Public Board Meeting Report

Single Oversight Framework Integrated Monthly Performance Report

Date 28 March 2019
Authors Senior Leadership Team
Lead Directors Executive Team

Overall Summary

This is our analysis of February 2019 (month 11) at Sherwood Forest Hospitals NHS Foundation Trust and the report reflects the views of all of the executive directors, not just the individual directors with a particular area of responsibility.

The best hospitals achieve a balance across their key areas of focus. They deliver safe, personalised and timely care to patients, they go about things in "the right way" and they deliver on their agreed financial position. Whilst February has been a more challenged and busier month, we believe we continue to deliver a balanced position. Our three key risks remain; failure to maintain financial sustainability, demand that overwhelms capacity and critical shortage of workforce capacity and capability.

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)

We have nine exception reports this month:

Organisational Health

- Sickness Absence

Patient Safety, Quality and Experience

- FFT
- Falls

- CDiff

Operational Performance and Access

- #NOF
- Cancer
- 52 weeks
- 18 Weeks
- 12 hour breaches

Organisational Health

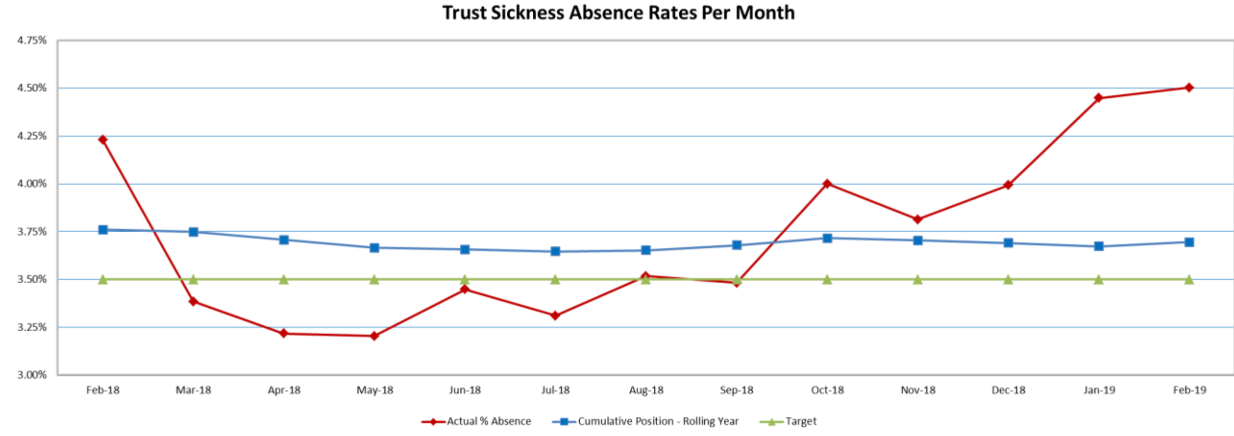
In February 2019, we maintained strong performance against workforce KPI's apart from sickness absence, for which an exception report has been produced. Although we maintained sickness absence at or below the 3.5% threshold for the first six consecutive months of the financial year, it has been above target and amber for all of quarter 3. Since then it has been red as in January 2019, it rose to 4.45%, and in February 2019, it rose again slightly to 4.50%. The stress, anxiety and depression sub-threshold was also breach at 1%.

The sickness absence rate will have had an impact on the number of shifts requiring bank or agency cover in order to maintaining safe staffing levels. However, that will have been mitigated to some extent by the reduction in medical and nursing vacancies. Given that our agency spend was well within our control total for February 2019, it suggests the majority of nursing and medical rota gaps created due to sickness are being filled by bank staff as opposed to agency workers. A key element affecting sickness absence is winter ailments. It is positive that we had a final flu vaccination rate of over 81.6% of front line staff.

Appraisal levels and mandatory training have remained at or above target throughout this financial year. Turnover was only 0.38% in February 2019.

Sickness Absence – 3.5% Target - RED (see exception report)

Sickness absence increased in February to 4.50% (January, 4.45%). This is the fifth consecutive month above the 3.5% target, however, this is the normal pattern for this time of year as October 2017 to February 2018 were all above the 3.5% target. Only one Division remained under the 3.5% target in February 2019, Corporate with 2.58%. The remaining Divisions above the target and red are: Women & Children's, 5.81%, Medicine, 4.98%, Surgery, 4.85%, Diagnostics & Outpatients, 4.59% and Urgent & Emergency Care, 4.00%.



It should be noted this chart now contains both the actual absence for the month (red line) and the 12 month cumulative absence, which indicates the overall trend. Sickness absence for February 2019 is 0.27% higher than February 2018.

The top three absence reasons in February are;

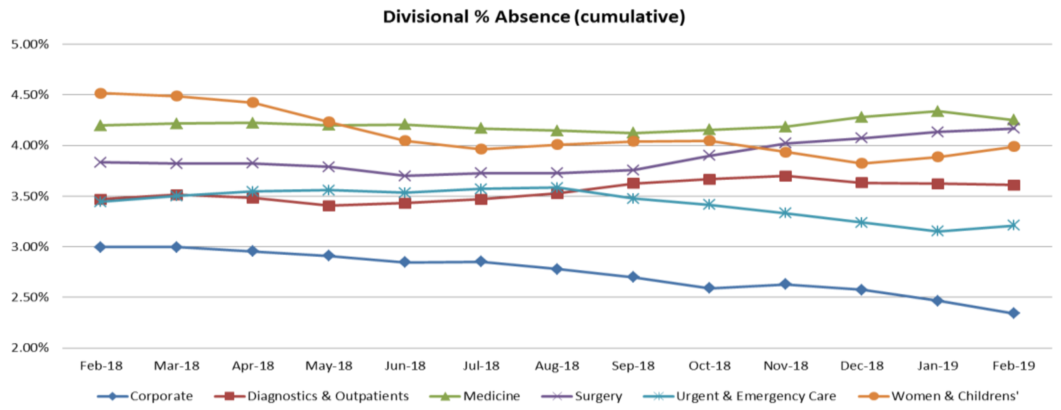
- Anxiety/stress/depression, 1.00%, 1137.34 FTE Days Lost which is an increase of 125.43 FTE days lost from January 2019
- Other Musculoskeletal, 0.61%, 693.23 FTE days lost which is an increase of 0.16 FTE days lost from January 2019
- Cold, Cough, Flu – Influenza is 0.53%, 598.79 FTE days lost which is a decrease of 296.41 FTE days lost from January 2019 and reflects the winter season.

