MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 7th November 2024**
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	**Patient Story - Positive Experience Through Surgery** Hannah West, Ward Sister- Day case	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 3rd October 2024** To be agreed as an accurate record	Agree	Enclosure 5
6.	09:25	**Action Tracker**	Update	Enclosure 6
7.	09:30	**Acting Chair's Report**	Assurance	Enclosure 7
8.	09:35	**Acting Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	09:45	**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 9.1
10.	10:00	**Strategic Objective 3 - Improve health and wellbeing within our communities.** • **Flu Annual Checklist** Report of the Director of People	Assurance	Enclosure 10.1

	Time	Item	Status	Paper
	Operational			
11.	10:15	**Emergency Preparedness Overview** Report of the Emergency Planning & Business Continuity Officer • **Business Continuity Policy** • **Emergency Planning Policy** • **Business Continuity Audit report**	Assurance Assurance Assurance Assurance	Enclosure 11 Enclosure 11.1 Enclosure 11.2 Enclosure 11.3
	BREAK			
12.	10:35	**Half Year Review and Integrated Performance Report (IPR)** Report of the Executive Team	Approve	Enclosure 12
13.	11:45	**Trust Strategy Progress** Report of the Acting Director of Strategy and Partnerships	Assurance	Enclosure 13
	Governance			
14.	12:00	**Board Assurance Framework** Report of the Chief Executive	Approve	Enclosure 14
15.	12:05	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (last meeting) • Partnerships and Communities Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance	 Enclosure 15.1 Enclosure 15.2 Enclosure 15.3
16.	12:15	**Outstanding Service – The Library Service – Supporting Down's syndrome children and their families**	Assurance	Presentation
17.	12:20	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
18.	12:25	**Any Other Business**		
19.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **5th December 2024, Boardroom, King's Mill Hospital**		
20.		**Chair Declares the Meeting Closed**		
21.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

Board of Directors Information Library Documents

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

Enc 10.1	• **Nursing and Midwifery Safer Staffing Reports**
Enc 12	• **Operational Plan Submission**
Enc 13	• **Significant Risks Summary**
Enc 15.1	• **Finance Committee – previous minutes**
Enc 15.2	• **Partnerships and Communities Committee – previous minutes**
Enc 15.3	• **Charitable Funds Committee – previous minutes**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 3rd October 2024, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Acting Chair	GW
	Steve Banks	Non-Executive Director	SB
	Barbara Brady	Non-Executive Director	BB
	Aly Rashid	Non-Executive Director	AR
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Manjeet Gill	Non-Executive Director	MG
	David Selwyn	Acting Chief Executive	DS
	Claire Hinchley	Acting Director of Strategy and Partnerships	CH
	Richard Mills	Chief Financial Officer	RM
	Simon Roe	Acting Medical Director	SR
	Rob Simcox	Director of People	RS
	Rachel Eddie	Chief Operating Officer	RE
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Phil Bolton	Chief Nurse	PB
In Attendance:	Paula Shore	Director of Midwifery	PS
	Kerry Bosworth	Freedom to Speak Up Guardian	KB
	Terri-Ann Sewell	Research Operations Manager	TS
	Mark Bolton	Associate Director of Operational Performance	MB
	Sue Bradshaw	Minutes	
	Jess Baxter	Producer for MS Teams Public Broadcast	
	Rich Brown	Head of Communications	
Observers:	Peter Saunders	Grant Thornton	
	Jamie Waller	Notts TV	
	Nik Mahida		
	Debbie Kearsley	Deputy Director of People	
	Ian Holden	Public Governor	
	Jane Hildreth	Communications Specialist	
	Andrew Fooks	360 Assurance	
	0 members of the public		
Apologies:	Andy Haynes	Specialist Advisor to the Board	AH

