Sherwood Forest Hospitals NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: Thursday 4th August 2022
Time: 09:00 – 12:30
Venue: MS Teams

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 7th July 2022** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Matters Arising/Action Log**	Update	Enclosure 5
6.	09:10	**Chair's Report**	Assurance	Enclosure 6
7.	09:15	**Chief Executive's Report** • **Integrated Care System Update** Report of the Director of Strategy and Partnerships	Assurance Assurance	Enclosure 7 Verbal
	Strategy			
8.	09:30	**2022/2023 Strategic Priorities Quarter 1 Update** Report of the Director of Culture and Improvement	Assurance	Enclosure 8
9.	09:45	**Strategic Objective 1 – To provide outstanding care** • **Maternity Update** Report of the Director of Midwifery o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model** o **Home Births Update**	Assurance	Enclosure 9.1
10.	10:05	**Strategic Objective 2 - To promote and support health and wellbeing** • **Freedom to Speak Up** Report of the Freedom to Speak Up Guardian	Assurance	Enclosure 10.1

	Time	Item	Status	Paper
11.	10:25	**Staff Story – The Story of Little Millers** Rebeca Freeman, Head of Medical Workforce, Deborah Hall, Day Nursery Manager and Sarah Bown, Day Nursery Manager	Assurance	Presentation
	BREAK (10 mins)			
	Operational			
12.	10:55	**Single Oversight Framework Performance – Quarterly Report** Report of the Executive	Consider	Enclosure 12
13.	11:40	**Board Assurance Framework** Report of the Chief Executive	Approve	Enclosure 13
	Governance			
14.	11:50	**Use of the Trust Seal** Report of the Director of Corporate Affairs	Assurance	Verbal
15.	11:50	**External Well-led recommendations, progress report** Report of the Director of Corporate Affairs	Assurance	Enclosure 15
16.	12:00	**COVID 19 Inquiry process** Report of the Director of Corporate Affairs	Assurance	Enclosure 16
17.	12:10	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • People, Culture and Improvement Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance Assurance	 Enclosure 17.1 Enclosure 17.2 Enclosure 17.3 Enclosure 17.4
18.	12:20	**Outstanding Service – National Breast Feeding Awareness Week**	Assurance	Presentation
19.	12:25	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
20.	12:30	**Any Other Business**		
21.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **1st September 2022, MS Teams (TBC)**		
22.		**Chair Declares the Meeting Closed**		
23.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

Board of Directors Information Library Documents

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

Enc 07	• **Estates Return Information Collection (ERIC) submission 2021-2022**
Enc 13	• **Significant Risks Report**
Enc 17.1	• **Audit and Assurance Committee – previous minutes**
Enc 17.2	• **Finance Committee – previous minutes**
Enc 17.3	• **Quality Committee – previous minutes**
Enc 17.3	• **Quality Committee Terms of Reference**
Enc 17.4	• **People, Culture and Improvement Committee – previous minutes**

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of a Public meeting of the Board of Directors held at 09:00 on Thursday 7th July 2022 via video conference

Present:	Claire Ward	Chair	CW
	Manjeet Gill	Non-Executive Director	MG
	Graham Ward	Non-Executive Director	GW
	Barbara Brady	Non-Executive Director	BB
	Steve Banks	Non-Executive Director	SB
	Aly Rashid	Non-Executive Director	AR
	Andrew Rose-Britton	Non-Executive Director	ARB
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	Richard Mills	Chief Financial Officer	RM
	Phil Bolton	Chief Nurse	PB
	Emma Challans-Rasool	Director of Culture and Improvement	EC
	Maggie McManus	Chief Operating Officer	MM
	Rob Simcox	Director of People	RS
	David Selwyn	Medical Director	DS
	David Ainsworth	Director of Strategy and Partnerships	DA
In Attendance:	Sue Bradshaw	Minutes	
	Danny Hudson	Producer for MS Teams Public Broadcast	
	Rich Brown	Head of Communications	
	Paula Shore	Director of Midwifery	PS
	Elizabeth Gemmill	Head of Research	EG
	Beth Carey	Falls Prevention Practitioner	BC
	Carl Miller	Deputy Chief Nurse & Associate Director of AHPs	CM
Observers:	Penny Darby	Corporate PA	
	Andrew Marshall	Deputy Medical Director	
	Mitchel Speed	Patient Experience Officer	
	Claire Page	360 Assurance	
	5 members of the public		
Apologies:	Shirley Higginbotham	Director of Corporate Affairs	SH

The meeting was held via video conference. All participants confirmed they were able to hear each other and were present throughout the meeting, except where indicated.

Item No.	Item	Action	Date
18/471	**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, via video conferencing 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. All participants confirmed they were able to hear each other.		
18/472	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
18/473	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Shirley Higginbotham, Director of Corporate Affairs.		
18/474	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors in Public held on 9th June 2022, the Board of Directors APPROVED the minutes as a true and accurate record.		
18/475	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 18/433.1, 18/433.2, 18/433.3, 18/438.1 and 18/438.2 were complete and could be removed from the action tracker.		
18/476	**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 reintroduction of the requirement to wear facemasks across the Trust and other Infection Prevention and Control (IPC) measures due to the increase in the number of Covid infections. The Board of Directors were ASSURED by the report		
18/477	**CHIEF EXECUTIVE'S REPORT**		
4 mins	PR presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective, highlighting the current intense pressure experienced by the Trust, the increase in the rate of Covid infections, the creation of Integrated Care Boards (ICB) from 1st July 2022 and Pride month.		

	PR welcomed David Ainsworth, Director of Strategy and Partnership, to his first meeting of the Board of Directors. It was acknowledged this is the first Board of Directors meeting for Richard Mills and Rob Simcox in their substantive roles of Chief Financial Officer and Director of People respectively. PR advised Rachel Eddie will be taking up her role as Chief Operating Officer for the Trust at the end of July. The Board of Directors were ASSURED by the report		
2 min	**Integrated Care System (ICS) Update** DA introduced himself and his role to the Board of Directors, advising there will be interesting opportunities ahead, with partnerships at the heart of the conversation. The NHS is moving away from commissioning and competition to a world of integration, which will require relationships and trust. There is a need to work together to address some of the inequalities which exist and there is an opportunity to create public value with partners by coming together in new ways. The Board of Directors ACKNOWLEDGED the update		
7 mins	**COVID-19 Vaccination Update** RS presented the report, highlighting the system position in relation to uptake of the spring booster, summer plans and the Autumn booster programme, which is anticipated will start early in September. The Trust is planning to co-administer the Covid booster and flu vaccinations. Due to the current low levels of activity, RS advised Covid vaccination updates to the Board of Directors will be paused until the Autumn booster programme commences. AH felt it would be useful for the position in terms of the unvaccinated population to be included in future reports. RS advised he will obtain visibility on the gap and provide assurance on the steps being taken to mitigate the gap. **Action** • **Information re: people who are unvaccinated to be included in future reports** DS advised there are some logistics issues to be worked through in terms of the co-administration of the Covid and flu vaccinations, as they are separate vaccines. The Board of Directors were ASSURED by the report	**RS**	**06/10/22**
18/478	**STRATEGIC PRIORITY 1 – TO PROVIDE OUTSTANDING CARE**		
9 mins	**Maternity Update** PS joined the meeting		

	Safety Champions update PB presented the report, highlighting concerns raised in relation to antenatal capacity at Newark, feedback from Safety Champion walkarounds, introduction of different coloured lanyards to identify different roles, Ockenden actions and SCORE safety survey. PS provided an update on the NHS England programme of avoiding term admissions to the neonatal unit. The Board of Directors were ASSURED by the report ***Maternity Perinatal Quality Surveillance*** PB presented the report, highlighting 3rd/4th degree tears and intrapartum stillbirth. PB advised the home birth service is scheduled to be reinstated on 4th September 2022. BB sought an update regarding the Continuity of Carer work. PS advised plans were submitted by 16th June 2022, as per the national request, including staffing profiles. The Trust's plan is aligned to Nottinghamshire within the Local Maternity and Neonatal System (LMNS). Once feedback is received, this will go through the assurance committees to discuss next steps. PB advised there is a need to have a system response. The Board of Directors were ASSURED by the report PS left the meeting		
18/479	**STRATEGIC PRIORITY 4 – TO CONTINUOUSLY LEARN AND IMPROVE**		
17 mins	**Research Strategy – Quarterly Report** EG joined the meeting EG presented the report, highlighting recruitment, finance, studies which have changed practice and the strategy for 2022-2027. MG noted there are some areas where there is no research activity, for example, diabetes and emergency care, and queried if there is any reason for this and how involvement in research can be encouraged. EG advised ED has been involved in studies, particularly relating to Covid, so there is interest in research. There are a number of active principal investigators across specialities. However, Board of Directors and divisional support would be appreciated to help people to recognise this is a priority. There is a need to appreciate the importance of research for patients and the Trust. It is recognised trusts which are actively involved in research get better outcomes for their patients. AR queried to what extent income from research covers the salary costs for people engaged in research within the Trust.		

	EG advised the majority of the research budget goes to the nursing staff who support research, with a small amount going to the medics involved with research. The money goes to the department for them to decide how it is allocated. The income provides fully for all the nursing staff, with just a small amount for medical staff. AR queried if there will be opportunities to fund appointments in medicine with more integrated research with Nottingham University Hospitals (NUH). EG advised this is something the Trust would be interested in being involved with. AH queried how the benefit within the population from grants which are held in Nottingham can be tracked. EG advised there will be different approaches depending on whether SFHFT is part of Nottingham's research as opposed to the Trust's own research. Patients come first and there is a need to get them involved in quality trials and a diverse range of studies, both those of benefit from a public health perspective which require partnership working and those which involve care provided at SFHFT. PR advised the two universities in Nottingham are working together and have a strong appetite to work with SFHFT and NUH. SB sought clarification in relation to studies which have changed practice as it appears all the activity over three years has only resulted in three changes. EG advised the three Covid related studies are highlighted in the report. Each study the Trust has been involved in has made a difference. ARB queried if there are any actions which can be taken to increase engagement with commercial organisations and if there is any merit in pursuing this. EG advised ensuring the studies are right for the Trust's patients is the priority. Commercial income is welcomed and it is hoped once the increased research facilities are opened in 2023, the Trust will be able to open up to those opportunities which are not currently available due to lack of facilities. The Board of Directors were ASSURED by the report EG left the meeting		
18/480	**PATIENT STORY – WALK THIS MAY**		
18 mins	BC and CM joined the meeting BC presented the Patient Story which highlighted National Walking Month and falls prevention work. CW felt the story was a good example of the work the Trust is doing to support patients. PR felt the story highlighted the importance of keeping active. EC advised colleagues across the organisation also got involved in 'Walk this May', accumulating nearly 5,500km. PB felt it was a timely and helpful story, demonstrating the falls prevention work which is ongoing within the Trust.		

	GW felt the patient comments were very powerful, demonstrating how important it is for the patient to feel they can progress. CM advised it is important to take a Multidisciplinary Team (MDT) approach to mobility and activity which will help promote a better discharge for the patient. DA noted people receiving homecare can become immobile, which may lead to a hospital admission. DA queried what value the Trust can offer in the community to promote mobility. BC advised she is part of a project working in a community practice with Nottinghamshire Healthcare colleagues in relation to falls prevention. Two community practice events have been held and a digital space is being created for clinicians to liaise between events. BC and CM left the meeting		
18/481	**SINGLE OVERSIGHT FRAMEWORK (SOF) MONTHLY PERFORMANCE REPORT**		
35 mins	**QUALITY CARE** PB highlighted falls, nosocomial Covid and clostridium difficile (C.diff) DS highlighted Venous Thromboembolism (VTE) risk assessments. **PEOPLE AND CULTURE** EC highlighted appraisals, mandatory training and improvement work. RS highlighted sickness absence, wellbeing agenda and vacancy rate. **TIMELY CARE** MM advised the ED 4 hour wait was 80%. The Trust performed well compared to peers. However, it was acknowledged patients are waiting longer than would be preferred. In terms of elective care, MM advised the Trust is not achieving the standard for follow up of outpatient attendances. This has been declared in the ICS plan. In terms of cancer, national performance against the cancer backlog trajectory has slipped and the Trust's position has also deteriorated, mainly due to delays at the tertiary centres the Trust works with. However, the Trust's 62 day performance is better than the national average and SFHFT continues to perform well against the faster diagnosis standard. There is a new governance structure in place for the cancer pathway which is clinically driven and drills down into tumour site level detail. CW queried what patients' views are on virtual appointments and if this has this increased as people are considering the additional costs of travelling to a face to face appointment.		

	MM advised the work of the virtual appointments project group is still ongoing. There is a considerable cohort of patients who prefer face to face appointments but work is ongoing to understand this and the travel cost implications. CW advised feedback from patients in relation to what the barriers for virtual appointments might be would be useful. DS advised virtual appointments are a national direction. There has been a mixed response from clinical teams and patient groups. While virtual appointments work well for certain groups of patients and conditions, this is not the case for all. Therefore, there is a need to identify which patients and/or conditions would benefit from virtual appointments. AR queried, in terms of complex cancer cases, if the Trust has explored the possibility of surgeons from the tertiary centre to come to SFHFT to undertake operations. MM advised several things have been explored to try to reduce the reliance on, or the availability of, capacity at places such as NUH, including looking to other tertiary centres to ensure patients are getting the right care. The option of mutual aid has been explored, using SFHFT's ability to undertake some lower complexity cancer work, which will then allow NUH to reduce their waiting times and deal with the more complex cases sooner. The ICS cancer taskforce is looking at how partners work across the system to improve cancer care for patients. DS advised the surgical event is only part of the whole perioperative care journey of the patient. There is a need to put the patient at the centre and design pathways around the care they need. The risk of moving surgeons from one organisation to another is any benefit of dealing with the surgical event will be lost as the rest of the team who need to care for the patient will not be moved as well. AH queried how much progress had been made in relation to putting measures in place at a system level to address the issue of patients who are medically fit for discharge, how many will reach activity before Winter and what impact will they have. MM advised some initiatives are further developed than others. Virtual ward will give some benefit over Winter. In terms of Discharge to Assess, work is ongoing in terms of what this will 'look like' and a more health focussed review is underway. The impact of Discharge to Assess in its current form is not what was expected. The system is not where it needs to be in terms of reducing the number of medically safe for discharge patients. PR advised there is a lot of work ongoing in the system with partners in relation to Discharge to Assess and seeking solutions. The NHS providers are taking greater control to find a solution to the risks which are noted for Winter. **BEST VALUE CARE** RM outlined the Trust's financial position at the end of Month 2. ARB queried if the cash position is likely to deteriorate further.		

	RM advised a cash plan for the remainder of the year was resubmitted as part of the updated plan submission. Tight working capital arrangements are in place to ensure this is managed. The cash position is reviewed on a daily basis and this fluctuates through the month. NHSE/I have facilities in place for when cash support in year may need to be accessed. GW noted there are significant risks for the remainder of the year, for example, Covid, inflation and pay awards, and felt it may be useful to provide an update to the Board of Directors in relation to this. RM advised a full detailed forecast and sensitivity analysis on the Q1 position will be reported to the Finance Committee in July. **Action** • **Full detailed forecast and sensitivity analysis on the Q1 position to be reported to the Finance Committee** The Board of Directors CONSIDERED the report	**RM**	**04/08/22**
18/482	**CANCER CAPACITY**		
9 mins	MM presented the report which outlined the outcome of a review of the benefit of converting routine elective capacity to cancer capacity, highlighting the main findings of the investigation and mitigations. AH noted the flexibility and adaptability to let clinicians decide how they distribute the workload is more effective than routinely taking down segments of activity. The Board of Directors were ASSURED by the report		
18/483	**DATA SECURITY PROTECTION TOOLKIT (DSPT) SUBMISSION**		
6 min	DS presented the report, advising the report provides an overview of the Trust's compliance with the Information Governance (IG) and security agenda, both nationally and locally. 108 of the 109 mandatory evidence items are complete. The evidence item which is not complete renders the submission standards as not met. This is in relation to staff achieving 95% of their annual Data Security Awareness Training. The independent auditors have provided their overall assessment on the DSPT as Moderate. Of the ten areas assessed, nine gained substantial assurance with one area Moderate. The Moderate outcome relates to Business Continuity. Work is in play to strengthen and improve this position. There have been three incidents which have been escalated as reportable to the Information Commissioners Office during 2021/2022. At present none of these has resulted in action from the regulators as the Trust has provided appropriate assurance.		

	It was noted during 2021/2022, the Trust processed a total of 600 Freedom of Information (FOI) requests and 2810 requests for access to patient records. CW queried if there are any themes in relation to the FOI requests received. DS advised themes usually follow the agenda of the national news, for example, waiting lists and backlogs. In addition, FOIs are received from commercial companies requesting information in relation to commercial relationships with providers, how many patients the Trust sends to alternative providers, etc. Requests are also received for research information as this is sometimes seen as an easier way to obtain information which is already in the public domain. Finally, there are a number of personal requests for information, but this is the smallest group. PR advised SH, as Senior Information Risk Owner, chairs the Information Governance Group which maintains the oversight of FOIs, subject access requests and the preparation and submission of the toolkit. The Board of Directors APPROVED the Data Security Protection Toolkit Submission		
18/484	**ASSURANCE FROM SUB COMMITTEES**		
8 mins	**Audit and Assurance Committee** GW presented the report, highlighting year end accounts, counter fraud, external audit, Head of Internal Audit Opinion, implementation of internal audit recommendations and non-clinical and clinical policies. **Finance Committee** ARB presented the report, highlighting approval of contract renewals. **People, Culture and Improvement Committee** MG presented the report, highlighting review of the Board Assurance Framework (BAF) risks, People, Culture and Improvement Strategy, deep dive into sickness absence and the people and development agenda across the system. The Board of Directors were ASSURED by the reports		
18/485	**OUTSTANDING SERVICE – CELEBRATING THE WORK OF OUR FREEDOM TO SPEAK UP (FTSU) GUARDIANS**		
8 mins	A short video was played highlighting the work of the FTSU Guardian and FTSU Champions.		

18/486	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 min	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Demand and pressure being faced by the organisation • Welcome to David Ainsworth as Director of Strategy and Partnerships • Integrated Care Board and the opportunity to strengthen system working • Maternity update • Research update • Patient Story • Cancer capacity		
18/487	**ANY OTHER BUSINESS**		
min	No other business was raised.		
18/488	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 4th August 2022 in the Boardroom at King's Mill Hospital at 09:00 (TBC) There being no further business the Chair declared the meeting closed at 11:30		
18/489	**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**		

18/490	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
5 min	CW advised a series of questions had been received in relation to the Covid vaccination, its impact on other conditions and how this relates to deaths. DS advised the current evidence does not support the view that any benefit of the Covid vaccination programme is outweighed by the side effects. Within the organisation and the system there are still vaccine preventable Covid-19 deaths, which has an impact on the clinicians caring for those patients, knowing the death could have been prevented. Equally, vaccine preventable flu related deaths have been seen. DS acknowledged people hold strong views, but expressed how disappointing it is as a clinician to see misinformation continuing. DS acknowledged there are some complications for some patients, but this is no different to any other drug. There is a 'yellow card system' in place and data relating to this is freely available in the public domain.		
18/491	**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
18/361	07/04/2022	Covid vaccination reports to show uptake of the flu vaccination when the flu vaccination campaign starts for 2022/2023	Public Board of Directors	None	06/10/2022	R Simcox			Grey
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
18/438.3	09/06/2022	Update on system waiting list performance to be provided to the Board of Directors	Public Board of Directors	None	01/09/2022	R Eddie			Grey
18/477	07/07/2022	Information re: people who are unvaccinated to be included in future Covid vaccination reports	Public Board of Directors	None	06/10/2022	R Simcox			Grey
18/481	07/07/2022	Full detailed forecast and sensitivity analysis on the Q1 position to be reported to the Finance Committee	Public Board of Directors	Finance Committee	04/08/2022	R Mills		**Update 28th July 2022** Forecast sensitivity analysis reported to Finance Committee on 26th July 2022 **Complete**	Green

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date**: 4 August 2022	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chair's perspective.		**Approval**	
		Assurance	**X**
		Update	**X**
		Consider	

Strategic Objectives				
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.

