Sherwood Forest Hospitals
NHS Foundation Trust

Public Board Meeting Report

Single Oversight Framework Integrated Monthly Performance Report – July 2018

Date	**30 August 2018**
Authors	**Senior Leadership Team**
Lead Directors	**Executive Team**

Overview – July 2018

The Single Oversight Framework Integrated Monthly Performance Report captures Organisational Health, Patient Safety, Quality and Experience, Access and Performance and Financial information and indicators for the month of July 2018. Where the information is for previous months, this is identified. There are **nine** exception reports this month.

July was another busy month for emergency care and was the third consecutive month in which we treated more emergency patients than the corresponding month in 2017-18. In July we experienced the highest ever number of Emergency Department attendances for Newark and King's Mill Hospitals combined. We treated 14,365 emergency patients which was 1165 (8%) more than July 2017 and is above planned levels by 12% in month and 6% year to date.

Admissions to medical beds have remained at the levels experienced during last winter, which is a positive indicator of the work that has been put into safely avoiding inappropriate admissions and overall emergency activity is above planned levels by 11% in month and 6% year to date. Additional costs to deliver the activity and capacity continue to be incurred and whilst income is sufficient to offset these costs the Trust remains above the NHSI Agency ceiling year by £0.42m year to date.

Elective and day case activity are both below plan in July. Overall, elective activity is below plan by £0.72m with no reduction in cost. This is within Gynaecology and most specialties within the Surgical division. In addition, births are below plan year to date by £0.40m and this is expected to continue for the remainder of the year.

The Trust's overall risk profile remains stable and are identified in the narrative of this report and the exception report. The risks were reviewed at the Risk Committee on 23 August.

Principle Risk	Current Risk Exposure	Tolerable risk
PR 1: Catastrophic failure in Standards of Care	High (12) ⟺ (no change)	Low (4)
PR2: Demand that overwhelms capacity	Significant (16) ⟺ (no change)	Medium (8)
PR3: Critical shortage of workforce capacity & capability	Significant (16) ⟺ (no change)	Medium (8)
PR4: Failure to maintain financial sustainability	Significant (20) ⟺ (no change)	High (10)
PR5: Fundamental loss of stakeholder confidence	High (12) ⟺ (no change)	Low (5)
PR6: Breakdown of Strategic Partnerships	Med (8) ⟺ (no change)	Low (4)
PR7: Major disruptive incident	High (10) ⟺ (no change)	Low (5)

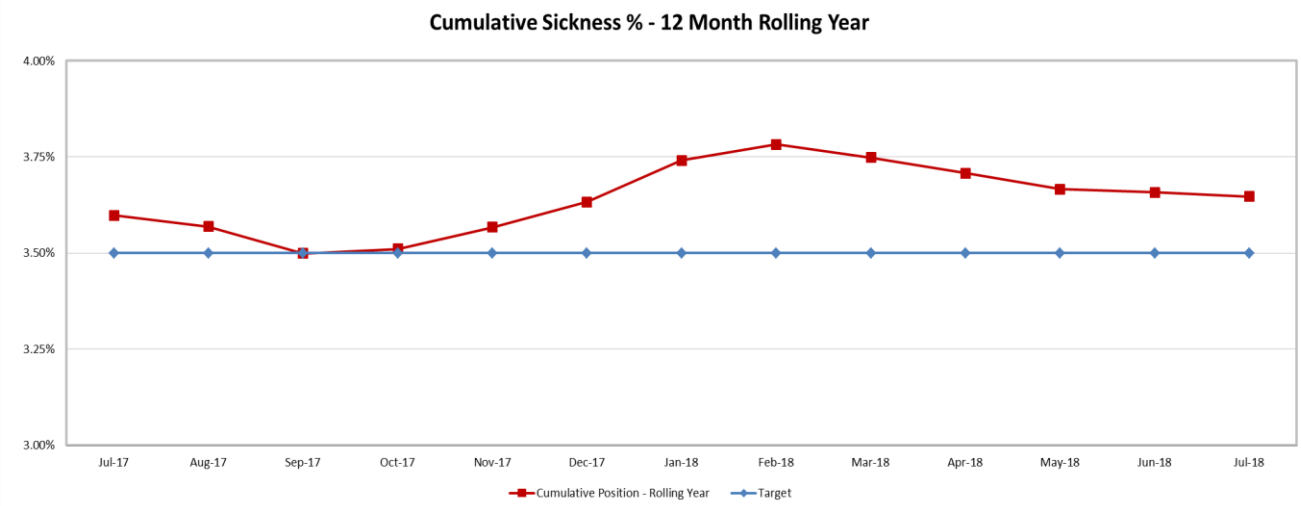
Organisational Health

During July the high level workforce KPIs were all on target. In particular, Trust level sickness at 3.31% was the fifth consecutive month below 3.5%. Whilst medical pay spend is £2.33m adverse to plan at month four and reflects specific sickness and vacancies in Medicine, Surgery and Women's and Children's, the above has had a positive impact on minimising the number of shifts requiring bank or agency cover which has been especially important to maintain safe staffing levels at a time when admissions to medical beds has remained high and overall emergency activity is well above planned levels.

