Mid-Nottinghamshire Integrated Care Partnership

NHS Sherwood Forest Hospitals NHS Foundation Trust

Single Oversight Framework

Reporting Period: Month 10

2021/22

Inspected and rated Good

CareQuality Commission

Single Oversight Framework – Month 10 Overview (1)

Sherwood Forest Hospitals
NHS Foundation Trust

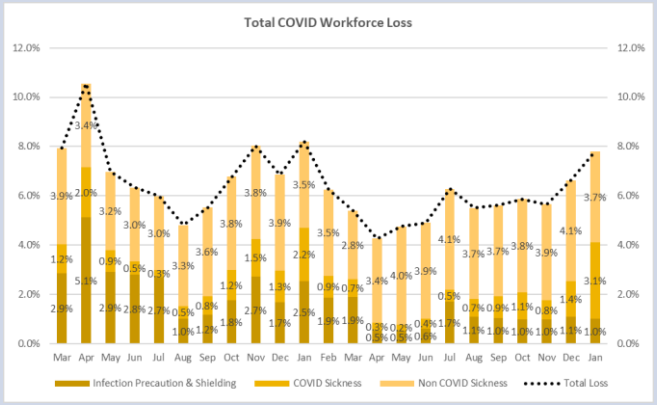
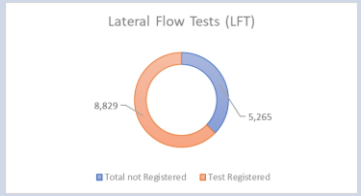
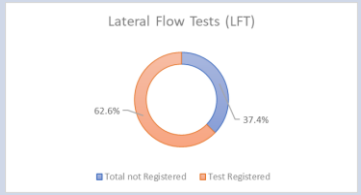
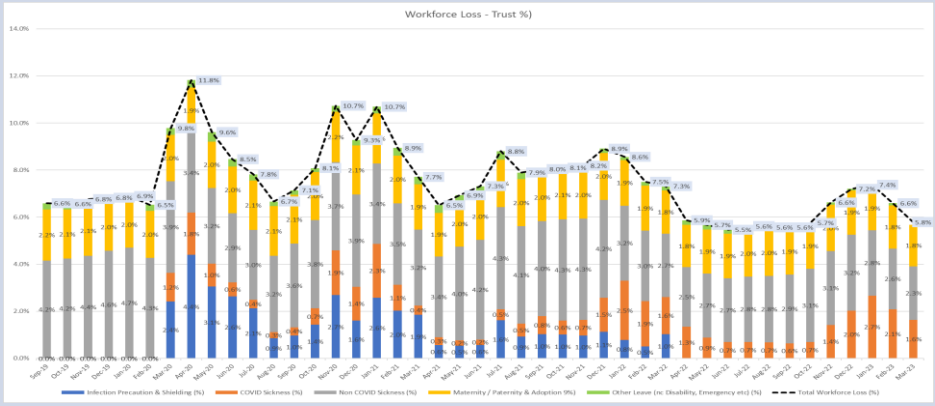
Domain	Overview & risks	Lead
Quality Care (exception reports pages)	During January we experienced the peak of the Omicron variant against a back drop of increased external delays for patients medically safe for discharge. This led to significant crowding within the Emergency Department and opening of super surge capacity over and above the ambitious winter plan. Despite this the care delivered to our patients has remained as safe as possible and of high quality. We have had no serious incidents declared that were attributed to staffing levels. Hospital acquired pressure ulcers remain consistently low. Infection control remains high on the agenda, both in terms of our Covid-19 response and continued focus on reduction of Cdiff cases. There are 4 exception reports for January 2022: • **Falls per 100 days:** performance 8.43 (YTD 7.03) against a target of 6.63. A significant amount of work continues to be undertaken to promote mobilisation across the organisation. This has been driven by a number of complex variables with clear actions identified. • **COVID-19:** during January we have had 17 hospital acquired cases (YTD 59). Covid 19 outbreaks are being managed in accordance with PHE/NHS I/E guidance. All hospital associated cases, requires completion of a root cause analysis. • **VTE risk assessments:** performance 91.9% (YTD 93.6%) target 95%. Access to ward areas was significantly restricted in January. Manual data collection recommenced and data collection has significantly improved. • **Cardiac arrests rate:** performance 2.31 (YTD 1.14) against a target of <1.0. There were no avoidable cardiac arrests identified in January.	MD, CN

Single Oversight Framework – 10 Overview (2)

Domain	Overview & risks	Lead
People & Culture (exception reports)	**People** During M10 we have noted a sharp increase in the overall sickness absence level, this is as a direct result of the Omicron variance and the requirements to isolate. Sickness absence levels were recorded at 6.8% and reached a level higher then previous COVID waves. It also sits the Trusts performance above the upper SPC level. Additional activity is evidenced through the services provided from the Trust **Occupational Health** Service, during M10 there has been decreased activity level, however the activity still sits above plan. It I anticipated that this level will continue to decrease over the next few months. Across M10 **appraisals** levels have been relatively stable and currently sit at 86%, this is below the Trust target however appraisals were paused at the end of December until February 2022 to increase possible workforce capacity to meet anticipated hospital surge. During February and March we expect the appraisal levels to increase. There has been a focus on increasing access for colleagues to the **Covid-19 Booster vaccine**. This has resulted in 85% of substantive staff receiving the Booster vaccine. The current front line flu uptake is 76%. People, Culture and Improvement strategy and key priorities identified for 2022/2025 and draft shared at People, Culture and Improvement Committee **Culture and Engagement** High levels of engagement in Culture Collaborative session held in Jan regarding sexual discrimination and sexual harassment/assault; further actions pending including listening spaces OD team reviewed winter offers with view to providing additional support to teams during covid peak and carried out weekly ground floor engagements visits (continue) working in partnership with H&WB team National Staff Survey 21 closed at 66.4% with more information on results available in coming weeks Q3 Pulse survey ran in Jan –21% response rate – in line with July response rate **Improvement** ICS-wide QI priorities plan developed in conjunction with OD/QI ICS group. QI Maturity Matrix deployed across senior leadership team in December, and anticipated to close at end February (pending current organisational challenges) QI face to face training suspended over January SCORE safety attitude questionnaire proposal approved at Culture and Improvement Cabinet 360 review of Clinical Effectiveness (including Clinical Audit) in train **Learning and Development** Mandatory & Statutory Training Compliance as at 31 January 2021 shows 86%; Training Task & Finish Group set up for the next 6 months; planning to review all F2F/virtual training and content with the goal of improving colleague experience and compliance Strengths Based Coaching Network and Career Clinics launched. Customer Service learning package now piloted and rolled out. Appraisal training refreshed and rolled out Health Ambassador Network –42 current Health Ambassadors in network, total of 42 hours engagement. Working in partnership with Care4Notts. 76 apprenticeships starts in 2021-22 to date –below target mainly due to covid. 37 pending a start date (11 TNAs, 10 Senior HCSWs 19 misc.) Career Pathway creation for Allied Health Professional staff to start 2022 Q4. Launch of new NHS Knowledge & Library Hub took place in January	DOP, DCI

