Sherwood Forest Hospitals NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: Thursday 1st June 2023
Time: 09:00 – 12:15
Venue: Boardroom, King's Mill Hospital

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 4th May 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Action Tracker**	Update	Enclosure 5
6.	09:10	**Chair's Report** • **Council of Governors' Highlight Report**	Assurance Assurance	Enclosure 6 Enclosure 6.1
7.	09:15	**Chief Executive's Report**	Assurance	Enclosure 7
	Strategy			
8.	09:30	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity Update** Report of the Director of Midwifery o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 8.1
9.	09:45	**Strategic Objective 3 – Empower and support our people to be the best they can be** • **Guardian of Safe Working** Report of the Medical Director • **Equality and Diversity Annual Report** Report of the Director of People	Assurance Assurance	Enclosure 9.1 Enclosure 9.2

	Time	Item	Status	Paper
10.	10:15	**Staff Story – Empowering our people to be the best they can be** Debbie Kearsley, Deputy Director of People, and Beth Hall, Business Support Officer	Assurance	Presentation
	BREAK (10 mins)			
	Operational			
11.	10:45	**People Strategy** Report of the Director of People	Approval	Enclosure 11
	Governance			
12.	11:30	**Board Assurance Framework (BAF)** Report of the Chief Executive	Assurance	Enclosure 12
13.	11:40	**Committee ToR, workplans and effectiveness reviews** Report of the Director of Corporate Affairs	Assurance	Enclosure 13
14.	11:50	**Assurance from Sub Committees** • Quality Committee Report of the Committee Chair (last meeting) • People, Culture and Improvement Committee Report of the Committee Chair (last meeting)	Assurance Assurance	Enclosure 14.1 Enclosure 14.2
15.	11:55	**Outstanding Service – Staff Networks**	Assurance	Presentation
16.	12:05	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
17.	12:15	**Any Other Business**		
18.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **6th July 2023, Boardroom, King's Mill Hospital**		
19.		**Chair Declares the Meeting Closed**		
20.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

Board of Directors Information Library Documents

The following information items are included in the Reading Room and should have been read by Members of the meeting.

Enc 09.2	• **EDI Full Annual Report**
Enc 11	• **People Strategy 2022-2025**
Enc 13	• **Committee Effectiveness Review – Audit and Assurance Committee**
Enc 13	• **Committee Effectiveness Review – Finance Committee**
Enc 13	• **Committee Effectiveness Review – Quality Committee**
Enc 13	• **Committee Effectiveness Review – People, Culture and Improvement Committee**
Enc 13	• **Committee Effectiveness Review – Charitable Funds Committee**
Enc 14.1	• **Quality Committee – previous minutes**
Enc 14.2	• **People, Culture and Improvement Committee – previous minutes**
Enc 17	• **Nursing & Midwifery Monthly Safe Staffing Report (April 2023 Data)**
Enc 17	• **Midwifery Monthly Safe Staffing Report**

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 4th May 2023 in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Graham Ward	Non-Executive Director	GW
	Barbara Brady	Non-Executive Director	BB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	Phil Bolton	Chief Nurse	PB
	Rob Simcox	Director of People	RS
	Richard Mills	Chief Financial Officer	RM
	David Ainsworth	Director of Strategy and Partnerships	DA
	David Selwyn	Medical Director	DS
	Rachel Eddie	Chief Operating Officer	RE
	Shirley Higginbotham	Director of Corporate Affairs	SH
In Attendance:	Sue Bradshaw	Minutes	
	Jessica Baxter	Producer for MS Teams Public Broadcast	
Observers:	Sally Brook Shanahan		
	Sue Holmes	Lead Governor	
	Ian Holden	Public Governor	
	Adam Vallins	Nottingham and Nottinghamshire Integrated Care Board (ICB)	
	2 members of the public		
Apologies:	Aly Rashid	Non-Executive Director	AR

Item No.	Item	Action	Date
23/129	**WELCOME**		
1 min	The meeting being quorate, CW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and any members of the public watching the live broadcast were able to submit questions via the live Q&A function.		
23/130	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
23/131	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Aly Rashid, Non-Executive Director.		
23/132	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 6th April 2023, the Board of Directors APPROVED the minutes as a true and accurate record.		
23/133	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 18/618.1, 23/042.1, 23/103 and 23/109 were complete and could be removed from the action tracker.		
23/134	**CHAIR'S REPORT**		
1 min	CW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective, highlighting Staff Excellence Awards and governor elections. The Board of Directors were ASSURED by the report		
23/135	**CHIEF EXECUTIVE'S REPORT**		
3 mins	PR presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective, highlighting recent industrial action, the second 'Step into the NHS' recruitment event at West Notts College, granting of planning permission for the Community Diagnostics Centre at the Mansfield Community Hospital site and parking spaces at Newark Hospital, key partnership meetings and the review of the Board Assurance Framework risks by the Risk Committee.		

	PR advised Shirley Higginbotham, Director of Corporate Affairs, retires on 31st May 2023, noting this is the last Board of Directors meeting Shirley will be attending. PR expressed thanks to Shirley for her work during her time with the Trust. Sally Brook Shanahan will take up the role of Director of Corporate Affairs from 15th May 2023. The Board of Directors were ASSURED by the report		
23/136	**2022/2023 STRATEGIC PRIORITIES QUARTER 4 UPDATE**		
12 mins	DA presented the report, advising all the strategic priorities have been assigned to an executive lead and are tracked by the relevant sub-committee. DA highlighted the green agenda, health and wellbeing, the people metrics and Friends and Family feedback. DA advised any outstanding areas of work have been built into the 2023/2024 strategic priorities, highlighting patients who are medically safe for transfer. GW noted delivery of the SFHFT Transformation and Efficiency Programme shows an upward change on the previous quarter. It was noted the Trust met the Financial Improvement Plan (FIP) target. However, this was only achieved by utilising mainly non-recurrent savings. GW felt showing an improvement in this area is the wrong message. AH noted success in part of the programme, but felt there should be a more in depth look at areas which have not gone as planned in order to ensure these are not passed on into the priorities for 2023/2024. PR asked DA to describe how the learning and outstanding issues in 2022/2023 delivery have been captured to take forward into 2023/2024 and beyond. PR felt it important not to 'leave behind' areas which are partly complete. There is also a need to maintain focus on areas which 'soft' measurements indicate were delivered. DA advised a bottom up, top down review of all schemes has been undertaken. Feedback from executive leads and sub-committees have shaped the thinking for the 2023/2024 priorities. The challenge going into 2023/2024 is to balance 'soft' measurements with building in numerical success criteria. RE advised in developing the priorities for 2023/2024, the Trust has tried to be clear about the metrics which are being monitored. In terms of impact, the way the priorities are rated does not allow the impact factor to be measured. This is something which needs to be considered. SB felt an area to look at further is the rollout of Electronic Prescribing and Medicines Administration (EPMA) in terms of the difference this has made to patient safety, finances, etc. DS advised an inter-project review was undertaken to help determine critical success factors which will be reviewed through the Quality Committee. With the move from project to business as usual, the risks are discussed at each meeting of the Patient Safety Cabinet. DS advised he would provide a report to a future Board of Directors meeting to describe the learning and benefits of EPMA, noting this will feed into Electronic Patient Record (EPR), which is the next large digital project for the Trust.		

	Action • **Report to be presented to the Board of Directors in relation to the learning and benefits of the EPMA rollout** SB sought clarification if a standard approach is used to review and monitor programmes which have required significant investment. RM advised various different approaches have been used and there is a need to refine the process to ensure there is routine monitoring. For large business cases there is a need to ensure this is factored into the workplan for the relevant sub-committee to review. For example, the Community Diagnostic Centre (CDC) is on the workplan for the Finance Committee and regular updates are received by the Executive Team. The Board of Directors were ASSURED by the report	**DS**	**06/07/23**
23/137	**STRATEGIC OBJECTIVE 1 – TO PROVIDE OUTSTANDING CARE**		
17 mins	PS joined the meeting **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting staff engagement, NHS Resolution (NHSR) successful funding bid and Care Quality Commission (CQC) actions. PB advised it remains unclear how the single delivery plan will be measured. Further work on this is being undertaken by the Local Maternity and Neonatal System (LMNS). PS highlighted the work of the Parent Voice Champion and quality improvement work. CW advised the information received by the maternity safety champions is that communication is crucial. Therefore, there is a need to collectively consider how communications can be improved. PS advised an action plan has been collated which brings together information from various sources. There is a focus on communication, a lot of which relates to continuity of teams. There is a need to ensure women have the same midwife and obstetrician so communication is not lost. This is an area of focus for the communication workstream. The Trust is also looking at how digital can be maximised. A digital notes system is in place and lots of communication can be sent out regularly via this system, which is available in multiple languages. In addition, the system provides the opportunity to signpost women to external charities, etc. who can provide support. There is a need to maximise the digital systems which are in place and this is being considered at a system level. MG requested if further information relating to health inequalities, analysis of unmet need and the work being undertaken to address this could be included in future reporting.		

	PS advised one of the big projects which is currently being worked on relates to specific communities and how they are supported. Deprivation is one of the biggest risk areas as women from deprived areas have a higher risk factor within pregnancy, which extends into early neonatal life and onwards into childhood. There are a few areas the Trust is trying to target and is trying to secure funding to support this work. The early implementer site work in relation to smoking cessation is a key factor. PS advised in April, for the first time in five years, the Trust's smoking at time of delivery rate is below the national average, noting the Trust had been a national outlier in this measure. CW expressed thanks to the Smoking Cessation Team for their work. AH noted the introduction of the SCORE culture survey has been delayed and sought clarification in relation to the timeline for outputs from this work. PS advised the background work to deliver the SCORE survey has been a challenge. The work was delayed initially due to the Pathway to Excellence Survey and Staff Survey as the Trust wished to separate out SCORE to make it clear to maternity teams why SCORE is different. The background work is now complete. The next stage is to formulate the timeline. AH noted a recent report which indicated 1 in 5 women giving birth have mental wellbeing issues and queried what the Trust's position is in relation to this. PS advised the Trust has a perinatal mental health team and offered to provide an update on their work. PB advised a report would be presented to the Quality Committee to provide further information on the themes raised. **Action** • **Report to be presented to the Quality Committee to provide assurance in relation to health inequalities, mental wellbeing, etc. in maternity services.** The Board of Directors were ASSURED by the report ***Maternity Perinatal Quality Surveillance*** PB presented the report, highlighting the home births service, elective caesarean sections, improvement in obstetric haemorrhage and third and fourth degree tears and the launch of the Opel scoring tool. PS advised the Trust is 100% compliant with the initial seven Immediate and Essential Actions (IEAs) from the Ockenden report. The Board of Directors were ASSURED by the report	**PB**	**01/06/23**

23/138	**STRATEGIC OBJECTIVE 3 – TO MAXIMISE THE POTENTIAL OF OUR WORKFORCE**		
42 mins	**Nursing, Midwifery and Allied Health Professions (AHP) Staffing 6 Monthly Report** PB presented the report, highlighting the Safer Nursing Care Tool (SNCT) compliance standards assessment, compliance with the developing workforce safeguards for nursing and midwifery, multidisciplinary establishment review, vacancy rate, staffing related incidents, international recruitment, 3-year delivery plan for maternity and neonatal services and job planning for the Allied Health Professions (AHP) workforce. GW noted the business case which has been approved to increase the establishment in ED due to the pressures faced, the expectation being staff will be redeployed to other areas when the situation improves. However, the report appears to indicate the additional staff have not yet been recruited and they will be deployed only in ED. GW sought clarification in relation to this and felt a post-implementation review is required. RE advised a report is scheduled to be presented to the Trust Management Team (TMT) in June 2023, followed by the Finance Committee. The majority of posts have been recruited to, although not all new staff have taken up post. There are some medical posts waiting for trainees to qualify. However, the majority of nursing posts have been recruited to. RE confirmed the additional posts will be taken out if the bed wait demand reduces. However, the Trust is not currently in a position to do that. If a sustained position of reduced number of medically safe for transfer patients and reduced bed waits in ED is achieved, staff will be redeployed elsewhere in the Trust. PB advised the additional staffing required in ED has previously been undertaken by high cost agencies. The business case provides the opportunity for the Trust to use its own staff, which is better from a quality perspective and also reduces spend, accepting there is still spend in the area which is over and above what was budgeted for. The Trust is committed to redeploying staff when they are no longer required in ED. It was noted the nursing staff have been appointed on rotational posts. RM advised nursing pay is circa £10m per month in total, 25% of which was, in previous years, through either bank or agency spend. Getting the establishment correct and investing in the substantive workforce will ensure wards are fully covered, but also helps make inroads into the financial position. BB sought further information in relation to the use of apprenticeships for areas where the Trust is struggling to recruit or for new roles. PB highlighted the nurse associate role, advising four cohorts of nurse associates have joined the Trust via the apprenticeship route. The first cohort are just converting to become registered nurses. It was noted it is a time consuming and expensive model to run, which has limited the numbers. However, the Trust will continue to run this and the AHP team are also looking at apprenticeship routes.		

	In terms of new roles, the Trust has been at the forefront of developing the Advanced Clinical Practitioner (ACP) role in the emergency care setting. There are over 40 ACPs in ED, but this has not yet been replicated and rolled out across the wider organisation. However, there are now two in critical care, with a further two being recruited. In addition, two have recently been recruited into the Neonatal Team. There is more work to do in relation to this, but the Trust has prioritised the roles and areas which will provide the most benefit for workforce gaps. The Trust has worked with the Integrated Care System (ICS) Faculty, as the best way to address some of these issues is to have a system approach. BB queried if there is anything the Board of Directors can do to support the development of ACPs and apprenticeships. PB advised people are not aware of career pathways and how to progress. The Trust has started to work with West Notts College in relation to this, but there is a need to make this more visible and accessible. RS advised the Trust has run two 'Step into the NHS' events in partnership with West Notts College. A third event is scheduled to take place on 20th June 2023 and will be hosted at King's Mill Hospital. RS encouraged members of the Board of Directors to attend this event, noting the focus will be on clinical roles. The event will be used as a platform for Trust staff to learn more about the opportunities available. MG queried what 'levers' are being considered in terms of addressing the vacancy rate and are the areas which may become fragile being predicted as part of workforce planning. MG sought assurance in relation to the consistency of exit interviews and how information from these is captured to inform learning. PB advised in terms of predictions and looking at levers, one area which is being looked at is the age profile of the workforce. For example, 35% of nurses can retire if they choose to. This is something which can be predicted. There are national shortages in some professions. There has been a huge piece of work over the last 6 years to increase numbers, but this takes time to work through. Some particular groups of staff are difficult to recruit to and the Trust needs to be attractive and a good employer. However, there are some services which SFHFT does not offer and, therefore, people have to go elsewhere to gain that experience or arranging rotational posts as a system needs to improve. RS advised the Trust is in the next phase of refreshing the strategic workforce plan. In terms of exit interviews, the concept of 'itchy feet' has been discussed by the People, Culture and Improvement Committee. As part of Year 2 of the People Strategy, the Trust is planning to introduce conversations with staff if they wish to have some variety or change of role; rotation is key. However, people have a sense of belonging at SFHFT and do not want to rotate out of the Trust. Therefore, the Trust is trying to create additional internal rotations. PB noted this fits in with retention. The Trust is looking at the internal transfer process to enable people who wish to work in another speciality to be able to do so without having to apply for jobs.		

	PS advised within maternity there is a specific midwife who focuses on recruitment and retention. 40% of midwives can retire and the others are very early career. The initial focus was to support early career midwives with rotation through different areas and there has been some success in terms of community, as historically community was difficult to recruit to but it is now fully established. The next phase of work is legacy mentors. Midwives who retire and return want to work fewer hours. Therefore, there is the opportunity for them to offer legacy support to early career midwives. The Trust is hoping to reflect this into wider teams. SB queried what the pipeline is like in Nottinghamshire for nurses who wish to come through the degree route. PB advised the pipeline is not as 'full' as it needs to be and there is a national drive to increase the pipeline. It will be five years before this pays dividends, and only if existing staff are retained. It has been confirmed international recruitment must continue, although there is some debate if this is ethical if the UK is taking nurses from other countries which may have a deficit. There is a need to continue to encourage the nurse associate route. SB queried if the Trust is engaging with other academic institutions in the same way as the partnership with West Notts College. PB advised the Trust works very closely with organisations in Nottingham, Derby, Lincoln and Sheffield. CW advised the Trust has recently had a meeting with Lincoln College, which has Newark College within its portfolio. The aim is to work towards having a similar relationship with them as the relationship with West Notts College. AH noted clinical nurse specialists are invaluable for service delivery and queried what the Trust's current position is. PB advised the Trust has a lot of nurse specialists. However, there is a need to be clear a nurse working in a specialism, is not necessarily a nurse specialist. There is more work to do to understand the competencies and experience of staff in those roles. CW noted the request for additional staff in the phlebotomy service, noting the blood clinic is increasingly busy. This increase is partly due to Primary Care pressures as referrals are made for blood tests at the Trust as a result of challenges faced by GP surgeries. CW queried what discussions have taken place on a wider basis with Primary Care to look at the source of the pressures, how the risk can be shared and a plan for provision of phlebotomy services in a wider context. PB advised there have been no wider conversations. The Trust has had to put in bank and additional hours to meet the demand. It is felt it would be better to have substantive staff as it is cheaper to run the service with substantive staff. It is important the Trust does not take all the risk. DS advised the walk in phlebotomy service provided by the Trust is excellent and Primary Care colleagues appreciate the 'open door'. It is acknowledged Primary Care have not invested in practice based phlebotomy in a way which has kept up with demand and, therefore, patients are coming to the Trust. There have been no significant discussions with the system about where the risk sits and how it is funded. This needs to be explored.		