Given these challenges, it is reassuring that appraisal levels (96%) and mandatory Training (94%) have been maintained above target through this busy period. Whilst turnover has remained below the 1% target, Band 5 Registered Nurse vacancies increased to 21.89% in July mainly due to promotions and flexible retirement, creating pressure on staffing levels and variable pay budgets. However, the 57 newly qualified students due to start with the Trust shortly, will help to off-set some of that staffing pressure before winter.

Sickness Absence - GREEN
Sickness absence decreased in July 2018 by 0.14% to 3.31% (June, 3.45%) This is the fifth consecutive month below the 3.5% threshold.

Sickness absence for July 2018 is 0.12% lower than July 2017. The 12 month rolling year (sickness average for the previous 12 month period for each month), was indicating a sustained improvement as the winter upturn has now been reversed.



- Three divisions are below the threshold and green: Women & Children's, 2.69%; Urgent & Emergency Care, 3.01%; Corporate, 3.31%.

- Three divisions are above the threshold and amber: Diagnostics & Outpatients, 3.51%; Surgery, 3.77% and Medicine, 3.94%.

- All Divisions above the 3.5% threshold have a trajectory and action plan for improvement which is monitored at the monthly divisional performance meeting.

Continually holding the sickness absence figure to below the 3.5% threshold supports the Trusts financial out-turn by reducing agency costs and also helps to ensure safe staffing levels.

Appraisal - Green
Trust wide appraisal compliance for July 2018 increased to 96% (June 2018, 95%). This is 1% above the Trust target of 95%. Compliance has been at or above target for all months of the 2018/19 financial year so far. This is a significant improvement on the previous year where compliance ranged from 91% to 93% for the same period.

All appraisals now include talent conversations which help to improve succession planning.

Training and Education - GREEN
Mandatory training increased in July 2018 by 1% to 94%* against a 90% target. The Trust has been at or above target on this KPI continually for two years. 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.*

Staffing and Turnover - GREEN
In July 2018, the overall turnover rate increased to 0.94% (June, 0.73%), this is below the 1% threshold. The only month this financial year so far to exceed the threshold was April 2018. There were 4.41 FTE more starters than leavers in July 2018 (42.09 FTE starters v 37.68 FTE leavers). The highest FTE leaving reason is flexi retirement at 9.92 FTE. However, although these individuals have left the Trust and are accessing their pensions, they will still provide some work for the Trust on a more flexible basis.

Nurse Vacancies
All Registered Nurse (RN) vacancies increased slightly in July to 14.55%, 195.78 FTE (June, 14.26%, 192.10 FTE). Band 5 RN vacancies increased to 21.89%, 162.08 FTE. (June, 21.35%, 158.22 FTE). The 21.89% RN band 5 vacancy rate leaves significant nursing shifts vacant which will need to be covered by bank or agency workers. This increase in vacancies was anticipated as substantive RN's employed by the Trust tend to decrease over the summer, but are replenished with the employment of newly qualified nurses.

This year, there are 57 newly qualified nurses due to commence with the Trust.

From our July Assessment Centre we appointed 7 qualified RN's and have 30 more booked into our August event, in addition to the newly qualified students mentioned earlier.

We currently have the following new starters scheduled to commence as follows: (student and qualified) 29 RN's in September 2018 and 38 in October 2018.

There are no exception reports for Organisational Health.

Patient Safety, Quality and Experience

During July there have been no single sex accommodation breaches and the Trust has continued to maintain compliance with providing single sex accommodation, recognising the importance placed on maintaining the privacy and dignity of our patients.

Careful monitoring of all healthcare associated infections continues and their management in line with national and local guidance. July saw six new cases of *Clostridium Difficile* Infection which took the Trust outside of our monthly objective. The Trust annual total to date is eleven cases against a trajectory of forty seven for the year. Please see attached exception report for more detail. Again there were ZERO MRSA bacteraemia identified and no further cases of influenza. There have been cases of *Escherichia Coli* bacteraemia confirmed for July, one of which was related to the presence of a urinary catheter. An outbreak of Pseudomonas Aeruginosa was identified on the Critical Care Unit, seven patients were tested positive and four have been confirmed as having the same strain.

With regard to pressure ulcers (PU) the Trust remains below target and reported no avoidable pressure ulcers during July. The roll out of new continence products alongside education with regard to improved skin care is anticipated to reduce the number of Pus attributed to moisture damage. Work is ongoing to increase the use of photography in pressure ulcer care with processes and the current photography consent form under review. It is anticipated this work will be concluded in October and that compliance with the use of photography will significantly improve as a consequence.

