

Public Board Meeting

Report

Subject: Single Oversight Framework Performance Report
Date: November 2016
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QUALITY & SAFETY

Introduction

The purpose of this element of this report is to provide a quarterly update to the Board on the key patient safety and quality priorities of the Trust.

The report provides an overview of performance / achievement against the Trust's three key quality priorities for 2016/17 as described within the Quality Report & Accounts (2015/16) in addition to a number of safety and quality indicators.

As part of the continuous development of the Trust Governance and Reporting Framework and the requirements of the recently published Single Oversight Framework a comprehensive review of the work programmes of the Quality and Safety elements of the Trust Committee structure has taken place.

As the Patient Safety Quality Committee (PSQB) has evolved it has provided the vehicle through which performance and achievement of the patient safety and quality agenda can be monitored. A review of the programmes of work to meet the key Quality Priorities within the Quality Account has been undertaken and an assessment made as to where each priority needs to report.

In addition to the Key priorities within the 2015/16 Quality Account, there are a number of additional Quality and Safety targets on which we are required to provide assurance and as expected as the Governance framework matures it has become clear that a number of key safety and quality issues do not currently have the associated work programme reported to PSQB. The Deputy Chief Nurse and the QIP Programme Director have reviewed each priority and these have now been included within the PSQB Annual Workplan.

Historically an assessment and future plans against these priorities and targets has been reported directly to the Board of Directors on a quarterly basis, however it is proposed that reports will be provided to the Quality Committee from November 2016 through the PSQB report to provide the assurance required with respect to achievement and progress. The Quality Committee will in turn provide assurance to the Board.

The Trusts agreed 3 key quality and safety priorities for 2016/17

Reduce mortality as measured by HSMR (Quality Priority 1)

Targets for 2016/17 are:

1. To reduce mortality as measured by HSMR to within the expected range
2. To implement a robust mortality reporting system that is visible from service to board
3. To eliminate the variation between weekend and weekday HSMR

How are we performing against this target:

The HSMR and SHMI position for the Trust remain within the expected normal range. The table below indicates the rolling HSMR for July 2015 – June 2016 as being 94 - that is statistically significantly better than expected and demonstrates that the improved position has been sustained over a number of months.

Table 1 indicates the cumulative HSMR, SHMI and Crude Mortality performance. It should be noted that the SHMI has shown a reduction to 95.9 for the period April 2015 – March 2016

Table 1

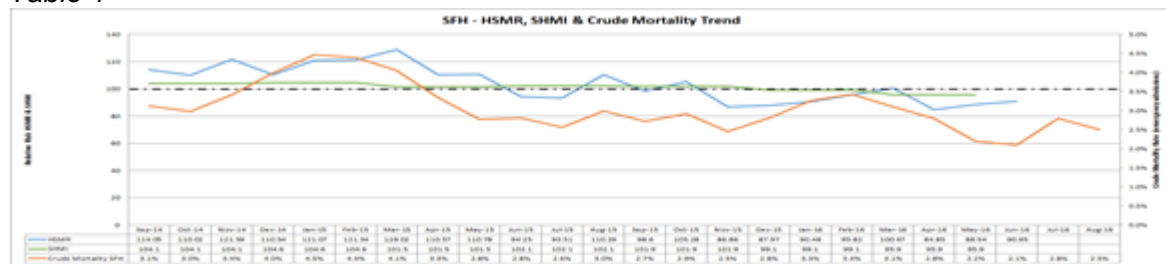


Table 2 indicates the position of SFH (yellow bar) in relation to other non-specialist acute providers in England = SHMI – 102nd from 136 (high to low)

Table 2

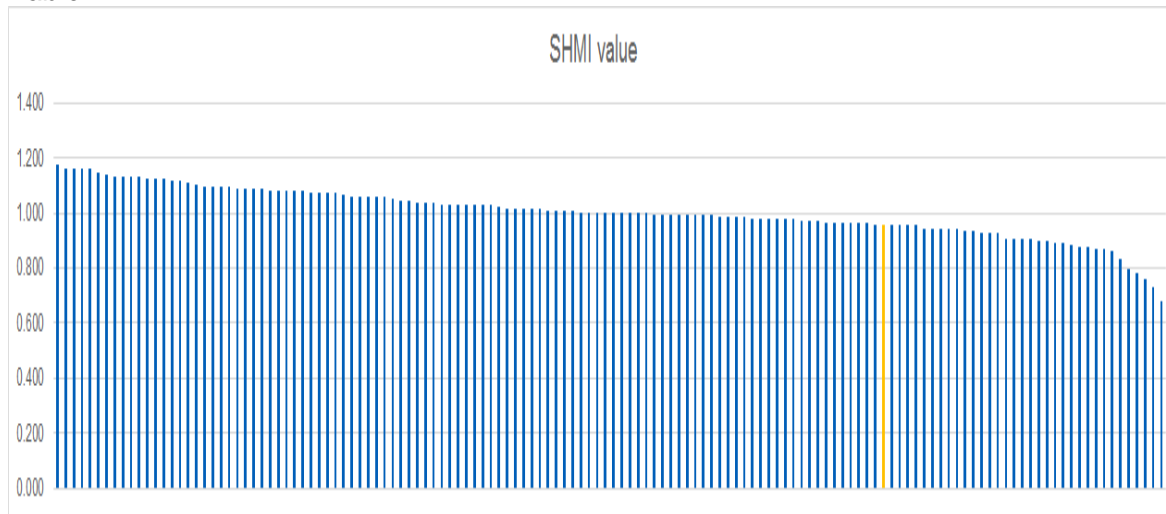
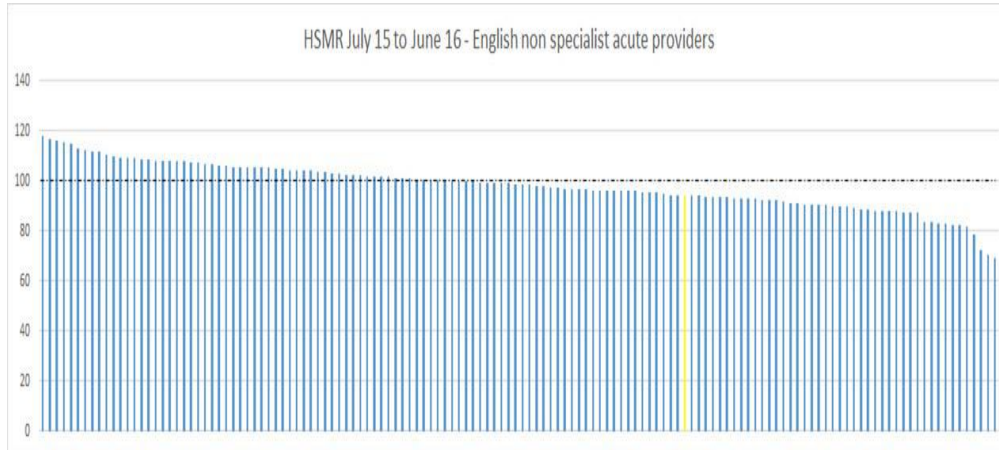


Table 3 indicates the Trust HSMR position (yellow bar) in relation to other non-specialist acute providers in England = HSMR – 92nd from 136 (high to low)

Table 3



The Trust Mortality Surveillance Group (MSG) meets on the first Tuesday of the month and is now well established within the Trust overall Governance Framework. MSG reports directly to the Deteriorating Patient Group that provides assurance to the Patient Safety Quality Board.

As has been consistently reported to the Board of Directors throughout the 2016/17 financial year the Trust HSMR has remained consistently within the expected range and this has enabled MSG to focus on improving the quality of the review of all deaths that occur across the organisation with a specific remit to identify those avoidable factors, changing practice where needed and identifying opportunities for learning.

Recognise and respond effectively to deteriorating patients (Quality Priority 2)

Targets for 2016/17 are:

Our priority is to recognise and respond effectively to deteriorating patients.

How are we performing against this target:

Following the lifting of the Section 31 enforcement action by the Care Quality Commission in May 2016 the weekly Sepsis Task force was decommissioned. It had long been recognised by the Trust that a wider focus on the deteriorating patient as a cohort rather than a small, defined group was required. The Deteriorating Patient Group (DPG) was formed in May of this year in response. DPG reports directly to the Patient Safety Quality Board.

The Terms of Reference clearly set out the purpose and objectives of the group and incorporate those disparate groups that manage acutely ill patients. It holds to account and agrees the work programmes of each group in order to receive the required assurances that the Trust has robust systems and processes in place to recognise and rescue individuals when their condition deteriorates and that we respond accordingly and appropriately.

