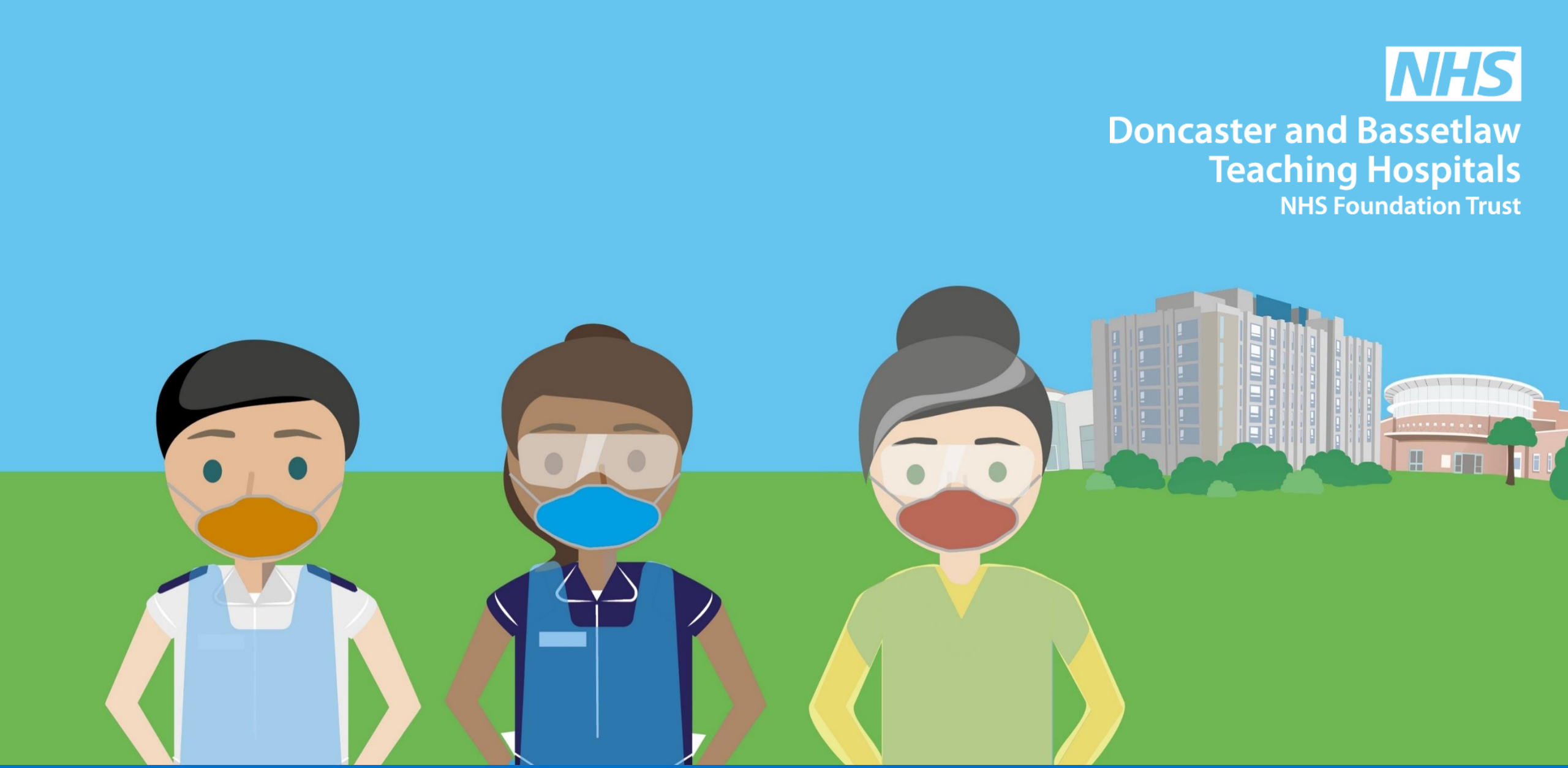


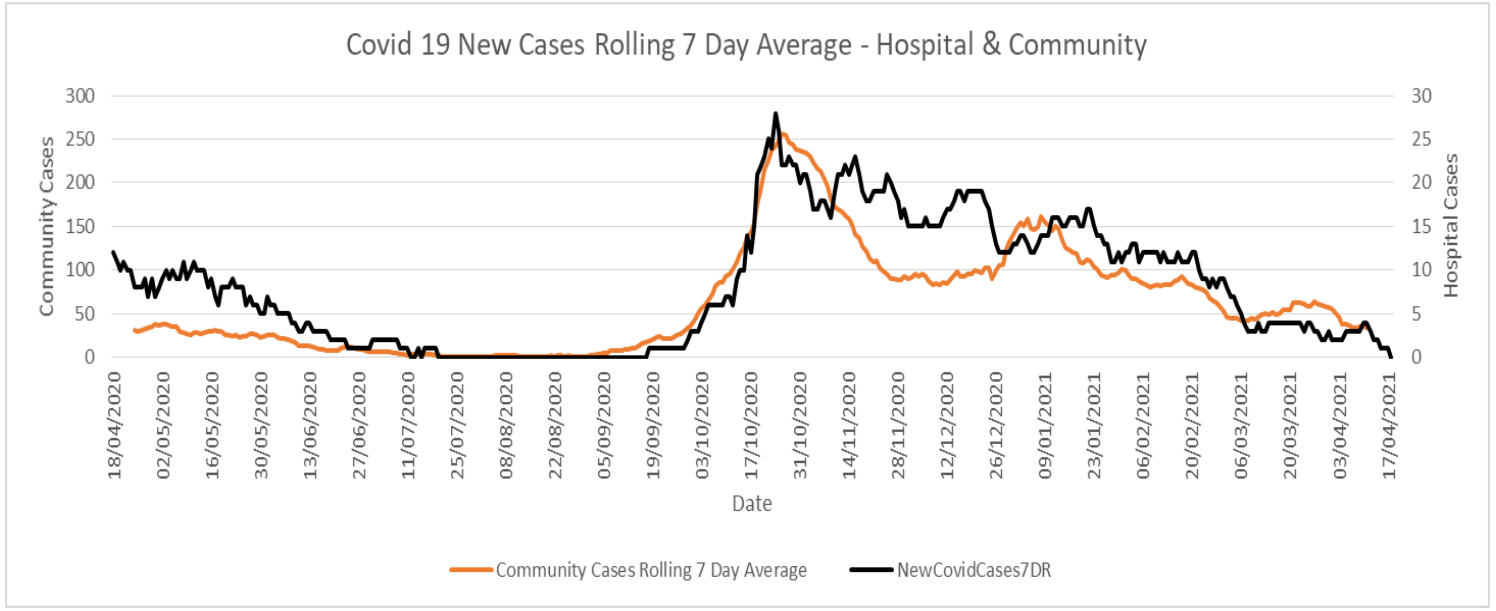

# Board of Directors April 