Sherwood Forest Hospitals NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: Thursday 2nd November 2023
Time: 09:00 – 12:30
Venue: Boardroom, King's Mill Hospital

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 5th October 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Action Tracker**	Update	Enclosure 5
6.	09:10	**Chair's Report**	Assurance	Enclosure 6
7.	09:15	**Chief Executive's Report**	Assurance	Enclosure 7
	Strategy			
8.	09:25	**Strategic Priorities update 2023/2024** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 8
9.	09:40	**Early findings from Public Engagement on Strategy for 2024-2029** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 9
10.	09:50	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity Update** Report of the Director of Midwifery o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 10.1
11.	10:05	**Strategic Objective 3 – Empower and support our people to be the best they can be** • **Nursing, Midwifery and Allied Health Professions (AHP) Staffing 6 monthly report** Report of the Chief Nurse • **Medical Workforce Staffing – 6 monthly report** Report of the Medical Director	Assurance Assurance	Enclosure 11.1 Enclosure 11.2

	Time	Item	Status	Paper
12.	10:25	**Patient Story –Michael's journey through ED – The impact of medical jargon** Joanne Eyre, ED Lead Nurse	Assurance	Presentation
	BREAK (10 mins)			
	Operational			
13.	10:55	**IPR (Integrated Performance) Report – Quarterly** Report of the Executive Team	Consider	Enclosure 13
	Governance			
14.	11:40	**Board Assurance Framework** Report of the Chief Executive	Approve	Enclosure 14
15.	11:50	**Partnerships and Communities Committee Terms of Reference** Report of the Director of Corporate Affairs	Approve	Enclosure 15
16.	12:00	**Use of the Trust Seal** Report of the Director of Corporate Affairs	Assurance	Enclosure 16
17.	12:00	**Emergency Preparedness** • **Emergency Preparedness (EPRR) Core Standards Self-Assessment** Report of the Emergency Planning & Business Continuity Officer • **Business Continuity Policy** Report of the Emergency Planning & Business Continuity Officer	Assurance Approve	Enclosure 17.1 Enclosure 17.2
18.	12:10	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting)	Assurance Assurance	Enclosure 18.1 Enclosure 18.2
19.	12:20	**Outstanding Service – Sherwood Forest Hospitals CARE values – Together we CARE**	Assurance	Presentation
20.	12:25	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
21.	12:30	**Any Other Business**		
22.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **7th December 2023, Boardroom, King's Mill Hospital**		
23.		**Chair Declares the Meeting Closed**		
24.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		

	Time	Item	Status	Paper
		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 14	• **Significant Risks Summary**
Enc 18.1	• **Finance Committee - previous minutes**
Enc 18.2	• **Charitable Funds Committee - previous minutes**
Enc 21	• **Improvement Advisory Group Quadrant report**

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 5th October 2023 in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Graham Ward	Non-Executive Director	GW
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Andrew Rose-Britton	Non-Executive Director	ARB
	Aly Rashid	Non-Executive Director	AR
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	Phil Bolton	Chief Nurse	PB
	Rob Simcox	Director of People	RS
	David Selwyn	Medical Director	DS
	Rachel Eddie	Chief Operating Officer	RE
	Richard Mills	Chief Financial Officer	RM
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	David Ainsworth	Director of Strategy and Partnerships	DA
In Attendance:	Paula Shore	Director of Midwifery	PS
	Alison Steel	Head of Research and Innovation	AS
	Jacqueline Read	Associate Director of People (Operations)	JR
	Amy Gouldstone	Health and Wellbeing Lead	AG
	Mark Bolton	Associate Director of Operational Performance	MB
	Charlotte Ainger	Associate Director of Operations – Planned Care	CA
	Kerry Bosworth	Freedom to Speak Up (FTSU) Guardian	KB
	Sue Bradshaw	Minutes	
	Jessica Baxter	Producer for MS Teams Public Broadcast	
Observers:	Harry Carpenter	Health Informatics Trainee	
	Georgia Richardson	Health Informatics Trainee	
	Precious Idienumah	General Management Trainee	
	Ian Holden	Public Governor	
	Sue Holmes	Public Governor	
	Jane Hildreth	Communications Specialist	
	Claire Page	360 Assurance	
	Anna Whittaker	Notts TV	
	2 members of the public		
Apologies:	Barbara Brady	Non-Executive Director	BB

Item No.	Item	Action	Date
23/308	**WELCOME**		
1 min	The meeting being quorate, CW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and any members of the public watching the live broadcast were able to submit questions via the live Q&A function.		
23/309	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
23/310	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Barbara Brady, Non-Executive Director.		
23/311	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 7th September 2023, the Board of Directors APPROVED the minutes as a true and accurate record.		
23/312	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 23/173.4, 23/252.1, 23/252.2, 23/252.4, 23/252.5, 23/282.1, 23/282.2, 23/285 and 23/289 were complete and could be removed from the action tracker. ***Action 23/252.3*** – RS advised this item had been deferred to the November meeting of People and Culture Committee.		
23/313	**CHAIR'S REPORT**		
1 min	CW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective. The Board of Directors were ASSURED by the report.		

23/314	**CHIEF EXECUTIVE'S REPORT**		
15 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 Integrated Care Board (ICB) led engagement in relation to the opening hours of the Urgent Treatment Centre (UTC) at Newark Hospital, the forthcoming opening of additional theatre capacity at Newark Hospital, progress with the Community Diagnostics Centre (CDC) at Mansfield District Hospital, the flu and Covid vaccination programme, operational pressures and industrial action. DS advised, the continued industrial action comes at a cost to the Trust, teams, colleagues and, most importantly, patients. The national waiting list is approaching 8 million and the national cost of industrial action is over £1 billion. Currently no further periods of industrial action have been announced, but there are also no talks in progress. This is a national dispute between the British Medical Association (BMA) and the Government and there is an increase in rhetoric from both sides. SFHFT needs to try to balance the demands from both sides, with the responsibility to care for patients. It was noted the recent period of industrial action saw a greater consultant loss than previous periods (45% compared to 33%), but this was balanced with reduced junior doctor loss (65% compared to 78-86%). The national Medical Director, Acting Chief Operating Officer and Chief Nurse have written to the BMA raising concerns in relation to the impact of continued periods of Christmas Day service on waiting patients, patient flow and the emergency pathway. RE advised the pressure on teams is impacting on the Trust's ability to progress other priorities, noting the upcoming Winter period. The effect of ongoing industrial action is being felt by all teams within the Trust, including administration teams who are dealing with patients who have had appointments cancelled. RE expressed thanks to all Teams across the Trust. MG queried if NHS England (NHSE) had issued any guidance in relation to the impact of industrial action on harm and safety risks. DS advised there is an understanding there have been a significant number of cancellations, including some urgent (P2) and cancer cases. It is known, from previous work, cancellation of P2 patients is associated with patient harm. The Trust has actively sought information relating to harm, noting it is difficult to identify harm and it will take some time. DS advised every meeting relating to industrial action, starts with the question, "Are there any urgent patient safety concerns". Over all the periods of industrial action, there have been a total of two concerns raised, noting one was not an issue and the other was rapidly addressed, with the patient coming to no significant harm. DS advised the greater concern is for patients on the waiting list, noting harm will be identified retrospectively. It is important not to underestimate the impact cancelling surgery has on patients' lives.		

	MG queried if there was anything further the Trust needed to consider, together with partners, in terms of managing communications with the community. DS advised people will vent their frustration against the Trust, despite the industrial action being as a result of a national dispute. It is important not to underestimate the societal and reputational risk to the Trust. PR noted the work involved in planning for industrial action in order to minimise disruption. PR acknowledged the recent media coverage in relation to delays to patient letters at hospitals in Newcastle and Nottingham, advising the Trust is taking positive action to seek assurance in relation to the efficiency of processes which are in place across the organisation. A working group has been established which will report to the Quality Committee. PR advised October is Black History Month and Speak Up Month. SB noted the issue in relation to delays to patient letters and queried if the approach being taken by the Trust will provide the Board of Directors with an early view of any issues and risks. PR advised the intention is to undertake a review and increase scrutiny in the form of a dashboard, which will provide information in 'real time' and provide assurance to the Quality Committee. The Board of Directors were ASSURED by the report.		
23/315	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
12 mins	PS joined the meeting. **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting 15 Steps walkaround of the Neonatal and Maternity Unit, first anniversary of the Home Births Service restarting, appointment of a registered nurse vaccinator within maternity, Ockenden insight visit, Lime Green Infant Feeding Team and actions being taken to address health inequalities within maternity. PS advised the Saving Babies Lives Care Bundle national upload has started. The Local Maternity and Neonatal System (LMNS) have undertaken an evidence review and they are happy with the Trust's submission. The Trust is compliant with Version 2 and is now working on Version 3. AH queried the timescale for the outcomes of the Score Survey to be known and queried what action is being taken to offer Covid vaccinations within maternity.		

	PS advised the registered nurse vaccinator has started and is able to administer flu vaccinations. Additional training is being provided to enable them to administer Covid vaccinations. These vaccinations will be provided in the clinic and all women will be offered vaccinations when they attend for their key scans. In terms of the Score Survey, the leads within the Surgery Division and Maternity are currently looking at the debriefing. The debriefing team in maternity will debrief in surgery and vice-versa. Once the debrief is complete, the findings will be brought together. MG queried how many home births have taken place over the past year and if there has been any feedback from families about their experience. PS advised there have been 40 home births since the service restarted in September 2022. The matron who oversees the service is preparing a report for Quality Committee which will focus on what was different with those births, patient stories, etc. The Trust has received lots of positive feedback from the LMNS and there has been shared learning with Nottingham University Hospitals (NUH) who are about to restart their service. MG sought clarification in relation to the Care Quality Commission (CQC) should do action noted in the report, "Leaders should continue to implement improvements to how they effectively communicate any changes in service provision with staff". PB advised feedback from the CQC visit was staff on wards and departments were not always sighted on the good work being undertaken and the improvements being made. Therefore, the Trust needs to consider how to improve the method of communication with teams. There are a number of things in place, for example, the Maternity Forum, walkarounds, newsletters, etc. It is important to have multiple methods in place as people respond to different things. There are innovative ways of communication in place and there has been a huge improvement over the last 12 months. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance*** PB presented the report, highlighting third and fourth degree tears and the impact of industrial action on the elective caesarean section list. It was noted there were no still births in August 2023. AR noted the method of measuring obstetric haemorrhage changed some time ago, but there are still a large number of haemorrhages. AR queried if there were any underlying issues in relation to this. PS advised there has been an increase in the number of caesarean sections, advising blood loss is higher with a caesarean section. It is important to look at the quality indicators which sit behind the haemorrhage, for example, length of stay, requirement for blood transfusion, percentage haemoglobin drop, etc. and there are no changes when these factors are considered. Difficulties remain in the accuracy of measuring blood loss. SFHFT is working with NUH in relation to the Rotem trial, which is looking at haemoglobin more rapidly as an indicative measure of the effect of the haemorrhage. If caesarean sections were removed from the data and different modes of birth were considered, the figures would be different. Reporting as a single figure is difficult as there is a need for the context.		

	AR queried if it was possible for comparative data from peer trusts, who use the same methodology for recording as SFHFT, to be included in future reports. PB advised this information is contained in the LMNS data which can be reported to the Board of Directors. It is important not just to look at the crude data, but consider if there was any patient harm, length of stay increase, admission to critical care, etc. This is the focus through thematic reviews. PB advised there will be increased information in relation to this in the report for Quality Committee. DS advised when this has been reviewed previously, aspects such as blood transfusion per patient were considered and there was no cause for concern. **Action** • **Comparative data in relation to obstetric haemorrhage to be included in future maternity update reports to the Board of Directors.** • **Further information on quality indicators linked to obstetric haemorrhage to be included in maternity reports to the Quality Committee.** The Board of Directors were ASSURED by the report. PS left the meeting.	**PB** **PB**	**02/11/23** **02/11/23**
19 mins	**Learning from Deaths** DS presented the report, highlighting Hospital Standardised Mortality Ratio (HSMR), Summary Hospital Level Mortality Indicator (SHMI), quality impact of deficiencies in patient care, identified areas for improvement, structured judgment reviews (SJR) and learning from Learning Disabilities Mortality Review (LeDeR) deaths. DS advised there are no concerning trends from the 100% independent review of deaths of patients in the Trust's care. DS advised the Quality Committee has undertaken a deep dive into HSMR. AR confirmed there had been an extensive discussion in relation to HSMR at the recent meeting of the Quality Committee, advising the Committee are assured the issues relating to HSMR are being discussed openly and multiple avenues are being explored. The Committee expressed concern in relation to the available resource for coding and noted this needs to be addressed. The Committee welcomed the fact the Trust is being opened to external scrutiny. SB queried if there was anything further which can be done to provide assurance in relation to HSMR, noting there may be some issues to which the Trust is currently unsighted. DS advised the assurance he takes is from the work undertaken so far, the Trust is convinced it is a data issue as opposed to a care issue as there are no issues with care highlighted by any of the triangulation work. Fixing the data is difficult. However, technology is improving and the Trust is transferring information relating to comorbidities onto the electronic platform. As the Trust moves through the electronic patient records process, coding aspects will be easier to identify. The Trust has good data in relation to what codes are missing, why they are missing and where they are		

	missing, which identifies the areas to target. The Trust used to be paid on the coding, i.e. if a certain degree of treatment was provided, payment would be made accordingly. However, with the move to block contracts, that element is not as clear and the Trust is doing more activity than it is being paid for. SB queried if there was an element of judgment in deciding which cases should be subject to an SJR. DS advised there are a series of case categories which definitely require an SJR. In addition, an SJR would be undertaken if there was a concern raised by family members, clinical teams or the independent scrutineer. SB queried if the Trust was losing income as a result of the block contract or suffering penalties. DS advised this is circa £1.1m. RM advised this is an indicative figure. The allocations, and the way in which the financial framework has worked over the last few years, has moved away from a payment by results tariff based service. In understanding costs and how they benchmark with other organisations, it is based on case mix. Anything elective related has reverted to a form of tariff. MG felt consideration should be given to how the information gathered through the work relating to HSMR could be used to look at prevention of health issues. DA advised the Trust, together with Nottinghamshire County Council, has been successful in attracting funding to look at the affects of alcohol on liver disease. DS advised the Trust is sharing HSMR data with the ICB. AH queried how mortality reviews and Medical Examiner reviews will link in with the new Patient Safety Incident Response Framework (PSIRF). DS advised a number of themes have been established which will be taken forward into the PSIRF programme. Reviews will be brought together into a single forum. DS advised an information session on HSMR will be arranged for members of the Board of Directors, who are not members of the Quality Committee, to increase understanding of HSMR. **Action** • **Information session on HSMR to be arranged for members of the Board of Directors, particularly those who are not members of the Quality Committee.** The Board of Directors were ASSURED by the report.	**DS**	**TBC**

23/316	**STRATEGIC OBJECTIVE 2 – IMPROVE HEALTH AND WELLBEING WITHIN OUR COMMUNITIES**		
3 mins	**Flu Vaccination Plan** RS presented the report, highlighting flu vaccination uptake in 2022/2023, target for 2023/2024, delivery approach for 2023/2024 and the communication plan. RS advised 1,800 vaccinations have been administered to 5th October 2023 since the programme commenced on 20th September 2023. Vaccine uptake will be tracked through the Integrated Performance Report (IPR) on a quarterly basis, with updates being provided to the People and Culture Committee. The Board of Directors were ASSURED by the report.		
23/317	**STRATEGIC OBJECTIVE 3 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE**		
14 mins	**Workforce Race Equality Standard Report (WRES) and Workforce Disability Equality Standard Report (WDES)** RS presented the reports, highlighting growth of Black and Minority Ethnic (BME) representation within the workforce, growth in disability declaration rates on the electronic staff records system (ESR), progress made in terms of challenging behaviours towards BME and disabled colleagues and improvements in BME and disabled colleagues feeling they can progress their career with the Trust. RS advised SFHFT is in the top 10% of trusts nationally for providing equitable recruitment processes. However, it is acknowledged there is further work to do, particularly in relation to racial abuse experienced by colleagues, embedding anti-racism at the Trust and reducing presenteeism from disabled colleagues. AR felt there is a need to be clear what is meant by 'Board representation', noting only two members of the Board of Directors are from a BME background. AR noted it is nationally recognised it is difficult for people from ethnic minorities to get above Band 8c level in the NHS. This needs to be noted and to ask the question as to why that is the case. AR noted there are a number of doctors in consultant positions within the Trust who are from a BME background, but felt their career progress beyond consultant level is unclear. AR felt there are some areas to concentrate on. RS acknowledged the points raised, which will be a continued focus for the People and Culture Committee. DS advised the Trust has a mature programme in terms of Clinical Fellows, which actively seeks to bring international graduates to the Trust and helps them develop in the NHS. There is a mature and structured process to support them through Certificate of Eligibility for Specialist Registration (CESR) accreditation, noting some of these doctors progress onto a conventional training programme. There are a number of doctors within the Trust who have progressed through the CESR programme into senior leadership posts. There is a diverse representation in terms of the Trust's medical workforce. There is an active Specialty and Specialist (SAS) doctors' forum, noting there is a high instance of that workforce coming from overseas.		

	MG advised there has been some research which suggests starting with senior levels as a focus to get the 'pull factor'. There is a need to consider what is the best strategy for achieving senior levels. RS advised actions are often described as positive action or high impact action. The approach will be considered by the People and Culture Committee. GW felt there is a need to get underneath the statistics and speak to BME and disabled staff to find out how they are feeling, how the present compares to previous years and what else can be done from their perspective. RS acknowledged there is a need to ensure the voice of these colleagues is heard and listened to and there is ongoing work with the staff networks in relation to this. Feedback from the networks will be included in future reports. PR advised it is important for the staff networks to feel supported and to stimulate interest in colleagues joining the networks. PR advised he will be visiting each of the networks over the next year to understand how the networks can be supported further. AR noted the data contained within the report in relation to consultant recruitment aggregated by ethnicity and felt it important for applicants who are not shortlisted, or appointed following interview, to be given the opportunity to receive the right kind of feedback to help them with future applications. RS advised it has been recognised the Trust's processes are equitable compared to the wider peer group, but acknowledged the figures are stark and it is a valid point. The Board of Directors were ASSURED by the reports.		
23/318	**STRATEGIC OBJECTIVE 4 – TO CONTINUOUSLY LEARN AND IMPROVE**		
24 mins	AS joined the meeting. **Research – update** AS presented the report, highlighting recruitment into trials, lack of recruitment into commercial trials, research activity across specialities, financial position, patient experience and progress against the 2022/2027 Research Strategy. AR felt it important to maximise the opportunity to apply for grants, noting it is very difficult to be successful in obtaining grant funding without academic partnership. AR queried what academic partnerships the Trust has, how strong they are and how many applications for grants the Trust has submitted. AR noted there is some research which requires bed space, but also desktop based research. AR queried if the possibility of bringing in large grants for non-physiological measurement research, in partnership with others, has been considered. AS advised SFHFT has had very little success in securing grant funding, mainly because the Trust does not have a formal relationship with an academic organisation, although it has been working on creating a collaboration with Nottingham Trent University to support nursing and midwifery teams. In terms of clinician colleagues, it has been very challenging to try to encourage them to be interested and		

	develop those partnerships to apply for large grants. It is hoped this will improve as part of the Clinical Research Facility (CRF) as this will bring the opportunity for closer partnerships with NUH and enable SFHFT and NUH to work together on grants. The Trust hopes to employ a clinical research fellow to be based in the CRF. Two deputy CRF directors have been appointed, funded by NUH. They will be free to develop relationships with other universities, not just one. GW felt consideration should be given to any actions the Board of Directors can take to support the commercial aspect of research. GW queried if the Trust has given any thought to applying for university status, as this may help with grants. It is important to develop relationships with universities in the best possible way. PB advised the Trust does work with universities, advising there are three posts, joint funded with the University of Nottingham, which have recently been appointed to, for nursing and Allied Health Professionals (AHP). These are not senior posts but are aimed at anyone with an interest or desire to develop their skillset. In addition, the academic research posts will look at pathways for staff who want a clinical academic pathway. DS advised one of the 'hot topics' for the ICB acute medical directors is research. DS advised he and PB have met with the Deputy Vice Chancellor of the University of Nottingham, who is keen to work with the Trust. DS advised the Trust is research active in other areas, for example the Trust is part of the East Midlands Imaging Network (known as EMRAD). MG queried what are the benefits of research for patients and the local population and how is this information captured. AS advised the main benefits of research, particularly the CRF, relates to the levelling up of opportunity. For the past two years the Trust has funded a joint post with primary care for someone to work alongside an academic GP in Huthwaite. This has quadrupled research activity across mid-Nottinghamshire and has spread across the Primary Care Networks (PCNs) with Ashfield PCN being particularly research active. This is an example of providing wider opportunities across the system. In terms of measuring the impact of studies the Trust participates in, this is difficult as the Trust is generally a participating site and is reliant on the sponsor of the study to disseminate the results. The Trust has been the lead on a couple of studies and has sponsored a couple of studies. The Trust is part of the Integrated Care System (ICS) Research Partners Group and there is funding from the Clinical Research Network (CRN) to develop the ICS Research Strategy. This will enable support colleagues in social care, public health and the voluntary sector to be more supported. The Trust is part of the 'CoLab' initiative, which is an initiative by the Universities for Nottingham, to support people in the community to put forward ideas for research and support them to take part in research activity. If the Trust has the opportunity to lead on more studies, there will be the opportunity to target areas people in the community think are important.		

	MG advised as part of 'levelling up', the Prime Minister has recently announced the area served by the Trust has been allocated £20m and queried if there was an opportunity for the Trust to secure some of that funding. AS advised she was not sighted to that opportunity. Funding for research at the Trust is limited to what is allocated by the CRN. Any additional funding which could be secured would be welcomed. The Board of Directors were ASSURED by the report. AS left the meeting.		
23/319	**STAFF STORY – MENOPAUSE IN THE WORKPLACE – LEARNING FROM AND SUPPORTING OUR COLLEAGUES**		
13 mins	JR and AG joined the meeting. JR and AG presented the Staff Story, which highlighted the support provided to staff going through the menopause. CW felt this is a very important service for staff, particularly given the number of women within the Trust's workforce. It is very important to ensure they feel their best when in work. GW recognised the work being done, advising this aids understanding of what the menopause actually means. Increasing awareness is very important. PB advised he chairs the Women's Network within the Trust and is often asked why this is the case. PB advised as someone who works with a predominantly female workforce, he made the conscious decision to deal with his own ignorance in relation to menopause. Everyone will come into contact with menopause in some way and everyone has an obligation to educate themselves and support colleagues. JR and AG left the meeting.		
23/320	**WINTER PLAN**		
23 mins	MB joined the meeting. RE advised the Winter Plan includes putting additional capacity in place, work to improve pathways to improve flow, etc. It will still be a very challenging Winter, but the combination of schemes will help to mitigate the risk to patients. MB presented the report, highlighting key principles for Winter planning, the approach taken, bed modelling, mitigations, elective activity, vaccination plans, communications approach, key areas of system focus, staff wellbeing offer and escalation plans and contingencies. The Winter Plan will continue to evolve and it forms part of a wider process across the ICS. Any significant variances to plan will be escalated. GW felt a plan is only as good as the assumptions it is built on and expressed concern in relation to the Trust's ability to reduce the number of Medically Safe for Transfer (MSFT) patients as outlined in the Winter Plan.		

	RE advised reducing the number of MSFT patients is the single biggest opportunity to create capacity. The Trust is currently working closely with PA Consulting, who have been engaged by the system to support the delivery of the urgent care pathway. They have initially been asked to focus on the discharge issue. There are opportunities in relation to discharge, but they are hard to realise due to complex working across a variety of system partners. However, there are also some internal opportunities. SB noted the impact of Virtual Ward is relatively small and queried if there was anything further which could be done to improve this. RE advised Virtual Ward had been discussed in detail at the recent meeting of the Quality Committee. Performance has started to improve, particularly as Outpatient Parenteral Antimicrobial Therapy (OPAT) services have come online. There will be further opportunities in relation to respiratory pathways as we head into respiratory season. DS advised Virtual Ward is 'work in progress' but the service is growing and the Trust is on trajectory to 'overproduce' Virtual Ward beds. However, there is work to do and other opportunities to be explored. ARB queried if there is anything further the Trust can do with the ICS in terms of risk management and sharing risks, particularly in relation to MSFT patients. RE advised this aligns with the work PA Consulting are currently undertaking, noting they are engaging with all system partners. PA Consulting were engaged initially for the diagnostic phase, which is due to finish in approximately 2 weeks' time. They have been looking at the interfaces with all partners. Engagement with the ICS in relation to the MSFT agenda is improving, with organisations working more collaboratively and trying to support each other to solve common problems. PR noted the regular meetings and collaborations RE attends with NHS Chief Operating Officers, which also include representation from social care across the county and other partners, for example, City Care. CW acknowledged there has been an ongoing challenge in terms of delivering To Take Out (TTO) medications in a timely manner. Noting there is a proposal in the Winter Plan to support a faster process, CW queried what actions are being taken which will be embedded, not just for Winter but also the longer term. RE advised a transformation group has been established within Pharmacy to look at this. There is a target of a two-hour turnaround time for TTOs and the trust is achieving above 90%. It is not solely a pharmacy process as it also involves junior doctors on the wards writing up the prescriptions and how ward rounds operate. Some small-scale work has been undertaken, starting with stroke and respiratory wards, to look at the process to identify anything which can be tightened up. RE advised she recently attended a regional Winter launch event, at which there was a presentation from the Regional Lead Pharmacist in relation to community services which could support hospital discharges, for example, Community Pharmacy Consultation Service, Discharge Medicines Service and voluntary services. Work is underway to identify if those opportunities can be expanded.		

	CW advised she has raised the issue of a Pharmacy First Service with the ICS, noting if patients are being encouraged not to attend the hospital as part of the Prevent Programme, they need to have access to a Pharmacy First Service, and this is currently not operational across Nottingham and Nottinghamshire. AH queried if the Trust has targeted sufficient mitigation into the January 'window' and if this could be increased. RE advised, as part of the broader system Winter planning process, there will be a more focussed piece of work looking at the December / January period. RE advised the approach to elective activity is different for 2023/2024, advising in 2022/2023 the aim was to protect elective activity due to the recovery position at the time. However, this became impossible by January and the Trust converted elective beds to medicine, but this was done in a way which was not planned for and was, therefore, not done int the most efficient or effective way. For 2023/2024, the Trust has put in a contingency plan for converting elective beds. This will only be enacted if necessary, but it will ensure there are plans in place to convert beds in the best possible way and safest way for patients. The Trust will also seek to identify other actions which can be put in place to mitigate the risks. DS advised the Winter Plan is an advanced plan, based on a number of assumptions. The modelling will be reflected on for future years. The plan is subject to change, depending on what challenges have to be faced, for example a big Covid wave or flu wave. SB queried if the Trust will review if the decision to reduce the bed base is a better decision financially and for patients. RE advised it is not an option to close escalation (route to balance) beds until there is evidence the number of MSFT patients is reducing on a sustained basis. While it may be better financially, it is not tenable from a quality and safety perspective. RM advised from a financial perspective the plan was the Trust would be able to remove some of the escalation beds, noting these were not classified as core beds. However, it has not been possible to remove those. The hope was there would be a reduction in demand, which would, therefore, be aligned to the removal of escalation beds. However, demand has remained at a higher level and, therefore, those adjustments have not been enacted to date. PR advised there are patients in beds across Nottinghamshire who are medically safe for transfer. There is a need to discharge those patients to the appropriate place in order to reduce the number of escalation beds open. This is the route to balance plan. GW advised the Trust will not reduce escalation beds if there is a concern about quality of care and safety of care. The Board of Directors APPROVED the Winter Plan. MB left the meeting.		

23/321	**PLANNED CARE ASSURANCE REPORT**		
7 mins	CA joined the meeting. RE advised NHSE has written to acute trusts requesting a self-certification against a number of key activities in relation to elective recovery. The submission has been discussed at the Quality Committee. It was noted the Trust is offering limited assurance against some of the agenda. However, the Quality Committee were happy to support the submission to NHSE. It was noted this is work in progress and there are a number of challenging standards the Trust needs to meet. Progress updates will be provided to the Quality Committee on a regular basis. CA presented the report, highlighting areas of challenge, areas of clinical risk and areas of strength. MG sought assurance all the areas identified in the report have an assurance process at executive level and queried what ongoing assurance will be provided to the Board of Directors. RE advised a governance structure is in place to look at all the areas in more detail. Updates on progress against the standards will be provided to the Quality Committee. The Board of Directors were ASSURED by the report and APPROVED the submission to the self-certification assessment to NHSE. CA left the meeting.		
23/322	**GOVERNANCE REVIEW FOLLOWING THE TRIAL OF LUCY LETBY**		
23 mins	KB joined the meeting. PR advised following the trial of Lucy Letby, NHSE wrote to all trusts setting out five requirements for Board governance and oversight, all of which relate to the Freedom to Speak Up (FTSU) agenda. It was noted these areas are detailed in the report, together with an additional 12 areas of broader governance and assurance mechanisms which have been identified within the Trust. KB presented the report, advising this details the Trust's response to the five areas raised in the letter from NHSE, highlighting the approach to reaching out to bank staff and staff who work out of hours, the need to raise awareness of FTSU and the FTSU training offer. KB advised the FTSU reflection and planning tool was completed in April 2022 on the old framework. This is due for review in April 2024, but as this is now a more detailed document, consideration will be given to brining this review forward.		

	ARB queried if agency staff can link into FTSU. KB advised FTSU is available to everyone who works in the organisation, including agency staff, volunteers, etc. In terms of those staff being aware of FTSU, this is reliant on the wards and department areas they cover promoting Speaking Up. Offering FTSU training to everyone as part of the mandatory training offer will help provide assurance people are aware of FTSU. DS referenced the query raised in the letter from NHSE in relation to boards seeking reassurance that staff can speak up with confidence and whistleblowers are treated well, noting this is not generally the case in the NHS. DS queried if there is evidence whistleblowers are treated well at SFHFT or if there are any areas for improvement. KB advised she seeks feedback and evaluation from people who use the FTSU process, noting the majority of people have reported a positive experience. KB advised she is aware she is unable to capture all feedback as people do not always provide this. KB advised she always seeks feedback regarding the process, rather than the concern and solution. The FTSU policy includes a detriment section and this is highlighted to people when the process is explained. AR sought assurance people would feel able to come forward if a similar situation to the Lucy Letby case arose within SFHFT, people would be protected and any signals would be identified at an early stage. KB advised the crimes of Lucy Letby pre-date FTSU being embedded in NHS organisations. KB advised she has the option to signpost and escalate with confidentiality to the National Guardians' Office if it is felt appropriate action has not been taken locally or if people do not feel able to speak up within the organisation. AR queried if KB could signpost nationally without the knowledge of her Trust line management. KB confirmed she is able to do this, advising another alternative is to go via Barbara Brady, Senior Independent Director. KB advised she has previously signposted people, who are fearful of speaking up via the usual routes, due to how they feel, to BB for a confidential conversation in the first instance. MG queried what reassurance processes are in place to confirm the effectiveness of controls which are in place and how does the Trust balance a culture which has values in relation to trust and respect, with a culture which is looking for criminal intent. PR advised the Trust has a process in place for reporting incidents and near misses, etc. and learning from those. PR noted 'bad' people do 'bad' things, advising it is everyone's responsibility to promote an open and transparent culture where incidents and near misses are reported and colleagues are supported to be able to speak out. The mechanisms outlined in the report enable this to happen. DS advised people do not come to work to do harm, but sometimes 'bad' things happen. The Trust has robust processes in place to investigate incidents and learn from them. The Trust does not want to start to change its culture to get the Police involved in every investigation. It is important not to lose sight of the balance of what the Trust is doing in the normal 'safety netting' and mechanisms for this exceptional case.		

	SB noted the recommendations for consideration in relation to FTSU training being made mandatory and the FTSU Reflection and Planning Tool being reviewed and queried if these recommendations would be taken forward. PR advised he had asked KB to provide a response to the specific points raised in the letter from NHSE. PR advised the recommendations made by KB would be adopted. RS advised there is a need for a degree of pragmatism in relation to the introduction of mandatory training. While the aspiration might be for all staff to receive mandatory FTSU training, there is a need to consider how the transition is made over a period of time to roll this out to 6,000 individuals. Training could be delivered to new starters as a key part of their orientation, but there is a need to use a variety of other options to deliver some of the key messages to all the workforce. SB felt one of the biggest differences which can be made relates to line management and how it feels as a line manager when someone is raising something which could feel like a complaint. It is easy to go into a defensive mode in this situation. The culture shift would be for concerns to be welcomed and acted on. AH felt it would be useful to undertake a review of the Trust's whistleblowing process over the past 5 years. MG queried how members of the Board of Directors can assure themselves they do not have optimism bias. MG noted fraud control is a well-established aspect of criminal intent and queried if there was any learning the Trust can take from the controls which are in place for fraud control. GW advised Counter Fraud reports to the Audit and Assurance Committee on a regular basis, noting this works very well. PR advised the transferable learning which can be taken from that into the FTSU agenda is the huge amount of work undertaken by Counter Fraud to raise awareness of fraud. DS advised it is key to recognise there might be optimism bias, call it out and for members of the Board of Directors to challenge each other. PR advised there will be recommendations for trusts arising from the public enquiry into the Lucy Letby case. When these are known, the Trust will implement those and at that point it may be useful to get an external view of the processes and mechanisms which the Trust has in place. The Board of Directors were ASSURED by the report. KB left the meeting.		

23/323	**UPDATED FIT AND PROPER PERSON TEST**		
3 mins	SBS presented the report, advising a new Fit and Proper Person Test Framework has been introduced from 30th September 2023, with the purpose to strengthen and reinforce individual accountability and transparency for board members, thereby enhancing the quality of NHS leadership. The five key elements of the new test are outlined in the report. The Board of Directors were ASSURED by the report.		
23/324	**ASSURANCE FROM SUB-COMMITTEES**		
9 mins	**Audit and Assurance Committee** SB presented the report, highlighting governance arrangements for Musculoskeletal (MSK) services. The Board of Directors were ASSURED by the report. **Finance Committee** GW presented the report, highlighting the financial position at the end of Month 5, application for Revenue Support from NHSE, Financial Recovery Plan and escalations to the ICB. The Board of Directors were ASSURED by the report. **Quality Committee** AR presented the report, highlighting increase in mortality rates, impact of continued industrial action, Safeguarding Annual Report, decrease in complaints received, Quality Strategy, Patient Safety Incident Review Policy, work commissioned in relation to Virtual Wards and review of Board Assurance Framework (BAF) Principal Risks. The Board of Directors were ASSURED by the report. **People and Culture Committee** SB presented the report, highlighting impact of industrial action, increase in employee relations cases and review of BAF Principal Risks. The Board of Directors were ASSURED by the report.		
23/325	**OUTSTANDING SERVICE – A VOLUNTEER'S JOURNEY THROUGH SHERWOOD FOREST HOSPITALS**		
6 mins	A short video was played highlighting the work of the Trust's volunteers. CW requested the video be shared with community partners. **Action** • **Volunteer's Journey outstanding service video to be shared with community partners.**	**DA**	**02/11/23**

23/326	**COMMUNICATIONS TO WIDER ORGANISATION**		
1 min	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Flu and Covid vaccinations • Impact of Industrial Action • Commencement of community diagnostic activity at Mansfield Community Hospital • Opening of new theatre facility at Newark Hospital • WRES and WDES • Preparations for Winter • Speaking Up Month • Staff story regarding menopause • Outstanding service video regarding volunteers		
23/327	**ANY OTHER BUSINESS**		
	No other business was raised.		
23/328	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 2nd November 2023 in the Boardroom, King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:15.		
23/329	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Claire Ward **Chair** **Date**		

23/330	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	CW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
23/331	**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
23/173.3	01/06/2023	Future Equality and Diversity Annual Reports to have an increased focus on the patient perspective	Public Board of Directors	None	Jun-24	R Simcox			Grey
23/252.3	03/08/2023	Review of long-term vacancies to be considered by the People, Culture and Improvement Committee	Public Board of Directors	People and Culture Committee	~~05/10/2023~~ 07/12/2023	R Simcox		**Update 23/08/2023** Item added to the September People, Culture and Improvement Committee agenda **Update 15/09/2023** Confirmed item on agenda for September People, Culture & Improvement Committee **Update 05/10/2023** Item deferred until the November meeting of the People and Culture Committee	Grey
23/255	03/08/2023	Recommendations from the external well-led report to be reviewed in 6 months, including a review of recommendations marked as complete	Public Board of Directors	None	Feb-24	S Brook Shanahan			Grey
23/284	07/09/2023	Progress report to be provided to the People, Culture and Improvement Committee regarding review into issues within Acute Medicine following exception reports raised by junior doctors	Public Board of Directors	People and Culture Committee	07/12/2023	D Selwyn			Grey
23/315.1	05/10/2023	Comparative data in relation to obstetric haemorrhage to be included in future maternity update reports to the Board of Directors	Public Board of Directors	None	~~02/11/2023~~ 04/01/2024	P Bolton		**Update 25/10/2023** Discussions are underway with the LMNS to identify the best method to capture this comparative data. It is anticpated that the mode of birth will be a key indcator in line with the increase in C-section. Once the dataset is agreed future scorecards will include the comparative data	Grey
23/315.2	05/10/2023	Further information on quality indicators linked to obstetric haemorrhage to be included in maternity reports to the Quality Committee	Public Board of Directors	Quality Committee	~~02/11/2023~~ 04/01/2024	P Bolton		**Update 25/10/2023** Discussions are underway with the LMNS to identify the best method to capture this comparative data. It is anticpated that the mode of birth will be a key indcator in line with the increase in C-section. Once the dataset is agreed future scorecards will include the comparative data	Grey
23/315.3	05/10/2023	Information session on HSMR to be arranged for members of the Board of Directors, particularly those who are not members of the Quality Committee.	Public Board of Directors	None	TBC	D Selwyn			Grey
23/325	05/10/2023	Volunteer's Journey outstanding service video to be shared with community partners.	Public Board of Directors	None	02/11/2023	D Ainsworth		**Update 19/10/2023** The video has been shared with GP practices asking it to be displayed in waiting rooms It has also been cascaded through the PBP partner comms leads. **Complete**	Green

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:** 2nd November 2023	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chair's perspective.		**Approval**	
		Assurance	**Y**
		Update	**Y**
		Consider	

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

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

Committees/groups where this item has been presented before

Not applicable

Acronyms

ATTFE = Academy Transformation Trust Further Education
SFH = Sherwood Forest Hospitals

Executive Summary

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

Membership and governor updates

Lead Governor Sue Holmes departs after serving her maximum tenure

As Sue Holmes's time as Lead Governor at Sherwood Forest Hospitals comes to an end, I wanted to share a message of thanks and appreciation for her brilliant service over nine years representing the views of our local communities.

Sue first joined the Trust's Council of Governors as Public Governor in 2014.

Since then, she has served the Trust's thousands of Trust members, patients and colleagues with pride and distinction, making an immeasurable difference in ensuring their voices are heard in the running of their local hospitals.

Her work and leadership has been essential to Sherwood Forest Hospitals navigating the huge difficulties it once faced to becoming the organisation we now know and are so proud of today.

We are grateful to Sue for the part she has played in making great patient care happen here at Sherwood, both during her time as a Public Governor and having also served for more than seven years as the Trust's Lead Governor.

Sue leaves her post with the very best wishes of our Board of Directors – and I am delighted to report she will be continuing to help with the running of her local hospitals, after agreeing to sign-up as one of the Trust's volunteers!

Changes to the Trust's Council of Governors

As a result of Sue Holmes leaving the Trust, there are a number of changes to the Trust's Council of Governors to update the Board of Directors about.

Following approval by the Council of Governors, Liz Barrett – a serving public governor in our Rest of East Midlands constituency – has been appointed to succeed Sue Holmes as the Trust's Lead Governor. Liz will take-up this post on Wednesday 1 November 2023.

Liz is a proud resident of Ashfield and is committed to raising aspirations within the local community, along with creating opportunities and improving quality of life. Liz is Principal of the local ATTFE College and has been a great supporter for getting more young people involved in our Trust and in feeding back on our services. We are very much looking forward to Liz picking-up Sue Holmes's great work.

Dean Wilson, who was appointed as a 'governor elect' following our most recent election in July, will now take his place on the Trust's Council of Governors. His appointment maintains our full complement of 10 governors in our Rest of East Midlands constituency.

Unfortunately, October did see one of our public governors in our Newark public constituency, Karen Nadin, resign her position. That post will remain vacant on our Council of Governors until our next election at a date to be confirmed.

You can find full details of all our Trust governors on the Sherwood Forest Hospitals website here: https://www.sfh-tr.nhs.uk/about-us/our-council-of-governors/

Recognising the difference made by our Trust Charity and Trust volunteers

October was another busy month for our Trust's Community Involvement team, both in how they encouraged financial donations to be made via our Trust Charity and through the thousands of hours that continue to be committed to support the Trust by our volunteers across our hospitals.

In October alone, 370 Trust volunteers generously gave over 4,142 hours of their time to help make great patient care happen across the 34 services they have supported during the month.

During the month, a new volunteer role has been piloted at Newark Hospital supporting staff and patients in the cardiac rehabilitation gym. Volunteers have also been deployed at King's Mill and Newark Hospitals to assist with PLACE and meal audits.

Other notable developments from our brilliant Community Involvement team and our volunteers during the month include:

- The SFH Charity has recently purchased two therapy chairs for patient use in Clinic 10, which will make a huge difference to our Therapy Services team.
- King's Mill Hospital volunteers have funded a new radio for the Endoscopy female waiting area
- Four 'baby bouncers' have been purchased for use on our Ward 25 Paediatric Ward, utilising generous donations to charitable funds

We remain so grateful to everyone who has given their time, money and support in other ways to support the Trust and our hard-working colleagues over the past month.

Other notable engagements:

- Local partnership meetings have been ongoing with all of our local district councils, recognising the importance that Sherwood Forest Hospitals plays as a local anchor organisation in helping to work together with other organisations locally to improve health and wellbeing and attract national funding to support that important agenda.
- Meeting with other Chairs across Nottinghamshire's NHS
- Attending the Health and Care Awards in Nottingham and Nottinghamshire ICS
- Visiting Barlborough Clinic to see how some of our patients receive treatment through our relationship with external partners.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date:** 2nd November 2023	
Prepared By:	Rich Brown, Head of Communication		
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	**Y**
		Update	**Y**
		Consider	

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

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

Committees/groups where this item has been presented before

None

Acronyms

BAF = Board Assurance Framework
CDC = Community Diagnostics Centre
NJR = National Joint Registry
SFH = Sherwood Forest Hospitals

Executive Summary

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

Operational updates

Industrial action updates

Over the past month, we have been monitoring national developments with interest around the ongoing discussions between the government and the British Medical Association (BMA) concerning the prolonged industrial action that continues to affect our NHS.

Whilst there has been no further industrial action called since the last Public Meeting of the Trust's Board of Directors on Thursday 5 October, the impact of this industrial impact continues to be felt across our hospitals.

At the time of writing, the Trust has needed to postpone over 6,348 appointments, procedures, and operations during 2023 in order to prioritise safe urgent and emergency care across all periods of industrial action.

The resulting reduced elective activity levels contribute to our growing waiting lists, including for those patients who are waiting the longest for the treatment they need.

It should also be noted that while these figures reflect the impact of this industrial action on our services, they do not take account of lost opportunities where appointments were not booked once we had received notification that strikes had already been called.

At the time of writing, the financial cost of this year's industrial action to Sherwood Forest Hospitals stands at over £1.8million – a figure that will continue to rise, unless a resolution to this national dispute can be found.

I reiterate my hope that we see an end to this national dispute as quickly and painlessly as possible in the interest of the colleagues, patients and the communities we are proud to serve.

Updates from Newark Hospital

The engagement from the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) on the overnight opening hours of Newark Hospital's Urgent Treatment Centre (UTC) has now come to a close

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) led a number of public engagement events to discuss the best permanent opening hours for the UTC. Residents were also given the opportunity to feedback via an online survey that was available on the ICB website.

The UTC, run by Sherwood Forest Hospitals NHS Foundation Trust, provides urgent care and non-life-threatening treatment for injuries or conditions, such as cuts, simple broken bones, wounds, minor burns and minor head, eye and back injuries.

The UTC is currently open for 13 hours a day between 9am to 10pm, slightly exceeding the national minimum standard of 12 hours per day.

Those opening hours were put in place in March 2020 as a temporary measure to address ongoing staffing issues made worse by the COVID-19 pandemic.

Prior to the pandemic, the UTC was often closed overnight at short notice due to lack of staff availability. Typically, when the UTC was open overnight, it would treat, on average, one patient per hour, in contrast to between 4-6 patients per hour during the daytime.

We are committed to working alongside our Integrated Care Board colleagues to provide a safe, sustainable urgent treatment centre at Newark Hospital, operating at least 12 hours per day, in line with the specification for urgent treatment centres across England.

As a Trust, we have been supporting the ICB in promoting these important discussions – including by attending and helping to lead their engagement discussions with local residents.

As part of that engagement period, we worked alongside ICB and NHS England colleagues to host a 'clinical senate' to give credibility to these discussions around the longer-term opening hours of the facility.

The senate saw a collective set of independent clinical advisors receive a presentation about proposals, as well as allowing the independent experts to visit and talk to several Newark Hospital colleagues about their experiences.

The output of that senate will form part of the written report that will contribute to the overall feedback that will be considered by the county's Health Scrutiny Committee before proceeding with next steps and before any decision is made.

Newark Elective Hub prepares to open its doors

By the time the Board of Directors meets, our multimillion pound expansion of our theatres at Newark Hospital will have celebrated its official opening and will be preparing to welcome its first patients.

The £5.6million project is due to result in up to 2,600 extra operations and procedures taking place at Newark Hospital each year. It will also provide a modern environment, contribute to reductions in waiting times and create new jobs for nursing and healthcare staff.

The extra capacity in elective care will improve patient choice and help to address access to health services for those who would previously have had to travel further afield for treatment.

The new suite, which includes a recovery area, anaesthetic room and scrub facilities, is being built beside the existing two theatres. The first operations are expected to take place in the new theatre this autumn.

As well as increasing capacity at the site, the new theatre will also allow the scope and range of services provided from the site to expand, with the laminar flow especially for orthopaedic operations helping to expand from hip and knee to shoulder surgery.

The site will also provide a range of ear, nose and throat treatments, as well as urology, gynaecology and ophthalmology, overall improving the range of services available to our local communities at Newark Hospital.

Work underway to create more parking spaces at Newark Hospital

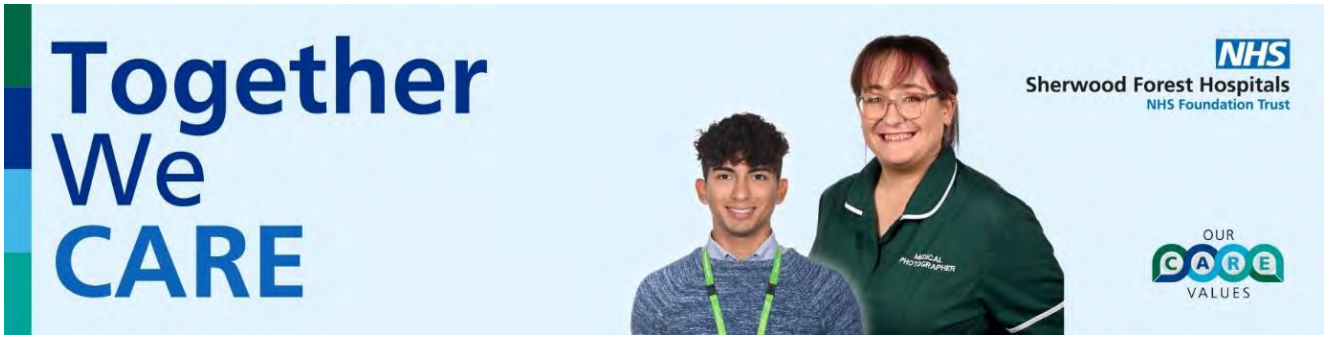
Our plans to further improve patient access to Newark Hospital has been turned into reality over the past month, as contractors officially started work on a new 80-space car park.

