



# Single Oversight Framework

Reporting Period: Month 5  
2021/22

Inspected and rated

Good



# Single Oversight Framework – M5 Overview (1)



Sherwood Forest Hospitals  
NHS Foundation Trust

Domain	Overview & risks	Lead
<p><b>Quality Care (exception reports pages)</b></p>	<p>During August the care delivered to our patients has remained safe and of a high quality. We have had no serious incidents declared that were attributed to staffing levels. Progress continues with the falls reduction work with a continued focus on reducing deconditioning through mobility awareness to promote patient independence. Hospital acquired pressure ulcers remain consistently low; there have been no category 3 PUs since Nov 18 and no category 4s since August 2017. Sadly 2 avoidable category 2s were reported during August. Both of these have been reviewed and actions put in place to address identified issues.</p> <p><b>Falls per 1000 days:</b> performance 7.32 (YTD 6.66) against a target of 6.63. A significant amount of work continues to be undertaken to promote mobilisation across the organisation. All but one of these were no or low physical harm.</p> <p><b>CDIF;</b> YTD we have had 24.71 cases per hundred thousand bed days compared to 19.93 cases in 2020. A trajectory of 57 cases per year has been given, with our YTD position being 39. Thematic review has been completed for all 29 cases and a call with the regional team has taken place with clear actions. The Quality Committee have reviewed our plan to reduce the incidence of Cdif.</p> <p><b>VTE risk assessments:</b> performance 93.9% (YTD 94.4%) target 95%, manual data collection continues since recommencing data collection has significantly improved.</p> <p><b>Complaints:</b> Current performance 1.91 (YTD 1.91) against a standard of ,1.9. The 3 top themes identified are clinical care and treatment, clinical diagnosis and admissions/transfers/discharge. Divisional teams continue to work on action plans and managing the complaint outcomes.</p> <p><b>ED friends and family recommendation:</b> performance 92.3% (YTD 91.2%) against a target of 94%; this compares favourably with national performance at 79%. Work with IQVIA and PET is on-going to address key themes and improve the overall response rate.</p> <p><b>Cardiac arrest rate:</b> performance 1.26 (YTD 0.97) against a target of &lt;1.0. There were no avoidable cardiac arrests identified in August</p>	<p>MD, CN</p>

# Single Oversight Framework – M5 Overview (2)



Sherwood Forest Hospitals  
NHS Foundation Trust

Domain	Overview & risks	Lead
<p><b>People &amp; Culture (exception reports )</b></p>	<p><b>People</b> Overall, from M4 COVID-19 has impacted on Staff Health and Wellbeing at the Trust. Sickness Absence levels have shown a decrease from the last month (July 21 – 4.6%) to 4.4%, and sits higher to the Trust target, this is as a result of the regional/national trend and impact of COVID19.</p> <p>Additional activity is evidenced through the services provided from the Trust Occupational Health Service as expected but presents capacity challenges.</p> <p>Overall resourcing indicators for M5 are positive with levels of vacancy's and turnover remaining low however compliance against Mandatory and Statutory Training has been impacted due to Covid-19.</p> <p>Appraisals levels are at the same position to last months to 87.0%, the reduction is a direct impact from the COVID surge.</p> <p>There has been a focus on increasing access for colleagues staff Covid-19 vaccine. This has resulted in 91% of substantive staff, with 96% of these staff receiving their second dose.</p> <p><b>Cultural Development</b> SFH Quarterly Pulse Survey – The Trust restarted the national quarterly pulse survey in July. Analysis of results indicates that the Trust has sustained a strong position in relation to overall colleague experience of working in Sherwood. This also includes the additional question that SFH chose to place in the survey; colleagues feeling supported from a wellbeing and welfare perspective.</p> <p>National Staff Survey – Final technical preparations were completed during August to support a ‘go live’ date of 4<sup>th</sup> October 21. The survey is open until 26<sup>th</sup> November 2021.</p> <p><b>Improvement</b> In relation to delivery of H2 priorities within Improvement, there are three significant activities within Q3:</p> <ol style="list-style-type: none"> <li>1. Sign off and deployment of the organisation-wide QI Maturity Matrix (supported by East Midlands AHSN).</li> <li>2. Submission of a business case for an organisation-wide Patient Safety Culture survey.</li> <li>3. Submission of a proposal for a standardised approach to providing psychological support for colleagues involved in human-centred critical incidents.</li> </ol> <p>All proposals are at an advanced stage of development and support our core value of objective to continuously learn and improve.</p> <p>Quality Improvement (QI) training recommenced in July and to date, 70+ colleagues have undertaken QI bronze training, with 26 colleagues having undertaken silver level training.</p>	<p>DOP, DCI</p>

# Single Oversight Framework – M5 Overview (3)



Sherwood Forest Hospitals  
NHS Foundation Trust

Domain	Overview & risks	Lead
<p><b>People &amp; Culture (exception reports )</b></p>	<p><b>COVID Absence</b> - The Trust produces a daily Workforce SitRep for the organisation; this includes all COVID related absence elements which are wider than the sickness element reported above. When this is reviewed the total COVID related absence for August 2021 was 5.5%, (July 2021 6.6%) this includes the following:</p> <p>Workforce loss since March 2020 is expressed below.</p> <p><b>Lateral Flow Tests</b> – Overall there were 11,760 test distributed, with 7,890 test registered (67.1%). Of the completed tests there has been 309 positive test (0.2% positive results).</p>	<p>DOP, DCI</p>

# Single Oversight Framework – M5 Overview (4)



Sherwood Forest Hospitals  
NHS Foundation Trust

Domain	Overview & risks	Lead
<p><b>Timely care (exception reports pages)</b></p>	<p>Emergency access stabilised in August and access remained comparatively positive, ranked 5th in the NHS. Demand continues to be high compared to previous months and 2019. PC 24 felt a lot of this increasing demand as well. The number of MSFT patients remains consistently above the ICS agreed threshold, mainly for home care (pathway 1 packages) and this is deteriorating. To manage this additional beds have been opened as well as additional staffing for ED, notably in the evenings, although fill rates are variable.</p> <p>For Cancer services the number of patients waiting more than 62 days on a suspected cancer pathway at the end of August 21, has remained relatively stable but is behind plan with 116 patients waiting against a trajectory of 65. An exception report detailing the root cause and actions being taken is included. A re-forecast of the backlog is also enclosed and sets out a revised assessment of assumptions on referrals and the impact this has on diagnostics and other key elements across the patient pathway. For the faster diagnosis standard, the Trust rank 69<sup>th</sup> nationally with 76% of patients being given the all clear or a diagnosis of cancer within 28 days of referral. 62 day performance for July was 68.6% giving a national ranking of 87th/128 (rank 75th In June). System performance for June was 66%. Average waits for first definitive treatment in July have increased to 58 days (55 in March 21 and 50 days in March 2020). The number of patients waiting 104 days at the end of July has reduced from 23 last month to 18.</p> <p>For Elective Care despite the sustained pressures from emergency care, wave 3 of Covid and peak annual leave; for August the Trust delivered 98% of 19/20 elective activity levels. An exception report for elective inpatient activity is included. The accelerator schemes have supported an additional 12,500 patients above the original H1 activity plan to be seen and/or treated since May. The mobile Endoscopy unit is now on site with a plan to be operational from early October. The programme of work to identify health inequalities on the waiting list is progressing well; a pilot looking at managing raised diabetes and weight loss pre-surgery has commenced and key themes around DNA, language, postcode analysis and communication is in development. The waiting list at the end of August is 37,834 with the number of patients waiting over 52 weeks slightly increasing to 1,136. The published national median wait for Incomplete pathways at the end of July was 11 weeks and 92nd percentile 44 weeks; for the Trust it was 10 and 40 and for August it is 11 and 38 weeks. This compares to a pre Pandemic wait for the Trust at 7 and 22 weeks.</p> <p>Diagnostics continue to perform relatively well despite increased pressure particularly for CT from both emergency and cancer pathways. ECHO continues to be the significant contributor to the 6 week backlog however, insourcing additional capacity as part of the accelerator programme has enabled a significant improvement from over 1,400 patients waiting for an ECHO over 6 weeks as at the end of May to 850 at the end of August. The support will continue into H2.</p>	<p>COO</p>

