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Sherwood Forest Hospitals
NHS Foundation Trust

Half Year Performance Review

Trust Board Meeting

H1 I&E Report

	YTD		
	Plan	Actual	Variance
Income:			
Clinical Income	243.76	244.21	0.45
Other Income	26.04	25.91	(0.13)
Total Income	**269.80**	**270.12**	**0.32**
Expenditure:			
Pay - Substantive	(149.15)	(142.69)	6.46
Pay - Bank	(10.92)	(15.59)	(4.67)
Pay - Agency	(6.01)	(7.39)	(1.38)
Pay - Other (Apprentice Levy and Non Execs)	(0.80)	(0.73)	0.07
Total Pay	(166.88)	(166.40)	0.47
Non-Pay	(84.14)	(85.79)	(1.62)
Depreciation	(7.88)	(7.78)	0.10
Interest Expense	(23.90)	(23.92)	(0.02)
PDC Dividend Expense	-	-	-
Total Non-Pay	(115.92)	(117.49)	(1.54)
Total Expenditure	**(282.80)**	**(283.89)**	**(1.10)**
Surplus/(Deficit)	**(13.00)**	**(13.77)**	**(0.78)**
Removal of PFI adjustment	12.99	12.99	-
Final Surplus/(Deficit)	**(0.00)**	**(0.78)**	**(0.78)**

- The Trust has a H1 deficit of £0.8m. This is being driven by
  - £0.3m Industrial Action income loss
  - £0.2m for redundancy costs on the vaccination service
  - £0.3m for the impact of the consultant pay award not being fully funded.
- The H1 plan is now at break-even following the non-recurrent deficit support funding (£13.6m) provided by NHSE.
- The Trust is also off plan on the efficiency programme at H1 by £2.9m but this is being mitigated with other non-recurrent measures such as prior year ERF overperformance.
- The H1 position still contains energy inflation funding from NHSE to the value of £3.0m (£6.0m FYE) which NHSE have recently highlighted as being a very high-risk assumption.
- Whilst H1 pay position is showing a marginal £0.5m underspend, there is a higher than planned reliance on temporary staffing expenditure to cover substantive roles.

24/25 Unmitigated Forecast

Category	Year to Date 2024/25 Actual £m	Year to Go (YTG) Actual £m	Forecast Out-turn Forecast £m	Movement Forecast £m
Clinical Income	244.21	227.07	471.28	(17.14)
Other Operating Income	25.30	25.90	51.20	0.60
Total Operating Income	**269.51**	**252.97**	**522.48**	**(16.54)**
Pay	(166.40)	(175.48)	(341.89)	(9.08)
Non Pay	(85.35)	(87.44)	(172.79)	(2.10)
EBITDA	**17.76**	**(9.96)**	**7.80**	**(27.72)**
				0
Operating Costs Excl. from EBITDA	(8.07)	(7.98)	(16.05)	0.09
Non Operating Income	0.50	0.79	1.29	0.28
Non Operating Expenditure	(23.92)	(5.18)	(29.10)	18.74
Surplus/(Deficit) on Accounts Basis	**(13.72)**	**(22.33)**	**(36.06)**	**(8.61)**
				0
Donated Asset Income	(0.15)	(0.15)	(0.30)	-
Donated Asset Depreciation	0.12	0.11	0.22	(0.01)
Gain / Loss on Disposal of Fixed Assets	(0.02)	0.01	(0.01)	0.03
Surplus/(Deficit) - ICS Achievement Basis	**(13.78)**	**(22.37)**	**(36.14)**	**(8.59)**
				0
IFRS16 PFI Adjustment	12.99	(5.96)	7.04	(18.95)
				0
Final Surplus/(Deficit)	**(0.78)**	**(28.32)**	**(29.11)**	**(27.54)**

- H2 assumes £16.5m less income than we have received in H1. The key drivers to this reduction are
  - Energy inflation funding not received
  - Non-Recurrent Revenue Support Received in H1
- H2 is forecasting £9.1m additional pay costs than we have incurred in H1. This is not linked to pay inflation. The key drivers of this increase are
  - Winter funding
  - Increased fill rate to vacant posts across operational and corporate areas
- H2 is forecasting £2.1m additional non-pay costs than we have incurred in H2. The expenditure increase will be linked to seasonality and increased consumables associated with ERF activity across H2
- This significant change in run rate is not sustainable for 24/25. Given the controls already in place, we need a refresh of the forecast at M7, especially when it comes to the £9.0m increase in pay level being forecast.

Financial Risk (outside of unmitigated forecast)

Risk Description	Internal/External	Notes
Pay Award Funding	External	Potential for adverse impact of Junior Doctor and Agenda for Change 24/25 pay awards. Currently anticipating both to be fully funded.
Winter (income loss)	Internal	Organisation is required to cancel elective activity due to emergency care pressures over winter
Band 2 to Band 3 pay settlement	External	Back dated national band 2 to band 3 uplift. Full impact is currently being worked through.
Contract disputes with the ICB	External	Multiple contractual discussions taking place with ICB regarding funding for services, value-based commissioning and outcome from service reviews. Potential double count of financial savings across N&N ICS.
Closed Loop Diabetes Pumps	External	NICE guidance changes driving a change in prescribing behaviours and cost is more than any national funding.
Delivery of Risk Adjusted Efficiency Forecast	Internal	We are currently assuming that our weighted forecast will be met within our current forecast. Any reduction to our weighted forecast achievement would worsen the unmitigated forecast position

Financial Recovery Plan Opportunities

Proposed Action	Proposal
Annual Leave Provision	To apply stricter controls around annual leave carry forward in 24/25 to allow full release of the current balance.
Medical Agency Review	To issue an agency expenditure limit for H2 for the organisation to prioritise resource accordingly and reduce expenditure
Increased scrutiny of vacancy control	Increased scrutiny of vacant posts and to review the categorisation of our services into the four levels
Discretionary Expenditure Controls	Continue recently introduced process for discretionary expenditure
Collaborative Procurement	Work with system partners to source best value contracts and supplies
ERF Income Achievement	Robust review of H2 ERF activity and income, ensuring all benefits from theatre and outpatient transformation is captured
De-risking the FIP plan	Work with PA consulting to de-risk the FIP plan across H2
Bank Expenditure Review	Continued work with system partners on bank rates and usage, with a view to reducing expenditure
Review of accounting policies	Trust to review accounting policies with system partners to ensure consistency of approach and seek any wider opportunities
Robust confirm and challenge on financial forecast	Given the above controls which are starting to take shape, a robust monthly forecast review is to take place to ensure ownership