The initiative has been made possible due to our partnership with Newark and Sherwood District Council. The Council has purchased the land on Bowbridge Road with the intention of converting it into additional hospital car parking to ensure residents have greater access to even more health care provision locally.

There are currently 170 pay and display spaces plus 20 spaces for blue badge holders in the main Newark Hospital car park. The new car park, which will have electric charging points, will provide parking for staff on site which will free up spaces in the main car park for patients and visitors.

It's exciting to see all our plans for Newark Hospital come to fruition and we are very grateful to the team at Newark and Sherwood District Council.

Other updates from across our hospitals



Reiterating our commitment to our Trust 'CARE' values

At previous Board meetings, we have spoken about the importance of ensuring we are properly supporting our colleagues as seasonal pressures across our hospitals intensify.

We recognise that it is really tough at the moment with so many competing pressures, especially after having worked under sustained operational pressure for such a long period of time.

This is precisely why we are keen to keep our 'CARE' values at the front of our thoughts as those pressures intensify as winter approaches. Those values will help steer us in continuing to be:

- C - Communicating and working together
- A - Aspiring and improving
- R – Respectful, inclusive and caring
- E - Efficient and safe

Our CARE values have been shaped through engagement with colleagues, patients, service users and volunteers to set out our ambition to provide outstanding care to the communities we serve and to support one another.

Now more than ever, it is important that we remind ourselves of our CARE values and why it is so important that we all behave in line with them.

And while we know that the vast majority of our colleagues live and breathe those CARE values every day, we know there are occasions when those values are not as visible as they could be and – in some cases – are not being followed.

In October, we have launched a Trust-wide campaign to underline the importance of those values to us all here at Sherwood. The campaign features real members of #TeamSFH telling their stories of what the values mean to them, as well as encouraging as many colleagues as possible to make their own pledges to live those 'CARE' values.

That pledge is something that I have personally made over the past month and, at our November Board meeting, it is something that I will be encouraging as many members of our Board of Directors to join me on.

Our work is progressing to bring Nottinghamshire's first Community Diagnostics Centre (CDC) to our area

Our work to bring the county's first Community Diagnostics Centre (CDC) to our area has continued over the past month.

The latest developments have focused on the roll-out of almost 500 health checks each week, as part of a programme of 'accelerated activity' that is helping to bring these health checks to our area longer before the full Centre is due to open its doors.

In October, we have made up to 255 additional blood tests available each week at Mansfield Community Hospital. Those sessions were initially offered at drop-in clinics but have now been made available as pre-bookable appointments.

As part of this same programme of accelerated activity, we have also made a further 130 scans available each week at a mobile unit that has been installed at the privately-run Nottingham Road Clinic in Mansfield.

By the end of 2023, the Trust is expecting to have launched a total of up to 500 of these 'accelerated' health checks each week.

The full multimillion pound Community Diagnostics Centre is expected to open its doors to patients in 2025, where it will run where a derelict building currently stands alongside Mansfield Community Hospital in Stockwell Gate.

As well as delivering tens of thousands of additional health checks each month, the Centre will also create 120 jobs for local people in a range of clinical and non-clinical roles.

The Improvement Faculty hosts visit from NHS England's National Director for Transformation and Digital

We were delighted to welcome Dr Vin Diwakar to our hospitals on Friday 20 October to showcase some of the brilliant work that the Trust is involved in around research, informatics, digital, personalisation, transformation, improvement and patient safety.

As well as being a practising Paediatrician, Dr Diwakar is also the Medical Director for Transformation in NHS England's National Transformation Directorate. He also leads on the secondary care portfolio in the National Improvement Directorate.

Dr Diwakar provides clinical leadership to national improvement and transformation programmes, including those which use improvement science, technology, digital and data.

The visit was arranged to provide Dr Diwakar with an insight into how the Trust works, after Sherwood was recommended to him as a place to visit. Dr Diwakar was extremely impressed with both the scale of the work the Trust is involved in, as well as the passion of those who are leading these areas.

He particularly enjoyed speaking with patients and clinicians during the day and noted the extremely friendly welcome he received from all colleagues across the Trust.

Thank you to everyone across the Trust who helped to make this visit possible – and showcase your brilliant work in the best possible light!

Sherwood receives National Joint Registry (NJR) Quality Data Provider Scheme Award, in recognition of our commitment to patient safety

We have been celebrating being acknowledged for our commitment to patient safety for the seventh year running, after receiving the National Joint Registry (NJR) Quality Data Provider Scheme award.

The award recognises hospitals that consistently provide accurate data that help to improve patient safety, standards in quality of care and overall cost-effectiveness in joint replacement surgery.

To gain this recognition, the Trust has had to meet several specific requirements regarding the data they provide.

Only hospitals that meet the strict targets outlined by the NJR are awarded the NJR Quality Data Provider Certificate. We are proud that Sherwood Forest Hospitals Trust has achieved scores of 90% or above for seven years in a row.

Since 2003, NJR has collected information about joint operations to improve patient safety and support clinicians and suppliers. It collects and analyses data about joint replacement surgery to improve service quality and deliver timely warnings on issues relating to patient safety. This means the Trust will be contacted by the NJR and advised to contact the patient immediately if issues arise with a joint implant.

The Orthopaedic Team at the Trust are particularly pleased that all their hard work throughout the year has paid off.

Trust risk ratings reviewed

The Board Assurance Framework (BAF) risks for which the Risk Committee is the lead committee have been scrutinised by the Trust's Risk Committee.

The Committee has confirmed that there are no changes to the risk scores affecting the following areas:

- Principal Risk 6: Working more closely with local health and care partners does not fully deliver the required benefits.
- Principal Risk 7: A major disruptive incident

The full and updated Board Assurance Framework (BAF) is due to be presented later at this public meeting of the Trust's Board of Directors.

It should also be noted that as part of a review of the Trust's cabinet and committee structures, our newly-formed Strategy and Partnerships Committee is to become the Lead Committee for monitoring the 'PR6' risk.

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust (SFH) 2023-24 Strategic Priorities

Quarter 2 Update

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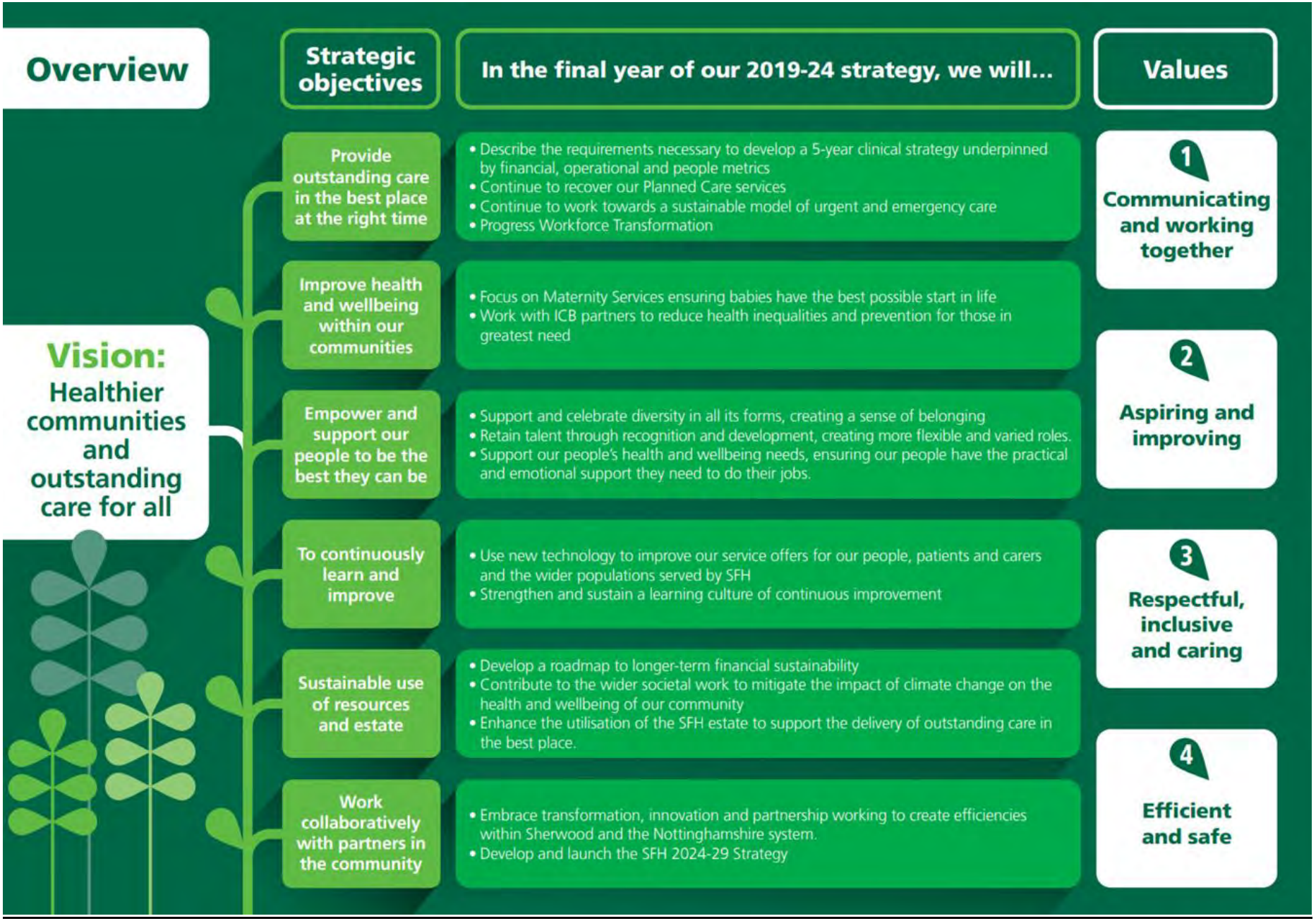


1. Summary – Qtr. 2. 'Position on a Page'

Ref	2023/24 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Overall RAG Qtr. 3	Overall RAG Qtr. 4	Change to Previous Qtr.
1.1a	Work with Clinical Divisions to develop Clinical Service Strategies	Medical Director					⇩
1.1b	Develop high level 5yr bed requirement model	Chief Operating Officer					⇔
1.2a	Expand Day Case Surgery Services at Newark Hospital	Chief Operating Officer					⇧
1.2b	Expand Diagnostic Services to Mansfield Community Hospital	Director of Strategy and Partnership					⇧
1.2c	Achieve elective activity levels, backlogs and patient waiting times	Chief Operating Officer					⇩
1.3	Progress bespoke projects that optimise patient flow, expand Same Day Emergency Care and Virtual wards and reduce the number of MSFT	Chief Operating Officer					⇔
1.4a	Progress Medical Workforce Transformation	Medical Director					⇔
1.4b	Progress Nursing, Midwifery & Allied Health Profession (NMAHP) workforce transformation	Chief Nurse					⇔

Overall RAG Key

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

Ref	2023/24 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Overall RAG Qtr. 3	Overall RAG Qtr. 4	Change to Previous Qtr.
2.1	Equitably transform our maternity services	Chief Nurse					⟺
2.2	Agree our approach and programme of actions around Health Inequalities and prevention	Medical Director					⇧
3.1	Delivery of the "Belonging in the NHS" supporting actions	Director of People					⟺
3.2	Delivery of the "Growing for the Future" supporting actions	Director of People					⟺
3.3	Delivery of the "Looking after our people" supporting actions	Director of People					⟺
4.1a	Electronic Prescribing implementation	Medical Director					⇧
4.1b	Develop EPR (Electronic Patient Records) business case	Medical Director					⟺
4.2a	Develop and embed the Patient safety Incident Response Framework (PSIRF)	Medical Director / Chief Nurse					⟺
4.2b	Embed the Improvement Faculty within the Trust	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

Ref	2023/24 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Overall RAG Qtr. 3	Overall RAG Qtr. 4	Change to Previous Qtr.
5.1	Establish an underpinning financial strategy	Chief Financial Officer					⇔
5.2	Deliver the objectives set out in the SFH Green Plan 2021-2026	Chief Financial Officer					⇩
5.3	Develop a multi-year capital investment programme	Chief Financial Officer					⇔
6.1a	Deliver the "New Ways of Working and delivering care"	Director of People					⇩
6.1b	Through the Provider Collaborative improve how we work together with services outside of SFH	Director of Strategy and Partnership					⇔
6.2	Through engagement develop the SFH 2024-29 Strategy	Director of Strategy and Partnership					⇔

Overall RAG Key

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

2. Detailed Quarter 2 Update

Ref	2023-24 Trust *Priority* and Deliverable	Executive Lead	SFH Governance	Measures of Success	Quarter 2 Update
1.1a	*Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics* Work with Clinical Divisions to develop Clinical Service Strategies at Specialty and Divisional level, to inform a Trust level Clinical Strategy	~~Director of Strategy and Partnership~~ Medical Director	Executive Team Meeting  **Off Track** – action underway to address minor issues.	• By the end of July 2023 the ICS Joint Forward Plan will have been made available to the Divisions. • By end Qtr. 2. Divisional service lines will have produced a 2 year plan that describes where they are now and key issues and opportunities in the 1-2 Year and 3-5 Year time horizon ensuring that options for fragile services are fully understood. • By the end of Qtr. 3. have in place a Trust level Clinical Services Strategy that supports longer term alignment of estates, people, technological, and financial plans.	- With national industrial action and other operational pressures it has been agreed with Divisions to extend the Service Line work from the end of Qtr 2 (September) to the end of October - We are still working towards, and on track to recover this in Qtr 3 noting national Industrial Action and operational pressures remain a risk - Further updates will be provided at the Board Time out 15-16 November
1.1b	*Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics* 'Develop high level 5yr bed requirement model	Chief Operating Officer	Executive Team Meeting  **On Track** - no issues to note.	• By the end of Qtr. 3 have an initial 5 year model in place that is informed by Divisional Service Line Plans • By the end of Qtr. 4 refine bed model to reflect Trust level clinical strategy.	- Initial scoping activity completed with Edge (company that supports SFH bed modelling) to understand approach to and cost of this modelling. - Work provisionally scheduled to be undertaken in Nov-23. Link to divisional service line plans may evolve as plans are available

1.2a	*Continue to recover our Planned Care services* 'Expand Day Case Surgery Services at Newark Hospital through the Transformation Investment fund (TIF)	Chief Operating Officer	Executive Team Meeting  **On Track** – action underway to address minor issues	• Service commencement by end of June 2023 • 90% of staff substantively in post by end of Qtr. 3. • By end of Qtr. 4 be achieving the monthly levels of activity required to meet the full year aspirations of the TIF submission.	- As detailed in the last update the modular theatre remains scheduled to open in Oct-23. This priority is now shown as 'on track' following confirmation of the revised build process timescales and the plans in place for staff recruitment and the commencement of activity - The establishment for Newark TIF has recently been updated which has resulted in some skill mix and wte changes which has increased the overall number of vacancies being recruited to. It is forecast that we will be at between 55 and 60% recruitment by the end of Qtr 3 against this new establishment (29 posts). The gap relates to (a) staffing for Medical Day Case and the procedure room which aren't due to be completed and open until February and (b) 2 wte anaesthetic roles which are challenging to recruit to and 1 wte T&O consultant. These gaps will be covered through Waiting List Initiatives and in house until recruitment has been successful. - A detailed operational plan is in development to deliver the level of activity in 2024-25 in line with business case aspirations and to maximise the 2023-24 activity levels.
1.2b	*Continue to recover our Planned Care services* 'Expand Diagnostic Services to Mansfield Community Hospital	Director of Strategy and Partnership	Executive Team Meeting  **On Track** – action underway to address minor issues	• Building works commenced by June 2023 • Staffing model and agreed development plan in place by Qtr. 2 (Feb 25 current go live date). • Mobile MRI service located on MCH site and fully operational by 1st December 2023	- New dates approved through SFH governance with Demolition pre-works scheduled to commence January 2024 - Schedule of accommodation (SOA) agreed and locked down with clinical and operational teams. A revised programme of works and costs to be developed from the approved SOA, inclusive of scoping the utilisation of existing Mansfield Community Hospital estate. Capital bid for £4.9m submitted to NHSE to mitigate against £6.9m forecasted overspend – awaiting outcome - SoA and predicted activity will support the

					development of the staffing model for the CDC - Accelerated activity – non contrast MRI scans and phlebotomy service commencing October 2023 - Additional NHSE revenue funding approved to assist with costs for current approved accelerated activity and to commence Echocardiograms diagnostics in 2023 - Activity submission and central costs for 2024-25 being collated – costs for additional revenue funding to pump prime workforce for go live in March 2025. Additional accelerated activity diagnostics being scoped to assist with reducing current backlogs
1.2c	*Continue to recover our Planned Care services* 'Achieve elective activity levels, backlogs and patient waiting times in line with the 2023/24 operational plan and supporting performance trajectories.	Chief Operating Officer	Executive Team Meeting  **Off Track** – action underway to address major issues	• Delivery of the following metrics in line with (or better than) plan: - Activity plans (Elective, Day Case, O/P) - PIFU - 52 and 65ww - Number of completed RTT pathways - 62-day cancer backlog - 28-day cancer FDS	- Aside from the ongoing instances of Industrial Action (IA), we are delivering strong elective activity levels - The IA has adversely impacted on elective activity levels meaning that backlogs have grown and patient waiting times increased. We have had a total of 21 working days relating to junior doctor and/or consultant strikes since April which has had a material impact on activity levels. Whilst our reported month end position for 52 and 65-week wait has increased, we are curently on track with the 65-week wait cohort trajectory (those we expect to breach at the end of the financial year). Our 62-day cancer backlog position was on track until Jul-23; however, like other areas, IA has impacted on patient pathways - Despite the challenges, there are areas of strength within the measures for success with strong PIFU and 28-day cancer FDS performance - Planned care performance data with associated narrative for all the merics of success is included in the the quarterly Integrated Performance Report

1.3	*Continue to work towards a sustainable model of urgent and emergency care* - Progress with the ~~Optimising Patient Journey (OPJ) improvement programme~~ bespoke projects that support patient flow. - Expand use of Same Day Emergency Care (SDEC) within Surgery - Embed and expand virtual wards - Work with the ICB and system partners to facilitate system actions to reduce the number of Medically Safe For Transfer (MSFT) Patients who should not be in an acute hospital bed	Chief Operating Officer	Executive Team Meeting  **Off Track** – action underway to address major issues	• Increase the number of patients using SDEC. • Increase the number of patients on a virtual ward pathway. • Reduce number of >20 day length of stay patients. • MSFT patient numbers in line with ICS trajectory.	- Agreed work programme in place supported by the Improvement Faculty which supplements improvement work underway across our divsional teams - Capital works on wards 14 and 33 have resulted in delays to the opening of Surgical Same Day Emergency Care. Work underway to progress in Q3. Across SFH however we continue to better the national 33% SDEC target, delivering circa 37%. - Virtual wards expanded over the summer to include the frailty pathway and the OPAT service is being counted under Virtual Ward with an expansion planned in Oct-23. The respiratory Virtual Ward is likely to seasonally increase over the winter period. Work is underway to refine and automate data collection processes - The number of long stay patients (>20days) has decreased throughout Q2 to be in line with our plan by the end of Sep-23. This is driven by our relaunched bi-weekly long stay review meetings providing greater focus and challenge - The number of MSFT patients has not yet reduced in line with the operational plan; however, reductions seen in Sep-23 have brought our MSFT levels to the lowest monthly level for over one year. With support from PA Consulting, the SFH discharge pathway has been mapped with a programme of work in place led by the SFH Chief Operating Officer with full system participation to improve discharge processes and data to help identify and resolve bottlenecks in the process' - Urgent and emergency care performance data with associated narrative for the metrics of success is included in the the quarterly Integrated Performance Report

1.4a	*Progress Workforce Transformation* - Progress Medical Workforce Transformation	Medical Director	~~People, Culture and Improvement Committee~~ Finance Committee  **Off Track** – action underway to address major issues	• Deliver Trust and ICB/ICS Agency Task Force Group measures • Specialties provide future workforce models by Qtr. 3 • Review NHSE workforce plan and put action plan in place in place within 2 months of publication.	- Average monthly spend is in line with 2022-23 however this remains a significant concern with agency costs currently running at 5.7% of total pay against the target of 3.7% - 90% of price cap breeches relate to medical spend with only one off-framework shift since May 2023 - Key pillar of Financial Recovery Cabinet
1.4b	*Progress Workforce Transformation* 'Progress Nursing, Midwifery & Allied Health Profession (NMAHP) workforce transformation	Chief Nurse	~~People, Culture and Improvement Committee~~ Finance Committee  **On Track** - no issues to note.	• Movement to sustainable use of agency usage staring with off framework/off cap • Month on month reduction in agency usage • Reduction of vacancies focusing on Band 5 Registered Nurses • Develop Allied Health Professional (AHP) Job Planning by Qtr.3 to meet Carter Review recommendations. • Annual Establishment review against current capacity completed by end of Qtr. 3 and development of longer term review process	- There continues to be a sustained reduction in the use of level 3 escalation agency usage across our services, with a renewed focus now aimed at supporting our level 2 usage. The 'Allocate on-Arrival' workforce initiative remains active and is regularly reviewed to ensure sustainability. Controls enabling escalation of staffing requests have been strengthened, and a focus on early de-escalation is being explored whilst ensuring safety is the driving priority - The senior corporate nursing team has supported clinical divisions with the bulk recruitment into the priority over establishment areas of Castle Ward, Lindhurst Ward, and Chatsworth Unit. Lindhurst Ward and Chatsworth Ward are now fully recruited for both registered nurse and support worker positions and will start to see the new staff members commence in post over the coming weeks and months. The team at Castle Ward has also fully recruited into all their substantive positions for registered nurses and 78% of their support worker roles, with adverts in progress for the remaining vacancies

					- International recruitment continues at pace with a trajectory of 26 new starters arriving on October 26th and a further 25 expected to arrive in late November. Collaborative work continues with the people directorate, corporate nursing team, and immigration regarding visa and certificates of sponsorship for a final cohort in December in line with the pipeline agreed with NHS England. This will then conclude this episode of international recruitment - Workforce planning data using the Safer Nursing Care Tool has continued and has now concluded for 2023. Analysis of this data is underway and will inform our establishment setting reviews due to commence in December
2.1	*Focus on Maternity Services ensuring babies have the best possible start in life* Work with the Local Maternity and Neonatal Services (LMNS) to equitably transform our maternity services through delivering a single delivery plan in line with the recommendations from the Ockenden and Kirkup review and CQC inspection.	Chief Nurse	Quality Committee  **On Track** - no issues to note.	• Implementation of the single maternity oversight framework, completion of the CQC must do and should do actions. • Ensure smoking at time of delivery becomes part of our 'Business as Usual' through planning for 2024-25. • Optimisation and stabilisation of the preterm infant principles introduced. • Implementation of NHSE guidance on Equity and Equality. • Annual Establishment review against birth rate plus completed by end of Qtr. 3 and development of longer term review process	- CQC 'must do' actions completed and green form signed off through Quality Committee, focus is now on 'Should Do' actions - Business case in preparation for 2024-25 for the Phoenix Team (smoking at time of delivery) - Maternity/Neonatal SIP work ongoing across the division, work presented around success of early breast milk at regional meeting - First planned session on Cultural Safety Training delivered as part of the implementation of the equity and equality strategy - Annual establishment review planned for Dec 23

2.2	*Work with ICB partners to reduce health inequalities and prevention for those in greatest need* agree our approach and programme of actions around Health Inequalities and prevention as a key strategic priority for the 24-29 strategy	Medical Director	Quality Committee  **On Track** - no issues to note.	• Assessment of 5 Year ICS NHS Joint Forward Plan within 2 months of publication (expected 30th June) to align areas of focus for Health Inequalities • Commence Health Inequalities reporting to Quality Committee Qtr. 3 • Agree with Board our approach to Health Inequalities and prevention and identify any gaps Qtr. 3 • Work internally and with partners to develop SFH or Joint proposals that qualify for any new Health Inequalities Investment Funding (HIIF) by January 2024	- Established ICB Health Inequalities (HI) group - 2023-24 funded HIIF schemes mobilising to be partly or fully implemented from November - Engaging with the ICB to develop process for bids for 2024-25 funding (£4.5m set aside in JFP) - University of Nottingham and North Trent Network have developed an evaluation framework to support HIIF and benefits realisation of these schemes - ICB HI dashboard under development by SAIU - ToR for new Trust Board sub-committee to provide assurance against HI, in development
3.1	*Support and celebrate diversity in all its forms, creating a sense of belonging.* 'Delivery of the "Belonging in the NHS" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, culture and Improvement Committee of the delivery of supporting actions • Evaluate impact of Staff Networks by Qtr. 3 • Evaluate 6 high impact actions by the end of Qtr. 4 • Deliver 'closing the gap' action plans to improve experiences for our people with protected characteristics by end of Qtr. 4.	- Continue to celebrate Diversity both within and outside of SFH (Pride, Carers and Reach Out) supported and delivered by our staff networks - Annual milestone event held to celebrate colleagues with 25 years + service - Development of national EDI Improvement plan incorporating 6 high impact actions - WRES/WDES data submitted to NHSE with results disclosed and upward improvements in both WRSE and WDES reported - Continued delivery of EDI awareness sessions with positive feedback - Preparations in train for delivery of NSS23 across the Trust for Q3 roll out
3.2	*Retain talent through recognition and development, creating more flexible and varied roles.* 'Delivery of the "Growing for the Future" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People,	- MAST Statement of Intent developed and implemented to launch the portability of 7 of 11 areas of mandatory training which is in line with Core Skills Framework

			 **On Track** - no issues to note.	Culture and Improvement Committee of the delivery of the supporting actions • Quarterly update to People Culture & Improvement Committee on where we are growing a future workforce. • Recruit 20 external apprentices by end of Qtr. 3 • Evaluate and further utilise the apprenticeship levy throughout 2023-24 (Ongoing) • Talent Management approach / Leadership Development programme implemented by the end of Qtr. 4	- Revised appraisal documentation created, consulted with via clinical and non-clinical forums and piloted in clinical and non-clinical areas. Launched revised appraisal paperwork in September including supporting videos - SFH Talent management strategy drafted incorporating the Leadership Development Framework, the People Strategy and the overall Trust Strategy. Implementation of the Leadership Development programme underway with recruitment to new training post to support delivery - 21 new external apprenticeships have now started within SFH (exceeding the target) with a further 3 in the pipeline and a new supporting your apprentice training programme launched. Deep dive of apprenticeship admin and financial processes completed and improvement plan in place, intelligence gathering around further planned apprentices will inform forecast - Work experience on target with opportunities in an additional 3 areas at SFH identified (Comms, Rheumatology Research and Cardiac Rehabilitation) - 11 events attended to date with a further 9 planned
3.3	*Support our people's health and wellbeing needs, ensuring our people have the practical and emotional support they need to do their jobs.* Delivery of the "Looking after our people" supporting actions in year 2 of the Trusts People Strategy 2022-2025.	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Develop cultural insights to support improved experiences for our people at SFH (Ongoing/by Qtr4.)	- Completion of Wellbeing fundamentals audit across 91% of areas across the Trust - Continued development of the Health and Wellbeing Strategy utilising national Wellbeing framework as a gap analysis - Development of wellbeing support for Q3 & Q4 to support Trusts Winter plan. 5 key areas of focus; Civility and Respect through CARE Values relaunch, wellbeing fundamental audit to ensure all have access to basic wellbeing needs, wellbeing spaces

				• Introduce a Health & Wellbeing Strategy by Qtr. 3 • Measure the effectiveness of our Health & Wellbeing offer including Vivup and Occupational Health by Qtr. 3	promotion, stress and burnout support and "Boost" vaccinations for both flu and COVID. - Continued wellbeing programmes of support for ED and students - Development of 'Culture Heat Map' with launch planned for Q3
4.1a	*Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH* Complete the first and commence the second stages of Electronic Prescribing implementation [1. Implementation, 2. stabilisation, 3. optimisation, 4. transformation]	Medical Director	Quality Committee  **Off Track** – action underway to address minor issues.	• Roll out EPMA to remaining areas by end of Qtr. 4 • Commence Stabilisation during Qtr2	- Medicines Management Technician recruited for second stage commence in Nov 2023 - Project Manager recruited for second stage commence Oct 2023 - Dedicated pharmacist resource recruitment underway - Critical Care, maternity roll out plans developed - Multiple reviews of workflow identified stabilisation/ optimisation e.g. VTE instruction addition
4.1b	*Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH* Develop EPR (Electronic Patient Records) business case	Medical Director	Quality Committee  **On Track** - no issues to note.	• Submission of business case Qtr. 2 • Approval dependent commencement of recruitment Qtr. 3	- Pre-procurement engagement sessions held with five suppliers - EPR OBC approved by SFH Trust Board - EPR OBC approved by ICB and letter of support drafted - EPR OBC submitted to Frontline Digitalisation

4.2a	*Strengthen and sustain a learning culture of continuous improvement* Develop and embed the Patient safety Incident Response Framework (PSIRF)	Medical Director / Chief Nurse	Quality Committee  **On Track** - no issues to note.	• Develop Patient Safety Incident response Framework (PSIRF) by end of Qtr. 2 • Implement PSIRF approach to match national patient safety framework during Qtr. 3 • In Qtr.4 set out the plan to embed this in 2024-25	- We have worked with stakeholders to prepare for transition to PSIRF & have developed our Patient Safety Incident Response Plan (PSIRP) and Patient Safety Incident Response Policy. We have successfully recruited 4 Patient Safety Partners - Levels 1 & 2 of the National Patient Safety Syllabus are available on the Trusts learning platform - We have trained 18 Patient Safety Incident Investigators and delivered oversight training to our triumvirates and senior leaders with oversight responsibilities - PSIRF went live on 2 October following a period of transition - During Q4 we will continue to recruit Patient Safety Partners and develop their role. We will focus on ensuring staff undertake the Level 1 Patient Safety syllabus training and support investigators and staff in understanding the new approach to patient safety incidents and ensure that lessons learnt and actions taken are robust with measurable outcomes
4.2b	*Strengthen and sustain a learning culture of continuous improvement* To embed the Improvement Faculty within the Trust whose role will be to provide a centre of excellence for transformational and improvement support.	Director of Strategy and Partnership	~~People, Culture and Improvement Committee~~ Quality Committee  **On Track** - no issues to note.	• Fortnightly matrix meetings established from early Qtr. 1, incorporating all teams for whom improvement is a component of their role. • By the end of Qtr. 1 all aspects of the Trusts Transformation and Efficiency Programme to have been assessed by the Improvement Faculty to determine validity and deliverability. • By the end of Qtr. 2 a physical Improvement Faculty office to be created for the colocation of the Transformation and Improvement Teams plus hot desk availability for other teams involved in the Faculty's work.	- Although the 'Improvement Advisory Group' (matrix meeting) has continued to meet on a fortnightly basis, it has been agreed this will move to become monthly. Revised ToR have been agreed by the group, and additional clinical input has been included in the core membership. This will commence at the beginning of Q3. - All aspects of the Trusts Transformation and Efficiency Programme have been assessed by the Improvement Faculty. A further programme, encompassing a series of bespoke projects to support earlier in the day discharge, is about to enter the delivery stage - The Improvement Faculty 'Hub' has now been created. Whilst this continues to host the

				• By the end of Qtr. 4 an Initial (independent) review of the Improvement Faculty's impact will have been completed and reported to the Finance Committee.	Transformation and Improvement elements of the Faculty, it is also regularly used as a hot-desk facility by various other colleagues from across the Trust; further compounding effective collaborative working -The NHS IMPACT self-assessment tool has been used to demonstrate progress against key domains and to provide guidance for the ongoing development of the Faculty
5.1	*Develop a roadmap to longer-term financial sustainability* Establish an underpinning financial strategy to act as the foundation for the delivery of our new 2024-29 Strategy	Chief Financial Officer	Finance Committee **On Track** – action underway to address minor issues	• A Financial Resources Oversight Group will be established by the end of Qtr. 1. • Use of Resources reviews undertaken by the end of Qtr2, to better understand where and how we spend our resources. • By the end of Qtr. 3 multi-year divisional budgets will be established. • We will have investment plans and financial efficiency plans for 2024-25 and beyond in place by Qtr. 4. • Establishment of a Strategic Procurement plan alongside ICS partners.	- Financial Recovery Cabinet in operation Procurement Team feeding into the FIP programme via the Deputy Director of Strategy and Partnerships; Financial Resources Oversight Group to be operational in Q3 - Medium Term Financial Plan, including stretch financial recovery targets to deliver multiyear budgets which return spending to control total limits in the medium term in production - Stretch savings targets to formulate into deliverable financial savings plans for 2024-25 during Q3&Q4 - Continued progress of the ICS Procurement Group. All have access to shared spend data and work plans. Next step is a shared work plan and Strategy

5.2	*Contribute to the wider societal work to mitigate the impact of climate change on the health and wellbeing of our community* Establish the Sustainability Development Steering Group and progress delivery of the objectives set out in the SFH Green Plan 2021-2026	Chief Financial Officer	Finance Committee  **On Track** - no issues to note.	• Improvements evidenced in key metrics (including energy and water consumption, waste and carbon emissions). • Annual Green Plan report to Board in Q3. • BAF PR8 score maintained or reduced. • Funding secured to progress Energy Reduction Projects.	- The report presented to SDSG in the October 2023 highlighted that gas and electricity consumption increased by 18.6% and 1.7% respectively. The SDSG will meet more frequently as information is triangulated to activity and other factors such as the ambient external temperature being lower than expected to triangulate the greater need for artificial heating/lighting. This work will inform any further actions - SDSG report being drafted for FC in Q3 and Board Sustainability Awareness training being scheduled. BAF PR8 was reviewed at SDSG in October 2023 and it was decided to maintain the existing risk score. SDSG were assured that the PR7 risk score was triangulated with the PR8 score to take into account climate adaption planning assumptions - The funding criteria scope changed which meant that the Trust did not progress a PSDS3b bid. A heat carbonisation plan is being drafted to ensure the Trust is eligible to apply for the PSDS3c funding rounds
5.3	*Enhance the utilisation of the SFH estate to support the delivery of outstanding care in the best place.* Complete a comprehensive space utilisation review of all Trust sites to underpin delivery of the Estates Strategy, develop a multi-year capital investment programme, and work with system partners to find solutions to long-standing estate challenges.	Chief Financial Officer	Finance Committee  **On Track** - no issues to note.	• Refreshed Space Utilisation Group operational and assessment of all SFH estate completed by Qtr. 4, to identify potential solutions that support delivery of the emerging Clinical Service Strategies. • Completion of the key capital schemes in line with planned timescales and budgets. • Multi-year capital investment programme in place. • Business cases prepared for future development opportunities.	- 2023-24 capital plan is anticipated to be fully utilised - Multi year capital plan approved by Finance Committee

6.1a	*We will embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.* Delivery of the "New Ways of Working and delivering care" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** – action underway to address minor issues	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework. • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Delivery tactical people plans by Qtr. 1 • Develop workforce transformation to deliver Newark Transformation Investment Funding (TIF) by July 23 and Mansfield Community Diagnostics Centre (CDC) by Qtr. 2 • Design and understand interfaces between People and Transformation programmes to support financial improvements by end of Qtr. 4.	- On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework. - Development of long-term strategic model with view launch in Q3 aligned to the clinical strategy development work. - Develop workforce transformation plan for Mansfield Community Diagnostics Centre (CDC) by October 23 (delayed from Qtr 2. due to changes to accommodation plan) - Arranged ESR standards of attainment assessment to understand effectiveness of ESR
6.1b	*We will embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.* As a Nottingham and Nottinghamshire provider collaborative we will identify and deliver opportunities to improve how we work together with colleagues and services outside of SFH.	Director of Strategy and Partnership	Executive Team Meeting  **Off Track** – action underway to address minor issues.	• 2023-24 Provider Collaborative at Scale (PC@S) Prospectus agreed during Qtr. 1 • PC@S Maturity Matrix Completed and action Plan in place by Qtr. 2 • 2023-24 PC@S areas of focus refreshed and agreed for 2024-25 by the end of December 2023	- The Nottinghamshire Provider Collaborative at Scale purpose, priorities and mission statement have been agreed and it is expected that a Memorandum of Understanding and Prospectus will be available as 'Papers in Common' for SFH Public Board In January or February 2024. This will depend on when paper submission dates fall - A distributed executive group (DEG) has been established now meets monthly to support decision making and to track progress

6.2	*Develop and launch the SFH 2024-29 Strategy* Through engagement with our People, Board, Council of Governors, Patient & Carers, the wider community we serve and our partners we will put in place a strategy that reflects our populations needs and contributes to our social, partner and regulatory agendas.	Director of Strategy and Partnership	Executive Team Meeting  **On Track** - no issues to note.	• Engagement plan in place by the end of May 2023 • Draft 'Consultation' Strategy completed for 5th October Board • Board Approval of Strategy - 4th Jan 24 • Clear set of priorities and actions for Year 1 agreed with Board during Qtr. 4 (updated annually) • 2024-29 Strategy launched Qtr. 4 2024	- Initial engagement with the Trust membership, staff and volunteers was completed during the summer and the high level findings have been included in the draft strategy - We are meeting the revised dates for a draft Strategy to go to the 25th October Board Time Out with a further dedicated session on strategy at the November Board Workshop - Following the Board Time out the draft will be finalised and engagement on the strategy commenced with feedback on the draft Strategy sought from colleagues and partners

Board of Directors Meeting in Public - Cover Sheet

Subject:	2023-24 Priorities – Qtr2	**Date: 2nd Nov 2023**
Prepared By:	Kevin Gallacher, Associate Director Planning and Partnerships	
Approved By:	**Claire Hinchley, Deputy Director Strategy & Partnerships**	
Presented By:	**David Ainsworth, Director of Strategy and Partnerships**	

Purpose		
To provide an update on the delivery of the 2023-24 SFH Strategic Priorities.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

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

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

Committees/groups where this item has been presented before

Executive Team Meeting

Acronyms

BAF – Board Assurance Framework
BHVA – Bullying, Harassment, Violence and Aggression
CDC – Community Diagnostic Centre
CFO – Chief Financial Officer
CROG – Capital Resources Oversight Group
CQC – Care Quality Commission
DLT – Divisional Leadership Team
ED – Emergency Department
EDI – Equality, Diversity, and Inclusion
ENT – Ear Nose and Throat
EPR – Electronic Patient Record
ESR – Electronic Staff Record
EPMA – Electronic Prescribing and Medicines Administration
FDS – Faster Diagnosis Standard
HI – Health Inequalities
HIIF – Health Inequalities Innovation Fund
ICB – Integrated Care Board
ICS – Integrated Care System
IT – Information Technology
JFP – Joint Forward Plan
LMNS – Local Maternity and Neonatal System
MAST – Management and Supervision Tool

MSFT – Medically Safer For Transfer
MTP – Medical Transformation Programme
MVP – Maternity Voice Partnership
NHSE – National Health Service England
NUH – Nottingham University Hospitals
NVP – Neonatal Voice Partnership
OBC – Outline Business Case
PIFU – Patient Initiated Follow Up
PR – Principal Risk
PSDS3 - Public Sector Decarbonisation Scheme: Phase 3
RTT – Referral to Treatment
SAIU- System Analytics and Intelligence Unit
SDEC – Same Day Emergency Care
SDOG - Sustainable Development Operational Group
SDSG – Sustainable Development Strategy Group
SFH – Sherwood Forest Hospitals
SIP – Safety Improvement Programme
SOF – System Oversight Framework
TMT – Trust Management Team
ToR – Terms of Reference
TRIM – Trauma Risk Management
VTE - Venous Thromboembolism
WRES/WDES - Workforce Race Equality Standard/Workforce Disability Equality Standard
Q1 or Qtr1 - April to June
Q2 or Qtr2 - July to September
Q3 or Qtr3 - October to December
Q4 or Qtr4 - January to March.

Executive Summary

The Trust's Strategic Priorities for 2023/24 were agreed at the Trust Board meeting in April 2023. The table below provides an update on progress at the end of Quarter 2 with sixteen priorities on track and a further seven with actions underway to address minor or major issues.

As part of the ongoing review of Board Governance three of these priorities have changed Board Sub Committee responsibility and priority 1.1a Clinical Strategy has been re assigned from the Director of Strategy and Partnerships to the Medical Director. Further realignment will take place when the Partnerships and Community Sub Committee is in place.

The three areas changed are:

1. Priority 1.4a 'Progress Medical workforce transformation'. Moved from People Culture and Improvement Committee to the Finance Committee.
2. Priority 1.4b 'Progress Nursing, Midwifery & Allied Health Profession (NMAHP) workforce transformation. Moved from People Culture and Improvement Committee to the Finance Committee.
3. Priority 4.2b 'Embed the Improvement Faculty. Moved from People Culture and Improvement Committee to the Quality Committee.

'Fuel Gauge' Assessment	Description	Total Number	Priority Reference:
	**On Track** - no issues to note.	Twelve	1.1b Develop high level 5 year bed model 1.4b Progress nursing, midwifery and allied health profession transformation 2.1 Equitably transform our maternity services 2.2 Agree our approach and programme of actions around health inequalities and prevention 3.1 Delivery of belonging in the NHS supporting actions 3.2 Delivery of growing for the future supporting actions 3.3 Delivery of looking after our people supporting actions 4.1b Develop EPR business case 4.2a Develop and embed the patient safety incident response framework 4.2b Embed the improvement faculty within the trust 5.3 Develop a multi-year capital investment profile 6.2 Through engagement develop the SFH 2024-29 strategy
	**On Track** – action underway to address minor issues	Four	1.2a Expand day case surgery services at Newark hospital 1.2b Expand diagnostic services to Mansfield community hospital 5.1 Establish an underpinning financial strategy 6.1a Deliver the new ways of working and delivering care
	**Off Track** – action underway to address minor issues.	Four	1.1a Work with clinical divisions to develop clinical service strategies 4.1a Electronic prescribing implementation 5.2 Deliver the objectives set out in the SFH green plan 2021-2026 6.1b Through the provider collaborative improve how we work together with services outside of SFH
	**Off Track** – action underway to address major issues	Three	1.2c Achieve elective activity levels, backlogs and patient waiting times 1.3 Progress bespoke projects that optimise patient flow, expand Same Day Emergency Care and Virtual wards and reduce the number of MSFT 1.4a Progress medical workforce transformation
	**Off Track** – issues identified no action underway	Nil	
	**Off Track** – issues not identified and no action underway	Nil	

The attached paper provides a 'position on a page' and narrative update against each priority for quarter 2. For the items off track, all have actions underway to bring back on track.

The Board is asked to:

Note the update.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Early findings from Public Engagement on Strategy for 2024-2029	**Date:** 2nd November 2023	
Prepared By:	Rich Brown, Head of Communication		
Approved By:	David Ainsworth, Director of Strategy and Partnerships		
Presented By:	David Ainsworth, Director of Strategy and Partnerships		
Purpose			
Report of the Director of Strategy and Partnerships on the progress being made to update the strategic priorities of Sherwood Forest Hospitals.		**Approval**	
		Assurance	Y
		Update	Y
		Consider	

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

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

Committees/groups where this item has been presented before

Trust Management Team 25th October 2023
Board workshop 26th October 2023

Acronyms

None

Executive Summary

During the summer months between April and July several opportunities to engage with members of the public, patients and colleagues were undertaken to help shape the new Trust Strategy. This is an important component of the strategy development not least because the environment in which the trust operates has changed.

The feedback has been incredibly useful in shaping the vision and priorities for the trust's new strategy. Providing a baseline for future use to benchmark ourselves against as we enter into the launch and implementation of the new strategy.

Broadly speaking our patients and public tell us they want better communication, shorter waiting times, personalised and joined up care. Our colleagues tell us they want timely communication, improvements to pathways, career development and return to basics with the CARE values.

I would like to take this opportunity in thanking everyone who gave their time and views into the process. There will be further such opportunities as the strategy continues it's journey to final design and through the launch period.

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Report from the Director of Strategy and Partnerships

"Following on from engagement activities with members of the public and our colleagues, I am pleased to share the following information which will be referred to as our 'baseline view' from which we have listened and shaped the future strategy for Sherwood Forest Hospitals."

INTRODUCTION

The Trust strategy sets out our ambition and plans to deliver our collective vision of **Outstanding Care** (given by) **Passionate People** (leading to) **Healthier Communities.**

We have engaged with and listened to our local population, patients, their families and carers, and our colleagues during the creation of this document to ensure it meets the expectations we all have of our local health services.

I would like to share my personal thanks with everyone who gave their time so generously in feeding back their views on the future provision of services at Sherwood Forest Hospitals. Alongside our regular engagement and feedback opportunities, your views ensure as a Board and provider of NHS services that we remain in touch with members of the public. We regard our patients, volunteers, local communities and colleagues as equal partners in developing the strategy and delivery of our services and you will see this as a theme through the lifetime of this strategy.

The feedback received re-enforces our ambition to continually demonstrate openness, candour, learning from things that could have gone better and having a continuous quality improvement mindset.

The information below summarises the feedback we have been gathering from members of the public, our patients, our colleagues, volunteers, foundation trust members and partners during the summer months of 2023.

SUMMARY

At the heart of the feedback given so generously by the public and our colleagues are four consistent themes from each that helped shape the trusts new strategy. Local people said they would like to see:

1. **Shorter waiting times.** You want us to offer prompt appointments and a diagnosis as quickly as possible. Continue to provide the best care and to provide access to consultants and treatments without delay.
2. **Better communication** from us that supports continuity of care inside and outside of the Trust in a timely way. This includes informing both our partners and patients of appointments, decisions and treatment summaries. It also includes improving our verbal communication in a way that is sensitive and inclusive to individuals.
3. **Joined up care.** We've been asked to reduce inconvenience (e.g. duplication, unnecessary appointments or tests) in any form. People tell us they know resources are scarce and need to be used wisely as well as correctly by delivering care together. We've been asked to provide as much care as possible locally.
4. **Personalised care.** We need to pay attention to people's individual needs such as wheelchair users, people with dementia, older adults, children and young people and people with sight difficulties for example. Our service delivery and the environment should take into account that we all have individual requirements of healthcare. Equity and equality should drive future service improvements and estate improvements.

(cont'd)

The key themes from engaging with our colleagues include:

PEOPLE - for colleagues to be supported through clear career development and good quality, appropriate and accessible training and development. Including personalised career chats and equitable access to development opportunities. For teams to have the right skill mix to both lead their services well and be well led at all levels of the organisation. So that people feel that the trust recognises them as our most important value they are.

PATIENT PATHWAYS AND TRANSFORMATION - team members highlighted many good areas for improving pathways and transforming services including strengthening and developing our partnerships, reviewing discharge processes, better use of digital and new technologies and integration.

COMMUNICATION - staff members talked about communication in the light of the organisation needing a multifactorial approach to ensuring information is shared with the correct people, both internally and externally in a timely fashion. Using varied delivery methods.

BACK TO BASICS - team members highlighted the importance of fundamental principles. For the need for everyone to adhere to the CARE values of the organisation, that our team members feel valued and are given sufficient time to care and for services to be developed involving our communities and team members from the outset.

Thank you once again to all our contributors. I hope you will recognise your feedback represented across our strategy and delivery plans over the next five years. We fully commit to working in partnership with you as we develop the maturity of the organisation throughout the lifecycle of the strategy, ensuring that the feedback and strategy joins-up with our wider sub strategies including clinical services strategy, people and culture strategy, financial strategy, quality strategy and partnerships strategy.

UNDERSTANDING OUR VISION

Our vision is to provide outstanding and consistent patient experience, outstanding care and work in partnership to support healthier communities. Our patient, public and colleague feedback has contributed to shaping what that means.

The principles we will strive to achieve across all our strategic objectives and priorities to deliver our vision are:

- We will provide the right care, in the right place, at the right time
- We will deliver efficient and personalised care
- We will deliver care that is compassionate and engaging, and will be transparent if we don't get things right
- We will co-design our services in partnership with those people who use them and deliver them.

The SFH strategy and supporting strategies describe in more detail how we will deliver our vision. Our supporting strategies can be found on our hospital website.

