Single Oversight Framework

Reporting Period: M7

2021/22

Single Oversight Framework – M7 Overview (1)

NHS
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Domain	Overview & risks	Lead
Quality Care (exception reports pages)	Noting that we remain in a global pandemic and under NHS Level 4 command and control operating instructions which impact on all aspects of our patients pathways, and significantly affect show we provide planned and emergency patient care. Despite this, during October, the metrics support that the care delivered to our patients has remained of a high quality. We have had no serious incidents declared that were attributed to staffing levels. In hospital falls reduction work remains a priority with a continued focus on reducing deconditioning through mobility awareness to promote patient independence. It is recognised that there is a complex balance between mobility, rapid deconditioning, length of stay and falls. Hospital acquired pressure ulcers remain consistently low. It is noted that there are 4 exception reports to highlight for October 2021: • **C-Difficile:** This year the organisation has been given a trajectory for Cdiff of 57 cases; to date the organisation has declared 61 Trust acquired cases as compared to 38 at this point in 2020 /21. • **VTE risk assessments:** performance 92.8% (YTD 94.1%) target 95%, manual data collection continues since recommencing data collection has significantly improved. The electronic solution is a component of the EPMA project. • **ED friends and family recommendation**: performance 87.9% (YTD 91%) against a target of 90%; this compares favourably with national performance at 72.3%. Work with IQVIA and PET is on-going to address key themes and improve the overall response rate. • **Cardiac arrest rate:** performance 1.26 (YTD 0.97) against a target of <1.0. There were no avoidable cardiac arrests identified in October.	MD, CN

Single Oversight Framework – M7 Overview (2)

NHS
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Domain	Overview & risks	Lead
People & Culture (exception reports)	**People** Overall, from M6 COVID-19 has impacted on Staff Health and Wellbeing at the Trust. Sickness Absence levels have shown a increase from the last month (September 21 – 4.6%) to 4.9%, and sits higher to the Trust target, this is as a result of the regional/national trend and impact of COVID19. Additional activity is evidenced through the services provided from the Trust Occupational Health Service as expected but presents capacity challenges, however these is a noted reduction in activity levels from September 21. Overall resourcing indicators for M7 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. Appraisals levels are at the same position to last months to 87.0%, the reduction is a direct impact from the COVID surge. There has been a focus on increasing access for colleagues to the Covid-19 Booster vaccine. This has resulted in 61% of substantive staff receiving the Booster vaccine. The current front line flu uptake is 65.1%. **Cultural Development** A successful Civility and Respect conference was held during October which was well received by colleagues and which gained national prominence; this has led to further requests for information and support from other national sites. Engagement planning to support the NHS Staff Survey continues. The survey ends at the end of November. In development is the establishment of a SFH Proud2bOps Network, building on the successes of the national Proud2bOps Network. An SFH Proud2bOps Admin event is being planned. **Improvement** In relation to delivery of H2 priorities within Improvement, there are two significant activities planned: Sign off and deployment of the organisation-wide QI Maturity Matrix (supported by East Midlands AHSN). Submission of a proposal for a standardised approach to providing psychological support for colleagues involved in human-centred critical incidents. Both proposals have now been signed off, and support our core value of objective to continuously learn and improve. Quality Improvement (QI) training recommenced in July and demonstrates that we achieved our target for silver level (QSIR 5 day) training in Q2, but were slightly under our target for bronze level training (38 trained out of a target of 40). We also registered 35 Bright Spark Ideas and QI projects over Q2 which is under our target of 45. Current hospital pressures have resulted in a slow start to colleagues being released to attend training, but we are confident that this will recover from month 8 due to our QI engagement within the Shared Governance agenda and system-level training.	DOP, DCI

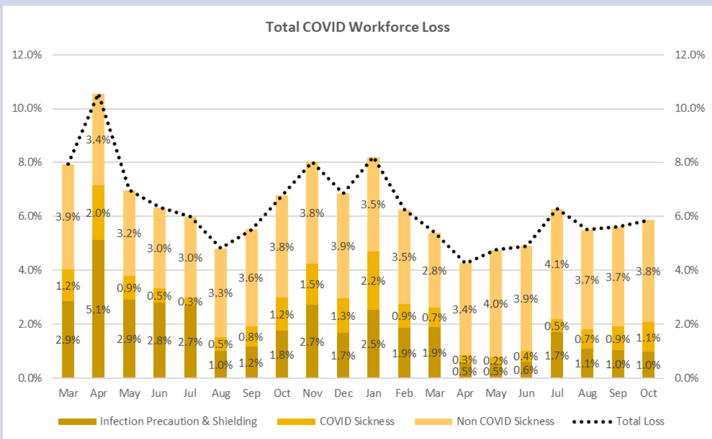
Single Oversight Framework – M7 Overview (3)

<table>
<tr><th>Domain</th><th>Overview & risks</th><th>Lead</th></tr>
<tr><td>People & Culture (exception reports)</td><td>

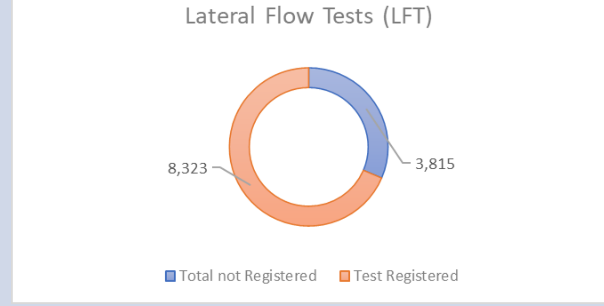
COVID Absence - The Trust produces a daily Workforce SitRep for the organisation; the workforce loss includes the sickness absence figures, but also includes those staff absent due to shielding and isolation (infection precaution), this estimates the 'total workforce loss'.

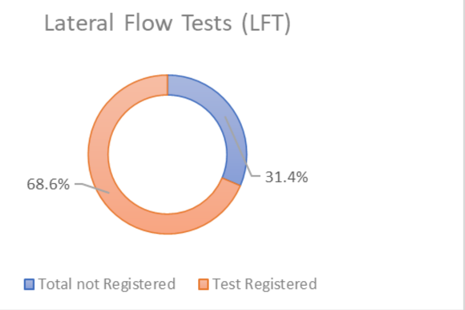
When this is reviewed the total workforce loss for October 2021 was 5.9%, (September 2021 5.6%), this includes the following:

Workforce loss since March 2020 is expressed below.



Lateral Flow Tests – Overall there were 12,138 test distributed, with 8,323 test registered (68.6%). Of the completed tests there has been 372 positive test (0.2% positive results).