Single Oversight Framework – Month 10 Overview (3)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
People & Culture (exception reports)	**COVID Absence -** 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 January 2022 was 7.8%, (December 2021 6.6%). **Lateral Flow Tests** – Overall there were 14,094 test distributed, with 8,829 test registered (62.6%). Of the completed tests there has been 1311 positive test (0.5% positive results). This increase is due to the Omicron variance    We have undertaken some **forecasted sickness modelling** until March 2023. The forecasts includes Infection Precaution, COVID and non COVID sickness, maternity and other leave types (inc emergency leave etc). The modelling shows that our sickness will peak each Winter. We have assumed that after March thee will not be a need to self isolate. 	DOP, DCI

Single Oversight Framework – M10 Overview

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Timely care (exception reports pages)	Emergency access remains at similar levels to previous months overall, but the early January period was still impacted on by the significant surge in Covid+ inpatients, requiring the implementation of the Trusts 'super surge' plan. The increase in the number of patients who are medically safe waiting for home care is now the key driver in high bed occupancy as demand has actually fallen below 19/20 corresponding months in the past quarter (although some this may be Covid related in January 22). The number of patients who are MFFD awaiting onward placement has increased further and is driven by severe workforce capacity issues in the homecare market, exacerbated by Covid+ colleagues working in that sector. To manage this additional beds have been opened as well as additional staffing for ED, notably in the evenings, although fill rates are variable. An implementation recovery plan has been developed across the ICS to mitigate the impact of this growth with a trajectory in place, but at this stage is not having the desired impact. For cancer services, the number of patients waiting more than 62 days on a suspected cancer pathway at the end of January increased to 144 patients, adverse to the re-forecast position of 129 and to the original trajectory set in H1. An exception report detailing the root cause and actions being taken is included. 62 day performance for December was 66.9% which holds the Trust national ranking at 71st/126. December's 62 day performance nationally was 66.9% and as a Nottinghamshire system 63.4%. The average wait for first definitive treatment in December was 62 days (49 in December 19). The number of patients waiting 104 days at the end of December was 36 (16 in December 19). For elective care in January the Trust delivered 99% of 19/20 activity levels and whilst the size of the waiting list was 1.7% higher than planned the number of patients waiting over 52 weeks and 104+ weeks remain well below trajectory. All long wait (78+) patients are monitored on a weekly basis, with a plan for next steps agreed. Outpatient and day case activity continues to perform well with inpatient activity at 79% against 19/20 levels. The root cause of inpatient activity below 19/20 remains the shift to day case activity predominantly in medical specialties alongside a small proportion in surgical specialties (specifically urology) as a result of short term staffing pressures and a greater number of patients cancelling after testing positive for covid. The published national median wait for incomplete pathways at the end of December was 11 weeks and 92nd percentile 37 weeks; for the Trust it was 10 and 33, these waits have been maintained for January. Pre pandemic waits for the Trust were at 7 and 22 weeks. RTT clock stops for January were 102.5% of 19/20 levels, exceeding the 89% target set in the H2 national operational planning guidance. Diagnostics continue to perform well despite increased pressure from both emergency and cancer pathways. A plan to reduce the volume of patients waiting for a non obstetric ultrasound is being developed, specifically to insource capacity at Newark. Mutual aid remains in place across the Nottinghamshire with both trusts supporting each other where there is inequity of wait.	COO

Single Oversight Framework – Month 10 Overview (5)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Best Value care (exception reports pages)	The Trust has reported a deficit of £2.35m for the month of January 2022 (Month 10). This represents an adverse variance to plan of £2.99m. Expenditure for the month totals £37.49m and includes the direct Covid-19 costs of £1.19m and costs relating to the Covid-19 vaccination programme of £0.98m, with offsetting income of £0.98m assumed. Based on the initial system-level calculation of elective recovery, no Elective Recovery Fund (ERF) income is included for the month of January. The reported year-to-date position to the end of January 2022 is a deficit of £7.34m, an adverse variance of £6.36m compared to the year-to-date plan. This includes the deficit of £1.86m previously reported for the H1 period (01 April to 31 September 2021). The financial forecast outturn for 2021/22 remains at a deficit of £13.34m (on an ICS achievement basis). The Financial Improvement Programme (FIP) delivered savings of £0.60m in January, compared to a plan of £0.87m. Year-to-date savings of £4.70m have been reported and the current forecast for the full year 2021/22 shows expected savings of £6.36m, which represents a shortfall against revised plan of £1.42m. Capital expenditure to the end of January 2022 totals £10.67m, which is £2.06m lower than planned. The capital expenditure forecast is regularly reviewed and schemes are on track to ensure full delivery of the planned programme. The closing cash position is £2.25m. The cash flow forecast continues to demonstrate sufficient cash to comply with the minimum cash balance required.	CFO

Single Oversight Framework – Month 10 Overview (1)

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Safe	Patient safety incidents per rolling 12 month 1000 OBDs	>41	Jan-22	47.15	47.44		G	CN	M
	All Falls per 1000 OBDs	6.63	Jan-22	7.03	8.43		A	CN	M
	Number of Assisted Falls	TBC	Jan-22	100	10				
	Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	22.6	Jan-22	22.48	17.29		G	CN	M
	Covid-19 Hospital onset	<37	Jan-22	72	30		R	CN	M
	Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0	Jan-22	0.58	0.00		G	CN	M
	Rolling 12 month MSSA bacteraemia infection rate per 100,000 OBD's	17	Jan-22	9.80	5.76		G	CN	M
	Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Dec-21	93.4%	92.2%		A	CN	M
	Safe staffing care hours per patient day (CHPPD)	>8	Jan-22	9.0	9.0		G	CN	M
Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Jan-22	1.53	1.04		G	MD/CN	M
	Recommended Rate: Friends and Family Accident and Emergency	<90%	Jan-22	91.1%	92.8%		G	MD/CN	M
	Recommended Rate: Friends and Family Inpatients	<96%	Jan-22	97.8%	97.5%		G	MD/CN	M
Effective	Cardiac arrest rate per 1000 admissions	<1.0	Jan-22	1.14	2.31		R	MD	M

Single Oversight Framework – Month 10 Overview (2)

Sherwood Forest Hospitals
NHS Foundation Trust

Staff health & well being	Sickness Absence	3.5%	Jan-22	4.7%	6.8%		R	DoP	M
	Take up of Occupational Health interventions	800 - 1200	Jan-22	23142	2947		R	DoP	M
	Flu vaccinations uptake - Front Line Staff	TBC	Jan-22	76.7%	-				DoP
	Employee Relations Management	<10-12	Jan-22	102	6		G	DoP	M
Resourcing	Vacancy rate	>6.0%	Jan-22	5.5%	3.5%		G	DoP	M
	Mandatory & Statutory Training	<90%	Jan-22	87.0%	86.0%		A	DoP	M
	Appraisals	<95%	Jan-22	88.0%	86.0%		R	DoP	M

Single Oversight Framework – Month 10 Overview (3)