David Ainsworth
Director of Strategy and Partnerships

Mid-Nottinghamshire Integrated Care Partnership

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Integrated Performance Report

Reporting Period: Q2
2023/24

Inspected and rated
Good
CareQuality Commission

Domain Summary: Quality Care

Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead
During Q2 the Organisation has seen some of the highest ever attends via the emergency pathways. This prolonged, unrelenting period of operational pressure impacts on our ability to provide good, safe patient care. We continue to see long waits for admission beds and over-crowding, within the Emergency Department. This continues to impact on our patients, carers and our colleagues. The 2023 BMA Industrial Action has intensified during Q2 with September seeing for the first time in the history of the NHS, four days in which junior doctors and consultants coordinated industrial action. During the four days we saw "Christmas Day" levels of staffing from both groups. With Industrial Action still occurring, a paper representing the current view on the impact across quality, access, people and financial metrics was commissioned by Quality committee and has been sent to all non-Executive Directors highlighting our concerns and impact on our patients and colleagues. The data review in this report highlighted that as a direct result of the Trust detailed preparation and subsequent implementation of a well-rehearsed and planned detailed mitigation process during periods of industrial action, the quality of care and safety of inpatients has been enacted effectively. There has however been significant numbers of patients who have seen their outpatient appointments, surgery, and procedures delayed disrupted or cancelled. The hidden consequences of strike action include reduced access to health care, increased strain on remaining healthcare staff, disruption to elective care and knock on effects on the waiting lists and much of the impact remains hidden and may never be truly revealed. This will be particularly relevant in the true patient experience and impact, colleague's moral injury and impact, organisation affect and hidden financial costs. Q2 has seen the continued reduction in falls per 1000 bed days and zero falls with lapses in care There are 5 domains during Q2 which will be reported on as off track: • Clostridium difficile reported in YTD: Offtrack however cases reported in Q2 considerably lower than in Q1, mirroring the pattern for this time past year. Nationally there continues to be an increase in Cdiff cases and organisations trajectories are going to be difficult to meet. Regional summit has been attended to examine themes and share best practice and task and finish groups being convened, with a view to expanding the review of each patients care to include all community and acute care in a specific time period. • Gram Negative blood stream infections: The national picture for all Gram Negative blood stream infections (includes Klebsiella and Pseudomonas) continues to deteriorate with an increasing number of cases. However our compliance as an organisation has improved since last year with our cases reducing and are at a similar rate to 2021-22 for both. We have identified 2 cases of Trust acquired Klebsiella and 2 cases of Pseudomonas during Quarter 2. The factors that may have affected our rate reduction include the environmental changes we have made to reinstate the deep clean programme and the continuation of the bed cleaning programme. • Case finding question, or diagnosis of dementia or delirium: Our compliance has improved considerably in recent years and although we fall below the high standard of 90% we can see an improving picture in Q2. • HSMR (12-month rolling position) remains "higher than expected" however in month position for June 2023 is within expected. SHMI remains "as expected" • Early neonatal deaths per 10000 live births. Currently we are looking at the data displayed to align to our child death processes – ensuring that we are only reporting inborn.	MD, CN

Scorecard: Quality Care

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	2023/24 YTD
Safe	Falls with lapse in care	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Falls per 1000 OBDs	≤6.63	✗ 6.9	✓ 5.9	✗ 7.0	✓ 6.6	✓ 5.2	✗ 6.9	✓ 6.0	✓ 6.1	✓ 6.3
	Never events	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Hospital acquired infection MRSA > 48 hours	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Hospital acquired infection C difficile > 48 hours	≤13	✓ 4	✓ 6	✓ 5	✗ 15	✓ 4	✓ 0	✓ 2	✓ 6	✗ 21
	Hospital acquired infection Ecoli BSI > 48 hours	≤22	✓ 2	✓ 3	✓ 5	✓ 10	✓ 2	✓ 2	✓ 6	✓ 10	✓ 20
	Hospital acquired infection Klebsiella BSI > 48 hours	≤1	✓ 0	✓ 1	✓ 0	✓ 1	✓ 1	✓ 1	✗ 0	✗ 2	✗ 3
	Hospital acquired infection Pseudomonas BSI > 48 hours	≤3	✓ 2	✓ 0	✓ 0	✓ 2	✓ 2	✓ 0	✓ 0	✓ 2	✗ 4
	HAPU (cat 2) per 1000 OBDs with a lapse in care		0.1	0.0	0.1	0.1	0.0	0.0	0.1	0.0	0.1
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1
Caring	Case finding question, or diagnosis of dementia or delirium	≥90%	✗ 82.1%	✗ 84.8%	✗ 86.2%	✗ 84.4%	✗ 88.1%	✗ 84.9%	✗ 83.7%	✗ 85.6%	✗ 85.0%
	Complaints per 1000 OBDs	≤1.9	✓ 1.1	✓ 1.2	✓ 1.0	✓ 1.1	✓ 1.5	✓ 1.3	✓ 1.3	✓ 1.4	✓ 1.2
	Compliments received in month		90	146	123	359	165	150	135	450	809
Effective	HSMR (basket of 56 diagnosis groups)	≤100	✗ 127	✗ 128	✗ 131	✗ 131	✗ 131	✗ 130	✗ 130	✗ 130	-
	SHMI	≤100	✗ 104	✗ 105	✗ 106	✗ 106	✗ 106	✗ 108	✗ 109	✗ 109	-
	Still birth rate	≤4.4	✓ 3.6	✓ 0.0	✓ 3.4	✓ 2.2	✓ 0.0	✓ 3.7	✓ 0.0	✓ 1.2	✓ 1.7
	Early neonatal deaths per 1000 live births	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✗ 6.9	✓ 0.0	✗ 3.3	✗ 3.5	✗ 1.7

Indicators in Focus: Quality Care – C Difficile & Gram Negative Blood Stream Infections

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

C Difficile:

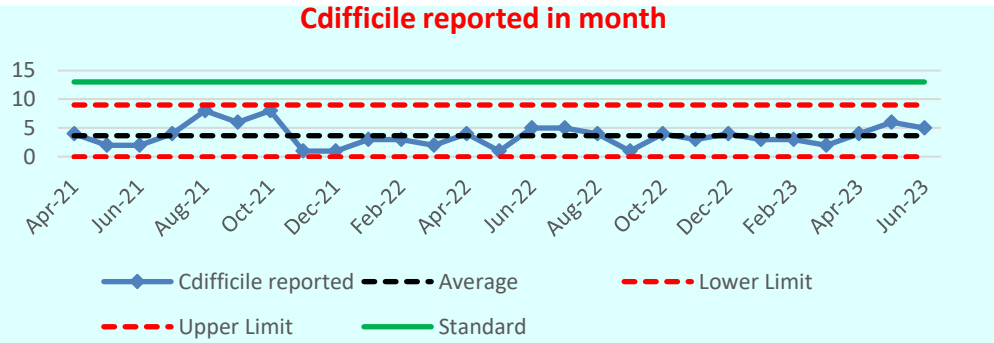
- This year our trajectory has been set at 57
- Nationally there continues to be an increase in CDiff cases and organisations trajectories are going to be difficult to meet.
- We continue to review our cases on rates per occupied bed days which shows last year we had our lowest rates during this time and this year we are following a similar pattern.
- Regional summit has been attended to examine themes and share best practice. There are new task and finish groups being convened, with a view to expanding the review of each patients care to include all community and acute care in a specific time period.

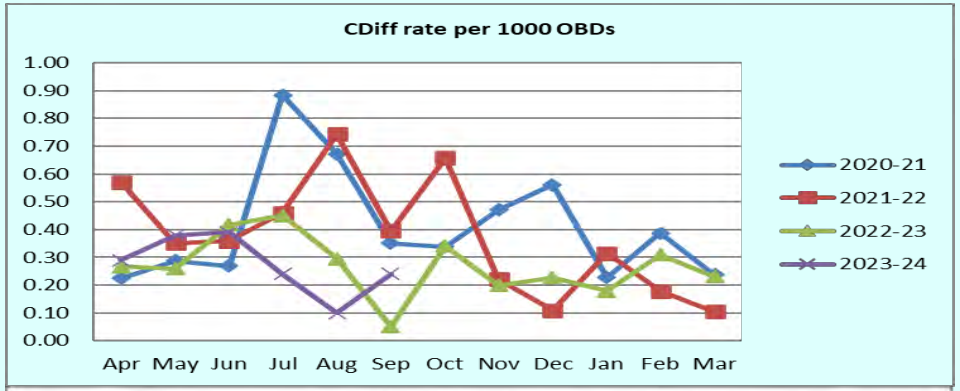
Gram Negative blood stream infections (Klebsiella & Pseudomonas)

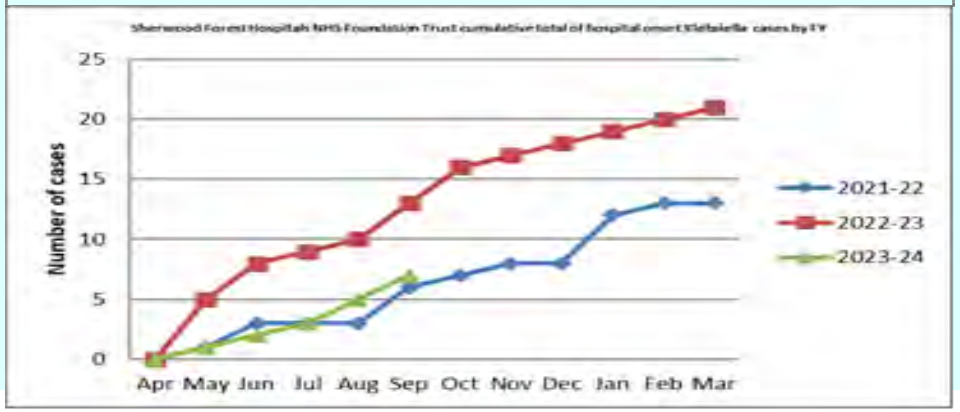
- The national picture for Klebsiella & Pseudomonas as with all Gram Negative blood stream infections continues to deteriorate with increasing number of cases. However, our compliance as an organisation has improved since last year with our cases reducing and are at a similar rate to 2021-22.

Root causes	Actions	Impact/Timescale
The root cause of the CDiff cases have been unavoidable due to patients being treated with antibiotics for other infections	• Deep clean programme recommenced at KMH • Changed the daily cleaning products from a chlorine base used by Medirest to a Peracetic Acid based cleaner which is a sporicidal • We are auditing the trollies used in the Trust for patients and looking at if we can implement the bed cleaning process with these also.	September 2023 September 2023 October 2023

Data







Indicators in Focus: Quality Care – Dementia or delirium case finding

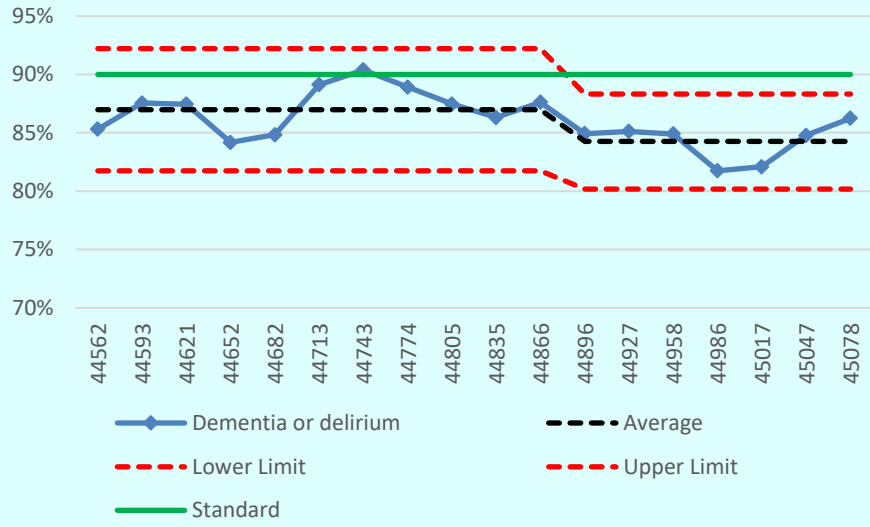
Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- All patients 65 years + admitted to the Trust for 72 hours and above are required to have a Dementia screen completed, this incorporates the Squib screening for delirium. The screen is completed by both Nursing and Medical staff and is support by the Dementia Team. This has seen an increase in compliance with the percentage rate consistently >80%.
- National reporting of the Dementia screening started in September 2013 until February 2020, this was paused due to the pandemic between April 202 and June 2021. Consultation followed and it was agreed that reporting nationally would be stepped down, although this has continued at Sherwood Forest Hospitals.
- The Dementia Nurse Specialist Nurse identifies patients that have not had a Dementia screen during admission to audit the potential issues and this is escalated through COEC.
- The National Dementia Audit results from 2022/2023 are now available and have highlighted that from the eligible patient group 95% of patients had a delirium screen on admission.

Root causes	Actions	Impact/Timescale
Whilst we have achieved compliance >80% of Dementia screening, we have not reached the Trust target of >90%	• Previous action included that the compliance target of >90% is changed to reflect national guidance. The emphasis should be identifying patients with delirium and supporting patients with dementia, including their carers as part of the 'Dementia Well Pathway'.	Work is ongoing with the Digital Team to align the screening tool to capture delirium by using the 4AT on Nervecentre. The Dementia Team are liaising with RRLP to develop this. This will be tracked through governance meetings.
Delayed National Dementia Audit results from 2022/2023	• The lead Geriatrician and Dementia Team to analyse the audit results to identify any gaps/actions.	Findings from the analysis will be shared Trustwide, with an action plan formulated from the findings to improve the patient journey.

Data



Indicators in Focus: Quality Care – HSMR and SHMI

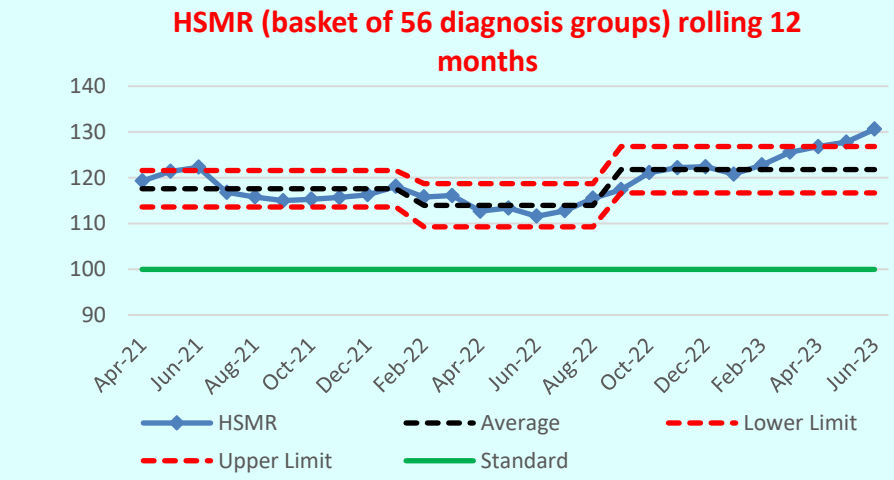
Sherwood Forest Hospitals NHS Foundation Trust

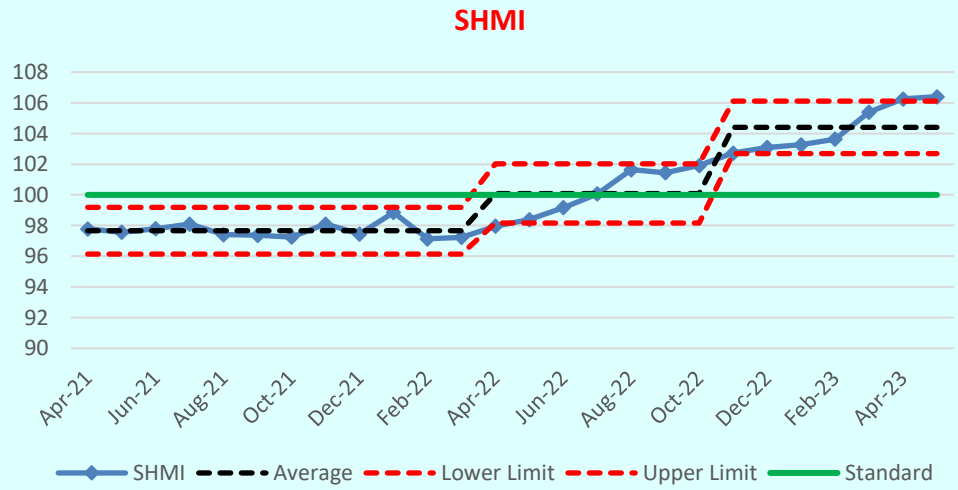
National position & overview

HSMR remains "higher-than-expected" (130.37), recognising this represents a 12-month rolling position and our in-month HSMR for June 2023 which is the latest reported month is 116.0 which is "within expected"
SHMI remains "as expected" at 108.64 for the rolling 12-month period to April 2023 although if the upward trend continues this will become "higher-than-expected" within the next few months.
A key factor driving the difference between these two metrics is believed to be specialist palliative care (SPC) for which we are a nationally low outlier.
Increasing upward trends in both metrics are likely due to ongoing issues with accurate capture of diagnosis and co-morbidity coding in clinical documentation without which it is not possible to code. We believe this is artificially lowering our "expected" mortality across both metrics
Our Learning from Deaths programme remains the vehicle for identifying and understanding signals from these metrics. Stronger signals are followed up with clinical case reviews which confirm issues around diagnosis coding. The work programmes tackling these includes improving our palliative care provision, admission workbook redesign and targeted case review, undergoes regular scrutiny via Quality Committee.

Root causes	Actions	Impact/Timescale
SPC coding	We have improved capture of SPC activity due to changes referral pathways, introduction of stickers to flag activity in notes	Small as SPC activity remains low.
Low level of SPC activity	Reconfiguration of SPC service to increase activity	Requires significant investment at Trust/ ICB levels
Coding/ Documentation of diagnosis and comorbidities	Intensive programme of communication and education around importance of coding. Redesigned admission workbook awaiting implementation.	Will take up to 12 months due to rolling nature of metrics

Data





Domain Summary: People and Culture

Sherwood Forest Hospitals NHS Foundation Trust

Overview	Lead
During the quarter we have seen continued events of **Industrial Action** held by the British Medical Association (BMA), there were a mix of junior doctors and consultant strikes held between July 13-18th (Juniors - 85% loss) July 20-21st (Consultant - 29.9% loss) July 11-14th (Junior - 81% loss), August 24-25th (Consultant 55% loss) and September 19-22nd (Consultant 31% loss / Juniors 63% loss). Our **engagement score** has remained at a high level and for quarter 2 is report at 7 (this is between a range of 1-10) Over the last three months we have seen a decrease in the Trust **vacancy** level, over the quarter this is recorded at 5.3% (Q1 – 6.5%), with the rate for September 2023 at 5.1%. Our **Mandatory and Statutory Training (MaST)** position is really positive where we are reporting above the Trust targets. **Appraisal** level for quarter 2 (89.0%) sits below the Trust target (90%), we have noted a reduction in compliance over quarter 2. During September 2023 the level has reduced to 88%, however, this is still a strong level of performance. During September we have re-launched our revised appraisal paperwork, this should support more meaningful discussion, around a less cumbersome process. Over Q2 our **sickness absence** level is reported at 4.4% (Q1 – 4.2%) and over the last few months has shown a gradual increase. Sickness does sit higher then Trust target (4.2%) and between the upper and lower SPC levels. There has been an increase with **employee relations** cases over the quarter (ave. 19) with September 23 recorded at 21 cases, this sits above our target (n.12) and above the upper SPC limit. Whilst there has been an increase in the number of formal cases we have seen an increase in support required for Managers relating to increases in stage 2 sickness cases and grievances cases, one of the key reasons for the increase in grievance cases is mainly relating to concerns being raised around attitude and behaviours and disagreement with outcomes at an informal stage. We are aware that across Nottinghamshire our ICB has been flagged for high **agency usage** and we have a system programme to review our agency usage. Across the ICB we are active in this agency working group and we do understand where we have high usage within the Trust. We also have developed internal control meetings that are supporting our financial improvements. Our current agency position is reported at 5.9%, with the quarterly position reported at 6.6%, although this does sit above the target level of 3.7% this has been impacted by the junior medical industrial action episodes and we have seen a reduction over the quarter. During quarter 2, 51.7% of total agency shifts filled were 'on framework' staff but **above the recommended NHSE price cap**, we have set a target of 30% for this metric, the majority of this sits with our medical workforce (98.6%). Over the year we aim to move towards this target. Additionally, of the agency shifts filled we have seen low levels of those filled by off framework workers over the last quarter (July - September 2023). To note there has been 0% off framework agency workers. We have arranged medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff, where possible, on to direct engagement contracts. As an example, we have had success with Intensive Care and Anaesthetics and are scoping out where we have risk and are developing a programme to enable these discussions and associated actions to be delivered.	DOP

Scorecard: People and Culture

Sherwood Forest Hospitals NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2
Belonging in the NHS	Engagement Score	≥6.8%	-	-	-	✓ 7.0				✓ 7.0
Growing the Future	Vacancy rate	≤6.0%	✗ 6.9%	✓ 5.8%	✗ 6.6%	✗ 6.5%	✓ 5.4%	✓ 5.3%	✓ 5.1%	✓ 5.3%
	Turnover in month	≤0.9%	✓ 0.79%	✓ 0.37%	✓ 0.36%	✓ 0.51%	✓ 0.65%	✓ 0.47%	✓ 0.47%	✓ 0.53%
	Appraisals	≥90%	✗ 87.1%	✓ 90.4%	✓ 90.2%	✗ 89.3%	✗ 89.5%	✗ 89.5%	✗ 88.0%	✗ 89.0%
	Mandatory & Statutory Training	≥90%	✓ 90.0%	✓ 90.0%	✓ 91.0%	✓ 90.3%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%
Looking after our People	Sickness Absence	≤4.2%	✗ 4.4%	✓ 4.2%	✓ 4.2%	✓ 4.2%	✗ 4.5%	✗ 4.3%	✗ 4.5%	✗ 4.4%
	Total Workforce Loss	≤7.0%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.2%	✓ 6.5%	✓ 6.4%	✓ 6.6%	✓ 6.5%
	Flu vaccinations uptake - front line staff	≥80%	-	-	-	-	-	-		
	Employee Relations Management	<12	✓ 11	✗ 14	✗ 15	✗ 13	✗ 18	✗ 17	✗ 21	✗ 18
New Ways of Working	Agency (Off Framework)	≤6.0%	✓ 0.1%	✓ 0.1%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%
	Agency (Over Price Cap)	≤30.0%	✗ 47.7%	✗ 59.6%	✗ 53.1%	✗ 53.3%	✗ 55.3%	✗ 48.9%	✗ 50.8%	✗ 51.7%
	Agency Usage (%)	<3.7%	✗ 6.1%	✗ 7.4%	✗ 6.0%	✗ 5.9%	✗ 7.4%	✗ 6.5%	✗ 5.9%	✗ 6.6%

Indicators in Focus: People and Culture – Appraisals

Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

The charts below expresses that our appraisal level sits below the Trust target (90%), we have noted a reduction in the appraisal level over quarter 2, with the average sitting at 89%. During September 2023 the level has reduced to 88%, however, this is still a strong level of performance.

Local benchmarking shows that the ICB provider appraisal level is reported at 80%.

Root causes

As stated, we have seen a decrease in the overall appraisal level over the last few months, this reduction does align to the acuity of the hospital.

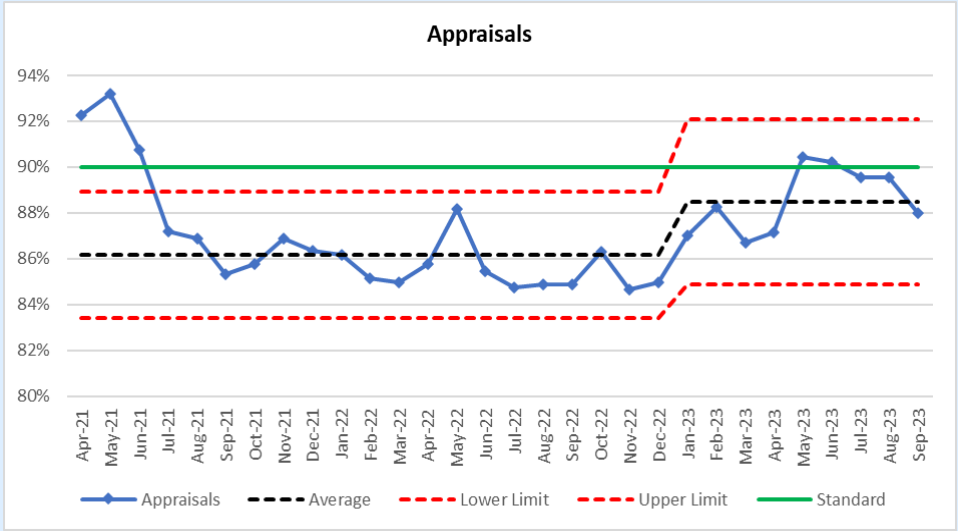
Actions

Service lines with low appraisal rates are supported to develop action plans to work on improving appraisal compliance. In addition, Service Lines are sighted on non-compliance rates and assurance is sought via Performance meetings on improving compliance. There are specific case conversations take place during monthly People & Performance reviews

Impact/Timescale

As we move into winter, we expect this level to fluctuate, this is largely due to acuity and winter pressures.

Data



Indicators in Focus: People and Culture – Sickness Absence

Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

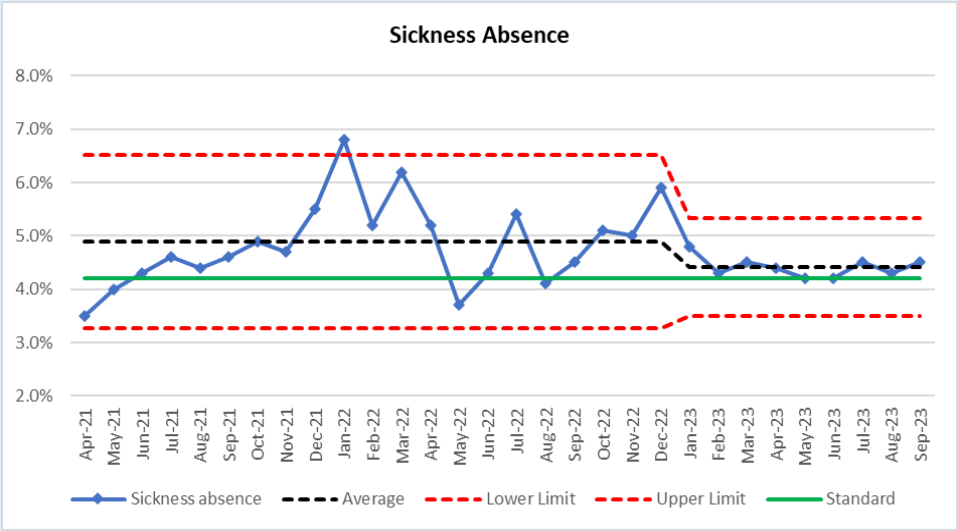
During quarter 2 our overall sickness absence level has been above our standard (4.2%) and has seen fluctuations around our rolling average sickness levels (4.4%). The position for quarter 2 sits between the upper and lower SPC levels.

Since April 2023 we have seen a steady level, with no significant variations.

Local benchmarking shows that the ICB provider sickness absence level is reported at 5.7%.

Root causes	Actions	Impact/Timescale
Our sickness level increases are as a relation to the industrial action, this is across two elements. Initially, the additional pressure and workload as a result on the numerous strikes. Secondly, we are noting an increase due to longer waiting and treatment times.	Service lines with high sickness absence rates are supported with managing sickness cases, and these are discussed and reported via Divisional Performance Reviews (DPRs). We review short and term cases and manage these using difference strategies, We also support where there are specific case conversations take place.	We actively manage sickness cases and are aware of outside influences that are contributing to an elevated sickness level.

Data



Indicators in Focus: People and Culture – Employee Relations

Sherwood Forest Hospitals NHS Foundation Trust

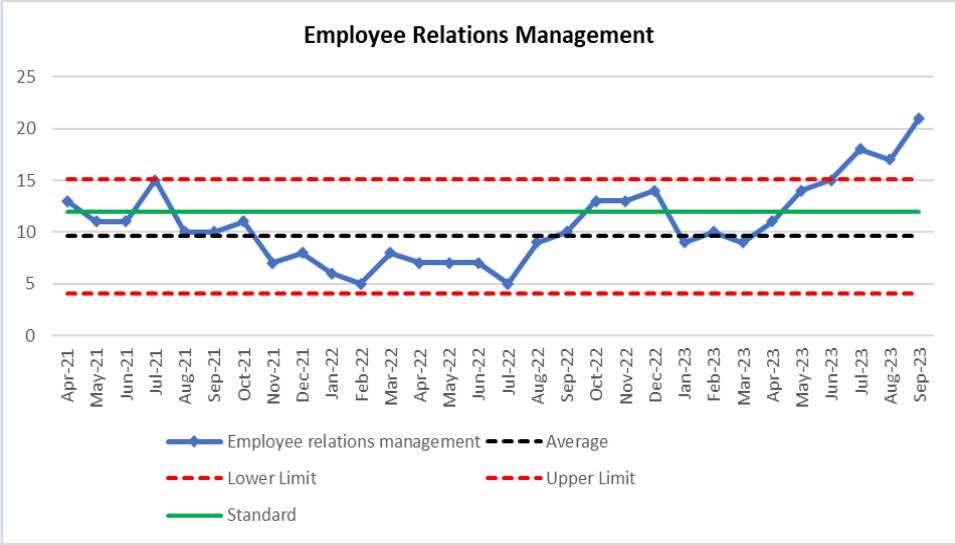
National position & overview

Since April 2023 we have seen a gradual increase to the employee relations cases, currently we are reporting 21 cases

Our level sits above the standard and is above the upper SPC level.

Root causes	Actions	Impact/Timescale
Since April we have seen a gradual increase in Employee Relation cases, we have noted an increase in stage 2 sickness cases and grievances cases, one of the key reasons for the increase in grievance cases is mainly relating to concerns being raised around attitude and behaviours and disagreement with outcomes at an informal stage.	We are supporting from a people leads perspective and will bring this intelligence into the Divisional People Boards. Local intelligence indicates there has been gradual increases across other providers in Employee Relation cases showing Sherwood is not an outlier.	We actively manage employee relation cases and are supporting services lines with these.

Data



Indicators in Focus: People and Culture – Agency Usage

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

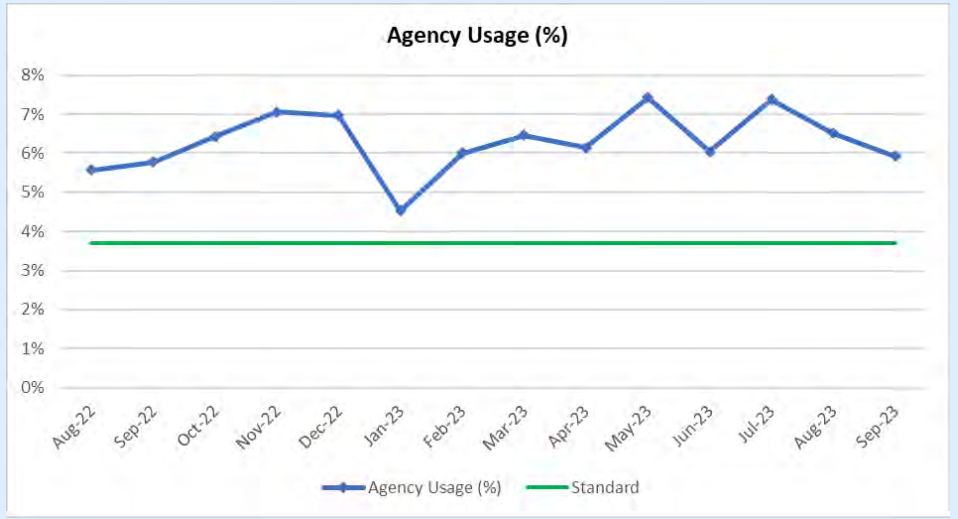
Our overall agency position is reported at 5.9%, although this does sit above the target level of 3.7%, and on framework over price cap is reported at 50.8% and is above our target 30.0%. This has been impacted by the medical industrial action episodes and acuity of the hospital

We are aware that across Nottinghamshire our ICB has been flagged for high agency usage and we have developed programmes to review our agency usage. Across the ICB we are active in this agency working group and we do understand where we have high usage within the Trust.

Local benchmarking shows that the ICB provider agency level is reported at 5.1%, with the percentage over price cap at 28.8%, however there is a relationship with off framework where the ICS figures is 4.2% (SFH report 0%).

Root causes	Actions	Impact/Timescale
As the data informs us our biggest risk is medical & dental staff over the NHSE price cap, these are also impacted by some of our fragile services were there are national speciality shortages.	To address this we are developing 100 day action please that are aligned to our Financial Improvement Cabinet, also supporting this we do discuss agency usage in the medical operational workforce group, with the information being discussed at Divisional Performance reviews (DPR's). We organise medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff, where possible, on to direct engagement contracts. A strict authorisation process for approval of shifts for Thornbury has been implemented in Nursing. Detailed reports illustrating areas using all Agency with Thornbury highlighted are produced for the Deputy Chief Nurse.	We have been actively filling medical roles, and have had success in some key specialities. We are continuing this work as well as provide the right level of intelligence within working groups and within DPRs.

Data



Domain Summary: Timely Care

Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead
In 2023/24 Q2 (Jul-Sep) our services have continued to operate under sustained pressure not usually seen over the summer period, much like many acute Trusts across the country. The combination of high attendance demand, length of stay pressures and mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals. This mismatch in demand and capacity resulted in us starting the day on OPEL 4 on 23 days during Q2 (six in Jul-23, six in Aug-23 and 11 in Sep-23). At times, patients experienced delays to admission due to a lack of beds. In response to these pressures, we enacted escalation actions and, where necessary, our full capacity protocol. Despite the challenges, we continued to provide strong ambulance handover consistently meeting the 30-minute standard; benchmarked well in terms of our four-hour performance; and have a strong medical Same Day Emergency Care (SDEC) offer exceeding national targets. When looking across the suite of Integrated Performance Report (IPR) metrics; although several of the timely care metrics are underperforming, the patient safety metrics overall remain strong indicating that patient care remains good. The subsequent pages highlight several key actions being taken to improve timely care, some of which are divisionally-led and others with the support and leadership of our Improvement Faculty. Whilst the interplay between emergency and elective pathways continues to create challenges, it has been the ongoing instances of industrial action that have resulted in curtailments in elective activity which adversely impacted on our elective activity, backlog and performance metrics. The national requirement to meet zero 78-week waiters has been narrowly missed. At the end of Sep-23 we had three 78-week wait patients for capacity-related reasons. We have successfully increased the number of first outpatients to above planned levels. We intend to expand planned care activity levels from Nov-23 as our Targeted Investment Fund (TIF) development opens at Newark hospital. We continue to work together as a system with patients being transferred between providers as part of mutual aid arrangements; this has resulted in us inheriting some long wait patients. We are benefiting from some mutual aid to help with our Echocardiograph position; one of our underperforming diagnostic tests, which together with insourcing plans will help us reduce the significant backlog. In Outpatients, we have consistently exceeded the 5% Patient Initiated Follow Up (PIFU) target and the 16% Advice and Guidance target throughout Q2. We continue to see in the region of 15% of outpatient non-face-to-face; we recognise that we have further work to ensure that we make full benefit of remote outpatient attendances; embedding the learnings from the height of the pandemic. Our outpatient improvement programme is maturing and launching a toolkit to support clinicians to drive increased, appropriate use of virtual appointments. Key metrics relating to the delivery of timely cancer care have deteriorated in Q2 as we saw more instances of industrial action. Like other organisations we have seen growth in Cancer two-week referrals. We continue our strong delivery of the national 28-day faster diagnostic standard with our ICS being one of the best in the Midlands region. Revised national cancer waiting time standards launched in Oct-23 with the original nine standards reduced to three. This report will be updated in Q3 to reflect the changes. Further details relating to timely care metrics are included in the following pages with some metrics grouped together within the relevant care pathways.	COO

Scorecard: Timely Care – Urgent Care

Sherwood Forest Hospitals NHS Foundation Trust

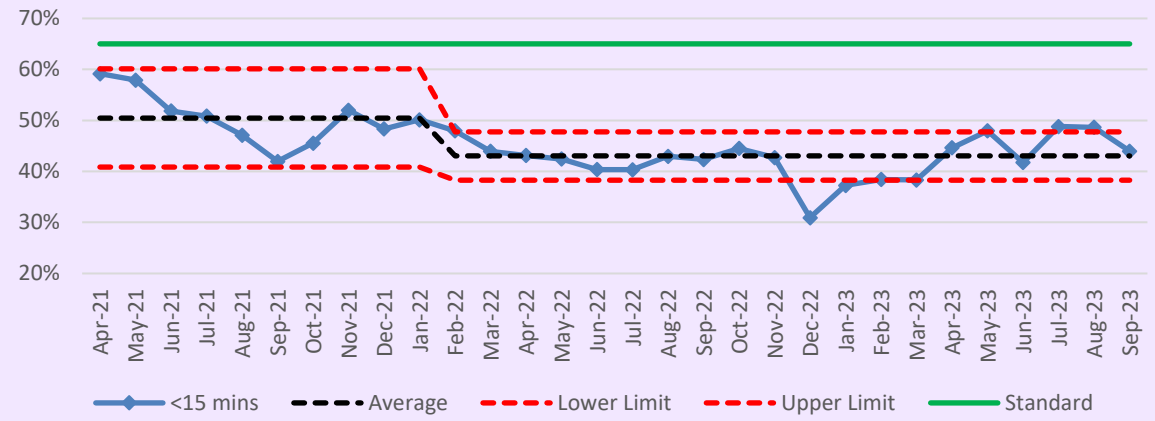
At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	2023/24 YTD
Urgent Care	Ambulance turnaround times <15 mins (%)	≥65%	✗ 44.6%	✗ 48.0%	✗ 41.7%	✗ 44.8%	✗ 48.8%	✗ 48.7%	✗ 44.0%	✗ 47.2%	✗ 46.0%
	Ambulance turnaround times <30 mins (%)	≥95%	✓ 96.0%	✓ 96.1%	✗ 94.0%	✓ 95.4%	✓ 96.5%	✓ 96.6%	✓ 95.2%	✓ 96.1%	✓ 95.8%
	Ambulance delays >60 mins (%)	0.0%	✗ 0.1%	✓ 0.0%	✗ 0.3%	✗ 0.2%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✗ 0.0%	✗ 0.1%
	ED 4 hour performance (%)	≥76%	✗ 75.6%	✗ 74.0%	✗ 73.1%	✗ 74.2%	✓ 77.0%	✓ 76.6%	✗ 72.3%	✗ 75.3%	✗ 74.7%
	Mean waiting time in ED (in minutes)	≤200	✗ 209	✗ 212	✗ 217	✗ 213	✓ 199	✓ 199	✗ 218	✗ 205	✗ 209
	ED 12 hour LoS performance (%)	≤2%	✗ 2.8%	✗ 2.4%	✗ 2.7%	✗ 2.6%	✓ 1.5%	✓ 1.9%	✗ 2.3%	✓ 1.9%	✗ 2.3%
	ED 12 hour DTA breaches	0	✗ 84	✗ 84	✗ 78	✗ 246	✗ 32	✗ 58	✗ 65	✗ 155	✗ 401
	Number of A & E attendances against plan	≤Plan	✓ 14,571	✗ 15,900	✗ 15,720	✗ 46,191	✗ 15,921	✓ 15,080	✗ 15,730	✗ 46,731	✗ 92,922
	Number of NEL admissions against plan	≤Plan	✓ 3,429	✓ 3,587	✓ 3,643	✓ 10,659	✓ 3,661	✓ 3,605	✓ 3,649	✓ 10,915	✓ 21,574
	SDEC activity (%)	≥33%	✓ 37.5%	✓ 37.6%	✓ 37.6%	✓ 37.5%	✓ 37.2%	✓ 36.5%	✓ 36.8%	✓ 36.9%	✓ 37.2%
	Adult G&A bed occupancy (%)	≤92%	✗ 95.7%	✗ 96.4%	✗ 96.3%	✗ 96.1%	✗ 94.0%	✗ 98.6%	✗ 95.4%	✗ 96.0%	✗ 96.1%
	Long length of stay (21+) occupied beds	≤Plan	✗ 136	✗ 127	✗ 127	✗ 130	✗ 123	✗ 119	✓ 110	✗ 118	✗ 124
	Inpatients MSFT >24 hours	≤40	✗ 106	✗ 116	✗ 106	✗ 109	✗ 107	✗ 110	✗ 93	✗ 104	✗ 107

Indicators in Focus: Timely Care – ED metrics (1/2)

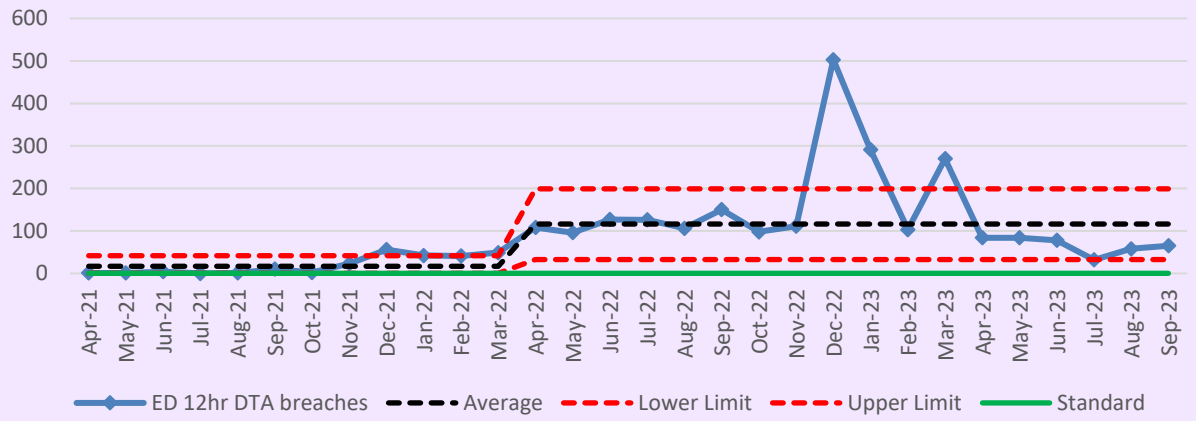
Sherwood Forest Hospitals NHS Foundation Trust

Data

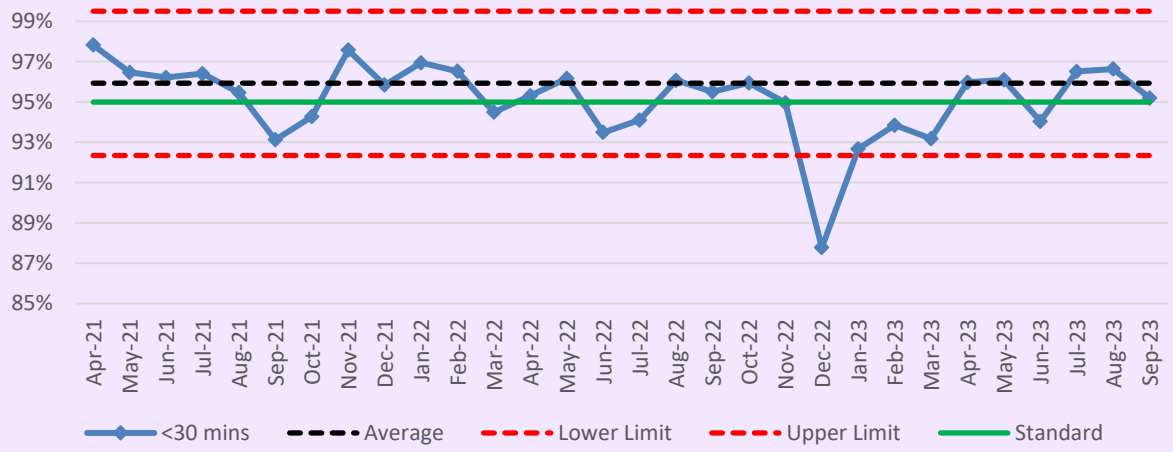
Ambulance turnaround times <15 mins (%)



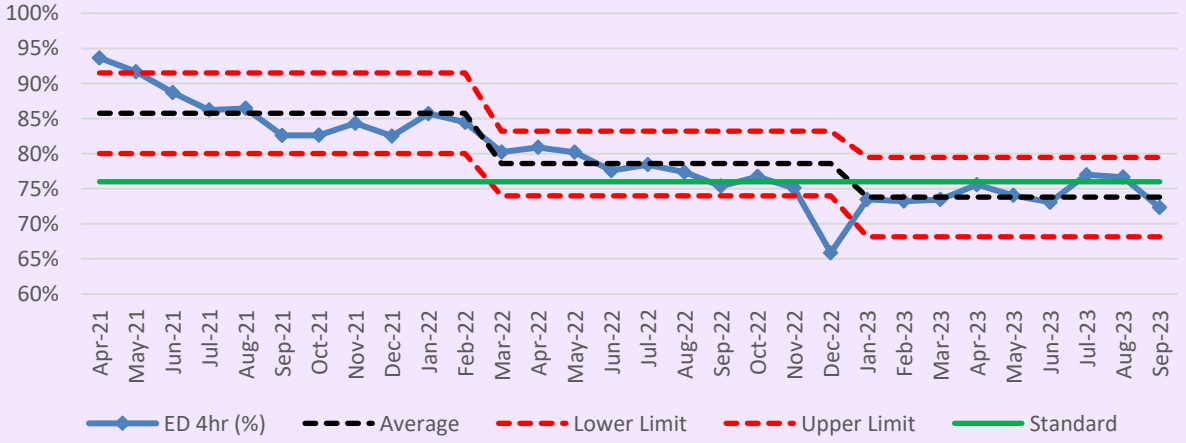
ED 12 hour DTA breaches



Ambulance turnaround times <30 mins (%)



ED 4 hour performance (%)



Indicators in Focus: Timely Care – ED metrics (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Our ambulance handover position is significantly better than the EMAS average:
  - Average regional handover time for EMAS is 30.1 mins with SFH at 16.5 mins.
  - 17.7% of regional EMAS ambulance handovers were over 30 minutes with SFH at 3.9% in Q2. At SFH the 30-minute target in the operational planning guidance is consistently being achieved.
  - 8.4% of regional EMAS ambulance handovers were over 60 minutes with SFH at zero in Aug-23 and Sep-23.
- 4-hour benchmark position is 2nd in the Midlands region and 15th nationally (improved from 24th nationally).
- Trust overall 4-hour performance of 75.3% in Q2 (against an operational planning guidance target of 76% by Mar-24). Newark Urgent Treatment Centre is performing at 99%.
- 12-hour benchmark position is now 50th nationally (in the Q1 report we were 61st) out of 120 providers submitting data.
- ED attends 6% year to date increase compared to 2022/23 and 11% increase compared to 2019/20.