2021 - Operational Update

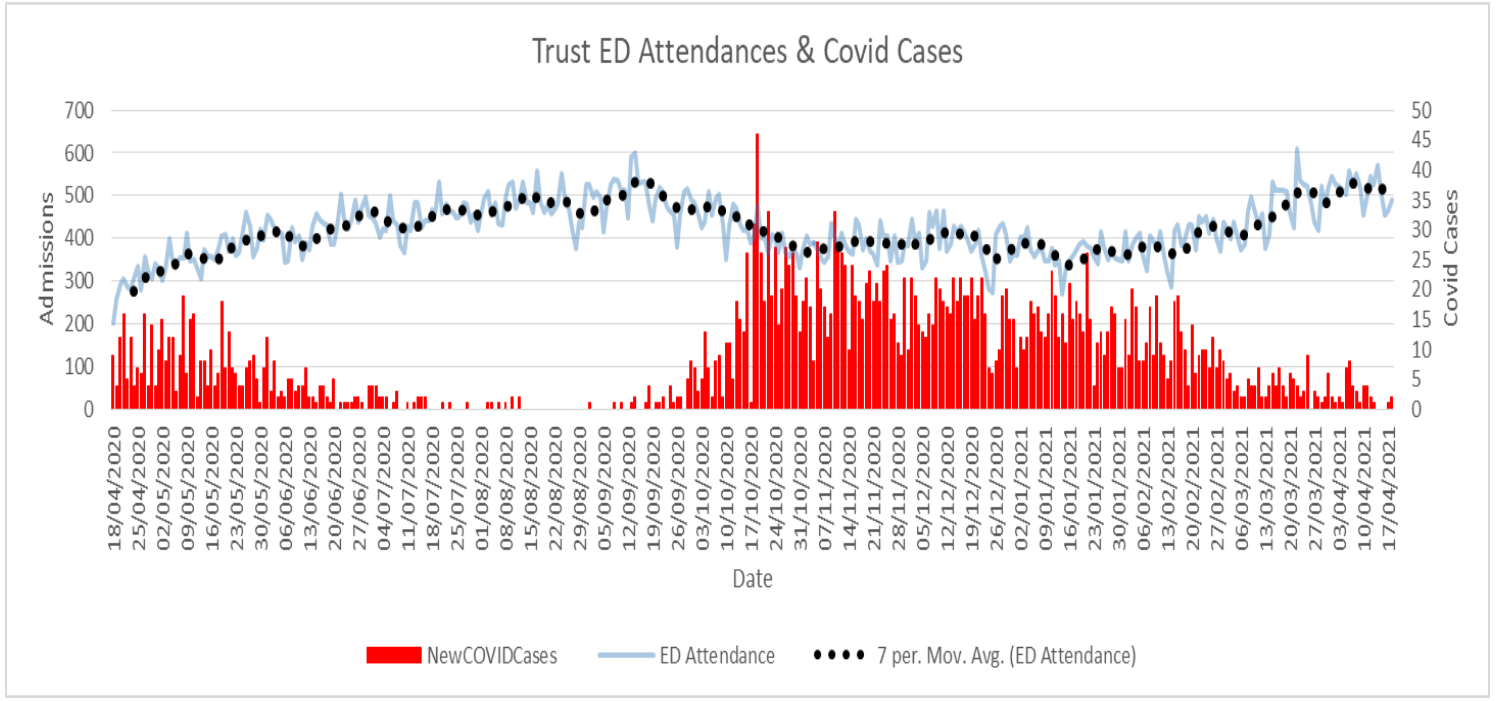
# Today

- Operational trends – where are we now
- Looking Forward – Planning Guidance & Operational Response
- Key points of our approach
- Next steps