	DA advised he and DS will take the conversation forward with Primary Care. It was noted the Community Diagnostic Centre will start to provide some phlebotomy services from October 2023. RM advised the Contract Delivery Groups and Activity and Performance Groups were stood down through Covid. These were the routine meetings with commissioners on a monthly basis and were the forum to look at activity trends, demand trends, etc. It was noted these will be re-established in the near future. RE felt the increased demand on hospital phlebotomy services is a legacy impact from Covid as GP practices discouraged patients from visiting the practice and, therefore, the activity drifted to the hospital. RE advised a mitigating action taken during the recent junior doctors' strike was, as clinics had been stood down, phlebotomists were released to go onto the wards. Having twice daily ward phlebotomy rounds had a positive impact on flow. If demand from a walk in and outpatient perspective can be controlled, there is an opportunity to redeploy resource into improving flow. **Action** • **Discussions to take place with Primary Care in relation to demand for phlebotomy services.** The Board of Directors were ASSURED by the report	**DA / DS**	**01/06/23**
15 mins	**Medical Workforce Staffing** DS presented the report, highlighting appraisals, revalidation process, an increase in the number of doctors connected to the Trust with the General Medical Council (GMC), job planning for 2023/2024, impact of the junior doctors' strike, provision of a suitable doctors' mess, appointment of Chief Registrar, Guardian of Safe Working recruitment, appointment of two Climate Action Fellows, new Trust bank rates, medical workforce data, vacancies, Task and Finish Group progress relating to challenged services, increase in training posts and Clinical Fellows recruitment. BB noted there are a number of vacancies in anaesthetics, noting there are also issues with AHP recruitment and retention in theatres. BB queried if issues are looked at in totality, rather than just through the lens of medics / nurses. RS acknowledged when things are considered in isolation, they can appear to be satisfactory, but when combined through a lens of different occupations there is a challenge. There is a need look at workforce in the round and have appropriate interventions through task and finish groups or wider fragile service conversations in relation to the use alternative roles, etc. DS advised the Trust has recently held an open day for theatre staffing and there was some success from this. Anaesthetics is one of the specialties which has been 'let down' by some of the national recruitment processes and workforce planning. Work is ongoing at a national level to address this.		

	BB noted the Clinical Fellows role and their Annual Review of Competency Progress and queried if this enables the Trust to have a more flexible offer. DS advised the Trust has had some success in recruiting specialists and the new specialists' role is something which will help. It was noted demand on national professional bodies equivalents to gain accreditation via the non-conventional training routes is increasing. ARB noted the increase in overdue appraisals and revalidation and queried if this poses a business or patient risk. DS advised current appraisal compliance is very good. As it is an annual process it does come in cycles. There was a 'dip' due to the recent industrial action but this will pick up. This is not seen as a risk. The Board of Directors were ASSURED by the report		
23/139	**STRATEGIC OBJECTIVE 5 – TO ACHIEVE BETTER VALUE**		
16 mins	**Improvement Faculty** DA presented the report, advising the Improvement Faculty will go live on 4th May 2023. From a governance perspective, the Faculty will report to the People, Culture and Improvement Committee. DA highlighted the four Pillars of Support and the initial work programme. PR felt it is important to create a movement for improvement across the organisation. The priorities outlined as the initial work programme align with the agreed strategic priorities. BB felt it would be useful for updates on some of the transformation programmes to be added to the Reading Room for the Board of Directors. SB noted the principle of "getting the quality right and financial improvement will follow" and queried how financial benefits will be measured in areas where these are expected. DA advised the Improvement Advisory Group will meet fortnightly. This is the vehicle by which the benefits realisation and tracking of implementations will be monitored. Projects will report to other committees as necessary for a focussed drill down. **Action** • **Quadrant reports from meetings of the Improvement Advisory Group to be included in Reading Room for each Board of Directors meeting** SB noted a challenge faced by the Trust is achieving the financial plan and queried how the work of the Improvement Faculty will contribute to helping achieve those targets. PR advised one of the initial priorities is the work in relation to optimising the patient journey, which relates to reducing length of stay. The key to delivering the financial plan is delivering improved length of stay and having a more effective discharge process which will allow consideration to be given to descaling the additional beds which are open. All these elements fit together as the right thing for patients and the financial position.	**DA**	**01/06/23**

	AH queried what the external interface will be to help deliver some of the projects. DA advised there is an improvement approach across the ICS which will feed into the work within the Trust. RE advised there are a lot of metrics which the Trust can drive which will improve the financial position, for example, theatre productivity which will deliver more Elective Recovery Fund. The approach to FIP has been changed for 2023/2024 as the accountability for the FIP target will sit with the divisions. The Board of Directors were ASSURED by the report		
23/140	**PATIENT STORY – A FAMILY'S JOURNEY THROUGH NICU (NEONATAL INTENSIVE CARE UNIT)**		
10 mins	PS presented the Patient Story, which highlighted the work of the Neonatal Intensive Care Unit and the Emily Harris Foundation. CW felt it was fantastic patient story and expressed thanks for the fundraising efforts of the Emily Harris Foundation. PS left the meeting		
23/141	**SINGLE OVERSIGHT FRAMEWORK (SOF) QUARTERLY PERFORMANCE REPORT**		
26 mins	**QUALITY CARE** PB highlighted serious incidents, including Strategic Executive Information System (StEIS) reportable incidents, MRSA bacteraemia, nosocomial Covid-19 infections. DS highlighted Patient Safety Incident Response Framework (PSIRF) work and Venous thromboembolism (VTE). **PEOPLE AND CULTURE** RS highlighted flu vaccination uptake, appraisals and mandatory training compliance. DA highlighted Quality Service Improvement and Redesign (QSIR) training and advised steps are being taken to build an 'improvement community'. MG queried what has driven the reduction in vacancy rate. RS advised this can be discussed further at the People, Culture and Improvement Committee. **Action** • **Reasons for reduction in vacancy rate to be reported to the People, Culture and Improvement Committee**	**RS**	**01/06/23**

	TIMELY CARE RE advised the last quarter has seen a period of significant pressure, leading to the Trust opening an additional 74 surge beds. During this period there were continued high levels of occupancy and high levels of patients medically safe for transfer. Despite the pressures, ED 4 hour performance has been maintained and the Trust remains in the top two in terms of ambulance handover times in the region. In terms of elective care, as of 31st March 2023 there was one SFHFT patient waiting over 78 weeks. It was noted this patient had chosen to delay their treatment. In addition, there were a further seven patients which the Trust had taken from Nottingham University Hospitals (NUH) as mutual aid. It was noted there will be a rolling programme of taking patients from NUH to equalise the very long waits across the system. The Trust has recently relaunched the transformation programme in relation to outpatients and there are early signs of improvement. However, the Trust has not achieved the target for the reduction in the number of follow up outpatient attendances. It has been made clear across the system this will not be achieved and this planning target has not been signed up to as a system as both SFHFT and NUH are carrying large overdue review lists. In terms of cancer, the Trust achieved the 2-week wait standard in Q4 for the first time in two years. In addition, the Trust is one of only two trusts in the Midlands to achieve the faster diagnosis standard. It was noted the 62 day backlog reduction is exceeding trajectory. GW felt there are opportunities to increase the number of remote attendances. RE advised this is an area the teams have been asked to focus on in the revised improvement programme. It was acknowledged this is an area which has not been prioritised given the other pressures recently. This is not being driven by patient feedback. There is a need to consider clinical engagement, technology aspects in terms of ensuring it is as easy as possible for patients and clinicians, and to be clear what is clinically appropriate for each speciality. AH felt there may be a need to consider if a different model is required for follow ups. RE advised overdue follow ups and patients waiting for first appointments are the backlogs which are of most concern. However, they are not nationally monitored. These have been reported through the Patient Safety Committee to ensure this risk is recognised. **BEST VALUE CARE** RM outlined the Trust's financial position at the end of Month 12. The Board of Directors CONSIDERED the report		

23/142	**APPLICATION OF THE TRUST SEAL**		
1 min	SH presented the report, advising in accordance with Standing Order 10 and the Scheme of Delegation, which delegates authority for application of the Trust Seal to the directors, the Trust Seal was applied to the following documents: • Seal number 101 was affixed to a document on 13th April 2023 for Keir Construction Ltd. The document related to the enabling works associated with the installation of a new modular unit adjacent to the existing building at the Newark Hospital site. (Keir project number 036980). The Board of Directors APPROVED the Use of the Trust Seal number 101		
23/143	**FIT AND PROPER PERSON**		
1 min	SH presented the report, advising the CQC Regulation 5, Fit and Proper Persons requirement, applies to all directors. A review of the personal files of all directors noted the evidence required to meet the requirements. The Board of Directors were ASSURED by the report		
23/144	**PROVIDER LICENSE SELF-CERTIFICATION DECLARATION**		
1 min	SH presented the report and advised this is an annual self-certification. This has previously been discussed by the Executive Team. There is no longer a requirement to submit the declaration to NHSE but it does need to be published on the Trust's website. The Board of Directors APPROVED the declarations required by General Condition 6 and Continuity of Service Condition 7 of the NHS provider licence. The Board of Directors APPROVED the FT4 declaration		
23/145	**ASSURANCE FROM SUB-COMMITTEES**		
12 mins	**Audit and Assurance Committee** GW presented the report, highlighting internal audit, draft annual accounts and indirect impacts of industrial action. RM advised the draft annual accounts are currently going through the external audit process. The Audit and Assurance Committee Annual Report was noted.		

	Finance Committee ARB presented the report, highlighting the review of the Board Assurance Framework (BAF) Principal Risk 4 (PR4), Failure to achieve the Trust's financial strategy, and PR8, failure to deliver sustainable reductions in the Trust's impact on climate change, 2022/2023 year end position and delegated powers to make necessary amendments to the 2023/2024 financial plan. The Finance Committee Annual Report was noted. GW noted the attendance of only two of the three non-executive directors who are members of the Finance Committee are noted in the committee's annual report. **Action** • **Attendance records of all non-executive director members of the Finance Committee to be added to the Finance Committee Annual report** **Quality Committee** BB presented the report, highlighting indirect impacts of industrial action, approval and sign off two CQC 'Must Do' actions which were a legacy from the 2020 inspection, approval and sign off two CQC 'Must Do' actions from the 2022 maternity inspection, review of BAF PR1, significant deterioration in standards of safety and care, and PR2, demand that overwhelms capacity, quality risk assessment associated with extending the surgical offer at Newark Hospital and limited assurance internal audit report in relation to nutrition and hydration. The Quality Committee Annual Report was noted. **Charitable Funds Committee** SB presented the report, highlighting delays in completing projects requiring estates works, approved of ultrasound proposal for Same Day Emergency Care and farewell to Tracey Brassington as she prepares to retire from her role of Community Involvement Manager. The Charitable Funds Annual Report was noted. RE noted the Committee's annual report does not include details of funds raised, spent, etc. SB advised this will be reported to the Board of Directors later in the year in their role as Corporate Trustee. SH advised details of how money raised is utilised is included in the Community Involvement Team's quarterly report, which is included in the Reading Room for members of the Board of Directors. CW expressed thanks on behalf of the Board of Directors to Tracey Brassington for her work. The Board of Directors were ASSURED by the reports	**RM**	**01/06/23**

23/146	**OUTSTANDING SERVICE – SUCCESSFULLY RELAUNCHING A 24/7 HOMEBIRTH SERVICE**		
6 mins	A short video was played highlighting the Homebirth Service.		
23/147	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Governor elections • Staff Excellence Awards • Thank-you and farewell to Shirley Higginbotham and Tracey Brassington • Welcome to Sally Brook Shanahan as she joins the Trust as Director of Corporate Affairs • Maternity Parent Voice Champion report • Launch of Improvement Faculty • Patient Story, particularly the work of the Emily Harris Foundation • Good Q4 performance despite challenges faced • Relaunch of 24/7 home birth service		
23/148	**ANY OTHER BUSINESS**		
	SH outlined the timetable for the forthcoming governor elections as follows: 10th May 2023 - Publication of Notice of Election 26th May 2023 - Deadline for receipt of nominations 30th May 2023 - Publication of Statement of Nominations 13th June 2023 - Notice of Poll/Issue of ballot packs 6th July 2023 - Close of Poll 7th July 2023 - Count and declaration of result		
23/149	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 1st June 2023 in the Boardroom, King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:15		
23/150	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Claire Ward **Chair** **Date**		

23/151	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
4 mins	CW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. Ian Holden (IH), Public Governor advised at a recent Meet Your Governor session at Newark Hospital he was informed a theatre list had been cancelled as there was no anaesthetist available. IH expressed concern about the Trust's ability to effectively staff theatres at Newark Hospital. RE advised the Trust is very aware of the current underutilisation of theatres at Newark Hospital, which has been influenced by the difficulties in recruiting anaesthetists. As the more urgent work is carried out at King's Mill Hospital, if there is a shortage of theatre staff on any given day, people will be moved across from Newark Hospital to King's Mill Hospital. RE acknowledged this is not good for patients at Newark Hospital, but there is a need to prioritise more urgent work. Discussion have been held with the division in terms of developing a more comprehensive workforce plan. It was noted anaesthetic resource is currently the biggest constraint for the Trust in terms of elective recovery. Sue Holmes (SuH), Lead Governor, advised over the years she had been concerned when the Staff Survey results indicated staff were in fear of experiencing violence and aggression. SuH advised it was pleasing to note steps are being taken to address this. RS advised DA has created additional links across Mid Nottinghamshire, bringing people together to start to describe some of the challenges faced.		
23/152	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

Key	
Red	Action Overdue
Amber	Update Required
Green	Action Complete
Grey	Action Not Yet Due

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
18/435	09/06/2022	Future Equality and Diversity Annual Reports to capture the impact of activity and provide further information on the data in terms of actions to be taken	Public Board of Directors	None	01/06/2023	R Simcox		**Update 17/05/2023** Details captured in the Equality and Diversity Annual Report **Complete**	Green
23/045	02/02/2023	Recommendations from the external well-led report to be reviewed in 6 months, including ensuring data in relation to gender and ethnicity is monitored	Public Board of Directors	None	03/08/2023	S Higginbotham			Grey
23/108	06/04/2023	Update on Virtual Ward to be provided to the May meeting of the Quality Committee	Public Board of Directors	Quality Committee	01/06/2023	D Selwyn		**Update 17/05/2023** Item included as part of the Quality Committee agenda for meeting on 18/05/2023 **Complete**	Green
23/136	04/05/2023	Report to be presented to the Board of Directors in relation to the learning and benefits of the EMPA rollout	Public Board of Directors	None	06/07/2023	D Selwyn		**Update 11/05/2023** To be included in Digital Strategy update, scheduled for July 2023	Grey
23/137	04/05/2023	Report to be presented to the Quality Committee to provide assurance in relation to health inequalities, mental wellbeing, etc. in maternity services.	Public Board of Directors	Quality Committee	03/08/2023	P Bolton		**Update 24/05/2023** Report to be presented to July meeting of Quality Committee	Grey
23/138	04/05/2023	Discussions to take place with Primary Care in relation to demand for phlebotomy services.	Public Board of Directors	None	01/06/2023	D Ainsworth / D Selwyn		**Update 23/05/2023** Discussions have taken place with the Place Based Partnership (PBP) team and Thilan Bartholomew. The availability of additional capacity has been welcomed. A targeted communication will support the awareness in the lead up to and as the service goes live. **Complete**	Green
23/139	04/05/2023	Quadrant reports from meetings of the Improvement Advisory Group to be included in Reading Room for each Board of Directors meeting	Public Board of Directors	None	01/06/2023	D Ainsworth		**Update 22/05/2023** First meeting to take place on 25/05/2023. Quadrant Reports to be provided to the Board from July 2023 onwards **Complete**	Green
23/141	04/05/2023	Reasons for reduction in vacancy rate to be reported to the People, Culture and Improvement Committee	Public Board of Directors	People, Culture and Improvement Committee	01/06/2023	R Simcox		**Update 17/05/2023** Item included as part of the People, Culture and Improvement Committee agenda for meeting on 30/05/2023 **Complete**	Green
23/145	04/05/2023	Attendance records of all non-executive director members of the Finance Committee to be added to the Finance Committee Annual report	Public Board of Directors	None	01/06/2023	R Mills		**Update 23/05/2023** Report amended **Complete**	Green

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's update	**Date:** 1st June 2023	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chair's perspective.		**Approval**	
		Assurance	X
		Update	X
		Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**X**	**X**

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Not applicable

Acronyms

ATTFE = Academy Transformation Trust Further Education
NHS = National Health Service
SFH = Sherwood Forest Hospitals

Executive Summary

An update regarding some of the most noteworthy events and items over the past month from the Chair's perspective.

Celebrating our colleagues' dedication and outstanding achievements at our annual *Excellence Awards*

We are continuing our preparations for this summer's #TeamSFH *Excellence Awards*, which are our Trust's single greatest opportunity to say 'thank you' to our hard-working staff for their outstanding efforts over the past year.

This will be the first time that our Trust *Excellence Awards* have been held in-person since before the start of the pandemic. The event will be held on Wednesday 5th July – the same day that our NHS will celebrate its 75th anniversary nationally, which we are excited to be celebrating as a Trust.

This year we have received hundreds of nominations for this year's awards from our staff, patients, partners and members of the public, all of whom have made their nominations to our hard-working colleagues and teams for the care they have provided.

We look forward to sharing a wealth of those heart-warming nominations over the coming weeks.

Celebrating the contributions of our amazing #TeamSFH volunteers during National Volunteers' Week

June's meeting of our Trust's Board of Directors will take place on Thursday 1st June on the first day of this year's national Volunteers' Week – an annual celebration of the contribution that millions of volunteers make across the UK by giving their time in their local communities.