# Single Oversight Framework – M5 Overview (5)



Sherwood Forest Hospitals  
NHS Foundation Trust

Domain	Overview & risks	Lead
<p><b>Best Value care (exception reports pages)</b></p>	<p>The Trusts financial position for the month of August is a deficit of £0.05m, compared to a planned surplus of £0.75m for the month. A year-to-date deficit of £0.23m has been reported, which compares favourably to plan by £0.43m. August expenditure totals £36.02m and includes the direct Covid-19 costs of £0.90m and costs relating to the Covid-19 vaccination programme of £1.82m, with offsetting income of £1.82m assumed.</p> <p>The reported forecast for the H1 period (April to September) has remained at a £1.30m deficit in August. This reflects the revision to the Elective Recovery Fund thresholds announced by NHS England &amp; NHS Improvement, which were retrospectively applied from 1 July 2021 and result in a £2.90m reduction in expected ERF income.</p> <p>Capital expenditure for August totals £1.95m, which is £0.80m more than planned. Delays to the ED/Resus and Mansfield Community Hospital schemes mean that the year-to-date capital expenditure is £1.16m lower than planned.</p> <p>The closing cash position is £2.49m higher than planned at £13.7m. This reflects the receipt of ERF and Covid-19 Vaccination Programme income in the month of August.</p>	<p>CFO</p>

# Single Oversight Framework – M Overview (1)



Sherwood Forest Hospitals  
NHS Foundation Trust

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Safe	Patient safety incidents per rolling 12 month 1000 OBDs	>41	Aug-21	50.52	48.61		G	CN	M
	All Falls per 1000 OBDs	6.63	Aug-21	6.66	7.32		A	CN	M
	Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	22.6	Aug-21	24.71	49.41		R	CN	M
	Covid-19 Hospital onset	<37	Aug-21	1	1		G	CN	M
	Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0	Aug-21	0.00	0.00		G	CN	M
	Rolling 12 month MSSA bacteraemia infection rate per 100,000 OBD's	17	Aug-21	9.88	12.35		G	CN	M
	Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Jun-21	94.4%	93.9%		A	CN	M
	Safe staffing care hours per patient day (CHPPD)	>8	Aug-21	9.1	8.9		G	CN	M
Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Aug-21	1.91	1.91		A	MD/CN	M
	Recommended Rate: Friends and Family Accident and Emergency	<94%	Aug-21	91.2%	92.3%		A	MD/CN	M
	Recommended Rate: Friends and Family Inpatients	<96%	Aug-21	97.9%	98.5%		G	MD/CN	M
Effective	Cardiac arrest rate per 1000 admissions	<1.0	Jul-21	0.97	1.26		R	MD	M

# Single Oversight Framework – M5 Overview (2)



Sherwood Forest Hospitals  
NHS Foundation Trust

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Staff health & well being	Sickness Absence	3.5%	Aug-21	4.2%	4.4%		A	DoP	M
	Take up of Occupational Health interventions	800 - 1200	Aug-21	8901	2460		R	DoP	M
	Employee Relations Management	<10-12	Aug-21	60	10		G	DoP	M
Resourcing	Vacancy rate	>6.0%	Aug-21	6.5%	5.4%		G	DoP	M
	Mandatory & Statutory Training	<90%	Aug-21	88.2%	87.0%		A	DoP	M
	Appraisals	<95%	Aug-21	90.0%	87.0%		R	DoP	M



# Single Oversight Framework – M5 Overview (3)



Sherwood Forest Hospitals  
NHS Foundation Trust

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency	
Timely Care	Number of patients waiting >4 hours for admission or discharge from ED	>90%	Aug-21	89.2%	86.4%		R	COO	M	
	Mean waiting time in ED (in minutes)	220	Aug-21	168	175		G	COO	M	
	Number of patients who have spent 12 hours or more in ED from arrival to departure	TBC	Aug-21	136	38			COO	M	
	Mean number of patients who are medically safe for transfer	22	Aug-21	53	58		R	COO	M	
	Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<10%	Aug-21	3.4%	4.4%		G	COO	M	
	Cancer Care	Number of patients waiting over 62 days for Cancer treatment	65	Aug-21	-	116		R	COO	M
		Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Jul-21	78.7%	76.2%		G	COO	M
	Elective Care	Elective Day Case activity against Yr2019/20	95.0%	Aug-21	99.0%	106.8%		G	COO	M
		Elective Inpatient activity against Yr2019/20	95.0%	Aug-21	67.5%	74.2%		R	COO	M
		Elective Outpatient activity against Yr2019/20	95.0%	Aug-21	96.3%	98.0%		G	COO	M
		Number of patients on the elective PTL	-	Aug-21	-	37,834			COO	M
		Number of patients waiting over 1 year for treatment	-	Aug-21	-	1136			COO	M

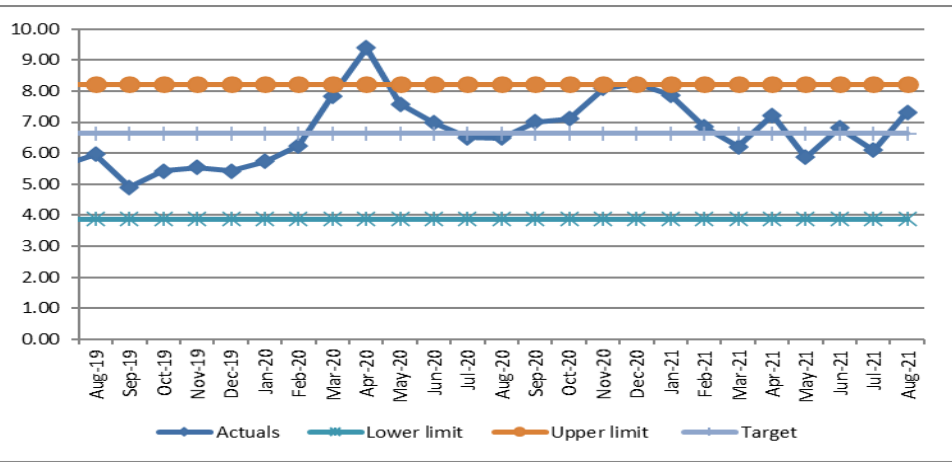
# Single Oversight Framework – M5 Overview (4)



Sherwood Forest Hospitals  
NHS Foundation Trust

At a Glance	Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Best Value Care	Trust level performance against Plan	£0.00m	Aug-21	£0.43m	-£0.80m		G	CFO	M
	Underlying financial position against strategy	£0.00m	Aug-21	tbc	tbc			CFO	M
	Trust level performance against FIP plan	£0.00m	Aug-21	-£0.01m	-£0.19m		G	CFO	M
	Capital expenditure against plan	£0.00m	Aug-21	-£1.16m	£0.80m		A	CFO	M

All Falls per 1000 OBDs	6.63	Aug-21	6.66	7.32		A	CN	M
-------------------------	------	--------	------	------	--	---	----	---



**National position & overview**

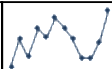
- The falls rate for August is 7.32 above the national average of 6.63 per thousand bed days.
- One third of all falls at SFH in August occurred whilst the patient was mobilising or participating in meaningful activity.
- There has been 1 neck of Femur Fracture which was deemed not STEIS reportable in month with no omissions of care identified.
- There have been no moderate harms reported for 8 months.
- Nationally deconditioning continues for both people at home and in hospital.
- Increasing numbers of patients admitted with COVID 19 in August.
- High numbers of patients attending ED.
- Further increasing numbers of medically safe patients remain in acute beds due to reduced capacity for community care and ability to safely discharge, reduces inpatient bed availability and adds pressure to ED : crowding, long waits.

Root causes	Actions	Impact/Timescale
-------------	---------	------------------

- In August the highest number of falls occurred when the patient was standing and/or mobilising
- Significant progress made with PJ paralysis results on ward 41, increase from 65% in July out of bed by mid day to 82% in August 21.
- Community acquired functional decline contributing to some inpatient falls. Patients are deconditioned and ability to mobilise safely is compromised.
- Hotspots identified on wards where increased incidence of falls reported, visibility, ergonomics footfall to be explored.
- Increase in ED attendance and reduced numbers of pathway 1 discharges causing bottle necks and waits. Increased number of falls in ED , 20 in month, 12 in July 21.
- Posture and seating, fundamentals need revisiting/knowledge/education.
- Patients still can be reluctant to use call bells, forget/don't want to ask for help.
- Continues to be a deterioration in the health of our inpatients and a significant number of falls in those with COVID and/or withdrawing from alcohol/drugs. Hypoxia related confusion and post COVID delirium.
- Focused work on ward 51 in July has shown a significant reduction in falls in August 21.