# Infection, Admission & Emergency Dept.

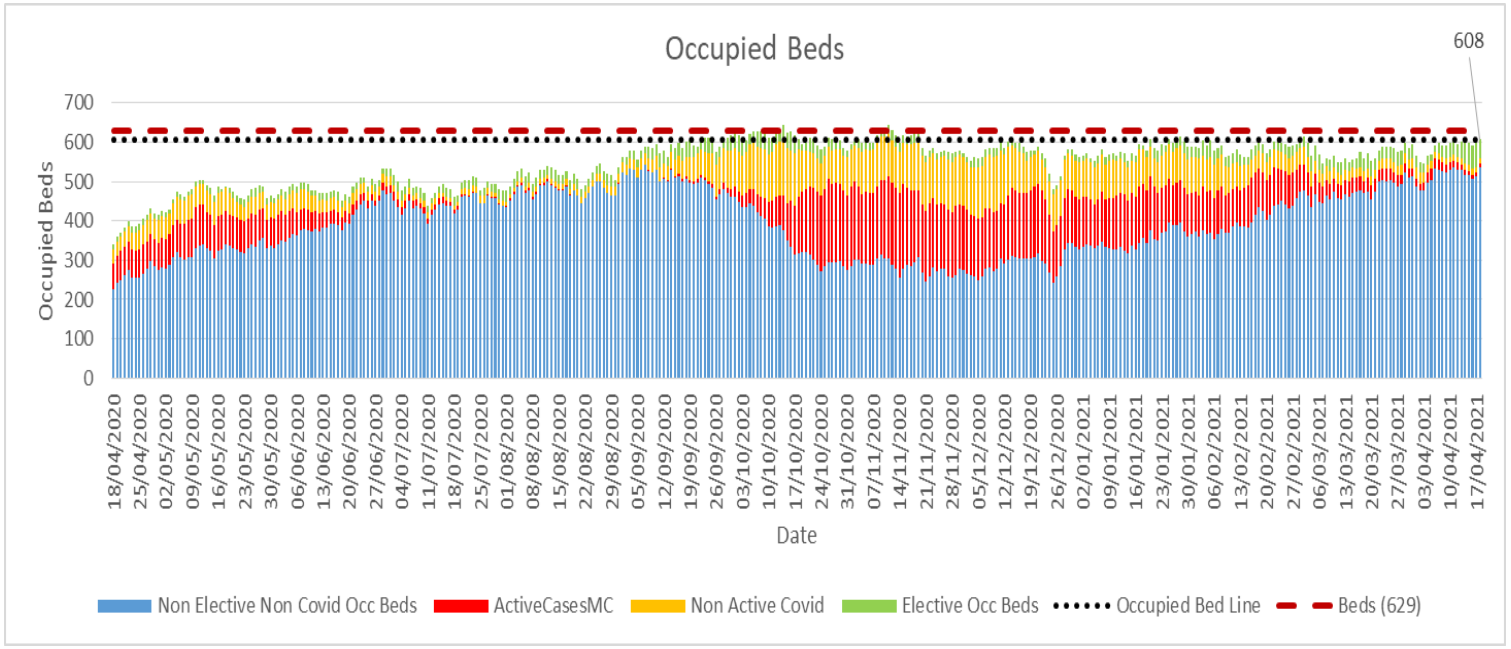
- Vaccination programme progressing well in Doncaster and Bassetlaw
- Breaking link between community cases & hospital admissions
- ED attendances rising quickly
  - Largely minor demand
  - High paeds numbers - schools return
- Analysis undertaken
  - Handful of practices appear to have a significant change in patient behaviour
  - Significant patient feedback re accessibility to GPs
  - Escalation to relevant CCGs for action (DCCG, BCCG, plus Wakefield & Barnsley)