Sherwood Forest Hospitals
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Emergency Care	Number of patients waiting >4 hours for admission or discharge from ED	>90%	Jan-22	86.4%	85.7%		R	COO	M
	Mean waiting time in ED (in minutes)	220	Jan-22	177	176		G	COO	M
	Number of patients who have spent 12 hours or more in ED from arrival to departure	TBC	Jan-22	812	141			COO	M
	Mean number of patients who are medically safe for transfer	22	Jan-22	66	98		R	COO	M
	Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<10%	Jan-22	3.9%	2.9%		G	COO	M
Cancer Care	Number of patients waiting over 62 days for Cancer treatment	54	Jan-22	-	144		R	COO	M
	Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Dec-21	70.5%	77.7%		G	COO	M
Elective Care	Elective Day Case activity against Yr2019/20	95.0%	Jan-22	97.6%	95.1%		G	COO	M
	Elective Inpatient activity against Yr2019/20	95.0%	Jan-22	72.7%	79.0%		R	COO	M
	Elective Outpatient activity against Yr2019/20	95.0%	Jan-22	98.8%	99.7%		G	COO	M
	Number of patients on the elective PTL	38339	Jan-22	-	38,991			COO	M
	Number of patients waiting over 1 year for treatment	970	Jan-22	-	678				
	Number of patients waiting over 2 years for treatment	23	Jan-22	-	9				
	Number of completed RTT Pathways against Yr2019/20	≥89%	Jan-22	102.3%	102.5%		G	COO	M

Single Oversight Framework – Month 10 Overview (4)

Sherwood Forest Hospitals
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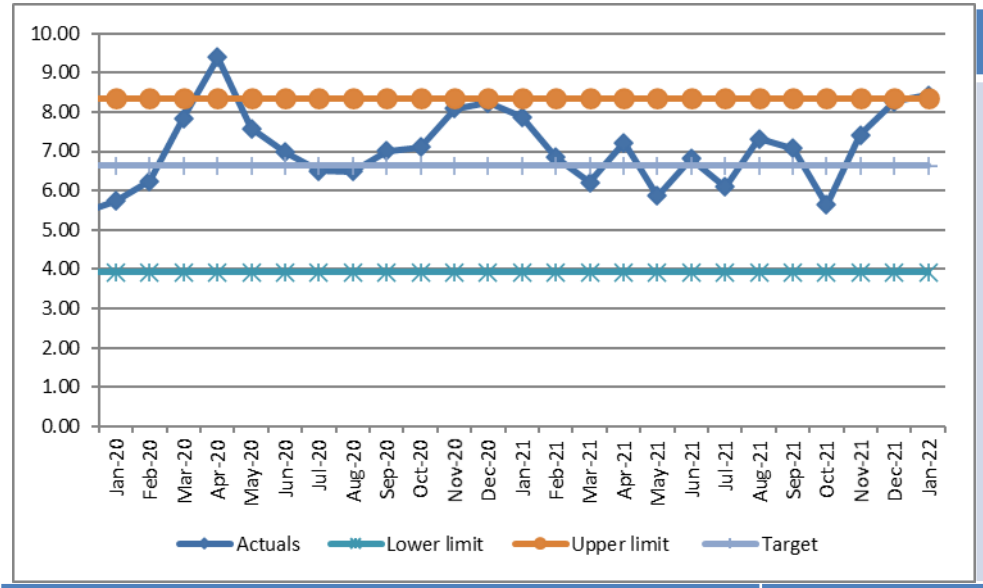
Finance	Trust level performance against Plan	£0.00m	Jan-22	-£6.36m	-£2.99m		A	CFO	M
	Underlying financial position against strategy	£0.00m	Jan-22	tbc	tbc			CFO	M
	Trust level performance against FIP plan	£0.00m	Jan-22	-£1.34m	-£0.28m		A	CFO	M
	Capital expenditure against plan	£0.00m	Jan-22	-£2.06m	£0.47m		A	CFO	M

All Falls per 1000 OBDs	6.63	Jan-22	7.03	8.43		A

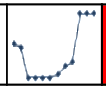
Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- The falls rate for January is above the national average of 6.63 per thousand bed days at 8.43.
- Repeat falls in month 26% of all falls.
- There have been 2 severe harms reported for January
- There had been 2 moderate harms reported for January.
- Nationally the pandemic of deconditioning continues and this is being reflected by the health of the nation and inactivity of people , especially older adults, which further increases risk of falls.
- Significant increase in numbers of MFFD patient in month residing in an acute bed due to insufficient capacity for community care, delaying D/C.
- Positive culture for reporting falls on datix is exemplary.

Root causes	Actions	Impact/Timescale
• Covid 19 cases and need for isolation and contact isolation causes continued challenges for use of cubicles/bays.	• Multifactorial falls risk assessment and falls care plan assurance audit.	Feb 2022
• High numbers of falls un-witnessed in cubicles (35% of all falls in month)	• Review of National audit for inpatient falls 2021 action plan to follow for SFH falls team to deliver QI through 2022/2023.	March 2022
• Very high numbers of repeat fallers in month, 42 repeat fallers in January (26% of all falls).	• Meet with IT clinical lead to look at opportunities within nerve centre to support falls prevention/safer mobility.	March 2022
• Continued high numbers of medically fit patients/ Pathway 1 residing in acute beds across our hospitals remains in month due to limited capacity for care in the community awaiting discharge. These patients are at risk of functional decline and higher risk of falls. As maturity of the new D2A model and capacity for care increases falls will reduce as a consequence.	• Substantiate additional role within the falls/safer mobility team.	August 2022
	• Re engage connected care agenda for 2022/ falls/dementia/EPO/moving and handling. High impact in working together.	Feb 2022
	• Hot topics to continue through 2022, continence and falls to start.	Ongoing
	• To further explore challenges with cubicles and raise awareness amongst staff groups to support patient care and safety in cubicles.	Feb 2022
• Continued inefficiencies due to flow in transfer of pathway 2 patients due to availability of beds, leads to overall need for longer stay and increased risk of falls as not in the right place.	• Falls and post falls Care plan reviews – aiming to create more personalised care, simple to complete with focus on quality of information to initiate right actions. Circulated for comments.	March 2022
• Significantly increased length of stay (no. of patients discharge with LOS >21 days has increased from 155 to 218 December 2021 to January 2022)	• Focus on primary fall prevention/anticipatory pro active care.	Feb/March 2022
	• Pull back redeployment of FPP end Feb as has been through Jan/Feb to support surge however review this as some benefit in hybrid working, to further consider possibilities.	March 2022

Covid-19 Hospital onset	<37	Jan-22	59	17		R	CN	M

Sherwood Forest Hospitals
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National position & overview

- All cases of Covid-19 deemed to be hospital associated, requires completion of an RCA.
- New cases identified 8 days post admission are deemed probable hospital acquired and new cases identified 15 days or more after admission are definite hospital acquired cases.
- During January we had 12 cases post 8-14 days of admission and 30 cases post 15 days of admission.

