days of receipt.	1
Urology	2. Delay to oncology clinic appointment due to capacity issues 3. Delay to oncology clinic appointment due to capacity issues. 4. Patient choice to delay staging test and delay to oncology clinic appointment due to capacity issues. 5. Delay to diagnostic test due to capacity issues 6. Patient choice to delay diagnostic test. Tertiary referral from SFHFT on day 82 of the pathway. Delay to surgical and oncology clinic	6.5

	appointment due to capacity issues. Further delay to treatment due to capacity issues. 7. Tertiary referral from SFHFT on day 126 of pathway. Delay to radiology reporting and surgical clinic appointment due to capacity issues. Patient choice to delay diagnostic test. 8. Tertiary referral from SFHFT on day 49 of pathway. Delay to clinic appointment and staging test at referring trust due to capacity issues then patient choice to delay clinic appointment. Treated within 24 days of receipt.	
Skin	1. Delay to clinic appointment and diagnostic test due to capacity issues then patient chose to delay treatment date.	1
Total		**17.5**

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
The forecast delivery date of December 2017 is currently under review.

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

Lead: Divisional General Managers

Executive Lead: Denise Smith, Acting Chief Operating Officer

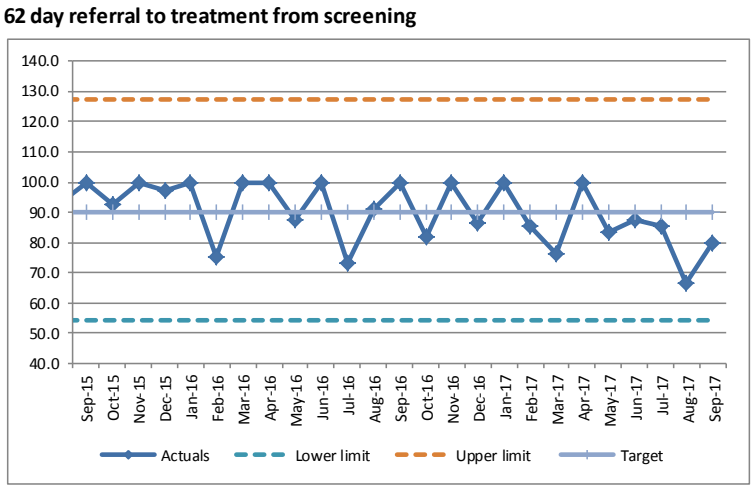
Exception Report

Indicator: 62 day referral to treatment from screening

Month: Month 6 September 2017

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

Current position
Trust performance in September 2017 was 80% against the 90% standard.



Causes of underperformance
The breach related to one patient in Breast. Treatment was delayed for medical reasons, the patient was at risk of DVT and therefore treatment was delayed by 6 weeks.

Actions to address		
Action	**Owner**	**Deadline**
Continued robust management of the PTL through local meetings involving the MDT lead and weekly escalation meetings	Steve Jenkins	In place – ongoing

Improvement trajectory
Due to the low patient numbers this standard is at ongoing risk of non-delivery.

Risks	
Risk	**Mitigation**
Unavoidable delays in patient pathways	Robust management of the PTL to avoid / minimise all delays

Lead: Steve Jenkins, Divisional General Manger Surgery

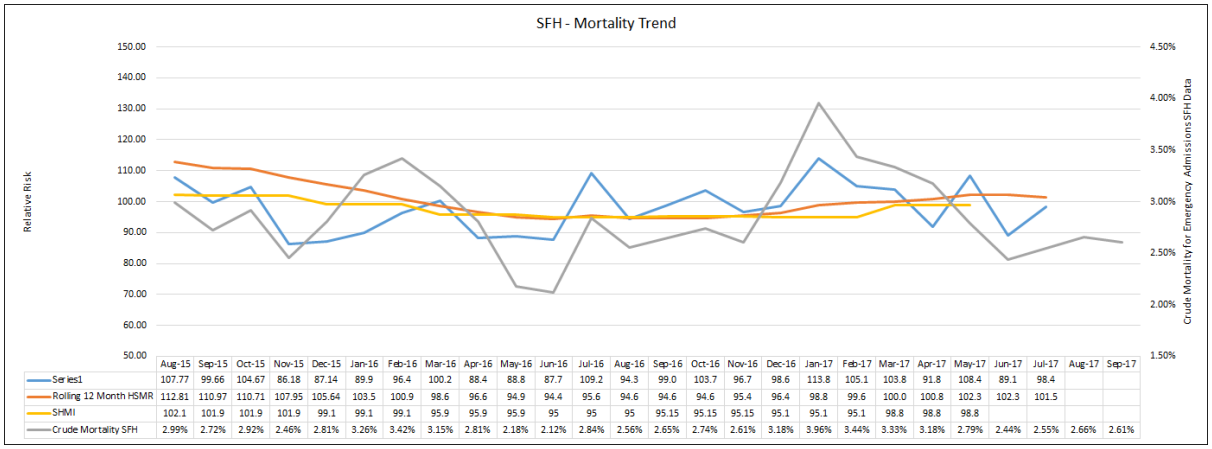
Executive Lead: Denise Smith, Acting Chief Operating Officer

QUALITY, SAFETY AND PATIENT EXPERIENCE

Hospital Standardised Mortality Ratio (HSMR)

HSMR rose slightly through the early part of the year, however the July position continues to show mortality to be as expected. The erratic nature of the mortality rate through this year has been partially created by the changes in rules regarding the coding of sepsis. This has had a lesser impact on the Trust as we had already accounted for these changes within our coding practices.

