Sherwood Forest Hospitals
NHS Foundation Trust

Public Board Meeting Report

Subject: **Single Oversight Framework Integrated Quarter One Performance Report**

Date: **28 June 2018**

Authors: Senior Leadership Team

Lead Directors: Executive Team

Overall Quarter One Summary

This is our analysis of Quarter One (Q1) at Sherwood Forest Hospitals NHS Foundation Trust. The quarterly report is a build on previous reports and is designed to provide an in-depth insight across our four key areas of focus; organisational health, quality, access and finance. The aim is to identify the key themes over the last quarter, with a concise account of the areas where the trust is performing well as well as areas of concern. We have reflected and analysed trends, set out projections and recovery trajectories and have been clear on the risks and risk mitigation actions. Some of the challenges in Q1 may have implications for our strategy and the current strategy of the wider health and social care system.

The report reflects the views of all of the executive directors, not just the individual directors with a particular area of responsibility. We now aim to take this report and build on it to improve the briefer monthly Board reports and the more detailed report which will next come to Board in October

The report recognises the largely positive and balanced start we have made to the year. As detailed below, patients at Sherwood, have in general continued to receive safe, personalised care in Q1 and we only have three exception reports within this domain for dementia assessment (May), falls (June) and Friends and Family (June). Our organisational health metrics remain very strong and there are no exceptions to report within the quarter. Whilst we have six exception reports within the quarter for access; % of all trolley waits > 12 hours (June), % Ambulance handover > 30 minutes / > 60 minutes (June), 18 weeks referral to treatment time – incomplete pathways (June), Number of cases exceeding 52 weeks referral to treatment (June), Breaches of the 28 day guarantee following a last minute (on the day) non-clinical cancelled elective operation (June), % of #NOF achieving BPT (May) and 62 days urgent referral to treatment (May), we have made good progress against all of our access standards especially emergency care. We have also delivered our Q1 financial control total, both within Sherwood and across the health system. This means we are reporting a deficit of £13.91m before Provider Sustainability Funding (PSF) which is £0.06m ahead of plan year to date (YTD). Achievement of PSF is based on delivery of the four hour access standard and delivery of the control total. At the end of Q1, PSF of £1.86m has been reflected as a result of delivery of the four hour access standard (see above) (£0.56m) and delivery of the control total both within SFH and system wide (£1.30m). The reported control total deficit is therefore £12.06m, in line with plan.

All of this has been achieved whilst we had a detailed Care Quality Commission assessment of seven of our core services, across our three sites, the Use of Resources assessment and the Well Led assessment. The outcome from the CQC report will be announced in mid-August. We also had the back end of the most difficult winter on record to manage and so far this summer has been very warm with high levels of emergency attendance. There is much to be pleased about and we are grateful to our staff and partner organisations for their contributions.

However in Q1 we have seen the further crystallisation of our three key risks which were also present last year; **failure to maintain financial sustainability, demand that overwhelms capacity and critical shortage of workforce capacity and capability**. In particular we have seen increasingly high levels of emergency attendances which are driving a number of our challenges and we have struggled in Q1 to develop a full financial improvement plan (FIP) for the year.

A key driver behind failure to maintain financial sustainability and demands that overwhelms capacity in Q1, is the level of non-elective (NEL) activity which is greater than plan. Our joint planning assumption with our commissioners was that activity would fall in Q1 of 2018/19, yet at the end of month 3 NEL activity is £1.9m over plan. The high activity has continued into Q2, and as a reference point, the weeks ending 15 and 22 July have been the two busiest weeks ever for emergency attendance at Sherwood. We are not unique and this position is replicated across the NHS. The costs to deliver this activity including capacity costs and non-pay continue to be incurred. Income is sufficient to offset costs but this represents a financial risk to our commissioners and therefore a financial risk to the local health system. The increase in activity is a key driver in our continued use of bank and agency staff. We had planned this summer to flex our bed capacity down before reopening in time winter but we have been unable to do this. We currently have more beds open than this time last summer which is impacted on our FIP plans. There is no evidence that the increase in NEL activity is impacting on patient care but unless we see greater traction on the actions that are being taken, it will impact on our access standards and our and commissioners financial position this winter.

Correspondingly if we are to continue to make progress with our organisational health metrics, our quality and access metrics and our financial performance we need to concentrate our efforts, working with partners in health and social care to manage the levels of emergency attendance and admissions. A reduction in attendance and admissions may be difficult to achieve this winter, but we need to continue to take positive action and we need to plan for a realistic level of activity for the remainder of the year.

We have agreed across the executive team and senior leadership team that we will have a renewed focus, working with partners across the system including primary care, social care, EMAS, commissioners and Notts Healthcare to stabilise and ideally reduce the growth in emergency attendances and admissions and to provide safe care to patients outside of Sherwood. Key elements within this are reducing conveyance to ED, reviewing the needs of high volume service users and the continued work to provide in reach into care and nursing homes. The other element to this is having a clear capacity plan in place for this winter and progress has been made in the last month to confirm the "how" behind the actions and this will come back to Board for sign off in August.

Another key element of maintaining financial sustainability is strengthening the delivery of our financial improvement plan and we have agreed a series of actions as an executive team to review the plans where we are senior responsible officers and to ensure FIP is viewed as a key area of collective focus whilst maintaining quality and access. This will also come back to Board in August.

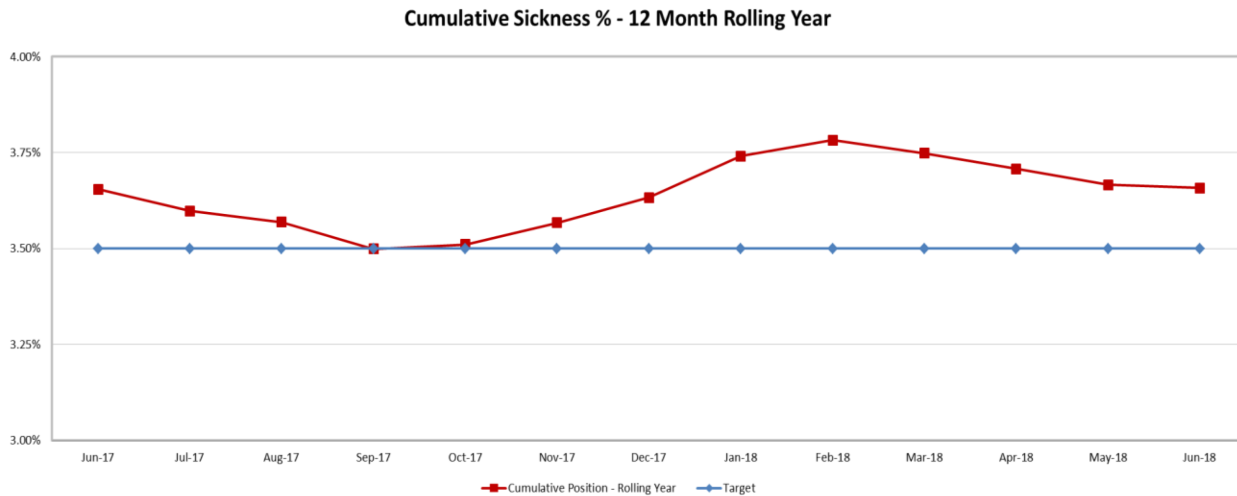
We continue to make progress with the third key risk, critical shortage of workforce capacity and capability and we plan to use our forthcoming CQC report as a key enabler for a further drive on our recruitment and retention.

July 2018

Quarter One Organisational Health

Sickness Absence (Green)

- Sickness absence increased over the quarter to a figure of 3.45% in June (April, 3.22%) Although this has increased, the overall quarter compliance has been below the trust 3.5% threshold.
- At Q1 the average monthly sickness absence is at 3.29%
- Levels of sickness absence for Q1 2018-19 are 0.36% lower than Q1 2017-18.
- The 12 month rolling year (sickness averaged for the previous 12 month period for each month), was indicating a sustained improvement as the winter upturn has now been reversed.