Root causes	Actions	Impact/Timescale
• The majority of the cases were related to a ward outbreaks of Covid-19 involving both patients and Staff.	• All outbreaks are managed in line with the trust policy • Regular outbreak meetings with NHSE/I and PHE to monitor progress of the outbreaks • All outbreak areas and high risk areas are having enhanced cleaning by Medirest • Daily hand hygiene, PPE and social distancing audits of any areas with an outbreak of cases of Covid are being conducted • All patients are to be screened every 48 hours on the wards to enable early identification of Covid infection and prevent ongoing transmission. • Citing of air scrubbers in ED and across outbreak areas to enhance ventilation. • Visiting restricted trust wide	• To reduce the transmission of Covid-19 • To review cases and development and action any learning • To reduce environmental contamination. • To monitor compliance with guidance and provide any learning required • To ensure all patients are screened at the required time to monitor for asymptomatic carriage of Covid • To reduce the transmission of Covid-19

Cardiac arrest rate per 1000 admissions	<1.0	Jan-22	1.14	2.31		R	MD	M

Sherwood Forest Hospitals
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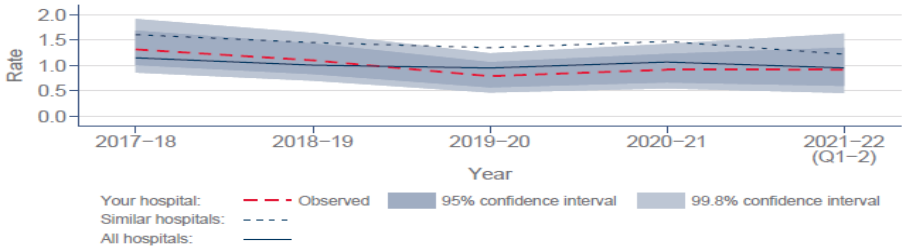
National position & overview

- NCAA now classifying hospitals as 'similar' on the basis of numbers of patients treated (no identification of services offered or acuity).
- SFH below national and similar hospitals trend for arrest rate per 1000 admissions.
- Data covers up to Q2 21/22 (Q3 & 4 not currently available).



Root causes	Actions	Impact/Timescale
Increase in acuity of patients during January 2022.	• No identified action on this issue. All events were reviewed, there were no lapses in care or treatment that contributed to patients deteriorating and suffering cardiac arrest.	• N/A
11 cardiac arrests – 3 deemed to be avoidable, so should not have happened. All were DNACPR issues: • 1 should have been DNACPR. • 2 had DNACPR but were resuscitated due to issues around the form not being visible to staff at the time of the event.	• Resuscitation services will ensure we provide a presence at ReSPECT group meeting to ensure this data is visible to the group and help inform and shape linked actions around process and education. • A stakeholder group is meeting to explore potential options to improve visibility of the ReSPECT forms at the patients bedside.	• Throughout 2022 – difficult to predict as action may occur across different systems (education, process). • Update at the end of Q1 2022/2023

Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Nov-21	93.6%	91.9%		A

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National position & overview

National reporting of VTE risk assessment screening was stopped in March 2020 in response to the developing Covid crisis.

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 91.93%

Root causes	Actions	Impact/Timescale
• The GSU team have resumed the pre Covid method of form collection from 1 April 21.	• The GSU team resumed the pre Covid method of form collection from 1 April 21.	• Completed
• The data collection process for VTE risk assessment is a manual process requiring a significant number of hours to complete the collection.	• EPMA/NerveCentre will resolve the data collection issues as the VTE assessment will be included as part of the package and will be mandatory. • The EPMA/NerveCentre VTE screening tool will be based on the NG89 standards.	• On-going - awaiting EPMA/NerveCentre electronic VTE screening tool roll out.
• Currently awaiting an electronic solution which may be via EPMA or via NerveCentre.	• NerveCentre team working with GSU build a electronic screening template. • Attendance at medical managers meeting to remind all of the need to document this assessment. • Appointment of a consultant VTE lead	• On going • Completed • On going

Sickness Absence	3.5%	Jan-22	4.7%	6.8%		R	DoP	M

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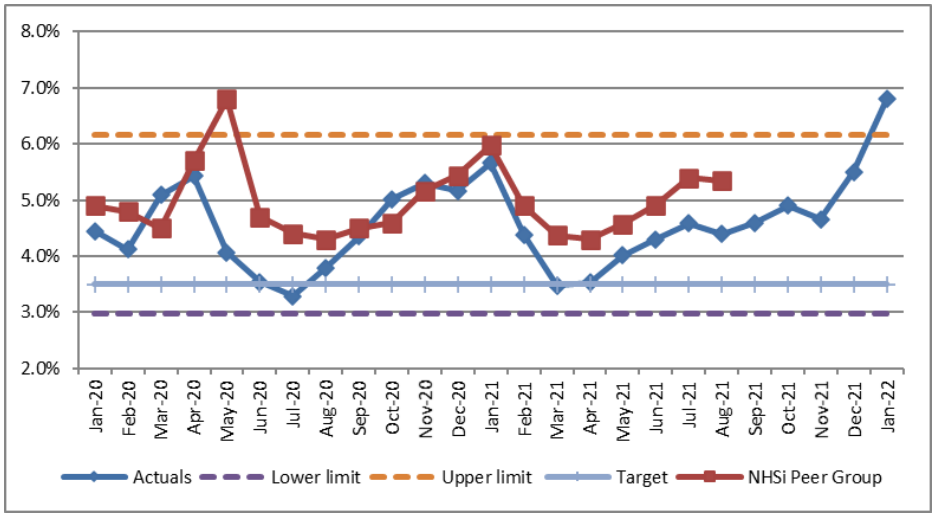

National position & overview

The Trust benchmarks favourably against a national and localised sickness figure

Our NHSi peer group follows a similar trend to the sickness absence level at Sherwood Forest Hospitals, however the Trust level has sat below the NHSi peer group.

Root causes

Sickness absence levels have continued to increase since November 2021 to a position of 6.8% in January 2022. This sits above the upper SPC and shows an upward trend. The sickness absence levels is above the sickness absence level in December 2020 (5.7%)

The short term sickness absence rate for January 22 is 4.9%. (December 21– 3.3%).

The long term sickness absence rate for January 22 is 2.0%. (December 21– 2.2%).

COVID related absence make up 3.1% of the sickness absence level and has shown a gradual increase over the last few months

Non COVID related absence has seen an gradual increase, however this is an expected annual movement.

Actions

The increase in absence levels coincidences with the increase nationally with the COVID surges and sicknesses associated with the winter period (Cold, Coughs and Flu)

We have forecasted an increase in sickness absence level over the next few months, to support our workforce during this period we have developed a Winter Wellbeing programme and are continuing to promote the COVID Booster and Influenza vaccine.

Impact/Timescale

The sickness levels are recorded above the Trust target (3.5%), and this sits above the upper SPC level.