Anxiety/stress/depression - 0.9% threshold – Amber

Anxiety/stress/depression was 1.00% in February 2019, in January it was 0.8%. Positively, there are three Divisions in month under the 0.9% threshold, these are: Corporate, 0.37%; Surgery, 0.54%; Diagnostics & Outpatients, 0.78%. The three Divisions above the target are: Women & Children's, 2.73%; Medicine, 1.31% and Urgent & Emergency Care, 1.05%.

Divisional sickness absence

Sickness absence trends in Divisions are below. It is based on a cumulative rolling 12 months, the same as the graph above.



In January 2019, on a rolling 12 months basis, two divisions were below the threshold and green: Corporate, 2.23% and Urgent & Emergency Care, 3.26%. Diagnostics & Outpatients has been fluctuating around the 3.5% target for the 12 month rolling period and is amber at 3.63%. All Divisions above the 3.5% threshold have a trajectory and action plan for improvement which is monitored at the monthly divisional performance meeting.

Appraisal – 95% Target - GREEN

Trust wide appraisal compliance has remained static for February at 96%. We have remained at or above the target of 95% for 12 consecutive months. All appraisals now include talent conversations which help to improve succession planning.

Training and Education – 93% Target - GREEN

Mandatory training has remained static at 95%* against the target of 93%. All Divisions have also remained static. Only one division, Urgent & Emergency Care at 92% is under the target.
**This rate refers to the number of competencies completed and not the number of staff compliant.*

Staffing and Turnover – 0.9% Target - GREEN
In February 2019, the overall turnover rate decreased to 0.36% (January, 0.81%). There were 7.23 FTE more starters than leavers in February 2019 (22.04 FTE starters v 14.81 FTE leavers). Registered Nurses had 2.63 FTE leavers, of these 0.60 FTE were Band 5. In month, all registered Nurse vacancies are at 10.90% and band 5 RN vacancies are at 16.98%. Turnover is consistently lower than the 0.9% threshold for registered nurses. Medical vacancies are at 6.84%

EU Nationals
We are tracking the movement of staff who are EU nationals and we gained two additional EU staff in February 2019.

	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19
Staff Headcount from an EU Country**	154	148	149	148	150
% Staff from EU	2.76%	2.61%	2.63%	2.59%	2.64%
Difference in Headcount in for EU Staff	-4	-6	1	-1	2

Patient Safety, Quality and Experience

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

All healthcare associated infections are carefully monitored and managed in line with national and local guidance. There were five case of *Clostridium Difficile* Infection (CDI) in February 2019, and this was above our monthly trajectory, bringing the annual total to 35 cases (see attached exception report). The annual trajectory for 2019/20 has reduced to no more than 47 cases in a year. ZERO MRSA bacteraemia were identified in February and four *Escherichia Coli* bacteraemia. There were no areas that reported any outbreaks of norovirus, however 157 episodes of influenza were seen in February, and this is similar to 2017/2018 season.

Reducing harm from pressure ulcers (PUs) has been identified as a supplementary quality priority in line with the Quality Account that will be implemented during 2018/19. During February one avoidable category 2 PU developed with low harm. There was also a category 2 and 3 both unavoidable with low harm as well as an unavoidable unstageable PU with low harm. The unavoidable suspected deep tissue injury from January evolved into a category 2 PU. All hospital acquired PUs are reviewed by the PU Root Cause Analysis panel chaired by the Chief Nurse, the Deputy Chief Nurse or Associate Chief Nurse and the Tissue Viability Nurse Consultant.

During February we reported 5.8 falls per 1000 bed days and remains significantly below the national average of 6.63. The reported falls resulting in moderate or severe harm was at 0.2 per 1000 bed days which remains within the target of 0.2 whilst the number of falls with low or no harm was slightly above our internal target at 5.5 per 1000 bed days (see attached exception report). There has been an increase in the numbers and the age demographics with higher numbers of older and frail patients admitted over the winter period. Other Trusts continue to show interest in our low falls rates with two visits planned in the near future to share our good practice.

January saw 99.7% of eligible patients identified and screened for dementia and 98.3% of those who were screened positively were referred on for further assessment and advice against a national target of 90% compliance with each of the three dementia screening elements.
The monthly VTE assessment audit demonstrated we achieved the 95% target during January 2019 with a total of 95% of assessments completed.