Welcoming our new Chief Operating Officer

We recently welcomed our new Chief Operating Officer, Rachel Eddie, to Sherwood Forest Hospitals at the end of July.

Rachel brings a wealth of experience and I'm sure will hit the ground running and make a real impact alongside our Deputy Chief Operating Officer, Maggie McManus, who has been brilliant in stepping-up as our Interim Chief Operating Officer over the past two months.

Rachel's arrival brings our Executive Team up to full complement, following the arrivals of Phil Bolton and David Ainsworth, and the substantive appointments of Richard Mills and Robert Simcox over recent months.

I look forward to working with them all to help make Sherwood Forest Hospitals an even more special place to work and receive treatment.

In the coming months, with our new executive and non-executive team, the Board will be considering the next phase of our strategy and how we meet the challenges facing our organisation. We are keen to develop our role as part of the Provider Collaborative, the Integrated Care System and the Place Based Partnership. All of these entities are important but for many members of the public they may not register with them as key drivers in the way in which health and care services will be delivered in coming years.

It is important that at SFHT, we find ways of helping our patients, the public and the wider community understand how services can adapt to meet their needs and why working collaboratively with other parts of the health and social care system is the best way to deliver improved outcomes.

Sharing #TeamSFH's experience of the pandemic with local schoolchildren

It was my pleasure to join colleagues from across Sherwood Forest Hospitals on a visit to The Joseph Whitaker School in Rainworth on Monday 11 July where we were invited to share our colleagues' experience of working for the NHS during the pandemic.

Engagement events like these are an essential part of our outreach to the local communities we serve and we hope that the stories we shared might just help to inspire the next generation of #TeamSFH doctors, nurses and staff!

I would like to pass-on my personal thanks to the school for arranging the reflection event, and welcoming my hardworking #TeamSFH colleagues to share their experiences of the pandemic with pupils, staff and parents at the school.

Governors' engagement events postponed due to rising COVID cases

Last month I was pleased to report that I had been out-and-about across our hospitals and encouraging our newly elected governors to do so too as part of our 15 Steps programme and the 'Meet your Governor' events.

While further 'meet your governor' events had been planned to take place in late July, the decision was taken to postpone those due to rising COVID-19 cases nationally, within the local community and in our own hospitals.

Both myself and our governors are committed to engaging with the Trust's membership in the longer-term and we look forward to being able to resume those engagement sessions in future. In the meantime, our governors continue to remain active in their communities to listen to the public about the services we provide at Sherwood Forest Hospitals.

Our annual Excellence Awards creates more opportunities to say 'thank you'

The Trust's annual *Excellence Awards* were officially launched recently to create an opportunity for our colleagues, patients, the public and our partners to say 'thank you' to our staff who they feel have gone above-and-beyond the call of duty in the past year.

A total of 18 awards will be handed-out at this year's annual celebration, which is due to be held on Friday 7 October.

The awards will also welcome nominations from members of the public for the *People's Award*, with members of the public and Trust partners encouraged to make their nominations before midnight on Sunday 21 August.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date**: 4 August 2022	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective.		**Approval**	
		Assurance	**X**
		Update	**X**
		Consider	

Strategic Objectives				
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.

Managing pressures in our hospitals

This month has seen the continuation of pressures across our services. This year, those pressures have extended far beyond those traditionally experienced during the height of winter and have recently been compounded by the recent red weather warning for extreme heat that was issued by the Met Office, resulting in a national incident being declared to help keep essential services running across the country.

Those pressures – including responding to the unique challenges presented by the extreme heat – continue to be managed as a truly Trust-wide response and I am grateful to my colleagues for their ongoing efforts in managing those pressures.

The Trust itself responded by holding daily incident meetings to manage its own response. Those meetings have now been stood-down and – as with any incidents of this kind – we will take the time to review what went well and draw upon colleagues' insights from across the Trust to understand how we can improve our incident response in future.

I also would like to express my thanks to all those who worked together to respond to the unprecedented challenges the heat presented to make things as comfortable as possible for the colleagues, patients and visitors in our hospitals during that time.

Reducing waiting lists for non-urgent treatments

We've been working with ICB colleagues to cut NHS waiting lists across Nottingham and Nottinghamshire, including by eliminating Sherwood Forest Hospitals' own two-year waiting lists for patients who have been waiting the longest to access the treatment they deserve.

Work to reduce those waiting lists will continue across the system and I thank all my hardworking colleagues for their efforts in helping to reduce those waiting lists to help our patients access their treatment as quickly as possible.

Vaccinations update

Our vaccine services team have been continuing their operational planning following the recent government announcement confirming which cohorts should be offered both a COVID-19 Vaccine Autumn Booster and a free flu vaccine from this autumn.

Our operational planning has been well underway for a number of weeks to ensure that those most at-risk of COVID and flu can boost their protection this autumn and winter.

We will continue those preparations to ensure that the Trust's vaccine services team can continue to be at the forefront of Nottingham and Nottinghamshire's vaccination programme this autumn and winter.

Pay award mention

The Government recently announced that NHS workers will be receiving a pay rise. That will be effective from 1 April 2022 with progressive distribution, meaning that the lowest bands on NHS Terms and Conditions Service will receive the greatest proportional uplift.

The Trust is waiting for the finer details to be communicated following the initial government announcement, which we will share details of with the Trust Board and our employees as soon as they are available and we are in a position to share those.

Ofsted re-inspection of our Little Millers Nursery

Colleagues at our Little Millers Day Nursery recently welcomed back Ofsted inspectors to the facility, who visited to re-inspect the facility in late July following the inspection which saw its overall rating downgraded earlier this year. While we are waiting to hear the outcome of its re-inspection, the initial feedback from inspectors recognises the progress made to address the points raised in its last inspection.

I would like to thank the Nursery team for how they have risen to the challenge of continuing to provide the best possible care for our Little Millers family and we look forward to sharing the outcome of this latest inspection with you – hopefully at our next public Board meeting.

Estates and Facilities 'Estates Return Information Collection'

The Executive Team recently approved the submission of the Trust's Estates and Facilities 'Estates Return Information Collection' (ERIC) for 2021/22, which forms the central collection of Estates and Facilities data from all NHS organisations in England during the fiscal year ending 31 March 2022.

All nominated leads participated in the data collection, taking ownership of their data. The Finance department played a vital role in providing all the financial data and have provided assurance that all data submitted reconciles back to the annual accounts and the quarterly NHSI Return. Professional support to manage the data collection and validation of the ERIC data return 2021/22 was undertaken by SAS Compliance.

Submissions are collated and the results reported via Model Health (formerly known as Model Hospital) which could result in efficiency opportunities being identified by NHSE. This will be considered when reports are made available in the autumn.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

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

Quarter 1 Update

Contents		Page

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

1. Summary – 'Q1 Position on a Page'

Ref	2022/23 Trust Priority	Executive Lead	Overall RAG
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
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	

Ref	2022/23 Trust Priority	Executive Lead	Overall RAG
3.2	Respond to the 2021 NHS Staff Survey. Identify Key Focus Areas.	Director of Culture and Improvement	
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	
5.1	Delivery of the SFH Transformation & Efficiency Programme that supports the delivery at PCB/ICP level.	Director of Culture and Improvement	
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 1 Update

Ref	2022-23 Trust Priorities	Executive Lead	SFH Governance	Measures of Success	Quarter 1 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	• The implementation of the new Friends and Family system is in its final stages. The system is now almost fully operational and being used to its full capacity. Once requested, staff can access reports on a monthly or weekly basis. • QR Codes have been piloted in the Maternity Ward, Sherwood Birthing Unit, Ward 25 and Ward 25 (CAU), Antenatal Clinic, Ward 14, GAU, EPU and Emergency Department (Newark and Kings Mill). This did not result in a large increase in feedback or collection of data. It was noted however that this was a useful method of feedback for our digital advanced patients. • Further training is planned around the new system with our teams within the Trust in order to highlight/identify any themes or trends within the departments. Questions can be changed at any time for Inpatients, Outpatients, ED patients to ensure they are always relevant.
1.2	**To Provide Outstanding Care** - 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	• Update will be provided in Q2.

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 2 SOF presented to Trust Board in July 2022 - https://www.sfh-tr.nhs.uk/media/13967/enc-11-final-sof-month-2.pdf. • Number of patients on the incomplete RTT waiting list **rated Amber**. • Number of patients waiting 78+ weeks for treatment **rated Green**. • Number of patients waiting 104+ weeks for treatment **rated Green**. • Number of completed RTT Pathways (against Yr2019/20) **rated Amber**.
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 2 SOF presented to Trust Board in July 2022 - https://www.sfh-tr.nhs.uk/media/13967/enc-11-final-sof-month-2.pdf. • 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 is complete; however there has been no evidence of positive change within the trust.

2.1	**<u>To Promote and Support Health and Wellbeing</u>** - 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.	• All Transformational Change Programmes must now have a completed Environmental Impact Assessment before proceeding. • The Trust, supported by the Board of Directors have signed the Climate Emergency UK declaration. • A series of events and significant dates have been publicised on the Trusts website (https://www.sfh-tr.nhs.uk/about-us/climate-action-at-sherwood/climate-action-2022/). These are routinely promoted via social media.
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	• There is significant work being undertaken to ensure our people are physically and emotionally well at work. There has been the development of a Financial Wellbeing group to understand the impact of the current cost of living crisis on our people, with the aim of developing and implementing innovative solutions including an internal food bank, a robust wellbeing campaign over the coming months. • A Menopause in the Workplace conference is currently being planned for world menopause day on 18 October 2022. • The Trust has worked with the ICS to review mileage rates in relation to car users, and the Trust has increased mileage rates by 26% on national terms and conditions. • There has been the reintroduction of Schwartz Rounds, which provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare.

					• During the recent heat wave, the People, Culture and Improvement directorates conducted walk arounds of the site to ensure our people were safe and well, while also reminding them of the importance of regular breaks and keeping hydrated.
2.3	**To Promote and Support Health and Wellbeing** - 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)	• The ongoing maternity recruitment and retention plan continues with positive outcomes. • There is some uncertainty around the pathway of Continuity of Carer (CoC) following recent national conflicting reports. • The SFH team have submitted the system plan for out CoC, aligned with NUH and are awaiting further feedback.
3.1	**To Maximise the Potential of our Workforce** - 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	• A strategic workforce plan has been developed and has been presented to various clinical and non-clinical forums in relation to the predicted workforce challenges over the next 3 - 5 years and the options to be considered. This document identifies risks and opportunities. A key element of this plan has been to involve the divisions and corporate functions in relation to its development and gaining commitment regarding implementation once approved.

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	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 progress is reported into an established workstream (except for Violence and Aggression which is a newly established group which sits in the 'Caring About You' pillar). • The Trust commitments have been shared across the organisation with monthly updates provided in the Staff Brief, Staff Bulletin, CEO blog, Facebook Group and other communication forums. Each month focusses on one of the commitment areas: May: commitments launch, June: Valuing You update, July: Caring about You update and August: Developing You update. • The Valuing You 3 metrics for improvement have also been included in the Q2 pulse survey which runs through July. • Progress against the Trust commitments is underway for all key improvement areas. A progress report was presented to PCIC on 26.07.2022.
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	• All aspects of the EPMA roll-out are on track for completion by the stated target date. • Analysis and system reporting functionality is now available; although this will only be embedded across the Trust once the data has been validated.

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)	• A decision on whether our EPR Business Case is approved by NHSE in expected by the end of Q2/beginning of Q3. • Once confirmation is received, this will then inform the production of a three-year digital investment plan. • All elements are on track.
4.3	**To Continuously Learn and Improve** - To introduce an Innovation Hub across the Mid Notts Place Based Partnership.	Director of Culture and Improvement	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)	• Despite remaining a priority for the Trust, the development of an Innovation Hub has been impacted by a combination of funding constraints and operational pressures. We have however recently secured some joint funding with our system partners to enact this. • This funding will help us to complete the infrastructure element of the Hub, which will in turn naturally lead to the operationalisation stage. • Although the Hub will not therefore be 'live' in Q1 as planned, we now have a funded plan to ensure this is operational by the end of Q2. A small multi-professional working group has been established to oversee this.
5.1	**To Achieve Better Value** - Delivery of the SFH Transformation & Efficiency Programme that supports the delivery at PCB/ICP level.	Director of Culture and Improvement	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	• A three-year Transformation and Efficiency Programme has been developed and has been signed-off by the Trusts Finance Committee. The programme includes a £11.7m financial improvement component, although qualitative benefits also form a large element of the programme's objectives. • Additional layers of governance have been added to both compliment and support the Transformation and Efficiency Cabinet. This

				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)	will help to ensure milestone delivery is monitored closely and action taken where required. • Associate Director of Transformation is an active member of the System Transformation Group.
5.2	**To Achieve Better Value** - 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. • SFH Planning and Transformation Leads are actively involved in establishing Provider Collaborative priorities and have provided data to support this.
5.3	**To Achieve Better Value** - Shape and define a new SFH Trust 5-year strategy (2023-2028) working with ICS 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	• The Director of Strategy and Partnerships is now in post, and a plan to ensure delivery is currently being developed. At this stage no issues have been identified. • A more detailed update will be provided in the Q2 report, including the measures of success against which delivery will be monitored. These measures will be taken to the Executive Directors Team meeting at the earliest opportunity.

5.4	**<u>To Achieve Better Value</u>** - 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**)	• The Director of Strategy and Partnerships is now in post, and a plan to ensure delivery is currently being developed. At this stage no issues have been identified. • A more detailed update will be provided in the Q2 report, including the measures of success against which delivery will be monitored. These measures will be taken to the Executive Directors Team meeting at the earliest opportunity.

Appendix A

Timetable for Updates

Period	Trust Board of Directors Meeting
Quarter 1 (April 2022 – June 2022)	4th August 2022
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)*

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	2022/2023 Strategic Priorities - **Quarter 1 Update**	**Date**: 4th August 2022	
Prepared By:	Jim Millns, Associate Director of Transformation		
Approved By:	Executive Director Leads		
Presented By:	Emma Challans-Rasool, Director of Culture and Improvement		

Purpose

The purpose of this paper is to provide the Board of Directors with a quarterly update on delivery of the 2022/23 Strategic Priorities.	**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	**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	**X**
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	**X**

Committees/groups where this item has been presented before

Updates on individual strategic priorities have been provided to respective Sub-Board Committees prior to being submitted to the Trust Board of Directors.

Executive Summary

Overview

The Trust has agreed a series of Strategic Priorities that will be delivered during 2022/23. Each of these priorities are aligned to the 5 overarching Strategic Objectives as outlined in our 5-year strategy: *Healthier Communities, Outstanding Care*. This is not however the complete list of what we plan to achieve and deliver during 2022/23, rather the areas that we consider key.

This paper will be the first of four quarterly updates provided to the Trust Board of Directors, showing progress and delivery. Future quarterly updates will be produced by the office of the newly appointed Director of Strategy and Partnership.

Whilst respective Executive Directors will continue to take the lead on ensuring delivery; each priority will now be 'owned' and overseen by a Sub-Board Committee. Quarterly updates will therefore be presented by Executive Directors on behalf of respective Committee's. It is expected therefore that quarterly updates will have been approved by Sub-Board Committee members beforehand. As Trust Board will recall, this approach was agreed by way of ensuring collective accountability was used to promote effective delivery in line with the stated deadlines.

Recommendation

The Board of Directors are asked to:

1. Note the updates against each of the Strategic Priority areas as detailed in the accompanying paper; and
2. Agree to receive a further update once quarter 2 is complete.

Mid-Nottinghamshire Integrated Care Partnership

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Single Oversight Framework

Reporting Period: Quarter 1

2022/23

Inspected and rated
Good
CareQuality Commission

Single Oversight Framework – Q1 Overview (1)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Quality Care	During June we continued to encounter significant challenges on our service across the organisation with additional capacity remaining open. Despite this the experience of those accessing our services remains positive. We have had no serious incidents declared that were staffing was a contributing factor. Hospital acquired pressure ulcers remain consistently low. Infection control remains a priority for the organisation During June there are 4 exception reports: • **Patient safety incidents:** Performance 43.70 (TYD 46.09) target >44. The trust continued to have good incident reporting culture. We have observed a slight increase in incidents being reported covered to the previous year. Incident report continues to demonstrate that there is no evidence for potential under reporting of incidents at SFH. • **CDIFF:** Performance 27.35 (YTD 18.23) against a standard of 20.6. A reduction in the number of hospital associated cases of Cdiff when compared with the same time last year, although there has been a increase during June. • **Rolling 12 month MRSA bacteraemia:** performance 5.47 (TYD 3.65) against a standard of 0**.** Investigation concluded and identified action plan being implemented. • **Rolling 12 month HSMR:** current performance 112.8 against a standard of 100. HSMR superimposed on fluctuations tracking the nation trends. A series of actions are scheduled to improve performance.	MD, CN

Single Oversight Framework – Q1 Overview (2)

Domain	Overview & risks	Lead
People & Culture	**People** In Q1 our sickness absence levels and overall workforce loss has fluctuated. The current sickness level is reported as 4.3% which is an increase when compared to 3.7% in May 2022. 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 7.1%, this sits above the target 6.3% but we are anticipating a reduction in these level over the next few months. 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. • Wellbeing Walk arounds by the People, Culture and Improvement Directorate. • Divisional coaching and 121 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 and circulated to all managers through People and Performance Overall resourcing indicators for Q1 2022 are positive, however our overall **vacancy's** has increased, but turnover sits under the trust target. There is currently a cost of living crisis and measures are being implemented to support our people. The Trust has implemented a 26% increase in national terms and conditions mileage rates to support staff who use cars as part of their role. The have also been the development of a financial wellbeing group to consider and implement support for staff in the current financial climate. **Improvement** As part of the vision for Continuous Improvement at SFH, our QI Maturity Matrix survey findings were shared with SLT in June 22, following analysis by EMAHSN. Ensuing actions will feedback into the PCI Strategy. Our aim is to increase visibility and understanding of our Improvement offer at SFH through a simplified message. 73 colleagues have undergone QI training in Q1 as part of both bronze and silver level offers, increasing in comparison to Q4 and a hopeful indication of a return to 'BAU' post-pandemic. The number of QI projects registered in Q1 has remained consistent compared to Q4. We hope to see an improvement in this in the coming months, once our AMAT 'QI module' launches and we gain additional resource within the team to support with colleague engagement activities. Significant progress continues at system level to develop an integrated QI/OD approach through the ICS OD & Improvement Community of Practice. We were successful in securing £20k in funding from the Health Foundation to progress the single digital Innovation Hub; 20 projects were funded nationally out of 130+ original bids. This is now being progressed with key stakeholders.	DOP, DCI

Single Oversight Framework – Q1 Overview (2)