- From a Q1 performance perspective, three divisions are below the Trust threshold and are green:
  Corporate – 1.96%
  Women & Children's - 2.89%
  Diagnostics & Outpatients - 3.16%
- From a Q1 performance perspective, two divisions are below the Trust threshold and are amber:
  Urgent & Emergency Care - 3.54%
  Surgery - 3.61%
- From a Q1 performance perspective, one division is below the Trust threshold and is red:
  Medicine - 4.00%
- All Divisions above the 3.5% threshold have a trajectory and action plan for improvement which is monitored at the monthly divisional performance meeting.
- Risks – risks associated with the effective management of sickness absence tend to increase over the winter months, due to flu and seasonal illnesses. Mitigation consists of a strong flu vaccination campaign, which is already being planned by our Occupational Health Department. The Trusts other health and well-being initiatives help to mitigate this risk.

Appraisal (Green)

- Trust wide appraisal compliance over the quarter has indicated an average figure of 95%. There was a slight decrease during this period in April when the Trust position was at 96%.
- As can be seen from the table below, Q1 of 2018-19 is significantly better than the same period in the previous year. All three months are green.

- Diagnostics & Outpatients; Urgent and Emergency Care and Women's and Children's Divisions have delivered at or above target for the whole period. The Surgery Division have seen some recent slippage and have an action plan to address this.

A Summary of Appraisal performance as at Q1 (April – June 2018)

Appraisal Compliance	Apr	May	Jun	Q1 Total
2018/2019 Trust Total	96%	95%	95%	95%
2017/2018 Trust Total	91%	92%	93%	92%
Corporate	95%	95%	94%	95%
Diagnostics & Outpatients Division	98%	98%	97%	98%
Medicine Division	94%	95%	94%	94%
Surgery Division	94%	93%	92%	93%
Urgent & Emergency Care Division	98%	95%	96%	96%
Women & Children's Division	98%	97%	96%	97%

- Risks – now that the Trust is regularly delivering at or above target, this KPI should be easier to maintain. Risks tend to relate to the availability of time to conduct the appraisal, which can be affected by clinical managers having to work in a clinical capacity more frequently to the detriment of their managerial activities. Risks are mitigated by each Division having clear compliance information down to departmental level which enables the early identification of slippage to compliance levels and the production of improvement trajectories and plans.

Training and Education (Green)

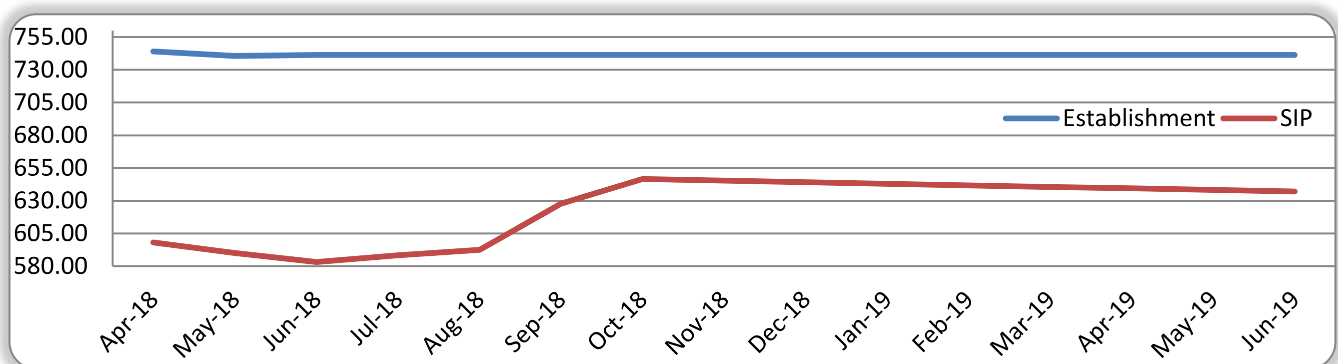
- Mandatory training increased to 93%* against a 90% target over the quarter from a start position of 92%. The Trust has been at or above target on this KPI for over a year. Divisional compliance ranking information shows all Divisions are at or exceeding the target. **This rate refers to the number of competencies completed and not the number of staff compliant.*
- Risks – now that the Trust is continually delivering at or above target, this KPI should be easier to maintain. However, compliance levels are affected by changes to the curriculum, catchment and frequency requirements of mandatory subjects. An example of this is the recent increased frequency and depth of safeguarding training. Where such changes are anticipated, an action plan and transition period is put in place to implement the new requirement whilst still maintaining compliance levels.
- Risks also tend to relate to the availability of time for staff to undertake the training, which can be affected by workloads and staffing levels. Risks are mitigated by each Division having clear compliance information down to departmental level which enables the early identification of slippage to compliance levels and the production of improvement trajectories and plans. This risk is also mitigated through the offer of a blended learning approach whereby many subjects are now offered via e-learning. Mandatory update programmes are also advertised one year in advance to help managers to plan rotas more effectively.

Staffing and Turnover (Green)

- The overall turnover rate increased has decreased to 0.73% from an April position of, 1.35%, and is inside of the threshold of 1%.
- The Q1 average for the quarter is 0.86% that is under the trusts 1% threshold
- The average number of starters across the quarter was identified as 37.36wte against an average number of leavers of 34.08wte

- All Registered Nurse (RN) vacancies increased in June to 14.26%, 192.10 FTE from an April position of 13.76%, 185.51 FTE).
- Medical vacancies at the end of the quarter have remained static at 11.09% in June from an April position of 11.09%. However, medical vacancies are still very significantly lower than over the last two years.
- The 21.35% RN band 5 vacancy rate leaves significant nursing shifts vacant which will need to be covered by bank or agency workers. However, this situation was anticipated as the substantive RN's employed by the Trust tend to decrease over the summer, but are replenished with the employment of newly qualified nurses in September. See the trajectory below.

<u>Registered Nurse projected trajectory Establish v's Staff in Post (SIP)</u>



- There are 56 newly qualified nurses due to commence with the Trust in early autumn. The final figure is expected to be higher than this as there are also nurse recruitment assessment centres due to take place still in July and August.
- From our recent Assessment Centres we have appointed the following RN's (who are serving notice and having employment checks undertaken), in addition to the newly qualified students mentioned earlier:

  - 12th May Nurse Assessment Centre: 5
  - 4th June Nurse Assessment Centre: 5
  - 26th June Women's and Children's Assessment Centre: 6

- Risks – exit information is used to help assess and manage the risks associated with turnover levels. The Trust offers flexible working and flexi-retirement where practical and also uses recruitment and retention incentives in key areas.
- Retention risks associated with HMRC pension rules and age demographics are currently being scoped and mitigations developed.
- The Trust mitigates the risk of new appointees taking up posts elsewhere with its keep in touch initiatives for people who are waiting to start employment with us.
- Risks associated with clinical staffing levels are mitigated through strong recruitment campaigns; international recruitment and the use of bank, locums and agency workers. In the longer term, reviews of skill mix and new roles are used.

Quarter One - Organisational Health summary

In summary the Q1 performance for organisational health demonstrates positive assurance around all workforce indicators that has resulted in no exception reports for Organisational Health being required. The Trust Workforce Strategy “Maximising our Potential” (MOP) is aligned and includes a range of initiatives to ensure aspects of organisational health are managed effectively in line with thresholds and seasonality trends.

Quarter One - Patient Safety, Quality and Experience

Single Sex Accommodation compliance

- During Q1 the trust continued to maintain compliance with providing single sex accommodation to its patients and reported no breaches, recognising the importance placed in maintaining the privacy and dignity of our patients.

Infection Prevention & Control

- Infection Prevention & Control at Newark Hospital have had no hospital infection for one year, and Minster Ward at Newark Hospital for over three years.
- All the 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 June 2018, which is within our monthly trajectory and brings the YTD total to five cases. This year's annual trajectory has been reduced to no more than 47 cases.

