Sherwood Forest Hospitals
NHS Foundation Trust

Single Oversight Framework

Reporting Period: Month 2

2020/21

Inspected and rated
Good
Care Quality Commission

Single Oversight Framework – Month 2 Overview

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Overview	This is the second use of our new Single Oversight Framework (SOF). It is shorter in length, it uses statistical process control graphs and it is designed to focus attention on the areas that require attention. Whilst the agreement to change the SOF was made prior to Covid-19, you will see the impact of Covid throughout all of the domains.	CEO
Quality Care (exception reports page 8)	During May the care delivered to our patients has remained safe and of high quality, nurse staffing levels have remained high and no serious incidents have been declared. While our falls rate has remained above the national average for the third consecutive month, there has been an improvement on last month's data. In response to this there are significant pieces of work underway across the Trust including the implementation of care reviews following every fall and 'confirm and challenge' meetings with the Chief Nurse and Falls Lead. A falls summit is planned for July. There was only one hospital acquired pressure ulcer declared in May and on review there were no lapses in care identified. There is one exception report for May with regard to dementia screening which, whilst showing an improvement on last month's figures, is still below the expected compliance rate.	MD, CN

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Domain	Overview & risks	Lead
People & Culture (exception reports pages 9-11)	Overall, in M2 staff health and wellbeing was consistent with what was expected. The impact of Covid-19 in May 2020 did have an impact on sickness absence and overall attendance, but it was lower than anticipated. Additional activity was evidenced through the Trust Occupational Health Service as expected where support and on-going reassurance has been provided. In addition, in April 2020 a new self care and wellbeing offer was introduced, where offers are evaluated in terms of staff engagement, value and feedback on a monthly basis. In M2 Turnover remained relatively low, along with levels of vacancies. Compliance against Mandatory and Statutory Training along with Appraisals have been impacted due to Covid-19 in May 2020 and actions are in place to address over the forthcoming period, noting a slight improvement with Appraisals.	DOP, DCI
Timely care (exception reports pages 12-17)	The availability of timely care for patients arriving as an emergency remains strong. This is supported by a reduced number of patients attending the emergency department during May, largely related to the Covid-19 pandemic. Work is underway across the ICS to try to keep this demand lower where it is safe to do so for patients. Cancer and elective care waiting lists and times have increased. This is largely associated with the temporary pausing of some services during the Covid-19 pandemic. The vast majority of these services have been restored in terms of the service being open to patients, but due to appropriately stricter infection control procedures the productivity of some services is greatly reduced. A further paper to Board is on the agenda that describes the work to try to recover waiting times.	COO
Best Value care (18 - 19)	The Trust continues to operate under the revised NHS Financial regime, with a requirement to break-even on a monthly basis for an initial period to 31 July 2020. On this basis a monthly budget has been set for the Trust by NHS England & NHS Improvement (NHSE/I) in line with 2019/20 run-rates, with a commitment that additional costs incurred in response to Covid-19 reimbursed in full. A break-even position has been reported for May 2020. The planning pause included financial improvement planning and therefore no delivery is expected. This has the effect of increasing the Trust's underlying deficit by £1.1m each month from the £12.2m adverse position as at 31/3/20. Capital plans are being managed and monitored at an ICS/system level with an 'envelope' of maximum spend issued by NHSI. The agreed SFH share of the envelope is £11.5m. Additionally, the Trust has incurred £1.1m of Covid-19 related capital costs in April and May 2020. These are not included with the envelope and are reimbursed separately by NHSI.	CFO

Single Oversight Framework – Month 2 Overview (1)

Sherwood Forest Hospitals
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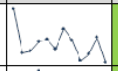
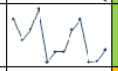
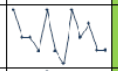
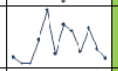
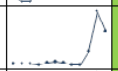
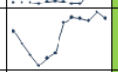
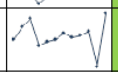
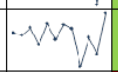
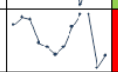
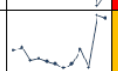
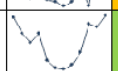
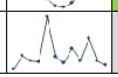
At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
QUALITY CARE	Safe	% of patients receiving harm free care		Suspended					MD/CN
		Admission of term babies to neonatal care as a % of all births	6%	May-20	3.5%	2.1%		G	CN
		Clostridium Difficile infection rate per rolling 12 months 100,000 OBD's	22.6	May-20	9.02	12.25		G	MD
		Definite Hospital Associated Covid infection	<2	May-20	14.0	2		A	MD
		MRSA bacteraemia infection rate per rolling 12 months 100,000 OBD's	0	May-20	0.00	0.00		G	MD
		MSSA bacteraemia infection rate per rolling 12 months 100,000 OBD's	17	May-20	9.02	12.25		G	MD
		Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Apr-20	95.8%	95.1%		G	CN
		Safe staffing care hours per patient day (CHPPD)	>8	May-20	14.8	13.4		G	CN
	Caring	Recommended Rate: Friends and Family Accident and Emergency	93.0%	May-20	94.1%	93.8%		G	MD/CN
		Recommended Rate: Friends and Family Inpatients	93.0%	May-20	97.6%	98.4%		G	MD/CN
		Recommended Rate: Friends and Family Maternity	93.0%	May-20	92.9%	100.0%		G	MD/CN
		Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	May-20	25.6%	29.1%		R	MD/CN
	Effective	Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Jan-20	106.4	-		A	MD
		SHMI	100	Dec-19	96.85	-		G	MD
		Cardiac arrest rate per 1000 admissions	0.83	May-20	0.64	0.58			MD

Single Oversight Framework – Month 2 Overview (2)