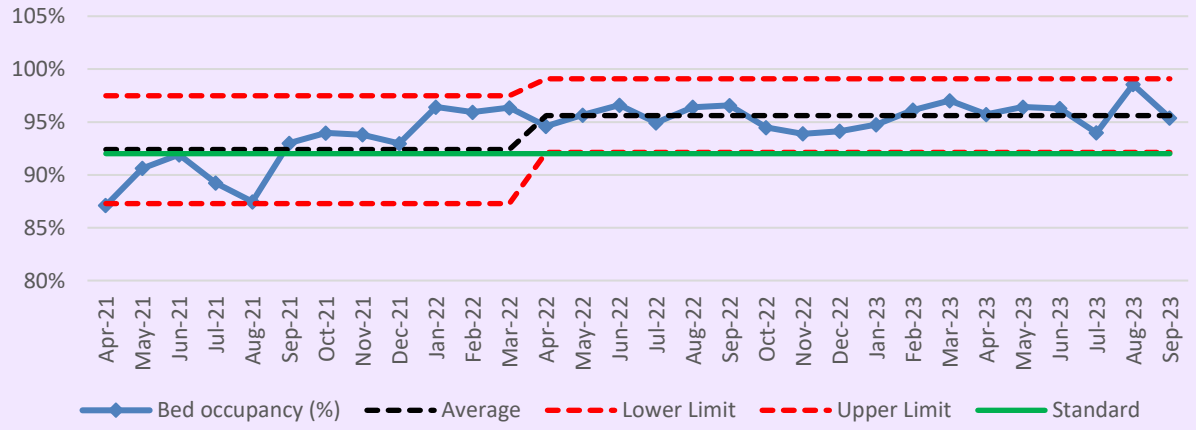
Root causes	Actions and timescale	Impact
Increased ED attendance demand.	Undertake a trial of a Rapid Assessment and Treatment area in Red Majors as part of a review of senior streaming and team-based nursing - scheduled for Dec-23 / Jan-24.	• Support ability to maintain Ambulance Turnaround time during increased demand – 95% within 30 minutes.
	Expand hospital Same Day Emergency Care (SDEC) services through: • Creation of Frailty SDEC with Geriatric input to be incorporated with the creation of the new Discharge Lounge currently scheduled to open Feb-24. • Introduction of a Surgical SDEC - reliant upon capital works to be undertaken on Wards 14 and 33 planned to commence in Q3. • Expansion of medical SDEC direct access to EMAS / GP and 111 from Oct-23.	• Reduction in Frail patients in ED by 20 hours per day. • Increase in SDEC will support decongestion of Emergency Department and reduce the average time spent in department supporting improved 4-hour performance.
	Introduce Virtual Fracture Clinic to increase Orthopaedic capacity to review patients in ED from Jan-24.	• Time to review in ED <60mins in Orthopaedics
	Joint working with Urgent Community Response, Mental Health services and EMAS to improve pre-hospital pathways to expand admission avoidance options. Working groups underway in Q3.	• Decreased conveyance rates from Q4.
Insufficient staffing to manage ED demand.	Implementing recruitment against ED business case: • Nursing rota from Apr-23 • Junior Doctor rota from Aug-23 • Tier 3/4 rota from Nov-23	• Average (mean) time in Department - non-admitted patient reduction to <180 mins. • Time to initial assessment KMH ED - Time to initial assessment for arrivals to A&E % seen within <= 15 minutes > 60% in Q4.
	Develop new, expanded 'Fit to Sit' area with the 12 spaces currently situated in Minors moving to be collocated with Majors to support enhanced patient flow and with an improved staffing model. Timescale to be determined following completion of estates scoping work to be undertaken in Q3.	• Reduction in overcrowding in ED and timely transfer from ED.
ED overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	Develop Discharge Lounge pathways in line with new location due to open in Feb-24. Further actions relating to improving hospital flow are detailed in the following slides.	• Improve patient experience as patients will be waiting to leave from discharge lounge rather than the Emergency Department. • Improved hospital flow between 6-8 beds.

Indicators in Focus: Timely Care – Hospital flow metrics (1/2)

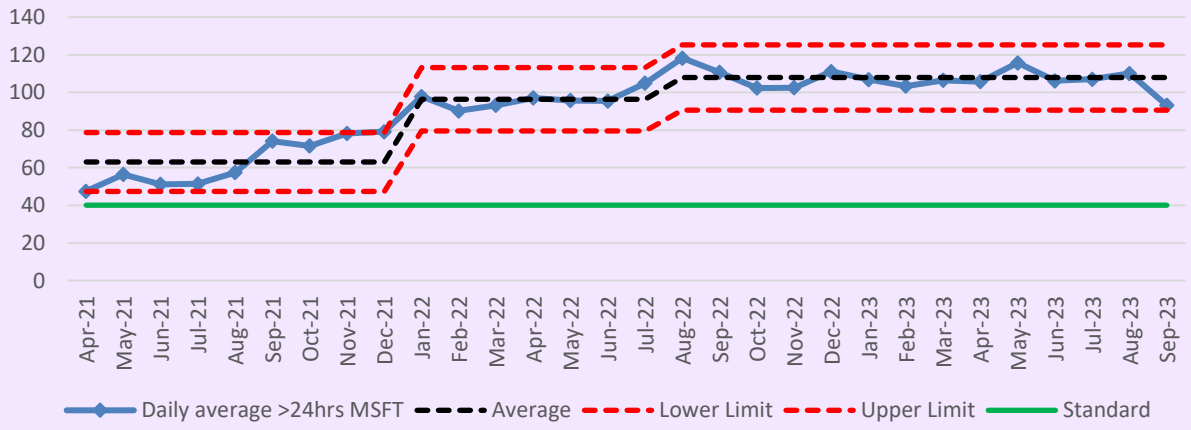
Sherwood Forest Hospitals NHS Foundation Trust

Data

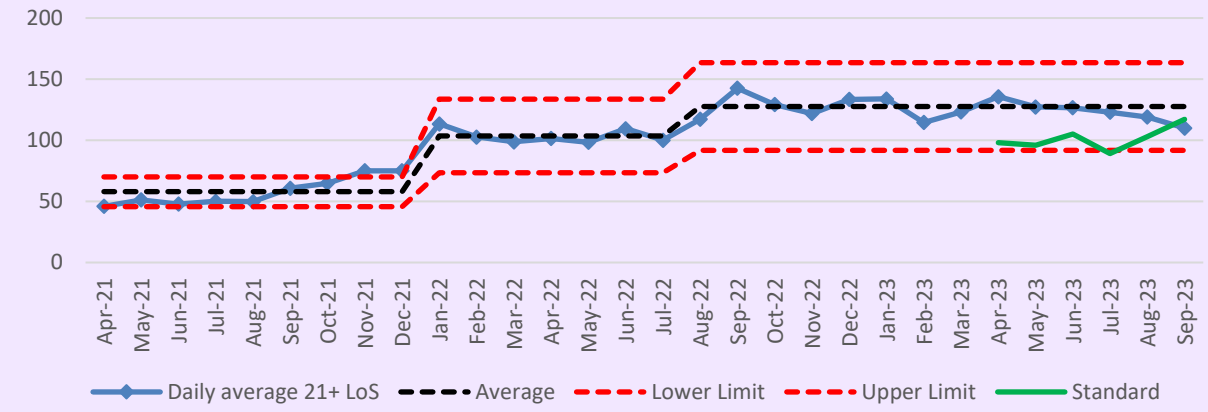
Adult G&A bed occupancy (%)



Inpatient MSFT >24 hours



Long length of stay (21+) occupied beds



Indicators in Focus: Timely Care – Hospital flow metrics (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- All community wards remain open; three at Mansfield Community Hospital and two at Newark Hospital.
- Our hospitals continue to operate at bed occupancy levels significantly higher than 92%; like many other Trusts nationally. Lower bed occupancy supports stronger 4-hour performance (as experienced in mid-Jul-23).
- The number of patients Medically Safe For Transfer (MSFT) over 24 hours has reduced towards the end of Q2. The local position remains above the agreed threshold both in terms of the 2023/24 plan value and the 2022/23 national planning guidance ambition (latter standard used on the chart).
- The number of long stay patients have followed a similar trend to MSFT inpatient numbers due to similarities in the patient cohort.

Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• The Improvement Faculty is leading board and ward round improvement programmes starting in Q3, focusing initially on Stroke and Respiratory wards.	• Delivery of today's work today and early identification of potential discharge barriers will lead to reduced length of stay (LOS).
	• Mapping of patient journey with focus on discharge planning from point of admission. During Q3 we are revising, updating and communicating information relating to key discharge fields on NerveCentre.	• Improvements to NerveCentre will enable us to track patients across the system highlighting gaps in discharge planning or resources required to facilitate discharge.
Delays to post-medically safe discharge processes.	• Development of a new Discharge Lounge (19 beds and 22 chairs) due to open Feb-24.	• Facilitate timely flow through the hospital by freeing up beds earlier in the day to enable admissions. Based upon indicative numbers we forecast a release of 6-8 base ward beds.
	• Transfer of Care Hub continues to develop. From Oct-23 it has moved to operating 6 days per week. The hub and discharge teams are now focussing on current delay themes including patients with housing issues and those from out of area.	• Specific focus on key themes will reduce long LOS for specific patient groups. This will continue the downward trend in the number of long stay patients.
	• The Improvement Faculty are now pursuing bespoke improvement projects around TTOs and Transport that are commencing in Q3 with project plans now being developed.	• Elimination of barriers to discharge and reduction in the number of abandoned discharges.
Insufficient community capacity to meet supported discharge demand.	• Weekly SFH specific discharge group now running with attendance from senior representatives from all system partners to problem solve live issues and current discharge delay themes.	• Rapid resolution of complex issues through multi agency working to support continued reductions in number of supported discharges waiting more than 24 hours.

Scorecard: Timely Care – Electives, Diagnostics and Cancer

Sherwood Forest Hospitals NHS Foundation Trust

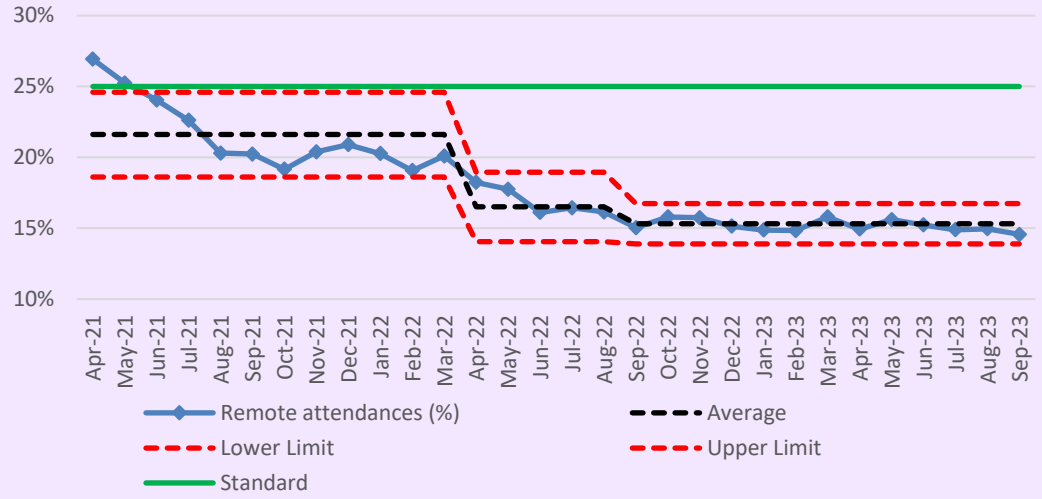
At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	2023/24 YTD
Electives	Advice & guidance (%)	≥16%	✓ 25.3%	✓ 23.8%	✓ 23.9%	✓ 24.3%	✓ 24.5%	✓ 26.5%	✓ 22.5%	✓ 24.5%	✓ 24.4%
	Remote attendances (%)	≥25%	✗ 14.9%	✗ 15.6%	✗ 15.2%	✗ 15.3%	✗ 14.9%	✗ 15.0%	✗ 14.6%	✗ 14.8%	✗ 15.0%
	Added to PIFU (%)	≥5%	✗ 4.9%	✗ 4.7%	✓ 5.5%	✓ 5.0%	✓ 6.0%	✓ 5.7%	✓ 6.0%	✓ 5.9%	✓ 5.5%
	Average daily referrals		274	311	341	309	316	309	-	-	-
	Outpatients - first appointment against plan	≥Plan	✓ 10,131	✓ 12,349	✓ 12,513	✓ 34,993	✓ 11,992	✗ 11,540	✓ 11,781	✓ 35,313	✓ 70,306
	Outpatients - follow up against plan	≤Plan	✗ 22,687	✗ 28,059	✗ 28,397	✗ 79,143	✗ 26,597	✗ 27,584	✗ 26,850	✗ 81,031	✗ 160,174
	Elective inpatient activity against plan	≥Plan	✗ 295	✗ 339	✗ 343	✗ 977	✗ 297	✗ 308	✗ 336	✗ 941	✗ 1918
	Daycase activity against plan	≥Plan	✓ 2,908	✓ 3,421	✓ 3,429	✓ 9,758	✗ 3,330	✗ 3,308	✗ 3,267	✗ 9,905	✗ 19,663
	Completed admitted RTT pathways against plan	≥Plan	✗ 910	✓ 1,179	✓ 1,163	✓ 3,252	✗ 1,044	✗ 1,033	✗ 1,072	✗ 3,149	✗ 6,401
	Completed non-admitted RTT pathways against plan	≥Plan	✗ 6,453	✓ 8,908	✓ 9,257	✗ 24,618	✗ 8,402	✗ 8,207	✓ 9,214	✗ 25,823	✗ 50,441
	Incomplete RTT waiting list against plan	≤Plan	✗ 49,956	✗ 51,459	✗ 51,946	✗ 51,946	✗ 52,814	✗ 54,047	✗ 53,949	✗ 53,949	-
	Incomplete RTT pathways +52 weeks against plan	≤Plan	✗ 924	✗ 1,087	✗ 1,186	✗ 1,186	✗ 1,349	✗ 1,532	✗ 1,728	✗ 1,728	-
	Incomplete RTT pathways +65 weeks against plan	≤Plan	✓ 141	✗ 180	✗ 208	✗ 208	✗ 236	✗ 309	✗ 352	✗ 352	-
	Incomplete RTT pathways +78 weeks	0	✗ 8	✗ 8	✗ 6	✗ 6	✗ 6	✗ 3	✗ 3	✗ 3	-
	Incomplete RTT pathways +104 weeks	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	-
Diagnostics	Diagnostics activity against plan	≥Plan	✓ 12,704	✓ 13,335	✗ 13,795	✓ 39,834	✓ 13,845	✓ 13,453	✗ 12,598	✓ 39,896	✓ 79,730
	Diagnostic DM01 Waiting List		10,952	11,476	11,462	11,462	11,121	10,155	10,377	10,377	-
	Diagnostic DM01 Backlog		3,737	3,538	3,508	3,508	3,704	4,101	3,928	3,928	-
	Diagnostic DM01 <6 weeks	≥99%	✗ 65.9%	✗ 69.2%	✗ 69.4%	✗ 69.4%	✗ 66.7%	✗ 59.6%	✗ 62.1%	✗ 62.1%	-
Cancer	Two week wait Cancer Referrals		1,417	1,527	1,669	4,613	1,721	1,748	-	-	-
	Cancer 2 week wait performance (%)	≥93%	✓ 93.4%	✓ 96.0%	✓ 94.4%	✓ 94.6%	✗ 91.6%	✗ 91.5%	-	-	-
	Faster Diagnosis Standard (%)	≥75%	✗ 73.4%	✓ 76.9%	✓ 79.2%	✓ 76.6%	✓ 82.8%	✓ 79.2%	-	-	-
	First definitive cancer treatments		115	124	147	386	102	123	-	-	-
	Cancer 31 day treatment performance (%)	≥96%	✗ 93.0%	✗ 91.1%	✗ 89.8%	✗ 91.2%	✗ 80.4%	✗ 74.8%	-	-	-
	Cancer 62 day performance (%)	≥85%	✗ 76.3%	✗ 63.7%	✗ 78.6%	✗ 72.4%	✗ 70.1%	✗ 72.4%	-	-	-
	2ww patients waiting >62 days for treatment	≤Plan	✓ 58	✓ 58	✓ 55	✓ 55	✓ 54	✗ 88	✗ 94	✗ 94	-

Indicators in Focus: Timely Care – Outpatient metrics (1/2)

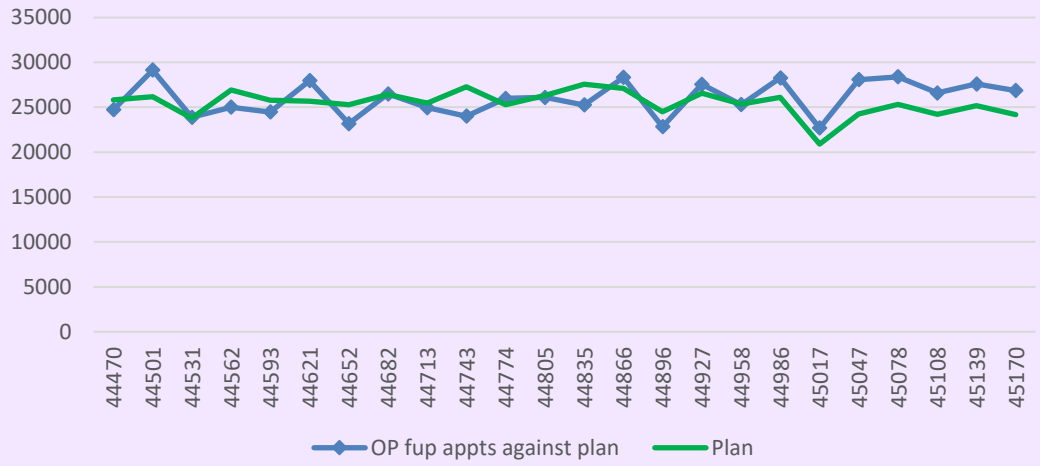
Sherwood Forest Hospitals NHS Foundation Trust

Data

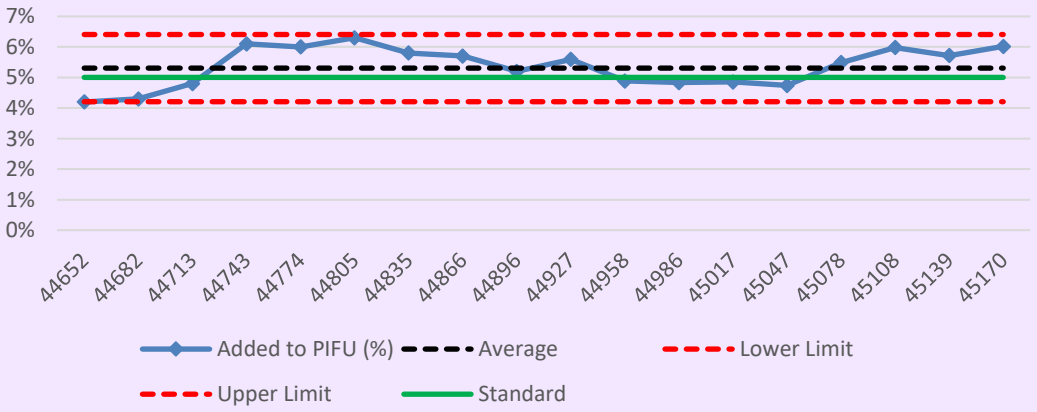
Remote attendances (%)



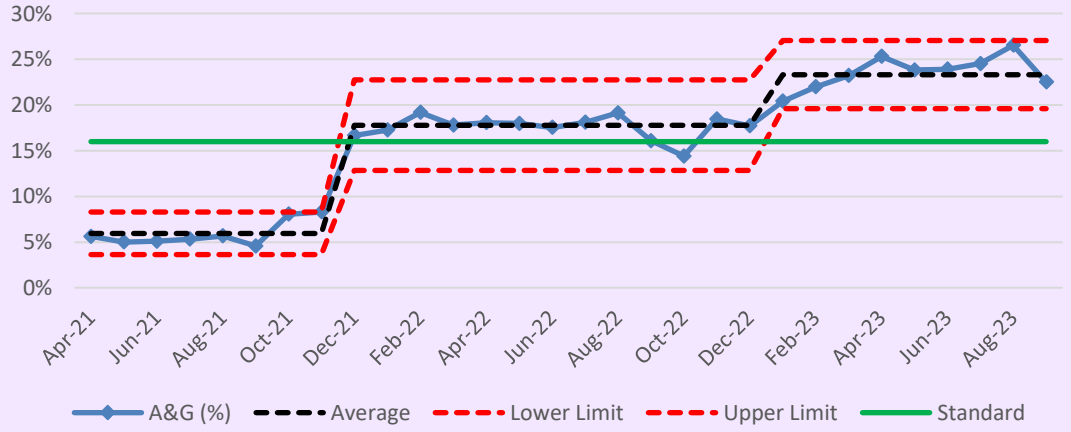
Outpatients - follow up against plan



Added to PIFU (%)



Advice & Guidance (%)



Indicators in Focus: Timely Care – Outpatient metrics (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- We consistently deliver on Patient Initiated Follow Up (PIFU) and Advice and Guidance performance surpassing national targets. Regionally we are recognised for our PIFU work in Ophthalmology.
- Trust outpatient first attendance activity levels remain consistently above planned activity levels.
- SFH (and the system) submitted a non-compliant plan against the outpatient follow-up reduction target of 25% in the 2022/23 and 2023/24 planning rounds. Our outpatient follow up activity levels have been above our non-compliant plan whilst we continue to experience challenges with patients waiting for overdue follow up reviews.
- The remote appointments agenda remains an area of underperformance across the Trust. The Operational Planning Guidance indicated that at least 25% of outpatient appointments should be delivered remotely via telephone or video consultation. We are currently delivering circa 15% which has been a stable position over the past year.

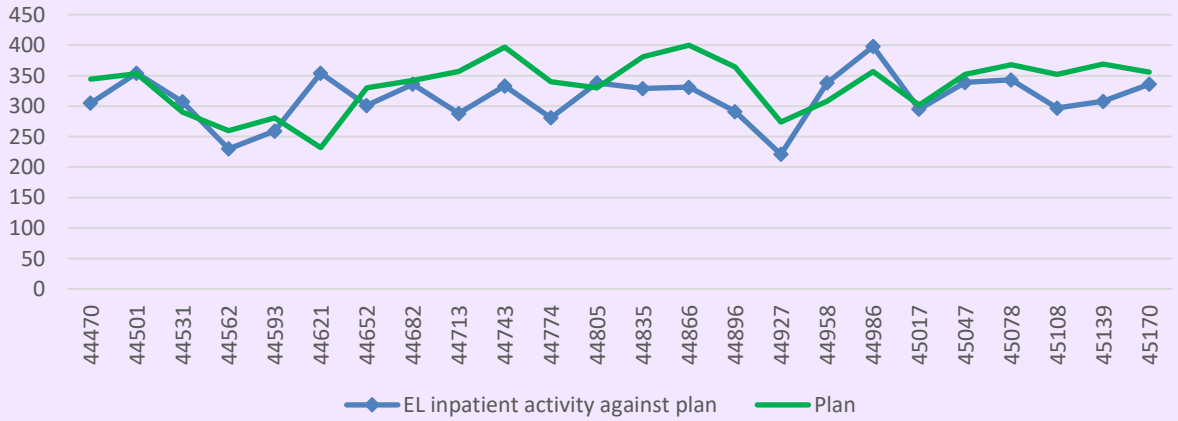
Root causes	Actions and timescale	Impact
Significant backlog of overdue reviews that developed during the Covid-19 pandemic due to lower outpatient activity levels as a result of social distancing and reduced clinician time allocated to seeing outpatients (focus on patients with higher clinical needs).	Rolling validation of the patients on the overdue review list to check if they still require their appointment.	Around 8% of patients contacted are removed from the waiting list. We typically contact 200 patients per week (approx. 16 patients removed from waiting list per week).
	Insourcing in specialties with high overdue review lists. Gastroenterology insourcing commenced in Oct-23. Insourcing to remain in place until at least Mar-24.	Insourcing to deliver circa 4,000 follow up appointments by Mar-24. Whilst this will increase follow up activity it will support a reduction in the number of overdue reviews which is better for patients and will place us in a stronger position for 2024/25.
Remote attendances below target due to clinician preference to see patients face-to-face.	Toolkit developed to assess at a specialty-level the current virtual attendance position, relevant benchmarking, potential trajectories, challenges and risks to inform clinical assessment of opportunity. Toolkit being launched during Q3.	Incremental increase in the percentage of remote attendances with the aim to achieve 17% by the end of the financial year.

Indicators in Focus: Timely Care – Elective activity and waiting list metrics (1/2)

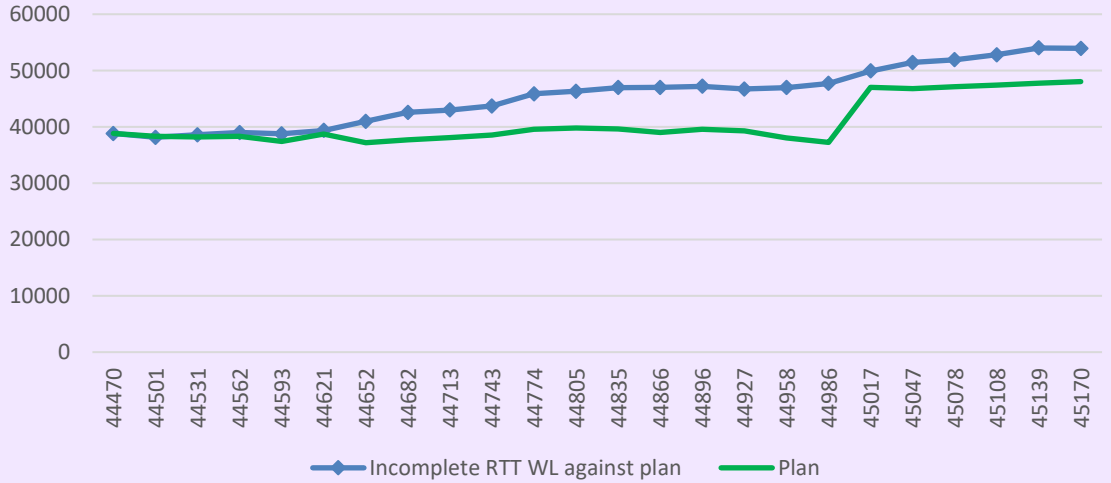
Sherwood Forest Hospitals NHS Foundation Trust

Data

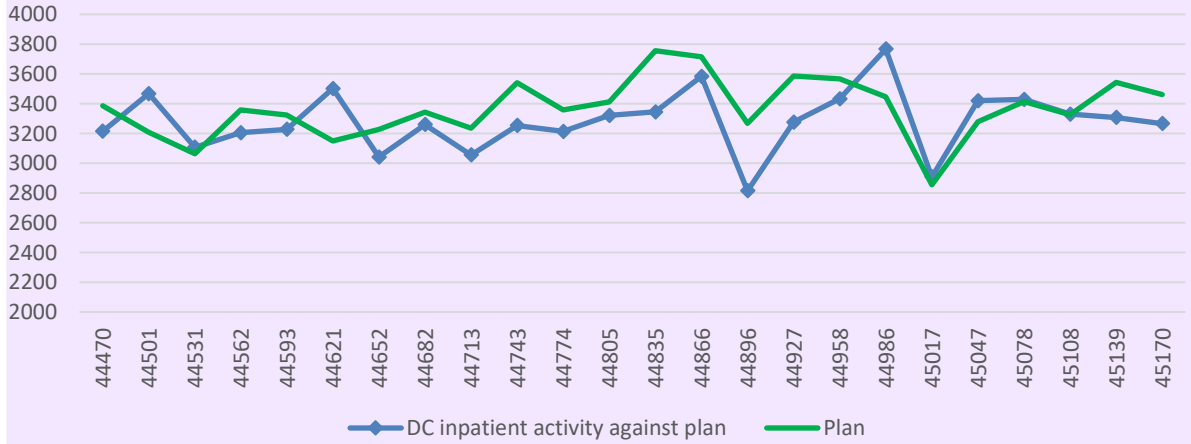
Elective inpatient activity against plan



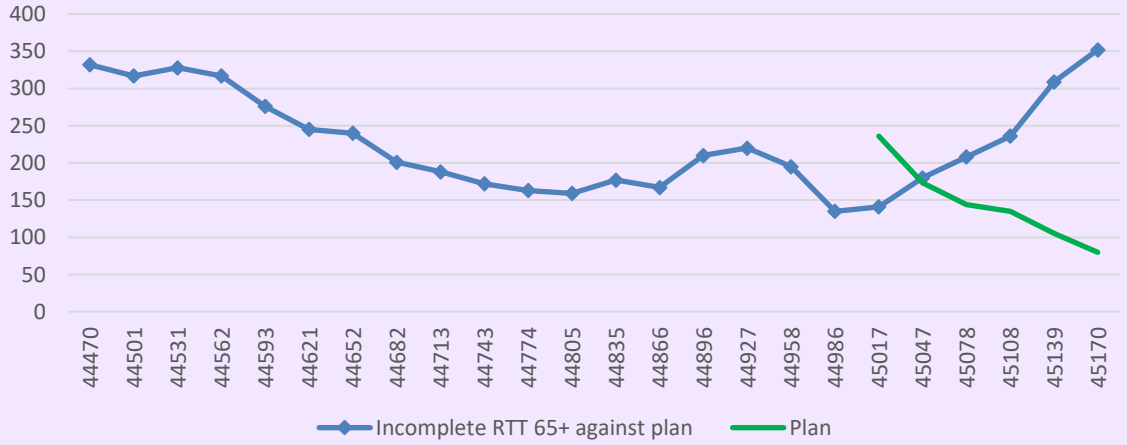
Incomplete RTT waiting list against plan



Daycase activity against plan



Incomplete RTT pathways +65 weeks against plan



Indicators in Focus: Timely Care – Elective activity and waiting list metrics (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Elective inpatient and daycase activity has been below planned levels throughout 2023/24 primarily due to industrial action. As seen nationally, industrial action has meant that available clinical time has been directed to support urgent and emergency care.
- Referral to treatment (RTT) waiting times across England continue to rise. Prior to the pandemic in Feb-20 there were nationally circa 4 million people on the waiting list, this has grown to circa 7.7 million by Aug-23. At SFH the RTT waits pre-pandemic was 26,000 patients and has continued to grow to just over 54,000 at the end of Sep-23.
- The national requirement was to have no patients on an RTT pathway waiting greater than 78-weeks by end of Mar-23. At SFH there were 3 patients waiting over 78 weeks at the end of Sep-23 – two due to capacity issues in pH manometry (consultant sickness) and one due to a patient being cancelled too late in the month with no capacity to rearrange in-month. We are currently 6th best (out of 23 trusts) in the Midlands region for the number of 78-week wait patients.
- While the actual 65-week wait patient numbers are above plan, the 65-week wait total cohort (considering those patients forecast to breach) is ahead of plan for Mar-24 delivery of the national requirement (zero patients waiting over 65-weeks).

Root causes	Actions and timescale	Impact
Industrial action impacting the delivery of planned care activity levels due to medical workforce constraints.	Continue to operationally manage instances of industrial action with a focus on what we can deliver whilst ensuring clinical prioritisation.	Minimise the number of patients who have their planned care delayed during industrial action. Focus on treating patients in order of clinical priority.
Challenges with workforce availability due to hard to fill vacancies, particularly in Anaesthetics.	Backfilling of in-week theatre lists and use of additional clinics and theatre lists at weekends via Waiting List Initiatives. Recruitment to anaesthetic vacancies ongoing, recent agreement to recruitment incentives proposal expected to have impact.	Additional 356 clinics since the start of 2023/24. Work underway to quantify impact of additional theatre lists - session utilisation for September, excluding impact of industrial action, was at 82.3%.
	Outsourcing services throughout 2023/24 (e.g. Ophthalmology cataract referrals) and utilisation of local Independent Sector for Orthopaedics, General Surgery and Urology.	Ophthalmology outsourcing delivering 20 cases per month. Independent Sector delivering 40 cases per month. Independent Sector activity will support backlog reduction; however, activity levels not currently counted by SFH but this will change pending new sub-contract arrangements from late Q3.
Lack of physical space and infrastructure to enable increased activity required to reduce backlogs.	Newark Targeted Investment Fund (TIF) development to expand procedures in Gynaecology and ENT and support the transfer of Orthopaedic activity from King's Mill to Newark to release capacity for more complex, long waiting patients. Building works due to complete at the end of Oct-23 with patients treated in the new facility in Nov-23.	A detailed operational plan is in development to maximise the level of activity through the TIF development in line with business case aspirations.
National focus on long waiting patients leading to provision of mutual aid within the system and an increase of long wait patients referred to Newark Hospital from Lincolnshire. Newark Hospital has limited capacity to receive the mutual aid referrals.	During Sep-23 patients referred from Lincolnshire to Newark Hospital have been contacted and offered an appointment at King's Mill Hospital. We will continue to triage Lincolnshire referrals to offer choice.	Mutual aid patients are given opportunity to receive care at either Newark Hospital or King' Mill Hospital with the intention to minimise the length of their wait. 60% of the Lincolnshire patients have agreed to be seen at King's Mill.

Indicators in Focus: Timely Care – Diagnostic metrics

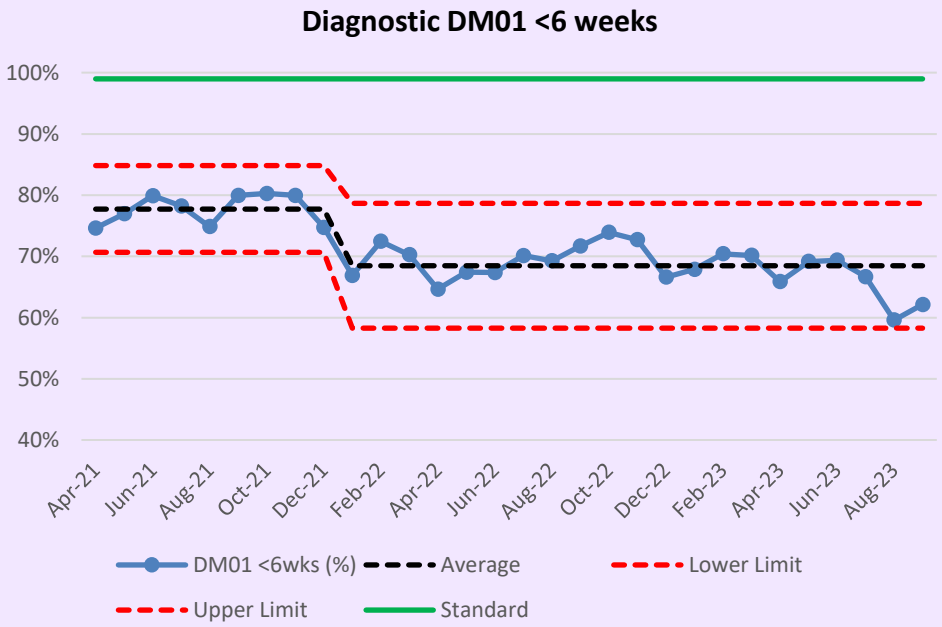
Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Nationally, the total number of patients waiting six weeks or more from referral for one of the 15 key diagnostic tests at the end of Aug-23 was 429,422. This meant that 73% of patients nationally were seen within 6-weeks against the national standard of 99%. The local position at the end of Q2 was 62% of patients seen within 6-weeks; below the national position.
- Across SFH there were a total of 10,154 patients waiting for DM01 reportable diagnostic tests of which 4,101 patients were waiting greater than 6 weeks. Most patients are awaiting Echocardiography where there is national shortages of Cardiac Physiologists.

Root causes	Actions and timescale	Impact
Echo backlog and insufficient workforce to meet demand. Equipment and physical space are constraining backlog recovery alongside the workforce challenges.	Insourcing at King's Mill Hospital in Sep-23 and Oct-23.	250 additional cases.
	Enhanced rates of pay to enable weekend working with existing teams from Jul-23 to Mar-24.	7 additional cases per week.
	Community Diagnostic Centre (CDC) funding insourcing for Newark Hospital to increase from 3 to 5 days from early Q4.	50 additional cases per week.
	Newly equipped CDC accelerator capacity at Mansfield Community Hospital to open early Q4.	50 additional cases per week.
	Mutual aid from NUH from Aug-23.	7 additional cases per week.
	The combined impact of the above mitigations will support gradual backlog reduction. Full recovery will require actions to continue into 2024/25.	
Sleep study backlog driven by increase in referrals and insufficient workforce to meet demand.	Additional adult sleep devices procured in May-23 to increase existing capacity.	DM01 performance increased to 78.56% in September from 30.72% in Jan-23.
	Additional weekend sessions from Jan-23 to Mar-24.	
	Paediatric pathway development underway in Q4 to move from inpatient to home sleep studies.	Impact to be quantified as part of the pathway development.
CT Cardiac backlog following continued increase in demand (50% 2022- 2023) further driven by the targeted lung health check programme expansion.	Capital case submitted to the Integrated Care System in Oct-23 to increase CT Cardiac capacity through the purchase of a new scanner. Implementation subject to external funding and bid approval.	Up to 20 CT Cardiac cases per day.

Data

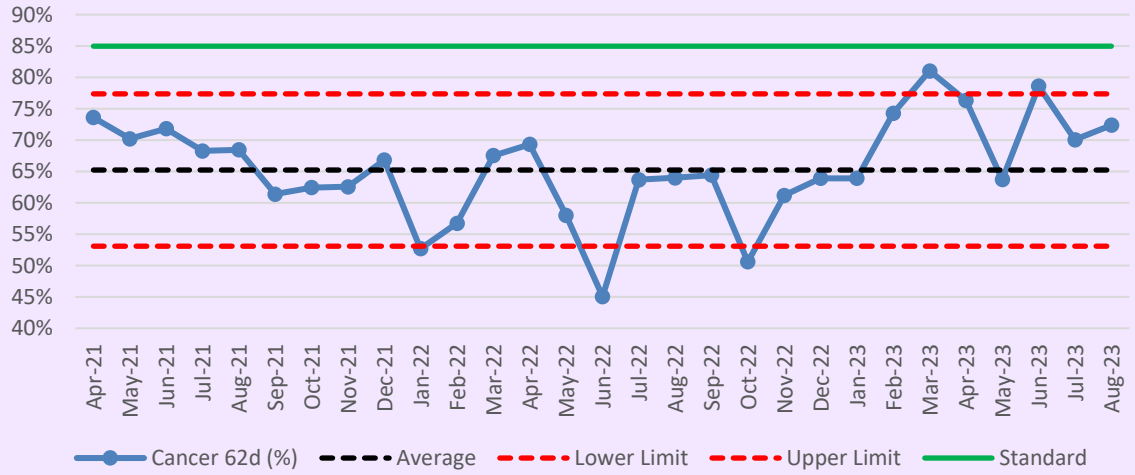


Indicators in Focus: Timely Care – Cancer metrics (1/2)

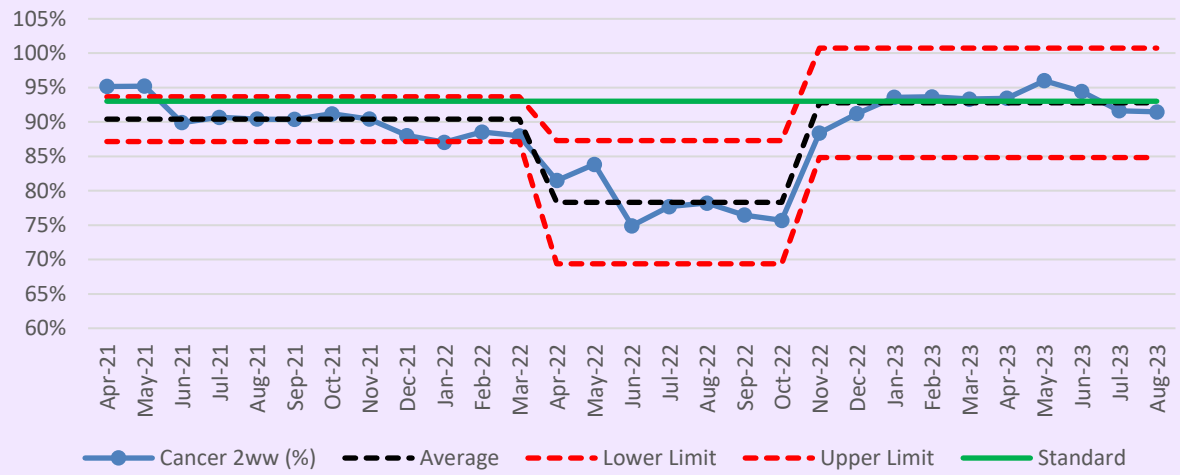
Sherwood Forest Hospitals NHS Foundation Trust

Data

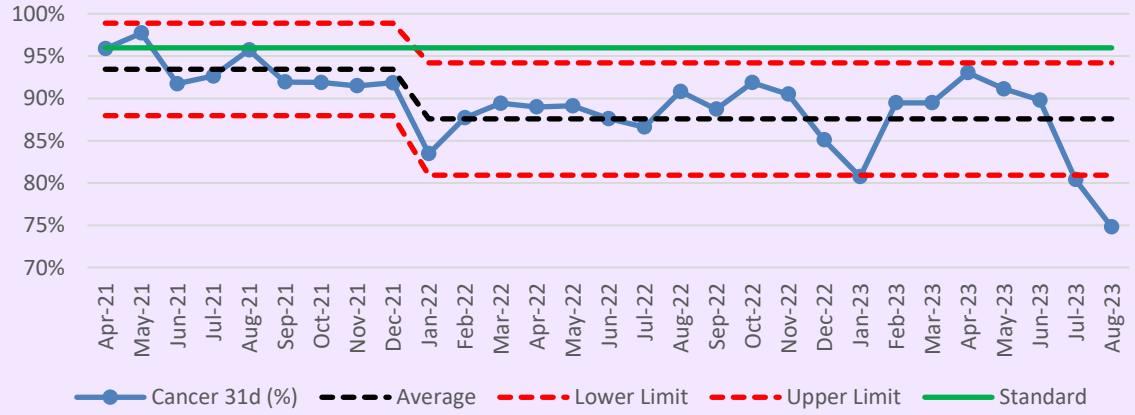
Cancer 62 day performance (%)



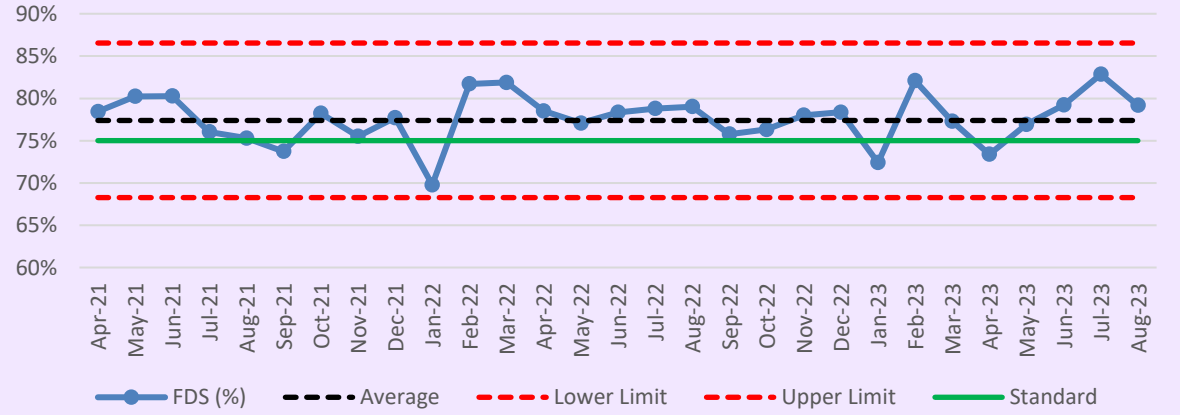
Cancer 2 week wait performance (%)



Cancer 31 day treatment performance (%)



Cancer Faster Diagnosis Standard (%)



Indicators in Focus: Timely Care – Cancer metrics (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

Considering the latest national data (Aug-23):

- Nationally 31-day treatment performance (first treatment) is 91% against the 96% standard; Midlands combined 88.5%.
  Our position is performing below the Midlands and England position and national standard.
- Nationally 62-day performance (urgent GP suspected cancer) 62.8% against the 85% standard; Midlands combined 56.1%.
  Our position is performing above the Midlands and England position; however, below the national standard.
- The Faster Diagnosis Standard (FDS) of 75% was achieved in Aug-23 at 79.2% and predicted to achieve in Sep-23.
- The two-week wait standard of 93% was below target in Aug-23 at 91.3% and predicted to be below the target in Sep-23. Previously achieved this standard from Jan-23 to Jun-23 consistently.
- The revised cancer waiting times standards launched on 1 Oct-23; this included removal of the two-week wait standard and terminology - now Urgent Suspected Cancer Referral. The nine standards have been reduced to three and include: 28-day faster diagnosis; 62-day (combined), 31-day (combined). Reporting against the revised standards will be available from Dec-23. This report will be updated to reflect the new standards for Q3.

Root causes	Actions and timescale	Impact
62-day standard - Lower GI has workforce challenges, high referral demand and difficulties with patient engagement.	Demand and capacity modelling complete and review with operational and clinical team underway.	Improved productivity within existing resources
	Tumour site optimal timed pathway development and working group in place since Apr-23.	Reduction in pathway delays
	By Q3 produce updated patient information and video for supporting bowel preparation. Audit completed Oct-23.	Improve engagement and increase test compliance.
2ww/31-day standards - Seasonal Skin tumour site referral demand.	Tele-dermatology working group established Nov-22 to be launched in Jan-24: • Bid to East Midlands cancer alliance for funding approved in July-23. • Recruitment of staff commenced July-23 and due for completion Dec-23. • Kit identified and to be purchased in Dec-23.	Reduce outpatient demand. Review patients earlier in their cancer pathway and improve patient experience.
Industrial action impacting the delivery of tumour site activity levels and MDTs due to medical workforce constraints.	Continue to operationally manage instances of industrial action with a focus on what we can deliver whilst ensuring clinical prioritisation.	Minimise the number of cancer patients who have their pathway delayed during industrial action.

Performance against 31-day and 62-day standards will temporarily reduce as the backlog is cleared. Once the backlog is reduced, we will be In a more sustainable position for future delivery.

Domain Summary: Best Value Care

Sherwood Forest Hospitals NHS Foundation Trust

Overview	Lead
Income & Expenditure: • The reported financial position for Q2 highlights some of the challenges the Trust is continuing to face in meeting the planning ambition to deliver a breakeven financial position • The Trust reported a deficit of £5.7m for the Q2 period, this represents an adverse variance to plan of £1.4m. Giving a year to date deficit of £10.5m against a plan of £8m showing an adverse position of £2.5m. The period saw the continuation of many of the challenges faced in the previous year and Q1 with the level of capacity open and high demand for beds. The level of patients medically fit for discharge has remained at levels above those assumed in the 2023/24 annual plan • The costs of additional capacity remains the largest element of the adverse variance to plan, with £2.8m spent in Q2 on escalation capacity and £6.1m year to date which is above levels assumed in planning. • The Q2 position also sees the continuation of unplanned costs relating to the Industrial action, with a direct financial impact that includes costs of covering gaps and an estimation of lost income relating to cancelled activity. • Q2 saw the continuation of assumed income brought forwards for CDC July-September element of £1.4m which was planned for later in the year • Although FIP is favourable to plan, this largely relates to non recurrent underspends and non divisional FIP. • The outturn position is currently forecast to breakeven with risks given the continuation of additional capacity open and continued industrial action. **Capital Expenditure & Cash:** • Capital expenditure of £1.8m has been reported for the Q2 period, with 2023/24 outturn expenditure currently forecast at £31m. This is £8.3m less than the financial plan due to changes in the CDC and EPR planned expenditure across financial years. • The cash balance at the end of Q2 stands at £1.6m, which is £0.1m lower than planned. **Agency Expenditure:** • The Trust reported agency expenditure of £4.5m during Q2, with 2023/24 outturn expenditure forecast at £14.8m.	CFO

Scorecard: Best Value Care

Sherwood Forest Hospitals NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	2023/24 YTD
Finance	Income & expenditure against plan (£m)	≥£0.00m	✓ £0.00	✗ -£0.98	✗ -£0.06	✗ -£1.04	✓ £0.06	✗ -£0.43	✗ -£1.06	✗ -£1.43	✗ -£2.47
	Financial Improvement Programme (FIP) against plan (£m)	≥£0.00m	✓ £0.01	✓ £0.03	✓ £0.00	✓ £0.04	✗ -£0.38	✗ -£0.83	✗ -£0.83	✗ -£2.04	✗ -£2.00
	Capital expenditure against Plan (£m)	≤£0.00m	✗ £0.23	✗ £1.15	✗ £6.71	✗ £8.09	✗ £2.08	✗ £1.29	✗ £6.35	✗ £9.72	✗ £17.81
	Cash balance against Plan (£m)	≥£0.00m	✗ -£8.73	✓ £4.35	✓ £5.10	✓ £0.72	✓ £5.17	✗ -£2.52	✗ -£3.43	✗ -£0.78	✗ -£0.06
	Agency expenditure against Plan (£m)	≥£0.00m	✓ £0.02	✗ -£0.32	✗ -£0.16	✗ -£0.46	✗ -£0.20	✓ £0.06	✗ -£0.10	✗ -£0.24	✗ -£0.70

Indicators in Focus: Best Value Care – Income and expenditure

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- The standard is the Trust financial plan which is a breakeven position for 2023/24
- The Trust has reported a Q2 deficit position of £5.7m which is £1.4m adverse to plan. Year to date the Trust has reported deficit position of £10.5m which is £2.5m adverse to the planned deficit position of £8m

Root causes

- The adverse variance is mainly due to the level of escalation beds that have remained open this financial year above planned levels
- Position also includes unplanned costs relating to the industrial action, including the costs of covering staffing gaps and an estimate of lost income relating to cancelled activity.
- Q2 deterioration position against run rate due to removal of income from NHSE to support the costs of capital

Actions

- CDC continuation of brought forward income from Q4 to be phased throughout the year ahead of plan
- Financial Recovery Cabinet in place reviewing opportunities through 100 day workstream plans
- Enhanced Financial Governance in place

Impact/Timescale

- CDC income brought forward from Q4 to be phased throughout the year ahead of plan
- 100 day Financial Recovery Workstream plans being reviewed, and opportunities being worked up
- Enhanced Financial Governance

Data

Indicators in Focus: Best Value Care – Financial Improvement Plan

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- The standard is the Trust financial Improvement Plan
- The Trust has a £10m Divisional Financial Improvement Programme which has reported year to date savings of £1.32m which is £2.0m behind plan.