</td><td>DOP, DCI</td></tr>
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Domain	Overview & risks	Lead
Timely care (exception reports pages)	Emergency access remains similar to September. The main driver of this is increased ED demand and admission demand along with the increase in the number of patients who are medically safe waiting for home care. This latter issue has maintained the deteriorated position seen in September and is driven by severe workforce capacity issues in the homecare market. To manage this additional beds have been opened as well as additional staffing for ED, notably in the evenings, although fill rates are variable. A recovery plan has been developed across the ICS to attempt to off set risks for both SFH & NUH and is being further developed into an implementation plan for the coming weeks. For cancer services the number of patients waiting more than 62 days on a suspected cancer pathway has continued to be relatively stable. At the end of October 21, 125 patients were waiting in the backlog which is in line with the expected re-forecast position of 140 but remains adverse to the original trajectory set in H1. An exception report detailing the root cause and actions being taken is included. 62 day performance for September was 61.4% giving a national ranking of 96th/126 (rank 79th In August). September's 62 day performance nationally was 68.0% and as a Nottinghamshire system 67.2%. The average wait for first definitive treatment in September was 61 days (55 in September 19). The number of patients waiting 104 days at the end of September was 37 (24 in August 21). The Faster Diagnosis Standard (FDS) fell short of the 75% standard in September at 73.7%, giving a national ranking of 55th/125 (rank 54th in August). An exception report is included. October's forecast is 78.2%. For Elective Care in October the Trust delivered 97% of 19/20 activity levels; achieving the size of PTL, 52+ and 104+ week wait trajectories as submitted in the H2 plan. Outpatient and Day case activity continues to perform well with Inpatient activity at 80% against 19/20 levels. As an ICS, Nottinghamshire are ranked 2nd from 42 systems for elective and outpatient restoration. The root cause of inpatient activity below 19/20 at SFH remains the shift to day case activity predominantly in medical specialties. The activity plan for all specialties in H2 forecasts a level which is very similar to that seen in 19/20 which leads to a forecast reduction in the size of the waiting list by up to 1% between now and the end of March 2022. The published national median wait for Incomplete pathways at the end of September was 12 weeks and 92nd percentile 45 weeks; for the Trust it was 10 and 35 and for October it is 10 and 34 weeks. Pre pandemic wait for the Trust at 7 and 22 weeks. RTT Clock stops for October were at 95% of 19/20 levels, this exceeded the 89% target set in the national operational planning guidance. For H2 the elective recovery fund (ERF) is based on clock stops at a system level. Diagnostics continue to perform well despite increased pressure particularly for CT from both emergency and cancer pathways. Mutual aid is in place across the Nottinghamshire system for MRI and CT capacity with both trusts supporting each other where there is inequity of wait.	COO

Single Oversight Framework – M7 Overview (5)

Domain	Overview & risks	Lead
Best Value care (exception reports pages)	The financial plan for the H2 period (01 October 2021 to 31 March 2022) has been finalised in line with NHS England & NHS Improvement (NHSE/I) timescales and submitted on 25 November 2021. The financial plan provides a financial break-even position for the full financial year of 2021/22. The Trust has reported a deficit of £1.16m for the month of October 2021. Expenditure for the month totals £37.40m and includes the direct Covid-19 costs of £1.05m and costs relating to the Covid-19 vaccination programme of £1.29m, with offsetting income of £1.29m assumed. Based on the initial system-level calculation of elective recovery, no Elective Recovery Fund (ERF) income is included for the month of October. This has resulted in a £0.36m adverse variance to plan in month. The reported year-to-date position to the end of October 2021 is a deficit of £3.12m, an adverse variance of £2.32m compared to the year-to-date plan. This includes the in-month variance noted above, as well as the deficit of £1.86m previously reported for the H1 period (01 April to 31 September 2021). The Financial Improvement Programme (FIP) delivered savings of £0.36m in October, compared to a plan of £0.87m. Year-to-date savings of £3.00m have been reported and the current forecast for the full year 2021/22 shows expected savings of £7.59, which represents a shortfall against the revised plan of £0.20m. Capital expenditure for the year-to-date totals £6.81m, which is £2.39m lower than planned. The current forecast shows delivery of the capital programme; however risk exists in relation to a number of schemes. A Capital Oversight Group has been established to monitor progress of existing schemes and provide further assurance on deliverability of the forecast outturn. The closing cash position is £10.76m, which is £1.41m below plan. This reflects the year-to-date deficit and timing of receipts.	CFO

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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	Oct-21	48.19	46.65		G	CN	M
	All Falls per 1000 OBDs	6.63	Oct-21	6.52	5.64		G	CN	M
	Number of Assisted Falls	TBC	Oct-21	77	6				
	Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	22.6	Oct-21	28.97	47.72		R	CN	M
	Covid-19 Hospital onset	<37	Oct-21	8	4		G	CN	M
	Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0	Oct-21	0.00	0.00		G	CN	M
	Rolling 12 month MSSA bacteraemia infection rate per 100,000 OBD's	17	Oct-21	10.23	11.93		G	CN	M
	Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Sep-21	94.1%	92.8%		R	CN	M
	Safe staffing care hours per patient day (CHPPD)	>8	Oct-21	9.0	8.7		G	CN	M
Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Oct-21	1.76	1.25		G	MD/CN	M
	Recommended Rate: Friends and Family Accident and Emergency	<90%	Oct-21	91.0%	87.9%		R	MD/CN	M
	Recommended Rate: Friends and Family Inpatients	<96%	Oct-21	97.8%	97.9%		G	MD/CN	M
Effective	Cardiac arrest rate per 1000 admissions	<1.0	Oct-21	1.06	1.88		R	MD	M

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Staff health & well being	Sickness Absence	3.5%	Oct-21	4.3%	4.9%		R	DoP	M
	Take up of Occupational Health interventions	800 - 1200	Oct-21	13945	2372		R	DoP	M
	Flu vaccinations uptake - Front Line Staff	TBC	Oct-21	60.2%	-				DoP
	Employee Relations Management	<10-12	Oct-21	81	11		G	DoP	M
Resourcing	Vacancy rate	>6.0%	Oct-21	6.2%	4.9%		G	DoP	M
	Mandatory & Statutory Training	<90%	Oct-21	87.6%	86.0%		A	DoP	M
	Appraisals	<95%	Oct-21	88.7%	86.0%		R	DoP	M