The reduction in falls against Trust trajectory continued throughout July and falls numbers were significantly below the national average. However there were five falls recoded in month where harm was identified as being moderate or above. Three related to patients who sustained long bone fractures. Following investigation the remaining two falls are likely to be downgraded and attributed to medical collapse due to cerebral bleed. The Falls Nurse continues to drive reduction in falls with a multi-disciplinary approach and to maintain the culture where falls are treated as unacceptable. There is a further focus this month on the reduction in patients who sustain repeat falls and those who sustain harm from falls.

The monthly VTE assessment audit demonstrated that the Trust again remained above 95% target during June. July's compliance rate will not be reported until September 2018, due to the delay in collection of the data.

Within the Safety Thermometer the Trust reported 96.34% harm free care during July 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 3.66% n = 18 and the new harms total is 4 (0.8%).

The focus remains on improving compliance with dementia screening. Despite a significant improvement during June the refer element of screening continues to remain below target. An issue with information sharing has now been resolved and this is expected to improve the referral rate to Rapid Response Liaison Psychiatry going forward. Further detail is given in the attached exception report.

In July the UNIFY data for safe staffing across some of the wards and departments, which are included within the UNIFY data collection, was reported as 101.3%. There were no harms reported to our patients in the areas which were scoring amber (which is areas which scored below 90% but above 80%).
There were three STEIS reportable incidents in July 2018, and there was no Never Events.

The trust did not have any over the date Patient Safety Alerts in July 2018.

In July, the Trust has the following exception reports for Patient Safety, Quality and Experience:

- Post 72 hours Clostridium Difficile Infection (July 2018)
- Pseudomonas Aeruginosa Outbreak on Critical Care (July 2018)
- Dementia – Find, Assess, Investigate and Refer (there are three parts) (June 2018)
- Friends and Family Test (July 2018)

Operational Performance/ Access

Performance on emergency access has been positive during July 2018 with 95.9% of patients discharged, transferred or admitted within 4 hours, this is above trajectory. Ambulance handover performance deteriorated in July; there was a 6.87% increase in ambulance arrivals compared to June 2018 and a 4% increase compared to July last year. There were also more days in the month where 100 or more ambulances arrived, this was 17 days in July (55%) compared to 10 days in June (33%).

Timeliness of access to Cancer care remains positive with the majority of standards being achieved and the 62 day standard meeting the June trajectory. Two week wait referrals remain above average in June, this is a sustained increase from March; conversion rate to treatment remains reasonably static at 7%.

Diagnostics performance is better than trajectory for July and the standard was delivered; this is expected to be achieved going forward but risks do remain with Cardiac CT and with the scheduled CT replacement in September.

RTT is below trajectory and the standard (90.6% v 92% trajectory) but has shown the third consecutive month of improvement. There is also an exception report for patients who have waited over 52 weeks for which there were 18.

In July, the Trust has the following exception reports for Operational Performance and Access:

- % of Ambulance handover >30 minutes / % of Ambulance handover >60 minutes (July 2018)
- 18 weeks referral to treatment time – incomplete pathways (July 2018)

- Number of cases exceeding 52 weeks referral to treatment (July 2018) 62 days urgent referral to treatment (June 2018)
- Fractured neck of femur achieving best practice tariff (June 2018)
- Breaches of the 28 day standard following on the day non-clinical cancelled elective operation (July 2018)

Finance

At month 4 the Trust is reporting a deficit of £17.49m before Provider Sustainability Funding (PSF), £0.20m behind plan year to date (YTD). At the end of month 4, PSF of £2.69m has been reflected as a result of delivery of the 4 hours access target in quarter 1 (actual) and quarter 2 (forecast), (£0.81m) and assumed cumulative delivery of the control total at the end of quarter 2 both within SFH (£1.61m) and system wide (£0.27m). The reported control total deficit is therefore £14.80m, £0.20m behind plan. This is £0.2m worse than was forecast for month 4 when the forecast was undertaken at the end of quarter 1.

Key areas of note in the position YTD are:-

- The Financial Improvement Plan (FIP) is behind plan by £0.47m.
- 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 4 NEL activity is £3.03m 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 £2.33m adverse to plan at month 4 and the increase in medical pay run rate is the driver of the overall position being adverse to forecast. Significant overspends reflect cover for sickness and vacancies mostly in Medicine, Surgery and W&C, costs of additional capacity covered by income, unmet FIP of £0.59m.
- Elective activity is below plan by £0.72m with no reduction in cost. This is within Gynaecology (£0.21m) and most specialties within the Surgical division.
- Births are below plan YTD and once non recurrent cost reductions are accounted for represent a £0.40m adverse position. Lower levels of activity are expected for the remainder of the year.
- Offsetting the above, the release of uncommitted reserves of £1.67m has supported the position at the end of month 4.
- Agency spend increased in July by £0.10m to £1.45m. This is in excess of the ceiling by £0.42m YTD.
- Cash balances are ahead of plan by £7.85m.
- Capital spend remains behind plan but is expected to return to plan.