Here at Sherwood, we are grateful for the amazing support of our 389 volunteers who generously give their time to support our clinical and non-clinical roles. Every moment they give really does make a different to help great patient care happen across our hospitals.

Our volunteers play an essential role in supporting our colleagues across #TeamSFH, bringing with them a wealth of professional and life experience that enhances the care we provide as a Trust.

In an average week across our hospitals, our volunteers give an amazing 967 hours of their time across 30 volunteer roles within the Trust. That equates to an incredible 50,284 hours over the course of a year – and for their commitment, we are so incredibly grateful.

Bidding a fond farewell to Tracey Brassington, #TeamSFH's Community Involvement Manager

This month we will bid a fond farewell to Tracey Brassington, our brilliant Community Involvement Manager, who has played an instrumental role in helping to drive-forward the work of our brilliant Community Involvement team.

For those of you who are not familiar with our Community Involvement team, they are the team who lead so much of our work around how we engage with our local communities, how we encourage financial support from our communities through donations to our Trust Charity, and how we welcome volunteers to give their time to support the Trust's work.

I have been proud to work alongside Tracey throughout my time here at Sherwood and I am so grateful for her skill, compassion and dedication. Tracey leaves an incredible legacy that has transformed the way we work with the communities we serve here at Sherwood.

Our Community Involvement function has come such a long way under Tracey's stewardship. She leaves with our best wishes and we wish her a long, happy and healthy retirement when that day comes later this month.

Tracey will pass the baton on to one of her very able deputies, Jo Thornley, who I know will continue Tracey's work in continuing to take our brilliant Community Involvement team in an exciting direction.

Update on this summer's governor elections

Our preparations for this summer's governor elections are now in full-swing and we have received really good interest in this exciting opportunity, with a good number of prospective governors making their nominations to stand for election in this summer's elections.

This summer's elections will look to fill seven vacancies for our public governors across our Rest of East Midlands (four vacancies) and Newark constituencies (three vacancies). We are also looking to fill one vacancy for a staff governor here at Sherwood.

A total of seven vacancies were originally advertised across all constituencies.

Since posting our notice of election, another of our public governors – Ann Mackie – decided to resign her position as a public governor in our Newark constituency which we will now look to fill in this summer's election. Ann's resignation follows the resignation of Maxine Huskinson, who has also resigned her position as a public governor over recent months. I thank them both for their excellent service during their time as governors here at Sherwood.

Our governors have a key role to play in helping the Trust to achieve its ambitions of providing healthier communities and outstanding care to all.

As part of our preparations for this summer's elections, we also held a number of online information events for aspirant governors to learn more about the roles before making their nomination to stand for election. Both virtual events were well-attended by a host of enthusiastic individuals who were keen to give something back to their local hospitals and our patients who receive care here. We are grateful for their interest.

Polls are due to open for this summer's governor elections on 13th June 2023, with votes being welcomed from the Trust's 14,000-plus members until Thursday 6th July. We plan to announce the results of those elections on Friday 7th July. I will aim to update on that at August's Board meeting.

Notable engagements from the past month: Sherwood Forest Coronation Event

I was delighted to join one of our Trust's public governors, Liz Barrett OBE – the Principal at Academy Transformation Trust Further Education (ATTFE) – for their Sherwood Forest Coronation Picnic earlier this month.

The day was an opportunity for the College to welcome their local partners – like the Trust – and to share with them the host of exciting inclusive learning opportunities that are provided by the College to local learners.

It was my pleasure to attend and see the connections between local students at ATTFE and primary schools. You can watch a video from the event that has been produced by ATTFE on YouTube here.

Claire Ward, Chair of Sherwood Forest Hospitals, alongside Liz Barrett OBE and Paula Hancock from Sherwood Forest Education Partnership at the Coronation event

Notable engagements from the past month:

- Visiting our partners Skanska with Roz Norman, our staff-side representative for Unison
- Representing the Trust at a special Coronation celebration ceremony at Southwell Minister
- Meeting with Chairs and Chief Executives to discuss progress with the ICS and Provider Collaborative.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's update	**Date:** 1st June 2023	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective.		**Approval**	
		Assurance	**X**
		Update	**X**
		Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**X**	**X**

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Not applicable

Acronyms

BMA = British Medical Association

Executive Summary

An update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective.

Pressures update

Despite seasonal demands subsiding to some extent, we continue to see high levels of demand within our Emergency Department at King's Mill Hospital and our Urgent Treatment Centre (UTC) at Newark Hospital. In fact, on an average day in May, over 500 people accessed those services – a figure that compares to the height of the winter months.

As well as managing pressures at our 'front door' of our hospitals, we also continue to care for more than 100 patients in our hospitals each day who have received the acute care they need from our hospitals and are now medically fit to be discharged to continue their recovery in wherever they call home.

We continue to work with our health and social care colleagues across the Nottingham and Nottinghamshire Integrated Care System (ICS) area to help manage those pressures and make every one of our hospital inpatient beds count over the summer months ahead.

Pressures update: Relocating our Sherwood Community Unit to Mansfield Community Hospital

A key component of the Trust's response to managing bed pressures over the past year has been our ability to flexibly increase the number of acute inpatient beds within the Trust to a point where, by January, we had more acute beds open in our hospitals than at any other point in our history.

One significant part of that response saw the opening of the Sherwood Community Unit – a former care home building that we transformed to extend the walls of our hospitals. The move allowed us to provide transitional care for patients who had received the attention they needed and were ready to leave hospital as soon as their onward care arrangements had been finalised.

In its year in operation, the Sherwood Community Unit cared for nearly 800 patients and has played a vital part in freeing-up hospital beds for those who need them most.

It is perhaps a sign of those pressures subsiding that we have now been able to close the Sherwood Community Unit in its standalone location and relocate it to its new home within Mansfield Community Hospital.

Throughout its time, the Unit has been a great example of how thinking differently can ensure that patients receive the best possible healthcare in the right place at the right time. It has had a positive impact in alleviating winter pressures and keeping essential NHS services running and we are so grateful to the team of staff, volunteers and community workers who made this possible.

By relocating the Unit into Mansfield Community Hospital, we will be able to transfer patients even more easily and efficiently while retaining the same innovative approach to continuing to care for our patients in the best possible way.

The Unit will now be known as the Chatsworth Centre in its new home at the modern Mansfield Community Hospital.

Pressures update: National 'level three' COVID incident stepped-down and removing the need to wear facemasks across our hospitals

On 18th May 2023, NHS England announced it was stepping-down the national incident from level three as the country's response to the COVID-19 pandemic moves to its next stage.

While the implications of this development nationally will largely only impact the workings of our hospitals behind-the-scenes, the impact of the pandemic continues to be felt across our services.

We have continued to treat patients who are critically ill with COVID in our critical care unit over the past year but – thankfully – examples of that are becoming less common now.

The country learning to 'live with COVID' has brought changes to how we are managing our ongoing response to the pandemic locally here at Sherwood as we took the decision to remove the need to wear a mask in most clinical areas of our hospitals in May.

Patients, staff and visitors are now only required to continue to wear a mask in clinical areas where we are caring for our most vulnerable patients. Clinical areas where masks will continue to be worn include our Critical Care Unit, NICU and other areas with high volumes of immunosuppressed patients. Those areas will have red 'You are in a high-risk area' posters displayed.

We have also changed patient testing requirements, including removing the need to test asymptomatic inpatients and will now only test inpatients and elective patients who are displaying symptoms of COVID or patients who are immunosuppressed.

All patients who are being transferred from our hospitals to another care provider – such as a care home or hospice – will also continue to be tested. Other NHS providers may also request that our patients are tested before they are transferred to them.

We have reduced the time infected patients need to isolate, in line with national guidelines. The requirement to isolate an infected patient is being reduced to a minimum of five days, with isolation to stop at a maximum of 10 days following a symptom review.

These latest changes bring Sherwood Forest Hospitals into line with national guidance and NHS providers working across the county.

We remind everyone to respect the wishes of those who choose to wear a face mask anywhere in our hospitals – whatever the reason. And, if patients would prefer hospital staff to wear a face mask while in close contact, we will be happy to accommodate those requests.

We remain grateful for the support of our colleagues for their continued work to manage the impact of the pandemic on our services, our colleagues and our patients.

Pressures update: Planning for future industrial action from the British Medical Association (BMA)

We have continued to watch national developments with great interest over recent weeks and, in particular, the announcement from the British Medical Association (BMA) of their intentions to hold a third round of strike action among their members.

This strike action is due to include junior doctors here at Sherwood, with the strike due to take place over a 72-hour period between 7am on Wednesday 14th June and 7am on Saturday 17th June.

We know how important the work of our junior doctors is across the Trust every day and our planning is well underway to prepare for the impact that this action will have on our colleagues, our services and the patients who use them each and every day.

The experience of recent industrial action tells us just how sorely their absence will be felt – not least in the impact this action will undoubtedly have on many of our services as we focus our efforts on providing urgent and emergency care as a priority across our hospitals.

We value the hard work and dedication of our colleagues and we understand the importance of good pay and conditions for both them as individuals and the organisation. As a Trust, we will do everything we can to ensure that they are properly supported over the months ahead.

We hope to see a national dispute as swiftly as possible.

Two #TeamSFH midwives receive national awards in recognition of their outstanding efforts

We were delighted to see two of our Trust's midwives presented with prestigious national awards in May in recognition of going above and beyond in their roles.

Our Trust's Recruitment and Retention Midwife, Sharon Parker, and Lead Professional Midwifery Advocate, Julia Andrew, were presented with the Chief Midwifery Officer Silver Award by Sascha Wells-Munro, Deputy Chief Midwifery Officer for NHS England, on a visit to King's Mill Hospital.

The award is presented to individuals who have demonstrated excellence in clinical practice, leadership resulting in improvement, championing diversity and inclusion.

Sharon Parker has worked at the Trust for 10 years and has been responsible for recruitment and retention since February 2022. In that time, she has successfully recruited into all vacant posts for newly-qualified midwives. All these midwives still work for the Trust, apart from one who has relocated to a different area.

Meanwhile, Julia has been a Professional Midwifery Advocate since February 2022 and has led the service since June 2022. She set up the Birth Options service which develops birth plans for women and birthing people who request care outside of guidance. She makes sure all women are empowered with supported decision making and offers bespoke support to midwives and obstetricians to ensure they feel safe and empowered to facilitate choice. Since the service was launched it has supported more than 70 families, providing them with individualised and responsive maternity care.

I congratulate them both on this brilliant national recognition for their outstanding achievements.

Julia Andrew (left) and Sharon Parker (right) with their Chief Midwifery Officer Silver Awards alongside Sherwood's Director of Midwifery, Paula Shore

Partnerships update: Michael Gove MP visits future Mansfield Connect hub following successful Levelling Up bid

On Thursday 18 May, we were delighted to be represented when the Government's Secretary of State for Levelling Up, Housing and Communities, Rt Hon Michael Gove MP, visited Mansfield to hear from local leaders about their ambitions to transform the town's former Beales building into 'Mansfield Connect'.

The visit follows an announcement in January which saw Mansfield District Council confirmed as being successful in its bid to the Government's Levelling Up Fund for £20million to regenerate the site.

The ring-fenced funding will see the old retail building in the town centre revitalised into a multi-agency hub – Mansfield Connect – that will house key partners in the district and become a one-stop shop for residents to access key services.

The hub is a positive move for the local area and its creation is one that we are proud to be playing a part in – both as a Trust and as member of the Mid Notts Place-Based Partnership.

Partnerships update: Provider Collaborative Leadership Board

The Provider Leadership Board met during May, where its mission statement was agreed. The Provider Leadership Board is the collective group of senior leaders representing the Provider Collaborative overseeing the priorities.

The emergent executive group formed through distributive leadership has now agreed its membership and its operating framework has now also been agreed.

Two priorities have also been identified and the group received updates on the scoping for each workforce and urgent care. It was noted as part of the conversations that identifying resources remains a risk as the work progresses. Outstanding areas for development are governance and communications, with one partner due to put in some short-term communications support.

There is also a planned workshop for Chairs, Non-Executives and CEOs to explore governance arrangements. which is likely to explore sovereignty and shared decision making across the Provider Leadership partnership.

Risk ratings reviewed

The Board Assurance Framework (BAF) risks, for which Risk Committee is lead committee, have been scrutinised by the Trust's Risk Committee. The Committee has confirmed that there are no changes to the risk scores affecting the following areas:

- Principal Risk 6: Working more closely with local health and care partners does not fully deliver the required benefits

- Principal Risk 7: A major disruptive incident

Welcome to Sally Brook Shanahan as the Trust's new Director of Corporate Affairs

I am delighted to welcome Sherwood's new Director of Corporate Affairs, Sally Brook Shanahan, to what is due to be her first Board of Directors Meeting in Public.

Sally joins us from Nottingham University Hospitals (NUH), where her background as a solicitor, her wealth of outstanding public service, and her strengths in corporate governance will serve her well in her new role.

Sally has the unenviable role of filling the shoes of her predecessor, Shirley Higginbotham, who is no doubt now enjoying what we hope will be a long, happy and healthy retirement.

I look forward to working with Sally as an invaluable part of our Trust's Executive Team over the months and years ahead.

Trust Board - Cover Sheet

Subject:	People Strategy 2022-2025	**Date:** 01/06/2023	
Prepared By:	Beth Hall, Business Support Officer – People Team		
Approved By:	Rob Simcox, Director of People		
Presented By:	Rob Simcox, Director of People		
Purpose			
To share an update and seek approval of the People Strategy for 2022-2025, highlighting key achievements from 2022/2023 (Year 1) and our plans for 2023-2025 (Year 2/3)		**Approval**	**X**
		Assurance	
		Update	
		Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
		X			

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

People Cabinet
People Senior Team Meetings
People Directorate Team Brief
People Transformation Sub-Cabinet
People Resourcing and Development Sub-Cabinet
People Wellbeing and Belonging Sub-Cabinet
JSPF
LNC
Clinical Chairs
via Divisional People Leads
Trust Management Team
People, Culture and Improvement Committee

Acronyms

None

Executive Summary

Overall context

We have successfully delivered Year 1 of our People Strategy, following its launch in Summer 2022/2023. Pages 11-14 outline our key achievements.

Due to the change in landscape within Sherwood Forest Hospitals we have refreshed the People Strategy for Years 2/3 (2023/2024 and 2024/2025). The main reason for updating this is due to Executive Leadership changes, but we also wants to reflect the new Sherwood strategic priorities and CARE values.

Summary of attachment

The **People Strategy has 4 delivery pillars** which deliberately anchor back to the NHS People Plan:

- **Looking after our People**
- **Belonging in the NHS**
- **Growing for the future**
- **New ways of working and delivering care**

We are pleased to say our vision statement now aligns to the refreshed Trust strategic objectives:

Empowering and supporting our people to be the best they can be

This creates a golden thread between People Directorate and Trust priorities and feel this shows how our People Strategy has matured and developed over the last year.

SOF metrics for 23/24 have been reviewed and aligned to our strategy delivery pillars

Updated action plans for 2023-2025

We are mindful given the changing landscape that our People Strategy needed to be refreshed to ensure it was relevant and aligned to latest Sherwood and national priorities. We have streamlined our priorities into 4 key overarching actions per delivery pillar to provide clear yet realistic direction.

Recommendation:

We ask Trust Board to approve the People Strategy ready for a launch to the wider Trust throughout June 2023.

People Strategy

Empowering and supporting our people to be the best they can be

Following successful delivery of Year 1 of our People Strategy for 2022-2025 we are pleased to share an update on our key achievements and plans for the next 2 years, which will help mitigate PR3 associated risks.

Our key achievements

2022/2023

Looking after our People | Belonging in the NHS | Growing for the future | New ways of working and delivering care

Best NHS Acute Trust in the Midlands.. to work for as voted by our staff for the fifth year running *

92 Wellbeing champions trained to date at SFH

>3,000 Hot drinks/mince pies offered to colleagues in December 2022 through implementation of the 'Festive thank you'

Awarded the Carer Friendly Quality Mark by Nottinghamshire Carers Association in recognition of the Carers Passport and Champions.

2023 ROSPA Gold Award — ROSPA Gold Health & Safety Award winners

>200 Entries to our Admin Awards

#1 Ranked 1st regionally in Staff Engagement, Staff morale and our People Promise theme: **We have a voice that counts**

We unveiled our #OneWorldOneTeamSFH artwork, celebrating our diverse workforce at #TeamSFH made up of 95 nationalities.