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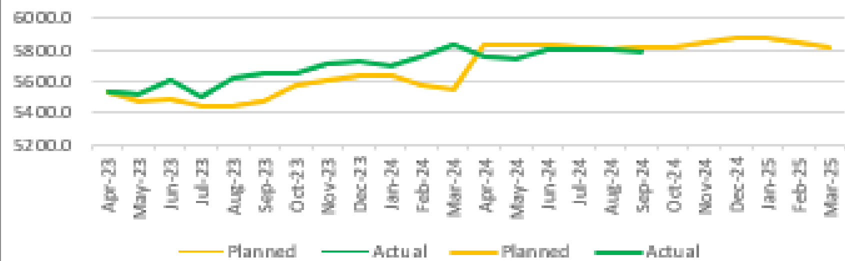
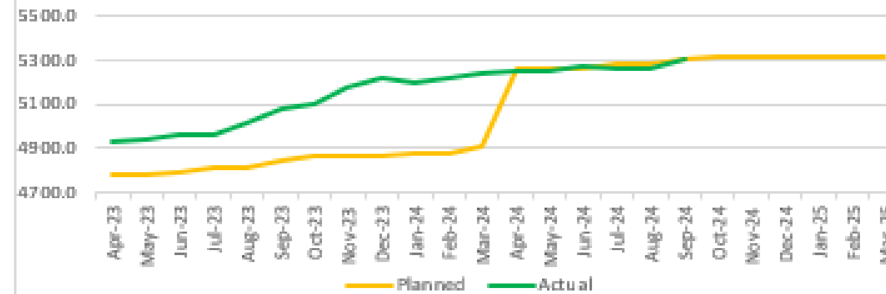
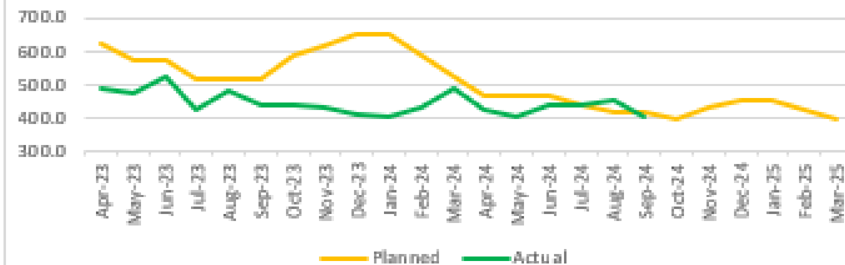
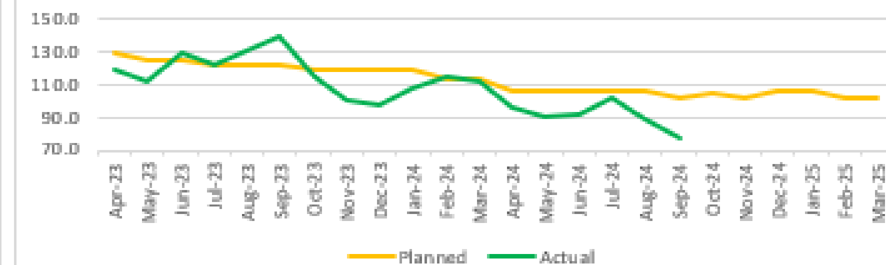
Workforce

Workforce Planning









- Overall, for Substantive, Bank, and Agency together the Trust was **0.6% or circa 32.3 WTE below plan**, this is lower than Month 5 where the Trust was 0.03% above plan.
- Trust **bank is 2.9% below plan** (12.2 WTE) and **agency WTEs are 23.9% (24.4 WTES) below plan**. Substantive workforce in month 6 is 0.1% (4.3 WTE) above plan, this increase demonstrates the work we are mobilising in substantivsing the workforce.
- Agency usage (3.5%) sits below our Trust planned figure (4.2%) and above the expected 3.2% NHSI target, and shows a decrease from Month 5. M6 position is reported at 3.5%, and without ERF reported at 2.8%.
- We have projected the winter plan into the planning assumptions, noting increases in bank and agency usage from November 24 to February 25.

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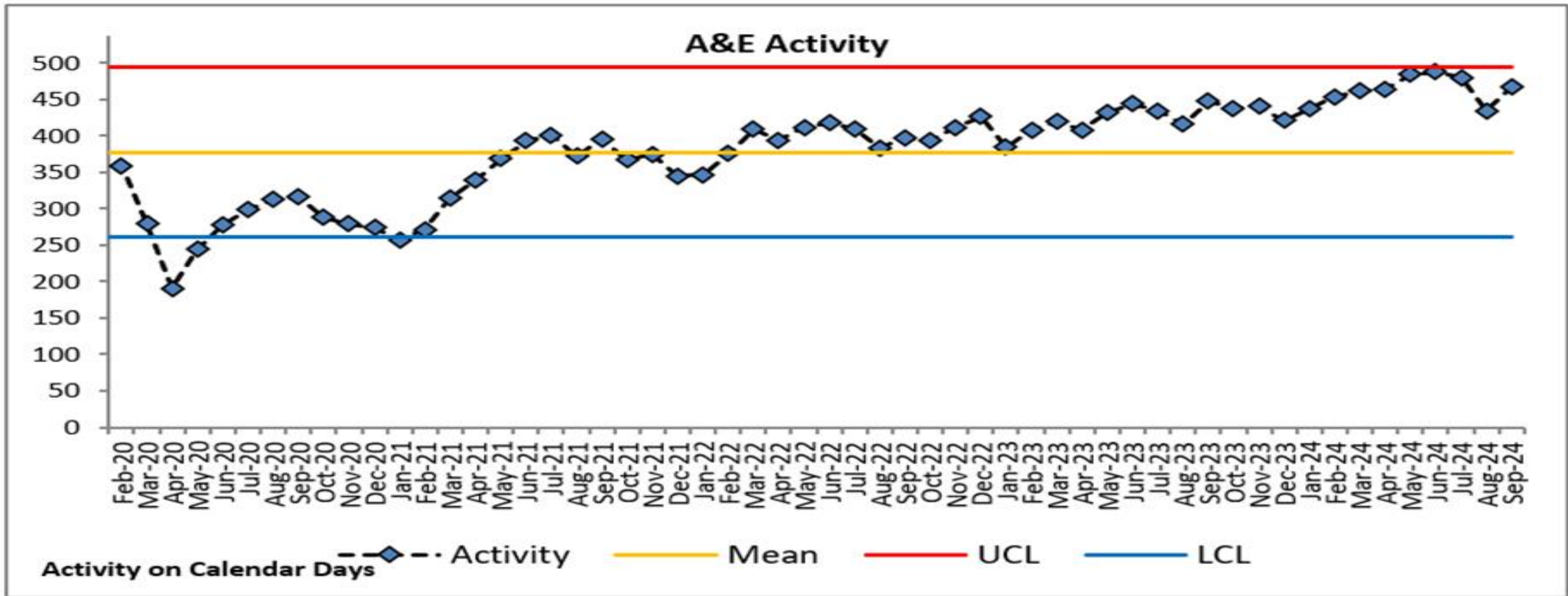
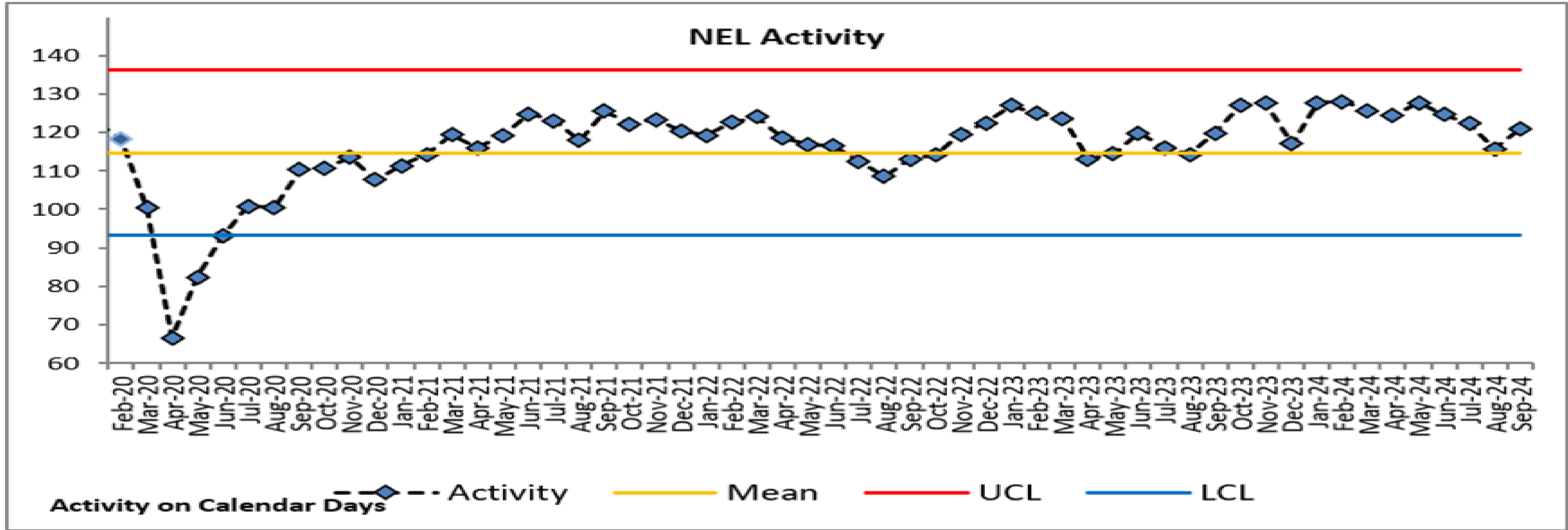
Activity