Item No.	Item	Action	Date
24/305	**WELCOME**		
1 min	The meeting being quorate, GW 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 the public were able to submit questions via the live Q&A function.		
24/306	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
24/307	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Andy Haynes, Specialist Advisor to the Board.		
24/308	**STAFF STORY – EXPECT RESPECT, NOT ABUSE - THE IMPORTANCE OF REPORTING STAFF ABUSE**		
16 mins	RS introduced the Staff Story, which highlighted the importance of staff reporting abuse experienced from patients and families. GW expressed the view this is a very powerful video, which highlights the strong message from staff that incidents which are reported on Datix need to be followed up and appropriate support is put in place. It is important the Trust does everything possible to support staff and reduce incidents of abuse as far as possible. AR advised the Quality Committee receives reports about incidents and the actions being taken to support staff. Incidents can stay with members of staff for a long time, with some staff reporting flashbacks for up to 12 months after the incident. It is important to recognise the impact on staff and provide ongoing psychological care. RS advised the Trust has an action plan to tackle violence and aggression, which is reviewed by the People Committee. Consideration will be given to how this can be made visible to all members of the Board of Directors. **Action** • **Consider how the visibility of the ongoing work in relation to the Violence and Aggression Action plan can be increased for the Board of Directors.** BB noted the need for timely support for staff. PB felt there is a need to be more consistent in relation to how incidents are managed, noting there are good examples of immediate wraparound support being provided, together with ongoing care, but	**RS**	**07/11/24**

	there are also examples of where people do not get that response. It is important not to normalise violence and aggression. Datix is a good mechanism to capture the learning from incidents, but this does not provide the timely support. There is a lot of work to do in this area. PB felt there are more incidents happening than are reported. Therefore, it is important to report all incidents, even if this is done retrospectively. DS expressed thanks to the colleagues involved in making the video for sharing their stories, acknowledging this would not have been an easy experience for them. When incidents are highlighted, the Trust does take action, noting there are occasions when letters are sent to patients and/or family members, describing the behaviours experienced by staff and the actions which will be taken if the behaviours continue. NM sought clarification how the actions being taken, and the timeframes, will be monitored. RS advised the Violence and Aggression plan is reported to the People Committee. It was noted currently all actions are on track.		
24/309	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 5th September 2024, the Board of Directors APPROVED the minutes as a true and accurate record.		
24/310	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/039, 24/108.2, 24/221.1, 24/252.1, 24/280 and 24/285 were complete and could be removed from the action tracker.		
24/311	**ACTING CHAIR'S REPORT**		
10 mins	GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chair's perspective, highlighting Staff Excellence Awards, Annual General Meeting (AGM), work of the Trust's volunteers and system level discussions. DS expressed thanks to the Communications Team for their work in organising the Staff Excellence Awards. DS advised Wes Streeting, Secretary of State for Health and Social Care, has expressed the need to cure the nation's 'sick society'. DS advised this will require behavioural changes to make the difference. BB advised the prevention agenda needs to be owned not just by the NHS, but by cross government. DS advised prevention is a long-term gain, but the current financial climate is very short-term. There is a need to recognise that conflict. MG felt the focus should be at the system level in terms of strategy, noting the need to look beyond prevention at the areas of focus and how actions will be delivered.		

	CH advised the mid-Nottinghamshire Place-Based Partnership have looked at different stages of life and have workstreams related to living well and aging well. SFHFT is looking to strengthen its action plan within those areas, working with local authority leads. Reports on progress will be provided to the Partnerships and Communities Committee. The Trust's strategic plan in relation to prevention will be incorporated into the session being planned for the Board of Directors development session in November 2024. The Board of Directors were ASSURED by the report.		
24/312	**ACTING CHIEF EXECUTIVE'S REPORT**		
20 mins	DS presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chief Executive's perspective, highlighting operational pressures, performance update, settlement of the dispute between the British Medical Association (BMA) and the government, noting the term 'junior doctors' has been replaced by 'resident doctors', implementation of Martha's Rule, flu vaccination campaign, health and social care workers eligibility for Autumn Covid vaccine, partnership update, Step Into the NHS event, Community Diagnostic Centre (CDC) update, Thirlwall Inquiry response and review of Board Assurance Framework (BAF) Principal Risk (PR) 7, Major disruptive incident. BB referenced previous challenges in terms of identifying staff uptake of the Covid vaccination and queried if this will be an ongoing challenge, noting the Trust no longer hosts a vaccination centre. DS advised national data in relation to the uptake of the vaccination will be available, but this will not be available at an organisational level. The Integrated Care Board (ICB) are doing some work in terms of targeting age groups, etc., but not specifically for Trust colleagues. RS advised the Trust will attempt to access as much data as possible, noting data in relation to uptake across Nottinghamshire should be available. BB noted the work underway with Newark and Sherwood District Council to improve hospital discharge, and work previously started with Mansfield District Council, and queried if there are any plans to work with Ashfield District Council. CH advised the recent workshop was targeted to Newark and Sherwood as it was felt the Trust did not have the right relationship with them. A further workshop is planned with Ashfield District Council. AR expressed the view there are a number of 'revolving door' patients, i.e. patients who present at ED multiple times, and queried if the Trust has identified this group of patients with general practice and taken action to reduce the number of attends. DS advised the Trust has information in relation to frequent attenders. SR advised the Integrated Care System (ICS) are starting to do some work in relation to the group of patients who are at high risk of admission due to their condition deteriorating, particularly in relation to respiratory and heart failure. A primary and secondary care interface group has been established and the first project, which is nearing a		