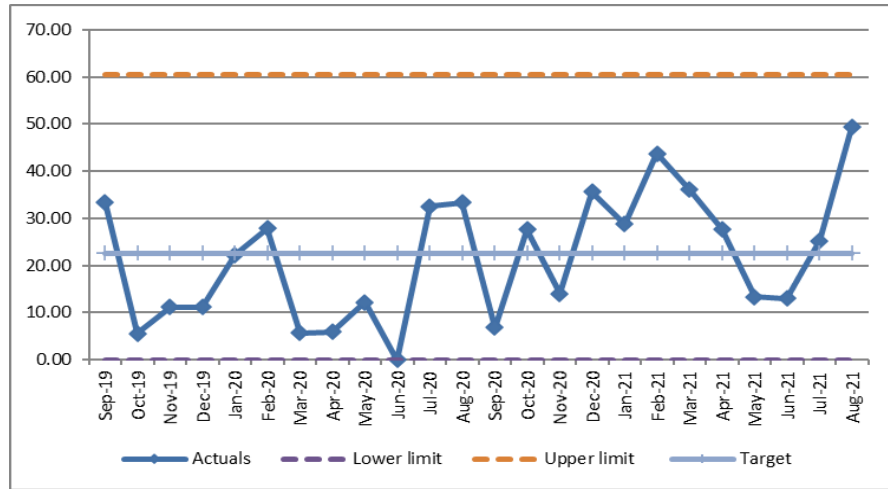
- End PJ Paralysis audit live on AMaT, all medical wards participating in month and roll out to other areas planned. Data shared at harms free group.
- I can posters in use successfully in 3 ward areas to promote safe mobility, plan to roll out.
- Falls Prevention Practitioner's continue to visit wards and departments in hours and OOH to provide support.
- Live datix review for trends/themes and real time intervention/support.
- Multiple service improvement projects in place as part of ward accreditation and pathway to excellent where reduction in falls is central.
- Ward maps have been obtained and team will identify area of fall and help to understand if there is a pattern/re occurrence.
- Planning audit for falls documentation.
- Review of all falls documentation has started, meeting with clinicians to continue review
- Midlands Falls Network is to collate local data to provide some local trends/comparisons.
- Connected Champions, Falls/Dementia/M&H re launch and training dates confirmed due 23/9
- Falls awareness week/ events/education/participation/communications
- Themes of the month established: August will include sleep and deconditioning. Seating and posture will also be covered as a theme and training given to champions.
- Refresh of 'don't fall, just call' posters, designed, going to networks for approval then roll out, posters ready to go.

- On going
- Oct 21
- On going
- On going
- On-going
- Oct 21
- Oct 21
- Sept 21
- Sept 21
- 21 Sept
- On going

Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	22.6	Aug-21	24.71	49.41		R
---	------	--------	-------	-------	--	---




**Sherwood Forest Hospitals**  
NHS Foundation Trust

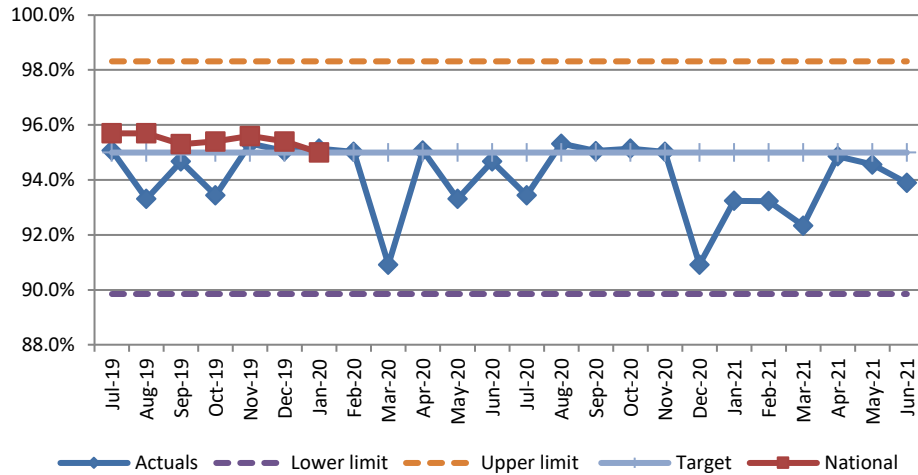


**National position & overview**

- This year the organisation has been given a trajectory for Cdiff of 57 cases.
- The Trust have seen and increase in the number of hospital onset hospital acquired cases of Cdiff when compared to 2020 and 2019
- The trust has also seen a significant increase in community onset hospital acquired Cdiff cases
- Total Trust Attributed Cdiff cases to date for this year is 42, compared to
  - 28 in 2020 /21
  - 26 in 2019/20
- The Quality Committee have reviewed a deep dive into Cdiff and our plans to reduce

Root causes	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• 2 Wards have had periods of increased incidence of cases, however they have proved to be different types and do not appear to be due to cross infection</li> <li>• There have been some lapses in care identified which have contributed to the cause of the Cdiff in these patients. These include 2 cases where antibiotics given were inappropriately.</li> <li>• There have also been delays in sampling which has not been a contributing to the cause of the Cdiff.</li> <li>• There has been interruption to the provision of UV cleaning and HPV cleaning.</li> <li>• There are 7 patients who have had a recurrence of their Cdiff and have been reported a second time.</li> </ul>	<ul style="list-style-type: none"> <li>• All possible samples have been sent to Leeds for ribotyping;           <ul style="list-style-type: none"> <li>• 15 different ribotypes</li> <li>• 7 samples were unable to be sent as not enough available</li> <li>• 2 samples did not grow Cdiff</li> <li>• 4 results are awaited</li> </ul> </li> <li>• Case review with individual prescriber by consultant microbiologist.</li> <li>• Antimicrobial pharmacists to be re-assigned to antimicrobial duties.</li> <li>• Shared learning via medical managers.</li> <li>• Discussed with ward leaders/matrons the importance of timely sampling</li> <li>• Review of antimicrobial prescribing being conducted by NHSE/I Antimicrobial Pharmacist.</li> <li>• Deep clean programme to recommence 5 beds at a time.</li> <li>• We have held a system wide meeting to review and themes and practices requiring improvement. We are now working together with the IPCT in the community to do a deep dive into the treatment provided to patients with a community onset case of Cdiff.</li> <li>• Conduct a gap analysis against the Cdiff – How to deal with the problem document.</li> </ul>	<p>On going</p> <p>Sept 2021 Sept 2021 Sept 2021 Complete Oct 2021</p> <p>Sept 2021 On going</p> <p>Sept 2021</p>

Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Jun-21	94.4%	93.9%		A	CN	M
---	-------	--------	-------	-------	--	---	----	---



### National position & overview

- National reporting of VTE risk assessment screening was stopped in March 2020 in response to the developing Covid pandemic.
- SFH continued with data collection for our own internal monitoring process. The data collection process for VTE risk assessment is a manual process requiring a significant number of man hours to achieve.
- The national target for VTE screening on admission to hospital is set at 95%.
- Covid infection control requirements changed the manual collection processes which has had a detrimental impact on compliance figures.
- Pre-Covid method of data collection restarted initially significantly improved the compliance score the data for June and July has demonstrated a downward trajectory with Julys compliance standing at 93.89%

Root causes	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• The GSU team have resumed the pre Covid method of form collection from 1 April 21.</li> <li>• The data collection process for VTE risk assessment is a manual process requiring a significant number of hours to complete the collection.</li> <li>• Currently awaiting an electronic solution which may be via EPMA or via NerveCentre.</li> </ul>	<ul style="list-style-type: none"> <li>• Continue with Pre-Covid method of form collection from 1 April 21.</li> <li>• EPMA/NerveCentre will resolve the data collection issues as the VTE assessment will be included as part of the package and will be mandatory.</li> <li>• The EPMA/NerveCentre VTE screening tool will be based on the NG89 standards.</li> <li>• Attendance at medical managers meeting to remind all of the need to document this assessment.</li> <li>• Appointment of a consultant VTE lead</li> </ul>	<ul style="list-style-type: none"> <li>• Completed</li> <li>• On going- Await EPMA/NerveCentre electronic VTE screening tool roll out.</li> <li>• October</li> <li>• On-going</li> </ul>

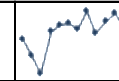
Complaints per rolling 12 months 1000 OBD's