Take up of Occupational Health interventions	800 - 1200	Jan-22	23142	2947		R	DoP	M

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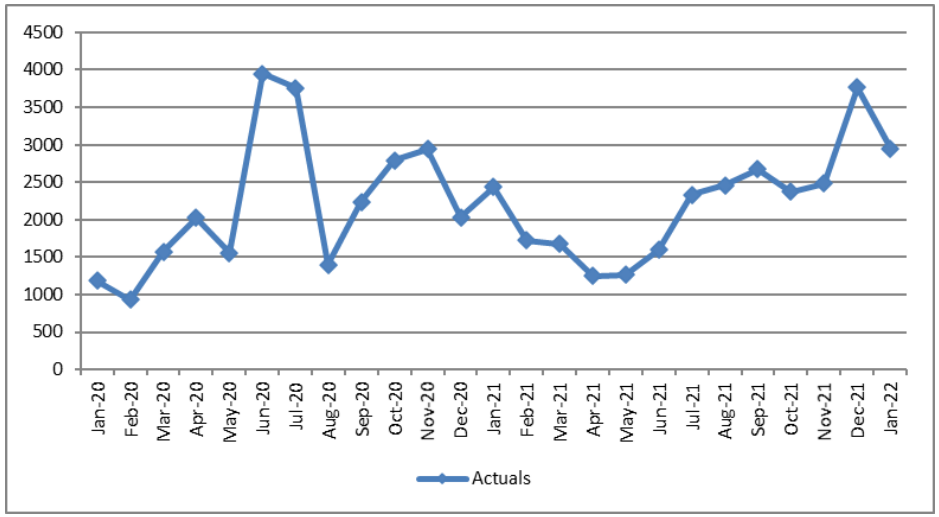


National position & overview

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

Root causes

Over the last month there has been a reduction in the overall workload, however this still remains high. The key cause of the increased levels and the above trajectory performance on the take up of Occupational Health interventions is mainly associated with the enhanced national increase with the pandemic and additional workload via the flu campaign and winter pressures.

Actions

The additional workload is being managed by:

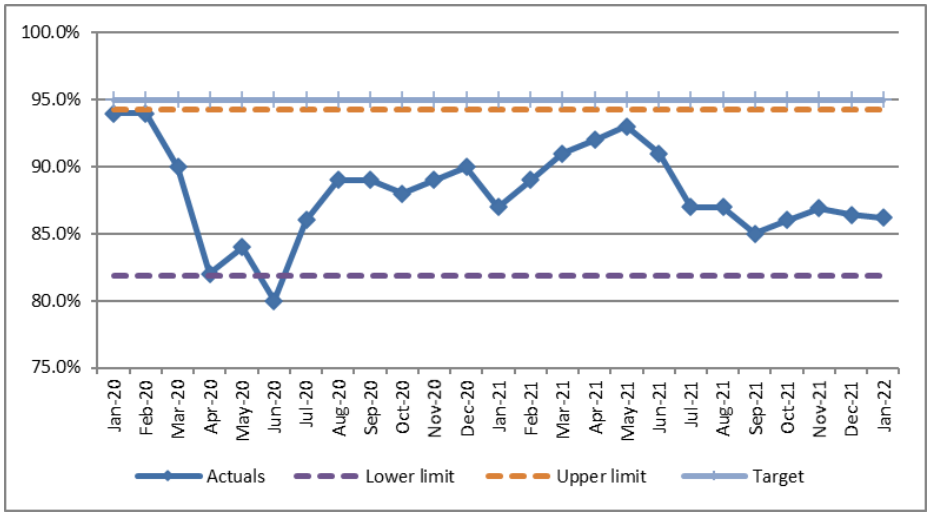
- New ways of working (Telephone /virtual consultations)
- Paper screening for work health assessments instead of face to face
- Smart working
- All substantive OH staff working overtime
- Bank admin support

Impact/Timescale

The expectations are that this workload will continue to show a decrease until March 22.

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

Appraisals	<95%	Jan-22	88.0%	86.0%		R	DoP	M



Sherwood Forest Hospitals
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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 Appraisal position is reported at 86%, and shows a similar position to last month (December 21 – 86.0%)

The key cause of below trajectory performance on the appraisal compliance is related to the delivery and capacity issues associated with the pandemic and winter pressures.

As a result of the pandemic derogations were put in place until January 22. During February and March we expect to see increase levels.

Actions

The Human Resources Business Partners are supporting discussions with line managers at confirm and challenge sessions to identify appraisals which are outstanding and seeking assurance regarding timescales for completion.

Impact/Timescale

Appraisal compliance to 90% by end of March 22

Number of patients waiting >4 hours for admission or discharge from ED	>90%	Jan-22	86.4%	85.7%		R	COO	M

Sherwood Forest Hospitals
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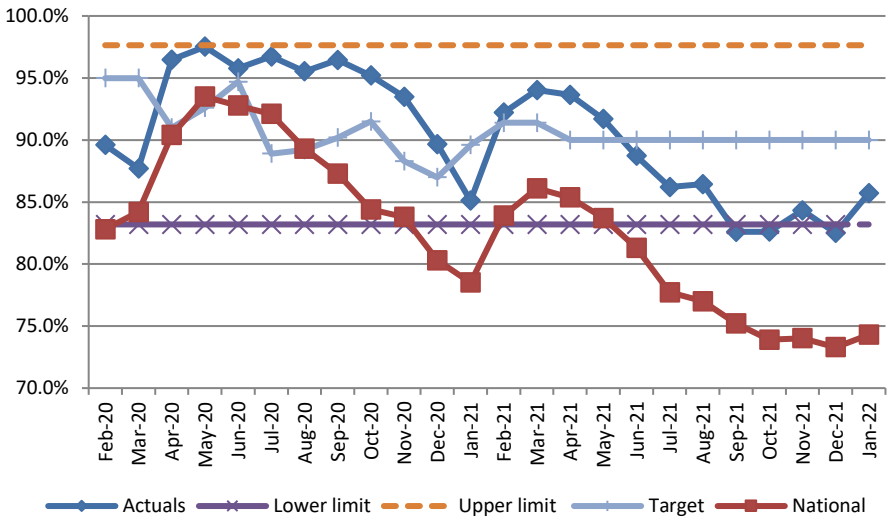

National position & overview

- SFH 85.7% - performance driven by bed exit block from ED which is mainly caused by high numbers of medical fit for discharge patients awaiting onward care outside of SFH.
- National rank 3rd out of 117 reporting Trusts
- Attends overall are lower then in Jan 2020 as were admissions. This is likely to be due to the significant surge in Covid-19 admissions
- Newark UTC performance remained excellent at 99%
- Bed pressure was a key driver of performance. The number of MSFT patients remained in excess of the ICS agreed threshold throughout the month and is showing a deteriorating position. MSFT is driving a total of 3 wards worth of demand against 2 in the spring and against a threshold of 1. This is shown in a further slide later in the SOF
- There were 40 patients who waited over 12 hours for admission to a bed, all in the first week of January as the system saw a surge in Omicron admission.
- SFH was the second most surged Trust in the Midlands for Covid+ admissions in late December and early January

Root causes	Actions	Impact/Timescale
Bed capacity pressure – Over the past 3 months the driver of performance has changed from being a mix of demand growth and MFFD to just MFFD, but this has grown significantly to offset any demand reduction against the 19/20 baseline. MFFD now represents 3 wards worth of capacity pressure above the agreed threshold. January's position includes some of the Christmas and New Year period as previously reported the Trust saw a significant surge in Covid-19 admissions and this has been subject to a briefing note to Board members .	In line with the winter plan agreed at Board in November, 66 additional beds continue to be open during January. The Respiratory Support Unit opened on 29/12/21 and Orthopaedic elective ward will become a medical ward for 2 months from 4/1/22, returning to Orthopaedics in early March. An additional 46 beds were identified to open as part of a wider surge plan to manage increasing admission and lower discharges due to the Omicron variant. 30 of these beds were opened in January. The maximisation of Same Day Emergency care continues to be successful and 40-50% more patients are seen in this service than in 2019, thereby avoiding admission to a bed A mitigation plan has been developed across the system for the opening of capacity to reduce patients waiting times for their onward needs when they are MSFT, this has been presented and there is now a weekly improvement trajectory the system is monitoring. However, this group continues to increase (as shown on a separate exception report to Board)	• Implemented • Implemented • Ongoing • Ongoing