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Emergency Care	Number of patients waiting >4 hours for admission or discharge from ED	>90%	Oct-21	87.3%	82.6%		R	COO	M
	Mean waiting time in ED (in minutes)	220	Oct-21	175	187		G	COO	M
	Number of patients who have spent 12 hours or more in ED from arrival to departure	TBC	Oct-21	319	72			COO	M
	Mean number of patients who are medically safe for transfer	22	Oct-21	59	72		R	COO	M
	Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<10%	Oct-21	4.1%	5.6%		G	COO	M
Cancer Care	Number of patients waiting over 62 days for Cancer treatment	56	Oct-21	-	125		R	COO	M
	Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Sep-21	77.3%	73.7%		R	COO	M
Elective Care	Elective Day Case activity against Yr2019/20	95.0%	Oct-21	98.0%	96.2%		G	COO	M
	Elective Inpatient activity against Yr2019/20	95.0%	Oct-21	71.1%	80.4%		R	COO	M
	Elective Outpatient activity against Yr2019/20	95.0%	Oct-21	97.2%	96.7%		G	COO	M
	Number of patients on the elective PTL	38816	Oct-21	-	38,825			COO	M
	Number of patients waiting over 1 year for treatment	926	Oct-21	-	928				
	Number of patients waiting over 2 years for treatment	4	Oct-21	-	4				
	Number of completed RTT Pathways against Yr2019/20	≥89%	Oct-21	94.7%	94.7%		G	COO	M

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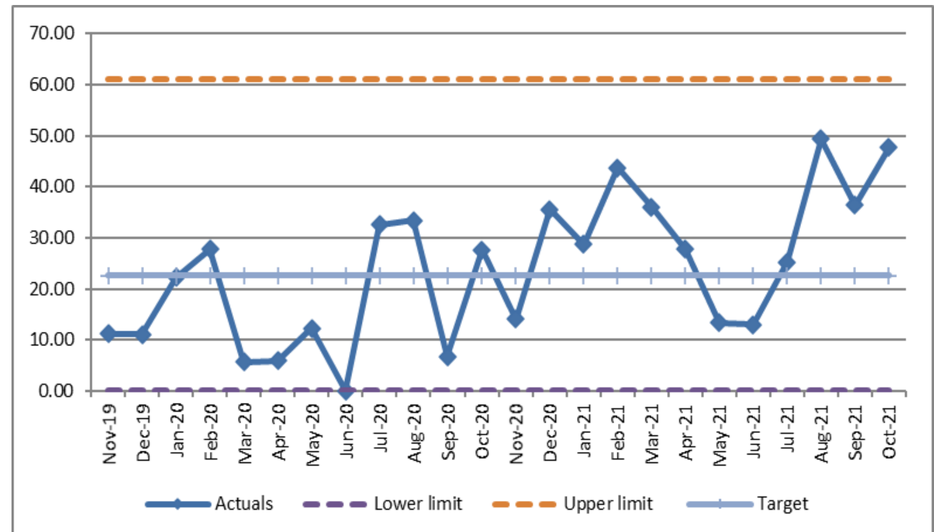
Finance	Trust level performance against Plan	£0.00m	Oct-21	-£2.32m	-£0.36m		A	CFO	M
	Underlying financial position against strategy	£0.00m	Oct-21	tbc	tbc			CFO	M
	Trust level performance against FIP plan	£0.00m	Oct-21	-£0.43m	-£0.51m		A	CFO	M
	Capital expenditure against plan	£0.00m	Oct-21	-£2.39m	-£2.05m		A	CFO	M

Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	22.6	Oct-21	28.97	47.72		R	CN	M



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National position & overview

- This year the organisation has been given a trajectory for C-difficile of 57 cases.
- The Trust have seen and increase in the number of hospital onset hospital acquired cases of C-difficile when compared to 2020 and 2019.
- The trust has also seen an increase in community onset hospital acquired C-difficile cases.
- Total Trust Attributed C-difficile cases to date for this year is 61, compared to 38 in 2020 /21.

Root causes

- The majority of cases had no lapses in care that caused the C-difficile.
- Unfortunately there has been some lapses in care identified which have contributed to the cause of the C-difficile in these patients. These include 2 cases where antibiotics given were inappropriate.
- There was delays in obtaining stool samples which have not contributed to the cause of the C-difficile but timely diagnosis.
- There has been interruption to the provision of UV cleaning and HPV cleaning.
- There are 7 patients who have had a recurrence of their C-difficile and have been report a second time.

Actions / Impact/Timescale

Actions	Impact/Timescale
All possible samples have been sent to Leeds for ribo-typin.g;	On going
Case review with individual prescriber.	Complete
Review of antimicrobial prescribing conducted by NHSE/I Antimicrobial Pharmacist – request to complete peer review document.	December 2021
Deep clean programme has recommenced – this includes bed cleaning by the decontamination team.	On going
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 C-difficile.	On going
New hand hygiene posters to be distributed around the Trust	Complete
To develop Communications on when to use soap and water and when to use alcohol gel.	Complete
Peer review to be conducted by NHSE/I , UKHSA and CCG	November 2021
CEO led exec Cdifficile taskforce in place	November 2021

Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Sep-21	94.1%	92.8%		R	CN	M

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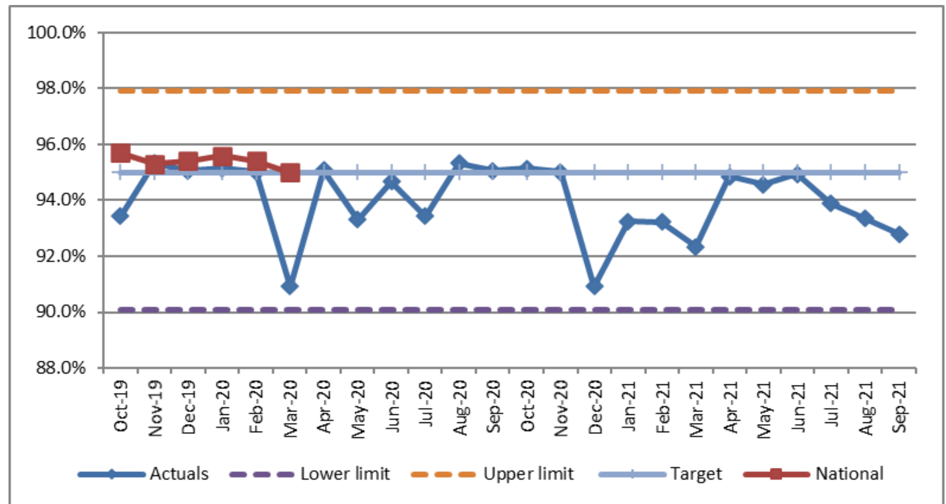

National position & overview

- National reporting of VTE risk assessment screening was stopped in March 2020 in response to the developing Covid 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 hours to complete.
- 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 initially significantly improved the compliance score the data for August and September has demonstrated a downward trajectory with Septembers compliance standing at 92.8%

Root causes

- The GSU team have resumed the pre Covid method of form collection from 1 April 21.
- The data collection process for VTE risk assessment is a manual process requiring a significant number of hours to complete the collection.
- The electronic solution will be delivered via Nervecentre EPMA planned for Q4

Actions

- The GSU team resumed the pre Covid method of form collection from 1 April 21.
- NerveCentre EPMA will resolve the data collection issues as the VTE assessment will be included as part of the package and will be a mandatory gateway.
- This VTE screening tool will be based on the NG89 standards.
- NerveCentre team to commence working with GSU build the electronic screening template.
- Attendance at medical managers meeting to remind all of the need to document this assessment.
- Appointment of a consultant VTE lead