	conclusion, was to identify ways of working better with primary care colleagues. The group is now considering the next steps, which includes developing discussions in relation to what action can be taken in relation to respiratory and heart failure. DS acknowledged the concept of being more proactive in working with primary care to identify patients likely to present multiple times to ED, in order to trigger a preventative review with primary care. This is an idea which is worthy of discussion with the Primary Care Network (PCN). PB advised the Trust has a high-volume service user team, which has a caseload of patients they work with, linking in with GPs, partners, etc. in terms of admission avoidance. SR noted there are pockets of work underway and there is a need to consider how this is pulled together. MG referenced some work undertaken approximately two years ago in relation to waiting times and the impact of inequalities and queried if it was possible for an update to be provided. RE advised an update would be prepared and reported to the Quality Committee. **Action** • **Update on waiting times and the impact of inequalities to be provided to the Quality Committee.** The Board of Directors were ASSURED by the report.	**RE**	**05/12/24**
24/313	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
8 mins	PS joined the meeting. **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting the service user voice, Safety Champion walkarounds, challenges faced in relation to estates within the community, recruitment to the role of Intrapartum Matron and Matron within the Children and Young People Service, Maternity and Neonatal Delivery Plan, NHS Resolution (NHSR) Maternity Incentive Scheme Year 6, Care Quality Commission (CQC) peer review and NHS England (NHSE) Perinatal Culture and Leadership Programme. AR sought clarification in relation to how progress against the ten safety actions will be monitored. PS advised the Perinatal Assurance Committee manages the evidence, actions, etc. and reports to the Quality Committee. The Board of Directors were ASSURED by the report.		

	Maternity Perinatal Quality Surveillance PB presented the report, highlighting the deep dive into third and fourth degree tears, low number of complaints, emerging workforce challenges and deep dive into elective caesarean sections. It was noted there were four suspensions of service in August 2024. The Board of Directors were ASSURED by the report.		
19 mins	**Learning from Deaths** SR presented the report, highlighting Summary Hospital-Level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), changes to the Dr Foster model (HSMR+), ongoing work in relation to improving coding, deep dives into Cumulative Sum (CuSUM) alerts, data in relation to place of death, Structured Judgment Review (SJR) process, coronial process and next steps. SB referenced the work looking into deaths due to alcoholic liver disease, noting the introduction of the fibroscan provision to primary care, and queried if this scan will eventually lead to a reduction in the number of deaths and better outcomes for patients. SR advised the fibroscan is an important part of diagnostic work, which can then lead to a preventative strategy for those patients. In terms of timeliness of these scans, there are community-based facilities in the local area, which care for this particular group of patients, and this may influence the flow into the Trust. However, if liver disease can be identified earlier, and appropriate actions be put in place, that will slow down the development of liver cirrhosis. DS advised historically the fibroscan equipment was funded by charitable bids. The Trust is involved in the cross-system alcohol liaison group, which is looking at harmonising resources. SR advised the early part of the liver disease pathway will be delivered in the community. However, there is a need to consider how the Trust can make every contact count by intervening in something which may not be the main reason for seeing the patient. MG noted the data in relation to place of death and queried if there was any learning which could be taken from other trusts regarding this. SR advised the Trust is learning from other organisations and there is a system-wide group looking at end of life care and care planning. BB requested future reports include a rolling death rate for alcoholic liver disease. **Action** • **Rolling death rate for alcoholic liver disease to be included in future learning from deaths reports.** BB noted the care bundle in relation to liver disease had not had the desired outcome and sought reflections on this.	**SR**	**03/04/25**