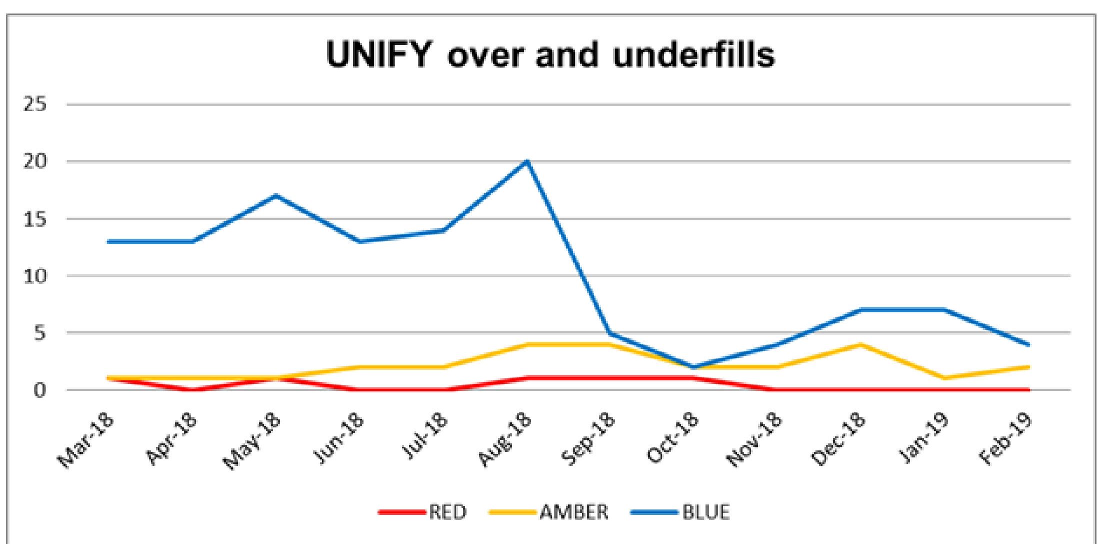
Within the Safety Thermometer we reported 95% harm free care during February against a standard of 95%. The standard includes ‘new’ harms that are acquired during that admission and ‘old’ harms which are present on admission, the total of all harms was 5% n = 29 and the new harms total is 7 (1.20%).

In February there were four Serious Incidents entered on STEIS. One of these was reported on Datix in December 2018 and was identified as Serious Incident at Sign Off on 5 February 2019. One was reported as an incident on Datix in January 2019, the patient died in February 2019 making this a Serious Incident. These are being investigated in line with the Serious Incident framework timeframe. There have been no Never Events during February 2019.

There have been no breaches of Safe Staffing Standard Operating Procedure in February 2019.

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.

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 was 1 (staffing fill rate is less than the accepted 90%, but above 80%) The recording as **blue** rating was 4 (actual staffing figures are greater than 110% fill rate). The remaining 23 wards and department were rated as **green.**

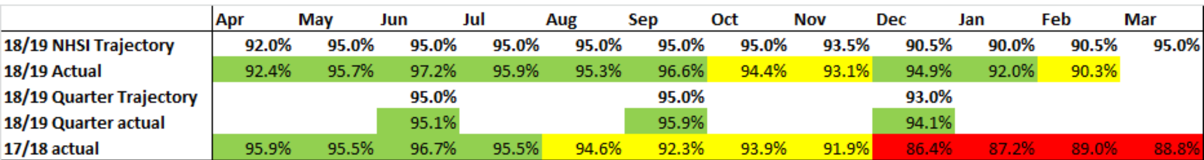


Operational Performance/ Access

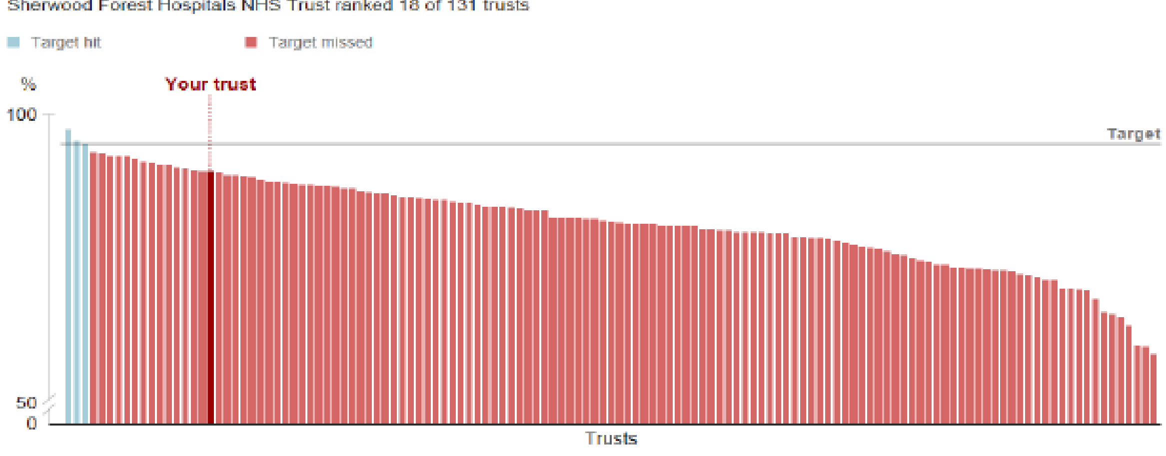
Emergency care

Emergency access performance against the 4 hour wait in February 2019 was 90.3%. This is 0.2% below the NHS Improvement agreed trajectory and 1.4% above the corresponding month in 2018, although it is worth noting that Kings Mill ED performance was 3% higher than in February 2018. February performance was ranked 18th of 131 Trusts in the NHS.

Ten patients waited >12 hours for admission from their decision to admit. Two of those patients were awaiting admission to psychiatric beds within Nottinghamshire Healthcare Trust. The other eight patients were awaiting medical beds on 10th/11th February and are subject to a separate briefing note to Board members as requested at February Board meeting. Harm reviews have been carried out for all the patients and no harm has been identified. The root cause was a gross imbalance between admissions and discharges on 10th/11th February. We went onto OPEL 4 and implemented its full capacity protocol. Full debriefs have taken place internally at the Patient Flow Group and externally with partners at the A&E Delivery Board. Actions to be taken forward have now been agreed and include reviews of OPEL 4 escalation out of hours, a review of the FCP, and the development of system triggers and actions via the A&E Delivery Board.