A&E Activity



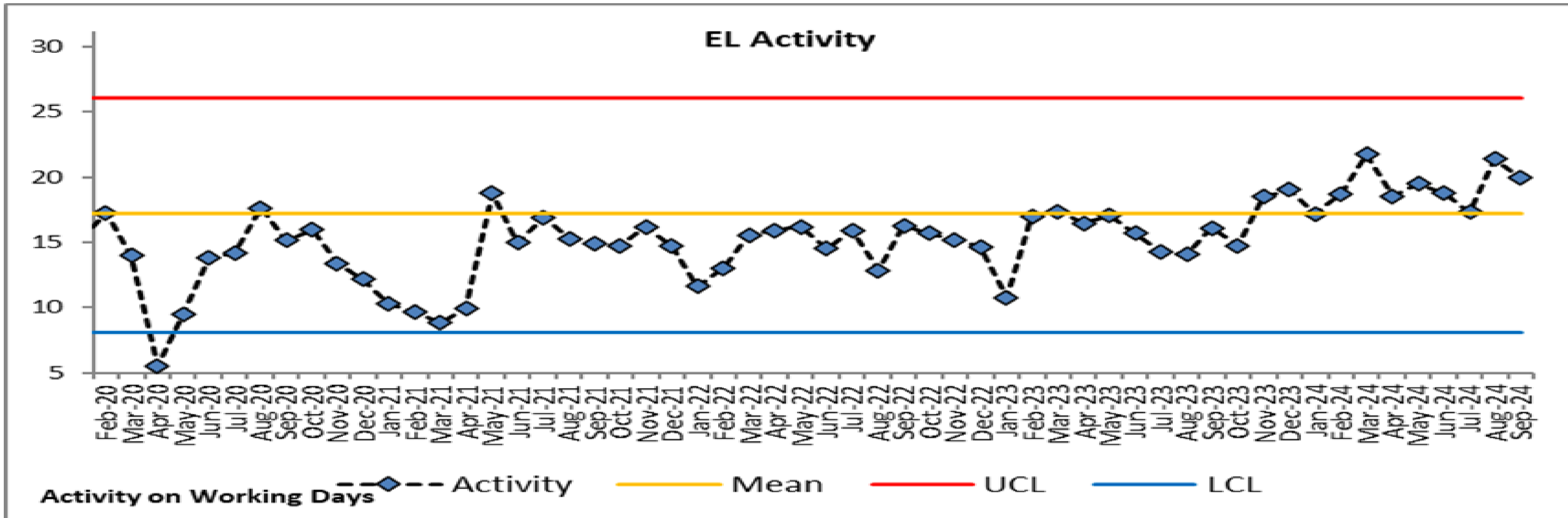
- Compared to September 2023, activity was 571 (4%) higher.
- Attendances per day in September 2024 = 467, compared to September 2019 = 381.

NEL Activity



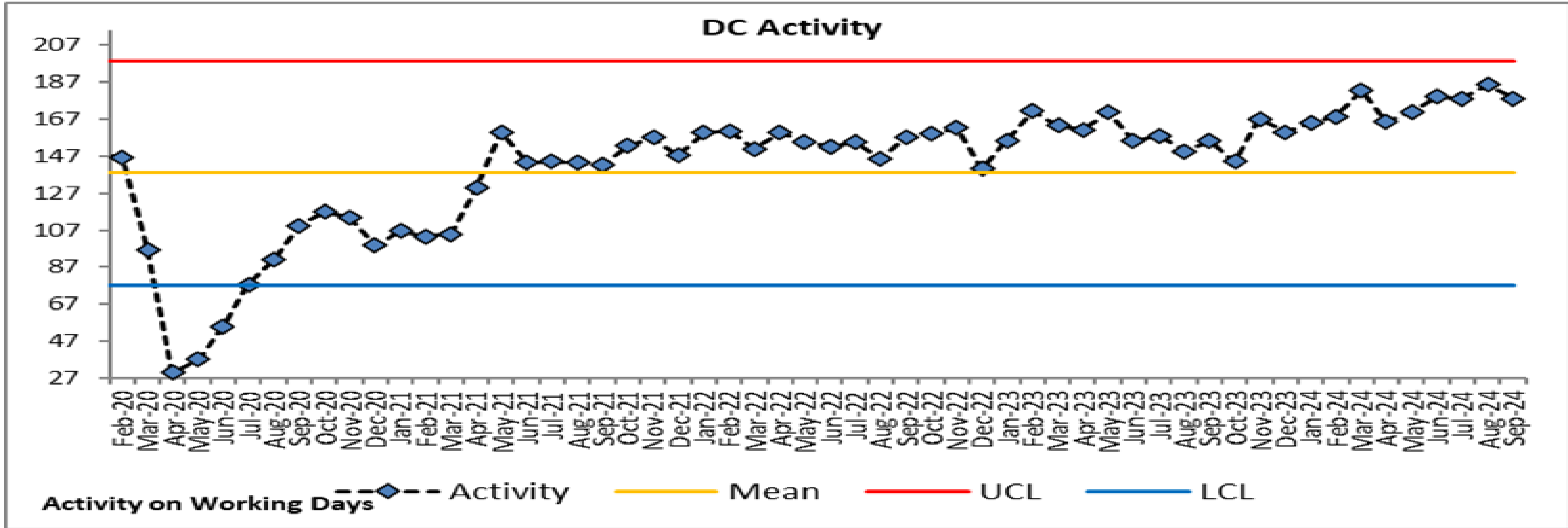
- Compared with September 2023, activity was 1% higher, with 30 more discharges.
- Discharges per day in September 2024 = 121, compared to September 2019 = 114.