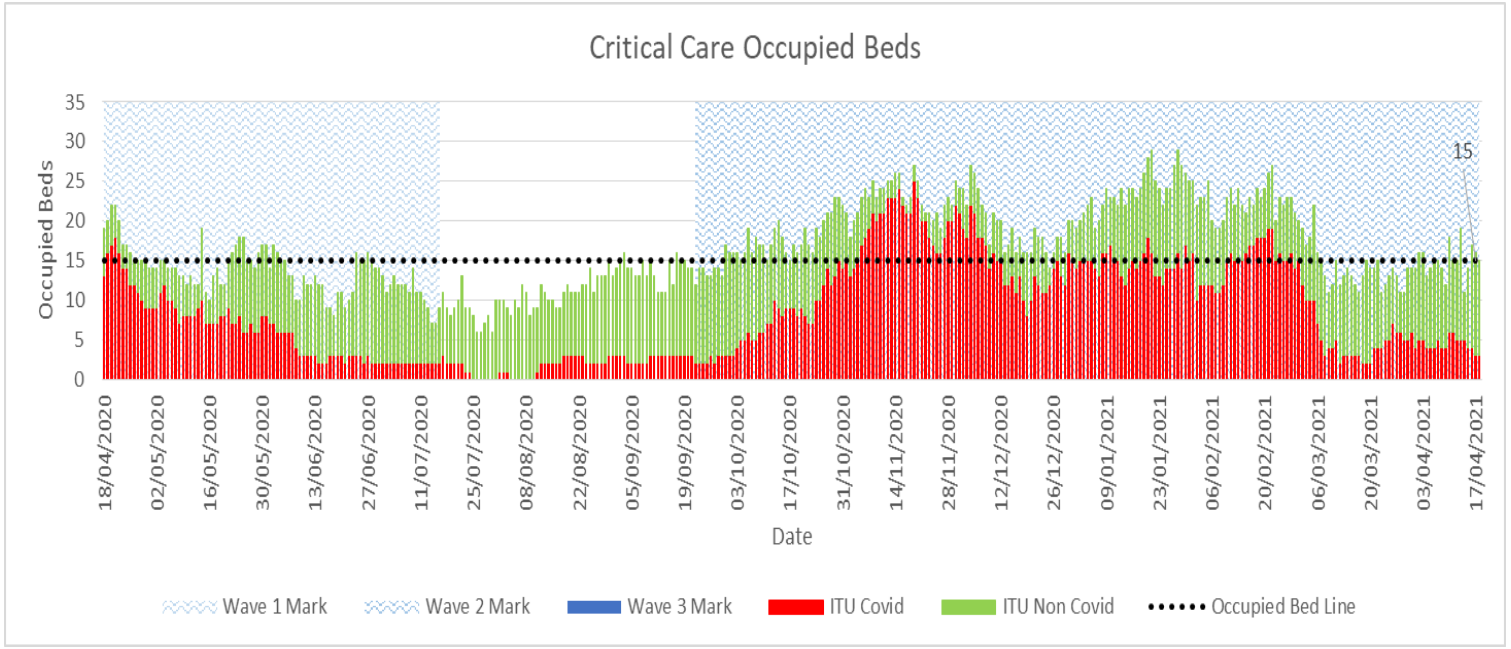


# Occupancy

- Occupancy of COVID beds dropping
- Total COVID occupancy = 3.6%.
  Active case occupancy = 2.2%
- Seeing rise in non COVID emergency demand filling beds
- Reducing pressures in ITU– now 2-3 patients.