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19 NHSI Trajectory	92.0%	95.0%	95.0%	95.0%	95.0%	95.0%	95.0%	93.5%	90.5%	90.0%	90.5%	95.0%
18/19 Actual	92.4%	95.7%	97.2%	95.9%	95.3%	96.6%	94.4%	93.1%	94.9%	92.0%	90.3%	
18/19 Quarter Trajectory			95.0%			95.0%			93.0%			
18/19 Quarter actual			95.1%			95.9%			94.1%			
17/18 actual	95.9%	95.5%	96.7%	95.5%	94.6%	92.3%	93.9%	91.9%	86.4%	87.2%	89.0%	88.8%

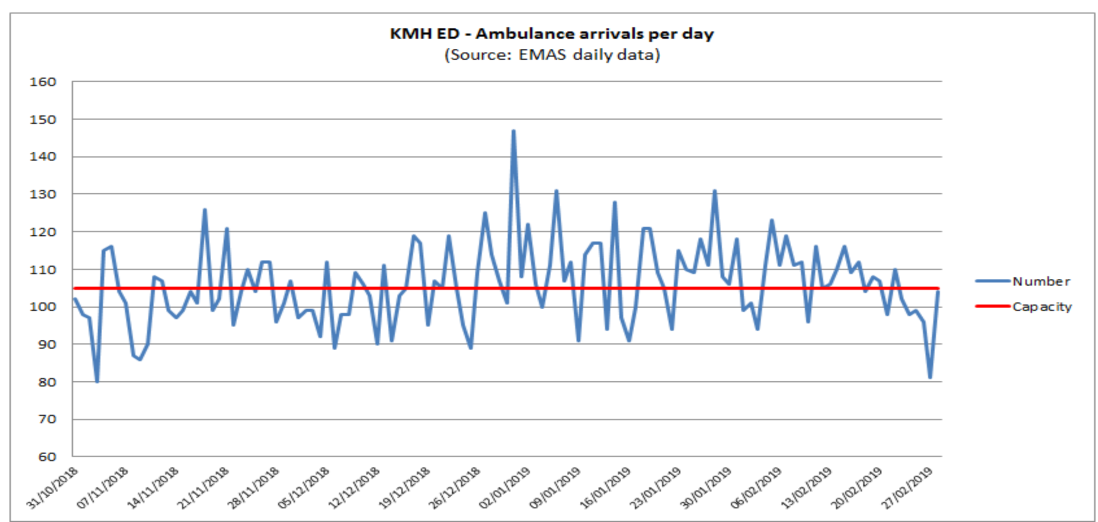


Ambulance arrivals

Ambulance arrivals have grown over the quarter and clearly some of this is expected to be the case over the winter months – growth has particularly been evident since of the middle of December and has been accompanied by an increase in variation. ED capacity is broadly 100-110 ambulances per day although some of this is dependent on the variation of arrival by hour. Waiting times start to deteriorate as ambulances arrivals go over 100.

February was again a busy month with regard to ambulance arrivals, but pressure did tail off in the final week of the month. The mean arrival rate was 105 per day. Most of the growth continues to be from local catchment areas.

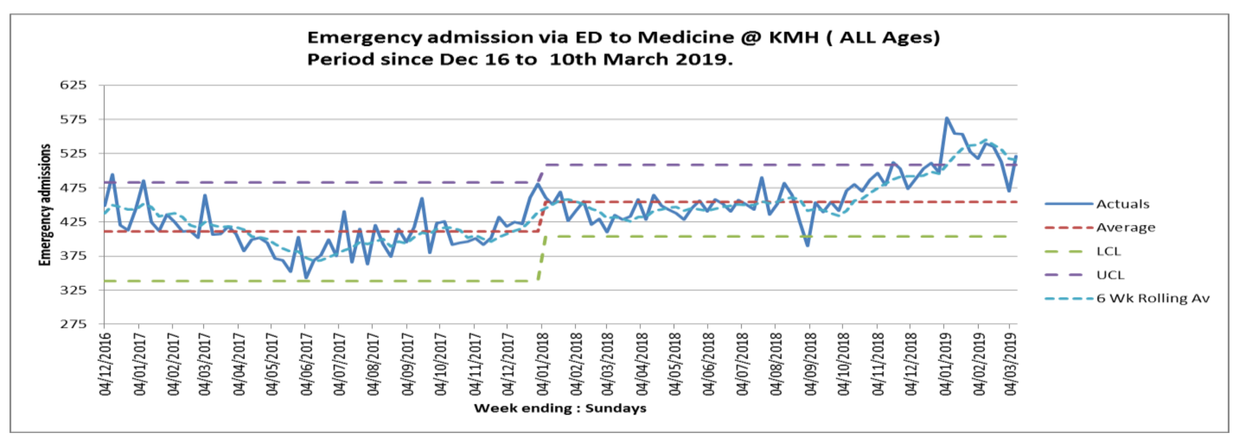
Despite this growth, handovers >30 minutes remain stable and are lower than EMAS levels overall. The ED team have done a tremendous job in improving handover times and during winter has improved the % of patients waiting over 30 minutes to be handed over from 24% in Dec 17 – Feb 18, to 8% in Dec 18 – Feb 19, despite a 7% growth in ambulance arrivals.



Admissions

Admission volumes to medicine and their variation remain the key pressure for waiting times within the UEC system. They were consistently high during February and continue to show special cause variation. Admission rates to medical pathways were 10% higher than in February 18'. The majority of the growth is in respiratory and cardiac conditions, some of which is related to flu which is showing a different trend to winter 2018, with a spike higher than 2018 in early January.

