Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: 3rd November 2022
Time: 09:00 – 12:30
Venue: Boardroom, King's Mill Hospital

No	Time	Item	Presenter	Status (Do not use NOTE)	Paper
1.	09:00	**Welcome**	Chair	Agree	Verbal
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.*	Chair	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)*	Chair	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 6th October 2022** To be agreed as an accurate record	Chair	Approve	Enc 4
5.	09:05	**Action Tracker**	Chair	Assurance	Enc 5
6.	09:10	**Chair's Report**	Chair	Assurance	Enc 6
7.	09:15	**Chief Executive's Report** • **Integrated Care System Update**	CEO Director of Strategy & Partnerships	Assurance Assurance	Enc 7 Enc 7.1
	Strategy				
8.	09:30	**2022/2023 Strategic Priorities Quarter 2 Update**	Director of Strategy & Partnerships	Assurance	Enc 8
9.	09:40	**Strategic Objective 1 – To provide outstanding care** • **Maternity Update** o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model** o **Ockenden Insight Update**	Director of Midwifery	Assurance	Enc 9.1
10.	09:55	**Strategic Objective 2 - To promote and support health and wellbeing** • **Covid Vaccination Update**	Director of People	Assurance	Enc 10.1

No	Time	Item	Presenter	Status (Do not use NOTE)	Paper
11.	10:05	**Strategic Objective 3 – To maximise the potential of our workforce** • **Nursing, Midwifery and Allied Health Professions (AHP) Staffing 6 monthly report** • **Medical Workforce Staffing – 6 monthly report**	Chief Nurse Medical Director	Assurance Assurance	Enc 11.1 Enc 11.2
12.	10:20	**Staff Story – Just and Restorative Culture – Sherwood Journey** Debbie, Kearsley, Deputy Director of People, and Roz Norman, Staff Side Chair	Deputy Director of People	Assurance	Presentation
	BREAK (10 MINS)				
	Operational				
13.	10:50	**Single Oversight Framework Performance – Quarterly Report**	Executive Team	Consider	Enc 13
14.	11:40	**Board Assurance Framework**	Chief Executive	Approve	Enc 14
	Governance				
15.	11:50	**Use of the Trust Seal**	Director of Corporate Affairs	Assurance	Verbal
16.	11:50	**Emergency Preparedness** • **Emergency Preparedness (EPRR) Core Standards Self-Assessment** • **Incident Response Plan**	Deputy Chief Operating Officer	Assurance Approval	Enc 16.1 Enc 16.2
17.	12:00	**Assurance from Sub Committees** • **Finance Committee** • **People, Culture and Improvement Committee** • **Charitable Funds Committee**	Committee Chair Committee Chair Committee Chair	Assurance Assurance Assurance	Enc 17.1 Enc 17.2 Enc 17.3
18.	12:10	**Outstanding Service – Celebrating our Volunteers**		Assurance	Presentation
19.	12:15	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Chair	Assurance	Verbal
20.	12:20	**Any Other Business**	All	Discussion	Verbal
21.		**Date of Next meeting** **Date: 1st December 2022** **Time: 09:00-12:30** **Venue: Boardroom, King's Mill Hospital**			

No	Time	Item	Presenter	Status (Do not use NOTE)	Paper
22.		**Chair Declares the Meeting Closed**			
23.		**Questions from members of the public present** (Pertaining to items specific to the agenda)			
24.		**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 13	• **SOF Dashboard**
Enc 14	• **Significant Risk Summary Report**
Enc 16.2	• **Incident Response Plan**
Enc 17.1	• **Finance Committee – previous minutes**
Enc 17.2	• **People, Culture and Improvement Committee – previous minutes**
Enc 17.3	• **Charitable Funds Committee – previous minutes**

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 6th October 2022 in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Graham Ward	Non-Executive Director	GW
	Barbara Brady	Non-Executive Director	BB
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Andrew Rose-Britton	Non-Executive Director	ARB
	Paul Robinson	Chief Executive	PR
	David Selwyn	Medical Director	DS
	Shirley Higginbotham	Director of Corporate Affairs	SH
	Phil Bolton	Chief Nurse	PB
	Rachel Eddie	Chief Operating Officer	RE
	Rob Simcox	Director of People	RS
	Richard Mills	Chief Financial Officer	RM
	David Ainsworth	Director of Strategy and Partnerships	DA
In Attendance:	Sue Bradshaw	Minutes	
	Danny Hudson	Producer for MS Teams Public Broadcast	
	Paula Shore	Director of Midwifery	PS
	John Tansley	Clinical Director for Patient Safety and Chair Learning from Deaths Group	JT
	Claire Allison	Tobacco Dependence Maternity Lead	CA
Observers:	Sue Holmes	Lead Governor	
	Ian Holden	Public Governor	
	Claire Page	360 Assurance	
	9 members of the public		
Apologies:	Aly Rashid	Non-Executive Director	AR
	Andy Haynes	Specialist Advisor to the Board	AH
	Emma Challans-Rasool	Director of Culture and Improvement	ECR

Item No.	Item	Action	Date
18/576	**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. Noting that due to the circumstances regarding Covid-19 and social distancing compliance, 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 the public were able to submit questions via the live Q&A function.		
18/577	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
18/578	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Aly Rashid, Non-Executive Director, Andy Haynes, Specialist Advisor to the Board and Emma Challans-Rasool, Director of Culture and Improvement.		
18/579	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors in Public held on 1st September 2022, the Board of Directors APPROVED the minutes as a true and accurate record.		
18/580	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 18/361, 18/477, 18/550, 18/554.1 and 18/554.2 were complete and could be removed from the action tracker.		
18/581	**CHAIR'S REPORT**		
2 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 the Annual General Meeting and Annual Members Meeting, approval of changes to the Trust Constitution, Governor Elections and Staff Excellence Awards. The Board of Directors were ASSURED by the report		
18/582	**CHIEF EXECUTIVE'S REPORT**		
3 min	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.		

	PR advised a critical incident was called at SFHFT, and across the Nottinghamshire Integrated Care System (ICS), on Thursday 29th September 2022. This followed an internal incident which was called by Nottingham University Hospitals (NUH) on 27th September 2022. The incident was called due to the extreme demand on the urgent care system. Extraordinary actions were taken within the Trust and across the system and the pressure eased going into the weekend. The Trust remains on Opel 4, but the incident was stood down on 5th October 2022 at SFHFT, NUH and across the system. PR expressed thanks to colleagues for going 'above and beyond' in response to the incident. The Trust's Finance Team have been awarded Level 3 accreditation by the NHS Finance Leadership Council. PR expressed thanks to Emma Challans-Rasool who is leaving the Trust to take up the role of Director of Organisational Development, Culture and Talent at Nottinghamshire Integrated Care Board (ICB). The Board of Directors were ASSURED by the report		
3 mins	**Integrated Care System (ICS) Update** DA advised the wider system has been responding to the recent critical incident and the overall Covid vaccination programme. A current key piece of work, which the Trust is involved with, is the development of an integrated care strategy. There is an opportunity for members of the Board of Directors to attend an ICS assembly on 25th October 2022. SFHFT is part of the Provider Collaborative at Scale with NUH and Nottinghamshire Healthcare Trust. Priorities are starting to emerge, for example, discharges and how the acute trusts work with primary care colleagues. Rachel Munton stepped down as the convener of Mid-Nottinghamshire Place in September 2022 and Hayley Barsby has stepped down from her role as Executive Lead for Place. The Board of Directors ACKNOWLEDGED the update		
18/583	**STRATEGIC OBJECTIVE 1 – TO PROVIDE OUTSTANDING CARE**		
12 mins	**Maternity Update** PS joined the meeting ***Safety Champions update*** PB presented the report, highlighting safety champions walkarounds and Ockenden insight visit. PS highlighted the Professional Midwifery Advocate Service. The Board of Directors were ASSURED by the report		

	Maternity Perinatal Quality Surveillance PS presented the report, highlighting 3rd and 4th degree tears, still birth rate and progress against NHS Resolution (NHSR) 10 Steps to Safety. BB queried if the deep dive into 3rd and 4th degree tears will be visible to the Quality Committee. PB confirmed following the deep dive, a report will be presented to the Quality Committee. Peers are invited to meetings of the Maternity Assurance Committee and the Trust is seeking to benchmark against, and get advice from, other trusts. **Action** • **Deep Dive into 3rd and 4th degree tears to be reported to the Quality Committee** CW sought an update regarding the home births service. PS advised referrals for home births are increasing and there are no staffing issues or reduction in services. A home birth has not yet been performed. Two women were cared for at home, but were transferred into the hospital for clinical reasons. PS advised she is working with the Communications Team to look for ways in which home births can be promoted. DS queried what, if anything, can be done to influence the occurrence of 3rd and 4th degree tears. PS advised this is not a quality marker but it is used to provide assurance there are no themes or trends with the operator, mode of birth, position in labour, etc. To date, no themes have been identified. The Maternity Team has access to a fantastic obstetric physiotherapy service and can make a rapid referral to them. SB noted there are a number of external standards linked to maternity and the Trust is performing well against those. SB queried if there is an overall plan to pull everything together. PS advised a current area of work is looking at the increase in bed rate and what impact that has. The data will be feeding into a plan looking at what is required for services at SFHFT. PB advised there is a need to look at plans and data at system level. The Board of Directors were ASSURED by the report PS left the meeting	**PB**	**01/12/22**
27 mins	**Learning from Deaths** JT joined the meeting DS presented the report, highlighting Hospital Standardised Mortality Rate (HSMR), work of the Learning from Deaths group, learning from Learning Disability Deaths, Standardised Hospital Mortality Indicator (SHMI) and changes which may result from the launch of the Patient Safety Incident Response Framework (PSIRF). DS acknowledged this is a complex subject matter and suggested patient safety and learning from deaths information be a topic for a future Board of Directors workshop.		

	Action • **Patient safety and learning from deaths information to be a topic for a future Board of Directors workshop and added to the workshop schedule** BB noted the reference in the report in relation to end of life specialist palliative care and the step change in September 2019. BB advised she could not recall a change in arrangements at that time and it was an ongoing issue. BB queried what is at the root of that step change. JT advised this is still unclear, but it is unlikely to be a single issue. There are various levels of reason for the change, for example, a change in the way things are coded, a change in how things are documented or a change in what is being done. From the 360 Assurance report, JT advised he was confident the coding represents what is written in the notes, but the question is if what is written in the notes represents the situation. Changing the way things are recorded has an ongoing impact on the way that is coded and recorded and reported back. There was a documentation change relating to end of life care circa 2019. Specialist palliative care is different from end of life care, although in some organisations this is coded the same. The Trust has the split right, given hospice consultants are not directly involved in the care of patients on last days of life care. JT advised there are no significant concerns. BB felt there is a need to understand what learning can be taken from the exploration of looking at what is happening in relation to deaths. DS advised a lot of resource has been put in to try to understand the data. When anything is examined, things which can be changed and improved are always found. Coding colleagues are carefully controlled in what they can and cannot record. There is a focus on palliative care coding. It is acknowledged SFHFT is 'adrift' to peer organisations and the national picture and a lot of work has been done in relation to end of life care. The Trust has had discussions with the local hospice, which provides an in-reach service to the Trust. These links are developing and the End of Life Team is being strengthened. Improvements will be seen, but it will take time. BB felt structured judgement reviews are powerful in understanding the reality of what has happened rather than the artefact of the coding issue. DS advised there needs to be a more timely and agile way of identifying hotspots. GW acknowledged the 360 Assurance report has provided a degree of additional assurance in relation to the process for moving from notes to coding, with notes being the key driver to what is subsequently coded. GW queried if any checks and balances on the notes are undertaken. JT advised from a learning from deaths point of view, there is a very retrospective look at notes. If there are any flags, these are passed to more experienced consultant clinicians to go through the notes to check the coding reflects what was in the notes and if the notes reflect what was wrong with the patient. In an ideal world this would be part of 'business as usual', but when teams are under pressure, learning from the work done is difficult.	**SH**	**03/11/22**

	It is not possible to review everything. Therefore, there is a need to look at areas which are providing 'soft signals'. DS advised if, for example, someone is coded as having a stroke, this can be anything from a patient who has had a minor weakness to a patient who is unconscious and on the critical care unit and will be associated with different outcomes. However, they go into the same diagnostic group, which comes with a 'norm' of what the outcome should be. GW noted while HSMR and SHMI are high, learning has to be the most fundamental aspect and acknowledged the work being undertaken to ensure things are done as robustly as possible. SB queried if the outcome of this work provides assurance that policies and procedures are 'fit for purpose' and are being followed. DS advised safety and output is not dependent on one particular aspect and there is always work to do and areas to improve. There are no other signals which are a concern in terms of the safety of patients. SB queried if there is any data on how often procedures are or are not followed, how often mistakes are made and any underlying causes. JT advised there is very rarely a single root cause. There is good evidence to suggest the circumstances which produce failure and success are very similar, the only thing which is different being the outcome. In a complex, adaptive system, policies are not always followed and there are tolerances between gross negligence and recklessness and working around issues. No organisation has the granularity of data in relation to the work which is done on a day to day basis. It is an interest in terms of modern safety culture and thinking that there should be a greater focus on learning from everyday working. The health service as a whole is not very mature at analysing why things work. DS advised there is a move in the investigation process towards finding themes rather than looking at root causes. The Board of Directors were ASSURED by the report JT left the meeting		
18/584	**STRATEGIC OBJECTIVE 2 - TO PROMOTE AND SUPPORT HEALTH AND WELLBEING**		
7 mins	**Flu Vaccination Plan** RS presented the report, advising the flu vaccination programme commenced on 3rd October 2022 and will run until February 2023. The programme is built on a model which has been proved to work in previous years and is being led by the Occupational Health Team. It is possible for staff to receive both the flu and Covid vaccinations together at the Hospital Hub. CW noted there is a change in the option for staff to donate their meal deal vouchers to Street Health and queried the reason for this change.		

	RS advised a monetary donation will be made to Street Health at the end of the programme. This is due to difficulties in previous years with some individuals donating food, which was not distributed in a timely manner and was wasted. BB queried what efforts will be made to offer long stay patients, particularly those medically fit for discharge, the flu and Covid vaccinations. RS advised this has been offered in previous phases of the Covid vaccination programme. DS advised previous campaigns have offered an individualised approach. If patients are well enough and giving them a vaccination will not impact their clinical course, they will be offered a vaccination. SB noted in previous years there has been a financial incentive for the Trust to reach a certain target and queried if this applies this year. RS advised there is a Commissioning for Quality and Innovation (CQUIN) attached to the target of 90% delivery to front line staff. The Board of Directors APPROVED the flu vaccination plan for 2022/2023		
6 mins	**Covid Vaccination Update** RS presented the report, advising Phase 5 of the Covid vaccination programme commenced on 12th September 2022. To date the Did Not Attend (DNA) rate is lower than previous phases. In terms of vaccine supply, the Moderna vaccine was supplied for the initial weeks of the Autumn boosters, with the Pfizer vaccine being available from 3rd October 2022. The Trust is still unable to access NEMS. Therefore, consistently reporting progress regarding the workforce accessing the vaccine, whether through the Hospital Hub or elsewhere, is difficult. However, across the system to date just over 13% of healthcare workers have been vaccinated. DS advised both the Pfizer and Moderna vaccines are mRNA technology. The Moderna vaccine was the first to be approved as a bivalent vaccine and the new Pfizer vaccine is also a bivalent vaccine. The Board of Directors were ASSURED by the report		
18/585	**PATIENT STORY – THE PHOENIX TEAM, TREATING TOBACCO ADDICTION IN PREGNANCY**		
15 mins	CA joined the meeting CA presented the Patient Story, which highlighted the work of the team treating tobacco addiction in pregnancy. CW expressed thanks to CA and her team for their work, noting it is having a positive impact. GW felt it is a brilliant service and noted the device provided for individuals to measure their carbon monoxide levels. This is a real strength as it demonstrates the improvement individuals are making.		

	CA advised a number of years ago the National Institute for Health and Care Excellence (NICE) recommended at least two carbon monoxide tests at 36 weeks. The NICE guidance changed in November 2021 and the Trust now tests every woman at every contact. The kit provided as part of the incentive scheme is a good motivational tool and women regularly send in updates via text messages. BB felt it is a wonderful service. BB noted the contribution this will have in tacking health inequalities and queried what learning can be taken from this and applied to other opportunities the Trust has as a health service provider. CA advised women on the incentive scheme receive vouchers, which they are using to buy school uniform, groceries, petrol, etc. rather than a treat for themselves. It is sad to listen to what they are spending the vouchers on. MG queried what the team feel about the outcomes being achieved. CA advised the team have the ability to build relationships with the families they are treating and are very motivated. PR noted it is very early days but the team are having a huge impact and improving outcomes. They should be very proud of their success to date. CA left the meeting		
18/586	**SINGLE OVERSIGHT FRAMEWORK (SOF) MONTHLY PERFORMANCE REPORT**		
23 mins	**QUALITY CARE** PB highlighted clostridium difficile (C.diff), nosocomial Covid-19 infections and MRSA bacteraemia. BB queried if there is currently a decant ward. PB advised there is currently no decant ward as all capacity is open. However, there is a decant programme and a decant ward has been factored into the Winter Plan. CW queried if there is anything further which can be done to support staff in terms of their wellbeing in the context of this busy period. PB advised a lot of the extraordinary measures are taken to ensure staff are looked after. For example, the Trust provides the right number of staff with the right skills and offers enhanced bank rates for short periods of time to recognise people are going 'over and above', as well as incentivising people to come forward to cover shifts. Wellbeing offers remain in place and there is a need to ensure these are accessible to front line staff. The Trust is reliant on people working additional hours, but there is a need to ensure they do not do too many and they can have some down time. RS advised it is important to support colleagues this Winter. There are dedicated themes in terms of mental and physical health and there is also the need to recognise some of the current financial challenges. There is a strong offer available to staff, but there is a need to ensure it is accessible. The Trust has a flexible workforce model.		

	PB advised staff are very tired and it is important leaders are visible to offer support. RE advised a pragmatic approach to recruitment has been taken. It was noted Castle Ward was largely staffed by bank and agency staff, but this is now staffed mainly by substantive staff. There is a need to ensure there is stability within teams. DS advised it is important to note teams are operating under relentless pressure. CW noted the issues relating to staff wellbeing and felt these have an implication and a risk factor on the quality and timeliness of care. DS highlighted Venous thromboembolism (VTE) assessment, noting there is now good compliance with this indicator. **PEOPLE AND CULTURE** RS highlighted staff health and wellbeing, appraisals, mandatory training, manager training offer and Staff Survey. **TIMELY CARE** RE advised there has been a decline in 4 hour performance, largely driven by exit block in terms of the number of patients who are medically fit for discharge. However, ambulance turnaround times remain good and the Trust benchmarks well in terms of admittance avoidance. Internal actions are in place aimed at improving patient flow through the organisation. The Transfer of Care Hub, which is the culmination of the Discharge to Assess business case, is due to open at King's Mill Hospital in mid-October 2022. In terms of elective care, the Trust benchmarks well in terms of long waits and there are currently no 104 week waits. SFHFT is carrying some 104 week waits which are cases taken to help reduce long waits at other trusts. These are not reported in the figures for SFHFT as part of a system wide agreement, but they are tracked carefully. The 78 week waits are on trajectory and the position is continuing to improve. The next challenge and area of focus is the 52 week waits. In terms of cancer, the 62 day backlog is reducing. The faster diagnosis standard remains very strong but some capacity issues remain in relation to the treatment part of the pathway, particularly in lower gastrointestinal (GI). **BEST VALUE CARE** RM outlined the Trust's financial position at the end of Month 5, highlighting income and expenditure performance against plan and agency expenditure. The Board of Directors CONSIDERED the report		

18/587	**WINTER PLAN**		
30 mins	RE presented the report, highlighting the current bed deficit position, the key principles on which the plan is based, assumptions made, model outputs, mitigations, financial implications, workforce requirements, wraparound support for the plan, risks and next steps. RM advised the £13.2m mitigation cost highlighted in the report is the full year cost. From October 2022, 24 beds will be returned into use at Mansfield Community Hospital (MCH) and there will be a cost associated with that. There will be a further cost in March 2023 when the second ward re-opens at MCH. Some of the costs in the Winter Plan are already included in the financial forecast. The likely impact of the Winter Plan in terms of the forecast will be circa £4m. It was noted the plan is built up to manage a safe winter and to have capacity which can be put in place for the demand to avoid overcrowding in ED. The next step is to review the value for money against the Winter Plan and identify any elements which can be done in a more efficient way. MG noted nationally there has been mention of the North Bristol Model for Winter planning. MG requested further information on this and queried if any of the 'best practice' is relevant to the Trust's approach. RE advised the Trust is currently refreshing the full capacity protocol and is reviewing the Bristol Model to identify any areas which can be incorporated. In the Bristol Model they send a patient from ED to the ward every hour on the hour, regardless of whether there is capacity on the ward or not. SFHFT and many other trusts do not do this. When the Trust is on Opel 4, we will go one over on the ward when there is a planned discharge for later in the day. What the North Bristol Model does, which is above and beyond that, is something called 'boarding'. This is putting an extra patient on a ward when there is no patient due for discharge and, therefore, putting a patient where there is no bed space and there may not be oxygen or appropriate staffing, etc. It comes down to a balance of risk and the driver in Bristol for taking the approach they have is they have some very long ambulance waits. If SFHFT was to go down that route, there would be a need to finely balance the risk of holding ambulances verses overcrowding in ED verses putting patients on the ward where they would not be in the right environment to be properly cared for. Boarding is a red line, but the pressure on ambulance waits is pushing trusts down that route. DS advised he would be nervous about boarding, advising it comes down to where the risk is being held, noting the Trust is prepared to hold the risk from the ambulances in ED. The danger of boarding is ill patients are being moved from an area where the Trust is well staffed, with equipment available, etc. to an area which is not necessarily as well staffed and the same resources are not available. The Trust has actively uplifted ED staffing to manage the capacity in ED and has put other mitigations in place. There is a need to be careful an unmitigated risk is not transferred onto the ward.		

	PB advised he does not feel the Bristol Model is a best practice model and it does contain risk. The main aim is to decompress ED and release ambulances. SFHFT does not currently have an issue with ambulance turnarounds due to other actions which are being taken. There are other 'unpalatable' actions which the Trust can and would take before considering a discussion about boarding. DS felt there can be a danger if something such as boarding is not done, the risk is entirely held by ED. Boarding does give an organisational sharing of the risk. GW noted the Trust is in a positive position in terms of ambulance turnaround times and felt this should be noted in the Winter Plan, given the current national focus on ambulance turnaround times. CW noted the planning in relation to staffing and queried if the Trust will be able to recruit the additional staff required to support the increased bed capacity. RE advised the recruitment offer available at SFHFT, and the organisation's ability to attract staff, is very good. It was acknowledged there are national shortages in some professions, but the Trust is able to attract individuals. There is a need to start recruitment as soon as possible as all organisations will be looking for people at the same time and there is a lead time to people being able to take up post. PB advised from a nursing perspective, SFHFT has a better base line compared to other organisations. There is some flexibility to safely reduce numbers on other wards and the Trust has a good bank. RS advised there is a degree of flexibility in employment modelling and the bank is a good example of how the Trust can flex up and down depending on acuity and demand. The Trust has a strong recruitment offer. SB advised he felt some of the risks identified will happen and queried if the actions the Trust would take if the circumstances are worse than the modelling should be included. RE advised it is important work on preparing for Winter does not to stop here and improvement work, both inside and outside the organisation, will continue. In terms of capacity, there is scope to go further, but it is unlikely this will be in time for this Winter. Throughout this Winter the Trust will look at any opportunities to safely surge further, noting there is a need to look at doing things in a planned rather than reactive way. The most concerning risk is demand, particularly the flu and Covid issue. The Trust has used national and system modelling, but the full impact of this is not known. The Board of Directors APPROVED the Winter Plan.		
18/588	**ASSURANCE FROM SUB COMMITTEES**		
8 mins	**Audit and Assurance Committee** GW presented the report, highlighting implementation of internal audit recommendations, the period of time taken to agree terms of reference for internal audit work and Healthcare Financial Management Association (HFMA) sustainability audit. The Committee agreed other committees should have a specific agenda item of 'Internal control issues to report to Audit and Assurance Committee'.		

	ARB queried if the Trust has the resources to complete the 72 items on the HFMA sustainability audit. RM advised the audit contains various topics relating to financial management, budgetary control and reporting, etc. The Finance Team and Project Management Office (PMO) have led on completing this work and all the evidence has been submitted to 360 Assurance for review, The Board of Directors were ASSURED by the report **Quality Committee** MG presented the report, highlighting the deep dive into performance relating to strokes and advising the Board Assurance Framework (BAF) risks were reviewed. The Board of Directors were ASSURED by the report **Finance Committee** GW advised an extraordinary meeting of the Finance Committee was held on 27th September 2022 to review the current financial position and the forecast for the remainder of the year. The Board of Directors were ASSURED by the report		
18/589	**OUTSTANDING SERVICE – THE DIGITAL MIDWIFE**		
7 mins	A short video was played highlighting the work of the Digital Midwife and the Badgernet system.		
18/590	**COMMUNICATIONS TO WIDER ORGANISATION**		
1 min	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Phoenix Project • Learning from Deaths • Digital Midwife • Winter Plan • Current pressure being faced by the Trust • Staff Excellence Awards • Staff Survey		
18/591	**ANY OTHER BUSINESS**		
	No other business was raised.		
18/592	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 3rd November 2022 in the Boardroom, King's Mill Hospital. There being no further business the Chair declared the meeting closed at 11:45.		

18/593	**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**		

18/594	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
	No questions were raised		
18/595	**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			Grey
18/512.2	04/08/2022	Tracking of trend analysis and movement on overall RAG ratings to be included in future Strategic Priorities update reports	Public Board of Directors	None	03/11/2022	D Ainsworth		**Update 19/10/2022** Information included in report for November Board **Complete**	Green
18/551	01/09/2022	Further information regarding gaps in the number of postgraduate doctors in training to be included in the next Guardian of Safe Working report	Public Board of Directors	None	01/12/2022	D Selwyn			Grey
18/583.1	06/10/2022	Deep Dive into 3rd and 4th degree tears to be reported to the Quality Committee	Public Board of Directors	Quality Committee	01/12/2022	P Bolton			Grey
18/583.2	06/10/2022	Patient safety and learning from deaths information to be a topic for a future Board of Directors workshop and added to the workshop schedule	Public Board of Directors	None	03/11/2022	S Higginbotham		Added to Board Workshop schedule **Complete**	Green

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date**: 3 November 2022	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
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				
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	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

Not applicable

Executive Summary

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

Celebrating the best of Sherwood Forest Hospitals at our annual *Excellence Awards*

On Friday 7 October, the Trust hosted its annual *Excellence Awards* to celebrate our Trust colleagues and partners who have gone above-and-beyond the call of duty for patients and the communities we serve over the past year.

I was delighted to be able to join colleagues from the Trust's Executive Team to announce the winners of this year's awards across 18 categories – including a special Chair's Award, which I was delighted to award to colleagues from our Sherwood Community Unit.

The Unit has been a hugely important part of our Trust plans to help free-up hospital beds for those patients that need them most this year, which has seen the Trust look creatively to extend the walls of its hospitals to transform an old care home into a temporary ward. The Unit plays an important role of providing transitional support for patients who no longer require hospital treatment but are waiting for confirmation of their discharge packages before they can be discharged to their home, care home or another community setting.

Lindsey Chapman, the Unit's Head of Nursing, has been an exceptional and inspirational leader throughout the first six months of the Unit opening, ensuring that the Unit provided safe and effective care while always demonstrating and setting the standards expected. She has been well supported by Mandy Toplis, her deputy, and Claire Haywood, who agreed to step-up to take the role of sister and lead nurse for the unit.

The team have been widely supported by colleagues from across the trust including in Skanska, Medirest and IPC who were all pivotal in helping to set up run and manage the unit.

I look forward to getting out to meet the team to present their award to them in person, as well as sharing more details about the Unit's work publicly over the coming weeks.

Starting work to refresh the Trust's five-year strategy

The Board set aside time together over the past month to prioritise planning for the future strategy of the Trust – an important piece of work that will set the direction of the organisation as we look to the future with a new-look Executive Team and working with our Integrated Care System partners.

Together, we considered the views of several partners, ranging from neighbouring NHS organisations to the wider public sector – including colleagues from the education sector.

Giving consideration to the way we plan and deliver services (as well as how we respond to the changing system architecture) was also at the heart of those conversations. We also recognised that getting closer to the communities we serve and positively impacting upon the challenges people face in their lives will be a critical success factor for that work.

I look forward to proposing a revised five-year strategy to the Board in the New Year.

October is Freedom to Speak Up month

The Trust has been supporting Freedom to Speak Up (FTSU) month throughout October as a month-long celebration to raise awareness and celebrate the difference that Freedom to Speak Up is making – including within the Trust.

The Trust's FTSU Champions have been out-and-about across the Trust's hospitals during the month, visiting each site to promote the work of the Champions so that colleagues know they will be supported when they do speak up. It is also vital that we all understand that speaking-up is an important part of improvement, learning and providing outstanding care.

We are really proud that 70.9% of our Trust colleagues told us in the 2021 NHS National Staff Survey that they would feel safe to speak up about anything that concerns them about the organisation, with 61.5% also saying they would be confident the organisation would act upon those concerns when raised. While there is always room for improvement, those scores place us well above the national averages in both categories and reflects the emphasis we have placed on this important area of work.

Our FTSU champions and guardian play an important part in making our hardworking NHS colleagues feel safe and supported in their work. I am grateful to them all for their continued contributions.

Continuing our 'Meet your governor sessions' across our hospitals

A programme of the Trust's *Meet Your Governor* events also took place during week commencing 24 October, allowing our Trust governors to get out-and-about in our hospitals and the wider community to talk to patients and members about their experiences of accessing our services.

The outcomes of those discussions will be fed back to the Trust to consider how it can improve its services in future, with similar sessions also planned for November and December.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date**: 3 November 2022	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
To update on key events and information from the last month.		**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	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

Not applicable

Executive Summary

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

County-wide critical incident declared in response to pressures

A county-wide 'critical incident' was declared around the time of last month's Board meeting, due to the high levels of demand we faced in hospital Emergency Departments across the county and the challenges NHS services continue to face in discharging medically fit patients from our hospitals in a timely way.

We are in a much better position than we were at the beginning of October, thanks to the skill and dedication of our hardworking NHS colleagues across the county.

However, it is important to recognise that we remain under significant pressure and we still face huge challenges as winter approaches. Our services remain very busy and we anticipate that there will be some difficult weeks ahead.

We understand how challenging it is for our NHS colleagues to work under such pressure for a sustained period and I want to assure our colleagues and the Board that we will continue to do everything possible to work with system partners to ensure these pressures don't become 'business as usual,' as they have over recent months.

I am grateful to all our NHS colleagues for the part they have played in ensuring we can manage the pressures and ensure that patients can access the care they need this winter.

We are also asking the communities we serve to help their local NHS to help them this winter – including by choosing the most appropriate NHS service for their needs.

Hospital Emergency Departments aren't always the best place to access the healthcare they need, so we are encouraging the public to think 'NHS 111 first' before attending our Emergency Department at King's Mill Hospital and our Urgent Treatment Centre at Newark Hospital. NHS111 professionals can direct people to the most appropriate place to help you get the support they need – including by directing people to appointments with their local GPs, pharmacies and other NHS services locally, even out-of-hours.

Preparing for potential industrial action

As a Trust, we are watching with interest at the potential for planned industrial action from employee groups nationally over the months ahead.

The Trust has business continuity plans in place so eventualities like these and we have established a Trust planning group to assess and prepare for the likely impact of any potential industrial action on the Trust, the services it provides, and the patients we care for.

We will continue to keep the Board updated with details of the specifics of those planning arrangements and the contingencies we will be putting in place, as soon as more detail on any planned industrial action becomes available.

Celebrating the best of Sherwood Forest Hospitals at our annual *Excellence Awards*

I was delighted to host our Trust *Excellence Awards* at the beginning of October to celebrate the amazing work our colleagues do here across our hospitals – and to recognise individual examples where our colleagues have consistently gone 'above and beyond' in their roles.

We were delighted to welcome hundreds of nominees, nominators, colleagues and members of the public to join this year's celebration – albeit virtually due to the continued threat of COVID to our workforce. The event was broadcast live on the Trust Facebook page.

This year, we received over 250 nominations and the judging process was hard, so I'd also like to thank everyone who made a nomination for this year's event to ensure that their colleagues can get the recognition they deserve.

I'd also like to thank everyone who helped to make this year's awards possible, including our sponsors from the Trust's charity and for the support from our local media partners from The Chad and the Newark Advertiser. We are grateful for their support for our hardworking colleagues.

I would like to thank each and every one of our Trust colleagues for delivering outstanding services for our patients and for making Sherwood Forest Hospitals such a great place to work.

Since the awards, I – alongside colleagues from across our Executive Team – have been getting out-and-about to meet our winners in-person to find out more about their work and to present their trophies to them.

I look forward to being able to share the stories of their achievements across our public and staff communications platforms over the coming weeks to continue those celebrations and to reflect just how proud and grateful we are for the work they do.

The Trust's 24-hour homebirth service returns

I am proud to confirm that our full, round-the-clock homebirth service restarted on Monday 19 September 2022.

For the past year the service has been running Mondays to Fridays between 9am and 5pm, due to staffing challenges caused by the pandemic. As a result of successful recruitment to the community midwifery service, the 24-hour service has been able to restart safely.

Reinstating the full 24-hour service as soon as it was safe for us to do so has been a priority for us because we know how important it is for families to have the option to birth at home.

During the past year, our on-call staff have gone above and beyond to support as many women as possible. We're really pleased that we're now in a position to offer a personalised choice to even more families and I thank all our teams who have helped to make the return to the 24-hour service possible.

Welcoming our first cohort of Trainee Nursing Associates (TNAs) to #TeamSFH

This month, Sherwood Forest Hospitals' welcomed its first cohort of Trainee Nursing Associates (TNAs) after they finished their two-year course at Nottingham Trent University's Mansfield Hub.

The group of 16 started their Foundation Degree Apprenticeship for Nursing Associates in October 2020 while employed by the Trust as Healthcare Support Workers (HCSWs). They studied on day-release from their regular role and completed 20 weeks of placements across adult, children's, mental health and learning disability areas in community, hospital, primary and social care settings to obtain as much experience as possible.

They have all secured Nursing Associate roles with Sherwood Forest Hospitals, where they will support wards and departments. The Nursing Associate role, which is registered with the Nursing and Midwifery Council, will see the group manage their own group of patients and support Registered Nurses. They will also mentor and support developing HCSWs and TNAs.