SHMI remains below the 100 mark indicating a stable position.



	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	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
Series1	107.77	99.66	104.67	86.18	87.14	89.9	96.4	100.2	88.4	88.8	87.7	109.2	94.3	99.0	103.7	96.7	98.6	113.8	105.1	103.8	91.8	108.4	89.1	98.4		
Rolling 12 Month HSMR	112.81	110.97	110.71	107.95	105.64	103.5	100.9	98.6	96.6	94.9	94.4	95.6	94.6	94.6	94.6	95.4	96.4	98.8	99.6	100.0	100.8	102.3	102.3	101.5		
SHMI	102.1	101.9	101.9	101.9	99.1	99.1	99.1	95.9	95.9	95.9	95	95	95	95.15	95.15	95.15	95.1	95.1	95.1	98.8	98.8	98.8				
Crude Mortality SFH	2.99%	2.72%	2.92%	2.46%	2.81%	3.26%	3.42%	3.15%	2.81%	2.18%	2.12%	2.84%	2.56%	2.65%	2.74%	2.61%	3.18%	3.96%	3.44%	3.33%	3.18%	2.79%	2.44%	2.55%	2.66%	2.61%

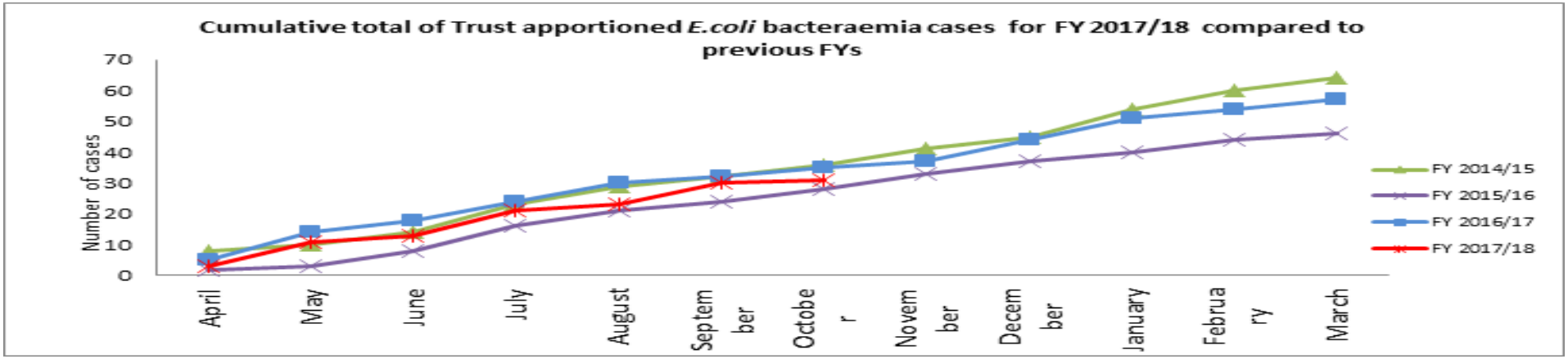
1. **Same sex accommodation**

The Trust remains compliant, reporting no same sex accommodation standards breaches in October 2017.

2. **Infection Prevention and Control**

All healthcare associated infections are carefully monitored and managed in line with national and local guidance. There were four cases of Clostridium Difficile Infection (CDI) in October 2017.

As part of the mandatory surveillance programme the Trust submits data on a number of other organisms against which there are no national targets. However in the past year there has been an increasing acknowledgement internationally that the numbers of Eschericia Coli bacteraemia across the country continue to rise. Therefore, as part of the NHS Quality Premium an overall reduction of 10% across the entire CCG has been requested. Nationally it has been acknowledged that this bacteria is community driven and the resulting infections are often driven by underlying conditions but secondary care does have a part to play in that reduction and work to understand what additional measures are required to reduce this specific infection. Therefore though there is no formal target there is an intention to reduce the numbers identified and in October we identified two cases. The graph below provides a comparison for the present year against the preceding three years.



3. Tissue Viability

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

Graph 1 (below) shows the percentage of pressure ulcers calculated by the occupied bed days (OBD). The grade 2 PUs remain at 0.06% for the second month running. That is one avoidable grade 2 PU developed in October. There are three suspected deep tissue injuries which developed towards the end of October. These will be reported in Novembers report when they can be graded.

Graph 1:

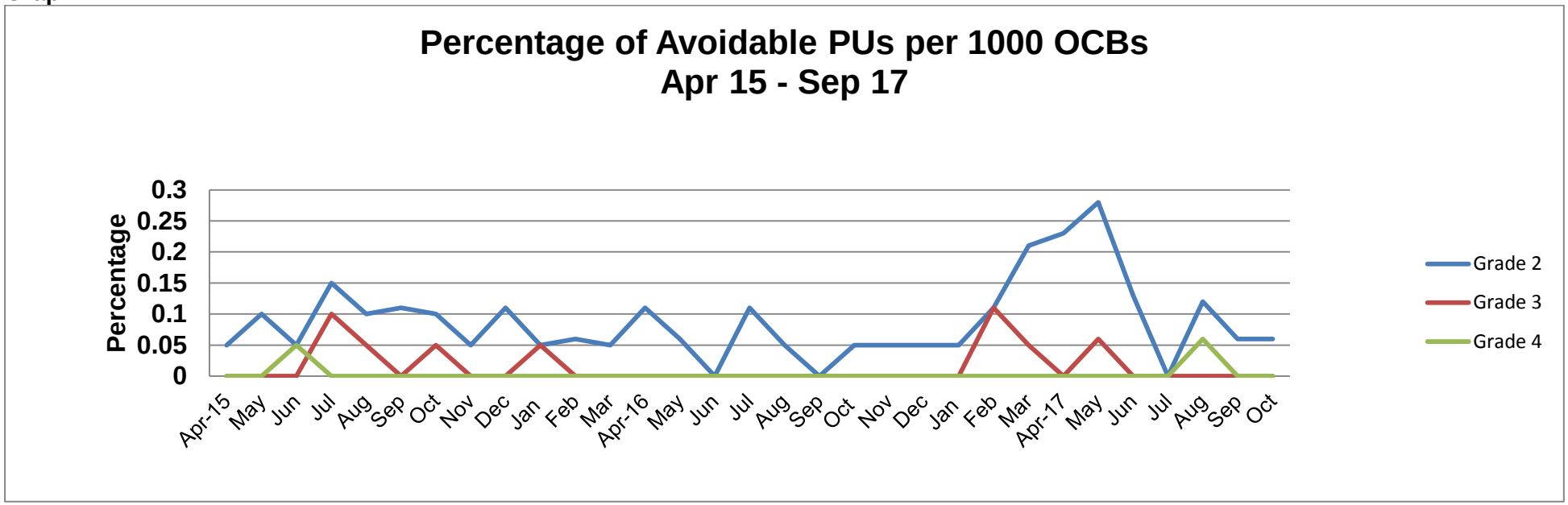


Table 1 - below shows the total number hospital acquired PUs, both avoidable and unavoidable by grade over a 17 month period

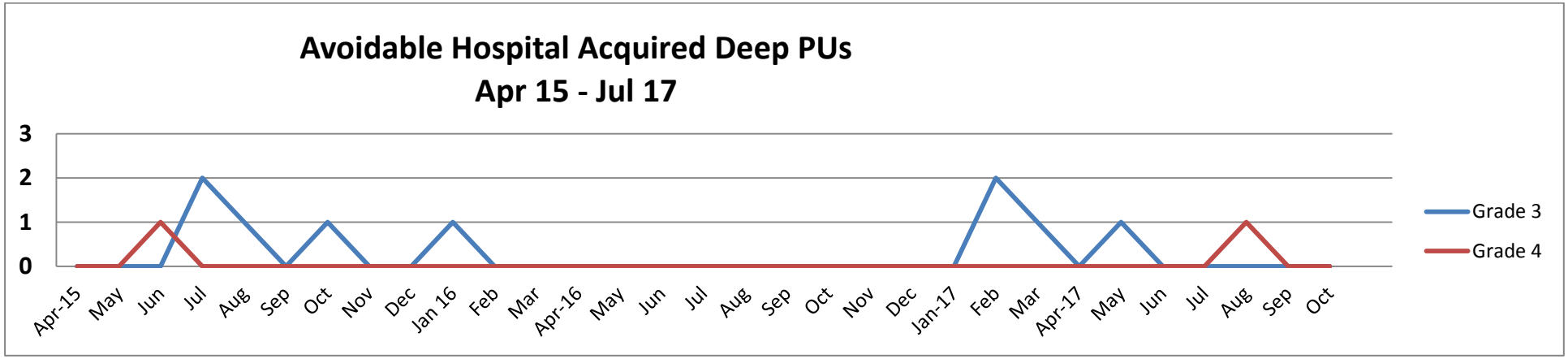
Table 1

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

Graph 2 - shows the number of avoidable hospital acquired grades' 3 and 4 - deep PUs, from April 15 to date.

- In October no definitive deep PUs developed. However there are three suspected deep tissue injuries categorised as low harm which will be reported next month once the grade can be confirmed

Graph 2



Mitigation plans and actions going forward

- The Tissue Viability team are completing monthly ward audits, with support to the staff
- The service providing dynamic mattresses across the Trust will transfer to the Sterile Services Department from 30.10.17 with a formal launch on the 20.11.17. This will improve the provision of the correct dynamic mattress to patients at the right time
- Tissue Viability (TV) Flash Report (includes KPIs and risks) presented to the Nursing and Midwifery Board as part of the Harms free Care Agenda
- TV report presented to the PSQB quarterly – starting in December
- TV Preceptorship study day to run three times a year starting in December
- Poster/display competition to be judged on November 16th – World Stop the Pressure Day by the Chief Nurse
- Fundamentals Study Day for all nurses across the Trust to include, Patient Safety, TV, ICP, deteriorating patients, pain. Accountability of RNs will focus throughout the day
- Consultant Nurse to meet with Heads of Nuring's monthly to agree actions for performance improvement

4. Harm-free Care (Safety Thermometer)

The Trust reported 96.08% harm free care during October against a standard of 95%. The standard includes 'new' harms that are acquired during that admission and 'old' harms which are present on admission, the total of all harms was 3.92% n= 22.