	SR advised care bundles are sometimes introduced as it is felt they are a 'good thing' but sometimes there is no evidence base to support this. There is a need to review the care bundle with the Gastroenterology Team. **Action** • **Liver disease care bundle to be reviewed with the Gastroenterology Team.** DS noted the forthcoming introduction of HSMR+ and while this is still 'work in progress', DS queried if the initial data provides more or less assurance in relation to the work the Trust is undertaking. SR advised the initial data shows a significant reduction in the Trust's HSMR rate. However, there is currently no information in relation to how the Trust's position relative to other organisations is impacted, noting there are indications the change will have more of an impact on SFHFT than other organisations. The significant change is the removal of palliative care. The Board of Directors were ASSURED by the report.	**SR**	**7/11/24**
24/314	**STRATEGIC OBJECTIVE 2 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE**		
17 mins	**Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual report** PB presented the report, highlighting the vacancy rate, Trainee Nurse Associate Programme, agency usage, recruitment to the role of Chief Nurse Clinical Fellow for Safer Staffing, developing the Allied Health Professionals (AHP) workforce, establishment reviews and challenges in the Maternity Team. PS advised the vacancy rate in Maternity has reduced. However, there is a significant amount of Maternity Leave within the team. Short-term mitigations are in place, but there is a need to focus on long-term planning in order to support the workforce. SB advised the report had been presented to the People Committee, who were assured by the report. However, the Committee did have concerns in relation to the long-term sustainability of midwifery staffing, as well as speech and language therapists and operating department practitioners. BB queried if the report includes pharmacy staffing. PB advised pharmacists are not AHPs. As a result of previous discussions by the Board of Directors, a report has been presented to the People Committee in relation to this group of staff to provide visibility and assurance. BB queried if it was possible for pharmacists to be included in future reports, noting the requirement to have the right workforce in place at the right time. PB advised the paper is a statutory paper and there are very clear guidelines as to what it can and cannot include.		

	DS advised a piece of work in relation to pharmacy has been undertaken and reports in relation to the Future Pharmacy Programme have been presented to the Quality Committee and People Committee. However, consideration needs to be given as to how the Board of Directors can be provided with visibility of broader staffing groups. RS advised there is the need to consider all professions, including administration and clerical. **Action** • **Consideration to be given as to how the People Committee and Board of Directors can be provided with visibility of broader staffing groups, not covered in the Nursing, Midwifery and AHP Staffing report.** NM noted the current workforce in midwifery is younger than it has been previously and sought assurance the base assumptions used to calculate headcount and cover are correct. NM noted the 24/7 provision in terms of place of birth will have an impact on headcount and queried if this is a mandated or aspirational service. NM referenced the role of the Maternity Support Worker and noted the Trust is looking to support all Band 2 healthcare support workers (HCSW) employed within maternity to progress to Band 3, in line with the Maternity Support Worker Competency, Education and Career Development Framework. NM queried how much midwifery time would be released if this was put in place, noting not all the clinical work in maternity services is required to be undertaken by midwives. PB acknowledged there is also the need to consider if the amount of 'headroom' in the establishment is sufficient to manage all mandatory training requirements. PB advised the Trust uses the BirthRate Plus tool to provide an evidence-based benchmark for the establishment setting process. PS advised maternity is an integrated unit at SFHFT, with no standalone midwifery service. Therefore, the options for place of delivery are hospital or home and the Trust has to provide that provision. Community services are currently more challenged due to the percentage of maternity leave. However, mitigations are in place. There is a need for some wider work in relation to increasing headroom. In terms of progressing Band 2 HCSW to Band 3, BirthRate Plus sets a 20:80 unregistered / registered workforce and the split within the Trust is currently at that level. The Trust is working with the BirthRate plus team to potentially bring forward a review, which is not due for another year, to look at the Band 2 to Band 3 transition. However, this will not release much more midwifery time as it is already built in. MG noted the report provides assurance about the past and present, but felt more information is required in relation to what is being done proactively to identify potential fragile areas and any actions being taken at a system level. RS advised the forward look can be included in future reports.	**RS**	**07/11/24**