C.Difficile				
Month	Kings Mill Hospital	Newark Hospital	Mansfield Community Hospital	Total
April	2	0	0	2
May	2	0	0	2
June	1	0	0	1
Q1 Total	5	0	0	5

- There have been ZERO MRSA bacteraemia identified in June 2018. There were three Escherichia Coli bacteraemia, which remains within our trajectory, and there were none related to the presence of a urinary catheter. For Q1 a total of 7 cases which remains below our threshold.
- In June there were no further cases of influenza. For Q1 the cumulative position of 13 patients testing positively for influenza with no cases recorded since April 2018.

Tissue Viability

- The management of our patient's skin integrity has remained a key focus, as reducing harm from pressure ulcers (PUs) has been identified as a supplementary quality priority in line with the Quality Account.
- The trust has had ZERO Grade 4 pressure ulcers in Q1 2018/19 and none since September 2017, ZERO Grade 3 pressure in Q1 2018/19 and none since December 2017, and below the target of 0.7 per 1000 occupied bed days (OBDs). There was one avoidable grade 2 pressure ulcer in May and one in June 2018 with none reported in April 2018.
- NHSI have issued new guidance in relation to reporting of pressure ulcers which will see a rise nationally and within the Trust of our reporting position. A summary of the potential implications will be brought to August Trust Board.
- In Q1 the Tissue Viability Team have worked with the ward teams to share learning found from the root cause analysis of the avoidable grade 2 pressure ulcers, and continue to focus on recording and documentation of patient's skin integrity. Ongoing training around fundamentals of care and link nurse training scheduled.

PUs by Grade	Apr-18	May-18	Jun-18	Q1
Grade 2 pressure ulcers				
Avoidable	0	1	1	2
Unavoidable	6	4	3	13
Grade 3 pressure ulcers				
Avoidable	0	0	0	0
Unavoidable	0	0	0	0
Grade 4 pressure ulcers				
Avoidable	0	0	0	0
Unavoidable	0	0	0	0
Grades 2 – 4 pressure ulcers				
Total	6	5	4	15

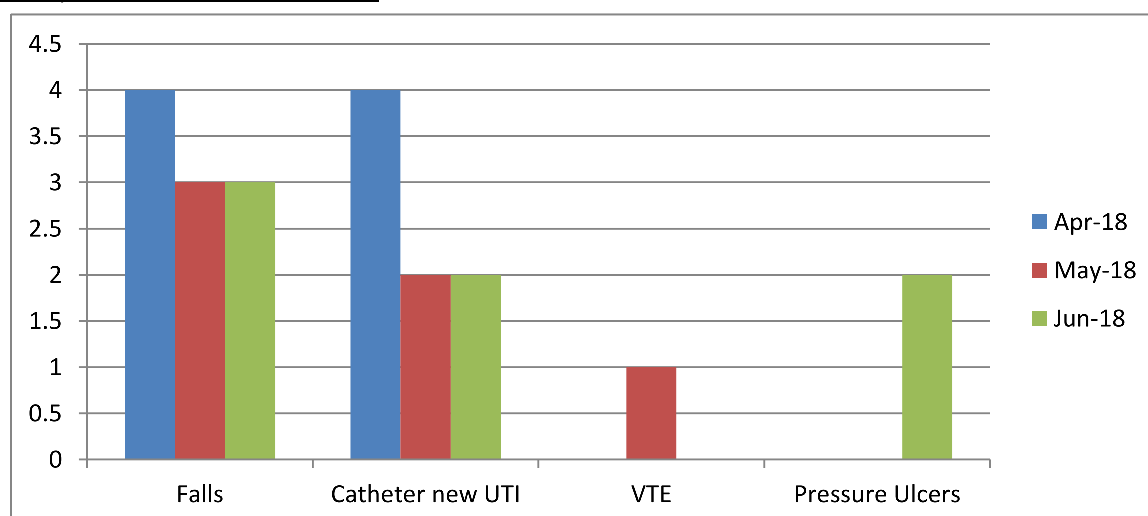
VTE

- The trust performance in April and May 2018 was above 95% and continues to remain above the target of 95%. The full Q1 position cannot be given until August 2018, due to the delay in collection of the data.
- In August 2018, the Digital Strategy Implementation Board will receive a paper to put VTE on the electronic ICE system. This will provide the trust with improved compliance, as bloods and x-rays will not be able to be requested without the VTE being completed – this is in line with other local trusts. This will ensure that the information provided will be in real time, rather than retrospective.

Harm Free Care

- Harm Free Care has been reported in Q1 as above the standard of 95%. The standard includes 'new' harms that are acquired during that admission and 'old' harms which are present on admission. In Q1 there were:-

Safety Thermometer Q1 2018

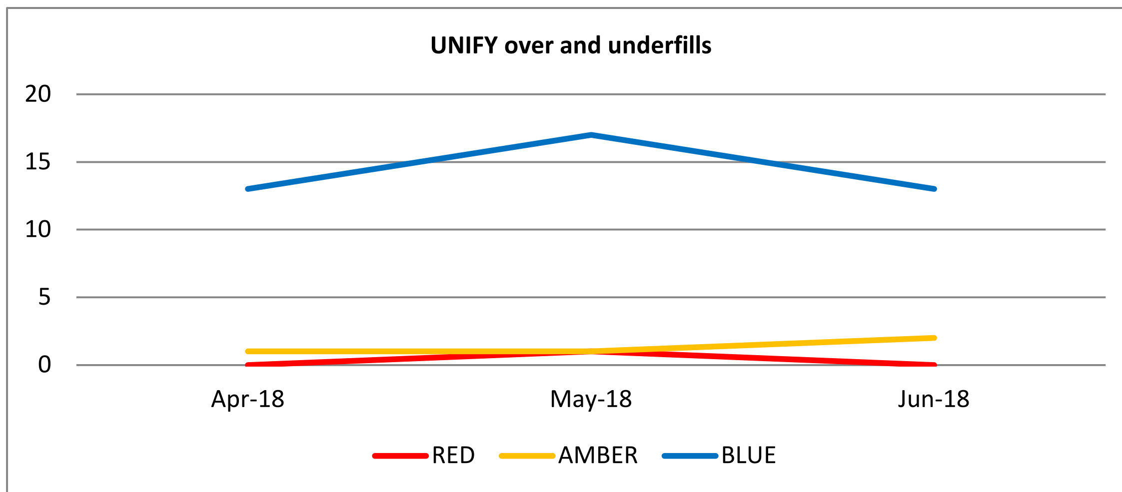


Safe Staffing

- 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 were 0 red ratings. The number of areas with amber ratings (staffing fill rate is less than the accepted 90%, but above 80%) The recording as blue rating (actual staffing figures are greater than 110% fill rate).
- There have been no breaches in the Safe Staffing Standard Operating Procedure and all wards have maintained appropriate staffing in line with their establishments.
- There were no harms in Q1 related to staffing.

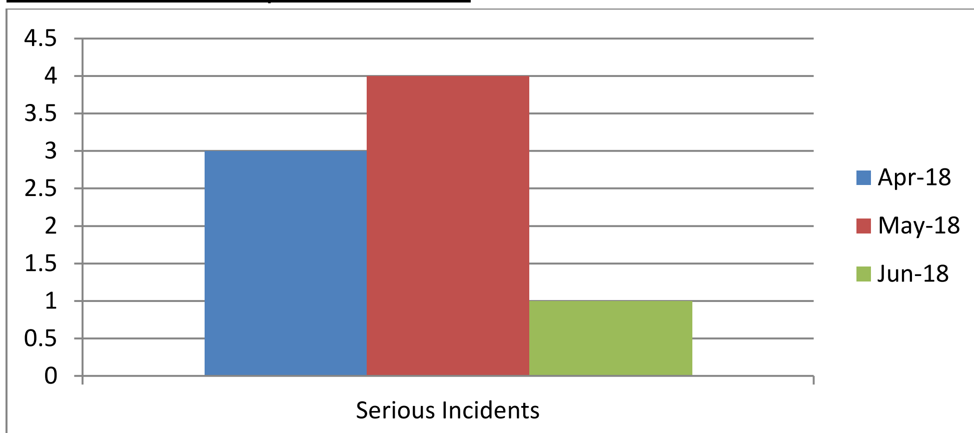
Staffing over and under-fill captured through the Unify report



