Public Board Meeting Report

Subject: **Single Oversight Framework Integrated Performance Report**
Date: **25th January 2017**
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Lead Directors: **Andy Haynes – Medical Director, Paul Robinson – Chief Financial Officer, Julie Bacon – Director of HR & OD, Roz Howie – Chief Operating Officer**

QUALITY, SAFETY AND PATIENT EXPERIENCE

Response Rate: Friends and Family Inpatients,
Response Rate: Friends and Family Accident and Emergency

What is driving the underperformance and what actions are being taken to improve performance:
Continue to support teams with increasing the response rates, the weekly reports are now sent to all relevant staff to provide a summary of the FFT data collection. Data continues to be collected via various mechanisms, including text messaging in ED, ipads and paper format

	Target	Nov 16	Forecast
Inpatients	≥24.1%	16.7%	January
A & E	≥12.8%	1.9%	January
	Expected date to achieve standard		May 2017
	Lead Director		Barbara Beal

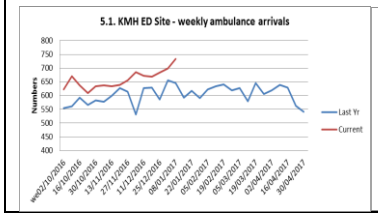
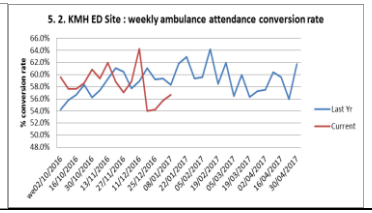
Hospital acquired Clostridium Difficile
During December the Trust identified 3 patients with hospital acquired Clostridium Difficile, learning around the impact of urinary tract infection and antimicrobial therapy increasing the risk of clostridium difficile. In one instance there was a delay in taking the sample though the patient was isolated in accordance with policy this brings the trust total to 20 which remains below the agreed threshold of 48.

Of greater challenge to patient care and safety during December was Norovirus; which despite stringent infection prevention and control precautions is highly communicable. During December, NHS England reported a national increase of 75% in the incidence of Norovirus, this increase was reflected in the local population and admissions to the Trust and resulted in the closure of 2 wards, closure of bays on 3 wards and extreme vigilance of the Kings Mill Hospital Emergency Department due to patients being cared for in ED with Norovirus.

Falls per 1000 bed days
The trust continues to demonstrate a reducing percentage of falls per 1000 bed days compared to the equivalent point 13 months previously. The current Trust figure for December 2016 is 6.00.The National average is currently 6.63.

Whilst the overall numbers of patient falls dropped in December the number of patients who experienced a fall with Harm increased slightly from 16 in November to 20 in December. Of these there were 2 moderate harms. One patient rolled out of bed and sustained a subdural haematoma the second patient was also found at the bed side and sustained a fractured scapula. There has been 1 severe harm reported. A Patient sustained a fractured neck of femur following a fall. All harms are currently being investigation and clarification as to the circumstances

OPERATIONAL STANDARDS

Emergency Access within four hours
Context Patients who attend the ED (Emergency Department) department must be seen, treated and discharged within 4 hours of arrival (regardless of decision to treat). Achieved October and November. Achieved 95.1% for Q3.
What is driving the underperformance and what actions are being taken to improve performance: 1. High overall demand – 4.4% increase in ED attendances in December 16 compared with December 17 with significant increases in attendances on 27th December (550). Higher than expected levels of ambulances. Although ambulance conveyance rates have increased as shown in graph 5.1 ambulance conversion rates have dropped (graph 5.2). **Actions:** Robust XMAS and New Year Plan developed and circulated. Daily calls set up with partners to resolve any key blockages on a daily basis. Attendance avoidance strategies identified at the Better Together Alliance meeting. EMAS conveyance rates discussed with CCG. As part of the winter planning, staffing increased in CDU to reduce admissions into the main organisation.      

2. Slow outflow from ED due to closed beds both within the organisation and Community (11 care homes shut) due to norovirus.
   Action: Swift action by ward teams and infection control team managed this extremely well across the organisation. Extra beds opened for a few days to mitigate reduction in bed capacity.