Impact/Timescale

- Completed
- On going awaiting EPMA/NerveCentre electronic VTE screening tool roll out.
- On going
- December 2021
- Completed
- Completed
- On going

Recommended Rate: Friends and Family Accident and Emergency	<90%	Oct-21	91.0%	87.9%		R	MD/CN	M

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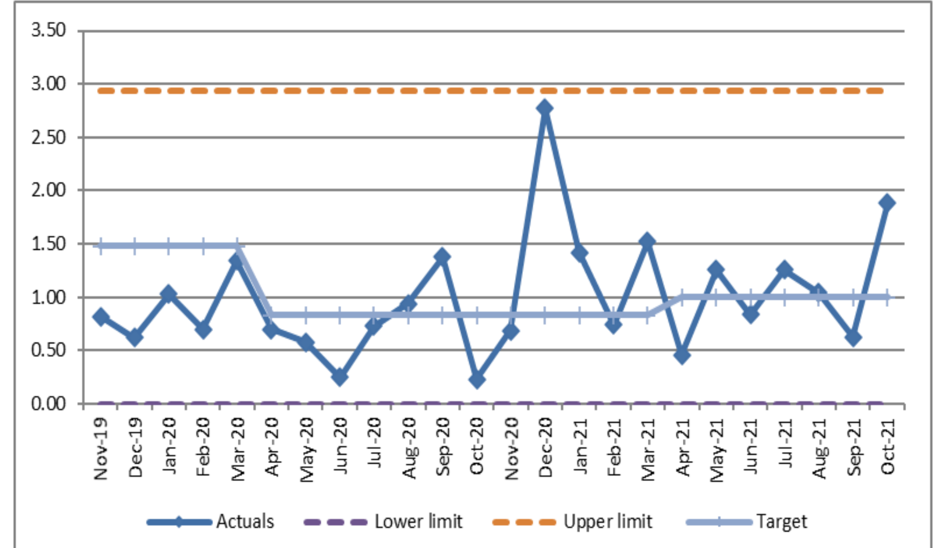
National position & overview

- Response rate remains low. 6754 eligible patients 1143responses. However have seen a slight increase compared to previous months following the introduction of QR codes.
- Theme identified around waiting times and communication.
- Positive themes identified around patients feeling cared for and staff in ED being excellent.

Root causes	Actions	Impact/Timescale
• Response rate remains low. 6754 eligible patients 1143responses. A slight increase has been observed compared to previous months following the introduction of QR codes.	• ED senior team to continue to encourage staff to promote FFT responses .	• December 2021
• Theme identified around waiting times and communication	• Lead nurses to share themes with the ED team - discussion around FFT at speciality and divisional governance meetings.	• December 2021
• Positive themes identified around patients feeling cared for and staff in ED being excellent	• Lead nurses to share themes with the ED team - discussion around FFT at speciality and divisional governance meetings.	• December 2021

Cardiac arrest rate per 1000 admissions	<1.0	Oct-21	1.06	1.88		R	MD	M



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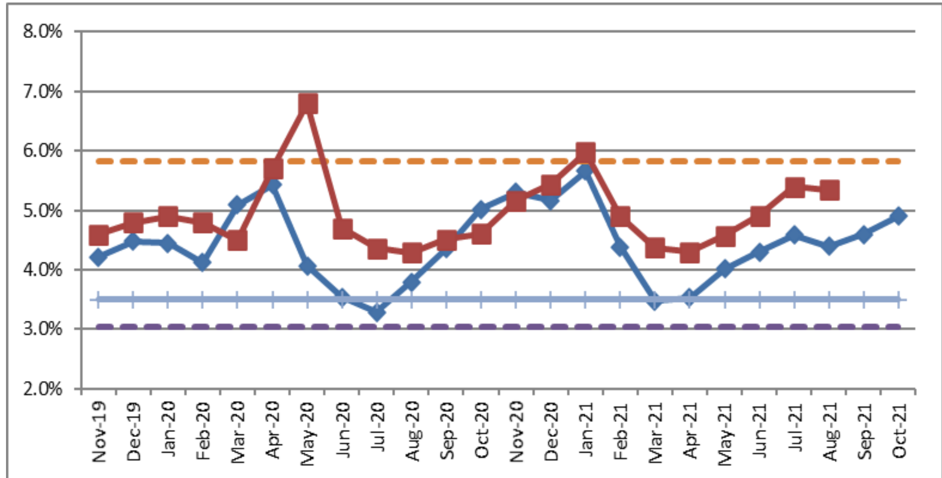
National position & overview

- The national cardiac arrest audit (NCAA) figures are anonymous and published quarterly, however quarter 2 2021 figures currently remain unpublished.
- Once NCAA is publicly reported we will be able to identify activity in organisations of similar size and scope.

Root causes	Actions	Impact/Timescale

• Overall low numbers of cardiac arrest activity in the trust mean small fluctuations in number of events can appear dramatic when reported statistically and graphically. We currently reported NCAA criteria arrests and also non-NCAA criteria arrest (Datix reported e.g. ED, ACC)
• For October two events within the national cardiac arrest audit (NCAA) activity are significant contributors to this effect:
  • The resuscitation of a patient on who had an active DNACPR decision in place.
  • The resuscitation of a collapsed patient, this patient demonstrated signs of life within the first cycle of chest compressions without any further intervention. It is likely this patient had not lost their pulse, but that staff took decisive action and started emergency care immediately.
	• Ongoing full audit of all cardiac arrest events by the clinical resuscitation team to review antecedents and identify any areas of concern or excellent practice for shared organisational learning.
	• Continue to participate in the NCAA audit, enabling our data to support and inform UK wide learning around in Hospital Cardiac Arrest.
	• Re-engage with the ReSPECT development group to highlight these issues and support ongoing work towards the development of an electronic ReSPECT from which will remove some of the failure points in the current paper based system.
	• Contact department leader to explore staff feeling and confidence around clinical emergency events, liaise with them to explore any educational support which team may benefit from to support them working in these situations.
	• Undertake a deep dive review into cardiac arrests events and present findings at quality committee
		• Ongoing.
		• Ongoing.
		• Attend Dec 2021 meeting for update.
		• Email to be sent 18/11/2021.
		• January 2021