Several of the newly-qualified Nursing Associates have already expressed an interest in further study to become Registered Nurses.

This initiative is a fantastic example of how the Trust is committed to investing in our colleagues and supporting their career development. A second group of 14 Trainee Nursing Associates have just started the final year of their course at the NTU Mansfield hub, while a further 18 were also due to start their training in October.

Congratulations to all of our new recruits – and I look forward to working alongside them in their new roles.

Risk ratings reviewed

The Board Assurance Framework (BAF) risks 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
- Principal Risk 8: Failure to deliver sustainable reductions in the Trust's impact on climate change.

Sherwood Forest Hospitals NHS Foundation Trust

Public Board - Cover Sheet

Subject:	Qtr 2 Board Assurance 22-23 Strategic Priorities	**Date**: 3rd November 2022	
Prepared By:	Kevin Gallacher, Associate Director – Planning & Partnerships		
Approved By:	David Ainsworth, Director of Strategy & Partnerships		
Presented By:	David Ainsworth, Director of Strategy & Partnerships		
Purpose			
To update the Board on delivery of the 22-23 Strategic Priorities.		**Approval**	
		Assurance	X
		Update	
		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	X	X

Identify which principal risk this report relates to:	
PR1 Significant deterioration in standards of safety and care	X
PR2 Demand that overwhelms capacity	X
PR3 Critical shortage of workforce capacity and capability	X
PR4 Failure to achieve the Trust's financial strategy	X
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	X
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

Trust Executive Team Meeting

Executive Summary

The enclosed document provides an update on progress against the Trusts 2022-23 Strategic Objectives at the end of September 2022 (Qtr. 2).

Changes to Executive Lead since the Qtr. 1 report are highlighted in red text for ease.

The Board is asked to:

- Note the update

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust (SFH) 2022/23 Strategic Priorities

Quarter 2 Update

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

1. Summary – 'Q2 Position on a Page'

Ref	2022/23 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Change to Previous Qtr.
1.1	Develop an action plan to re-launch Family and Friends feedback, plus develop a framework for assurance (on actions taken).	Chief Nurse			⟺
1.2	Improve the Quality and Safety of the services we provide to children with complex needs.	Medical Director	Update will be provided in Q2		n/a
1.3	Achieve the levels of waiting times as identified in the 2022/23 plan and trajectories.	Chief Operating Officer			⇧
1.4	Work with all partners to reduce the number of patients who are delayed moving to their onward destination outside of SFH.	Chief Operating Officer			⟺
2.1	Delivery of the SFH Green Plan and provide support to deliver the ICS Green Plan.	Chief Financial Officer			⇩
2.2	To embed and enhance the current offer of support regarding the Mental and Physical Wellbeing of our Colleagues.	Director of People			⟺
2.3	Design and deliver a recruitment and retention programme for maternity; to right size the service and enable the delivery of the Continuity of Carer Health Inequalities service delivery model (Maternity Transformation).	Chief Nurse			⟺
3.1	Develop and Implement a Strategic workforce Plan for SFH in collaboration with the ICS.	Director of People			⟺

Overall RAG Key

	**On Track** - no issues to note.		**On Track** – action underway to address minor issues		**Off Track** – action underway to address minor issues
	**Off Track** – action underway to address major issues		**Off Track** – issues identified no action underway		**Off Track** – issues not identified and no action underway

Ref	2022/23 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Change to Previous Qtr.
3.2	Respond to the 2021 NHS Staff Survey. Identify Key Focus Areas.	~~Director of Culture and Improvement~~ Director of People			⇔
4.1	Successfully implement and optimise the use of EPMA.	Medical Director			⇔
4.2	Develop a refreshed Digital Strategy.	Medical Director			⇩
4.3	To introduce an Innovation Hub across the Mid Notts Place Based Partnership.	~~Director of Culture and Improvement~~ Director of Strategy & Partnerships (tbc)			⇩
5.1	Delivery of the SFH Transformation & Efficiency Programme that supports the delivery at PCB/ICP level.	~~Director of Culture and Improvement.~~ Chief Financial Officer			⇩
5.2	Be a key partner in the development of the Provider Collaborative.	Chief Executive			⇔
5.3	Shape and define a new SFH Trust 5-year strategy (2023-2028) working with ICS partners.	Director of Strategy and Partnership			⇔
5.4	Continue to progress Pathology Network initiatives alongside NUH (and across the region where required).	Director of Strategy and Partnership			⇔

Overall RAG Key

	**On Track** - no issues to note.		**On Track** – action underway to address minor issues		**Off Track** – action underway to address minor issues
	**Off Track** – action underway to address major issues		**Off Track** – issues identified no action underway		**Off Track** – issues not identified and no action underway

2. Detailed Quarter 2 Update

Ref	2022-23 Trust Priorities	Executive Lead	SFH Governance	Measures of Success	Quarter 2 Update
1.1	**To Provide Outstanding Care** - Develop an action plan to re-launch Family and Friends feedback, plus develop a framework for assurance (on actions taken).	Chief Nurse	Quality Committee	• Action plan developed to re-launch Family and Friends feedback • ~~Design and implement a Community Gynae Service~~ Establish assurance framework by the end of Qtr 3	• The new system is implemented, and we have trained 149 users, including Compass colleagues, with unique role related access. Training continues. • SMS Totals sent out • June 40,001 • July - 34, 537 • August - 52, 544 • Inpatient areas are included (not previously) • Response's • inpatient - 516 (postcards) 1288 (online) and smartphone/app/tablet 378. Maternity 42 (online) • Outpatients 49 (postcards) 2332 (online) • ED 1453 (online) • We are working on sending SMS to under-16s in collaboration with the Paediatric consultant, LAC, and CPPPC • PET continues working with our volunteer colleagues who have returned and visit wards (KM&NH) to help with engagement and collection of FFT data

					• Monthly reports are shared, all teams can access responses to focus on improvements • New QR codes as the old ones were not compatible with our new system. • A number of system changes have limited progress in community service. QR codes will be re-launched following amendment. The implication of the impact of these and the launch of new IT system should be complete at the end of November.
1.2	**<u>To Provide Outstanding Care</u>** - Improve the Quality and Safety of the services we provide to children with complex needs.	Medical Director	Quality Committee	• Appoint SFH lead to lead transition of complex paediatric patients into adult service via MDT forum by the end of Q2 2022/23 • Support ICB to link SFH, NHCT and NUH transition MDTs by the end of Q3 2022/23 • Develop business case for ICB wide transition nurse specialist team to support parents, patients and service development by the end of Q4 2022/23	• Associate Medical Director appointed to SFH role in Q1 • Progressing system wide MDT's • System wide business case development awaited.

1.3	**To Provide Outstanding Care** - Achieve the levels of waiting times as identified in the 2022/23 plan and trajectories.	Chief Operating Officer	Quality Committee	• 'Timely care' SOF metrics to be presented to Trust Board of Directors, which will illustrate performance (reported monthly) (*Note: this will also include system performance metrics*)	• Month 5 SOF presented to Trust Board in October 2022 • Number of patients on the incomplete RTT waiting list **rated Amber**. The RTT waiting list is made up of new and overdue review patients to ensure that they are not lost to follow up • Number of patients waiting 78+ weeks for treatment **rated Green**. Patients are tracked weekly through the elective care Patient tracking List (PTL) and a trajectory is in place at specialty level. The majority of specialties are ahead of plan with the remaining either able to improve in month or as a result of providing mutual aid to other organisations (NUH/UHL) • Number of patients waiting 104+ weeks for treatment **rated Green**. There are no SFH patients waiting over 104 weeks. Any over 104 wait patients are as a result of providing mutual aid to other organisations • Number of completed RTT Pathways (against Yr2019/20) **rated Green**.This is monitored against a trajectory at the weekly elective care PTL

1.4	**To Provide Outstanding Care** - Work with all partners to reduce the number of patients who are delayed moving to their onward destination outside of SFH.	Chief Operating Officer	Quality Committee	• 'Timely care' SOF metrics to be presented to Trust Board of Directors, which will illustrate performance (reported monthly) (*Note: this will also include system performance metrics*)	• Month 5 SOF presented to Trust Board in October 2022 • The local position continues to remain significantly above the agreed threshold of 22 delayed patients. The worsening position is a direct link to capacity issues within adult social care and care agencies. • Additional winter capacity remains open and there is a further national drive to support the roll out of Virtual Wards for early supported discharge. • The system D2A business case and trajectory have been signed off however there has been no clear sign of improvement. The SFH Transfer of Care Hub is due to open w/c 17 October 2022 which will significantly improve communication between system partners to expedite discharge to the most suitable care environment.
2.1	**To Promote and Support Health and Wellbeing** - Delivery of the SFH Green Plan and provide support to deliver the ICS Green Plan.	Chief Financial Officer	Executive Team Meeting	• Embed Environmental Impact Assessment into all planning and investment case process by end of Q2 2022/23 • Evidence that the SFH Green Plan has been promoted internally and externally, including public commitments by the Trust Board of Directors.	• Environmental Impact Assessment incorporated in the standard business case template and considered as part of the decision-making process. • Update on Green Plan and Net Zero ambitions provided to Trust Management Team scheduled in October 2022. • Bid submitted to Phase 3b of the Public Sector Decarbonisation Scheme (PSDS) to support heat decarbonisation and energy efficiency schemes (decision likely in 2022/23 Q4). • Further activities planned: o Review of published ERIC (Estates Return Information Collection) data to assess performance compared to peers (Q3) • Carbon Literacy and Sustainability Awareness training with the Board of Directors (Q3/Q4)

2.2	**<u>To Promote and Support Health and Wellbeing</u>** - To embed and enhance the current offer of support regarding the Mental and Physical Wellbeing of our Colleagues.	Director of People	People, Culture and Improvement Committee	• Staff health and well-being SoF metrics to board each month (On-going) • Introduction of a dedicated Health and Wellbeing Approach by the end of Q2 2022/23 • Embedded Health and Wellbeing Approach by the end of Q4 2022/23	• Development of focused Wellness Campaign to support the next few months with focus on Physical, Mental and Financial Wellbeing • Wellbeing framework being rolled out across the organisation to support with development of the Trust Wellbeing Strategy. • Schwartz rounds have been implemented and embedded with sessions undertaken online and face to face. Sessions have been focused on Women in the Workplace, Reflections from past 2 years and a focus session for Junior Doctors. This supported staff psychological wellbeing across the whole organisation. • Wellbeing Champion programme continues with 35 Wellbeing Champions in place since April 2022 to support staff and champion the Wellbeing agenda. Wellbeing champions support areas of work including menopause, financial wellbeing and physical health. • SFH Virtual exercise group (#SFHVEG) "Fitness for All" is well established via a Wellbeing Champion with over 700 members. Focus for September was Divisional step challenge. • Introduction of Thrive App with 200 registered from across SFH. • People Directorate and Wellbeing team supported walkarounds at peak times during heatwave with focused message on rehydrate and refuel as well as supporting general wellbeing at work during this time • Menopause work continues with a conference scheduled for 18th October 2022. • "Take a Pause for Menopause" sessions introduced for all staff to attend. This is confidential space to share experiences and ask questions. • Financial Wellbeing group established to support with proposals and initiatives to support staff financial wellbeing through winter. Initiatives include consideration of food banks, exploration of hardship funds, buy a meal/drink scheme. • Links have been made with Citizen Advice Bureau to support staff with advice and guidance. These close

					links developed include the offer of open appointments for staff to access Citizens advice off site and also on site once per month.
2.3	**<u>To Promote and Support Health and Wellbeing</u>** - Design and deliver a recruitment and retention programme for maternity; to right size the service and enable the delivery of the Continuity of Carer Health Inequalities service delivery model (Maternity Transformation).	Chief Nurse	Quality Committee	• Delivery of Ockenden recommendations for Continuity of Carer (by end of Q4 2022/23)	• NHSE published a letter dated 21 September which clarified the situation relating to COC. They have indicated the national target to deliver this was removed. Local systems are asked to focus on the recruitment and retention and growth of the workforce • We continue to work toward delivering principle of CoC to all women but particularly those from vulnerable groups. • The Trust programme related to workforce continues with successful recruitment ongoing. We are delighted to have recently managed to gain registration for our second international midwifery recruit.
3.1	**<u>To Maximise the Potential of our Workforce</u>** - Develop and Implement a Strategic workforce Plan for SFH in collaboration with the ICS.	Director of People	People, Culture and Improvement Committee	• Resourcing SoF metrics to board each month (On-going) • Introduction of a dedicated Strategic Workforce Plan by the end of Q2 2022/3 • Annual refresh of dedicated Strategic Workforce Plan by the end of Q4 2022/23	• Our Strategic People Plan was agreed at Trust Board in October 2022, and we have been meeting with clinicians to understand current workforce pressures. We have also been developing a template for the tactical people plans that we will use to provide service lines intelligence on their workforce and use for prioritising workforce pressures.

3.2	**To Maximise the Potential of our Workforce** - Respond to the 2021 NHS Staff Survey. Identify Key Focus Areas.	~~Director of Culture and Improvement~~ Director of People	People, Culture and Improvement Committee	A number of detailed metrics will be monitored via the People, Culture and Improvement Committee. These will be focused on: • **Valuing YOU**; enough staff to do my job, recognition and reward programme • **Caring about YOU**; reducing colleague experience of V&A/BH from patients/users/colleagues • **Developing YOU**; improve quality of appraisals, fair career development Improvement trajectories have been set and a summary of performance will be reported to the Trust Board of Directors via quarterly updates throughout 2022/23.	• All commitment pillars have an allocated lead and working group in place • Trust commitments are shared routinely via all Trust communications channels with updates provided on a minimum of a monthly basis • August DPRs focussed on discussions with Divisions regarding their Cultural improvement progress and plans in line with the Trust commitment areas • Q2 pulse survey indicated some reduction in experience compared to previous quarters but still benchmark high nationally against comparable Trusts • NSS22 launched successfully on 03.10.22 with communications and You Said Together We Did comms linking back to our 2021 commitment areas.
4.1	**To Continuously Learn and Improve** - Successfully implement and optimise the use of EPMA.	Medical Director	Executive Team Meeting	• Roll out EPMA into surgery, incorporate VTE screening tool, develop and embed fluids module, scope requirements for ED EPMA module. Complete by end of Q2/beginning of Q3 2022/23 • Develop and embed analysis and system reporting opportunities by the end of Q4 2022/23	• VTE screening tool launched and data capture and analysis feeding into SoF • Surgery live with ePMA • Fluid module roll out in piloting on 2 wards • Next areas to roll out in project board development

4.2	**To Continuously Learn and Improve** - Develop a refreshed Digital Strategy.	Medical Director	Executive Team Meeting	• EPR Business case approved by NHSE by the end of Q4 2022/23 • Production of three-year digital investment plan in line with the Multi Year planning process (Dates to be published by NHSE)	• EPR FBC approved by Trust Board and submitted to NHSE Frontline Digitisation • Awaiting formal feedback on submission and business case development process
4.3	**To Continuously Learn and Improve** - To introduce an Innovation Hub across the Mid Notts Place Based Partnership.	~~Director of Culture and Improvement~~ Director of Strategy & Partnerships (tbc)	People, Culture and Improvement Committee	• Introduction of an Innovation Hub, working in partnership with key ICS Partners, implemented by Q1 2022/23 • Key principles and year 1 aspirations defined and implemented by Q1 2022/23 (including methodology for quantifying impact on patient care)	• As noted in the quarter 1 update, we have secured some joint funding with our Integrated Care System partners to develop a Nottinghamshire wide online hub. We are currently in the design stage. • Our hub will be based on the Alder Hay Innovation Centre model (https://www.alderheyinnovation.com/) which has been developed specifically to enable quick access to help, assistance and sources of online information and support. We have used part of the funding to commission specialist web design expertise. • Discussions are ongoing with system partners to ensure that despite the hub being viewed as a system resource, we maintain respective local identities. This will help promote local innovation and encourage individuals with relatively small innovative ideas to seek help in the development, implementation, and evaluation of their ideas. • We anticipate that the design stage will be complete shortly, following which implementation can begin.

5.1	**<u>To Achieve Better Value</u>** - Delivery of the SFH Transformation & Efficiency Programme that supports the delivery at PCB/ICP level.	~~Director of Culture and Improvement.~~ Chief Financial Officer	Finance Committee	• Deliver Year 1 of the 2022-25 Transformation and Efficiency Programme ('the Programme') by 31st March 2023 • Deliver Financial Improvement element of the Programme by 31st March 2023, ensuring it is delivered on a recurrent basis • Have in place a plan for the delivery of Year 2 of the Programme (plan developed Q3 2022/23, implementation begins Q4 2022/23) • Continuously review delivery milestones ensuring that changes are enacted where there is a risk of under delivery (ongoing and overseen by the Transformation and Efficiency Cabinet) • Proactively contribute to the ICS/PBP Transformational Programmes of work, ensuring all collaborative opportunities are exploited ((ongoing and overseen by the Transformation and Efficiency Cabinet)	• Although a three-year Transformation and Efficiency Programme has been developed and is being implemented, which includes a £11.7m financial improvement component; the current forecast is that £4.0m will be delivered. • Urgent mitigation work is therefore underway, focusing on the following areas: a. Discretionary spend and non-pay budgets. b. Refreshed benchmarking and comparative data (including Model Hospital). c. Maximising elective activity income opportunities. d. System opportunities. e. Creating additional divisional support. f. Governance and delivery models. • Associate Director of Transformation continues to remain an active member of various System Transformation Groups.
5.2	**<u>To Achieve Better Value</u>** - Be a key partner in the development of the Provider Collaborative.	Chief Executive	Executive Team Meeting	• Provider Collaborative Formally Established by 1st July 2022 • PC priorities established by 30th September 2022 • Formal review of PC achievements reported to SFH and System Boards March 2023	• SFH is a proactive contributor to the Provider Leadership Board and Provider Collaborative Work Programme. • CEO and Chair are key members of the Nottingham and Nottinghamshire Provider Collaborative Chairs and CEO Group. • Priorities now established • NUH CEO is Executive Lead and now in post • Managing Director now appointed and start date to be confirmed.

5.3	**To Achieve Better Value** - Shape and define a new SFH Trust 5-year strategy (2023-2028) working with ICS and wider partners.	Director of Strategy and Partnership	Executive Team Meeting	• Strategy agreed at SFH Board November 2022 • Launch of new strategy completed by 31st January 2023	• Board time out held 13/14 October to shape the strategy – update on progress presented and discussed.
5.4	**To Achieve Better Value** - Continue to progress Pathology Network initiatives alongside NUH (and across the region where required).	Director of Strategy and Partnership	Executive Team Meeting	• Programme Delivery in line with existing programme plan and national planning expectations (**to be refined once Director of Strategy and Partnership commences**)	• Attended first Pathology network board – now need to establish the right level of resource to represent the trust and ensure we are part of the decision making for future service provision. • Clinical representation has been consistent through the divisional clinical director.

Appendix A

Timetable for Updates

Period	Trust Board of Directors Meeting
Quarter 2 (July 2022 – September 2022)	3rd November 2022
Quarter 3 (October 2022 – December 2022)	2nd February 2023 *(TBC)*
Quarter 4 (January 2023 – March 2023)	4th May 2023 *(TBC)*

Mid-Nottinghamshire Integrated Care Partnership

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Single Oversight Framework

Reporting Period: Quarter 2

2022/23

Inspected and rated
Good
Care Quality Commission

Single Oversight Framework – Q2 Overview (1)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Quality Care	In September 2022 (M06 – Q2) our prolonged period of exceptional pressure across all services and pathways within the Trust. Throughout the month additional bed capacity was flexed to meet the demands (Full Capacity Protocol), and the Trust remains above the initial 'winter plan' and this has required the Trust to utilise super-surge, as has previously been described. The pressure has been felt across the organisation including within the Emergency Department with ongoing episodes of overcrowding and long waits, which impacts on the nursing and medical staff to give care and treatment in a safe, consistent manner and does not allow our patients to have a good positive experience. The Emergency Assessment Unit has had the impact of the 'one over' Standard Operating Procedure, which has been risk assessed and a Quality Impact Assessment has been undertaken. The staff have also had an impact on their experience and morale during these difficult times, and despite these challenges and difficulties our teams have continued to focus on delivering good quality care in the safest manner possible. There are five exception reports to note for September 2022:- **Exception reports:** **Covid-19 Hospital onset –** there has been an increase in nosocomial cases of Covid-19 across the regional, which is reflected in the Trust and this has increased by over 84% in the last few weeks (regionally). **Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBDs –** the trust has breached the MRSA trajectory for the year, the number was set at 0, and to date the Trust has had 3 cases. The last case was reported in July 2022. **Recommended Rate: Friends and Family Accident & Emergency –** there has been a downward trend in the FFT nationally, and this has been reflected at the Trust, although the Trust is above the national picture, and just below the planned trajectory. **Rolling 12 months HSMR (basket of 56 diagnosis group)** **Cardiac arrest rate per 1000 admissions** – low numbers of annual cardiac arrests within the Trust, means that staff are not exposed to the emergency situation. Looking at simulation cardiac arrests to support confidence.	MD, CN

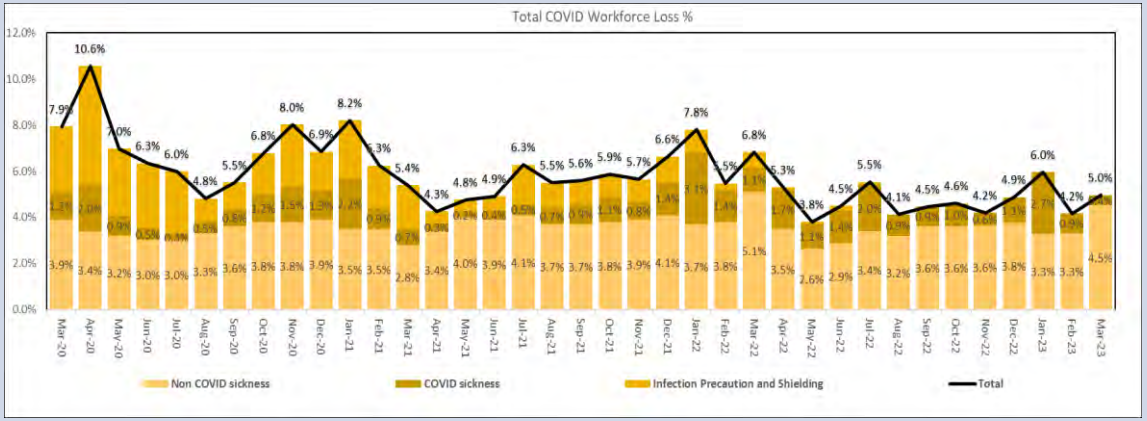
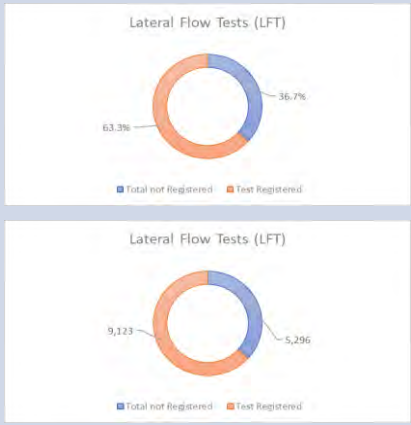
Single Oversight Framework – Q2 Overview (2)

Domain	Overview & risks	Lead
People & Culture	**People** In Q2 our sickness absence levels and overall workforce loss has fluctuated The current sickness level is reported as 4.5% which is an increase when compared to 4.3% in June 2022 (Q1) This sits above the revised trust target 4.0% The main reasons for sickness are reported as Chest and Respiratory and Stress and Anxiety problems. Total workforce loss (Inc sickness, maternity and infection precaution) sits at 6.6% this sits above the target 6.3%. We are still seeing a high proportion of absences relating to stress and anxiety but our soft intelligence informs us this related to personal stressors outside of the workplace rather than work related reasons Measures to support this include: • Wellbeing support continues across the Trust via a dedicated wellbeing team which is ensuring this is embedded within the division and corporate areas • Directorate support and visibility walk arounds by the People, Culture and Improvement Directorate • Divisional coaching and specific sickness and wellbeing conversation to support for managers is in place with the People Partner team, • Development of financial wellbeing group to offer support to staff in the context of a cost of living crisis • A range of online sickness absence management training is also available via Sherwood E Academy • Dedicated sickness absence training for Medirest Colleagues to support ROE staff health and wellbeing • Colleague support leaflet introduced for both wellbeing and financial wellbeing and circulated to all managers through People and Performance Overall resourcing indicators for Q2 2022 are positive, however our overall vacancy's have remained at the same level, but turnover has increased, but sits under the Trust target. On the 18 October 2022 the Trust held a menopause conference on world menopause day. This event was attended by over 60 colleagues and provided information and support to colleagues regarding the menopause. In addition October is Black History month and there have been a number of events which have celebrated black history. There was a successful Reach Out Event to celebrate Black History month for colleagues, which recognised, embraced and celebrates diversity within the Trust. We have developed and agreed a Wellbeing plan for next few months to support our Trust Winter plans, the focus is on physical, mental and financial wellbeing. This has all been signed off and agreed and over Q3 we will focus on the implementation of this. Following the Board of Directors meeting (6th October) we have an agreed Strategic People Plan. We are now developing an implementation programme to enable us to mobilise the strategic people plan, as part of this we will be undertaking the development of tactical people plans that will aim to identify service line risks both 0-12 months, 12-36 months and 36-60 months. Tactical people plans will be developed in collaboration with services to identify the current risks and support decision making aligning to service development. We will focus these where we have hard to fill roles, high vacancy areas or high agency usage. In addition, the plans will prioritise future challenges, fragile services, and winter services. The plan is to prioritise these areas so we can maximise our impact. As part of the Strategic People Plan there is also on-going work to support the Trust to delivery its winter plan. Currently an additional 175.5 WTE have been identified as being required to deliver the plan. 135.5 WTE are already within the establishment with an additional 40 WTE required, and which will form part of the Trust's substantive and temporary workforce recruitment plans.	DOP

Single Oversight Framework – Q2 Overview (2)

Domain	Overview & risks	Lead
People & Culture	**Culture and Engagement** Successful National Staff Survey 2022 launch on 3rd October. Focussing on ensuring we continue to progress with and update colleagues on action against our 2021 results in line with our 3 theme commitments focussed on **'Valuing You'** '**Caring about You'** and **'Developing You'**. Divisional and Trust Wide 'You said Together we did' action will be shared as part of the NSS22 communications plan with Divisional focus weeks planned in throughout October and November. **Reward and Recognition** continues to be a key focus for the team and Trust with regards to 'getting the foundations right'. A review and approach was approved at TMT and ET. Feedback has also been sought from Divisions to ensure the approach is in touch with colleagues needs currently. A number of new offers including better recognising retirement from the Trust are being introduced across the Autumn. Funding has also be secured for the Charity to support out welcome to SGH sense of belonging work, with Team SFH lanyards and welcome postcards on their way. We have also taken receipt of 5000 George Cross pin badges aimed to recognise colleagues efforts during Covid especially. The OD team contributed to a system with Civility, Kindness and Respect week (Sept-22) run in partnership with Nottinghamshire ICS, and are moving into trailblazer phase for our new 'ACTIVATE' programme designed to bring CRK to life at a team level. Our **Mandatory Training and Development** compliance currently sits at 88% this is up from 87% last month but still sits below the Trust target (90%). Training has now resumed as normal and our Task & Finish Group have been working together to improve compliance. The group is developing plans to support increasing capacity due to relaxing of IPC regulations and implementation plans for the new MAST and induction programmes. Sign off of the revised workbook offer is underway and implementation of Learning Governance Groups (to manage the process ongoing) are due to be in place by end Oct-22. We expect to see an upturn in compliance during the coming months. The new induction process is due to be introduced from mid-October and as such, increased assurance and compliance of all MAST requirements. **Appraisals** levels sit at 83.7% for September, this is sits below the Trust target. And is showing a declining trend. This is a reflection of workforce loss during Q2 due to COVID absences, along with Annual Leave impact during School summer holidays. Divisional trajectories have been sent to support improving compliance to 90% by the end of December 2022 and 95% by 31 March 23 - all dependant upon capacity and ensuring we undertake quality appraisals rather than a tick box. A working group is in place to improve compliance and experience, agreement is look at revised paperwork as an interim measure with digitalisation during 22/23. **Improvement** Following a QI Review session with the SLT in June, a Board development session on QI was held in August. 48 colleagues have undergone bronze QI training in Q2, uptake was reduced over summer holidays as expected and there were no cohorts of silver level training within the quarter but this will increase again in Q3 including a first trial of delivering the ICS programme at Kings Mill to improve access for colleagues across the north of the county. The number of QI projects registered in Q2 was lower than expected over Q2, and this may be a reflection on organisational challenges over this period, annual leave and the capacity of the Audit team to support information capture. The Audit and Improvement team is working at a third of its capacity until new team members join in December and January : this is impacting negatively on clinical audit and improvement activities	DOP

Single Oversight Framework – Month 5 Overview (2)

Domain	Overview & risks	Lead
People & Culture	**COVID Absence –** The Trust produces a daily Workforce SitRep for the organisation; this includes all COVID related absence elements which are wider than the sickness element reported above. When this is reviewed the total COVID related absence for September 2022 was 4.5%, (August 2022 4.1%). This is expressed in figure 1. **Lateral Flow Tests** – Overall there were 14,419 test distributed, with 9,123 test registered (63.3%). Of the completed tests there has been 3,815 positive test (1.2% positive results). This is expressed in figure 2. Figure 1 – Total COVID Workforce Loss  Figure 2 – Lateral Flow Tests  	DOP, DCI

Single Oversight Framework – Q2 Overview (3)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Timely care	September continued to be an increasing challenge across the emergency pathway with average daily attendances of 475. 8 days of the month saw attendances over 500. Performance against the 4 hour standard worsened in September 2022 to 75.4%. The trust ranked 19th in the country and 4th regionally. A System wide critical incident was declared 29th September and stood down 5th October. In response to the increasing attendance pressures, the trust extended use of Sherwood Care Home and increased the number of beds at Newark. 5 wards continue to be used for the care of patients that are medically fit requiring social care support. MSFT patient numbers have improved slightly in September dropping from 119 to 111 but significantly above the agreed position of 22. The trust continued to declare OPEL level 4 throughout the month, with patients experiencing long delays in ED. Bed occupancy remains higher than the national target (92%) at 96.6% 24 days out of 30, 18 days were over 95%. The trust submitted a non compliant plan against the follow up reduction target of 25% in the 2022/23 planning round. To date the reduction made has been small (4.3%) and due to the size of the overdue review list it is unlikely that this will improve significantly. Good progress has been made against the 5% Patient Initiated Follow Up target with performance exceeding the target. The number of patients waiting more than 62 days on a suspected cancer pathway in September was 102 which is over trajectory. 62 day performance for August improved slightly on the previous month increasing to 64% against a standard of 85%. Faster Diagnosis Standard (FDS) performance continues to be in target. September achievement was 75.9% against the 75% standard.	COO

Single Oversight Framework – Q2 Overview (4)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Best Value care	**Income & Expenditure:** • The Trust has reported a deficit of £3.8m for Month 6 (September 2022), which is £3.4m adverse to plan. This includes the removal of £2.8m of planned Community Diagnostic Hub (CDH) funding, which is yet to be confirmed. • Year-to-Date performance for the period to the end of Quarter 2 is a deficit of £9.5m, which is £4.8m adverse to plan. As well as the £2.8m income adjustment noted above, this also reflects cost pressures of £1.9m relating to Covid-19 expenditure and the additional bed capacity that has remained in place. • The forecast outturn at Quarter 2 shows delivery of the planned £4.7m deficit for the financial year. However, a risk assessed forecast outturn has been calculated which estimates an adverse variance to plan of £13.4m. This includes the risks of continued Covid-19 expenditure (£5.3m) and non-receipt of the CDH funding (£5.5m). Other risks include the receipt of Elective Recovery Funding, the delivery Transformation & Efficiency savings and ongoing cost pressures relating to additional capacity. **Financial Improvement Programme (FIP):** • The Financial Improvement Programme (FIP) has delivered savings of £0.6m to the end of Quarter 2, which is £3.1m lower than planned. A reprioritisation of Transformation and Efficiency Programme resources has been agreed by the Executive Team, to ensure a focus on projects and programmes that are more likely to deliver benefits in the remainder of 2022/23. **Capital Expenditure & Cash:** • Capital expenditure of £1.1m has been reported for Month 6, against a plan of £1.9m. The year-to-date capital expenditure is £3.6m, which is £5.7m lower than planned. The phasing of the plan contributes to this. The Trust's Capital Oversight Group continues to review progress on key schemes and has received assurances relating to the full-year delivery. • Closing cash at 30th September 2022 was £1.7m, which is £0.3m higher than planned. The year-to-date deficit means that the Trust has required working capital PDC support. A detailed daily cash flow forecast is being maintained and the Trust is liaising with ICB partners and NHS England colleagues to ensure sufficient cash is available to manage our position. **Agency Expenditure:** • The Trust has reported year-to-date agency expenditure of £8.9m. This is £2.0m adverse to the planned spend of £6.9m, largely due to additional capacity opened and agency covering vacancies within Divisions. • The Nottingham & Nottinghamshire ICB has been set a system agency ceiling of £54.6m by NHSE/I for 2022/23, which represents a reduction of 29% compared to 2021/22 reported expenditure. The indicative SFH ceiling is £14.7m, which is aligned to the financial plan.	CFO

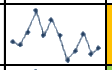
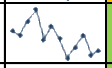
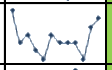
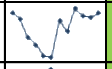
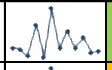
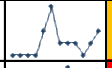
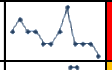
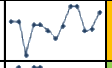
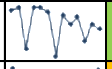
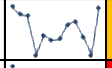
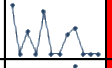
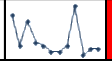
Single Oversight Framework – Q2 Overview (1)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
QUALITY CARE	Safe	Rolling 12 month count of Never Events	0	Sep-22	1	-		A	MD/CN	Q
		Serious Incidents including Never Events (STEIS reportable) by reported date	<21	Sep-22	18	9		G	MD/CN	Q
		Patient safety incidents per rolling 12 month 1000 OBDs	>44	Sep-22	46.66	50.04		G	MD/CN	M
		All Falls per 1000 OBDs	6.63	Sep-22	7.56	7.54		A	CN	M
		Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	20.6	Sep-22	17.61	5.28		G	CN	M
		Covid-19 Hospital onset	<37 PA	Sep-22	116	36		R	CN	M
		Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0 PA	Sep-22	2.64	0.00		R	CN	M
		Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Aug-22	95.7%	97.9%		G	CN	M
		Safe staffing care hours per patient day (CHPPD)	>8	Sep-22	8.9	8.6		G	CN	M
	Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Sep-22	1.26	1.06		G	MD/CN	M
		Recommended Rate: Friends and Family Accident and Emergency	<90%	Sep-22	89.3%	86.5%		R	MD/CN	M
		Recommended Rate: Friends and Family Inpatients	<96%	Sep-22	95.1%	94.1%		A	MD/CN	M
		Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	Sep-22	87.5%	87.5%		A	MD/CN	Q
	Effective	Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Jun-22	121.4	-		R	MD	Q
		SHMI	100	Jun-22	101.64	-		A	MD	Q
		Cardiac arrest rate per 1000 admissions	<1.0	Sep-22	0.89	1.28		R	MD	M
		Cumulative number of patients participating in research	2200	Sep-22	1167	-		G	MD	Q