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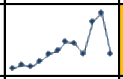
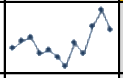
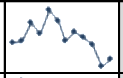
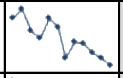
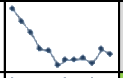
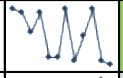
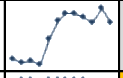
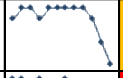
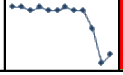
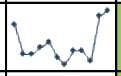
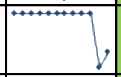
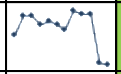
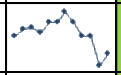
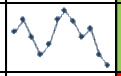
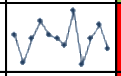
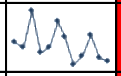
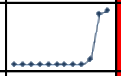
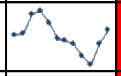
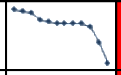
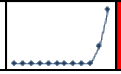
At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
PEOPLE & CULTURE	Staff health & well being	Health & Well Being Sickness Absence	3.5%	May-20	4.8%	4.1%		A	DOP
		Take up of Occupational Health interventions		May-20	3449	1497			DOP
		Take up of MSK interventions		May-20	79	44			DOP
		Employee Relations Management		May-20	28	12			DOP
	Resourcing	Vacancy rate		May-20	6.5%	6.4%			DOP
		Turnover in month (excluding rotational doctors)	0.8%	May-20	0.4%	0.3%		G	DOP
		Number of apprenticeships		May-20	223	107			DOP
		Mandatory & Statutory Training	93%	May-20	91.0%	90.0%		A	DOP
		Appraisal	95%	May-20	83.0%	84.0%		R	DOP

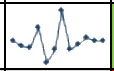
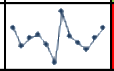
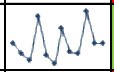
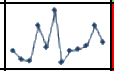
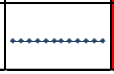
Single Oversight Framework – Month 2 Overview (3)

Sherwood Forest Hospitals NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Timely Care	Emergency Care	Emergency access within four hours Total Trust	91%	May-20	97.1%	97.5%		G	COO
		General & Acute Bed Occupancy	92%	May-20	49.2%	56.2%		G	COO
		Number of inpatients >21 days	73	May-20	-	58		G	COO
		Number of Ambulance Arrivals	3242	May-20	5285	2785		G	COO
		Percentage of Ambulance Arrivals > 30 minutes	8.7%	May-20	4.2%	3.6%		G	COO
	Cancer Care	62 days urgent referral to treatment	85.0%	Apr-20	72.7%	72.7%		R	COO
		Cancer faster diagnosis standard	75.0%	Apr-20	70.8%	70.8%		R	COO
	Elective Care	Diagnostic waiters, 6 weeks and over-DM01	0.9%	May-20	-	57.6%		R	COO
		Total number of patients on an incomplete RTT pathway (PTL/waiting list size)	25609	May-20	-	27,763		R	COO
		% of patients within 18 weeks referral to treatment time - incomplete pathways	86.6%	May-20	-	77.4%		R	COO
		Number of cases exceeding 52 weeks referral to treatment	0	May-20	62	47		R	COO

Single Oversight Framework – Month 2 Overview (4)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director
Best Value Care	Finance	Trust level performance against FIT target	£0.00m	May-20	£0.00m	£0.00m			CFO
		Underlying financial position against strategy	£0.00m	May-20	-£14.35m	-£1.13m			CFO
		Trust level performance against FIP plan	£0.00m	May-20	N/A	N/A			CFO
		Capital expenditure against plan	£0.00m	May-20	£0.16m	-£0.34m			CFO
		Procurement League Table Score	49.8	2019/20	41.9	41.9			CFO

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	May-20	25.6%	29.1%		R	MD/CN

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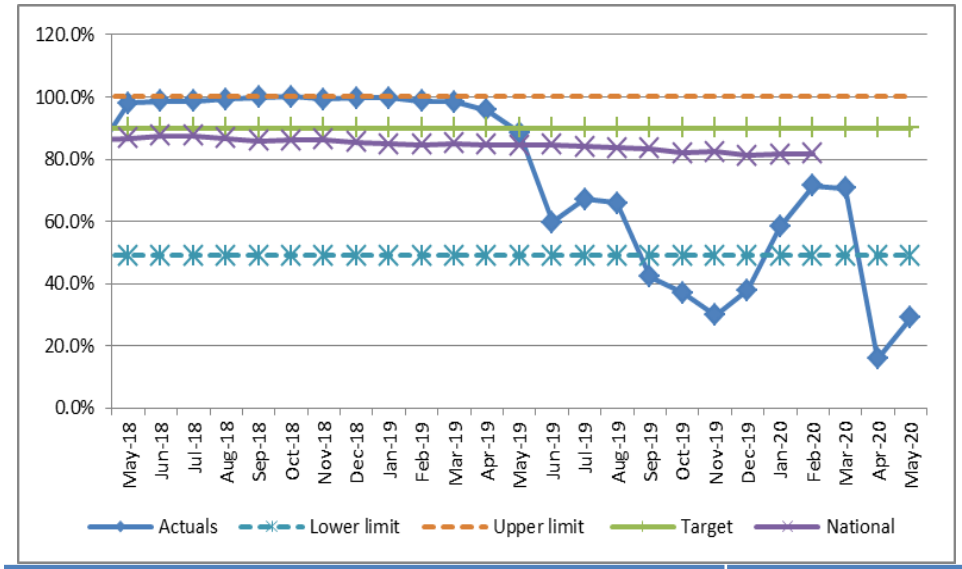