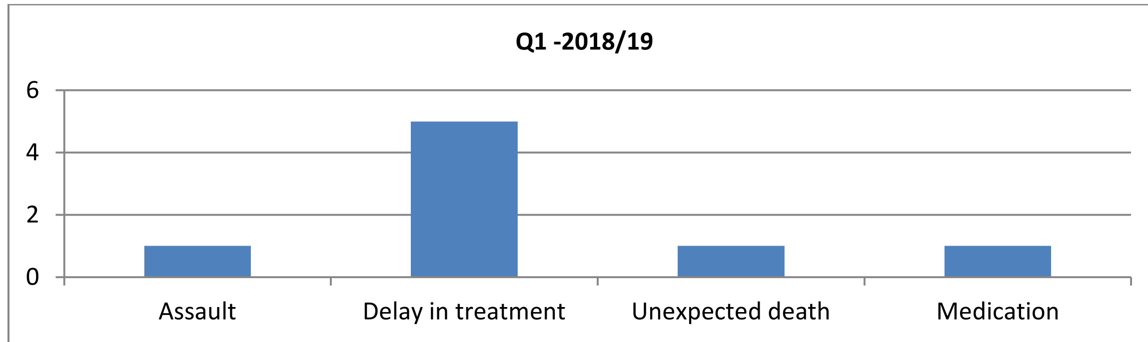
Serious Incidents including Never Events (STEIS reportable) by reported date

- In Q1 the trust reported eight Serious Incidents in accordance with NHS England's Serious Incident Framework (May 2015). Of the eight incidents, none were deemed to be Never Events. The number of STEIS reportable serious incidents per month (by the date the incident was reported on Datix) is demonstrated below:

Serious Incidents reported Q1 2018



Serious incident by type for Q1 2018/19



- In Q1 the trust had three Serious Incidents which required an extension to the agreed deadline. A Standard Operating Procedure is to be developed to support the decision for extension, which will drive the number of Serious Incidents to be signed off within the deadlines.

Patient Safety Alerts compliance

- The trust did not have any over the date of compliance to report in Q1.
- In Q1, the trust has **three exception reports for dementia assessment (May), falls (June) and Friends and Family (June)**. The dementia assessment has a further risk of deteriorating as the dementia assessment nurse post has become vacant and will take time to recruit. The trust falls continues to undulate around the target and further mitigations have been added to the exception report.

Quarter One - Patient Safety, Quality and Experience summary

- The quality and safety position for Q1 shows a positive position for the Trust. There is evidence of improvement for our dementia reporting and assessing and this is in line with our improvement trajectory for September 2018. Our falls position for Q1 shows an undulation around the threshold set for the year. Significant work is ongoing with the Falls and Patient safety work within the Trust. Fundamentals study days which are held monthly for Nurses and Allied Health professionals is proving successful and has taken a scenario based approach to flow through the harms of falls, deteriorating patient, Infection control, pain management and human factors.
- Q1 has seen an increase in sickness absence and vacancies for Band 5 nurses, in particular within Urgent and Emergency care, surgery and medicine. There is also evidence of an increase in attendance within the Trust. Despite this Q1 has not seen any evidence of harms associated with safe staffing. Q1 has seen a reduction in the utilisation of Thornbury nurses and Chief Nurse / Gold approval alongside a RCA is maintained for any use. All short term escalated rates are also pre-authorised using the approval process. There have been no reported breaches in safe staffing standards.

Exception Report – Dementia

Indicator: Dementia – Find, Assess, Investigate and Refer [there are three parts]

Month: May 2018

Standard: Maintain identification of patients with dementia and delirium at a high level, to prompt appropriate referral and follow up after they leave hospital and to ensure that hospitals deliver high quality care to people with dementia. Desired performance is 90% on each part of the indicator.

Current position		
FIND - During May 2018, 98.0% of eligible patients were identified; this has increased from the April return (April data – 82.2%). ASSESS AND INVESTIGATE - During May 2018, 77 patients were identified as scoring positive on the case-finding question or having a clinical diagnosis of delirium and they were all reported as having had a dementia diagnostic assessment [100%]. REFER - There were 58 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 42 of these patients were referred for further diagnostic advice in line with local pathways [72.4%].		
Causes of underperformance		
REFER -There were 16 people who do not appear to have been referred: • 11 – positive to the case-finding question • 5 – delirium but no evidence of referral		
Actions to address	**Owner**	**Deadline**
A Dementia Assessment Nurse commenced in post and we are now achieving over 90% for FIND. Performance on REFER has already shown improvement as part of her work is to refer to RRLP as per pathway	Debbie King	1st September 2018
The other Dementia Assessment Nurse post is being interviewed for on July 17th. When this person is in post, this will ensure that assessments of eligible patients are carried out seven days a week.	Tina Hymas-Taylor	17th July 2018
Improvement trajectory		
Performance remains in line with September trajectory		

Lead: Tina Hymas- Taylor

Executive Lead: Chief Nurse

Exception Report

Indicator: Falls

Month: June 2018

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

Since April 2018 the reporting of falls in SFHT now follows the new SOP which provides clarity around the reporting structure and management of falls data in line with national guidance. Inpatient falls data now includes paediatrics and Maternity in the total monthly figures.

Separate data is now available for the following:

- Outpatients /RIDDOR/assist to floor and falls from low beds/seizures or fits/falls on corridor/falls in car parks

Whilst there has been a slight in month increase in falls with low or no harm this still remains below the national average.

Causes of underperformance
Staff are required to communicate in more detail regarding a patients falls risk and history when a patient is transferred to another area of care .Thus highlighting the receiving area to be more aware of the patients risk. Re-assessment of a patient when their condition changes or if moved to a less visible area.

Actions to address/Mitigation		
Action	Owner	Deadline
• Out of hours site visits arranged for July –assurance /education/audits	JLH	July 2018
• Bed and sensor alarms trial ward 53/54 continues	JLH	Review September 2018
• Lie/stand BP recording chart reviewed for discussion at July ward assurance meeting.	JLH	
• New fall weekly audits and a 3 site comprehensive audit August 2018.	JLH	Sept 2018
• Fundamentals Of Care study day	Nurse specialists	Ongoing
• Sept 28th- Falls Study day arranged with Tim Reddish as a guest speaker to address vision and falls prevention	JLH	Sept 2018

Improvement trajectory
To remain below the national average for all falls 6.63 on a monthly basis. Below Trust Indicator of 5.5 low or no harm and 0.8 moderate /severe falls

Risk	Mitigation
Unfilled shifts to provide Enhanced patient care for those patients who are at risk of falls.	

Lead: Joanne Lewis-Hodgkinson RN Executive Lead: Chief Nurse

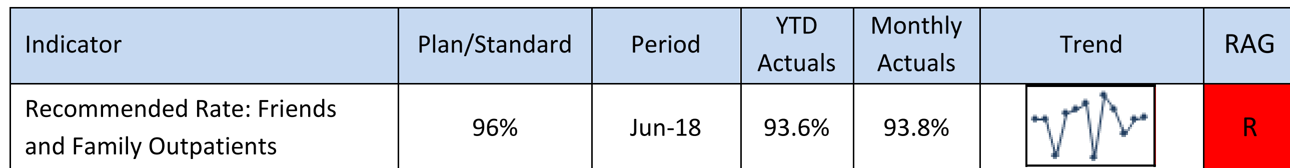
Exception Report

Indicator: Friends and Family Test

Month: June 2018

Standard: Friends and Family Test (FFT)

Current position



Indicator	Plan/Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG
Recommended Rate: Friends and Family Outpatients	96%	Jun-18	93.6%	93.8%		R

Causes of underperformance

1. The FFT recommendation rate in Outpatient Services – recommendation rating is 2.2% off plan for June 2018.

Sexual Health – Sites in Community – MCH, KMH, Ollerton, Warsop, Newark and Oates Hill Surgery

- Waiting times
- Car park fees at Newark Hospital
- Mores support from staff
- More privacy

Orthopaedic, Ophthalmology, and Diabetics Clinics

- Waiting times
- Car parking charges
- Air conditioning in waiting area

Newark Clinics – Radiology, Podiatry and Pain Management

- More time with doctor
- Provide a map to the departments
- Waiting times

Therapy Services

- More reception staff – MCH
- Music required – Newark

Actions taken by Division

Weekly OPD Matron and Clinical Lead review all Friends and Family responses and shares the negative comments with the relevant staff.