	Action • **'Forward look' to be included in future Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual reports.** The Board of Directors were ASSURED by the report. PS left the meeting.	**PB**	**06/03/25**
13 mins	**Medical Workforce Staffing – bi-annual report** SR presented the report, highlighting job planning, medical appraisal compliance, General Medical Council (GMC) revalidation, industrial action, changes to resident doctor workforce and resident doctor training. MG queried what the current position is in terms of agreeing a standard bank rate of pay across the ICS. RS advised this is an ongoing conversation in terms of ensuring colleagues are renumerated appropriately. MG sought further information in relation to the annual leave audit, in particular cases where leave has been overtaken. SR advised this relates to changes in people's working arrangements, particularly in relation to compressed working hours. It was noted there is work to do with individuals who are requesting leave and the teams responsible for signing off the leave. MG felt it would be useful for further assurance to be provided to the Quality Committee. DS advised the Trust has robust data in terms of activity management which can be shared. **Action** • **Results and learning from the annual leave audit, particularly in relation to overtaken leave, to be presented to the Quality Committee.** AR noted, in terms of resident doctor training, there are still some areas with ongoing support, including Trauma and Orthopaedics and EAU, and sought clarification in relation to this. SR advised in terms of Trauma and Orthopaedics, the issue relates to ensuring appropriate support is provided to resident doctors on the ward, particularly at senior decision maker level, and processes in relation to ward rounds and non-resident on call rotas. Within EAU there are some challenges related to the pressure in that area and how the systems work in terms of the clerking and the senior review process. AR queried if any Trust colleagues are impacted by events in the Middle East and, if so, what steps is the Trust taking to ensure they are appropriately supported. RS advised he was unsure of the demographic in terms of colleagues who may have family members in the area. However, RS advised the Trust has reinforced the details of the support which is available to all colleagues and a check and balance will be undertaken to identify any colleagues directly affected.	**SR**	**05/12/24**

	SB noted that the training period for resident doctors working less than full time hours will be extended and queried if there is anything which can be done to address this. SR advised the training is competency-based programmes, which are not time defined. If there is an increasing number of trainees working less than full time hours, who are not at work on particular days of the week, they may miss elements of the training. Therefore, there is a need to be flexible when training is offered. The Board of Directors were ASSURED by the report.		
23 mins	**Freedom to Speak Up (FTSU)** KB joined the meeting. KB presented the report, highlighting the findings of the National Guardians' Office (NGO) FTSU Reflection and Planning Tool, FTSU Champions event, proactive engagement with FTSU from specific divisions who have requested help, Leadership Development Programme, FTSU Guardian resource / capacity and improving visibility of FTSU to the workforce. It was noted the actions arising from the NGO FTSU Reflection and Planning Tool will be monitored by the People Committee. AR queried if the concerns raised by colleagues from an ethnic minority background differed from other concerns raised. KB advised the majority of all concerns relate to worker safety and wellbeing and attitudes and behaviours. There are no discrimination concerns being raised. NM noted some of the issues raised relate to poor leadership and dealing with issues in a timely manner, and the fact it may be 2-3 years before the training in relation to handling difficult conversations has been rolled out, and queried what action can be taken to shorten this timeframe and ensure all frontline managers are dealing with issues in a timely manner. SBS advised the outcome of tool has been shared with colleagues in HR and a meeting has been arranged to discuss what support is available to ensure people are responded to in the correct way when they raise concerns. RS advised all new leaders joining the organisation are expected to attend a leadership fundamentals course which is aimed at ensuring new leaders are trained and supported and have the necessary skills. 80%-90% of colleagues attend this training within their first 6 months of employment. In addition, there are other leadership opportunities available. MG noted the theme of behaviours exhibited and queried if positive and negative behaviours are outlined in the Trust's values. RS advised the Trust's CARE values were relaunched in 2023 with the 'We CARE' description which outlines how individuals are expected to behave.		

	BB queried how FTSU works in conjunction with other initiatives across the Trust, for example, the cultural heatmap. BB noted when FTSU is mentioned, people immediately think of KB as the FTSU Guardian. However, FTSU needs to be organisationally owned and reach into all areas of the Trust. BB queried if KB is feeding into the right level within the people structure. SBS advised KB reports into the People, Wellbeing and Belonging Subcabinet, together with reporting to the People Committee and the Board of Directors on a 6-monthly basis. Consideration is being given to KB also reporting to the People Cabinet. DS noted the need to capture more meaningful data in relation to the impact of FTSU. DS sought clarification regarding the interpretation of the national benchmarking of FTSU concerns raised. KB acknowledged this is a crude data point taken from the NGO's data. DS requested KB ask the NGO for some tangible metrics in terms of the impact of FTSU. RS noted the need for the Trust to learn from colleagues' experience of speaking up and what action was taken as a result. KB acknowledged the need to close the feedback loop. **Action** • **Tangible metrics for Freedom to Speak up, in terms of impact, to be requested from the National Guardians' Office.** The Board of Directors were ASSURED by the report. KB left the meeting.	**SBS / KB**	**06/02/25**
24/315	**STRATEGIC OBJECTIVE 4 – CONTINUOUSLY LEARN AND IMPROVE**		
16 mins	TS joined the meeting. **Research Strategy Update** TS presented the report, highlighting recruitment, open studies, finance, patient experience, strategy update and how the studies fit into the strategic goals. AR noted the Trust had not been selected for a large maternity study and queried if the Trust had received any feedback. TS advised the Trust fulfilled the entry criteria. Three applications were made for this study and the feedback each time was that the study was closed to new sites. However, on checking the database, these studies were still showing as open. This has been challenged and they are now closed to new sites. AR felt it would be useful for the Trust to build academic links as this may help strengthen bids. SR noted the Principal Investigators (PI) do not have the time to undertake studies and queried if this is mainly from a medical perspective. TS advised this is across the board. Some studies are in depth and require a lot of PI input, whereas the researchers can do the work for other studies and just require sign off by the PI.		