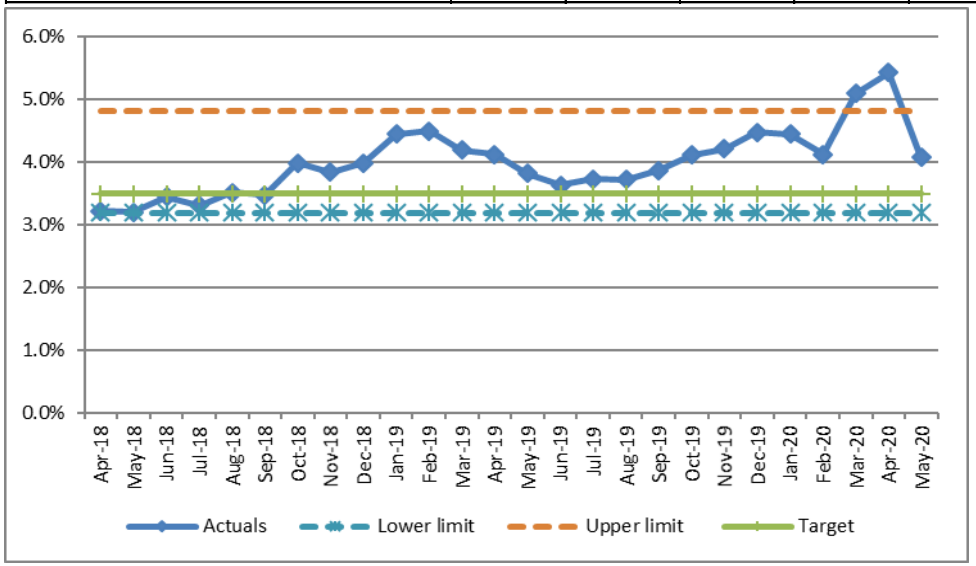
National position & overview

- All patients 75yrs + admitted to the Trust for 72hrs and above to have a dementia screen completed
- Trusts provided with a target to achieve 90% of these screens
- Monthly data collected and uploaded to the UNIFY record
- Prior to May 2019 the Trust achieved this target
- May 2019 an electronic screening method introduced in to the organisation
- Decision made that doctors to complete the assessment by clinical lead for dementia
- Band 3 Health Care worker appointed to assist process Jan 2020
- Assessments stood down due to Covid-19 April 2020

Root causes	Actions	Impact/Timescale
Assessments not being completed on Nervecentre by medical teams.	• Drs are aware of the screening and how to complete, reminders have been given and these will be undertaken again when screening back in place. • Short electronic survey planned for all doctors to complete regarding poor compliance, and the reasons why.	Comms. to support sending surveys and reminders to all medical colleagues, surveys to be completed by mid July 2020. And analysed by end of July2020.
Assessments stood down for 3 month period.	• Assessments to be re-introduced and agreed process to be decided and communicated across the Trust.	July 2020
Nervecentre not implemented in ED.	• Nervecentre for observations only fully implemented in ED, UCC at Newark to start this week, following this a date to introduce assessments will be agreed.	To be confirmed

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Health & Well Being Sickness Absence	3.5%	May-20	4.8%	4.1%		A	DOP

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

The data from model hospital is only available as at March 2020. The national median was 5.52% , SFH median was 5.11%.

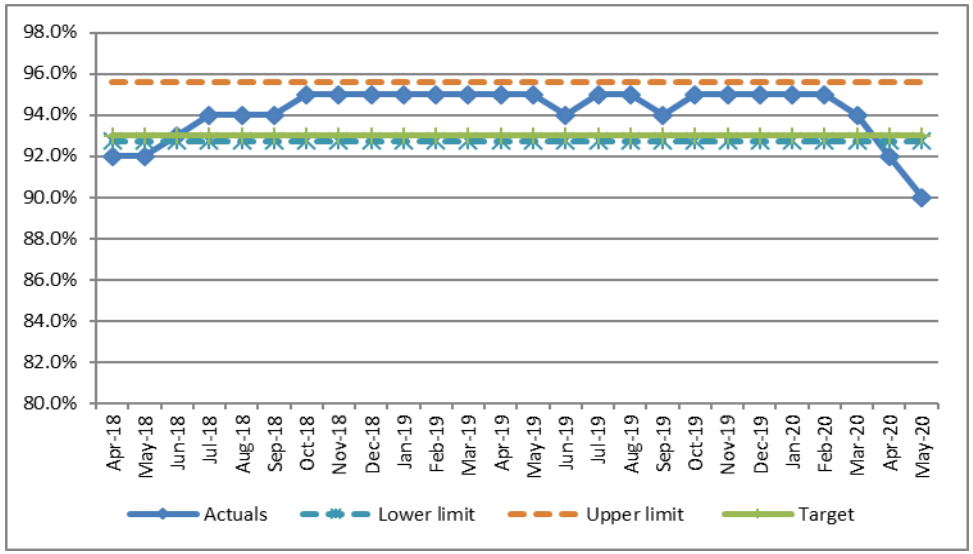
Trust's performance is 49th out of 135 Trusts in March 2020 (Performance was within quartile 2 of 4) Position improved from 54th in February 2020.

Local intelligence suggests the Trust is not an anomaly and the Trust benchmarks favourably.

The Trust has recruited an additional 200 HCAs and 44 Registered Nurses therefore the service impact as a result of increased absence due to ill health has been mitigated

Root causes	Actions	Impact/Timescale
The key cause of the elevated level on Health & Well-being - Sickness Absence is related to the COVID-19 pandemic. However, the Trust is seeing a reduced sickness level in May 20 (4.1%). The short term sickness absence rate for May 2020 is 2.2% (April 20 – 3.1%). The main reason for short term sickness is chest & respiratory with 923.8 FTE days lost, followed by anxiety, stress, depression with 281.5 FTE days lost. The long term sickness absence rate for May 2020 is 1.9% (April 2020 - 2.3%.) The main reason for long term sickness is anxiety, stress, depression with 1,373.3 FTE days lost and the second reason is chest & respiratory	Confirm and challenge sessions facilitated by the Human Resources Business Partners, to support leaders implement person cantered decision when managing sickness absence. Implementation of Rapid Access Acute Crisis Team/Services for staff via Nottinghamshire Healthcare NHS Foundation Trust. Development of 'A Psychologically Safe Organisation' strategy Undertake a 'deep dive' exercise to understand if 'burnout' and 'fatigue' as a result of the COVID-19 pandemic is impacting on sickness absence and develop associated action plan. The Trust are undertaking Anti-Body testing for COVID-19.	Confirm and challenge sessions across the Trust are on going and the aim is to reduce sickness further. Implementation of Rapid Access Acute Crisis Team/Services July 2020 to prevent and reduce sickness attributed to anxiety, stress, depression. The development of 'A Psychologically Safe Organisation' strategy will be created by June 2020. Once the strategy has been approved, an associated implementation plan will be developed with the aim of reducing and preventing sickness attributed to anxiety, stress, depression Deep dive to be undertaken and key items to be captured in the Q1 report. This will allow for targeted actions to be developed and implemented with the aim of reducing sickness absence.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Mandatory & Statutory Training	93%	May-20	91.0%	90.0%		A	DOP