<1.9

Aug-21

1.91

1.91



A



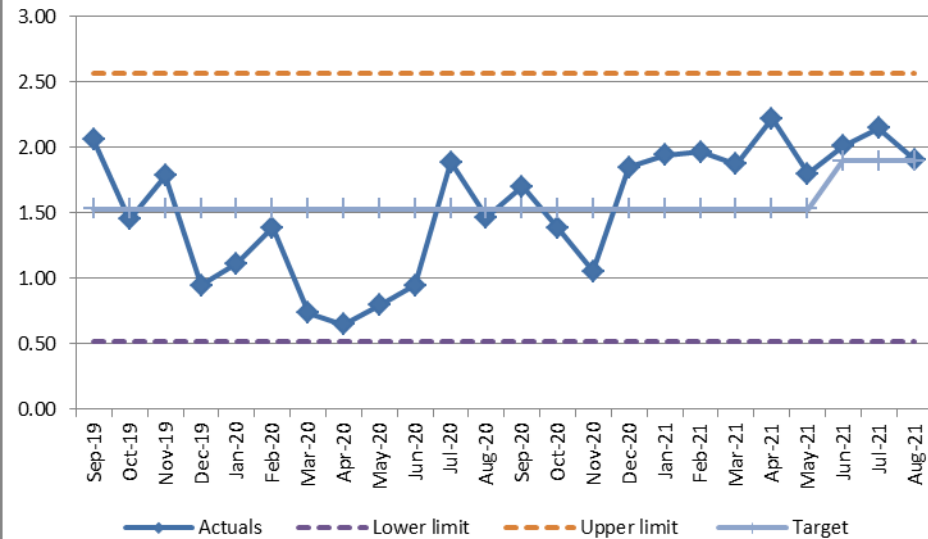
**Sherwood Forest Hospitals**  
NHS Foundation Trust

**National position & overview**

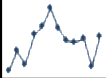
- During August the Trust received 34 complaints. The break down of these by division can be seen in the table below.
- The number of complaints remains within the normal range for SFH between 30 – 40 per month across the organisation.

Top 5 Themes for August:

- Communication – Admin
- Clinical Treatment
- Appointment cancellation/delay
- Communication- Doctor
- Communication – Nurse/Midwife



Root causes	Actions	Impact/Timescale																																																																								
<p>30 complaints were closed in month:</p> <ul style="list-style-type: none"> <li>• Upheld = 1</li> <li>• Partially upheld = 12</li> <li>• Not upheld = 17</li> </ul> <p>Ombudsman:</p> <ul style="list-style-type: none"> <li>• Opened = 1 (relating to COVID vaccination)</li> <li>• Closed = 0</li> <li>• On-going = 4</li> </ul>	<ul style="list-style-type: none"> <li>• Complaints team have moved into the Governance Support Unit</li> <li>• Benchmarking against local Trusts re complaints timescales .</li> <li>• Development of complaints module in new Datix IQ to support timely notification and easy reporting.</li> <li>• Planned pilot for clinical team to be first responder to a complainant with the aim of early resolution.</li> <li>• Development of our priorities for patient experience in consultation with patients and colleagues</li> </ul>	<ul style="list-style-type: none"> <li>• Completed</li> <li>• Oct 21.</li> <li>• Dec 21.</li> <li>• Pilot to commence Oct 21.</li> <li>• Dec 21</li> </ul>																																																																								
<table border="1"> <thead> <tr> <th></th> <th>Mar</th> <th>Apr</th> <th>May</th> <th>Jun</th> <th>Jul</th> <th>Aug</th> <th>Total</th> </tr> </thead> <tbody> <tr> <td>Covid Vaccination Programme</td> <td>5</td> <td>5</td> <td>5</td> <td>2</td> <td>2</td> <td>3</td> <td>22</td> </tr> <tr> <td>Corporate Division</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td>1</td> </tr> <tr> <td>Diagnostic and Out-patients</td> <td>0</td> <td>1</td> <td>2</td> <td>0</td> <td>3</td> <td>3</td> <td>9</td> </tr> <tr> <td>Emergency Urgent Care</td> <td>3</td> <td>8</td> <td>5</td> <td>10</td> <td>9</td> <td>11</td> <td>46</td> </tr> <tr> <td>Medicine Division</td> <td>8</td> <td>9</td> <td>6</td> <td>8</td> <td>11</td> <td>5</td> <td>47</td> </tr> <tr> <td>Surgery Division</td> <td>7</td> <td>7</td> <td>7</td> <td>7</td> <td>6</td> <td>5</td> <td>39</td> </tr> <tr> <td>Women and Children's Division</td> <td>4</td> <td>3</td> <td>1</td> <td>5</td> <td>3</td> <td>6</td> <td>22</td> </tr> <tr> <td><b>Total</b></td> <td><b>27</b></td> <td><b>33</b></td> <td><b>26</b></td> <td><b>32</b></td> <td><b>34</b></td> <td><b>34</b></td> <td><b>186</b></td> </tr> </tbody> </table>		Mar	Apr	May	Jun	Jul	Aug	Total	Covid Vaccination Programme	5	5	5	2	2	3	22	Corporate Division	0	0	0	0	0	1	1	Diagnostic and Out-patients	0	1	2	0	3	3	9	Emergency Urgent Care	3	8	5	10	9	11	46	Medicine Division	8	9	6	8	11	5	47	Surgery Division	7	7	7	7	6	5	39	Women and Children's Division	4	3	1	5	3	6	22	<b>Total</b>	<b>27</b>	<b>33</b>	<b>26</b>	<b>32</b>	<b>34</b>	<b>34</b>	<b>186</b>		
	Mar	Apr	May	Jun	Jul	Aug	Total																																																																			
Covid Vaccination Programme	5	5	5	2	2	3	22																																																																			
Corporate Division	0	0	0	0	0	1	1																																																																			
Diagnostic and Out-patients	0	1	2	0	3	3	9																																																																			
Emergency Urgent Care	3	8	5	10	9	11	46																																																																			
Medicine Division	8	9	6	8	11	5	47																																																																			
Surgery Division	7	7	7	7	6	5	39																																																																			
Women and Children's Division	4	3	1	5	3	6	22																																																																			
<b>Total</b>	<b>27</b>	<b>33</b>	<b>26</b>	<b>32</b>	<b>34</b>	<b>34</b>	<b>186</b>																																																																			

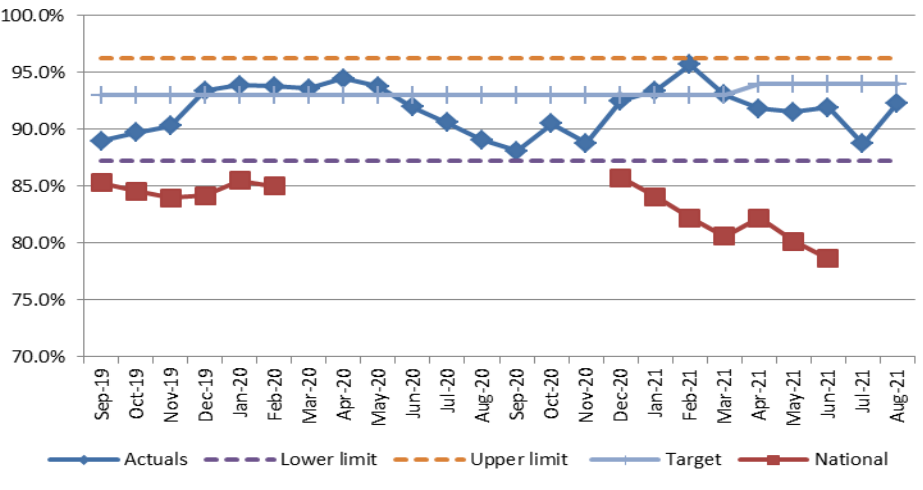
Recommended Rate: Friends and Family Accident and Emergency	<94%	Aug-21	91.2%	92.3%		A
---	------	--------	-------	-------	--	---



**Sherwood Forest Hospitals**  
NHS Foundation Trust

**National position & overview**

- The national recommendation rate is significantly lower than SFH score and threshold
- Response rate remains low which affects the recommended rate score
- Issue identified with text responses only 1 response reported for minors this has been the same the last two months which may suggest an error
- Themes identified in responses around communication and waiting times