48 Wellbeing sessions with topics from financial wellbeing to menopause*

5 Schwartz rounds delivered following launch in Q1

#2 Ranked 2nd regionally in the People Promise theme: **We are always learning**

220 Colleagues are part of one of our 5 Staff Networks

75 International Nurses appointed

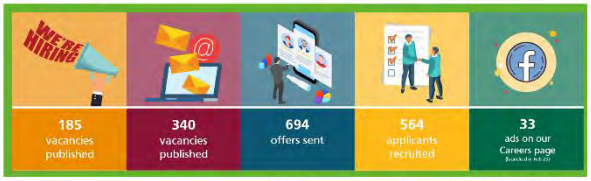
>50 Members joined our Women at Sherwood network - launched Summer 2022

20 Apprenticeship places confirmed Trust-wide for 23/24

2,938 Colleagues took part in training* delivered by our People Development Team

>650 people attended our Step into the NHS Careers Fair in partnership with West Notts College/NTU

87% of Newark theatres posts recruited to (to date) supporting the TIF project



*Recruitment/vacancy figures above are for Q4 22/23

People Strategy: Year 2 and 3 (2023/2024 and 2024/2025)

Sherwood Forest Hospitals NHS Foundation Trust

Delivery Pillar	Action Plans 2023/2024	Key Success Measures 2022/2023	Action Plans 2024/2025
Looking after our People	• Review fundamental wellbeing needs across the Trust and develop action plans to address gaps.	• Fundamental wellbeing needs clearly identified, audit undertaken and action plan in place by Q4 • Wellbeing Strategy introduced by Q3 and promoted across the organisation	• Empower our teams to have regular debriefings
	• Measure the impact of our health and wellbeing offers, flexing and adapting as required.	• 80% of Occupational Health appointments are offered within 10 days. • Key Schwartz rounds metrics: o Minimum of 4 Schwartz Rounds held per year. o Attendance levels to be a minimum of 10 with and outcome of 70% positive feedback score	• Expand and develop our benefits package
	• Introduce the Trauma Risk Management (TRIM) programme.	• Minimum of 16 TRIM practitioners trained by Q3	• Hold People strategy refresh session to inform our next 3 years.
	• Take a deliberate and Trust wide approach to address violence and aggression from patients/public towards employees.	• Reduction in experience of V&A reported via Quarterly Pulse surveys in 23/24 plus National Staff Survey 2023	
Belonging in the NHS	• Develop a Culture Heat Map which will help identify high priority teams requiring support.	• Culture Heat Map process in place by end of 23/24 with high priority teams identified and agreed support programmes in place	• Delivery against model employer goals. Increasing black and minority ethnic representation at senior levels across SFH/ICS.
	• Implement an employee feedback process and programme, from new starters to leavers and key milestones in between.	• Increased compliance against all key employee feedback markers with process in place to share key themes with Divisions/Professional Groups as appropriate by end of 23/24	• Review our recruitment process to reduce nepotism and unconscious bias towards colleagues with protected characteristics.
	• Define a colleague Reward and Recognition programme.	• 4 key Trust wide celebration events delivered by end of 23/24 • Process in place for recognising long service milestones • New approach to recognition for long service retirement in place	
	• Empower our Staff Networks to support delivery of our Equality, Diversity and Inclusion strategy.	• Priority actions from the 6 High Impact Action plan to be delivered by the end of 23/24	
Growing for the future	• Develop a portable Mandatory and Statutory Training offer with system partners.	• Achieving a Mandatory Training completion rate of >90% across SFH each quarter	• Introduction of a Divisional lead integrated talent map and a placements programme for students and young people.
	• Implement revised appraisal documents to simplify the process and support quality conversations.	• Achieving an Appraisals completion rate of >90% across SFH each quarter	• Continue to work with our ICS partners to develop a People Hub concept across Nottinghamshire.
	• Define the Trust Talent Management approach and deliver the Leadership Development programme.	• Talent Management approach to be implemented by the end of Q4 23/24 • Leadership Development programme to be launched and enacted by Q4 23/24	• Extension of external facing E-Academy site (Sherwood Learning Hub) for use in other organisations.
	• Develop plans around apprenticeships, work experience, Health Ambassadors, and recruitment events.	• A minimum of 20 external apprenticeships in post by the end of 23/24 • 10% increase in work experience placements by end of 23/24 • A minimum of 12 recruitment/careers events by end of 23/24	
New ways of working and delivering care	• Deliver Year 2 of the Strategic People Plan, including delivery and monitoring of associated tactical people plans at a service line level.	• 100% of tactical people plans delivered for Service Lines and Divisions by Q1 2023/24	• Embed digitalisation to support the Green agenda.
	• Develop and implement workforce plans to support Newark Theatres expansion and Mansfield Community Diagnostic Centre.	• 90% of vacancies filled for Newark Theatres TIF by Q2 2023/24 • People workforce plans developed and agreed for Mansfield CDC by Q2 2023/24	• Work with our NHIS partners to complete an IT audit, ensuring our people have the core equipment, hardware and software they need for their role.
	• Work collaboratively with the Improvement Faculty through our new governance structure.	• Agency usage (off framework) <6% each quarter • Agency usage (over price cap) <30% each quarter • Agency usage <3.7% each quarter • No locum bookings >12m by Q4 2023/24	• Consider how we can utilise agile working as a positive recruitment tactic.
	• Review and optimise the systems we manage as a People Directorate ie. ESR, Health Roster and TRAC.	• 10% increase in ESR utilisation score by Q4 2023/24 • Maintenance of Health Roster effectiveness score	• Enhance our relationships with ICS partners and continue to support the Improvement Faculty from a People perspective.

Board Assurance Framework (BAF): May 2023

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, which forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level)
- Risk ratings – current (residual), tolerable and target levels
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise
- A statement of risk appetite for each threat and opportunity, to be defined by the Lead Committee on behalf of the Board (**Averse** = aim to avoid the risk entirely; **Minimal** = insistence on low-risk options; **Cautious** = preference for low-risk options; **Open** = prepared to accept a higher level of residual risk than usual, in pursuit of potential benefits)
- Key elements of the risk treatment strategy identified for each threat and opportunity, each assigned to an executive lead and individually rated by the lead committee for the level of assurance they can take that the strategy will be effective in treating the risk (see below for key)
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance** functions (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers)
- Clearly identified gaps in the primary control framework, with details of planned responses each assigned to a member of the Senior Leadership Team (SLT) with agreed timescales

Key to lead committee assurance ratings:

Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity

- no gaps in assurance or control AND current exposure risk rating = target
  OR
- gaps in control and assurance are being addressed

Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy

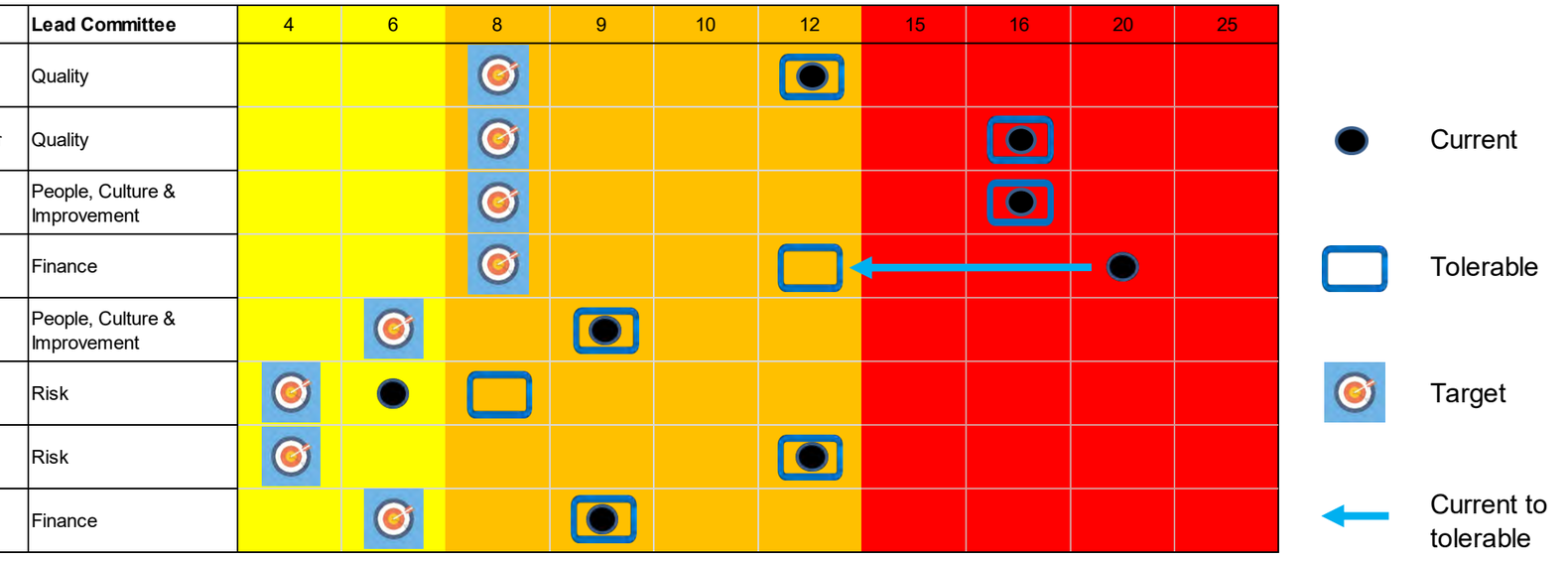
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

This approach informs the agenda and regular management information received by the relevant lead committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally or there are a significant number of near misses / incidents at a lower consequence level	Will probably happen/recur, but it is not necessarily a persisting issue/ circumstances	Will undoubtedly happen/recur, possibly frequently
Probability Will it happen or not?	Less than 1 chance in 1,000 (< 0.1%)	Between 1 chance in 1,000 and 1 in 100 (0.1 - 1%)	Between 1 chance in 100 and 1 in 10 (1- 10%)	Between 1 chance in 10 and 1 in 2 (10 - 50%)	Greater than 1 chance in 2 (>50%)
Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating					

This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities and the risk scores:

		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People, Culture & Improvement
PR4	**Failure to achieve the Trust's financial strategy**	Chief Financial Officer	Finance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Director of Strategy and Partnerships	People, Culture & Improvement
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	Risk
PR7	**Major disruptive incident**	Director of Corporate Affairs	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance



Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** ~~Significant~~ Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 3. Possible	3. Possible	2. Unlikely		
Last reviewed	18/05/2023	**Risk rating**	~~16. Significant~~ 12. High	**12. High**	**8. Medium**		
Last changed	18/05/2023						

Strategic objective	1. To provide outstanding care in the best place at the right time

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
~~A widespread loss of~~Inability to maintain ~~organisational focus on~~ patient safety and quality of care leading to increased incidence of avoidable harm~~, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction~~ and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Scoping and sign-off process for incidents and SIs ▪ Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC Bi-monthly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight	Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care ePMA project issues identified as part of the maturing rollout ~~Lack of oversight of established clinical governance when meetings are stood down due to operational pressures~~	Review of informatics function and development of informatics strategy ~~**Progress:** Strategic paper developed, awaiting TMT review~~ **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~February 2023~~Complete – business case submitted, currently unsupported Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People ~~**Progress:** People, Culture and Improvement Strategy launched, and a number of task and finish groups established~~ **Timescale:** ~~March 2023~~Complete – awaiting imminent release of NHS Workforce Plan Oversee the ePMA project board to resolve identified issues with eTTOs, critical medicines and allergy documentation **SLT Lead:** Medical Director **Timescale:** September 2023 Review and describe which committees are essential to maintain quality and patient care and safety when the Trust in a state of sustained heightened clinical activity **SLT Lead:** Director of Patient Safety **Timescale:** ~~May 2023~~Complete	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board qrtly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports **Risk and compliance:** Quality Dashboard and SOF to PSC Monthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC bi-monthly; Significant Risk Report to RC monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)		Positive No change since April 2020

Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease ~~(such as pandemic influenza; Coronavirus; norovirus; infections resistant to antibiotics)~~ that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Public communications re: norovirus and infectious diseases ▪ Coronavirus identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, ~~CCG,~~ PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions ▪ Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements			**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan:~~; CQC Rating Good with Outstanding for Care May 20;~~ UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; ~~HSE visit (COVID-19 arrangements) Dec 21 – no concerns highlighted;~~ IPC BAF Peer Review by Medway Trust; HSE External assessment and report; ~~HSIB IPC assessment and report Nov 20~~CQC Maternity Review Dec 22		Positive Last changed November 2022

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	~~5. Very likely~~ 4. Somewhat likely	4. Somewhat likely	2. Unlikely		
Last reviewed	18/05/2023	**Risk rating**	~~20~~16. Significant	**16. Significant**	**8. Medium**		
Last changed	18/05/2023						

Strategic objective	1. To provide outstanding care in the best place at the right time

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • Further waves of admissions driven by Covid-19, Flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ SFH Same Day Emergency Care service in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care – regular meetings with NEMS ▪ Trust and System escalation policies and processes, including Full Capacity Protocol and Pandemic Surge Plan ▪ ~~COVID-19 Incident planning and governance process~~ ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today e.g. turnaround times such as diagnostics are completed within 1 day ▪ SFH annual capacity plan with specific focus on the Winter period ▪ Patient pathways, some of which are joint with NUH ▪ Referral management systems shared between primary and secondary care ▪ Optimising Patient Journey Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Elective Steering Group ~~relaunched~~ to steer the recovery of elective waiting times ▪ Emergency Steering Group ~~relaunched~~ to steer improvement across the emergency pathway ▪ Incident Control Team	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions e.g. reducing elective operating, bedding patients in alternative areas i.e. daycase	Bed modelling and review of funded/escalation capacity **SLT Lead:** Chief Operating Officer **Timescale:** ~~January to April 2023~~Complete Work on mitigations to address bed modelling outcomes: - Secure funding for additional ward area (bid submitted in Feb 23 was unsuccessful) - Identify schemes to increase efficiency through length of stay reductions – agreed 4 areas of focus **SLT Lead:** Chief Operating Officer **Timescale:** ~~June 2023~~ Complete Develop delivery plans with system partners for the 4 areas of focus to mitigate demand pressures **SLT Lead:** Chief Operating Officer **Timescale:** July 2023	**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; Winter Plan considered by Board in Oct 22; Planning documents for 23/24 to identify clear demand and capacity gaps/bridges; Waiting list update to TMT ~~monthly~~ as required; Super Surge Plan considered by Board in Feb 22; Bed model outcomes to Exec Team Feb 23 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Single Oversight Framework Integrated Monthly Performance Report including national rankings to Board; ~~Incident Control Team governance structure considered by TMT in Mar 20; Cancer services report considered by Board in Jun 21~~ **Independent assurance:** ~~NHSI Intensive Support Team reviewed cancer processes in May 20;~~ Performance Management Framework internal audit report Jun 22 ~~with actions under way.~~		Positive Last changed December 2020
Reductions in availability of hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group ▪ ICS Discharge to Assess business case being implemented ▪ Multidisciplinary Transfer of Care Hub opened at SFH Oct 22 ▪ Opening of additional beds ▪ ~~(~~Sherwood Care Home ~~May 22~~transferred to MCH Apr 23 ▪ ~~,~~Mansfield Community Hospital Nov 22 ~~– Mar 23)~~ ▪ Use of Ashmere	Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 22	Delivery of ICS Discharge to Assess Business Case **SLT Lead:** Chief Operating Officer **Timescale:** ~~Phased to April 2023~~throughout 23/24 Virtual ward programme implementation **SLT Lead:** Chief Operating Officer **Timescale:** ~~1st phase to April 2023~~expanding throughout 23/24	**Management:** Daily and weekly themed reporting of the number of MFFD patient in hospital beds. Reports into the system CEOs group; ICS UEC Delivery Board and ICS Demand and Capacity Group **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the SOF	Further refinements to MFFD reporting to ensure a single and shared version of the truth within the Trust and between system partners **SLT Lead:** Chief Operating Officer **Timescale:** Continual review and improvement to June 2023	Inconclusive No change since threat added in January 2022

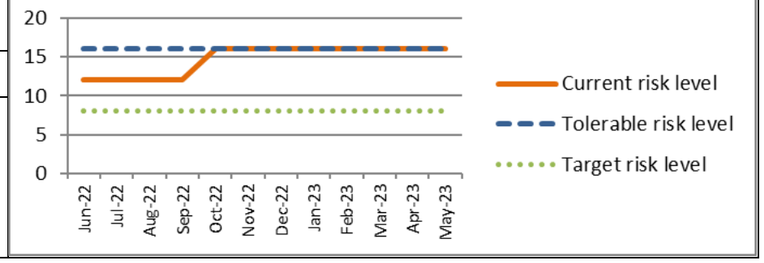
Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly Chief Officer calls across ICS, including Primary Care ▪ Mid Notts ICP represented at weekly Incident Control Team meeting			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand	Lack of visibility in primary care demand and capacity **Action:** Continue to push via ICS UEC Delivery Board and ICS Demand and Capacity Group the importance of system-wide oversight of demand and capacity **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development. ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors			**Risk and compliance:** NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area **Action:** Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Positive Last changed November 2022
Growth in demand for care in our maternity services (population growth and increase in out of area referrals)	▪ Over-established midwifery by 10% from 2021/22 ~~▪ Fully restarted home birth services following closure during the pandemic (and partial re-opening in early post-pandemic phase)~~ ▪ Additional antenatal clinics based on overtime/bank ▪ Recruited additional consultants (12 in 2020 to 14 at time of writing) ▪ Maternity assurance group (monthly) ▪ Director of Midwifery providing Board-level oversight	Midwifery staffing vacancies (gap of 5.6% WTE against establishment) No increase in junior medical staffing Nursing gaps in neonatal unit No standalone junior out-of-hours on-call for neonatal (as per critical care review) Physical capacity/estate will be insufficient should growth trends continue in the coming years	Maternity and Neonatal service review document in development **SLT Lead:** Chief Operating Officer **Timescale:** ~~end of March 2023~~Q1 23/24 ANP recruitment under way **SLT Lead:** Chief Operating Officer **Timescale:** ~~Current recruitment round to complete in 22/23 Q4~~ Complete	**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings) **Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)		Positive New threat added January 2023

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care						
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	4. Somewhat likely	2. Unlikely		
Last reviewed	22/05/2023	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**		
Last changed	22/05/2023						

Strategic objective	~~3: To maximise the potential of our workforce~~ 3. Create an environment for all our colleagues to thrive