The new harms total is 4 (0.71%) and includes the following:-

- 1 venous thromboembolism (VTE)
- 2 pressure ulcers
- 1 patient sustained a fall with harm.

5. VTE

The Trust met this standard for the month of September (95.3% 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.

This new VTE identified as part of the October Safety Thermometer has been reviewed and is not a hospital acquired thrombus.

6. 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. Patients are screened using the Abbreviated Mental Test Score (AMTS). Currently the Trust is screening 97.2% of eligible patients (September 2017).

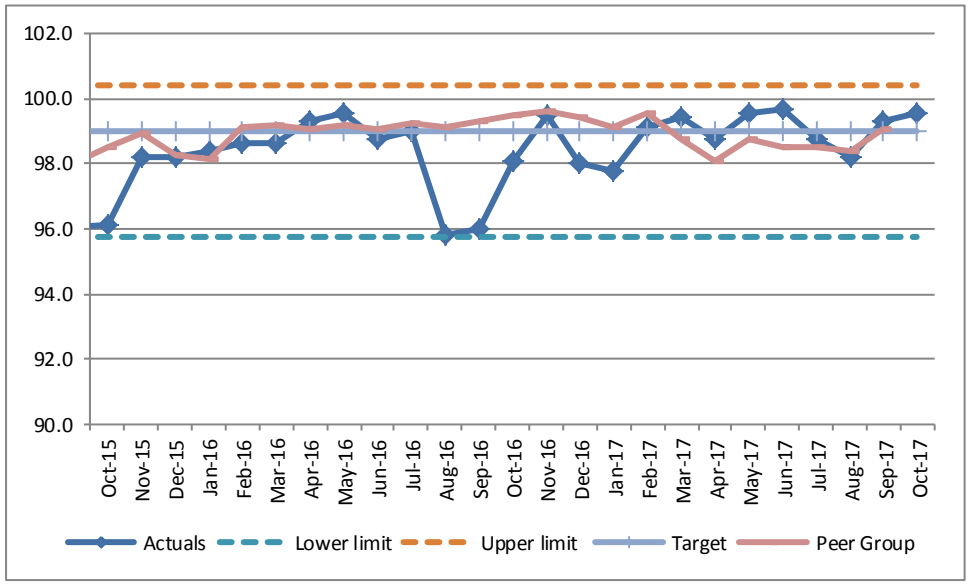
Interviews were held on 14 November for a Band 3 Data Collection Administrator to work with the Specialist Dementia Nurse, and an appointment was made, and the start date will be confirmed once pre-employment checks are complete.

OPERATIONAL STANDARDS

1. Diagnostics

Overall the standard was achieved with Trust performance in October 2017 at 99.5%. However, two specialties failed to achieve the standard

Diagnostic waiters, 6 weeks and over-DM01



Graph 7

	Oct-17			
	Under 6 wks	6 weeks and over	Grand Total	%
Magnetic Resonance Imaging	1123	1	1124	99.91%
Computed Tomography	681	2	683	99.71%
Non-obstetric ultrasound	1455	0	1455	100.00%
Barium Enema	0	0	0	
DEXA Scan	192	0	192	100.00%
Audiology - Audiology Assessments	467	0	467	100.00%
Cardiology - echocardiography	683	0	683	100.00%
Cardiology - electrophysiology	0	0	0	
Neurophysiology - peripheral neurophysiology	0	0	0	
Respiratory physiology - sleep studies	165	4	169	97.63%
Urodynamics - pressures & flows	58	15	73	79.45%
Colonoscopy	200	2	202	99.01%
Flexi sigmoidoscopy	46	0	46	100.00%
Cystoscopy	106	0	106	100.00%
Gastroscopy	165	1	166	99.40%
Total	**5341**	**25**	**5366**	99.53%

ORGANISATIONAL HEALTH

Sickness Absence

Sickness absence figures increased in October 2017 by 0.43% to 3.58% (September 2017, 3.15%), which is still only just above target.

Short term sickness increased to 2.16%, an increase of 0.46% (September 2017, 1.70%) however, long term sickness reduced by 0.03% to 1.42% (September 2017, 1.45%)

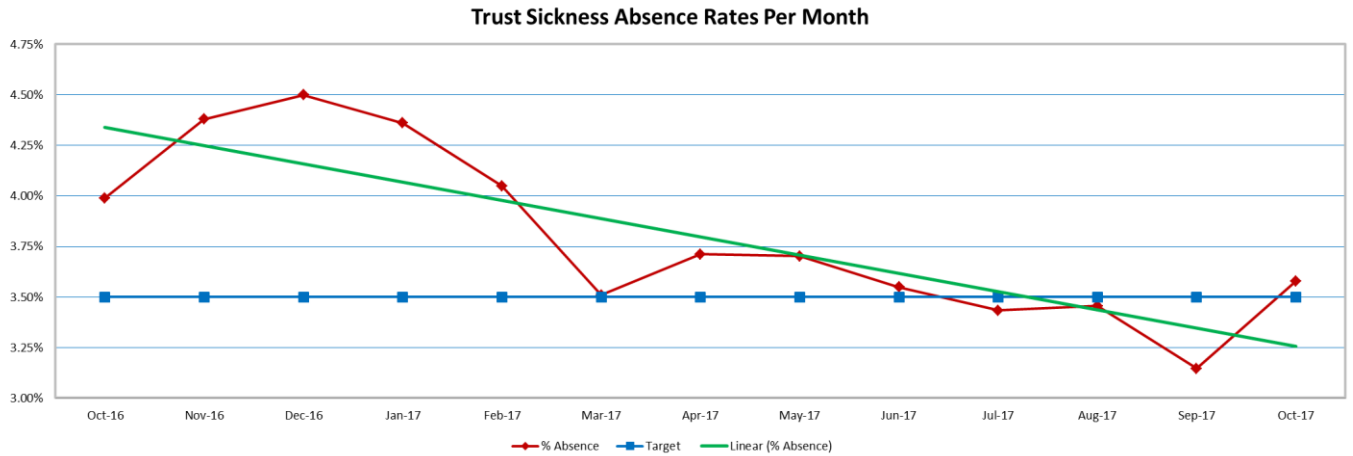
Two out of six Divisions achieved or exceeded the 3.5% target:

- Corporate – 2.23% (September, 3.15%) which was a reduction of 0.92%
- Surgery – 3.15% (September, 2.31%)

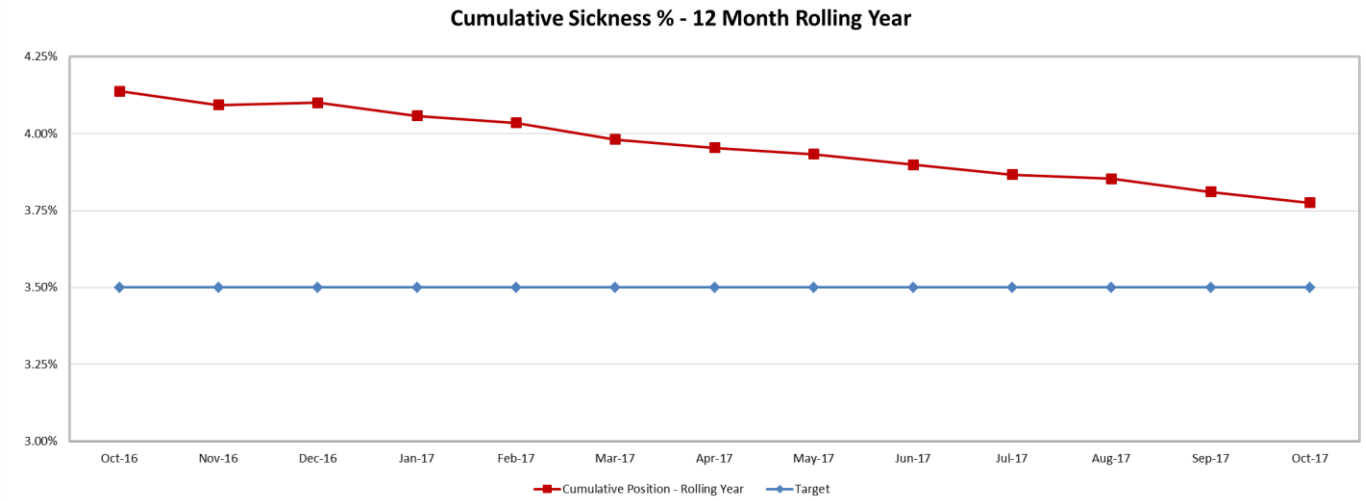
The four divisions above target in October 2017 were:

- Diagnostics & Outpatients – 3.63% (September, 3.50%) an increase of 0.13%. Short term sickness by 0.33% to 2.30%, however long term sickness decreased by 0.20% to 1.33%.
- Urgent & Emergency Care - 4.10% (September 3.04%), an increase of 1.06%. Short term sickness for this Division increased by 0.78% in month to 2.59% and long term increase by 0.27% to 1.50%.
- Medicine – 4.12% (September, 3.51%) an increase of 0.61%. Short term sickness increased by 0.82% to 2.53% however long term sickness decreased by 0.21% to 1.59%.
- Women & Childrens' – 4.21% (September, 3.39%), an increase of 0.82%. Short term sickness increased by 0.59 % to 2.46% and long term sickness increased by 0.22% to 1.75%.

As can be seen from the chart below, although October 2017 has increased, the sickness absence is significantly lower than the same period in October 2016, a reduction of 0.41%.



In order to clearly depict the sickness absence trend an additional chart is used. Below is a chart showing a 12 month rolling year (sickness averaged for the previous 12 month period for each month). This indicates a significant sustained improvement.



The three sickness absence reasons which have had the highest increase in month are: S26 Genitourinary & gynaecological disorders, increasing by 168.45 FTE days lost to 428.57 FTE days lost (September, 260.12); S13 Cold, Cough, Flu – Influenza increasing by 125.87 FTE days lost to 253.51 FTE days lost (September, 127.63) and S10 Anxiety/stress/depression/other psychiatric illnesses increasing by 113.56 FTE Days lost to 1155.14 FTE days lost (September, 1041.58 FTE days lost)

S10 Anxiety/stress/depression/other psychiatric illnesses is the absence reason with the highest FTE Days lost in month, 0.94% of all sickness absence in October 2017 (September, 0.88%). This is split by Division as follows:

	FTE Days Lost		
Division	**Short Term Sickness**	**Long Term Sickness**	**Grand Total**
Corporate	40.00	104.99	144.99
Diagnostics & Outpatients Division	153.49	122.76	276.25
Medicine Division	128.25	156.08	284.33
Surgery Division	29.59	81.40	110.99
Urgent & Emergency Care Division	63.56	31.00	94.56
Women & Childrens Division	78.33	165.71	244.03
Grand Total	**493.21**	**661.93**	**1155.14**

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 October 2017 across the Trust:

Across the Trust, there were 11.92 FTE more starters than leavers in October 2017. (49.37 FTE starters v 37.45 FTE leavers) the turnover rate slightly increased to 0.94% in October (September, 0.80%). However, this is still below the threshold of 1%. All Registered Nurse vacancies have increased In October 2017 to 11.12%, 148.59 FTE (September, 10.69%, 142.52 FTE). Band 5 Registered Nurse vacancies have decreased by 1.36% to 15.68%, 118.2 FTE (September, 17.04%, 129.07 FTE).