Risks to achieving in January
91.22% as of 16th January 2017. High levels of demand 5.6% increase for first 10 days of January 17 compared with January 2016, since 9th January attendances have decreased. Up to 59 medically fit patients within the hospital who were delayed waiting for social care packages, healthcare packages, DSTs etc.

Target	December	YTD	Forecast
≥95	94.05%	94.48%	January 
Expected date to achieve standard			Feb 2017
Lead Director			Roz Howie

Ambulance handover delays >30 minutes and >60 minutes

Context: Handing over a patient from an ambulance to an ED is expected to take no more than 15 minutes.

What is driving the underperformance and what actions are being taken to improve performance:

Overall demand on emergency department has been very high (see graphs presented in ED performance slide) particularly over the past 2 weeks.
We have seen challenges with the batching of ambulances and out of hours including weekends.
At times the flow has been restricted from ED into ward beds (compromised by increased levels of norovirus both internally and externally).

Action:

Daily review of all ambulance waits over 30 minutes by Head of Service

Additional staffing resource put into ED to support handovers on an evening
Improved outflow with resilient winter pressures plan in place
Improved enhanced streaming of patients with greater presence of ED consultants
Transfer team has been launched to support outflow and patient moves which have released ED nurses to support ambulance handovers.
New dashboard and screens in place to proactively monitor handover times.
Waits of over 60 minutes (termed 'black breaches) escalated to silver and gold in real time

Specialties Exceeding 18 week referral to treatment time (incomplete pathways)

Context
Since October 2015, the RTT (Referral to Treatment) waiting times are reported solely in terms of the Incompletes Pathways Standard – this measures the proportion of patients waiting under 18 weeks as a snapshot at month end (with a target of 92% under 18 weeks).

What is driving the underperformance and what actions are being taken to improve performance:

RTT achieved in December at 92.07%

The failing specialties for the latest extract are as follows General Surgery, T&O, ENT, Plastic Surgery (Interfaces with NUH), Gastroenterology, Cardiology, Dermatology, Respiratory, Geriatrics (Validation).

Actions:

- Micro-manage Patient Transfer Lists (PTLs) expediting long waiters
- Re-modeling of demand and capacity
- Additional sessions arranged in key specialties
- Additional Divisional Validators recruited
- Evening and weekend clinics
- Utilisation of IS (for ENT) and weekend theatres
- Recruitment of key personnel - respiratory
- Partnership working with NUH in ENT and Plastic Surgery.
- Business case for endoscopy agreed at execs.

Risks to achieving in January
The need to pace elective operating to cope with non-elective demand will impact in January for T&O. Elective orthopedic operating was due to commence on 3rd January however due to increased demand, DTOCs and acuity operating cancelled. Due to start Wednesday 18th

January however this poses risk to achieving in January.

Target	December	YTD	Forecast
0	9	8	January
Expected date to achieve target			June 17
Lead Director			Roz Howie

Number of cases exceeding 52 weeks referral to treatment

Context

Since October 2015, the RTT (Referral to Treatment) waiting times are reported solely in terms of the Incompletes Pathways Standard – this measures the proportion of patients waiting under 18 weeks as a snapshot at month end (with a target of 92% under 18 weeks). Any patients exceeding 52 weeks are reported.

What is driving the underperformance and what actions are being taken to improve performance:

2 patients breached 52 weeks:

General Surgery patient: This patient has been very complex and has breached due to lack of HDU capacity (cancelled twice). We are attempting to bring the patient in for surgery ASAP however currently there is only 1 level 3 bed within the region. The aim will be to operate before the end of January.

Paedeatric patient:

The patient has an appointment for 24th January. The root cause has been identified as “human error”. A number of actions have been taken over the last year to improve booking processes including; additional staff being appointed in the booking and call-centre, changes in booking team structure, training in RTT, training matrix to monitor admin competencies, specialty audits and developing a suite of DQ reports to identify errors. Further recommendations have been suggested to tighten up the validation processes and training of staff. A paper with a full overview of recommendations was presented to Execs on 14th December 2016.