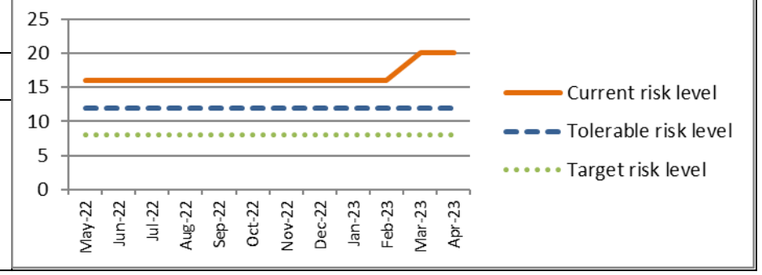
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff due to ~~demographic changes (including a significant impact of external factors and/or unforeseen circumstances) and/or unforeseen circumstances) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition), or mental health issues relating to the working environment~~market factors, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People ~~Culture and Improvement~~ Strategy 2022-2025 ▪ People ~~and Inclusion~~ Cabinet ~~▪ Culture and Improvement Cabinet~~ ~~▪ Medical and Nursing task force~~ ▪ Activity, Workforce and Financial plan ▪ ~~2~~5-year strategic workforce plan supported by associated Tactical People Plans~~Workforce Planning Group and review processes (consultant job planning; workforce modelling; winter capacity plans)~~ ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of Consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ~~▪ Operational grip on workforce gaps reporting into the Incident Control Team~~	Workforce gaps across key areas such as Medical, ~~n~~Nursing, AHP and ~~m~~Maternity ~~staff gaps in key areas across the Trust~~, which may impact on the quality and standard of care Lack of consistency across the system with regard to recruitment and retention, creating competition and not maximising opportunities	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** ~~March 2023~~Complete Deliver the People, Culture and Improvement Strategy – Year 2 **SLT Lead:** Director of People **Timescale:** March 2024 Work with the Chief People Officer to form a provider collaborative forum for recruitment and retention **SLT Lead:** Director of People **Timescale**: June 2023	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to PCI Committee Jun 22; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to PCI Committee bi-monthly; Leadership Development Strategy Assurance Report to PCI Committee Jun 22 **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators to People Cabinet (Monthly) - Quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Pre-employment Checks internal audit report Feb 21 – significant assurance; HSJ Award for Acute Trust of the Year 2021; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr 21	Staff mental health issues as a result of psychological trauma Train Trauma Risk Management practitioners to provide psychological support following traumatic events **SLT Lead:** Deputy Director of People **Timescale:** August 2023	Positive Last changed June 2022

Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
	▪ Communication of daily SitReps (Situation Reports) for workforce gaps ▪ ~~Nursing and Midwifery Workforce Transformation Cabinet~~ ▪ ~~Medical Workforce Transformation Cabinet~~ ▪ ~~Strategic People Plan~~ ▪ ~~Partnership agreement with Vision West Notts College~~					
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement, which could lead to a detremental impact on patients and service users ~~a reduction in effort above and beyond contractual requirements amongst a substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint, workforce fatigue or wellbeing issues, or failure to achieve consistent values and behaviours in line with desired culture~~ ~~This could also lead to lack of engagement with patients, resulting in failure to address patient empowerment and self-help and failure to work across the system to empower patients and carers to enable personalised patient centred care~~	▪ People ~~Culture and Improvement~~ Strategy 2022-2025 ▪ People ~~and Inclusion~~ Cabinet ▪ ~~Culture and Improvement Cabinet~~ ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood ~~Time to Change~~Welbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ ~~Staff morale identified as 'profile risk' in Divisional risk registers~~ ▪ ~~Star of the month/ milestone events~~Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and ~~r~~Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ ~~Winter wellbeing approach for 2022/23~~ ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** ~~March 2023~~Complete Develop and embed staff network groups to address inequalities in staff inclusivity **SLT Lead**: Director of People **Timescale**: June 2023 Violence and Aggression Working Group to establish an action plan in related to the V&A agenda **SLT Lead:** Director of People **Timescale:** Oct 2023	**Management:** Staff Survey Action Plan to Board May 2~~1~~3; Staff Survey Annual Report to Board ~~Jun 21~~ Apr 23; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board ~~Jun 21~~ Sep 22; Quarterly Assurance reports on People Cabinet ~~& Inclusion and Culture & Improvement~~ to People Culture and Improvement Committee; ~~Winter Wellness Campaign report to Board Oct 21~~ Wellbeing report to People, Culture and Improvement Committee Dec 22; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug ~~21~~22; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr ~~21~~23; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr ~~21~~22; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar ~~21~~23; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22	Potential impact of cost-of-living issues on staff morale and wellbeing ~~Expected increase in staff sickness and isolation levels due to COVID-19 and influenza~~ Potential industrial action up to and including strike action from all NHS unions, affecting all system partners Develop operational plans for any junior doctor strikes **SLT Lead:** Director of People Timescale: ~~February 2023~~Complete Capture learning from the doctors' strike to implement in ongoing plans for potential future strikes **SLT Lead**: Director of People **Timescale**: ~~April 2023~~ Complete	Inconclusive Last changed October 2022

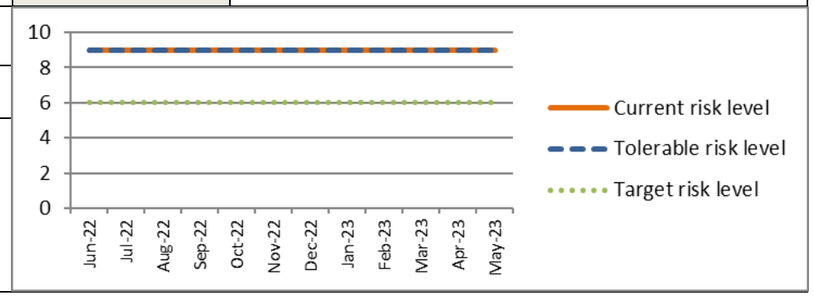
Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action	~~5: To achieve better value~~ 5. Sustainable use of resources and estate
Lead director	Chief Financial Officer	**Consequence**	4. High	4. High	4. High	**Risk appetite**	Cautious	
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 5. Very likely	3. Possible	2. Unlikely			
Last reviewed	25/04/2023	**Risk rating**	~~16~~20. Significant	**12. High**	**8. Medium**			
Last changed	25/04/2023							



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ Transformation and Efficiency Cabinet, FIP planning processes and PMO coordination of delivery ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ COVID-19 related funding application process in place at Trust level ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Capital Oversight Group	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework Revenue business case process may not adequately represent the longer-term priorities and potential consequences of future years	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** 2023/24 financial plan in development Longer-term financial strategy to be finalised during 2023/24 as part of strategic priorities, in line with clinical and operational strategies **SLT Lead:** Chief Financial Officer **Timescale:** ~~January 2023~~March 2024 Review and implement enhanced business case process for 2023/24 planning and in-year prioritisation **Progress:** Business case process for 2023/24 planning completed – process for in-year prioritisation post-planning to be confirmed **SLT Lead:** Chief Financial Officer **Timescale:** ~~January 2023~~June 2023	**Management:** CFO's Financial Reports and Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ICS finance report to Finance Committee (monthly); Capital Oversight Group; Divisional Performance Reviews (monthly); Divisional risk reports to Risk Committee bi-annually; Transformation & Efficiency Cabinet updates to Executive Team **Risk and compliance:** Risk Committee significant risk report Monthly **Independent assurance**: Deloitte audit of COVID-19 expenditure; External Audit Year-end Report 2021/22 Internal Audit reports: - Key Financial Systems - Asset Register Jan 22 - ~~Integrity of the General Ledger and Financial Reporting Dec 21~~ - ~~Financial Reporting Arrangements Nov 21~~ - Improving NHS financial sustainability Dec 22	~~Off trajectory to achieve year-end financial plan, including FIP target~~ Complete the steps of the forecast change protocol and agree a revised forecast with ICB partners and NHS England **SLT Lead:** Chief Financial Officer **Progress:** We have been instructed by NHSE not to change the forecast for month 9 **Timescale:** ~~February 2023~~Complete	Positive Last changed July 2022
ICB system deficit results in a negative financial impact to the Trust	▪ Full participation in ICB planning ▪ SFH plan consistency with ICB and partner plans ▪ ICB DoFs Group ▪ ICB Operational Finance Directors Group ▪ ICB Financial Framework	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **SLT Lead**: Chief Financial Officer **Timescale:** ~~TBC~~ March 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board		Positive Last changed July 2022

Board Assurance Framework (BAF): May 2023

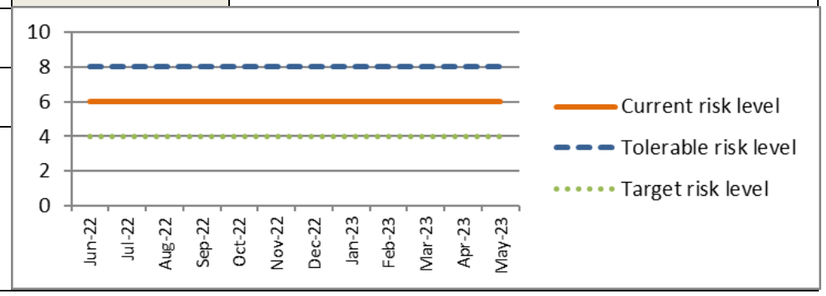
Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective**	4: To continuously learn and improve
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	~~Reputation~~ Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	22/05/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	22/05/2023								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform	The improvement function needs to be defined and organisationally embedded following the restructure	Development of an ideas platform within the remit of the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** June 2023	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** SOF Culture and Improvement indicators; SFH Trust Priorities to Board quarterly **Independent assurance:** Internal Audit of FIP/ QIPP processes Sep 21; 360 assessment in relation to Clinical Effectiveness - report May 2022	Lack of capacity for colleagues to engage with improvement Consider ways to provide the capacity to progress improvement activity **SLT Lead:** Director of Strategy and Partnerships **Timescale:** June 2023 **Progress:** the transformation programme has now been designed and integrated with strategic priorities and FIP to reduce the number of things we ask the organisation to focus on and to make connections across multiple layers of our business. This will assist in a reduction of meetings and programme reviews. Thereby releasing headspace Improvement Faculty launched 4th May	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working. ~~This may be difficult because of differences in governance, objectives and appetite for and ability to change~~						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of Strategy and Partnerships	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely		
Last reviewed	09/05/2023	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**		
Last changed	09/05/2023						

Strategic objective	~~2: To promote and support health and wellbeing~~ 6. Work collaboratively with partners in the community

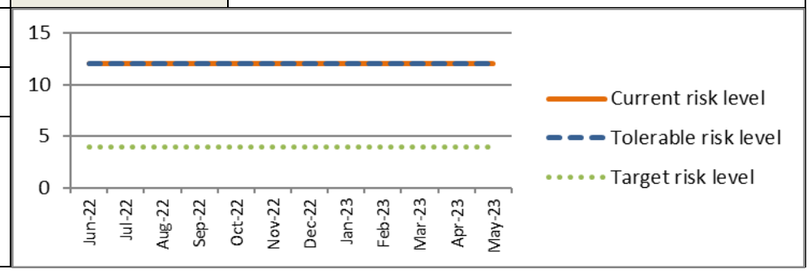


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP ~~breakthrough objectives signed off July 2020~~annual work plan • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSE • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans through the joint forward plan • Full alignment of organisational priorities with system planning ~~for 2022/23~~ • Independent chair for ICP • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative ~~development~~ • ICS System Oversight Group • ~~Engagement with the establishment of the formal ICB and place-based partnership~~ • SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services (both formally established on 1st July 2022) • Mid Notts Place Executive • Mid Notts Place-based Partnership			**Management:** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board **Risk and compliance:** Significant Risk Report to RC monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities, which limits our ability to care for patients in the right place, at the right time	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ Clinical Directors and PCN Directors clinical partnership working	The needs of the population ~~and the statutory obligations of each individual organisation~~ will not be ~~met~~fully understood or aligned to our clinical services until the ICS Clinical Services Strategy is implemented	Refreshed ICS Clinical Services Strategy led by the ICB Medical Director **SLT Lead:** Medical Director **Timescale:** September 2023	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place		Positive Last changed October 2022

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**3. Possible**	3. Possible	1. Very unlikely		
Last reviewed	09/05/2023	**Risk rating**	**12. High**	**12. High**	**4. Low**		
Last changed	09/05/2023						

Strategic objective	1: To provide outstanding care in the best place at the right time

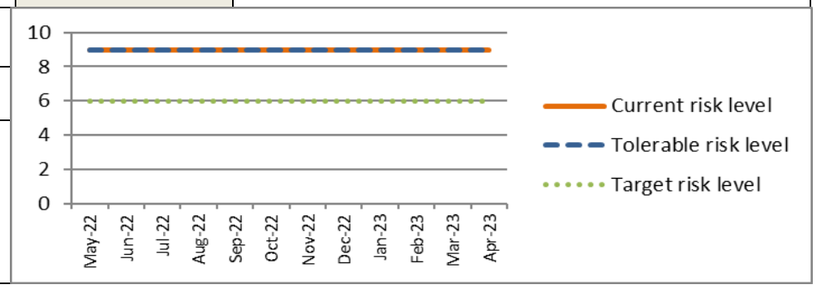


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ Cyber news – circulated to all NHIS partners ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead	Systems connected to the network are not all supported by the respective software suppliers, so are not receiving the latest security updates	A report on unsupported systems to be presented to the Risk Committee **SLT Lead:** Director of NHIS **Timescale:** ~~February 2023~~ Complete A report on the data protection implications from unsupported systems to be presented to the Risk Committee **SLT Lead:** Data Protection Officer **Timescale:** ~~March 2023~~ Complete Ensure all systems have support in place, or the cyber risk is assessed and appropriately mitigated **SLT Lead:** Chief Digital Information Officer **Timescale:** May 2023	**Management:** Data Security and Protection Toolkit submission to Board Jul 22- compliant on 108/109 elements; Hygiene Report to Cyber Security Board monthly; Cyber Security Assurance Highlight Report to Cyber Security Board monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine **Risk and compliance:** **Independent assurance**: ISO 27001 Information Security Management Certification; TIAN / 360 Assurance Cyber Security Survey - The impact of Covid-19 on the NHS Dec 20; CCG Cyber Security Report Mar 21- Significant Assurance; 360 Assurance NHIS Governance and Interface audit – limited assurance; 360 Assurance Data Security and Protection Toolkit audit Jul 22 –moderate assurance; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan 22		~~Positive~~ Inconclusive ~~No change since April 2020~~ Last changed February 2023
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Water Safety Update Report to Risk Committee Jul 20; Patient Safety Concerns report to QC March 21; Hard and soft FM assurance reports **Risk and compliance:** Monthly Significant Risks Report to Risk Committee **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct~~21~~22) – Substantial Assurance; Water Safety report (WSP) to Joint Liaison Committee Oct 19; WSP report – hard FM independent audit; MEMD ISO 9001:2015 Recertification Mar 21; British Standards Institute MEMD Assessment Report Feb 22	~~Potential insufficient capacity within the Estates department to deliver major capital projects~~ Review of capacity and planned projects **SLT Lead:** Associate Director of Estates and Facilities **Timescale:** ~~March 2023~~ Complete	Positive ~~No change since April 2020~~ Last changed March 2023

Board Assurance Framework (BAF): May 2023

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
~~A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period~~	~~▪ NHS Supply Chain resilience planning Business Continuity Management System & Core standards~~ ~~▪ CAS alert system – Disruption in supply alerts~~ ~~▪ Major incident plan in place~~ ~~▪ PPE Strategy~~ ~~▪ COVID-19 Pandemic Surge Plan~~ ~~▪ Procurement Influenza Pandemic Business Continuity Plan~~ ▪ ~~Interim provision for transmission of personal data to the United Kingdom clause within the EU Exit agreement~~			~~**Management:** Procurement Annual Report to Audit & Assurance Committee; Oxygen Supply Assurance report to Incident Control Team Apr 20; COVID-19 Governance Assurance Report to Board May 20~~ ~~**Risk and compliance:**~~ ~~**Independent assurance**: 2021/22 Counter Fraud Annual Report; 360 Assurance Procurement Review Apr 21 – Significant Assurance; 360 Assurance internal audit of contract management – limited assurance~~		Positive No change since April 2020
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident plan in place ▪ Industrial Action Group			**Management:** Industrial Action debrief report to Executive Team Mar 23 **Independent assurance:** EPRR Core standards compliance rating (Oct22) – Substantial Assurance		Positive New threat added May 2023

Board Assurance Framework (BAF): May 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable						**Strategic objective**	~~2: To promote and support health and wellbeing~~ 2: Improve health and wellbeing within our communities
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action	
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious	
Initial date of assessment	22/11/2021	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely			
Last reviewed	25/04/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	28/03/2023							

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Strategy Group ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support ▪ Process in place for gathering and reporting statistical data ▪ Adoption of NHS Net Zero building standard 2023 for all works from October 2023 ▪ Awareness to, and applications for, funding sources both internally and externally such as the Public Sector Decarbonisation Scheme and grants from Salix Ltd	Education of Board and staff at all levels Dedicated capacity to implement ideas for change	Training of the Board, decision makers and all staff at an appropriate level to increase awareness and understanding of sustainable healthcare **Progress:** Training package developed with Notts Healthcare Trust – awaiting ratification and training dates **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~December 2022~~July 2023 Proposal to ICB partners for collaborative approach and resource **Progress:** At the ICB Estates Group in March 2023 a common approach to system wide sustainability reporting and resourcing was suggested and will be reflected in revised ToR **Lead:** Chief Financial Officer **Timescale:** ~~December 2022~~June 2023	**Management:** Sustainability update report to TMT Oct 22; Green updates provided routinely to Finance Committee **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback		Positive Last changed November 2022

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date**: 1st June 2023	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Paul Robinson, Chief Executive		

Purpose		
To enable the Board to review the effectiveness of risk management within the Board Assurance Framework (BAF) and approve the proposed changes agreed by the respective Board committees, and for oversight of significant operational risks.	**Approval**	✓
	Assurance	
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
✓	✓	✓	✓	✓	✓

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	✓
PR2	Demand that overwhelms capacity	✓
PR3	Critical shortage of workforce capacity and capability	✓
PR4	Failure to achieve the Trust's financial strategy	✓
PR5	Inability to initiate and implement evidence-based Improvement and innovation	✓
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	✓
PR7	Major disruptive incident	✓
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	✓

Committees/groups where this item has been presented before

Lead Committees review individual principal risks at each formal meeting (Quality Committee; Finance Committee; People, Culture and Improvement Committee; Risk Committee). Risk Committee reviews the full BAF quarterly.