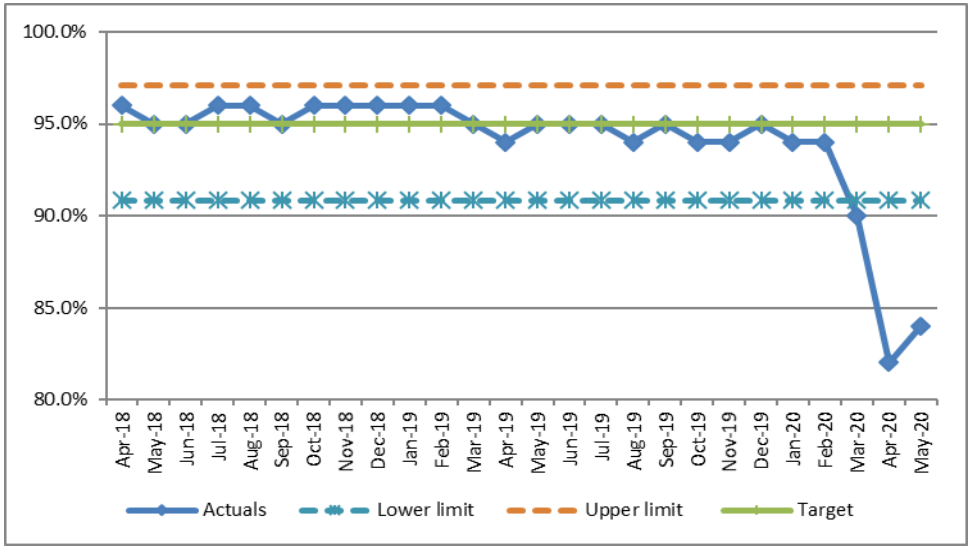
Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

The Trust benchmarks favourably nationally and local intelligence suggests the Trust's Mandatory and Statutory Training l rates are amongst the highest in the region.

Root causes	Actions	Impact/Timescale
The key cause of below trajectory performance on the mandatory & statutory training compliance is related to the delivery and capacity issues associated with the COVID-19 Pandemic. The Workforce Group approved on 23rd March 2020 the pausing for the requirement for staff to complete the undertake mandatory & statutory training, with a review in arranged for September 2020.	The Workforce Group to bring forward the review to June 2020 regarding the pausing of mandatory & statutory training. Agreement to re-commence clinical mandatory update training day from July 2020 and provide additional mop up sessions to prioritise training for staff who have become out of date with their mandatory update training. Develop communications following the review of the pause process to provide clarity and requirements for managers and staff.	To review the pause process in June 2020. Communications to be issued June 2020. Guidance to be amended June 2020. Increase in mandatory & statutory training compliance to 93% by end of November 2020.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Appraisal	95%	May-20	83.0%	84.0%		R	DOP



Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

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

Root causes	Actions	Impact/Timescale
The key cause of below trajectory performance on the appraisal compliance is related to the delivery and capacity issues associated with the COVID-19 Pandemic. The Workforce Group approved on 23rd March 2020 the pausing for the requirement for staff to complete the annual appraisal process with a review in arranged for September 2020.	The Workforce Group to bring forward the review to June 2020 regarding the pausing of appraisals. Develop communications following the review of the pause process to provide clarity and requirements for managers and staff. To amend the appraisal guidance providing advice regarding conducting appraisals for staff who are working remotely utilising digital technology. The Human Resources Business Partners to have discussions with line managers at confirm and challenge sessions to identify appraisals which are outstanding and seeking assurance regarding timescales for completion.	To review the pause process in June 2020. Communications to be issued June 2020. Guidance to be amended June 2020. Increase in Appraisal compliance to 90% by end of Quarter 2.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
62 days urgent referral to treatment	85.0%	Apr-20	72.7%	72.7%		R	COO

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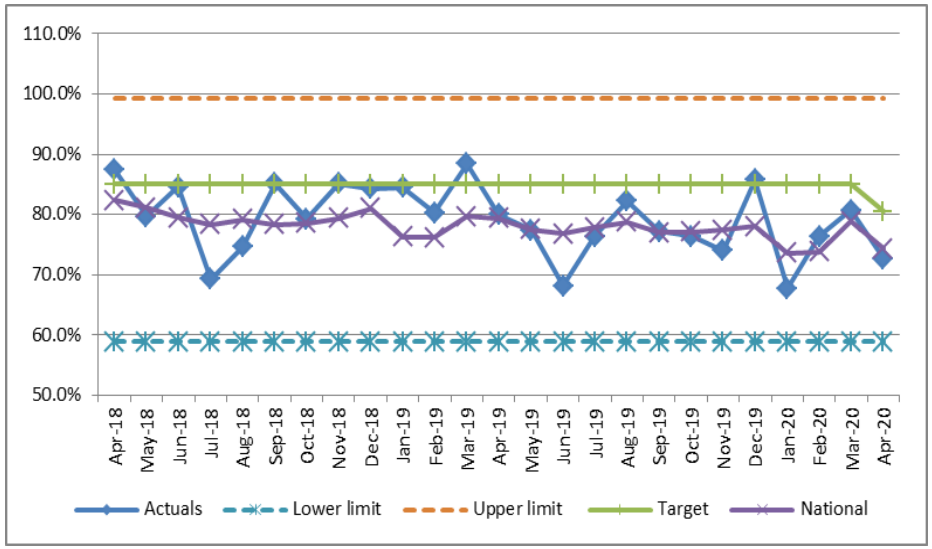

National position & overview

- Nationally, for the month of April 74.3% of patients began their first definitive treatment within 62 days of referral for suspected cancer (78.9% in March 2020).
- The Trust reported 72.7% for April giving an indicative national ranking of 87th from 135 Trusts.
- At the end of April the volume of patients waiting >62 days was 123 of which 21 were waiting 104+ days.
- April saw a 45% reduction in 2WW referrals and 66 recorded treatments.