Risks to achieving in January

Validation issues paper presented to execs. DGMs currently looking at high risk specialties to:

1. Identify priorities?

2. Agree month cut off for bulk closure i.e. patients not seen for 6M, 12M,18M
3. Which 'hold reasons' we could potentially bulk close and which will require further validation (i.e. if the hold reason is 'waiting list' do we need to validate that there has been a corresponding waiting list addition that is now actioned and subsequent admission)

Target	December	YTD	Forecast
0	0		January 
Expected date to achieve standard			February 17
Lead Director			Roz Howie

Diagnostic Monitoring (DMO1)

Context
The DMO1 reports on a suite of diagnostic tests grouped into categories of Imaging, Physiological Measurement and Endoscopy. Any patient waiting over 6 weeks for a specific diagnostic test constitutes a breach.

What is driving the underperformance and what actions are being taken to improve performance:
The drop in performance was due to endoscopy diagnostics. Demand is currently being met by running waiting list initiatives (WLIs) as described at the last Board meeting. Staff were reluctant to undertake WLIs over XMAS and New Year leading to a drop in overall achievement.

Action:

- Waiting lists booked for January and on-going.
- Business case for a 4th room and additional staffing approved at Execs – Impact April 17

Risks to achieving in January
Clearing the backlog from December in Endoscopy. Increased NEL demand impacting upon adult sleep studies.

Target	December	YTD	Forecast
99%	98%		January 
Expected date to achieve standard			February 17
Lead Director			Roz Howie

Last minute (on the day) non-clinical cancelled elective operations as a % of elective admissions

Context: This standard applies to all planned or elective admissions where an OPCS-4 operation code procedure was to be carried out. This includes patients admitted for day surgery. Invasive X-ray procedures carried out on inpatients or day cases is counted as an operation for the purpose of monitoring this standard.

What is driving the underperformance and what actions are being taken to improve performance:

17 patients cancelled on the day of surgery for non-clinical reasons in December 2016. 6 patients were cancelled as a result of no HDU available, 4 due to unexpected list over-runs, 4 due to lack of Paedeatric beds and 2 for lack of trauma capacity and 1 administrative error with patient not receiving the TCI letter.

Actions: RCA being completed to understand administrative error.

Risks to achieving in January

An early decision was made to stand down elective Orthopaedic operating until Wednesday 17th January 2017 which would limit the number of on the day cancellations. Surgery has also limited the number of HDU bookings to only urgent, cancer or previous cancelled elective patients through the first two weeks of January 2017.

Target	December	Forecast
0.8%	1.1%	January 
Expected date to achieve standard		February 2017
Lead Director		Roz Howie

Breast symptomatic 2week wait (cancer)

Context

Only about half of diagnosed breast cancers were coming through the urgent 2ww route so in January 2010 the 2ww standard was expanded so that any patient referred with breast symptoms would be seen within 2 weeks, whether cancer was suspected or not. Symptomatic breast 2ww standard **is where the** GP refer**s** a patient for breast symptoms but does not suspect cancer.

What is driving the underperformance and what actions are being taken to improve performance:

3 patients breached this target all were patient choice to delay their first outpatients.

Action: Establish if patients sent 2ww leaflet.

Target	November	YTD	Forecast

93%	91.2%		December
Expected date to achieve standard			December 16
Lead Director			Roz Howie

ORGANISATIONAL HEALTH

WTE lost as a % of contracted WTE due to sickness absence within last 12 months

What is driving the underperformance and what actions are being taken to improve performance:
Winter ailments are driving the underperformance, together with the fact that it is a stretch target; managers are supported by HRBPs to implement the sickness policy

Target	YTD	Forecast
≥3.5%	4.5%	January
Expected date to achieve standard		May 2017
Lead Director		Julie Bacon

STAFFING:

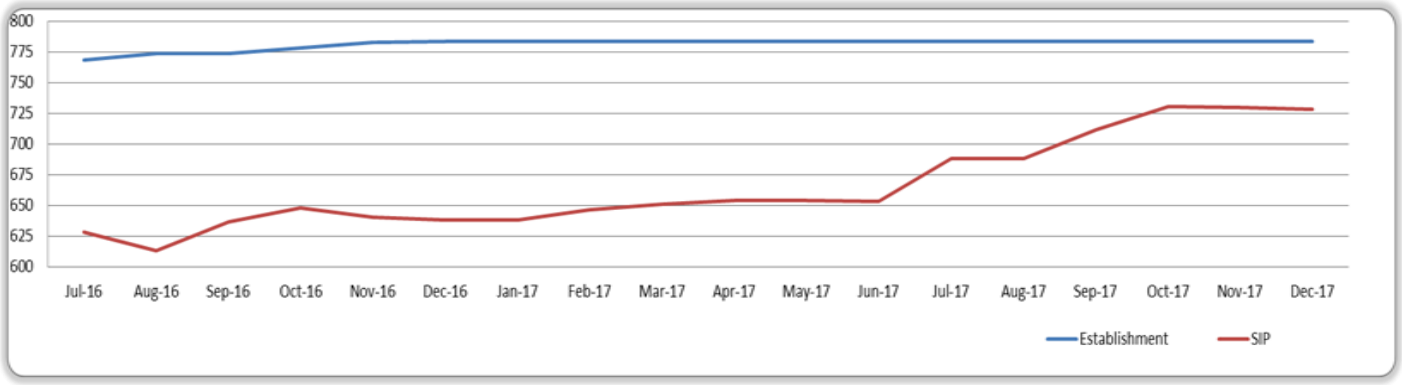
This table shows the net position with staff in post against establishment in December 2016 across the Trust:

	Dec-16								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Total Trust									
Admin & Clerical	1111.10	1025.01	1258	86.09	7.75%	8.74	4.91	0.48%	20
Allied Health Professionals	213.56	207.08	254	6.48	3.03%	2.00	1.00	0.48%	7
Ancillary	38.46	36.47	42	1.99	5.17%	0.00	0.00	0.00%	1
Medical & Dental	484.02	414.14	432	69.88	14.44%	18.10	19.10	4.61%	21
Registered Nurse Operating Line * - ALL Bands	1336.69	1165.48	1361	171.21	12.81%	4.43	10.50	0.90%	28
Scientific & Professional	214.90	185.62	200	29.28	13.63%	1.00	2.75	1.48%	8
Technical & Other	267.72	242.40	299	25.32	9.46%	1.00	0.00	0.00%	2
Unregistered Nurse	556.31	546.44	644	9.87	1.77%	5.43	4.81	0.88%	6
Total - Trust	**4264.00**	**3822.64**	**4490**	**441.36**	**10.35%**	**40.70**	**43.07**	**1.13%**	**93**
Band 5 Registered Nurse Only operating line *	783.63	638.35	755	145.28	18.54%	3.00	5.19	0.81%	22

**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.*

There were 43.07 FTE leavers compared to 40.70 FTE starters, the turnover rate increased to 1.13% in December which is an increase of 0.59% from November (0.54%).

Band 5 Registered Nurses (RN) Trajectory:



6 RNs left in December. One Retirement, one promotion into private sector, two relocations, one for health reasons and one for voluntary resignation – adult dependant.

A Nursing Open Day was held on the 4th January 2017 with 16 offers made, of which 9 are students who will qualify later in the year but encouragingly 7 are qualified nurses looking to join as soon as they can. Unfortunately 2 have since withdrawn due to receiving an alternative offer of employment.

The pooled approach to Healthcare Support Workers is now in place with the next assessment day happening on the 17th January.

The insight work has now been carried out internally and externally to understand why nurses choose to work where they do and what attracts them to roles. The results of this work are being analysed and will form the basis of the new nurses' campaign. The branding will be ready for 1st March 2017.

FINANCE REPORT

Financial performance compared with plan remains good. The Trust is £0.41m ahead of its YTD control total excluding LTP costs. Capital expenditure is £1.71m behind plan but is forecast to deliver to plan at year end. The Trust is forecasting to achieve its control total and as a result is forecasting receipt of an additional £0.56m of SFT incentive funding.

	Dec In-Month			Year to Date			Annual Plan	Forecast	Forecast Variance
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	£m	£m	£m
Surplus/(Deficit) - Control Total Basis	(4.41)	(4.64)	(0.23)	(48.75)	(42.14)	6.61	(57.02)	(50.17)	6.84
Long Term Partnership (LTP)	(0.16)	(0.13)	0.02	(15.41)	(9.21)	6.20	(15.88)	(9.75)	6.13
Surplus/(Deficit) - Excluding LTP - Control Total Basis	(4.25)	(4.50)	(0.25)	(33.33)	(32.93)	0.41	(41.14)	(40.43)	0.71
Use of Resources Metric YTD				3	3		3	3	
CIPs	1.31	1.54	0.23	8.62	9.80	1.18	12.60	12.60	0.00
Capex	0.78	1.29	0.50	8.47	6.75	(1.71)	9.53	9.53	0.00
Closing Cash	1.45	1.45	0.00	1.45	1.45	0.00	1.45	1.45	0.00
Agency Cap - Excluding LTP	(1.35)	(2.19)	(0.83)	(13.77)	(21.28)	(7.50)	(17.91)	(27.74)	(9.83)
Better Payment Practice Code - (Value / Number)		92.1% / 90.8%			93.5% / 89.2%				