Mean number of patients who are medically safe for transfer	22	Jan-22	66	98		R	COO	M

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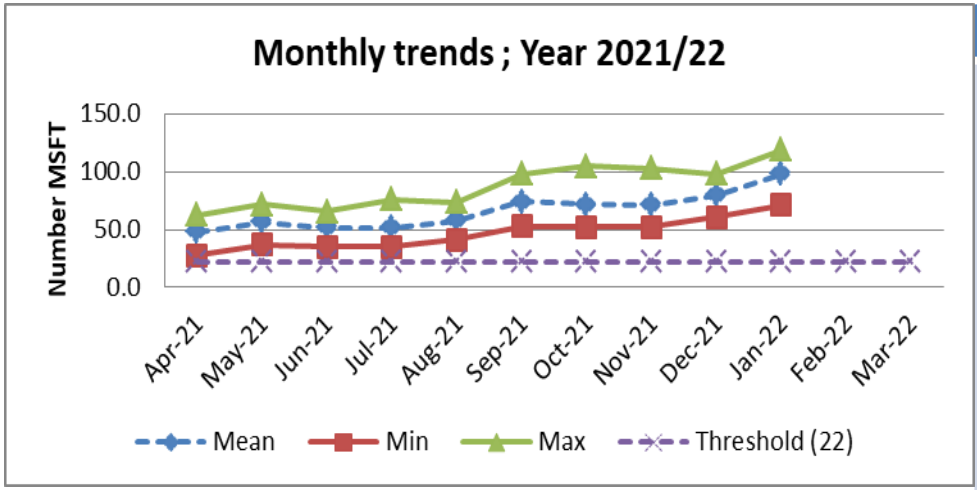

National position & overview

- The local position continues to significantly worsen 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, care agency hand back of care, closed care homes and further covid impact.
- The super surge capacity has closed with winter capacity remaining open.
- Further work is being undertaken locally to focus on P0 as well as continuing work on P1-P3
- The outputs of the accelerated discharge events with support from NHSI continue
- Further national drive to support the roll out of Virtual Wards for early supported discharge is in progress.

Root causes	Actions	Impact/Timescale
• 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. • Care home closures for staffing and infection prevention issues have also contributed to delayed discharge allocation. • Internal process issues contributing to referral delays due to minimum staffing numbers on the wards and IPC issues.	• Internal focus on P0-3- audit undertaken and report awaited • Changes to daily meeting escalation process from the MADE event outputs • QI programme commencing to focus on ward based discharge process- audit outcomes required • Daily bed capacity received • NHSEI supporting complex transfers and placements • Virtual ward T+F group in progress to launch broader service from 1st April 22 • Trusted Assessor development and training commenced • HoS recruited **Escalation** • Delays and workforce issues escalated through CEO group, D2A Board with daily system conversations. • Potential patient harms as becoming unwell whilst waiting to be discharged	23rd February 22 In place 1st March 22 In place As required on individual basis 1st April 20th March 22 full impact Start date TBC

Number of patients waiting over 62 days for Cancer treatment	54	Jan-22	-	144		R	COO	M

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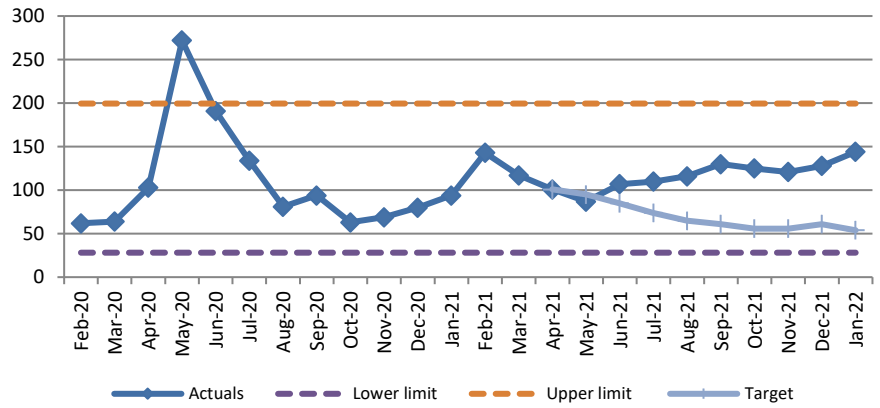

	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Original trajectory	98	95	85	74	65	61	56	56	61	54	49	45
Re-forecast							140	132	129	129	127	126
Actual	101	87	110	110	116	130	125	121	128	144		

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 seen in February 20 (45 patients for SFH).
- A trajectory was developed in March 21 with 5 key risks to delivery highlighted: demand, diagnostic capacity, lower GI, dependency on the tertiary provider and the residual impact of covid. A re-forecast was shared with Board in October 21 (left). January ended at 144, above the trajectory of 54 and above the reforecast of 129.
- The latest wait data shows average waits at 62 days for December 21 against 49 days for December 19 with 85th percentile waits were at 101 days (62 days December 19). Increased 85th percentile waits are seen following a number of long waiting urology patients (104 days+).

Root causes

- Year to date **referrals 20% above the 19/20** average (average is currently 1,500 per month compared to 1,270). LGI has seen a 30% increase.
- Referral increase **impact on diagnostic capacity** such as CT colon; compounded by a high volume of DNA/patient cancellations.
- **Other diagnostic and treatment delays** provided by the tertiary centre including PET scans, surgical dates and oncology.

Actions

- Increasing CTC list capacity by 1 patient per list (14%) by utilising imaging assistants for cannulation and preparation.
- Same day staging from colonoscopy and same day CT for failed colonoscopies in lower GI
- Increase outpatient/triage and testing capacity through Rapid Diagnostic Centre funding:
  - Gynae – increase consultant workforce, expand see and treat capacity, streamline straight to test (STT)
  - Urology and head and neck – expand STT capacity
- ICS assessment and review of sustained increased demand
- Gynaecology mutual aid meetings set up to support tertiary provider with capacity. Likely to extend SFH waits further but support an overall reduction across the system. Derby also supporting tertiary provider with complex cases.

Impact/Timescale

- Appointments started in January 22. Training will be complete by March 22.
- Both in place from 14/02
- Throughout Q4 21/22 into Q1 22/23:
  - Consultant advert closes 27/02, 85% scopes arrived, additional sessions planned in March.
  - CSW in post (Jan 22), further recruitment underway – expected in post in Q4.
- Underway – initial discussions taking place between COO and Director of Commissioning
- Initial meeting 22/02 to understand the extent of support required.