Single Oversight Framework – Q2 Overview (2)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
PEOPLE & CULTURE	Staff health & well being	Sickness Absence	<4.0%	Sep-22	4.5%	4.5%		A	DoP	M
		Total Workforce Loss (inc Sickness, Maternity, Infection Precaution)	<6.5%	Sep-22	6.7%	6.5%		G	DoP	M
		Employee Relations Management	<10-12	Sep-22	45	10		G	DoP	M
	Resourcing	Vacancy rate	<6.0%	Sep-22	4.7%	4.9%		G	DoP	M
		Turnover in month (excluding rotational Drs.)	<0.9%	Sep-22	0.6%	0.5%		G	DoP	M
		Mandatory & Statutory Training	>90%	Sep-22	87.0%	88.0%		A	DoCI	M
		Appraisals	>95%	Sep-22	85.5%	84.0%		R	DoCI	M
	Culture & Improvement	Recommendation of place to work	≥80%	Qtr2 2022/23	78.7%	78.7%		A	DoCI	Q
		Recommendation of place to receive care	≥80%	Qtr2 2022/23	84.1%	84.1%		G	DoCI	Q
		Qi Training - Bronze	>60	Qtr2 2022/23	107	48		A	DoCI	Q
		Qi Training - Silver	>15	Qtr2 2022/23	14	0		R	DoCI	Q
		Number of QI Projects	>40	Qtr2 2022/23	36	10		R	DoCI	Q

Single Oversight Framework – Q2 Overview (3)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
TIMELY CARE	Emergency Care	Percentage of patients waiting >4 hours for admission or discharge from ED	95.0%	Sep-22	78.3%	75.4%		R	COO	M
		Mean waiting time in ED (in minutes)	220	Sep-22	208	224		A	COO	M
		Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<5%	Sep-22	4.8%	4.5%		G	COO	M
		Number of patients who have spent 12 hours or more in ED from arrival to departure as a % of all ED Attendances	shadow monitoring	Sep-22	2.6%	3.9%			COO	M
		Mean number of patients who are medically safe for transfer	<22	Sep-22	104	111		R	COO	M
		Adult G&A Bed Occupancy (8:00am position as per U&EC Sitrep)	<92%	Sep-22	95.5%	96.6%		R	COO	M
	Elective Care	Remote Attendances as a percentage of Total Outpatient Attendances	on trajectory	Sep-22	16.7%	15.5%		R	COO	M
		Outpatient Episodes moved / discharged to a Patient Initiated Follow-up Pathway	on trajectory	Sep-22	5.2%	6.3%		G	COO	M
		Follow Up Outpatient Attendances reduce against Yr2019/20	on trajectory	Sep-22	-3.4%	-0.5%		R	COO	M
		Elective Day Case activity against Plan	on trajectory	Sep-22	95.1%	97.2%		A	COO	M
		Elective Inpatient activity against Plan	on trajectory	Sep-22	90.1%	105.2%		G	COO	M
		Elective Outpatient activity against Plan	on trajectory	Sep-22	101.4%	103.1%		G	COO	M
	Diagnostics	Diagnostics activity increase against Yr2019/20	on trajectory	Sep-22	111.2%	111.7%		G	COO	M
	RTT	Number of patients on the incomplete RTT waiting list	on trajectory	Sep-22	-	46346		A	COO	M
		Number of patients waiting 78+ weeks for treatment	on trajectory	Sep-22	-	33		G	COO	M
		Number of patients waiting 104+ weeks for treatment	on trajectory	Sep-22	-	0		G	COO	M
		Number of completed RTT Pathways against Yr2019/20	on trajectory	Sep-22	97.7%	98.9%		A	COO	M
	Cancer Care	Number of local 2ww patients waiting over 62 days for cancer treatment	87	Sep-22	-	102		R	COO	M
		Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Aug-22	78.0%	79.0%		G	COO	M

Single Oversight Framework – Q2 Overview (4)

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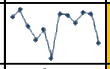
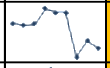
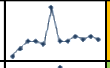
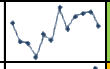
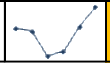
At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Best Value Care	Finance	Income & Expenditure - Trust level performance against Plan	£0.00m	Sep-22	-£4.80m	-£3.38m		A	CFO	M
		Financial Improvement Programme - Trust level performance against Plan	£0.00m	Sep-22	-£2.95m	-£1.02m		A	CFO	M
		Capital expenditure against Plan	£0.00m	Sep-22	£5.65m	£0.77m		A	CFO	M
		Cash balance against Plan	£0.00m	Sep-22	£0.26m	-£2.38m		G	CFO	M
		Agency expenditure against Plan	£0.00m	Sep-22	-£2.04m	£0.30m		A	CFO	M

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Covid-19 Hospital onset	<37 PA	Sep-22	116	36		R	CN	M

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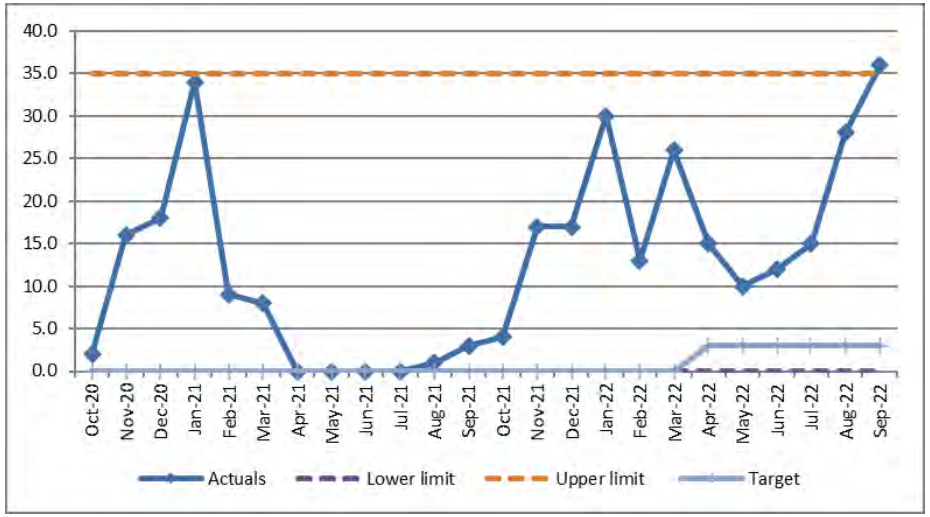

National position & overview

Regionally nosocomial cases of Covid-19 have increased by over 84% in the last few weeks.

During September we saw 36 cases of definite hospital acquired Covid-19 and 10 probable cases. This is an increase of 16 cases from August.

Root causes

- The majority of our cases in September were related to our open outbreaks or were the contact of a community positive case.

Actions

- Continuation of asymptomatic testing within the Trust
- Maintaining the use of chlorine for cleaning areas that have Covid-19 cases.
- Additional communications to visitors to wear masks during their visit to the hospital

Impact/Timescale

- To identify Covid-19 cases as early as possible and commence isolation.
- To reduce environmental contamination
- To reduce the risk of cross infection from visitors who may be asymptomatic for Covid-19.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0 PA	Sep-22	2.64	0.00		R	CN	M

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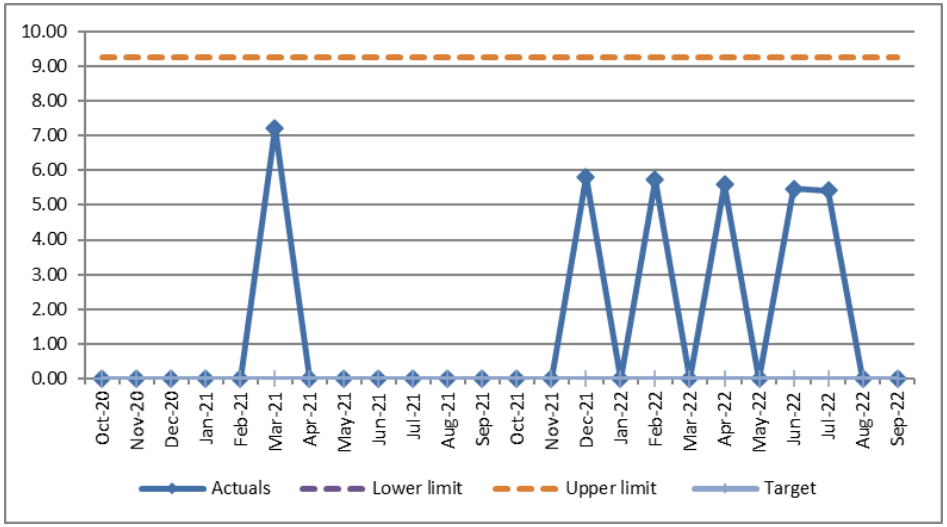

National position & overview

- The trust has breached our MRSA trajectory for the year, which was set at 0 and we have now had 3 cases. The last case being in July 2022.
- All other organisation in our region have also breached their target and 7 of our peer Trusts.

Root causes

- There have been no further cases of MRSA in September 2022.

Actions

- The representative from Schulke who provide our decolonisation treatment have agreed to come to the Trust to do some additional training on why and how to use the products effectively. They will be able to visit each area.

Impact/Timescale

- To support all patients who are high risk getting the correct treatment in a timely manner.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Recommended Rate: Friends and Family Accident and Emergency	<90%	Sep-22	89.3%	86.5%		R	MD/CN	M

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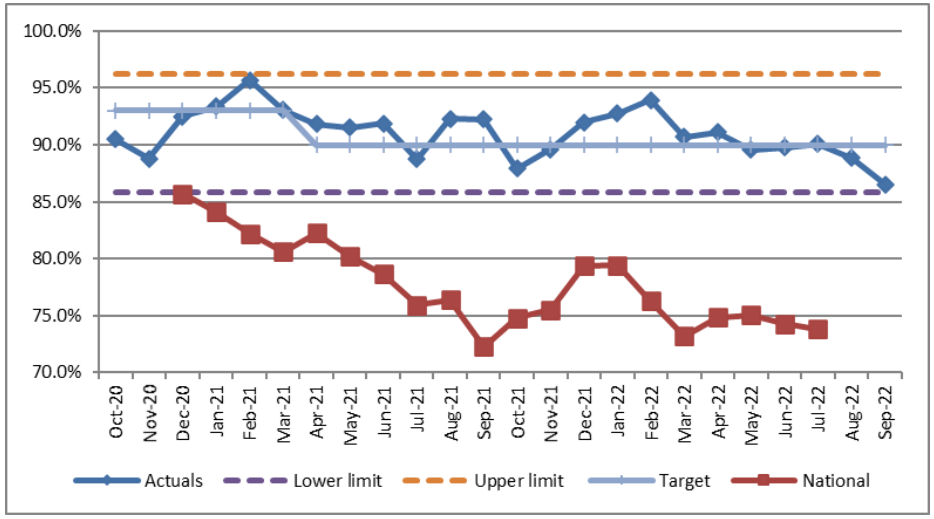

National position & overview

- In comparison to other local Trusts the Friends and Family is below the plan and standard. Nationally all Emergency Departments are under extreme pressure and overcrowding, and the Trust's actual reflects the national picture.

Root causes

- The pressures in the Emergency Department with the Full Capacity Protocol being enacted majority of the time, have not allowed the staff time to hand out the FFT.
- St Johns Ambulance have had a positive impact in ED over the last 2 years during the pandemic, and had been supporting this function, but these have now stopped.

Actions

- Volunteers are supporting in ED and lead nurse will discuss with the Volunteer Manager to establish if this is something that is within their remit.

Impact/Timescale

- Improved FFT within three months.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Jun-22	121.4	-		R	MD	Q

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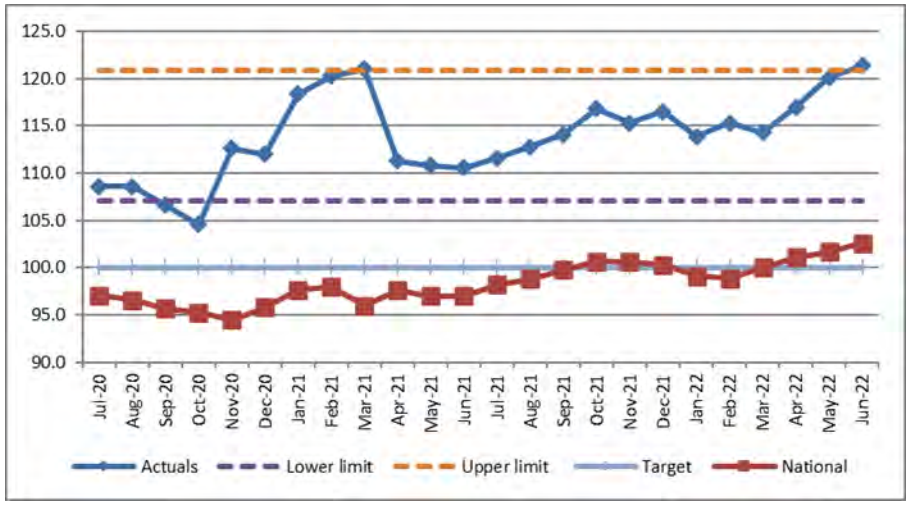

National position & overview

The trust has seen a continuing upward trajectory of the HSMR and the remaining position is that of "significantly higher than expected".

The SHMI has also seen a rise above 100 but remains "as expected".

12-month benchmarking and regional variance have been particularly volatile, partly as a result of Covid related activity. This continues to impact reliability of peer-comparison and ability to provide internal assurance.

Triangulation of other soft and hard markers of mortality and quality do not support the elevated HSMR.

Root causes

Crude Mortality Rate-
- Trust remains higher than the peer, regional or national average. Trust "Expected" rates are lower than peers but we have been seeing a rising volume of deaths; the crude rate is not following regional or national trends.

Palliative care
- Continues to be a key driver for HSMR outlier position.

Documentation of clinical co-morbidities and accuracy of coding-
- Felt to have an additional impact on wider HSMR data.

Dr Foster toolkit-
- Appears little used by trust colleagues / divisions with need for greater ownership and pro-active approach of data and actions.

Actions

Coding Activity and Data Quality-
- The trust has commenced initial discussions with Maxwell Stanley Consulting to consider opportunities to review activity data through their mortality algorithm, particularly focussing on Charlson Co-morbidity indices.

Use of Data-
- Key stakeholder meeting to agree how patient re-identification processes are undertaken
- Learning from Deaths to identify "outlier" areas (triangulated through Dr Foster and CUSUM trends) for divisional targeted review.

Palliative Care-
- The trust has been looking into "standards" of coding against undertaken activity with regard to palliative care (Z515 Specialist Palliative Care / Z518 Non-specialist) as this continues to be recognised and felt to have a marked impact on the both overall HSMR but also data within individual elements of the basket.
- As part of a wholescale review of processes and flow, an external quality control coding audit is being undertaken, stage 2 involving a case-note review and due to commence November 2022.

Impact/Timescale

- Agreed use of the Dr Foster toolkit (HIP) and patient re-identification processes will enable divisions (via mortality leads) to better understand their data, track trends, proactively respond to outlier alerts and take greater ownership.
- Targeted caseload reviews / deep to be reported into Learning from Deaths and, alongside internal morbidity / mortality meetings help guide any next steps in a more pro-active and formal manner
- It is envisaged changes could take 6-12 months to show true impact on HSMR reporting data but, with greater use of toolkit and pro-active approach, local intelligence and on the ground experience should identify variation or see improvements sooner.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Cardiac arrest rate per 1000 admissions	<1.0	Sep-22	0.89	1.28		R	MD	M

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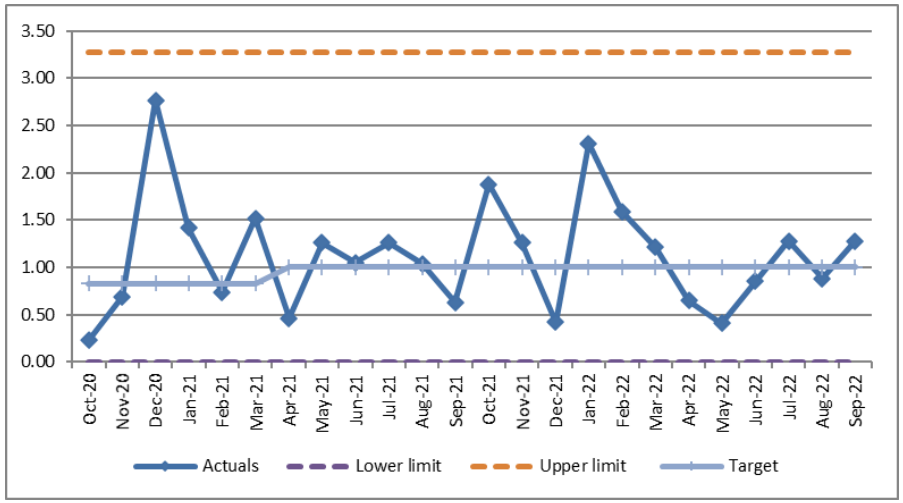
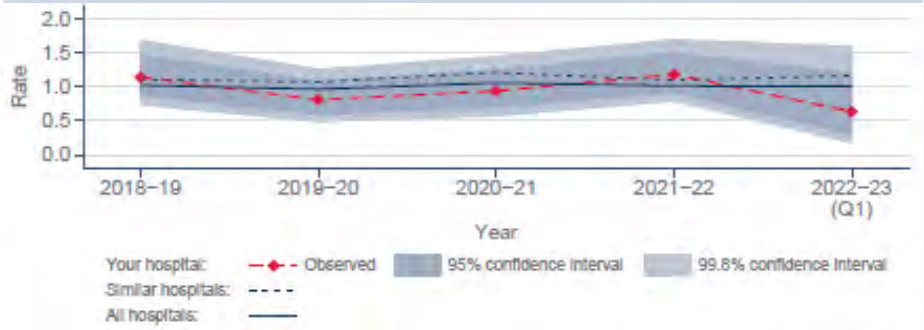


National position & overview

NCAA report Q1 22-23
Nationally comparable (NCAA reporting trusts) cardiac arrest rate per 1000 admissions:



Root causes	Actions	Impact/Timescale
• 6 total NCAA reportable cardiac arrests, 2 of which are considered (subjectively) avoidable by the resuscitation services team:		
EAU 02/09/2022 (DW173380) patient had previous ReSPECT/DNACPR in old notes, identified as DNACPR on post take ward round but no form completed. As no form completed nursing staff commenced CPR at point of arrest as per trust protocol.	• Flagged to UEC division via datix for investigation and learning. Under current process the physical form is the trigger for CPR/no CPR for the clinical team, form must exist and be present for decision to be actioned. This is being reinforced during training with all groups – Resus services will discuss at next respect meeting ?presentation/discussion of case at grand round.	• Ongoing work to reduce the number of patients with DNACPR who receive CPR. Compare 21-22 to 22-23 data April 23.
Ward 42 08/09/2022 (DW173671) ward team acted quickly with information immediately available and commenced CPR. Patient rapidly recovered – unlikely cardiac arrest but has to be reported under NCAA criteria.	• Low number of annual cardiac arrest events = low staff exposure = significant stress effect at bedside when patient 'appears' in arrest. Staff act in interests of patient to provide robust and timely care. ? Would insitu 'mock arrest events' support building workforce confidence – this is not currently resourced within the trust.	• Exploratory discussions in trust around resourcing robust 'insitu' simulation programme. Timescale unknown.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Appraisals	>95%	Sep-22	85.5%	84.0%		R	DoCI	M

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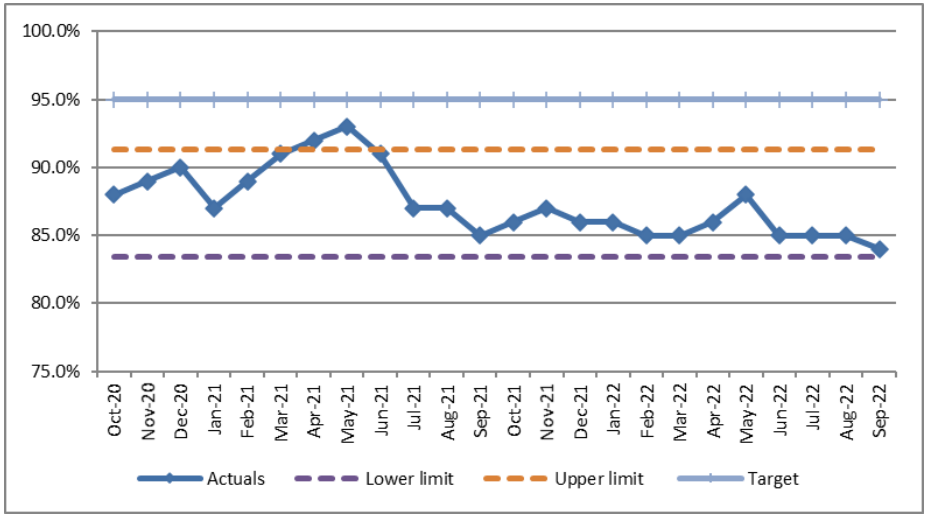

National position & overview

The Trust benchmarks favourably against a national and localised appraisal figure, across NHS providers. Across the ICB the appraisal level for M5 are recorded at 81.8%.

Root causes

The Appraisal position is reported at 84%, and is at a lower level than last month.

The key cause of below trajectory performance on the appraisal compliance is related to workforce loss during Q2 is due to COVID absences, along with Annual Leave impact during School summer holidays.

Actions

Our People Partners will continue to support discussions with Line Managers at confirm and challenge sessions seeking assurance and offering guidance.

Ongoing actions:
A working group is in place to improve compliance and experience, agreement is look at revised paperwork as an interim measure with digitalisation during 22/23. The move to a digital platform is thought to offer as more streamlined and collaborative approach to undertaking appraisals, moving away from the clunky paper-based approaches.

PLT policy will also protect time around appraisal activity to ensure that staff feel the importance of quality appraisal.

Impact/Timescale

Divisional trajectories have been sent to support improving compliance to 90% by the end of December 2022 and 95% by 31 March 23. This is dependant upon capacity and ensuring we undertake quality appraisals rather than a tick box

Update PLT policy and highlight through relevant cabinets then nursing / midwifery cabinet.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Qi Training - Silver	>15	Qtr2 2022/23	14	0		R	DoCI	Q

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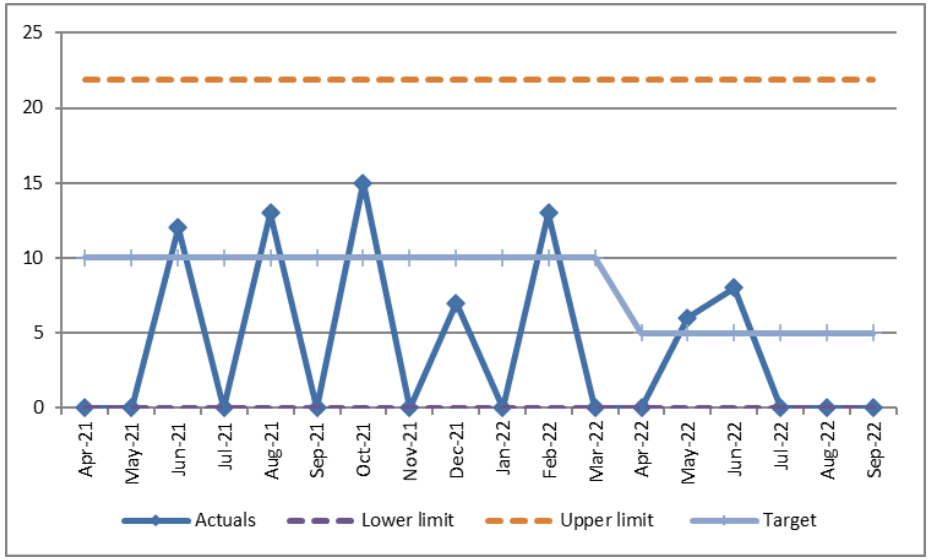

National position & overview

No national overview on performance.

Root causes	Actions	Impact/Timescale
The silver 'Quality Service Improvement Redesign' offer is a 5 day course that equips colleagues to have a robust knowledge and understanding of Improvement tools and science. It is run as an ICS-wide offer, with delivery shared across provider organisations. There was no scheduled 5 day training held in July and August as up take has historically been weaker over this period.	A cohort started in mid September with completion in October, and this metric is expected to be back in green in Q3 to reflect the on-going and scheduled cohorts until end 22/23.	We are expecting to be reporting as green in Q3 and Q4. .

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of QI Projects	>40	Qtr2 2022/23	36	10		R	DoCI	Q

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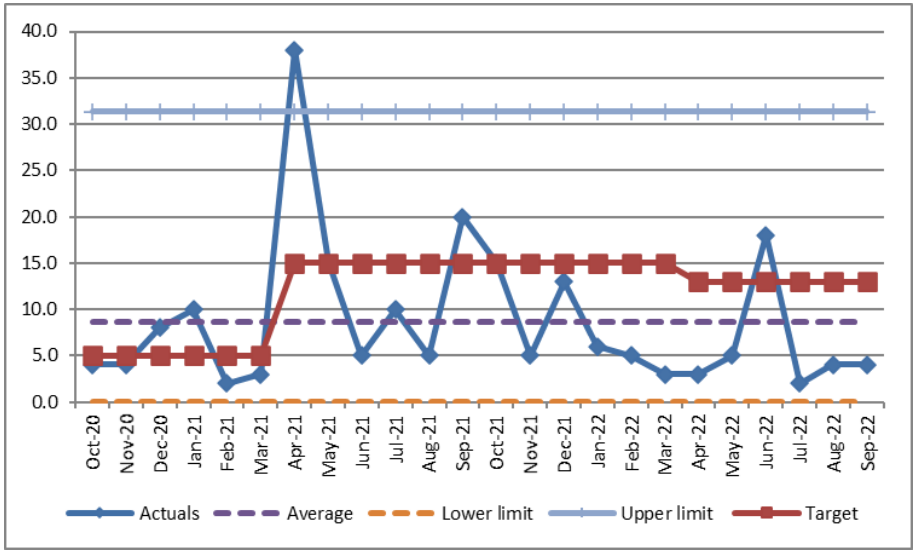

National position & overview

No national position to report on.

Root causes	Actions	Impact/Timescale
The number of Improvement projects on AMAT has flagged as red in Q2, with 10 being registered on the system. This is due to a lack of visibility of the tool, lack of capacity within the Audit and Improvement team to support colleagues to input this data and a combination of annual leave and organisational challenges.	As part of the review of Improvement (QI, Transformation Team, Patient Safety) the use and utilisation of this platform to capture knowledge and information on improvement activities will be reviewed. The Improvement team have been sharing the tool with corporate functions – Finance, People etc to encourage colleagues to add Impro0vement projects to the system, as well as coordinating outputs from the ward accreditation process and team leadership training. The Audit and Improvement team is operating at a third of its capacity until new team members join in December and January, and the team has scaled back promoting AMAT to focus on core bus9iness.	Over Q3, this platform will be considered as part of the Improvement review, with recommendations made over November. Two new members will join the Audit and Improvement team in Q3 which will free up capacity to promote AMAT across the organisation.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Percentage of patients waiting >4 hours for admission or discharge from ED	95.0%	Sep-22	78.3%	75.4%		R	COO	M

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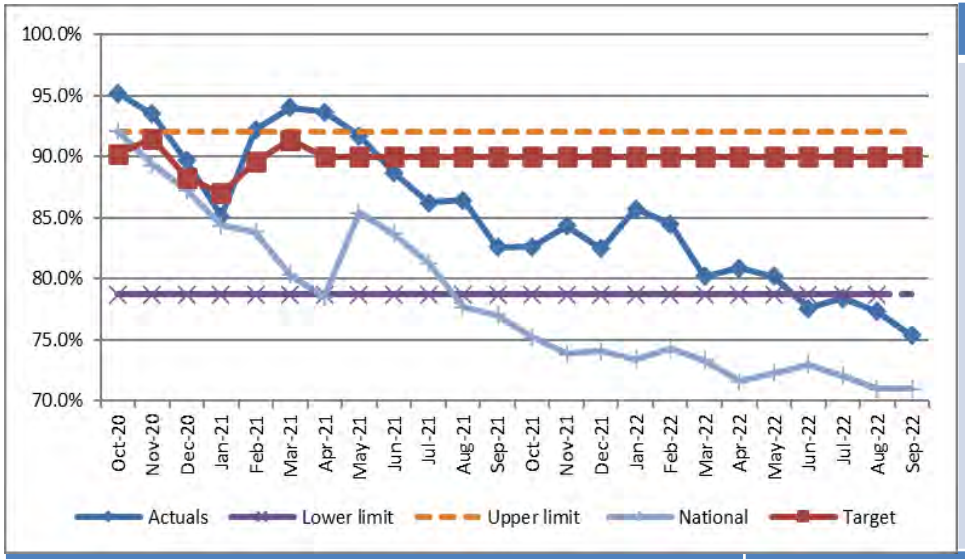

National position & overview

- SFH performance was 75.4% for September 2022.
- Performance continues to be driven mainly by exit block and high numbers of MSFT, although there was a slight improvement on August MSFT numbers .
- National rank 19th out of all comparison Trusts.
- Regional rank 4th out of all comparison Trusts.
- September average attendances were 475, with 8 days of the month exceeding 500.
- 12 hr DTA , 150, rank 50th out of 107 comparison trusts.
- Newark UTC averaged at 98.74% of patients seen and treated under 4 hrs.
- Bed pressure was a key driver of performance.
- MSFT is driving a total of 4 wards worth of demand against a threshold of one. This is shown in a further slide later in the SOF.
- System wide critical incident declared 29th September and stood down 5th October.

Root causes	Actions	Impact/Timescale
Bed capacity pressure • The Trust continues to experience delays in the discharge of patients who require social care support following discharge. There continues to be 5 wards worth of capacity that is currently being used solely for the care of patients who are medically fit but have no onward destination.	Extended the use of Sherwood Care Home and increased the number of beds at Newark Hospital on Castle Ward - These beds do not mitigate the MSFT risk fully.	• In place
	The opening of Oakham ward at MCH has been delayed due to estates issues. Mitigation put in place to enable 12 beds to open on 1 November with the remaining 12 opening towards the end of November.	• November 2022
Waiting to be seen / Time to Decision • Attendances in July were 14, 258 (average of 475 per day) which continues to be more than planned capacity coupled with increased acuity.	Utilising the UCR capacity for 'settling in' where patients who attend ED are able to be discharged safely with the UCR team to bridge any gap in smaller POC over night/for a few hours.	• November 2022
• The opening of Oakham ward at MCH has been delayed due to estates issues. Mitigation put in place to enable 12 beds to open on 1 November with the remaining 12 opening towards the end of November.	Capacity and Demand exercise complete across ED Nursing and Medical staffing – business case finalised pending, subject to TMT approval.	• November 2022
	The Optimising Patient Journey (OPJ) Improvement Programme focus and approach has been mandated by the Executive Team, following wide clinical engagement. A four week rapid improvement cycle across all adult wards begins on 31st October, with outcomes reported into the Emergency Care Steering Group.	• October 2022

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Mean number of patients who are medically safe for transfer	<22	Sep-22	104	111		R	COO	M

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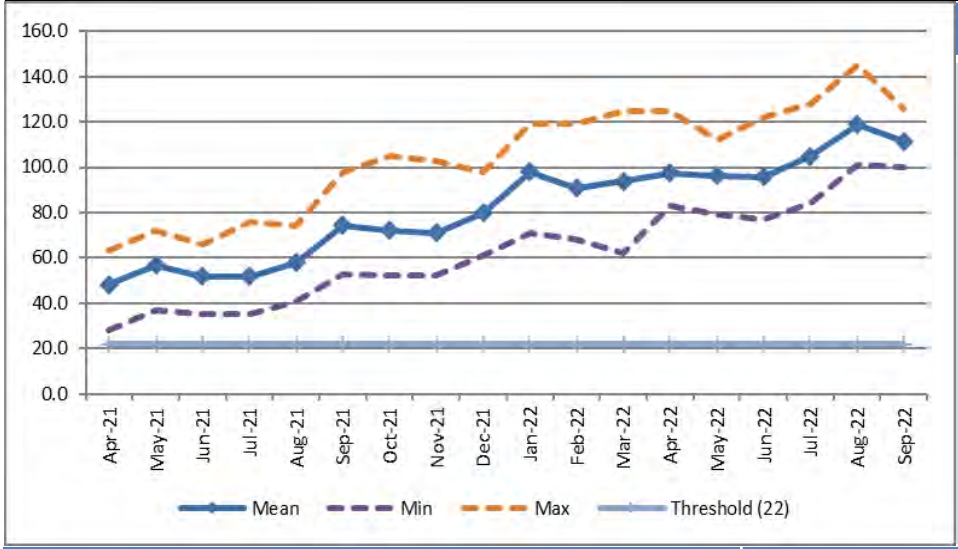

National position & overview

- Whilst there has been a slight improvement in September from the August position, the local position remains significantly above the agreed threshold of 22 patients in the acute trust, in delay.
- There are currently over 5 wards worth of patients in delay .
- The position is a direct link to capacity issues within adult social care and care agencies.
- Additional winter and surge capacity remains open, additional capacity opened at short notice as part of escalation on OPEL 4.
- System Virtual Ward Business Case signed off but delayed start and reduced numbers due to Notts Health care staffing shortages.
- System D2A business case due to start November 2022 for SFH.
- Working with system discharge lead to improve internal discharge process.