Root causes

- The adverse variance is mainly due to delays in identifying schemes in time to deliver savings in line with plan. Current escalation capacity and Industrial Action will have taken time away from Divisions bandwidth to progress schemes.

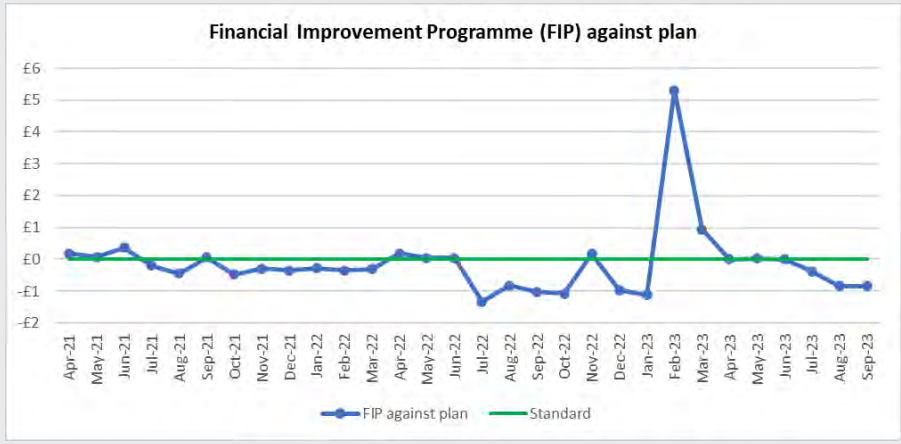
Actions

- Financial Recovery Cabinet in place with FIP being a key workstream in this process. Currently reviewing opportunities through 100 day workstream plans
- Several schemes are in the process of Quality Impact Assessment sign off and will move to 'In-Delivery' for month 7 reporting.

Impact/Timescale

- 100 day FIP Financial Recovery Workstream plans being reviewed, and opportunities being worked up
- Pipeline schemes progress to in-delivery for month 7 reporting.

Data



Indicators in Focus: Best Value Care – Cash Balance

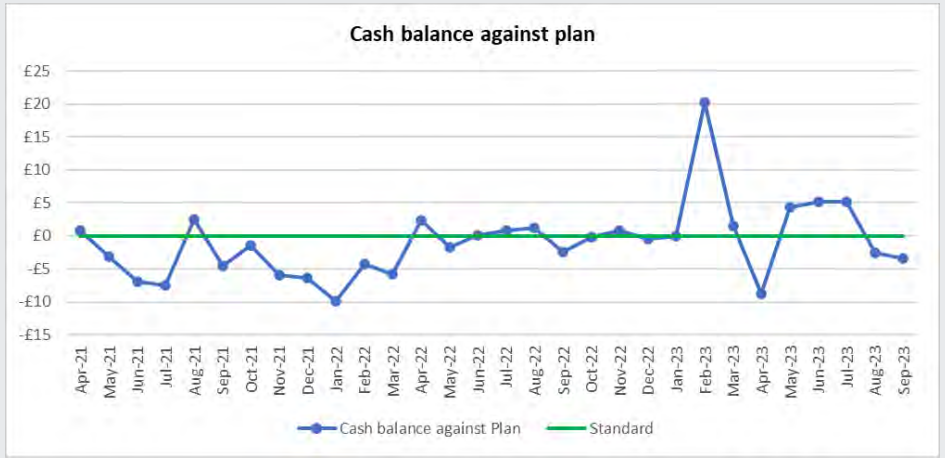
Sherwood Forest Hospitals
NHS Foundation Trust

Standard & overview

- Standard is the plan and the minimum cash balance required by DHSC of £1.45m as part of our support.
- Marginal variance year to date to plan.
- Plan and actual requires revenue borrowing PDC cash support from DHSC.

Root causes	Actions	Impact/Timescale
Planned deficit and forecast deficit is driving the need for additional cash support above plan.	• Quarterly borrowing submission submitted to DHSC • DHSC advised as part of Q2 submission likely that cash support above plan will be required in Q4. • Agreement in principle for cash transfer Q3 to be repaid Q4.	Risk to Q3 if cash transfer between Trusts does not materialise. May require reforecast of borrowing to DHSC which would be above the deficit plan.

Data



Indicators in Focus: Best Value Care – Capital expenditure

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- Standard is the plan.
- Significant variance year to date to plan due to the phasing of EPR and Mansfield CDC.
- Plan requires capital borrowing support of £6.49m, which presents a risk to the forecast expenditure if not approved, due to cash position of the Trust.
- Known forecast overspends in relation to discharge lounge and Newark TIF capital schemes.
- Plan and actual requires Capital PDC borrowing from DHSC.

Root causes

Variance is primarily being driven by the phasing of Mansfield CDC and EPR.

Actions

- Agreed with NHSE reprofiling of the expenditure and associated borrowing relating to CDC, £2m and EPR £6.31m removed form 2023/24 and rephased into 2024/25.
- Capital plan has been reforecast in year to cover known overspends in relation to Discharge lounge and Newark TIF.
- Capital leads reforecasting planned expenditure profile for 2023/24.
- Monthly monitoring via Capital Resources Oversight Group.
- Capital loan submitted and with NHSE for approval and submission to DHSC.
- 5 year capital plan currently being refreshed as part of financial planning.

Impact/Timescale

Risk to capital plan delivery and cash until capital borrowing confirmed. If rejected would require capital spend to be halted in year, due to availability of funds.

Data

Indicators in Focus: Best Value Care – Agency expenditure

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- The standard is the planned agency spend
- The Trust has reported agency expenditure of £4.5m for Q2, this is £0.2m adverse to the planned spend of

Root causes

- Mainly due to the additional capacity that has remained open above planned levels which is covered by variable pay (including agency)

Actions

- Executive approved changes to substantivize 'priority 1 & 2' beds will mean a reduction on reliance of variable pay cover in these areas.
- Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews, Divisional Finance Committee's and Financial Recovery Cabinet
- Focussed reduction in off framework usage
- Continued reviews of direct engagement bookings

Impact/Timescale

- Revised divisional governance structures to include agency spend & compliance reviews
- Continued reviews of long line bookings and market re-test as required

Data

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – Q2 2023-2024	**Date:** 2nd November 2023	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Executive Team		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
To provide assurance to the Board regarding the Performance of the Trust as measured in the Integrated Performance Report		**Approval**	
		Assurance	
		Update	
		Consider	X

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

Principal Risk		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	**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 - 25th October 2023

Acronyms

SOF – Single Operating Framework

Executive Summary

This is the new style Integrated Performance Report (IPR) to replace the previous SOF format. It provides the Board with assurance regarding the performance of the Trust in respect of the performance Indicators allocated to four domains: Quality Care, People and Culture, Timely Care and Best Value Care. It is intended to continue to provide these reports on a quarterly basis.

This report is for Quarter 2 2023/24. Rather than being RAG rated, the performance indicators identified on the report are marked as "met" or "not met" via a green tick and red cross, respectively. A graph is provided for each standard that is not met that identifies trends.

Maintaining good performance against the key indicators contained in the report has been challenging for the whole of the NHS. This report describes the areas of key challenge for the Trust and these are consistent with all NHS trusts and healthcare systems. However, the Trust's performance compares favourably across the NHS in key areas of vacancy and sickness absence rates, emergency care access, ambulance turnaround times, cancer and diagnostics.

There are a total of 61 indicators reported on the Q2 IPR report, of those 25 are rated as met, and 36 are rated as not met. These are reported by individual Domains as follows:

Quality Care
Of the total 15 indicators, 10 are rated as met and 5 as not met for Quarter 2.

People and Culture
Of the total 11 indicators, 6 are rated as met and 5 as not met for Quarter 2.

Timely Care
Of the total 30 indicators, 9 are rated as met and 21 as not met for Quarter 2.

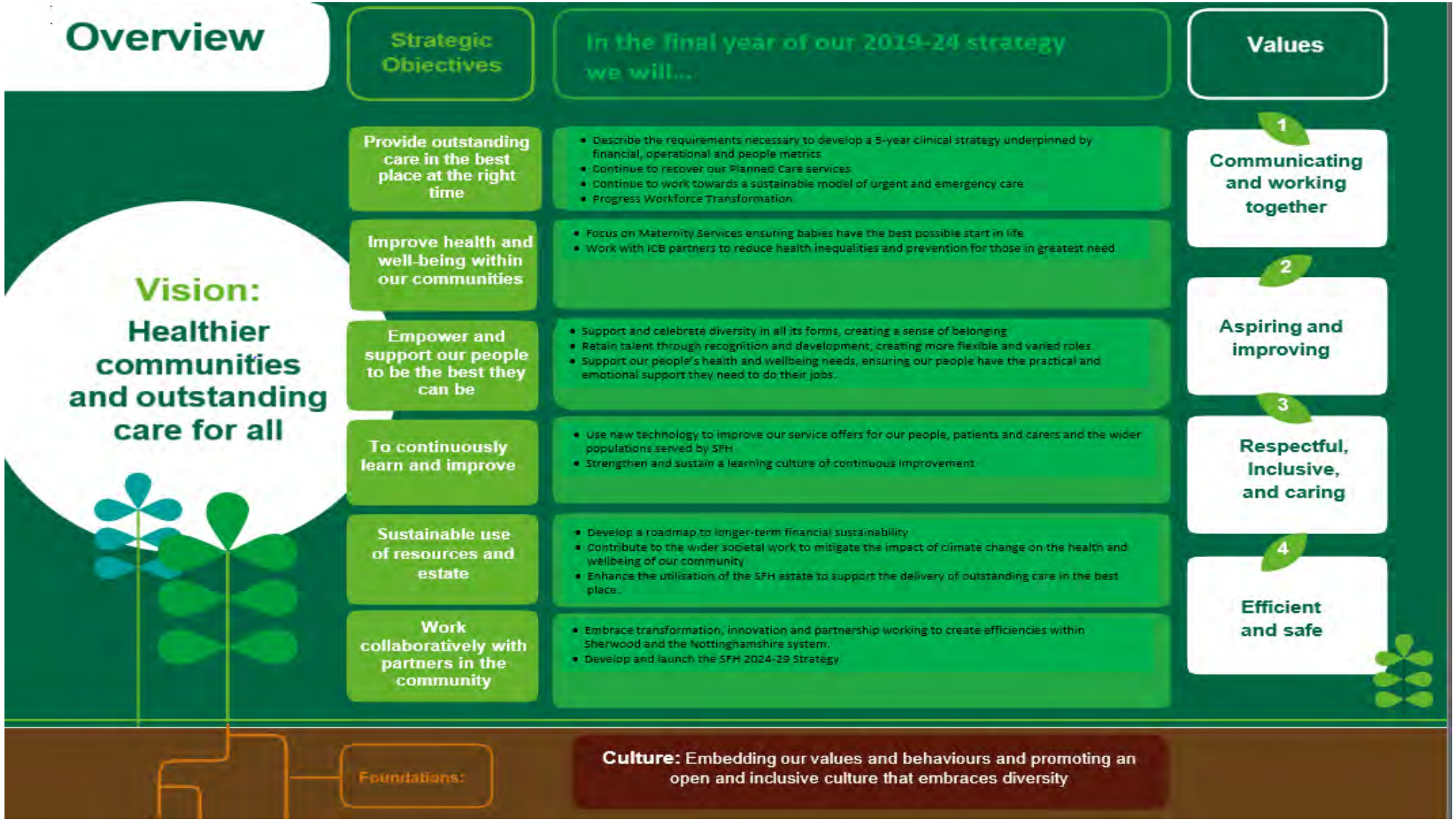
Best Value Care
Of the total 5 indicators, 0 are rated as met and 5 as not met for Quarter 2.

Details of the trajectories and actions being taken to address these indicators are shown in the individual graphs for each Domain.

Recommendation

- The Board of Directors to take assurance for the Performance of the Trust, against the background of the new quarter, including noting the periods of industrial action.

Appendix 1


Overview
Strategic Objectives
In the final year of our 2019-24 strategy we will...
Values
Vision:
Healthier communities and outstanding care for all
Provide outstanding care in the best place at the right time
Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics
Continue to recover our Planned Care services
Continue to work towards a sustainable model of urgent and emergency care
Progress Workforce Transformation
Improve health and well-being within our communities
Focus on Maternity Services ensuring babies have the best possible start in life
Work with ICB partners to reduce health inequalities and prevention for those in greatest need
Empower and support our people to be the best they can be
Support and celebrate diversity in all its forms, creating a sense of belonging
Retain talent through recognition and development, creating more flexible and varied roles
Support our people's health and wellbeing needs, ensuring our people have the practical and emotional support they need to do their jobs.
To continuously learn and improve
Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH
Strengthen and sustain a learning culture of continuous improvement
Sustainable use of resources and estate
Develop a roadmap to longer-term financial sustainability
Contribute to the wider societal work to mitigate the impact of climate change on the health and wellbeing of our community
Enhance the utilisation of the SFH estate to support the delivery of outstanding care in the best place.
Work collaboratively with partners in the community
Embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.
Develop and launch the SFH 2024-29 Strategy
1
Communicating and working together
2
Aspiring and improving
3
Respectful, Inclusive, and caring
4
Efficient and safe
Foundations:
Culture: Embedding our values and behaviours and promoting an open and inclusive culture that embraces diversity

Board Assurance Framework (BAF): October 2023

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

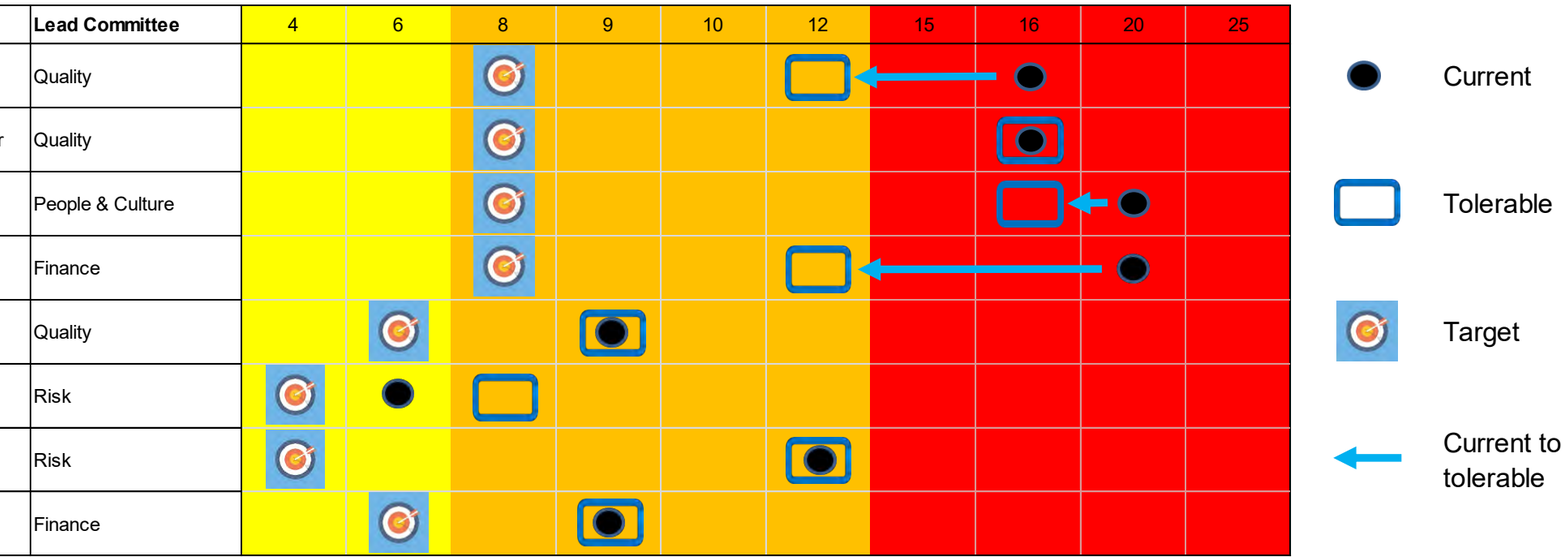
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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

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

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

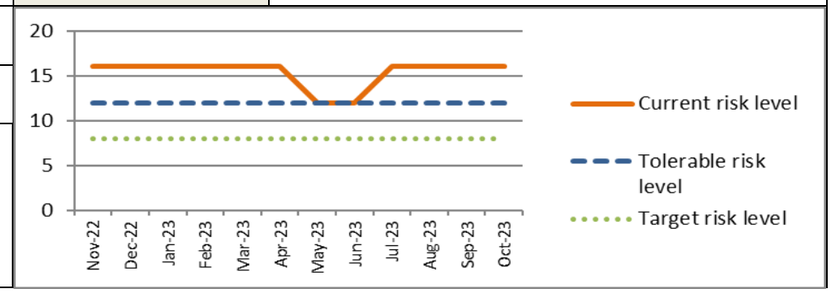
		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People & Culture
PR4	**Failure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



Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**4. High**	3. Possible	2. Unlikely		
Last reviewed	03/10/2023	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	03/10/2023						

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



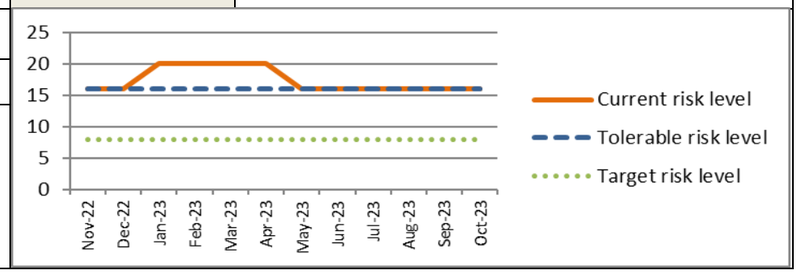
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to maintain patient safety and quality of care leading to increased incidence of avoidable harm and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Review, oversight and learning from patient safety incidents Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC quarterly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight ▪ Digital Strategy Group	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 Difficulty in maintaining the safety of our existing in-patients during prolonged periods of industrial action Inability to re-provide MDT or appointments in a timely way impacting on cancer pathway metrics and overall patient care	Review of informatics function and development of informatics strategy **SLT Lead:** Chief Digital Information Officer **Timescale:** March 2024 Progress: business case supported and progressing with recruitment Oversee the ePMA project board to resolve identified issues with eTTOs, critical medicines and allergy documentation **SLT Lead:** Medical Director **Timescale:** ~~September 2023~~Complete – risks known and monitored	**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; Digital risks reported to Risk Committee 6-monthly and DSG monthly **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)	Unmitigated risk associated with the continuation and escalation of industrial action, the lack of progress towards a negotiated solution and the impact across professional groups who inevitably step up to provide cover in service gaps	Positive No change since April 2020

Board Assurance Framework (BAF): October 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease 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, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions ▪ Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements		Autumn Covid and influenza vaccination programme **SLT Lead:** Director of People **Timescale:** December 2023	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; CQC Maternity Review Dec 22		Positive Last changed November 2022

Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care						**Strategic objective** 1. To provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	4. Somewhat likely	2. Unlikely		
Last reviewed	03/10/2023	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**		
Last changed	03/10/2023						



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • Further waves of admissions driven by Covid-19, flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ SFH Same Day Emergency Care service in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care – regular meetings with NEMS ▪ Trust and System escalation policies and processes, including Full Capacity Protocol and Pandemic Surge Plan ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today e.g. turnaround times such as diagnostics are completed within 1 day ▪ SFH annual capacity plan with specific focus on the Winter period ▪ Winter Planning Group ▪ Patient pathways, some of which are joint with NUH ▪ Referral management systems shared between primary and secondary care ▪ Optimising Patient Journey Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Elective Steering Group to steer the recovery of elective waiting times ▪ Emergency Steering Group to steer improvement across the emergency pathway	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions e.g. reducing elective operating, bedding patients in alternative areas i.e. daycase	Develop delivery plans with system partners under the oversight of the ICS Plan Delivery Group **SLT Lead:** Chief Operating Officer **Timescale:** ~~July 2023~~Superseded by the PA Consulting action Winter Planning documents for 23/24 to identify clear demand and capacity gaps/bridges to be presented to Board in September and October 2023 **SLT Lead:** Chief Operating Officer **Timescale:** October 2023 PA Consulting to complete process mapping in relation to patient discharge to identify areas for improvement **SLT Lead:** Chief Operating Officer **Timescale:** November 2023	**Management:** Performance management reporting arrangements between Divisions, Service Lines, ~~and~~ Executive Team and Board on an at least bi-monthly basis~~; Waiting list update to TMT as required; Bed model outcomes to Exec Team Feb 23~~ **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board quarterly **Independent assurance:** Performance Management Framework internal audit report Jun 22		Positive Last changed December 2020

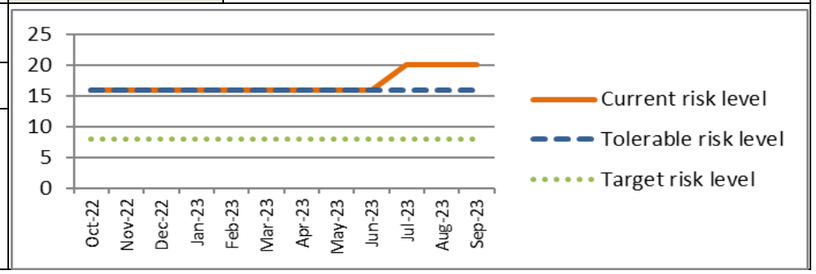
~~Reductions~~ Constraints in availability of hospital bed capacity caused by ~~increasing~~elevated numbers of MFFD (medically fit for discharge) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group
	▪ ICS Discharge to Assess business case being implemented
	▪ Multidisciplinary Transfer of Care Hub opened at SFH Oct 22
	▪ Use of additional beds
	  ▪ Mansfield Community Hospital (3 wards)
	  ▪ Use of Ashmere
		Lack of consistent achievement of the mid-Notts threshold for MSFT patients of ~~22~~40	Delivery of ICS Discharge to Assess Business Case
			SLT Lead: Chief Operating Officer
			Timescale: throughout 23/24
			
			Virtual ward programme implementation
			SLT Lead: Chief Operating Officer
			Timescale: expanding throughout 23/24
			
			PA Consulting to complete process mapping in relation to patient discharge to identify areas for improvement
			SLT Lead: Chief Operating Officer
			Timescale: November 2023
				Management: Daily and weekly themed reporting of the number of MFFD patients in hospital beds - reports into the ~~system CEOs group,~~ ICS UEC Delivery Board and ICS Demand and Capacity Group monthly
				Risk and compliance: Exception reporting on the number of MFFD into the Trust Board via the Integrated Performance Report quarterly
						Inconclusive
						
						No change since threat added in January 2022

Board Assurance Framework (BAF): October 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly Chief Officer calls across ICS, including Primary Care			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand	Lack of visibility in primary care demand and capacity **Action:** Continue to push via ICS UEC Delivery Board and ICS Demand and Capacity Group the importance of system-wide oversight of demand and capacity **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development. ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors			**Management:** Weekly reports provided by NHSE Regional Team showing performance against key Urgent and Emergency Care metrics ~~**Risk and compliance:** NUH service support to SFH paper to Executive Team~~	Lack of control over the flow of patients from the surrounding area **Action:** Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Positive Last changed November 2022
Growth in demand for care in our maternity services (population growth and increase in out of area referrals)	▪ Over-established midwifery by 10% from 2021/22 ▪ Additional antenatal clinics based on overtime/bank ▪ Maternity assurance group (monthly) ▪ Director of Midwifery providing Board-level oversight	Midwifery staffing vacancies ~~(gap of 5.6% WTE against establishment)~~ No increase in junior medical staffing Nursing gaps in neonatal unit No standalone junior out-of-hours on-call for neonatal (as per critical care review) Physical capacity/estate will be insufficient should growth trends continue in the coming years	Maternity and Neonatal service review document in development **SLT Lead:** Chief Operating Officer **Timescale:** Q2 23/24	**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings) **Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)		Positive New threat added January 2023

Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care						**Strategic objective** 3. Empower and support our people to be the best they can be
Lead committee	People &~~,~~ Culture ~~&~~ ~~Improvement~~	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	5. Very likely	4. Somewhat likely	2. Unlikely		
Last reviewed	26/09/2023	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	26/09/2023						

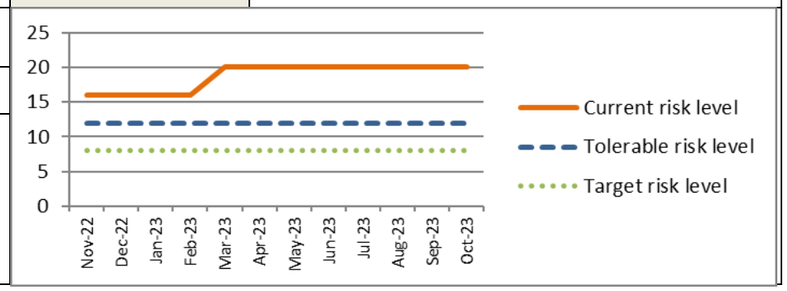


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff due to market factors, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Activity, Workforce and Financial plan ▪ 5-year strategic workforce plan supported by associated Tactical People Plans ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of Consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Communication of daily SitReps (Situation Reports) for workforce gaps	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, 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 2 **SLT Lead:** Director of People **Timescale:** March 2024 Work with the Chief People Officer to form a provider collaborative forum for recruitment and retention **SLT Lead:** Director of People **Progress:** Retention Lead post recruited to at ICB, and provider collaborate workforce programmes being worked up **Timescale**: November 2023	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to PCI Committee Jun 22; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to PCI Committee bi-monthly; Leadership Development Strategy Assurance Report to PCI Committee Jun 22; Assurance Report to People, Culture and Improvement Committee quarterly **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators to People Cabinet (Monthly) - Quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; ~~Pre-employment Checks internal audit report Feb 21 – significant assurance~~ Recruitment of agency staff audit report Jun 23; ~~HSJ Award for Acute Trust of the Year 2021; People Plan to People, Culture and Improvement Committee Apr 21~~	Staff mental health issues as a result of psychological trauma Train Trauma Risk Management practitioners to provide psychological support following traumatic events **SLT Lead:** Deputy Director of People **Timescale:** ~~August 2023~~Complete Implementation of a standard operating procedure for Trauma Risk Management Practitioners to support staff following traumatic events **SLT Lead:** Deputy Director of People **Timescale:** December 2023	Positive Last changed June 2022

Board Assurance Framework (BAF): October 2023

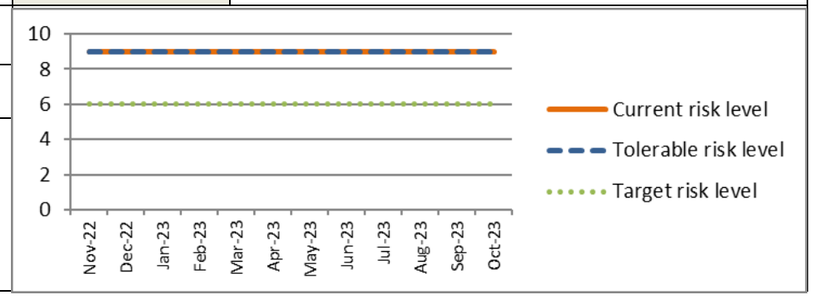
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement, which could lead to a detremental impact on patients and service users	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Wellbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users	Undertake a review in accordance with the National Improvement Plan and highlight associated actions **SLT Lead**: Director of People **Timescale**: ~~September 2023~~Complete Implement the actions from the Equality, Diversity and Inclusivity improvement plan **SLT Lead**: Deputy Director of People **Timescale**: March 2024 Violence and Aggression Working Group to establish an action plan in related to the V&A agenda **SLT Lead:** Director of People **Timescale:** October 2023	**Management:** Staff Survey Action Plan to Board May 23; Staff Survey Annual Report to Board Apr 23; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board Sep 22; Quarterly Assurance reports on People Cabinet to People Culture and Improvement Committee; Wellbeing report to People, Culture and Improvement Committee Dec 22; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug22; 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 23; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr22; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar23; 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 ~~Potential i~~Industrial action up to and including strike action from all NHS unions, affecting all system partners Co-ordinated strike action by consultants and junior doctors – on strike days Christmas Day cover only	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**	5. Sustainable use of resources and estate
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
Lead director	Chief Financial Officer	**Consequence**	4. High	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	5. Very likely	3. Possible	2. Unlikely				
Last reviewed	31/10/2023	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**				
Last changed	31/10/2023								

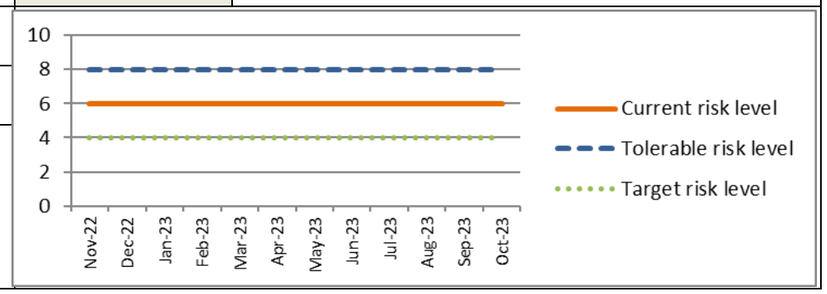
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Capital Resources Oversight Group overseeing capital expenditure plans ▪ ~~Enhanced financial governance established, including bi-monthly finance-focussed Divisional Performance Review meetings. Divisional Finance Committees are also being established~~Divisional Finance Committees established in most divisions ▪ Financial Recovery Cabinet (monthly) and Financial Recovery Plan workstreams established ▪ Financial controls self-assessment completed and working group set up to undertake improvement actions	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework Revenue business case process may not adequately represent the longer-term priorities and potential consequences of future years	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~2023/24 financial plan in development Longer-term financial strategy to be finalised during 2023/24 as part of strategic priorities, in line with clinical and operational strategies~~ Longer-term financial in development as part of strategic priorities, in line with clinical and operational strategies, annual planning for 2024/25 in progress **SLT Lead:** Chief Financial Officer **Timescale:** March 2024 Review and implement enhanced business case process for 2023/24 planning and in-year prioritisation **Progress:** Business case process for 2023/24 planning completed. ~~– process for in-year prioritisation post-planning to be confirmed; however limited resources mean that business cases are currently paused and managed through the risk management framework~~ Limited resources mean that business cases are currently paused, however in-year cases are managed through the Financial Recovery Cabinet and Trust Management Team on an exceptional basis. All paused cases are managed through the risk management framework A further review of the business case process will be undertaken as part of the 2024/25 Planning round **SLT Lead:** Chief Financial Officer **Timescale:** ~~September 2023~~March 2024	**Management:** CFO's Financial Reports and Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ICS finance report to Finance Committee (monthly); Capital Resources Oversight Group quadrant reports to Execs; Divisional Performance Reviews and Divisional Finance Reviews (monthly); Divisional risk reports to Risk Committee bi-annually; Monthly Agency reports to Trust Management Team; Financial Recovery Cabinet quadrant reports to Finance Committee (Monthly) **Risk and compliance:** Risk Committee significant risk report monthly **Independent assurance**: Deloitte audit of COVID-19 expenditure; NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2022/23 Internal Audit reports: - Key Financial Systems - Asset Register Jan 22 - Improving NHS financial sustainability Dec 22 - Key Financial Systems – Pay Expenditure Jul 23		Positive Last changed July 2022
ICB system deficit results in a negative financial impact to the Trust	▪ Full participation in ICB planning ▪ SFH plan consistency with ICB and partner plans ▪ ICB DoFs Group ▪ ICB Operational Finance Directors Group ▪ ICB Financial Framework ▪ ICB Agency Reduction Group (Chaired by SFH CFO)	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **SLT Lead**: Chief Financial Officer **Timescale:** March 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board		Positive Last changed July 2022

Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective**	4: To continuously learn and improve
Lead committee	~~People, Culture & Improvement~~Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	03/10/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	03/10/2023								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform ▪ Improvement Faculty ▪ Financial Recovery Programme	The improvement function needs to be organisationally embedded following the restructure	Structured programme of engagement and communications to be developed and delivered **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~September 2023~~Complete Continue communications to promote further engagement while the Continuous Improvement Strategy is being developed **SLT Lead:** Director of Strategy and Partnerships **Timescale: March 2024**	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** ~~SOF Culture and Improvement indicators;~~ SFH Trust Priorities to Board quarterly **Independent assurance:** ~~Internal Audit of FIP/ QIPP processes Sep 21;~~ 360 assessment in relation to Clinical Effectiveness - report May '22	Lack of capacity for colleagues to engage with improvement Promote the training an ongoing support available to all colleagues via the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** September 2023 Lack of organisational clear direction in terms of continuous improvement across the Trust Develop and roll out a Continuous Improvement Strategy **SLT Lead:** Director of Strategy and Partnerships **Timescale:** March 2024	Inconclusive Last changed October 2022

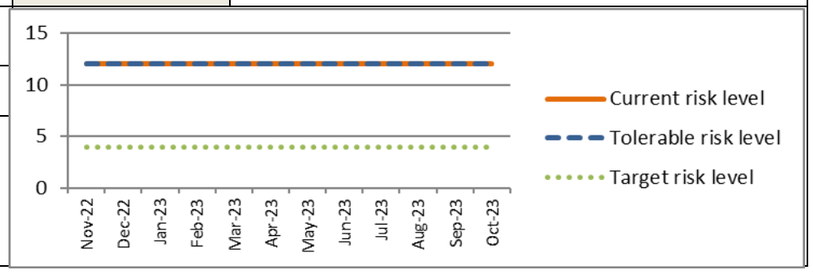
Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working							**Strategic objective**	6. Work collaboratively with partners in the community
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely				
Last reviewed	13/10/2023	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**				
Last changed	12/09/2023								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP annual work plan • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSE • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans through the joint forward plan • Full alignment of organisational priorities with system planning • Independent chair for ICP • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative • ICS System Oversight Group • 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) • New Place-based Partnership (PBP) leadership arrangements in place • PBP priorities and work plan agreed for 2023/24 • New PBP executive providing oversight and leadership • Distributed Executive Group • East Midlands Acute Providers (EMAP) Network - attendance at both the Chief Executive Forum and Executive Group		~~A shadow provider collaborative executive team is due to meet in July and will be responsible for overseeing the work programme. This will provide a single responsible group with delivery accountability~~ Distributed Executive Group has now met twice and is in place	**Management:** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to Finance Committee (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board; East Midlands Acute Provider Collaborative report to Board Sep 23 **Risk and compliance:** Significant Risk Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities, which limits our ability to care for patients in the right place, at the right time	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ Clinical Directors and PCN Directors clinical partnership working ▪ A new health inequalities fund has been launched across the ICS targeting funding towards prevention activities	The needs of the population will not be fully understood or aligned to our clinical services until the ICS Clinical Services Strategy is implemented	Refreshed ICS Clinical Services Strategy led by the ICB Medical Director **SLT Lead:** Medical Director **Timescale:** September 2023 Desktop analysis of service lines is under way in preparation for meetings with clinical teams	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place		Positive Last changed October 2022

Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community							**Strategic objective**	1: To provide outstanding care in the best place at the right time
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**3. Possible**	3. Possible	1. Very unlikely				
Last reviewed	13/10/2023	**Risk rating**	**12. High**	**12. High**	**4. Low**				
Last changed	13/10/2023								

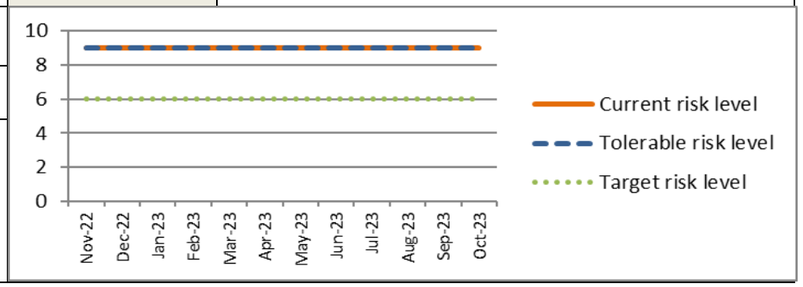


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
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 ▪ Devices that have failed to take the most recent security patch checked after 21 days of inactivity – disabled after 28 days ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead	Systems connected to the network are not all supported by the respective software suppliers, so are not receiving the latest security updates	Ensure all systems have support in place, or the cyber risk is assessed and appropriately mitigated **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~May 2023~~November 2023	**Management:** Data Security and Protection Toolkit submission to Board ~~Jul 22~~Jul 23- compliant on ~~108/109~~ all 113 elements; Hygiene Report to Cyber Security Board bi-monthly; Cyber Security Assurance Highlight Report to Cyber Security Board bi-monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine Mar 22 **Risk and compliance:** **Independent assurance**: ISO 27001 Information Security Management Certification Mar 23; ~~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 Apr 21 – limited assurance~~; 360 Assurance Data Security and Protection Toolkit audit ~~Jul 22 -~~ Jun 23–moderate assurance; ~~IT Healthcheck – 2 of 9 elements failed (negative assurance);~~ Cyber Essentials Plus accreditation ~~Jan 22~~Dec 22		Inconclusive Last changed February 2023
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; ~~Water Safety Update Report to Risk Committee Jul 20; Patient Safety Concerns report to QC March 21~~; ~~Hard and soft FM assurance reports~~ **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct22) – Substantial Assurance; ~~Water Safety report (WSP) to Joint Liaison Committee Oct 19; WSP report – hard FM independent audit;~~ MEMD ISO 9001:2015 Recertification (3-year) Mar 21; British Standards Institute MEMD Assessment Report Feb 22		Positive Last changed March 2023

Board Assurance Framework (BAF): October 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident plan in place ▪ Industrial Action Group			**Management:** Industrial Action debrief report to Executive Team Mar 23, and following each subsequent period of industrial action **Independent assurance:** EPRR Core standards compliance rating (Oct22) – Substantial Assurance		Positive New threat added May 2023

Board Assurance Framework (BAF): October 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable							**Strategic objective**	2: Improve health and wellbeing within our communities
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action		
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	22/11/2021	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	31/10/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	25/07/2023								

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

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date**: 2nd November 2023	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Paul Robinson, Chief Executive		

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

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

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

Committees/groups where this item has been presented before

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

Acronyms

See below

Executive Summary

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

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

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

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

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

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

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

Schedule of BAF reviews since last received by the Board of Directors on 3rd August:

- Quality Committee: PR1, PR2 and PR5 – October
- People & Culture Committee: PR3 – September
- Finance Committee: PR4 and PR8 – October
- Risk Committee: PR6 and PR7 – August, September and October

As agreed at the September meeting of the Board of Directors, Quality Committee is now the Lead Committee for PR5. The Partnerships & Communities Committee will become Lead Committee for PR6, but not until the February 2024 meeting due to the meetings schedule.

PR1, PR2, PR3 and PR4 remain significant risks; PR1, PR3 and PR4 are 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

Acronyms used in the Board Assurance Framework

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

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

TERMS OF REFERENCE

Name of Committee	**PARTNERSHIPS AND COMMUNITIES COMMITTEE**
Constitution	The Board of Directors hereby resolves to establish a committee to be known as the Partnerships and Communities Committee.
Membership	Three Non-Executive Directors one of whom shall be nominated as Chair and one as Vice Chair. The Chair of the Committee shall be appointed by the Board of Directors. The Chair of the Trust shall not be a member of the Committee.
Attendance at Meetings	The following will be in attendance at meetings: • Chief Executive • Medical Director • Director of Strategy and Partnerships • Associate Director of Strategy and Partnerships Executive Directors shall send deputies if they are unable to attend. All other Directors shall be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director. The Committee shall determine other attendees as required to fulfil its Work Programme.
Role	The principal purpose of the Partnerships and Communities Committee is to Report on System Wide activities in order to give assurance to the Board that the Trust is fulfilling its role as an anchor organisation and to assess the priorities and benefits from strategic partnerships.
Duties P&CoWP4 P&CoWP5 P&CoWP10 P&CoWP6 P&CoWP7	Receive, refine and review the Trust's Partnership Plan and oversee its implementation. Monitor and keep under review Principal Risk 6 – Working more closely with local health and care partners does not fully deliver the required benefits. Receive and assess key updates from strategic forums in the System and provide assurance to the Board that the Trust is championing those aspects of its overall Strategy that are executed through strategic partnerships. Analyse gaps in partnerships arrangements and propose options for solutions. Assess the impact of the Provider Collaborative at Scale and monitor the effectiveness of the Trust's response. Monitor the effectiveness of the Trust's role as an anchor organisation to include: • The adequacy and impact of the Trust's contribution to the health inequalities and prevention agenda.

Name of Committee	**PARTNERSHIPS AND COMMUNITIES COMMITTEE**
	• The enhancement of local employment opportunities. • The maintenance of strategic partnerships with the education sector. • The development and maintenance of links with the wider determinants of health and wellbeing including housing. Provide reports of items for escalation to the Board.
Serviced By	Corporate Secretariat whose duties include: • Agreement of meeting agendas with the Committee Chair. • Advising the Committee on pertinent areas and ensure it is fully informed of activities in its Sub-Committees. • Ensuring minutes and collation of papers are undertaken. • Ensure papers for the meeting are distributed one week prior to the meeting.
Frequency of Meetings	Meetings shall be held bi-monthly.
Required Attendance	Members should attend the majority of meetings 5/6.
Quorum	Two Non-Executive Members (one of whom must be the Committee Chair or Vice Chair), and one Executive Director.
Reporting Procedures	The Committee Chair shall draw to the attention of the Board of Directors any issues that require disclosure or escalation.
Minutes Circulated To	The Corporate Secretariat shall circulate minutes of meetings to all members within five days of the meeting.
Date Approved	TBC
Process For Monitoring The Effectiveness Of The Above P&CoWP8	The Committee shall conduct an annual review of its work and these terms of reference and make recommendations to the Board of Directors as necessary.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Partnerships and Communities Committee Terms of Reference			**Date:** 2nd November 2023	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs				
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs				
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs				
Purpose					
To approve the terms of reference for the new Board Partnerships and Communities Committee.				**Approval**	X
				Assurance	
				Update	
				Consider	
Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
	X				**X**

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

Committees/groups where this item has been presented before
Executive Committee
Acronyms
ToR – Terms of Reference
Executive Summary
Following the Board's agreement to establish a new Committee to be known as the Partnerships and Communities Committee, it is necessary to have terms of reference in place in readiness for the Committee's inaugural meeting on 6th November 2023. The final draft terms of reference have been reviewed by the Executive Committee and the Committee Chair and are now presented to the Board with a recommendation for approval.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Quarterly Reflection Report - Documents Sealed and Signed (Quarter 2, 2023/24)	**Date:** 2nd November 2023	
Prepared By:	Laura Webster, Corporate Secretariat Team Leader		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		
Purpose			
This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal, ensuring transparency and accountability in its application		**Approval**	
		Assurance	**X**
		Update	
		Consider	

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

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

Committees/groups where this item has been presented before

N/A

Acronyms

Q2 – Quarter 2

Executive Summary

This quarterly reflection report provides an overview of the documents sealed and signed by the Board during Q2 2023/24. In accordance with Standing Order 10 and the delegated authority in the Scheme of Delegation, the Sherwood Forest Hospitals (NHS) Foundation Trust Official Seal has been affixed to the following documents during Q2:

Seal number 104 - 7th July 2023
Between *Sherwood Forest Hospitals NHS FT* and *Nottinghamshire Hospitals Plc ("Project Co")*

- Arrangements for the conversion of Old Ward 3 to create a new Discharge Lounge to be delivered at King's Mill Hospital.

Seal number 105 - 7th July 2023
Between *Sherwood Forest Hospitals NHS FT* and *Nottinghamshire Hospitals Plc ("Project Co")*

- Arrangements for a modular laminar flow theatre and internal repurposing and reconfiguration of Theatre Spaces to be delivered at Newark General Hospital.

Seal number 106 - 17th August 2023
Between *Sherwood Forest Hospitals NHS FT* and *Nottinghamshire Healthcare NHS Trust*

- Lease in relation to Room 034075, Level 4, Tower 3, KMH.

Seal number 107 - 17th August 2023
Between *Sherwood Forest Hospitals NHS FT* and *Newark & Sherwood District Council*

- Deed of variation.

Following the sealing and signing of these documents, this record is brought to the subsequent Board meeting for assurance.

The Board is asked to **NOTE** the use of the Trust Seal.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 3 November 2023	
Prepared By:	Paula Shore, Director of Midwifery/ Divisional Director of Nursing for W&C		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/ Divisional Director of Nursing for W&C. Phil Bolton, Chief Nurse		

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

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

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

Committees/groups where this item has been presented before

- Nursing and Midwifery AHP Committee
- Maternity Assurance Committee
- Quality Committee

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity Voice Champion (MVP)
- Maternity Assurance Committee (MAC)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)

Executive Summary

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

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

This report provides highlights of our work over the last month

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

1. Service User Voice

Work from the service user voice representative from both Maternity and Neonates has focus on looking at the delivery plan and model for the next year, ensuring that this plan has been co-produced.

The proposed plan and funding streams will be presented to the Executive Partners meeting in November.

The MVP has further supported the engagement work around induction of labour, a theme which appeared within the CQC Maternity Survey 2022/23 and Walk the Patch from the MVP. The detail of this will feature within next month's MNSC update.

2. Staff Engagement

On the 3rd of September the MNSC planned walk round. The higher activity was felt and reported on by all the team, but assurance was provided around the staffing levels to support it.

The MNSC spoke with some of the early career Midwives who had newly started and student Midwives, on the shortened MSc Programme, who are due to qualify in January 2024. All reported that they were looking forward to joining the team and had already had contact with the R&R Midwife.

Maternity Forum was conducted on the 4th of October. With the members that joined, a discussion was held around reforming the forum. The outcome was that the meeting will become hybrid so that colleagues can continue to join via MS Teams but through holding the opportunity for face-to-face engagement within a clinical area. Feedback was given around the actions from the previous meeting, specifically regarding the venue for the antenatal education and log design for Maternity.

3. Governance Summary

Three Year Maternity and Neonatal Plan:

Key members of the Maternity Safety Team attended the planned regional workshop to look at how to progress the bespoke workbook. Updates from this workshop will be brought through the MNSC and MAC meeting, we are still awaiting the updates to the workbook **from the system.**

Ockenden:

The annual Ockenden insight visit was conducted on the 9th of October. The agenda for the day included opportunities from the visiting to panel to speak with both staff across all levels and service users. The initial feedback provided was very positive around the culture and embedding of the initial Ockenden immediate and essential actions. We have yet to receive formal feedback, once provided this will be reviewed through the MNSC for action.

NHSR:

Through the MAC this month we have started to present the evidence, as discussed through the MNSC meeting, for compliance against the Year 5 Maternity Incentive Scheme. Safety actions 2, 5 and 7 have been presented and approved as compliant.

Saving Babies Lives:

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) in version 2 and following the uploaded evidence submitted to the regional teams we have received confirmation that we have achieved the agreed over 70% of compliance for version 3. Work continues to ensure that we aim for full compliance within the agreed time thresholds.

CQC:

Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) the evidence has been rated as "green" through the QC, further is needed for these actions to become embedded. The "Must-Do" progress will be tracked through the MNSC.