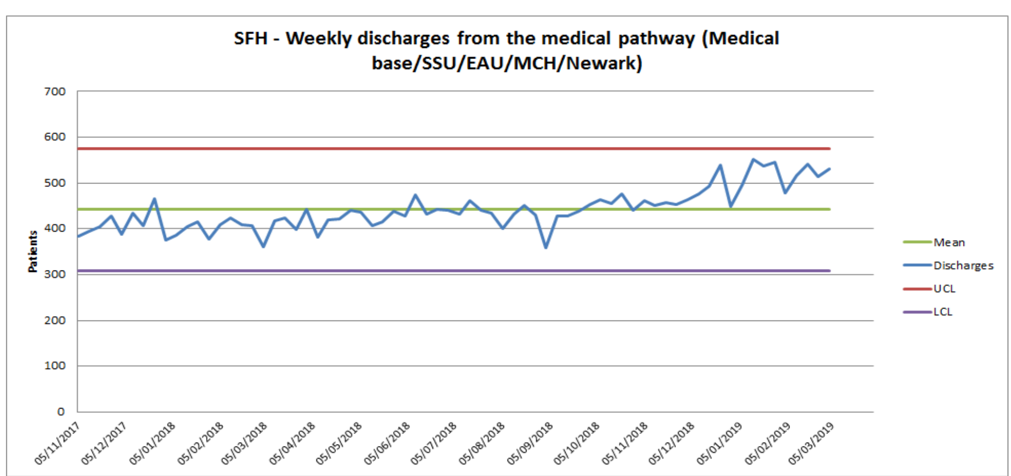
Admissions to medicine have not materially fallen since winter 16/17 when they saw an unusual dip between April and October.



There continues to be work undertaken to manage patients in a different way, where safe, other than admission to medicine, this is mainly via the work to increase the use of ambulatory care (thus reducing patients length of stay) which has seen a 48% increase in the number of patients who have been admitted through that pathway Dec – Feb 19 against Dec – Feb 18. With partners, there has also been strengthening of the 'front door' team to try to get patients into community services as an alternative to admission.

Discharges & Capacity to cope with admissions in a timely manner

The ability to cope with admissions and their growth, and to particularly ensure this is managed in a timely manner, is through a variety of means outlined below. There have overall been an increasing number of discharges from the medical pathway and the winter plan has opened additional medical capacity on time as per the plan.



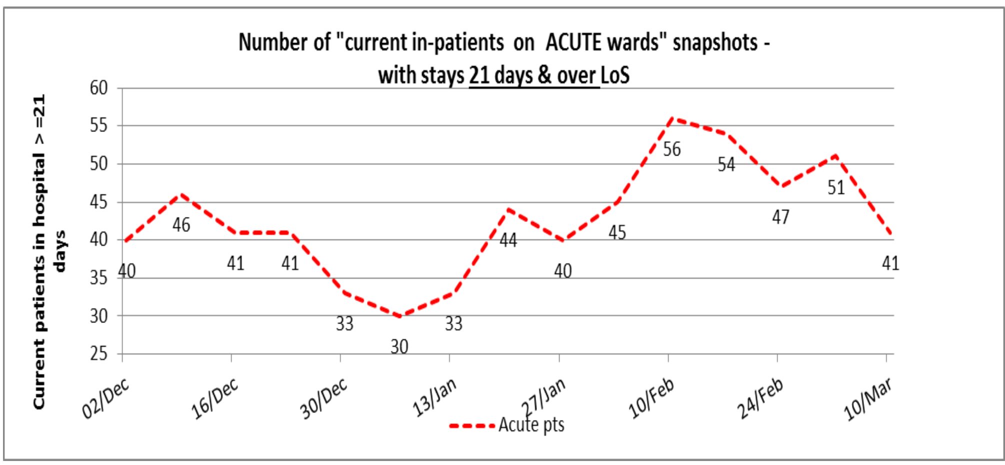
Patients with a stay >21 days

As mentioned in the January Board report, one of the reasons for a drop in performance from January to February was related to increased bed occupancy created by an increasing number of longer stay patients, particularly in the middle of February.

Despite this increase, progress is being made in this area with a 6% fall in patients and a 27% drop in bed days used against February 2018 meaning that the number of patients who are reaching 21 days in an acute bed is falling, but the time they spend in the beds is falling significantly.

Some of this growth during February is related to increased acuity of patients with around 50% of the group being non-medically fit for discharge, many patients on IV anti-biotics. For the groups of patients who are medically fit it is a complex picture in terms of growth with no one dominant theme. There continues to be a daily review meeting with partners to ensure all patients are followed up in terms of plans in a timely manner. This is along with NHSI best practice with regard to long stay patients including an on ward review every week. The Chief Operating Officer has been attending the daily review twice a week.

These actions are starting to reduce further the number of patients, as well as their bed day consumption as shown in the below chart.



Winter plan creating more capacity

All winter bed capacity has been implemented by the end of December as per the reports approved by the Board in September and updated on at subsequent meetings. There are now an extra 35 beds (across the system) above 2017/18 levels and increase in the overall bed base available for medical patients by 86 for Q4. During February the following additional capacity was in place for the medical pathway:

- 48 additional medical beds went live as part of the winter plan with the switching of two wards from surgery
- 10 extra surgical beds opened
- The opening of 20 additional ‘transfer to assess’ beds within the community
- 8 additional rehabilitation beds at Newark

As per the winter plan, the available capacity to medicine is due to reduce by 24 beds at the beginning of March as Ward 21 switches back to Orthopaedics.

Performance by day of week

Feb 19 - Day	Mean % under 4 hours (Mar 18 - Feb 19)	Mean % under 4 hours (Feb 19)	Variance	Mean pts waiting >4 hours (Mar 18 - Feb 19)	Mean pts waiting >4 hours (Feb 19)	Variance	Mean admissions (Mar 18 - Feb 19)	Mean admissions (Feb 19)	Variance
Monday	91.3%	86.2%	-5.2%	41	69	27	94	108	13
Tuesday	92.7%	84.4%	-8.3%	31	70	39	89	102	13
Wednesday	94.0%	88.3%	-5.8%	26	52	27	86	82	- 4
Thursday	94.4%	93.2%	-1.2%	24	29	5	89	102	13
Friday	94.5%	92.6%	-2.0%	23	33	11	88	100	12
Saturday	95.8%	95.7%	0.0%	18	19	1	73	83	10
Sunday	95.2%	93.2%	-2.0%	21	32	10	74	81	6

During February, the days that showed the most variation were Mondays, Tuesday and Wednesdays. This was mainly created by bed demand and capacity imbalances from weekends, Sundays being a particular issue. This led to 3 out of 4 Mondays during the month seeing medical patients waiting for beds from overnight Sunday night. Often it takes 48 hours to recover the bed balance as the deficit into Monday is compounded by the busiest days of the week (Mondays/Tuesday) for both admissions and attendances. This was certainly the case during February as performance recovered from late Wednesday onwards.