Sickness Absence	3.5%	Oct-21	4.3%	4.9%		R	DoP	M

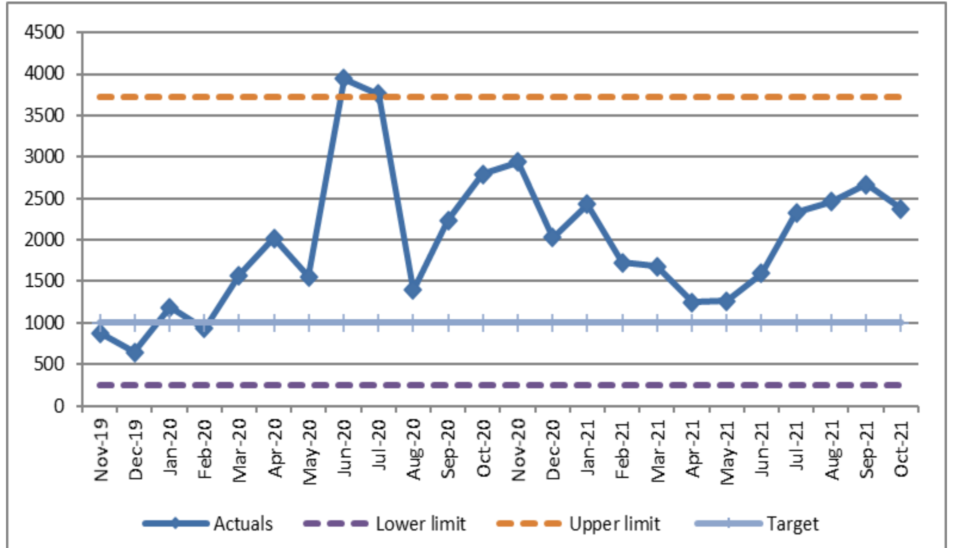


National position & overview

The Trust benchmarks favourably against a national and localised sickness figure.

Root causes	Actions	Impact/Timescale
Sickness absence levels have shown an gradual increase since April 2021 to a position of 4.9% in October 2021. This does sit below the upper SPC, however this does show an upward trend. The short term sickness absence rate for February 21 is 2.5%. (January 21– 3.7%). The long term sickness absence rate for October 21 is 2.1%. (September 21– 1.8%.) COVID related absence make up 1.1% 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.	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	The sickness levels are recorded above the Trust target (3.5%), however this sits below the upper SPC level. We have forecasted that sickness will marginally increase during the next few months

Take up of Occupational Health interventions	800 - 1200	Oct-21	13945	2372		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

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 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

This elevated level is expected to continue with additional expectations around IPC and COVID.

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%	Oct-21	88.7%	86.0%		R	DoP	M

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	Actions	Impact/Timescale
The Appraisal position is reported at 86%, and shows a positive movement from September 21 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. Divisions are undertaking Appraisals, however we are anticipating a increasing level of workforce loss between November and January and as such we may see a further deterioration in compliance levels	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.	Appraisal compliance to 95% by end of March 22

Number of patients waiting >4 hours for admission or discharge from ED	>90%	Oct-21	87.3%	82.6%		R	COO	M

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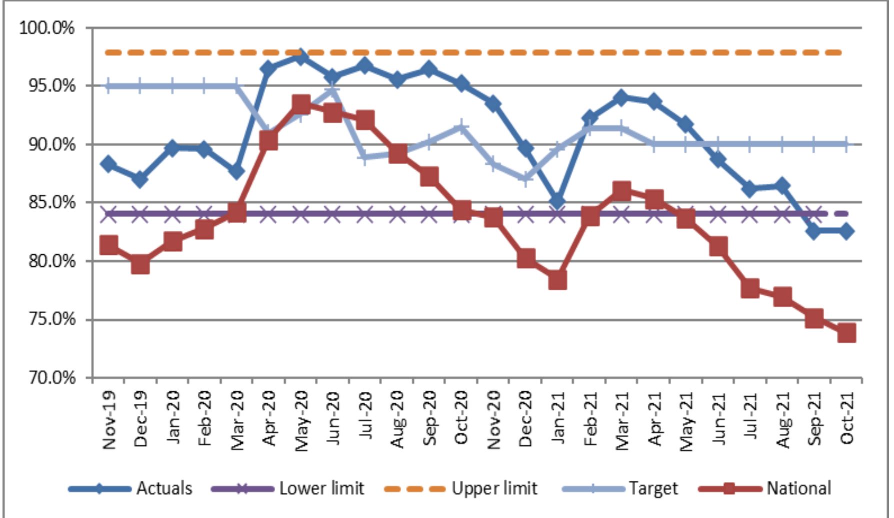

National position & overview

- SFH 82.6% - performance driven by increase ED, admission demand along with increasing occupancy due to increases in medically safe patients waiting onward care
- National rank 10th out of 117 reporting Trusts
- Attends to KMH ED similar levels to October 19, but 3% higher than Oct 18. Attends overall are 4% higher than Oct 19 and 9% higher than in Oct 18
- PC24 had 217 more patients wait over 4 hours than Oct 19 and this also contributed to SFH position
- Newark UTC performance was excellent at 97%
- Bed pressure was a key driver of performance. Admission demand was 5% higher than Oct 19 and has driven a wards worth of extra demand. 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

Root causes	Actions	Impact/Timescale
• **Demand growth** across KMH ED & PC24 well in excess of previous years, notably ambulance demand leading to high admission growth.	• As with SFH, 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. • Work is underway with primary care on attendances – most of these attendances are now being streamed to PC24 • ICS wide ambulance conveyance programme which is hoped will get patents conveyed to the right service first time	• In place • December 21'
• **Capacity pressure** – bed pressures have continued, mainly driven by demand growth in admissions (1 wards worth of demand growth) and increasing numbers of patients who are medically safe for transfer – MSFT- (1 wards growth since spring/ summer). Workforce supply to put up lots of additional capacity remains a challenge, particularly with recent Covid pressures on isolation.	• In line with the winter plan agreed at Board last month, 36 additional beds continue to be open during October and Chatsworth ward opened on 15/11/21 with an additional 16 beds at MCH. • Additional medical and nursing shifts continue to be rostered in ED, but fill rates continue to be variable • The maximisation of Same Day Emergency care continues to be successful and 259 (42%) more patients were seen in this service than in Oct 19, 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 and this is being developed into a week by week roll out by the ICS	• In place • Ongoing • Ongoing • December 21'

Mean number of patients who are medically safe for transfer	22	Oct-21	59	72		R	COO	M

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Monthly trends ; Year 2021/22

Number MSFT: 0, 20, 40, 60, 80, 100, 120

Apr-21, May-21, Jun-21, Jul-21, Aug-21, Sep-21, Oct-21, Nov-21, Dec-21, Jan-22, Feb-22, Mar-22

Mean, Min, Max, Threshold(22)

National position & overview

- The local position continues to 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 and to a degree, community partners and closed care homes.
- Additional bed capacity remains open - 27 beds Ashmere, 16 beds SFH, 16 beds MCH with an additional 6 beds used to surge with over 20 medical and surgical outliers into respective areas
- There have been up to 55 patients in delay residing in an acute care bed

Root causes

- 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 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.