Acronyms

See below

Executive Summary

Each principal risk in the BAF is assigned to a Lead Director as well as to a Lead Committee, to enable the Board to maintain effective oversight of strategic risks through a regular process of formal review. The principal risks are:

PR1 Significant deterioration in standards of safety and care
PR2 Demand that overwhelms capacity
PR3 Critical shortage of workforce capacity and capability
PR4 Failure to achieve the Trust's financial strategy
PR5 Inability to initiate and implement evidence-based improvement and innovation
PR6 Working more closely with local health and care partners does not fully deliver the required benefits
PR7 Major disruptive incident
PR8 Failure to deliver sustainable reductions in the Trust's impact on climate change

Lead committees have been identified for specified principal risks and consider these at each meeting, providing a rating as to the level of assurance they can take that the risk treatment strategy will be effective in mitigating the risk.

The Risk Committee further supports the Lead Committees in their role by maintaining oversight of the organisation's divisional and corporate risk registers and escalating risks that may be pertinent to the lead committee's consideration of the BAF.

To provide Board oversight, a report of significant operational risks is available in the reading room. This report outlines significant risks on the Trust's risk register at the time of the last Risk Committee, and the respective principal risks on the Board Assurance Framework to which they apply.

The Risk Committee reviews all significant risks recorded within the Trust's risk register every month. This process enables the Committee to take assurance as to how effectively significant risks are being managed and to intervene where necessary to support their management, and to identify risks that should be escalated.

Proposed amendments to the BAF, agreed by the respective Lead Committees, are on the attached document - additions to the text are in red type and removals are in blue type (struck out).

The discussion at the 27th of April Board workshop and changes to strategic objectives are captured.

Schedule of BAF reviews since last received by the Board of Directors on 2nd February:

- Quality Committee: PR1 and PR2 – March and May
- People, Culture and Improvement Committee: March and May *
- Finance Committee: PR4 and PR8 – March and April
- Risk Committee: PR6 and PR7 – February, April and May

* The People, Culture and Improvement Committee meeting is scheduled for 30th May so some of the proposed changes had not been reviewed by the committee at the time of submitting this report.

PR2, PR3 and PR4 remain significant risks, and the following changes to 'current exposure' risk scores are proposed:

- PR1 reduced to below the 'significant' level
- PR2 reduced to 16 following the previous increase
- PR4 increased to 20 to reflect the current financial pressures

The reductions in current risk scores for PR1 and PR2 bring them into line with their respective 'tolerable' scores. PR4 remains above its tolerable risk rating.

Board members are requested to:

- Review the principal risks in light of proposed changes agreed by the respective lead committees
- Consider the implications of any current risk ratings being above tolerable levels
- Agree any further changes
- Approve the BAF subject to any further changes identified

Acronyms used in the Board Assurance Framework

Acronym	Description
AHP	Allied Health Professional
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BSI	British Standards Institution
CAS	Central Alerting System
CFO	Chief Financial Officer
CQC	Care Quality Commission
CYPP	Children and Young People's Plan
DoF	Director of Finance
DPR	Divisional Performance Report
ED	Emergency Department
EoLC	End of Life Care
ePMA	Electronic Prescribing and Medicines Administration
EPRR	Emergency Preparedness, Resilience and Response
eTTO	electronic To Take Out (medications)
FC	Finance Committee
FIP	Financial Improvement Plan
FM	Facilities Management
GIRFT	Getting it Right First Time
HQIP	Healthcare Quality Improvement Partnership
HSE	Health and safety Executive
HSIB	Healthcare Safety Investigation Branch
HSJ	Health Service Journal
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IGAF	Information Governance Assurance Framework
IPC	Infection prevention and control
JAG	Joint Advisory Group
LGBT	Lesbian, gay, bisexual and trans
MEMD	Medical Equipment Management Department
MFFD	Medically fit for discharge
MHRA	Medicines & Healthcare products Regulatory Agency
MSFT	Medically safe for transfer
NEMS	NEMS Community Benefit Services (formerly Nottingham Emergency Medical Services)
OD	Organisational development
PC&IC	People, Culture and Improvement Committee
PCI	People, Culture and Improvement
PFI	Private Finance Initiative
PHE	Public Health England

Acronym	Description
PLACE	Patient-Led Assessments of the Care Environment
PMO	Programme Management Office
PPE	Personal protective equipment
PSC	Patient Safety Committee
PSC	Patient Safety Culture
QC	Quality Committee
QIPP	Quality, Innovation, Productivity and Prevention
SFFT	Staff Friends and Family Test
SI	Serious incident
SLT	Senior Leadership Team
SOF	Single Oversight Framework
TIAN	The Internal Audit Network
TMT	Trust Management Team
TTO	To Take Out (medications)
UEC	Urgent and Emergency Care
UKAS	United Kingdom Accreditation Service
UKHSA	UK Health Security Agency
WAND	We're Able aNd Disabled
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Sherwood Forest Hospitals
NHS Foundation Trust

Public - Board of Directors

Committee Effectiveness Report 1st June 2023

Author – Shirley A Higginbotham, Director of Corporate Affairs

Introduction

Effective Board Meetings and committees of the Board are a key part of an effective governance structure it is therefore important to ensure the Trust's organisational governance aligns with best practice and national guidance.

Scope of Review of Effectiveness

The Trust has undertaken a review of the effectiveness of the Committees of the Board, using a standardised, committee Health check self-assessment tool. The checklist is divided into five sections:

- Role and responsibilities
- Membership and independence
- Skills and experience
- Scope of work
- Communication

The aim of the Health Check is to help committees to review their governance arrangements, check they have appropriate systems in place and identify areas where they could improve.

Members of the committees completed each question and considered the evidence available to determine where the committee is on the following scale:

- Fully Met: The committee is confident that the requirement is in place and there is evidence to support it
- Part Met: The committee partly carries out the requirement and there is some evidence to support it, but current practice needs adapting or improving
- Not Met: The committee does not meet the requirements practice and current practice needs adapting or improving.

The current governance for the Trust is provided through a properly constituted Board established in accordance with the Trusts constitution. The Trust Board has the following approved committees:

- Audit and Assurance
- Finance
- Quality
- People, Culture, and Improvement

The Charitable Funds Committee, although not a committee of the Board reports regularly to the Board, as the Corporate Trustee, to appraise of the outcomes of the committee meetings and provide assurance the committee is aligned with delivering the strategic objectives of the Trust.

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The terms of reference and work plans for the committees were also reviewed, in accordance with the annual requirement identified in the Terms of Reference.

Key Findings

The detailed key findings for each of the committee is included in the reading room, where questions were assessed as part met or not met and action plan has been developed which details the action required, the lead officer and the timelines. These action plans will be monitored within each of the committees.

A brief analysis of the actions identified for each of the committees is detailed below

Quality Committee

No actions identified

Finance Committee

- Routine updates on the longer-term financial strategy to be incorporated into Committee Work-Plan.
- Committee Effectiveness Review to be shared with internal and external auditors to seek external assurance on the Committee maturity.

Charitable Funds Committee

- Governor workshop held December 2020. Requirement for further governor training session - scheduled for September 2023

Audit and Assurance Committee

- No actions identified for the 2022/23 report
- One outstanding action from the HFMA's NHS Audit Committee Handbook review undertaken for the 2021/22 self-assessment exercise
    - Review performance of the internal and external auditors annually at the private meeting with the auditors– this has been added to the workplan

People, Culture and Improvement

- No actions identified

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Committee Effectiveness Report	**Date**: 1st June 2023	
Prepared By:	Shirley Higginbotham, Director of Corporate Affairs		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		
Purpose			
To provide the Board of Directors with assurance regarding the effectiveness of the Committees of the Board.		**Approval**	
		Assurance	**X**
		Update	
		Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Audit and Assurance Committee, Finance Committee, Quality Committee, and Charitable Funds Committee have all completed the self-assessments.

Acronyms

HFMA – Healthcare Financial Management Association

Executive Summary

The Board is supported by its committees, to ensure the committees are demonstrating good governance and identifying areas of improvement a Committee Health Check self-assessment review has been undertaken.

There have been three actions identified through the self-assessment review process, two for the Finance Committee and one for the Charitable Funds Committee. There is one outstanding action from the 2021/22 HFMA's Audit Committee Handbook review of the Audit and Assurance Committee and this is in progress.

The Terms of Reference and Work plans for all committees have been reviewed and agreed.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Council of Governor Chair's Highlight Report to Board of Directors

Subject:	Council of Governors	**Date:** 1st June 2023	
Prepared By:	Claire Ward, Chair		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
To provide assurance to the Board of Directors		**Assurance**	Sufficient

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
Friends and Family feedback, lack of consistency in collection of data across divisions. Food choices and availability – some patients not able to have their first or second choices. The map of the KMH site to be reviewed as difficult to understand.	Workshop to be led by the appointed governor for Nottinghamshire County Council in respect of data and systems. Governors to receive a presentation from committee chairs when seeking governor observers. Governor elections – to conclude July 2023
Positive Assurances to Provide	**Decisions Made**
Feedback report from 15 steps programme Quality priorities as detailed in the 2022/2023 Quality Accounts Estates update Staff Survey results Improvement Faculty development Fit and Proper Person Annual Report	Chairs appraisal approved Approval of Remuneration Committee report regarding the revised Code of Governance for NHS provider Trusts and the implications for the Chair and NEDs

Comments on Effectiveness of the Meeting

- Good meeting, clear papers and presentations

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet template and Guidance for all governance meetings

All reports MUST have a cover sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 1 June 2022	
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for W&C		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for W&C, Phil Bolton, Chief Nurse		

Purpose		
To update the board on our progress as maternity and neonatal safety champions	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X	**X**		**X**	

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

- Nursing and Midwifery AHP Committee 24/05/2023
- Maternity Assurance Committee 26/05/2023

Acronyms

- MNSC-Maternity and Neonatal Safety Champion
- CQC- Care Quality Commission
- LMNS- Local Maternity and Neonatal System

Executive Summary

The role of the maternity provider safety champions is to support the regional and national maternity safety champions as local champions for delivering safer outcomes for pregnant women and babies. At provider level, local champions should:

- build the maternity safety movement in your service locally, working with your maternity clinical network safety champion and continuing to build the momentum generated by the maternity transformation programme and the national ambition
- provide visible organisational leadership and act as a change agent among health professionals and the wider maternity team working to deliver safe, personalised maternity care
- act as a conduit to share learning and best practice from national and international research and local investigations or initiatives within your organisation.

This report provides highlights of our work over the last month.

Summary of Maternity and Neonatal Safety Champion (MNSC) work for May 2023

1.Service User Voice

This month we have celebrated the work that our Parent Voice Champion, Sarah has brought to the role and wished her well in her newly appointed role as Independent Senior Advocate for Nottinghamshire ICB, where she will be working with our families at SFH. As part of the Maternity Voice Partnership re-design, they are looking at how this will support SFH, taking the learning from this Sarah. An action plan is being developed to support the report as to "What good care looks like- a thematic analysis" and this will be shared once completed.

As MNSC we wanted to acknowledge and say thank you for all Sarah's work over the last 12 months and we are looking forward to our continued working with her in her new role.

2.Staff Engagement

To support the celebrations of the International Day of the Midwives on the 5th of May 2023, as part of the planned events the MNSC spent time with the teams talking through and celebrating (with cake) the Maternity and Neonatal Services at SFH. Staff spoke openly about the improved staffing, the elective caesarean section list and engagement which made a difference to their working lives.

The Maternity Forum ran on the 9th of May 2023, with colleagues joining from all areas across the division. Updates and resolutions were provided around previously raised issue surrounding car parking for on call staff and last months Daisy award winner (as below). Positive updates came from the team regarding the planned Midwifery recruitment day on the 12th of May, with 30 students confirmed to attend and that our Recruitment and Retention Lead Midwife has been asked to take part on the Chief Midwifery Officers blog for June. Our Lotus team also updated on the Mental Health Awareness Week and the activities that took place, further information on this team is provided below in this months QI update.

3.Governance Summary

Three Year Maternity and Neonatal Plan:

The anticipated Single Delivery Plan was launched on the 31st of March, following a delay and title change as the "Three Year Delivery Plan for Maternity and Neonatal Services (NHSE, 2023). The plan focuses upon four key themes:

1. Listening to and working with women and families with compassion
2. Growing, retaining and supporting our workforce
3. Developing and sustaining a culture of safety, learning and support
4. Standards and structures that underpin safer more personalised and more equitable care

As a system we have looked at how to address, understanding the local data and demand and have provisional proposed an initial focus upon two key priority areas, which are aligned to the ICS Integrated Care Strategy commitments:

1.Embedding the voice of women, birthing people and families – and ensuring key learning from service users is the main driver in transforming our maternity and neonatal services. This includes but is not limited to development of MVP and NVP

2. Equity as the lens through which we view all areas of the LMNS – ensuring equity across our services and local population, with a focus on experience as well as outcomes, looking at localized data for Nottingham and Nottinghamshire.

These areas were approved through Executive Partners meeting on the 16th of May 2023.

Ockenden:

The outstanding action required for full compliance for the initial 7 IEA's focuses on a co-produced action plan was approved at the panel meeting and we have now 100% compliance for Ockenden initial 7IEA. We will continue with our monthly local level meeting which will feed into the LMNS as to the assurance of the embedding on the 7 IEAS**.**

NHSE have confirmed that the system is not required to report compliance against Ockenden II. However, NHSE have suggested local Trust actions plans are developed and progressed to deliver the IEAs set out in Ockenden II. SFH completed this work and have been advised to review their delivery plans.

NHSR:

Following a bid from SFH, we have been successful, and the amount returned is yet to be confirmed. The year 5 of the Maternity Incentive Scheme has yet to be launched nationally but is anticipated the announced in Q1 2023/24 to date has yet to be released.

Saving Babies Lives:

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) v2. On-going progress is reported externally quarterly to NHSE via the Midlands Maternity Clinical Network. Discussed at MNSC and shared as part of the reading room is the monthly data for the SBLCB taken from Badgernet, which is showing an improving position and is being used for governance papers through division. We remain on track for the compliance for the two areas who currently have agreed divergence against with support from both the LMNS and regional team. Version 3 of the SBLCB is due out imminently, to support the additional element and the reporting requirements for this we have funded an internal secondment for 12 months to support.

CQC:

Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) an action plan has bee approved by the Quality Committee on the 13th of April 2023 and the two "Must do" actions are progressing. The progress of these and the commencing of the "Should do" actions will be discussed through Maternity Assurance Committee. The "must do" action for mandatory training has been completed for the training year 2022/23 with the Trust Mandatory training meeting the planned trajectory of 91% (Trust target 90%). Subsequent planning has been applied to the 2023/24 training year and a clear trajectory, which is monitored through governance. The second "Must do" relates to triage, we have a planned live launch on the 5th of June, with a clear improvement plan which remains on track for delivery.

4. Quality Improvement

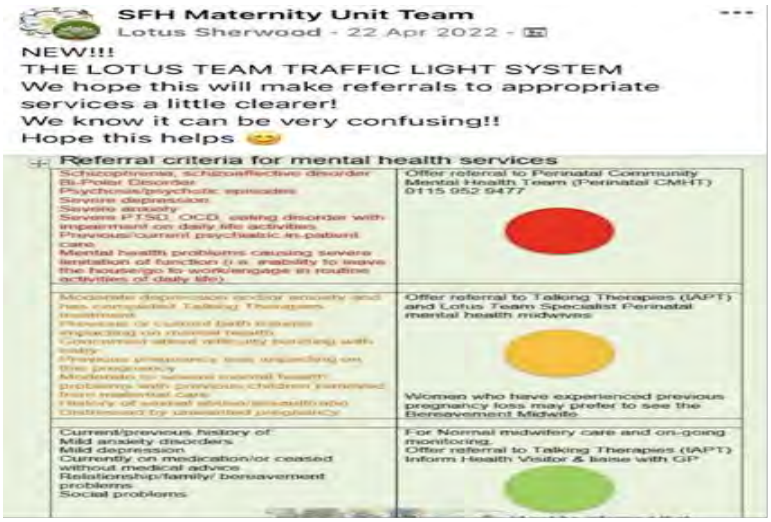
Since 2014 we have had a Specialist Midwife for Perinatal Mental Health but overtime the service grew and required additional support. Following a service review with the support of the national guidance, the Lotus Team Launched in February 2020, which includes two Perinatal Mental Health Midwives and an Obstetrician.

The Lotus Team

The **Lotus Obstetric Clinic** (code LMKLO) led by Leena Maddock Khan is in place. The clinic is held on alternate Thursday afternoons.

- **Dr Leena Maddock Khan sees the ladies together with a Lotus Team mental health midwife**
- **We aim to see ladies who either have severe mental illness, are under the care of the Perinatal Community Mental Health Team (formerly the Perinatal Psychiatry Service) or in other adult mental health services.**
- **We anticipate that most women should be identified at booking by their community midwife and referred to the clinic then. If women are identified later in their pregnancy, they can be transferred to the clinic (unless they prefer to stay with their obstetrician)**

The team have focused upon the clinics, referral criteria alignment and then how this is shared with our teams. To support the communication and reflect the pattern within the division the team have shared their communication via email, notice board updates and via a closed social media page, example as below.