To date there has been good attendance from the reporting groups and the Terms of Reference of each group has been aligned to DPG. There is further work to be done to identify appropriate representation from each of the Divisions but discussions are underway with the Divisional Clinical Governance Leads to ensure they are represented and that an Exception Report is provided from their Divisional Governance Meeting. The following summarises the actions from the groups that report into DPG:

i. Mortality Surveillance Group

- The development of the Mortality Dashboard
- Implement the use of the Mortality Data Collection tool across all specialties to ensure consistency in mortality data collection
- To achieve the required 90% of all deaths reviewed at local Mortality & Morbidity meetings
- To review all Level 2 Mortality Reviews at the Mortality Surveillance Group

ii. Sepsis Working Group

- Sepsis-related HSMR continues to be reported through the Mortality Surveillance Group
- The weekly inpatient sepsis screening audit continues with exception reports for opportunities missed, including the ongoing audit of Critical Care admissions. The weekly audit also reports compliance with appropriate escalation, sepsis screening and application of the Sepsis Six Care Bundle (this includes the administration of antibiotics within 1 hour)
- An e-learning module is under development in collaboration with NUH
- Work is underway to align SFH and NUH procedures to ensure compliance with the Sepsis NICE Guidance by March 2017 (requirement to be 90%)
- An electronic Sepsis Screening Tool has been developed through Nerve Centre
- SFH involved in the regional work to develop an electronic Sepsis Screening Tool for Paediatrics
- SFH supporting the Sepsis HSMR review in NUH as part of the benchmarking exercise pre-merger

Table 3 – Sepsis HSMR indicating that SFH performance remains within the expected range

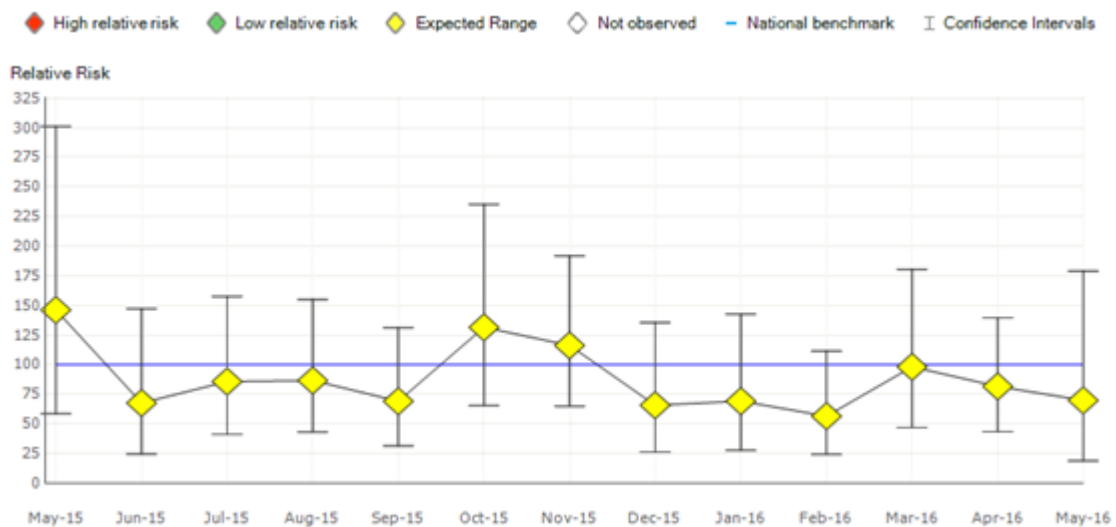
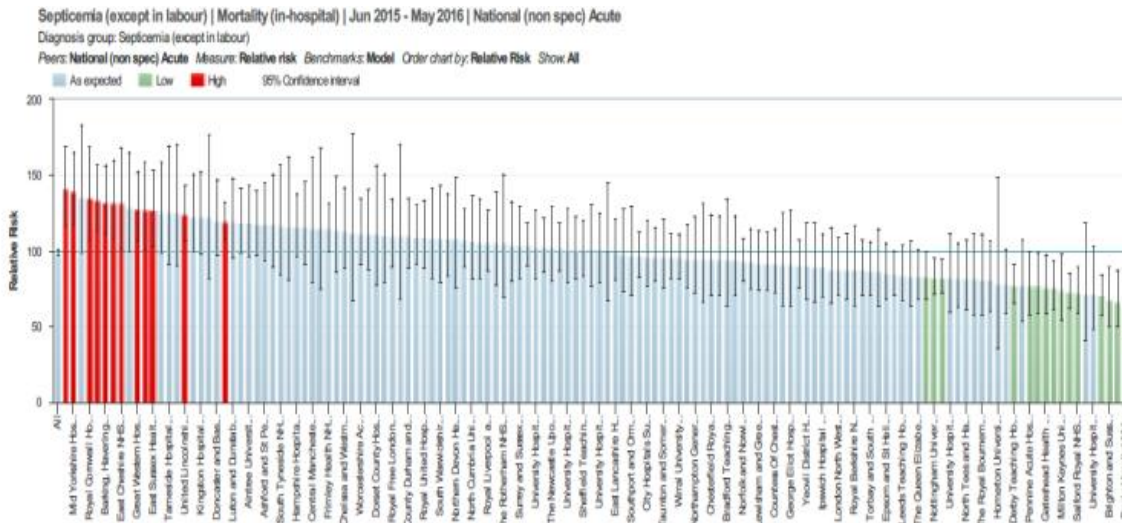


Table 4 - illustrates the position of SFH in relation to Acute Hospitals in England showing a relative risk score of 82.7



The Trust is working towards full compliance with the CQUIN in relation to the review and reduction of anti-microbial prescribing, which is a key feature of the appropriate management of Sepsis. Q1 and Q2 compliance has been met and the audit to monitor Q3 performance commenced on 1st October

iii. Acute Kidney Injury Group

The Acute Kidney Injury Group has been re-launched with NUH and SFH membership. The Terms of Reference are currently being agreed as well as the annual work programme. The DR Foster Report had identified Acute Kidney Injury (AKI) HSMR as a clinical area that required further investigation. An audit of patients with AKI as a primary diagnosis of death has been carried out and the finding will be presented to the Mortality Surveillance Group on October 4th.

iv. Resus Advisory Group

- The Paediatric Emergency Trolley replacement programme will be rolled out in November/December
- The new Manual Defibrillator rollout commenced on 12th September
- The Resus team are increasing the use of CPR feedback in training to improve the quality and standards of CPR
- Two additional EPALS (Paediatric) courses have been planned for September and November to meet the training needs of both SFH and NUH
- The Quarter 1 National Cardiac Arrest Report (02/08/16) has been received. Key outcomes are listed below:

The National Cardiac Arrest Audit (NCAA) is the national, clinical, comparative audit for in-hospital cardiac arrest. The purpose of the NCAA is to promote local performance management through the provision of timely, validate comparative data to participating hospitals. NCAA is a joint initiative between the Resuscitation Council (UK) and the Intensive Care National Audit & Research Centre (ICNARC).

This report is based on the following numbers of admissions to SFH, 2222 calls, cardiac arrests attended by the team and the number of individuals attended to.

The Report favourably indicates the Trust performance in relation to response and outcomes for those patients suffering a cardiac arrest whilst an in-patient in a significant number of the audit indicators. The rate of cardiac arrests attended by the team per 1000 hospital admissions (trended) has seen a steady improvement since September 2012 and is now in line with the NCAA expected range.

The Report will be fully considered by the resus Advisory Group and any actions required will be presented to the Deteriorating patient Group as part of the reporting structure. A full copy of the Report is available in the Reading Room.

v. Critical Care Outreach

- Critical Care Outreach now provided between 8am-12midnight, 7 days per week
- Audit of sepsis-related admissions to Intensive Care Unit (ICU)
- Audit of appropriate escalation of 'deteriorating' patient in response to National Early Warning Score (NEWS)
- The development of a Critical Care Delivery Group

To Improve the Safe Use of Medicines (Quality Priority 3)

Targets for 2016/17 are:

Our priority is to:

- Achieve Zero medication-related 'never-events'
- Introduce Guardrails® IV pump software to minimise infusion incidents
- Revitalise the self-administration of medicines across the Trust
- Improve the management of patients with allergies and adverse reactions to medication.
- Increase the reporting rate for medication-related incidents and near-misses reported on Datix® and improve learning from the incidents.
- Increase the number of patients whose medicines are reconciled within 24 hours of hospital admission.
- Increase access to the Summary Care Record (SCR) database
- Reduce the number of patients with omitted doses of critical medicines.
- Reduce the number of medication-related incidents resulting in moderate / severe harm by 25% (compared to 2015/16 data), particularly for high-risk medicines such as opioids, insulin, anticoagulation etc.

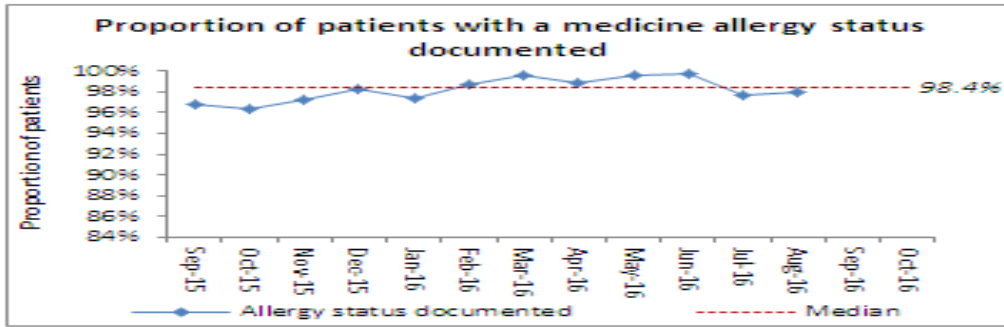
How are we performing against this target:

There has been no medication Never events reported at Sherwood Forest Hospitals from April 2015 to present day.

Intravenous (IV) protocols to be ratified by Drugs and Therapeutics Committee and Medicines Management Committee (DTC/MMC) on 23rd September with a go-live date set for 3rd October. Training will commence week beginning 19th September.