Although the Trust had more registered nurse starters than leavers in October, increases in establishment, nurses reducing their hours or changing from a substantive post to a bank post tends to increasing vacancy rates. (the latter does not show up as a leaver but impact the staff in post figure as these only reflect substantive employees.

	Oct-17								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Total Trust									
Admin & Clerical	1148.61	1065.04	1305	83.57	7.28%	13.52	10.98	1.03%	36
Allied Health Professionals	226.51	213.00	266	13.51	5.96%	2.00	1.27	0.60%	9
Ancillary	40.27	37.50	44	2.77	6.89%	0.00	0.00	0.00%	1
Medical & Dental	496.97	436.60	459	60.37	12.15%	5.20	3.00	0.69%	22
Registered Nurse Operating Line * - ALL Bands	1336.54	1187.95	1399	148.59	11.12%	19.31	11.40	0.96%	21
Scientific & Professional	215.70	189.85	206	25.85	11.98%	4.49	1.00	0.53%	0
Technical & Other	270.38	258.24	323	12.14	4.49%	3.43	3.60	1.39%	4
Unregistered Nurse	595.58	576.95	672	18.63	3.13%	1.43	6.20	1.07%	6
Total - Trust	**4370.23**	**3965.13**	**4674**	405.10	9.27%	**49.37**	**37.45**	0.94%	**99**
Band 5 Registered Nurse Only operating line *	753.68	635.49	758	118.20	15.68%	15.94	6.00	0.94%	-

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.*

Medical Staff vacancy levels

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
May 17	494.09	428.44	65.65	13.29	-1.24
June 17	494.09	427.84	66.25	13.41	-1.12
July 17	493.77	444.54	49.23	9.97	-4.56

Aug 17	493.74	430.79	62.95	12.75	-1.78
Sept 17	496.07	435.27	60.80	12.26	-2.27
Oct 17	496.07	436.60	60.37	12.15	-2.38

Nursing

Reasons for leaving across all registered nurse leavers, (11.40 FTE), were: Flexi Retirement, 3.80 FTE, Voluntary – Work Life Balance, 1.60 FTE; Voluntary – Other/Not Known,1.00 FTE; Dismissal – Conduct, 1.00 FTE; Retirement Age, 1.00 FTE; Voluntary – Promotion, 1.00 FTE; Voluntary – Relocation, 2.00 FTE. Below are Registered Nurse vacancy levels tracked against an August 2016 baseline.

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
May 17	1326.90	1167.43	159.46	12.02	-5.37
June 17	1325.60	1166.15	159.46	12.03	-5.36
July 17	1327.51	1162.07	165.44	12.46	-4.93
Aug 17	1332.86	1165.50	167.36	12.56	-4.83
Sept 17	1333.25	1190.73	142.52	10.60	-6.70
Oct 17	1336.54	1187.95	148.59	11.12	-6.27