Waiting times in clinics. Patient's wait over 20 minutes are shared with the relevant division. Waits are displayed in clinics and nursing staff update patients of delays. Car parking vouchers and beverages are offered to patients with delayed appointments. Leadership rounds are undertaken by senior team to ensure actions are being addressed.

Environmental - some comments in month related to air conditioning (can assume this is linked to the recent hot weather). Therapy is undertaking a patient flow review to address issues with waiting areas and the flow within the department. Escalated to Ben Widdowson the comments around signage.

Staff attitude comments are dealt with individually or as a group if area is known.

Car Parking - Car parking issues escalated to Ben Widdowson and Wes Burton.

Action	Owner	Deadline
Divisional Management teams to receive and review FFT comment reports. This will enable Divisional teams to develop and implement changes that can respond to the concerns and improve the experience for service users.	Kim Kirk (Head of Patient Experience)	Completed and ongoing- weekly and monthly reported provided.

Improvement trajectory

All divisions to review and share feedback in team meetings.

Risks: Continued decrease in recommendation rate for OPD

Mitigation: Actions agreed and this will be monitored monthly

Lead: Kim Kirk – Head of Patient Experience

Executive Lead: Dr Andy Haynes – Executive Medical Director

Quarter One - Access

Emergency care

- Emergency access performance improved again in June with 97.21% of patients discharged, transferred or admitted within four hours. The 4 hour standard was also achieved in quarter 1 with quarterly performance at 95.14%.
- Attendances remain high with June attendances higher than the same period for the last 4 years. This trend is also mirrored for the quarter overall, with quarter 1 attendances higher than the same period for the last 4 years.
- Admissions to Medicine for patients aged 75 and over remain above normal levels and have not materially fallen since winter, although some of the variation has reduced, but bed availability to ED has improved mainly due to reduced length of stay on EAU (down by 4 hours) and increases in discharges from the short stay unit.
- One patient waited 12 hours from decision to admit in June. A full investigation has been undertaken and delays in identifying a mental health bed followed by a long wait for ambulance transport were identified.
- Ambulance handover times improved in June and throughout the quarter, with fewer patients waiting over 30 minutes and over 60 minutes from arrival to handover.
- Whilst emergency care performance has improved throughout the quarter, concerns remain about the high levels of attendances and admissions together with the continued challenges in securing medical staff in the Emergency Department.
- The trajectory for performance against the 4 hour standard is shown below

	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19
17/18 Actual	95.9%	95.6%	96.7%	95.5%	94.6%	92.3%	94.0%	91.9%	86.4%	87.2%	89.0%	88.8%
18/19 Forecast	**92.0%**	**95.0%**	**95.0%**	**95.0%**	**95.0%**	**95.0%**	**95.0%**	**93.6%**	**90.5%**	**90.0%**	**90.5%**	**95.0%**
18/19 Actual	92.36%	95.66%	97.21%									
Standard	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%

	Q1	Q2	Q3	Q4
17/18 Actual	96.0%	94.2%	90.7%	88.3%
18/19 Forecast	**95.0%**	**95.0%**	**92.0%**	**90.5%**
18/19 Actual	95.14%			
Standard				

Cancer

- As forecast, the 62 day standard was not achieved in May with performance at 79.7%. However, 101 treatments were recorded in month, against an average of 73 treatments per month, of which 20.5 were provided > 62 days. The majority of the increased treatments in month were in Breast, Skin and Urology and reflect an overall 20% increase in 2 week wait referrals in March. This increase in referrals has been mirrored across the region.
- Two week wait referrals were relatively static at an average of 960 per month December 2017 – February 2018. As noted above, an increase was seen in March and although there was a slight drop in April the referral rate remained above average. The referral rate increased again in May which will impact on performance in July.
- Breach analysis across all tumour sites shows that the majority of breaches (13/20.5) were due to patient choice or for clinical reasons such as complexity or multiple diagnostics. The remaining breaches (7.5/20) were due to capacity and / or process delays. It is noted that 4.5 of the breaches occurred within 7 days of the 62 day breach date.
- National performance against the 62 day standard in May was 81.1%; regional performance was 79.5% with 30 / 42 Trusts failing the standard. The Trust is forecasting delivery of the standard in quarter 1, with forecast performance for June at 87%.

Diagnostics

- The standard continues to be achieved although the risk to delivery remains due to demand for Cardiac CT and the scheduled CT replacement in September 2018.

RTT

- Performance in June 2018 was 90.04% against the 92% standard. Whilst this is below the June trajectory of 91.75% a month on month improvement in performance has been seen since April 2018.
- The Trust has also seen a month on month improvement in the number of specialties that are delivering the standard, increasing from 4/16 specialties in April to 8/16 in June.
- Delivery of the standard is dependent on recovery in 4 specialties – Urology, Trauma and Orthopaedics, Cardiology and Gastroenterology. Comprehensive action plans are in place, as detailed in the exception report, and the current forecast for July is 90.4%
- In June, 21 patients waited over 52 weeks from referral treatment. Of these, 17 were identified as part of the historical validation of open pathways and the remaining 4 were due to multiple patient cancellations (1), multiple patient cancellation and diagnostic delay (1) and incorrect clock stop (2). Further 52 week breaches may continue to be identified until the historical validation work is complete at the end of December 2018.

In Q1, the Trust has the following exception reports for access:

- % of all trolley waits > 12 hours (June)
- % Ambulance handover > 30 minutes / > 60 minutes (June)
- 18 weeks referral to treatment time – incomplete pathways (June)
- Number of cases exceeding 52 weeks referral to treatment (June)
- Breaches of the 28 day guarantee following a last minute (on the day) non-clinical cancelled elective operation (June)
- % of #NOF achieving BPT (May)
- 62 days urgent referral to treatment (May)

Quarter One - Access summary

Q1 has seen a return to consistent improvement in Urgent and Emergency Care, RTT and Diagnostics. Across both Urgent and Emergency Care and Cancer, performance has remained relatively strong against a back-drop of increasing attendances, admissions, referrals and treatments. Whilst there continues to be a number of challenges they are well understood and are underpinned by a set of clear actions to sustainably deliver timely access for patients.

During Q2 the focus will be on robust planning for Winter to ensure actions are credible, will maintain a high quality service and are affordable.

Exception Report

Indicator: % of 12 all trolley waits > 12 hours
Month: June 2018
Standard: 0 patients waiting longer than 12 hours from decision to admit

Current position
The Trust reported a 12 hour wait on 4 June for a patient awaiting a mental health bed.

Causes of underperformance
On arrival at ED the patient was promptly assessed and referred to the Rapid Response Liaison Psychiatry (RRLP) team (run by Nottinghamshire Healthcare NHS Trust - NHT). Within 2 hours of receipt of referral, RRLP assessed the patient and made the decision to admit to a mental health bed. Delays occurred in NHT securing a mental health bed and EMAS transport being available to transfer the patient. A root cause analysis has been undertaken.

Actions to address		
Action	Owner	Deadline
Reaffirmation of the long wait escalation process 24/7 is in place - 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
Guidance on the management of waiting times for mental health patients provided to all Bronze / Silver / Gold	COO	Complete
Meeting with Adult Mental Health Services to discuss current capacity pressures and agree actions to address	COO	Complete

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

Risks	
Risk	Mitigation
Continued mental health inpatient capacity pressures	Timely escalation to ensure Silver / Gold Adult Mental Health teams are involved in resolving issues.