EL Activity



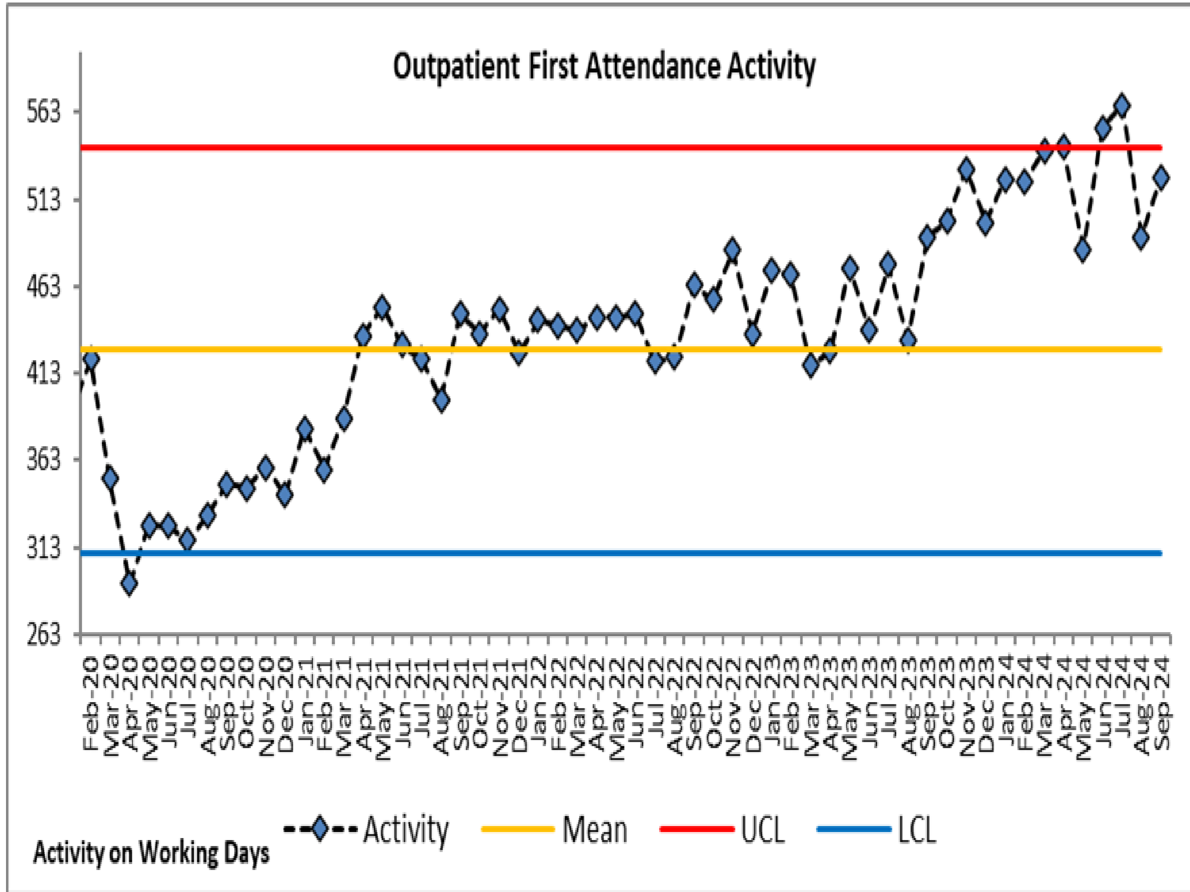
- Elective activity per working day has decreased compared to the previous month.
- Compared with September 2023, activity is 24% higher (81 spells).
- Discharges per working day in September 2024 = 20, compared to September 2019 = 18.

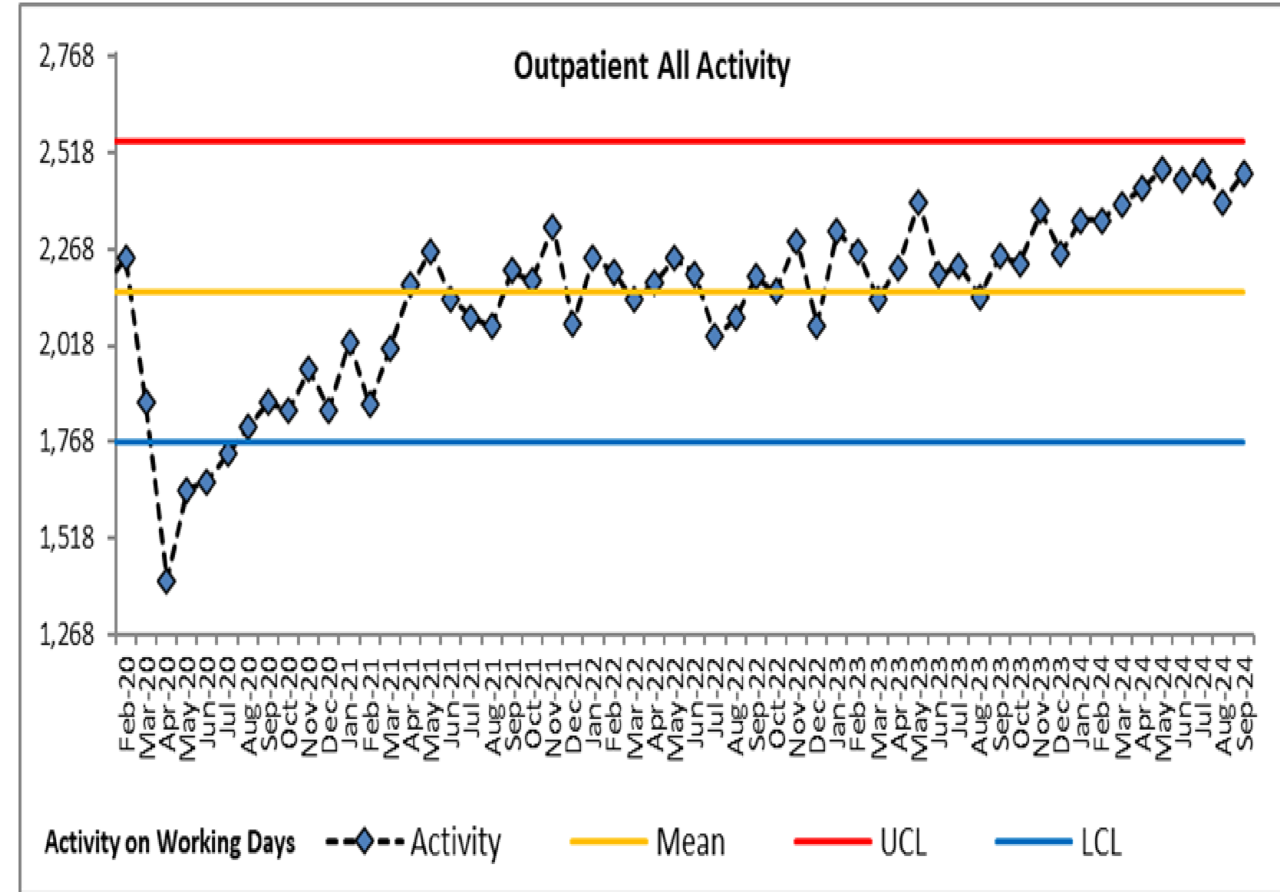
DC Activity



- Day case activity in September has decreased compared to the previous month.
- Compared with September 2023, activity is 15% higher (478 more spells).
- Attendances per working day in September 2024 = 179 compared to September 2019 = 133.