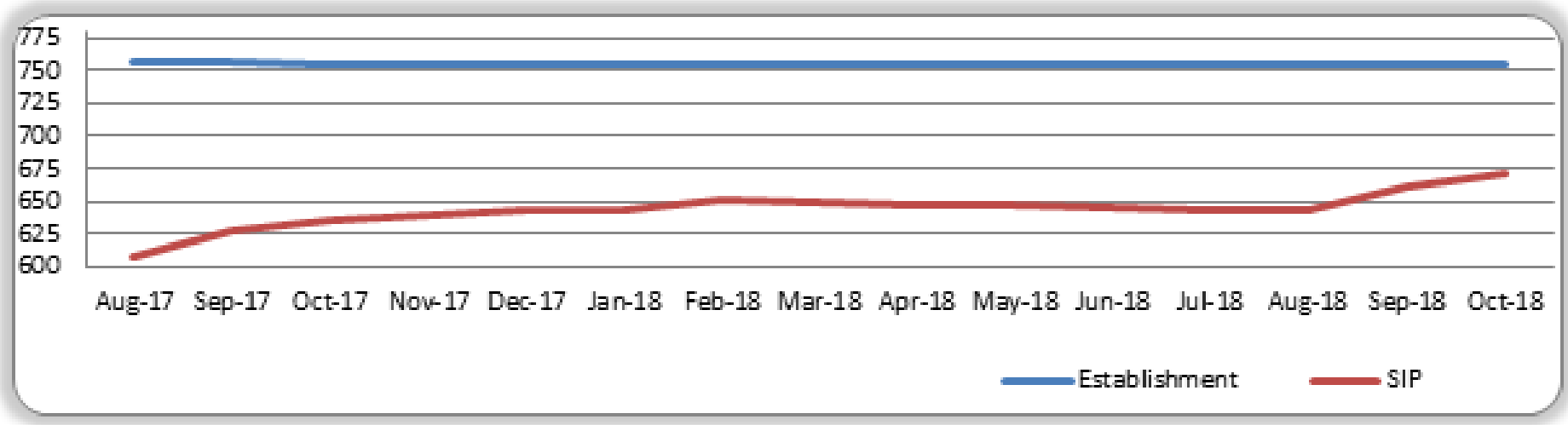
Registered Nurses – Band 5

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
May 17	748.05	629.85	118.20	15.80	-4.85
June 17	751.01	624.67	126.34	16.82	-3.83
July 17	751.77	615.46	136.32	18.13	-2.52
Aug 17	756.87	607.22	149.65	19.77	-0.88

Sept 17	757.24	628.17	129.07	17.04	-3.60
Oct 17	753.68	635.49	118.20	15.68	-4.97

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. This is also complemented by low sickness absence rates.

Band 5 registered nurses (RN) trajectory:



The Trust had 6 FTE Registered Nurses leave in October, one retired but will return on reduced hours, one was dismissed, two have relocated, one has move to Derby Hospitals with the another leaving voluntarily but the reason was unknown.

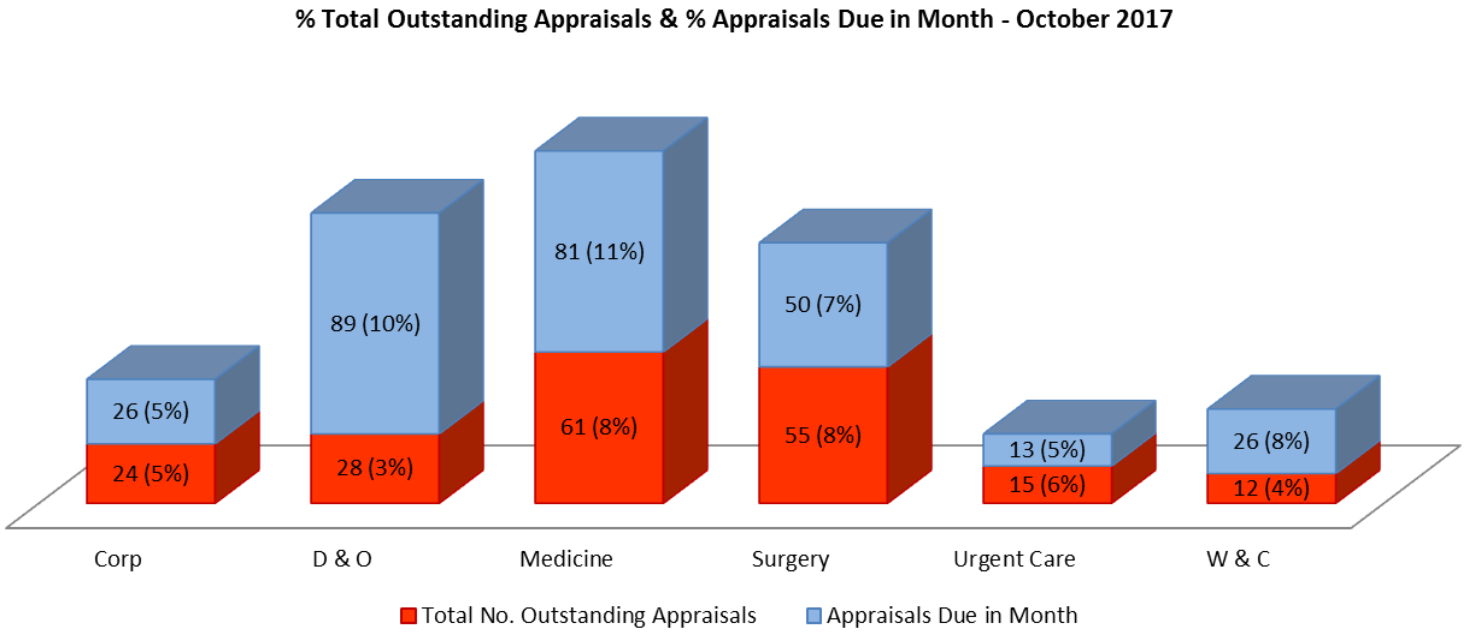
The Trajectory shows a further 10.88 FTE decrease in vacancies at Band 5 RNs bringing the vacancy factor to a new lowest figure at 15.7%.

The success of the assessment centre approach was recognised at the recent Staff Excellence Awards and Assessment Centres are now booked in every month for the coming year. The next one is on the 23rd November with 27 nurses invited so far. There is also an Assessment Day happening for Health Care Support Workers in the 17th November to support backfilling the Virtual Ward over winter.

Appraisal

Trust wide appraisal compliance was 94% for October 2017 an increase of 1% from September 2017. This is against a target of 95%. For many months compliance has been solidly in the 90's and now it is only 1% short of target. It is expected that with the concentrated effort continuing on appraisals that the target of 95% will be achieved early in 2018.