- In month, excluding LTP, the Trust is £0.25m behind control total. YTD the control total deficit is £32.93m, £0.41m ahead of plan (on control total basis).
- YTD Long Term Partnership costs are £9.21m, £6.20m better than plan.
- The finance element of the Single Oversight Framework is a score of 3 against a plan of 3.
- CIP YTD delivery of £9.80m against plan of £8.62m.
- Capex expenditure position was ahead of plan in December with an in month spend of £1.29m. Cumulatively capex is now £1.71m behind YTD plan although forecast to deliver to plan at year end.

- Closing cash at 31st December was on plan at £1.45m.
- Agency cap excluding LTP costs - YTD agency spend totalled £21.28m against the cap of £13.77m.
- BPPC YTD performance is 93.5% by value of invoices paid and 89.2% by number of invoices paid, within 30 days.

The Trust is ahead of its planned deficit by £0.41m at the end of December excluding LTP, driven by income over-performance and CIP delivery. This is £0.10m worse than forecast in month. Including LTP costs the Trust is £6.61m ahead of plan.

	Dec In-Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Income	19.63	20.08	0.46	185.01	186.13	1.12
Other Operating Income	3.03	3.40	0.37	26.49	28.29	1.80
Total Operating Income	22.66	23.48	0.83	211.50	214.42	2.91
Pay	(15.80)	(15.93)	(0.13)	(144.85)	(145.74)	(0.89)
Non Pay	(8.74)	(9.69)	(0.95)	(93.41)	(88.69)	4.72
EBITDA	**(1.88)**	**(2.14)**	**(0.25)**	**(26.75)**	**(20.01)**	**6.74**
Operating Costs Excl. from EBITDA	(0.83)	(0.88)	(0.06)	(7.44)	(7.76)	(0.31)
Non Operating Income	0.00	0.00	(0.00)	0.01	(0.09)	(0.10)
Non Operating Expenditure	(1.70)	(1.62)	0.08	(14.61)	(14.32)	0.29
Surplus/(Deficit)	**(4.41)**	**(4.64)**	**(0.23)**	**(48.79)**	**(42.18)**	**6.61**
Technical Adjustments to Control Total	(0.01)	(0.01)	0.00	(0.05)	(0.05)	0.00
Surplus/(Deficit) - Control Total Basis	**(4.41)**	**(4.64)**	**(0.23)**	**(48.75)**	**(42.14)**	**6.61**
Long Term Partnership	(0.16)	(0.13)	0.02	(15.41)	(9.21)	6.20
Surplus/(Deficit) - Excluding LTP - Control Total Basis	**(4.25)**	**(4.50)**	**(0.25)**	**(33.33)**	**(32.93)**	**0.41**

Operating statement identifies:

- The Trust has received £2.26m of income from NHSE on behalf of the CCGs, which has been transferred to them. This income has to be accounted for as other operating income with an offsetting adjustment to clinical income £1.90m was received November and £0.36m December. The overall impact to the Trust is nil.
- If this technical adjustment is disregarded then clinical income is above plan by £0.84m in month and ahead of YTD plan by £3.38m. This is primarily as a result of continued non elective and outpatient growth.
- S&T monies are below plan by £0.04m in month and £0.26m less than plan YTD due to non delivery of the cancer trajectory. This is not forecast to be recovered and will continue until the end of the year.

- The valuation agency has reviewed and increased the rateable value of the Trust's estate wef 1/4/15. The YTD position includes additional expenditure of £0.25m for 15/16 and £0.19m for 9 months of 16/17. This is being disputed.