The revenue forecast undertaken at the end of Q1 has been updated to reflect M4 actual results. This identifies a total net risk of £8.94m, an increase of £2.07m in month 4 following further deterioration to divisional forecasts. The most significant risk is non delivery of FIP. The Trust is in the process of developing a recovery plan, with external assurance, focusing on delivery of the FIP, divisional recovery plans, a balance sheet review and improved grip and control. 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 4 shows a downside of £12.06m adverse to plan pre PSF, largely driven by non-delivery of the FIP target. The upside shows a £5.09m favourable to plan position pre PSF.

Financial Summary

At the end of July the Trust is £0.20m behind its control total including and excluding Provider Sustainability Funding (PSF).

	July 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	(3.32)	(3.58)	(0.26)	(17.29)	(17.49)	(0.20)	(46.37)	(46.37)	0.00
Surplus/(Deficit) - Control Total Basis Inc PSF	(2.49)	(2.75)	(0.26)	(14.60)	(14.80)	(0.20)	(33.97)	(33.97)	0.00
Finance and Use of Resources Metric YTD				3	3		3	3	
Financial Improvement Programme (FIP)	1.33	1.22	(0.11)	3.51	3.04	(0.47)	17.30	13.30	(4.00)
Capex (including donated)	(0.59)	(0.33)	0.27	(1.88)	(1.25)	0.63	(9.75)	(9.75)	0.00
Closing Cash	2.62	10.47	7.85	2.62	10.47	7.85	1.76	1.76	0.00
NHSI Agency Ceiling - Total	(1.32)	(1.45)	(0.13)	(5.35)	(5.77)	(0.42)	(16.66)	(16.66)	(0.00)

- Both the Trust and the STP are forecasting to meet cumulative financial control totals at the end of Q2 and the Trust achieved the 95% ED target in Q1 and is forecasting to do so in Q2, therefore the full value of PSF is included at M4.

- YTD FIP delivery is below plan by £0.47m. The 18/19 FIP programme is forecast to deliver savings of £13.30m.

- YTD capital expenditure is £0.63m behind plan; however, full achievement of the annual plan is forecast.

- Closing cash at 31st July was £7.85m greater than plan reflecting the receipt of 2017/18 STF (PSF). Borrowing for July and August has been reduced to nil to offset.

- Agency spend is above NHSI ceiling level in YTD by £0.42m and is in line with ceiling at year end. There is a risk in exceeding the ceiling due to winter capacity requirements.

- The Trust is forecasting to achieve its control total for 2018/19, with a risk of £8.94m.

Exception Reports

Indicator **Post 72 hours Clostridium Difficile Infection**
Month **July 2018**

Current position

There were 6 Clostridium Difficile Infections (CDI) in July, bringing the cumulative total to 11, the annual objective is 47

A review of the 6 CDI identified that 2 are possibly linked, the others were sporadic cases. A period of increased incidence has been identified on the Stroke Unit possibly linking the 2 cases. An initial meeting was held to review the period of increased incidence and some learning points and actions were taken as a result, these included:

- Medirest tasked with checking room is up to standard before a HPV fogging commences
- Monthly HPV fogging of the gym to be undertaken, any equipment suitable to be included;
- Twice daily equipment cleaning by Ward staff;
- all patients previous infection history to be reviewed
- To identify patients who have an antibiotic allergy and establish if this is a true allergy

All of the samples from July have been sent to Birmingham for Ribotyping to identify if any are the same strain. All patients are being reviewed to identify if there has been any cross over in areas they were cared for.

Causes of underperformance

For this type of organism, patient factors are a major contributor to the increased risk of infection. Where antibiotics are required to treat a primary infection there is an increased risk that this will drive incidence of CDI occurring.

Actions to address

Action	Owner	Deadline
For all samples to have a ribotyping result	IPCT	24/08/2018
For the stroke unit to commence a monthly HPV fogging of the gym	Soft facilities and Medirest	24/08/2018
Review of all 6 patient movements around the Trust	IPCT	17/08/2018

Improvement trajectory

To achieve reduced nationally set objective for 2018/2019 of 47 cases.

Risks

Risk	Mitigation

Patient factors – early identification of primary infection and appropriate treatment	Timely microbiology samples to ensure appropriate treatment is given early
High levels of flow reduces ward ability to clean to high enough specification (fogging)	To increase frequency of 'Amber cleaning' to minimise risk of environmental contamination
Patients identified as having an antibiotic allergy with no further details on type of reaction they have	To establish more information on the patients admission, to enable more appropriate antibiotics to be given.