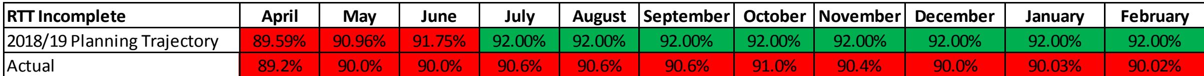
Improvements to this lie within the weekend admission and discharges rates. Over winter, a weekend discharge team has been deployed to provide extra medical and discharge team capacity to improve the discharge rate, but there remains variances to improve on in the coming annual plan, particularly making available the same level of same day emergency (ambulatory) care at the weekends.

Elective Access Standards

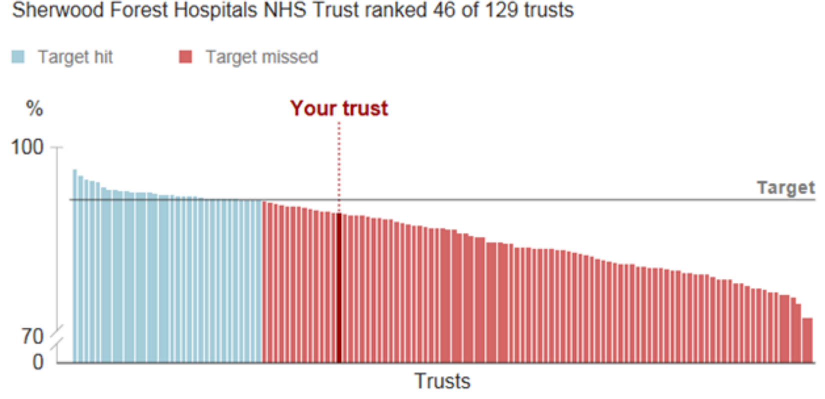
RTT

The RTT position for February 2019 against the incomplete standard is 90.02%. Performance has remained consistent throughout the winter period, underpinned by an elective plan to maintain cancer and urgent inpatient activity, day case and non-admitted activity in January and February.

We are committed to delivering the 92% standard and as a minimum will continue to deliver 90%.



RTT Incomplete	April	May	June	July	August	September	October	November	December	January	February
2018/19 Planning Trajectory	89.59%	90.96%	91.75%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%	92.00%
Actual	89.2%	90.0%	90.0%	90.6%	90.6%	90.6%	91.0%	90.4%	90.0%	90.03%	90.02%



January performance as a national ranking is 46th from 129 Trusts. National performance for the month was 86.7%. February (at time of writing) is not yet published by NHS England.

The size of the Incomplete PTL has reduced to 25,862 and remains off trajectory; however the position is better than the revised forecast submitted to NHSI in January 2019. The reduction is driven by the number of clock stops in February (9,864) exceeding the YTD average (9,162) by 8%. This is prominent in ENT, T&O, Ophthalmology, Dermatology and Gastroenterology non-admitted activity all of which have delivered on or better than the month 11 activity plan.

RTT PTL Size	April	May	June	July	August	September	October	November	December	January	February	March
2018/19 Planning Trajectory	24,976	26,001	25,461	25,512	25,920	25,189	24,819	24,915	25,041	24,155	23,535	23,205
Actual	24,274	24,585	24,794	25,698	25,890	25,586	26,001	26,377	27,333	26,672	25,863	
Note c.1,000 of the increase is the transfer of community paeds.												

As mentioned in the January Board report, the overall size of the PTL is 1,100 higher than trajectory due to the transfer of Community Paediatrics which commenced in September 2018. The other 50% is across a number of specialties including Ophthalmology, ENT, General Surgery, Rheumatology, Cardiology and Dermatology. With the exception of Rheumatology and ENT all are delivering OP levels greater than plan. Key specialties have completed a bridge to close the demand and capacity gap for 1st Outpatient however many depend on outline business cases for additional staff, therefore further work is required to ensure that transformational opportunities are considered.

11 patients were waiting longer than 52 weeks as at the end of February. Our trajectory is set to zero by the end of March 2019, based on a plan to complete a project to review and close historic pathways which remained open due to DQ or process errors. Throughout the year patients requiring an appointment have been contacted and their pathway has been completed. Our RCA and harm review process has been followed for all patients waiting 52+ weeks, 1 low grade harm has been identified from the project which is in its final stages and will be complete by the end of March.

There is a risk to the end of March trajectory due to patient choice or clinical requirement to delay next steps, the Deputy COO for Elective care has full oversight on a daily basis of the status of every potential 52+ wait. Any future risk will be mitigated through ongoing validation and an enhanced elective care training programme for all new and existing administrative staff.

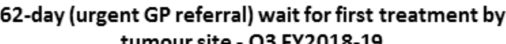
Cancer

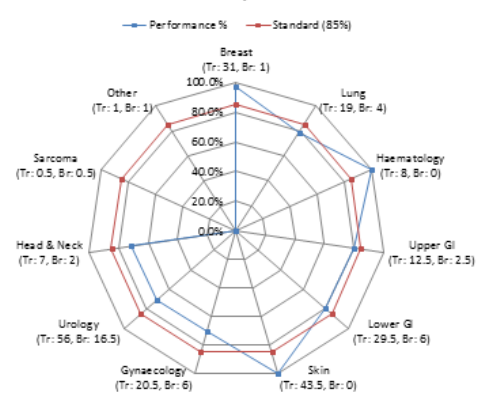
We delivered 84.5% for the month of January 2019; the 2WW Breast, Breast symptomatic and 62 day screening standards were delivered for January however, we failed the 31 day standard and 31 day subsequent surgery and drug standards.