Outpatient Activity





- Compared with September 2023, outpatient first activity was 7% higher (700 more attendances in month per working day).
- Outpatient first attendances per working day in September 2024 = 525, compared to September 2019 = 395.
- Total Attendances per working day in September 2024 = 2,466 compared to September 2019 = 2,130.

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Operational Performance

Cancer

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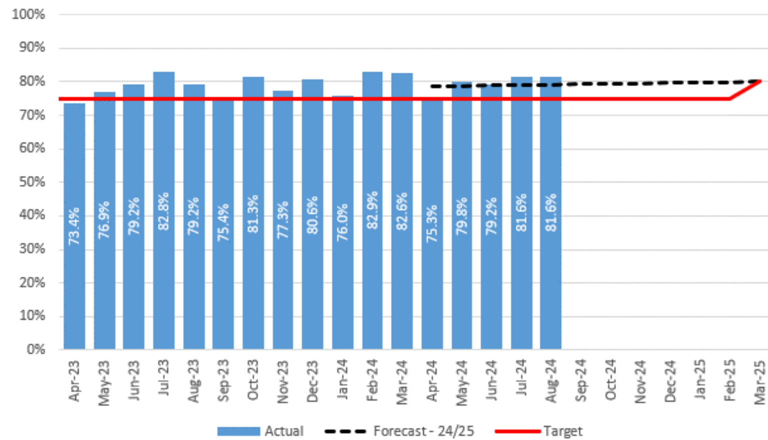

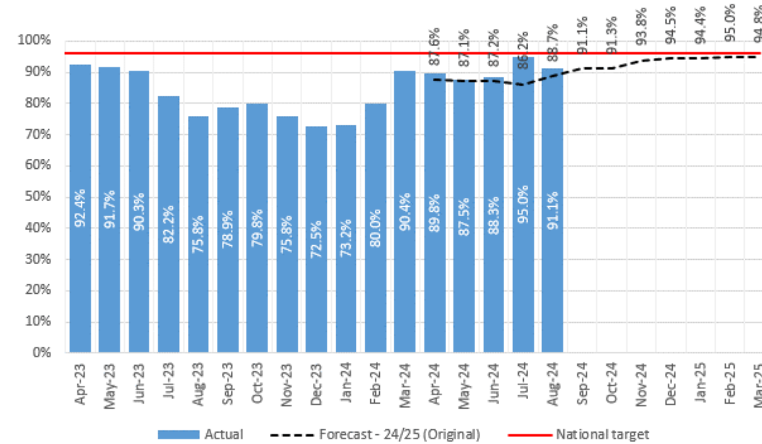

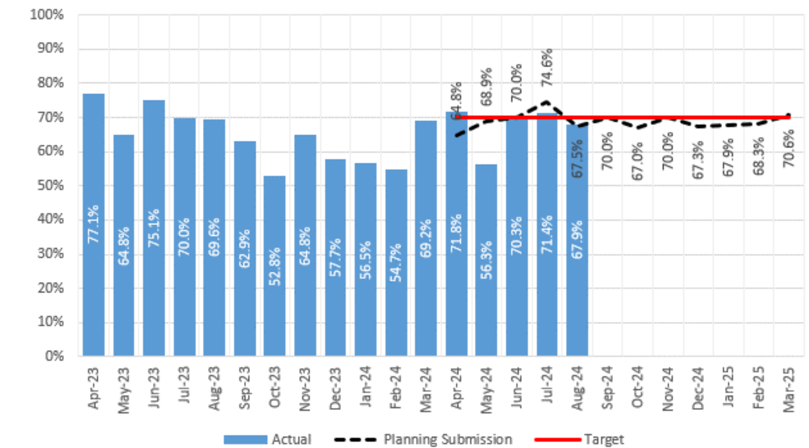

Progress during 2024/25 H1

- Throughout H1, we have achieved the **Cancer 28-Day Faster Diagnosis Standard and 31-day performance standard** in line with our operational plan forecast.
- **Cancer 62-day performance** has been strong from Jun-24 to Aug-24. While we fell short of our ambitious operational plan in Jul-24, our performance remained above the current national target of 70%.
- SFH is performing above the **national average** for 28-day FDS performance, but slightly below **national average** for cancer 31-day and 62-day performance.
- The two biggest tumour sites impacting **31-day performance** are Lower GI and Urology. **Lower GI** has been above plan during Jun-24 and Jul-24. **Urology** remains just below a plan of 100%. **Skin** has been the greatest contributor to improved 31-day performance and delivery of our recovery trajectory, achieving the national standard in Aug-24 for the first time this financial year.
- **Skin** has achieved consistently high **cancer 62-day performance** through H1, while **Upper GI** has improved significantly from 50% to 85% in Aug-24.

Priority areas of focus and 2024/25 H2 outlook

- There is a growing 62-day backlog in **Head & Neck** that is impacting on 62-day performance due to diagnostic capacity. This is being addressed, with additional local radiology capacity and mutual aid.
- The **Lung 62 backlog has increased** and impacted performance due to complex pathways and an increased requirement for interval diagnostics (at 3 months,) with patients remaining on the cancer pathway. However, Lung are compliant with the Best Practice Timed pathway.
- Our operational plan suggests that **Lower GI** is expected to **dip in 31-day performance** until Dec-24, but will rise in the following months to **achieve 95% by year-end**.
- **Improving histology turnaround** impacting on pathway delays across all tumour sites is a key focus. A SOP to mitigate current challenges is being developed and will be operationalised in H2.
- Reducing waits for diagnostic tests and increasing reporting turnaround for all pathways, in particular CT colon and US FNA, is a key focus and will be achieved through increased capacity and mutual aid.

Diagnostics

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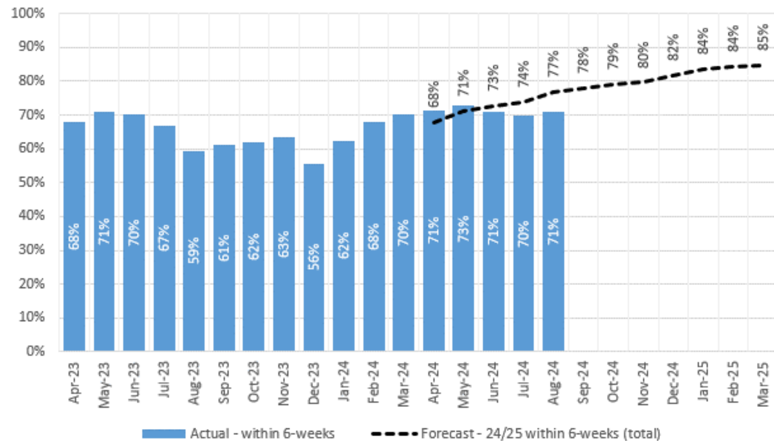