Root causes

- The key cause of below trajectory performance is related to the time taken from referral to cancer diagnosis – mainly driven by demand and capacity imbalances in Radiology & Endoscopy. Other causes include:
  - Multiple tests
  - Patient choice
  - Treatment delayed for medical reasons

Actions

- Additional MR scanner to be added as the first phase of the Radiology strategy
- Strategy to reduce 1st cancer outpatient waiting times to 7 days with a clear demand and capacity model behind it to reduce the initial wait for clinic
- To develop a clear approach to the reduction of the demand and capacity gap for Endoscopy which gives clarity to the strategic approach to reducing this gap, both in the short term and medium term
- To respond to any of the recommendations in the NHSIE/ IST summary report

Impact/Timescale

- Endoscopy Cancer capacity restored to pre-COVID levels by 15/06/2020
- Reduce wait for outpatients from 14 days to 7 days by September 2020
- Reduce wait for MR – in place by April 2021

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Cancer faster diagnosis standard	75.0%	Apr-20	70.8%	70.8%		R	COO

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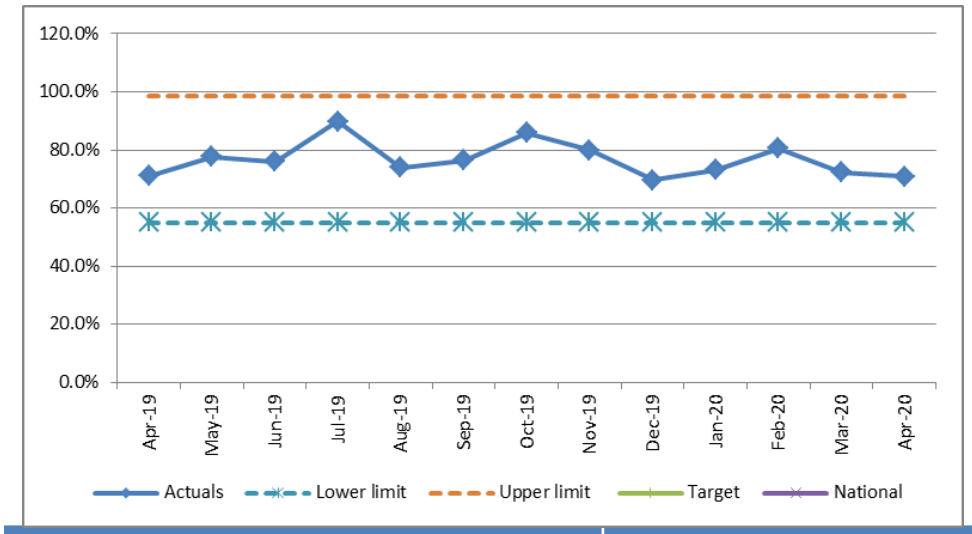

National position & overview

- The planning guidance for 2020/21 outlined from April 2020 Trusts should be meeting the Faster Diagnosis Standard (FDS) at an initial threshold of at least 70%.
- In line with other changes to contractual measures, nationally the decision has been taken to delay the publication of the first FDS data until at least the end of Q1 2020/21.
- April's data remains unpublished however, the Trust delivered 70.8% against a planning trajectory of 75%.

Root causes

There are 3 main drivers to deliver the FDS standard. They are:

1. Time to first seen and test - 2WW and diagnostic capacity gaps
2. The volume of tests required to confirm or rule out cancer
3. Method of communication – mainly face to face but where it is non face to face there remains a strong reliance on letters.

The key tumour sites that fail the standard are: Lower GI / Haematology and Head and Neck. Breast, Lung and Skin traditionally perform well.

Actions

- 2WW capacity is being right-sized as part of the restoration of outpatient capacity. All tumour sites are restoring with a mix of face to face, non face to face appointments and triage straight to test where appropriate.
- Continue to restore and monitor diagnostic capacity notably Endoscopy and Radiology.
- All tumour sites to review methods of communication used for FDS. Moving to telephone clinics where possible to reduce the number of days patients are waiting for outcomes.

Impact/Timescale

- All 2WW outpatient and diagnostic to be fully restored by mid-June.
- The FDS standard requires the use of the 'letter sent date' to be recorded. Use of telephone clinics could reduce FDS waits by 7-10 days.
- Patient choice remains a risk with many choosing to decline appointments due to COVID fears.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Diagnostic waiters, 6 weeks and over-DM01	0.9%	May-20	-	57.6%		R	COO