Actions

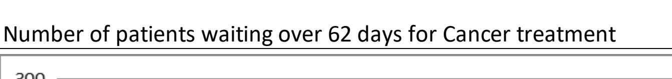
- CURTT/ ASC are working closely with Tuvida agency to increase availability of care packages. and undertake joint assessments.
- ASC strategy shared with the system
- SFHT supporting ASC with further investment to Tuvida capacity
- Emphasis to utilise Virtual Hospital for non covid resp
- ASC returning to SFHT site
- Workforce consultation completed to begin feedback and execute change
- Exploration of third sector support to discharge in progress
- Additional bed capacity opened and deployment of winter plan

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 and FTCC becoming EoL.

Impact/Timescale

- On-going actions



Number of patients waiting over 62 days for Cancer treatment	56	Oct-21	-	125		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					

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). October ended at 125, above the trajectory of 56 but below the reforecast of 140.
- The latest wait data shows average waits at 61 days for September 21 against 55 days for September 19, with 85th percentile waits at 99 days (78 days September 19).

Root causes

- Year to date **referrals 20% above the 19/20** average (average is currently 1500 per month compared to 1270)
- 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 EFGR in Lung, PET scans, surgical dates and oncology.

Actions

- New LGI cancer support worker (CSW) triage **role in place**. Call reminder and DNA audit progressing.
- New referral form process introduced in LGI aligned to wider Nottinghamshire system.
- **Increasing CTC list capacity by 1 patient per list** (14%) by utilising imaging assistants for cannulation and preparation.
- Temporary **mutual aid CTC capacity agreed with NUH creating appointments for up to 30 SFH patients (7 days of capacity at SFH).**
- Radiology trialling reduced prep to support better backfill for short notice cancellations.
- Pathology independent sector outsourcing EGFR to improve turnaround times.
- Urgent actions being explored with NUH to mitigate the loss of oncology staff i.e. redistributing staff and use of space.
- Mobile endoscopy and CT in place. Expansion of mobile endoscopy to 7 days is being explored with the provider.

Impact/Timescale

- CSW supervised triage underway, expected to be independent at end of November.
- Mandatory LGI referral information now in place for GPs.
- Recruitment underway to start in January 22 with training complete by March 22.
- Mutual aid commenced 15 November for 6 weeks, reducing CTC waits at SFH by up to 7 days.
- Reduced prep trial successful and approved. Patients attending from 1 January 22 will follow new process.
- EGFR outsourcing continues average turnaround times reduced from 21 days to 10 and remain stable.
- Oncology pressures continue to be jointly managed with NUH and remain stable.
- Units fully open as of October and achieving/over achieving planned activity. Increased endoscopy is sought with the provider to start in December.

Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Sep-21	77.3%	73.7%		R	COO	M

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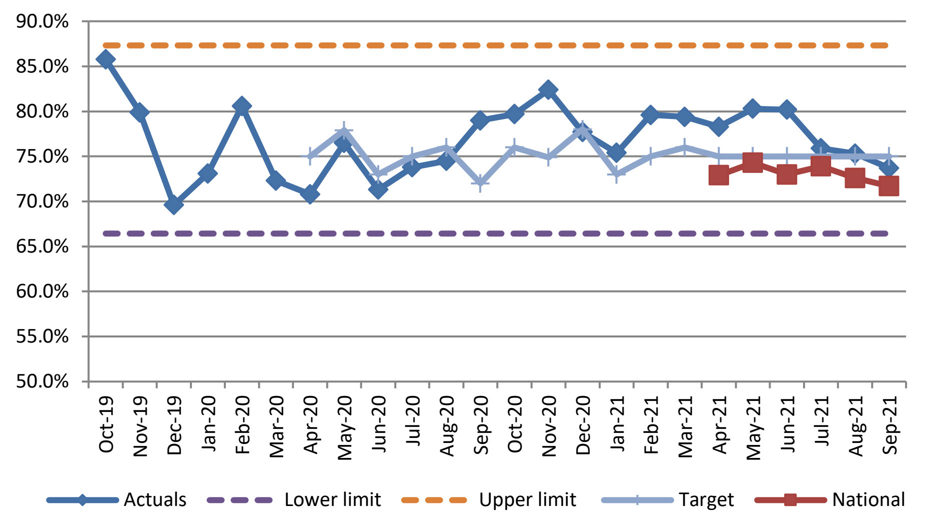

National position & overview

- In the 2021/22 operational planning guidance, NHS England (NHSE) set out a key objective for systems to meet the Faster Diagnosis Standard (FDS) from October 21, initially set at a level of 75%. Data has been published since spring 21.
- In September, 73.7% of patients received their diagnosis by day 28 at SFH, compared to 71.7% nationally and 78.1% as a Nottingham system.
- October's forecast is 78.2%, returning to achievement of the standard.
- The latest FDS data shows average waits for a patient to be informed of their diagnosis to be 23 days for September 21 (21 days September 19), with 85th percentile waits at 41 days September 21 (42 in September 19).

Root causes	Actions	Impact/Timescale
• **Referral increases** continue to drive pressure in diagnostics, particularly in lower GI where waits have been up to 6 weeks (42 days) for CT colon. Increased numbers of patients are also then referred to endoscopy. • **Delays in time to first seen and test** across a number of services due to capacity constraints, specifically in lung, urology, upper GI, skin and gynaecology.	• A range of actions are in place as part of the lower GI improvement programme, with specific effort around mutual aid, increasing patients per list and DNA/short notice cancellation reduction. Increased endoscopy capacity is available since the open of the mobile unit in October. • Successful bid to be an accelerator site for the Rapid Diagnostic Centre programme with specific plans for gynaecology, skin, urology and head and neck tumour sites as well as histopathology to improve turn around times. Plans include expansion of one stop services, more timely results review and increased 2ww capacity. • In lung, appropriate bloods were not being completed, leading to delays. Reminders have been shared via the GP newsletter with CCG support.	• On-going • Throughout H2 in 21/22 and in to 22/23. Recruitment in many areas commenced, including project support to review pathways. • October 21