19 instances in 2015/16 where patients received a medication to which they had a documented allergy - there have been 7 reported instances YTD. Medicines Safety Thermometer (MST) shows good compliance with the documentation of allergy status on medication charts with an average of 98.4% compliance. Graph 1 below shows allergy documentation at Sherwood Forest Hospitals.

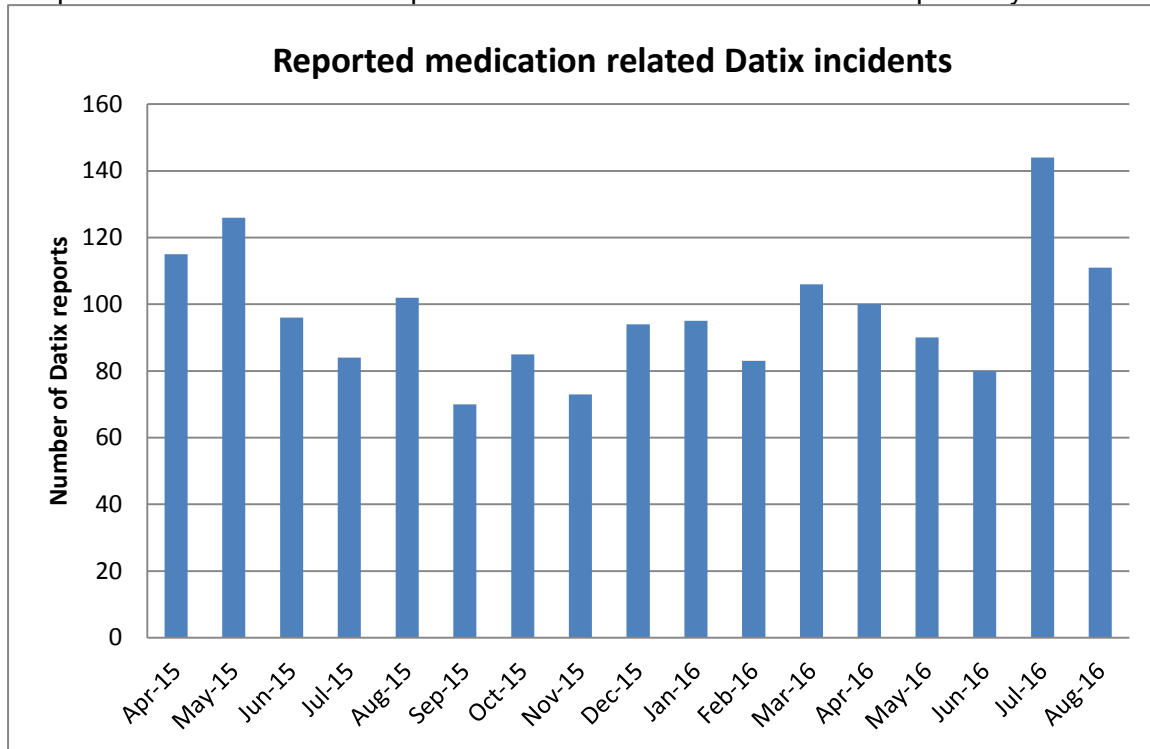
Graph 1: Allergy documentation at Sherwood Forest Hospitals as recorded on the Medicines Safety Thermometer.



National average is 96.5% for documentation of allergy.

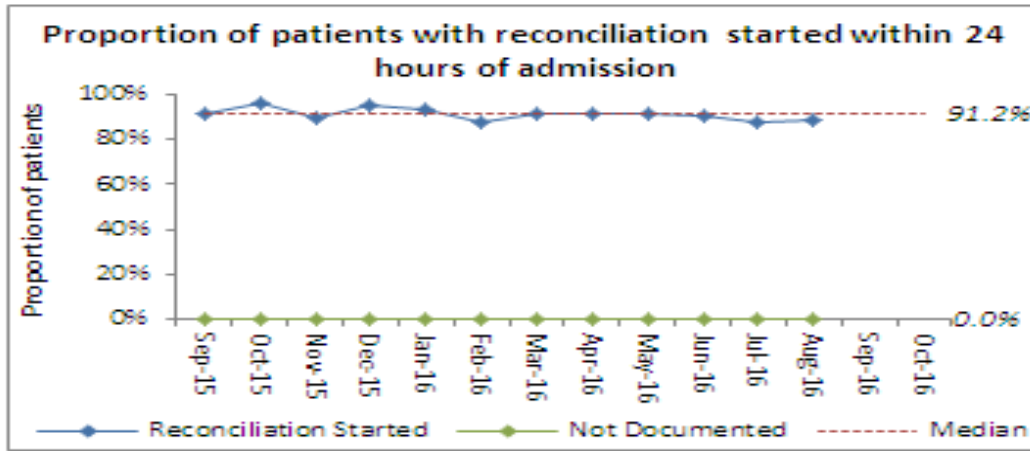
1129 medication related Datix reports received in 2015/16, on average 94 per month. 111 Datix reports received for July 2016 as shown in Graph 2 below.

Graph 2: Number of incident reports on Datix at Sherwood Forest Hospitals by month



Medicines Safety Thermometer data shows we are starting 91.2% of all medicines reconciliation within 24 hours as shown in graph 3.

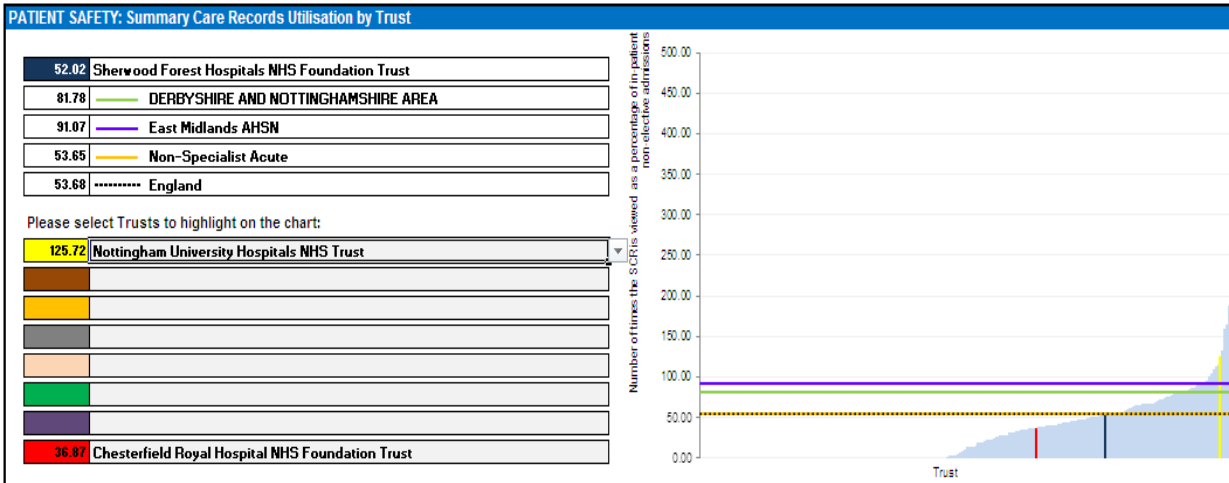
Graph 3: Medicines reconciliation started within 24 hours of admission for patients at Sherwood Forest Hospitals.



The national average for medicines reconciliation started within 24 hours of admission is 73.7%

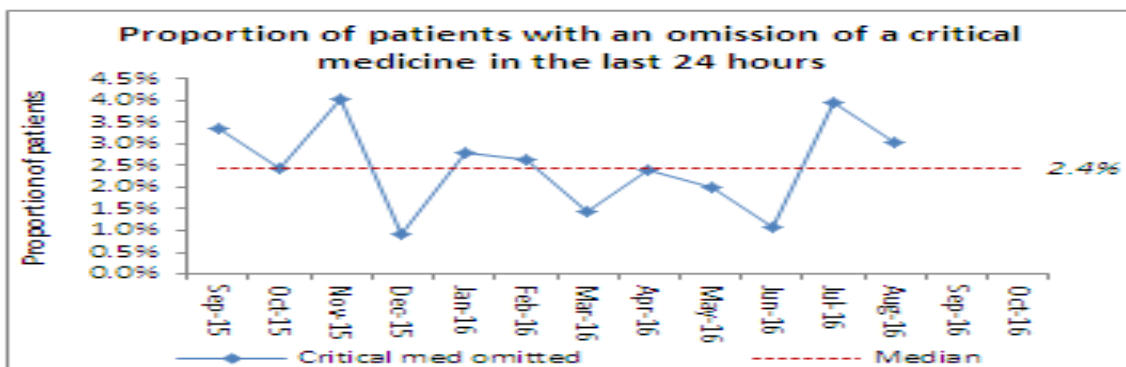
Summary Care Record (SCR) continues to be accessed by the Pharmacy team. This is currently accessed for 52.2% of admissions up to May 2016. The Medicines Optimisation dashboard is due to be refreshed in November 2016. Chart 1 below shows the Sherwood Forest data (blue) compared to the levels of access at NUH (yellow) and Chesterfield (red) as comparators.

Chart 1: SCR access for Sherwood Forest Hospitals.



The MST shows SFHFT is below the national average for missed critical medications, graph 4 below shows the proportion of patients with a missed critical medication.

Graph 4: Patients with a missed critical medicines within the previous 24 hours at Sherwood Forest Hospitals.



The national average for a missed critical medication is currently 6.3%.

12 reported Datix incidents for 2015/16 resulted in moderate harm or above. 1 reported incident YTD for 16/17 with moderate harm or above.