There were 197* (6%) appraisals required in October to reach 100%. However there were also an additional 285 (8%) appraisals due to be completed which expired in month, a total of 480. Therefore 14% of appraisals were required to be completed in October.
These were spread 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

All Divisions either remained static or increased the % compliance in October 2017. However, there were three Divisions which achieved or exceeded the 95% target, these are:

- Diagnostics and Outpatients – 97% (September, 96%)
- Women and Children's – 96% (September, 95%)
- Corporate – 95% (September, 94%)

The three divisions below target are:

- Urgent & Emergency Care – 94% (September, 93%)
- Surgery – 92% (September, 92%)
- Medicine – 92% (September, 90%). This Division had the highest increase in month, 2%.

Training and Education

Mandatory training has increased to 93% for October 2017 (September, 92%), this remains above the 90% target* and has done so continuously for over a year.

The Divisional compliance ranking information below shows only one Division below target which is Urgent and Emergency Care, this is 4% below target although it has increased in month by 1%:

- Corporate – 97% (September, 97%)
- Diagnostics & Outpatients – 95% (September, 95%)
- Women & Children's – 93% (September, 92%)
- Surgery – 93% (September, 92%)
- Medicine – 92% (September, 90%)
- Urgent & Emergency Care – 86% (September, 85%)

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

FINANCE REPORT

The Trust is reporting a position at month 7 that is £0.3m worse than control total before Sustainability and Transformation Funding (STF). This is the first month this year that a deficit to plan has been reported. The Trust did not deliver the 4 hour emergency access target in quarter 2 and is not anticipating to do so in quarter 3, as such a loss of £0.8m of STF has also been reflected year to date (YTD). Overall the position is therefore £1.1m worse than control total post STF. 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. In 2016/17 allocations of bonus and incentive STF were made based on the pre STF control total.

Overall the position in month is worse than plan due to Divisions, primarily Surgery, not delivering improvements as forecast in their recovery plans. Actions are in place to identify mitigations and to 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 income was in line with plan in month, before STF and remains in line with plan YTD. Clinical income net of pass through payments is higher than plan in month and YTD. The level of day case activity delivered has continued to grow from 2016-17 and is over plan. The main areas of activity under-performance fall within the urgent care pathway where ED attendances and the number of subsequent admissions is below plan. Outpatient activity is under planned levels most notably within first attendances but offset with an increased number of procedures undertaken during an outpatient attendance.

Expenditure in month was £0.4m worse than plan and £0.3m worse than plan YTD. Overall Cost Improvement Plan (CIP) delivery is £0.1m better than plan YTD. The Sustainability and Transformation Partnership (STP) element of the CIP target YTD is £3.1m has been offset on a non recurrent basis by SFH mitigations including the control total adjustment and interest payment benefits.

Pay overspends of £0.3m YTD are as a result of the non delivery of pay CIP although it should be noted that medical and nursing overspends, which are offset by Corporate underspends. Agency spend was £1.2m in month, in line with September and expenditure remains below the YTD NHS Improvement (NHSI) ceiling. Agency spend Is now forecast to be below the ceiling following a review of the costs of winter. Medical agency spend is below the NHSI target by £1.35m YTD.

Non pay (including non-operating expenses) is £0.2m better than plan YTD.

As in previous months the forecast outturn has been reviewed in detail. The Trust is able to report a deficit of £46.4m in line with control total before STF, as at month 6. However, the deterioration in divisional positions represents a likely risk of £0.7m to the year end. NHSI's reporting mechanism requires forecasts to be amended at quarter end only. The risk range before STF has a downside of £8.8m and an upside of £1.7m, compared to £8.8m downside and £3.1m upside last month. The shift towards downside reflects the reduced confidence in delivery of divisional forecasts.

The forecast outturn post STF is a £38.9m deficit which is £1.3m worse than control total. This is due to forecast non achievement of the 4 hour emergency access target in quarter 3. Overall, £7.5m of STF is expected against a plan of £8.8m.

The capital loan has been delayed and was formally submitted by NHSI to DOH for review and approval 18th September 2017. The Trust is currently reviewing all capital schemes to assess the increased level of operational risk of this ongoing delay in funding and the impact on deliverability in year.

Overall, the month 7 position has deteriorated compared to plan by £0.3m in month prior to STF. Non delivery of the 4 hour access target means £0.8m of STF has been lost year to date so the position is £1.1m worse than plan post STF. There is increased risk of delivery of the forecast outturn prior to STF due to Divisional positions not improving as forecast. Mitigations are now being identified and commitments being reviewed.

	October 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	(3.04)	(3.40)	(0.37)	(25.71)	(26.03)	(0.32)	(46.44)	(46.44)	0.00
Surplus/(Deficit) - Control Total Basis Inc STF	(2.16)	(2.79)	(0.63)	(21.75)	(22.86)	(1.11)	(37.62)	(38.94)	(1.32)
Finance and Use of Resources Metric YTD				3	3		3	3	
CIPs	1.55	1.93	0.38	8.02	8.14	0.12	16.26	16.26	0.00
Capex (including donated)	(0.73)	(0.17)	0.56	(6.11)	(2.28)	3.83	(9.67)	(9.67)	0.00
Closing Cash	1.45	1.46	0.01	1.45	1.46	0.01	1.45	1.45	0.00
NHSI Agency Ceiling - Total	(1.56)	(1.21)	0.35	(10.54)	(10.10)	0.44	(17.91)	(17.37)	0.54
NHSI Agency Ceiling - Medical	(1.11)	(0.79)	0.33	(7.80)	(6.45)	1.35	(13.37)	(10.39)	2.98