Root causes	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• Response rate remains low which affects the recommended rate score</li> </ul>	<ul style="list-style-type: none"> <li>• QR codes have now gone live in ED, it is anticipated this will improve response rates. Nursing staff to encourage patients to use it.</li> </ul>	<ul style="list-style-type: none"> <li>• Nov 2021</li> </ul>
<ul style="list-style-type: none"> <li>• Issue identified with text responses only 1 response reported for minors this has been the same the last two months which may suggest an error.</li> </ul>	<ul style="list-style-type: none"> <li>• Weekly feedback from the PET team to be shared with the team in ED.</li> </ul>	<ul style="list-style-type: none"> <li>• On going</li> </ul>
<ul style="list-style-type: none"> <li>• Themes identified in responses around communication and waiting times.</li> </ul>	<ul style="list-style-type: none"> <li>• PET team exploring if there is an issue with the SMS service.</li> </ul>	<ul style="list-style-type: none"> <li>• Nov 2021</li> </ul>
<ul style="list-style-type: none"> <li>• The threshold set for SFH is significantly higher than the national average.</li> </ul>	<ul style="list-style-type: none"> <li>• ED team to share with colleagues.</li> </ul>	<ul style="list-style-type: none"> <li>• Nov 2021</li> </ul>
	<ul style="list-style-type: none"> <li>• The Head of Patient Experience has recommended the threshold for SFH be reduced to 90% to ensure it represents a stretch on the national average but is realistic. This has been supported by the NMAHP committee and the Quality committee</li> </ul>	<ul style="list-style-type: none"> <li>• Nov 2021</li> </ul>

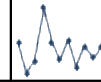
Cardiac arrest rate per 1000 admissions

<1.0

Jul-21

0.97

1.26



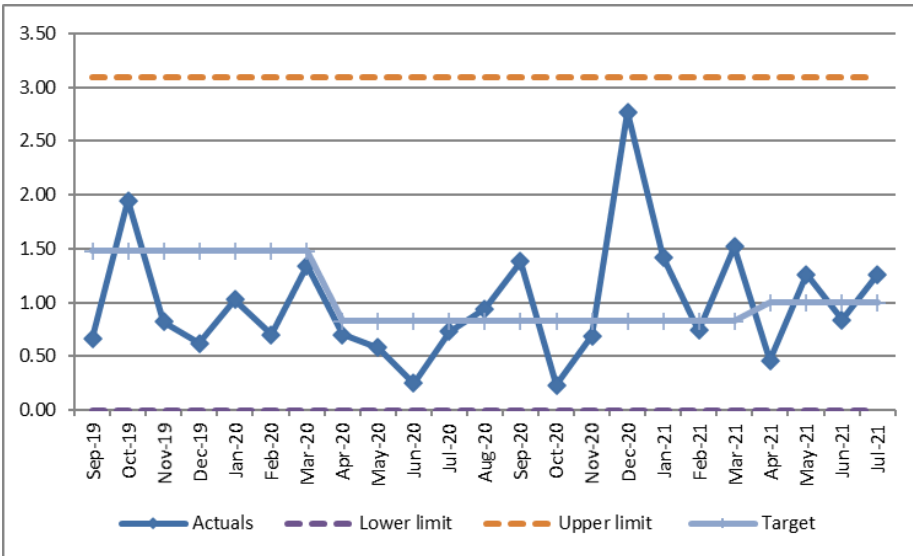
R



**Sherwood Forest Hospitals**  
NHS Foundation Trust

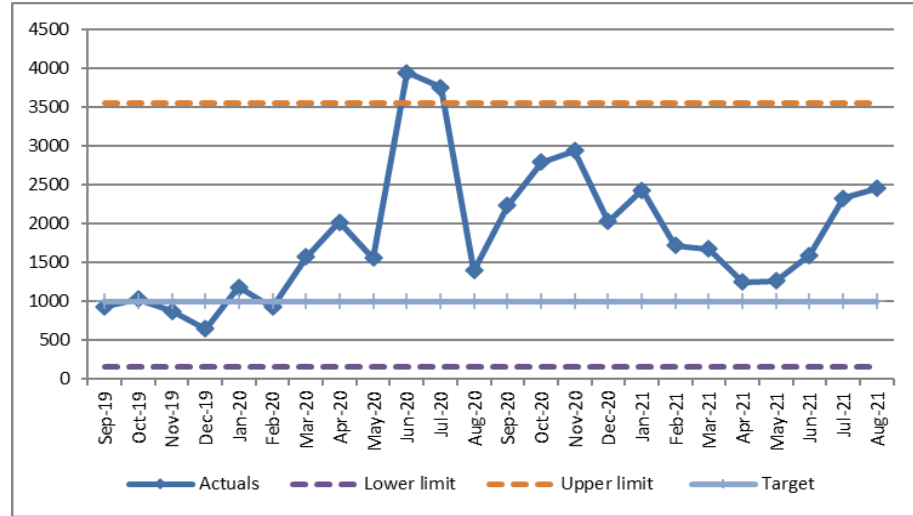
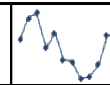
**National position & overview**

- The annual incidence of in hospital cardiac arrest (IHCA) is 1 to 1.5 per 1,000 hospital admissions (Resus Council UK, 2021)
- We continue to report into NCAA and receive reports. With Low numbers of arrests and wide confidence intervals, continuing caution is needed in interpreting results.
- No avoidable arrests identified in August



Root causes	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• Increase in cardiac arrest</li> </ul>	<ul style="list-style-type: none"> <li>• Continue to review all cardiac arrests</li> <li>• Escalate any failure to respond to the acutely unwell patient and investigate accordingly.</li> </ul>	<ul style="list-style-type: none"> <li>• Ongoing</li> </ul>






National position & overview

Local intelligence suggests the Trust is not a anomaly due to national increase in the requirements for Occupational Health services and support.

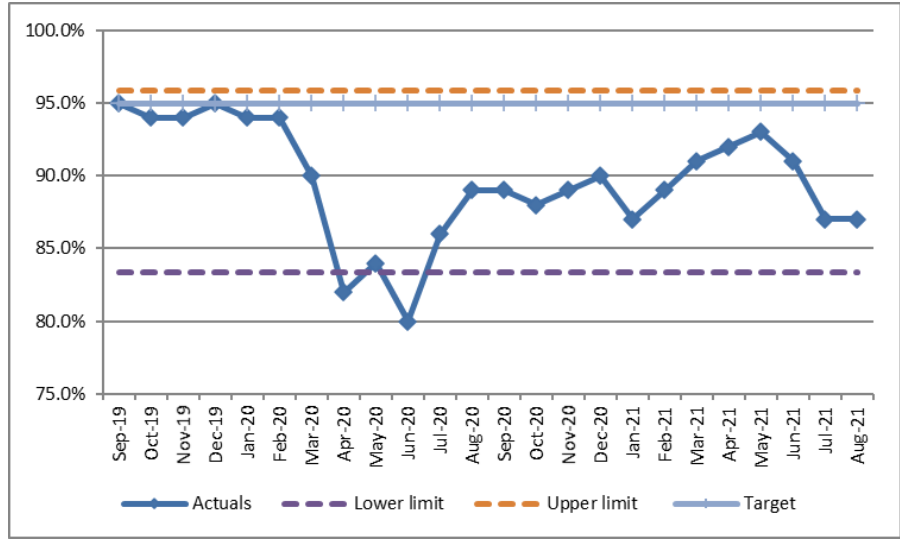
The Trust benchmarks favourably against a national sickness figure.

Root causes	Actions	Impact/Timescale
<p>The key cause of above trajectory performance on the take up of Occupational Health interventions is mainly associated with the enhanced national increase with the pandemic.</p>	<p>This was additional achieved through:</p> <ul style="list-style-type: none"> <li>• New ways of working (Telephone /virtual consultations)</li> <li>• Paper screening for work health assessments instead of face to face</li> <li>• Smart working</li> <li>• All substantive OH staff working overtime</li> <li>• Bank admin support</li> </ul>	<p>This elevated level is expected to continue with additional expectations around IPC and COVID.</p> <p>Pre COVID-19 pandemic, the Occupational Health service had already experienced a substantial increase in utilisation of the service with a 51% increase in overall activity seen over the last 5 years</p>

Appraisals	<95%	Aug-21	90.0%	87.0%		R
------------	------	--------	-------	-------	--	---



**Sherwood Forest Hospitals**  
NHS Foundation Trust



**National position & overview**

- The Trust benchmarks favourably nationally and local intelligence suggests the Trust's appraisal rates are amongst the highest in the region.

**Root causes**

The key cause of below trajectory performance on the appraisal compliance is related to the delivery and capacity issues associated with the surge in the COVID-19 Pandemic.