Mitigation plan (actions to date and future planning)

Regional sharing of information relating to Never Events via the Medicines Safety Officer Medicines Safety Officer (MSO) group allows us to learn from other Trusts. Presentation to be delivered to Grand Round in October highlighting local incidents as an opportunity for learning. Programme of work underway in relation to the never events to ensure processes are embedded to prevent future issues.

Guardrails project risks:

- a. Appointment of a lead for the general ward roll out required – all protocols will be ratified by DTC/MMC in the absence of a medical lead. This will occur on 23rd September.
- b. Paediatrics/NICU delayed to allow collaboration with NUH.
- c. Policy to be written to cover the governance aspects of the Guardrails project post roll out to ensure correct ratification of IV protocol changes and a ensure a robust process is in place for the review of the data.

Self-administration policy was ratified on 1st July at DTC/MMC and is now available on the intranet. Plan for embedding the Policy to be discussed at DTC/MMC on 23rd September.

Red wrist bands are now available and communications have been sent out in relation to this Trust-wide. Trust MSO involved in a national project to identify potential work streams to improve prescribing in relation to allergy status. Pharmacy Pre-Registration Pharmacist will audit the uptake of the red bands against the local guidance. This will be completed early 2017 in line with their national programme for the pre-reg year.

iCare 2 bulletins sent in relation to the importance of incident reporting. All medication related incidents are reviewed by the Pharmacy Medication Safety team and feedback sent. All incidents causing patient harm – grade 2 or above are discussed as part of the Medicine Safety Group (MSG) agenda on a monthly basis. Medicines Safety Bulletin is released on a monthly basis via the MSG for Trust wide distribution to highlight medication related safety issues and to share learning from incidents. August’s bulletin highlighted issues relating to Patient Group Directives and insulin prescribing errors. The Medication Safety Facebook group is now available online. Prescriber newsletters are published on a regular basis to share the learning from incidents as they are reported. This will be advertised to a wider audience in September.

Continued data collection as part of the MST. Pharmacy continues to prioritise the service to the admissions areas to ensure timely medicines reconciliation. The MST is a

national data collection tool where data is collected on one day per month, the same day nationally, and then uploaded onto a central database.

SCR access has been superseded by a Nottinghamshire wide strategic decision to allow access to key staff groups to the community portal. This will allow access to SCR as well as other health related information. NHIS are involved in the county wide project and the project plan is to follow. Access is expected to begin from the autumn 2016. SCR will therefore remain with Pharmacy.

Missed dose data is collected as part of the MST on a monthly basis. The missed dose incident reports are analysed on a quarterly basis by the Practice Development Matron and any themes addressed through the MSG. Next review of the Datix reports due in September. Trends and themes will be reported through DTC/MMC.

All incidents with moderate harm or above will be subject to an internal investigation. All incidents are reviewed on a monthly basis to highlight trends and themes. This is shared via the governance routes.

Quality priorities

This section describes achievement of the Trusts quality priorities which have not thus far been included into the PSQB work plan.

Falls

Falls targets for 2016/17 are:

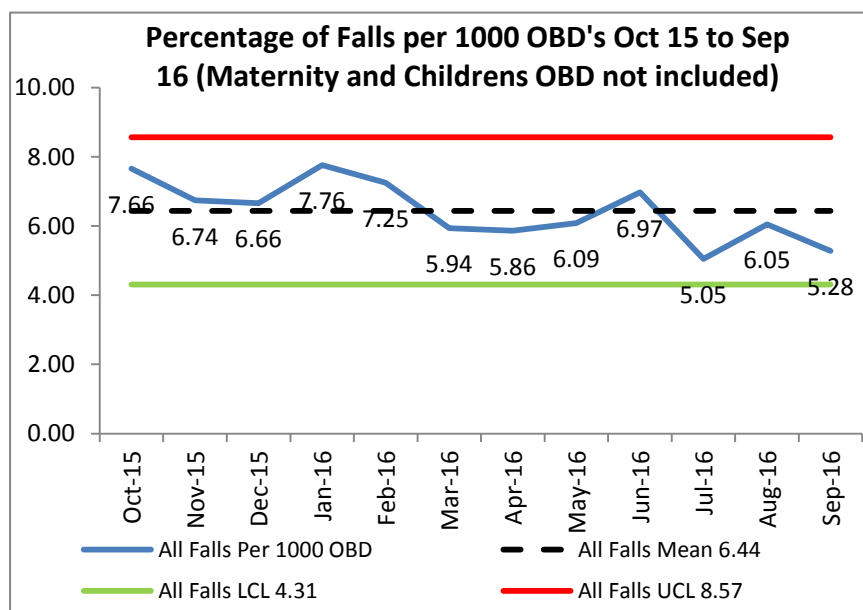
- 1 To reduce the number of inpatients falling in hospital against an agreed trajectory to less than the national average per 1000 occupied bed days
- 2 To deliver a safety improvement programme utilising best practice both from a local and national perspective
- 3 Work in collaboration with Alliance partners to reduce harms from falls
- 4 To review the impact of the redeveloped enhanced patient care tool

How are we performing against this target?

1. To reduce the number of inpatients falling in hospital against an agreed trajectory to less than the national average per 1000 occupied bed days

Graph 5 (below) shows the percentage of falls calculated by the occupied bed days (OBD) as per the National Audit of Inpatient Falls criteria. The trust continues to demonstrate a reducing percentage of falls per 1000 bed days compared to the equivalent point 13 months previously, the Trust figure for September 2016 is 5.28%

Graph 5



In July 2016 the total number of reported falls was 82 and in September 84 which when compared to a 13 Month period demonstrates a noticeable reduction.

In Quarter 1 there were 10 repeat fallers-patients that fell more than twice. In Quarter 2 there were 4. Staff appear to be more proactive putting in safety measures and completing risk assessments.

Table 6 below shows the number of falls by severity of harm over a 13 month period. The trend is beginning to demonstrate a slight downward improvement for the period.

Table 6

In-patient Falls by severity of harm	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16
No harm Falls	123	106	95	87	111	95	86	90	83	89	64	73	72
Low harm Falls	16	22	17	17	17	20	19	8	13	21	18	26	12
Moderate harm Falls	3	3	1	4	1	2	0	0	0	0	0	1	0
Severe harm Falls	3	1	0	1	1	1	0	1	1	1	0	0	0
Total	145	132	113	109	130	118	105	99	97	111	82	100	84

There have been no moderate harms reported for the period commencing March 2016 which again demonstrates a downward trend. In July an extended Incident scoping meeting graded a previous moderate harm to no trust appointed harm.

In July and September 2016 there were no severe harms reported. In August there was 1 fractured neck of femur reported which has been subject to an internal concise investigation, the lady returned to her normal baseline mobility.

The number of low harm falls reported for August 2016 shows an increase when compared to a 13 month period. The Falls Lead Nurse has investigated the low harms reported in August.

The types of low harms reported in August were:

Minor cuts/bumps
Abrasions/ skin tears

There was no evidence of a trend or that any particular area had reported a marked increase in low harm falls. It should be noted that the number of low harms in September was reported as 12.

The Falls Nurse has been analysing data in conjunction with the PMO department looking at possible seasonal variations over a 24 month period which includes agency nurse usage and annual leave, non-have been identified.

Communications were issued regarding the Head Injury Policy and observations required when a patient has an un-witnessed fall or a head injury. This follows noncompliance issues picked up from the Incident forms and when investigations were recently carried out regarding an inpatient fall.

Mitigation plan (actions to date and future planning)

- The safety equipment for the 4 trial wards were distributed .The Falls Grab Boxes were distributed to wards and selected departments across all 3 sites. The safety interventions will be evaluated in order to seek their effectiveness, providing an evidence base for future service plans. The Falls Lead Nurse is attending an award ceremony in London in recognition of the Falls Grab Box in conjunction with NHS Fab Stuff Academy. The Falls Nurse has also been contacted by various Trusts concerning the Grab box as a result of the initiative being highlighted in professional social media forums.
- A trial environmental ward audit in relation to falls prevention, along with the health and Safety officer, took place in September and more visits are planned. Any actions highlighted will be circulated to the ward or department leads.
- The Emergency Department are looking to purchase hi/lo trolleys following an investigation into a recent fall.
- The current Falls Policy is in the process of being updated. The New Falls Care plan has also been ratified.
- The quarterly Falls Champion meeting was held in September with presentations from pharmacy and a discussion around the risk of falls at night with a Duty Nurse Manager. Patient stories were also presented.
- The 2 day health community action learning set was attended in September 2016. Further dates to network and carry actions forward are being arranged.
- The Falls Lead Nurse has carried out teaching sessions with Medical Students. The sessions include both theory and a practical session. Topics that were discussed included medication reviews, post fall actions, medical reasons for falls.
- The Falls Nurse continues to analyse Incident forms and responds to any actions that may be required. The falls data also continues to be analysed on a monthly basis and a report is sent out to ward or department leaders and matrons. The report highlights trends, themes and areas that may require actions, for example educational input. This enables bespoke ward education by the Falls Lead Nurse.
- The Falls Lead Nurse is developing mobile Falls Prevention trolleys. The trolleys will be taken to wards and departments by the Falls Nurse at all 3 hospital sites. The *Front - Line Falls* trolleys will take the Falls information direct to the wards and departments, for example, research information, patient and relative information leaflets also allowing for on the spot updates or training.
- In July the Falls Lead Nurse held an event in the hospital which highlighted safer footwear to avoid slip trips and falls. The event gave information and advice to people when choosing safe footwear. The voluntary sector also attended the event.