Lead: Rosie Dixon, Nurse Consultant - IPC
Executive Lead: Dr Andrew Haynes, Executive Medical Director

Indicator **Pseudomonas Aeruginosa Outbreak on Critical Care**
Month **July 2018**

Current position

An outbreak of Pseudomonas Aeruginosa has been identified on the Critical Care Unit. 7 patients had positive samples and 4 of these have been confirmed as the same strain, the remaining 3 are sporadic cases.
Several actions were implemented as soon as this outbreak was identified and these included:

- Point of Use filters have now been fitted to all sinks by Skanska wherever possible – some taps physically unable to fit filters and no alternatives. Some other issues arose but have since been rectified.
- Staff are required to maintain good hand washing standards, using alcohol hand rub after drying.
- Any sinks without filters on the unit are to be used for staff handwashing only.

An outbreak meeting has taken place and further concerns were raised and further actions were implemented, which include:

- All ICCU sinks to be sampled – there are issues with this but TW can facilitate when testing required
- Water coolers also to be tested (considered low risk) – hot water supply is fine.
- Ensure any equipment/products/trays etc close to any sink are moved away from any sink to reduce risk of splashing. (Highlight possible splash area with black/yellow tape)
- Cleaning of sluice concerns – Medirest staff need directing not to clean/touch tap filters, ICCU staff only to clean with alcohol wipes.
- Increased patient screening for Pseudomonas, routine screens from specific sites
-

Causes of underperformance

For this type of organism, it can sometimes be associated with contact with contaminated water or the organism can contaminate devices that are left inside the body, such as respiratory equipment and catheters.

These causes are being investigated at this time.

Actions to address

Action	**Owner**	**Deadline**
Ongoing monitoring of all above actions.	IPCT/ICCU/Skanska and Strategic Planning	31/08/2018

Improvement trajectory

To prevent a further outbreak

Risks	
Risk	**Mitigation**
Patient factors – early identification of primary infection and appropriate treatment	Timely microbiology samples to ensure appropriate treatment is given early

Lead: Rosie Dixon, Nurse Consultant - IPC
Executive Lead: Dr Andrew Haynes, Executive Medical Director

Indicator: **Dementia – Find, Assess, Investigate and Refer (there are three parts)**
Month: **Reporting on data collected in June 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 June 2018, 98.6% of eligible patients were identified (May data – 98.0%). ASSESS AND INVESTIGATE – During June 2018, 109 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 83 patients for whom the outcome of further assessment and investigation was positive or inconclusive and 74 of these patients were referred for further diagnostic advice in line with local pathways [89.2%]. This is an improvement on May performance [72.4%].
Causes of underperformance
REFER –The cause of underperformance relates to the fact that 9 people were not referred to RRLP in accordance with the dementia care pathway despite these patients responding positive to the case-finding question. RRLP were unable to identify the patients at this time however this has been addressed and should not be a problem moving forward with the process for sharing information that is now in place

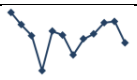
Actions to address	**Owner**	**Deadline**
A member of the safeguarding team is working one day a week to ensure that patients are screened within 72 hours of admission.	Debbie King	31st October 2018
Practice Developments Nurses will be working with the Data Collection Administrator to ensure that eligible patients are on the appropriate pathways.	Tina Hymas-Taylor	On-going
The Dementia care pathway and acute confusion/ delirium pathway will be included in the revised mandatory up-date presentation.	Fiona McCandless-Sugg	31st August 2018
Specialist Dementia Nurse will provide oversight and support the cover provided by the PDNs and safeguarding team to ensure there are no gaps.	Fiona McCandless-Sugg	On-going

Specialist Dementia Nurse will continue to provide assurance around analysis of thebdata.	Fiona McCandless-Sugg	On-going
Data collection will be moving to an electronic format.	Tina HymasTaylor	Autumn 2018
Improvement trajectory		
Data collected in July demonstrated performance above 90% on all three components.		

Lead: Tina Hymas-Taylor Head of Safeguarding
Executive Lead: Suzanne Banks Chief Nurse

Indicator: **Friends and Family Test**
Month: **July 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%	Jul-18	93.9%	94.8%		R
Response Rate: Friends and Family Accident and Emergency	≥12.8%	Jul-18	13.0%	12.6%		R
Recommended Rate: Friends and Family Maternity	96%	Jul-18	96.1%	94.0%		R

Causes of underperformance

1. **The FFT recommendation rate in Outpatient Services** – recommendation rating is 1.2% off plan for July 2018.

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

- The use of apps to book appointments
- Availability of a water cooler

Newark Clinics – Radiology, Podiatry and Pain Management

- Improved car parking

Therapy Services

- Availability of refreshments
- Appointment times in clinic

Actions taken by Division

Weekly OPD Matron and Clinical Lead review all Friends and Family responses and share the negative comments with the relevant staff.
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.
Car Parking - Car parking issues escalated to Ben Widdowson and Wes Burton.