Elective Inpatient activity against Yr2019/20	95.0%	Oct-21	71.1%	80.4%		R	COO	M

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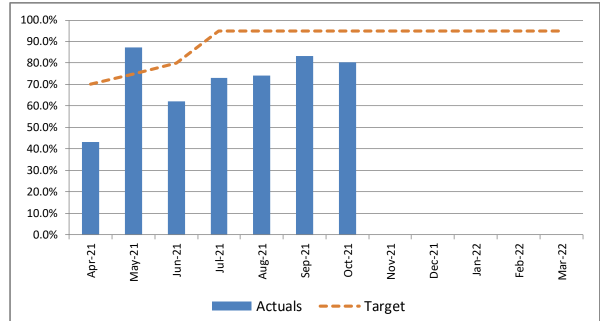
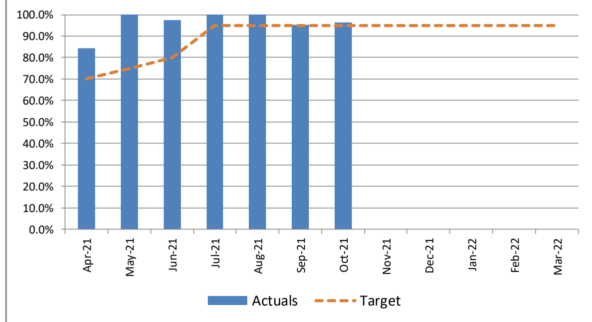
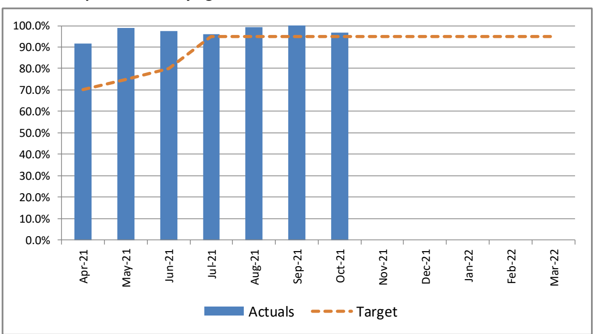
Elective Inpatient activity against Yr2019/20



Elective Day Case activity against Yr2019/20



Elective Outpatient activity against Yr2019/20



National position & overview

- For October 2021 (working day adjusted) the activity volume is at 96.5% when compared to October 2019 (39,627 vs. 41,070)
- This is further split by:
  - Day case - 96% (3,210 vs. 3,337)
  - Outpatient – 96.7% (36,109 vs. 37,350)
  - Elective inpatient – 80.4% (308 vs. 383)
- The Trust has exceeded the Elective Recovery Fund (ERF) threshold in all months year to date. Note for H2 the allocation of ERF will be based on the volume of RTT clock stops compared to 19/20 and will remain on a system basis. It is important to continue to recognise 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 and support mutual aid where there may be a disparity in waits.

Root causes	Actions	Impact/Timescale
• 50% 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. • Specifically for October, the other 50% is due to casemix and complexity in General Surgery, Breast, Urology and Gynaecology.	• Baseline adjustments to be factored into H2 planning for shift from elective to day case activity if possible. • Specialty plans have been agreed for H2 incorporating accelerator, targeted investment fund (TIF) and any other elective funding.	• Elective plans for H2 submitted 16/11 baseline adjustments could not be made. • Oct 21 to March 21 elective plan is set to deliver 1,760 elective Inpatient spells and 19,500 day case spells. Collectively this delivers an activity level of 90% when compared to 19/20.

Best Value Care

H2 Plan

- The proposed H2 plan has been reflected in these slides, with formal submission to NHSE/I on 25th November 2021.
- The overall 21/22 plan is to achieve a break-even position, on ICS Achievement Basis (excluding donated items and gain on asset disposals), with the H1 deficit being recovered in H2.
- A separate planning update is being prepared for Finance Committee.

M7 Summary

- The Trust has reported a YTD deficit of £3.12m against a plan of £0.81m deficit.
- The Trust is currently forecasting to return to a break-even position on ICS Achievement Basis by 31/03/22
- Month 7 Capital expenditure was £6.81m, which is £2.39m lower than planned.
- Closing cash at 31st October was £10.76m.

	October In-Month			YTD			Plan	Forecast	Forecast Variance
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m			
Income	38.16	36.58	(1.59)	263.00	255.70	(7.30)	451.64	445.93	(5.71)
Expenditure	(38.97)	(37.74)	1.23	(263.80)	(258.82)	4.98	(451.64)	(445.93)	5.71
Surplus/(Deficit) - Break-even Requirement Basis	**(0.80)**	**(1.16)**	**(0.35)**	**(0.80)**	**(3.02)**	**(2.21)**	0.02	0.12	**0.10**
Surplus/(Deficit) - ICS Achievement Basis	**(0.81)**	**(1.16)**	**(0.35)**	**(0.81)**	**(3.12)**	**(2.32)**	0.00	0.00	**(0.00)**
Capex (including donated)	(2.63)	(0.57)	2.05	(9.20)	(6.81)	2.39	(14.69)	(16.25)	(1.55)
Closing Cash	12.18	10.76	(1.41)	12.18	10.76	(1.41)	12.18	12.18	0.00

Best Value Care

Break-even Requirement 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	0.00	0.00	0.00	0.00	0.00	143.10	142.74	0.00	142.74	(0.36)	143.10	142.74	0.00	142.74	(0.36)
Top-Up System	3.71	3.71	0.00	3.71	0.00	25.98	25.98	0.00	25.98	0.00	44.54	44.54	0.00	44.54	0.00
ERF	1.08	0.04	0.00	0.04	(1.04)	13.94	4.20	0.00	4.20	(9.74)	19.36	9.62	0.00	9.62	(9.74)
COVID Income	1.73	0.88	0.85	1.73	(0.00)	12.12	7.18	4.95	12.12	(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	4.17	4.17	0.00	4.17	0.00	7.14	7.14	0.00	7.14	0.00
Other Income	30.71	30.16	0.00	30.16	(0.55)	63.19	65.90	0.00	65.90	2.71	216.14	220.44	0.00	220.44	4.30
Total Income	**37.83**	**35.39**	**0.85**	**36.24**	**(1.59)**	**262.51**	**250.16**	**4.95**	**255.11**	**(7.40)**	**451.06**	**436.06**	**9.19**	**445.25**	**(5.81)**
Expenditure:															
Pay - Substantive	(19.66)	(18.22)	(0.11)	(18.33)	1.33	(129.37)	(125.82)	(0.93)	(126.75)	2.62	(226.01)	(221.36)	(1.52)	(222.89)	3.12
Pay - Bank	(3.16)	(3.10)	(0.54)	(3.64)	(0.48)	(30.63)	(24.18)	(2.85)	(27.03)	3.60	(45.46)	(36.58)	(5.28)	(41.86)	3.60
Pay - Agency	(1.27)	(1.38)	(0.12)	(1.49)	(0.22)	(7.50)	(7.92)	(0.83)	(8.75)	(1.25)	(13.95)	(14.37)	(0.83)	(15.20)	(1.25)
Pay - Other (Apprentice Levy and Non Execs)	(0.13)	(0.14)	0.00	(0.14)	(0.01)	(0.69)	(0.99)	0.00	(0.99)	(0.30)	(1.34)	(1.64)	0.00	(1.64)	(0.30)
Total Pay	(24.22)	(22.83)	(0.77)	(23.60)	0.62	(168.20)	(158.92)	(4.61)	(163.53)	4.67	(286.76)	(273.95)	(7.63)	(281.59)	5.17
Non-Pay	(12.07)	(11.20)	(0.28)	(11.48)	0.59	(78.66)	(76.41)	(1.99)	(78.40)	0.26	(135.72)	(132.21)	(3.02)	(135.23)	0.49
Depreciation	(1.08)	(1.06)	0.00	(1.06)	0.02	(7.76)	(7.59)	0.00	(7.59)	0.16	(13.10)	(12.94)	0.00	(12.94)	0.16
Interest Expense	(1.26)	(1.26)	0.00	(1.26)	(0.00)	(8.70)	(8.72)	0.00	(8.72)	(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	(14.41)	(13.52)	(0.28)	(13.80)	0.61	(95.11)	(92.72)	(1.99)	(94.71)	0.41	(164.30)	(160.65)	(3.02)	(163.67)	0.64
Total Expenditure	**(38.63)**	**(36.35)**	**(1.05)**	**(37.40)**	**1.23**	**(263.31)**	**(251.63)**	**(6.60)**	**(258.23)**	**5.08**	**(451.06)**	**(434.60)**	**(10.65)**	**(445.25)**	**5.81**
Surplus/(Deficit)	**(0.80)**	**(0.96)**	**(0.20)**	**(1.16)**	**(0.36)**	**(0.80)**	**(1.47)**	**(1.66)**	**(3.12)**	**(2.32)**	**(0.00)**	**1.46**	**(1.46)**	**0.00**	**0.00**