Root causes	Actions	Impact/Timescale
• Lack of staff within care agencies to support P1 discharges.	• Working with adult social care and ICB to significantly improve the interim bed offer process.	• Ongoing
• Ongoing delays for patients requiring Decision Support Tool (DST) assessment for higher level Funded Nursing Care (FNC).	• Transfer of Care Hub opened.	• Mid October
	• Electronic solution for D2A form to ensure agencies all have up to date information for decision making and forward planning will be live for start of TOCH.	• Mid October
	• Provider collaborative action with Notts health Care to expand current scheme to deliver home care.	• In place
	• Internal audit of bed designation taking place to inform system wide actions.	• Complete

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Adult G&A Bed Occupancy (8:00am position as per U&EC Sitrep)	<92%	Sep-22	95.5%	96.6%		R	COO	M

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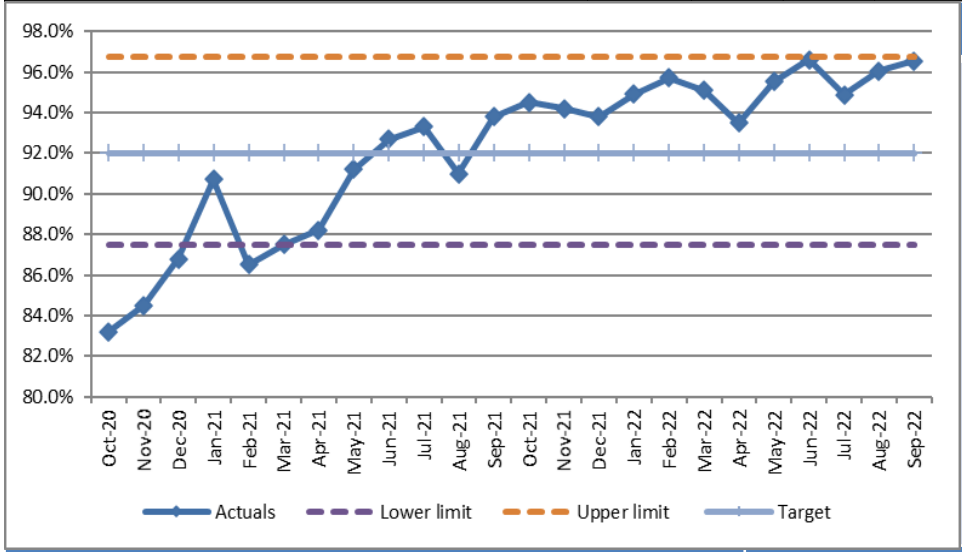

National position & overview

- The trust continues to operate at occupancy levels significantly higher than the planned 92%.
- Delays to the onward care of MSFT patients continue to have a detrimental effect on capacity and flow.
- Throughout September the trust operated above 92% occupancy on 24 days out of 30 days, of those, 18 were over 95%.
- Additional capacity is opened and closed in response to internal bed flow pressures which temporarily improves occupancy.

Root causes	Actions	Impact/Timescale
• The Trust continues to experience delays in the discharge of patients who are MSFT.	• Daily MSFT calls with system to place patients. Escalation to daily system call.	• Ongoing
	• System calls attended by DCOO to ensure appropriate challenge to partners.	• Ongoing
• There are 5 wards of patients who are medically fit for transfer but have no onward destination.	• Continue to utilise SDEC and Streaming pathways to turn patients around at the front door and avoid admission.	• Ongoing
	• Progressing alternative discharge pathways with system colleagues through the Provider Collaborative.	• In place
• Bed modelling shows that the occupancy of the trust is almost entirely driven by increasing MSFT numbers and associated increasing length of stay.	• D2A programme due to start for SFH in November 2022.	• November 2022
	• Transfer of Care Hub opened.	• Mid October 2022
	• Audit to understand the numbers of delayed patients by pathway within the organisation to inform system conversation.	• Complete
	• Proactively working with system discharge lead to review internal discharge process and improvements.	• November 2022
	• OPJ actions regarding ward process brought forward to achieve occupancy reduction before onset of winter.	• October 2022

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Remote Attendances as a percentage of Total Outpatient Attendances	on trajectory	Sep-22	16.7%	15.5%		R	COO	M

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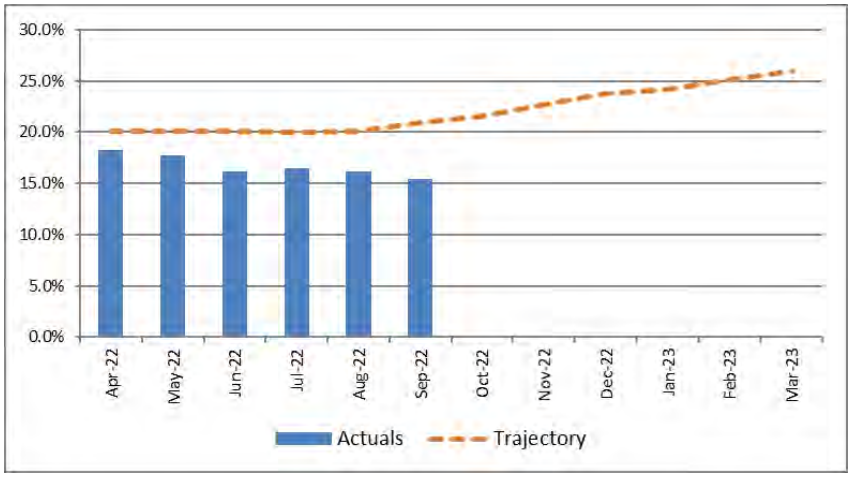


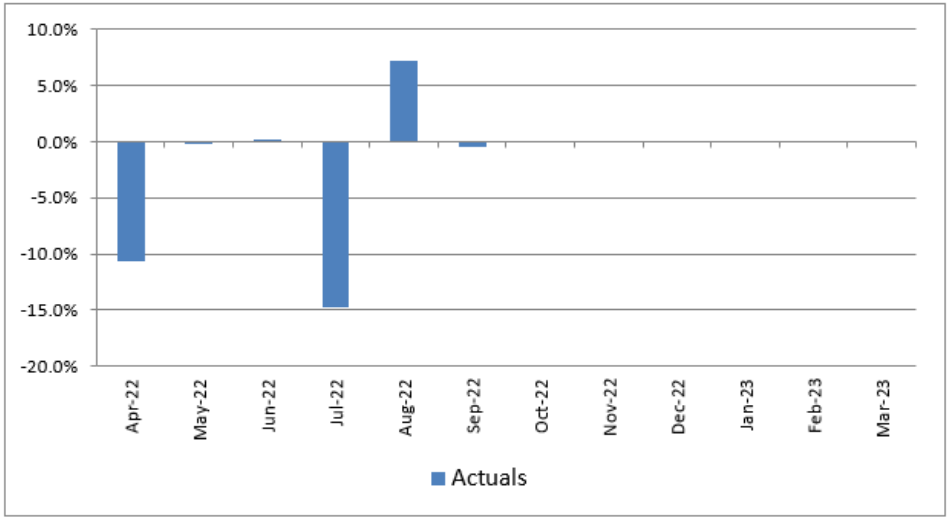
National position & overview

- National target to deliver 25% of all outpatient attendances virtually.
- Currently delivering 15.5% of outpatient consultations virtually against the national target of 25%.

Root causes	Actions	Impact/Timescale
• Clinical preference for face to face consultations.	1. A **project team** has been set to define problems and actions to address.	• Complete
• Infrastructure issues with regards to connectivity, space and support.	**2. Analysis of Regional Benchmarking & SFH Virtual Appointments Dashboard** To understand where the opportunities for development may be.	• Complete
• Capacity of comms/IT colleagues to develop patient information repository to support virtual appointments.	**3. Engagement - Survey of clinicians** - Views of virtual. appointments (appetite, challenges and perceived benefits), Equipment needs, Space requirements.	• Complete
	4. Engagement with Clinical Chairs - Senior clinical buy-in for increased use of virtual appointments.	• Complete
	5. PID & QIA completed – stage 2 QIA required.	• November 2022
	6. Implementation Plan – developed, outlines 4 workstreams to increase virtual attendances, these are: Data (ensuring our recording and reporting is correct) Admin processes (Ensure our processes support virtual consultations) Governance & Safeguarding (Ensure we have Trust wide processes in place) Priority Areas of Focus – The priority areas for phase 1 are: Rheumatology, Diabetes, Clinical Haematology where regional benchmarking shows there is the largest opportunity.	• November 2022 to March 2023

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Follow Up Outpatient Attendances reduce against Yr2019/20	on trajectory	Sep-22	-3.4%	-0.5%		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

• The Trust delivered 5.5% more follow-up appointments in August 2022 versus 19/20. Year to date, the Trust have reduced follow-up appointments by 4.3% compared to 19/20, against the 25% target.

• The Trust still has a significant volume of overdue reviews which is impacting on the ability to reduce overall follow up attendances.

• The Trust have currently discharged 6% of patients to a Patient Initiated Follow-Up (PIFU) pathway, against a national target of 5% by March 2023.

Root causes	Actions	Impact/Timescale
• Overdue review backlog circa 14,000. • Patient Initiated Follow Up (PIFU) pathways are not in place for all specialities.	The trust have been clear that due to the size of the overdue review list, we will not achieve the 25% reduction this year. A non-compliant position was reported in the 2022/23 planning submission.	• October/November 2022
	SFH have expressed an interest to be part of the NHS E/I online forms pilot that will implement a number of forms to patients preventing the need for further appointment due to assurance received. Forms can be linked to patients on the waiting lists, PIFU, pre-op and much more. The initial meeting to discuss the pilot start is 26/10.	• October/November 2022
	Expansion of PIFU pathways underway. Phase 2 PIFU Plan focussed on specialities with open appointments, an audit of current PIFU Pathways and development of patient comms. Paediatrics is the remaining speciality to move to PIFU under phase 2 plan and discussions are planned in November to progress. Audits are underway and improvements have been recommended to specialities. Patient related comms due to commence in November.	• Phase 2 – June 2022 –March 2023
	Phase 3 plan is in development, this will focus on expanding the use of PIFU for patients with long term conditions who are not discharged.	• Phase 3 – November 2022 – March 2023

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of local 2ww patients waiting over 62 days for cancer treatment	87	Sep-22	-	102		R	COO	M

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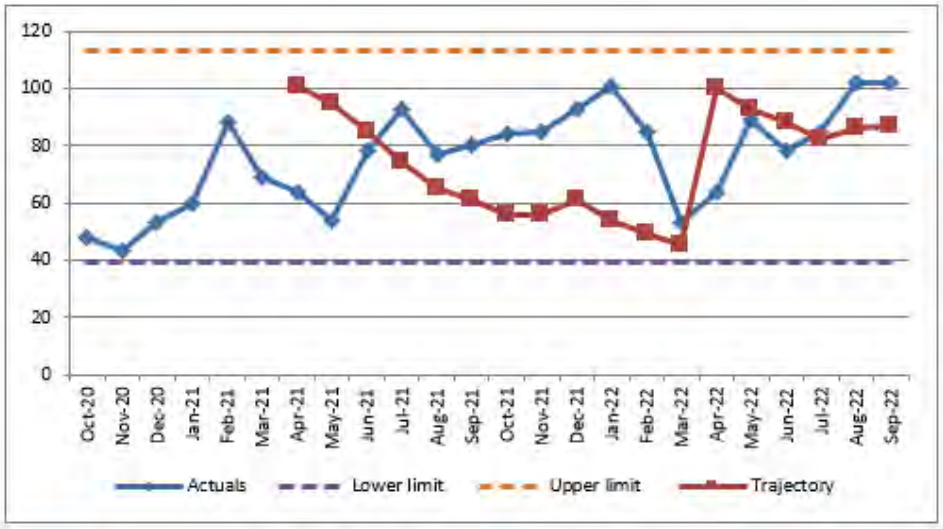


National position & overview

- September 2022 backlog is 102 against a trajectory of 87.
- Breast, Gynaecology, Haematology, Head and Neck and Upper GI were on or ahead of trajectory at the end of September.
- Lower GI, Lung, Skin and Urology were behind trajectory at the end of September.
- 64% of patients in August were within 62 days against a target of 85% (75 patients in total were within target with 27 breaches).

Root causes	Actions	Impact/Timescale
• Lower GI contributes to over 50% of the 62 day cancer backlog. Increase in referrals of 36% *in comparison to pre covid Feb 20* has not been matched by a proportionate increase in diagnostic or treatment capacity.	• Targeted improvement support has been identified to support lower GI with demand and capacity review and improvement actions required to address capacity gap. • Locum consultant recruitment underway to bolster routine clinics to release time for cancer clinics. • Additional dedicated Corporate Cancer PTL focused on Lower GI. • PTL deep dive with tumour site and cancer clinical lead.	• Commencing October 2022 • Underway • Commenced October 2022 • 26 October 2022
• Overall increase in average number of weekly referrals from 314 pre-covid to 381, with an upper limit of 473.		
• Skin affected by consultant capacity.	• Locum consultant appointed to start end of October. • Speciality consideration of alternatives e.g. teledermatology.	• Appointed to • Initial meeting to be held early November
• Urology affected by waits for biopsy's.	• Pilot of biopsy's in a clinic setting as opposed to in theatres to increase capacity by 75% and reduce waiting times to deliver in line with optimal prostrate timed pathways.	• Phase 1 commencing end of October 2022

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

Income & Expenditure *Trust Level Performance against Plan*	In-Month	**(£3.38m)**	The Trust has reported a deficit of £3.75m for Month 6 (September 2022), on an ICS Achievement basis. This is a £3.38m adverse variance to the planned deficit.
	Year-to-Date	**(£4.80m)**	The Trust has reported a deficit of £9.54m for the Year-to-Date, on an ICS Achievement basis. This is a £4.80m adverse variance to the planned deficit.
	Forecast Outturn	**£0.00m**	The forecast outturn reported at Month 6 is aligned to the 2022/23 financial plan, as a deficit of £4.65m.
Financial Improvement Programme *Trust Level Performance against Plan*	In-Month	**(£1.02m)**	The Trust has reported FIP savings of £0.36m for Month 6 (September 2022), which is £1.02m lower than planned (includes notional Elective Recovery Fund (ERF) of £0.0m).
	Year-to-Date	**(£2.95m)**	The Trust has reported FIP savings of £1.85m for the Year-to-Date, which is £2.95m lower than planned (includes notional Elective Recovery Fund (ERF) of £0.00m).
	Forecast Outturn	**£0.00m**	The Trust has forecast FIP savings of £13.95m for the Financial Year 2022/23, which is aligned to the plan (includes notional Elective Recovery Fund (ERF) of £2.21m).
Capital Expenditure Programme *Trust Level Performance against Plan*	In-Month	**£0.77m**	Capital expenditure in Month 6 (September 2022) totalled £1.10m, which is £0.77m less than planned.
	Year-to-Date	**£5.65m**	Capital expenditure totals £3.59m for the Year-to-Date, which is £5.65m less than planned.
	Forecast Outturn	**£0.00m**	The Trust has forecast capital expenditure totalling £19.46m for the Financial Year 2022/23, which is aligned to the plan.
Cash Balance *Trust Level Performance against Plan*	In-Month	**(£2.38m)**	The Trust's cash balance decreased by £3.01m in Month 6 (September 2022), which is an adverse variance of £2.38m compared to the plan.
	Year-to-Date	**£0.26m**	The Trust reported a closing cash balance of £1.73m as of 30th September 2022, which is £0.26m higher than planned.
	Forecast Outturn	**£0.00m**	The Trust has forecast a year end cash balance of £1.45m for 2022/23, which is aligned to the plan, but which requires working capital borrowing support.

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

Agency Expenditure Against Plan *Trust Level Performance against Plan*	In-Month	**£0.30m**	The Trust has spent £1.33m in month 6 (September 2022). This is a £0.30m favourable variance to the planned level of spend.
	Year-to-Date	**(£2.04m)**	The Trust has spent £8.90m for the Year-to-Date on agency, This is a £2.04m adverse variance to the planned level of spend.
	Forecast Outturn	**(£3.42m)**	The forecast outturn reported at Month 6 is to spend £18.10m on agency. This will be £3.42m adverse to the planned level of spend.

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

M6 Summary

- The Trust has reported a year-to-date deficit of £9.54m for the period up to the end of September 2022 on an ICS Achievement basis. This is an adverse variance of £4.80m to the planned deficit of £4.74m.
- The forecast outturn reported at Month 6 is a £4.65m deficit in line with the 2022/23 financial plan.
- Capital expenditure for Month 6 (September 2022) was £1.10m. This was £0.77m lower than plan primarily relating to MRI where funding has yet to be formally approved. The capital plan requires PDC capital support, and the associated request has been submitted to NHS England for review and approval.
- Closing cash as at 30th September was £1.73m, which is £0.26m higher than planned. The cashflow forecast demonstrates that working capital PDC support is required to support the forecast cash outflow. A submission has been made to DHSC in October for support in November. This is a consequence of delays in receiving funding, current slippage to plan including delivery of cash releasing efficiency savings and utilisation of balance sheet items which are not cash backed in year. Cash support of £2.413m was received in October.
- The Trust has reported year-to-date agency expenditure of £8.90m. This is £2.04m adverse to the planned spend of £6.86m due to additional capacity opened and agency covering vacancies within Divisions.

	September In-Month			Year to Date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	42.47	40.42	(2.05)	231.05	230.45	(0.60)	459.31	461.09	1.78
Expenditure	(42.86)	(44.18)	(1.32)	(235.84)	(239.94)	(4.10)	(464.06)	(465.73)	(1.67)
Surplus/(Deficit) - ICS Achievement Basis	**(0.38)**	**(3.75)**	**(3.38)**	**(4.74)**	**(9.54)**	**(4.80)**	**(4.65)**	**(4.65)**	**(0.00)**
Capex (including donated)	(1.88)	(1.10)	0.77	(9.24)	(3.59)	5.65	(19.46)	(19.46)	-
Closing Cash	(0.63)	(3.01)	(2.38)	1.47	1.73	0.26	1.45	1.45	-
Agency Spend	(1.62)	(1.33)	0.30	(6.86)	(8.90)	(2.04)	(14.68)	(18.10)	(3.42)

FY23 Target		FY23 Forecast		FY23 Variance		M6 Target		M6 Actual		M6 Variance		YTD Target		YTD Actual		YTD Variance		Overall Status
FIP £11.73m	ERF £2.21m	FIP £11.73m	ERF £2.21m	FIP £0.00m	ERF £0.00m	FIP £1.20m	ERF £0.18m	FIP £0.13m	ERF £0.22m	FIP (£1.06m)	ERF £0.04m	FIP £3.69m	ERF £1.11m	FIP £0.56m	ERF £1.29m	FIP (£3.13m)	ERF £0.19m	ation Trust
£13.94m		£13.94m		£0.00m		£1.38m		£0.36m		(£1.02m)		£4.80m		£1.85m		(£2.95m)		A — Amber rated due to YTD shortfall to plan and potential impact on full year forecast

Section 2 - Financial Improvement Plan Actual Delivery (Month 6)

Year To Date Delivery

a. In-month FIP delivery is behind plan. **We have delivered £0.60m against a plan of £3.7m**.
b. There are currently 17 schemes in delivery (an increase of 1 from last month).
c. Procurement savings were phased to start delivering from April. There is however currently only one scheme in delivery (started in July) for pacing consumables. It is anticipated more schemes will be included from month 7.
d. The Medical and Nursing, Midwifery & AHP Transformation programmes were planned to start delivering in July. 3 schemes have started to deliver in August, concerns continue for projects such as 'Reduction of Bank Rates' where costs were previously aligned to the 'Covid' budget and may now be classed as Cost Avoidance.
e. The savings planned for Ophthalmology Transformation were due to start in July. Delivery for this programme is anticipated to catch-up.
f. The savings planned for Diagnostics Transformation were due to start in July. Delay to the appointment of the Diagnostics Improvement Programme Manager has had an impact on delivery. The new Programme Manager started on the 19th September.
g. Within Corporate Services, energy savings have been delivered non recurrently in month of £0.3m.
h. Other Corporate Services projects have been delayed such as a decision to delay the re-introduction of parking charges for staff and awaiting for the outcomes of the National Consultation on uniforms. Further work is required to identify other opportunities to replace projects that won't deliver such as electric car charging points and vacancy underspends.
i. Operational capacity has been impacted by the recent critical incident; divisional FIP engagement has understandably been challenging.

Programme	Overall Trust Target v Delivery			FIP Delivery - Year to Date																	
				Corporate Services Division			Diagnostics & Outpatients Division			Medicine Division			Surgery, Anaesthetics & Critical Care Division			Urgent and Emergency Care Division			Womens & Childrens Division		
	Target £'000	Actual Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG
Medical Transformation	£987	£9		£0	£0		£28	£0		£452	£0		£242	£9		£187	£0		£78	£0	
Nursing Midwifery and AHP Transformation	£670	£98		£0	£2		£23	£0		£286	£55		£133	£20		£121	£28		£107	-£8	
Ophthalmology Transformation	£17	£0		£0	£0		£0	£0		£0	£0		£17	£0		£0	£0		£0	£0	
Outpatients Innovation	£10	£18		£10	£18		£0	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Pathology Transformation	£13	£2		£0	£0		£13	£2		£0	£0		£0	£0		£0	£0		£0	£0	
Procurement	£200	£31		£45	£0		£10	£0		£75	£31		£50	£0		£10	£0		£10	£0	
Estates & Facilities	£0	£319		£0	£319		£0	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Other Corporate Services	£453	£0		£453	£0		£0	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Diagnostics Transformation	£67	£0		£0	£0		£67	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Divisional Schemes	£1,277	£81		£293	£0		£203	£9		£307	£7		£257	£42		£113	£0		£103	£23	
Total	**£3,693**	**£559**		**£802**	**£340**		**£344**	**£11**		**£1,120**	**£93**		**£699**	**£72**		**£431**	**£28**		**£298**	**£16**	

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	SOF – Integrated Performance Report – Quarter 2 2022/2023	**Date**: 3rd November 2022	
Prepared By:	Shirley A Higginbotham – Director of Corporate Affairs		
Approved By:	Executive Team		
Presented By:	Paul Robinson - CEO		
Purpose			
To provide assurance to the Board regarding the Performance of the Trust as measured in the SOF Integrated Performance Report		**Approval**	
		Assurance	x
		Update	
		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	x	x

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	x
PR2	Demand that overwhelms capacity	x
PR3	Critical shortage of workforce capacity and capability	x
PR4	Failure to achieve the Trust's financial strategy	x
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

Executive Team 26th October 2022

Executive Summary

The SOF – Integrated Performance report provides the Board with assurance regarding the performance of the Trust in respect of the standards identified on the dashboard.

This report is for Quarter 2 2022/23

All standards, identified on the report are RAG rated and the threshold for each standard is noted on the dashboard. An SPC chart which identifies trends is provided for each standard these are illustrated in the individual slides.

For Quarter 2 2022/23 there are 14 Standards rated as Red, these are noted below.

<u>Quality Care</u>

COVID 19 Hospital Onset

Regionally nosocomial cases of Covid-19 have increased by over 84% in the last few weeks. This is reflected in the number of increases in the Trust with 36 definite cases and 10 probable cases identified in September.

Rolling 12-month MRSA bacteraemia infection rate per 100,000 OBD's

There has been one case in Quarter 2, in July 2022.

Recommended Rate – Friends and Family, Accident and Emergency

The pressures in the Emergency Department have not allowed sufficient staff time to hand out the FFT. Volunteers are supporting to help increase the feedback received.

Rolling 12 months HSMR (basket of 56 diagnosis groups)

The trust has seen a continuing upward trajectory of the HSMR, and the remaining position is that of "significantly higher than expected". Coding Activity and Data quality is being reviewed focussing on Charlson Co-morbidity indices. Triangulation of information regarding learning from deaths to identify outlier areas is also being undertaken.

Cardiac Arrest rate per 1000 admissions

Work is ongoing to reduce the number of patients with DNACPR who receive CPR. Exploratory discussions are underway around resourcing robust 'insitu' simulation programme.

<u>People and Culture</u>

Appraisals

The position is 84%, which below trajectory and is mainly a result of workforce loss during Q2 due to COVID absences, along with Annual Leave impact during School summer holidays.

QI Training – Silver

No training has taken place over the summer and this has impacted on the performance, training sessions have been reinstated from September

Number of QI projects

The number of Improvement projects registered on AMAT in the period is below trajectory. As part of the review of Improvement (QI, Transformation Team, Patient Safety) the use and utilisation of this platform to capture knowledge and information on improvement activities will be reviewed.

<u>Timely Care</u>

Number of patients waiting >4 hours for admission or discharge from ED

Performance against this standard was 75.4% for September 2022. The Trust ranked 19th nationally and 4th regionally with comparison Trusts.
The continuing high numbers of MSFT patients negatively impacts on performance.

Mean number of patients who are medically safe for transfer

Whilst there has been a slight improvement in September from the August position, there remains over 5 wards worth of patients in delay. The Trust continues to work with adult social care and partners to significantly improve the interim bed offer process. The Transfer of Care Hub which will support the ongoing work has opened.

Adult G & A Bed Occupancy (8.00am position as per U & EC Sitrep)

The trust continues to operate at occupancy levels significantly higher than the planned 92%. Bed modelling shows that the occupancy of the trust is almost entirely driven by increasing MSFT numbers and associated increasing length of stay.

Remote Attendances as a percentage of Total Outpatient Attendances

The Trust is currently delivering 15.5% of outpatient consultations virtually against the national target of 25%. A project team has been established define problems and identify actions to address.

Follow up Outpatient Attendances reduce against 2019/20

The Trust delivered 5.5% more follow-up appointments in August 2022 versus 19/20. Year to date, the Trust have reduced follow-up appointments by 4.3% compared to 19/20, against the 25% target. The Trust has been clear that due to the size of the overdue review list, we will not achieve the 25% reduction this year. A non-compliant position was reported in the 2022/23 planning submission. The Trust ha discharged 6% of patients to a Patient Initiated Follow-Up (PIFU) pathway, against a national target of 5% by March 2023.

Number of patients waiting over 62 days for Cancer treatment

In September the backlog was 102 against a trajectory of 87. Lower GI contributes to over 50% of the 62-day cancer backlog. Targeted improvement support has been identified to support lower GI

Board Assurance Framework (BAF): October 2022

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that 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%)

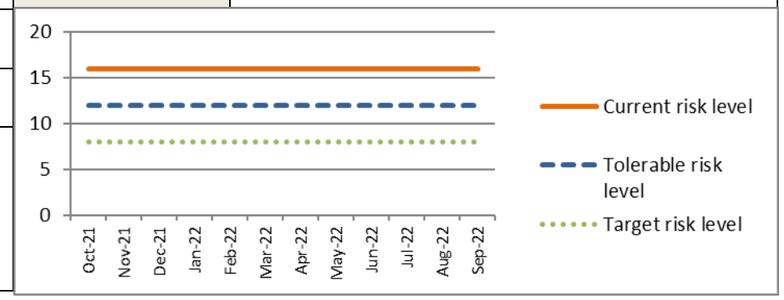
Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating

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

Reference	Principal risk	Lead director	Initial date of assessment	Last reviewed	Target risk score C x L	Previous risk score (at previous review/update) C x L	Current risk score C x L
PR1	Significant deterioration in standards of safety and care	Medical Director	01/04/2018	12/09/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR2	Demand that overwhelms capacity	Chief Operating Officer	01/04/2018	12/09/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR3	Critical shortage of workforce capacity and capability	Director of People	01/04/2018	25/10/2022	4 x 2 = 8	4 x 3 = 12	4 x ~~3~~4 = ~~12~~16
PR4	Failure to achieve the Trust's financial strategy	Chief Financial Officer	01/04/2018	25/10/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR5	Inability to initiate and implement evidence-based improvement and innovation	~~Director of Culture and Improvement~~Chief Executive	17/03/2020	25/10/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	Director of Strategy and Partnerships	01/04/2020	11/10/2022	2 x 2 = 4	2 x 3 = 6	2 x 3 = 6
PR7	Major disruptive incident	Director of Corporate Affairs	01/04/2018	11/10/2022	4 x 1 = 4	4 x 3 = 12	4 x 3 = 12
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	Chief Financial Officer	22/11/2021	11/10/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9

Board Assurance Framework (BAF): October 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes							**Strategic objective**	1. To provide outstanding care
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	2. Unlikely				
Last reviewed	12/09/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	12/09/2022								

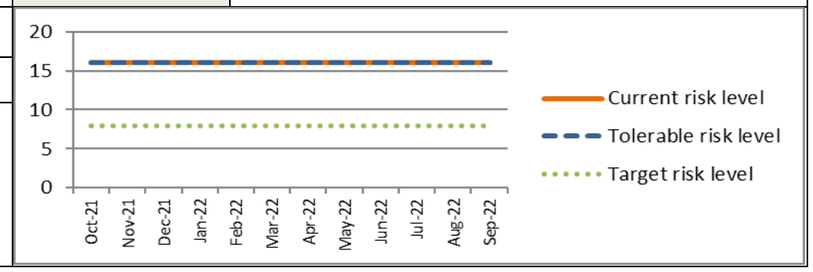


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread loss of 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	▪ 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	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	Review of informatics function and development of informatics strategy **SLT Lead:** Chief Digital Information Officer **Timescale:** January 2023 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:** ~~September 2022~~March 2023	**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): October 2022

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 and issues relating to COVID-19** (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			**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~~; PLACE Assessment and Scores Estates Governance bi-monthly~~; ~~Public Health England~~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	~~Business case to enhance oxygen capacity/flow has been delivered – BOC commencement date April 2022~~	Inconclusive Last changed April 2020

Board Assurance Framework (BAF): October 2022

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							**Strategic objective**	1. To provide outstanding 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**	**4. Somewhat likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	12/09/2022	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**				
Last changed	12/09/2022								

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 gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • A further Covid 19 wave of admissions driven by Omicron variant • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ Single streaming process for ED & Primary Care – regular meetings with NEMs ▪ Trust and System escalation process ▪ Cancer Improvement plan ▪ Trust leadership of and attendance at A&E Board ▪ Patient pathway, some of which are joint with NUH ▪ Inter-professional standards across the Trust to ensure turnaround times such as diagnostics are completed within 1 day ▪ Proactive system leadership engagement from SFH into Better Together Alliance Delivery Board ▪ ~~Patient Flow~~ Improving Patient Journey Programme ▪ SFH internal Winter capacity plan & Mid Notts system capacity plan ▪ Referral management systems shared between primary and secondary care ▪ MSK pathways ▪ COVID-19 Incident planning and governance process ▪ ~~Some cancer services maintained during COVID-19~~ ▪ Risk assessments to prioritise individual patients ▪ Elective Steering Group now meeting monthly to steer the recovery of elective waiting times ▪ ~~Accelerator Programme – SFH has been successful in being part of the national Elective Accelerator programme attracting £2.5m of funding to help speed up the recovery of services~~ ▪ Super Surge Plan			**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; Winter Plan to Board Nov '21; Cancer 62-day improvement plan to Board; Planning documents for 22/23 to identify clear demand and capacity gaps/bridges; COVID-19 Recovery Plan to Board Sep '20; Elective Steering Group report to Executive Team weekly; Waiting list update to Board quarterly; Super Surge Plan to Board Feb '22 **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 to TMT Mar '20; Cancer services report to Board Jun '21 **Independent assurance:** NHSI Intensive Support Team review of cancer processes May '20; Performance Management Framework internal audit report Jun '22		Positive Last changed December 2020
Reductions in availability hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	▪ Daily and weekly themed reporting of the number of MFFD patients in hospital beds ▪ The provision of a 'Discharge Cell' meeting with system partners to take forward this work ▪ Mitigation Plan to reduce number of MSFT patients in hospital beds – Discharge to Assess Business Case signed off by ICB August 2022	Lack of consistent achievement of the Mid-Notts threshold for MSFT patients of 22 – this is mainly associated with social care packages (Pathway 1) and is related to home care workforce shortages	Business case for social care expansion **SLT Lead:** ~~TBC~~ Chief Operating Officer **Timescale:** ~~TBC~~ phased to March 2023 Virtual ward model of care funding plan to be considered by Executive Team 27th April **SLT Lead:** Chief Operating Officer **Timescale:** April 2022	**Management:** Reporting into the group reports into the system CEOs group; Trust winter plan presented to Board Nov '21; Mitigation Plan to reduce number of MSFT patients in hospital beds to Board Dec '21 **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the SOF		Inconclusive New threat added January 2022

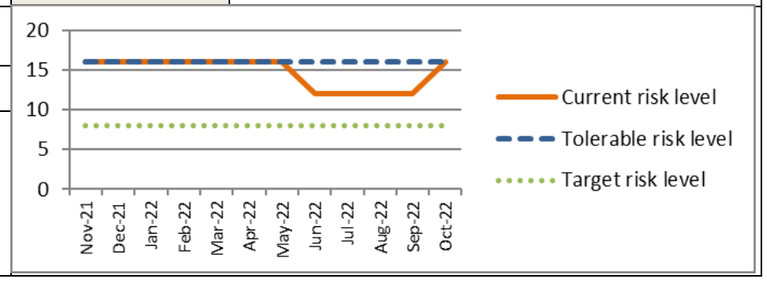
Board Assurance Framework (BAF): October 2022

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 gap and issues relating to COVID-19** (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 CCG risk register/BAF entry relating to operational failure of General Practice ▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development ▪ Weekly Executive meeting with the CCGs ▪ Weekly Mid Notts Network Calls			**Management:** Routine mechanism for sharing of CCG and SFH risk registers – particularly with regard to risks for primary care staffing and demand		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 ▪ Weekly management meeting with the Service Director from Notts HC ▪ Bilateral work – Strategic Partnership forum			**Risk and compliance:** Divisional NUH/SFH strategic partnership forum minutes and action log; NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area	Inconclusive No change since April 2020

Board Assurance Framework (BAF): October 2022

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**	~~3. Possible~~ 4. Somewhat likely	4. Somewhat likely	2. Unlikely		
Last reviewed	25/10/2022	**Risk rating**	~~12. High~~ 16. Significant	**16. Significant**	**8. Medium**		
Last changed	25/10/2022						

Strategic objective	3: To maximise the potential of our workforce

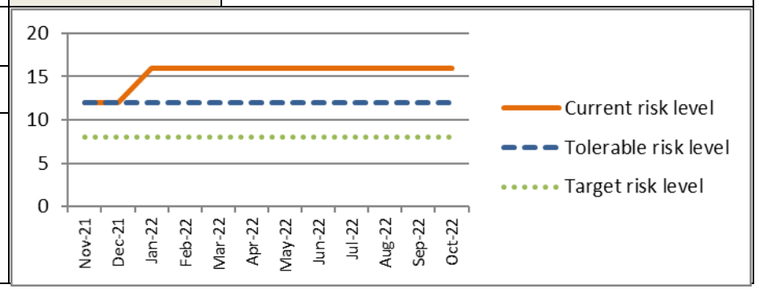


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 and issues relating to COVID-19**	**Assurance rating**
Inability to attract and retain staff due to demographic changes (including a significant impact of external factors 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, resulting in critical workforce gaps in some clinical services	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Medical and Nursing task force ▪ Activity, Workforce and Financial plan ▪ 2-year workforce plan supported by 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 ▪ Education partnerships ▪ Director of People attendance at 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 ▪ Nursing and Midwifery Workforce Transformation Cabinet ▪ Medical Workforce Transformation Cabinet ▪ Strategic People Plan	Medical, nursing, AHP and 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 Visibility around Sherwood's contributions to leading aspects of the People and Culture development across the system **SLT Lead:** Director of People **Timescale:** ~~October 2022~~Complete Involvement in the recruitment process for the system Chief People Officer **SLT Lead:** Director of People **Timescale**: November 2022	**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 (Monthly); 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 Potential impact of pending changes to the pensions arrangements and NI rules Explore the implementation of payment via multiple assignments to reduce pension tax liabilities **SLT Lead:** Director of People **Timescale**: November 2022	Positive Last changed June 2022