Domain	Overview & risks	Lead
People & Culture	**Culture and Engagement** The Q1 2022 quarterly pulse survey ran across April. In March the Trust moved to a new provider (Cisco) for patient and colleague experience. Unfortunately, a small number of questions were missed off our survey, meaning recommendation as a place to work and recommendation as a place to receive care results are unavailable for Q1. This has been rectified for the Q2 pulse survey running in July. In the 21/22 Q4 pulse survey, recommend as a place to work had dropped to 75.4%, with our national staff survey results (Oct/Nov) reported as 74.8%. Whilst disappointing, this result was 15.4% above national average for our comparator group, with notable decline seen across the whole of the NHS. Our commitments to improve across 2022/23 aim to support colleagues experience of Sherwood, thus helping to sustain and improve where possible. Engagement of 2021 National Staff Survey results continues – results were analysed with 3 theme commitments identified focussed on **'Valuing You'** '**Caring about You'** and **'Developing You'**. Progress at a Trust level against these themes is underway with updates reported through existing governance frameworks and Trust communications channels. Divisional and team actions continue to be supported at a local level with progress discussed as part of the DPR process quarterly. **Learning & Development** Our **Mandatory Training and Development** compliance for June/Q1 is 87%. This is marginally below the Trust target (90%). Training has now resumed as normal and we expect to see an upturn in the coming months. Mandatory Training workbook reviews continued throughout Q1, with engagement sessions to colleagues around changes. The introduction of the 'Request for new workbooks' form continues to work well following launch in April. **Appraisals** levels currently sit at 85% for June (86% for Q1/YTD), this is below the Trust target but favourable in comparison to National/local levels. A working group is in place to improve compliance and experience, with the first meeting being held in June.	DOP, DCI

Single Oversight Framework – Q1 Overview (3)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Timely care	June continued to be challenging across the emergency pathway with the highest average daily attendances through the emergency department so far this year (512), 17 days of the month saw over 500 attendances. Quarter 1 saw the trust receive the highest number of attendances in Q1 since recording of the data in its current format commenced in 2019. MSFT patient numbers continued to be high over the month and whilst a dip was apparent in May, this has now returned to April levels. The trust continued to declare OPEL level 4 throughout the majority of the month, with patients experiencing long delays in ED however there were a few days were the trust was able to deescalate to level 3 due to reduced attendances and some high discharge days across the wards. SFH ED 4hr standard was lower than in the first two months of the quarter however use of SDEC remained high and admission avoidance pathways used to maximum benefit. This may in part have adversely affected the 4hr position as patients were fully worked up in ED to avoid a deeper admission as the patients were not appropriate for admission. The pressure experienced in the trust was replicated across the country and whilst it was a challenging month, SFH ED performance was ranked 9th Nationally and 1st in the region. Bed occupancy remains higher than the national (93%) and regional (93.4%) levels resulting in long waits for patients and overcrowding in ED. Elective Inpatient procedures were adversely affected over the month of June, in the main due to two factors, lack of anaesthetic cover as a result of vacancies and the end of locum contracts and the repurposing of medical outpatient diagnostic capacity to Inpatient emergency pathway capacity to assist with emergency flow and admission avoidance. 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 (4.4%) and due to the size of the overdue review list it is unlikely that this will improve significantly. Good progress has been made however against the 5% Patient Initiated Follow Up target and the trust presented areas of good practice at the national NHS Confed conference in June. The number of patients waiting more than 62 days on a suspected cancer pathway in June was 137 which is above trajectory. 62 day performance for May was 58% which was below the national average of 61.5% but above the ICS average of 55.9%. The average wait for first definitive treatment in April was 67 days (68 in May 2019). The Faster Diagnosis Standard (FDS) performance was 77.1% against the 75% standard with SFHT ranked 27 out of 125 trusts.	COO

Single Oversight Framework – Q1 Overview (4)

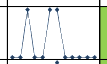
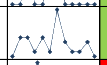
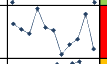
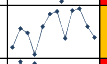
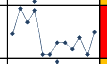
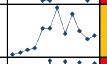
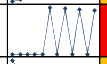
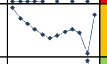
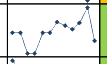
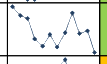
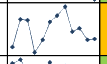
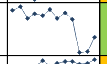
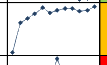
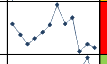
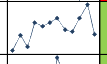
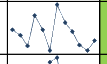
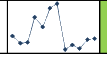
Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead

Best Value care	**Income & Expenditure:**
	• The 2022/23 Quarter 1 Finance report details the Trust's financial performance for the period to the end of June 2022. The annual plan is a deficit position of £4.7m.
	• Year-to-Date performance at Month 3 is a deficit of £5.2m, which is £1.3m adverse to plan. This is mainly due to the continued operational pressures and the need for additional winter capacity to remain open during Quarter 1 of 2022/23.
	• A detailed forecast outturn has been prepared at Quarter 1 and this shows delivery of the planned £4.7m deficit for the financial year. However, numerous risks to this delivery exist, particularly in relation to:
	  • Elective Recovery Funding
	  • Transformation & Efficiency Plan
	  • Covid Expenditure
	  • Operational Pressure and Additional Capacity
	• The reported position includes expenditure of £2.5m for COVID-19 and Covid-19 Vaccination Programme costs of £2.6m.
	Financial Improvement Programme (FIP):
	• The Financial Improvement Programme (FIP) delivered savings of £0.3m in June 2022, compared to a plan of £ 0.2m. The expected full-year savings for 2022/23 total £13.9m, including the expected benefit of Elective Recovery Funding (ERF).
	Capital Expenditure & Cash:
	• Capital expenditure of £1.1m has been reported to the end of June 2022 against a plan of £3.5m The underspend to the original plan is being primarily driven by the MRI scheme, which is subject to a separate funding bid, and general underspends across all three capital expenditure headings. This is in part driven by the timing of receipt of goods where orders have been placed.
	• Closing cash for the period was £2.9m, which is £0.6m better than plan. The forecast continues to demonstrate sufficient cash to comply with the minimum cash balance required, however, there are some timing pressures on receipt and payment which need to be managed.
		CFO

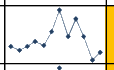
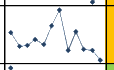
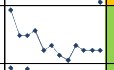
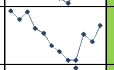
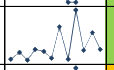
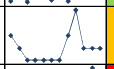
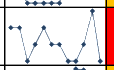
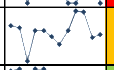
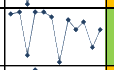
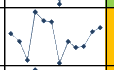
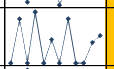
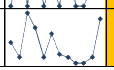
Single Oversight Framework – Q1 Overview (1)

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	Jun-22	0	-		G	MD/CN	Q
		Serious Incidents including Never Events (STEIS reportable) by reported date	<21	Jun-22	4	4		G	MD/CN	Q
		Patient safety incidents per rolling 12 month 1000 OBDs	>44	Jun-22	46.09	43.70		R	MD/CN	M
		All Falls per 1000 OBDs	6.63	Jun-22	7.58	6.73		A	CN	M
		Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	20.6	Jun-22	18.23	27.35		R	CN	M
		Covid-19 Hospital onset	<37	Jun-22	37	12		A	CN	M
		Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0	Jun-22	3.65	5.47		R	CN	M
		Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	May-22	92.3%	94.2%		A	CN	M
		Safe staffing care hours per patient day (CHPPD)	>8	Jun-22	9.0	8.8		G	CN	M
	Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Jun-22	1.24	0.88		G	MD/CN	M
		Recommended Rate: Friends and Family Accident and Emergency	<90%	Jun-22	90.1%	89.8%		A	MD/CN	M
		Recommended Rate: Friends and Family Inpatients	<96%	Jun-22	95.2%	96.0%		G	MD/CN	M
		Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	Jun-22	86.0%	89.1%		A	MD/CN	Q
	Effective	Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Jun-22	112.8	-		R	MD	Q
		SHMI	100	Nov-21	97.13	-		G	MD	Q
		Cardiac arrest rate per 1000 admissions	<1.0	Jun-22	0.64	0.85		G	MD	M
		Cumulative number of patients participating in research	2200	Jun-22	502	-		G	MD	Q

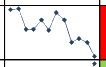
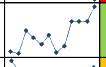
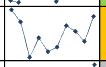
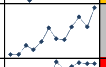
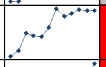
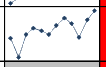
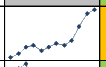
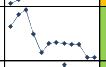
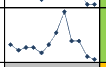
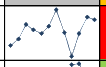
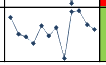
Single Oversight Framework – Q1 Overview (2)

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%	Jun-22	4.4%	4.3%		A	DoP	M
		Total Workforce Loss (inc Sickness, Maternity, Infection Precaution)	<6.5%	Jun-22	7.1%	6.7%		A	DoP	M
		Employee Relations Management	<10-12	Jun-22	21	7		G	DoP	M
	Resourcing	Vacancy rate	<6.0%	Jun-22	4.6%	5.1%		G	DoP	M
		Turnover in month (excluding rotational Drs.)	<0.9%	Jun-22	0.6%	0.6%		G	DoP	M
		Mandatory & Statutory Training	>90%	Jun-22	87.0%	87.0%		A	DoCI	M
		Appraisals	>95%	Jun-22	86.3%	85.0%		R	DoCI	M
	Culture & Improvement	Recommendation of place to work	≥80%	Qtr4 2021/22	76.7%	75.4%		A	DoCI	Q
		Recommendation of place to receive care	≥80%	Qtr4 2021/22	84.4%	85.1%		G	DoCI	Q
		Qi Training - Bronze	>60	Qtr1 2022/23	59	59		A	DoCI	Q
		Qi Training - Silver	>15	Qtr1 2022/23	14	14		A	DoCI	Q
		Number of QI Projects	>40	Qtr1 2022/23	26	26		A	DoCI	Q

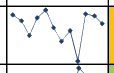
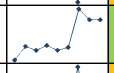
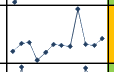
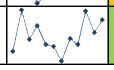
Single Oversight Framework – Q1 Overview (3)

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	Number of patients waiting >4 hours for admission or discharge from ED	90.0%	Jun-22	79.5%	77.6%		R	COO	M
		Mean waiting time in ED (in minutes)	220	Jun-22	203	210		G	COO	M
		Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<5%	Jun-22	4.8%	6.1%		A	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	Jun-22	2.2%	2.7%			COO	M
		Mean number of patients who are medically safe for transfer	<22	Jun-22	97	96		R	COO	M
		Adult G&A Bed Occupancy (8:00am position as per U&EC Sitrep)	<92%	Jun-22	95.2%	96.6%		R	COO	M
	Elective Care	Remote Attendances as a percentage of Total Outpatient Attendances	on trajectory	Jun-22	17.4%	16.1%		R	COO	M
		Outpatient Episodes moved / discharged to a Patient Initiated Follow-up Pathway	on trajectory	Jun-22	-	4.8%		G	COO	M
		Follow Up Outpatient Attendances reduce against Yr2019/20	on trajectory	Jun-22	-4.4%	-2.2%		R	COO	M
		Elective Day Case activity against Plan	on trajectory	Jun-22	95.3%	94.2%		A	COO	M
		Elective Inpatient activity against Plan	on trajectory	Jun-22	90.1%	81.0%		R	COO	M
		Elective Outpatient activity against Plan	on trajectory	Jun-22	100.9%	100.1%		G	COO	M
	Diagnostics	Diagnostics activity increase against Yr2019/20	on trajectory	Jun-22	111.1%	113.4%		G	COO	M
	RTT	Number of patients on the incomplete RTT waiting list	on trajectory	Jun-22	-	43012		A	COO	M
		Number of patients waiting 78+ weeks for treatment	on trajectory	Jun-22	-	72		G	COO	M
		Number of patients waiting 104+ weeks for treatment	on trajectory	Jun-22	-	0		G	COO	M
		Number of completed RTT Pathways against Yr2019/20	on trajectory	Jun-22	95.8%	99.6%		A	COO	M
	Cancer Care	Number of patients waiting over 62 days for Cancer treatment	88	Jun-22	-	134		R	COO	M
		Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	May-22	77.7%	77.1%		G	COO	M

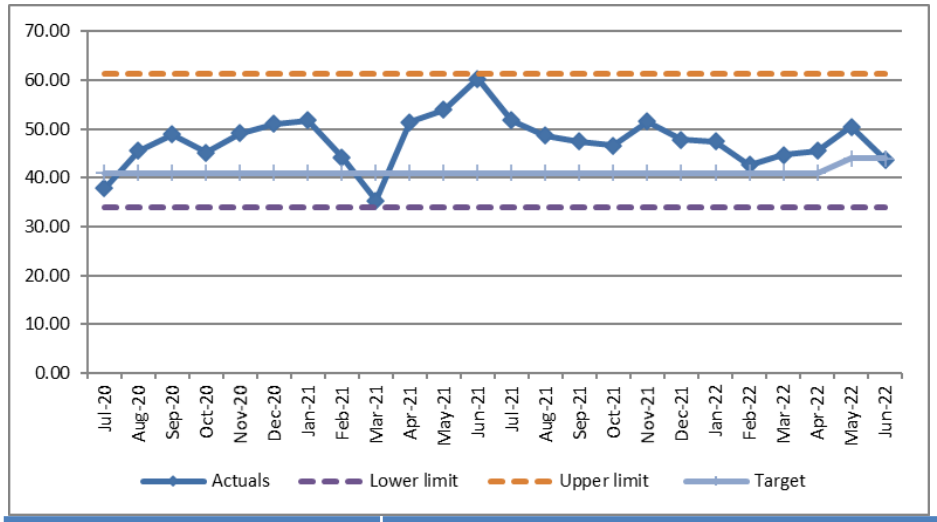
Single Oversight Framework – Q1 Overview (4)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
BEST VALUE CARE	Finance	Income & Expenditure - Trust level performance against Plan	£0.00m	Jun-22	-£1.31m	-£1.09m		A	CFO	M
		Financial Improvement Programme - Trust level performance against Plan	£0.00m	Jun-22	£0.27m	£0.04m		G	CFO	M
		Capital expenditure against Plan	£0.00m	Jun-22	£2.45m	£1.46m		A	CFO	M
		Cash balance against Plan	£0.00m	Jun-22	£0.60m	£0.04m		G	CFO	M

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Patient safety incidents per rolling 12 month 1000 OBDs	>44	Jun-22	46.09	43.70		R	MD/CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

The latest NRLS report demonstrates that between April 2020 – March 2021, the Trust continued to have a positive incident reporting culture with the numbers increasing slightly when compared to the previous year. The report continues to demonstrate that there is no evidence for potential under reporting of incidents at SFH. We are still awaiting the report for 2021/22

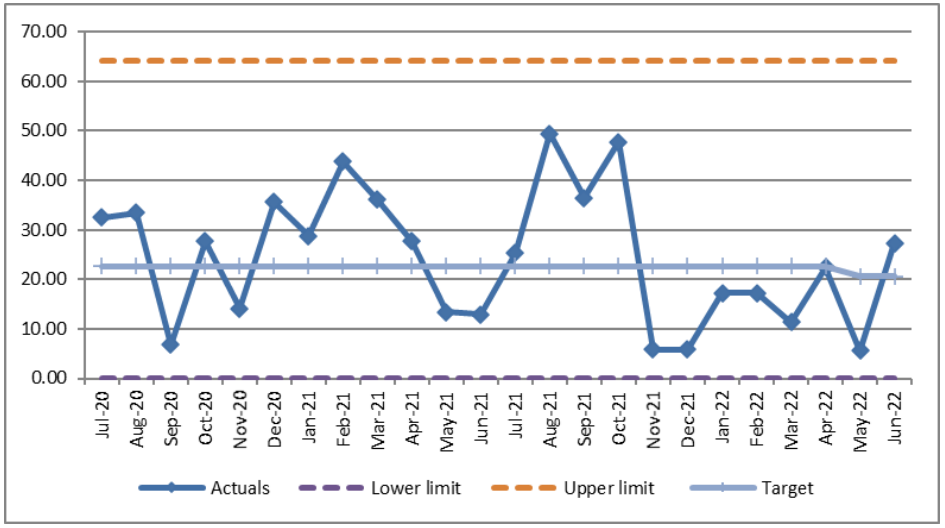
A total of 3262 incidents were reported on Datix during Q1. Of these:

- 2547 reported as 'no harm'.
- 660 reported as 'low harm'.
- 15 reported as 'moderate harm'.
- 5 reported as 'severe harm'.
- 8 reported as 'catastrophic harm'

Root causes	Actions	Impact/Timescale
• Colleagues are encouraged to report incidents via training and monthly incident updates delivered across a variety of forums. • The highest reported incident remains Pressure Ulcers – the overwhelming majority being present on admission. Falls are the second highest followed by skin damage and medication.	• Continue to encourage high reporting rates. • Continue to share the learning from incidents while developing innovative new methods to disseminate learning. • Continue to develop the knowledge and skills of staff to manage and investigate incidents . • Continue to monitor reporting rates and identify themes and trends. • Preparation continues for the launch of the Patient Safety Incident Response Framework (PSIRF) which will replace the Serious Incident Framework. • Preparation continues for the launch of the Learning From Patient Safety Events service (LFPSE) which will replace NRLS for the recording and analysis of patient safety incidents in healthcare. • Preparation continues for the roll out of the new Datix IQ . • Investigate all incidents	• Continue • Continue • Continue • On hold • March 2023 • On going • On going

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	20.6	Jun-22	18.23	27.35		R	CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



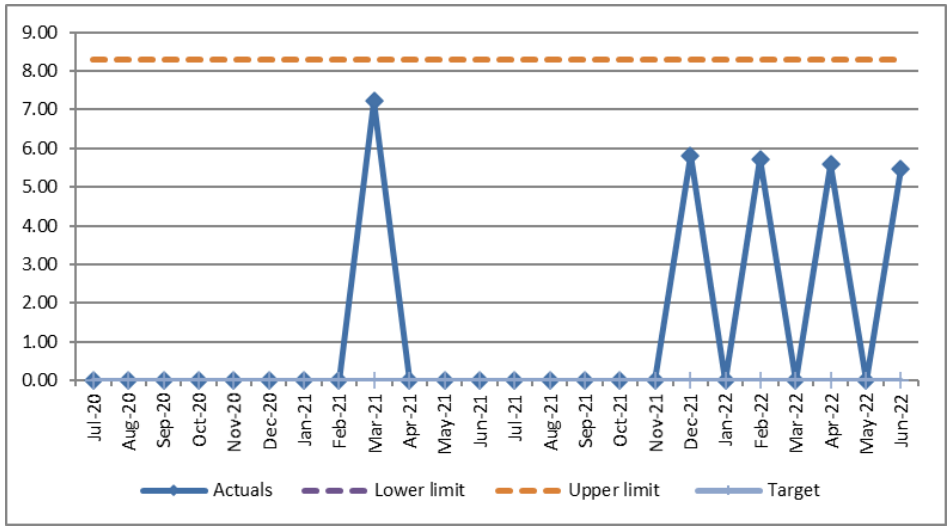
National position & overview

- This year the organisation has been given a trajectory for Cdiff of 92 cases, however this is higher than usual and is currently under review therefore we are continuing to work to our previous trajectory of 57.
- The Trust have seen a reduction in the number of hospital associated cases of Cdiff when compared with the same time last year, although there has been a slight increase during June.
- Total Trust Attributed Cdiff cases to date for this year is 17, compared to 21 in 2021 /22

Root causes	Actions	Impact/Timescale
• There have been 5 cases of hospital acquired Cdiff in June. • 3 are related to 1 ward that is being investigated as an outbreak, unfortunately 2 of those cases have the same ribotype, indicating cross infection.	• All samples are being sent to Leeds for ribotyping; • Additional typing carried out on those 2 that are the same ribotype and has return as indistinguishable • RCA's are being carried out on all cases. • Outbreak meetings being held with regards to increase in cases on one ward. • Daily audits are being undertaken on the outbreak ward by the Infection Control Team	• Ongoing • Complete • Completed • Next meeting 29/07/2022 • Until the outbreak is closed, usually after 28 days after declaeration.