2. **The FFT recommendation rate in Maternity Services** – recommendation rating is 2% off the target for July 2018

Sherwood Women's Centre – Newark

- Waiting times in clinic

Women's and Childrens – KMH

- Car parking charges
- Fans required on Maternity Ward
- Doctors inappropriate attitude towards midwife and care staff

3. **The FFT response rate in Accident and Emergency** – recommended response rate 0.2% below target for July 2018, decrease by 0.8%

- Staff continue to use paper surveys, iPads with the support of volunteers and text messaging to collect feedback. Staff continue to engage with patients with the aim of improving. The FFT responses are also reviewed as part of the monthly ward assurance meeting.

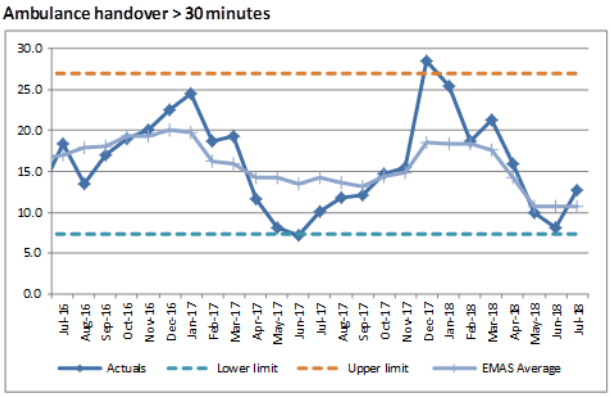
Action	**Owner**	**Deadline**
Divisional Management teams to receive and review FFT comment reports. This will enable Divisional teams to develop and implement changes that can respond to the concerns and improve the experience for service users.	Kim Kirk (Head of Patient Experience)	Completed and ongoing- 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 and ED response rate		
Mitigation: Actions agreed and this will be monitored monthly		

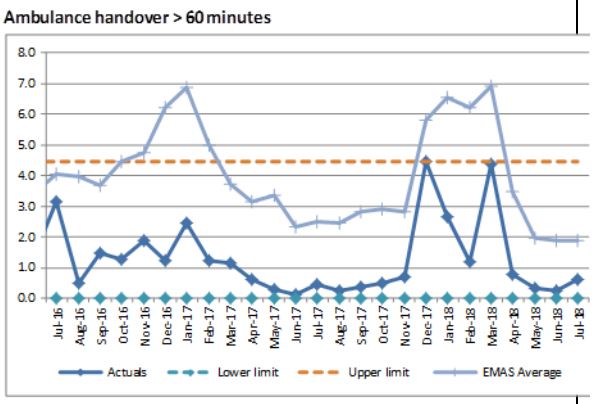
Lead: **Kim Kirk – Head of Patient Experience**
Executive Lead: **Dr Andrew Hayes – Medical Director**

Indicator **% of Ambulance handover >30 minutes / % of Ambulance handover >60 minutes**
Month **July 2018**
Standard **0 patients delayed more than 30 mins / 60 mins from arrival to handover**

Current position

In July 2018, 12.7% of ambulance handovers took longer than 30 minutes and 0.6% took longer than 60 minutes.





Average clinical handover time has deteriorated from 17.36 minutes in June to 19:06 minutes in July.

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 July there were over 100 ambulances on 17 days in the month (55%), this was 10 days in June (33%) and 13 days in May (42%). There has been an 6.87% increase in ambulance arrivals in July compared to June (197) and a 4% (133) increase this July compared to July last year.

Actions to address

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

EMAS to address operational issues, identify learning and make improvements		2018)
Ensure joint electronic handover process with EMAS is adhered to.	Richard Clarkson	Ongoing (started Jan 2018)
Monthly review of all ambulance handovers taking ≥ 60 minutes to identify lessons that can be learned	Richard Clarkson	Ongoing (started April 2018)
Explore options for electronic patient registration	Siobhan McKenna	Ongoing (started July 2018)
Develop ambulance performance dashboard to identify process issues and trends	Siobhan McKenna	30 September 2018
Relaunch and rebrand 'fit to sit' to maximise physical capacity within ED	Richard Clarkson	Ongoing (started August 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

Indicator **18 weeks referral to treatment time – incomplete pathways**
Month **July 2018**
Standard **Maximum time of 18 weeks from referral to treatment – RTT (92%)**

Current position
Since April 2018, performance against the national standard for RTT has improved month on month. At the end of July 2018, the volume of patients on an Incomplete RTT pathway was 25,698 of which 2,415 were waiting >18 weeks. This position delivered performance of 90.60% against a trajectory of 92%.
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 total 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. As at the end of July 2018: 1. Surgical activity in two specialties T&O and Urology continues to be impacted by Trauma and Cancer demand. The volume of patients waiting > 18 weeks has reduced by 430 since 12th April. 2. Neurology@NUH service confirmed date of transfer 1st August. Now complete. 3. The total size of the PTL had been lower than trajectory in Q1. July was 0.7% higher than trajectory. Recovery in 3 specialties underpins delivery of the standard. These are Urology, Trauma and Orthopaedics and Cardiology.