Board Assurance Framework (BAF): October 2022

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 and issues relating to COVID-19**	**Assurance rating**
A significant loss of workforce productivity arising from a short-term reduction in staff availability or 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 ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Chief Executive's blog / Staff Communication bulletin ▪ Engagement events with Staff Networks (BAME, LGBT, WAND, Time to Change) ▪ Schwartz rounds ▪ Learning from COVID ▪ Staff morale identified as 'profile risk' in Divisional risk registers ▪ Star of the month / milestone events ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Winter wellbeing approach for 2022/23 ▪ Staff counselling / Occ Health support ▪ 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 developing preparedness for the Trust and system	Inequalities in staff inclusivity and wellbeing across protected characteristics groups	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** March 2023	**Management:** Staff Survey Action Plan to Board May '21; Staff Survey Annual Report to Board Jun '21; Equality and Diversity Annual Report Jun '22; WRES and WDES report to Board Jun '21; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Winter Wellness Campaign report to Board Oct '21; 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; 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; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr'21; Anti-Racism Strategy to Board Mar '22; Mental Health Strategy to PCI Committee Jun '22 **Independent assurance:** National Staff Survey Mar '21; 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 Finalise and implement the industrial action plan **SLT Lead:** Director of People **Timescale**: November 2022	~~Positive~~ Inconclusive Last changed ~~June 2022~~October 2022

Board Assurance Framework (BAF): October 2022

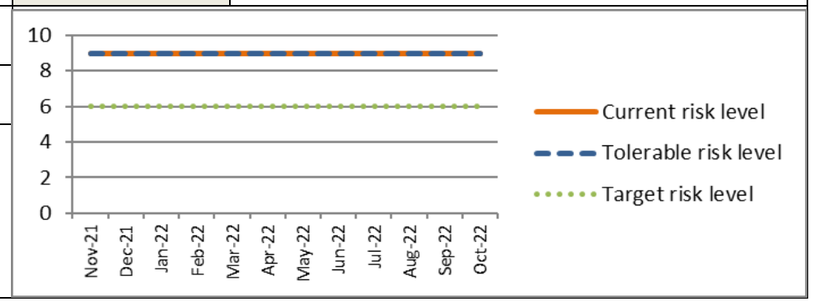
Principal risk (what could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**	5: To achieve better value
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
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	3. Possible	2. Unlikely				
Last reviewed	25/10/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	25/10/2022								

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** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**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**	**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. SLT Lead: Chief Financial Officer Timescale: January 2023 Review and implement enhanced business case process for 2023/24 planning and in-year prioritisation **SLT Lead:** Chief Financial Officer **Timescale:** January 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	Off trajectory to achieve FIP target Reprioritisation to achieve FIP recovery plan **SLT Lead:** Chief Financial Officer **Timescale:** November 2022	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 (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): October 2022

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						
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation
Lead director	~~Director of Culture & Improvement~~Chief Executive	**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	25/10/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	25/10/2022						

Strategic objective	4: To continuously learn and improve

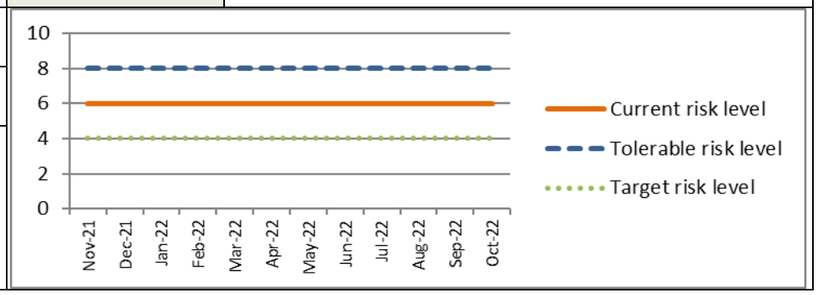


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**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 and issues relating to COVID-19**	**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		Establishment of an Innovation Hub **SLT Lead:** Director of Culture and Improvement **Timescale:** December 2022 **Progress:** Successful bid for £20k from the Health Foundation to support development of an organisational level Innovation Hub, and a Provider Collaborative Hub between SFH, NUH and NHCT	**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	Delays in training, planned improvement and innovation programmes due to COVID-19 Lack of capacity for colleagues to engage with improvement Consider ways to provide the capacity to progress improvement activity **SLT Lead:** Chief Executive **Timescale:** December 2022	~~Positive~~ Inconclusive ~~No change since April 2020~~Last changed October 2022

Board Assurance Framework (BAF): October 2022

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	11/10/2022	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**		
Last changed	11/10/2022						

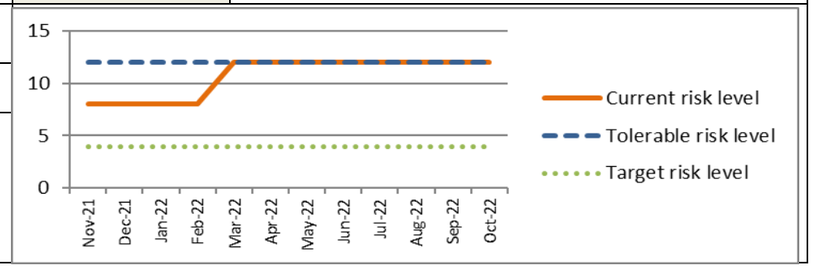
Strategic objective	2: To promote and support health and wellbeing



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** (are further controls possible in order to reduce risk exposure within tolerable range?)	**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 and issues relating to COVID-19**	**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 ~~Board~~ • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP breakthrough objectives signed off July 2020 • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSE~~I~~ • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans • Full alignment of organisational priorities with system planning for 2022/23 • Independent chair for ICP • ~~ICS Transition and Risk Committee~~ • 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)	~~Suboptimal system oversight and arrangements for discharge of complex patients~~	Consideration by ICS Chief Executives Group of sustainable architecture to enable effective and timely discharge of MFFD patients. Provider collaborative considering taking ownership **SLT Lead:** Chief Executive Officer **Timescale:** ~~TBC~~Complete	**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	▪ 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	The needs of the population and the statutory obligations of each individual organisation will not be met until the ICS Clinical Services Strategy is implemented	~~Implement the ICS Clinical Services Strategy~~Refreshed ICS Clinical Services Strategy led by the ICB Medical Director **SLT Lead:** Medical Director **Timescale:** ~~TBC~~September 2023 ~~**Progress:** ICB Medical Director appointed – initial focus to formulate ICB Clinical Strategy building on previous work around ICS Clinical Services Strategy~~	**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		~~Inconclusive~~ Positive Last changed ~~May~~ October 2022

Board Assurance Framework (BAF): October 2022

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							**Strategic objective**	1: To provide outstanding care
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	11/10/2022	**Risk rating**	**12. High**	**12. High**	**4. Low**				
Last changed	09/08/2022								

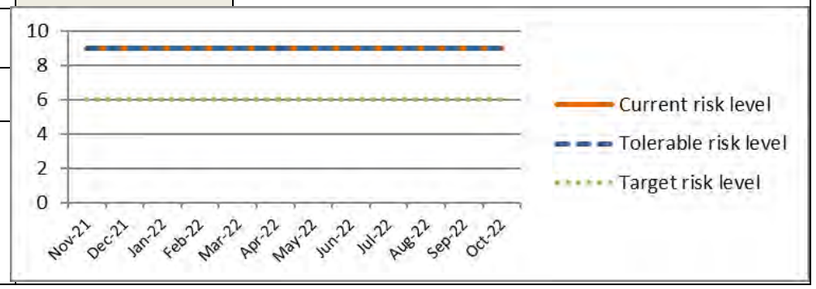


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**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 and issues relating to COVID-19**	**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			**Management:** Data Security and Protection Toolkit submission to Board ~~Apr '21~~Jul '22- ~~100% compliance~~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 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 ~~May '21~~Jul '22 – ~~substantial~~ moderate assurance; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan '22		Positive No change since April 2020
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 Risk Report to Risk Committee **Independent assurance:** Premises Assurance Model to RC Dec '18; EPRR Core standards compliance rating (Oct'21) – 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		Positive No change since April 2020

Board Assurance Framework (BAF): October 2022

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** (are further controls possible in order to reduce risk exposure within tolerable range?)	**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 and issues relating to COVID-19**	**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**: ~~2020/21~~2021/22 Counter Fraud~~, Bribery and Corruption~~ 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

Board Assurance Framework (BAF): October 2022

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
Lead committee	Risk	**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	11/10/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	13/09/2022								

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** (are further controls possible in order to reduce risk exposure within tolerable range?)	**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 and issues relating to COVID-19**	**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 ▪ 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	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 **Lead:** Associate Director of Estates and Facilities **Timescale:** December 2022 Review of existing approaches and capacity to act on ideas to improve the Trust's impact on climate change. **Lead:** Chief Financial Officer **Timescale:** October 2022 Proposal to ICB partners for collaborative approach and resource. **Lead:** Chief Financial Officer **Timescale:** October 2022	**Management:** **Risk and compliance:** Green Plan to Board Apr '21 Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	~~Reporting to Transformation and Efficiency Cabinet not yet defined~~ Governance structure for reporting on progress to be confirmed ~~Agree reporting structure~~ **Lead:** ~~Associate Director of Estates and Facilities~~Chief Financial Officer **Timescale:** ~~July~~ October 2022	Inconclusive New risk added November 2021

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date**: 3rd November 2022	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Shirley Higginbotham, 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				
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**
✓	✓	✓	✓	✓

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.

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).

Schedule of BAF reviews since last received by the Board of Directors on 4th August:

- Quality Committee: PR1 and PR2 – 12th September
- People, Culture and Improvement Committee: PR3 and PR5 – 25th October
- Finance Committee: PR4 – 25th October
- Risk Committee: PR6, PR7 and PR8 – 9th August, 13th September and 11th October

PR1, PR2 and PR4 remain significant risks, and it is proposed that the current risk rating for PR3 increases to significant to reflect the potential industrial action.

The current risk ratings for PR1 and PR4 remain above their tolerable risk ratings.

The Lead Director for PR5 has been changed to reflect the current structure.

As part of stage 2 of the Head of Internal Audit opinion work programme, 360 Assurance are proposing to undertake a Board survey again this year to understand Board member views of the effectiveness of governance and risk management arrangements. The survey is due to be issued in November and the findings presented to the January Audit and Assurance Committee meeting.

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

Sherwood Forest Hospitals
NHS Foundation Trust

Public Board of Directors meeting
Coversheet and Report

Subject:	Integrated Care System Update	**Date**: 3rd November 2022	
Prepared By:	David Ainsworth, Executive Director of Strategy & Partnerships		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	David Ainsworth, Executive Director of Strategy & Partnerships		
Purpose			
To update on key events and information from the past month.		**Approval**	
		Assurance	x
		Update	
		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**

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

None

Executive Summary

Integrated Care System (ICS)

The ICS held it's first partner assembly on 25th October 2022. With the intention to share priorities and early draft of the strategy. The event was well attended by partners across the wider determinants of health and wellbeing. This included the voluntary sector.

Board can expect to receive a draft strategy in November for our feedback and approval to sign up to the principles.

The availability of a system strategy will signal where the focus on system leaders is likely to focus and should assist the Trust in aligning its own strategy refresh due for launch in April 2023.

Provider collaborative at Scale

The collaborative has successfully appointed Claire Culverhouse at the Managing Director. This will assist in providing capacity pointed towards delivery. The collaborative will need to focus on what other resource is required to be successful. Areas like business intelligence, finance, people and clinical.

The work through operational teams on the discharge processes is underway. HR Directors have held their first discussion to focus on the priority areas we might choose to work on at scale.

Place Based Partnership

The executives of sovereign organisations in the Mid Nottinghamshire place, namely chief executives of district councils and the Paul Robinson, met to discuss the future of place based partnership working. The outputs of this discussion will result in changes in senior leadership and a move towards a central support team. The latter will form the capacity and skills required to implement transformational change at place. The focus of which will be wider health determinants such as cost of living, housing and frailty.

Wider Partnerships

The Trust continues to engage with the education sector and local councils on common themes that add civic value to our local communities. A recruitment fair is being organised by the people directorate in collaboration with West Notts College. Board members are invited to play a part on the day in encouraging young people to see the various roles available in the NHS and to promote the Trust as a place to work. Scheduled at West Notts College campus on 29 November.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

All reports MUST have a cover sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** October 2022	
Prepared By:	Paula Shore, Director of Midwifery/ Head of Nursing		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/ Head of Nursing, Phil Bolton, Chief Nurse		

Purpose		
To update the Board of Directors 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**	**X**	

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	**X**
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

Maternity and Neonatal Safety Champions Meeting

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 (MTP) 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.

Update on Mandated Maternity and Neonatal Safety Champion (MNSC) work for September 2022

1. Service User Voice

Our Parent's Voice Representative has provided an update to the activity within her role, following listening events both with the hospital and community the below details were provided.

Some of the themes which keep coming up are:

- Kindness/compassion in bucketloads – staff are always willing to help & nothing is too much trouble
- Staff really listening to women and understanding what they need
- Everything really clearly explained during labour
- Women/birthing people feel safe
- Individual needs are taken into account & communication is excellent between staff and service users.

Some of the key suggestions for improvement that our women are asking for are:

- More information on the induction process
- Improved communication between different professionals – i.e. awareness of all information that is documented so that everyone is giving the same message
- More information on what to expect at the different appointments / scans and what the purpose of these are
- Careful use of language and clarity about when there is a choice

These comments are provided to the teams and actions are monitored through the MNSC meetings.

2. Staff Engagement

The MNSC Walk Round was completed on Tuesday 6th October 2022. Feedback on the day was positive particularly around the support despite the constant challenges.

The Maternity Forum which was due to be held on the 29 September 2022 had to be cancelled on the day due to high clinical activity. Any action updates have been sent out to the team with an apology from the Director of Midwifery.

Our Freedom to Speak up Champions have produced some focused communication for October.

You said- we did feedback:

An action taken from both the recent walk round and forum was around Antenatal Clinic capacity with a specific focus on the Diabetic Clinic. Given the concern and the impact this was taken a separate action from the overarching paper around the impact of the increasing birth rate. Working with colleagues from both Diagnostic and Outpatients and the Medical Division we have managed to obtain an additional session for Wednesday morning creating an additional 10 scan and clinical appointments to ease the pressures on the full day Tuesday clinic. This has been reported back to the team outside of the forum due to this being cancelled.

3. Governance

Ockenden: out of the final 5, 14 have been peer reviewed and
we are awaiting the final IEA which relates to Anaesthetic, which we have not progressed due to clinical commitments and reviewing the Maternity Incentive Scheme evidence through MAC to ensure the submission deadline is met. There remains no national reporting plan yet for the final 15 IEA's.

The LMNS quarterly panel met on the 21st of September 2022, in which our gap analysis submitted was approved taken the compliance of IEA 7 up to 91%. As this is approved, we can now start the work around the action plan for this analysis. We are further working on as both an organisation and a system on how we can sustain some of the actions.

Final plans have been made for the Ockenden Quality Insight Visit on the 4th of October which will be performed by the regional team as part of one their recommendations from the report.

NHSR: Due to the challenges, the weekly meeting continues with the additional business support. During a conference in October, it was announced that the safety actions and submissions are under revision. We are continuing to work to the current deadlines until clarity is provided.

4. Quality Improvement Approach

The Maternity and Neonatal SIP programme has been re-energised with the focus around the optimisation and stabilisation of the pre-term infant. The team, led by the Consultant Midwives contains colleagues from both neonatal and maternity services. After reviewing the baseline data the team will provide an improvement plan which will be monitored through the MNSC meeting.

5. Safety Culture

The Pathway to Excellence Survey is now live and all staff have been encouraged to engage. The SCORE survey has been delayed until Q4 2022/23 but will be using the previous results to provide a local quality improvement plan which will be signed off through the MNSC meeting in November. We currently have the national staff survey live which all colleagues are being supported around engaging

Maternity Perinatal Quality Surveillance model for September 2022

	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD	GOOD

2019	
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	72%
Proportion of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	89.29%

Sherwood Forest Hospitals
NHS Foundation Trust

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

3rd and 4th Degree Tears (2.4% Sep 2022)

- Rate below national threshold.
- Deep dive review into cases and comparison to be performed with June completed. No identifiable themes are trends found.
- Paper to be taken through Maternity and Neonatal Safety Champions and Maternity Assurance Committee.

Stillbirth rate year to date (3.3/1000 births)

- SFH stillbirth rate, for year to date now returned and remains below the national ambition of 4.4/1000 birth
- Two reportable cases in September, requiring PMRT review only. Awaiting test and investigation findings before full review panel.

Staffing red flags (Sep 2022)

- 11 staffing incident reported in the month.
- No harm related incidents reported.

Home Birth Service

- Homebirth services resumed on the 19th of September.
- 3 Homebirth conducted since the writing of the paper with no issues around staffing.

FFT (Sep 2022)

- FFT remains improved following revised actions
- New system implementation delayed
- Service User Representative in post and providing additional pathways for maternal feedback

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• NHSR year 4 guidance revised, 3rd version due for release on the 11/10/2022- unsure of changes and implication • Interim post in to support the delivery of evidence	• Initial 7 IEA- final IEA is 91% compliant following evidence review at LMNS panel. • Final 15 IEA, 14 have been peer assessed with plan for the final 1

Incidents reported Sep 2022 (96 no/low harm, 1 moderate or above)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 14	Themes includes Category 1 LSCS, 3rd and 4th degree tears and PPH

Other

- Birth-rate comparable for September average, 284 births noting higher acuity particularly around category 3 LSCS and Induction of Labour.
- Midwifery Continuity of Carer, pause in target letter received and escalated to the LMNS for planning meeting for the system.
- Regional Ockenden Insight Visit completed, overwhelmingly positive feedback. A couple of points for consideration which don't affect the overall self assessed RAG status of the initial 7 IEA's
- One Moderate case reported PPH, reviewed through MDT meeting and harm downgraded.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals										
	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE					WELL LED
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD					GOOD

Maternity Quality Dashboard 2020-2021	Alert [national standard/average	Running Total/ average	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC pathway											
Women reccving MCOC intraprtum											
Total BAME women booked											
BAME women on CoC pathway											
Spontaneous Vaginal Birth			63%	61%	59%	55%	60%	60%	60%	58%	55%
3rd/4th degree tear overall rate	>3.5%	2.18%	2.78%	2.52%	2.90%	3.00%	6.20%	3.72%	2.84%	6.30%	2.40%
Obstetric haemorrhage >1.5L	Actual	116	6	8	7	6	9	7	7	3	9
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.12%	3.30%	2.60%	2.20%	3.20%	2.45%	2.45%	1.10%	3.20%
Term admissions to NNU	<6%	3.62%	5.00%	3.50%	3.50%	1.60%	4.00%	2.60%	2.60%	3.70%	3.1%
Apgar <7 at 5 minutes	<1.2%	1.56%	1.90%	1.80%	2.00%	0.84%	0.40%	1.20%	1.20%	1.20%	0.79%
Stillbirth number	Actual	11	1	1	0	1	2	2	1	0	2
Stillbirth number/rate	0	4.63			3.727			5.952			3.300
Rostered consultant cover on SBU - hours per week	<60	60	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	10
Midwife / band 3 to birth ratio (establishment)	>1:28		1:29	1:22	1:22	1:22	1:22	1:24.5	1:27	1:27	1:27
Midwife/ band 3 to birth ratio (in post)	>1:30		1:28	1:24	1:24	1:24	1:24	1:26.5	1:29	1:29	1:29
Number of compliments (PET)		0	0	0	1	1	1	1	1	1	2
Number of concerns (PET)		9	0	0	2	2	1	0	0	0	1
Complaints		11	1	1	2	1	0	2	1	0	0
FFT recommendation rate	>93%		92%	91%	90%	89%	88%	88%	94%	91%	91%
PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	94%	95%	95%	95%	96%
K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%
Core competency framework compliance			81%	81%	88%	95%	95%	95%	95%	95%	95%
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above										
Maternity incidents no harm/low harm	Actual	697	83	45	69	58	70	99	105	72	96
Maternity incidents moderate harm & above	Actual	7	1	1	1	1	1	1	1	0	0
Coroner Reg 28 made directly to the Trust		Y/N	0	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	Y	N	N

Sherwood Forest Hospitals NHS Trust

Maternity Services – Overview findings of Regional and System Insight Visit

4th October 2022

NHS England and NHS Improvement

Visit Purpose

An Insight visit to SFH NHS Trust maternity services was completed on the 4th October 2022.

The purpose of the visits was to provide assurance against the 7 immediate and essential actions from the Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

Conversations were held with members of the senior leadership team and many front line staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions headings

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Insight Visit Team members: Midlands Perinatal Team ;Sandra Smith Deputy Regional Midwife Midlands Perinatal Team; Chantal Knight Regional Governance and Assurance Lead Midwife; Natalie Whyte Regional MVP Midlands Perinatal Team; Joanna Morris Interim Head of Quality; Marie Teale Senior Project Manager Nottinghamshire LMNS ICB

Key Headlines

Points for Celebration

- Supportive, open and honest organisation with a shared understanding of issues at all levels and strong culture of escalation.
  - Loyal staff with access to career development and progression, who genuinely enjoy working at the unit
- Experienced senior leadership team with clear executive and NED visibility
- Wide range of specialist midwife roles in place with knowledgeable, enthusiastic and inspiring staff in post
- Good engagement with the executive team and safety champions demonstrating close links to Parents Representative
- A strong Parents Representative employed on temporary basis who is able provide robust user feedback
  - maximising the potential to reach minority groups
  - Links closely with all staff groups and senior leadership team

Key Headlines

Points for Consideration

- Strengthen audit plan to incorporate **all** Ockenden actions frequently and regularly reported throughout the division.
  - Ensure staff are aware of audit results and Ockenden requirements using a variety of communication pathways including information boards in clinical areas, social media and training study days
- Over reliance on small number of key obstetricians for multiple roles - risk if absences occur with need to support antenatal clinic capacity following increase in bookings from NUH
  - Review and increase the obstetric workforce to take this into account
  - Review and share PA allocation for important and essential additional obstetric roles including; governance lead; SBLCBv2 lead, audit lead, guideline lead, PMRT lead, fetal monitoring lead
- PMRT meetings should be coordinated by the governance team
  - currently led by the bereavement midwife, could lead to conflict of interest
  - all cases should be reviewed by external MDT
- Progress work to revisit the Birthrate + assessment
  - ensure the operational challenging increase in bookings from NUH and medical complexity of women are taken into account for recruitment of midwives

Summary of Insight Visit Review of Ockenden IEAs Status

IEA	i	ii	iii	iv	v	vi	vii	viii
1) Enhanced safety								
2) Listening to women and families	N/A	N/A						
3) Staff training and working together								
4) Managing complex pregnancy								
5) Risk assessment throughout pregnancy								
6) Monitoring fetal well-being		*			*			
7) Informed consent								
Workforce Planning								
Guidelines								

*Q35 & 38 remains amber whilst not fully SBLCBv2 compliant

IEA1 Enhanced Safety

- Points for Celebration
- Clear Perinatal Clinical Quality Surveillance Model in place
- All SI cases have external review
- Good internal review of PMRT cases includingof HSIB colleagues to fully discuss cases if required
- 100% of HSIB cases are reported and 95% + cases for PMRT are commenced in the timescale required

Points for Consideration

- Work towards external review for all PMRT case - consider grouping cases into thematic reviews for external clinical opinion e.g. congenital abnormality and severe prematurity
  - This will assist with workload requirement e.g. congenital abnormality and severe prematurity

IEA1	RAG
Q1 - Dashboards	
Q2 – External review of SIs	
Q3 – SIs to Board/LMNS	
Q4 - PMRT	
Q5 - MSDS	
Q6 - HSIB	
Q7 - PCQSM	
Q8 – SIs to Board/LMNS	

IEA2 Listening to Women & Families

Points for Celebration

- Posters with details of all maternity safety champions were visible in clinical areas
- A strong Parents Representative has been employed on a short term basis who is able provide robust user feedback
  - maximising the potential to reach minority groups
  - Links closely with all staff groups and senior leadership team

Points for Consideration

- PMRT meetings should be coordinated by the governance team
  - currently led by the bereavement midwife, could lead to conflict of interest
  - all cases should be reviewed by external MDT
- PMRT cases have MDT review and are taken for external review - consider grouping cases into thematic reviews for external clinical opinion e.g. congenital abnormality and severe prematurity
  - this would assist with workload for this requirement
- Support parent representative with longer term post to continue the excellent work underway

IEA2	RAG
Q9 – Advocate role	N/A
Q10 – Advocate role	N/A
Q11 – NED	
Q12 - PMRT	
Q13 – Service user feedback	
Q14 – Bimonthly safety champ meetings	
Q15 – Service user feedback	
Q16 – NED	

IEA3 Staff Training and Working Together

Points for Celebration

- Achieved the required standard for MDT training
- Comprehensive understanding of training data and training compliance rates
- At least twice daily consultant ward rounds are well embedded and feedback from staff is positive and supportive

Points for Consideration

- The upcoming implementation of a bespoke maternity EPR will assist in robust recording of the consultant ward round occurrences for evidence of continuing compliance

IEA1	RAG
Q17 – MDT Training	
Q18 – Cons. Ward Rounds	
Q19 – Ring-Fenced Funding	
Q20 -	
Q21 – 90% MDT Training	
Q22 – Cons Ward Rounds	
Q23 – MDT Training Schedule	

IEA4 Managing Complex Pregnancy

Points for Celebration

- All women who were classified as high risk pregnancies were allocated a named consultant
- Maternal Medicine Network pathways are in place

Points for Consideration

- Two divergences are in place for SBLCBv2 with actions in place to address the non compliance
  - Continue to progress at pace UtAD training and the care pathway of women with a BMI of >35 to conform with national requirements

IEA4	RAG
Q24 – MMC Criteria	
Q25 – Named Consultant	
Q26 – Complex Pregnancies	
Q27 – SBLCBv2	
Q28 – Named Cons/Audit	
Q29 – MMC	

IEA5 Risk Assessment Throughout Pregnancy

IEA5	RAG
Q30 – Risk assessment	
Q31 – Place of Birth RA	
Q32 – SBLCBv2	
Q33 – RA recorded with PCSP	

Points for Celebration

- Antidotally antenatal risk assessment is carried out at every contact with evidence confirming compliance
- Review of incidents looks at care pathways and antenatal risk assessment compliance
- Points for Consideration
- Two divergences are in place for SBLCBv2 with actions in place to address the non compliance
  - Continue to progress at pace UtAD training and the care pathway of women with a BMI of >35 to conform with national requirements
- The upcoming implementation of a bespoke maternity EPR will assist in robust recording of the antenatal risk assessment occurrences and interactive PCSP for evidence of continuing compliance

IEA6 Monitoring Fetal Well-Being

Points for Celebration

- Fetal wellbeing leads in post with clinical expertise
- Achieved the required standard for MDT training
- Comprehensive understanding of training data and training compliance rates

Points for Consideration

- Two divergences are in place for SBLCBv2 with actions in place to address the non compliance
  - Continue to progress at pace UtAD training and the care pathway of women with a BMI of >35 to confirm with national requirements
- *Q35 & 38 remains amber whilst not fully SBLCBv2 compliant

IEA6	RAG
Q34 – Leads in post	
Q35 – Leads expertise	*
Q36 – SBLCBv2	
Q37 – 90% MDT Training	
Q38 – Leads in post	*

IEA7 Informed Consent

Points for Celebration

- A strong Parents Representative has been employed on a short term basis who is able provide robust user feedback
  - maximising the potential to reach minority groups
  - Links closely with all staff groups and senior leadership team
- Reinstatement of Homebirth services is welcomed to provide choice for women in place of birth

Points for Consideration

- Consider reviewing the existing forward audit plan to ensure the evidence demonstrates that women's choices have been respected, informed choice has been given and accessible information in all formats is available
- lack of patient information regarding choice of birth on trust website impacting on informed choice process.
  - trust website function converts english into other languages does not convert leaflets into the relevant language.
  - ensure the website can give service users access to pathways of care in any language required and capability of providing information for women and their families who have auditory and visual impairments

IEA7	RAG
Q39 – Accessible Information, Place of Birth	
Q40 – Accessible Information, All Care	
Q41 – Decision making and Informed Consent	
Q42 – Women's Choices Respected	
Q43 – Service User Feedback	
Q44 - Website	

Workforce Planning & Guidelines

Points for celebration

- Visible leadership from director of midwifery and triumvirate in place, meeting weekly to discuss current concerns and solutions
- New dedicated retention midwife in post and already demonstrating ability to support staff to stay in post
- Wide range of specialist midwife roles in place who were extremely knowledgeable, enthusiastic and inspiring staff in post
- Coherent matron team who work well together

Points for consideration

- There is an over reliance on a small number of key obstetricians for multiple roles which is a risk if any absences occur and additionally to support antenatal clinic capacity with the increase in bookings from NUH
  - Review and increase the obstetric workforce to take this into account
  - Review and share the PA allocation for important and essential additional obstetric roles including; governance Lead; SBLCBv2 lead, audit Lead, guideline Lead, PMRT Lead, fetal monitoring lead
- Continue the plan to recruit a Head of Nursing to support the DOM for Children's and Neonates workload

WFP & G	RAG
Q45 – Clinical Workforce Planning	
Q46 – Midwifery Workforce Planning	
Q47 – D/HoM Accountable to Exec Dir	
Q48 – Strengthening Midwifery Leadership	
Q49 - Guidelines	

Additional Celebration Points

- Effective induction of labour pathway in place keeping delays to a minimum
- Excellent Blood spot screening QI project –improving the screening pathway and experience of women and babies
- Introduction of the Each Baby Counts Escalation Tool to improve safety and support staff in structured conversations
- Listening event has been undertaken to hear the voices of obstetric trainees and plan solutions following concerns raised in HEE survey

Additional Points for Consideration

- Progress the work underway to fully implement BSOTS when staffing allows
  - continue to monitor outcome data and ability to achieve timely assessment in triage

Offers of Support to Trust

- Link SFH Digital lead Midwife with other Trusts using Badgernet

The visiting team would like to express thanks to all the staff who on the day of the visit were very welcoming in sharing their thoughts regarding the maternity services.

#TeamSFH

Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals NHS Trust
Action Plan- Maternity Service Regional and System Insight Visit
4th October 2022

#TeamSFH

Sherwood Forest Hospitals NHS Foundation Trust

Action Plan- Maternity Service Regional and System Insight Visit

The purpose of the visits was to provide assurance against the 7 immediate and essential actions (IEAS) from the Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

A Regional and System team conducted the Insight Visit on the 4th of October 2022.

The following action plan will be monitored through the Maternity Assurance Committee, with this and the report being shared with our Maternity and Neonatal colleagues and Trust Board.

To note the below points do not cover the area which we have already self-assessed amber. None of the below actions have led to any green assessed IEA's requiring to become amber.

The insight team have advised that we score any IEA's that contain work related to SBLCB as amber due to our current system and regional agreed divergence.

#TeamSFH

Sherwood Forest Hospitals
NHS Foundation Trust

Action Plan- Maternity Service Regional and System Insight Visit

Identified Points for Celebration identified from the review of the 7 IEA's

- Supportive, open and honest organisation with a shared understanding of issues at all levels and strong culture of escalation.
- Loyal staff with access to career development and progression, who genuinely enjoy working at the unit
- Experienced senior leadership team with clear executive and NED visibility
- Wide range of specialist midwife roles in place with knowledgeable, enthusiastic and inspiring staff in post
- Good engagement with the executive team and safety champions demonstrating close links to Parents Representative
- A strong Parents Representative employed on temporary basis who is able provide robust user feedback

    Maximising the potential to reach minority groups

    Links closely with all staff groups and senior leadership team

#TeamSFH

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Action Plan- Maternity Service Regional and System Insight Visit

The below actions where identified as points for consideration from the review of the 7 IEA's. These points do not cover the area which we have already self-assessed amber due to the ongoing work around the Trust website. None of the below have led to any green assessed IEA's requiring to become amber.

	Action	By Whom	When	Evidence
1	Strengthen audit plan	Matron for Maternity Governance/Audit Midwife	Nov 22	Revised audit plan
2	Obstetric Workforce • Specialist roles • Increased pressure due to birth rate	Clinical Chair	Nov 22	Revised PA plan Divisional plan for increased activity
3	PMRT • Lead Midwife • External review plan	Matron for Maternity Governance	Nov 22	Email confirmation System plan for external review support
4	Birthrate Plus-work towards recommendations (report due Nov 22)	Director of Midwifery	Jan 23	Revised establishment

#TeamSFH

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Action Plan- Maternity Service Regional and System Insight Visit

The team provided additional points to celebrate and consideration, listed below, which are already under action through local governance meetings.

Additional Celebration Points

- Effective induction of labour pathway in place keeping delays to a minimum
- Excellent Blood spot screening QI project –improving the screening pathway and experience of women and babies
- Introduction of the Each Baby Counts Escalation Tool to improve safety and support staff in structured conversations
- Listening event has been undertaken to hear the voices of obstetric trainees and plan solutions following concerns raised in HEE survey

Additional Points for Consideration

- Progress the work underway to fully implement BSOTS when staffing allows continue to monitor outcome data and ability to achieve timely assessment in triage

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Regional and System Ockenden Insight Visit- action plan	**Date:** November 2022	
Prepared By:	Paula Shore, Director of Midwifery/ Head of Nursing		
Approved By:	Philip Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/ Head of Nursing and Philip Bolton, Chief Nurse		
Purpose			
To update the Board of Directors on recent insight and any actions required		**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**	**x**	

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		x		

Risks/Issues	
Financial	
Patient Impact	**x**
Staff Impact	**X**
Services	**x**
Reputational	**x**

Committees/groups where this item has been presented before

Maternity Assurance Committee

Executive Summary

The purpose of the visit was to provide assurance against the 7 immediate and essential actions (IEAS) from the Ockenden report. The Insight Visit Team used an appreciative enquiry and learning approach to foster partnership working to ensure that the actions taken to meet the Ockenden recommendations were embedded in practice.