Divisional Lead: Siobhan McKenna, Divisional General Manager Urgent and Emergency Care
Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

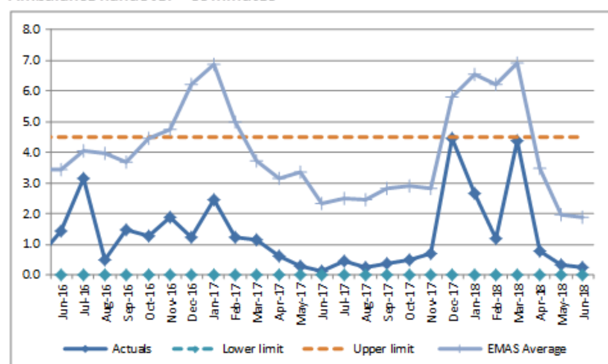
Indicator: % of Ambulance handover >30 minutes / % of Ambulance handover >60 minutes

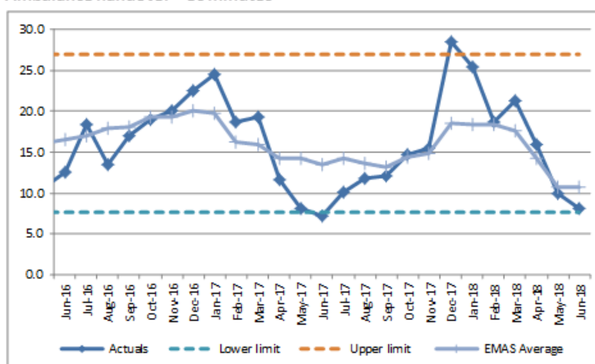
Month: June 2018

Standard: 0 patients delayed more than 30 mins / 60 mins from arrival to handover

Current position

In June 2018, 8.2% of ambulance handovers took longer than 60 minutes, this shows a month on month improvement from April (25%) and May (16%).
0.2% of ambulance handovers took over 60 minutes, this equates to 7 ambulances out of the total 2,878 ambulances arriving at the Trust in June 2018. This is compared to 0.5% in May and 0.3% in April.





Average clinical handover time has improved throughout the quarter from 22.2 minutes (April), 18 minutes (May) to 17.36 minutes (June).

NHS Improvement has recently worked with the ED team and EMAS to review current handover processes and identify areas for improvement.

Causes of underperformance

The Emergency Department is designed to manage 80-90 ambulance arrivals per day. If the number of ambulances is higher than this, particularly ≥ 100 per day, this creates physical capacity constraints as there is insufficient space within the Department to take handover. This situation is exacerbated if a high volume of ambulances present at the same time.

In April there were over 100 ambulances on 13 days in the month (43%), this was 13 days in May (42%) and 10 days in June (33%).

Actions to address

Action	Owner	Deadline
Develop case of need for investment in additional trolleys	Head of Service	Complete
Agree operational handover policy and escalation process with EMAS	Head of Service	31 Aug 2018
Continue work with EMAS and the CCG to increase 'see and treat' and reduce the number of ambulance conveyances.	Head of Service	In progress through 18/19
Regular operational meetings in place with EMAS to	Head of Service	Ongoing (started Feb

address operational issues, identify learning and make improvements		2018)
Ensure joint electronic handover process with EMAS is adhered to.	Head of Service	Ongoing (started Jan 2018)
Monthly review of all ambulance handovers taking ≥ 60 minutes to identify lessons that can be learned	Head of Service	Ongoing (started April 2018)
Implement recommendations following NHSI review of ambulance process	DGM	31 Jul 2018

Improvement trajectory
To consistently deliver ≤ 10% of ambulance handovers taking 30 minute or more and to have zero ambulance handovers taking 60 minutes or more.

Risks	
Risk	**Mitigation**
Continued capacity pressures if the volume of ambulance arrivals per day ≥ 100	Progress non-conveyance work with EMAS / CCG Identify expansion capacity / escalation processes to manage peaks in demand

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: June 2018
Standard: Maximum time of 18 weeks from referral to treatment – RTT (92%)

Background
On average the Trust treats or 'stops the RTT clock' on over 8,500 pathways per month. 15% of these are admitted pathways (daycase and elective activity) and 85% are non-admitted pathways (outpatient and diagnostics). The Trust has a strong history of delivering the RTT standard and did so throughout 2016/17 and in the first five months of 2017/18. Nationally, the standard has not been delivered since February 2016. A down-turn in the position at the Trust emerged from September 2017, in the main due to insufficient capacity to undertake overdue follow-ups, medical staff vacancies across a range of specialties, the planned reduction in routine elective operating due to emergency pathway pressures and the prioritisation of capacity for cancer patients. These factors led to a build-up in the volume of patients waiting over 18 weeks reaching a peak in February 2018 at 2,714 which has reduced to 2,470 at the end of June. To sustainably deliver the standard the volume of patients waiting over 18 weeks must be no greater than 1,900.
Current position
Since April 2018, performance against the national standard has improved month on month. At the end of June 2018, the volume of patients on an Incomplete RTT pathway was 24,794 of which 2,470 were waiting >18 weeks. This position delivered performance of 90.04% against a trajectory of 91.75%. Published data at the end of May shows 92 out of 100 patients at SFHFT were waiting less than 19 weeks to start treatment. This is an improvement on the March and April position of 20 weeks and favourable against the national wait position of 22 weeks. For patients who completed their treatment in May and needed an admission 19/20 were treated within 33 weeks (national wait 36 weeks). Where treatment did not require an admission 19/20 were treated in 25 weeks, this is an improved position on April (26 weeks) and in line with National waits. The Trust continues to make progress in the number of specialties that are delivering the 92% standard which has also risen for the 3rd consecutive month to 8/16 (April 4/16, May 7/16). Activity against plan YTD shows under-delivery of <1% in DC and 5% in Elective activity. This contrasts with a 4% over-delivery in all outpatient activity. In the main the under-delivery in DC is within Gastroenterology; other specialties such as General Surgery and Urology are seeing an under-delivery against their elective plan offset with over-delivery against their DC plan. In terms of theatre utilisation the Trust has delivered the 85% target in 8 out of the last 12 months. The 4 months below target were January to April. May utilisation is 86.1% and June 87.9%.
Reasons for underperformance
In March 2018 the Trust set a trajectory to deliver the 92% Incomplete RTT standard for the month of July 2018 onwards. The key assumptions underpinning the trajectory were: 1. By the end of July 2018 surgical activity would "recover" post winter and the volume of patients waiting >18 weeks would reduce by 800. 2. By the end of June 2018 Neurology@NUH would transfer to Nottingham University Hospitals. 3. The size of the PTL would be as predicted using 3 years historical data as a baseline. The position as at the end of June 2018 has clearly indicated that in terms of: 1. Surgical activity - Orthopaedic Trauma and cancer demand has impacted on capacity to deliver the expected >18 week wait reduction in T&O and Urology. Across all specialties the Incomplete

backlog has reduced by 7% (165) against the YTD trajectory of 22% (533). This includes;

2. Delays due to system issues leading to a revised transfer date for the Neurology@NUH service of 2nd August 2018.
3. The total size of the PTL has been lower than trajectory for April, May and June. Whilst it has remained relatively stable between 24,200 and 24,500 the impact on performance for each month has been April (0.31%), May (0.55%) and June (0.26%).

Recovery in 4 specialties underpins delivery of the standard. These are Urology, Trauma and Orthopaedics and Gastroenterology.