The table above shows the YTD deficit of £3.12m, £2.32m 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.

H1 Covid-19 costs of £6.60m are £1.46m higher than planned. This reflects the increased pressures driven by Covid-19 from July, with an increase in positive patients and in workforce unavailability.

The table includes the Vaccination Programme, YTD costs of £14.86m (£13.81m Pay and £1.05m Non pay), are £2.56m lower than planned. This cost is a pass through and it has been assumed that this is fully offset in income.

Best Value Care – Transformation & Efficiency Plan

FY22 Target		FY22 Forecast		FY22 Variance		M7 Target		M7 Actual		M7 Variance		YTD Target		YTD Actual		YTD Variance	
FIP £5.95m	ERF £1.84m	FIP £5.91m	ERF £1.68m	FIP (£0.04m)	ERF (£0.16m)	FIP £0.71m	ERF £0.16m	FIP £0.36m	ERF £0.00m	FIP (£0.36m)	ERF (£0.16m)	FIP £2.38m	ERF £1.05m	FIP £2.11m	ERF £0.89m	FIP (£0.27m)	ERF (£0.16m)
£7.79m		£7.59m		(£0.20m)		£0.87m		£0.36m		(£0.51m)		£3.42m		£3.00m		(£0.43m)	

Overall Status	
A	Amber rated due to YTD and full year forecast delivery.

Target

1. The 2021-22 Financial Improvement Plan (FIP) target has been revised, based on H2 planning guidance. The revised target is £7.79m (previously £6.4m). Delivery of the target will be made up of £5.95m cost reduction schemes and a further £1.84m from schemes that are predicated on the delivery of Elective Recovery Funding (ERF).
2. The Target for H2 has been phased in equal 6ths.
3. Based on current forecasts the full year variance will be £0.20m below target.

YTD Delivery

1. As at month 7 the YTD delivery is behind target by £0.43m. The main drivers are the Same Day Emergency Care Programme (SDEC) (£0.15m), the Procurement Programme (£0.03m), the Variable Pay Programme (£0.08m) and the Estates & Facilities Programme (£0.03m). We also have £0.03m unallocated FIP.
2. The Estates & Facilities Programme is expected to deliver against target in quarter 4. Work however is ongoing in relation to ensuring the Procurement, Variable Pay and SDEC Programmes 'catch-up',
3. The schemes predicated on Elective Recovery Fund Income are also behind plan (£0.16m). Although the individual schemes have delivered against their objectives, ERF is predicated on system delivery which in month 7 has resulted in a much lower-than-anticipated payment.
4. The main programmes ahead of plan are the Pathology Programme (£0.01m) and the Corporate Division FIP (£0.06m).

Mitigation

Urgent mitigation work continues to focus on:

1. Non-medical pay underspends and 'general' underspends across all budget lines;
2. Expediting the medical variable pay programme and quantifying the Nursing, Midwifery and AHP programme (which we will support through the deployment of additional resource) ;
3. Exploring options for additional elective activity to allow us to 'draw down' additional ERF; and
4. The redeployment of resource to help the ICS deliver specific programmes e.g. backroom functions.

Item 1: Cumulative Phased Forecast Savings Plan

£8,000,000
£6,000,000
£4,000,000
£2,000,000
£0

Apr-21 May-21 Jun-21 Jul-21 Aug-21 Sep-21 Oct-21 Nov-21 Dec-21 Jan-22 Feb-22 Mar-22

Target
Actual
Forecast

Item 2: Summary by Programme

(Note: ERF actual figures are estimated)

Key	> 95%	> 75%	< 75%

Programme	Month 7 YTD Forecast			Month 7 YTD Actual			Delivery RAG
	FIP	ERF	Total	FIP	ERF	Total	
Outpatients Innovation	£7,387	£637,000	£644,387	£7,387	£546,000	£553,387	
Theatres Productivity	£196,140	£409,091	£605,231	£198,840	£340,909	£539,749	
Variable Pay Programme	£79,300	£0	£79,300	£0	£0	£0	
Comparative and Benchmarking - SDEC	£150,000	£0	£150,000	£0	£0	£0	
Comparative and Benchmarking - Procurement	£28,550	£0	£28,550	£0	£0	£0	
Comparative and Benchmarking - Estates and Facilities	£26,667	£0	£26,667	£0	£0	£0	
Comparative and Benchmarking - Workforce	£5,500	£0	£5,500	£0	£0	£0	
Pathology Transformation	£0	£0	£0	£11,850	£0	£11,850	
Transactional - Trust Wide	£1,328,833	£0	£1,328,833	£1,328,833	£0	£1,328,833	
Transactional - Corporate	£283,500	£0	£283,500	£347,500	£0	£347,500	
Transactional - D&O	£112,402	£0	£112,402	£118,582	£0	£118,582	
Transactional - Medicine	£5,000	£0	£5,000	£0	£0	£0	
Transactional - Surgery	£32,694	£0	£32,694	£11,861	£0	£11,861	
Transactional - UEC	£0	£0	£0	£0	£0	£0	
Transactional - W&C	£8,940	£0	£8,940	£607	£0	£607	
COVID Spend Reduction	£83,333	£0	£83,333	£83,333	£0	£83,333	
Unallocated	£25,932	£0	£25,932	£0	£0	£0	
Total	**£2,374,178**	**£1,046,091**	**£3,420,269**	**£2,108,793**	**£886,909**	**£2,995,702**	