The Falls Lead Nurse held an event at SFHT during October. The event addressed the benefits of exercise in relation to falls prevention with the voluntary and community sector along with public health.

Safety Thermometer

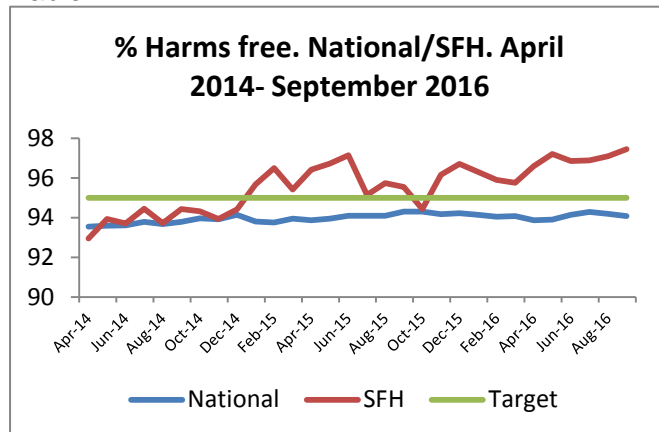
Safety Thermometer targets for 2016/17 are:

- I. Ensure harm free care for patients (>95%), as measured by the Safety Thermometer, a tool to measure local improvement and reduction in harms over time.
- II. We understand that it is essential that the care we provide for our patients is free from harm. The Safety Thermometer allows healthcare professionals to measure a snapshot (or prevalence) of harm and the proportion of patients that are 'harm free' in relation to
- III. Grade 2, 3 and 4 pressure ulcers, Catheter associated urinary tract infections (CAUTI), Falls, and Venous thrombo-embolism (VTE).
- IV. The Safety Thermometer was fully implemented across our Hospitals in April 2012 and harms data is now collected for every patient on the same day, once a month with the exception of patients in theatres, emergency department and outpatients.
- V.

How are we performing against this target:

- I. Table 7 shows the national/SFH Harm Free care %
We have consistently performed above the national Harm Free Care of 95% since May 2014, with the exception of October 2015 (94.43%)

Table 7



The specialists continue to verify all reported harms prior to submission.

Datix incidents relating to falls during the 72 hour period are cross checked with the safety thermometer data collection to provide an accurate account of reported falls and their severity.

To ensure we are collecting the correct information around 'New VTE's' any patient admitted with symptoms of a VTE and then commences treatment are reviewed to see if the reason for admission is related to this and therefore does not indicate a hospital associated VTE.

Pressure Ulcers

Pressure Ulcers targets for 2016/17 are:

- I. Less than 3 grade 2 avoidable pressure ulcers per month with a yearly trajectory of no more than 36.
- II. Zero grade 3 and 4 avoidable pressure ulcers.

How are we performing against this target:

NUMBER OF AVOIDABLE PRESSURE ULCERS BY GRADE PER MONTH AGAINST TARGET														
		Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	T
Grade 2	Target	3	3	3	3	3	3	3	3	3	3	3	3	
2015/16	Actual	1	2	1	3	2	2	2	1	2	1	1	1	
2016/17	Actual	2	1	0	2	1	0							
Grade 3	Target	0	0	0	0	0	0	0	0	0	0	0	0	
2015/16	Actual	0	0	0	2	1	0	1	0	0	1	0	0	
2016/17	Actual	0	0	0	0	0	0							
Grade 4	Target	0	0	0	0	0	0	0	0	0	0	0	0	
2015/16	Actual	0	0	1	0	0	0	0	0	0	0	0	0	
2016/17	Actual	0	0	0	0	0	0							

- I. Grade 2 Pressure Ulcers: achieved, one avoidable grade 2 pressure ulcers developed in quarter 2 against a target of nine per quarter. A total of six avoidable pressure ulcers have developed since Q1 against a target of 18 for the two quarters.
 - II. Grade 3 Pressure Ulcers: achieved, no avoidable grade 3 pressure ulcers in quarter 2.
 - III. Grade 4 Pressure Ulcers: achieved, no grade 4 pressure ulcers developed quarter 2.
- The introduction of the new pressure ulcer risk assessment tool (PURPOSE –T) continues across the Trust.

Venous Thromboembolism

Venous Thromboembolism (VTE) targets for 2016/17 are:

- I. 95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment
- II. 100% of cases of hospital acquired thrombosis (HAT) have a root cause analysis performed.

How are we performing against this target:

Table 10 shows the percentage of eligible patients risk assessed by month. With a target of 95% of patients who have been identified as being at risk of venous thromboembolism (VTE) to receive appropriate preventative treatment.

Table 10

2016/17	Apr	May	Jun	Jul	Aug	Sep
Target is 95%	95.25%	96.07%	93.36%	95.02%	95.02%	93.20%

The monthly VTE 95% target was not reached in September 2016. 2.86% of the risk assessment forms were found to be blank and on case note review 2.20% were found to be

missing. Work is on-going with the Emergency admission areas to bring performance back on track.

The protocol for the identification and investigation of hospital acquired thrombosis (HAT) has been progressed over quarter 2, 2016/17 and all potential HAT have been reviewed by the appropriate medical team.

A Datix incident has been raised for 3 cases that require further investigation to establish if they were preventable and to also determine the associated level of harm. The findings will be discussed in the relevant specialty clinical governance meeting and reports signed off by the division.

SAFER STAFFING

October's staffing data continues to reflect the challenge of ensuring optimum safe staffing levels in response to fluctuating patient acuity and dependency with a challenging vacancy position. However the balance between planned and actual staffing this month is much closer with a slight reduction in areas identifying staffing levels at 80% below or 110% above planned staffing. Safe staffing issues were escalated appropriately during October and actioned in line with guidance. No ward reported unsafe staffing levels.

The trust has fully recruited to the HCA vacancies within the virtual ward with 31 individuals planned to commence in HCA posts in January 2017 and for a third consecutive month the Registered Nurse attrition rate has been successfully below 1.3%

The Trust has been allocated 15 places to train Nursing Associates. There is a national requirement for the Nursing Associate trainees to be recruited and commence training before the end of January 2017 and the trust is undertaking work to meet this challenging timeline. The successful applicants will be identified by competitive interview, from within the Trust existing workforce.

Work is in planning to further enhance the electronic rostering process with the pilot and implementation of Safer Care which will additionally allow the monitoring of patient acuity and dependency alongside staffing levels

OPERATIONAL STANDARDS

Cancer

8 out of 9 cancer standards achieved in September. The 62 day referral to treatment standard was not achieved in September.

The 62 day standard (77.5%) and 62 day screening standard (83.9% - 4.5 breaches therefore small numbers) has not been achieved in Q2.

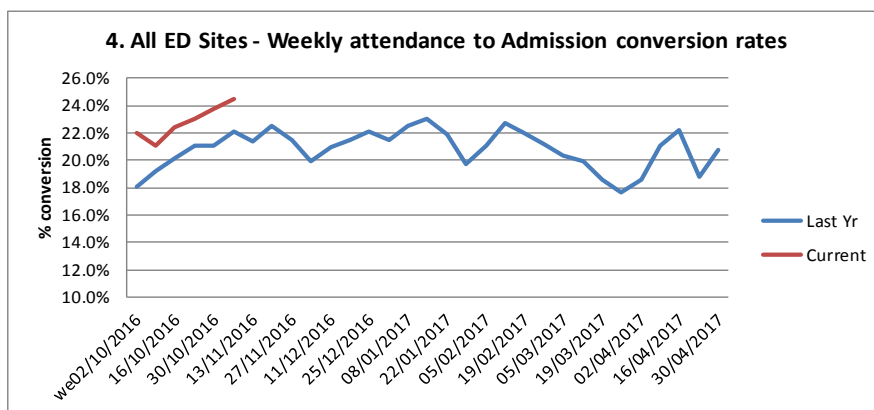
As described at the last Board meeting the standard is unlikely to be achieved in October and there is a risk to achieving in November. The main breach reasons are: achieving the diagnostic turnaround time standards and patients requiring treatments in tertiary centres (NUH and Derby). Recovery plans are in place for all specialities however detailed breach analysis is being undertaken to ensure that the actions being taken are targeting the right areas.

Four hour wait

The Trust achieved 95.16% in Q2.

The Trust achieved 96% in October.

The joint single streaming pilot commenced in October (see separate evaluation) 1.7% more patients were streamed into primary care (7 extra patients per day) compared with pre-pilot. As of 20th November SFH is currently at 94.8% for November. ED attendances over the past 9 days have been 11.8% higher than November 15. Conversion rates have been higher for the last 2 weeks as shown in the graph below:



A number of actions identified in the winter plan have been implemented; The Respiratory Assessment Unit pilot commenced on 7th November and the Frailty Assessment Unit pilot commenced on 16th November. The discharge lounge is now opening on a Saturday to enable earlier flow and staffing numbers have been increased in CDU to reduce zero to 1 day length of stay patients going into the main hospital.

Referral to Treatment Times (RTT)

The 'Incomplete' pathway (target 92%):

May	June	July	August	Sept	Oct
93.8%	92.56%	92.40%	92.52%	92.3%	92.25%

1 patient exceeded 52 weeks referral to treatment as a consequence of a "hidden list" that became visible via the Medway PAS upgrade. The patient is being seen by a Consultant on 24th November, they were offered an earlier date however chose not to attend sooner.