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	Jun-22	3.65	5.47		R	CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



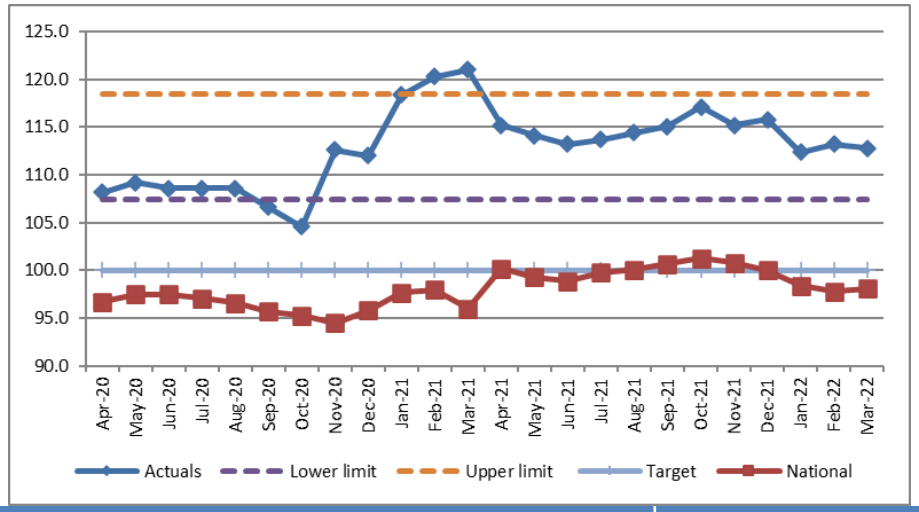
National position & overview

- The Trusts national trajectory for MRSA bacteraemia is zero for 2022-23.
- All organisations nationally now have a zero target for MRSA.
- Other organisations in the region have also observed an increase in MRSA blood stream infections.

Root causes	Actions	Impact/Timescale
• The direct source of this bacteraemia has been investigated and can not be determined.	• Complete RCA	• complete
• This patient had a previous history of MRSA colonisation to their skin and has been treated on several occasions since 2011.	• Screened in line with policy on each admission.	• Complete
• Decolonisation treatment was not commenced on admission for the patient due them being high risk.	• Ward update reminded to commence decolonisation on admission and IPCT reminding teams on all wards.	• Ongoing

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	112.8	-		R	MD	Q

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

Reporting (June 2022) highlights 10 alerting diagnosis groups, including:

Inflammation of the eye, Coagulation / Haemorrhagic disorders, Epilepsy Viral infections, Intestinal infection, Deficiency and anaemia, COPD (see below), Connective Tissue disease Cancer (other / unspecified) and Stomach

Removal of Covid-19 activity removes viral infections, deficiency / anaemia and connective tissue disease alerts

2 new CUSUM alerts:

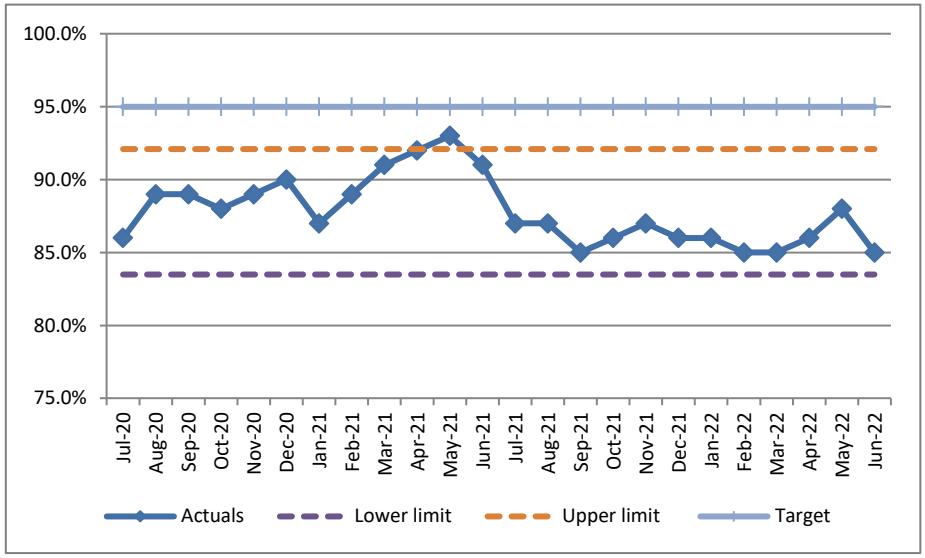
- Inflammatory (male genital) – 1 death
- Septicaemia (except labour) – 249 deaths

Low Palliative coding continues to be highlighted as a key influencer on HSMR but not SHMI.

Root causes	Actions	Impact/Timescale
High numbers of residual codes were reported in latest data; a one-month delay is therefore being used to show the most accurate and up to date reflection of position. Despite a step-reduction the month previous, latest HSMR at SFHT has seen a small rise, factors thought to include the modelling adjustment and residual codes. •HSMR 113.2 (109.6 ex-covid)- Above Expected (previous report 117 / 108.8) •To be "as expected", there would need to be a minimum 4-5pt reduction. •SMR 116.9 (111.5 ex-covid)- High (previous report 123.2 / 109.3) •SHMI 97.96- As Expected (previous report 97.45) The report highlights HSMR outlier alerts, the majority with small volumes of deaths. These have low impact on overall HSMR but still do contribute to the gap between observed and expected.	Early escalation and review highlighted potential incomplete (and delay in) data submission supporting the need to time-lag reporting. Initial review of coding related to Eye infection (3 patients), Coagulation (4 patients) and Epilepsy (8 patients), highlighted coding of presentation was generally accurate but did not always relate to direct (or primary) cause of death as per MCCD. On going work with Dr Foster to analyse the associated data with CUSUM alerts	• SUS submission to be earlier in month • Continue to observe for persistence/ recurrence • On going

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Appraisals	>95%	Jun-22	86%	85%		R	DoCI	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

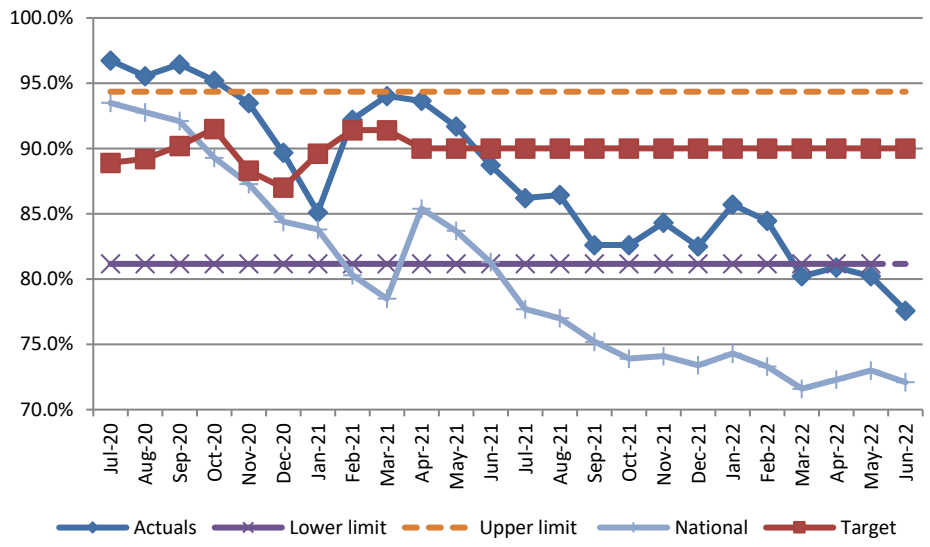
The Trust benchmarks favourably nationally and local intelligence suggests the Trust's appraisal rates are amongst the highest in the region.

The Trust benchmarks favourably against a national and localised appraisal figure, across NHS providers in Nottinghamshire SFH sits above the ICS average (84.2%)

Root causes	Actions	Impact/Timescale
The Appraisal position is reported at 85.0% in June (86% for Q1/YTD)	Our Trust People Partners will continue to support discussions with Line Managers at confirm and challenge sessions, seeking assurance and guidance on expected completions.	We will strive for improvements in compliance between now and September but recognise this is prime time for leave so will continue to monitor.
The key cause of below trajectory performance on the appraisal compliance is related to the delivery and capacity issues associated with the pandemic and hospital pressures. Operational pressures during May and June impacted on compliance plus we have seen workforce loss rise due to COVID absences.	**Ongoing actions:** Consider including appraisals within Protected Learning Time Policy (PLT) to ensure appraisals are prioritised.	By end of 22/23.
Access to the face to face skills element of mandatory training is difficult, this is due to non attendance and blocking of paces, in some cases we have seen double and triple booking.	Consider removing Talent Management from appraisals and dedicate separate time to this to avoid consumption of conversations. Appraisals working group to commence in July to review and improve process.	Appraisals working group meeting went ahead in July, producing an options appraisal as regards the digital vs paper-based approach. Options Appraisal due to go out to group for consideration, feedback to be reviewed to identify next steps by end of Q2.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of patients waiting >4 hours for admission or discharge from ED	95.0%	Jun-22	79.5%	77.6%		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust



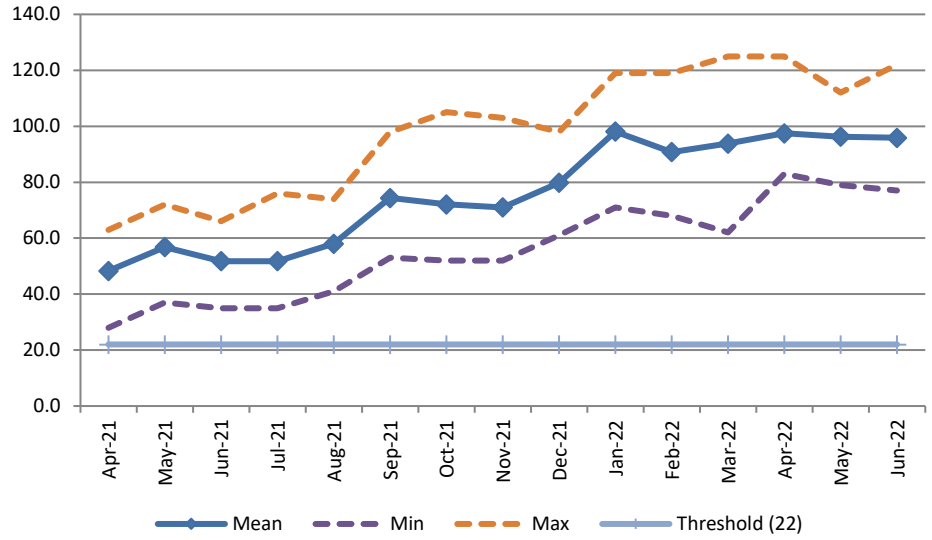
National position & overview

- SFH performance was 79.5% for June 2022. Performance continues to be driven mainly by exit block and high numbers of MSFT, although average attendances were up in comparison to May 2022
- National rank 9th out of all comparison Trusts
- Regional Rank 1st out of all comparison Trusts
- In Q1 the trust saw the most ED attendances since recording in its current format started in 2019
- Newark UTC performed well with an average 98.5% of patients seen and treated under 4 hrs, well above the 95% standard
- Bed pressure was a key driver of performance. The number of MSFT patients remained in excess of the ICS agreed threshold throughout the month and is showing a deteriorating position. 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
- Admission avoidance is still good across the trust and is the lowest in Q1 2022/23 than the last 4 years. This has a negative impact on the 4hr performance standard as patients are staying longer in ED to be discharged home rather than be admitted

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 4 wards worth of capacity that is currently being used solely for the care of patients who are medically fit but have no onward destination **Activity** • The trust experienced the highest Q1 attendances since internal recording began in its current format in 2019 (45282 v 41645)	• Additional beds open across KMH, Newark and the Sherwood Community Unit • The maximisation of Same Day Emergency care continues to be successful with 40-50% of patients streamed through to avoid admission • Optimising Patient Journey initial development meeting with divisions and stakeholders took place at the beginning of July. Pillar leads have been identified • Capacity and Demand exercise to be undertaken across ED Nursing and Medical staffing to try to minimise the effect of increased attendances where possible • Full review of local, regional and national UEC actions to take place late July/early August • Working with system partners to look at reasons for increased attendances	• Implemented • Implemented • Development • Development • Development • Development

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	Jun-22	97	96		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust



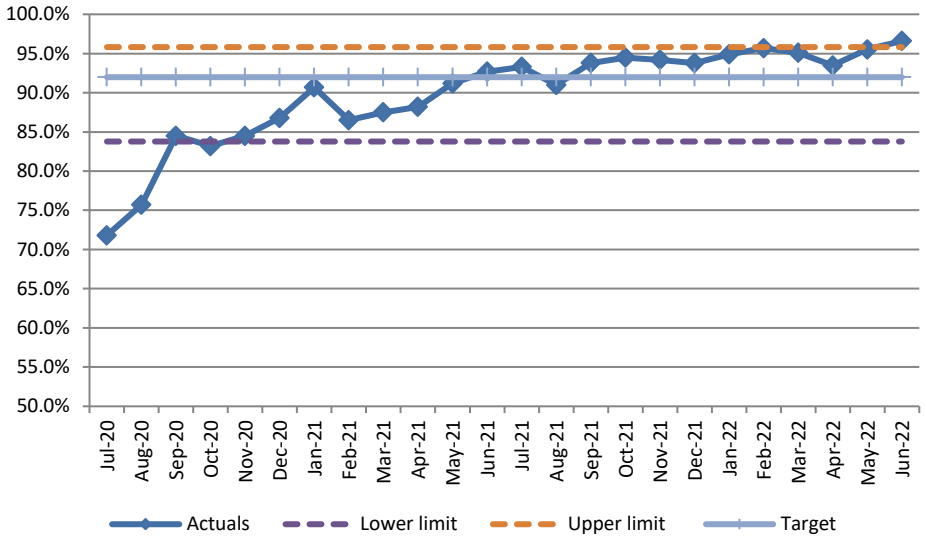
National position & overview

- The local position continues to remain significantly above the agreed threshold of 22 patients in the acute trust, 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
- System Virtual Ward Business Case has been signed off
- System D2A business case on hold. Provider collaborative to pull forward ideas from health providers as winter mitigation
- System 'what good looks like' session to take place end of July to identify a system approach to MSFT
- 100 day discharge challenge task and finish group in place
- Discharge is one of the pillars of the internal Optimising Patient Journey (OPJ) improvement programme, pillar lead required

Root causes	Actions	Impact/Timescale
• Pathway 1 and 2 demand and the available capacity to meet the variation in demand. This reflects the lack of available staff in care agencies (on the framework) to meet demand in particular for double up care QDS and TDS , as well as availability of social workers to manage the allocations. Recruitment into care and social worker roles is proving very difficult with posts unfilled and no agency cover.	• T2A (Ashmere/pathway 2 patients) process with system partners in place	• Implemented
• Internal process issues contributing to referral delays although EPMA/TTO's may improve this	• Continuation of winter and surge capacity, although the location of part of this has changed from SSU and Sconce to Castle ward at NCH	• Ongoing
• No visible workforce plan/ timelines to improve the D2A delays within the system, in line with D2A business case.	• D2A business case refocus	• Developing
• Challenging system landscape inhibiting joined up working	• System virtual ward business case agreed, currently recruiting for the service to commence in late August/September	• Developing
	• System wide agreement continues to progress for FNC assessments, interim placements and wider bedded capacity access, although this is cumbersome and inflexible	• Developing
	• Sherwood Community Care Home continues to support up to 19 MSFT patients	• Ongoing
	• Development of discharge pillar actions and workplan as part of OPJ programme	• Developing
	• Transfer of Care Hub to move back to site following remote working through COVID	• Developing

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%	Jun-22	95.2%	96.6%		R	COO	M

NHS
Sherwood Forest Hospitals
NHS Foundation Trust



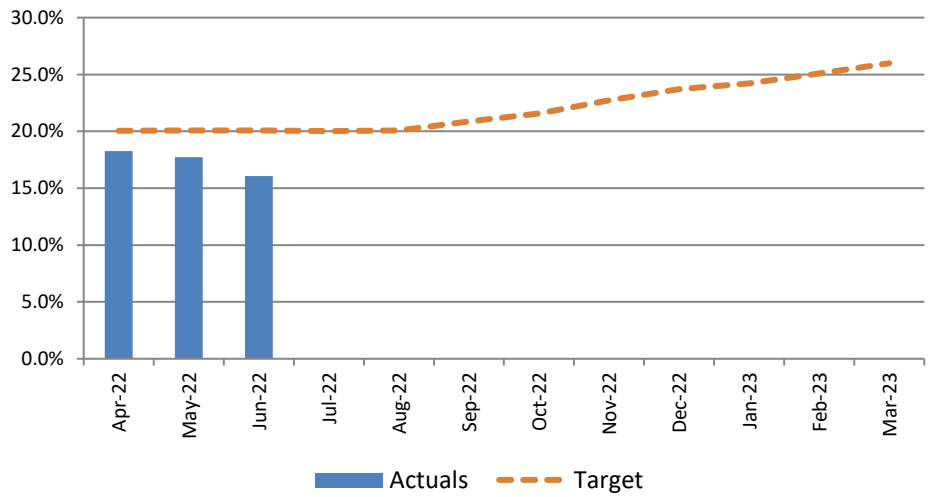
National position & overview

- 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
- The national average occupancy for type 1 providers is 93% with a slight increase on this for the Midlands region of 93.4% for June
- Occupancy reduction will form part of the Optimising Patient Journey programme launched in July 2022 by the COO and MD, through focussed discharge projects
- Q1 Admissions are the lowest they have been since the trust started recording activity in its current format in 2019 (4123 v 4597)

Root causes	Actions	Impact/Timescale
• The Trust continues to experience delays in the discharge of patients who are MSFT	• Occupancy reduction will form part of the Optimising Patient Journey programme launched in July 2022 by the COO and MD	• Developing
• There are 4 wards of patients who are medically fit for transfer but have no onward destination.	• Daily MSFT calls with system to place patients. Escalation to daily system call.	• Implemented
• Bed modelling shows that the occupancy of the trust is almost entirely driven by increasing MSFT numbers	• System calls attended by DCOO to ensure appropriate challenge to partners	• Implemented
	• Continue to utilise SDEC and Streaming pathways to turn patients around at the front door and avoid admission	• Implemented
	• Progressing alternative discharge pathways with system colleagues through the Provider Collaborative	• Implemented

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	Jun-22	17.4%	16.1%		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- Remote attendances incorporate both Telephone and Video consultations
- National target to reduce attendances by 25% (SFH submitted non compliant plan against this metric in ICS planning round)
- The outpatient and transformation board are overseeing this piece of work.
- Specialities are being individually reviewed to understand why there has been deterioration against previous performance and to learn best practice from those specialities where it is working well
- Clinical engagement is the biggest barrier to continued development of the virtual platform.
- Wider piece of work required to look at job plans, signal issues and availability of kit

Root causes	Actions	Impact/Timescale
• Clinical appetite to progress 'virtual' agenda, preference to see a patient face to face	• Project Team with Clinical Lead to be established to progress this agenda. Phase 1 to include – review of infrastructure and equipment to enable virtual appointments, review of clinic types and recruitment of Clinical Champion to help engagement and further understand challenges.	• Developing
• There are a number of barriers including: equipment, signal issues, support for staff and patients to conduct 'virtual' sessions, fixed clinic sessions for video consultation.	• Exploring the role of a virtual receptionist to provide a better patient experience for virtual appointments. Role profile being developed and will be put forward as a temporary position.	• Developing • Implemented
• Review of existing telephone and email advice lines not currently recorded or reported.	• The process for recording and reporting this activity has been relaunched	

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	Jun-22	-4.4%	-2.2%		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust

New Data Table in Development

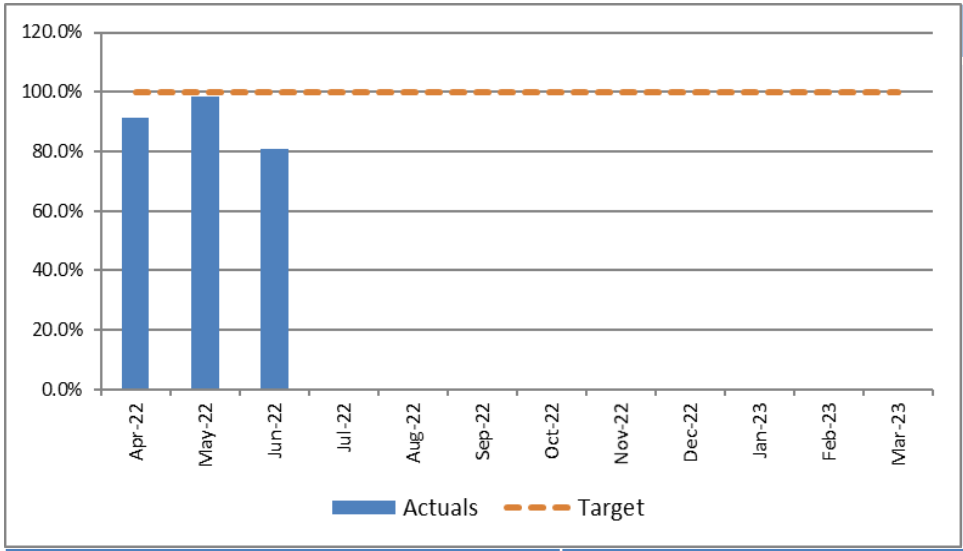
National position & overview

- National Planning 2022/23 target to reduce follow up appointments by 25% of 2019/20 actuals
- SFH submitted a plan declaring that would not be compliant with the target in 2022/23 due to the size of the current overdue review backlog and activity plan aim to achieve 110% of 2019/20 activity
- The target will still be monitored and reported against at a trust level
- Most acute trusts in the midlands declaring a non compliant position
- Alternatives to Follow Up are being progressed through Patient Initiated Follow Up (PIFU)
- Current year to date position against plan is 4.4%
- Patient Initiated Follow Up is part of the overall follow up reduction scheme

Root causes	Actions	Impact/Timescale
• PIFU pathways are not set up in all specialities.	• PIFU working group established • Project in place • Two cohorts. Cohort 1: Review of specialties using open appts and PIFU. Cohort 2: specialities only using open appts.	• Developing
• Standard PIFU pathways not suitable for patients with long term conditions.	Development of a PIFU pathway for patients with long term conditions (PIFU SOS) will need to be established to enable all open appts to be transferred to PIFU pathways, as these patients will not be discharged.	• Implemented
• Patient Knows Best (PKB) tool is in use within the clinical specialties but not being rolled out at the pace required. This tool allows patients to monitor and manage their own conditions and reduce the need to attend hospital unnecessarily (Non PIFU but an enabler)	Deputy DGMs from Medicine and Surgery to progress PKB and report back to the Board with support offered via the Transformation team.	• Implemented

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Elective Inpatient activity against Plan	on trajectory	Jun-22	90.1%	81.0%		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust



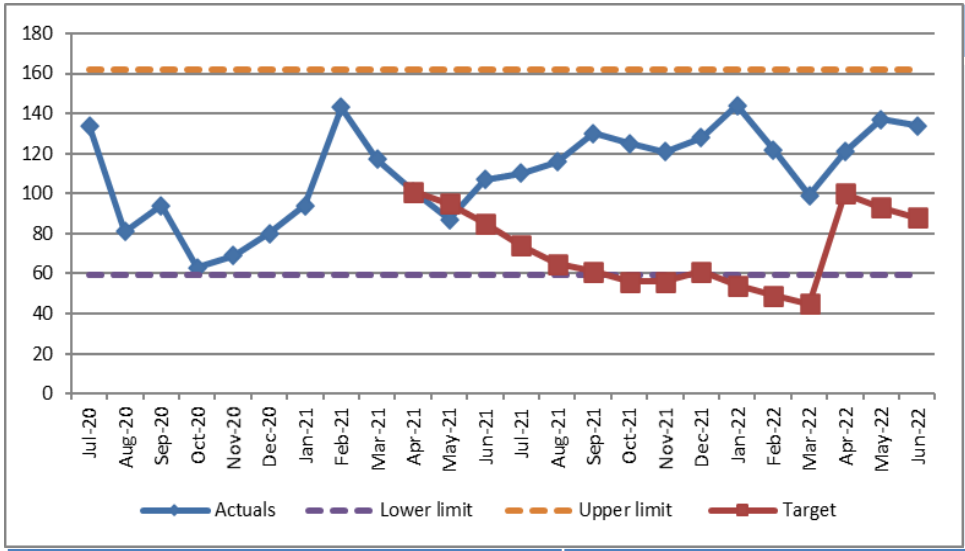
National position & overview

- For June 2022 the activity volume is 81% against the 2022/23 plan and 60% of 2019/20 activity.
- When comparing the June 2022 projection to June 2019, activity for both years:
  - Elective inpatient – 289 v 480 (–191)
- Elective IP activity throughout June was adversely affected due to increased emergency pathway pressures with specialties such as Cardiology cancelling elective lists to arrange additional inpatient lists to increase discharge and improve flow.
- Limited internal anaesthetic cover, with up to 19 lists cancelled in one week due to the lack of anaesthetists

Root causes	Actions	Impact/Timescale
• Sustained urgent and emergency care pathway pressures	• Additional lists to make up the lost capacity • Plans to increase the number of lists available	• Implemented • Implemented
• Anaesthetic cover	• Plans to use external agency to 'insource' anaesthetists • Successful recruitment of anaesthetists in June, the benefit of which may not be seen until July/August • Flexibly using available lists across all specialties and trauma to ensure that patients are seen in a timely way	• Implemented • Implemented • Implemented

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of patients waiting over 62 days for Cancer treatment	88	Jun-22	-	134		R	COO	M

NHS
Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- In the 2022/23 priorities and operational planning guidance, Cancer recovery objectives - Return the number of people waiting for longer than 62 days to the national average in February 2020. For SFH this was 70
- SFH were ranked 27^{h} out of 125 providers for Faster Diagnosis Standard achieving 77.1% against the 75% standard
- SFH were ranked 80th out of 125 providers for 62 day performance
- SFH 62 day waiting time was 58.0% for May, against the national 61.5% and ICS 55.9%
- The average wait for definitive treatment in May was 67 days (68 in May 2019)
- A trajectory was developed in March 22 with 5 key risks to delivery highlighted: demand, diagnostic capacity, lower GI, dependency on the tertiary provider and the residual impact of covid. June ended at 134, above the February 2020 average of 70 and above the trajectory of 105

Root causes	Actions	Impact/Timescale
• Delays to STT in Gynae due to Hysteroscopy capacity	• Gynae – Expand see and treat capacity, streamline straight to test (STT) Additional lists provided throughout May, June and July to support STT.	• Additional lists for Gynae to be added in July For Gynae STT. Significant improvements being seen in waits for STT
• Delays to first seen in Skin due to clinic capacity	• Skin – Additional clinic capacity being put in place for August and return to original clinic space.	• Improvement in late Aug
• Urology, Head and Neck clinic waits both locally and at the tertiary centre due to consultant leave.	• Head and neck working with NUH colleagues to understand gap and address clinic capacity.	• Throughout Q1 and Q2 22/23.
• Lower GI impacted by consultant leave due to annual leave .	• Urology working to increase template capacity with the start of MRI fusion in outpatients.	• Developing
• Other diagnostic and treatment delays provided by the tertiary centre including PET scans, surgical dates and oncology.	• Lower GI to add additional clinics and theatres where possible. • ICS assessment and review of sustained increased demand • New cancer Steering Group in place to give greater focus to the cancer agenda and reducing patient waits	• Developing • Developing • First meeting took place 16/6/22. Next meeting 18/8/22
	• Significant investigatory work to understand the drivers of the backlog being undertaken by the Head of Elective Care	• Developing

Best Value Care

Sherwood Forest Hospitals NHS Foundation Trust

Income & Expenditure *Trust Level Performance against Plan*	In-Month	**(£1.09m)**	The Trust has reported a deficit of £0.98m for Month 3 (June 2022), on an ICS Achievement basis. This is a £1.09m adverse variance to the planned deficit.
	Year-to-Date	**(£1.31m)**	The Trust has reported a deficit of £5.24m for the Year-to-Date, on an ICS Achievement basis. This is a £1.31m adverse variance to the planned deficit.
	Forecast Outturn	**£0.00m**	The forecast outturn reported at Month 3 is aligned to the 2022/23 financial plan, as a deficit of £4.65m.
Financial Improvement Programme *Trust Level Performance against Plan*	In-Month	**£0.04m**	The Trust has reported FIP savings of £0.26m for Month 3 (June 2022), which is £0.04m higher than planned (includes notional Elective Recovery Fund (ERF) of £0.26m).
	Year-to-Date	**£0.27m**	The Trust has reported FIP savings of £0.92m for the Year-to-Date, which is £0.27m higher than planned (includes notional Elective Recovery Fund (ERF) of £0.92m).
	Forecast Outturn	**£0.00m**	The Trust has forecast FIP savings of £13.94m 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	**£1.46m**	Capital expenditure in Month 3 (June 2022) totalled £0.32m, which is £1.46m less than planned.
	Year-to-Date	**£2.45m**	Capital expenditure totals £1.09m for the Year-to-Date, which is £2.45m 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	**£0.04m**	The Trust's cash balance increased by £0.87m in Month 3 (June 2022), which is a favourable variance of £0.04m compared to the plan.
	Year-to-Date	**£0.60m**	The Trust reported a closing cash balance of £2.90m as of 30th June 2022, which is £0.60m higher than planned.
	Forecast Outturn	**£0.00m**	The Trust has forecast a year end cash balance of £1.45m for the Financial Year 2022/23, which is aligned to the plan.

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

M3 Summary

- The Trust has reported a Year-to-Date deficit of £5.24m for the period up to the end of Quarter 1 (June 2022), on an ICS Achievement basis. This is an adverse variance of £1.31m to the planned deficit of £3.93m.
- NHS England & NHS Improvement (NHSE/I) has confirmed additional allocations in relation to excess inflation costs, and this additional income was recognised in the Trust plan resubmissions of 20th June 2022. The updated financial plan for SFH shows a deficit of £4.65m.
- The forecast outturn reported at Month 3 is a £4.65m deficit, in line with the 2022/23 Financial Plan.
- Capital expenditure for Month 3 (June 2022) was £0.32m. This was £1.46m lower than plan, primarily relating to MRI where funding has yet to be formally approved.
- Closing cash on 30th June was £2.89m, which is £0.60m higher than planned. The cash flow forecast continues to demonstrate sufficient cash to comply with the minimum cash balance required. However, there are some timing pressures on receipt and payments which will need to be closely monitored and managed.

	June 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	39.07	38.78	(0.29)	112.41	112.10	(0.31)	450.09	452.97	2.88
Expenditure	(38.97)	(39.77)	(0.80)	(116.36)	(117.29)	(0.93)	(454.84)	(457.65)	(2.81)
Surplus/(Deficit) - ICS Achievement Basis	**0.11**	**(0.98)**	**(1.09)**	**(3.93)**	**(5.24)**	**(1.31)**	**(4.65)**	**(4.65)**	**(0.00)**
Capex (including donated)	(1.77)	(0.32)	1.46	(3.54)	(1.09)	2.45	(19.46)	(19.46)	0.00
Closing Cash	0.83	0.87	0.04	2.30	2.89	0.60	1.45	1.45	-

FY23 Target		FY23 Forecast		FY23 Variance		M3 Target		M3 Actual		M3 Variance		YTD Target		YTD Actual		YTD Variance	
FIP £11.73m	ERF £2.21m	FIP £11.73m	ERF £2.21m	FIP £0.00m	ERF £0.00m	FIP £0.04m	ERF £0.18m	FIP £0.00m	ERF £0.26m	FIP (£0.03m)	ERF £0.07m	FIP £0.11m	ERF £0.55m	FIP £0.01m	ERF £0.92m	FIP (£0.10m)	ERF £0.36m
£13.94m		£13.94m		£0.00m		£0.22m		£0.26m		£0.04m		£0.66m		£0.92m		£0.27m	

Overall Status	
G	Green rated due to full year achievement assumption

Financial Improvement Plan Delivery

a. In-month delivery was slightly behind plan due to a delay in procurement savings; though these are expected to catch-up. Digital letters continued to achieve above plan.

Elective Recovery Funding (ERF)

a. The Transformation & Efficiency Programme continues to contribute to the delivery of ERF. This will however be reported separately. Should activity exceed plan however, and this results in the delivery of additional ERF, this additional funding will be allocated to the FIP.

b. In-month delivery is above the planned trajectory overall, however the Theatres Transformation activity is below plan. The overall impact on the achievement of ERF in month 3 is not yet known. The figures shown are therefore indicative at this stage.

c. The planned trajectory for 2022-23 is being reviewed, in line with revised (stretch) targets.

Full Year Forecast

a. It has been assumed, at this stage, that the 2022-23 FIP will be delivered in full by the end of the year. The 'overall status' therefore has been rated green.

b. The Medical, NMAHP and Procurement Programmes are expected to be included in month 4 reporting.

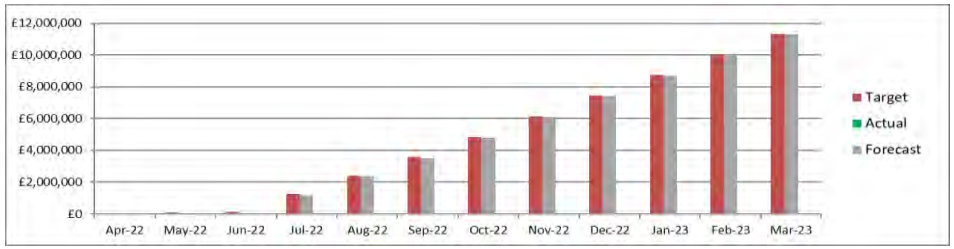
c. There is currently £3.8m unallocated FIP, which has notionally been assigned to individual divisions. There are 50+ programme specific ideas currently being worked up, with an additional 40+ schemes on the idea's log. These ideas will help address the unallocated amount.

Issues and Risks

a. Although a large-scale Transformation and Efficiency programme has been worked up, there is (as noted above) £3.8m currently unallocated. This and the targets for all programmes are expected to be split across the Divisions for month 4 reporting.

b. Delays in the re-establishment of 'pre-Covid bank rates' will potentially delay savings identified as part of the NMAHP Transformation Programme.

Item 1: Cumulative Phased Forecast Savings Plan (excl. ERF)



Item 2: Summary by Programme

Key	> 95%	> 75%	< 75%

Programme	Month 3 YTD Target			Month 3 YTD Actual			Delivery RAG
	FIP	ERF	Total	FIP	ERF	Total	
Outpatients Innovation	£5,000	£365,937	£370,937	£8,071	£916,056	£924,127	
Theatres Transformation	£0	£187,500	£187,500	£0	£0	£0	
NMAHP Transformation	£0	£0	£0	£0	£0	£0	
Medical Transformation	£0	£0	£0	£0	£0	£0	
Pathology Transformation	£0	£0	£0	£0	£0	£0	
Diagnostics Transformation Programme	£0	£0	£0	£0	£0	£0	
Ophthalmology Transformation	£0	£0	£0	£0	£0	£0	
Corporate Services	£100,000	£0	£100,000	£0	£0	£0	
Divisional Schemes	£0	£0	£0	£0	£0	£0	
Total	£105,000	£553,437	£658,437	£8,071	£916,056	£924,127	

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	SOF – Integrated Performance Report – Quarter 1 2022/2023	**Date**: 4th August 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 27th July 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 the first quarter of 2022/23, there are a number of standards which are only reported on quarterly these are included in the report.

There are 52 on the quarterly dashboard covering four sections

Section	Number of standards	Red	Amber	Green	No Rating
Quality Care	17	4	5	8	0
People and Culture	12	1	7	4	0
Timely Care	19	7	4	7	1
Best Value Care	4	0	2	2	0

All standards 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 and forms part of the dashboard report.

A report is produced for each individual standard rated as red; this includes:

The performance against the standard, both monthly and year to date, the trend graph, the Executive owner, a comparison against the national position, the root causes, with actions to address, the expected outcome and timeline for completion.

For the first quarter of 2022/23 there are 12 Standards rated as Red:

Quality Care

Patient safety incidents per rolling 12 months 1000 OBDs: At year end 2021/22 performance was 45.86, the standard for this year is >44 Green and <44 Red. Quarterly performance at 46.09 is above the standard, and reflects an increase in the reporting of incidents, the highest reported incidents being Pressure Ulcers, Falls, skin damage and medications.

Rolling 12-month Clostridium Difficile infection rate per 100,000 OBD's: The trajectory agreed for the Trust this year is 92 cases, however this is higher than usual therefore we continue to work to the previous trajectory of 57 for the year. There were 5 cases of hospital acquired Cdiff in June, 3 relating to one ward, therefore an outbreak meeting is scheduled for 29th July 2022. Two cases have the same ribotype indicting cross infection.

Rolling 12-month MRSA bacteraemia infection rate per 100,000 OBDs: The national standard for this is zero for all trusts. The trust has seen over 5 cases in June, actions have been identified and completed to address this.

Rolling 12 months HSMR (basket of 56 diagnosis groups): In June the Trust is reporting at 112.8, actions have been identified regarding delay in data submission, review of coding and ongoing work with Dr Foster

People and Culture

Appraisals: Although the standard for Q1 was 86% below the target of 95%, we are performing favourable when assessed against our partners the ICS average is 84.2%. An Appraisals working group has been developed, which has issued an options paper regarding digital vs paper-based approach. The feedback will be reviewed to identify further actions to be taken during Q2

Timely Care

Number of patients waiting >4 hours for admission or discharge from ED: In June the Trust achieved 79.5%, which is a reduction on the previous months. This is in the main due to increased occupancy, increased MSFT and the highest level of attendances since recording began in its current format in 2019. The Trust continues to reduce the percentage of patients that convert from attendances to admissions.

Mean number of patients who are medically safe for transfer: There was a slight dip in the numbers of MSFT patients in May. However, June returned to levels comparable with previous months. In June there were 96 patients waiting for onward care against the system agreed target of 22 for SFH.

Adult G & A Bed Occupancy (8.00am position as per U & EC Sitrep): Occupancy continues to rise and was at 96.6%. This is driven in the main by MSFT as admissions have not risen.

Remote Attendances as a percentage of Total Outpatient Attendances: There has been a further reduction this month to 16% against the 25% target. This is driven in the main, but not exclusively, by clinical preference for face to face appointments. Connectivity, space and

infrastructure are also significant contributors. There is a programme in development to address some of these issues and make progress.

Follow up Outpatient Attendances reduce against Yr 2019/20: The Trust submitted a plan that was non-compliant against this metric due to the size of the overdue review list. There has been some improvement against the 25% target using Patient Initiated Follow Up, which is sitting at 4% against a target of 5% and well within trajectory.

Elective Inpatient Activity against Plan: The Trust is at 80.1% of plan due to a reduction in theatre capacity over the month as a result of anaesthetic cover gaps and increased emergency pathway pressure in the main.

Number of patients waiting over 62 days for Cancer treatment: The cancer backlog position of 134 patients is higher than the February 2020 average of 70 and our internal trajectory of 105. There is a significant amount of investigatory work being carried out within cancer services to understand the driver of the position and actions required for improvement.

Board Assurance Framework (BAF): July 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.