Elective Inpatient activity against Yr2019/20	95.0%	Jan-22	72.7%	79.0%		R	COO	M

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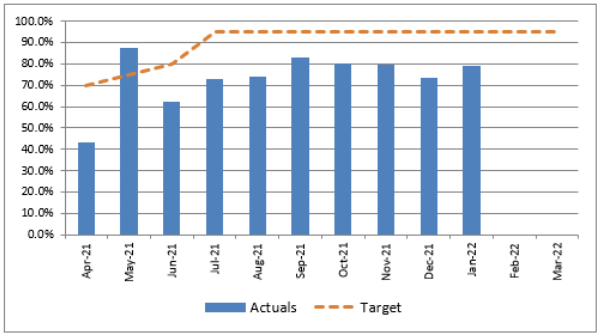
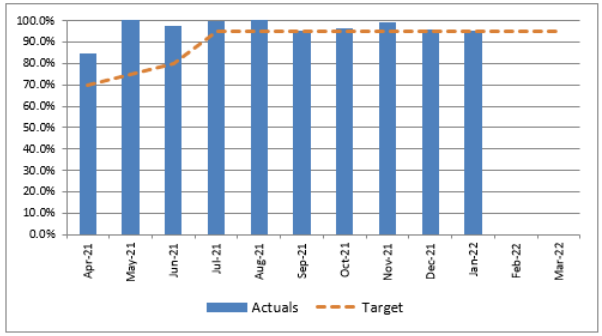
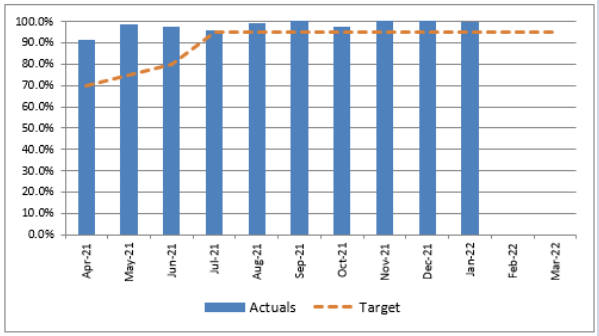
Elective Inpatient activity against Yr2019/20



Elective Day Case activity against Yr2019/20



Elective Outpatient activity against Yr2019/20



National position & overview

- For January 2022 (working day adjusted) the activity volume is at 99% when compared to January 2019 (39,141 vs. 39477)
- This is further split by:
  - Day case - 95% (3,204 vs. 3,368)
  - Outpatient – 100% (35,707 vs. 35,818)
  - Elective inpatient – 79% (230 vs. 291)
- For H2 the allocation of elective recovery funds (ERF) is based on the volume of RTT clock stops compared to 19/20 and remains on a system basis. For January the volume of clock stops is 102.5% of 19/20 levels (admitted 86% and non admitted 105%) this is against a backdrop of the impact of the Omicron variant.
- The on-going risk to elective activity due to the Omicron variant continued in to January. A number of medical specialties planned to reduce or convert their OP workload to virtual to support the wards. From a surgical perspective the first 2 weeks of January saw an increase in cancellations by patients due to testing positive for covid. Staffing absence has impacted too however where possible theatre lists were merged or re-ordered to ensure that negative patients were not cancelled.

Root causes	Actions	Impact/Timescale
• 20% of the IP gap is in surgical specialties, notably Urology. This is due to unexpected short term capacity issues and increased patient cancellations after testing positive. • 80% 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.	• Daily surgical prioritisation call established from 04/01/2022 • A shift to day case where appropriate to do continues to be supported	• Staffing and patient position reviewed daily flexing capacity where required to ensure that cancer / urgent and long wait patient operating is maintained.

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M10 Summary

- The Trust has reported a YTD deficit of £7.34m at M10, against a plan of £0.98m deficit.
- The Trust has updated the forecast outturn at M10, to a forecast deficit position of £13.34m for 2021/22.
- Capital expenditure YTD was £10.67m, which is £2.06m lower than planned due to delays in the Estates element of the capital plan.
- Closing cash at 31st January £2.25m. The forecast continues to demonstrate sufficient cash to comply with the minimum cash balance required

	January In-Month (H2 Plan)			YTD			Plan	Forecast	Forecast Variance
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m			
Income	38.17	35.15	(3.03)	376.13	366.91	(9.22)	451.64	441.22	(10.43)
Expenditure	(37.53)	(37.49)	0.04	(377.10)	(374.24)	2.86	(451.64)	(454.55)	(2.91)
Surplus/(Deficit) - ICS Achievement Basis	**0.64**	**(2.35)**	**(2.99)**	**(0.98)**	**(7.34)**	**(6.36)**	0.00	(13.34)	**(13.34)**
Capex (including donated)	(1.08)	(1.55)	(0.47)	(12.73)	(10.67)	2.06	(14.69)	(20.43)	(5.74)
Closing Cash	12.18	2.25	(9.92)	12.18	2.25	(9.92)	12.18	8.60	(3.58)

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ICS Achievement Basis, All values £'m	In Month					Year-to-Date					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
Income:															
Block Contract	23.82	23.90	0.00	23.90	0.08	238.40	238.22	0.00	238.22	(0.17)	286.04	285.87	0.00	285.87	(0.17)
Top-Up System	3.71	3.71	0.00	3.71	0.00	37.12	37.12	0.00	37.12	0.00	44.54	44.54	0.00	44.54	0.00
ERF	1.56	(0.02)	0.00	(0.02)	(1.58)	17.10	4.68	0.00	4.68	(12.43)	19.36	4.68	0.00	4.68	(14.69)
COVID Income	1.73	0.88	0.85	1.73	(0.00)	17.32	9.83	7.49	17.32	(0.00)	20.78	11.59	9.19	20.78	(0.00)
Growth and SDF	0.60	0.60	0.00	0.60	0.00	5.95	5.95	0.00	5.95	0.00	7.14	7.14	0.00	7.14	0.00
Other Income	6.74	5.22	0.00	5.22	(1.51)	59.69	63.04	0.00	63.04	3.34	73.20	77.56	0.00	77.56	4.36
Total Income	**38.16**	**34.30**	**0.85**	**35.15**	**(3.01)**	**375.58**	**358.83**	**7.49**	**366.32**	**(9.26)**	**451.06**	**431.37**	**9.19**	**440.57**	**(10.50)**
Expenditure:															
Pay - Substantive	(19.07)	(18.60)	(0.11)	(18.71)	0.36	(187.44)	(181.38)	(1.27)	(182.65)	4.79	(225.15)	(219.80)	(1.53)	(221.33)	3.82
Pay - Bank	(3.22)	(2.59)	(0.60)	(3.19)	0.03	(40.69)	(32.44)	(4.47)	(36.91)	3.78	(46.63)	(37.57)	(6.87)	(44.43)	2.20
Pay - Agency	(1.33)	(1.65)	(0.12)	(1.78)	(0.45)	(11.53)	(12.49)	(1.12)	(13.62)	(2.09)	(14.26)	(16.11)	(1.36)	(17.46)	(3.20)
Pay - Other (Apprentice Levy and Non Execs)	(0.13)	(0.14)	0.00	(0.14)	(0.01)	(1.08)	(1.39)	0.00	(1.39)	(0.32)	(1.34)	(1.66)	0.00	(1.66)	(0.32)
Total Pay	(23.74)	(22.98)	(0.83)	(23.81)	(0.07)	(240.74)	(227.71)	(6.86)	(234.57)	6.17	(287.38)	(275.13)	(9.75)	(284.89)	2.49
Non-Pay	(11.44)	(10.92)	(0.36)	(11.28)	0.16	(112.39)	(112.83)	(2.83)	(115.67)	(3.28)	(135.10)	(136.73)	(3.59)	(140.32)	(5.21)
Depreciation	(1.07)	(1.14)	0.00	(1.14)	(0.07)	(10.98)	(10.95)	0.00	(10.95)	0.02	(13.10)	(13.23)	0.00	(13.23)	(0.13)
Interest Expense	(1.26)	(1.26)	0.00	(1.26)	(0.00)	(12.44)	(12.46)	0.00	(12.46)	(0.02)	(14.85)	(14.87)	0.00	(14.87)	(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	(0.64)	(0.64)	0.00	(0.64)	0.00
Total Non-Pay	(13.78)	(13.33)	(0.36)	(13.69)	0.09	(135.81)	(136.25)	(2.83)	(139.08)	(3.27)	(163.69)	(165.47)	(3.59)	(169.05)	(5.37)
Total Expenditure	**(37.52)**	**(36.31)**	**(1.19)**	**(37.50)**	**0.02**	**(376.55)**	**(363.96)**	**(9.69)**	**(373.65)**	**2.90**	**(451.06)**	**(440.60)**	**(13.34)**	**(453.94)**	**(2.88)**
Surplus/(Deficit)	**0.64**	**(2.01)**	**(0.34)**	**(2.35)**	**(2.99)**	**(0.98)**	**(5.14)**	**(2.20)**	**(7.34)**	**(6.36)**	**0.00**	**(9.23)**	**(4.15)**	**(13.37)**	**(13.37)**