The diagnostic RTT (DMO1) (target 99%):

May	June	July	August	Sept	Oct
99.6%	98.77%	99.02%	95.85%	95.98%	98.1%

As highlighted as a risk in last month's report to Trust Board SFH failed to achieve the standard in October due to capacity in echocardiography (vacancies). It can be seen however that the recovery plan is on track with the Trust only narrowly missing the target in October. The Trust is expecting the target to be achieved in November. There is an on-going risk with endoscopy highlighted to Board previously.

Outpatient & Inpatient performance metrics:

- The DNA rates - new outpatients at 7.16% (8.71% nationally) and the follow up rate of 7.26% (9.21% nationally).
- The new to follow up ratio is 1:1.95 against a national position of 1:2.0.
- Cancelled inpatient operations stand at 0.4% remaining below the target of 0.8%.
- Theatre utilisation performance remains good at 83.6% compared with October 15 at 71%.

October 16/17 Forecast Risks

As detailed above the key risks identified are:

- DMO1
- October/November 62 day cancer standard
- October cancer 62 day screening standard – patient choice

FINANCE

Financial Summary

Financial performance remains strong, with the Trust £0.74m ahead of its planned deficit YTD excluding LTP costs. Capital expenditure is £1.81m behind plan but is forecast to deliver to plan at year end. The Trust is forecasting to achieve its control total and discussions are on-going with NHSI regarding costs for LTP, the delayed merger and their impact on the control total. LTP costs now reflect real costs for NUH with a resulting underspend to date of £7.05m, this underspend is expected to be fully utilised over the period to March 2017.

	Oct In-Month			Year to Date			Annual Plan	Forecast	Forecast Variance
	Plan	Actual	Variance	Plan	Actual	Variance			
	£m	£m	£m	£m	£m	£m			
EBITDA	(0.79)	5.48	6.27	(24.19)	(16.29)	7.90	(27.58)	(27.34)	0.24
Surplus/(Deficit)	(3.30)	2.97	6.27	(41.25)	(33.46)	7.79	(57.08)	(57.08)	0.01
Long Term Partnership (LTP)	(0.16)	6.03	6.19	(15.10)	(8.05)	7.05	(15.88)	(15.88)	(0.00)
Surplus/(Deficit) - Excluding LTP	(3.14)	(3.06)	0.08	(26.15)	(25.41)	0.74	(41.20)	(41.19)	0.01
EBITDA % of Income	(3.3%)	23.1%	26.4%	(14.7%)	(9.8%)	4.9%	(9.7%)	(9.5%)	0.2%
Single Oversight Framework Finance Rating	3	3		3	3		3	3	0
CIPs	1.28	1.09	(0.19)	6.01	7.00	0.99	12.60	12.60	0.00
Capex	1.33	0.23	(1.10)	6.89	5.08	(1.81)	9.53	9.53	0.00
Closing Cash	1.45	1.49	0.04	1.45	1.49	0.04	1.45	1.45	0.00
Agency Cap - Excluding LTP	(1.41)	(2.11)	(0.70)	(11.06)	(17.22)	(6.16)	(17.91)	(28.82)	(10.91)
Better Payment Practice Code - (Value / Number)		94.4% / 88.6%			93.4% / 89.9%				

- In month, excluding LTP, the Trust is £0.08m ahead of plan. YTD the deficit is £25.41m, £0.74m ahead of plan.
- YTD Long Term Partnership costs of £8.05m, £7.05m ahead of plan, discussions continue with NHS Improvement regarding total costs for 2016/17. YTD costs reflect real costs incurred for both SFH and NUH: SFH £0.81m vs a plan of £1.53m and NUH £7.24m vs a plan of £13.57m.
- The finance element of the Single Oversight Framework is a score of 3 against a plan of

3.

- CIP YTD delivery of £7.00m against plan of £6.01m.
- Capex expenditure position was behind plan in October with an in month spend of £0.23m due most significantly to slippage in IT projects delayed when merger was being actively progressed. Cumulatively capex is now £1.81m behind YTD plan although forecast to deliver to plan at year end.
- Closing cash at 31st October was £1.49m against plan of £1.45m.
- Agency cap excluding LTP costs - at 31st October YTD agency spend totalled £17.22m against the cap of £11.06m.
- BPPC YTD performance is 93.4% by value of invoices paid and 89.9% by number of invoices paid, within 30 days.

Operating statement (Including LTP)

The Trust is ahead of its planned deficit by £0.74m at the end of October excluding LTP, driven by income over-performance and early CIP delivery. This is £0.93m better than forecast in month. Including LTP costs the Trust is £7.79m ahead of plan with costs in the position to date representing those incurred. The positive excluding LTP is £0.74m better than plan due to income over-performance and early delivery of CIP.

Year to date

	Oct In-Month			Year to Date		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Clinical Income	20.80	20.82	0.02	144.45	146.46	2.02
Other Operating Income	3.05	2.93	(0.12)	20.48	19.99	(0.50)
Total Operating Income	23.85	23.74	(0.10)	164.93	166.45	1.52
Pay	(15.67)	(16.06)	(0.39)	(113.28)	(113.82)	(0.54)
Non Pay	(8.97)	(2.20)	6.77	(75.84)	(68.92)	6.92
EBITDA	(0.79)	5.48	6.27	(24.19)	(16.29)	7.90
Operating Costs Excl. from EBITDA	(0.83)	(0.87)	(0.04)	(5.79)	(5.99)	(0.20)
Non Operating Income	0.00	0.00	(0.00)	0.01	(0.09)	(0.10)
Non Operating Expenditure	(1.68)	(1.64)	0.04	(11.28)	(11.08)	0.20
Surplus/(Deficit)	(3.30)	2.97	6.27	(41.25)	(33.46)	7.79
Long Term Partnership	(0.16)	6.03	6.19	(15.10)	(8.05)	7.05
Surplus/(Deficit) - Excluding LTP	(3.14)	(3.06)	0.08	(26.15)	(25.41)	0.74

Operating statement identifies:

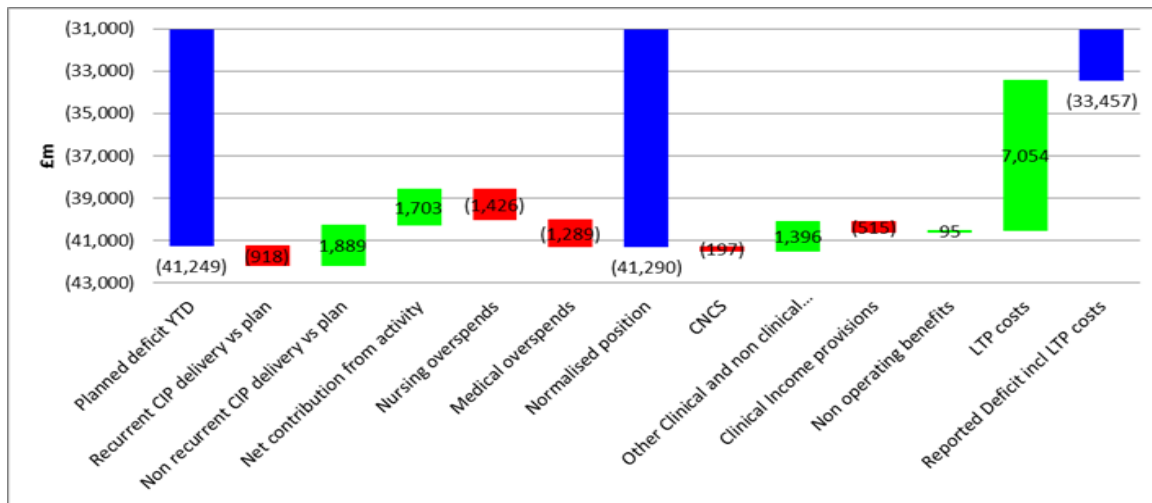
Clinical income is on plan by in month and ahead of YTD plan by £2.02m. This is primarily as a result of continued non elective and outpatient growth. In month provisions have been made to reflect CCG challenges.

S&T monies are on plan in month and £0.13m less than plan YTD due to non-delivery of the cancer trajectory. This is not forecast to be recovered.

Pay spend is reduced by £0.11m in October compared to September, mostly related to medical pay. The pay overspend of £0.39m in October is consistent with

September.

Normalised year to date position



Analysis of the YTD position shows a normalised deficit of £41.3m, exactly in line with the planned deficit, a worsening to the position seen earlier in the year.

Key areas of challenge to the position are medical and nursing pay and CIP delivery.

Forecast Outturn Position (Including LTP)

The forecast continues to evolve and month 7 results are better than forecast by £0.93m excluding LTP. Delivery of the planned deficit of £57.1m is still forecast to be achievable. Key assumptions include; 100% delivery of CIP, payment by commissioners of income over-performance net of provisions made for counting and coding challenges and assumes delivery to the winter plan. The forecast risk range continues to be developed.