The post has been well established at Sherwood since 2014 and Diane, our initial Midwife has supported the women, their families, and the service from the outset. Last month we were able to present her with a Daisy award from a nomination from one of her women and the difference the support of her and the clinic had on her pregnancy, birthing experience and journey into motherhood.

5.Safety Culture

We now have a planned first wave of the culture survey, due to launch on 19 June, with the timetable as below.

Wave 1 – W&C and Surgery

Staff lists submitted 5th June

Survey launch 19th June

Survey close 7th July

Results available 24th July

Once the results are available we will present the to the MNSC.

Maternity Perinatal Quality Surveillance model for June 2023

Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

2022/23	
Proportion of Midwives responding with Agree" or "Strongly Agree" on whether they would recommend their Trust as a place to work of receive treatment (reported annually)	74.9%
Proportion of speciality trainees in O&G responding with "excellent or good" on how they would rate the quality of clinical supervision out if hours (reported annually)	89.2%

Exception report based on highlighted fields in monthly scorecard using April data (Slide 2)

Massive Obstetric Haemorrhage (Apr 4.7 %)

- Increase in cases this month, no harm attributed and team are monitoring.
- ICB request for system to review cases/ plan improvement trajectory through system quality and safety meeting given the regional position- meeting on-going

Stillbirth rate 2022/23 (4.0/1000 births)

- Once reportable case in April, attended with first episode of altered fetal movement, intrauterine fetal death confirmed on arrival.
- SFH stillbirth rate, for year 22/23 below the national ambition of 4.4/1000 birth (SFH rate 4.0). Unit will continue to work and support the national, regional and local work to reduce rates

Staffing red flags (Apr 2022)

- 4 staffing incident reported in the month.
- No harm related

Suspension of Maternity Services

- No suspension of services within April 23

Home Birth Service

- 23 Homebirth conducted since re-launch, 5 completed in April

Elective Care

- Elective Caesarean section commenced, refining work underway however noting daily improvements and no cancelations noted.
- Induction of Labour, delays improved revised QI work ongoing around the supportive MDT meeting

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• Bid for funding supported by NHSR awaiting final confirmation of the amount. • No dates yet for Year 5- working group on pause until confirmed.	• Initial 7 IEA- final IEA is 100% compliant following evidence review at LMNS panel • Three year neonatal plan launch and ongoing work with the LMNS to look at local deliverables • Next regional insight visit planned for Oct 23

Incidents reported Apr 2023 (58 no/low harm, 0 moderate or above)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 12	No themes outside of the "trigger" list
No incidents reported as 'moderate'	

Other

- 3rd and 4th Degree tears improved this month, to monitor.
- SBLCB, remain complaint anticipated launch of version 3 imminently due out – secondment role out to recruit to sup[port the delivery of the 2024 ambition
- National Midwifery Officer team onsite to present x2 awards on the 16th of May 2023

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Maternal Perinatal Quality Surveillance Scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Running Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	Trend
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	55%	54%	43%	56%	56%	55%	60%	
3rd/4th degree tear overall rate	<3.5%	2.18%	2.40%	4.30%	2.80%	1.80%	3.10%	5.60%	3.50%	3.30%	
3rd/4th degree tear overall number		46	4	8	6	2	5	9	6	6	
Obstetric haemorrhage >1.5L number		59	9	9	14	14	5	5	5	13	
Obstetric haemorrhage >1.5L rate	<3.5%	3.24%	3.20%	3.90%	4.60%	4.80%	3.90%	2.00%	1.90%	4.70%	
Term admissions to NICU	<6%	3.62%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	4.00%	
Stillbirth number		8	2	0	2	2	2	0	1	1	
Stillbirth rate	<4.4/1000	4.63	3.300			3.240			4.000		
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	
Number of compliments (PET)		0	2	2	2	3	2	3	3	6	
Number of concerns (PET)		9	1	2	1	1	1	1	1	1	
Complaints		11	0	0	0	0	0	0	0	0	
FFT recommendation rate	>93%		91%	89%	90%	90%	89%	91%	91%	91%	

External Reporting	Standard	Running Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Feb-23	Feb-23	Trend
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above										
Maternity incidents no harm/low harm		595	96	72	80	79	64	70	64	70	
Maternity incidents moderate harm & above		0	0	0	0	0	0	0	0	0	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	
HSIB/CQC etc with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Guardian of Safe Working Report	**Date:** 1st June 2023	
Prepared By:	Rebecca Freeman - Head of Medical Workforce, Jayne Cresswell – Medical Workforce Specialist		
Approved By:	David Selwyn – Medical Director		
Presented By:	David Selwyn – Medical Director		

Purpose		
To provide the Board of Directors with an update on the exception reports received from Postgraduate Trainees and Clinical Fellows between 1st February 2023 and 30th April 2023.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	**X**	**X**	**X**		

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	**X**
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Joint Local Negotiating Committee

Acronyms

TCS – Terms and Conditions of Service
HEEM – Health Education East Midlands
FTE – Full Time Equivalent
PA – Programmed Activity
CF – Clinical Fellow

Executive Summary

The paper provides the Committee with an update on the exception reports received from Postgraduate Trainees and Clinical Fellows between 1st February 2023 and 30th April 2023.

The Board of Directors is asked to note the following:

- For the first time there have been more exception reports from Surgery, Anaesthetics and Critical Care than from the Medical Division.
- The overall increase in Exception reports from this time last year.
- Clinical Fellows are now using the Allocate system to complete exception reports

- The system now sends regular reminders to supervisors and doctors where action is required to either respond to an exception report or to close an exception report.
- The Medical Workforce Team is now responding to the more simple Exception Reports
- Although the number of reports have increased since the same time last year, there is still some under reporting, particularly amongst the Senior Clinical Fellows/ST3+ doctors.
- A Guardian of Safe Working has been recruited.

Guardian of Safe Working Report covering the period from 1st February 2023 to 30th April 2023

Introduction

This report provides an update on exception reporting data, from 1st February 2023 to 30th April 2023. It outlines the exception reports that have been received during the last three months, the actions and developments that have taken place during this time and work that is ongoing to provide assurance that there is safe working as per TCS of the 2016 junior doctors' contract.

As can be seen from the below, 201 (196.6 FTE) postgraduate doctors in training have been allocated to the Trust by Health Education East Midlands (HEEM). The Trust has an establishment of 224 trainee posts, so this rotation there are 23 vacant trainee posts, this is due to HEEM not being able to fill these posts for a number of reasons, including doctors being on maternity leave (2 doctors, 1.8 FTE), not passing their exams, doctors leaving the training programme or there not being enough trainees following a particular training pathway to fill the posts across the country. The Trust isn't always informed of the reasons for the vacant posts and as can be seen from previous reports, these vacancy numbers fluctuate. Further information is included in the vacancies section.

High level data as of 30th April 2023

	Posts	Heads	FTE
Established doctor in training posts:	224		
Number of doctors in training in post:	201	204	196.6
Number of vacant training posts:	23	-	27.4
Number of unfilled training posts filled by a non-training doctor:	5	-	4.8
Established non-training doctor posts:	97		

Number of non-training doctors in post:	90	90	89.6
Number of vacant non-training posts:	7	-	7.4

High level data from previous quarter (as of 31st January 2023)

	Posts	**Heads**	**FTE**
Established doctor in training posts:	224		
Number of doctors in training in post:	202	205	200.8
Number of vacant training posts:	22	-	23.2
Number of unfilled training posts filled by a non-training doctor:	6	-	5.6
Established non-training doctor posts:	98		
Number of non-training doctors in post:	82	82	81.4
Number of vacant non-training posts:	16	-	16.6

The doctor in training posts have remained static at 224. The non-training doctor posts have decreased by 1 due to a Clinical Fellow post being converted to an Acute Care Practitioner post in Geriatrics.

Amount of time available in the job plan for the guardian:	1 PA
Administrative support provided to the guardian:	0.1 WTE
Amount of job planned time for Educational Supervisors:	0.25 PA per trainee

Exception reports From February 2023 (with regard to working hours)

The data from 1st February 2023 to 30th April 2023 shows there have been 93 exception reports in total, 80 related specifically to safe working hours while 9 were related to educational issues and 4 related to service support.

Four of the exception reports were categorised by the postgraduate trainees as immediate safety concerns. Further details of the immediate safety concerns can be found in Table 1.

By month there were 45 exception reports in February 2023, 40 in March 2023 and 8 in April 2023.

Of the 80 exception reports relating to safe working hours all 80 were due to working additional hours.

Of the total 93 exception reports all have been closed, with 7 being unresolved due to the doctor in training needing to accept the outcome.

For the exception reports where there has been an initial meeting with the supervisor the median time to first meeting is 16 days. Recommendations are that the initial meeting with the supervisor should be within 7 days of the exception report. In total 54 (58%) of all exception reports either had an initial meeting beyond 7 days or have not had an initial meeting. During this period of reporting, the system has been upgraded to send regular reminders to supervisors that an exception report is awaiting their response. Whilst this has increased the responses to exception reports, these responses are still not being completed in a timely manner by the supervisors. In some of the more straightforward cases the Medical Workforce Team have responded on behalf of the supervisor. This will continue to happen, therefore it is anticipated that the time to the first meeting will reduce going forwards.

Where an outcome has been suggested there are 21 (22%) with time off in lieu (TOIL) totaling 19 hours and 41 minutes, 64 (69%) with additional payment totaling 81 hours and 34 minutes at normal hourly rate and 3 hours at premium rate and 8 (9%) with no further action.

The Allocate software used to raise exception reports and document the outcome does not currently have the facility to be able to link to the eRota system to confirm TOIL has been taken or additional payment received, therefore this is actioned manually by the Medical Workforce Team, a report is completed for the rota coordinators to ensure that time off in lieu is added to the doctor's record or any payment is made.

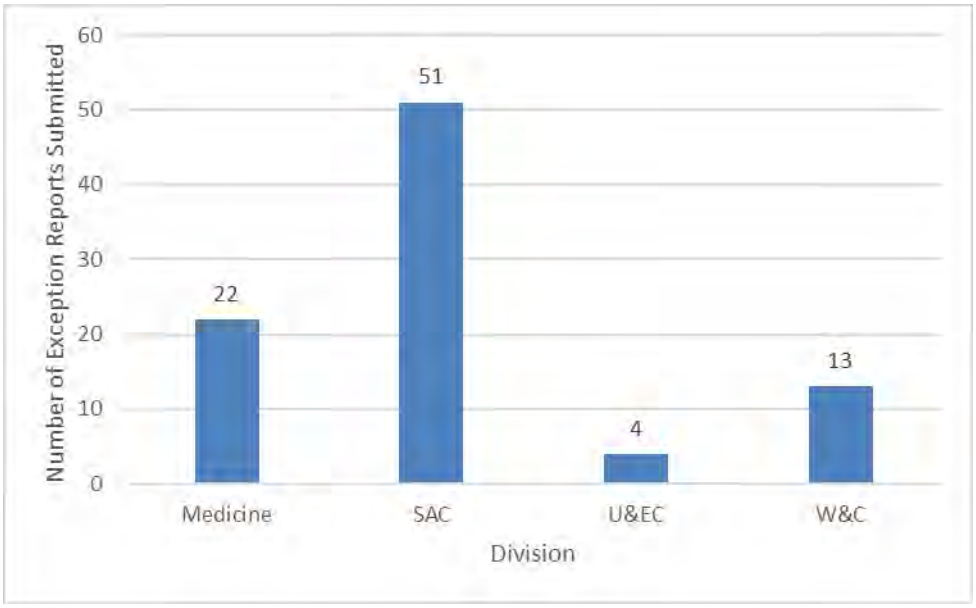


Figure 1. Exception reports by Division for Trainees

Figure 1 shows that the majority of the exception reports received during this period - 51 (55%) in total - are from postgraduate doctors working in the **Surgery, Anaesthetics and Critical Care (SAC) Division**.

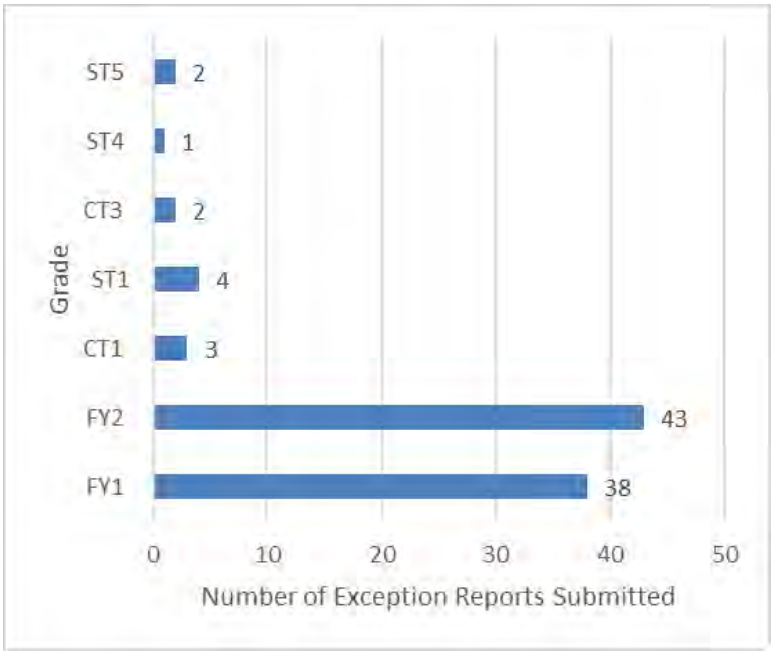


Figure 2. Exception reports by Grade for Trainees

Figure 2 shows a high number of exception reports were submitted by the Foundation Year 1 and Foundation Year 2 Doctors. In total 38 (41%) of the exception reports have come from the Foundation Year 1 Doctors, 43 (46%) from the Foundation Year 2 Doctors, 7 (8%) CT1/2 and ST1/2 doctors and 5 (5%) from CT3/ST3+ doctors.

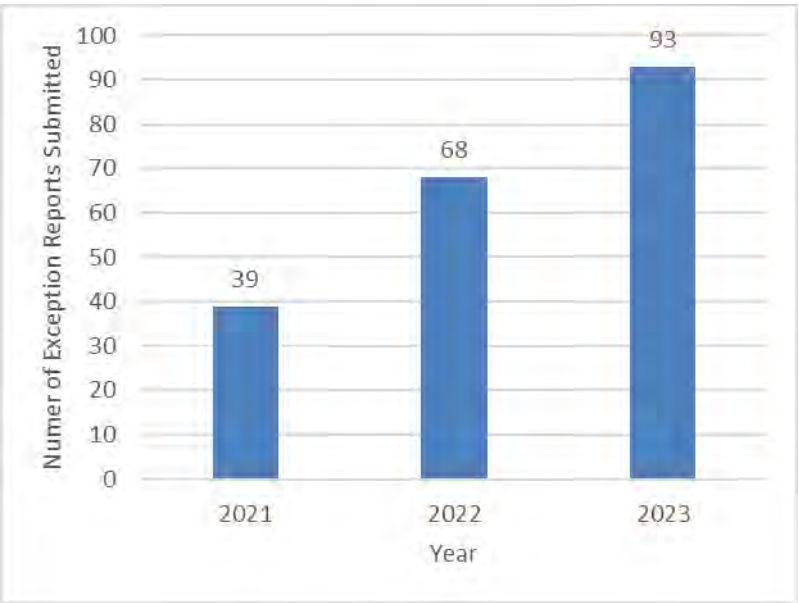


Figure 3. Comparison of number of exception reports for the same period between 2021, 2022 and 2023

Before the Pandemic, in 2018 for the same quarter, this number was 111 and in 2019 it was 56.

Date	Grade and Specialty of Doctor	Details of Immediate Safety concern reported by the Trainee	Action Taken	Status of the Concern
18.02.23	F1 in General Surgery	The Trainee worked an additional 30 minutes on a very busy day to ensure the patients were safe	Registrar and consultant aware	The report has been closed.
03.03.23	F2 in T & O	Covered 23 patients some of which were quite unwell and needed additional support. A number of TTO's were also requested. Asked for additional	Supervisor aware and payment for additional hours has been made.	The report has been closed.

		support but no one was available to assist. Worked an additional 2 hours.		
23.03.23	F1 in Medicine	Night junior doctor did not arrive for shift. Leaving 1 doctor to clerk, take referrals and care for EAU patients. Worked an additional ½ hour.	Supervisor aware and reviewing staffing	The report has been closed.
01.04.23	Clinical Fellow in Acute Medicine	CF felt that they were looking after too many patients and didn't have the senior support. Unable to take break.,	Supervisor aware and asked the doctor to contact consultant on call in future.	The report has been closed.