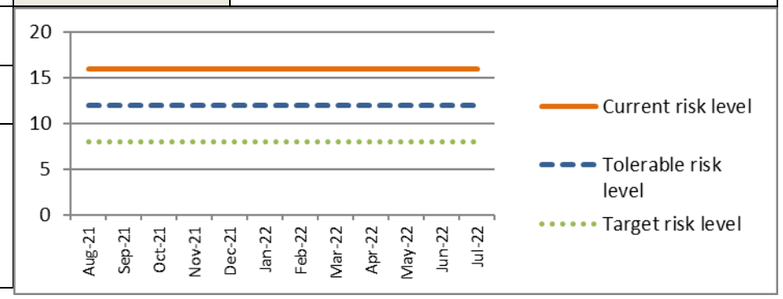
Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally 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 committee	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	11/07/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR2	Demand that overwhelms capacity	Chief Operating Officer	01/04/2018	11/07/2022	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	26/07/2022	4 x 2 = 8	4 x 3 = 12	4 x 3 = 12
PR4	Failure to achieve the Trust's financial strategy	Chief Financial Officer	01/04/2018	26/07/2022	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 & Improvement	17/03/2020	26/07/2022	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	~~Chief Executive Officer~~Director of Strategy and Partnerships	01/04/2020	12/07/2022	2 x 2 = 4	2 x 3 = 6	2 x 3 = 6
PR7	Major disruptive incident	Director of Corporate Affairs	01/04/2018	12/07/2022	4 x 1 = 4	4 x 2 = 8	4 x 3 = 12
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	Chief ~~Executive~~ Financial Officer	22/11/2021	12/07/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9

Board Assurance Framework (BAF): July 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		
Executive lead	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	11/07/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	11/07/2022								



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	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	Information, EPMA, EPR and IT Developments in development or progress **SLT Lead:** Medical Director **Progress:** EPMA rollout commenced; EPR business case to Board in June 2022 **Timescale:** ~~June 2022~~Complete 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 **Timescale:** September 2022	**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

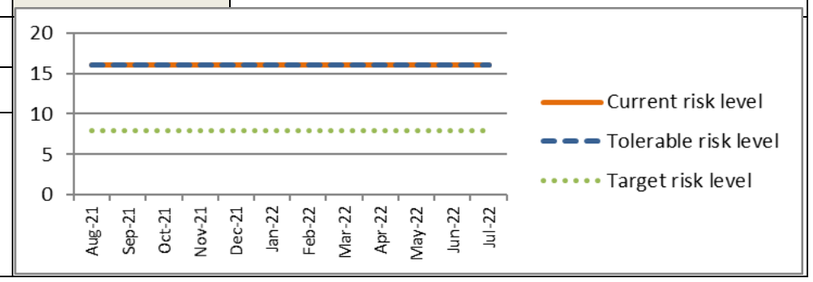
Board Assurance Framework (BAF): July 2022

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 **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 attendance at 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	Business case to enhance oxygen capacity/flow has been delivered – BOC commencement date April 2022	Inconclusive Last changed April 2020

Board Assurance Framework (BAF): July 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						
Lead Committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Executive lead	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	11/07/2022	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**		
Last changed	11/07/2022						

Strategic objective	1. To provide outstanding care



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 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~~; Identifying and capturing Potential Harm Resultant from COVID-19 Pandemic report to Board Jun '20~~; 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	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 **Timescale:** TBC Virtual ward model of care funding plan to beconsidered 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

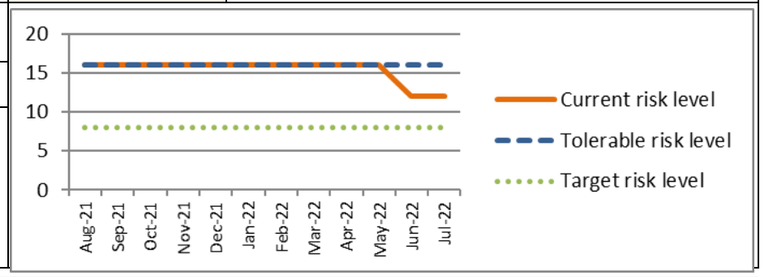
Board Assurance Framework (BAF): July 2022

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 **Independent assurance:**		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): July 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
Executive lead	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	2. Unlikely		
Last reviewed	26/07/2022	**Risk rating**	**12. High**	**16. Significant**	**8. Medium**		
Last changed	26/07/2022						

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	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:** Executive 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:** Executive Director of People **Timescale:** ~~August~~ October 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 ~~Board Oct '21~~PCI Committee Jun '22; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to PCI Committee ~~quarterly~~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	Positive Last changed June 2022

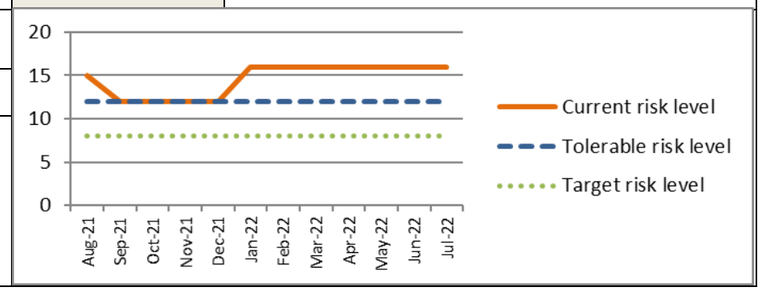
Board Assurance Framework (BAF): July 2022

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 ▪ 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	Inequalities in staff inclusivity and wellbeing across protected characteristics groups	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Executive Director of People **Timescale:** March 2023	**Management:** Staff Survey Action Plan to Board May '21; Staff Survey Annual Report to Board Jun '21; ~~Diversity & Inclusion Annual report 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	Positive Last changed June 2022

Board Assurance Framework (BAF): July 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						
Lead Committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action
Executive lead	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	26/07/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	26/07/2022						

Strategic objective	5: To achieve better value

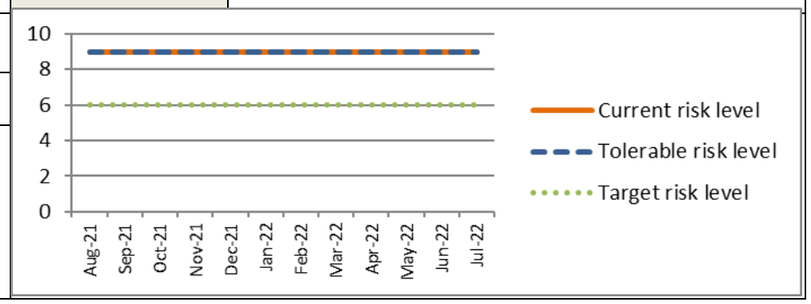


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk 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 ICBS 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	~~No long term commitment received for liquidity / cash support~~ ~~Financial allocations for 2022/23 not yet confirmed~~ Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework.	Submission of cash plan for 2022/23 **SLT Lead:** Chief Financial Officer Timescale: ~~April 2022~~Complete Final 2022/23 Financial Plan submission in April 2022. **SLT Lead:** Chief Financial Officer **Timescale:** ~~April 2022~~Complete 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	**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; Divisonal 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**: ~~Internal Audit of FIP/ QIPP processes Sep '21; EY Financial Recovery Plan;~~ Deloitte audit of COVID-19 expenditure; 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	~~NHSE/I feedback to be sought on final plan submission~~	~~Inconclusive~~ Positive Last changed July ~~2020~~2022
ICBS system deficit results in a negative financial impact to the Trust	▪ Full participation in ICBS planning ▪ SFH plan consistency with ICBS and partner plans ▪ ICBS DoFs Group ▪ ICBS Operational Finance Directors Group ▪ ICBS Financial Framework	ICS underlying financial deficit ICB Medium/Long Term Financial Strategy to be developed	Final aligned SFH and ICS financial plan submission for 2022/23 SLT Lead: Chief Financial Officer Timescale: ~~April 2022~~Complete 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	~~NHSE/I feedback to be sought on final plan submission~~	~~Inconclusive~~ Positive Last changed July ~~2020~~2022

Board Assurance Framework (BAF): July 2022

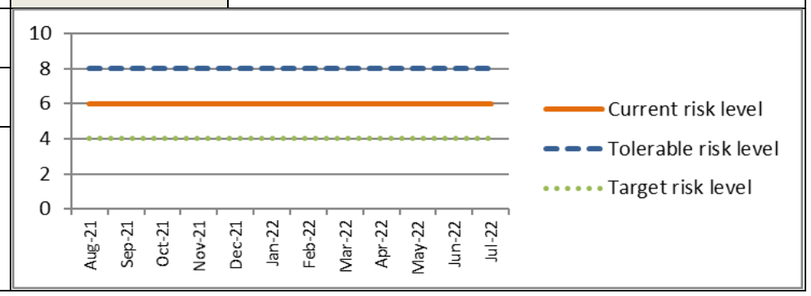
Principal risk (what could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care						
Lead Committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation
Executive lead	Director of Culture & Improvement	**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	26/07/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	26/07/2022						

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:** ~~May 2022~~December 2022 **Progress:** ~~Pursuing a joint venture with Notts Healthcare and NUH~~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 Groupquarterly; 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	Positive No change since April 2020

Board Assurance Framework (BAF): July 2022

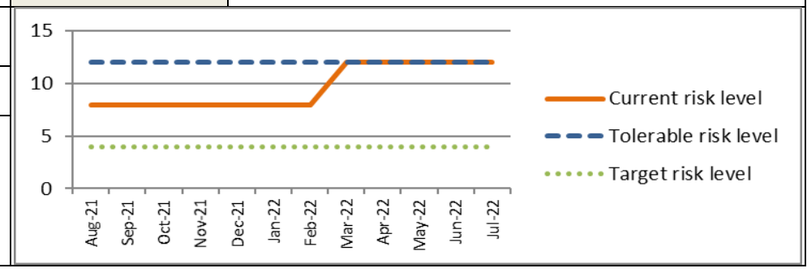
Principal risk (what could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working. This may be difficult because of differences in governance, objectives and appetite for and ability to change						**Strategic objective**	2: To promote and support health and wellbeing
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services	
Executive lead	~~Chief Executive Officer~~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	12/07/2022	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**			
Last changed	12/07/2022							

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**
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 NHSI • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans • ~~Statutory submission of Trust plans as a component of the ICS plan for the system~~ • 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)	~~Continued misalignment in organisational priorities~~ Suboptimal system oversight and arrangements for discharge of complex patients	Delivery of the agreed system priorities and plans **SLT Lead:** Chief Executive Officer **Timescale:** ~~March 2022~~Complete Consideration by ICS Chief Executives Group of sustainable architecture for to enable effective and timely discharge of MFFD patients. Provider collaborative considering taking ownership **SLT Lead:** Chief Executive Officer **Timescale:** TBC	**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	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 **SLT Lead:** Medical Director **Timescale:** TBC **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 Last changed May 2022

Board Assurance Framework (BAF): July 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						
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Executive lead	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	12/07/2022	**Risk rating**	**12. High**	**12. High**	**4. Low**		
Last changed	12/07/2022						

Strategic objective	1: To provide outstanding care

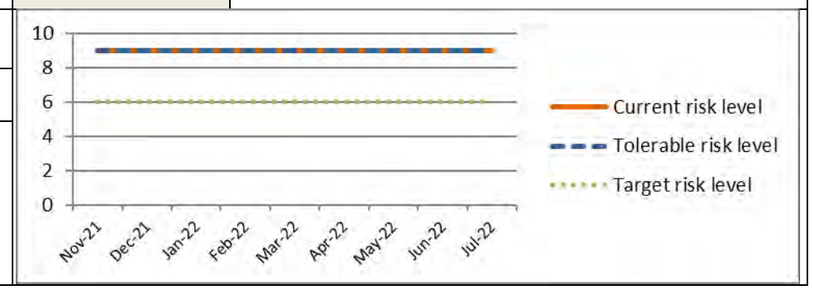


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk 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- 100% compliance; 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 – substantial 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	360 Assurance internal audit of contract management **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** ~~April 2022~~Complete **Progress:** Terms of Reference agreed	Positive No change since April 2020

Board Assurance Framework (BAF): July 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 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): July 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	
Executive lead	Chief ~~Executive~~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	12/07/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	12/07/2022							

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	~~Lack of data to accurately measure and monitor improvements~~ Education of Board and staff at all levels ~~Lack of Environmental Impact Assessments~~	Develop and embed processes for gathering and reporting statistical data **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~June 2022~~ Complete 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:** ~~June~~December 2022 Capital Oversight Group to develop a mechanism to ensure that environmental impact assessments are embedded in decision making processes and key documents (e.g. business cases, investment cases, board papers, capital bids, new and existing policies) **Lead:** Chief Financial Officer **Timescale:** ~~March 2022~~ Complete **Progress:** Environmental Impact tool approved by TMT	**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 Agree reporting structure **Lead:** Associate Director of Estates and Facilities **Timescale:** July 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**: 4th August 2022	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
Presented By:	Paul Robinson, Chief Executive Officer		
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 9th June:

- Quality Committee: PR1 and PR2 – 11th July
- People, Culture and Improvement Committee: PR3 and PR5 – 26th July
- Finance Committee: PR4 – 26th July
- Risk Committee: PR6, PR7 and PR8 – 12th July

PR1, PR2 and PR4 are significant risks.

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

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

Board of Directors Meeting in Public - Cover Sheet

Subject:	External Well-led Review – Recommendations, Progress Report	**Date**: 4th August 2022	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Shirley A Higginbotham, Director of Corporate Affairs		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
The purpose of this paper is for the Board to receive assurance regarding progress against the achievement of the recommendations identified in the final report from the Grant Thornton Well Led Review March 2022		**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**
xx		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	x
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	x

Committees/groups where this item has been presented before

Executive Team 20th July 2022

Executive Summary

Grant Thornton undertook an external Well-led review of the organisation, delivering its final report to the Trust in March 2022.

The Well-Led review is an important assessment for the Trust, not only because trusts are expected to advise NHSE/I of any material governance concerns that have arisen from the review and the action plan in response to those concerns, but more importantly because it provides the opportunity for the Trust to fully understand the strengths and weaknesses of its current governance arrangements and implement actions at an appropriate pace.

The initial report detailing the 15 recommendations was presented to Board in April 2022

This report provides progress against those recommendations, noting 8 are complete and 7 are not yet due.

Board of Directors Meeting in Public

Subject: External Well-led Review – Recommendations, Progress Report
Date: 4th August 2022
Author: Shirley A Higginbotham, Director of Corporate Affairs

Grant Thornton undertook an external Well-led review of the organisation, delivering its final report to the Trust in March 2022.

This Well-Led review was undertaken during the Covid-19 pandemic. All interviews and meeting observations were undertaken virtually using MS Teams.

The Well-Led framework for governance reviews considers 8 key lines of enquiry (KLOEs):

The table below summarises the assessment of the Trust's performance against the 8 key lines of enquiry outlined in NHSI's Well-Led framework. The 2018 Well-Led report ratings for comparison.

NHSI Well-Led framework			
#	KLOE	2018 rating	GT rating
1	Is there the leadership capacity and capability to deliver high quality, sustainable care?	GREEN	AMBER/GREEN
2	Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?	AMBER/GREEN	AMBER/GREEN
3	Is there a culture of high quality sustainable care?	AMBER/GREEN	AMBER/GREEN
4	Are there clear responsibilities, roles and systems of accountability to support good governance and management?	AMBER/GREEN	GREEN
5	Are they clear and effective processes for managing risk, issues and performance?	GREEN	GREEN
6	Is appropriate and accurate information being effectively processed, challenged and acted on?	AMBER/GREEN	AMBER/GREEN
7	Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?	AMBER/GREEN	GREEN
8	Are there robust systems and processes for learning continuous improvement and innovation?	AMBER/GREEN	AMBER/RED

Overall, 15 recommendations, were identified in the report, there were no high-level recommendation; three medium level recommendations; and 12 low level recommendations

8 actions were due for completion at the end of June 2022, these have all been completed, 6 actions are due for completion by the end of September 2022 and 1 by the end of December 2022. Progress against these actions are detailed in the report below

No.	Risk	Recommendation	Action	Lead		Timeline
KLOE 1. – Is there the leadership capacity and capability to deliver high quality, sustainable care?						
1	**Medium**	**Internal v external priorities** The Director of Human Resources is a joint post with Nottinghamshire Healthcare NHS Foundation Trust. However, due to the way the portfolio of work is arranged and the existence of a strong deputy this appears to and is reported to work well. The Director of HR is also prominent in the Integrated Care System (ICS) leading the people agenda and this workload needs to be regularly reviewed to ensure it remains manageable. **Recommendation:** As external priorities become more apparent in the establishment of the ICS a watching brief should be reviewed to ensure executives continue to have sufficient bandwidth to undertake their portfolio of work.	All joint posts with Nottinghamshire Healthcare have ceased **Complete**	Chief Executive Officer		June 2022
2	**Low**	**Succession planning** The Trust had undertaken a formal succession planning exercise for its executive roles in 2019, and this is best practice. It is important to refresh this periodically and this should be completed following the appointment of the CEO.	A report will be presented to the Nomination and Remuneration Committee **Progress update:** Draft report presented to the CEO – to be further	Chief Executive Officer	Not yet due	September 2022

		Some Trusts include the NED skills in this exercise as this can help to identify any gaps and target skill sets of future appointments. **Recommendation:** Following the appointment of the Chief Executive post the Trust should refresh its succession planning and consider extending the exercise to include NEDs and Divisional triumvirate team members	discussed with the Executive Team in August 2022, once all Executives are in post.			
3	**Low**	**Structured visits programme** The structured quality visit programme where NEDs and Executive Directors undertake more formal visits to the services has been suspended and is planned to be reinstated when the Covid -19 restrictions on access to clinical areas allow. This will be particularly helpful to the new NEDs as they familiarise themselves with the Trust's services. **Recommendation:** As soon as Covid 19 restrictions allow the Board should reinstate its structured visits programme to its services. This will be particularly beneficial to the new NEDs and existing NEDs who have missed the opportunities to undertake	Visits did commence once restrictions were lifted unfortunately these have now been paused due to the increase in COVID infections across the Trust. Visits will re-commence as soon as current restrictions are lifted, schedules for visits have been developed and are in place. **Complete**	Chief Nurse		June 2022

		face to face activities				
KLOE 2 – is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?						
4	**Low**	**Quality Strategy** A new Quality Strategy is in development. A working draft version was presented at the November 2021 Quality Committee. The new strategy will run from 2022-2025 and has four campaigns on delivery quality care: 1. Create a positive practice environment to support the delivery of safest and most effective care 2. Excellent patient experience for users and the wider community 3. Strengthen and sustain a culture of continuous quality improvement and learning 4. Deliver high quality care through kindness and supporting each other It is not clear however how the third campaign links to the improvement techniques and training that are currently being rolled out in the Trust and this should be made more explicit **Recommendation** The Quality Strategy should more explicitly document the quality improvement methodology that is being rolled out within its campaign to strengthen and sustain a culture of	The Quality Strategy will detail the quality improvement methodology embedded throughout the Trust **Progress update:** The Draft Quality Strategy was approved by Quality Committee in April 2022, further work is underway to establish success measures for each of the campaigns including ensuring the improvement methodology embedded.	Chief Nurse	Not yet due	September 2022

		continuous quality improvement and learning.				
	KLOE 3 – Is there a culture of high quality sustainable care?					
5.	**Low**	**Freedom to Speak up Guardian meetings with Divisions** The Guardian has regular meetings within one Division as these were established by her predecessor however does not regularly meet with all of the Divisional triumvirates, generally only meeting with them to discuss specific cases. **Recommendation:** The FTSU Guardian should schedule regular meetings with the Divisional triumvirate teams to develop relationships and establish a more proactive approach	Regular meetings with all triumvirates have been scheduled **Complete**	Director of Corporate Affairs		June 2022
6.	**Low**	**Freedom to Speak Up Guardian meetings with the Guardian of Safe Working Hours** Nationally the data suggests medical staff tend not to use FTSU mechanisms to raise concerns and in some trusts we see the Guardian of Safe Working Hours used to raise a broad range of issues. The Trust has successfully recruited a doctor to a FTSU Champion role and this may encourage medical staff to speak up if they have concerns. The FTSU Guardian does not meet with the	Regular meetings with the Guardian of Safe Working Hours have been scheduled **Complete**	Director of Corporate Affairs		June 2022