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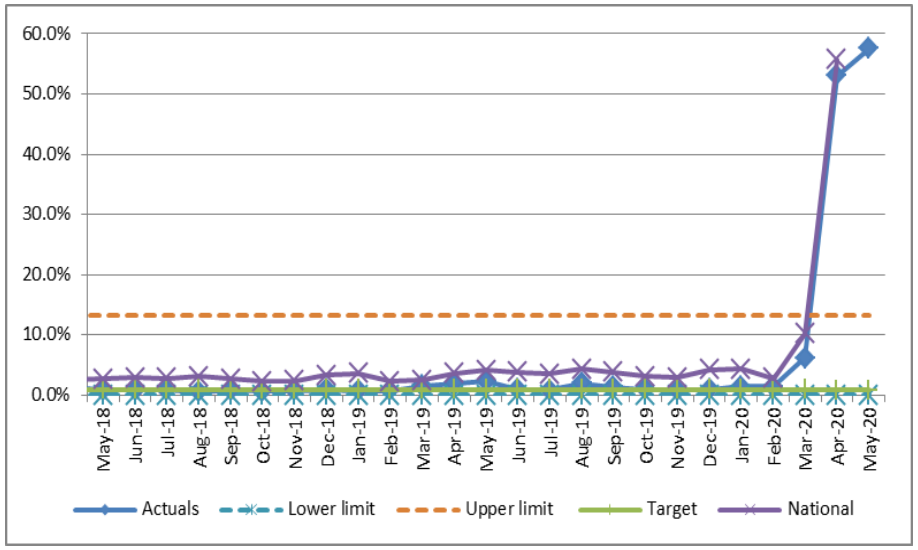

National position & overview

- At the end of May 2020 the Trust failed the DM01 standard with performance of 57.6% against a standard of <1%. Performance was based on 4,456 breaches from a waiting list of 7,912 procedures.
- At time of writing May National data remains unpublished. April performance nationally was 55.7%
- The test with the smallest proportion of patients waiting six weeks or more was Uro-dynamics with 0.6%. The tests with the highest proportion are MRI at 12 % and Non-Obstetric Ultrasound at 12.5%

Root causes	Actions	Impact/Timescale
Routine diagnostic test activity and waiting times have been significantly impacted by the COVID crisis, therefore data for the current reporting period is not be comparable to previous periods.	• Urgent and cancer diagnostic capacity restored by 15/06/2020. • Continue to restore routine diagnostic capacity for Radiology (CT and Ultrasound weekend sessions), Audiology and Endoscopy by 30/06/2020. • On-going use of the Independent sector for MRI capacity in place from W/C 18/05/2020. Endoscopy to be secured by 30/06/2020 • Newark CT upgrade to support CT cardiac capacity – software installation taking place W/C 06/07/2020	• Endoscopy at Newark and increase capacity for Urology at KMH W/C 22/06/2020 • Endoscopy Independent sector W/C 29/06/2020 • Radiology weekend sessions for ultrasound commenced 20/06/2020 • Radiology additional CT on site W/C 22/06/2020 • DEXA scans W/C 22/06/2020 Risks to restoration include patient anxiety to attend an acute setting and requirement to maintain social distancing in waiting areas.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Total number of patients on an incomplete RTT pathway (PTL/waiting list size)	25609	May-20	-	27,763		R	COO

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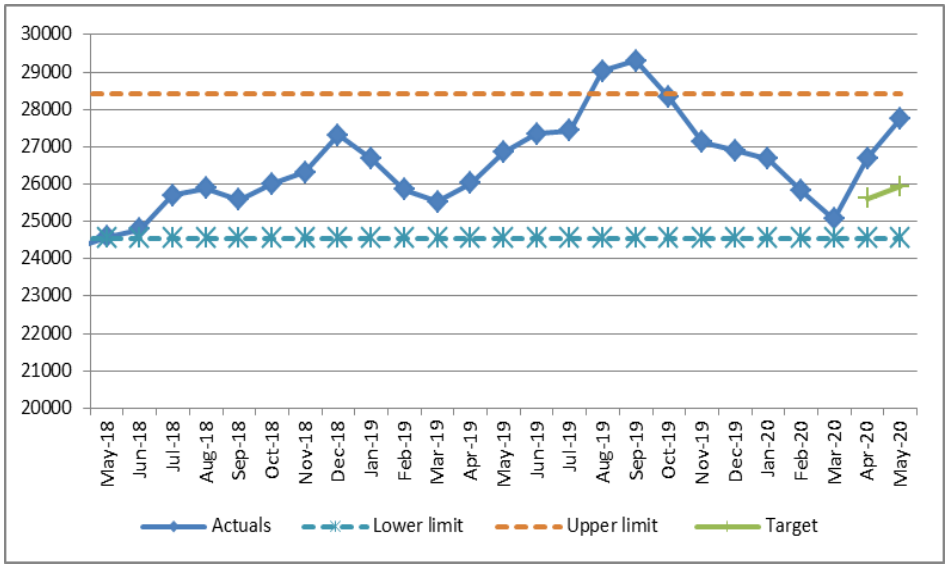

National position & overview

- The size of the waiting list (PTL) is driven by the volume of clock starts (new referrals and overdue reviews) and the volume of clock stops (for treatment or no treatment required).
- The number of RTT patients waiting to start treatment at the Trust rose by 4% at the end of May 2020 to 27,763 (April 26,690).
- Nationally, the number of RTT patients waiting to start treatment at the end of May 2020 is unpublished. For the end of April the number was 3.9 million (excluding estimate for missing data).

Root causes

- The key cause for an increase in the size of the PTL is the response to the COVID-19 pandemic which, led to a pause of routine elective outpatients, diagnostics and operating from mid-March.
- Clock starts for May were c.7,100. Clock stops were c.6,100

Actions

- Continue to re-instate routine (long wait) capacity – OP, Diagnostics and Surgery by 30/06/2020 in line with social distancing limitations and PPE/Testing requirements.
- On-going use of the Independent sector for Orthopaedics, Urology, Gynae and Radiology - in place from W/C 18/05/2020. Expect Endoscopy by 30/06/2020.
- Continued focus on non face to face outpatient activity – 60% of clinics are currently via telephone or virtually.
- On-going review of clinic set up for all specialties to determine limitations of social distancing on face to face capacity and formalise non face to face capacity. 60% KMH site restored and plans for Newark and MCH by the end of June 2020.
- Secure external modelling expertise by 30/06/20 to support recovery scenarios - medium to longer term.