Key Specialty actions	Owner	Deadline
Urology – Position driven in the main due to prioritising capacity for cancer patients and medical staffing vacancies. To deliver 92% the volume of patients waiting >18 weeks needs to reduce by at least 130. 70% is non-admitted and 30% admitted. The plan is to offer choice to a volume of admitted activity for the Independent Sector (IS) and focus internally on overdue follow up's and general outpatient demand and cancer activity through additional sessions.	DGM	Additional sessions and use of the IS in July and August.
T&O - The expectation was through a mix of utilising all in-week sessions and additional weekend sessions 25-30 additional clock stops/per week would have taken place over the last 10 weeks. This would have been sufficient to cover the activity displaced by the planned reduction in elective activity over the winter period. In-week sessions have been impacted by Trauma demand and consultant uptake for weekend sessions has been low but will continue to be put on where possible. To deliver 92% the volume of patients waiting >18 weeks needs to reduce by at least 100. The plan is to offer 50 patients the choice of the IS by the end of July and continue with WLI's. Use of the Independent Sector for orthopaedic activity will form a part of the Trusts 2018/19 winter plan.	DGM	Additional sessions and use of the IS in July and August.
Cardiology – On average 40 patients per week are moving into a wait-band >18 weeks. This volume of patients was previously managed by WLI clinics, however there is little appetite to undertake WLI's due to the volume of sessions that are being delivered in the Cardiac Catheter Suite, inpatient activity and on-call commitments. To deliver 92% the volume of patients waiting >18 weeks needs to reduce by 300. System partners have identified a GP with Specialist Interest (GPSWI) to focus on over-due reviews and triaging new referrals. The GPWSI will undertake an audit of 50-70 overdue follow up's in early August and if deemed in line with Trust guidelines will discharge or redirect to a community clinic / other service as appropriate.	DGM	August 2018
Gastroenterology – Main issues have been the volume of over-due follow up's and medical capacity. To deliver 92% the volume of patients waiting >18 weeks needs to reduce by 60. The plan is for additional tele-clinic sessions undertaken by IBD nurses and additional OP capacity through WLI's and a locum who is due to	DGM	Additional sessions in July and August.

start at the end of August.		
A review of outpatient demand and capacity has commenced, this will drive internal forward planning.	Dep. COO	End of August 2018

Improvement trajectory

2018/19 Actual vs Trajectory:

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July Trajectory	July Forecast
Total Incompletes	24,976	24,274	26,001	24,585	25,461	24,794	25,512	24,954
>18	2,600	2,633	2,350	2,457	2,100	2,470	2,040	2,392
<18	22,376	21,641	23,651	22,128	23,361	22,324	23,472	22,562
%	89.59%	89.15%	90.96%	90.01%	91.75%	90.04%	92.00%	90.41%

The Trust is committed to delivering the standard before winter 2018 and as a minimum will continue to deliver 90%. Based on actions plans in place the current forecast for the end of July is 90.4%.

To deliver 92% the volume of patients >18 weeks (based on the end of June position) needs to reduce by at least 500. The actions described above will deliver a c320 reduction by the end of September:

- Use of the Independent Sector -100
- Additional sessions - 80
- Cardiology GPWSI - 100
- Transfer of Neurology – 40

To close the gap the Trust will focus on:

- Additional actions to support Cardiology and Gastroenterology
- Theatre productivity gains
- Outpatient demand and capacity modelling
- Validation and admin staff training

Risks	Mitigation
• Historically August sees an increase in the volume of patients waiting >18 weeks • Outpatient demand – ASI's and Follow up's. • Medical cover over Summer • Cancer demand – Urology / Head and Neck	• Use of the IS and additional sessions planned • Additional sessions targeted where most needed • Forward plan for annual leave to ensure appropriate cover • Working with NUH to ensure capacity particularly in Head and Neck is utilised across both organisations.

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

Exception Report

Indicator: Number of cases exceeding 52 weeks referral to treatment
Month: June 2018
Standard: Zero

Current position		
Regionally, SFHFT were one of 24 Trusts with a combined total of 589 52+ week waits reported for the month of May. Nationally 3,101 patients were waiting more than 52 weeks. At the end of June, the Trust reported 21 patients waiting 52+ weeks of which; 8 were Urology, 5 ENT, 2 T&O, 2 Oral Surgery, 2 Rheumatology, 1 Ophthalmology and 1 Cardiology. 13/21patients have an appointment in July, 4 in August, 1 patient is awaiting MRI results, 2 patients require a TCI. Contact has been attempted with 1 patient via telephone or letter - awaiting a response.		
Causes of underperformance		
17/21 patients were identified as part of the historic validation of open pathways. Of the remaining 4/21 one patient had cancelled multiple appointments and is now re-booked for July, a second patient breached due to patient choice and diagnostic delays and have subsequently been treated early July. Two patients were identified as having an incorrect clock stop through routine validation, 1 is dated in July and 1 early August.		
Actions to address	**Owner**	**Deadline**
Validation team in place undertaking a methodical review of open pathways	Data Quality Manager / DGM	Dec 2018
Patient pathways found to require a review are escalated to the divisional teams to identify immediate capacity to offer an OP appointment within 2 weeks	DGM	In place
Patient found to require a review will trigger the harm review process immediately. A formal apology will be sent to the patient	Data Quality Manager	In place

Improvement trajectory

52 week breaches may continue to be identified until the historic validation work is complete (end of December 2018). The Trust trajectory is to be at zero by the end of March 2019.

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July - December Trajectory	January to February Trajectory	March Trajectory
52+	20	29	17	40	15	21	12	6	0

Risk	Mitigation
Further breaches identified due to ongoing validation programme	Appoint patients as soon as any breaches are identified
On-going live errors recorded on Medway PAS	Patient management reports to be reviewed on at the weekly RTT meeting

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

Exception Report

Indicator: Fractured neck of femur achieving best practice tariff
Month: May 2018
Standard: 75%

Current position		
For patients with a fragility hip fracture, care needs to be quickly and carefully organised. By rapidly stabilising patients and ensuring that expert clinical teams respond to their complex frail conditions, the most positive outcomes can be achieved. For May 2018 the Trust achieved 59.1% of best practice tariff measures against the standard of 75%.		
Causes of underperformance		
8 patients failed to meet the best practice criteria of which 6 would be considered unavoidable due to clinical reasons. Of the avoidable criteria one was due to the absence of a 4AT assessment documented during a weekend discharge and the second was due to lack of theatre time. The patient was operated on the following day.		
Action	Owner	Deadline
Capacity and Demand for Trauma to be undertaken - Additional Trauma Lists to be planned flexibility whilst completing this analysis.	DGM	August 2018
Business Case to be developed to improve compliance with BPT for tracking of patients.	DGM	September 2018
Process mapping to be undertaken in order to improve the pathway and times to treatment.	DGM	October 2018
Improvement trajectory		
Planned improvement in June to > 70%, July performance expected to deteriorate due to surges in Trauma demand.		

Risk	Mitigation
Increased demand due to a surge in Trauma would impact on the ability to operate within 36 hours	Flex utilisation of emergency and elective theatre lists to manage overall demand

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

Exception Report

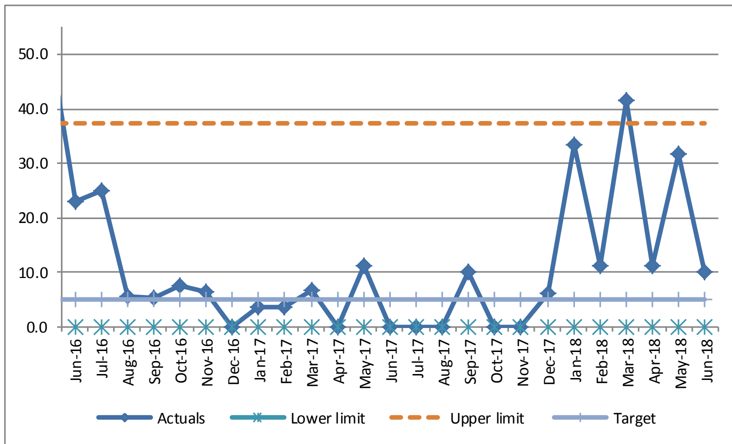
Indicator: Breaches of the 28 day standard following on the day non-clinical cancelled elective operation

Month: June 2018

Standard: 0

Current position
There were ten on the day elective cancellations for non-clinical reasons in June 2018. Nine patients were re-booked and treated within 28 days, one patient was offered a date within 28 days but chose to wait until day 36 (16th July) for their treatment.

Breaches of the 28 day guarantee following a Last minute (on the day) non clinical cancelled elective operation



Causes of underperformance
The patient was cancelled on 11th June 2018 due to lack of theatre time. This was as a result of the previous patient becoming unwell in theatre and taking longer than scheduled.