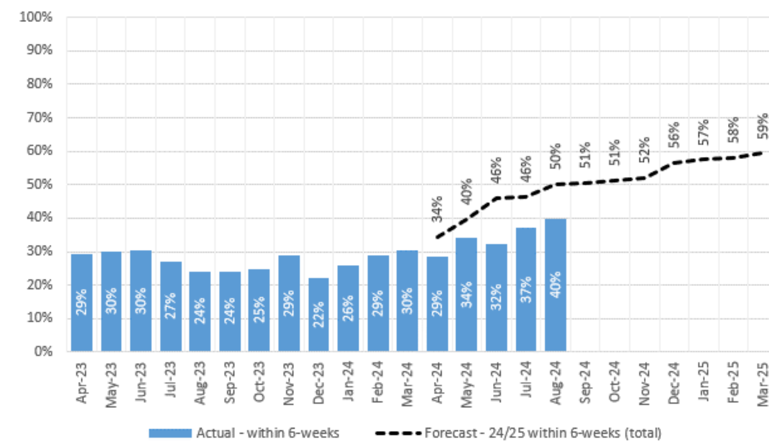

Progress during 2024/25 H1

- During H1, our **performance against the Diagnostic 6-week standard** has remained relatively stable against a requirement to improve performance month-by-month. In Aug-24, we were circa 6% below plan.
- **Echocardiography** was the biggest challenge through H1, though has been improving, and has achieved above plan in the last two weeks (at the time of writing).In real terms - this takes performance from 28.6% to 56.7% (unvalidated). This progress has been reflected in the 13-week backlog, which has dropped from 1,695 to 131 through H1.
- **Computed Tomography** has observed a decrease in performance of ~10% during H1, diverging consistently from a rising operational plan. Deviation from plan has been significantly affected by delays in operationalisation of a new CT Cardiac scanner.
- Recent challenges have been observed in **Audiology and Non-Obstetric Ultrasound**. A significant driver of Audiology performance relates to system support provided to NUH as agreed through SOG. Performance decreases seen in Non-Obstetric Ultrasound have been driven by rising demand, Doppler referral increases, and staffing challenges.

Priority areas of focus and 2024/25 H2 outlook

- Improvements seen in **Echocardiography** are anticipated to continue through the remainder of the year, with plans in place to recover CDC activity, put on additional 'stress Echo' sessions, continue to utilise a fifth room at King's Mill Hospital with additional locum support.
- Echocardiography 13ww waiters are expected to be eliminated by end of Oct with a primary focus on 'stress echo' which carries the greatest risk due to being a single consultant service.
- **Non-Obstetric Ultrasound** performance is showing early signs of improvement back towards plan, with extra Doppler scanning clinics initiated to mitigate increased referral demand, and maximisation of CDC capacity being monitored.
- The new **CT Cardiac scanner** is now set to go online in Feb-25. To mitigate this, system support from Doncaster and Bassetlaw Teaching Hospitals, Nottingham University Hospitals and the independent sector support is in place, while extra CT activity at weekends at Newark campus is being provided. A request to Chesterfield for support is also being considered.
- **Sleep** will see improved performance throughout H2 as a process for inpatient sleeps on the discharge lounge is agreed and they operationalise their ERF bid to increase capacity.

Referral to Treatment

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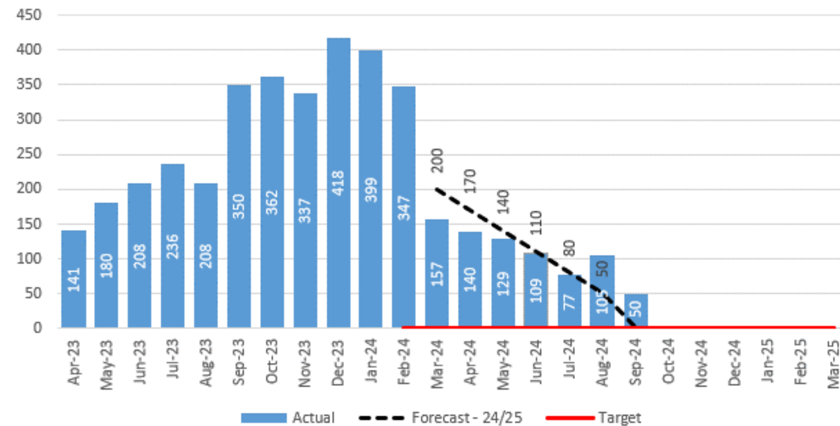

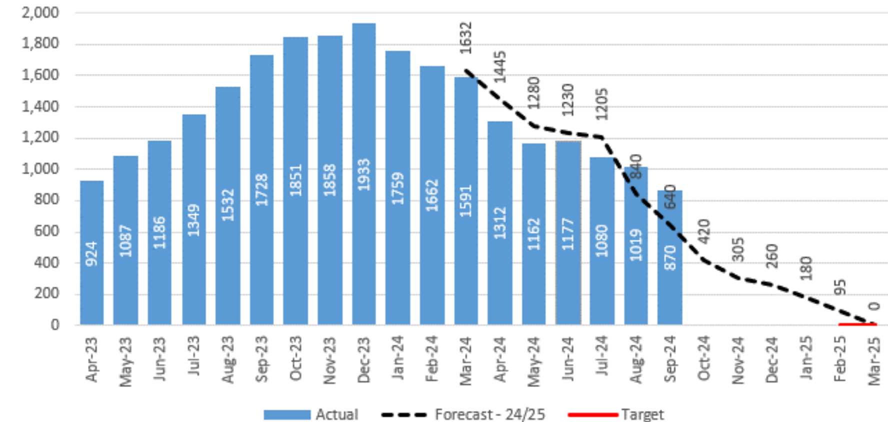

Progress during 2024/25 H1	Priority areas of focus and 2024/25 H2 outlook
▪ **78ww backlog was eliminated in H1 –** a risk of 'drop ins' remain from active validation ▪ **65ww backlog** has reduced during H1, falling from 157 to 50. However, our operational plan committed to eliminating 65ww by the end of H1, which we have not achieved. ▪ The two specialties with the largest 65ww backlog **are ENT and General Surgery**, accounting for over 40 patients on the backlog. ▪ **ENT 65ww backlog has been adversely impacted** by a demand and capacity mismatch that is seen at regional and national level. SFH is also providing system support for NUH. Capacity required for high number of 52ww CYP patients. ▪ **52ww backlog** has reduced significantly in H1 from 1,591 to 870. However, this is behind plan with anticipated reductions in Aug-24 not fully realised. ENT is the biggest driver of this position. ▪ Significant 52ww **backlog improvements** have been observed in **Gastroenterology, Endocrinology and Orthopaedics**. However, Orthopaedics remains slightly behind plan. ▪ Hit plan to minimise DNA rates in Sept to 6% - additional income of ~£0.5m YTD	▪ Excluding **ENT, General Surgery, patient choice and complex pathways** all services are forecasting an elimination of 65ww by the end of October ▪ **Focus remains on ENT and General Surgery to reduce and eliminate 65ww's.** Insourcing capacity for ENT is being implemented November alongside an ongoing anaesthetic contract, which is improving session utilisation. Virtual review clinics in place to improve timeliness of patient removal from pathway. Pre-operative assessment PTL in place to ensure patients ready for surgery. ▪ Expectation to **eliminate 52ww** in line with operational plan by the end of the year. Plans to achieve this include: ○ Ensure all patients in the 52ww cohort have attended a First outpatient appointment by December 31st ○ Contacting patients through DrDoctor to ensure the waiting list is accurate. Expansion of Central Validation team to reflect Total incomplete PTL size. ○ Continue to access System Support from NUH, other acute providers in region and the Independent Sector. ▪ Continued focus on theatre utilisation / booking & POA processes through FEI programme ▪ Ability to identify and operationalise new ERF schemes at pace – in line with H1