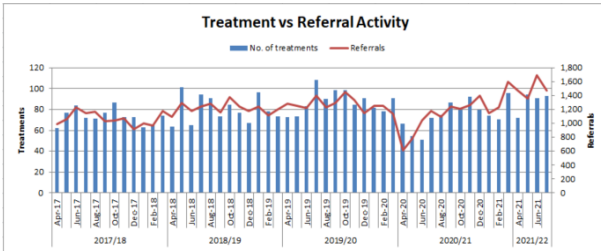
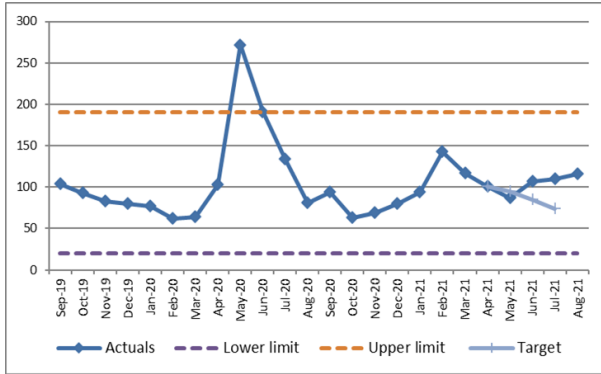
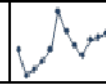
However, significant work was undertaken since January 21 and a gradual increase in the figures was noted. However, the current position shows a reported level at 87.0%.

**Actions**

The People and Inclusion Cabinet are to keep a watching brief on the COVID surge and where appropriate, based on total workforce loss, discuss the re-pausing of appraisals to support divisional capacity.

**Impact/Timescale**

We have forecasted the total workforce loss until March 2022, as a result of this we are reviewing our derogations to support our services over the winter period.



### National position & overview

- In the 2021/22 operational planning guidance, NHS England (NHSE) set out a key objective to return the number of people waiting for longer than 62 days (“the backlog”) to the level observed in February 20 (45 patients for SFH).
- A trajectory was developed in March 21 and presented to Board in May 21. Since then the risks anticipated have had a material impact which at the end of August 21 meant that 116 patients were waiting against a trajectory of 65.
- Whilst the trajectory remains the same, a re-forecast has been developed with an updated set of assumptions for referrals and other variables based on more recent trends (next slide).
- The latest wait data shows average waits at 58 days for July 21 against 56 days for July 19, with 85<sup>th</sup> percentile waits at 95 days (81 days July 19).

### Root causes

- Year to date referrals 20% above the 19/20 average.
- Referral increase impact on diagnostic capacity such as CT colon with waits reaching up to 42 days; compounded by a high volume of DNA/patient cancellations.
- Other diagnostic and treatment delays provided by the tertiary centre including EGFR in Lung, PET scans, surgical dates and oncology.

### Actions

- New LGI cancer support worker (CSW) triage role in place.
- Call reminder and DNA audit trial launched.
- Increasing patients per CTC list by utilising imaging assistants for cannulation and preparation of patients.
- Radiology trialling reduced prep to support better backfill for short notice cancellations.
- Pathology outsourcing EGFR to improve turnaround times. Early findings on a small number of patients suggest average turnaround times have reduced by 11 days.
- Urgent actions being explored with NUH to mitigate the loss of oncology staff i.e. redistributing staff and better use of space.

### Impact/Timescale

- CSW induction through September - independent triage in October.
- Call reminder and audit live as of September.
- Radiology bank staff in place but due to staff absences have not been able to measure yet.
- Reduced prep trial commenced July and positive outcome to date. Assessment of full data in October to confirm if able to introduce.
- EGFR IS trial live as of August.
- Urgent oncology review in place with immediate and longer term impact and actions being assessed.

# 62 day re-forecast

	Actual vs trajectory					Re-forecast vs trajectory						
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
<b>Original trajectory</b>	98	95	85	74	65	61	56	56	61	54	49	45
<b>Actual/re-forecast</b>	101	87	110	110	116	137	140	132	129	129	127	126

In early March 2021, a trajectory to reduce the 62 day backlog to the February 2020 position of 45 was developed. At time of writing there were 5 key risks to delivery, all of which have materialised with increasing demand and pressure on diagnostic capacity having the biggest impact. Other risks included dependency on tertiary provider, the residual impact of COVID and any delays to the LGI Improvement programme.

The current Trust backlog position is reflective of the wider system with NUH and other providers across the region also seeing a significant increase in the number of patients waiting. As a proportion of the backlog the 104+ waits is one of the lowest in the East Midlands region and we continue to be one of the best performing Trusts in dating our surgical P2 cancer patients with 80% of patients currently waiting for surgery with a TCI. The areas most adverse to trajectory are lower GI, urology, lung, UGI and gynaecological and their re-forecast is shown in more detail below.

Top 5 tumour sites adverse to trajectory		Actual vs trajectory					Re-forecast vs trajectory						
		April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Lung	Plan	5	5	4	4	3	2	2	2	2	2	2	2
	Actual/new	5	4	13	6	13	19	16	12	11	11	11	11
UGI	Plan	12	10	9	8	7	5	5	5	5	5	5	5
	Actual/new	9	10	11	14	10	12	12	10	10	10	10	10
LGI	Plan	35	36	34	30	27	27	22	22	27	22	18	14
	Actual/new	39	29	44	47	40	45	50	50	50	50	50	50
Gynae	Plan	4	3	3	2	2	4	4	4	4	4	4	4
	Actual/new	6	8	4	12	11	7	11	11	8	8	7	6
Urology	Plan	22	19	17	15	12	10	10	10	10	10	10	10
	Actual/new	20	13	11	10	20	35	33	33	33	33	33	33

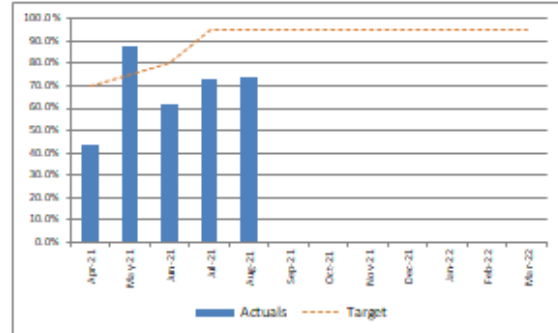
The re-forecast makes the following assumptions:

- Referrals remain 20% higher than 19/20 overall. Noting that lower GI is expected to continue at a rate of 28% higher than 19/20.
- LGI improvement works (including the turn around time for CT colons) continue to hold off demand pressures but will not be able to make any significant backlog reductions.
- NUH bed and theatre pressures continue meaning that waits for surgery are extended in lung and urology.
- Issues with oncology staffing (whilst mostly mitigated) are likely to continue to have some impact
- Access to P2 Cancer ITU/HDU capacity is retained
- The impact of COVID and gaps on staffing do not worsen.

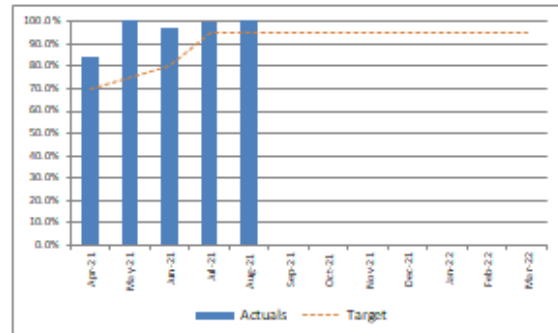
This re-forecast does retain a level of risk. All patients continue to be monitored, tracked and welfare calls in place if required.

Elective Inpatient activity against Yr2019/20	95.0%	Aug-21	67.5%	74.2%		R
---	-------	--------	-------	-------	--	---

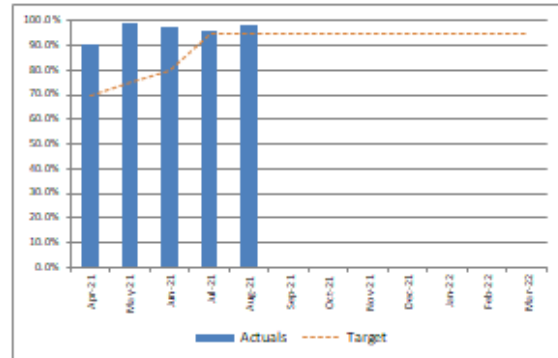
**Elective Inpatient activity against Yr2019/20**



**Elective Day Case activity against Yr2019/20**



**Elective Outpatient activity against Yr2019/20**



**National position & overview**

- For August 2021 (working day adjusted) the activity volume is at 98% when compared to August 2019 (37,393 vs. 38,006)
- This is further split by:
  - Day case - 107% (3,012 vs. 2,819)
  - Outpatient - 98% (34,062 vs. 34,757)
  - Elective inpatient - 73% (319 vs. 430)
- The Trust has exceeded the Elective Recovery Fund (ERF) threshold in all months year to date, however the amount of funding received is based on system delivery. It is important to note the on-going risk to surgical elective inpatient activity due to the surge plan for ITU, in particular the impact it has on orthopaedic elective operating. Operating remains in priority order with an elective hub in place across the system to identify where there may be a disparity in waits.