A Regional and System team conducted the Insight Visit on 4 October 2022 speaking to colleagues across the divisional and the Executive team.

The Senior Leadership received formal feedback on the day and the formal report was received on the 10 October 2022 (Appendix 1).The feedback was overwhelming positive with points of considerations which align to area already identified within the division.

The following action plan (Appendix 2) will be monitored through the Maternity Assurance Committee, with this and the report being shared with our Maternity and Neonatal colleagues and Trust Board.

To note, the below points do not cover the area which we have already self-assessed amber. None of the below actions have led to any green assessed IEA's requiring becoming amber.

Summary of Regional and System Insight Visit

Planned visit as part of the initial Ockenden Report into the Maternity Services at Shrewsbury and Telford Hospitals.

Following a packed agenda, conversations were held with members of the senior leadership team and many front line staff ranging in job roles. Emerging themes from conversations were organised under the immediate and essential actions headings.

1. Enhanced Safety
2. Listening to Women & Families
3. Staff Training and Working Together
4. Managing Complex Pregnancy
5. Risk Assessment Throughout Pregnancy
6. Monitoring Fetal Well-Being
7. Informed Consent
8. Workforce Planning and Guidelines

Key headlines were provided around points for celebration and consideration, forming at attached action plan.

The considerations have not changed any of the previously self-assessed RAG rated scoring. However, the team did advise to support the progression of the Saving Babies Lives Care Bundle elements which have an agreed divergence against to give us some further traction to progress. This will be taken through the next LMNS panel review meeting for discussion.

The aspects of IEA 7 which we are awaiting the final work to progress to green were not discussed as part of the visit.

Recommendations:

- Board notes the content of the report and subsequent action plan

Monitoring of this plan will be managed through the MAC.

Sherwood Forest Hospitals
NHS Foundation Trust

Phase 5 – COVID-19 Autumn Booster Vaccination Programme Update

October 2022

Robert Simcox Director of People
Kim Kirk, Operations Lead for Hospital Hub

Sherwood Forest Hospitals
NHS Foundation Trust

Background

The COVID-19 Autumn Booster Vaccination Programme continues to progress with almost 10 million of eligible people receiving booster vaccines to date.

The eligibility criteria includes On 12th September 2022, Autumn Boosters were rolled out nationally inviting:

- aged 50 and over
- pregnant
- aged 5 and over and at high risk due to a health condition
- aged 5 and over and at high risk because of a weakened immune system
- aged 5 and over and live with someone who has a weakened immune system
- aged 16 and over and a carer, either paid or unpaid
- living or working in a care home for older people
- Health and social care workers

Autumn Booster Summary

Sherwood Forest Hospitals
NHS Foundation Trust

KMH Hospital Hub

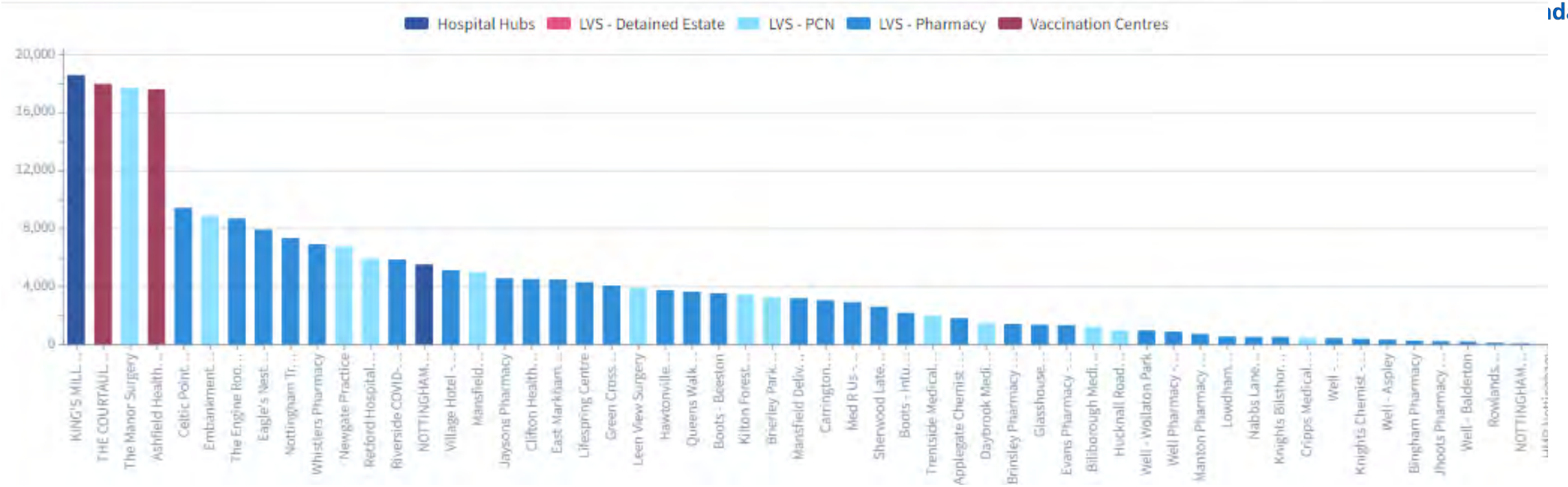
- KMH Hub open Monday-Friday, 8am-8pm (last vaccination 7.45pm) and Saturday 8am-2pm (last Vaccination 1.45pm) with staggered clinics offering Autumn Boosters, Ever Green Offer (primary dose) and Paediatric Clinics.
- Walk in COVID and Flu vaccines available to SFH staff from 3rd October 2022.
- COVID vaccines offered to all HCSW on bookable and walk in basis. SFH Communications shared with NHCT.
- Bookable appointments and walk ins available daily.

Vaccine Supply

- National vaccine supply has transitioned to Pfizer/BioNTech (Comirnaty bivalent), and Nuvaxovid (Non-mRNA).
- Nuvaxovid delivery date to be confirmed at KMH Hub – escalated to regional and national team.
- Vaccine storage to transfer to Hub with electronic monitoring reflecting SFH Pharmacy policy in place. Flu vaccines are stored in KMH Hub to offer co-administration to staff.

Autumn Booster Programme Performance (1)

Sherwood Forest Hospitals
idation Trust



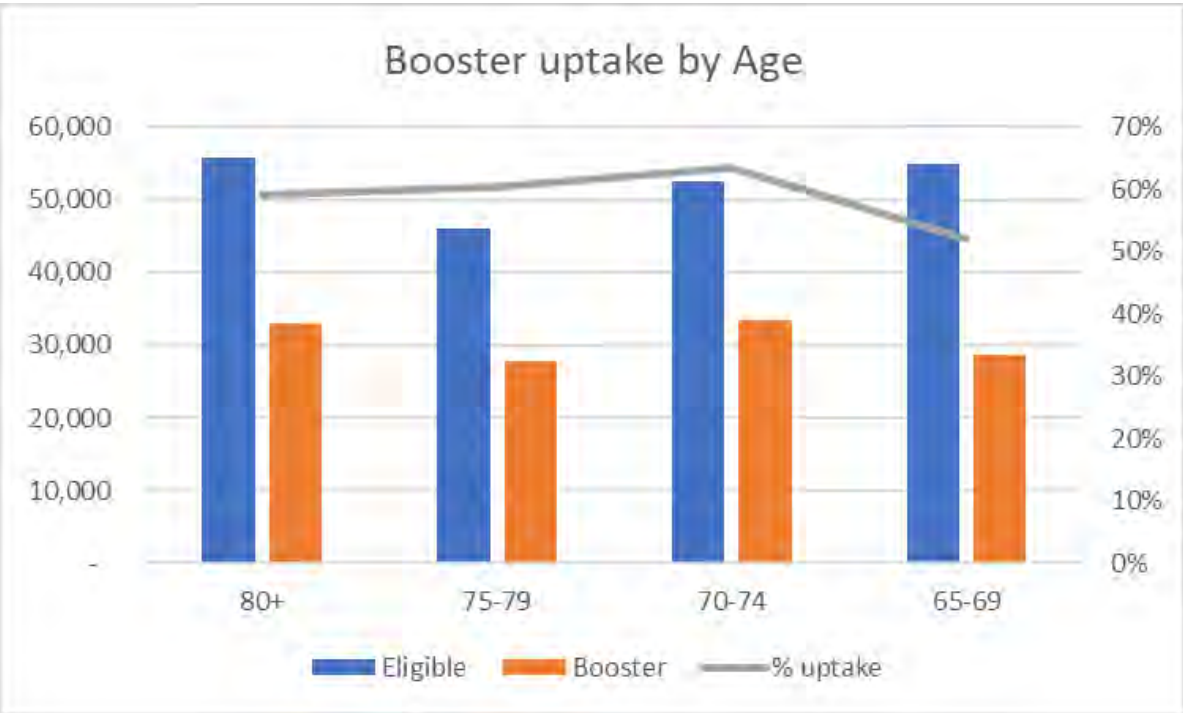
Pillar	04/09/2022	11/09/2022	18/09/2022	25/09/2022	02/10/2022	09/10/2022	16/10/2022
Vaccination Centre	-	540	5,592	4,455	7,709	5,643	5,273
Hospital Hub	372	170	3,414	3,890	4,528	4,010	3,851
PCN	93	342	4,443	8,655	9,591	14,806	13,349
Community Pharmacy	532	536	16,741	17,672	20,558	18,347	16,386
Plan	**728**	**1,583**	**18,500**	**33,900**	**37,100**	**41,500**	**41,500**

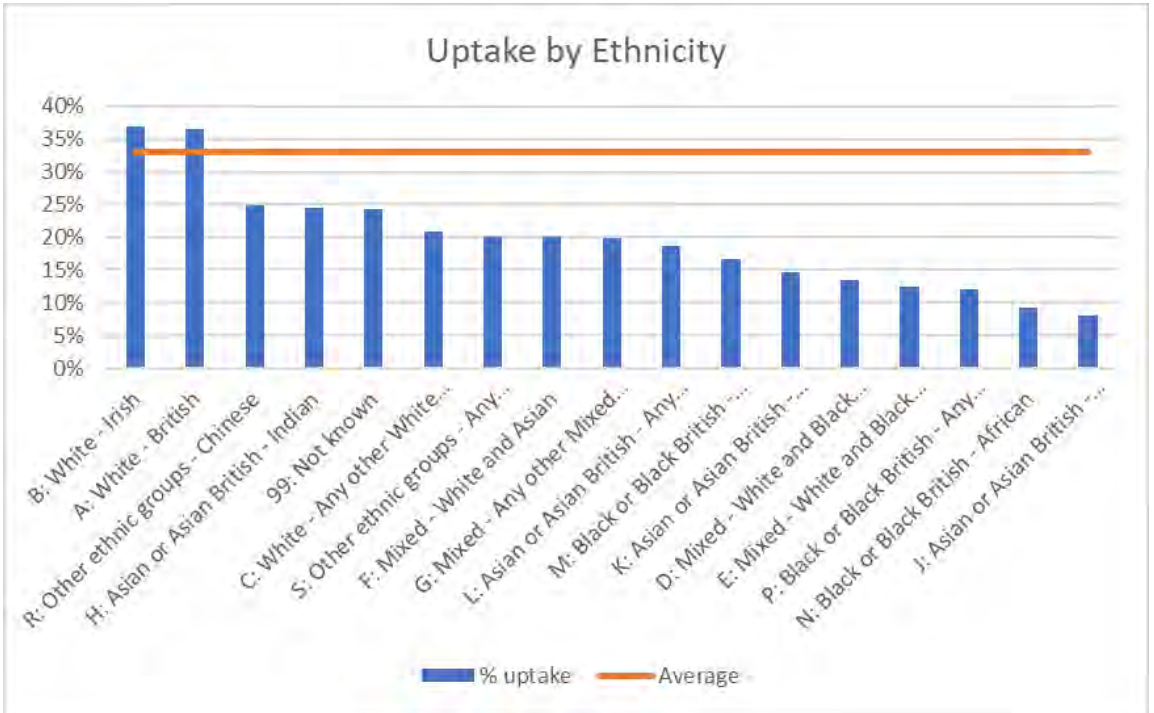
- Autumn booster vaccine uptake 32.9%
- KMH Hub exceeding plan by 20%

Home, Community, Hospital.

Autumn Booster Programme Performance (2)

Sherwood Forest Hospitals
NHS Foundation Trust





- 59% uptake of people 80+
- 60% uptake of people aged 75 and 79 year old
- 63% uptake of people aged 70 and 74 year old
- 52% uptake of people aged 65 and 69 year olds

- Highest Uptake in the White and Irish and White populations
- Lowest Uptake Black ethnic and Asian or Asian British

Autumn Booster Programme Performance (3)

Sherwood Forest Hospitals
NHS Foundation Trust

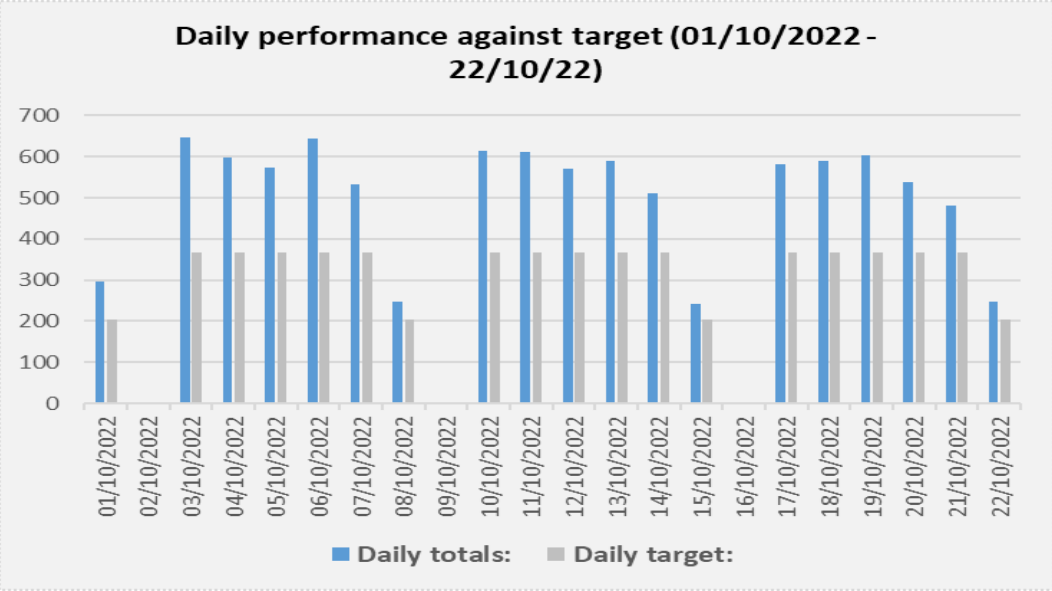
:VI	National	Midlands	BSOL	CW	HW	JUCD	LLR	LINCS	NHAMP	NOTTS	STW	SSOT	BC
1: Care Home Residents & Residential Care Workers	64.56%	67.81%	62.66%	75.83%	69.61%	68.21%	70.94%	75.53%	68.96%	65.33%	68.44%	70.38%	56.43%
2: Healthcare Workers	23.98%	24.17%	17.35%	24.70%	27.92%	29.33%	23.45%	28.08%	23.48%	25.69%	25.71%	25.98%	18.57%
3: Social Care Workers	17.86%	19.05%	13.06%	22.04%	20.19%	21.21%	19.53%	20.97%	21.57%	20.20%	20.11%	17.62%	16.12%
4: 80+	56.96%	58.49%	51.36%	63.01%	60.37%	56.84%	58.53%	60.97%	61.77%	58.62%	60.69%	62.35%	52.17%
5: 75-79	57.72%	60.01%	56.04%	64.07%	57.97%	59.64%	59.06%	61.24%	64.08%	60.28%	61.67%	63.80%	53.49%
6: 70-74	60.11%	60.63%	51.68%	65.11%	58.02%	62.20%	61.74%	61.95%	66.92%	63.24%	64.14%	60.78%	54.41%
7: 65-69	52.28%	50.34%	41.10%	55.54%	48.35%	51.68%	51.14%	51.68%	57.45%	51.85%	54.74%	51.13%	44.02%
8: At Risk	20.58%	21.47%	14.54%	23.28%	22.85%	23.36%	21.88%	22.90%	26.79%	22.25%	24.28%	22.63%	18.00%
9: 12-15 At Risk	8.40%	8.10%	4.64%	10.13%	5.30%	9.65%	5.82%	9.54%	8.07%	14.20%	9.30%	8.56%	5.89%
10: 12-17 Household contacts of immunosuppressed	0.81%	0.94%	0.81%	0.81%	0.38%	0.77%	1.11%	0.75%	1.56%	1.41%	1.63%	0.74%	0.54%
11: 5-11 At Risk	15.10%	18.09%	20.48%	20.78%	11.45%	18.52%	12.31%	17.96%	16.96%	20.27%	17.27%	22.46%	17.67%
12: 60-64	12.43%	12.90%	11.43%	17.27%	16.50%	9.90%	12.97%	11.96%	14.98%	10.76%	13.83%	12.12%	11.87%
13: 55-59	7.51%	7.69%	6.95%	10.13%	11.16%	6.00%	7.53%	5.23%	8.84%	6.26%	7.73%	7.81%	7.35%
14: 50-54	5.54%	5.44%	4.99%	6.58%	8.32%	4.22%	5.14%	4.02%	5.71%	4.20%	5.71%	6.14%	5.23%

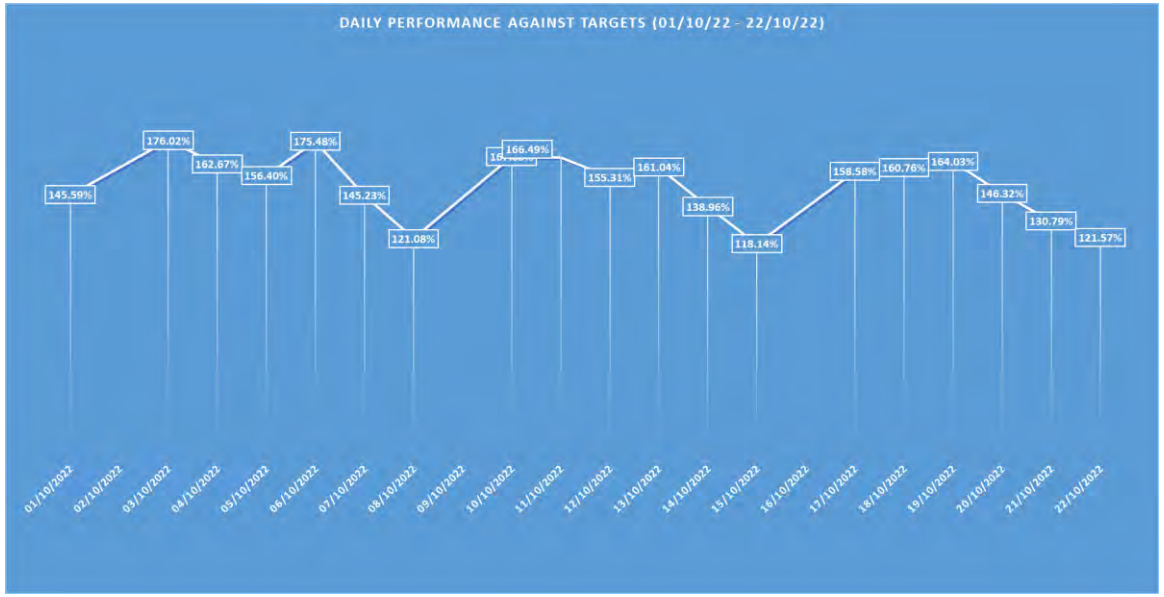
Equal to or greater than National Uptake Change
Within the 70th Percentile of National Uptake Change
Below the 70th Percentile of National Uptake Change

KMH Hub Performance - 1st October-22nd October 2022

Sherwood Forest Hospitals
NHS Foundation Trust

Autumn Booster Vaccines administered	No of Walk ins	Overall number of other Vaccines administered	Number of staff Flu vaccines given this month
13282	3090	575	576





Home, Community, Hospital.

Next Steps

Sherwood Forest Hospitals
NHS Foundation Trust

KMH Hospital Hub

- From 31st October 2022, introduction of KMH Roving Service to offer COVID-19 and Flu vaccines to SFH staff and eligible inpatients. Vaccine status will be confirmed via Nerve Centre for eligible patients, with vaccines recorded at point of administration to update patient GP records.
- Communications plan to include staff profiling of vaccine uptake to encourage staff uptake.

Wider Nottinghamshire Vaccination Programme

- Medivans to recommence in late October 2022 to focus on inequalities, targeting asylum, refugee and homeless communities.
- Three additional communities satellite clinics to be scoped for City and South Notts.
- Newark satellite clinic to commence booster delivery.

Sherwood Forest Hospitals
NHS Foundation Trust

Subject:	Covid-19 Vaccination Programme Autumn Booster Update	**Date**: 3rd November 2022
Prepared By:	Robert Simcox, Director of People Kim Kirk, Operations Lead for Hospital Hub	
Approved By:	Robert Simcox, Director of People	
Presented By:	Kim Kirk, Operations Lead for Hospital Hub	

Purpose		
The paper updates the Executive Team on the COVID-19 Vaccination Autumn Booster Programme Performance and Plan.	**Approval**	
	Assurance	X
	Update	
	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	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	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

None

Executive Summary

Background

The 2022 Autumn Booster programme continues to build on the success of 2021 with almost 10 million people in England receiving their booster vaccine.

The KMH Hospital Hub continues to provide COVID-19 vaccines to eligible people locally, and co-administration of COVID-19 and Flu vaccines to SFH staff.

The attached slides provide operational programme details and performance noting:

- 32.9% Autumn boosters' doses given by ICB Programme
- 25.69% Healthcare workers received COVID-19 vaccine exceeding national uptake (23.98%)
- KMH Hub performance continues to exceed programme plan (20%)
- 13,282 Vaccines administered within October from KMH Hospital Hub (1st October-22nd October)
- Co-admiration of COVID-19 and Flu vaccines has commenced
- Introduction of KMH Roving Service to offer COVID-19 and Flu vaccines to SFH staff and eligible inpatients has commenced

Recommendation

The Trust Board is asked to take assurance from the report and to note the significant contributions made by colleagues at Sherwood Forest to enable the successful delivery of vaccinations to the citizens of Nottinghamshire and colleagues working at Sherwood and surrounding NHS Trusts.

Board of Directors

Subject:	Nursing, Midwifery, and Allied Health Professional Bi-annual Staffing Overview Report.	**Date:** October 2022
Prepared By:	Rebecca Herring (Corporate Matron for Safe Staffing) Paula Shore (Director of Midwifery and Head of Nursing) Kate Wright (Associate Chief Allied Health Professional)	
Executive Sponsor:	Phil Bolton (Chief Nurse)	
Presented By:	Phil Bolton (Chief Nurse)	

Purpose		
The purpose of this report is to provide the Board of Directors with an overview of nursing, midwifery, and allied health professional (AHP) staffing capacity and compliance within Sherwood Forest Hospitals Foundation NHS Trust (SFHFT). It is also to provide assurance of our compliance with the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance, National Quality Board (NQB) Standards, and the NHS Improvement (NHSI) Developing Workforce Safeguards. It is a national requirement for the Board of Directors to receive this report bi-annually.	**Approval**	
	Assurance	**X**
	Update	
	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**	**X**

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	

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, Midwifery, and Allied Health Professional Committee: October 2022.

Executive Summary

1.0 Background

1.1 The purpose of this report is to provide an overview of nursing, midwifery, and AHP (NMAHP) staffing capacity and compliance within SFHFT which is aligned to NICE Safe Staffing Guidance, NQB Standards, and the NHSI Developing Workforce Safeguards Guidance.

1.2 Nursing and Midwifery Staffing Overview

1.3 Since the start of 2022/2023 the overall Trust vacancy rate has held a relatively stable yet static position of approximately 6% and captures all NMAHP staff from band 2 upwards.

1.4 Ongoing efforts have been maintained within nursing and midwifery in reducing the vacancy deficit, especially since the pressures of Covid-19 have remained a constant presence. International recruitment and the expansion of the nursing associate role across services have been well received and plans are in place to continue with these programmes of work. The Trust's commitment to the NHS Long Term Plan to reduce nursing vacancies to 5% by 2028 remains a key priority, nonetheless, the national workforce fragility is acknowledged, and our workforce planning strategies will continue to be aligned with national policy and embedded within the strategic steer for the Trust.

1.5 In line with the agency usage, there has been sustained demand for the use of escalated rates from May to July, however, August saw a significant reduction in the overall usage. Early cautious indications suggest that this has been significantly influenced by the introduction of the surge bank payment initiative in high-usage areas across the organisation. Further reviews are underway to gain a greater understanding of the

potential positive impact this may have had. Themes and trends continue to be monitored by the Temporary Staffing Office regarding the underlying reasons for each request. The leading request reasons since our last report are as expected and triangulate with the correlating information discussed within this report, additional capacity, short-term sickness, Covid-19 sickness, and vacancies remain key themes.

1.6 Despite the continued challenges over the previous six months, the Trust overall has consistently remained above 95% of the planned staffing fill rates for registered staff and unregistered staff. Healthcare support worker (HCSW) fill rates are consistently overfilled which is reflective of the increased dependency needs of patients accessing our services. The national narrative supports that there has been an increase in patients who have become physically deconditioned since the start of the pandemic and this is not isolated to the local community accessing services at SFHFT.

1.7 Midwifery staffing has been safely aligned to birth activity over the last six months, and we continue to utilise the registered nurse shift in the Maternity Ward. This has been evaluated well and we plan to build this into the establishment.

1.8 374 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system since March 2022. All incidents were recorded as no or low harm, and when documented the appropriate actions were taken at the time. We continue to see persistent themes of high activity, increased capacity, and rising numbers of patients requiring enhanced patient observations; all of which have an impact on staffing resources. 17 of these incidents have been identified as *red flag* incidents (as defined by NICE) and largely due to a delay in fundamental care or delays in time-critical activity. It is acknowledged that despite no adverse clinical outcome, the delays will have had a negative impact on the patient's overall experience.

1.9 Reoccurring red flag themes noted within BirthRate Plus® have been the inability to provide 1:1 care to women in established labour, delays in beginning the process for inductions of labour, delays with the artificial rupture of membranes, and the inability to maintain the supernumerary status of the coordinator. Additional quality metrics are monitored and included in the safe staffing reports which are presented to the Maternity Assurance Committee, NMAHP Committee, and the People, Culture, and Improvement Committee.

1.10 Recruitment and Retention:

1.11 Since our last report, the Trust has maintained pace with international registered nurse recruitment, with 35 out of the agreed 50 individuals on-site. We are expecting a cohort of seven to arrive in late October and the remainder in December 2022. This will complete the intense national recruitment drive that was set for by NHS England in the recruitment of 50k additional nurses across the NHS.

1.12 SFHFT continues to lead the HCSW programme across the Nottingham and Nottinghamshire Integrated Care System (ICS) and the Associate Director of Resourcing will be presenting to the senior nurses and midwives at October's Nottinghamshire Nursing & Midwifery Cabinet.

1.13 The Trust is working towards the completion of the NHS England Nursing & Midwifery Retention Self-Assessment Tool and an update will be provided to the NMAHP Committee in October 2022, from this will be a development of an action plan to improve our retention. There are six areas – Health & well-being; autonomy & shared profession; leadership and teamwork; professional development & careers; pride & meaningful recognition and flexible working.

1.14 Vacancies within the community midwifery team have stabilised since our last report and this has been influenced by the easing of the pension abatement and the national pause in reporting for Midwifery Continuity of Carer (MCoC).

1.15 To support of midwifery workforce the Trust has hosted the Shortened Midwifery MSc programme provided by the University of Birmingham. There are currently five students accessing this course and will they move into year 2 in October, with a further five students commencing studies later this year. Alongside this, there is a rolling recruitment campaign for registered midwives which includes the recruitment days led by our Lead Midwife for Recruitment and Retention

1.16 The annual maternity workforce review originally included a forecast of additional staffing requirements within the context of the Maternity Transformation Programme and noted staffing resource was described as a significant risk to the delivery of maternity transformation on the SFHFT risk register (Risk ID 2395, score 6), and, on the Local Maternity and Neonatal System risk register under various classification described as understaffing and capacity, with scores between 9 and 16.

1.17 This review sought to provide assurance about the current midwifery establishment within the context of a completed establishment review, and the requirements of the maternity transformation agenda. However, this may change due to the recent letter published by NHS England (21st September 2022) outlining the changes to MCoC. In response to this, the Trust has produced a system plan which requires approval through our executive partners' meeting prior to the review of any risks. In addition, a request for a revised BirthRate Plus® report has been made given the notable increase in births and the removal of MCoC, we expect to receive this report towards late October 2022.

1.18 **AHP Overview**

1.19 Currently, there is no single guidance or standard approach to inform safe staffing levels required in services provided by AHPs. Each AHP has profession-specific information and guidance to support staffing levels of a particular type of service, and where appropriate this guidance is embedded to ensure we have an evidence base for our workforce planning processes.

1.20 With the continued Opel 4 and critical incidents declared, additional bed capacity at SFHFT is continually being flexed and, the AHP workforce covers additional capacity within the existing resources and restraints of the teams. This is extremely challenging and creates pressure on existing staffing and the ability to cover the wards and departments. Additional capacity has been funded by the winter plan, but it is fixed-term, non-recurrent funding therefore the AHP professions rely on agency and limited bank resources to cover the additional winter posts. Agency and bank staffing are increasingly challenging to secure due to competing organisations within the ICS also requiring staff. This balanced with temporary staff needs, for longer-term security with the current cost of living, makes it an ongoing concern.

1.21 Constraints regarding substantive recruitment have eased slightly within the AHP services with successful appointments into several vacancies. Speech and language therapy (SLT) and dietetics have small specialist staffing establishments but continue to remain below the benchmark of other organisations of a similar size (Model Hospital, NHS England).

1.22 Within dietetics we have seen several successful recruitments, these include:

- Paediatrics have successfully recruited into the band 6 dietitian role; the post was approved via a business case supported by an AHP job plan.
- A Dietitian Advanced Clinical Practitioner (ACP) for ICCU (band 8a), has been appointed. The successful candidate was recruited internally which has resulted in a vacancy within the adult in-patient service. It is anticipated that some flexibility with cover between ICCU and the in-patient service will be required whilst recruitment occurs in order to backfill this vacancy.

1.23 SLT at SFHFT has recently completed a month-long pilot supporting patients in the Emergency Department and the Emergency Assessment Unit. Funding to extend the pilot for the winter period has been applied for, and the findings are currently being evaluated. Initial results are extremely positive with patients being seen much quicker on admission and some admission avoidance also being noted as a result of SLT being visible and available in these departments during the working week. Colleagues' response to the pilot both within and external to SLT has been positive.

1.24 Physiotherapy continues to support two therapy assistants on the Physiotherapy Apprenticeship Programme at Sheffield Hallam University. The current apprentices are due to qualify in May 2023 and we hope to retain them at SFHFT via the recruitment process. There are plans to support two additional physiotherapy apprentices who will commence studies in March 2023

1.25 A successful bid resulted in SFHFT supporting 2.0 WTE, one-year Health Education England Fellowship posts that commenced in September 2022. The fellowships are to support workstreams reviewing recruitment, retention, and development of the 'small and vital professions' including Operating Department Practitioners (ODPs), orthotics and prosthetics, podiatry, and therapeutic radiography.

1.26 Therapy services are continuing to work closely with the Integrated Discharge Advisory Team (IDAT) and system colleagues to deliver the Discharge 2 Assess model. An occupational therapist, working with IDAT screens pathway 1 patients for adult social care packages and START, supporting the social care pressures. There are now 15 'trusted screeners' identified within therapy services who are able to recommend care packages. Progress so far demonstrates it is proving beneficial, improving the efficiency of transfer of care between acute and social care and reducing the length of

stay for this cohort of patients. Work is ongoing to secure substantive funding for this model.

1.27 **National Compliance**

1.28 The Developing Workforce Safeguards published by NHS Improvement in October 2018 were designed to help Trusts manage workforce planning and staff deployment. Trusts are now assessed for compliance with the triangulated approach to deciding staff requirements detailed within the NQB guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time. The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

1.29 The Chief Nurse has confirmed they are satisfied that staffing is safe, effective, and sustainable.

1.30 **Recommendations**

1.31 The Board is asked to receive this report and note the ongoing plans to provide safe staffing levels within nursing, midwifery, and AHP disciplines across the Trust.

1.32 The Board is asked to note the maternity staffing position and the local position which is common with the national profile.

1.33 The Board is asked to note the AHP staffing position within the report whilst noting the ongoing recruitment plans to support each service.

1.34 The Board is asked to note the compliance standards used in relation to the developing Workforce Safeguards and SNCT, and the ongoing quality of data they provide to underpin the Trust establishment process.

Nursing, Midwifery, and Allied Health Professional Bi-annual Staffing Report 2022

2.0 Purpose:

2.1 The purpose of this report is to provide an overview of NMAHP staffing capacity and compliance with the NICE Safe Staffing, NQB Standards, and the NHSI Developing Workforce Safeguards guidance.

2.2 It will provide a cumulative oversight of CHPPD and the available data for the cost per care hours (CPCH) each month.

2.3 This is supported by an overview of staffing availability since the last report and progress with assessing the acuity and dependency of patients on ward areas.

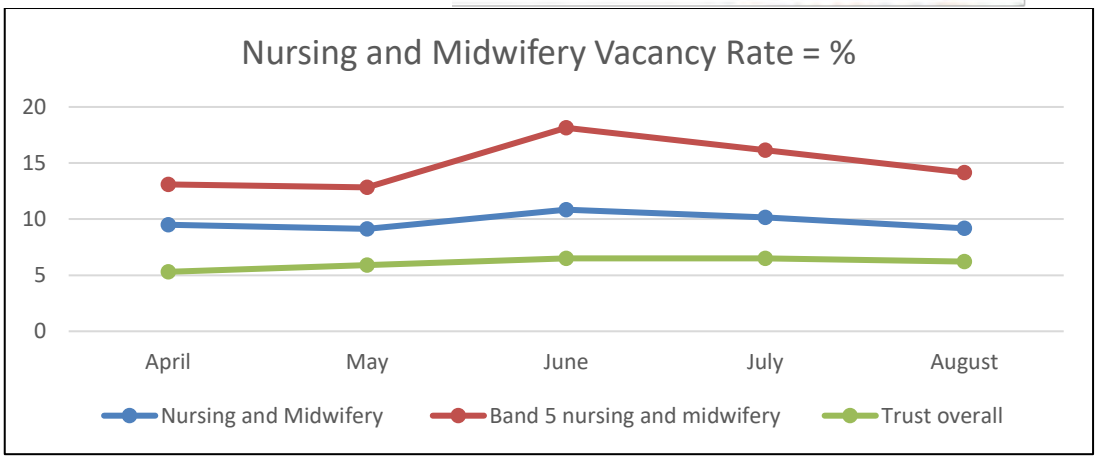
Nursing and Midwifery Overview

3.0 Local Nursing and Midwifery Context:

3.1 Since the start of 2022/2023 the overall Trust vacancy rate has held a relatively stable yet static position of approximately 6% and captures all NMAHP staff from band 2 upwards.