Urgent and Emergency Care

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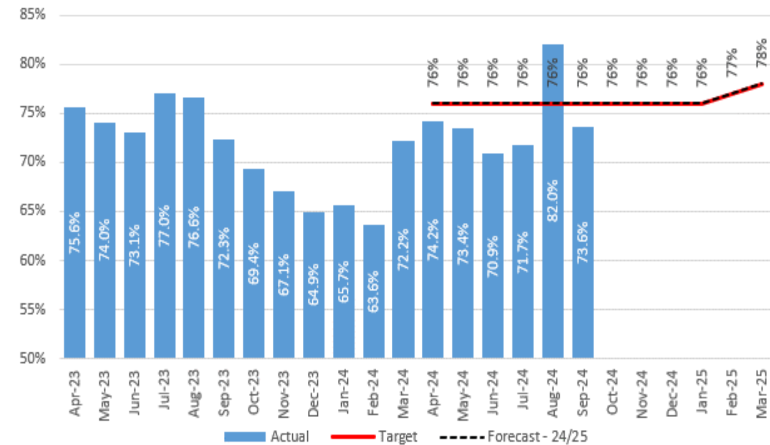

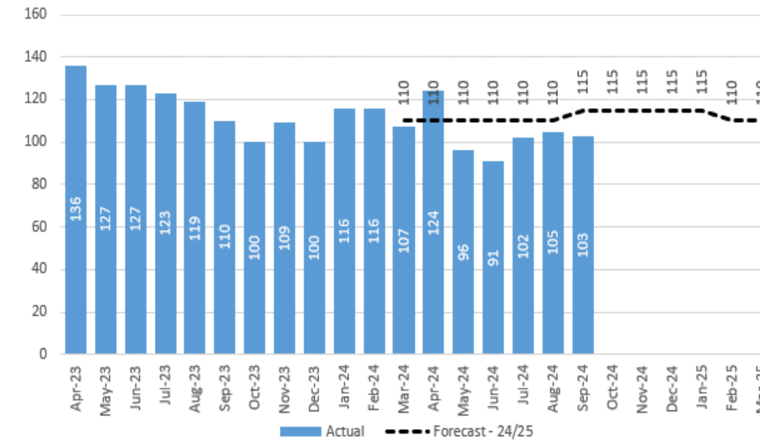

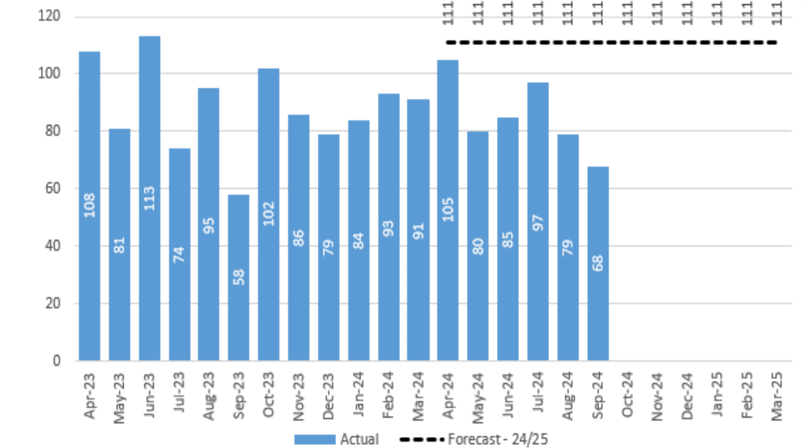

Progress during 2024/25 H1	Priority areas of focus and 2024/25 H2 outlook

Progress during 2024/25 H1

- **A&E 4-hour performance** delivered a step change improvement in Mar-24 after enhancing the medical and nursing staffing teams in ED to support the rise in attendance demand. This improved position has been sustained in 2024/25; however, our performance has been consistently below our ambitious (and compliant) operational plan throughout H1, apart from in Aug-24. Apr-24 to Jul-24 attendance levels were 10% higher than the equivalent period last year. Type 1 attendances were 11.2% higher. Newark Type 3 attendances were 12.6% higher.
- Aug-24 saw a **significant increase in 4-hour performance** at the same time as a reduction in attendances during the school summer holidays.
- **Long length of stay (LLOS)** levels have remained at circa 100 patients since May-24, inside operational plan following a challenging Apr-24. Lower levels of medically safe for transfer (MSFT) patients will be contributing to this position and supporting the reduced use of Ashmere Care Home group beds (from 27 in H1 2023/24 to 17 in H1 2024/25).
- **No criteria to reside (NCTR, also known as MSFT)** levels have reduced in Q2 to 68 patients, following a rise to 97 in Jul-24. Throughout H1, SFH has continued to track well inside of the operational plan. Our new Discharge Lounge which opened in Apr-24 and expanded Discharge Coordinator team are supporting improved patient flow.

Priority areas of focus and 2024/25 H2 outlook

- Despite improved 4-hour performance in Aug-24, **significant pressures** and challenges to performance and A&E crowding are expected during winter, with a bed model peak forecast **bed gap of 48 beds** during Jan-25.
- Agreed **winter plans** being mobilised to ensure this bed gap and resultant pressure on A&E is minimised. Expansions to SDEC services, focus on frailty and other flow improvement plans are particularly key.
- **Dynamic rostering** to be trialled in Oct-24 to match predicted attendances with appropriate levels of A&E staffing, with a view to implement through H2.
- **LLOS and NCTR positions** expected to remain inside operational plan levels through H2 and our ambition is to keep medically safe over 24hrs no higher than 50 as we know that delayed discharge negatively impacts both those delayed and those awaiting a bed.
- A particular focus will be placed on both reducing internal delays and abandoned discharges and robust management of external demand to reduce the potential impact of the bed gap referenced above.

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Quality of Care

Quality of care

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Overview	Lead: Chief Nurse/Medical Director

During H1, we received 901 compliments, 864 concerns, 125 formal complaints, and closed 129 formal complaints. We continue to identify actions and themes that are tracked through the Patient Experience Committee.

The Patient Safety Incident Response Framework (PSIRF) is now well embedded in the Trust and from Apr-24, Infection Prevention and Control (IPC) is aligned with the PSIRF model. The Patient Safety Incident Response Plan has been refreshed and approved by the Patient Safety Committee. It will be presented to Quality Committee for final ratification.

The Trust has not had an MRSA bacteraemia for over two years (we are the only Trust in the region not to have had one this financial year). National targets for infection prevention and control were released in August; we have had increases for CDiff to 65 (24 cases in H1) and Pseudomonas BSI to 14 (1 case in H1) and reductions for Klebsiella BSI to 16 (5 cases in H1) and Ecoli BSI to 83 (20 cases in H1). Infection Prevention Control (IPC) have commenced undertaking rapid reviews for all hospital associated infections and had completed 125 at the end of August with learning being shared as part of all divisional governance reports. There have been two reported CDiff deaths and investigations have taken place for both which have identified that both patients received the appropriate treatment and care.