Action	Owner	Deadline
Develop weekly report for all potential 28 day breaches	DGM	1st August 2018

Risk	Mitigation
Lack of theatre or surgeon capacity to ensure patient is offered a date within 28 days	Divisional management of weekly 28 day report

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

Executive Lead: Simon Barton, Chief Operating Officer

Exception Report

Indicator: 62 days urgent referral to treatment
Month: May 2018
Standard: Maximum 62 day wait for first treatment from urgent GP referral for suspected cancer (85%)

Current position

The Trust delivered 79.7% for the month of May and saw the highest volume of treatments recorded in one month at 101 of which 20.5 were treated >62 days. This is against an average of 73 treatments per month.

A significant increase in the volume of treatments in May were in Breast, Skin and Urology and are considered a direct result of an overall 20% increase in 2WW referrals in March. The increase in referrals is replicated across the region, most notably within Urology and cited as due to the high celebrity profile of prostate cancer. For the month of May, national performance was 81.1% and the region 79.5% with 30/42 Trusts failing the standard.

All other Cancer targets were met in May 2018 except for the 2WW Breast symptomatic standard which failed for the first time since April 2017 at 90.5%; all 4 breaches were due to patient choice.

Causes of underperformance

2WW referrals had been relatively static with an average of 960 per month December – February. For the month of March this rose to 1,174 reducing to 1,094 in April and rising again to 1,294 in May. The latter will impact on July's performance.

Over half of the patients that breached the standard in May were Urology. There was a 25% increase in the volume of referrals in this tumour site in March, this impacted predominantly on diagnostic capacity such as access to MRI and biopsy with the wait times averaging 18 days for a first MRI and up to 21 days for a template biopsy.

Breach analysis across all tumour sites has identified 13/20.5 breaches were due to patient choice to delay or for clinical reasons such as complexity or required multiple diagnostics. 7.5 were due to a range of capacity and process delays.

4.5 of the total breaches were within 7 days of their 62-day breach date.

Action	Owner	Deadline
Identify early warning signs and actions to address an increase in 2WW referrals	Janet Duffin	July 2018
Additional diagnostic biopsy capacity identified for June, July and August	Rebecca Stuart	In place
Systematic root cause analysis to be undertaken by clinical teams to match common themes to improvement actions.	Steve Foley	June 2018
Clinically led cancer task force to focus on improvement initiatives cross tumour site and modality in place. This forum leads on performance improvement and transformational plans.	Steve Foley	In place since May 2018
Focussed Prostate pathway improvement event to be held to identify unnecessary delays. A prostate workstream will take forward any actions identified.	Rebecca Stuart	26th July

Improvement trajectory

In March 2018 the Trust submitted a trajectory to NHSI which showed non-delivery of the standard in all 3 months in Quarter 1. At that time the key assumption under-pinning the trajectory was the

national implementation of the inter-provider policy having a negative impact on performance of between 1 and 3%. This subsequently has been delayed until October 2018.

With forecast performance for June at 87%, the Trust will have delivered in 2/3 months and expect to deliver for Quarter 1, however the impact of the increase in referrals particularly within Urology and the demand for diagnostic capacity has resulted in a shift of non-delivery to July and August.

Recovery is expected from September onwards.

Risk	Mitigation
Volume of referrals continue to be higher than expected	Early warning indicators share with tumour sites and diagnostic colleagues to support proactive capacity management.
Impact of national breast screening service and conversion to treatment	Additional weekend screening capacity in place. No significant conversion to date.
CT replacement programme August /September 2018	Option to secure a mobile van for the 8 week duration

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

Quarter One - Finance
At month 3 the Trust is reporting a deficit of £13.91m before Provider Sustainability Funding (PSF), £0.06m ahead of plan year to date (YTD). Achievement of PSF is based on delivery of the 4 hour access standard and delivery of the control total. At the end of quarter 1, PSF of £1.86m has been reflected as a result of delivery of the 4 hours access standard (see above) (£0.56m) and delivery of the control total both within SFH and system wide (£1.30m). The reported control total deficit is therefore £12.06m, in line with plan.

Key areas of note in the position YTD are:

- The Financial Improvement Plan (FIP) is behind plan by £0.40m. Delivery of the FIP programme is vital to delivery of the Trust control total.
- Non elective (NEL) activity and therefore income remains at levels seen in quarter 4. The planning assumption was that activity would fall in quarter 1 of 2018/19. At the end of month 3 NEL activity is £1.9m over plan. Correspondingly, costs to deliver this activity including capacity costs and non-pay continue to be incurred. Income is sufficient to offset costs.
- Medical pay spend is £1.5m adverse to plan at month 2. This has improved marginally to month 2. Significant overspends reflect cover for sickness and vacancies mostly in Medicine, Surgery and W&C of £0.78m, costs of additional capacity covered by income of £0.35m, unmet FIP of £0.37m.
- Elective activity is below plan by £0.24m with no reduction in cost. This is within Gynaecology (£0.18m) and most specialties within the Surgical division.
- Births are below plan YTD and once non recurrent cost reductions are accounted for represent a £0.24m adverse position. Lower levels of activity are expected for the remainder of the year.
- Offsetting the above, release of uncommitted reserves of £0.60m have supported the position to deliver in line with plan at the end of quarter 1.
- Agency spend fell in June to £1.35m. This is in excess of the ceiling by £0.29m YTD.
- Cash balances are behind plan but in line with minimum cash balances reflecting active working capital management to keep interest costs as low as possible.
- Capital spend is behind plan but is expected to return to plan following agreement with NHSI that 17/18 Sustainability and Transformation monies will be used to support the plan, removing the need for borrowing.

A full revenue forecast has been undertaken at the end of Q1. This identifies a total risk of £6.87m which is offset by a contribution from additional NEL activity and the release of uncommitted reserves to enable the control total of a maximum deficit of £46.37m to be delivered. This relies most significantly on delivery of the FIP programme, which has been assumed to achieve £13.32m of the £17.30m plan. It continues to be assumed (as per planning assumptions) that any impact of new, significant QIPP schemes can be offset with a reduction to cost.
The risk range at the end of month 3 shows a downside of £12.36m adverse to plan pre PSF, largely driven by non-delivery of the FIP target. The upside shows a £1.64m favourable to plan position pre PSF.

Quarter One - Finance summary
At the end of June the Trust is £0.06m ahead of control total including and excluding Provider Sustainability Funding (PSF).

	June 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 PSF	(4.38)	(4.07)	0.30	(13.97)	(13.91)	0.06	(46.37)	(46.37)	0.00
Surplus/(Deficit) - Control Total Basis Inc PSF	(3.76)	(3.46)	0.30	(12.11)	(12.05)	0.06	(33.97)	(33.97)	0.00
Finance and Use of Resources Metric YTD				3	3		3	3	
Financial Improvement Programme (FIP)	0.90	0.54	(0.36)	2.18	1.82	(0.36)	17.30	13.32	(3.98)
Capex (including donated)	(0.71)	(0.28)	0.43	(1.29)	(0.93)	0.36	(9.75)	(9.75)	0.00
Closing Cash	2.62	1.57	(1.05)	2.62	1.57	(1.05)	1.76	1.76	0.00
NHSI Agency Ceiling - Total	(1.31)	(1.35)	(0.03)	(4.03)	(4.32)	(0.29)	(16.66)	(15.25)	1.41

- In Q1 both the Trust and the STP have met their financial control totals and the Trust has also achieved the 95% ED target, therefore the full value of PSF is included for Q1.
- YTD FIP delivery is below plan by £0.36m.
- YTD capital expenditure is £0.36m behind plan.
- Closing cash at 30th June was £1.05m less than plan reflecting timing of payment of 2017/18 capital creditors.
- Agency spend is above NHSI ceiling level in Q1 by £0.29m, but is forecast to be £1.41m below ceiling at year end.
- The Trust is forecasting to achieve its control total for 2018/19, with a risk of £6.87m.