		Guardian of Safe Working Hours and this would be a useful link. **Recommendation:** The FTSU Guarding should arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles.				
7.	**Low**	**Awareness of detriment** It is important to ensure that people do not suffer detriment as a result of speaking up. Currently, following the closure of a case, the FTSU Guardian sends out a short four question email to staff who have raised concerns, however the response rate is low and the questions do not adequately assess if there has been any detriment. **Recommendation:** The FTSU Guardian should formalise a process to contact staff who have raised concerns three to six months following closure of the case to discuss how they are and if they have suffered detriment as a result of speaking up	A formal process to contact staff who have raised concerns to ascertain if they have suffered detriment has been developed and implemented **Complete**	Director of Corporate Affairs		June 2022
8.	**Low**	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office	Future reports to Board from the FTSU guardian and Guardian of Safe Working Hours will include	Director of Corporate Affairs and Executive Medical Director	Not yet due	September 2022

		and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation:** The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.	data by gender and ethnicity. **Progress update**: The next report due to Board from the FTSU Guardian is August 2022 and the Guardian of Safe Working Hours will present in September 2022			
	KLOE 4 – Are there clear responsibilities, roles and systems of accountability to support good governance and management?					
9.	**Low**	**Highlight report to the Board of Directors** There is variance in the quality of reporting the work of the Committees to the Board. A more common approach using a quadrant style reporting could more effectively identify key issues and action taken. **Recommendation:** Committee Chairs should consider the use of a quadrant style report to present at the Board meeting. Headings of the 4 quadrants are commonly: • Matters of concern or key risks to escalate	A quadrant template has been developed and has been implemented from April Committees. **Complete**	Director of Corporate Affairs		June 2022

		• Major actions commissioned / work underway • Positive assurances to provide • Decisions made				
10.	**Low**	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation:** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.	A schedule to ensure all chairs of committees observe the key meetings which feed into their committees will be developed and implemented	Director of Corporate Affairs	Not yet due	September 2022
11.	**Low**	**People, Culture and Improvement Committee** The Chair of the Committee does not routinely meet with the Lead Executive for this Committee, more ad-hoc arrangements occur. Setting up a scheduled arrangement would be beneficial to allow for regular discussion of progress, current issues and the identification of areas where further work my b indicated **Recommendation:**	A schedule of regular meetings prior to committee meeting will be developed and implemented **Complete**	Director of People and Director of Culture and Improvement		June 2022

		The Chair of the People, Culture and Improvement Committee should set up regular meetings with the lead Executive Directors				
	KLOE 5. – Are there clear and effective processes for managing risks, issues and performance?					
12.	**Low**	**Divisional Performance Reviews** We attended the November 2021 round of Performance Reviews for all five clinical Divisions. The Performance Review meetings are well organised and mutually supportive. We note that Urgent and Emergency Care Division presented an informative HR performance report and whilst other Divisions talk about their HR issues, they did not include a presentation of metrics. HR performance reports are routinely created and supplied to Divisions via the HR Business Partner, and these should be presented at each Division Performance Review. **Recommendation:** All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.	All future Divisional Performance Reviews will include the presentation of their HR Performance report. All divisions now have an HR report which they present monthly within their DPRs **Complete**	Chief Operating Officer		June 2022
	KLOE 6 – Is appropriate and accurate information being effectively processed, challenged and acted on					

13.	**Medium**	**Data Quality Strategy** The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However, the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore, the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. The Trust is currently in the process of moving to a more integrated approach, where data quality is owned and monitored across the wider governance structure. It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework, but this process is not yet fully documented, and roles and responsibilities need to be clarified. It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed.	**Progress update:** The Chief Digital Information Officer has implemented a Patient Information and Data Assurance Group. This group will establish and implement a Data Quality Assurance Model	Executive Medical Director	Not yet due	December 2022

		Recommendation : Once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.				
14.	**Low**	**Data Quality Assurance Indicators** The Trust does not at present utilise a Data Quality Assurance Indicator. A data quality traffic light or kite mark could be used to appear next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based **Recommendation:** The Trust should consider the use of Data Quality Assurance Indicators to inform users of any data quality risks attached to the data that might impact decision making.	**Progress update:** A review of the key indicators is being undertaken as a pilot. This work will be concluded by the end August 2022. A paper will then be prepared for Execs and Board to agree proposals to how this will be taken forward	Director of Corporate Affairs		September 2022
	KLOE 7. – Are people who use services, the public, staff and external partner engaged and involved to support high quality sustainable					

	services?					
	We have not made any recommendations in this area as the Trust is already working on issues identified.					
	KLOE 8. – Are there robust systems and processes for learning, continuous improvement and innovation?					
15.	**Medium**	**Continuous Improvement** The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation:**	**Progress update:** The QI Maturity Matrix survey results were shared with the Executive Team (8th June) and wider SLT 16th June. SLT was facilitated by independent partner the East Midlands Academic Science Network who has independently assessed the results of the maturity assessment. Recommendations will provide a new focus for QI. Regular Improvement development sessions with all Senior Leaders are scheduled over 2022/2023. Confirmed schedule to be completed following 16th June SLT session. The new Quality Strategy is aligned with the SFH vision for Continuous Improvement and the Trust approach to improvement. Thus, strengthening being	Director of Culture and Improvement		September 2022

		Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.	embedded throughout the Trust. **Completed.** Sharing of Quality Improvement projects will be further captured through the new AMaT audit and improvement portal. **Ongoing.**			

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Public

Subject:	Covid-19 Inquiry - Process	**Date**: 4th August 2022	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Shirley A Higginbotham, Director of Corporate Affairs		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
The purpose of this paper is for the to receive assurance regarding the process the Trust is undertaking in response to the publication of the Covid-19 Inquiry Terms of Reference		**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	X19	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	x
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	x

Committees/groups where this item has been presented before

N/A

Executive Summary

The Government announced in May 2021 there would be an independent public inquiry into the governments handling of the Covid-19 pandemic.

At the announcement of the Inquiry the Trust developed a Covid-19 Inquiry working group, the first meeting was July 2021. The Director of Corporate Affairs is the Chair of the group.

The working group met twice during 2021 to ensure the preservation order was enacted and was then temporarily paused awaiting confirmation of the Terms of Reference.

The Terms of Reference for the Inquiry were published in June 2022 and the working group has had a meeting in July to identify areas of focus.

On 21st July 2022 the Covid-19 Inquiry launched its first investigation, identifying three modules, the public hearings for the first two modules will take place in the spring and summer of 2023.

The third module will focus on healthcare systems, timings for this module will be published in the coming weeks.

Subject: Covid-19 Inquiry - Process **Date:** 4th August 2022
Prepared By: Shirley A Higginbotham, Director of Corporate Affairs

The Government announced in May 2021 there would be an independent public inquiry into the government's handling of the Covid-19 pandemic. The Chair of the inquiry, Baroness Heather Hallett was appointed in December 2021, the Terms of Reference were consulted on, and the final version published on 28 June 2022.

At the announcement of the Inquiry the Trust developed a Covid-19 Inquiry working group, the first meeting was July 2021. The Director of Corporate Affairs is the Chair of the group.

The first task was to implement a preservation order, to ensure no documents were destroyed. Also, all staff who were involved in any Covid 19 meetings or correspondence and were leaving were asked to leave their contact details should they be required for anything in relation to the inquiry.

The working group met twice during 2021 to ensure the preservation order was enacted and was then temporarily paused awaiting confirmation of the Terms of Reference. These have now been re-instated and the latest meeting was in July 2022.

The Terms of Reference identify the aims of the Inquiry as:

Aim 1 Examine the Covid-19 response and the impact of the pandemic in England, Wales, Scotland and Northern Ireland and produce a factual narrative account, including:

- The public health response across the whole of the UK
- The response of the health and care sector across the UK
- The economic response to the pandemic and its impact, including governmental interventions

Aim 2 Identify the lessons to be learned from the above, to inform preparations for future pandemics across the UK

A link to the full Terms of Refence is here UK COVID-19 Inquiry: terms of reference - GOV.UK (www.gov.uk)

The key areas of focus for the group, as identified in the Terms of Refence are:

The Public health response across the whole of the UK

a) Preparedness and resilience
b) How decisions were made, communicated, recorded and implemented
c) The impact on health and care sector workers and other key workers
d) The safeguarding of public funds and the management of financial risk. – Covid-19 expenditure details

The response of the health and care sector across the UK

a) Preparedness, initial capacity and the ability to increase capacity and resilience – Documentation as b) above.
b) The management of the pandemic in hospitals, including infection prevention and control, triage, critical care capacity, the discharge of patients, the use of Do not attempt cardiopulmonary resuscitation' (DNACPR) decisions, the approach to palliative care, workforce testing, changes to inspections and the impact on staff and staffing levels.

c) Antenatal and post-natal care
d) The procurement and distribution of key equipment and supplies, including PPE and ventilators
e) The development, delivery and impact of therapeutics and vaccines
f) The consequences of the pandemic on provision for non-Covid related conditions and needs
g) Provision for those experiencing long-Covid

The group are collating and reviewing:

- Business Continuity Plans.
- documentation from the Incident Control Team meetings and other governance meetings, including the executive team meetings and decisions and the items reviewed discussed and approved at Board of Director meetings.
- Health and well-being support offers to staff and volunteers.
- Covid-19 expenditure details

These areas of focus may expand as the inquiry progresses.

On 21st July 2022 the Covid-19 Inquiry launched its first investigation, identifying three modules

Module 1 – which opened on 21st July will examine the resilience and preparedness of the UK for the coronavirus pandemic

Module 2 – will be split and will examine core political and administrative governance and decision making by the UK government. Modules 2A, 2B and 2C will address the same overarching and strategic issues from the perspective of Scotland, Wales and Northern Ireland.

Module 3 – will investigate the impact of Covid, and the governmental and societal responses to it on healthcare systems, including on patients, hospital and other healthcare workers and staff.

Procedural hearing for Modules 1 and 2 will begin in September and October 2022, with public hearings for Module 1 commencing in spring 2023 and summer 2023 for Module 2. The timings for Module 3 will be released in the next few weeks.

Further modules will be announced in 2023 and these are expected to cover both the system and impact of issues including: Vaccines, therapeutics, anti-viral treatment, the care sector, Government procurement, Personal Protective Equipment (PPE), testing and tracing, Government business and financial response; health inequalities and the impact of Covid-19 on education, children and young people and the impact of Covid-19 on other sectors.

The Chair of the Inquiry has pledged to deliver reports with analysis, findings and recommendations whilst the Inquiry's investigations are ongoing, so that key lessons from the pandemic are learned quickly.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

All reports MUST have a cover sheet

Subject:	Maternity Update - Maternity and Neonatal Safety Champions update	**Date:** 04/08/2022
Prepared By:	Paula Shore, Director of Midwifery/ Head of Nursing	
Approved By:	Phil Bolton, Chief Nurse	
Presented By:	Paula Shore, Maternity and Neonatal Safety Champion & Claire Ward Non-Executive Board Safety Champion.	

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

None

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 their service locally, working with their 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 June 2022

1. ***Service User Voice***
   As part of our ongoing engagement with the Maternity Voice Partnerships (MVP), on 15 June 2022 the Director of Midwifery, Consultant Midwife and Professional Midwifery Advocate (PMA) attended the MVP showcase event leading the Q&A panel with colleagues from Nottingham University Hospitals.

   Key guest speakers and women and their families attended the day and relationships continue to be established. At SFH the work of both the Parent's Voice representative and PMA's continue and the learning from these sessions are fed back through the MNSC meetings for action.

2. ***Staff Engagement***
   The MNSC walk round was completed on 7 June 2022. Team members spoke up about the increased activity and the impact across the service. However, recognition was noted pertaining to how the increase in staffing was supporting the increased pressure that is evident within the service. The Maternity Forum meeting was moved this month due to clinically acuity and was rearranged to take place on 5 July 2022.

   Staff raised concerns about the proposed termination of enhanced bank pay rates within maternity which they felt may result in a reduced shift fill. A 3-month extension was agreed whilst shift rates are aligned and a workstream has been established with NUH ,through the LMNS, to agree a standardised and aligned rate across the system

3. ***Governance***
   Ockenden: The final 5 peer assessed IEA's are under review with a plan to provide an update to the Board of Directors in August.

   NHSR: The pause on the Year 4 work was lifted on 6 May 2022. The divisional working group has been relaunched to help the delivery of the scheme. All current deadlines have been met and forward reporting has been mapped against key meetings. 360 assurance have commenced external validation process on 4 of the 10 safety actions.

   SFH attended and contributed towards an extraordinary NMC review of the Nottingham University Maternity training triggered by the NUH CQC report and Ockenden pending review. Outcome of the review is expected later in July 2022.

4. ***Quality Improvement Approach***
   The senior maternity team attended the planned regional day on the 8 June 2022 and have brought the wider learning back to implement within the project team. There was an update on the work around the Prevention of Pre-term birth. Work continues on the Maternity and Neonatal Safety Improvement Programme focusing on this within the 2022-23 improvement plan.

5. ***Safety Culture***
   The national team from NHSE/I have contacted SFH to ask what support would be needed to launch the SCORE survey. Feedback has been provided accordingly around the communication needs for this which are predominantly why the SCORE survey differs from the staff survey. The plan remains on track for August 2022 and is being led by the Service Improvement Team. The SCORE results will be used alongside the existing staff survey data and it is hoped this will provide a more detailed area to focus on and outputs to support cultural improvement work within maternity

Maternity Perinatal Quality Surveillance model for June 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%

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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

3rd and 4th Degree Tears (3.72% 2022)

- Rate just above national trigger threshold.
- Deep dive review into cases have found no themes or trends. Plan is to observe and action as needed.
- Noted that all 3rd and 4th Degree tears are reportable via Datix, none have been rated as moderate or above.

Stillbirth rate Q1 (5.9/1000 births)

- SFH rate above the national ambition of 4.4/1000 births for this quarter.
- Year end rate for 2021-22 was 2.37/1000
- All cases have been managed through the governance process, two requiring referral to HSIB and two managed through the PMRT process.
- Any immediate actions have been taken, team are awaiting the return of further tests and investigations for the full PMRT review.

Staffing red flags (June 2022)

- 4 staffing incident reported in the month
- No further issues raised around staffing, aligned with the successful recruitment and ongoing re-designed preceptorship programme.

Home Birth Service

- Due to vacancies and sickness homebirth services remains limited as per Board approval. This has been further escalated to the CCG and regionally for awareness.
- 1 Homebirth conducted in Jun 22, plan in place to re-start the full service on the 18th Sept 2022

FFT (88% Jun 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 relaunched on the 6th of May 2022 • Divisional working group effective, reporting timeline mapped against key meetings	• Initial 7 IEA- final IEA is 86% completed plan underway for final action • Final 15 IEA, 14 have been peer assessed with plan for the final 1

Incidents reported June 2022 (98 no/low harm, 1 as moderate)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 18	Cases included, PPH, term admission and 3rd/4th degree tears
One incident reported as 'moderate'	

Other

- One case reported as moderate- taken through Trust Scoping Process, following a panel review for Divisional Report.
- Active recruitment continues. Open day in June completed and a further 12 WTE newly qualified midwives recruited- acute maternity fully recruited in Sept 2022 with plans to target community.
- No formal letters received and all women who have a planned homebirth, all women due in August have been written to by the Director of Midwifery to outline current situation.
- Midwifery Continuity of Carer system submission made on the 16th of June 2022- awaiting national feedback

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 where available]	Running Total/ average	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22
Perinatal	1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Women booked onto MCOC pathway			20%	20%	20%							
	Women receiving MCOC intraprtum			0%	0%	0%							
	Total BAME women booked			20%	20%	20%							
	BAME women on CoC pathway			15%	15%	15%							
	Spontaneous Vaginal Birth			51%	61%	57%	56%	63%	61%	59%	55%	60%	60%
	3rd/4th degree tear overall rate	>3.5%	2.18%	0.94%	2.11%	3.00%	2.50%	2.78%	2.52%	2.90%	3.00%	6.20%	3.72%
	Obstetric haemorrhage >1.5L	Actual	116	8	9	10	9	6	8	7	6	9	7
	Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.51%	2.90%	3.50%	3%	2.12%	3.30%	2.60%	2.20%	3.20%	2.45%
	Term admissions to NNU	<6%	3.62%	2.16%	3.70%	3.20%	3.70%	5.00%	3.50%	3.50%	1.60%	4.00%	2.60%
	Apgar <7 at 5 minutes	<1.2%	1.56%	1.20%	1.52%	2.03%	2.10%	1.90%	1.80%	2.00%	0.84%	0.40%	1.20%
	Stillbirth number	Actual	11	1	0	0	3	1	1	0	1	2	2
	Stillbirth number/rate	>4.4/1000	4.63	2.176			3.400			3.727			5.952
Workforce	Rostered consultant cover on SBU - hours per week	<60 hours	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	10
	Midwife / band 3 to birth ratio (establishment)	>1:28		1:30.4	1:29	1:29	1:29	1:29	1:22	1:22	1:22	1:22	1:24.5
	Midwife/ band 3 to birth ratio (in post)	>1:30		1:31.4	1:29	1:29	1:28	1:28	1:24	1:24	1:24	1:24	1:26.5
Feedback	Number of compliments (PET)		0	0	0	0	0	0	0	1	1	1	1
	Number of concerns (PET)		9	2	4	0	0	0	0	2	2	1	0
	Complaints		11	1	3	2	1	1	1	2	1	0	2
	FFT recommendation rate	>93%		92%	88%	96%	96%	92%	91%	90%	89%	88%	88%
Training	PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	100%	100%	100%	100%	94%	95%
	K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	98%
	Core competency framework compliance			50%	62%	70%	70%	81%	81%	88*%	95%	95%	95%
Reporting	Progress against NHSR 10 Steps to Safety	<4 <7 7 & above											
	Maternity incidents no harm/low harm	Actual	709	76	63	57	89	83	45	69	58	70	99
	Maternity incidents moderate harm & above	Actual	8	0	1	1	0	1	1	1	1	1	1
	Coroner Reg 28 made directly to the Trust		Y/N	N	N	N	0	0	0	0	0	0	0
	HSIB/CQC etc with a concern or request for action		Y/N	N	N	N		N	N	N	N	N	N

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

All reports MUST have a cover sheet

Subject:	Maternity Update - Home Birth Service	**Date:** 04/08/2022
Prepared By:	Melanie Johnson, matron for Community & Outpatients Lisa Butler, Deputy Head of Midwifery	
Approved By:	Phil Bolton , Chief Nurse	
Presented By:	Paula Shore, Director of Midwifery/ Head of Nursing	

Purpose		
The purpose of this paper is to inform the Board of Directors that we are planning to recommence our overnight home birth service which was suspended in September 2021, therefore providing 24-hour cover from the 19 September 2022.	**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**		**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	**X**
PR4	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Maternity Assurance Committee

Executive Summary

The purpose of this paper is to inform Trust Board of Directors that we are recommencing our overnight home birth service, which was suspended in September 2021. The plans will be to provide a 24-hour cover from the 19th of September 2022. This is in line with NUH who are also proposing to recommence their service in September 2022.

BACKGROUND

Following on from the suspension of our home birth service back in September 2021 there has been good progress made in recruiting midwives to join the community midwifery service. Staffing is now at a level deemed safe to recommence our 24-hour on call home birth service.

HOME BIRTH SERVICE

On average our home birth service delivers six babies per month. Whilst this number is low, we are aware of the impact this facility has on our women. Women will have multiple reasons for choosing a home birth due to the benefits from birthing at home. ***Board of Directors members are asked to note that because of the low numbers of home births there are only two midwives on call overnight for this service. This means that if more than one woman commences in labour overnight we may not be able to facilitate this.*** During the woman's birth plan discussions, the community midwifery team ensures that this is shared with the women.