	The Board of Directors were ASSURED by the report. TS left the meeting.		
24/316	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
35 mins	**Financial Improvement Performance 2024 / 2025 Update** RM presented the report, highlighting efficiency targets, efficiency forecast, de-risking exercise, governance changes, discretionary spend controls, vacancy control process, Quality Impact Assessment (QIA) process, actions being taken to translate non-recurrent savings into recurrent savings, Investigation and Intervention (I&I) process and improvement in productivity. MG requested sight of recurrent and non-recurrent savings in percentage terms to enable this to be tracked. MG noted the Trust's Financial Efficiency Programme of £38.5m and queried what part of that figure is cost controls, and hence what are the risks to safety and quality, what part is efficiencies and what part is transformational. MG sought assurance on the effectiveness of schemes and the deliverability of them, including if there are adequate governance arrangements in place. MG noted QIAs are being completed for each scheme, but queried if there was anything strategic at a programme or thematic level, particularly in relation to stakeholder expectations. GW advised there is a need to understand the potential impact of FIP activity across the system on the Trust. NM advised the Finance Committee agreed recurrency of savings is the key theme. RM advised information in relation to recurrent and non-recurrent savings will be reported to the next meeting of the Finance Committee. The 2025/2026 planning process starts in October 2024. As part of the budget setting principals, there will be an expectation to transact a higher proportion of efficiency savings from the budget. GW noted it would be useful to understand the full year effect of recurrent savings which are identified for 2025/2026, noting there will not be the full year effect for 2024/2025. RM advised predominately the savings are either cost control or revenue related. Support will be provided where there are transformation schemes which may change services in future years and lead to efficiencies. There is a need to ensure the Trust is 'doing the right things', taking the right actions and following the processes which are in place. Progress is monitored by the Finance Committee. However, there is also a reporting line in the governance structure to the Quality Committee from the Financial Recovery Cabinet. An update on the Efficiency Programme is provided to the Executive Team each week, which provides the opportunity to raise any concerns about the potential impact on quality and safety of any proposed actions. DS advised the executives jointly own the delivery of the year end position, which is across the portfolios of all the executives. There is robust challenge, but clinical safety is prioritised.		

	MG queried if the processes included a stakeholder process of identification, understanding of expectations, management, action plans, etc., risk assessments and QIAs. RM advised there is a QIA in every scheme which is completed and signed off by the divisional triumvirate. The programme leads are brought together in weekly meetings, which provides the opportunity for cross checking by different stakeholders. DS acknowledged the difficult balance between quality and safety, operational pressures and financial sustainability. A half year update will be provided to the Board of Directors in November, which will incorporate the financial position and quality and operational metrics. **Action** • **Half year update, incorporating the financial position and quality and operational metrics, to be presented to the November meeting of the Board of Directors.** BB queried if the Trust has visibility of QIAs completed for schemes in the system which may impact on the Trust. PB advised he is assured by the internal QIA process, but is less assured by the system process. GW advised he has escalated this issue to the ICB. RE advised there are a number of large schemes underway across the ICS, which may impact on capacity over Winter, and she has not had sight of any QIAs. The process is in its infancy, but there is a need to have sight of QIAs. This issue is being escalated at every opportunity. CH advised every financial improvement project has a Project Initiation Document (PID) which captures information relating to stakeholder expectations, risks and actions. Each project is reviewed at the weekly meetings to check it is delivering and is on track and if any additional support, changes, etc. are required. The majority of projects are cost reduction projects rather than transformational. However, some of the earlier projects are being closed down and the resource to run those projects is being used differently, to look at high-cost services. This is where the transformation projects will start to come alive. DS advised it is important to note transformational schemes take a long time to enact and are, therefore, multi-year projects. AR queried what the benefits are of being a foundation trust and queried if SFHFT had reached out to other foundation trusts to establish if they are able to generate income on a different basis which allows use of the foundation trust status. GW felt this is an area for the Executive Team to explore further and report findings to the Finance Committee. GW requested an update on financial improvement performance be provided to each Board of Directors meeting. In addition, financial improvement to be included on the agenda for People Committee and Quality Committee.	**DS**	**07/11/24**