3.2 Ongoing efforts have been maintained within nursing and midwifery in reducing the vacancy deficit, especially since Covid-19 has remained a constant presence. International recruitment and the expansion of the nursing associate role across services have been well received and plans are in place to continue with these programmes of work. The Trust's commitment to the NHS Long Term Plan to reduce nursing vacancies to 5% by 2028 remains a key priority, nonetheless, the national workforce fragility is acknowledged. Our workforce planning strategies will continue to be aligned with national policy and embedded within the strategic steer for the Trust.

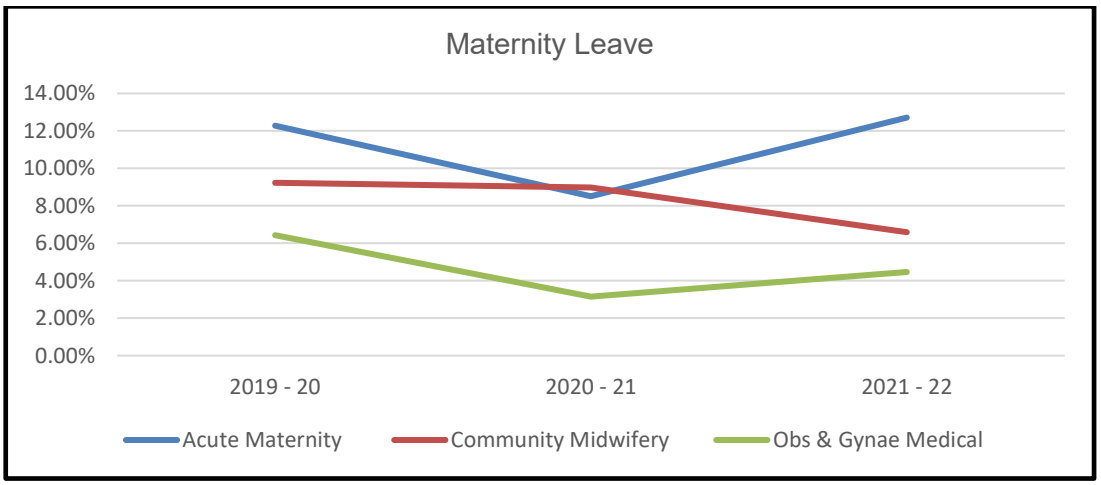
Figure 1:



Data Source: Workforce Informatics

3.3 Sickness absence had showed significant improvements across the maternity workforce and is in line with the Trust reduction of short-term sickness related to Covid-19. Furthermore, workforce loss due to maternity leave has reduced within the community midwifery services but remains at a higher rate within the acute service reflecting previous reports (Figure 2).

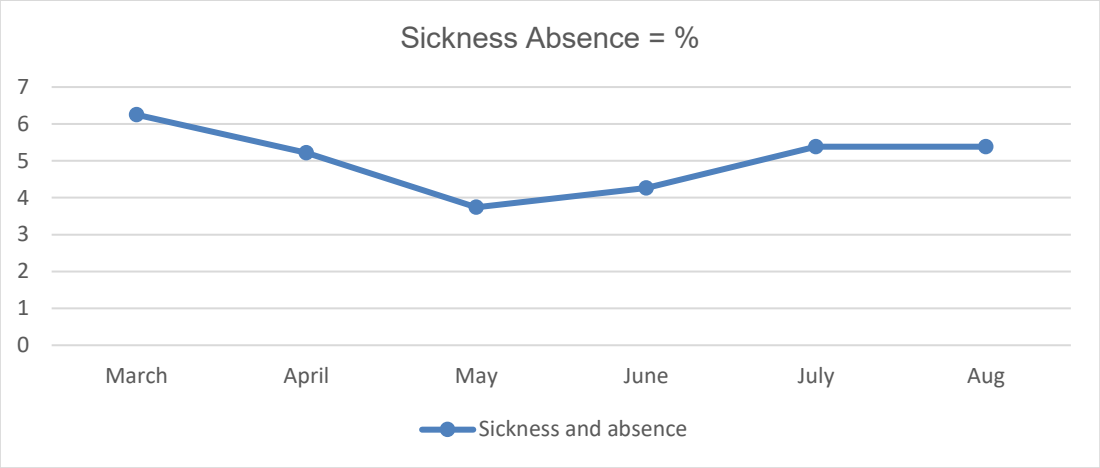
Figure 2:



Data Source: Workforce Information

3.4 Overall sickness absence for all staff groups has continued to be an ongoing challenge, with the peak of absences being noted in March. Following a positive decline from March onwards, May noted a change in the previous trajectory. Contributing factors of unseasonably high service demand and non-covid workforce loss have contributed to the rising trend seen in figure 3.

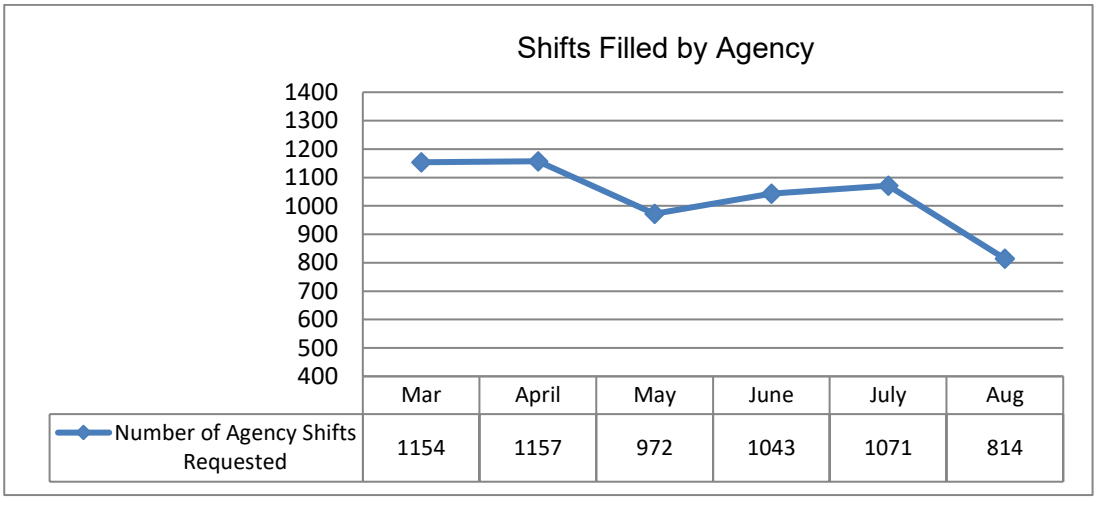
Figure 3:



Data Source: Workforce Informatics.

3.5 Agency usage across our clinical areas has continued to demonstrate a sustained reliance, however, the overall trajectory does reflect a positive downward trend as we move further into 2022. The acuity and dependency needs of patients attending the hospital have continued to remain high and this has been combined with unprecedented high levels of flow and capacity. These complex challenges have required additional surge capacity to remain open across the organisation and the required additional workforce to safely support these areas.

Figure 4:



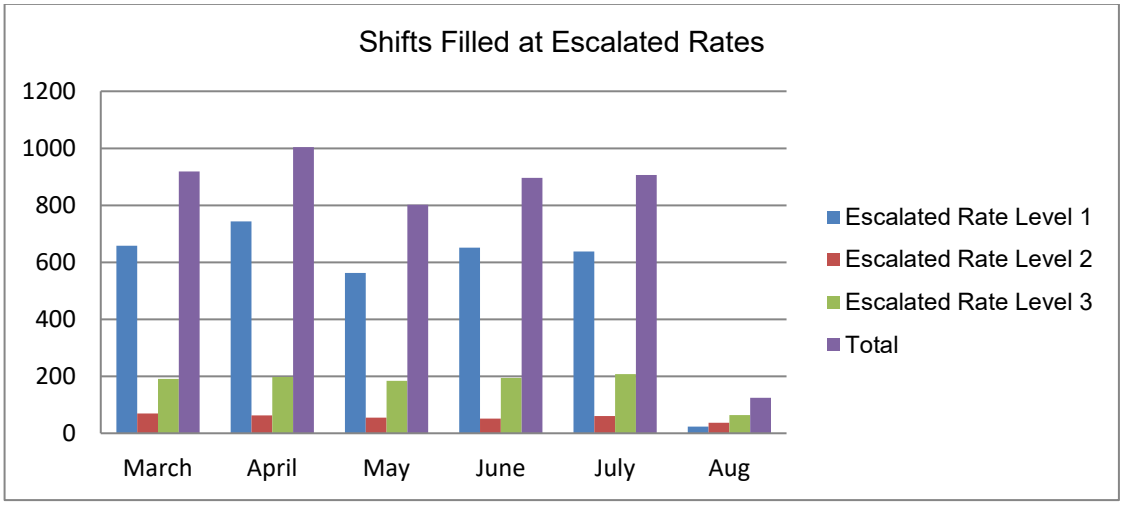
	Mar	April	May	June	July	Aug
Number of Agency Shifts Requested	1154	1157	972	1043	1071	814

Data Source: Temporary Staffing Office.

3.6 In line with the agency usage, there has been sustained demand for the use of escalated rates from May to July, however, August saw a significant reduction in the

overall usage. Early indications suggest that this has been significantly influenced by the introduction of the surge bank payment initiative in high-usage areas across the organisation. Further reviews are underway to gain a greater understanding of the potential positive impact this may have had. Themes and trends continue to be monitored by the Temporary Staffing Office regarding the underlying reasons for each request. The leading request reasons since our last report are as expected and triangulate with the correlating information discussed within this report, and additional capacity, short-term sickness, Covid-19 sickness, and vacancies remain key themes.

Figure 5:



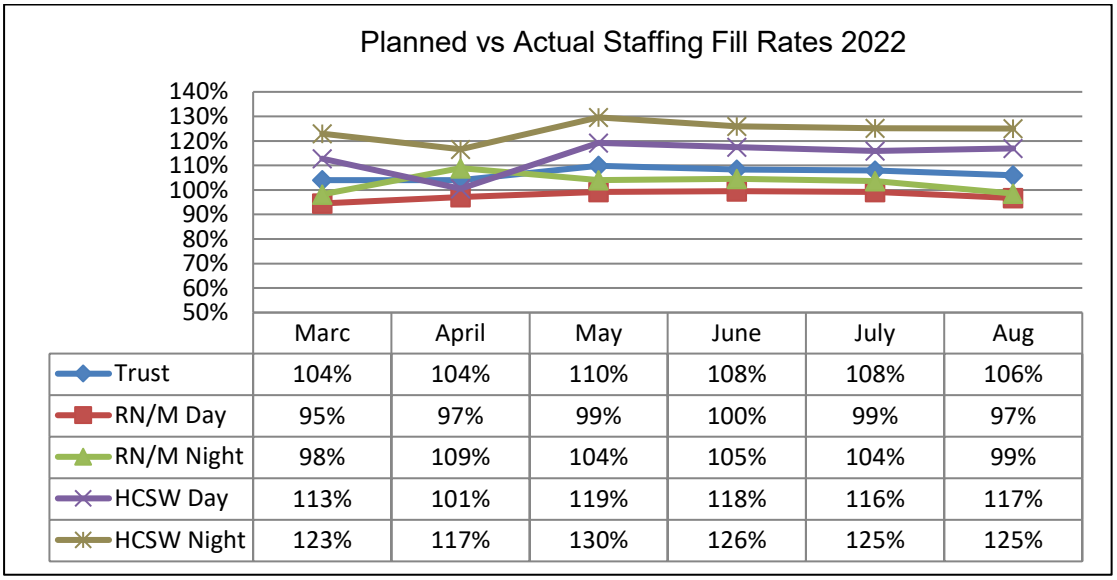
Data Source: Temporary Staffing Office.

4.0 Planned versus Actual Staffing & Care Hours per Patient Day (CHPPD):

4.1 All NHS providers are required to publish inpatient nursing and midwifery staffing data monthly along with a national report submission. This data highlights the planned staffing hours (hours planned into a working roster template) aligned to actual staffing hours worked (actual hours worked by substantive and temporary staff). In addition to CHPPD, cost-per-care hours (CPCH) are also monitored.

4.2 Despite the continued challenges over the previous six months, the Trust overall has consistently remained above 95% of the planned staffing fill rates for registered staff and unregistered staff. Figure 6 demonstrates HCSW fill rates as consistently overfilled which is reflective of the increased dependency needs of patients accessing our services. The national narrative supports that there has been an increase in patients who have become physically deconditioned since the start of the pandemic and are not isolated to the local community accessing services at SFHFT.

Figure 6:



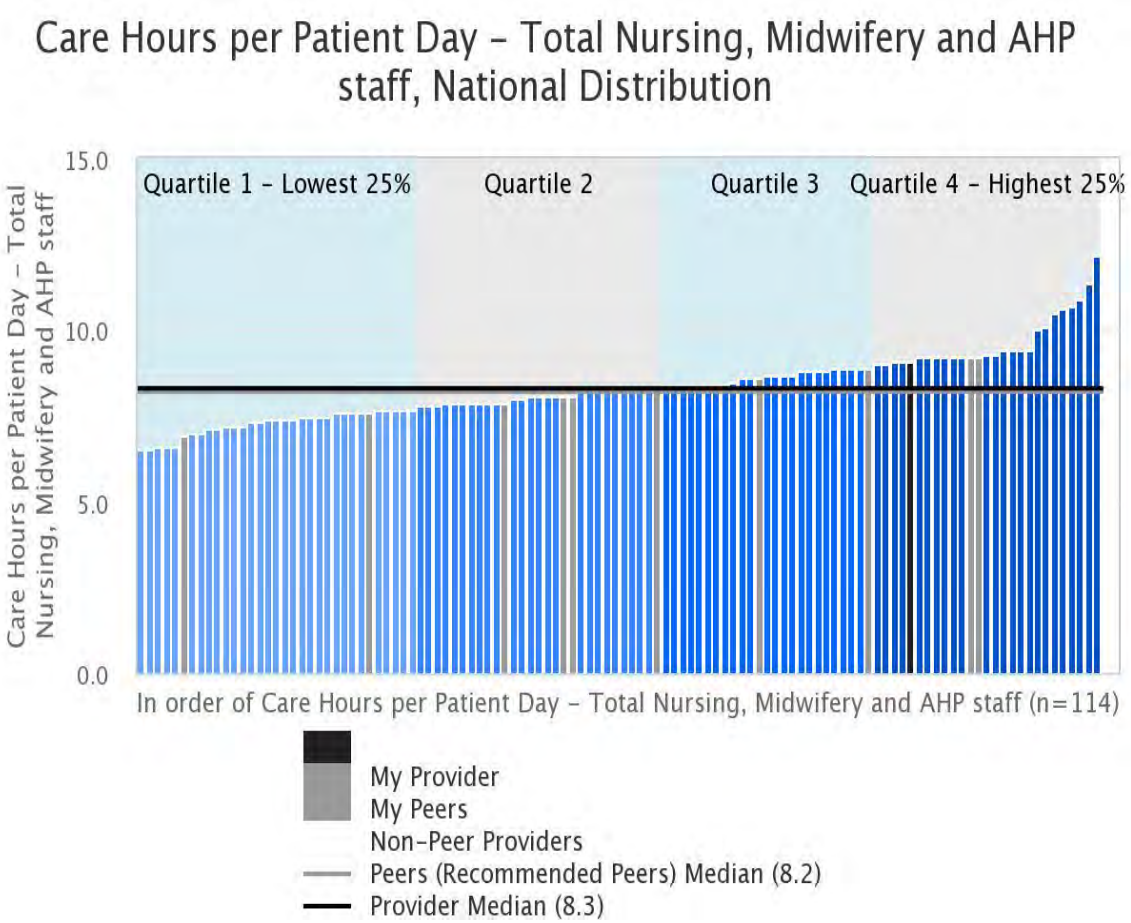
	Marc	April	May	June	July	Aug
Trust	104%	104%	110%	108%	108%	106%
RN/M Day	95%	97%	99%	100%	99%	97%
RN/M Night	98%	109%	104%	105%	104%	99%
HCSW Day	113%	101%	119%	118%	116%	117%
HCSW Night	123%	117%	130%	126%	125%	125%

Data Source: Unify Staffing Data.

4.3 CHPPD is calculated by adding together the hours of registered nurses/ midwives and HCSWs and dividing the total by every 24 hours of inpatient admissions. This provides a value that demonstrates the average number of actual registered nursing care hours spent with each patient per day. Data from Trust and ward level for all acute Trusts are published on NHS Model Hospital to enable a central and transparent comparable data set. Very low rates may indicate a potential patient safety risk, whereas very high rates may suggest an organisation has several unproductive wards or inefficient staff rostering processes.

4.4 The CHPPD at the Trust level has remained consistent demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs. However, benchmarking data from Model Hospital (May 2022) confirms that the Trust value does sit within the fourth quartile at 9.1 and is slightly above the national and peer median of 8.3.

Figure 7:



Data Source: Model Hospital

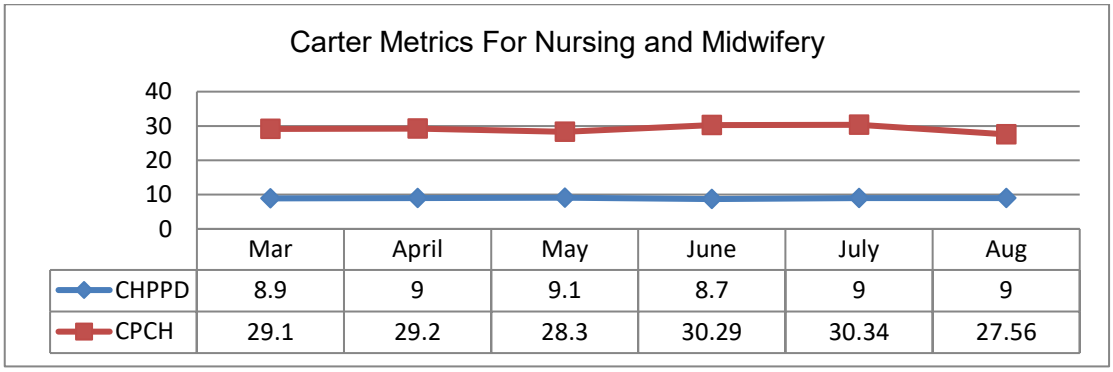
4.5 Divisional narrative from the matron team highlights safe staffing remains a constant priority across all services and undoubtedly this has been significantly challenging for all involved. Nonetheless, staffing resource has been flexed and deployed to meet patient demand, activity, and acuity when required.

4.6 Midwifery staffing has been safely aligned to birth activity over the last six months, we continue to utilise the registered nurse shift in the maternity ward as this has been evaluated well and we plan to build this into the establishment. We have also successfully recruited a Lead Midwife into the role of recruitment and retention. This role has been created to support the current needs within acute maternity services, providing individualised situated support in the clinical environment for students, return-to-practice learners, and early career midwives. This role has become embedded within the Trust workforce meeting and is evaluating well. The positive impact is being reflected are seen within the retention and recruitment rates.

4.7 To support ongoing challenges the Trust continues to support midwives in receiving an enhanced payment rate for bank shifts. This runs alongside the system engagement work, to review an aligned system pay. The previous shortages within community service have significantly improved through successive recruitment and completion of the revised preceptorship programme, leading to the full reinstatement of the home birth service.

4.8 CPCH is measured as the average cost spent per hour of care, and benchmarking variance at the ward level with peers can help to identify potential savings opportunities in the cost of providing care. Safe staffing and financial returns include substantive, bank, and agency staff; therefore, a higher cost may indicate greater reliance on agency staff as a proportion to substantive. Since our last report, CHPPD illustrates a consistent stable picture, however, the CPCH continues to hold a solid trajectory which may be indicative of persistent reliance on agency and temporary staff. This is illustrated below in figure 9.

Figure 9:



	Mar	April	May	June	July	Aug
CHPPD	8.9	9	9.1	8.7	9	9
CPCH	29.1	29.2	28.3	30.29	30.34	27.56

Data Source: Finance Services

5.0 Measure and Improvement

5.1 To ensure there is a triangulated approach in our oversight of safe staffing and the provision of quality care, the senior nursing and midwifery team review workforce metrics, indicators of quality, and measures of productivity monthly within the monthly Safe Staffing Report. It is important to acknowledge metrics should not be reviewed in isolation when understanding quality.

Figure 10:

2022	March	April	May	June	July	Aug

Staffing Incidents	76	83	53	45	49	68
Red Flags (within Datix)	5	4	1	2	3	4

Data Source: Datix Reporting System

5.2 374 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system since March 2022. All incidents were recorded as no or low harm, and when documented the appropriate actions were taken at the time. We continue to see persistent themes of high activity, increased capacity, and rising numbers of patients requiring enhanced patient observations; all of which have an impact on staffing resources. 17 of these incidents have been identified as *red flag* incidents (as defined by NICE) and are largely due to a delay in fundamental care or delays in time-critical activity. It is acknowledged that despite no adverse clinical outcome, the delays in care will have a negative impact on the overall patient experience.

5.3 In addition to Datix reporting, red flags, clinical and management actions for midwifery services are recorded within Birth Rate Plus®. Reoccurring red flag themes noted within Birthrate Plus have been the inability to provide 1:1 care to women in established labour, delays in beginning the process for inductions of labour, delays with the artificial rupture of membranes, and the inability to maintain the supernumerary status of the coordinator. Additional quality metrics are monitored and included in the safe staffing reports which are presented to the Maternity Assurance Committee.

5.4 SNCT continues to provide an evidence-based process to our adult and paediatric inpatient area establishment reviews, and the Trust has supported NHS England with pilot testing of the next iteration of the national tool.

5.5 SNCT for emergency departments was recently published and nationwide training has been delivered by NHS England. The Trust has acquired the license for use, and the first cycle of acuity and dependency scoring has taken place. Analysis of the data is underway and will support the establishment review process going forward.

6.0 Nursing and Midwifery Recruitment and Retention:

6.1 Since our last report, The Trust has maintained pace with international registered nurse recruitment, with 35 out of the agreed 50 individuals on-site. We are expecting a cohort

of seven to arrive in late October and the remainder in December 2022. This will complete the intense national recruitment drive that was set for by NHS England in the recruitment of 50k additional nurses across the NHS.

6.2 The Objective Structured Clinical Examination (OSCEs) continues to be a risk to the Trust, with waits of up to 13 weeks from arrival to test, this has been escalated to the regional and national teams and is recorded as a risk on the NMAHP Transformation Group's risk log. There have been additional concerns raised regarding the Leeds Nursing and Midwifery Council Test of Competence centre, where the rates of failure have been identified as high. Although the Trust has continued to use the test centre, our rates of failure initially were 66%, with only 34% passing the first time. There are currently 11 international registered nurses in training with OSCEs booked for October, and a further eight to commence training with dates scheduled in November.

6.3 There have been changes to the NHS Employers Code of Practice for International Recruitment, which the Trust has reviewed and is compliant with all the actions, this will be reported to the NMAHP Committee in September, and this will be sent to the Midlands Nursing Workforce team by the end of September.

6.4 The Trust is reviewing its offer to our international colleagues who work for SFHFT and will look towards accreditation for the Pastoral Care Quality Awards, a position is currently in the recruitment process for a full-time chief nurse clinical fellow to support Pastoral Care Quality Awards.

6.5 The 2020 cohort of trainee nursing associates will complete their training on the 5th of October and will be registering with the Nursing and Midwifery Council in November 2022, we are also pleased that we will have an additional 16 nursing associates working within the Trust. The 2021 cohort of trainee nursing associates will move into their second year in October and there will be 17 trainee nursing associates. The Trust has successfully recruited 20 trainee nursing associates to commence in October 2022, however, this number has reduced since initial recruitment down to 18, as one healthcare support worker has been accepted for her MSc nursing degree at Derby University, and we will continue to support her in her studies and with additional bank shifts. The second healthcare support worker has sadly had to withdraw from her offer, as she is not eligible for the apprenticeship levy having not resided in the UK for more than three years, nonetheless, we will continue to support and develop her until she is eligible.

6.6 There are 19 registered nurse degree apprenticeship students who have moved into their second year, and they have all received their Performance Appraisal and Development Review, along with their annual work plan review to fully comply with the apprenticeship standards.

6.7 In September 2022, the Trust held a large recruitment event for HCSWs to work on the bank and support the vacancies in the wards over the winter period, and to support the winter plan and the additional capacity that will be open over the coming months.

6.8 SFHFT continues to lead the Healthcare Support Worker programme across the Nottingham and Nottinghamshire ICS and the Associate Director of Resourcing will be presenting to the senior nurses and midwives at October's Nottinghamshire Nursing & Midwifery Cabinet.

6.9 The Trust is working towards the completion of the NHS England Nursing & Midwifery Retention Self-Assessment Tool and an update will be provided to the NMAHP Committee in October 2022, from this will be a development of an action plan to improve our retention. There are six areas – Health & well-being; autonomy & shared profession; leadership and teamwork; professional development & careers; pride & meaningful recognition and flexible working.

6.10 The Trust has recently appointed a Corporate Matron for Exemplar Rostering; this role will support safe staffing by ensuring effective rostering principles are consistently applied to roster management to strengthen and potentially optimise our workforce capability.

6.11 Vacancies within the community midwifery team have stabilised since our last report and this has been influenced due to the easing of the pension abatement and the national pause in reporting for MCoC.

6.12 To support of midwifery workforce the Trust has hosted the Shortened Midwifery MSc programme provided by the University of Birmingham. There are currently five students accessing this course and will they move into year 2 in October, with a further five students commencing studies later this year. Alongside this, there is a rolling recruitment campaign for registered midwives which includes the recruitment days led by our Lead Midwife for Recruitment and Retention.

6.13 It is acknowledged by the Royal College of Midwives (2021) that a high proportion of early career midwives are leaving the profession, however since the introduction of the Lead Midwife for Recruitment and Retention position, the support of this role is positively contributing to our low attrition rate in this cohort of staff.

7.0 Midwifery Forward Planning:

7.1 The annual maternity workforce review originally included a forecast of additional staffing requirements within the context of the Maternity Transformation Programme and noted staffing resource was described as a significant risk to the delivery of maternity transformation on the SFHFT risk register (Risk ID 2395, score 6), and, on the Local Maternity and Neonatal System risk register under various classification described as understaffing and capacity, with scores between 9 and 16.

7.2 This review sought to provide assurance about the current midwifery establishment within the context of a completed establishment review, and the requirements of the maternity transformation agenda. However, this may change due to the recent letter published by NHS England (21st September 2022) outlining the changes to MCoC. In response to this, the Trust has produced a system plan which requires approval through our executive partners' meeting prior to the review of any risks.

7.3 The BirthRate Plus® workforce review that was completed in September 2020 provided richer detail to the complex variables affecting overall staffing requirements within a maternity service. The current position is outlined in figure 11 against our current WTE for Band 5 to 7 RMs and Band 3 Maternity Support Workers. In addition, a request for a revised BirthRate Plus® report has been made given the notable increase in births and the removal of MCoC service, we expect to receive this report towards late October 2022.

Figure 11:

Budgeted WTE	Actual WTE	Vacancies WTE
152.20	**135.81**	**16.39**

Data Source: Workforce Information

Allied Health Professions Overview

8.0 Safe Staffing Levels:

8.1 Currently, there is no single guidance or standard approach to inform safe staffing levels required in services provided by AHPs. Each AHP has profession-specific information and guidance only to support staffing levels of a particular type of service, and where appropriate this guidance is embedded to ensure we have an evidence base for our workforce planning processes.

8.2 We have recently been successful in recruiting an AHP Chief Nurse Clinical Fellow band 7 (0.4 WTE) for six to 12 months and will implement job planning across the AHP workforce at SFHFT. This supports the NHS England mandatory requirement to job plan the AHPs and will enable us to review capacity against clinical hour contacts required for each AHP profession.

8.3 Risks and Constraints:

8.4 With the continued Opel 4 and critical incidents declared, additional bed capacity at SFHFT is continually being flexed and, the AHP workforce covers additional capacity within the existing resources and restraints of the teams. This is extremely challenging and creates pressure on existing staffing and the ability to cover the wards and departments. Additional capacity has been funded by the winter plan, but it is fixed-term, non-recurrent funding therefore the AHP professions rely on agency and limited bank resources to cover the additional winter posts. Agency and bank staffing are increasingly challenging to secure due to competing organisations within the ICS also requiring staff. This balanced with temporary staff needs, for longer-term security with the current cost of living, makes it an ongoing concern.

8.5 Constraints regarding substantive recruitment have eased slightly within the AHP services with successful recruitment into several vacancies. Speech and language therapy and dietetics have small specialist staffing establishments but continue to remain below the benchmark of other organisations of a similar size (Model Hospital, NHS England).

9.0 Dietetics:

9.1 Within dietetics we have seen several successful recruitments, these include:

- Paediatrics have successfully recruited into the band 6 dietitian role; the post was approved via a business case supported by an AHP job plan.

- A Dietitian Advanced Clinical Practitioner (ACP) for ICCU (band 8a), has been appointed. The successful candidate was recruited internally which has resulted in a vacancy within the adult in-patient service. It is anticipated that some flexibility with cover between ICCU and the in-patient service will be required whilst recruitment occurs in order to backfill this vacancy.

9.2 Current recruitment includes:

- The band 6 diabetic and endocrinology vacancy was unsuccessful in appointing, however, there is currently a locum secured for this post and the recruitment process is due to commence again imminently.

9.3 Referral to in-patient dietetics in 2021 increased by 43% in comparison to 2020. It has increased a further 58% in the year ending March 2022 resulting in a 101% increase in referrals to the in-patient service in the previous two years. There has been no increase in the establishment to match this demand. The Royal College of Physicians staffing guidelines for stroke units indicates that at SFHFT, we require an additional 1.0 WTE dietitian to support the increase in beds. This is being reviewed in a current business case.

10.0 Speech and Language Therapy (SLT):

10.1 SLT at SFHFT has recently completed a month-long pilot supporting patients in the Emergency Department and the Emergency Assessment Unit. Funding to extend the pilot for the winter period has been applied for, and the findings are currently being evaluated. Initial results are extremely positive with patients being seen much quicker on admission and some admission avoidance also being noted as a result of SLT being visible and available in these departments during the working week. Colleagues' response to the pilot both within and external to SLT has been positive.

10.2 Current recruitment with the service includes:

- An ICS-wide SLT rotation of band 5 staff between SFHFT, Nottinghamshire Healthcare Trust (NHC), and Nottingham University Hospitals (NUH) commenced in October 2022., and all three posts have been recruited and have now commenced in post.

11.0 Occupational Therapy (OT):

11.1 Successful recent recruitment includes:

- A newly established band 7 post in ICCU has been appointed and the new staff member is due to commence in post in October 2022. This will support a new rotation for band 6 posts to attract and retain OTs in specialist roles.

11.2 Current recruitment includes:

- A rolling recruitment process to attract band 5 OTs to SFHFT. The main shortfall in staffing is due to a significant percentage of OT staff on maternity leave. The AHP Faculty workstream includes supporting an increase in OT placements across SFHFT to aid recruitment with the 'system' considering an ICS OT rotation.
- There are plans to utilise assistant posts to support two OT apprenticeships which are expected to commence in March 2023.

11.3 As with other AHP professions (with the exception of ODPs), AHP apprenticeship posts are not supernumerary and are supported by the use of existing established assistant posts. However, this does create a shortfall in the support workforce.

12.0 Orthotics:

12.1 We are currently running a fully established service.

13.0 Orthoptists:

13.1 Current recruitment includes:

- Band 6 (0.4 WTE) to be recruited to backfill the orthoptist who has recently been appointed into the chief nurse clinical fellow role for AHP job planning.

14.0 Physiotherapy:

14.1 Successful recent recruitment includes:

- Physiotherapy ACP post for ICCU, (band 8a) at SFHFT

14.2 Current recruitment within the service includes:

- Band 6 musculoskeletal and band 5 rotational physiotherapists.
- Band 7 MSK team leader post.

14.3 Physiotherapy continues to support two therapy assistants on the Physiotherapy Apprenticeship Programme at Sheffield Hallam University. The current apprentices are due to qualify in May 2023 and we hope to retain them at SFHFT via the recruitment process. There are plans to support two additional physiotherapy apprentices who will commence studies in March 2023

15.0 Radiology:

15.1 Successful recent recruitment includes:

- Three sonographers (band 7) have been recruited and are due to commence their ACP training programme.
- Our first AHP consultants at SFHFT have been appointed in radiography. Two breast care radiography consultants have also been appointed.

15.2 Current recruitment within the service includes:

- Band 5 vacancies,
- Band 8a MRI/CT Manager vacancy.

15.3 There is a current workforce plan underway for the new MRI department. Two additional scanners are planned, operating seven days per week and this will be a challenge to fully recruit into these posts. It is acknowledged that NUH currently has 11 band 6 vacancies in MRI.

15.4 There is an ongoing business case for the Community Diagnostic Centre (CDC) that requires significant numbers of radiography staff. SFHFT will support the staffing of this centre but will need a significant increase in established staffing to do so. The resources required will be challenging to recruit. This will be considered within the business case.

15.5 As with other AHP professions, the staffing capacity remains the biggest risk with additional beds open due to the increased surge and demands upon our services. The AHP workforce continues to be responsive to Opel 4 and is providing additional support to weekend working with additional overtime being utilised in some services.

15.6 The in-patient therapy professions (Physio, OT, SLT, Dietetics, and OT), are commencing establishment and pathway reviews to ensure the maximising usage of

staff and review alternative ways to support the discharge to assess (D2A) model within and outside the scope of existing establishments. Job planning will aid this process.

16.0 AHP Faculty and AHP Cabinet:

16.1 The Associate Chief AHP for SFHFT continues to be a key member of the AHP Faculty and ICS AHP cabinet, and, the Nottingham and Nottinghamshire AHP Faculty and ICS Cabinet have various work-streams currently underway to support AHP workforce across Nottinghamshire.

16.2 The AHP Faculty Lead post remains a fixed term contract funded by Health Education England supports operationalisation of the workstreams and has dedicated time to support the faculty in representation at ICS workforce forums and as a senior project manager. This is a 1.0 WTE post, currently a job shared by a physiotherapist from SFHFT (0.6WTE) and an SLT from NHC (0.4 WTE). This post is funded until March 2023.