The forecast continues to evolve and the FOT at month 9 is better than the FOT at month 9 by £0.56m excluding LTP, due to the assumed receipt of STP Incentive funding. Total costs for LTP are forecast to be £6.13m better than the £15.88m control total. Key assumptions include; 100% delivery of CIP, payment by commissioners of income over-performance net of provisions made for counting and coding challenges and delivery to the winter plan.

	Forecast Outturn		
	Plan £m	Actual £m	Variance £m
Clinical Income	247.05	250.97	3.92
Other Operating Income	38.31	37.92	(0.39)
Total Operating Income	285.36	288.89	3.53
Pay	(193.07)	(194.87)	(1.80)
Non Pay	(119.87)	(114.57)	5.30
EBITDA	**(27.58)**	**(20.55)**	**7.03**
Operating Costs Excl. from EBITDA	(9.92)	(10.44)	(0.51)
Non Operating Income	0.26	0.16	(0.10)
Non Operating Expenditure	(19.84)	(19.53)	0.31
Surplus/(Deficit)	**(57.08)**	**(50.35)**	**6.73**
Technical Adjustments to Control Total	(0.06)	(0.18)	(0.12)
Surplus/(Deficit) - Control Total Basis	**(57.02)**	**(50.17)**	**6.84**
Long Term Partnership	(15.88)	(9.75)	6.13
Surplus/(Deficit) - Excluding LTP - Control Total Basis	**(41.14)**	**(40.43)**	**0.71**

The forecast outturn identifies an expected underspend of £6.13m on LTP costs and that delivery of the control total of £41.14m excluding LTP is on track. Assumed within this is 100% delivery of CIP target of £12.6m, continuation of and payment by commissioners of over-performance net of provisions made and delivery to the winter plan. The above forecast includes £0.56m of additional STF incentive monies (see separate slides).

The forecast outturn ranges from £9.1m worse than plan to £5.8m favourable to control total. The downside risk relates principally to commissioner non payment and the deteriorating position would mean no S&T funding payable in Q4. The upside opportunity is principally additional STF incentive monies for LTP part of the control total and CCG provisions not required.
NHSI only permit changes to forecast at quarter ends, the revised forecast above will be reported this month.

SAFER STAFFING REPORT

December 2016 staffing data continues to reflect the challenge of ensuring optimum safe staffing levels in response to fluctuating patient acuity and dependency against a challenging vacancy position. This was further challenged towards the end of December 2016 by the opening of additional bed capacity to support additional patient admissions. Of further concern was the reduced skill mix within ward and department areas created through the requirement to move substantive Trust nurses to the additional capacity and backfill through agency staffing.

The Trust demonstrated an increase in the number of wards (to 4 wards from 1 ward) where actual staffing was lower than 80% of planned however this was not related to the movement of staff rather a reduction in required staffing levels due to a reduction in planned elective activity for orthopaedics and Day Case Unit and a reduction in demand on the children's ward.

Patient dependency continues to be reported as higher than normal and as such 15 wards reported a staffing overfill (actual staffing more that 110% of planned). This included the trauma orthopaedic ward and all medical wards apart from 2 wards at Mansfield Community Hospital and an acute respiratory ward at Kings Mill Hospital.

Safe staffing issues were escalated appropriately during December and actions taken in line with Trust guidance. No ward reported unsafe staffing levels. However, an increase in patient falls was identified; reviews for some of these incidents are still being undertaken. Currently no direct correlation has been identified between the location, type of falls or harm level and the wards reporting an under or overfill staffing levels. Other nurse sensitive indicators were reduced.

The Trust undertook a highly successful recruitment event on 4th January 2107 recruiting 20 nurses a number of whom are existing registered nurses.

The Trust's 15 Nursing Associates posts have been recruited to from the Trust existing HCA workforce and will commence on the programme though the University of Derby on the 30th January 2017. There is a plan to backfill these posts from the HCA's who commenced employment with the Trust during January. Further recruitment events will be undertaken to support employment of staff within the Trust Nurse Bank and the Virtual Ward.

The pilot and implementation of *SafeCare* described in the October 2016 Board paper will commence at the end of January 2017. Implementation of this module will support the Trust to be fully compliant with the NICE Safer Staffing guidance and enhance the monitoring in real-time of safer staffing from both planned activity and patient activity perspectives.