The table above shows the YTD deficit of £7.34m, £6.36m adverse to plan. This reflects a) the impact of a change in ERF thresholds, which reduced the level of ERF income available to support the Trust's elective recovery programme, and b) ERF income being dependent on the performance of the ICS which has meant that SFH has not received all of the ERF income earned on an individual Trust basis.

YTD Covid-19 costs of £9.69m are £2.08m higher than planned. This reflects the increased pressures driven by Covid-19 from July, with an increase in positive patients, workforce unavailability and super surge mitigations including Cardiac Cath beds, Discharge Lounge beds, Lyndhurst Ward and enhanced cleaning costs.

The table includes the Vaccination Programme, YTD costs of £19.01m (£17.33m Pay and £1.68m Non pay), are £2.60m lower than planned. This cost is a pass through and it has been assumed that this is fully offset in income.

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FY22 Target		FY22 Forecast		FY22 Variance		M10 Target		M10 Actual		M10 Variance		YTD Target		YTD Actual		YTD Variance	
FIP £5.95m	ERF £1.84m	FIP £4.74m	ERF £1.62m	FIP (£1.21m)	ERF (£0.22m)	FIP £0.71m	ERF £0.16m	FIP £0.42m	ERF £0.17m	FIP (£0.29m)	ERF £0.02m	FIP £4.52m	ERF £1.52m	FIP £3.37m	ERF £1.33m	FIP (£1.15m)	ERF (£0.19m)
£7.79m		£6.36m		(£1.42m)		£0.87m		£0.60m		(£0.28m)		£6.04m		£4.70m		(£1.34m)	

Overall Status

R

Red rated due to YTD and full year forecast delivery.

Target

1. Based on current forecasts the full year variance will be £1.42m below target. This is a slight improvement on the month 9 position (£1.44m).

YTD Delivery

1. As at month 10 the YTD delivery is behind target by £1.34m. The main drivers continue to be Same Day Emergency Care Programme (SDEC) (£0.60m), the Procurement Programme (£0.13m), the Variable Pay Programme (£0.32m) and the Estates and Facilities Programme (£0.11m).
2. The Estates and Facilities Programme is expected to deliver against target in Q4.
3. The main programmes ahead of plan are the D&O Divisional FIP (£0.02m), the Pathology Programme (£0.02m) and the Corporate Divisional FIP (£0.16m).

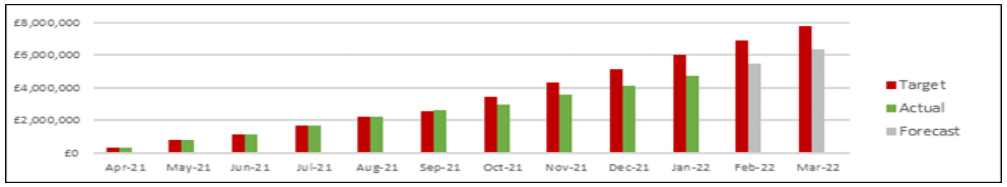
Mitigation

1. Mitigation work continues to focus on non-medical pay underspends and 'general' underspends across all budget lines.
2. Work is also continuing to determine the impact of SDEC (and associated pathways) on the Trusts underlying financial position.

2022/23 – 2024/25 Planning

1. Benchmarking packs using data and information from *Model Hospital* and *Dr Foster* have been produced and have been distributed to all Divisions to highlight areas of variation. Meetings are currently being held to support the Divisions inform their Transformation and Efficiency plans based on this data.
2. Focused work is being carried out on idea's/schemes that have not started or delivered in 2021-22 to understand if these opportunities can be harvested in 2022-23, such as the variable pay programmes, procurement programme and increased elective activity.
3. Work is also ongoing with Divisional Finance Managers to understand the recurrency of schemes and additional 'cost out' opportunities; especially around those schemes that are activity based.

Item 1: Cumulative Phased Forecast Savings Plan



Item 2: Summary by Programme

Key: > 95% | > 75% | < 75%

(Note: ERF actual figures are estimated)

Programme	Month 10 YTD Forecast			Month 10 YTD Actual			Delivery RAG
	FIP	ERF	Total	FIP	ERF	Total	
Outpatients Innovation	£10,553	£910,000	£920,553	£12,187	£988,715	£824,164	
Theatres Productivity	£280,200	£613,636	£893,836	£298,026	£340,909	£638,935	
Variable Pay Programme	£317,200	£0	£317,200	£0	£0	£0	
Comparative and Benchmarking - SDEC	£600,000	£0	£600,000	£0	£0	£0	
Comparative and Benchmarking - Procurement	£114,200	£0	£114,200	£0	£0	£0	
Comparative and Benchmarking - Estates and Facilities	£106,667	£0	£106,667	£0	£0	£0	
Comparative and Benchmarking - Workforce	£22,000	£0	£22,000	£0	£0	£0	
Pathology Transformation	£0	£0	£0	£16,980	£0	£16,980	
Transactional - Trust Wide	£1,898,333	£0	£1,898,333	£1,898,333	£0	£1,898,333	
Transactional - Corporate	£405,000	£0	£405,000	£568,000	£0	£568,000	
Transactional - D&O	£160,574	£0	£160,574	£184,904	£0	£184,904	
Transactional - Medicine	£20,000	£0	£20,000	£0	£0	£0	
Transactional - Surgery	£112,038	£0	£112,038	£56,664	£0	£56,664	
Transactional - UEC	£0	£0	£0	£0	£0	£0	
Transactional - W&C	£34,200	£0	£34,200	£867	£0	£867	
COVID Spend Reduction	£333,333	£0	£333,333	£333,333	£0	£333,333	
Unallocated	£103,729	£0	£103,729	£0	£0	£0	
Total	£4,518,027	£1,523,636	£6,041,663	£3,369,294	£1,329,624	£4,698,918	