Impact/Timescale

- The current expectation is the size of the PTL will continue to grow. The rationale for this being that; new referrals (clock starts) are likely to increase in the coming weeks and clock stops particularly for routine activity will remain low.
- Urgent and cancer capacity has been restored to 100% pre-COVID levels.
- Currently c150 Orthopaedic patients and >200 MRI requests have been completed in the Independent Sector.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
% of patients within 18 weeks referral to treatment time - incomplete pathways	86.6%	May-20	-	77.4%		R	COO

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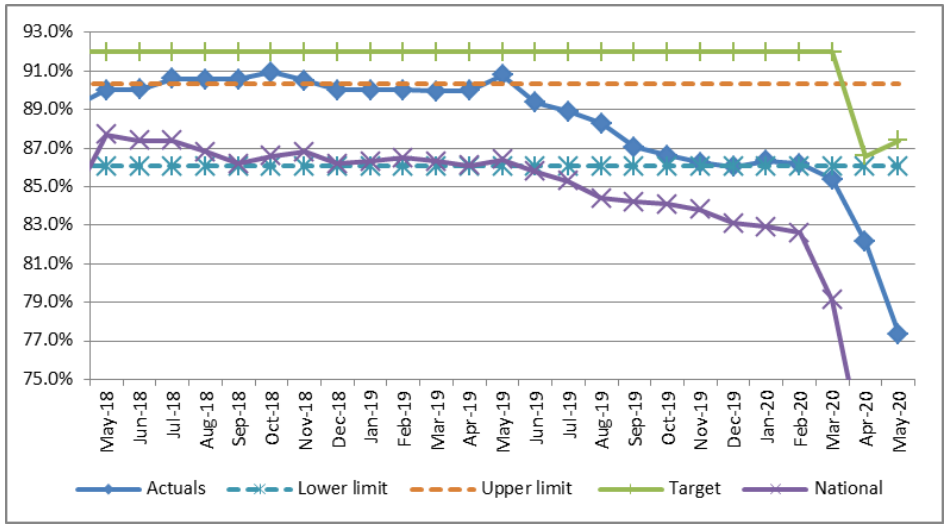

National position & overview

- Referral to Treatment performance for May at time of writing is unpublished however at 77.4% it is 9% adverse to plan.
- Nationally, for the month of April performance was 71.3%. Trust performance for April at 82.1% ranked 25th from 133 Trusts
- For patients waiting to start treatment at the end of April 2020, the median waiting time was 9 weeks (National 12 weeks). The 92nd percentile waiting time was 25 weeks (National 31 weeks).

Root causes

- The key cause of below trajectory performance is the shift in the shape of the waiting list due to 3 factors:
  - Reduced referrals (low wait clock starts)
  - Reduced elective activity in response to COVID (long wait stops)
  - Focus on urgent and cancer activity (low wait stops)
- The specialties with the largest proportion of patients waiting >18 weeks are:
  - Ophthalmology
  - Orthopaedics
  - ENT

Actions

- Continue to re-instate routine (long wait) capacity – OP, Diagnostics and Surgery by 30/06/2020 in line with social distancing limitations and PPE/Testing requirements.
- On-going use of the Independent sector for Orthopaedics, Urology, Gynae and Radiology - Continued focus on non face to face outpatient activity – Telephone and Virtual clinics.
- Secure external modelling expertise by 30/06/20 to support recovery scenarios - medium to longer term.

Impact/Timescale

- Urgent and cancer capacity has been restored to 100% pre-COVID levels. DC Surgery at Newark recommenced W/C 09/06/2020
- OP capacity restored to 60% at KMH site – face to face restricted by 2m social distancing. Plan to restore Newark and MCH by 30/06/2020
- Independent sector capacity in place with c150 Orthopaedic patients and >200 MRI requests completed to date. Expect Endoscopy by 30/06/2020.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly Actuals	Trend	RAG Rating	Executive Director
Number of cases exceeding 52 weeks referral to treatment	0	May-20	62	47		R	COO

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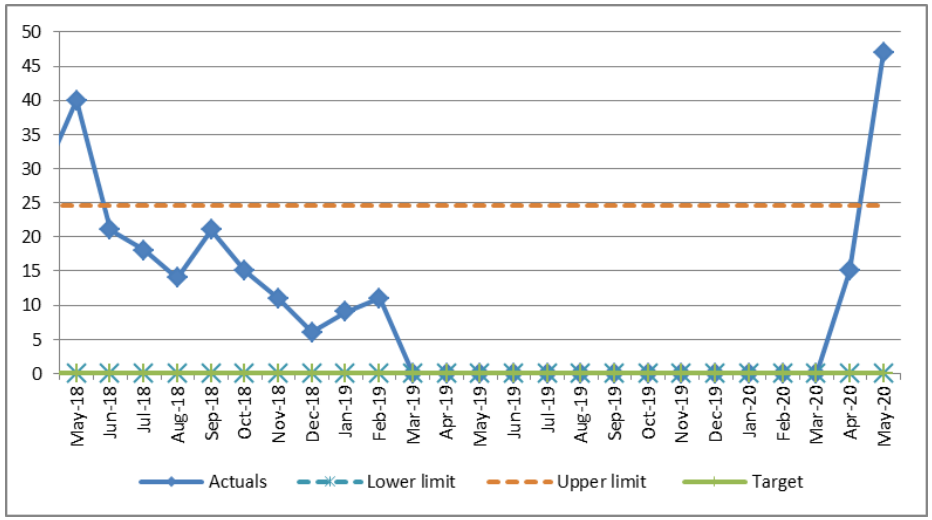

National position & overview

- Nationally, performance for May (at time of writing) is unpublished. However, at the end of April the number of RTT patients waiting more than 52 weeks nationally was 11,042. The Trust reported 15.
- For the month of May the Trust reported 47 patients waiting more than 52 weeks. Breaches occurred in the following:
  - Ophthalmology – 12
  - Trauma and Orthopaedics – 9
  - Urology - 6 / Cardiology - 6
  - General Surgery - 5 / ENT 5
  - Vascular 1 / Dermatology 1 / Gynae 1 / Respiratory 1

Root causes

- The key cause for waits greater than 52 weeks at the end of May is the response to the COVID-19 pandemic which led to a pause of routine elective outpatients, diagnostics and operating.
- However, as previously noted extended waits and their root cause were being actively managed pre-COVID in the following specialties:
  - Ophthalmology - capacity gap c.18 clinics per week for 1st Outpatient / wait for an overdue follow up
  - T&O – due to reduced elective operating over Winter.