**Root causes**


- 40% of the gap to 19/20 is where medical specialties have seen a shift to day case. This is in a number of areas such as Gastroenterology, Cardiology and Clinical Haematology and is driven by case mix, use of MDCU and some cancellations to facilitate non-elective care.
- 30% is in Urology and is due to the shift to day case from overnight stays and commencing nephrectomies in August which means a reduction in the number of patients on a specific list from 4 to 1 patient
- 30% is the Paediatric comparison to 19/20 when a backlog of sleep studies was cleared.

**Actions**

- Baseline adjustments to be factored into H2 planning for shift from elective to day case activity.
- Urology teams at NUH and SFH are identifying patients to ensure that capacity is being maximised across the system. A small number of NUH patients have already transferred to SFH for their treatment. This work will be on-going.

**Impact/Timescale**

- Draft elective plans for H2 received 03/09.
- Modelling to understand the impact on the size and shape of the waiting list will be undertaken in October.

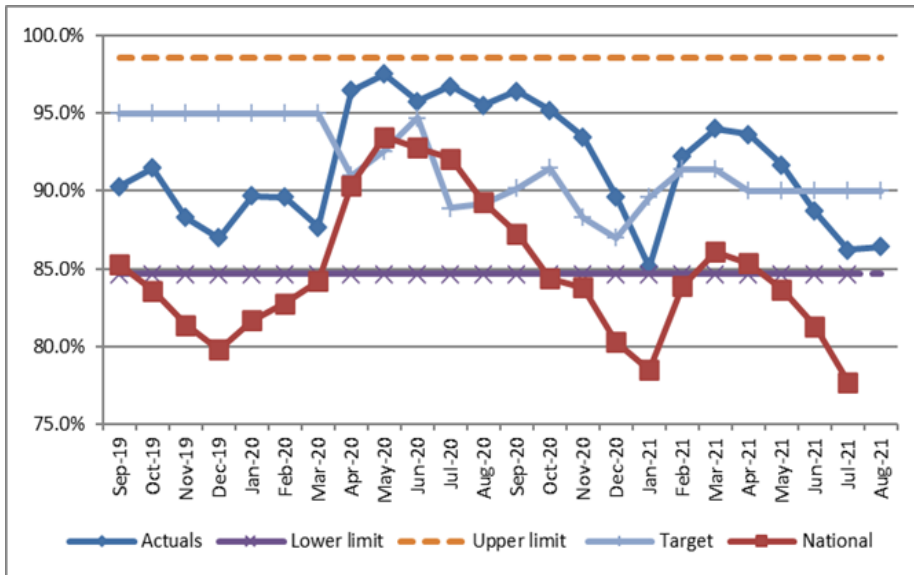
Number of patients waiting >4 hours for admission or discharge from ED	>90%	Aug-21	89.2%	86.4%		R
--	------	--------	-------	-------	--	---



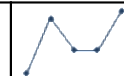
## Sherwood Forest Hospitals NHS Foundation Trust

### National position & overview

- SFH 86.4%, 3.6% below the local H1 aim
- National rank 5<sup>th</sup> out of 117 reporting Trusts
- Similar attendance levels to August 2019, but 11% growth on July 2018
- PC24 had 186 more patients wait over 4 hours and this also contributed to SFH position
- KMH ED performance saw a 3% growth in attends on August 2019
- Newark UTC performance was excellent at 96.3%
- Bed pressure continued during August, this was driven by non-elective admissions, Covid admissions and elective admissions.
- The number of MSFT patients remained in excess of the ICS agreed threshold throughout the month and is showing a deteriorating position – this is a key risk for the rest of the year dealt with on further exception report

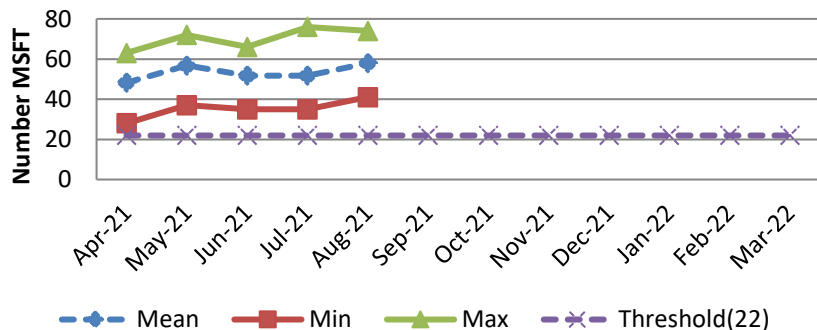


Root causes	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• <b>Demand growth</b> across KMH ED &amp; PC24 well in excess of previous years, notably ambulance demand leading to high admission growth.</li> <li>• <b>Capacity pressure</b> – admission pressures have been similar to winter, but winter capacity has unable to be fully replicated given the requirement to provide some priority to elective care. H1 funding methodology has also constrained some of this. Workforce supply to put up lots of additional capacity remains a challenge, particularly with recent Covid pressures on isolation. Increasing Covid admissions during July has also increase pressure on isolation capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• Much of the analysis from the Nottinghamshire ICS AEDB continues to show that there is demand pressure across the NHS in hospitals, primary care, 111 and EMAS.</li> <li>• Work is underway with the Locality Director for Primary care in Mid Notts to understand variability in ED attend levels despite the significant increases in activity being undertaken by primary care and should report over the next month</li> <li>• 26 additional beds continue to be open and Ward 41 has been converted from a pure rehabilitation ward to a sub-acute rehabilitation ward giving greater flexibility for admission</li> <li>• Additional medical and nursing shifts have been rostered in ED, but fill rates continue to be variable</li> <li>• The maximisation of Same Day Emergency care continues to be successful and 415 (60%) more patients were seen in this service than in August 19, thereby avoiding admission to a bed</li> <li>• Capacity planning work for 2021/22 H2 has commenced against a 4% growth on 2019. At present this represents a material gap in capacity and it is likely that elective activity may be impacted. The H2 capacity plan is updated is the subject of a separate paper to the Board this month.</li> </ul>	<ul style="list-style-type: none"> <li>• In place</li> <li>• In place</li> <li>• Ongoing</li> <li>• October 21'</li> </ul>



**Sherwood Forest Hospitals**  
NHS Foundation Trust

**Monthly trends ; Year 2021/22**



**National position & overview**

- The local position has worsened and remains above the agreed threshold of 22 patients in the acute trust in delay
- The worsening position is a direct link to workforce issues within adult social care, and to a degree, community partners and closed care homes
- Additional bed capacity remains open with 26 beds
- There have been up to 47 patients who are MSFT who are residing in an acute care bed

Root causes	Actions	Impact/Timescale
<ul style="list-style-type: none"> <li>• Pathway 1 demand and the available capacity to meet the variation in demand. This reflects the lack of available staff in care agencies (on the framework) to meet demand in particular for double up care QDS and TDS , as well as availability of social workers to manage the allocations. Recruitment into care and social worker roles is proving very difficult with posts unfilled and no agency cover.</li> <li>• Care home closures for staffing and infection prevention issues have also contributed to delayed discharge allocation.</li> <li>• The MADE pilot has had to be temporarily postponed due to community staffing loss again increasing delays.</li> <li>• Internal process issues contributing to referral delays outside the 48hr window have improved but work is on-going as a small few remain.. This allows more time for social care to allocate/ find care.</li> </ul>	<ul style="list-style-type: none"> <li>• The community teams are working closely with Tuvida agency to increase availability of care packages. And undertake joint assessments.</li> <li>• Community/ASC teams continue with recruitment and there needs to be more visibility of this plan in the system.</li> <li>• Planned transformational change re workforce finalised 29<sup>th</sup> Sept.</li> <li>• Joint communication with care home cell and CHC on a 1:1 basis to place patients safely where possible.</li> </ul> <p><b>Escalation</b></p> <ul style="list-style-type: none"> <li>• Delays and workforce issues escalated through CEO group, D2A Board with daily system conversations.</li> <li>• Visibility of system workforce plans for assurance- required.</li> <li>• Covid impact on staff/ care home capacity.</li> </ul>	<ul style="list-style-type: none"> <li>• Will allow the MADE pilot to recommence Oct 21</li> <li>• 4<sup>th</sup> Oct</li> <li>• On-going</li> <li>• 29<sup>th</sup> Sept – March 22 end point</li> <li>• Oct 21</li> </ul>

## Best Value Care

### H1 / H2 Plan

- The Trust has submitted a plan to NHS England & NHS Improvement covering the period 1st April 2021 to 30th September 2021. This is referred to as the '2021/22 H1 Plan'. An updated version of the plan including rephased Elective Recovery Fund (ERF) income was submitted 22nd June. The values in these slides reflect this updated plan.
- The H1 Plan shows a break-even financial position for the period, however the phasing of the plan includes surplus or deficit positions in each month. This is due to the expected timing of income and expenditure.
- The financial framework for H2 covering the period 1st October 2021 to 31st March 2022 has still to be published (expected mid September) and so is not reflected in this report. It is expected however that H2 will be on a similar basis to H1 and detailed planning work has commenced on this basis.