	Actions • **Ability to use foundation trust status to generate income in a different way to be explored and reported to the Finance Committee.** • **Update on financial improvement performance be provided to each Board of Directors meeting.** • **Financial improvement to be included on the agenda for People Committee and Quality Committee.** The Board of Directors were ASSURED by the report.	**RM** **RM** **RS / PB / SR**	**05/12/24** **07/11/24** **5/12/24**
24/317	**WINTER PLAN**		
13 mins	MB joined the meeting. MB presented the report, highlighting the key principles for Winter planning, structured plan, bed modelling, proposal for elective activity, mitigations, including shortlisted bed schemes, indicative workforce implications and reserve schemes, and the staff wellbeing offer. MB advised the Winter Plan may continue to evolve and it forms part of a wider ICS process, which is still underway. Specific plans will be developed for the Christmas and New Year period. RE advised work with the ICS to try to stem demand is still ongoing. This is the area of greatest challenge and the Trust is working closely with partners to address this. BB queried if the Trust has insight into what is being thought through at a system level and what the implications are for the Trust. RE advised the Winter Plans from partners are pulled together by the ICS and work is ongoing in relation to this. The Board of Directors APPROVED the Winter Plan for 2024/2025.		
24/318	**ASSURANCE FROM SUB-COMMITTEES**		
5 mins	**Audit and Assurance Committee** MG presented the report, highlighting audit targets, limited assurance report for the Outpatients, Appointments and Remote Consultations audit and external audit fees. The Board of Directors were ASSURED by the report. **Finance Committee** GW presented the report, highlighting Financial Improvement Programme, potential evaluation of Band 2 HCSW role to Band 3, revenue deficit support and concern about the timeliness of payment to suppliers. GW advised the Soft FM Deed has now been agreed. The Board of Directors were ASSURED by the report.		

	Quality Committee AR presented the report, highlighting the importance of the Clinical Services Strategy and the balance between finance, quality, and safety. The Board of Directors were ASSURED by the report. **People Committee** SB presented the report, highlighting staff wellbeing support, risk from implications of potential employment legislation change and review of BAF PR3, Critical shortage of workforce capacity and capability. The Board of Directors were ASSURED by the report.		
24/319	**OUTSTANDING SERVICE – SFH EXCEEDING NATIONAL AVERAGE FOR AMBULANCE HANDOVER TIMES**		
7 mins	A short video was played highlighting the work to improve ambulance handover times.		
24/320	**COMMUNICATIONS TO WIDER ORGANISATION**		
3 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Encourage colleagues to complete the 2024 Staff Survey. • Flu vaccination campaign. • Staff to be encouraged to have Covid vaccination. • Martha's Rule launch. • Freedom to Speak Up. • Financial position. • Winter Plan. • Ambulance Handover Times.		
24/321	**ANY OTHER BUSINESS**		
	No other business was raised.		
24/322	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 7th November 2024 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:45		

24/323	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Acting Chair** **Date**		

24/324	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	GW 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.		
24/325	**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.		