Forecast outturn – Trust Wide

	Forecast Outturn		
	Plan £m	Actual £m	Variance £m
Clinical Income	247.05	251.17	4.11
Other Operating Income	38.31	37.35	(0.95)
Total Operating Income	285.36	288.52	3.16
Pay	(192.44)	(195.45)	(3.01)
Non Pay	(120.50)	(120.41)	0.09
EBITDA	(27.58)	(27.34)	0.24
Operating Costs Excl. from EBITDA	(9.92)	(10.36)	(0.44)
Non Operating Income	0.26	0.16	(0.10)
Non Operating Expenditure	(19.84)	(19.54)	0.30
Surplus/(Deficit)	(57.08)	(57.08)	(0.00)
Long Term Partnership	(15.88)	(15.88)	(0.00)
Surplus/(Deficit) - Excluding LTP	(41.20)	(41.20)	(0.00)

The forecast outturn identifies that delivery of the planned deficit of £57.1m including LTP is on track. Assumed within this is 100% delivery of CIP target of £12.6m, continuation of and

payment by commissioners of over-performance net of provisions made and delivery to the winter plan.

The forecast outturn ranges from £13.5m worse than plan to £4.7m favourable to plan. The downside risk relates principally to commissioner non payment and the deteriorating position would mean no S&T funding payable in Q3 and Q4

Forecast outturn – by Division

	Forecast Outturn		
	Plan	Actual	Variance
	£m	£m	£m
Diagnostic and Outpatients	(11.78)	(11.80)	(0.02)
Medicine	11.10	10.16	(0.95)
Surgery	13.79	13.78	(0.01)
Urgent and Emergency Care	5.82	3.79	(2.04)
Women & Children	11.39	11.02	(0.37)
Central Income	12.71	11.99	(0.73)
Corporate	(71.80)	(67.19)	4.61
Corporate Finance	(28.32)	(28.82)	(0.50)
Total	(57.08)	(57.08)	(0.00)
Long Term Partnership	(15.88)	(15.88)	(0.00)
Total (Excluding LTP)	(41.20)	(41.20)	0.00

Each Division is now forecasting an overspend, with D&O and Surgery deteriorating in month. The CFO has met with each Division to discuss their forecast in detail and overall there has been a £1.5m improvement in divisional base forecasts. The Corporate forecast continues to improve (by £0.71m in October) reflecting the reviews undertaken with the directorates. Specific actions underway are:-

On-going development of divisional recovery plans.

On-going development of CIP to deliver target in full.

On-going engagement with commissioners to ensure payment for activity undertaken.

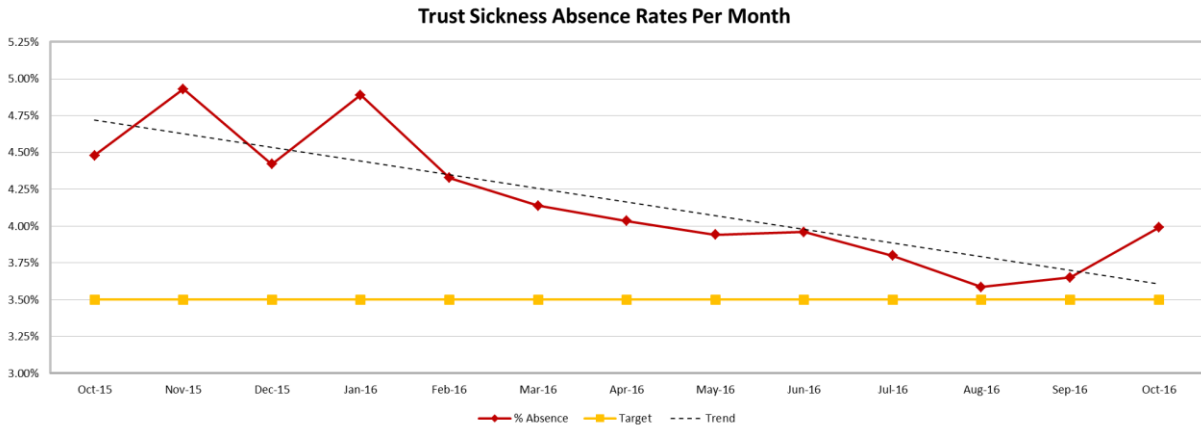
WORKFORCE

NOTE: A Divisional restructure has taken place which prevents trend analysis across the Divisions prior to April 2016

Sickness absence:

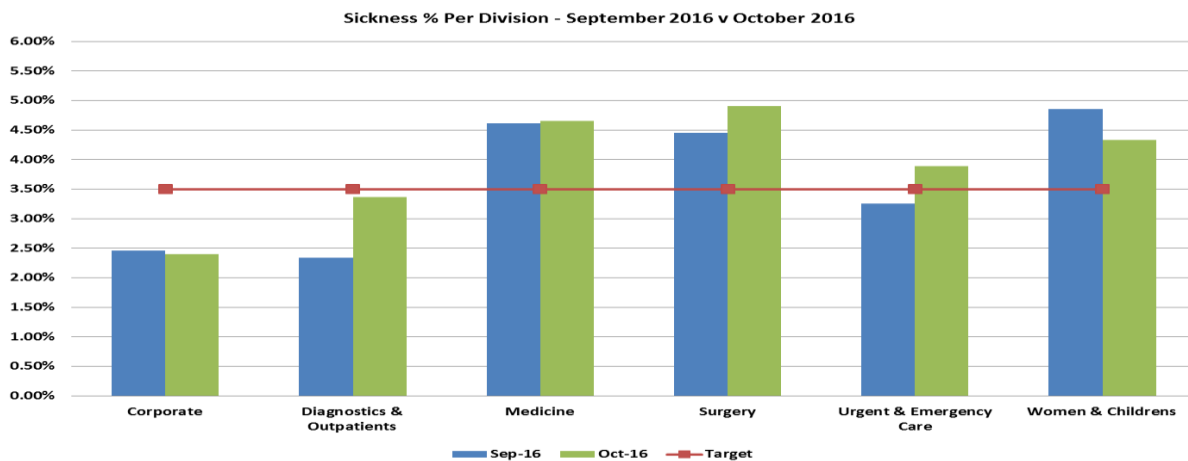
Trust wide sickness absence

Overall sickness levels increased by 0.34% in month to 3.99% (September, 3.65%). Short term sickness increased by 0.33% (2.30%) and long term sickness increased by 0.01% (1.69%)



There has been a downward trend in sickness absence across the year. Absence rates in October 2016 were 3.99%. This was 0.49% lower than the absence rates in the same month a year ago.

Sickness Absence by Division:



The Divisions with the highest increase are Diagnostics & Outpatients rising by 1.02% (3.36%), Urgent & Emergency Care, rising by 0.64% (3.89%) and Surgery rising by 0.46% (4.91%). The Division with the largest total reduction was Women and Childrens which decreased by 0.52% (4.33%). This area had seen considerable increases in LT sickness from June 2016 (1.51%) to September (2.46%) which was due to employee relations issues and a high number of vacancies within the Paediatric area, October LT sickness reduced by 0.64% (1.82%). The sickness absence target is 3.5%.

Long term sickness across the Trust increased by 0.01% (1.69%) in month with short term sickness increasing by 0.33% (2.30%). Diagnostics & Outpatients had the most significant increase in LT Sickness increasing by 0.63% (1.15%) with ST sickness increasing by 0.39% however this Division still remains below the 3.5% sickness target.

Sickness by staff group:

2016-2017	Sep	Oct	Difference in Month
Technical & Other	3.29%	5.06%	1.76%
Unregistered Nurse 2016/2017	5.91%	6.89%	0.97%
Scientific & Professional	2.74%	3.68%	0.94%
Medical & Dental	1.94%	2.61%	0.67%
Band 5 Registered Nurse 2016/2017	2.61%	2.83%	0.22%
Admin & Clerical	3.18%	3.37%	0.19%
Registered Nurse 2016/2017	3.85%	3.74%	-0.11%
Allied Health Professionals	2.86%	2.57%	-0.30%
Ancillary	8.02%	4.43%	-3.59%
Trust Total	3.65%	3.99%	0.34%

- Technical & Other had the highest differential in month, 138 FTE days lost, an increase of 1.76% (5.06%). The top 3 highest increase in absence reasons were: Cold, cough, flu (30.04 FTE days lost) Injury fracture (29.43 FTE days lost) and Anxiety/stress (20.39 FTE days lost)
- Unregistered Nurse increased by 0.97% with 141.23 FTE days lost due to Other musculoskeletal.
- Band 5 Registered Nurse sickness absence increased by 0.07% (0.87%) with Anxiety/stress showing as the highest absent reason with 248.23 FTE days lost, this was an increase of 68.40 FTE days lost in month
- Across the Trust the top 3 highest increases in absence reasons are Cold, cough, flu increasing by 195.77 FTE days lost, Unknown causes* increasing by 107.12 FTE days lost and Other Musculoskeletal increasing by 84.56 FTE days lost. Anxiety/stress increased by 38.99 FTE days lost but this was the 8th highest increase in month.
- The HR Business Partners are to remind all managers that the Unknown cause's absence category should not be used as all reasons for absence should be known.