### Month 5 Summary

- The Trust has reported a YTD deficit of £0.23m for August, which is £0.43m better than the planned deficit of £0.66m.
- YTD Capital expenditure to August was £4.31m, which is £1.16m lower than planned.
- Closing cash at 31st August was £13.70m, which is £2.49m above plan. This is mainly due to the YTD deficit being £0.43m better than plan, and YTD capital expenditure £1.16m lower than plan.

	August In-Month			YTD			Forecast H1		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	37.99	35.99	(1.99)	186.53	181.76	(4.77)	224.83	217.33	(7.50)
Expenditure	(37.24)	(36.05)	1.19	(187.19)	(181.99)	5.20	(224.83)	(218.63)	6.20
<b>Surplus/(Deficit) - Break-even Requirement Basis</b>	<b>0.75</b>	<b>(0.05)</b>	<b>(0.80)</b>	<b>(0.66)</b>	<b>(0.23)</b>	<b>0.43</b>	<b>0.00</b>	<b>(1.30)</b>	<b>(1.30)</b>
Capex (including donated)	(1.15)	(1.95)	(0.80)	(5.47)	(4.31)	1.16	(6.58)	(5.63)	0.95
Closing Cash	11.22	13.70	2.49	11.22	13.70	2.49	12.18	12.18	0.00



## Best Value Care

**Break-even Requirement All values £'m**

	In Month					Year-to-Date					H1 Forecast				
	Plan	Non-Covid Actual	Covid Actual	Total Actual	Variance	Plan	Non-Covid Actual	Covid Actual	Total Actual	Variance	Plan	Non-Covid Forecast	Covid Forecast	Total Forecast	Variance
<b>Income:</b>															
Block Contract	23.85	23.91	0.00	23.91	0.06	119.25	119.48	0.00	119.48	0.23	143.10	143.58	0.00	143.58	0.48
Top-Up System	3.71	3.71	0.00	3.71	0.00	18.56	18.56	0.00	18.56	0.00	22.27	22.27	0.00	22.27	0.00
ERF	2.70	0.99	0.00	0.99	(1.71)	9.92	4.80	0.00	4.80	(5.12)	12.86	4.80	0.00	4.80	(8.07)
COVID Income	1.73	1.05	0.68	1.73	(0.00)	8.66	5.25	3.41	8.66	(0.00)	10.39	6.29	4.10	10.39	(0.00)
Growth and SDF	0.60	0.60	0.00	0.60	0.00	2.98	2.98	0.00	2.98	0.00	3.57	3.57	0.00	3.57	0.00
Other Income	5.38	5.03	0.00	5.03	(0.35)	27.04	27.15	0.00	27.15	0.11	32.49	32.56	0.00	32.56	0.07
<b>Total Income</b>	<b>37.96</b>	<b>35.29</b>	<b>0.68</b>	<b>35.97</b>	<b>(1.99)</b>	<b>186.40</b>	<b>178.21</b>	<b>3.41</b>	<b>181.62</b>	<b>(4.78)</b>	<b>224.68</b>	<b>213.07</b>	<b>4.10</b>	<b>217.17</b>	<b>(7.51)</b>
<b>Expenditure:</b>															
Pay - Substantive	(18.18)	(17.19)	(0.11)	(17.29)	0.89	(91.41)	(87.34)	(0.63)	(87.96)	3.45	(109.72)	(105.04)	(0.82)	(105.86)	3.86
Pay - Bank	(4.43)	(3.11)	(0.41)	(3.52)	0.90	(22.70)	(18.00)	(1.87)	(19.86)	2.84	(27.47)	(21.18)	(2.29)	(23.46)	4.01
Pay - Agency	(1.05)	(1.08)	(0.03)	(1.12)	(0.07)	(5.23)	(5.22)	(0.40)	(5.62)	(0.40)	(6.23)	(6.62)	(0.40)	(7.02)	(0.79)
Pay - Other (Apprentice Levy and Non Execs)	(0.09)	(0.13)	0.00	(0.13)	(0.04)	(0.47)	(0.73)	0.00	(0.73)	(0.26)	(0.56)	(0.85)	0.00	(0.85)	(0.29)
<b>Total Pay</b>	<b>(23.74)</b>	<b>(21.51)</b>	<b>(0.55)</b>	<b>(22.07)</b>	<b>1.68</b>	<b>(119.81)</b>	<b>(111.29)</b>	<b>(2.89)</b>	<b>(114.18)</b>	<b>5.63</b>	<b>(143.99)</b>	<b>(133.69)</b>	<b>(3.51)</b>	<b>(137.20)</b>	<b>6.79</b>
Non-Pay	(11.10)	(11.27)	(0.35)	(11.62)	(0.52)	(55.47)	(54.79)	(1.25)	(56.04)	(0.57)	(66.58)	(65.70)	(1.63)	(67.34)	(0.75)
Depreciation	(1.11)	(1.07)	0.00	(1.07)	0.04	(5.57)	(5.40)	0.00	(5.40)	0.16	(6.68)	(6.48)	0.00	(6.48)	0.20
Interest Expense	(1.26)	(1.26)	0.00	(1.26)	(0.00)	(6.22)	(6.23)	0.00	(6.23)	(0.02)	(7.43)	(7.45)	0.00	(7.45)	(0.02)
PDC Dividend Expense	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
<b>Total Non-Pay</b>	<b>(13.47)</b>	<b>(13.61)</b>	<b>(0.35)</b>	<b>(13.95)</b>	<b>(0.48)</b>	<b>(67.25)</b>	<b>(66.42)</b>	<b>(1.25)</b>	<b>(67.68)</b>	<b>(0.42)</b>	<b>(80.69)</b>	<b>(79.64)</b>	<b>(1.63)</b>	<b>(81.27)</b>	<b>(0.58)</b>
<b>Total Expenditure</b>	<b>(37.21)</b>	<b>(35.12)</b>	<b>(0.90)</b>	<b>(36.02)</b>	<b>1.19</b>	<b>(187.06)</b>	<b>(177.71)</b>	<b>(4.14)</b>	<b>(181.85)</b>	<b>5.21</b>	<b>(224.68)</b>	<b>(213.32)</b>	<b>(5.15)</b>	<b>(218.47)</b>	<b>6.21</b>
<b>Surplus/(Deficit)</b>	<b>0.75</b>	<b>0.16</b>	<b>(0.22)</b>	<b>(0.05)</b>	<b>(0.80)</b>	<b>(0.66)</b>	<b>0.50</b>	<b>(0.73)</b>	<b>(0.23)</b>	<b>0.43</b>	<b>0.00</b>	<b>(0.25)</b>	<b>(1.05)</b>	<b>(1.30)</b>	<b>(1.30)</b>

The table above shows that the YTD Trust deficit of £0.23m reported for Month 5 is £0.43m better than the phased H1 plan deficit.

M5 YTD Covid-19 costs of £4.14m are £0.38m higher than planned. Forecast H1 Covid-19 spend is £5.15m, £1.05m more than planned. This reflects the increased pressures driven by Covid-19 in July and August, with an increase in positive patients and in workforce unavailability.

The table includes the Vaccination Programme, M5 YTD costs of £11.82m (£10.87m Pay and £0.95m Non pay), are £1.53m lower than planned. This cost is a pass through and is fully offset by income.

The Trust's H1 forecast remains at £1.30m deficit. This reflects the impact of a change in ERF thresholds announced by NHSE/I, which reduces the level of ERF income available to support the Trust's elective recovery programme. This is a system issue and the Nottingham & Nottinghamshire ICS has requested support from the NHSE/I regional team to mitigate the impact.