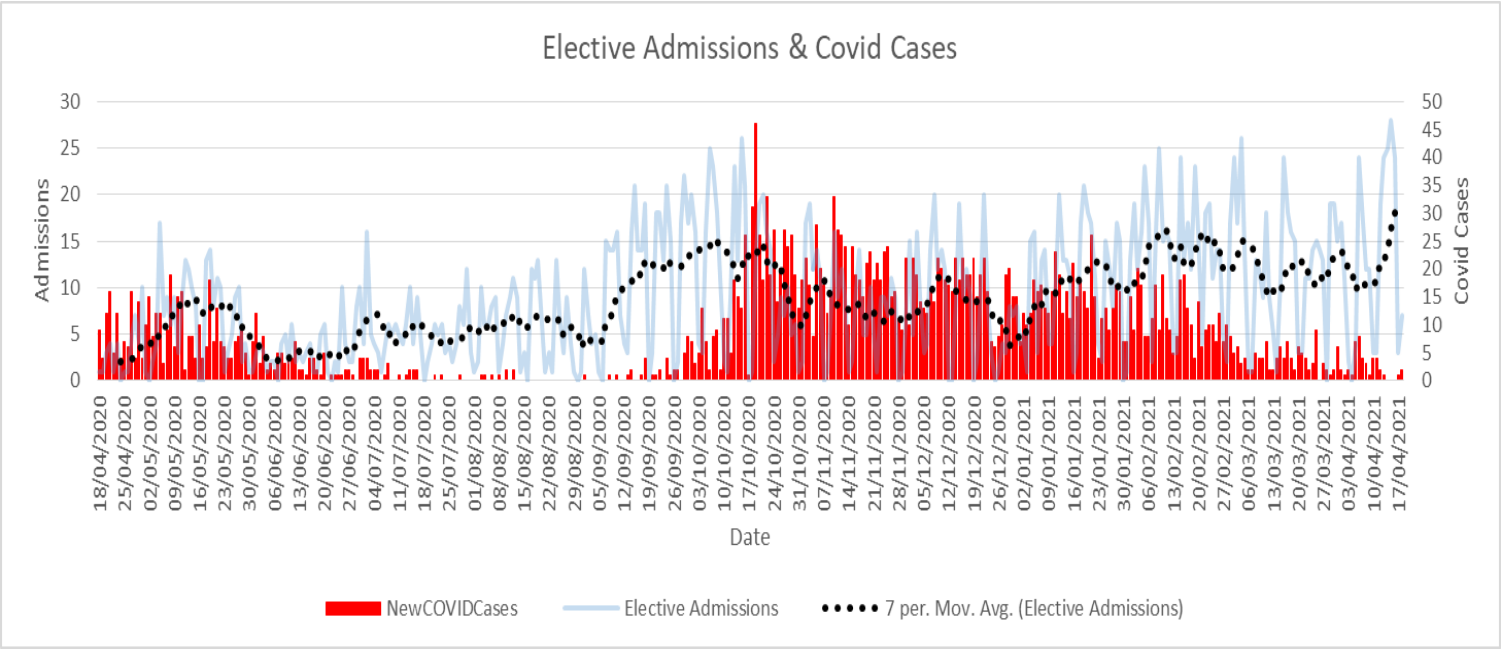



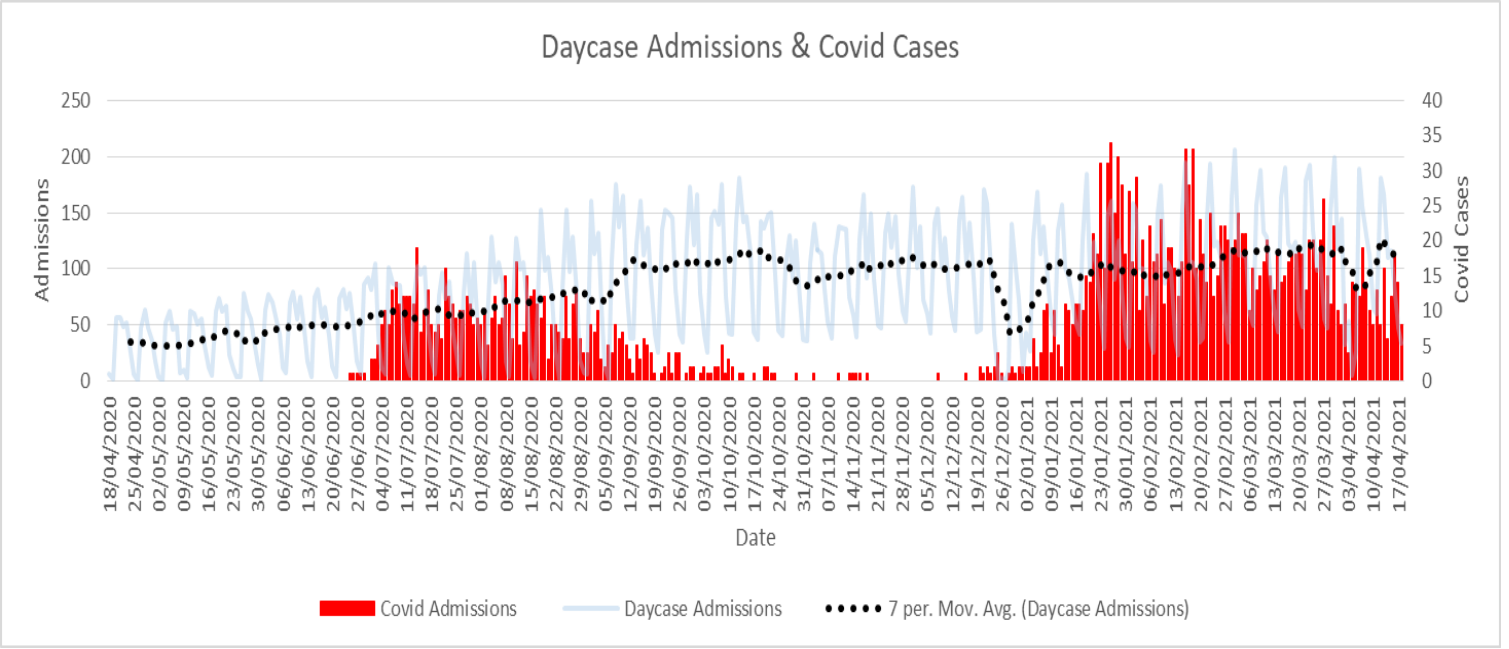
# Elective

Rolling 4 week average to w/e 21 March – now comparing well on Outpatient, Day case. More work to do on inpatient elective:

- IP elective – c 45% of 19/20 levels. Need to focus on theatre step up plan
- DC elective – 85% of 19/20 levels – comparing well to peers
- OP – 85% (new) & 85% f/up of 19/20 levels

*NB: Benchmarking to 19/20 includes COVID Elective "step down" from mid March 2021*



# Other Elective Issues

- 52 week position – 2394 at March end. Growth slowing (2272 Feb end). Theatre step up will support reduction
  - – more work to do – an issue shared by many providers – specialty specific trajectories

- Growing focus by NHS E on P2 delivery within timescales.
  - Benchmarking indicates a changing Trauma and orthopaedic position - validation taking place

- Cancer – small number waits over 104 days – lowest number across ICS

- Focus on reduction of > 62 day waiters & recovery trajectories to end Feb 2020 average – development of detailed plan underway

# Looking Forward

# Must Dos for 20/21 – National Guidance

- **Phased return of elective activity from 70% in April to 85% from July onwards -** as a percentage of the value of 2019/20 activity.

- Access to Elective Incentive Fund on an ICS basis (not at organisational level – 5 gateway criteria

    - Addressing health inequalities
    - Transforming outpatient services (25% tel / video attendance & focus on Advice and Guidance)
    - System led recovery – top quartile performance plus focus on MSK, Ophthalmology and Cardiac
    - Clinical validation & prioritisation, waiting list data quality and reducing long waits
    - People recovery

- Restore full operation of **cancer services**

    - return to number no more patients waiting over 62 day by March 22 compared to Feb 19 (or national average)
    - meet increased levels of referrals and treatment through 20/21
    - Deliver 75% Faster Diagnosis Standard from Q3
    - Focus on health inequalities & Cancer Alliance approach

# Must Dos for 20/21 – National Guidance

- During Q1 roll out the Emergency Care Data Set to all services (time to initial assessment, proportion of patients spending > 12 hours in ED, proportion of patients spending > 1 hour after they have been declared “clinically ready to proceed”
- Adopt consistent Same Day Emergency Care (SDEC) model, support use of booked time slots in ED via 111
- Deliver timely and appropriate discharge from hospital inpatient settings and improve ALOS especially > 14 days and > 21 days
- System based collaborative working and health inequalities key theme throughout guidance
- From a finance perspective, SY&B ICS has agreed that each organisation needs to develop their own plan with each organisation required to break even within the funding allocations provided by the ICS.