Actions

- Weekly RTT meetings were re-instated from W/C 15/06/2020 chaired by the Deputy COO. Focus on securing plans for long wait patients in line with specialty restoration and recovery plans.
- Restoration of elective capacity – notably plan for diagnostic tests within Cardiology by the end of June 2020.
- Restoration of capacity at Newark hospital by the end of June 2020.
- On-going use of Independent Sector capacity for Orthopaedics and Urology.
- Review and update plan for Ophthalmology by Mid-July 2020.

Impact/Timescale

- Of the 47 patients waiting, 31 previously had a TCI or appointment <52 weeks. Current status:
  - 33 require an admitted TCI
  - 14 require a non admitted TCI
- 52 week waits are likely to continue for some time. This is due in part to restrictions on capacity but also patient anxiety and requirement to self-isolate pre and post surgery for 14 days.

Best Value Care

Sherwood Forest Hospitals
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The revised financial framework for 2020/21 requires all NHS providers to break-even on a monthly basis for an initial period to 31 July 2020. On this basis a monthly budget has been set for the Trust by NHS England & NHS Improvement (NHSE/I) which assumes expenditure of £30.0m (excluding Covid-19 costs) offset by income of £30.0m.

Performance against these budgets is reviewed on a monthly basis, with additional 'True-Up' funding assumed to cover any shortfall as well as the direct costs of Covid-19. A summary of the Trust's M02 position is in the table below, which shows that additional 'True-up' funding of £8.0m has been assumed to achieve break-even, £5.7m to cover the direct costs of Covid-19 and £2.3m shortfall in Block contract and Top up funding.

The Trust has received a True Up payment for Month 1, which was £0.4m lower than that requested. NHSE/I have advised that this is a cash shortfall and that we should continue to reflect the full value of Month 1 requested funding in our reported Month 2 position.

£000	NHSE/I Budget	M2 excluding Covid-19	Variance	Pension Top-Up	Covid-19	Reported Month 2	True-Up Ask
Income:							
Block Contract	46,802	46,802	0			46,802	0
Top-Up Value	5,668	5,670	2			5,670	2
Pensions Top-Up	0	0	0	1,431		1,431	1,431
Other Income	7,586	4,890	(2,696)			4,890	(2,696)
Finance Income	16	(1)	(17)			(1)	(17)
Total Income	60,072	57,361	(2,711)	1,431	0	58,792	(1,280)
Expenditure:							
Pay - Substantive	(31,338)	(32,434)	(1,096)		(830)	(33,264)	(1,926)
Pay - Bank	(2,776)	(2,581)	195		(1,986)	(4,567)	(1,791)
Pay - Agency	(2,142)	(2,000)	142		(752)	(2,752)	(610)
Pay - Other (Apprentice Levy / Pension)	(142)	(155)	(13)	(1,431)	0	(1,586)	(1,444)
Total Pay	(36,398)	(37,170)	(772)	(1,431)	(3,568)	(42,169)	(5,771)
Non-Pay	(19,390)	(17,933)	1,457		(2,135)	(20,068)	(678)
Depreciation	(1,702)	(1,879)	(177)		0	(1,879)	(177)
Interest Expense	(2,438)	(2,467)	(29)		0	(2,467)	(29)
PDC Dividend Expense	(144)	(207)	(63)		0	(207)	(63)
Total Non-Pay	(23,674)	(22,486)	1,188	0	(2,135)	(24,621)	(947)
Total Expenditure	(60,072)	(59,656)	416	(1,431)	(5,703)	(66,790)	(6,718)
Surplus/(Deficit)	0	(2,295)	(2,295)	0	(5,703)	(7,998)	(7,998)

Best Value Care

Sherwood Forest Hospitals
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	May In-Month			Year to Date (YTD)			Annual Plan	Forecast	Forecast Variance
	Plan	Actual	Variance	Plan	Actual	Variance			
	£m	£m	£m	£m	£m	£m	£m	£m	£m
Income	30.04	33.24	3.20	60.07	66.79	6.72	360.43	400.74	40.30
Expenditure	(30.04)	(33.24)	(3.20)	(60.07)	(66.79)	(6.72)	(360.43)	(400.74)	(40.31)
Surplus/(Deficit) - Control Total Basis excl. Impairment	**(0.00)**	**(0.00)**	**(0.00)**	**(0.00)**	**0.00**	**0.00**	**0.00**	**(0.00)**	**(0.00)**
Capex (including donated)	(0.80)	(0.76)	0.04	(1.64)	(1.64)	0.00	(16.47)	(16.47)	0.00
Closing Cash	1.49	29.02	27.53	1.49	29.02	27.53	1.69	1.69	0.00

It is assumed that the Trust will break even on a Control Total basis in 2020/21, though both expenditure and income will be significantly above the NHSE/I budgets, which do not include costs relating to the management of Covid-19. The forecast above has been based on extrapolation of the M02 YTD position for the remainder of the year.

Capital expenditure at M02 is slightly below plan and includes COVID-19 related Capital expenditure. A revised 2020/21 capital expenditure plan is now finalised with NHSE/I. The Trust is forecasting to meet it's capital expenditure plan in full.

Closing cash at M02 is £29.02m, £27.53m above plan, this includes additional cash which has been made available to support Covid-19 management, it is assumed that this excess cash balance will reduce over the year and that the Trust will meet its cash plan of £1.69m at 31st March 2021.