16.3 Workstreams recently concluded (October 2022) include:

- Continue professional expansion programme (CPEP) for Physiotherapy, Occupational therapy, SLT, and dietetics.
- Retention and support for students, newly qualified workforce, and early careers,
- Apprenticeships,
- Profession-specific growth,
- AHP support workforce.

16.4 SFHFT has been the host organisation for all the above projects with the Associate Chief AHP as the named lead. A gap analysis, recommendations, and action plans have been submitted to Health Education England and shared with the ICS and providers for consideration of the next steps. An 18-month ICS workforce plan that included SFHFT, NCH, and NUH, was submitted to Health Education England in July 2022.

16.5 A successful bid resulted in SFHFT supporting 2.0 WTE, one-year Health Education England Fellowship posts that commenced in September 2022. The fellowships are to

support workstreams reviewing recruitment, retention, and development of the 'small and vital professions' including ODPs, orthotics and prosthetics, podiatry, and therapeutic radiography.

16.6 An additional Radiography Health Education England Fellowship has been awarded to SFHFT to enable a clinical educator to support radiology services at SFHFT. This is due to commence in October 2022. The posts are jointly supported by Health Education England and the Associate Chief AHP at SFHFT.

17.0 Discharge to Assess (D2A):

17.1 Therapy services are continuing to work closely with IDAT and system colleagues to deliver the D2A model. An Occupational therapist, working with IDAT screens pathway 1 patients for adult social care packages and START, supporting the social care pressures. There are now 15 'trusted screeners' identified within therapy services who are able to recommend care packages. Progress so far demonstrates it is proving beneficial, improving the efficiency of transfer of care between acute and social care and reducing the length of stay for this cohort of patients. Work is ongoing to secure substantive funding for this model.

17.2 In addition to D2A, Hospital at Home models of care are being explored by therapy services.

National Compliance

18.0 The Developing Workforce Safeguards published by NHS Improvement in 2018 were designed to support effective workforce planning and staff deployment. Trusts are assessed for compliance with the triangulated approach to deciding staff requirements described within the National Quality Board guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

18.1 The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

18.2 The Chief Nurse has confirmed they are satisfied that staffing is safe, effective, and sustainable.

18.3 Appendix one details the Trust's compliance with the nursing and midwifery elements of the Developing Workforce Safeguards recommendations.

Recommendations

19.0 The Board of Directors is asked to receive this report and note the ongoing plans to provide safe staffing levels within nursing, midwifery, and AHP disciplines across the Trust.

19.1 The Board of Directors is to note the maternity staffing position and the local position which includes a recruitment and retention risk, which is common with the national profile.

19.2 The Board of Directors is asked to note the AHP staffing and risk position within the report whilst noting the ongoing recruitment plans to support each service.

19.3 The Board of Directors is asked to note the compliance standards used in relation to the developing Workforce Safeguards and SNCT and the ongoing quality of data they provide to underpin the Trust establishment process.

APPENDIX ONE: Compliance with Developing Workforce Safeguards (Nursing, and Midwifery):

20.0 The Workforce Safeguards were published in 2018 by NHS Improvement and are used to assess compliance with the Triangulated approach to staff planning in accordance with the National Quality Board guidance.

20.1 Although the guidance applies to all staff, this paper will outline nursing and midwifery's current compliance with the 14 safeguards recommendations and identify any areas of improvement.

Recommendation:	Compliance:
Recommendation 1: Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	**Compliant** ✓ SNCT has been embedded within adult in-patient areas, paediatric in-patient areas, and the Emergency Department. ✓ BirthRate Plus is embedded with Maternity services and a refresh of training has been undertaken.
Recommendation 2: Trust must ensure the three components are used in their safe staffing process.	**Fully Compliant** ✓ SNCT and BirthRate are in use at the Trust and provide an evidence base benchmark for our establishment setting process. Nurse-sensitive indicators information is aligned to each establishment review and professional judgement is always considered.
Recommendation 3 & 4: Assessment will be based on a review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.	**Fully Compliant** ✓ Confirmation is included in the annual governance statement that our staffing governance processes are safe and sustainable.
Recommendation 5: As part of the yearly assessment, assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes.	**Fully Compliant** ✓ Data is reviewed and collated every month for a range of workforce metrics, quality indicators, and productivity measures – as a whole and not in isolation from each other.
Recommendation 6: As part of the safe staffing review, the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable.	**Fully Compliant** ✓ Biannual and Annual Nursing, Midwifery, and Allied Health Professional Staffing Report sign off.

Recommendation 7: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.	**Fully Compliant** ✓ Annual submission to NHS Improvement
Recommendation 8: They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	**Fully Compliant** ✓ Monthly Safe Staffing Reports for Nursing and Midwifery and staffing dashboard triangulates this information.
Recommendation 9: An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	**Partially Compliant.** ✓ A bi-annual review for nursing is not completed across all services; establishments are reviewed on an annual basis. ✓ An annual and bi-annual staffing report is presented to the Nursing, Midwifery and Allied Health Professional Committee, People, Culture and Improvement Committee, and the Board of Directors
Recommendation 10: There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	**Fully Compliant** ✓ SNCT and Birthrate Plus are in use as per license agreements.
Recommendation 11 & 12: As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	**Fully Compliant** ✓ Completed as part of the establishment setting process and any changes in service provision. These are monitored by the Nursing, Midwifery, and Allied Health Committee.
Recommendation 13 & 14: Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	**Fully Compliant** ✓ Daily staffing meetings. Staffing resource is also discussed at the flow and capacity meetings throughout the day. ✓ Staffing escalation process via Matron and Bronze on call. ✓ Safe Staffing Standard Operating Procedure. Maternity Assurance Committee. ✓ Monthly Safe Staffing Report for Nursing and the Monthly Safe Staffing Report for Midwifery.

APPENDIX TWO: SNCT Assessment Criteria:

Criteria	Compliance	Evidence
Have you got a licence to use SNCT from Imperial Innovations?	**Yes**	✓ Licence was renewed which has been confirmed by the Chief Nurse.
Do you collect a minimum of 20 days of data twice a year for this?	**Yes**	✓ Held on central database
Are a maximum of 3 senior staff trained and are the levels of care recorded?	**Yes**	✓ Held on the central database: - due to staffing challenges during the pandemic there are some areas that have requested 4 staff (all senior levels) to enable guaranteed continuity.
Is an established external validation of assessments in place?	**Yes**	✓ Held on the central database – A member of the senior nursing team is allocated to ward areas and undertakes validation each week during the cycle. A core group of staff is maintained to ensure consistency.
Has an inter-rater reliability assessment been carried out with these staff?	**Yes**	✓ Held on central database.
Is A&D data collected daily, reflecting the total care provided for the previous 24 hours as part of a bed-to-bed ward round review?	**Yes**	✓ Held on central database.
Are enhanced observations (specials) patients reported separately?	**Yes**	✓ Requests for additional staffing for enhanced patient observations are reported through Datix Reporting System.
Has the executive board agreed on the process for reviewing and responding to safe staffing recommendations?	**Yes**	✓ Escalation process and SOP in place.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	**Medical Workforce Report**		**Date: 3rd November 2022**	
Prepared By:	Rebecca Freeman			
Approved By:	Dr David Selwyn - Medical Director			
Presented By:	Dr David Selwyn - Medical Director			
Purpose				
The purpose of this report is to provide the Board of Directors with an overview of the Medical Workforce. The report will focus on staffing capacity, recent developments, initiatives, and compliance with regulatory requirements.			**Approval**	
			Assurance	**X**
			Update	
			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**	**X**	**X**
Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		X		
Risks/Issues				
Financial	**X**			
Patient Impact	**X**			
Staff Impact	**X**			
Services	**X**			
Reputational	**X**			
Committees/groups where this item has been presented before				
None. This report will be presented to the Joint Local Negotiating Committee (LNC) and the People and Inclusion Cabinet following presentation at the Board of Directors meeting.				

Executive Summary

The report gives an overview of the progress against the regulatory aspects; medical appraisal and revalidation, describes the progress in medical job planning for 2022-23 and the preparation for the job planning round for 2023/24.

The report includes details of the current Medical vacancies, the progress being made in recruiting to these vacancies and describes key areas of focus, with the aim of reducing agency expenditure going forwards. It also notes progress within the most fragile services.

The report describes a review that is currently being undertaken of the bank rates both within the Trust and across the ICS.

It includes the junior doctor fill rate for August 2022 and the bid for additional Senior Trainee posts for August 2023.

The report refers to the appointment of two SAS Advocates and how that role will support this group of doctors.

The report also includes the composition and age profile of the Medical workforce and the challenges presented by that profile.

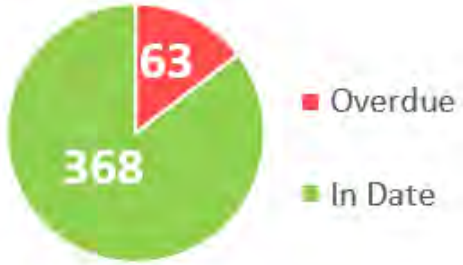
The Board of Directors is asked to:

- Note the contents of the report.
- Recognise that this work cuts across and feeds into a number of other areas of focus including the Guardian of Safe Working report, Strategic Direction of Medical Training and Education at the Trust and the Medical Transformation Programme.

Looking after our People

Appraisal

- NHSi October 2022 Figure 85%
- 63 are outstanding (20/10/2022)



As can be seen from the figure above, the appraisal compliance for Consultants, Specialists and Specialty Doctors is 85%. The number of doctors that are connected to the Trust as their designated body is 409. Both the compliance figure and the number of doctors connected to the Trust have recently reduced as 27 Senior/Clinical Fellows left the Trust to take up training posts in August.

There are 63 appraisals that are overdue and work is being undertaken to encourage these doctors to complete their appraisal.

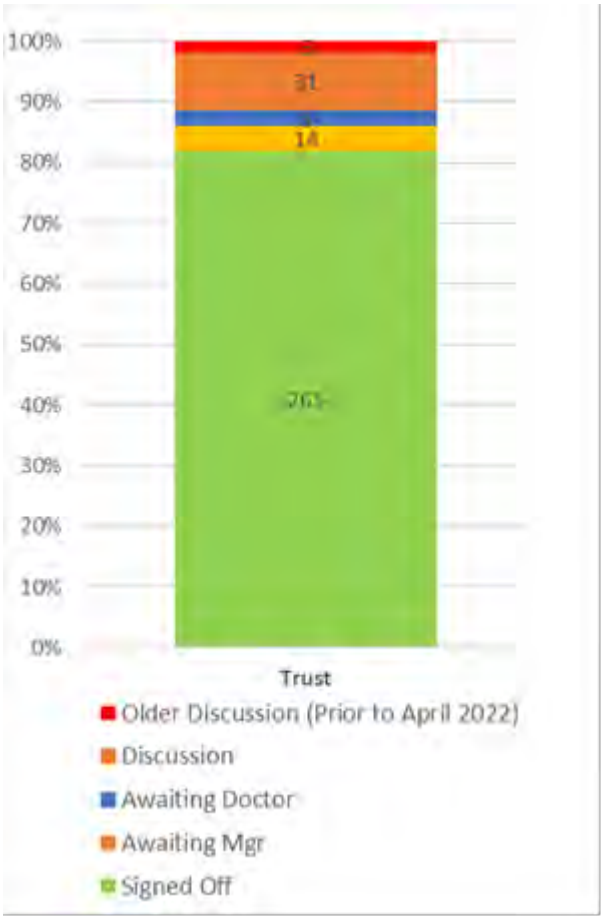
A recruitment campaign for Trust appraisers was held over the summer with an additional 8 appraisers being recruited, increasing the number of appraisers across the Trust to 31.

Senior Clinical Fellows and Clinical Fellows employed by the Trust undertake an annual review of their progress against specified competencies (ARCP) which is where each doctor presents their e-portfolio to a panel of consultant representatives who make an assessment of progress to date. This approach mirrors that undertaken by Health Education East Midlands for the Trainees across the Trust. Currently there are 76 Senior Clinical Fellows and Clinical Fellows going through this process. This group of doctors find the ARCP process supportive and they feel it prepares them for a post as a doctor in training which almost all of our Clinical Fellows go on to become.

Revalidation

From April 2022 until March 2023, 69 doctors are due to be revalidated. To date 28 doctors have been revalidated with 7 doctors being deferred, the main reason for deferral is due to doctors being new to the Trust and not having the information needed to revalidate. 41 doctors are due to be revalidated between January and March 2023.

Job Planning



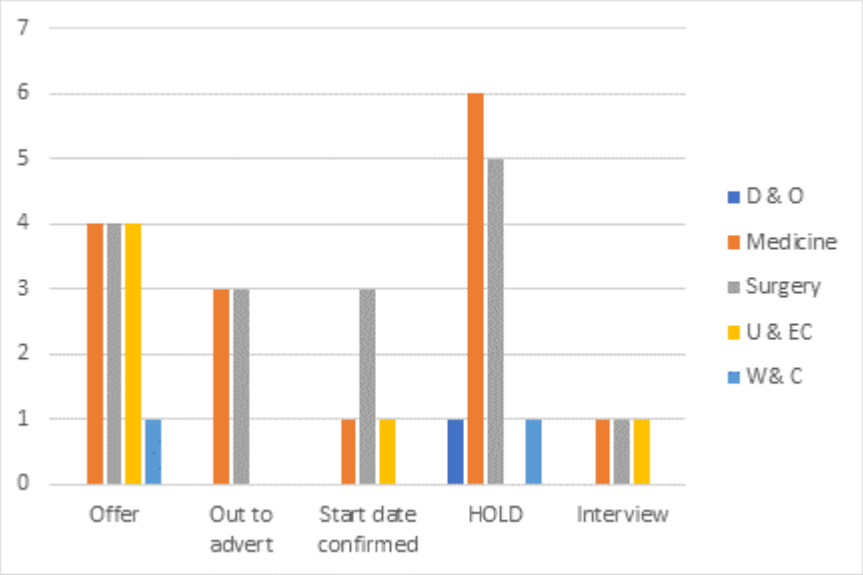
82% of doctors have a signed off job plan for this year, this number far exceeds any other Trusts in the region. In addition, there are currently 79 in year changes currently being made to job plans, 31 of the 79 are in discussion whereas 21 are going through the sign off process.

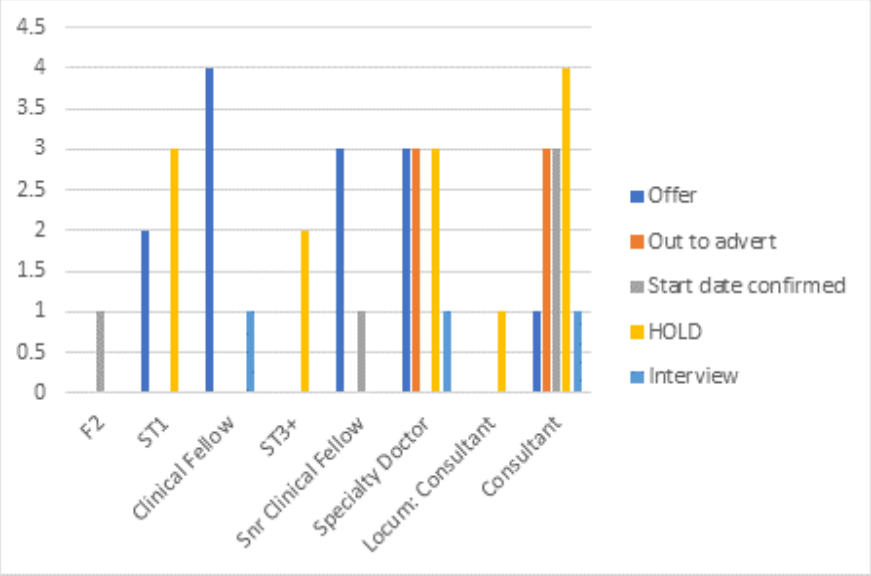
As soon as job plans are fully signed off any changes to programmed activities are reported to pay services to enable changes to salaries to be made in a timely manner.

The Trust job planning toolkit is currently being reviewed in preparation for the 2023/24 round of job planning. This will be presented to the LNC meeting in November, after which it is expected that the job planning process will commence.

Belonging in the NHS

Medical Vacancies





The tables above show the current medical vacancies by Division and grade. These figures don't include any newly established posts. As can be seen from the above, good progress is being made in recruiting to the vacancies. As previously reported, there is a continued focus on recruitment in both Anaesthetics and Critical Care with a Task and Finish group having been established and meeting regularly, recruitment plans have been developed for both specialties with good progress being made.

With regard to Anaesthetics, there has been a review of the establishment which has led to a number of posts at all grades being created. Both the fixed term Consultant and the Specialty Doctor vacancies have been advertised and have attracted some interest. Shortlisting is taking place for both posts and interviews are planned week commencing 7th November.

Recruitment for the substantive Consultant and Specialist vacancies is also in progress.

Intensive Care have three remaining vacancies at Consultant level, interviews will be held in November for one substantive post, a candidate who was previously offered a post and declined the post has expressed an interest in a fixed term consultant post and this is being progressed. A trainee has also expressed an interest in coming to Sherwood Forest Hospitals on completion of their training in October 2023.

The other two vulnerable services across the Trust are Haematology and Gastroenterology, whilst neither of these specialties are currently actively recruiting, work is ongoing in both specialties including plans for establishment of speciality Task & Finish groups.

The Trust has recently entered into a single agency agreement with Remedium Partners who are supporting the Trust with the recruitment to the hard to fill vacancies. This arrangement has just commenced, and to date one candidate has been appointed to a fixed term consultant post with five candidates being interviewed for Senior Clinical Fellow and Specialty Doctor vacancies over the next two weeks.

The Operational Medical Transformation Group for Medical Workforce has now been established and is focusing on a number of areas including agency expenditure and in particular, the tracking of agency doctors covering vacant posts.

Bank Rates

Work is being undertaken both across the ICS and within the Trust to review the current bank rates. The BMA released rates that it expects to be paid for work undertaken by both consultants and middle grade doctors that is in addition to their contract. These rates are not supported by NHS Employers. However, it is acknowledged that the current Trust bank rates are not equitable across specialties and therefore the review is being undertaken of the rates, together with an escalation process, pending the completion of the work across the ICS along with a regionally review using the East, and West, Midlands Acute Providers forum. The revised bank rates will be presented to the LNC in November.

Trainees

Junior Doctors Changeover in August

The Trust was allocated 230 posts, of these, 216 (94%) of the posts were filled. This is the highest fill rate to date. There are a number of reasons why the Trust don't receive a full allocation of trainees, these can include trainees not passing exams and therefore not being able to take up the posts, trainees declining offers where they have obtained a job elsewhere or there has been a change in personal circumstances. The Trust has a good relationship with Health Education East Midlands and they will endeavour to give the Trust as much notice as possible of likely vacant training posts, so that alternative arrangements can be made in good time. Most of these vacancies have been or are in the process of being filled by Clinical Fellows or Foundation Year 3 doctors, taking a year out of training following completion of the formal Foundation Programme.

The table below shows the percentage fill rate by Division.

Division	Percentage Fill Rate
Medicine	97% (2 vacancies)
Women & Children's	96% (2 vacancies)
Surgery	95% (4 vacancies)
Diagnostics & Outpatients	87.5% (1 vacancy)
Urgent & Emergency Care	79% (5 vacancies)

The new rotas in Medicine as described in the previous paper are in place and initial indications are positive, these rotas provide much improved coverage across the Division. A questionnaire will be sent to the trainees next month to obtain more formal feedback.

An opportunity has arisen for the Trust to bid for additional trainee posts at St3+ level for August 2023. The Trust has bid for an additional 17 posts. It is at this more senior grade of trainee where additional support is needed as there hasn't been an allocation of this grade of trainee since 2008, therefore should any of the bids be successful this will provide much needed senior support enabling the development of more robust rotas.

Specialists, Associate Specialists and Specialty Doctors (SAS)

Two SAS Advocates have recently been appointed. The role of a SAS advocate is key in maintaining a strong level of engagement and collaboration amongst SAS staff. And was introduced with the SAS contract reform in 2021. Whilst this role isn't mandatory, the Trust has felt that it is important to invest in this role to support our SAS workforce. We are one of two Trusts in the region that have invested in the SAS Advocate role.

10th to 14th October 2022 was the SAS doctors week where a number of articles from SAS doctors were included in the Bulletin and one of the Advocates and the SAS Tutor attended the team brief.

The Medical Workforce

The Medical Workforce at Sherwood Forest Hospitals is made up of 585 doctors, 342 (58%) Male, 34 of which work less than full time. There are 243 (42%) female doctors 55 of which work less than full time.

Age Profile of the Medical Workforce

Age Band	Headcount	% Heads	FTE
21-25	48	8.21	48.00
26-30	107	18.29	106.31
31-35	79	13.50	76.91
36-40	91	15.56	87.54
41-45	81	13.85	78.14
46-50	61	10.43	59.30
51-55	45	7.69	42.93
56-60	43	7.35	39.95
61-65	20	3.42	16.25
66-70	7	1.20	6.13
>=71 Years	3	0.51	1.35
Grand Total	**585**	**100.00**	**562.79**

The majority of our trainees and Clinical Fellows will be in the top 3 age bands. These are our transient Medical Workforce, the trainees will be rotating between Trusts whilst the majority of our Clinical Fellows will leave after two years to obtain a training post.

Our substantive Medical workforce are in the last 8 age bands. The table shows that there is a significant number of substantive Medical Staff over 50 years of age (118 in total). With the current pension rules, the Trust has seen a significant number of Medical Staff retire, or retire and return where in some cases they have returned on a less than full time basis. Whilst work is ongoing locally to look at mitigating the impact of the pension rules, it is likely that this trend will continue.

Conclusion

Whilst the Trust has robust controls in place to manage day to day operational medical staffing demands and gaps, there are a number of more strategic areas that will facilitate our recruitment and retention plans for the future medical workforce at the Trust.

Trust Board is asked to;

- Note the contents of the report,
- Recognise that this work cuts across and feeds into a number of other areas of focus including the Guardian of Safe Working report, Strategic Direction of Medical Training and Education at the Trust and the Medical Transformation Programme.

Meeting of The Board of Directors – 3rd November 2022

SFH – Emergency Preparedness Self- Assessment Against 2022 NHSE Core Standards

Introduction

Annually the Trust must submit an assessment of its preparedness to respond to emergencies and major incidents to NHS England/Improvement.

This is done via a spreadsheet submission, rating compliance against a number of core standards.

The standards are split (this year) into 49 questions within ten sub-categories as follows:

- Governance
- Duty to Assess Risk
- Duty to Maintain Plans
- Command and Control
- Training and Exercising
- Response
- Warning and Informing
- Cooperation
- Business Continuity
- CBRN

The organisation should rate whether it is Fully, Partially, or Non-compliant against each of the 49 questions, and of course be able to provide the necessary evidence.

The assessment is then subject to a “confirm and challenge” session with NHSE Region Team and the ICB .

For information the results since 2017 have been as follows:

2017 - Partially Compliant

2018 - Substantially Compliant

2019 –Substantially Compliant

2020 - Process was suspended

2021 – Substantially Compliant

2022 Submission

There are four possible outcomes from the self-assessment, which are:

Fig 1

Organisational rating	Criteria
Fully compliant	The organisation if fully compliant against 100% of the relevant NHS EPRR Core Standards
Substantial compliance	The organisation is fully compliant against 89-99% of the relevant NHS EPRR Core Standards
Partial compliance	The organisation is fully compliant against 77-88% of the relevant NHS EPRR Core Standards
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS EPRR Core Standards

The individual ratings are prepared by the Emergency Planning Officer and agreed at the Trust's Resilience Assurance Committee (this year this was on September 20th).

The following submission was agreed for this year:

Fig 2

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	10	7	3	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0

Warning and informing	4	4	0	0
Cooperation	4	2	2	0
Business Continuity	10	6	4	0
CBRN	14	14	0	0
Total	64	53	11	0

No areas this year were deemed non-compliant though there have been a number of areas moved from Full to Partial, which is mainly due to a more rigorous approach adopted during the confirm and challenge process and less tolerance or perceived policy gaps etc.

The gaps in compliance were as follows:

Governance	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.

Action – EPO to ensure the EP Policy highlights the process by which the Board reviews the EP resource annually.

Duty to maintain plans	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment

Action – EPO to ensure the Mass Countermeasures Plan to be amended to outline arrangements for self-presenters in ED.

Duty to maintain plans	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.

Action – EPO to make amendments to existing plan to reflect the latest national guidance.

Duty to maintain plans	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.

Action – EPO to ensure "Carbon Steeple" action card is added to the CBRN plan .

Response	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).

Action – EPO to make amendment to ensure arrangements are captured incident response plans.

Cooperation	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.

Action – EPO to ensure arrangements for requesting military aid is captured in IRP.

Cooperation	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.

Action – Information Sharing Protocol to be replaced with updated version.

Business Continuity	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.
Business Continuity	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).
Business Continuity	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure

Action – EPO to undertake full review of BCMS

Business Continuity	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.

Action – IT and data protection staff to ensure the data protection toolkit is compliant when next submitted

The foregoing means that the outcome of the process is that the Trust now has a **Partial Compliance** rating.

Confirmation Process

The submission was sent to NHSEI Regional EPRR team on 26th August this year, with copy to our ICB, both of whom then attended r a "confirm and challenge" session with the Chief Operating Officer (the Trusts Accountable Emergency Officer (AEO) and the EPO on 7th October.

The outcome was presented to Risk Committee on 11th October.

Conclusions

The assurance process in 2022 was, as a whole system, far more rigorous than previous years and NHSE colleagues have challenged on a line – by – line basis each policy, plan and procedure presented as evidence. The resultant effect is that SFH is far from alone in having its rating downgraded this year.

Positively however, many of the shortcomings require small and simple amendments to documents to regain compliance.

Recommendation

The Board is requested to be **UPDATED** of the submission and the "Partial" compliance rating. For 2022.

End

By Mark Stone

Emergency Planning & Business Continuity Officer

November 2022

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Emergency Preparedness (EPRR) Core Standards Self-Assessment	**Date**: 3rd November 2022	
Prepared By:	Mark Stone – Emergency Planning Officer		
Approved By:	Rachel Eddie – Chief Operating Officer		
Presented By:	Maggie McManus – Deputy Chief Operating Officer		

Purpose		
The purpose of the paper is to update the Board with the outcome of this years annual self-assessment against NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR).	**Approval**	
	Assurance	
	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	

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	x
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Resilience Assurance Committee (September 2022)
Risk Committee (October 2022)

Executive Summary

Annually the Trust must submit to NHS England a self-assessment of its Emergency Preparedness, Resilience and Response (EPRR) arrangements by rating itself against the Core Standards, which are designed around the six legal obligations the Trust must comply with under the Civil Contingencies Act (2004).

There are four possible outcomes from the process:

Full Compliance
Substantial Compliance
Partial Compliance
Non-Compliant

For the past three years the Trust has held a Substantial Compliance rating.

The Emergency Planning Officer completes the assessment, after gathering and preparing the required evidence. The assessment is then subject to a confirm and challenge session led by NHS England and our ICB partners.

This year the process was much more rigorous than previous years and highlighted minor gaps in plans, previously deemed good and compliant. The Trust rating this year has therefore dropped to

Partial Compliance.

The following table shows the categories against which the assessment is judged and the non or partially compliant areas:

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	1	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	10	7	3	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	2	2	0
Business Continuity	10	6	4	0
CBRN	14	14	0	0
Total	64	53	11	0

Some of the partially compliant areas related to a specific line in a plan or policy.

In no area was the Trust non-compliant. A number of the partially compliant sections have already been addressed and the EPO will work to address the remainder over the coming weeks and months.

It should be noted that SFH is not an outlier in having its score downgraded, as our colleagues at other partners have returned similar results.

Recommendation

The Board of Directors is asked to note the result of the 2022 Core Standards self-assessment process.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Incident Response Plan 2022	**Date**: 3rd November 2022	
Prepared By:	Mark Stone – Emergency Planning Officer		
Approved By:	Rachel Eddie – Chief Operating Officer		
Presented By:	Maggie McManus – Deputy Chief Operating Officer		
Purpose			
The purpose of the paper is to gain approval/ratification for the updated Incident Response Plan (formerly the Major Incident Plan)		**Approval**	x
		Assurance	
		Update	
		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	

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	X
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

The ICB
NHSE Region Team
The Resilience Assurance Committee
Risk Committee

Executive Summary

The Trust's Incident Response Plan is one of the most important documents it possesses at it sets out a framework in which the Trust would respond to and recover from serious incidents.

The document outlines arrangements for command and control of an incident and clearly identifies roles and responsibilities.

The plan also contains action cards for key individuals who would be involved directly in the response and useful contact details for external escalations.

The changes to the document are largely the result of updated guidance, or feedback from the 2021 and 2022 EPRR self-assessment processes.

The majority of the document is unchanged since the 2019 version, but here is a summary of the main changes:

Summary of Changes

1. Title – from Major Incident Plan to Incident Response Plan
2. Section 1.7 (Plan Review) – clarity about the annual and 3 yearly review processes
3. Section 1.8 (Governance) – updated organizational structure for HEPRR
4. Section 1.10 (National Threat Levels) – added to plan
5. Fig 3 : Activation Flowchart – wording change
6. Fig 5: Incident Levels Escalation and De-escalation – added to plan
7. Fig 6: Incident Declaration Guide -flowchart added to plan
8. Section 2.2 (Plan Activation) – detail added regarding on-call escalation
9. Section 2.6 (Regional Mass Casualty Dispersal – reference to the Concept of Operations guidance stating the requirement to free up 20% bed capacity within 12 hours
10. Section 2.7 (Mutual Aid) – guidance added to plan
11. Section 3.1 (Structure) -diagram insertion
12. Section 3.1 (Structure) – reference to defensible decision-making added
13. Fig 7: EPRR Response Structure for NHS in England – updated table.

The document has been shared with NHS England and ICB partners and has been reviewed and approved by both the Resilience Assurance Committee and the Risk Committee. It should also be noted that the EPRR assurance process recently conducted against our Core Standards submission made a request for only two small admissions to the document, which are contained in this version.

The main document is over 200 pages (including the action cards) and is available to read in Reading Room for Board Members

Recommendation

The Board of Directors is asked to **APPROVE** the updated Incident Response Plan (2022).

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Chair's Highlight Report to Trust Board

Subject:	Finance Committee meeting	**Date:** 25th October 2022	
Prepared By:	Richard Mills - Chief Financial Officer		
Approved By:	Andrew Rose-Britton – Finance Committee Chair		
Presented By:	Andrew Rose-Britton – Finance Committee Chair		
Purpose			
The paper summaries the key highlights from the Finance Committee meeting held on 25th October 2022		**Assurance**	**Sufficient**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• At Month 6 the Trust has reported an adverse variance to the financial plan and a number of risks remain in relation to the forecast outturn. • Board Assurance Framework Principle Risk 4 remains at a score of 16 (Significant) in recognition of the financial risks facing the organisation.	• National Cost Collection update paper to be provided to December 2022 meeting, to provide analysis of outcomes and benchmarking. • MRI business case to be amended ahead of an extraordinary meeting of the Finance Committee to consider approval.
Positive Assurances to Provide	**Decisions Made**
• ICS Financial update received and aligned to SFH reporting. • The Trust's Planning Oversight Group has begun the process of planning for 2023/24. • Assurance received on NHIS financial and operational performance. • Strategic Priority 5.1 (in relation to Transformation & Efficiency) update discussed and assurance received. • Procurement Forward View discussed, providing assurance on contract management and advanced notice of upcoming projects. • PFI contract performance and governance reported and discussed. • National Cost Collection return submitted in line with national timescales.	• Additional meeting of the Finance Committee to be scheduled in November 2022, to maintain focus on financial performance. • Renewal of mobile phone contract approved in accordance with Scheme of Delegation. • Agreed that updates on Strategic Priority 2.1 (in relation to the SFH Green Plan) would be provided to Finance Committee on a routine basis. • Agreed that the tolerable level for Board Assurance Framework Principal Risk 4 should remain at a score of 12. • Graham Ward appointed as Vice Chair of the Finance Committee. • Amendment to workplan agreed. • Annual meeting schedule, including Single Item Agenda meetings, approved.
Comments on Effectiveness of the Meeting	
All papers and verbal reports were of a high quality which enabled discussion and decisions to be made in an assured way.	

Healthier Communities, Outstanding Care

NHS 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:** 25/10/22	
Prepared By:	Manjeet Gill, Non-Executive Director		
Approved By:	Rob Simcox, Director of People		
Presented By:	Manjeet Gill, Non-Executive Director		
Purpose			
		Assurance	**X**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
An update on appraisals and mandatory training gave detailed assurance of work underway. Following a review of PR3 and PR5 risks in the Board assurance framework, Committee decided to increase the risk level for PR3 due to threat of industrial action. The risk for PR5 were kept at the same level. Some of the gaps in assurance highlighted in the report were felt to have been addressed with the assurance received during the committee in areas such as mental health and cost of living part of the Winter Wellbeing Plan report Two areas of potential risks on the horizon are industrial action and impact of pensions and further assurance was provided on mitigation actions, which included an industrial action taskforce and collaboration at system level. A workshop on improvement looked at the key issues for improvement and more assurance was sought on the 3 or 4 key	The improvement strategy and work updated once further developments have taken place following the workshop discussion. The Equality Diversity and Inclusion strategy and work will receive regular updates to the committee. An update on the workforce plan implementation plans, especially a focus on the immediate critical areas and actions being taken to mitigate. This was referred to as 'fragile' services in both clinical and non-clinical areas.

strategic areas of focus, outcomes, capacity and teams motivated and empowered to deliver improvement, a ongoing areas of work.	
Positive Assurances to Provide	**Decisions Made**
Positive assurance was received in various areas such as wellbeing, Employee relations, freedom to speak up. The safe staffing report for nursing, gave a quarterly update with positive news that band 5 nurse vacancies fell below 100 in September. The quarter 2 report, for the People, Culture and Improvement Strategy highlighted the range of activity. Positive assurance in areas of leadership, culture, equalities, diversity and recruitment. A report on the system level work on people and workforce gave detailed assurance on the workstreams, governance structures and deliverables.	The Committees Annual Workplan was updated and approved for the forthcoming year Board to receive assurance on industrial action if this matter escalates into industrial action. The Committee appointed Steve Banks as Vice Chair to the Committee
Comments on Effectiveness of the Meeting	
The Committee's agenda has many important reports and items for assurance and the ongoing challenge is ensuring that enough time is given to a subject area as well doing this in an efficient and timely manner. Further thought also to how we triangulate beyond committee and board reports, including walkabouts or meetings with key colleagues and service areas.	