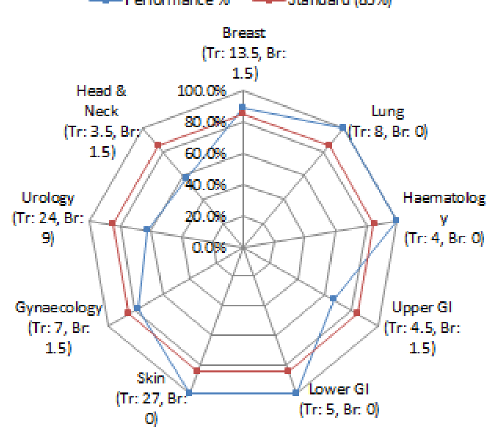
62 day performance has remained relatively consistent with 2017/18 against a back drop of treating 10% more patient's year to date. We remained off trajectory but is one of the better performing Trusts in the region.

Cancer 62 day	April	May	June	July	August	September	October	November	December	January
Trajectory	83.80%	83.80%	84.60%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%	85.40%
Actual	87.60%	79.80%	84.60%	69.30%	74.30%	85.10%	79.30%	85.10%	84.30%	84.50%

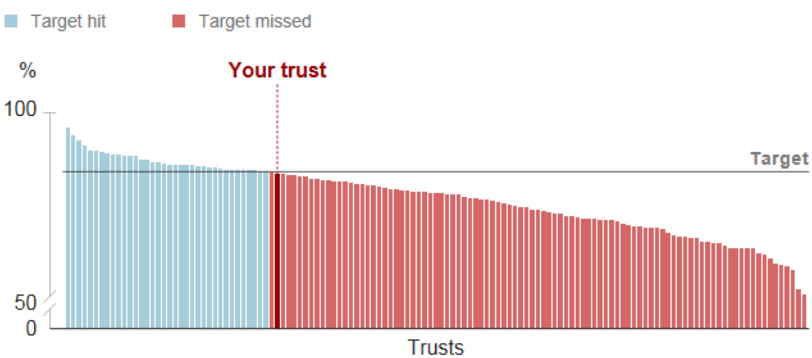
Performance by tumour site for Quarter 3 (82.71%) and January (84.5%) is as follows:







Sherwood Forest Hospitals NHS Trust ranked 38 of 131 trusts



The national ranking for January was 38th from 131 providers; national performance for the month was 76.2%.

5 of the 9 tumour sites delivered the 85% standard with a total of 15 breaches from 96.5 treatments. This is the second highest number of treatments recorded in 2018/19 and 50% more than January 2018. The increase in treatments is most notable within Skin, followed by Breast and Urology.

As at the end of January there were 15 patients waiting 104+ days. All patients with a confirmed diagnosis have started the harm review process. The main reason for breaches of the 62 day standard across a number of tumour sites continues to be the delay to diagnosis/treatment planning and this remains the key focus in the recovery action plan. Other reasons include oncology and surgical capacity at NUH and complex pathways involving multiple clinical teams

Good progress is being made with increasing the volume of patients with a first appointment by day 7 – See table 1. Divisions have undertaken 2WW demand and capacity modelling and have submitted bridges to close the capacity gaps, for example Lower GI are planning 1 additional middle grade clinic from March 2019 and are in the early stages of monitoring the impact of the implementation of FIT testing in January 2019. Capacity issues are currently escalated to the Divisions if there no capacity within 10 days of referral, the escalation will move to 7 days with immediate effect. Overall 2WW referrals are 15% higher YTD when compared to 2017/18. This equates to an increase of 1, 600 patients, notably within Skin, Breast, Lower GI and Urology.

2018/19	0 - 7 days	8 - 10 days	11 - 14 days	> 14 days	Grand Total
November	40%	37%	19%	4%	100%
December	41%	36%	21%	2%	100%
January	59%	24%	14%	3%	100%

Delays to diagnosis/ treatment

The 62 day recovery action plan focussed predominantly on reducing the time to diagnosis. There were 22 actions of which 18 have been completed and 4 delayed. The 4 actions will continue to be progressed and monitored at the monthly Cancer taskforce group.

A separate Urology recovery plan will build on the actions already completed and support consistent delivery at tumour site and Trust level. The plan will be formed by the end of March. If we can sustainably deliver 85% for Urology (and maintain performance in other tumour sites) the overall position would be within the range of 82% -90% - see table 2 below.

SFH performance if Urology breaches within normal limits

	Actual 62d Breaches	Urology 62d Breaches	Urology % of 62d Breaches	62d Performance If Urology within normal limits	Actual 62d Performance	Percentage Difference
Apr-18	8	1.5	19.00%	85.00%	87.40%	-2.40%
May-18	20.5	11.5	56.00%	88.10%	79.70%	8.40%
Jun-18	9.5	4	42.00%	86.90%	84.60%	2.30%
Jul-18	29	18	62.00%	85.20%	69.30%	14.90%
Aug-18	22.5	14.5	65.00%	87.80%	74.60%	13.20%
Sep-18	11	7	64.00%	90.50%	85.00%	5.50%
Oct-18	17.5	11.5	66.00%	89.30%	79.30%	10.00%
Nov-18	11.5	2.5	22.00%	84.40%	85.10%	0.70%
Dec-18	10.5	2	19.00%	82.80%	84.30%	-1.50%
Jan-19	15	9	60.00%	90.60%	84.30%	6.30%

To enable a return to normal limits and deliver the national optimal pathway for prostate patients, the tumour site need to increase the volume of patients who are 1st seen and diagnosed by day 28. The current time to diagnosis has improved from 62+ days to 43 days through the introduction of a referral vetting service to identify patients suitable for straight to test MRI and a virtual clinic post scan to identify patients requiring a TRUS or template biopsy.