# ICS Level Discussions Regarding Assumptions in Plan for SYB

Following assumptions in the draft plans to be submitted on 6 May to be tested – agreed by Health Executive Group (HEG):

- Each provider can recover 85% activity within baseline funding (including independent sector capacity)
- All P2 patients will be seen within 28 days from the end of quarter 1.
- There will be no patients waiting more than 52 weeks at the end of March 2022.
  - this is significant issue for DBTH due to the shape of the waiting list pre pandemic
- Possible national “Forerunner” programme with associated funding for systems which can go further faster on clearing 52 weeks

# Activity Forecasts - High level summary and risks

The headline output from the capacity work to date shows that on an activity basis the Trust would meet the thresholds for H1 (1st six months of 2021/ 2022).

| | **H1 Forecast** | Adjustment for Annual leave (AL) | Adjustment for case mix | Adjustment for N:FU deterioration | **Risk adjusted forecast** |
|---|---|---|---|---|---|
| Outpatients | **85.5%** | 5.0% | | 3.9% | **76.6%** |
| Elective | **86.7%** | 5.0% | 2% | | **79.7%** |
| Day-case | **90.9%** | 5.0% | | | **85.9%** |

There are however a number of further pieces of analysis to complete to more accurately forecast the position and risks we may need to adjust for namely:

- Annual leave adjustment – On average the Trust's medical staff have carried over 9 days of annual leave, without backfill this would reduce delivery of consultant led activity by 5%
- Case mix adjustment – The figures quoted here are based on volumes which masks shifts from high tariff to low tariff work. For example a reduction/ increase in orthopaedic electives could result in a significant move in the tariff value
- We are currently forecasting a higher N:FU ratio than 19/20, we've previously been penalised for this and the guidance references "taking all possible steps to avoid attendances of low clinical value
- There are also potential delivery risks as some work is still ongoing i.e. finalising the bed plan

# Delivering the Operational Plan

- **Theatres**
  - 19th April step up to 68% sessions
  - 1st May 100% step up at Bassetlaw and Doncaster
  - 1st May 74% step up at MMH
  - 1st June 100 % step at MMH

- **All Sites**
  - From 01.05.2021 = 83% across all sites (note works in women's theatre)

- **Independent Sector**
  - Parkhill 15- 20 cases p/w through April, 30 cases from 1st May for 6 months
  - May model is 2 x BAU model @ financial risk

- **Bed Plan**
  - Agreed at DRI and Bassetlaw. Based upon the 20% increase in LOS seen during the pandemic.
  - Enables DRI fire works

- **Outpatients**
  - Largely robust plans – Medicine, W&F, CSS
  - Focus on handful of specialties in surgery and 1 or 2 others

# Key points of operational approach

- Full set of risks & mitigation considered by Finance and Performance committee

  – significant level of uncertainty, risk & challenge

- Approach to administration developed to improve processes and “governance” of elective processes – key enabler to elective recovery

- “Getting the basics right” is the key principle of the approach – scheduling, utilising well, focused improved on some big wins

- IQPR being refreshed plus cancer/ 52 week trajectories etc. Weekly performance meeting refresh

- Focused improvement with the CCG – Patient Led Follow Up, Advice & Guidance, Demand Reduction

- Cancer plan & Urgent Emergency Plan to follow – focus at next Finance and Performance.

# Conclusions

1. National guidance outlines specific performance & quality requirements, alongside a duty to collaborate and a system wider approach to financial planning and incentives

2. Significant work has taken place on the business planning process with a robust understanding of post covid capacity and demand

3. Must deliver as a minimum 70/75/80/85% elective value thresholds alongside clinical priority, cancer and wider performance standards. There remains significant risk locally and within the ICS

4. Additional work is needed in a handful of specialties, largely surgical specialties where significant risks to delivery need to be mitigated to ensure delivery of the overall plan.

5. Need to ensure that the final operational plan supports delivery but recognises the need to respond to change. Focus on stepping up & “getting the basics right”.

6. Must play our part in collective ICS wide solutions and agreements; (specialty specific, Cancer Alliance plans etc.)

7. We must deliver breakeven on financial plan; if system top up funding is removed a significant deficit would develop in H2 (second half of the year) c£14m.

8. Throughout the year we need to get the balance right between delivering additional activity to address backlogs to reduce clinical risk and balancing delivery of the financial plan. This will be a tension for the Board like no other year.