Table 1. Immediate Safety Concern Concerns Raised

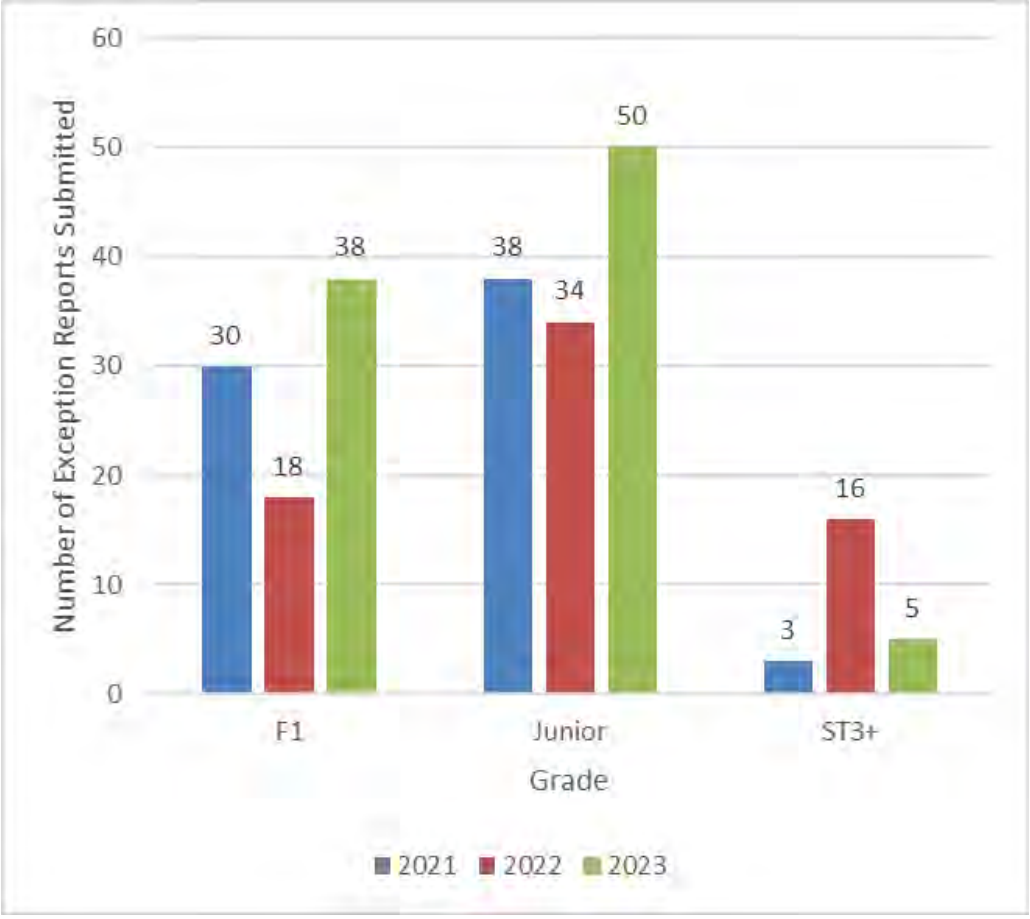


Figure 4. Number of Exception reports by doctors by grade for the same quarter between 2021, 2022 and 2023.

Figure 4 shows that this year there have been more exception reports from the foundation year 1 doctors and junior grade doctors than in previous years but there are less exception reports from the ST3+ doctors than in 2021. However, overall the number of exception reports is increasing.

Exception Reports from Clinical Fellows

Clinical Fellows are now using the allocate system and prior to this commencing two reports were received and they were both due to working additional hours. Both have since been closed.

Work Schedule Reviews

There have been no work schedule reviews. Exception reports continue to be dealt with as a one-off with few progressing to a work schedule review for issues that are recurrent.

Fines

There were no fines issued this quarter.

Vacancies

The Trust currently has 208 doctors in training. As mentioned in the introduction, there are 16 vacancies currently where the Trust has not been allocated trainees by HEEM, the reasons for these posts not being filled were also mentioned in the introduction, 5 of the vacancies are currently filled by Clinical Fellows. Clinical Fellow recruitment is ongoing with the aim of filling as many training vacancies as possible.

The remaining gaps will be filled by doctors on the bank where needed to support the rotas, which represents a cost pressure to the Trust.

The numbers of clinical fellows that have been recruited for the August changeover have been increased to allow more flexibility to cover trainee vacancies in August and to support the Trust over the winter period. This will negate the need for as many agency doctors and bank doctors as have been used in previous years at a junior and middle grade level. The additional numbers recruited have been based on the need in previous years.

Qualitative information

The number of exception reports made by the more senior trainees' still remains low. Although the overall number of exception reports has increased particularly amongst the F2 doctors, the hospital has remained extremely busy, therefore it is felt that there is still some under reporting, however, this is reducing. The response to the exception reports by Educational and Clinical Supervisors within the required 7 days remains low. Table 3 below indicates the number and percentage of exception reports that were not responded to within the required time frame of 7 days over the last year. Despite reminders, this number still remains high.

This will be an area of focus going forward for the Guardian of Safe Working. For the first time there have been more exception reports in the Surgery, Anaesthetics and Critical Care Division than in Medicine and these have generally come from General Surgery and Trauma & Orthopaedics. These reports are mainly related to working additional hours. For both areas, the rotas are currently being reviewed for the new intake of junior doctors in August. There will also be additional posts in both areas in August 2023.

Date of the Guardian Report	**Number and Percentage of reports <u>not</u> responded to within 7 days**
February 2023 – April 2023	58% of all reports received 54 reports
November 2022 - January 2023	75% of all reports received 65 reports
August 2022 – October 2022	66% of all reports received 72 reports
May 2022 – July 2022	25% of all reports received 10 reports
February 2022 – April 2022	56% of all reports received 38 reports

Table 3 Exception Reports <u>not</u> responded to within 7 days

The Guardian of Safe Working has been appointed. Three applicants applied for the post and Dr Nav Sathi was successful. Dr Sathi is a consultant in Diabetes and Endocrinology and has previously worked in both Acute Medicine and Respiratory Medicine. Dr Sathi will commence in post on 1st June 2023. A communication to the Trust and an induction programme are both currently being organised.

Work is currently underway preparing for the August rotation. A number of additional training posts both at Foundation Level and at St3+ level have been allocated to the Trust from August.

As has been seen from previous reports there has been investment in both Foundation posts and additional Clinical Fellow posts for Medicine, however, there has not been any investment in Senior posts, therefore this is welcomed as a number of exceptions do raise the lack of support at a Senior level. Rotas are currently being revised based on the increased numbers and the feedback received from Exception Reports.

As previously reported in the Medical Workforce Report presented to the Board of Directors at the meeting in May 2023, a Task and Finish Group has been established to manage the relocation of the doctors mess. This work is continuing, a walk around the new site for the mess took place on 28th April 2023 and a Business case has been completed for presentation at the Capital Oversight Group meeting on Thursday 25th May 2023.

A further period of Industrial Action by Junior Doctors has been announced this commences at 7am on 14th June and ends at 6.59am on Saturday 17th June 2023. Preparations are underway to ensure the emergency pathway and the wards are prioritised during this period.

Conclusion

- Note that for the first time there have been more exception reports from Surgery, Anaesthetics and Critical Care than from the Medical Division.
- Note the overall increase in Exception reports from this time last year.
- Clinical Fellows are now using the Allocate system to complete exception reports
- The system now sends regular reminders to supervisors and doctors where action is required to either respond to an exception report or to close an exception report.
- The Medical Workforce Team is now responding to the more simple Exception Reports
- Although the number of reports have increased since the same time last year, there is still some under reporting, particularly amongst the Senior Clinical Fellows/ST3+ doctors.
- A new Guardian of Safe Working has been recruited.

Appendix 1

Issues/Actions arising from the Guardian of Safe Working Report

Action/Issue	Action Taken (to be taken)	Date of completion
Exception reports being responded beyond the first 7 days.	The Medical Workforce Team have started to manage the more straight forward exception reports, whilst still encouraging the Clinical Supervisors to respond to those requiring Clinical input. The impact of this change will be evaluated in the next report.	31st July 2023
Recruitment to the post of Guardian of Safe Working	A new Guardian of Safe Working has been appointed and an induction programme is currently being arranged for the new incumbent.	1st June 2023
Investment in additional posts at F2 and St3+ level	Rotas are currently being developed to incorporate the additional posts and the feedback received from Exception reports.	5th June 2023

EQUALITY, DIVERSITY AND INCLUSION

ANNUAL REPORT 2022/23

SUMMARY AND HIGHLIGHTS

Sherwood Forest Hospitals NHS Foundation Trust

Mandatory Reporting

Workforce Race Equality Standard:

- ✓ Overall increase in the number of BAME colleagues in the Trust
- ✓ BAME candidates more likely to be appointed the White applicants

Workforce Disability Equality Standard:

- ✓ Increase in the number of colleagues declaring their disability on ESR
- ✓ No disabled colleagues entering the formal capability process

Gender Pay Gap Report:

- ✓ Reduction in our overall gender pay gap
- ✓ More women in senior roles in the Trust
- ✓ Over 30% reduction in consultant bonus pay over last 5 years

All mandatory report data was submitted on time and published on the Trust website in accordance with deadlines

Chaplaincy

During the past year, the service had over 5,000 patient contacts and over 2,000 visitor contacts including nearly 350 out of hours calls.

116 individual hospital contact funerals were undertaken for both adults and families who experienced pregnancy or baby loss.

Continued to provide cover 24/7 with an out of hours on call rota.

Developed a new multi-faith calendar to support celebrations of all faiths within the Trust.

Staff Networks

- Launched new Women in Sherwood network
- Rebranded staff networks
- Successful relaunch in August '22 increased membership by 37.5% by Feb '23
- 148 new members since 2022 annual report

EDIMATTERS ETHNIC MINORITY STAFF NETWORK

EDIMATTERS LGBTQ+ STAFF NETWORK

EDIMATTERS WAND STAFF NETWORK

EDIMATTERS CARERS STAFF NETWORK

EDIMATTERS WOMEN IN SHERWOOD

Mandatory Training

Over 5,000 colleagues completed EDI training in 22/23.

Disability Confident Employer

Retained our accreditation until March 2026.

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Allyship in Sherwood

Developed and launched Allyship training in August 2022. To date over 50 colleagues have received the training.

REACH OUT!

October 2022 saw our inaugural REACH OUT! event at Sherwood. A day dedicated to the celebration of Race, Ethnicity And Cultural Heritage. A huge success, the event featured staff stories, a guest speaker, entertainment, a best-dressed competition and delicious food! This year's event is in the planning and will take place during Race Equality Week September.

Project SEARCH

Sherwood became a host employer for the Project SEARCH programme in 21/22 and saw our first intake of four students in September 2022.

Working in partnership with Vision West Notts college, Nottinghamshire County Council, Medirest and Skanska, the programme aims to provide a pathway to work for people with learning disabilities and neurodiversity conditions through an internship in the learners final academic year which, it is hoped, will lead to employment.

International Recruitment

- ✓ 65 International Nurses recruited
- ✓ Issued 58 new certificates of sponsorship to overseas nationals
- ✓ Issued a further 42 certificates of sponsorship for professional colleagues wishing to stay in the UK but move to the local area or for those wishing to extend their employment with the Trust

Translation and Interpreting Services

77.7% increase in service demand over the last 2-years.

In 22/23, over 2,500 interpreting arrangements were made for our patients.

The service is offered face to face, via telephone or video.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Equality, Diversity and Inclusion (EDI) Annual Report	**Date:** 1 June 2023	
Prepared By:	Ali Pearson, People Equality, Diversity and Inclusion Lead		
Approved By:	Rob Simcox, Director of People		
Presented By:	Rob Simcox, Director of People		
Purpose			
This report is being presented to provide a summary of the Equality, Diversity and Inclusion activity that has taken place during 2022/2023.		**Approval**	**X**
		Assurance	
		Update	**X**
		Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**x**	**x**

Principal Risk		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

People Cabinet
People, Culture and Improvement Committee

Acronyms

EDI – Equality, Diversity and Inclusion
AfC – Agenda for Change
WRES – Workforce Race Equality Standard
WDES – Workforce Disability Equality Standard
CQC – Care Quality Commission
EDS – Equality delivery System
LGBTQ+ - Lesbian, Gay, Bisexual, Trans and Questioning
EqIA – Equality Impact Assessments
AGM – Annual General Meeting
SFH – Sherwood Forest Hospitals
ICS – Integrated Care System

DWP – Department for Work and Pensions
ICB – Integrated Care Board
LD – Learning Disabilities

Executive Summary

Background

The Trust is required to report to the Board annually it's EDI activity for colleagues and patients. This report, which will be published on the Trust website, also enables us to demonstrate that we are meeting our obligations under the Public Sector Equality Duty.

The report describes how we govern Equality, Diversity and Inclusion within the Trust and describes the mandatory reporting that has been completed in the 2022/2023 year as required by the Government and/or NHS England and Improvement and signposts to where this information has been published.

The report provides an overview of our workforce based on Ethnicity, Gender, Disability, Age and Sexual Orientation and we describe what various departments have worked on during 2022/2023 to support the EDI agenda in the Trust.

The report highlights the services we offer to patients who have additional needs to ensure their care is not compromised in any way as a result of their needs, including but not limited to, translation services, accessibility and chaplaincy.

The report also provides a summary of the events that have taken place during 2022/2023 to raise the profile of EDI and to raise awareness of particular topics on the agenda, for example, Race Equality.

The highlight report

This reports provides a two-page summary of the key highlights from the last 12-months and will be published alongside the main report as a summary.

Summary

Whilst it has been another challenging year for the Trust, we have maintained a focus on EDI and have seen some great achievements in the last 12-months, including;

- Held our inaugural REACH OUT! event to celebrate the diversity within Sherwood
- Our Chaplaincy team have engaged with over 7,000 patients and visitors
- We made over 2,500 interpreting arrangements for our patients
- We have seen positive movement in our Gender Pay Gap Report, WRES and WDES results
- Membership to our staff networks increased in the last year and we have launched our Women in Sherwood network
- We have developed an Allyship training session and delivered to over 50 colleagues since launch.

We are once again very proud of the work that has been achieved and detailed within the report and look forward to reporting to you next year.

Recommendation

Trust board are to note the progress associated with Equality, Diversity and Inclusion agenda, approve the annual report and support the ongoing work associated with Equality, Diversity and Inclusion will continue to be reported to the People Cabinet and People, Culture and Improvement Committee who oversee this work.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Quality Committee Chair's Highlight Report to Trust Board

Subject:	Quality Committee	**Date:** 18/4/2022	
Prepared By:	Barbara Brady – Non - Executive Director		
Approved By:	Barbara Brady – Non - Executive Director		
Presented By:	Barbara Brady – Non - Executive Director, Chair of Quality Committee		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ Lack of clarity provided by single maternity delivery plan. Expectation being that the responses to the 3 national reports Ockenden I, II and Kirkup would be combined into a single improvement plan, this has not been the case ▪ Pharmacy, impact of capacity on essential patient facing services. ▪ Impact of changes to mandatory training on fundamentals of care ▪ Capacity to deliver initial health assessments and health reviews for looked after children (statutory responsibility)	▪ External review of C Diff arrangements ▪ Review of SFHT statutory responsibilities that are within the scope of Quality Committee ▪ Review of the arrangements of the sub groups which support and are accountable to QC
Positive Assurances to Provide	Decisions Made
▪ Fragile services, which included discussion regarding redefining the scope to include all services which are essential to the delivery of SFHT business (original focus had been on services medically lead) ▪ Progress to date on virtual wards, relatively early in its development, with further work to do to scale up.	▪ Approval of Quality Account ▪ Amendments to SOF from a quality perspective ▪ BAF o Changes to PR1 reducing current exposure to 12 - High as a result of Likelihood reducing to Possible o Changes to PR2 reducing current exposure to 16 – Significant as a result of Likelihood reducing to Somewhat likely
Comments on Effectiveness of the Meeting	
▪ Good quality papers supported by effective confirm and challenge from members of the committee	

Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

People, Culture & Improvement Committee Chair's Highlight Report to Trust Board

Subject:	People, Culture & Improvement Committee Highlight Report	**Date 30th May 2023**	
Prepared By:	Manjeet Gill, Non-Executive Director		
Approved By:	Manjeet Gill, Non-Executive Director		
Presented By:	Manjeet Gill, Non-Executive Director		
Purpose			
		Assurance	**Positive**

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
• Pending Junior Doctor's industrial action, board to be updated on measures in place for the mid-June 72 hours of industrial action • Agreed to ensure committee are kept informed regarding the work under way regarding the violence and aggression agenda, along with further visibility and assurance on how we are learning from incidents that involve violence and aggression	• Visibility regarding the details associated with the wider Improvement and transformation programmes in place across the Trust in 23/24 • Details on the approach to introduce an "Improvement culture" and assurances on how incentivise to win hearts and minds • Patient and service user involvement, experience and voice, development of culture and mechanisms to promote • Agreed to shared example Tactical workforce plans for fragile areas
Positive Assurances to Provide	**Decisions Made**
• Review of year 1 of the People Strategy and the focused approaches for year 2 and year 3 • A welcomed approach to Hospital walkarounds and how these can feed into the triangulation of assurance from other sources • Improvement faculty, work programme and governance • Medical revalidation and deep dive into analysis of medical gender pay gap. • Safe staffing for nursing, Midwifery and AHP • Freedom to Speak Up reports.	• Approval of the People Strategy re-set and welcomed focused approaches for year 2 and year 3 • Board assurance framework approved, and the current ratings as proposed, however noted further assurance for PR5 is required • Committee Board assurance action plan approved as completed and agreed focused 6 monthly committee effectiveness reviews • Approval of Annual EDI report ahead of approval at Board

• Onwards next steps and areas of focus for the National Staff Survey 2022 • Strategic workforce Plan, culture and engagement and EDI Q4 assurance • Volunteers work • Employee relations • Report on violence & aggression and positive outcomes • Work associated with Project Search and the positive outcomes from the last cohort	

Comments on Effectiveness of the Meeting

Committee and reports effectiveness review looked at further addtional means of assurance and triangulation, to include more NED attendance at certain meetings to triangulate assurance provided by reports.

To increase more strategic focus by reducing frequency and level of detail in reports, that will be aligned to a revised of work cycle of the committee to include further focus on Improvement and Principal Risk 5