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 140. 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 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 14 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	DGM	Additional sessions and use of the IS in August.

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. At the end of July 45 suitable patients were identified for the private sector, formally accepted early 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

Improvement trajectory

2018/19 Actual vs Trajectory:

RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July Trajectory	July	August 2018 - March 2019 Trajectory
Total	24,976	24,274	26,001	24,585	25,461	24,794	25,512	25,698	25,920 - 23,205
>18	2,600	2,633	2,350	2,457	2,100	2,470	2,040	2,416	2,070 - 1,850
<18	22,376	21,641	23,651	22,128	23,361	22,324	23,472	23,282	23,850 - 21,355
%	89.59%	89.15%	90.96%	90.01%	91.75%	90.04%	92.00%	90.60%	92.01%

The Trust is committed to delivering the standard before winter 2018 and as a minimum will continue to deliver 90%. Based on the actions plans in place the current forecast for the end of August is 90.26%.

To deliver 92% the volume of patients >18 weeks (end of July position) needs to reduce by at least 390. The actions described will deliver a c160 reduction by the end of September:

- Use of the Independent Sector - 30
- Additional sessions - 80
- Cardiology GPWSI - 50

To close the gap the Trust will focus on:

- Additional actions to support Cardiology
- Focus on reduction in follow up activity
- Theatre productivity gains

Risks	Mitigation
• Historically August sees an increase in	• Use of the IS and additional sessions planned

the volume of patients waiting >18 weeks • Outpatient demand – ASI's /Follow up's. • Medical cover over Summer • Cancer demand – Urology / Head and Neck	• 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

Indicator **Number of cases exceeding 52 weeks referral to treatment**
Month **July 2018**
Standard **Zero**

Current position

At the end of July the Trust reported 18 patients waiting 52+ weeks of which; 10 are Urology, 4 ENT, 1 T&O, 1 Oral Surgery, 1 Cardiology and 1 Neurology
Nine patients have a date in August, 5 have a date in September, 1 transferred to NUH, 1 has had diagnostic tests and is awaiting a follow up appointment, 1 patient has changed and re-booked their outpatient appointments, has subsequently attended in July and is now awaiting next steps, 1 patient requires a date.

Causes of underperformance

Fourteen patients were identified as part of the historic validation of open pathways.
Of the remaining 4; two patients identified through routine validation, both incorrectly stopped. One was an oral surgery patient admitted for surgery in November 2017 but cancelled on the day as unfit. Identified in July 2018, patient offered OPD 02/08 but declined. Agreed OPD 13/09. The second is a neurology patient whose clock was stopped following a cardiology appointment, now transferred to NUH. Two patients breached due to capacity. One urology patient had a long delay for a bladder pressure study. Now dated for TURP 20/08. Second patient is cardiology. Long delay for first OPD due to x2 hospital cancellations, awaiting myocardial perfusion scan followed by angiogram. Patient was seen on 01/08 and subsequently discharged to GP.

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
Weekly review of patients waiting 40+ Weeks at RTT PTL meeting.	Deputy COO (Elective)	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.

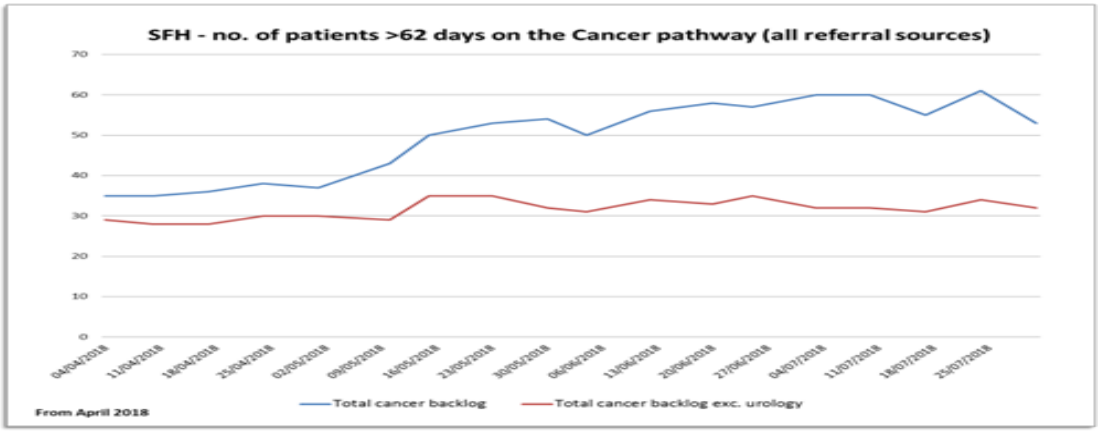
RTT Incomplete	April Trajectory	April Final	May Trajectory	May Final	June Trajectory	June Final	July Trajectory	July Final	August to December Trajectory	January to February Trajectory	March Trajectory
52+	20	29	17	40	15	21	12	18	12	6	0

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 PTL meeting.