The table below shows MRI turnaround times at 14, 10 and 7 days. Whilst good progress has been made to increase the number of patients scanned within 14 days; to deliver a 7 day turnaround time an additional static MRI scanner is required. This is a longer term action requiring significant capital and staffing resource.

Diagnostic Test	September	October	November	December	January	February
MRI (14 Day)	42%	82%	91%	92%	83%	92%
MRI (10 Day)	20.2%	51.6%	59.8%	30.5%	50.5%	57.5%
MRI (7 Day)	6.9%	26.0%	29.1%	16.8%	26.2%	24.1%

Other opportunities to reduce the time to diagnosis in the prostate pathway include rightsizing the capacity required for TRUS and Template biopsies; the current wait fluctuates between 10 - 20 days. A demand and capacity model based on current conversion rate from MRI will be completed by the end of March this will include a bridge to identify actions to deliver a maximum 7 day wait.

Post biopsy the patients' condition is discussed at a joint MDT meeting with NUH and a treatment plan is outlined. The patient is then invited back to clinic to discuss the treatment options available; it is at this point where there have been consistent delays with oncology and surgical capacity provided by NUH for which there are short and medium term actions in place.

Diagnostics

The 6 week diagnostic performance for February is 99.3%.

Diagnostic 6 Week	April	May	June	July	August	September	October	November	December	January	February
Trajectory	98.73%	98.83%	99.02%	99.01%	99.01%	99.01%	99.02%	99.01%	99.01%	99.01%	99.01%
Actual	98.59%	99.12%	99.12%	99.13%	99.45%	99.16%	99.37%	99.24%	99.03%	99.13%	99.30%

Exception reports are included with regard to the RTT Incomplete standard, volume of 52+ week and 62 day cancer standard.

Finance Report

At the end of month 11 we are reporting a deficit of £43.02m before Provider Sustainability Funding (PSF), £0.18m ahead of plan year to date (YTD). This is £0.03m better than was forecast at month 10. At the end of month 11, PSF of £9.16m has been reflected. The reported control total deficit including PSF at month 11 is £33.86m, £1.61m behind plan.

The forecast year end position is we will will achieve the control total excluding PSF, deficit of £46.37m. The forecast position including PSF is a deficit of £36.34m, £2.37m behind plan.
Key areas of note are:

- Clinical income is £11.01m above plan at month 11 and is forecast to be £12.10m above plan at year end, reflecting ongoing non-elective (NEL) activity, high cost drugs and agenda for change pay award funding. At the end of month 11 NEL activity is £8.96m over plan.
- Pay costs are £11.79m above plan at month 11 and are forecast to be £13.26m above plan at year end. Medical pay spend is £6.27m above plan at month 11, significant overspends reflect cover for sickness and vacancies mostly in Medicine, Surgery and Urgent Care, costs of additional capacity covered by income, and unmet FIP/FRP of £1.59m. Nursing pay spend is £4.29m above plan at month 11 due to non delivery of pay FIP/FRP of £2.45m and cover for vacant posts and sickness. At month 11 worked WTEs of 4,384 exceed budgeted WTEs of 4,286 by 98.
- Agency spend reduced in February by £0.03m to £1.01m. This is below the ceiling in month by £0.45m and by £1.60m YTD.
- Uncommitted reserves of £3.10m support the position at the end of month 11.
- The Financial Improvement Plan (FIP) & Financial Recovery Plan (FRP) are behind plan by £0.88m. The 18/19 FIP & FRP programmes are forecast to deliver savings of £16.48m, a shortfall of £0.82m against plan.
- PSF of £9.16m has been reflected at month 11, £2.42m due to 4 hours access target, £6.55m for delivery of the SFH control total at the end of month 11 and £0.19m for delivery of the system wide control total in quarter 1. We continue to forecast achievement of its cumulative control total, however is not forecasting delivery of ED requirements in Q4 and therefore is not anticipating £1.30m of ED PSF for Q4. The system is forecasting that the system control total will not be recovered by the end of Q4 and therefore £1.07m of system PSF for Q2, Q3 and Q4 will not be received.
- Capital spend at month 11 is £6.83m, behind plan by £2.21m. Capital programme leads are forecasting an outturn of £10.69m, £0.95m greater than plan, as a result of receipt of public dividend capital of £1.14m which was not known at the time of planning
- Closing cash at 28th February was £1.74m, £0.08m below plan and is anticipated to be on plan at 31/03/19.
- At M11 the forecast and FRP have been reviewed and the risk to achievement of the pre PSF control total has now been fully mitigated.

Financial Summary

	February 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	(3.83)	(4.32)	(0.49)	(43.20)	(43.02)	0.18	(46.37)	(46.37)	0.00
Surplus/(Deficit) - Control Total Basis Inc PSF	(2.38)	(3.45)	(1.07)	(32.25)	(33.86)	(1.61)	(33.97)	(36.34)	(2.37)
Finance and Use of Resources Metric YTD				3	3		3	3	
Financial Improvement Programme (FIP) & (FRP)	1.87	1.52	(0.35)	15.42	14.54	(0.88)	17.30	16.48	(0.82)
Capex (including donated)	(0.67)	(1.17)	(0.50)	(9.03)	(6.83)	2.20	(9.75)	(10.69)	(0.95)
Closing Cash	1.82	1.74	(0.08)	1.82	1.74	(0.08)	1.76	1.76	0.00
NHSI Agency Ceiling - Total	(1.46)	(1.01)	0.45	(15.18)	(13.57)	1.60	(16.66)	(14.94)	1.72