The areas with the top 5 headcount which have had 0% sickness in October 2016 are:

Cost Centre	Department / Ward	Staff headcount - SIP
TN05729	Research & Development	18
TF11651	Financial Management	18
TH17700	GP Rotation	18
PG17263	Medical Staff - Urology	13
PH17270	Medical Staff - Ophthalmology	12

September's top 6 headcount with 0% sickness were:

Cost Centre	Department / Ward	Staff headcount - SIP
TM19655	Clinical Coding	27
ER34145	Oakham Ward	25
CS19442	Admissions - Days	24
TH17700	GP Rotation	18
TN05725	Governance Support Unit	17
CR24425	KMH - Breast Screening	17

Additional Information:

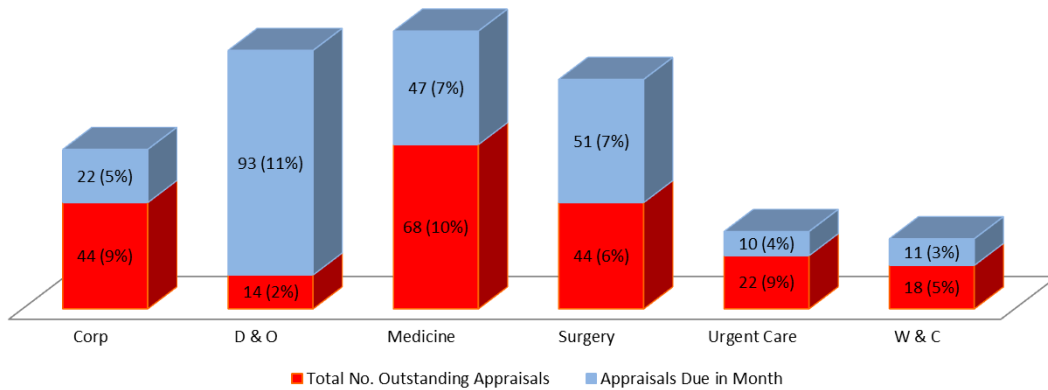
The Trust Occupational Health Service is to run a pilot increased Musculoskeletal (MSK) service for staff as part of the Health & Wellbeing CQUIN initiative from November 2016 to March 2017. The pilot will initiate and evaluate a staff self-referral service to an occupational health physiotherapy service. Staff off sick with musculoskeletal problems will be targeted and offered the opportunity to opt in to a self-referral physiotherapy service to help facilitate a return to work. The pilot will be evaluated and a business case developed, and it is anticipated this will provide evidence that the service has reduced and/or prevented MSK related sickness absence. Results of the pilot will go to the OD and workforce committee for consideration.

Appraisal:

Trust wide appraisal compliance increased by 1% to 94%. The Trust appraisal compliance target is 98%.

There were 210 (6%) appraisals required in October to reach 100%. However there were also an additional 234 appraisals due to be completed which expired in month, a total of 444 (13%) required to be completed in October 2016. These were spread across the Divisions below:

% Total Outstanding Appraisals & % Appraisals Due in Month - October 2016



Staffing:

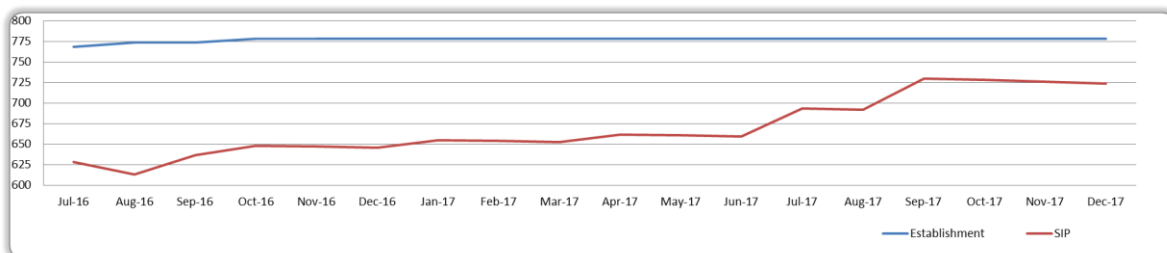
This table shows the net position with staff in post against establishment in October 2016 across the Trust:

	Oct-16								
	Budget - FTE	SIP - FTE	SIP - Headcount	Vac - FTE / Gap - FTE	% Vacancy / % Gap	Starters	Leavers	% Turnover	Active Adverts
Admin & Clerical	1099.95	1008.95	1240	91.00	8.27%	14.67	9.17	0.91%	32
Allied Health Professionals	213.60	201.29	248	12.31	5.76%	3.71	0.45	0.23%	12
Ancillary	38.63	35.67	41	2.96	7.66%	0.00	1.00	2.80%	2
Medical & Dental	484.42	416.03	436	68.39	14.12%	8.00	2.68	0.64%	17
Registered Nurse Operating Line *	1307.98	1172.27	1362	135.71	10.38%	29.48	12.30	1.05%	31
Scientific & Professional	214.16	188.11	203	26.05	12.16%	1.40	2.15	1.14%	5
Technical & Other	268.96	240.02	297	28.94	10.76%	4.31	3.61	1.50%	6
Unregistered Nurse	553.73	530.97	637	22.76	4.11%	7.81	3.76	0.71%	5
Total - Trust	4250.27	3793.31	4464	456.96	10.75%	69.38	35.12	0.93%	110
Band 5 Registered Nurse Only operating line *	777.95	644.26	760	133.68	17.18%	25.23	4.69	0.73%	22

*Establishment and thereby vacancies in the Band 5 RN category have been reduced by 5% of establishment (40.94 fte) in order to reflect the margin that would usually be left unfilled to fund the cover for unplanned absences such as sickness with bank and agency. This margin is never filled with substantive staff. This impacts both the band 5 RN figure and the total RN figure.

There were 35.12 FTE leavers compared to 69.38 FTE starters, the turnover rate reduced to 0.93% in October which is a reduction of 0.11% from September (1.04%).

Band 5 Registered Nurses (RN) Trajectory:



Band 5 nurse vacancies have reduced this month as expected as a result of a further intake

of Newly Qualified nurses and the first 4 Filipino nurses. There has also been lower than expected attrition rate for the 3rd month in succession.

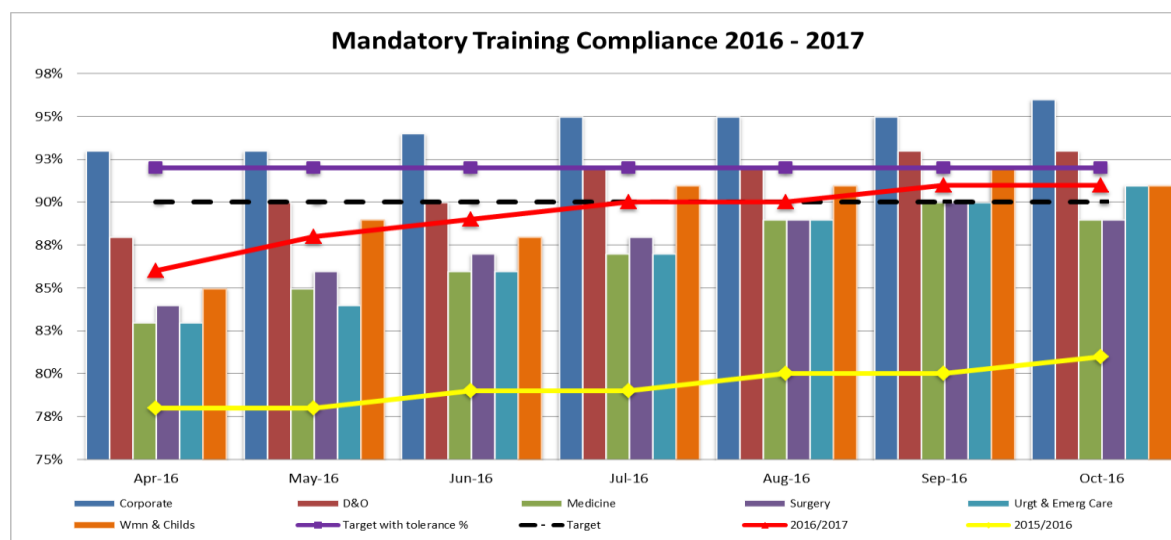
The next nursing open day has been changed to Weds 4th January 2017 and a new time of 3pm-8pm, with the aim of increasing footfall.

A new pooled approach to recruiting Healthcare Support Workers has been undertaken. We will build on this approach for nurse recruitment coinciding with a new recruitment branding campaign in November. A promotional video of the Trust has been designed to attract nurses and will provide presence in two shopping centres (Chesterfield and Derby) in the new year. This video will then be used across key recruitment.

Training and Education:

Mandatory training has remained static in month at 91%, the target is 90%* (92% with a 2% tolerance). This is the fourth consecutive month that the target has been achieved/exceeded. Corporate and Urgent & Emergency Care are the only areas which increased in month.

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



Recommendation:

For the Board of Directors to receive this high level summary report and the attached dashboard and trend graphs for discussion and to raise any queries for clarification.

Relevant Strategic Priorities (please mark in bold)

Ensure the highest standards of safe care are consistently delivered by, and for, individuals, teams and departments

Ensure that patients experience the very best care, building on good practice and listening and learning from both negative and positive feedback and events

Provide timely access to diagnosis, treatment and care when people need it and safely reduce the time patients spend in hospital

Raise the level of staff engagement through strong leadership, communication, feedback and recognition

Reduce the scale of our financial deficit by reducing costs, improving utilisation of

Work in partnership to keep people well in the community, and enable them to return

resources and productivity, and achieving best value for money	as soon as they are ready to leave hospital
Develop and implement a programme of work in conjunction with Nottingham University Hospital NHST to create a new combined organisation	

How has organisational learning been disseminated	
Links to the BAF	All risks identified on the BAF
Financial Implications/Impact	The financial implications associated with any performance indicators underachieving against the standards are identified.
Legal Implications/Impact	Failure to deliver key indicators results in NHSI placing the trust in breach of its authorisation
Partnership working & Public Engagement Implications/Impact	
Committees/groups where this item has been presented before	Board Sub Committees and relevant management Committees, e.g. PSQB, CIP Board