RECOMMENCEMENT OF THE HOME BIRTH SERVICE

It has been a year since our homebirth service ran in its true form which may have de-skilled some staff and in addition we have recruited a number of new staff. Therefore, the following actions will be put in place to ensure the workforce is well supported.

1. Staff will now go out to home births in pairs. This will support our junior/new midwives and enable fresh eyes to take place during auscultation.
2. Workshops have been arranged for all community midwives to access during August 2022 and early September 2022 in preparation for recommencement of the home birth service. The workshops will be facilitated by our Practice Development team and experienced community midwives who can share their wealth of knowledge. These workshops will include looking at kit required, calling for help and emergency skills.
3. Team leaders are going to look at skill mix when allocating nights on call to ensure the midwives that have not yet attended a homebirth have support.

CONCLUSION

A full 24-hour home birth service should be available for people choosing to birth at our hospital by 19 September 2022 providing staffing levels remain stable.

RECOMMENDATIONS

Trust Board are asked to note the following:-

1. **All of the aforementioned proposals are based on staffing levels remaining stable until September 2022. If this changes reconsideration may be required to ensure a safe service is in place.**

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Freedom To Speak Up	**Date**: 4th August 2022	
Prepared By:	Kerry Bosworth - Freedom To Speak Up Guardian		
Approved By:	Shirley Higginbotham – Director of Corporate Affairs		
Presented By:	Kerry Bosworth - Freedom To Speak Up Guardian		
Purpose			
The purpose of this paper is to provide an update to the Board on the Freedom to Speak Up Agenda within the Trust and provide assurance of the Speaking Up service.		**Approval**	
		Assurance	x
		Update	x
		Consider	

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

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

People Culture and Improvement Committee receive FTSU reports – last presented June 2022

Executive Summary

This report is a six-monthly report to inform the Board of Speaking Up cases within the Trust, analyse themes of concerns within the organisation, FTSU progress, alignment to current national recommendations and improvements being made. Contains a case study and feedback on FTSU. Contains latest mandate from NHSEI requiring all leaders be trained in speak up, listen up and follow up

Abbreviations used-
SFH – Sherwood Forest Hospitals
EDI – Equality, Diversity & Inclusion
FTSUG - Freedom To Speak Up Guardian
FTSU - Freedom To Speak Up
NGO - National Guardians Office
HR - Human Resources
F2F – face to face
NHIS – Nottinghamshire Health Informatics Service
OD - Organisational Development
NHSEI - NHS England and Improvement

Freedom To Speak Up

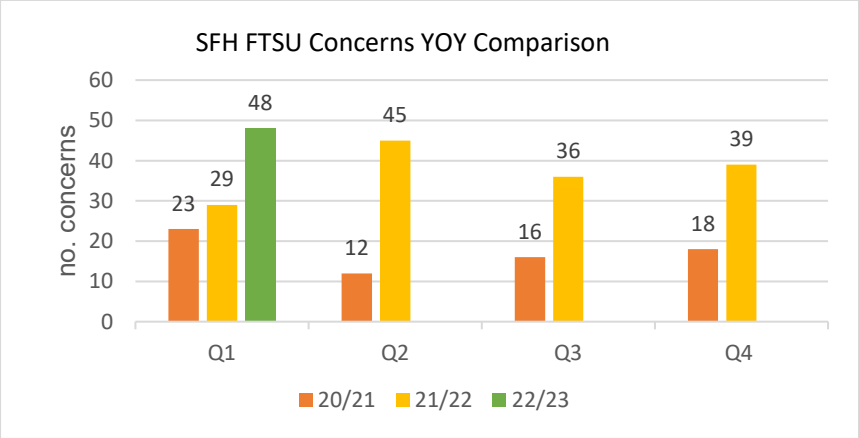
SFH Board Report – August 2022

Kerry Bosworth FTSU Guardian

Sherwood Forest Hospitals NHS Foundation Trust

Overview

The number of SFH colleagues raising concerns through FTSU continues to increase. Year on year comparisons show progress in numbers of workers raising concerns



Year Totals

20/21 = 69 concerns

21/22 = 149 concerns

Out of the 22/23 Q1 concerns raised, 36 were escalated openly, 12 were escalated confidentially (known to FTSUG only) and there were no anonymous concerns. This continues to show increasing trust in escalating concerns openly to those in a position to support and follow up the concerns

All Divisions are represented in using FTSU

To understand inclusivity in those who use FTSU , EDI data is now included in this report

Q1 EDI data – 22 completed EDI forms returned

Ethnic origin	15 White British , 3 British Asian , 3 British African ,1 White Irish
Gender	19 Female , 3 Male
Sexuality	20 Heterosexual , 2 LGBTQ
Age	>40yrs = 13
	<40yrs = 9
Disability	2

Medical FTSU Speaking Up

Medical colleagues remain represented in raising concerns which is welcomed The concerns focus on incivility , sexism and leadership response to these issues .

Triangulation of these concerns with HR and Medical Directors Office is prompting a response led by HR ,to look at medical leadership training and educational needs relating to above concerns . Exploring how we equip medical leaders in behaviour management , incivility , conflict and allyship issues

Concerns raised Q4 21/22 and Q1 22/23

Bullying & Harassment

- Bullying from a peer
- Bullying from line manager
- Bullying culture within team
- Sexual Harassment

Attitudes and Behaviours

- Misogynistic behaviours - unconscious bias / lack of professional respect
- Incivility
- Inappropriate behaviour – racism

Leadership Style Behaviours

Remains a significant theme in the concerns.

- Poor response to raising concerns locally
- Processes and policy not followed – HR issues
- Incivility in teams not addressed
- Incivility in response from line manager/ senior leader
- Favouritism
- Recruitment to roles – inconsistent approach
- Interview panels not inclusive , poor feedback
- Lack of consultation for changes
- Wellbeing – mental health poor understanding , impact on individuals' emotional wellbeing due to concerns in workplace

Patient, People Safety & Quality

- Behaviours of incivility impacting patient safety ,patient care and experience
- Emotional impact on workers , fatigue and reduced resilience

Case Review - FTSU Concern Involving Leadership Style and Behaviours

Leadership style and behaviour concern

- Worker suffering difficult personal challenges , requested adjustments . Initially agreed but then withdrawn . Mode of communication was all via email .
- Line manager then questions performance on a misinformed work issue and phones direct whilst at work with no pre warning
- Worker goes off sick as so distressed with issues
- Betrayal of confidentiality to other team members about personal circumstances
- Long period of sickness as feels unable to return , team dynamics different
- Returns after long period , to an uncompassionate review meeting , no apology or acceptance of issues
- Comes to FTSU as wants to leave organisation

FTSU actions and learning

- Ensured awareness of Wellbeing Services
- Create confidential escalation with Dept Lead
- Dept Lead supports mediation with both workers
- Mediation over several appts – difficult and barriered
- FTSU remains as support for individual in moving through mediation
- Agreement in mediation made with acknowledgement of learning points and way forward on how to work together in future made
- Dept focuses work on line manager styles and feedback from case – have implemented F2F touch points for individual and learning that communication via emails to teams / individuals is not supportive when someone has concerns
- Leadership tools and education for line manager
- Theme fed to Culture & Improvement Directorate for Trust wide learning – scoping of what leadership training and education offers exist for leaders regarding issues such as incivility , having difficult conversations , in receipt of me and supporting speaking up . FTSUG feeds case review and themes into existing leadership training and consideration ongoing of how we engage existing leaders in the sessions

FTSU Progress at SFH

NHSEI Freedom To Speak Up Review Tool

Review tool completed April 22 by FTSU Executive and FTSUG . Presented at People Culture and Improvement Committee June 22. Gaps identified are -review and further development of the FTSU Strategy by Jan 2023 and review of SFH Speak Up Policy by Nov 22

Growing the FTSU Champion Network

Following several FTSU Champions standing down due to leaving SFH , there has been further recruitment to the role to ensure our grassroots representation . New Champions completed training in May and there is a waiting list for training in the Autumn . This is encouraging that colleagues wish to represent FTSU and they care about our values and improving culture of improvement by supporting everyone to have a voice

Recognising the vital role FTSU Champions play in speak up culture, we now have representation in Estates & Facilities and NHIS – areas where we haven't had Champions previously . We also have a new Medical FTSU Champion

The FTSUG has developed a Champions Toolkit to support them in signposting services and avenues of support for colleagues who speak to them . From the regular Champion Forums , it was felt there were gaps in knowledge of which services support speak up and recognition of the emotional impacts of speaking up but also in hearing concerns, so the toolkit contains important wellbeing resources as well as pathways for concerns to be shared

Collaboration with SFH Wellbeing Team

The emotional impacts of poor worker experience and the impacts on mental health when raising concerns has become more evident in the workforce when raising concerns to the FTSUG .

Therefore action and collaboration with the SFH Wellbeing Team has forged new relationships and enables the FTSUG to refer to the Wellbeing Team directly and vice versa, when they are supporting colleagues whose work experience is the cause of their emotional and mental distress .

National Staff Survey 2021

SFH demonstrates an increase in the number of staff who feel safe to speak up about unsafe practice , feel encouraged to report errors and feel confident the organisation would address concerns about safe practice . SFH is above the national average for all the speak up questions and gives encouragement that colleagues feel able to have their say

HSJ Award Entry

Recognising a good year for FTSU within SFH , an entry for the FTSU award at the HSJ Awards has been submitted .

FTSU Feedback

Feedback from those who use FTSU remains positive . This is requested via MS Forms . Additional to feedback requests , the FTSUG will follow up approximately 6 months post concern with a detriment questionnaire to ensure no harm is experienced from speaking up and improvement is sustained – commenced July 2022

Recent feedback –

"I tried to raise a concern within a service at SFHT, but I was belittled in the first instance and struggled to get any meaningful acknowledgement and response when things still did not feel right after trying to take my concern further. Kerry was extremely supportive and listened to my experience. Kerry created an environment that made me feel like the sharing of my experience was worthwhile and what I had to say had some value. Kerry instantly recognised important themes associated with my experience that had not been addressed and needed investigating. Kerry very swiftly ensured that I was listened to, that my concerns were properly investigated, and the outcomes were shared with me. The FTSU service is essential, and I would recommend the service to anyone who feels they cannot speak up or that they have tried but have not been listened to. If something does not feel right, we have a duty to speak up. My experience of this is that it can feel daunting, emotional and stressful but the FTSU service was there to listen and offer support throughout the process."

"I think my concerns were very clearly taken on board seriously and with clarity and a good understanding, and action was taken appropriately at all levels."

National Updates

NHSEI updates

1.Following the publication of the Ockenden Review , a letter from the NHS Executive Team was sent to all provider organisations in April 2022 . Within this letter there was action required with relevance to speak up -

"*The report illustrates the importance of creating a culture where all staff feel safe and supported to speak up. We expect every trust board to have robust Freedom to Speak Up training for all managers and leaders and a regular series of listening events. A dedicated maternity listening event should take place in the coming months"*

2. NHSEI and NGO publish new Speak Up Policy and FTSU Reflection Tool June 2022

NHSEI is asking all trust boards to be able to evidence by the end of January 2024:

- An update to their local Freedom to Speak Up policy to reflect the new national policy template
- Results of their organisation's assessment of its Freedom to Speak Up arrangements against the revised guidance and tool by Jan 2024

3. Launch of final NGO eLearning module Jun 2022 – Follow Up .

This completes the trilogy of modules called Speak Up , Listen Up and Follow Up .

Follow Up is aimed at senior leaders , executives and non-executive directors to ensure self-reflection and understanding of their roles in FTSU to drive improvement . This will form part of the Board Development Session in Aug 22 , presented by the FTSUG .

Recommendations for SFH –

1. **All leaders / line managers to complete Speak Up & Listen Up training.**
    - **This can be delivered across the organisation to existing and new leaders by completing NGO eLearning modules – Speak Up & Listen Up , Follow Up to be completed by senior leaders . Accessible on Sherwood eAcademy**

The SFH Board are asked to receive assurance from the report regarding the Freedom to Speak Up agenda and agree the above recommendations

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Audit & Assurance Committee Chair's Highlight Report to Trust Board

Subject:	Audit & Assurance Committee (AAC) Report	**Date:** 4th August 2022
Prepared By:	Graham Ward – AAC Chair	
Approved By:		
Presented By:	Graham Ward – AAC Chair	

Purpose	
To provide Assurance to the Board regarding the activities of the Audit Assurance Committee. The Committee met on 21st July 2022, the meeting was quorate	**Assurance**

Matters of Concern or Key Risks to Escalate	**Major Actions Commissioned / Work Underway**
▪ Internal Audit – Implementation of internal audit recommendations is still problematic, though there are early signs of improvement. ▪ Internal Audit Limited Assurance Report (Contract Management) - The report and actions progress were presented by the Strategic Head of Procurement. The Committee took assurance from the planned actions against the three recommendations and the progress being made and will continue to monitor action implementation. ▪ Risk Committee – fragile corporate services had been highlighted as a new risk and a report is to be presented to Board.	▪ Non-Clinical Policies – there are still a number of these that are out of date across all executive directors and as a priority these need reviewing, updating as appropriate and approving. Executive directors will be asked to attend the next Audit Committee with an update on progress where still outstanding.
Positive Assurances to Provide	Decisions Made
▪ Counter Fraud – Actions are in place to support maintaining all 14 measures of the Functional Standard Requirement rated as Green for 2022/23. ▪ Internal Audit – 360 Assurance are developing a Divisional Governance Toolkit which will be rolled out across all divisions to measure and help further develop their governance processes	

▪ External Audit – KPMG presented the final External Audit Annual Report which will now be published on our website. ▪ Procurement – the Strategic Head of Procurement presented the annual procurement report which highlighted the strength of the department and the value it continues to deliver to the Trust. ▪ Clinical Audit – the annual report (which has also been presented to Quality Committee) was tabled. While a lot of disruption to reports has happened due to Covid good progress was evidenced. It was agreed that future reports would highlight progress from the previous years.	
Comments on Effectiveness of the Meeting	
▪ All papers were of a high quality and clear which helped the meeting run smoothly.	

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Chair's Highlight Report to Trust Board

Subject:	Finance Committee meeting	**Date:** 4th August 2022	
Prepared By:	Richard Mills, Chief Financial Officer		
Approved By:	Andrew Rose-Britton Non-Executive Director		
Presented By:	Andrew Rose-Britton Non-Executive Director		
Purpose			
This paper summarises the key highlights from the Finance Committee meeting held on 26th July 2022		**Assurance**	**Sufficient**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Board Assurance Framework Principal Risk 4 remains at a score of 16 (Significant) in recognition of the financial risks facing the organisation.	• Recommendations of 2021/22 Contract Management internal audit to be actioned. • To review number of Finance Committee meetings for 2023. • Financial challenges: Deeper dives to be instigated to provide further assurance on financial risks.
Positive Assurances to Provide	**Decisions Made**
• The format of the Monthly Finance Report has been refreshed and the paper prompted a good conversation about pertinent issues. • A Procurement Forward View was shared, giving advanced notice of significant upcoming projects. • Positive action has been taken in response to the recommendations outlined in the 2021/22 Contract Management internal audit report. • The Trust is progressing its self-assessment against the HFMA Financial Sustainability report. • We are on track to complete and submit the National Costs Collection return in line with NHSE/I timescales.	• Sherwood Community Unit approval was confirmed. • The risk associated with Board Assurance Framework Principal Risk 4 was considered and maintained at 16, in recognition of the financial risks discussed. • Approved a funded case to support the development of a Community Diagnostics Centre (CDC). • To ensure that the committee recognised the need to align forecasts with operational pressures
Comments on Effectiveness of the Meeting	
The Committee felt the meeting was productive and the papers were well presented which enabled decisions to be made in a considered manner.	

Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

Quality Committee Chair's Highlight Report to Trust Board

Subject:	Report from the Quality Committee	**Date:** 4th August 2022
Prepared By:	Barbara Brady, Non – Executive Director, Chair of QC	
Approved By:	Barbara Brady	
Presented By:	Dr Aly Rashid, Non – Executive Director and member of the Quality Committee	
Purpose		
To provide Assurance to the Board regarding the activities of the Quality Committee. The Committee met on 11th July 2022, the meeting was quorate		**Assurance**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ Negative impact of COVID-19 on clinical capacity resulting in poor attendance and limited contribution to key forums within the Trust e.g. Drug and Therapeutics Committee, GIRFT, and CYP Board (this has been temporarily suspended) ▪ Relocation of services due to COVD-19 related operational pressures has had an impact on patient care e.g. impact of discharge lounge relocation on vascular clinic ▪ Results of the Sentinel Stroke National Audit	▪ Deep Dive into Stroke services ▪ Review of how SFHT Quality Committee relates to Quality forum for Nottinghamshire ICS
Positive Assurances to Provide	**Decisions Made**
▪ PFI Quality Dashboard, with particular focus on water quality issues ▪ Progress on Medicines optimisation ▪ Clinical Audit programme and work to better align this programme with Clinical Effectiveness and Quality Strategy	▪ BAF PR1 & PR2 reviewed, overall risks remain the same. ▪ Terms of reference approved.
Comments on Effectiveness of the Meeting	
▪ Good discussion, debate and healthy challenge.	

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:** 4th August 2022	
Prepared By:	Manjeet Gill, Non-Executive Director		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
Presented By:	Manjeet Gill, Non-Executive Director		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
Areas such as staff absence, mandatory training, appraisals and wellbeing continue to be key concerns and risks and a key part of the Committees focus. Following a review of PR3 and PR4 risks in the Board assurance framework, Committee decided to keep the same risk level and were assured they have greater visibility on some of the workforce capacity issues as a result of the work force planning analysis. Two areas of potential risks on the horizon are industrial action and impact of pensions. The Strategic Workforce Plan ongoing development shared the analysis by types of staff and divisions. The trajectory of staff leaving the Trust, versus staff recruited was projected as negative in most service areas, which informs the mitigations proposed and being taken. Further work is taking place with services on detailed actions to mitigate against, these future scenarios.	The People Culture and Improvement Strategy implementation will include further ongoing development of its measurable outcomes in areas such as rates of staff turnover and specific targets where protected characteristics show negative variations to the Trust wide outcome. The next Committee workshop will seek to develop a collective understanding and agreement on how assurance is given on measuring impact of strategy work. Estates scorecard requested to establish assurance on management of people in the service and by partner teams such as Medirest. This to be aligned with the PCI strategy metrics scorecard and presented to a future committee. The Equality Diversity and Inclusion strategy and work will receive regular updates to the committee. Leadership Development and Talent Management approach to incorporate medics and make greater links to EDI agenda. Further development of agency spend and controls in place to reduce

	agency usage, this work to be taken through the Medical and Nursing Taskforce meetings and to be presented back to the committee. The latest draft of the Strategic Workforce Plan was presented and more detail of the engagement taking place across the divisions was shared. The October Committee will receive the final plan.
Positive Assurances to Provide	**Decisions Made**
An update was presented regarding the work undertaken to implement the People, Culture and Improvement Strategy 2022-2025. The committee noted the work which has taken place to socialise and commence delivering the strategy. Positive assurance was received in various areas such as wellbeing, Employee relations, estates scorecard, external funding secured for collaborative work, Involvement Charter, QI Maturity Matrix and agency reporting dashboard. Update report on the People, Culture and Improvement Strategy highlighted the range of activity in the first quarter. A lot of good progress made. Positive assurance received regarding the 360 Audit Assurance report on the Equality, Diversity & Inclusion (EDI) agenda with its recommendations, actions taken and proposed. Equality impact assessment of the virtual wards project highlighted issues, mitigations and benefits and is to be aligned with the technology impact assessment for virtual wards.	Strategic Workforce Plan to be scheduled for presentation to Board later in the year once finalised in the autumn. Board to receive assurance on industrial action if this matter escalates into industrial action. Audit and Assurance Committee to be informed of the assurance received by this Committee and actions being taken regarding the audit report on Equality Diversity and equality strategy.

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.