The focus has move on the "should do" actions, and a subsequent action plan will be cited at MNSC and MAC in the subsequent months. These "should do" actions are:

The trust should ensure all medicines are stored safely and appropriately in line with trust policy.

The trust should continue to implement their new electronic system. To support auditing the quality of the service. When issues are identified from audits action is taken further auditing cycles are undertaken to demonstrate if improvements and changes in practice have improved patient outcomes and improved practice.

Leaders should continue to implement improvements to how they effectively communicate any changes in service provision with staff.

At the MNSC meeting this month we reviewed the action plan and approved.

4. Quality Improvement

On the 13th of October, the teams were able to celebrate the work that they have supported over the last year at the Trust's Celebrating Excellence Event. Both the Maternity and Neonatal team presented their work around Cultural Safety and Neonatal Baby Friendly Initiative at the event sharing the key work and futures plans.

5.Safety Culture

Following on from last month's focus on the Equity and Equality work, this month saw the first two-day training in Cultural Safety. This new mandatory training is being rolled out across maternity services for the next three years, with the focus of the days listening to parents lived experiences, drafting action to reduce inequalities and ends with collective support for the group.

Maternity Perinatal Quality Surveillance model for October 2023

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

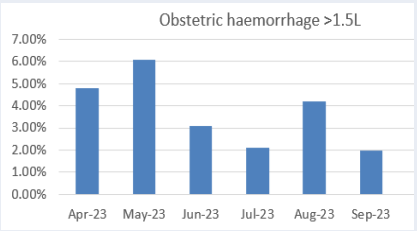
Sherwood Forest Hospitals
NHS Foundation Trust

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

Exception report based on highlighted fields in monthly scorecard using September data (Slide 2 & 3)

Massive Obstetric Haemorrhage (Sep 2.0%)

- Rise in cases this month, reviewed and no harm, themes or trends.



Elective Care

Elective Caesarean (EL LSCS)

- Increased service demand in Sept, planned lists to support demand effective

Induction of Labour (IOL)

- Lead Midwife continuing with the QI to improve the service
- QI work to be presented to the LMNS PSQG meeting 01/11/2023

Midwifery Workforce

- Current vacancy rate 3.2% , New recruited Midwives now onsite and in preceptorship programme
- Supported University of Derby with additional student placements

Staffing red flags (Sept 2022)

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

Suspension of Maternity Services

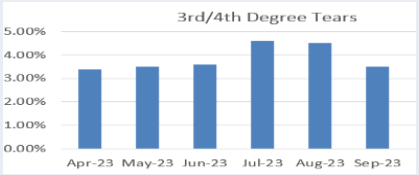
- Two suspension of services within September

Home Birth Service

- 43 Homebirth conducted since re-launch

Third and Fourth Degree Tears (Sep 3.5%)

- Rate within threshold
- Perinatal Pelvic Health Service has first regional face to face to review service specification.



Stillbirth rate (1.2 /1000 births)

- One stillbirth reported in September, PMRT completed awaiting further review with findings from tests and investigations
- Rate remains below the national ambition of 4.4/1000 births
- MBRRACE-UK report released, noted national increase in still birth in 2021

Maternity Assurance

NHSR	Ockenden
• Working commenced flash reports to MAC/QC • Additional sign off meetings planned • Submission due 2nd of Feb 2024	• Initial 7 IEA- 100% compliant • Positive initial feedback from the Ockenden Insight Visit- formal report to follow

Incidents reported Sept 2023 (110 no/low harm, 3 moderate or above)

Most reported	Comments
	MOH, Cat 1 LSCS
Triggers x 16	No incidents required external escalations
3 Incidents reported as 'moderate or above', see below	

Other

- Two incidents report as moderate are linked regarding twins requiring an exchange transfusion and are currently under investigation. The final incident, a neonatal death, has been reported as catastrophic and is subject to internal and external investigation.
- During the month of September, the Maternity Unit attempted to suspend services, due to high acuity, on two occasions. On both occasions the neighbouring units were unable to support, and the suspension was managed through the current policy. No incidents reported during these time had been reported as moderate or above.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Running Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	54%	43%	56%	56%	55%	
3rd/4th degree tear overall rate	<3.5%	3.80%	3.40%	3.50%	3.60%	4.60%	4.50%	3.50%	
3rd/4th degree tear overall number		39	6	7	6	8	6	6	
Obstetric haemorrhage >1.5L number		64	13	19	9	6	11	6	
Obstetric haemorrhage >1.5L rate	<3.5%	3.40%	4.80%	6.10%	3.10%	2.10%	4.20%	2.00%	
Term admissions to NICU	<6%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	
Stillbirth number		2	1	0	1	0	1	0	
Stillbirth rate	<4.4/1000				2.200			1.200	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	
Number of compliments (PET)		15	2	2	3	2	3	3	
Number of concerns (PET)		7	2	1	1	1	1	1	
Complaints		2	0	0	0	0	1	1	
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	

External Reporting	Standard	Running Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Trend
Maternity incidents no harm/low harm		499	58	78	85	86	85	107	
Maternity incidents moderate harm & above		6	0	1	1	0	1	3	
Findings of review of all perinatal deaths using the real time monitoring tool	Sep-23	To date all cases reportable to PMRT are within reporting timeframes- awaiting reports							
Findings of review all cases eligible for referral to MNSI	Sep-23	Three current live cases with MNSI no current completed reports							
Service user voice feedback	Sep-23	Theme around IOL, QI work to be present at LMNS Transformation Board							
Staff feedback from frontline champions and walk-abouts	Sep-23	Improve work around LSCS, reporting higher activity espcially elective work							
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	
Progress in Achievement of CNST 10	<4 <7 7 & above								

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board

Subject:	**Nursing, Midwifery, and Allied Health Professional Bi-annual Staffing Report.**	**Date:** 2nd November 2023
Prepared By:	Rebecca Herring (Lead Nurse for Safer Staffing) Paula Shore (Director of Midwifery and Divisional Director of Nursing) Kate Wright (Associate Chief Allied Health Professional)	
Approved By:	Phil Bolton Chief Nurse	
Presented By:	Phil Bolton Chief Nurse	

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

Strategic Objectives					
Provide outstanding care in the best place at the right time	Improve health and well-being within our communities	Empower and support our people to be the best they can be	To continuously learn and improve	Sustainable use of resources and estate	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**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	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	

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

Committees/groups where this item has been presented before

Nursing, Midwifery, and Allied Health Professional Committee August 2023
People, Culture, and Improvement Committee, September 2023

Acronyms

Allied Health Professional (AHP)

Sherwood Forest Hospitals Foundation NHS Trust (SFHFT).

National Institute for Health and Care Excellence (NICE),

National Quality Board (NQB)

Care Hours per Patient Day (CHPPD)

Adult Safer Nursing Care Tool (SNCT)

Care Quality Commission (CQC)

NHS Improvement (NHSI)

Objective Structured Clinical Examinations (OSCEs).

Healthcare support workers (HCSWs)

NHS England (NHSE)

Local Maternity and Neonatal Systems (LMNS)

Whole-time equivalent (WTE)

Health and Care Professions Council (HCPC).

Clinical Services, Therapies, and Outpatient (CSTO)

Speech and Language Therapy (SLT)

Integrated Care System (ICS)

Integrated Care Board (ICB)

Nursing and Midwifery Council (NMC)

Occupational Therapy (OT)

Operating Department Practitioner (ODP)

Registered nurse (RN)

Nursing associate (NA)

Trainee nursing associate (TNA)

Executive Summary

1.0 Background

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

Guidance.

1.2 This is supported by an overview of staffing availability over the previous 5 months, the quality impact upon nurse-sensitive indicators, and progress with assessing the acuity and dependency of patients in ward areas. Furthermore, forward planning progress will be discussed across the outlined disciplines.

Nursing and Midwifery Staffing Overview

1.3 Since our last report the Trust's collective vacancy rate for nursing, midwifery, and AHPs across all divisions has seen a persistent increase since March of this year, however, the turnover rate has remained consistently low and in a healthy position. Therefore, the vacancy increase is partially attributed to the increase in the baseline establishments following the re-setting of budgets from April 2023.

1.4 The national picture for nursing vacancies remains tumultuous, therefore greater emphasis within the NHS Long Term Workforce Plan (NHSE, 2023) has been placed on growing domestic education, training, and recruitment. Nursing, and midwifery vacancies at SFHFT have remained aligned with the national position and is an encouraging indication that recruitment campaigns are preventing our current position from worsening. Nonetheless, we recognise our band 5 nursing workforce is our largest safety-critical resource, and reducing that deficit remains an ongoing challenge. International recruitment continues to be a key indicator for recruitment and is also being echoed nationally.

1.5 A continued reliance on agency staffing across all clinical areas continues as we move through 2023 with several winter capacity areas remaining operational beyond the predicted time frame. Nonetheless, the overall trajectory for 2023 continues to positively reduce and is indicative of the ongoing improvement work and strategic focus work being undertaken in terms of agency expenditure.

1.6 In line with the continued decreasing agency usage, agency shifts at escalated rates have also remained on the same positive downward trend. This favourable position continues to be influenced by surge payments, enhanced rates for 'hotspot' areas, and the allocation on arrival scheme. Priority focus has been placed on timely escalation of staffing shortfalls and de-escalation when service needs allow. This has

enabled regular opportunities to review, evaluate, and ensure safety and quality care remain the overarching priority.

1.7 Care Hours per Patient Day (CHPPD) at Trust level has remained stable demonstrating where safely possible, the workforce is being deployed to meet patient activity and patient needs. Benchmarking data from Model Hospital (June 2023) demonstrates that the Trust value sits within the third of four quartiles at 8.7 and is very slightly above our peer's median of 8.4. With that said, due to the various productivity workstreams being undertaken, we have seen a positive progression from the fourth quartile (highest), down into the third quartile of the Model Hospital data set.

1.8 Since March 2023, 271 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system. All incidents were recorded as no or low harm, and the appropriate actions were taken at the time (when investigations had been successfully closed).

1.9 12 of these incidents have been identified as *red flag* incidents due to delays in fundamental care, delays in time-critical activity, unable to provide 1:1 care during established labour, or delays in the inductions of labour. It is recognised that there is a possibility of underreporting.

Nursing and Midwifery Forward Planning

1.10 Safer Nursing Care Tool (SNCT) acuity and dependency cycles will conclude with its final cycle planned for October, the data will support and inform the establishment setting process scheduled to commence in December, in line with the financial planning phase.

1.11 A rolling programme for connected working and development has been commenced for band 7 and band 8 colleagues, which is being led by the Deputy Head of Corporate Nursing. Right-sizing the workforce and the key principles underpinning safer staffing have been recently delivered with a priority focus on upcoming establishment reviews and frontline engagement.

1.12 Recruitment support from the corporate senior nursing team has been provided to Lindhurst and Chatsworth Ward for RN and HCSW vacancies due to the

commissioning provided to establish these areas long-term. Outstanding efforts have been made by the team at Mansfield Community Hospital with several days of recruitment taking place during June and early July. Approximately 99% of all RN vacancies have now been recruited with a final drive to recruit to the last remaining HCSW vacancies out to advert.

1.13 The Trust continues to have representation upon the Chief Nursing Officer Safer Staffing Fellowship delivered by NHSE and Birmingham City University. The Trust Lead Nurse for Safer Staffing will progress into year 2 of the Healthcare Workforce Planning, Delivery, and Assurance Master of Science Degree Programme in October.

1.14 SFHFT recommissioned a new BirthRate+ Report which was completed in January 2023 to ensure that staffing reflected the increase in activity and acuity and reflected the changes in the national maternity agenda. The recommendations for the report were embedded into the 2023/24 establishments and successful recruitment has continued. Once all recruited midwives commence in post throughout September to January, our maternity services will be fully established. We will continue to advertise vacancies to facilitate over-recruitment to assist with the high levels of maternity leave across the services.

Recruitment and Retention

1.15 The Recruitment and Retention Lead Midwife role continues to be evaluated successfully. Targeted work supporting preceptorship and ongoing pastoral support remains aligned with NHSE Long Term Workforce Plan (2023), which in fact has highlighted that this role has ensured all midwives that have been recruited have remained in post here at SFHFT. Furthermore, the Trust has been invited to support a Midwifery Retention Project Videography in September in collaboration with NHSE.

1.16 The Trust currently has two MSc Midwifery programmes in operation, one programme is with Birmingham City University which four student midwives will complete in January 2024, and the second programme is with Derby University where five student midwives will complete in January 2025. Expressions of interest have been invited and drop-in sessions have been communicated.

1.17 We have four Nursing Associates (NAs) on the top-up programme who will complete their studies in March 2024, and we are currently working with them to ensure that they get their place of choice as an RN. We will have a further 10 who will complete their top-up in September 2024, and we will support these as they move into their final year.

1.18 SFHFT has been awarded further funding from NHSE for a further 70 international RNs by 31 December 2023. To achieve this, the Trust has secured a second recruitment agency to recruit further staff. In July, we interviewed and appointed 26 international RNs, but unfortunately, we did not deploy any in July. We have developed a plan with NHSE Midland's team to meet our trajectory for December, which means we will be looking at deploying approximately 20 international RNs per month.

AHP Overview

1.19 AHPs are a wide-ranging group of clinicians who work in diagnosis, treatment, rehabilitation, health promotion, discharge, and improving the quality of life of patients. AHP professional titles are recognised by NHSE, protected by law, and registered and regulated by the Health and Care Professions Council (HCPC). Collectively they are the third largest workforce in the NHS and are essential in the delivery of the NHS People Plan, to support future demands, transform sustainable healthcare, and assist deliverables of the NHS Long Term Plan.

1.20 The Speech and Language Therapy (SLT) team has now completed job planning for all bands. Band 5 Job plans for the remaining AHPs are near completion and a band 6 capacity and demand exercise is currently underway in therapy services. Therapy services are in the process of moving physiotherapy, occupational therapy (OT), orthotics, and dietetics onto electronic rostering.

1.21 OT is a workforce risk and is on the Clinical Services, Therapies, and Outpatient (CTSO) division risk register. OTs have been deemed by NHSE an 'at risk' professional group. Nationally, there are significant challenges in recruitment across acute settings partnered with limited bank and agency workforce available. Acute

placements are not mandated as part of the undergraduate training of an OT.

1.22 Operating Department Practitioners (ODPs) continue to be a workforce risk. Two international ODPs have now commenced but significant recruitment and retention issues remain. Current recruitment workstreams include international recruitment, rolling band 5 recruitment, apprenticeships, video promotion with Care4Notts, and an ongoing communication plan. Substantive staff are covering significant overtime due to a high agency workforce (with less experience) covering vacancies.

1.23 Two level 6 physiotherapy apprentices have successfully completed their training and have now qualified. They have both successfully obtained band 5 physiotherapist posts at SFHFT.

1.24 The Trust has hosted and supported an ICS AHP Faculty Practice Learning Facilitator, supporting high-quality practice-based learning, and aligning placement capacity with predicted future workforce needs.

1.25 SFHFT and the Associate Chief AHP will be the host organisation for NHSE/ICB AHP funds including:

- ICS AHP workforce, training, and education improvement fund,
- ICS AHP leadership scoping role will be extended until December 2023,
- Student placement (quality and capacity) and preceptorship workstreams.

This will include secondment opportunities for AHPs to develop leadership and project manager skills by supporting and delivering these projects for 6 months. These roles are currently out for recruitment.

National Compliance

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

1.27 The recommendation from the Chief Nurse and Director of Nursing is that there is good compliance with the Developing Workforce Safeguards.

1.28 The Chief Nurse and Director of Nursing have confirmed they are satisfied that staffing is safe, effective, and sustainable.

1.29 Appendix two details the Trust's compliance with the nursing and midwifery element of the Developing Workforce Safeguards recommendations.

Recommendations

1.30 The Board is asked to:

- Receive this report and note the ongoing plan to provide safe staffing provisions within nursing, midwifery, and AHP disciplines across the Trust.
- The Board is asked to note the AHP staffing and risk position within the report whilst noting the ongoing recruitment plans to support services.
- The Board is asked to note the compliance standards used in relation to SNCT, and the ongoing quality of data it provides to underpin the Trust establishment process.

Nursing, Midwifery, and Allied Health Professional Bi-annual Staffing Report 2023

2.0 Purpose

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

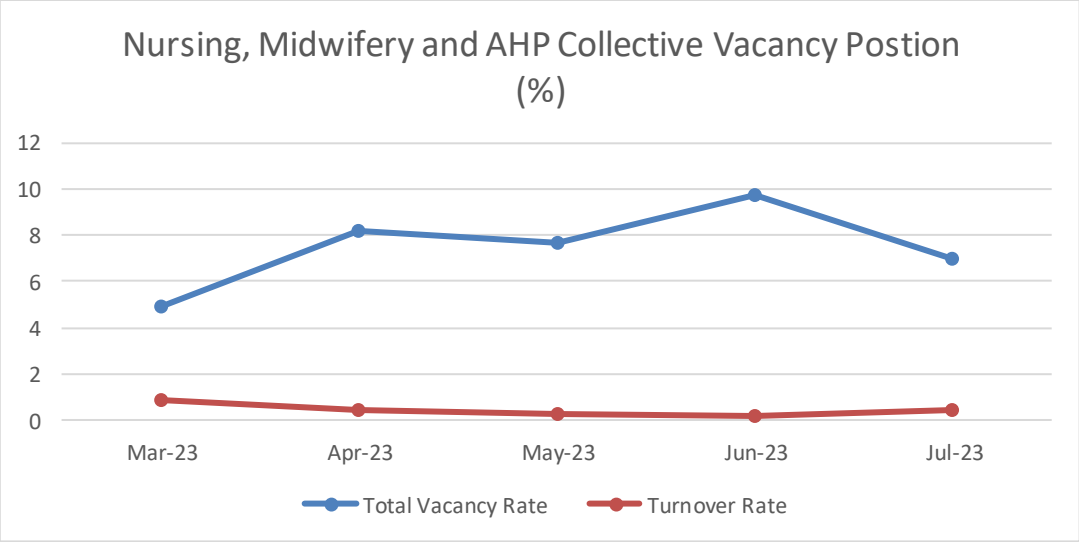
2.2 This is supported by an overview of staffing availability since our last report, oversight of nurse-sensitive indicators, progress with assessing the acuity and dependency of patients across ward areas, ongoing recruitment, and service development across our services.

Nursing and Midwifery Overview

3.0 Local Nursing and Midwifery Context

3.1 Since our last report the Trust's collective vacancy rate for nursing, midwifery, and AHPs across all divisions has seen a persistent increase since March of this year. However, the turnover rate has remained consistently low and in a healthy position, therefore the vacancy increase is partially attributed to the increase in the baseline establishments following the re-setting of budgets from April 2023.

Figure 1:

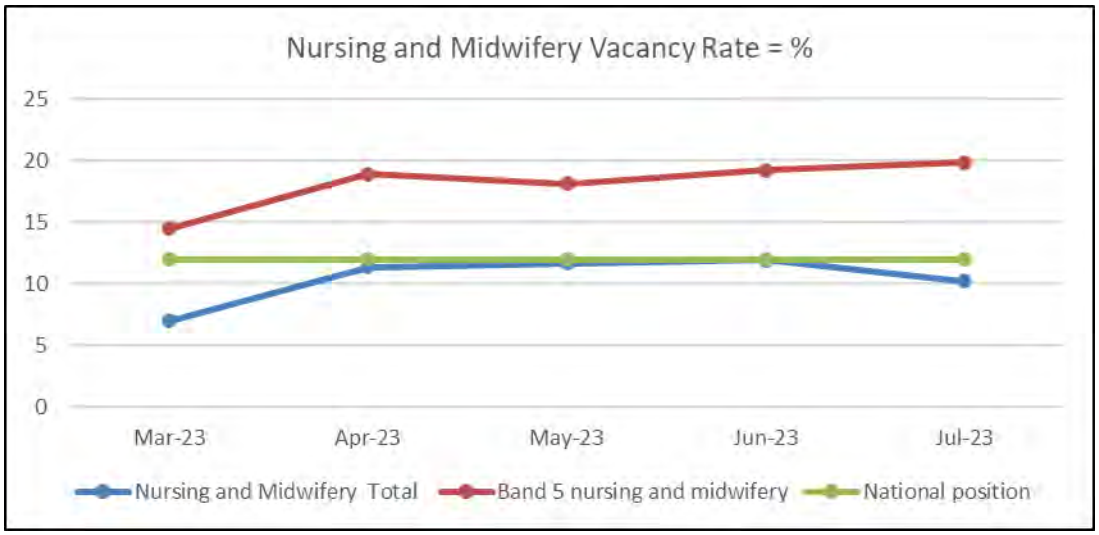


Data Source: Workforce Informatics.

3.2 The NHS Long Term Workforce Plan (2023) states the NHS has many times the number of staff, including doctors, nurses, therapists, and scientists, and is therefore capable of delivering a far greater volume and breadth of care. But, at the same time, national vacancies total over 112,000. The national picture for nursing vacancies remains tumultuous, therefore greater emphasis within the NHS Long Term Workforce Plan has been placed on growing domestic education, training, and recruitment.

3.3 Nursing, and midwifery vacancies at SFHFT have remained aligned with the national position and is an encouraging indication that recruitment campaigns are supporting our current position and preventing it from worsening. Nonetheless, we recognise our band 5 nursing workforce is our largest safety-critical resource, and reducing that deficit remains an ongoing challenge but is being supported through international recruitment, which is being echoed nationally.

Figure 2:

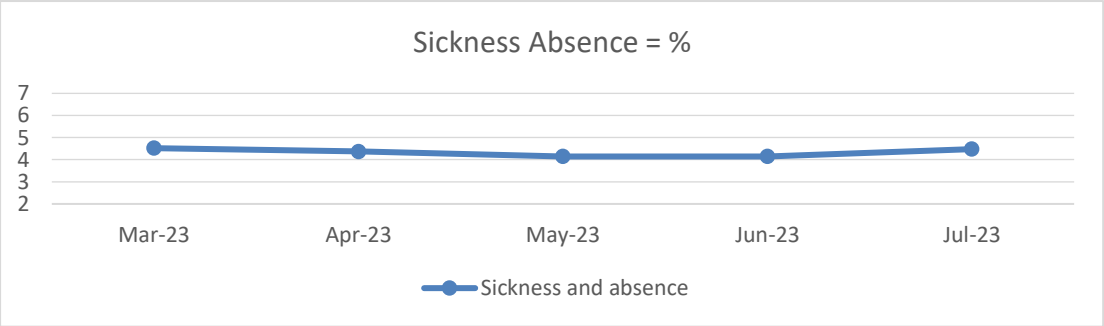


Data Source: Workforce Informatics.

3.4 Recognising the importance of a coordinated individual approach, an annual band 5 programme for nursing recruitment and pre-registration engagement is being developed to showcase the outstanding teams and core values of SFHFT, but more importantly, enabling frontline staff through a shared governance framework to enable this.

3.5 Since our last report, we have continued to maintain a stable position in relation to sickness absence overall for all staff groups, and this is a sustained improvement when compared to 2022.

Figure 3:

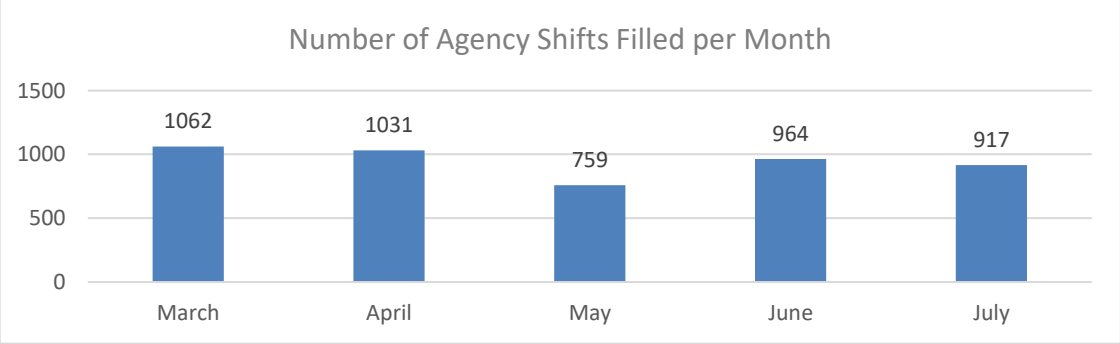


Data Source: Workforce Informatics.

3.6 A continued reliance on agency staffing across all clinical areas continues as we move through 2023, and several winter capacity areas have remained open beyond the predicted time frame. Acuity and dependency requirements of our patients attending the hospital have continued to remain high, coupled with immense flow and capacity throughout the year. Once again this is not localised to SFHFT as unprecedented pressures across the NHS system are being experienced nationwide.

3.7 Despite this, the overall trajectory for 2023 continues to positively reduce and is indicative of the ongoing improvement work and strategic focus work being undertaken in terms of agency expenditure.

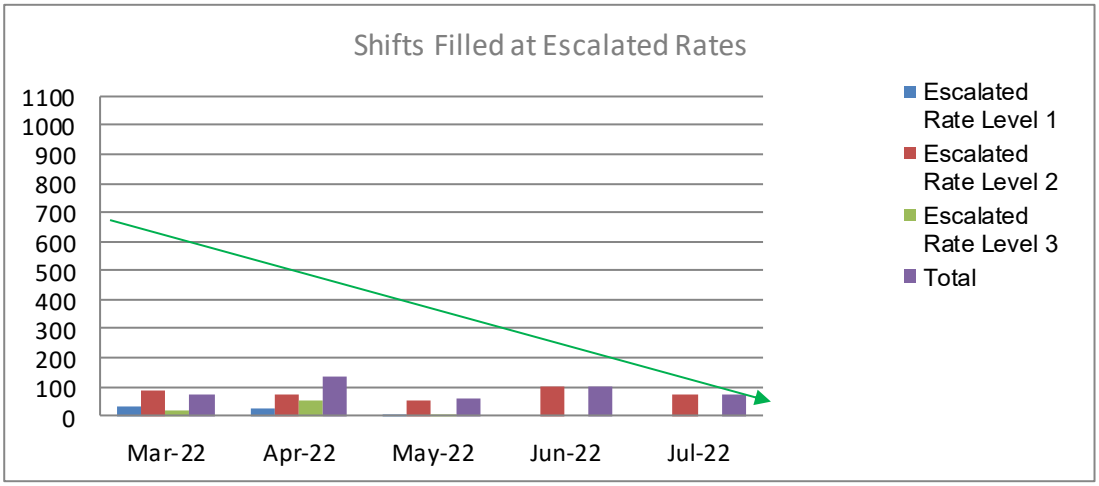
Figure 4:



Data Source: Temporary Staffing Office 2023 Data

3.8 In line with the continued decreasing agency usage, agency shifts at escalated rates have also remained on the same positive downward trend. This favourable position continues to be influenced by surge payments, enhanced rates for 'hotspot' areas, and the allocation on arrival scheme. Priority focus has been placed on timely escalation of staffing shortfalls and de-escalation when service needs allow, which has enabled regular opportunities to review and evaluate the Trust's financial position whilst ensuring safety and quality care remain the superseding priority.

Figure 5:



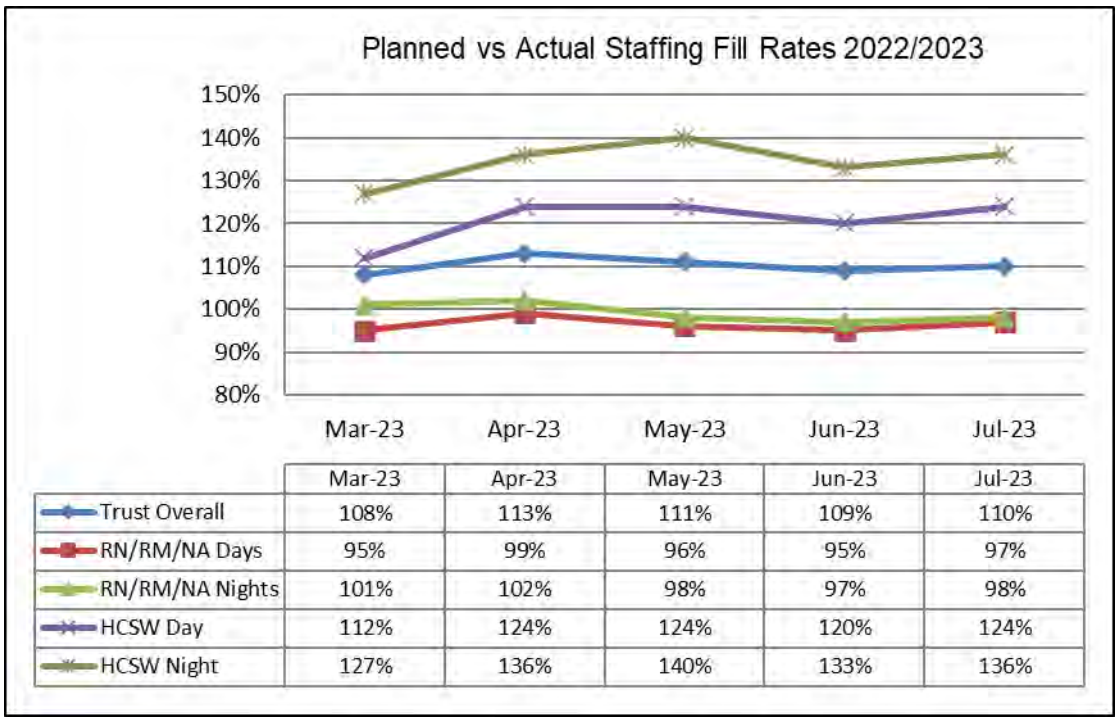
Data Source: Temporary Staffing Office 2023 Data

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

4.1 All NHS providers are required to publish inpatient nursing and midwifery staffing data and a national report is submitted each month. This data highlights the planned staffing hours (hours planned into a working roster template) aligned to actual staffing hours worked (actual hours worked by substantive and temporary staff).

4.2 The previous months have remained challenging for certain areas due to sickness absence and leave, but clinical leaders have worked hard to ensure our staffing levels have remained safe and aligned with national guidance. The Trust overall has consistently remained above 95% of the planned staffing fill rates for registered staff and unregistered staff. The Trust continues to experience a high caseload of patients who require enhanced observations to reduce the risk of harm, and the consistent HCSW fill rates are demonstrative of the increased needs of patients accessing our services.

Figure 6:



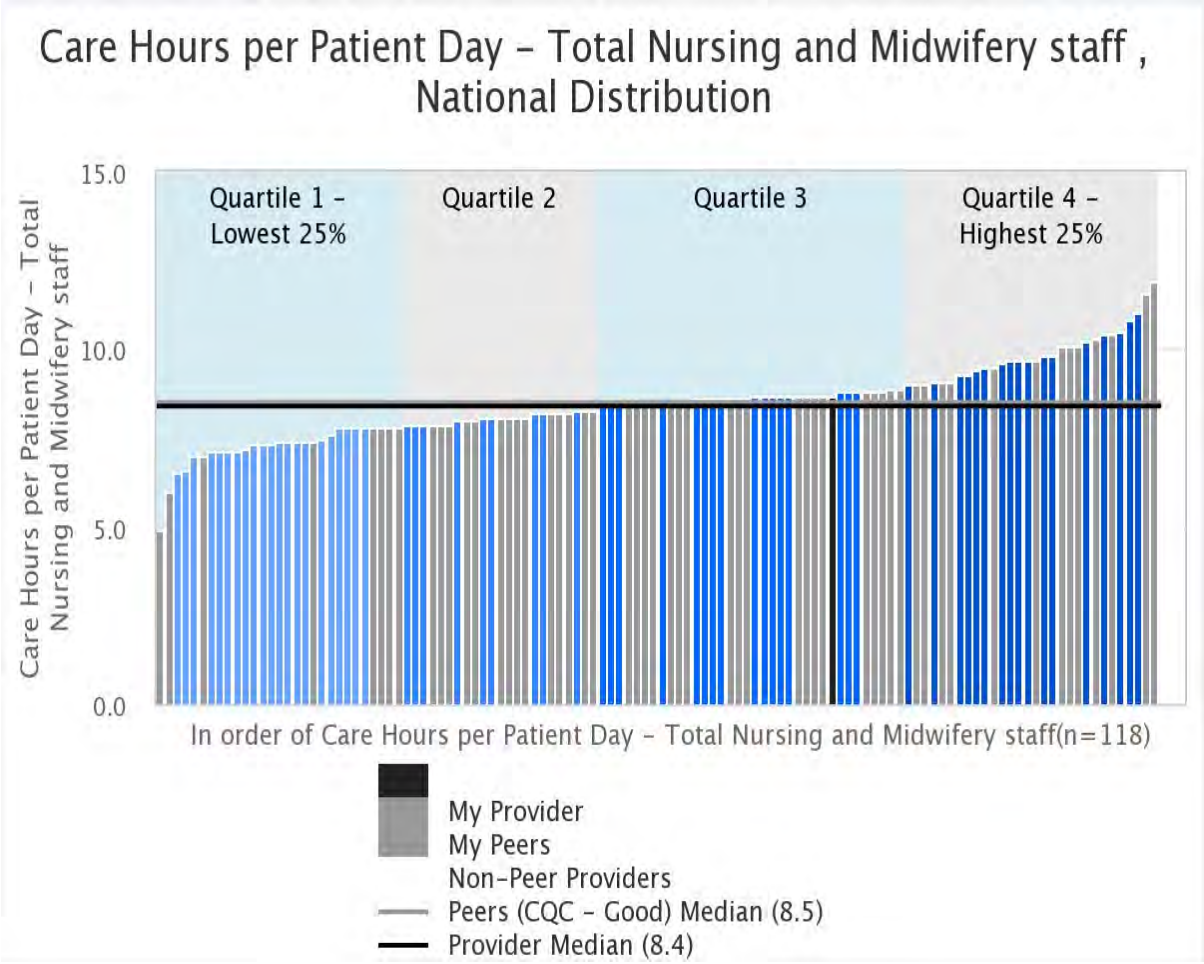
	Mar-23	Apr-23	May-23	Jun-23	Jul-23
Trust Overall	108%	113%	111%	109%	110%
RN/RM/NA Days	95%	99%	96%	95%	97%
RN/RM/NA Nights	101%	102%	98%	97%	98%
HCSW Day	112%	124%	124%	120%	124%
HCSW Night	127%	136%	140%	133%	136%

Data Source: Unify Staffing Data.

4.3 CHPPD is calculated by adding together the hours of registered nurses/ midwives and health care support staff (HCSW) and dividing the total by every 24 hours of inpatient admissions. This provides a value that demonstrates the average number of actual registered nursing care hours spent with each patient per day. Data at Trust and ward level for all acute Trusts is published on NHS Model Hospital to assist in reducing unwarranted variation by providing a transparent comparable data set.

4.4 The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being deployed to meet patient activity and patient needs. Benchmarking data from Model Hospital (June 2023) demonstrates that the Trust value sits within the third of four quartiles at 8.7 and is very slightly above our peer's median of 8.4. Whilst this metric should not be used in isolation, it does indicate that our staffing levels are reflective of similar-sized peer organisations across the country. With that said, due to the various productivity workstreams being undertaken, we have seen a positive progression from the fourth quartile (highest), down into the third quartile of the Model Hospital data set.

Figure 7:



Data Source: Model Hospital

4.5 Divisional feedback from the matron team indicates safe staffing across all services remains an ongoing priority, particularly with the seasonal variables and the exceptional circumstances of industrial action amongst the teaching profession. With that said, staffing resource has been efficiently flexed and deployed to meet patient demand, activity, and acuity. We recognise that at times, this has meant clinical areas are working with staffing levels that have not been optimum. Nonetheless, minimum staffing levels have been maintained and red flag incidents continued to be monitored and reviewed.

5.0 Measure and Improvement

5.1 Patient care that is of high quality is the absolute driver in our assurance that our staffing is safe and responsive, therefore the senior nursing and midwifery team

reviews workforce metrics, indicators of quality, and measures of productivity monthly within the monthly Safe Staffing Reports.

5.2 Since March 2023, 271 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system. All incidents were recorded as no or low harm, and the appropriate actions were taken at the time (when investigations had been successfully closed).

Figure 8:

2022-2023	March	April	May	June	July
Staffing Incidents	58	58	49	52	54
Red Flags	2	2	1	3	4

Data Source: Datix Reporting System

5.3 12 of these incidents have been identified as *red flag* incidents (as defined by NICE) due to a delay in fundamental care, delays in time-critical activity, unable to provide 1:1 care during established labour, or delays in the inductions of labour. It is recognised that there is a possibility of underreporting therefore emphasis is being placed on informing staff of red flag events and detailing the impact upon patient care when staffing concerns are being reported.

5.4 In addition to Datix reporting, red flags for midwifery services are also recorded within BirthRate Plus® system. The theme of red flags reported aligns with the incidents reported within the Datix system highlighted above. As per our previous report, the themes remain consistent with actions undertaken to meet patient acuity by utilising redeployment of staff, matron on-call working clinically, and escalation to managers enacted to mitigate risk.

6.0 Nursing Forward Planning

6.1 SNCT acuity and dependency cycles will conclude with its final cycle planned for October and the data will support and inform the establishment setting process scheduled to commence in December, in line with the financial planning phase.

6.2 A rolling programme for connected working and development has been commenced for band 7 and band 8 colleagues, which is being led by the Deputy Head of Corporate Nursing. Right sizing the workforce and the key principles underpinning safer staffing session has recently been delivered with a focus on the upcoming establishment reviews and frontline engagement.

6.3 The Trust continues to have representation upon the Chief Nursing Officer Safer Staffing Fellowship delivered by NHSE and Birmingham City University. The Trust Lead Nurse for Safer Staffing will progress into year 2 of the Healthcare Workforce Planning, Delivery, and Assurance Master of Science Degree Programme in October.

6.4 Recruitment support from the corporate senior nursing team has been provided to Lindhurst and Chatsworth Ward for RN and HCSW vacancies due to the commissioning provided to establish these areas long-term. Outstanding efforts have been made by the team at Mansfield Community Hospital with several days of recruitment taking place during June and early July. Approximately 99% of all RN vacancies have now been recruited with a final drive to recruit to the last remaining HCSW vacancies out to advert.

6.5 The recruitment support offer has also assisted Castle Ward with RN and HCSW vacancies. Collaboration with the communications team is underway to drive the profile of our Newark site and the range of opportunities it has to offer, starting with short video staff case studies and a review of the Newark site landing page.

6.6 From October 2023, we will have 11 trainee nursing associates (TNAs) taking up their NA posts within the Trust, and they were all successful in the areas of their choice.

6.7 Ongoing work continues to align our preceptorship programme with the National Preceptorship Framework. An annual review is scheduled to identify areas of improvement to support our journey towards achieving the Quality Preceptorship Mark.

6.8 International Recruitment

6.9 The Trust been awarded further funding from NHSE for a further 70 International RNs by 31 December 2023. To achieve this, the Trust has secured a second recruitment agency to recruit further staff. In July, we interviewed and appointed 26 international RNs, but unfortunately, we did not deploy any in July. We have developed a plan with NHSE Midland's team to meet our trajectory for December, which means we will be looking at deploying approximately 20 international RNs per month.

6.10 We have continued to train our international RNs to complete their Objective Structured Clinical Examinations (OSCEs) and the current waiting time from arrival to commencing their training is 4 weeks. In July, there were 9 who took their OSCEs, 1 passed the first time, 8 on the second attempt, and 1 passed on the third attempt.

6.11 We are reviewing the retention of our international RNs as we are aware that there are 20 who are leaving and moving to Australia. As most of these are in their first year at the Trust, we are looking at the NHS Employee guidance on recuperating costs in line with their recommendations.

6.12 Nursing Associates

6..13 The 2022 cohort will move into their second year and are achieving their objectives, and we have appointed 18 TNAs who will commence their training in 2023 at Nottingham Trent University.

6.14 We have four NAs on the top-up programme who will complete their studies in March 2024, and we are currently working with them to ensure that they get their place of choice as an RN. We will have a further 10 who will complete their top-up training in September 2024, and we will support these as they move into their final year.

6.15 Registered Nurse Degree Apprenticeships

6.16 Our registered nurse degree apprentices will move into their final year in September, and we will commence supporting them in moving into their future posts of choice in September 2024, and will complete this by December 2023.

7.0 Midwifery Forward Planning

7.1 SFHFT recommissioned a new BR+ report which was completed in January 2023 to ensure that staffing reflected the increase in activity and acuity and was in line with changes in the national maternity agenda.

7.2 The recommendations for the report were embedded into the 2023/24 establishments and successful recruitment has continued. Once all recruited midwives commence in post throughout September to January, our maternity services will be fully established. We will continue to advertise vacancies to facilitate over-recruitment to assist with the high levels of maternity leave across the services.

7.3 Specialist midwife's roles have also been reviewed and will be factored into future recruitment ensuring the Trust is aligned with the national agenda, mainly the Three-Year Delivery Plan for Maternity and Neonatal Services (March 2023).

7.4 The Three-Year Delivery Plan combines findings from reports on maternity services nationally and details a framework for the delivery of its recommendations. The implementation will be led via the Local Maternity & Neonatal Systems (LMNS) which have recently launched the 'LMNS Oversight and Assurance Panel' in response to the plan. The maternity team remains committed to supporting its successful implementation.

7.5 The alignment of the MSW to the national framework continues and plans are in place to support our current staff to meet educational requirements within this framework. This also aligns with the Three-Year Delivery Plan and the RCM Position Statement (2022) which outlined that registered nurses should not be used within maternity services and that organisations should look at the development of the Maternity Support Worker (MSW) workforce.

7.6 As part of Maternity Transformation within Sherwood Birthing Unit the rollout of the Birmingham Symptom Specific Obstetric Triage System pathway has seen initial success and responds to recommendations within the planned Care Quality Commission (CQC) Maternity Service inspection undertaken in November 2022. Furthermore, the commencement of the elective caesarean section lists has seen

positive responses from both staff and service users and will continue to be monitored to capture data on patient safety and satisfaction.

7.7 Our Recruitment and Retention Lead Midwife role continues to be evaluated successfully. Targeted work supporting preceptorship and ongoing pastoral support remains aligned with the Long-Term Workforce Plan (NHSE, 2023), and has highlighted that this role has ensured all midwives that have been recruited have remained in post here at SFHFT. Furthermore, the Trust has been invited to support a Midwifery Retention Project Videography in September in collaboration with NHSE.

7.8 The Trust currently has two MSc midwifery programmes in operation, one programme is with Birmingham City University where four student midwives will complete in January 2024, and the second programme is with Derby University where five student midwives will complete in January 2025. Expressions of interest have been invited and drop-in sessions have been communicated.

Allied Health Professions Overview

8.0 AHPs are a wide-ranging group of clinicians who work in diagnosis, treatment, rehabilitation, health promotion, discharge, and improving the quality of life of patients. AHP professional titles are recognised by NHSE, protected by law, and registered and regulated by the HCPC. Collectively they are the third largest workforce in the NHS and are essential in the delivery of the NHS People Plan, to support future demands, transform sustainable healthcare, and assist deliverables of the NHS Long Term Plan.

8.1 There is no single guidance or standard approach to inform safe staffing levels required within services provided by AHPs. Each AHP has profession-specific information and guidance only, available to support staffing levels of a particular type of service. At SFHFT, we currently employ 9 of the 14 AHP professions as defined by NHSE.

8.2 A local AHP tactical profile has been developed, collating workforce data and intelligence. This is currently being validated against ESR and Model Hospital. It initially provides a baseline of AHP profiles at SFHFT. Metrics include skill mix, ethnicity, retention and recruitment, and support workforce. Further analysis, in

addition to job planning, will support the planned development of an AHP quality dashboard.

9.0 Job Planning

9.1 The SLT team has now completed job planning for all bands. Band 5 Job plans for the remaining AHPs are near completion and a band 6 capacity and demand exercise is currently underway in therapy services. Therapy services are in the process of moving physiotherapy, OT, orthotics, and dietetics onto electronic rostering.

9.2 The AHP Chief Nurse Clinical Fellow post supporting the implementation of AHP job planning is expected to conclude in November 2023.

10.0 AHP Staffing Updates

10.1 Therapy posts (physiotherapy, OT, SLT, and dietetics) and additional acute and stroke bed funding have been agreed and substantive recruitment is underway.

10.2 OT is a workforce risk and is on the CSTO risk register. OTs have been deemed by NHSE an 'at risk' professional group. Nationally, there are significant challenges with recruitment in acute settings partnered with limited bank and agency workforce available. Acute placements are not mandated as part of the undergraduate training of an OT.

10.3 OT posts vacant at SFHFT include two band 6 OT posts, and two band 5 OTs have also recently given notice. In addition, there are two staff on long-term sickness being supported. This significantly impacts the workforce and the ability to support flow and discharges within this team. Recruitment is underway and if there are successful applicants, over-establishment is being considered. The Associate Chief AHP is undertaking all AHP exit interviews to establish any themes.

10.4 The ICS OT rotational scheme has been launched to aid recruitment and retention within the Nottingham and Nottinghamshire ICS. It will be the first national OT rotational scheme to incorporate health and social care and the Trust is part of this scheme which is due to commence in October 2023.

10.5 The SLT ICS rotational scheme continues to be successful and fully recruited and SFHT has committed to being part of this scheme and has one band 5 post supported. There are currently no vacancies in the SLT service currently. The SLT Head and Neck band 8a specialist post continues to be provided by agency staffing whilst awaiting a surgical business case approval. (The service was previously provided by Nottingham University Hospitals).

10.6 Dietetics has recently recruited to a new band 7 post (funded by MacMillan) supporting patients' pre-diagnosis, and undergoing treatment, plus a band 7 young adult post in diabetes, funded by NHSE. A further 1.6 WTE vacancies remain in adult and paediatrics, and this has had a significant impact on the small team. There are current challenges in recruiting ward-based posts therefore the People Directorate and the Associate Chief AHP are supporting recruitment options and advertising. Maternity leave and delays in recruitment to cover posts in ICCU and Outpatients have resulted in a need for agency staff support whilst recruiting.

10.7 ODPs continue to be a workforce risk. Two international ODPs have now commenced in post but significant recruitment and retention issues remain. Current recruitment workstreams include international recruitment, rolling band 5 recruitment, apprenticeships, video promotion with Care4Notts, and an ongoing communication plan. Substantive staff are covering significant overtime due to a high agency workforce (with less experience) covering vacancies.

10.8 Orthotics are fully established with no vacancies.

10.9 Orthoptics have a new band 6 post in recruitment to support additional paediatric clinics. Areas of development and concern include SFHFT not meeting national standards in its provision for learning-disabled patients and there is no screening lead Orthoptist in the community or schools.

10.10 Against the national trend, Radiology has been successful in appointing a band 8a PACS manager and band 7 MRI team leader, due to start September 2023. A band 8a team leader has been appointed in reporting radiography and 8 band 5 newly qualified radiographers have been appointed and are expected to commence over the next few months. Ultrasound posts are in recruitment for the early accelerator Clinical Diagnostic Centre.

11.0 Apprenticeships

11.1 To support apprenticeships, AHP services need to utilise existing support workforce posts and do not have any supernumerary apprenticeship posts established. There are no support staff in dietetics, SLT, orthotics, or orthoptics so currently, apprenticeships are not able to be considered in these professions. This will have implications for implementing recommendations from the NHS Long Term Workforce Plan.

11.2 Radiology has recently appointed its first level 6 apprentice, who is due to commence in March 2024.

11.3 Two level 6 physiotherapy apprentices have successfully completed their training. They have both obtained band 5 physiotherapist posts at SFHFT.

11.4 In March 2023, therapy supported a further three level 6 physiotherapy apprentices and two OT level 6 apprentices.

11.5 NHSE has just confirmed they will fund NHS providers to support an additional level 3 and level 5 apprenticeship for AHP support workers (to be determined).

12.0 Advanced Practice

12.1 A Paramedic Advanced Clinical Practitioner (ACP) into critical care, and they are due to commence in post in November.

13.0 ICS AHP Faculty and AHP Cabinet

13.1 The Trust has hosted and supported an ICS AHP faculty Practice Learning Facilitator, supporting high-quality practice-based learning, and aligning placement capacity with predicted future workforce needs. In addition, ICS AHP project posts support NHSE workstreams including:

- Preceptorship and early careers,
- Support workforce,
- Orthotic and prosthetic pipeline

These workstreams are now complete (August 2023) with recommendations submitted to NHSE.