National Inpatient Survey 2024:Compared to the other sector organisations, 22 scores are in the top 20% range, 26 are in the intermediate-60%, and 1 is in the bottom 20%. Areas where the Trust scores well include privacy & dignity, cleanliness and availability of drinks. Areas for improvement include opportunity to feedback on quality of care, information on medicines at time of discharge, support from Health & Social care following discharge and family involvement in discussions about discharge. The trust has received the Maternity inpatient survey, it is currently embargoed and we are working through themes/ free text comments to look at a plan for sharing.

During H1, 11 Patient safety incident investigations (PSII) were commissioned by the Patient Safety Incident Response Group (PSIRG); this followed an in-depth discussion during which the ICB were present. There were two confirmed coroner's investigations in relation to a delay in recognition and treatment of a low magnesium and the delay in cardiology processes and task list issues - RAG rated red by the Trust legal team. Further information in relation to the patient involved in the Never Event related to retained drill fragment has been requested by the coroner.

Falls per 1000 occupied bed days - The falls rate for H1 is 6.3; this is slightly below the national target of 6.63.

There are four domains during H1 which will be reported as off track for H1:
Never Events – in H1 we reported 2 Never Events (wrong site surgery in dermatology, and retained drill fragment following orthopaedic surgery)
Category 3/4 Hospital acquired pressure ulcers (HAPU) and ungradable pressure ulcers with lapses in care - SFH has had three avoidable category 3 pressure ulcers in H1
Early neonatal deaths per 1000 live births - rate increased to 3.2 in September, but H1 rate 0.6 is within target
Hospital Standardised Mortality Ratio (HSMR)- Latest 12-monthly rolling figure= 122.14 (Jun-23 – May-24); (quarter one report 126.9). Remains above expected but a continued downward trend, alongside individual month reporting remaining "as expected" (Note- awaited changes to HSMR+ methodology).
Summary Hospital-level Mortality Indicator (SHMI)- Latest reporting = 105.96 (May 23- Apr 24); (quarter one report 108.0). Remains as expected.

Further detail relating to mortality indicators, Never Events and regulatory activity is described on the following slide.

Quality of care

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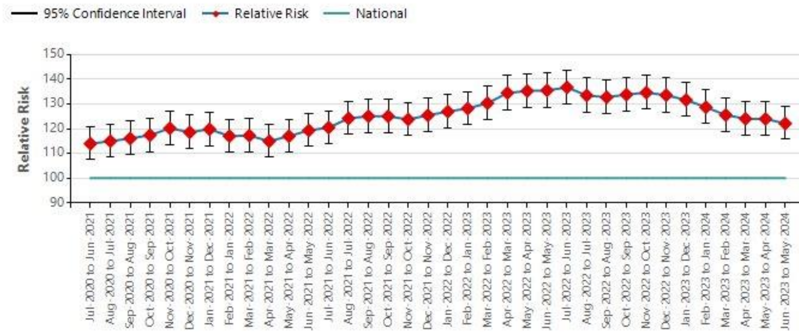
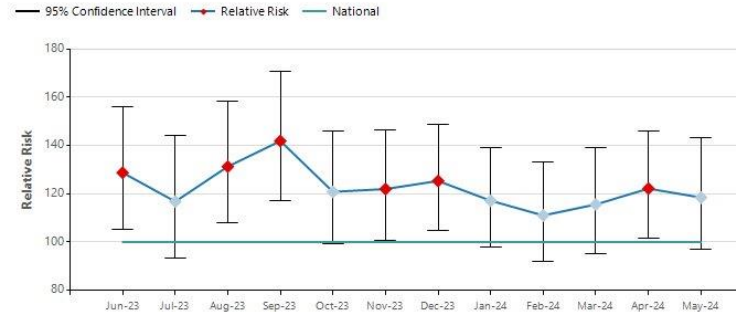
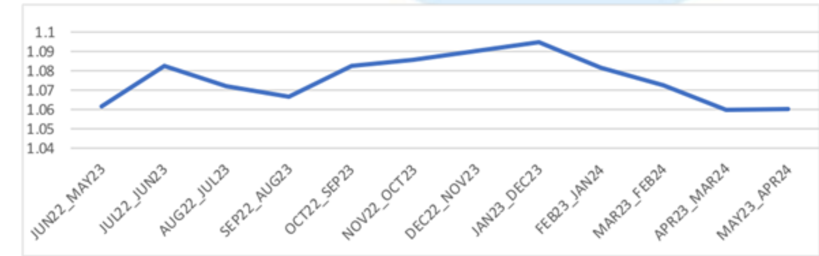
HSMR 3 yearly (12 month rolling) trend



HSMR single month trend



SHMI: Rolling 12 months (Latest May 23- Apr 24)



Mortality Indicators

HSMR- Latest 12-monthly rolling figure= 122.14 (Jun 23 – May 24); (Q1 report 126.9). Remains above expected but a continued downward trend, alongside individual month reporting remaining "as expected" (Note- awaited changes to HSMR+ methodology)
SHMI- Latest reporting = 105.96 (May 23- Apr 24); (Q1 report 108.0). Remains as expected.
Work on root causes continues focussing on:
Data Quality- Emphasis on timely diagnosis, documentation, coding and co-morbidity capture.
Pathways and Patient Flow- Review of admission pathways, use of management bundles and effective signposting.
Palliative Care Coding- Remains lowest, nationally. Discussion with local SPC provider to identify opportunities for improvement.
Learning from deaths – Representation from ME service, divisional leads, ICS and BI. Close working with Telstra. Actions include data interrogation, targeted reviews/ deep dives and audit.
Data Intelligence- HSMR+ (plus) is due to "go live" Q3 2024; it is understood, changes in methodology mean an improved HSMR+ and trend when compared to HSMR and expected values.
External peer review - Visit to Dudley Group Hospitals (DGH) undertaken 1st October with an emphasis on Learning from Deaths and to review processes, approaches to engagement and coding practice.
Wider accountability – Meeting with ICB medical director Sept 24 to review HSMR, assurance measures, coding practices. Development of quality dashboard.

Never events / Coronial process / CQC

Never events: In Apr-24 SFH reported an incident relating to wrong site surgery in Dermatology: A patient attended for a punch biopsy but there was an incorrect site skin lesion biopsy.
An external review has been commissioned and is being undertaken by colleagues from Nottingham University Hospitals NHS Trust (NUH). The investigation is ongoing.
In September 2024 SFH reported an incident when following a surgical procedure, it was identified that a drill bit used during the procedure had broken. Upon review of the image intensifier, it has been confirmed that the broken drill bit can be seen in the patient's elbow which had not been recognised prior to completion of the surgery. It is not thought that this incident contributed to the patient's death and a structured judgement review (SJR) has been commissioned to look at the episode of care.

Coronial matters: The Trust has responded to 4 Prevention of Future Deaths reports, 2 related to the management of sepsis and 2 related to ante-partum haemorrhage. Significant work has been undertaken to review pathways related to sepsis within ED. A new sepsis lead has been appointed. Maternity colleagues have revised guidelines around APH and undertaken additional learning related to this.

CQC: During the last 6 months the Trust has had 2 visits from CQC, including an unannounced visit to ED to review sepsis pathways and a visit to our nuclear medicine department. The Trust has received initial written feedback from both visits. Both visits identified areas of good practice. Formal reports are awaited.