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

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

Current position
The Trust delivered 84.6% for the month of June and 83.3% for Quarter 1. In month all other Cancer targets were met.
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, rising again to 1,294 in May and 1,178 in June. The crude average conversion rate from 2WW to cancer treatment is in the region of 6.8%. In May this rose to 9%, June 6% and July to date is 7%. 40% of the patients that breached the standard in June were Urology. There was a 25% increase in the volume of referrals in this tumour site in March and whilst they reduced in April, they rose again in May. The impact is predominantly felt in 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. The graph below shows that the volume of non-urology patients waiting >62 days has remained relatively static, whilst urology has grown.    A focussed Prostate pathway improvement event to be held to identify unnecessary delays took place on 26th July. This was well attended and generated a number of improvement ideas including Straight to Test MRI, One stop MRI Results Clinic with TRUS same day or template biopsy within 7 days, Pathology planning and post MDT joint oncology/surgical clinic.

Action	**Owner**	**Deadline**
Identify early warning signs and actions to address an increase in 2WW referrals	Janet Duffin	Complete

Additional diagnostic biopsy capacity identified for 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	Monthly in place
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
Prostate steering group and workstreams to commence September 2018	Rebecca Stuart	Set up to be complete by August 2018

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. The impact of the increase in referrals particularly within Urology and subsequent demand for diagnostic capacity has resulted in failing the standard in 2/3 months in Q1 and forecast non delivery for July and August. The aim is to recover 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	Mobile CT scanner secured for the 8 week duration

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

Indicator **Fractured neck of femur achieving best practice tariff**
Month **June 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 June 2018 the Trust achieved 71.9% of best practice tariff measures against the standard of 75%.
Causes of underperformance
Twelve patients failed to meet the best practice criteria of which five would be considered unavoidable due to clinical reasons. Of the avoidable criteria, six were due to time to theatre and one was a delay in geriatric review.

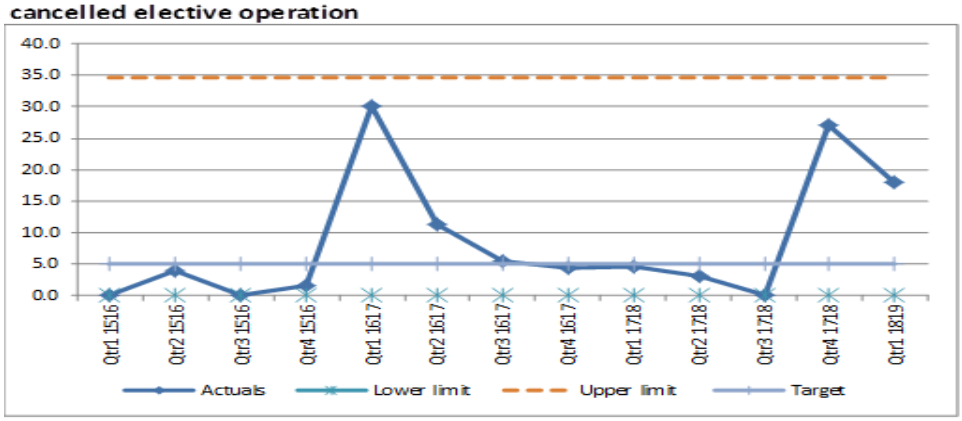
Action	**Owner**	**Deadline**
Capacity and demand analysis for Trauma to be undertaken - Additional Trauma Lists to be planned flexibly whilst completing this analysis.	DGM	August 2018
Business Case to be developed to improve compliance with BPT for tracking of patients.	DGM	September 2018
Process mapping 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.

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**

Indicator **Breaches of the 28 day standard following on the day non-clinical cancelled elective operation**
Month **July 2018**
Standard **≤ 5%**

Current position
There were 9 on the day elective cancellations for non-clinical reasons in July 2018. 6 patients were re-booked and treated within 28 days, 3 were not. **Breaches of the 28 day guarantee following a Last minute (on the day) non clinical cancelled elective operation** 
Causes of underperformance
Of the 3 patients not re-booked within 28 days, 1 was offered a date within 28 days but declined and 2 were unable to be offered a date within 28 days due to capacity pressures and prioritisation of patients on a cancer pathway.

Action	**Owner**	**Deadline**
Develop weekly report for all potential 28 day breaches	DGM	Complete
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**