13.2 SFHFT will be the host organisation for NHSE/ICB AHP funds including:

- ICS AHP workforce, training, and education improvement funds,
- ICS AHP leadership scoping role (extended until December 2023),
- Student placement (quality and capacity) and preceptorship.

This will include secondment opportunities for AHPs to develop leadership and project manager skills, which include supporting and delivering these projects for 6 months. These roles are currently out for recruitment.

National Compliance

14.0 The Developing Workforce Safeguards published by NHSI in October 2018 were designed to help Trusts manage workforce planning and staff deployment. Trusts are now assessed for compliance with the triangulated approach to deciding staff requirements described within the NQB guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

14.1 The recommendation from the Chief Nurse and Director of Nursing is that there is good compliance with the Developing Workforce Safeguards (2018).

14.2 The Chief Nurse and Director of Nursing have confirmed they are satisfied that staffing is safe, effective, and sustainable.

14.3 Appendix two details the Trust's compliance with the nursing and midwifery element of the Developing Workforce Safeguards recommendations.

Recommendations

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

15.1 The Board of Directors is asked to note the ongoing recruitment plans to support each service.

15.2 The Board is asked to note the AHP staffing and risk position within the report whilst noting the ongoing recruitment plans to support services.

15.3 The Board of Directors is asked to note the compliance standards used in relation to SNCT, and the ongoing quality of data it provides to underpin the Trust establishment process.

15.4 The Board of Directors is asked to note the compliance standards relating to the Developing Workforce Safeguards and the Trust's conformity against these.

16.0 Appendix One: SNCT Compliance Standards 2023 Assessment

Criteria	Compliance	Evidence
Have you got a license to use SNCT from Imperial Innovations?	**Yes**	The licenses for all participating areas (Children and Young People, Adult in-patient Areas, Adult Assessment Areas, and The Emergency Department) were renewed in 2022.
Do you collect a minimum of 20 days of data twice a year for this?	**Yes**	Data analysis is held on a central database.
Are a maximum of 3 senior staff trained and are the levels of care recorded?	**Yes**	Held on a central database: - Due to staffing challenges and increased capacity areas, there are some areas that have requested 4 staff (all senior levels) to enable guaranteed continuity.
Is an established external validation of assessments in place?	**Yes**	Information is held on a central database – A member of the senior nursing team is allocated to ward areas and undertakes validation each week during the cycle. A core group of staff is maintained to ensure consistency. This is led by the Lead Nurse for Safe Staffing
Has inter-rater reliability assessment been carried out with these staff?	**Yes**	Information is held on a central database – A member of the senior nursing team is allocated to ward areas and undertakes validation each week during the cycle. A core group of staff is maintained to ensure consistency. This is led by the Lead Nurse for Safe Staffing
Is A&D data collected daily, reflecting the total care provided for the previous 24 hours as part of a bed-to-bed ward round review?	**Yes**	Held on central database.
Are enhanced observations (specials) patients reported separately?	**Yes**	Requests for additional staffing for enhanced patient observations are reported through Datix Reporting System.
Has the executive board agreed on the process for reviewing and responding to safe staffing recommendations?	**Yes**	SNCT, BirthRate Plus, and specialty guidance applied to support an evidence-based approach. A triangulation of nurse-sensitive indicators, benchmarking data, and rostering metrics.

17.0 Appendix Two: Compliance with Developing Workforce Safeguards, Nursing and Midwifery

17.1 The Workforce Safeguards published by NHSI in October 2018 are used to assess compliance with the Triangulated approach to staff planning in accordance with the NQB guidance.

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

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

Recommendation 7: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.	**Fully Compliant** Annual submission to NHS Improvement
Recommendation 8: They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly.	**Fully Compliant** Monthly Safe Staffing Reports for Nursing and Midwifery and staffing dashboard triangulates this information.
Recommendation 9: An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources. This must also be linked to professional judgement and outcomes.	**Fully Compliant.** SNCT is undertaken 2-3 times per year. An annual and bi-annual staffing report is presented to the Nursing, Midwifery, and Allied Health Professional Committee, People, Culture and Improvement Committee, and the Board of Directors.
Recommendation 10: There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool.	**Fully Compliant** SNCT and Birthrate Plus are in use as per license agreements across ED, adult in-patient areas, adult inpatient assessment areas, and children and young people inpatient areas.
Recommendation 11 & 12: As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review.	**Fully Compliant** Completed as part of the establishment setting process and monitored by the Nursing, Midwifery, and Allied Health Committee.
Recommendation 13 & 14: Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes. Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality.	**Fully Compliant** Daily staffing meetings. Staffing is also discussed at the flow and capacity meetings throughout the day. Staffing escalation process. Safe Staffing Standard Operating Procedure. Maternity Assurance Committee. Monthly Safe Staffing Report for Nursing and the Monthly Safe Staffing Report for Midwifery.

Board of Directors Meeting in Public

Subject:	Medical Workforce Update	**Date:**	2nd November 2023
Prepared By:	Rebecca Freeman, Head of Medical Workforce		
Approved By:	David Selwyn, Medical Director		
Presented By:	David Selwyn, Medical Director		

Purpose		
The purpose of this paper is to provide the Board of Directors Meeting with an update of Medical Workforce initiatives currently being taken forward for their assurance.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

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

Principal Risk		
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

Some of this information has been presented at People & Culture Committee

Acronyms

BMA – British Medical Association
O & G – Obstetrics & Gynaecology
A & E – Accident & Emergency

Executive Summary

The Board of Directors is asked to take assurance from the update that this paper provides and to note the following:

- the progress with job planning, appraisal, and revalidation
- the progress being made in relation to the doctors' mess project
- the progress being made to recruit to the vacancies and the support that is being provided by Remedium Partners and the continuing work focusing on the challenged services.
- the Medical Workforce Data, the increase in the numbers of doctors of all grades
- the challenges that have been experienced by the ongoing Industrial Action.

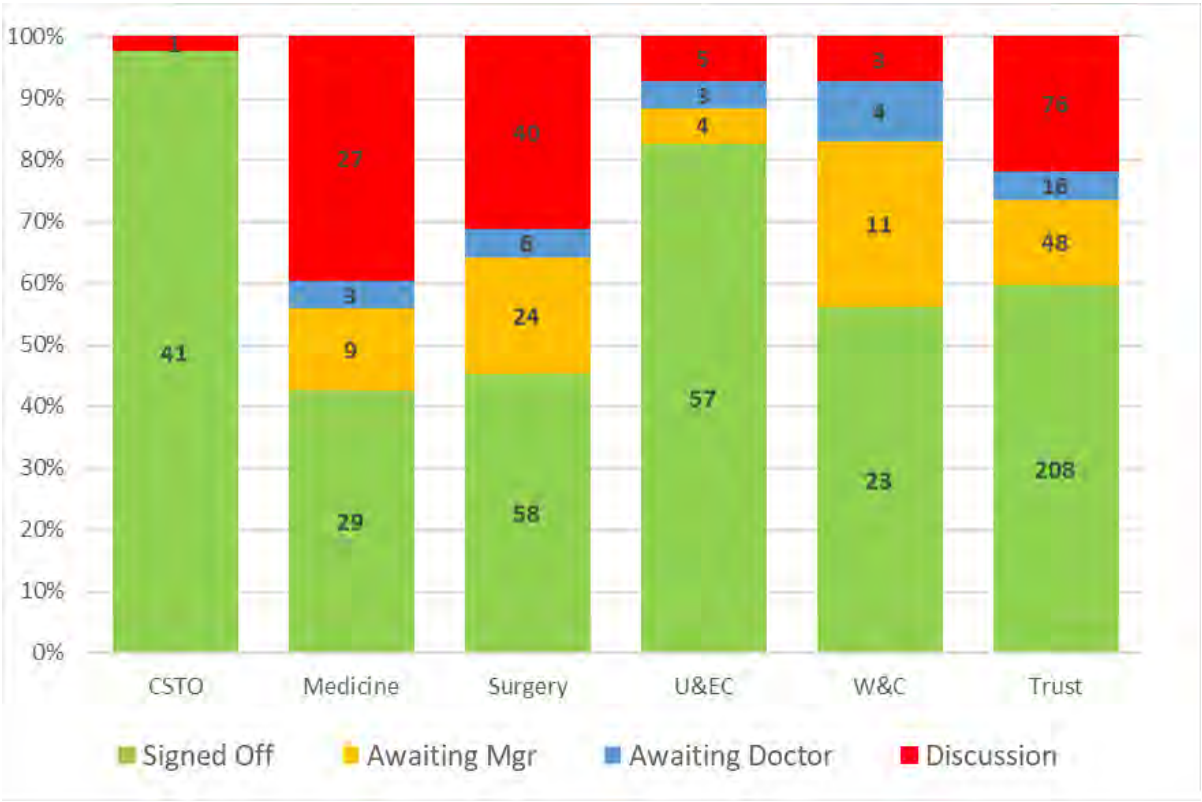
Looking after our People

Job Planning

The job planning round for 2023/24 continues to progress with a small number of areas continuing to require further support to obtain full sign-off of the job plans.

The chart below highlights the sign off stages for each division and at Trust level for this job planning round. Within the graph, there are also over 70 job plans that have changed for a variety of reasons since April that are shown as signed off within the chart. There are now 45 job plans ready for Trust Job Planning Panels which will be completed by the end of November for those remaining areas.

The Job Planning Toolkit is currently being revised and a draft document will be shared with the Joint Local Negotiating Committee at the next meeting in November. The new toolkit will be introduced for the next job planning round in 2024/25.

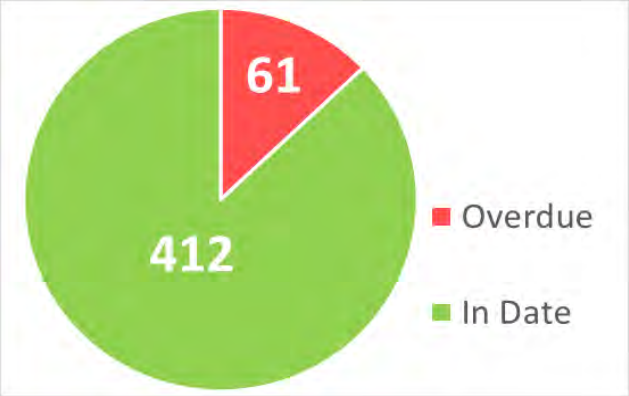


Appraisal

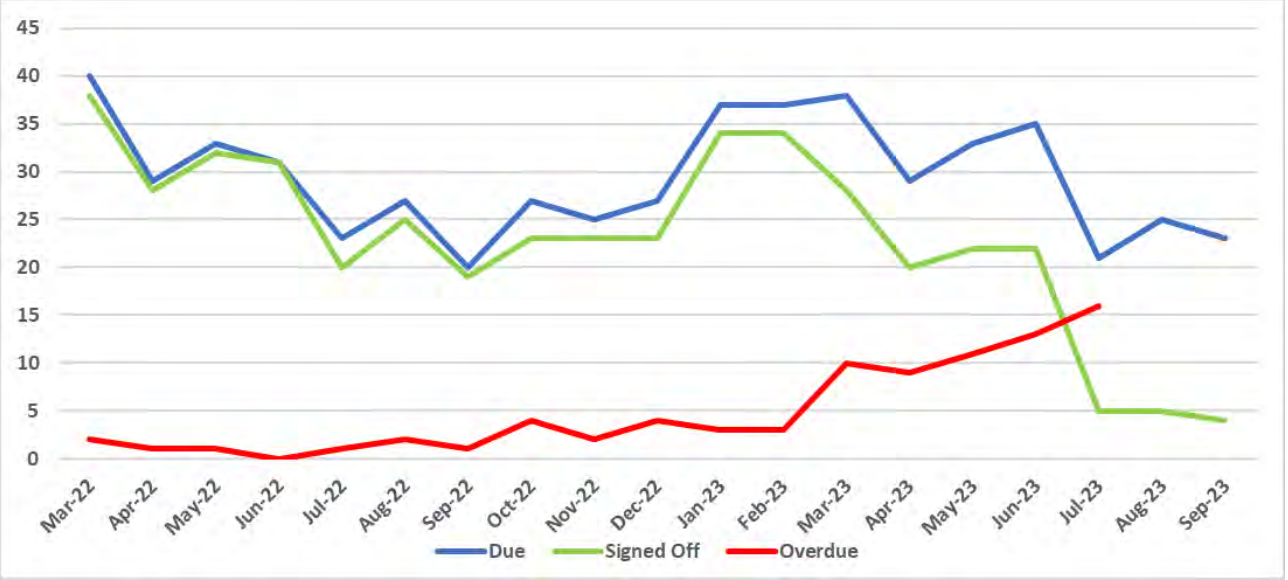
As we approach the winter period where the required numbers of appraisals due to be completed each month reduces, we will generally see the compliance rate increase. Industrial action has, however, had an impact on the completion rates which have reduced from 88% (July) to 87% (September).

The Trust currently has 26 appraisers undertaking appraisals; however, this number will reduce over the next three months with expected retirements, therefore the Associate Medical Director for Workforce will be asking for expressions of interest from colleagues wishing to become a Trust appraiser.

The pie chart shows the number of total appraisals that are compliant and those that are overdue. The Medical Workforce Manager and the Associate Medical Director for Workforce are working closely with colleagues that are still to complete their appraisal.



The graph below shows the gap between the due appraisals versus the completed appraisals.



Revalidation

There are 63 doctors due to revalidate between April 2023 and March 2024. To date 24 doctors have been revalidated and 7 have been deferred. The deferrals are due to several reasons, including not having patient feedback outputs and extended periods of leave being taken such as maternity leave.

Complaints made to the General Medical Council

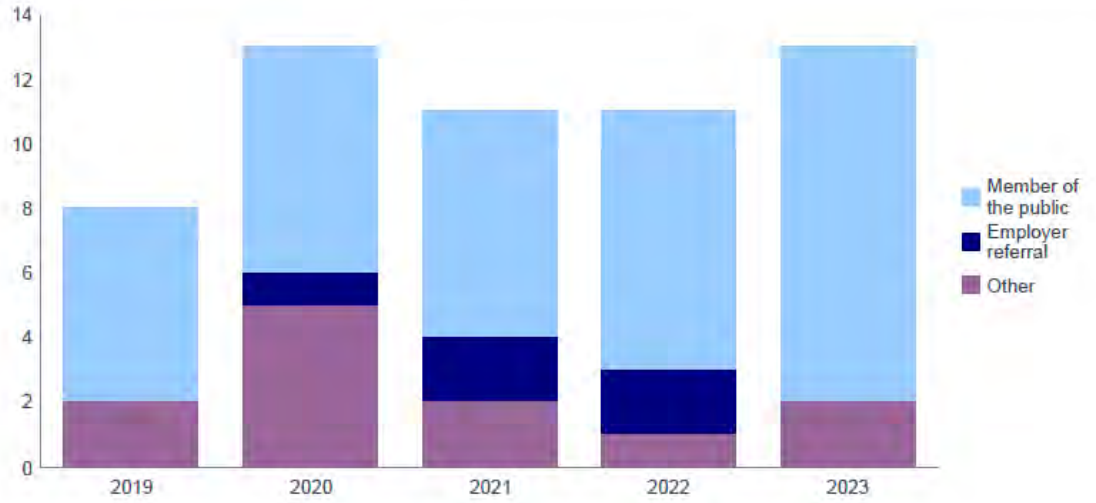
Complaints breakdown *(based on incident location by complaint received year)*

Showing data for your selected organisation

	2019	2020	2021	2022	2023
Complaints	**8**	**13**	**11**	**11**	**13**

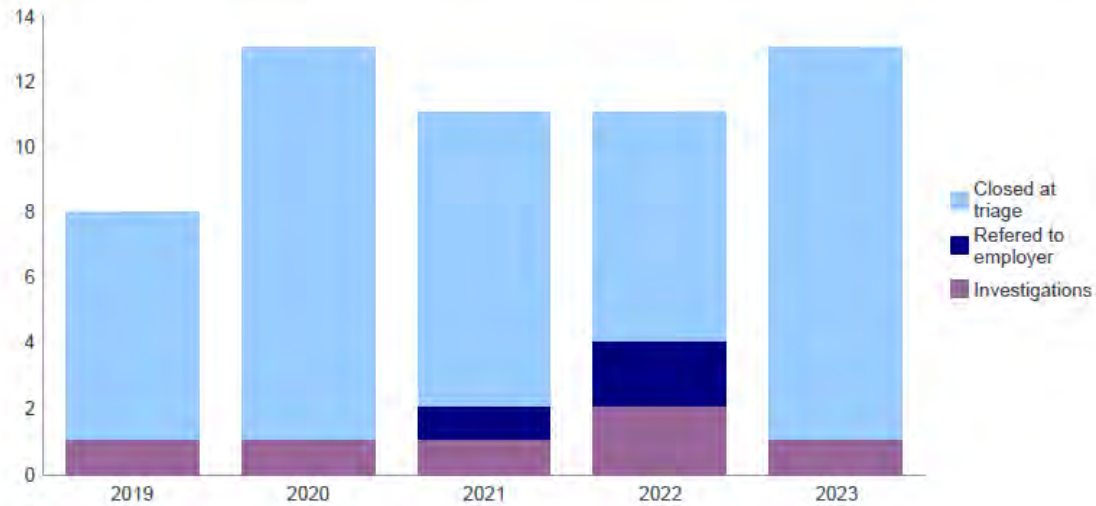
Complaint Source

Member of the public	6	7	7	8	11
Employer referral	0	1	2	2	0
Other	2	5	2	1	2



Complaint Outcome

Closed at triage	7	12	9	7	12
Refered to employer	0	0	1	2	0
Investigations	1	1	1	2	1



The Charts above show the number of complaints made to the GMC over the last 5 years and the outcome of those complaints. As can be seen the majority of complaints received during this five-year period have been closed at the triage stage.

In the last 12 months, the Trust has referred one doctor to the GMC, this has been a recent referral, therefore isn't included in the figures above. The referral was made as a result of the conduct of the doctor not being in line with the GMC Code of practice.

All of the referrals made by the Trust over the last five years have been as a result of conduct issues.

Industrial Action

Since the last medical workforce update, there have been a number of periods of industrial action taken by the Junior Doctors and Consultants. The most recent period of joint industrial action took place from 7am on Monday 2nd October until 7am on Thursday 5th October. During this period both Consultants and Junior doctors went on strike. "Christmas Day cover" was provided across both groups of staff. This cover mirrors the rotas that were worked on Christmas Day 2022 with the focus being to provide cover for the emergency pathway and the inpatients wards.

There were no picket lines at the Trust during the more recent periods of industrial action. The Trust has continued to support with a well-being offer including tea, coffee, cold drinks and snacks in the Deli Marche.

The duration and frequency of strike action has had a considerable impact on both staff and patients. Strike fatigue has been described by a number of those affected by the strike action. The work that has been involved in the preparation and the management of each strike is considerable and is having an impact on the timely delivery of other planned projects/tasks.

There are currently no further planned strikes and it is understood that talks are currently taking place between the Government and the BMA.

With regard to the SAS doctors the result of an indicative ballot found that 88% of respondents would be prepared to strike over pay and working conditions.

Junior Doctors Changeover

248 Junior Doctors joined the Trust in August. Overall, there has been an increase of 16 Foundation Programme Doctors and 12 St3+ trainees.

There were 14 posts that had not been filled by Trainees, however, 5 of the 14 have been filled by Senior/Clinical Fellows and one post was filled by a trainee in September, therefore leaving a total of 8 posts unfilled.

Clinical Fellows

A decision was taken to over recruit to the Clinical Fellows in preparation for August Changeover. This has enabled the unfilled training posts in Medicine to be filled. Due to the over recruitment, a number of doctors will be able to support during the winter period.

Recruitment to Clinical Fellows is continuing to ensure that there are doctors available when vacancies arise due to promotion within the Trust or Clinical Fellows accepting training posts.

The Senior Clinical Fellow Medicine rotation for Newark is due to commence within the next few weeks with several fellows now able to rotate to Newark, this will be a phased approach with support being provided by the Medical Lead Consultant at Newark.

Within Trauma & Orthopaedics all the Clinical Fellows required for Newark had been recruited, however, two of the Clinical Fellows have been promoted to Specialty Doctors within the specialty and NHSE have informed the service that the allocation of trainees due to commence in December will be reduced by two specialty trainees. One Clinical Fellow has resigned and a Clinical Fellow due to commence shortly is in Gaza. Therefore discussions are taking place to consider contingency plans for Newark.

Medical Workforce Data

The figures below show the increase in the Medical Workforce since September 2017 when the Medical Workforce team was established. Since 2017 this Workforce has grown by almost a third with the largest increases in Clinical Fellows, Consultants and Doctors in Training.

September 2017

448 TOTAL

- *174 Consultants/locum*
- *11 Associate Specialists*
- *49 Specialty Doctors*
- *35 Clinical Fellows*
- *174 Doctors in Training (DiTs)*

September 2023

715 TOTAL

- *229 Consultants/locum*
- *22 Specialists*
- *100 Specialty Doctors*
- *106 Clinical Fellows*
- *242 Doctors in Training (DiTs)*

Belonging in the NHS

Chief Registrar Post

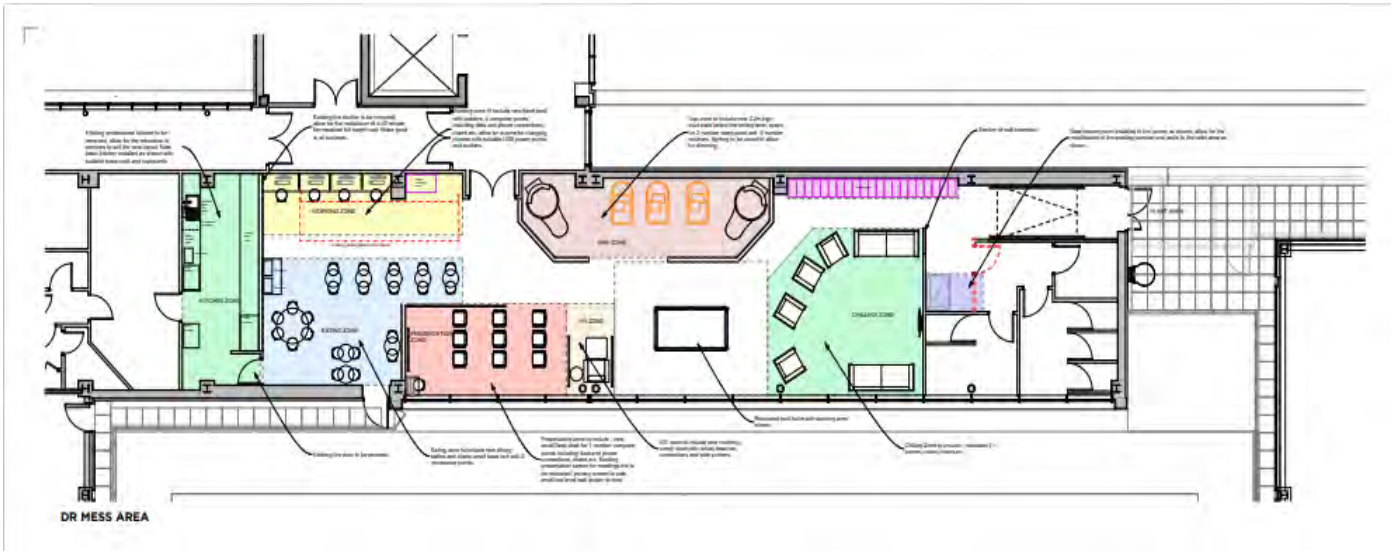
Dr Oliver Smith – a Specialty Registrar in Obstetrics & Gynaecology has been appointed as the Chief Registrar and he commenced in post on 2nd August. This programme provides a doctor in training with the opportunity to develop their leadership skills and to take forward quality improvement projects.

Oliver will be instrumental in providing a vital bridge between senior leaders and the trainee workforce which is extremely important during what is proving to be a particularly challenging time.

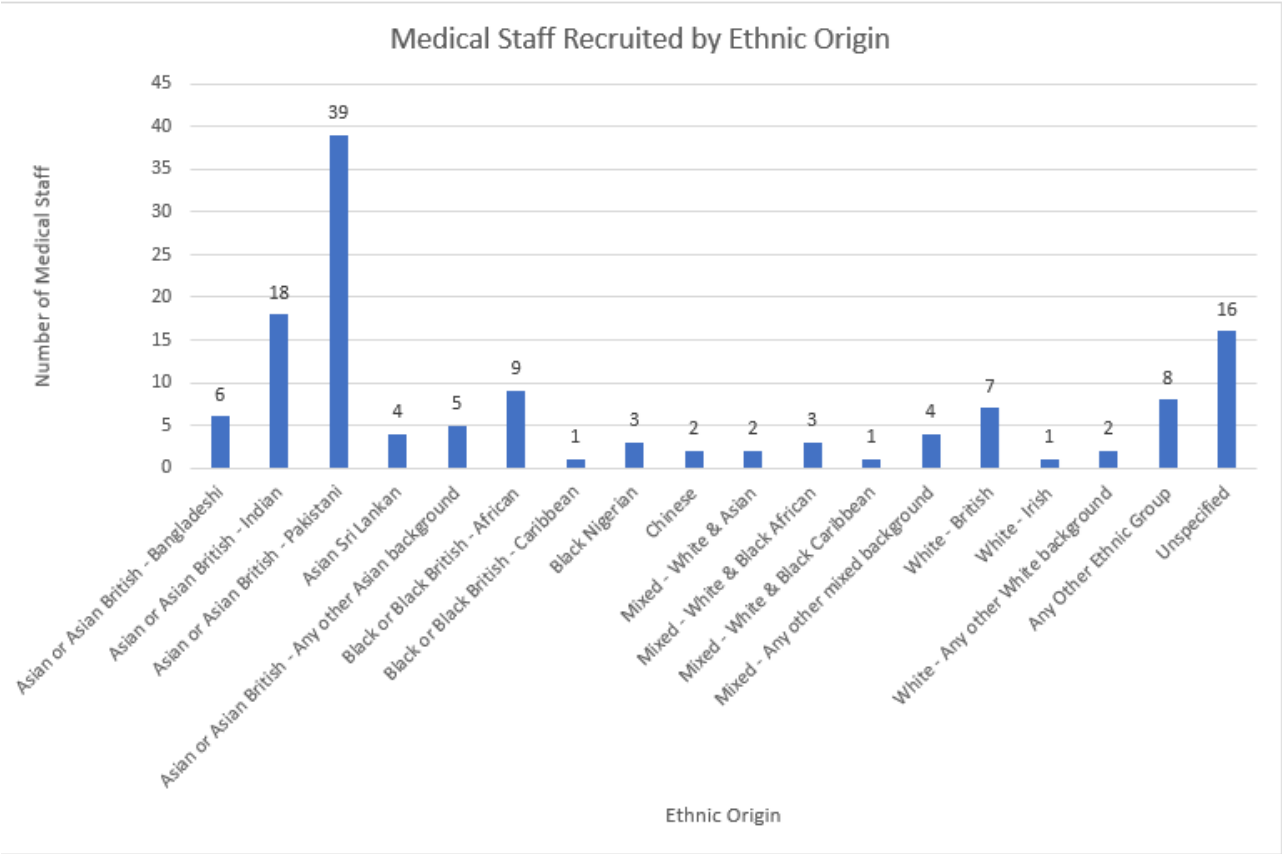
Doctors Mess

Work to relocate the Doctors mess from its current location to the Deli Marche is underway. Several meetings have been held with the members of the Task and Finish group and plans have been agreed.

It is anticipated that the work will be completed by December. The new facility will provide a wonderful space for the doctors, it has been said that Sherwood Forest Hospitals will have the best Doctors Mess in the region. There will be various areas that will include an eating area, a rest area, an area for the doctors to work and a changing area. There will be an official opening of the Mess on completion of the work. Whilst the plan has not been formally lockdown, this gives an indication of the development and improvements proposed.



Medical Staff Recruited by Ethnic Origin



The chart above shows the number of Medical Staff recruited by ethnic origin between 1st October 2022 and 31st September 2023. This information excludes trainees as they are allocated to the Trust as part of their rotational training programme.

Exit Interviews

1 October 2022 to 30 September 2023	
Doctors in Training (up to ST2 level) & Clinical Fellows	
Number of leavers	27
Number of leavers eligible for an exit interview (excluding flexible retirements and internal moves)	27
Number of exit interviews offered	24
Number of exit interviews conducted	19
% of eligible leavers offered exit interviews	89%
Themes > Great support > Rest facilities could be improved > Clinical Fellow Programme is really good for new doctors to the UK and very supportive > Experience across different medicine specialties is not consistent > Workload high, especially in Acute Medicine and ED	

Specialty Doctors, Doctors in Training (ST3+ level) and Senior Clinical Fellows	
Number of leavers	9

Number of leavers eligible for an exit interview (excluding flexible retirements)	9
Number of exit interviews offered	8
Number of exit interviews conducted	5
% of eligible leavers offered exit interviews	89%
Themes > Would benefit from more career development > More support required for doctors coming from abroad > Need more staff > Well supported	

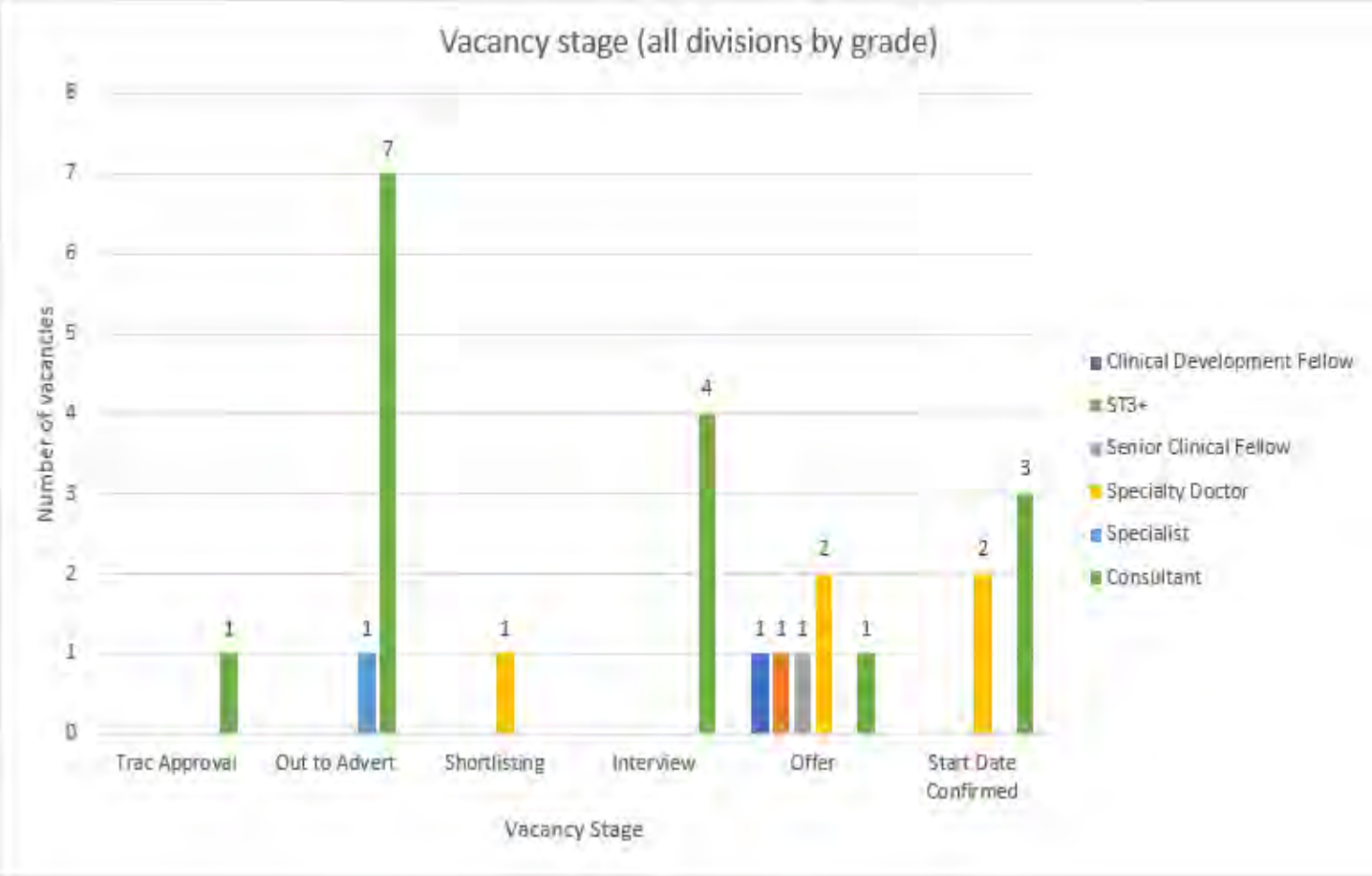
Specialists and Consultants	
Number of leavers	10
Number of leavers eligible for an exit interview (excluding flexible retirements)	10
Number of exit interviews offered	10
Number of exit interviews conducted	10
% of eligible leavers offered exit interviews	100%
Themes > Well supported > Need more staff > Enjoyed working at SFH	

Total number of leavers/exit interviews carried out	
Number of leavers	46
Number of leavers eligible for an exit interview	46
Number of exit interviews offered	42
Number of exit interviews conducted	34
% of eligible leavers offered exit interviews	91%
% of eligible leavers where exit interviews were conducted	74%

For all doctors that leave the Trust other than Trainees who rotate to other Trusts the Medical Workforce Team offer an exit interview. Where trainees leave the training programme, an exit interview is offered. The above shows the number of exit interviews conducted over the last year. The data obtained from the exit interviews is used to improve systems process and to understand what the Trust does well in the eyes of the employees. The summary above shows that 91 % of eligible leavers were offered exit interviews and 74% of interviews were conducted. 4 doctors were not offered exit interviews during the last year, the reasons for not offering interviews can be that the Medical Workforce Team may not have been informed that the individual was leaving, this will have been the situation in the case of the Specialty Doctor. With regard to the Clinical Fellows, these were leavers during July and unfortunately the Medical Workforce Team did not have the capacity to invite everyone to interview due to the work involved in the onboarding of the trainees and Clinical fellows commencing in August 2023 and unfortunately 3 doctors were missed. Although invited to have an exit interview and encouraged to attend, a small number do decline or just do not attend the interview. Themes from the interviews are raised with the relevant areas to enable any concerns to be addressed.

New Ways of Working

Vacancies



The graph above shows the current recruitment position for Medical vacancies across the Trust. As can be seen 6 offers of appointment have been made and start dates have been confirmed for five successful candidates, three of which are consultants.

The graph also shows that there are 12 consultant posts that are being actively recruited to.

Remedium Partners

Remedium Partners have been working closely with the Trust to support the recruitment of Medical posts. The contract with Remedium Partners is for a period of two years and they have been successful in recruiting to several posts as detailed below during the first year.

They have been particularly successful with the Specialty Doctor/Middle Grade posts. Support from Remedium will continue for a further 12 months.

Weekly vacancy progress meetings are held with Remedium and a meeting is planned to discuss future Medical workforce requirements for the Trust with the Chief Executive of Remedium Partners, the Associate Director of People Transformation and the Head of Medical Workforce. Recruitment includes;

1 Consultant in Rheumatology
1 Fixed term Acute Medicine Consultant
7 A&E Specialty Doctors
2 Anaesthetic Middle Grades
1 O&G Senior Clinical Fellow
1 Geriatrics Senior Clinical Fellow

Task and Finish Group progress

The Task and Finish Groups are progressing across the challenged services. With regard to Anaesthetics, interviews are scheduled to take place on 15th December with 2 candidates having been shortlisted for the substantive consultant post. There are 6 applicants for the locum consultant post which is currently being shortlisted and interviews are being arranged for mid November.

The consultant in Gastroenterology is currently being shortlisted and there are two applicants.

The Medical Division is currently reviewing the current configuration of the Consultant posts within Haematology.

The Head of Medical Workforce has made contact with Consultants at other neighbouring Trusts requesting support with recruitment to Stroke. Stroke is proving to be the most difficult specialty to recruit to.

The Medical Division has introduced a meeting that will be held on a monthly basis to review the progress of all of the individual task and finish groups within the Medical Division on an ongoing basis, providing additional support where required.

A monthly meeting is also being held with the Head of Medical Workforce and the Divisional General Manager and Clinical Chair in Surgery, Anaesthetics and Critical Care to review progress.

Conclusion & Recommendations

The Board of Directors is asked to take assurance from the update that this paper provides and is asked to:

- Note the progress being made in relation to the doctors mess project

- Note the progress being made to recruit to the vacancies and the support that is being provided by Remedium Partners and the continuing work focusing on the challenged services.

- Note the Medical Workforce data and particularly the increase in numbers of doctors of all grades
- Note the challenges that have been experienced by Industrial Action.

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
Domain 1 - Governance									
1	**Governance**	**Senior Leadership**	Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources and budget to direct the EPRR portfolio.	Evidence • Name and role of appointed individual • AEO responsibilities included in role/job description	Fully compliant				
2	**Governance**	**EPRR Policy Statement**	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	The policy should: • Have a review schedule and version control • Use unambiguous terminology • Identify those responsible for ensuring policies and arrangements are updated, distributed and regularly tested and exercised • Include references to other sources of information and supporting documentation. Evidence Up to date EPRR policy or statement of intent that includes: • Resourcing commitment • Access to funds • Commitment to Emergency Planning, Business Continuity, Training, Exercising etc.	Fully compliant				
3	**Governance**	**EPRR board reports**	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	These reports should be taken to a public board, and as a minimum, include an overview on: • training and exercises undertaken by the organisation • summary of any business continuity, critical incidents and major incidents experienced by the organisation • lessons identified and learning undertaken from incidents and exercises • the organisation's compliance position in relation to the latest NHS England EPRR assurance process. Evidence • Public Board meeting minutes • Evidence of presenting the results of the annual EPRR assurance process to the Public Board • For those organisations that do not have a public board, a public statement of readiness and preparedness activitites.	Fully compliant				
4	**Governance**	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	Fully compliant				
5	**Governance**	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	Fully compliant				

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6	**Governance**	**Continuous improvement**	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Fully compliant				
Domain 2 - Duty to risk assess									
7	**Duty to risk assess**	**Risk assessment**	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	Fully compliant				
8	**Duty to risk assess**	**Risk Management**	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	Evidence • EPRR risks are considered in the organisation's risk management policy • Reference to EPRR risk management in the organisation's EPRR policy document	Fully compliant				
Domain 3 - Duty to maintain Plans									
9	**Duty to maintain plans**	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	Partially compliant	MS to create sheet for recording all collaboration undertaken, and affix to updated plans	M Stone	End Dec 2023	
10	**Duty to maintain plans**	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	Arrangements should be: • current (reviewed in the last 12 months) • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Partially compliant	MS to update plan and remove references to out of date legislation and guidance	M Stone	End Dec 2023	
11	**Duty to maintain plans**	**Adverse Weather**	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	Fully compliant				

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12	**Duty to maintain plans**	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles. https://www.england.nhs.uk/coronavirus/secondary-care/infection-control/ppe/ffp3-fit-testing/ffp3-resilience-principles-in-acute-settings/	Partially compliant	IPC lead to create protoicol for managing HCID and append to Infectious Disease Outbreak Policy	Sally Palmer	End November 2023	
13	**Duty to maintain plans**	**New and emerging pandemics**	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
14	**Duty to maintain plans**	**Countermeasures**	In line with current guidance and legislation, the organisation has arrangements in place to support an incident requiring countermeasures or a mass countermeasure deployment	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Mass Countermeasure arrangements should include arrangements for administration, reception and distribution of mass prophylaxis and mass vaccination. There may be a requirement for Specialist providers, Community Service Providers, Mental Health and Primary Care services to develop or support Mass Countermeasure distribution arrangements. Organisations should have plans to support patients in their care during activation of mass countermeasure arrangements. Commissioners may be required to commission new services to	Partially compliant	MS to update plan and incorporate updated guidance .	M Stone	End Dec 2023	

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15	**Duty to maintain plans**	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	Partially compliant	Protocl for freeing up 124 surgical beds to be agreed with system partners and added to the IRP	M Stone	End Dec 2023	
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
18	**Duty to maintain plans**	**Protected individuals**	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs),high profile patients and visitors to the site.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Fully compliant				
Domain 4 - Command and control									

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20	**Command and control**	**On-call mechanism**	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	• Process explicitly described within the EPRR policy statement • On call Standards and expectations are set out • Add on call processes/handbook available to staff on call • Include 24 hour arrangements for alerting managers and other key staff. • CSUs where they are delivering OOHs business critical services for providers and commissioners	Fully compliant				
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency	Fully compliant				
Domain 5 - Training and exercising									
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	Evidence • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	Fully compliant				
23	**Training and exercising**	**EPRR exercising and testing programme**	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	Organisations should meet the following exercising and testing requirements: • a six-monthly communications test • annual table top exercise • live exercise at least once every three years • command post exercise every three years. The exercising programme must: • identify exercises relevant to local risks • meet the needs of the organisation type and stakeholders • ensure warning and informing arrangements are effective. Lessons identified must be captured, recorded and acted upon as part of continuous improvement. Evidence • Exercising Schedule which includes as a minimum one Business Continuity exercise • Post exercise reports and embedding learning	Fully compliant				
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	Evidence • Training records • Evidence of personal training and exercising portfolios for key staff	Fully compliant				

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25	**Training and exercising**	**Staff Awareness & Training**	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Fully compliant				
Domain 6 - Response									
26	**Response**	**Incident Co-ordination Centre (ICC)**	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Fully compliant				
27	**Response**	**Access to planning arrangements**	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	Planning arrangements are easily accessible - both electronically and local copies	Fully compliant				
28	**Response**	**Management of business continuity incidents**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	• Business Continuity Response plans • Arrangements in place that mitigate escalation to business continuity incident • Escalation processes	Fully compliant				
29	**Response**	**Decision Logging**	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	Fully compliant				
30	**Response**	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	• Documented processes for completing, quality assuring, signing off and submitting SitReps • Evidence of testing and exercising • The organisation has access to the standard SitRep Template	Partially compliant	Updated templaates to be added to IRP	M Stone	End Dec 2023	
31	**Response**	**Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'**	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				
32	**Response**	**Access to 'CBRN incident: Clinical Management and health protection'**	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	Guidance is available to appropriate staff either electronically or hard copies	Fully compliant				

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Domain 7 - Warning and informing									
33	**Warning and informing**	**Warning and informing**	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	Fully compliant				
34	**Warning and informing**	**Incident Communication Plan**	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	Fully compliant				
35	**Warning and informing**	**Communication with partners and stakeholders**	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident or business continuity incident.	• Established means of communicating with staff, at both short notice and for the duration of the incident, including out of hours communications • A developed list of contacts in partner organisations who are key to service delivery (local Council, LRF partners, neighbouring NHS organisations etc) and a means of warning and informing these organisations about an incident as well as sharing communications information with partner organisations to create consistent messages at a local, regional and national level. • A developed list of key local stakeholders (such as local elected officials, unions etc) and an established a process by which to brief local stakeholders during an incident • Appropriate channels for communicating with members of the public that can be used 24/7 if required • Identified sites within the organisation for displaying of important public information (such as main points of access) • Have in place a means of communicating with patients who have appointments booked or are receiving treatment. • Have in place a plan to communicate with inpatients and their families or care givers. • The organisation publicly states its readiness and preparedness activities in annual reports within the organisations own regulatory reporting requirements	Fully compliant				

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36	**Warning and informing**	**Media strategy**	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	Fully compliant				
Domain 8 - Cooperation									
37	**Cooperation**	**LHRP Engagement**	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	Fully compliant				
38	**Cooperation**	**LRF / BRF Engagement**	The organisation participates in, contributes to or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	• Minutes of meetings • A governance agreement is in place if the organisation is represented and feeds back across the system	Fully compliant				
39	**Cooperation**	**Mutual aid arrangements**	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating and maintaining mutual aid resources. These arrangements may include staff, equipment, services and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	• Detailed documentation on the process for requesting, receiving and managing mutual aid requests • Templates and other required documentation is available in ICC or as appendices to IRP • Signed mutual aid agreements where appropriate	Fully compliant				
40	**Cooperation**	**Arrangements for multi area response**	The organisation has arrangements in place to prepare for and respond to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	• Detailed documentation on the process for coordinating the response to incidents affecting two or more LHRPs • Where an organisation sits across boundaries the reporting route should be clearly identified and known to all	Not applicable				
41	**Cooperation**	**Health tripartite working**	Arrangements are in place defining how NHS England, the Department of Health and Social Care and UK Health Security Agency (UKHSA) will communicate and work together, including how information relating to national emergencies will be cascaded.	• Detailed documentation on the process for managing the national health aspects of an emergency	Not applicable				
42	**Cooperation**	**LHRP Secretariat**	The organisation has arrangements in place to ensure that the Local Health Resilience Partnership (LHRP) meets at least once every 6 months.	• LHRP terms of reference • Meeting minutes • Meeting agendas	Not applicable				
43	**Cooperation**	**Information sharing**	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	• Documented and signed information sharing protocol • Evidence relevant guidance has been considered, e.g. Freedom of Information Act 2000, General Data Protection Regulation 2016, Caldicott Principles, Safeguarding requirements and the Civil Contingencies Act 2004	Partially compliant	Informaton Sharing Protocol to be updated	J Widdoweson	End Dec 2023	
Domain 9 - Business Continuity									

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44	**Business Continuity**	**BC policy statement**	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	The organisation has in place a policy which includes intentions and direction as formally expressed by its top management. The BC Policy should: • Provide the strategic direction from which the business continuity programme is delivered. • Define the way in which the organisation will approach business continuity. • Show evidence of being supported, approved and owned by top management. • Be reflective of the organisation in terms of size, complexity and type of organisation. • Document any standards or guidelines that are used as a benchmark for the BC programme. • Consider short term and long term impacts on the organisation including climate change adaption planning	Fully compliant				
45	**Business Continuity**	**Business Continuity Management Systems (BCMS) scope and objectives**	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	BCMS should detail: • Scope e.g. key products and services within the scope and exclusions from the scope • Objectives of the system • The requirement to undertake BC e.g. Statutory, Regulatory and contractual duties • Specific roles within the BCMS including responsibilities, competencies and authorities. • The risk management processes for the organisation i.e. how risk will be assessed and documented (e.g. Risk Register), the acceptable level of risk and risk review and monitoring process • Resource requirements • Communications strategy with all staff to ensure they are aware of their roles • alignment to the organisations strategy, objectives, operating environment and approach to risk. • the outsourced activities and suppliers of products and suppliers. • how the understanding of BC will be increased in the organisation	Fully compliant				

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46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the BIA should be used throughout the organisation. • BIA method used should be robust enough to ensure the information is collected consistently and impartially.	Partially compliant	MS to continue to deve,op new BCMS systen in line with the NHSE BC Toolkit	M Stone	End June 2024	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations • Appendix/Appendices	Partially compliant	MS to continue to deve,op new BCMS systen in line with the NHSE BC Toolkit	M Stone	End June 2024	
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	Fully compliant				

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49	**Business Continuity**	**Data Protection and Security Toolkit**	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	Fully compliant				
50	**Business Continuity**	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	• Business continuity policy • BCMS • performance reporting • Board papers	Partially compliant	MS to continue to deve,op new BCMS systen in line with the NHSE BC Toolkit	M Stone	End June 2024	
51	**Business Continuity**	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	• process documented in EPRR policy/Business continuity policy or BCMS aligned to the audit programme for the organisation • Board papers • Audit reports • Remedial action plan that is agreed by top management. • An independent business continuity management audit report. • Internal audits should be undertaken as agreed by the organisation's audit planning schedule on a rolling cycle. • External audits should be undertaken in alignment with the organisations audit programme	Partially compliant	MS to continue to deve,op new BCMS systen in line with the NHSE BC Toolkit	M Stone	End June 2024	
52	**Business Continuity**	**BCMS continuous improvement process**	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review • Debriefs • After action reviews • Lessons learned through exercising or live incidents	Fully compliant				
53	**Business Continuity**	**Assurance of commissioned providers / suppliers BCPs**	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
54	**Business Continuity**	**Computer Aided Dispatch**	Manual distribution processes for Emergency Operations Centre / Computer Aided Dispatch systems are in place and have been fully tested annually, with learning identified, recorded and acted upon	• Exercising Schedule • Evidence of post exercise reports and embedding learning	Fully compliant				
Domain 10 - CBRN									
55	**Hazmat/CBRN**	**Governance**	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	Fully compliant				
56	**Hazmat/CBRN**	**Hazmat/CBRN risk assessments**	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	Fully compliant				
57	**Hazmat/CBRN**	**Specialist advice for Hazmat/CBRN exposure**	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	Staff are aware of the number / process to gain access to advice through appropriate planning arrangements. These should include ECOSA, TOXBASE, NPIS, UKHSA Arrangements should include how clinicians would access specialist clinical advice for the on-going treatment of a patient	Fully compliant				
58	**Hazmat/CBRN**	**Hazmat/CBRN planning arrangements**	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •Command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination processes for contaminated patients and fatalities in line with the latest guidance •Arrangements for staff decontamination and access to staff welfare •Business continuity plans that ensure the trust can continue to accept patients not related/affected by the Hazmat/CBRN incident, whilst simultaneously providing the decontamination capability, through designated clean entry routes	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
59	**Hazmat/CBRN**	**Decontamination capability availability 24 /7**	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also has plans, training and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	Documented roles for people forming the decontamination team - including Entry Control/Safety Officer Hazmat/CBRN trained staff are clearly identified on staff rotas and scheduling pro-actively considers sufficient cover for each shift Hazmat/CBRN trained staff working on shift are identified on shift board Collaboration with local NHS ambulance trust and local fire service - to ensure Hazmat/CBRN plans and procedures are consistent with local area plans Assessment of local area needs and resource	Fully compliant				
60	**Hazmat/CBRN**	**Equipment and supplies**	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
61	**Hazmat/CBRN**	**Equipment - Preventative Programme of Maintenance**	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity arrangements as a commissioned supplier/provider under Core Standard 53	Fully compliant				
62	**Hazmat/CBRN**	**Waste disposal arrangements**	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	Fully compliant				
63	**Hazmat/CBRN**	**Hazmat/CBRN training resource**	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	Fully compliant				

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
64	**Hazmat/CBRN**	**Staff training - recognition and decontamination**	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	Fully compliant				
65	**Hazmat/CBRN**	**PPE Access**	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS availbile for immediate deployment to safetly undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	Completed equipment inventories; including completion date Fit testing schedule and records should be maintained for all staff who may come into contact with confirmed respiratory contamination Emergency Departments at Acute Trusts are required to maintain 24 Operational PRPS	Fully compliant				
66	**Hazmat/CBRN**	**Exercising**	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	<u>Evidence</u> • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	Fully compliant				
67	**CBRN Support to acute Trusts**	**Capability**	NHS Ambulance Trusts must support designated Acute Trusts (hospitals) to maintain the following CBRN / Hazardous Materials (HazMat) tactical capabilities: • Provision of Initial Operational Response (IOR) for self presenting casualties at an Emergency Department including 'Remove, Remove, Remove' provisions. • PRPS wearers to be able to decontaminate CBRN/HazMat casualties. • 'PRPS' protective equipment and associated accessories. • Wet decontamination of casualties via Clinical Decontamination Units (CDU's), these may take the form of dedicated rooms or external structures but must have the capability to decontaminate both ambulant and non – ambulant casualties with warm water. • Clinical radiation monitoring equipment and capability. • Clinical care of casualties during the decontamination process. • Robust and effective arrangements to access	Evidence predominantly gained through assessment and verification of training syllabus (lesson plans, exercise programme), ensuring all key elements in "detail"" column are expressed in documentation. This will help determine: -If IOR training is being received and is based on self-presenters to ED. -Whether PRPS training is being delivered. -Training re: decontamination and clinical care of casualties. Specific plans, technical drawings, risk assessments, etc. that outline: -The acute Trusts' CDU capability and how it operates. -Its provision of clinical radiation monitoring. -How scientific advice is obtained (this could also be an interview question to relevant staff groups, e.g., ""what radiation monitoring equipment do you have, and where is it?" Any documentation provided as evidence must be in-date, and published (i.e., not draft) for it to be credible. Documented evidence of minimum completion of biannual reviews (e.g., via a collated list).	Not applicable			

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Self assessment RAG Red (not compliant) = Not compliant with the core standard. The organisation's work programme shows compliance will not be reached within the next 12 months. Amber (partially compliant) = Not compliant with core standard. However, the organisation's work programme demonstrates sufficient evidence of progress and an action plan to achieve full compliance within the next 12 months.	Action to be taken	Lead	Timescale	Comments
68	CBRN Support to acute Trusts	Capability Review	NHS Ambulance Trusts must undertake a review of the CBRN/HazMat capability in designated hospitals within their geographical region. Designated hospitals are those identified by NHS England as having a CBRN/HazMat decontamination capability attached to their Emergency Department and an allocation of the national PRPS stock.	Documented evidence of that review, including: -Dates of review. -What was reviewed. -Findings of the review. -Any associated actions. -Evidence of progress/close-out of actions.	Not applicable				

Meeting of The Board of Directors – 2nd November 2023
SFH – Emergency Preparedness Self- Assessment against 2023 NHSE Core Standards

Introduction

Annually the Trust must submit an assessment of its preparedness to respond to emergencies and major incidents to NHS England and Nottingham and Nottinghamshire Integrated Care Board (ICB).

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

The standards are split (this year) into 62 separate areas within ten sub-categories as follows (please see Appendix 1 for the complete document):

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

The organisation then rates whether it is fully, partially, or non-compliant against each of areas based on the evidence it can produce.

The assessment is then subject to a “confirm and challenge” session with NHS England’s (NHSE) Regional EPRR Team and the ICB.

For information the results since 2017 have been as follows:

2017 - Partially Compliant

2018 - Substantially Compliant

2019 - Substantially Compliant

2020 - Process was suspended

2021 - Substantially Compliant

2022 - Partially Compliant

2023 Submission

The four possible outcomes from the self-assessment, are based on the criteria depicted in Fig 1 follows:

Fig 1

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

The individual ratings are prepared by the Emergency Planning Officer and reviewed at the Trust's Resilience Assurance Committee, with oversight throughout the process from the Accountable Emergency Officer.

The following submission was agreed for this year:

Fig 2

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	6	5	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Cooperation	4	3	1	0
Business Continuity	10	6	4	0
CBRN	12	12	0	0
Total	62	51	11	0

There were no areas this year which were deemed non-compliant though there have been a number of areas that have moved from full to partial, which is mainly due some changes to the evidence requirements and perhaps a more rigorous approach adopted during the confirm and challenge process.

For context it is important to acknowledge that SFH is not an outlier and that most neighbouring Trusts in Nottingham, Derbyshire and South Yorkshire have had a similar experience.

The gaps in compliance were as follows:

CS9

Duty to maintain plans	**Collaborative planning**	Plans and arrangements have been developed in collaboration with relevant stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.

ACTION - EPO to create sheet for recording all collaborations with partner agencies and the feedback received. Record sheet will be appended to each plan going forward. For completion by end Dec 2023.

CS10

Duty to maintain plans	**Incident Response**	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.

ACTION - EPO to update IRP and remove references to out of date legislation and guidance and include EMAS in self-presentation process. For completion by end Dec 2023

CS12

Duty to maintain plans	**Infectious disease**	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases (HCID).

ACTION - IPC Lead to create protocol for managing HCID and append to the Infectious Disease Outbreak Policy. For completion by end December 2023

CS14

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

ACTION – EPO to amend plan in line with updated national guidance. For completion by end December 2023

CS15

Duty to maintain plans	**Mass Casualty**	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.

ACTION - EPO and COO to work with system partners to create protocol for freeing up surgical bed capacity. EPO to describe in plan the process for holding and treating Burns patients. For completion by end March 2024.

CS30

Response	**Situation Reports**	The organisation has processes in place for receiving, completing, authorising and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.

ACTION - EPO to add updated templates to the Incident Response Plan. For completion by end December 2023.

CS43

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

ACTION - IG Lead to ensure all Information Sharing Protocols are updated. For completion by end March 2024.

CS46

Business Continuity	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).

ACTION – EPO to continue to develop updated Business Continuity Management System (BCMS) in accordance with the NHSE Business Continuity Toolkit. For completion by end June 2024.

CS47

Business Continuity	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure

ACTION – EPO to continue to develop updated BCMS in accordance with the NHSE BC Toolkit. For completion by end June 2024.

CS50

Business Continuity	**BCMS monitoring and evaluation**	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.

ACTION – EPO to continue to develop updated BCMS in accordance with the NHSE BC Toolkit. For completion by end June 2024.

CS51

Business Continuity	**BC audit**	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.

ACTION – EPO to continue to develop updated BCMS in accordance with the NHSE BC Toolkit. For completion by end June 2024. Independent audit planned for 2024.

The foregoing means that the outcome of the process is that the Trust retains a **Partial Compliance** rating of 83%.

Confirmation Process

The submission was sent to NHSE's regional EPRR team on 25th August this year, with a copy to our ICB. Both attended a "confirm and challenge" session on 12th October with the Chief Operating Officer (the Trusts Accountable Emergency Officer) and the EPO. A further session was held on 20th October and a final position agreed.

Conclusions

The assurance process in 2023 has again been very challenging for emergency planning teams across the region in keeping up with changing national guidance and a sometimes inconsistent interpretation of evidence requirements.

It was acknowledged by our system partners that closer collaboration on the evidence requirements throughout the year will help create a better process and higher attainment levels going forward.

The Emergency Planning Team will endeavour to address the current gaps as a priority in the annual workplan.

Recommendation

The Board is requested to be **UPDATED** of the submission and the "Partial" compliance rating for 2023.

End

By Mark Stone
Emergency Planning & Business Continuity Officer
November 2023

Appendix 1

2023 FINAL Submission – EPRR Core Standards 2023.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Emergency Preparedness (EPRR) Core Standards Self-Assessment	**Date: 2nd November 2023**	
Prepared By:	Mark Stone – Emergency Planning Officer		
Approved By:	Rachel Eddie – Chief Operating Officer		
Presented By:	Mark Stone – Emergency Planning Officer		

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

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

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

Committees/groups where this item has been presented before

None

Acronyms

EPO – Emergency Planning Officer
EPRR – Emergency Preparedness, Resilience and Response
ICB – Integrated Care Board

Executive Summary

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

There are four possible outcomes from the process:

- Full Compliance
- Substantial Compliance
- Partial Compliance
- Non-Compliant

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

Our initial submission this year had only three areas of partial compliance which would have meant the Trust achieving a substantial rating.

However, the confirm and challenge sessions identified some gaps in our evidence and also some changes in the evidence requirement, meaning we attained a level of compliance of 83%. This equates to a partial rating.

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

Core Standards	Total standards applicable	Fully compliant	Partially compliant	Non-compliant
Governance	6	6	0	0
Duty to risk assess	2	2	0	0
Duty to maintain plans	11	6	5	0
Command and control	2	2	0	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	3	1	0
Business Continuity	10	6	4	0
CBRN	12	12	0	0
Total	62	51	11	0

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

In no area was the Trust non-compliant, and the EPO will work to address the partially compliant sections over the coming weeks and months.

Recommendation

The Board of Directors is asked to be **UPDATED** with the result of the 2023 Core Standards self-assessment process.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Business Continuity Policy	**Date: 2nd November 2023**	
Prepared By:	Mark Stone – Emergency Planning Officer		
Approved By:	Rachel Eddie – Chief Operating Officer		
Presented By:	Mark Stone – Emergency Planning Officer		
Purpose			
To seek APPROVAL for the updated policy, in line with established governance arrangements.		**Approval**	**x**
		Assurance	
		Update	
		Consider	

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

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

Committees/groups where this item has been presented before

Resilience Assurance Committee

Acronyms

Executive Summary

The Business Continuity Policy has undergone its annual review as part of the Trust annual self-assessment against the NHSE EPRR Core Standards.

The review has not resulted in any material changes to the document.

The Board is asked to **APPROVE** the updated version.

POLICY

Reference	BCP0519		
Approving Body	Resilience Assurance Committee		
Date Approved	19th January 2023		
For publication to external SFH website	**Positive confirmation received from the approving body that the content does not risk the safety of patients or the public:**		
	YES	**NO**	**N/A**
			x
Issue Date	January 2023		
Version	Version 7		
Summary of Changes from Previous Version	Updating to incorporate minor recommendations in EPRR Core Standards Self-Assessment 2023		
Supersedes	Version 6		
Document Category	Business Continuity		
Consultation Undertaken	Members of the Resilience Assurance Committee		
Date of Completion of Equality Impact Assessment	21st August 2023		
Date of Environmental Impact Assessment (if applicable)	21st August 2023		
Legal and/or Accreditation Implications	Civil Contingencies Act NHSE EPRR Framework Health and Social Care Act		
Target Audience	All service leads, Business Support Managers, Resilience Assurance Committee, EPRR leads		
Review Date	January 2024		
Sponsor (Position)	Chief Operating Officer		
Author (Position & Name)	Mark Stone - Emergency Planning & Business Continuity Officer		
Lead Division/ Directorate	Corporate		
Lead Specialty/ Service/ Department	Emergency Planning		
Position of Person able to provide Further Guidance/Information	Emergency Planning & Business Continuity Officer		

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
N/A	**N/A**

CONTENTS

APPENDICIES

1.0 INTRODUCTION

1.1 Sherwood Forest Hospitals NHS Foundation Trust is a Category 1 responder under the Civil Contingencies Act (2004) and as such, there is a requirement to create and publish Business Continuity Plans. To comply with the Act, the Trust needs to be able to demonstrate that an effective Business Continuity Management System (BCMS) has been established and embedded across the organisation. All plans are to be produced in accordance with the NHS England Business Continuity Toolkit, which aligns with the ISO22301 standard, and need to be exercised and reviewed regularly.

1.2 Business Continuity plans will therefore be created to define the response to all identified threats contained within the Nottingham and Nottinghamshire Local Resilience Forum Risk Register, the Trust's Risk Register and any potential threats identified at a service/ward level.

1.3 The plans will be designed initially to minimise and control harm arising from the identified risk. Thereafter, the plans will assist in the return to normal activity as soon as possible.

1.4 Where appropriate, the plans should be compiled in conjunction with partner agencies and other Category 1 responders.

1.5 The process of ensuring Business Continuity will include:

- Assessment of risk based on knowledge of the organisation and the likely threats to it,
- An assessment of the impact those risks would have should they materialise.
- Development of plans to mitigate the adverse effects of the identified risk,
- Training and Education of staff in the plans,
- Regular testing, maintenance and review of the plans.

1.6 This Policy should be read in conjunction with the following Trust Policies and Procedures;

- **Risk Management and Assurance Policy**
- **Emergency Planning Policy**
- **Incident Response Plan (2022)**
- **SFH Business Continuity Management Framework**

2.0 POLICY STATEMENT

2.1 The Trust will so far as is reasonably practicable fulfil its obligations under the Civil Contingencies Act (2004) to enable it to respond effectively to threats and disruptions to the organisations ability to perform its critical functions. The Trust will also comply as far as is reasonably practicable with all statutory requirements concerning Business Continuity.

2.2 The Trust will develop, maintain and test its Business Continuity plans to ensure they are fit for purpose and provide an effective response to any event, internal or external, which threatens the continuity of care offered by the Trust.

2.3 The Trust will ensure that appropriate structures and resources are made available to support the delivery and implementation of this policy.

2.4 The Trust is committed to ensuring that none of its policies, procedures and guidelines discriminate against individuals directly or indirectly on the basis of gender, colour, race, nationality, ethnic or national origin, age, sexual orientation, marital status, disability, religion, beliefs, political affiliation, trade union membership, and social and employment status.

2.5 An equality impact assessment (EIA) of this policy has been conducted by the author using the EIA tool developed by the diversity and inclusivity committee. The score of this policy when assessed by the tool on 21st August 2023 was rated as **'low'.**

3.0 SCOPE AND OBJECTIVES

Scope

3.1 This policy applies to all critical activities and functions carried out by Trust in delivery of its services.

3.2 The policy will apply to all sites which form part of Sherwood Forest Hospitals NHSFT

3.3 The policy will apply to Trust services and those provided by third parties across each site

3.4 The policy will not apply to any agency, or building located on any of its sites, which are not involved in the delivery of services which SFH is commissioned to deliver.

Objectives

3.5 To identify critical functions which if interrupted would have a detrimental effect on patient care, Trust reputation and Trust finances.

3.6 To provide a framework for critical functions to be able to continue during periods of disruption

3.6 To provide SFH staff with a structure for developing plans based on Business Impact Assessments and Risk Assessments.

3.7 To provide assurance to commissioners and external partners that SFH has robust planning arrangements in place in order to continue to deliver its key services during disruptions of any foreseeable nature.

4.0 RESOURCE REQUIREMENTS

4.1 The Trust is committed to ensuring sufficient resources in terms of staff and equipment are available in order to ensure its Business Continuity Management System is robust. The Accountable Emergency Officer will provide an annual update to the Board in this respect.

5.0 DEFINITIONS/ ABBREVIATIONS

5.1 **Trust**: *means the Sherwood Forest Hospitals NHS Foundation Trust.*

5.2 **Staff:** *means all employees of the trust including those managed by a third party organisation on behalf of the Trust.*

5.3 **Category 1 Responder:** as defined in the Civil Contingencies Act 2004**,** *Category 1 Responders are those emergency services which are likely to be at the forefront of the response, such as Health, Police and Fire and Rescue, Category 2 responders are those organisations whose role is likely to be supportive such as transport or the utilities.*

5.4 **Business Continuity Management System (BCMS)** is defined as "a *holistic management process that identifies potential threats to an organisation and the impacts to business operations those threats, if realised, might cause, and which provides a framework for building organisational resilience with the capability of an effective response that safeguards the interests of its key stakeholders, reputation, brand and value-creating activities".* *(The Business Continuity Institute (BCI) "Good Practice Guidelines, Global Edition, 2013)*

6.0 ROLES AND RESPONSIBILITIES

6.1 The Chief Executive

The Chief Executive has overall accountability for Business Continuity Management across the organisation including compliance and adherence to the requirements of legislation and guidance.

As part of this accountability the Chief Executive will;

- Implement effective management structures and processes to ensure compliance with this policy and delivery of the required compliance outputs
- Seek assurance that the organisation has robust Business Continuity plans in place (response and recovery) to respond to identified events which could impact on safety and service delivery
- Ensure that the Board of Directors are regularly updated with BCMS performance and matters of escalation.

Whilst the Chief Executive accepts overall accountability for the delivery of this policy, the operational day to day delivery has been delegated to the Chief Operating Officer, who will act on their behalf, as the Trust's Accountable Emergency Officer (AEO).

6.2 Chief Operating Officer (AEO and Chair of the Resilience Assurance Committee)

The Chief Operating Officer is responsible for the operational delivery of all roles and responsibilities delegated to him/her by the Chief Executive; and for the escalation of issues to the Trust Management Board that have arisen from the Resilience Assurance Committee. The COO will identify, monitor and arrange appropriate resources to ensure BCM procedures are embedded across the organisation.

The COO will also ensure partner agencies are updated with accurate and timely submission of situation reports, signed off by the appropriate Executive lead.

6.3 Risk Committee

The Risk Committee will;

- Ensure that the Business Continuity Management System is appropriately resourced, managed and embedded within the culture of the organisation
- Receive an annual Resilience Assurance Report detailing the organisation's preparedness in relation to all aspects of Emergency Planning and Business Continuity management and compliance.
- Act as a point of escalation for any risks or concerns regarding the BCMS and its implementation.

6.4 The Emergency Planning and Business Continuity Officer

The Emergency Planning and Business Continuity Officer is responsible for the day- to- day management of the Trust BCMS.

Specifically he/she will be responsible for:

- Ensuring all critical functions have a business continuity plan in place
- To ensure the plans are readily accessible by key stakeholders during any incident
- To arrange an annual programme of testing divisional and service-line BCP's
- Carry out training on producing BCP's
- Provide advice and guidance to service leads on all matters relating to the BCMS
- Report to the Risk Committee any concerns in respect of Trust preparedness for BC incidents.

6.5 Divisional Clinical Directors, Divisional General Managers, Corporate Service and Contracted Function Managers

Divisional Clinical Directors, Divisional General Managers, Heads of Nursing, Corporate and Contracted Service Managers will;

- nominate a senior manager to act as the Divisional Lead for Business Continuity who will lead and oversee the production and implementation of local business continuity plans across the Division.
- ensure that Business Continuity compliance is reviewed regularly at the Divisional Governance meetings to ensure agreed plans are being delivered and key performance indicators met.
- in March each year, produce and agree with the Resilience Working Group an annual work plan for the production, testing and review of Business Continuity plans. Delivery of these work plans will be monitored by the Resilience Working Group on a six-monthly basis.

6.6 Divisional Leads for Business Continuity

Divisional Leads for Business Continuity will;

- Oversees the production, maintenance and validation of their area plans and action cards in accordance with Trust policy and procedures
- attend the Trust's internally run training programme on developing Business Continuity Plans (BCM02) and subsequent refresher programme every 18 months.
- as part of the Business Continuity Plan; ensure each area undertakes a Business Impact Analysis and Risk Assessments in accordance with the guidance contained in this policy and the BCMS Framework Document.
- Identify local leads (where necessary) to assist in the development of local plans and action cards.
- Undertake an annual audit of the Divisions level of Business Continuity preparedness.
- Oversee and ensure staff participation in mandated training and exercises
- Oversee learning and improvement from Business Continuity exercises and incidents; and where relevant, reflect these in local plans and action cards
- Ensure that staff attend BC-related training, as set out in the Trust's Training Needs Analysis.

6.8 Heads of Service, Ward and Departmental Managers

Heads of Service, Ward and Departmental Managers will;

- Have input to the development of local Business Continuity plans and action cards
- Through documented local induction, ensure that all staff have a detailed working understanding of local business continuity plans and their individual / collective roles and responsibilities.
-

- Facilitate the Communications cascade to all staff.
- Be proactive in determining/assessing risks to business continuity and reflect these in local risk registers with appropriate escalation via the agreed risk management processes.
- Share and disseminate plans as part of local induction and ongoing staff update training.
- Complete training module (BCM02) and subsequent refresher programme every 18 months.

6.9 **All Staff**

Staff play a vital role in Business Continuity planning and delivery.

Staff should;

- be aware of your role in any Business Continuity incident / event.
- be familiar with local Business Continuity plans and action cards.
- report any deficiencies in Business Continuity provision or arrangements.
- attend Business Continuity training provided commensurate with their role.
- participate fully in all Business Continuity exercises and provide feedback.
- have an understanding of local Business Continuity risks and the actions in place to mitigate them.
- undertake Business Continuity Training (BCM02) on an annual basis.

6.9.1 **Resilience Assurance Committee (RAC)**

The Resilience Assurance Committee will oversee all aspects of BCM and compliance. In fulfilling this function, the RAC will;

- provide a focus for all Business Continuity activity
- produce an annual work plan detailing all Business Continuity activity.
- develop key performance indicators based upon the agreed terms of reference and work plan outputs
- receive the annual Divisional Business Continuity work plans to ensure quality and consistency with Policy and the RAC work plan outcomes
- oversee training delivery plans
- oversee and respond to changes in the Nottingham and Nottinghamshire Local Resilience Forum Risk Register and Trust Risk Register relating to BC requirements.
- escalate concerns to appropriate Committees for review and action in accordance with Trust Risk Management Policies and processes.
- complete annual training to support their role on an annual basis.

7.0 APPROVAL

7.1 This Policy has been presented to the following:

Contributors	Method	Timings (Dates Consulted)
NHS England (Midlands Region)	E-mail to NHS Futures	September 2023
Resilience Assurance Committee	Face to Face/Email	January 2023

8.0 DOCUMENT REQUIREMENTS

The aim of this Policy is to provide an understanding of the requirements of Business Continuity planning to enable the production of robust plans detailing the actions and arrangements that will be taken to mitigate the impact of foreseeable events that services could adversely impact on service provision.

The process centres around; a business impact assessment which identifies both generic and service specific impacts which need to be prioritised and encapsulated in local and trust wide business continuity plans.

8.1 Trust Wide Business Continuity Plans

Support functions such as Estates and Facilities, HR and ICT, in addition to their own local Business Continuity Plans, will also develop Trust wide infrastructure focused business continuity response plans to ensure prompt correction of the fault / issue in order for the Trust to revert back to normal operation. These plans will often run in addition to Local Business Continuity Plans across the Trust.

8.2 Local Business Continuity Plans

Through the Business Impact Assessment areas will identify a range of hazards where loss of provision will / could adversely impact on service delivery.

Whilst the list of hazards will vary from one location to the next; they will fall into either generic (common to all areas) or specific to the location (service specific hazards).

8.2.1 Generic Hazards

- Loss of Utilities (including water, electricity, gas and drainage)
- Infrastructure failures (Heating, Cooling, Fire Alarm, Access Control)
- ICT System (Network, Information systems, Telecommunications failure / loss)
- Delay or Loss in Internal / External Supply (for example, food, consumables, linen)

- Staff Shortage (Influenza, Infectious Disease, Industrial action)
- Evacuation (triggered by Fire, Bomb Threat, Flood etc.)

8.2.2 **Service Specific Hazards**

- Ventilation Failure in critical areas (Theatres, Pharmacy Production etc.)
- Spillage / exposure from hazardous substances / materials
- Radiation sources
- Service critical equipment failures (e.g. CT Scanner, ophthalmic microscopes,
- Scavenging, piped medical gases and suction etc.)

8.3 **Stakeholders**

8.3.1 There are multiple stakeholders with an interest in the BCMS, these include:

a) All patients of SFH
b) SFH staff and contractors
c) Divisional/Service leads
d) Board of Directors
e) Integrated Care Boards
f) NHS England/NHS Improvement

8.4 **Guidance**

The quality of your local plans will be dependent on care taken to identify potential threats and hazards (Business Impact Assessment).

This requires a full and accurate assessment of activities as it will enable services to assess the threats and therefore form the basis of a risk assessment and mitigating contingency plans.

The Forms provided in **Appendix 1** (Business Impact Analysis and Risk Assessment) will help to identify the critical services and equipment required to deliver the described activity.

A generic list is pre-populated on the forms, however there may be additional ones that apply only to specific areas. These must all be included on the form.

The form format will then guide you through the factors that need to be considered or described in order to define the impacts of the specified loss in provision / failure. It is important to consider the unusual causes and consequential causes: for example, loss of mains failure may be mitigated by local equipment UPS (Uninterruptable Power Supply) but this will only last so long and is dependent on battery condition, servicing and maintenance. The effectiveness of the UPS as a control needs to be considered along with an understanding of what you would do if this failed.

The thought process applied needs to consider all impacts. For example; whilst the obvious impact of a telecommunications failure will cause the loss of telephone communications it could

also impact on the bleep system as well as the ability to communicate with other areas. Different options to cope with the failure may be needed to be considered for each consequence.

Once you have considered and documented the failures that could impact on service delivery (generic and specific) the next step is to identify the alternative actions or systems available to eliminate or mitigate the loss, and assessing their potential effectiveness in maintaining the ability to deliver critical functions

For each consequence, it is necessary to develop ways of minimising the impact. They may appear to be simple, but they must also be robust and practical. For example, if heating is lost in winter, the use of extra blankets may form part of your mitigation. It is important however to check and confirm that the source for extra blankets is identified and is sufficient to ensure supply (particularly as other areas may also be seeking extra blankets as well).

It is also important that roles are identified to undertake these actions. For example, it may be appropriate for a Ward Manager to ring the Duty Nurse Manager and ask for assistance, but a porter could go for blankets.

Once the potential mitigations are defined the formwork provides a second risk assessment score to assess the impact of the mitigation (controls) on the initial risk score. This will indicate if the proposed mitigations effectively manage the risk.

If the assessment is that the risk is satisfactorily contained, you should proceed to the next stage, if not, you should look for further ways to reduce it, seeking advice if required.

Completion of the form confirms that all risks described are managed / mitigated. If identified risks cannot be satisfactorily mitigated, they should be reported and escalated through the Trust Risk Management process and structures.

The completed forms will provide a series of Action Cards / Contingency Plans to respond to specific risks at local level. It is important that the contents of the action cards are shared with staff at local induction and ongoing in service training and exercises.

These separate action cards plans should also be drawn together into the Department/Ward/Service Area Business Continuity Plan. The Plan should follow a prescribed standard format, provided in **Appendix 5**. This is to ensure that local procedures within the Trust take a consistent approach.

Once in place and trained it is important the plans remain fit for purpose, are updated and quality assured. This will be undertaken through learning from enaction of plans in real incidents and/or as part of incident drills and exercises. The Resilience Assurance Committee will ensure that incidents which result in plans being activated are reviewed and lessons learned and reflected in plan amendments and improvements. The process of BC planning is cyclic with each cycle leading to ongoing refinement and improvement of plans based on experience and learning.

Plans should always be reviewed;

a) annually
b) if a new piece of equipment, or system is introduced
c) if an incident has occurred
d) following an exercise

9.0 MONITORING COMPLIANCE AND EFFECTIVENESS

The Trust will monitor its Business Continuity Management System through a set of key performance Indicators, listed below:

1) The service has a detailed BC Plan to take account of (as a minimum) the effect the following likely disruptions would have on its critical functions;
    a) Utilities Failure
    b) Denial of Access
    c) Staff Shortage
    d) Infrastructure Failure
    e) Supply Chain Disruption
    f) IT Failure
    g) Service Specific Breakdown
2) The plans been tested
3) The plans are up to date
4) The plans have been written by a staff member trained on producing BC Plans

The review and testing schedule will be captured in and monitored through the Resilience Assurance Committee Annual Workplan

Minimum Requirement to be Monitored **(WHAT – element of compliance or effectiveness within the document will be monitored)**	**Responsible Individual** **(WHO – is going to monitor this element)**	**Process for Monitoring e.g. Audit** **(HOW – will this element be monitored (method used))**	**Frequency of Monitoring** **(WHEN – will this element be monitored (frequency/ how often))**	**Responsible Individual or Committee/ Group for Review of Results** **(WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)**
Effectiveness of the Procedure	Author, Ward / Service, Dept Managers, EPO, Resilience Assurance Committee	Formal Review on a 3 year basis in line with Trust Risk Assessment and in line with local / national guidance	Every three years	Author, Resilience Assurance Committee, Board Risk Committee

Minimum Requirement to be Monitored (WHAT – element of compliance or effectiveness within the document will be monitored)	Responsible Individual (WHO – is going to monitor this element)	Process for Monitoring e.g. Audit (HOW – will this element be monitored (method used))	Frequency of Monitoring (WHEN – will this element be monitored (frequency/ how often))	Responsible Individual or Committee/ Group for Review of Results (WHERE – Which individual/ committee or group will this be reported to, in what format (eg verbal, formal report etc) and by who)
Compliance with the KPI's	Author, Ward / Service, Dept Managers, EPO, Resilience Assurance Committee	Bi-monthly RAC meetings update. Six monthly RAC performance report to the Risk Committee. Annual EPRR Core Standards Self- Assessment	6-monthly and annually	EPO RAC Risk Committee External Partners (ICB/NHSE&I) 360 Assurance
Monitoring Incidents and Learning	EPO, Resilience Assurance Committee, Board Risk Committee	Activity within the Incident De-brief process and in line with the Procedure	Every three years, or after any serious incidents	Emergency Planning Officer reporting to the Resilience Assurance Committee

10.0 TRAINING AND IMPLEMENTATION

10.1 Annual training in Business Continuity Planning and Business Continuity Plan review will be provided by the Emergency Planning Department which all nominated BC Leads and appropriate staff will be required to attend.

10.2 A record of any training will be made and sent to the Training, Education & Development Department.

10.3 Following approval, this Policy will be made available to:

- All Trust staff via the Intranet.
- Emailed to RAC members.
- Emailed to Departmental Managers.
- Emailed Managers of Contracted Functions.

11.0 IMPACT ASSESSMENTS

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix One
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix Two

12.0 EVIDENCE BASE (Relevant Legislation/ National Guidance) AND RELATED SFHFT DOCUMENTS

12.1 Civil Contingencies Act
12.2 Health and Social Care Act
12.3 NHS England EPRR Framework Guidance

Related SFHFT Documents:
12.4 SFH – Incident Response Plan
12.5 SFH – Corporate Risk Register
12.6 Risk Management and Assurance Policy

13.0 APPENDICES

13.1 APPENDIX ONE - EQUALITY IMPACT ASSESSMENT FORM (EQIA)
13.2 APPENDIX TWO – ENVIRONMENTAL IMPACT ASSESSMENT
13.3 APPENDIX THREE – BUSINESS IMPACT ANALYSIS
13.4 APPENDIX FOUR - RISK ASSESSMENT TEMPLATE
13.5 APPENDIX FIVE - RISK ASSESSMENT MATRIX
13.6 APPRNDIX SIX - BUSINESS CONTINUITY ACTION CARD

13. 1 APPENDICES

APPENDIX ONE – EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Emergency Planning Policy			
New or existing service/policy/procedure: Existing Policy			
Date of Assessment: 21st August 2023			
For the service/policy/procedure and its implementation answer the questions a – c below against each characteristic (if relevant consider breaking the policy or implementation down into areas)			
Protected Characteristic	**a) Using data and supporting information, what issues, needs or barriers could the protected characteristic groups' experience? For example, are there any known health inequality or access issues to consider?**	**b) What is already in place in the policy or its implementation to address any inequalities or barriers to access including under representation at clinics, screening?**	**c) Please state any barriers that still need to be addressed and any proposed actions to eliminate inequality**
The area of policy or its implementation being assessed:			
Race and Ethnicity	None	Not Applicable	None
Gender	None	Not Applicable	None
Age	None	Not Applicable	None
Religion	None	Not Applicable	None
Disability	None	Not Applicable	None
Sexuality	None	Not Applicable	None
Pregnancy and Maternity	None	Not Applicable	None

Gender Reassignment	None	Not Applicable	None
Marriage and Civil Partnership	None	Not Applicable	None
Socio-Economic Factors (i.e. living in a poorer neighbourhood / social deprivation)	None	Not Applicable	None

What consultation with protected characteristic groups including patient groups have you carried out?
None

What data or information did you use in support of this EqIA?
None

As far as you are aware are there any Human Rights issues be taken into account such as arising from surveys, questionnaires, comments, concerns, complaints or compliments?
No

Level of impact

From the information provided above and following EQIA guidance document Guidance on how to complete an EIA (click here), please indicate the perceived level of impact:

Low Level of Impact

Name of Responsible Person undertaking this assessment:
Mark Stone – Emergency Planning Officer

Signature:
Mark Stone

Date:
21st August 2023

13.2 APPENDIX TWO – ENVIRONMENTAL IMPACT ASSESSMENT

The purpose of an environmental impact assessment is to identify the environmental impact, assess the significance of the consequences and, if required, reduce and mitigate the effect by either, a) amend the policy b) implement mitigating actions.

Area of impact	Environmental Risk/Impacts to consider	Yes/No	Action Taken (where necessary)
Waste and materials	• Is the policy encouraging using more materials/supplies? • Is the policy likely to increase the waste produced? • Does the policy fail to utilise opportunities for introduction/replacement of materials that can be recycled?	No	N/A
Soil/Land	• Is the policy likely to promote the use of substances dangerous to the land if released? (e.g. lubricants, liquid chemicals) • Does the policy fail to consider the need to provide adequate containment for these substances? (For example bunded containers, etc.)	No	N/A
Water	• Is the policy likely to result in an increase of water usage? (estimate quantities) • Is the policy likely to result in water being polluted? (e.g. dangerous chemicals being introduced in the water) • Does the policy fail to include a mitigating procedure? (e.g. modify procedure to prevent water from being polluted; polluted water containment for adequate disposal)	No	N/A
Air	• Is the policy likely to result in the introduction of procedures and equipment with resulting emissions to air? (For example use of a furnaces; combustion of fuels, emission or particles to the atmosphere, etc.) • Does the policy fail to include a procedure to mitigate the effects? • Does the policy fail to require compliance with the limits of emission imposed by the relevant regulations?	No	N/A

Energy	• Does the policy result in an increase in energy consumption levels in the Trust? (estimate quantities)	No	N/A
Nuisances	• Would the policy result in the creation of nuisances such as noise or odour (for staff, patients, visitors, neighbours and other relevant stakeholders)?	No	N/A

13.3 Appendix 3: - Business Impact Analysis

"BIA is a process for identifying, quantifying and qualifying the impacts on a service of a loss, interruption or disruption of a critical activity and it's supporting processes and resources". **(BS NHS 25999-2:2009, Part 2: Specification)**

Business Impact Analysis (BIAV.FEB16)

Name of Division/Service:	**Enter Name of Division/Service Area**

Operational Requirements	Hazards Identified	Internal/External Dependencies	Minimum Service Requirements	Time period for recovery of minimal service requirements	Recovery Resources Required	Maximum Tolerable Period of Disruption before normal service must be resumed	Recovery Time Objective
What critical functions are associated with service delivery.	*What could go wrong with critical functions*	*This column should identify all internal and/or external dependencies relevant to the Critical Risk Activity. This should also include suppliers and outsourced partners.*	*This column should identify the minimum service level at which each Critical Risk Activity needs to be performed.*	*This column should identify the time period for the recovery of the minimum service requirements identified in the previous column.*	*This column should detail the estimated resources required to assist with the recovery of the Critical Risk Activity.*	*This column should detail the maximum tolerable period of disruption for each Critical Risk Activity by identifying the maximum time period after the start of a disruption within which each activity needs to be resumed*	*This column should identify the time period for the resumption of Critical Risk Activities within their maximum tolerable period of disruption*
Utilities	Loss of water, electricity gas or drainage.						
Infrastructure	Loss of heating, cooling, fire alarm, access control.						
ICT Systems	Loss of network, information systems, telecoms.						

Supply Chain	Delay or loss of internal/external supply (e.g. food, consumables, linen)						
Staff	Loss of staff due to infectious disease, industrial action, adverse weather.						
Evacuation	Loss of access to work area as a result of Fire, Flood, Bomb Threat						
Service Specific Requirement	Detailed as required						

13.4 Appendix Four : - Risk Assessment Template

Risk Area		Critical Impact of Hazard	Initial RAG Assessment			Risk Reduction Contingencies / Controls already in place	Actions	Timescale	Revised RAG Assessment		
Operational Requirements	Hazards Identified		Impact	Likelihood	Score				Impact	Likelihood	Score
Utilities	Loss of water, electricity gas or drainage										
Infrastructure	Loss of heating, cooling, fire alarm, access control										
ICT Systems	Loss of Network information systems, telecoms.										
Supply Chain	Delay loss of internal/external supply (e.g. Food, consumables, linen)										
Staff	Loss of staff due to infectious disease, industrial action, adverse weather.										

Evacuation	Loss of access to work area as a result of Fire, Flood, Bomb Threat.										
Service Specific Requirements	Detailed as required.										

13.5 Appendix Five:- Risk Assessment Matrix

In terms of assessing business continuity risks, the Trust has adopted the following risk categorisations:

	Consequence score and descriptor with examples				
Risk type	**Very low 1**	**Low 2**	**Moderate 3**	**High 4**	**Very high 5**
a. Patient harm or **b. Staff harm** or **c. Public harm**	Minimal physical or psychological harm, not requiring any clinical intervention. e.g.: Discomfort.	Minor, short term injury or illness, requiring non-urgent clinical intervention (e.g. extra observations, minor treatment or first aid). e.g.: Bruise, graze, small laceration, sprain. Grade 1 pressure ulcer. Temporary stress / anxiety. Intolerance to medication.	Significant but not permanent injury or illness, requiring urgent or on-going clinical intervention. e.g.: Substantial laceration / severe sprain / fracture / dislocation / concussion. Sustained stress / anxiety / depression / emotional exhaustion. Grade 2 or 3 pressure ulcer. Healthcare associated infection (HCAI). Noticeable adverse reaction to medication. RIDDOR reportable incident.	Significant long-term or permanent harm, requiring urgent and on-going clinical intervention, or the death of an individual. e.g.: Loss of a limb Permanent disability. Severe, long-term mental illness. Grade 4 pressure ulcer. Long-term HCAI. Retained instruments after surgery. Severe allergic reaction to medication.	Multiple fatal injuries or terminal illnesses. e.g.: Major incident casualties. Multiple missed cancer diagnoses. Outbreak of serious infectious disease.
d. Services	Disruption to peripheral aspects of service affecting one or more services.	Disruption to essential aspects of service affecting one or more services.	Temporary service closure affecting one or more services or disruption to services across multiple divisions.	Extended service closure affecting one or more services or prolonged disruption to services across multiple divisions.	Hospital or site closure.
e. Reputation / regulatory action	Minimal reduction in public, commissioner and regulator confidence. e.g.: Concerns expressed / small number of complaints received.	Minor, short term reduction in public, commissioner and regulator confidence. e.g.: Recommendations for improvement. Multiple complaints received.	Significant, medium term reduction in public, commissioner and regulator confidence. e.g.: Improvement / warning notice. Independent review. Adverse local media coverage.	Widespread reduction in public, commissioner and regulator confidence. e.g.: Prohibition notice. Sustained adverse national / social media coverage.	Widespread loss of public, commissioner and regulator confidence. e.g.: Special Administration. Suspension of CQC Registration. Parliamentary intervention.
f. Finances	Adverse financial impact but not sufficient to affect the achievement annual budgets for any service / department.	Adverse financial impact affecting the ability of one or more services / departments to operate within their budget in the current year.	Adverse financial impact affecting the ability of one or more divisions to achieve their financial control total in the current year.	Adverse financial impact affecting the ability of the organisation to achieve its financial control total in the current year.	Adverse financial impact affecting the long-term financial sustainability of the organisation.

	Likelihood score and descriptor with examples				
	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 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%)

Risk scoring matrix						
Consequence	**5**	**5**	**10**	**15**	**20**	**25**
	4	**4**	**8**	**12**	**16**	**20**
	3	**3**	**6**	**9**	**12**	**15**
	2	**2**	**4**	**6**	**8**	**10**
	1	**1**	**2**	**3**	**4**	**5**
		1	**2**	**3**	**4**	**5**
		Likelihood				

Rating	Very low (1-3)	Low (4-6)	Medium (8-9)	High (10-12)	Significant (15-25)

Healthier Communities, Outstanding Care

13. 6 Appendix Six:-

Business Continuity Action Card

Standardised Trust Format for All BCM Action Cards

Title:
Department / Area Covered:
Specific Failure / Hazard: ***to which the action card relates***
Date of Issue:
Review Date;
Author:

- Risk
  Describe the risk.
  Will the risk impact on patient safety, staff safety, damage to the infrastructure or disruption to day to day operations?

- Communication
  Who to contact in the event of the risk materializing? i.e. Switchboard, Security, Estates etc. (Remember to include specific contact numbers)

- Action
  What action do we need to take to affect an appropriate response? E.g. Evacuate the building, turn off all power, shut windows and doors, responsibility for patient safety etc.
  Ensure that your actions follow a logical sequence and that they do not compromise the Health, Safety & Welfare of staff, patients and visitors.

- Recovery
  Describe the actions that would be undertaken to ensure that normal services are resumed as soon as possible. These actions will differ for every type of situation e.g. if there has been major structural damage then it would be unlikely that you would be able to go back into the building. An incident debrief should also be included as part of these actions.

Notes:

When the plan has been finalised and agreed by the Division / Corporate function to which it relates, an educational plan should be agreed. This will vary from area to area but should ensure that all members of staff are familiar with its contents.

Thereafter, the plan should be tested, and lessons learned used to refine and improve the plan. The Action Card must include Author and Review details.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:** 2 November 2023	
Prepared By:	Graham Ward – FC Chair		
Approved By:			
Presented By:	Graham Ward – FC Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee meeting of 31st October 2023.		**Assurance**	Significant

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Month 6 Finance Report – The deficit year to date is £10.5M (£2.5M adverse to plan). Recognised that plan is going to be increasingly difficult to deliver. Key issues include the running costs of keeping the escalation beds open, ERF, agency spend and having adequate cash resources. • Financial Recovery Plan – This is progressing through the 'cabinet' and the four workstreams. A detailed review of the developing plans will be reported back to the Committee at the November and December meetings. These in turn will feed into a reforecasting exercise ahead of Month 9 reporting. • ICB Month 6 Finance Report – The deficit year to date is £79.3M, £61.8M adverse to plan.	• Procurement Forecast – forthcoming IT system and rent/lease procurement and extensions to be brought to future Committee meetings 12 months ahead of any renewal / procurement with a recommended strategy for approval.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• NHIS Performance – Financially NHIS is on track to break-even. Slight deterioration in average speed to answer and calls abandoned was noted. Further work on improving access and content for self-service is being looked at to help address. • Trust Strategic Priorities Update – progress on the financial strategy, Green Plan and Multi-Year Capital Plan were noted and RAG ratings of Green (no change) for the financial strategy and Capital Plan agreed. Slight worsening of the RAG rating due to limited resource availability	• Imaging Transformation Additional Asset Bid – this business case was approved subject to assurances that the capital cost will be fully funded and that the revenue implications at least show a break-even position. Agreed that final approval would be 'virtual' if assurance can be given. • Byron Court Lease – business case for lease extension for 5 years with a 3 year break clause approved. • BAF – Current risk ratings of 20 for PR 4 (failure to achieve the Trust's

noted for the Green Plan. • Procurement Forecast – assurance gained on the steps being taken to have increased and earlier control of future IT system procurements (including contract 'roll-overs'). Approach agreed to be extended to rent/lease agreements. • PFI Governance – assurance gained on the progress being made on the Operational Development Plan and the Settlement Agreement. Further work to be undertaken on future contract management (both by CNH and the Trust), this is a key focus area raised by DHSC. It was noted that the settlement paper is expected to be tabled at the next Committee meeting.	financial strategy) and 9 for PR 8 (failure to deliver sustainable reductions in the Trust's impact on climate change) were reviewed and discussed with agreement that the current risk score for PR 4 was appropriate and a request that PR 8 be further reviewed due to the concerns over future resource availability. • Terms of Reference and Work Plan – changes were approved.
Comments on Effectiveness of the Meeting	
• All papers were of a high quality and clear which helped the meeting run smoothly and promoted good constructive challenge and discussion.	

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NHS Sherwood Forest Hospitals NHS Foundation Trust

Charitable Funds Committee Highlight Report to Board of Directors

Subject:	Charitable Funds Committee Update	**Date:**	24th October 2023
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Andrew Rose-Britton, Committee Chair		
Presented By:	Andrew Rose-Britton, Committee Chair		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Delays with progress to create 16 enhanced End of life rooms. Final costings and designs awaited. Full attendance required at the reconvened meeting on 13th November 2023 to ensure progress is not further delayed.	• A Working Part to be set up to review patients' access to TV and its cost to ensure this is equitable across all SFH hospital sites • New charitable funds enquiry form developed and process for monthly review of requests by Charitable Funds Request Group. • Option appraisal to be brought to the next meeting about the extension of the use of the Harlequin CRM software from Finance Department to include Charitable Funds staff as well. • Review of the process for the use of charitable funds for individuals' training to ensure it is consistent and fair, including the provision for re-payment, where appropriate. • A Review of Charitable Funds investments to take place prior to the expiry of the current Investment Managers' contract
Positive Assurances to Provide	**Decisions Made**
• Introduction of new form for applications for charitable funds • NHS Together Stage 3 recovery grant of £43K awarded for OPUS music therapy and outdoor seating for the KTC courtyard • Agreement to recommend the Annual Report and Accounts and Letter of Representation to the Corporate Trustee for approval.	• NEW Policy approvals: External Fundraising on Hospital Site Policy and Charity Privacy Policy • ANNUAL Policy updates and approvals: Charitable Funds Investment and Reserves Policy, Charitable Funds Expenditure Policy, Charitable Funds Governance Framework Policy, Charitable Funds Income Policy, Charitable Funds Legal and Statutory Information Policy and Charitable Funds Administration, Investments and Reporting Policy.

	• Approval of updated Committee Terms of Reference • Two funding request Approvals: Recliner chairs for Maternity Overnight stays and an Ultrasound scanner for Ward 22 (noting VAT Exemptions to be utilised where applicable)
Comments on Effectiveness of the Meeting	
Meeting under its new chairship went well with good discussion.	