Outstanding Care,
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Healthier Communities

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
24/183.2	06/06/2024	Sub-committee annual reports to follow same format	Public Board of Directors	None	Apr-25	S Brook Shanahan			Grey
24/223	04/07/2024	Information in relation to the cost of maintaining the current IT landscape, and what the costs are likely to be in five years' time, to be reported to the Finance Committee.	Public Board of Directors	Finance Committee	06/02/2025	D Selwyn	N Turner	**Update 16/10/2024** Update to be provided to Finance Committee on 29th October 2024, with a full report to Finance Committee in January 2025	Grey
24/251.1	01/08/2024	Report outlining progress in relation to Quality, Service Improvement and Redesign (QSIR) training, including lessons learned, etc. to be presented to the Quality Committee.	Public Board of Directors	Quality Committee	05/12/2024	C Hinchley		**Update 21/08/2024** Improvement will be the 'Hot Topic' at the November Quality Committee meeting.	Grey
24/252.2	01/08/2024	Graph to be included in the IPR showing agency spend as a financial cost.	Public Board of Directors	None	07/11/2024	R Eddie	M Bolton	**Update 24/10/2024** Included in IPR to be presented to Board of Directors in November 2024 **Complete**	Green
24/308	03/10/2024	Consider how the visibility of the ongoing work in relation to the Violence and Aggression Action plan can be increased for the Board of Directors.	Public Board of Directors	None	07/11/2024	R Simcox		**Update 30/10/2024** On People Committee workplan, and will be regularly updated via People Committee. **Complete**	Green
24/312	03/10/2024	Update on waiting times and the impact of inequalities to be provided to the Quality Committee.	Public Board of Directors	None	05/12/2024	R Eddie			Grey
24/313.1	03/10/2024	Rolling death rate for alcoholic liver disease to be included in future learning from deaths reports	Public Board of Directors	None	03/04/2025	S Roe			Grey
24/313.2	03/10/2024	Liver disease care bundle to be reviewed with the Gastroenterology Team	Public Board of Directors	None	07/11/2024	S Roe		**Update 30/10/2024** Action plan from gastroenterology team include: 1) Continue to engage with Emergency care leadership team to focus on completing admission clerking documentation 2) Re-initiate education in-reach programme into EAU to drive up completion of the liver care bundle on admission 3) Look at increasing middle grade staffing in Gastroenterology service to provide additional in-reach into EAU to review patients who are waiting to come to Gastroenterology ward to ensure their care is progressing and that they are closely monitored for early signs of deterioration These actions will be monitored via the medicine division governance meeting **Complete**	Green

24/314.1	03/10/2024	Consideration to be given as to how the People Committee and Board of Directors can be provided with visibility of broader staffing groups, not covered in the Nursing, Midwifery and AHP Staffing report.	Public Board of Directors	People Committee	~~07/11/2024~~ 07/02/2025	R Simcox		**Update 30/10/2024** On People Committee workplan for January 2025	Grey
24/314.2	03/10/2024	'Forward look' to be included in future Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual reports	Public Board of Directors	None	06/03/2025	P Bolton			Grey
24/314.3	03/10/2024	Results and learning from the annual leave audit, particularly in relation to overtaken leave, to be presented to the Quality Committee	Public Board of Directors	Quality Committee	05/12/2024	S Roe		**Update 24/10/2024** SR confirmed this item should be presented to People Committee not Quality Committee	Grey
24/314.4	03/10/2024	Tangible metrics for Freedom to Speak up in terms of impact to be requested from the National Guardians' Office	Public Board of Directors	None	06/02/2025	S Brook Shanahan	K Bosworth		Grey
24/316.1	03/10/2024	Half year update, incorporating the financial position and quality and operational metrics, to be presented to the November meeting of the Board of Directors.	Public Board of Directors	None	07/11/2024	D Selwyn		On agenda **Complete**	Green
24/316.2	03/10/2024	Ability to use foundation trust status to generate income in a different way to be explored and reported to the Finance Committee	Public Board of Directors	Finance Committee	05/12/2024	R Mills			Grey
24/316.3	03/10/2024	Update on financial improvement performance be provided to each Board of Directors meeting	Public Board of Directors	None	07/11/2024	R Mills		**Update 24/10/2024** Included in IPR to be presented to Board of Directors in November 2024 **Complete**	Green
24/316.4	03/10/2024	Financial improvement to be included on the agenda for People Committee and Quality Committee	Public Board of Directors	Quality Committee and People Committee	05/12/2024	R Simcox / S Roe / P Bolton			Grey

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chair's report	**Date:**	7th Nov 2024
Prepared By:	Rich Brown, Head of Communication		
Approved By:	Graham Ward, Acting Chair		
Presented By:	Graham Ward, Acting Chair		

Purpose

An update regarding some of the most noteworthy events and items over the past month from the Acting Chair's perspective.	**Approval**	
	Assurance	**Y**
	Update	**Y**
	Consider	**Y**

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	Insufficient financial resources available to support the delivery of services	
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

ICB = Integrated Care Board
NICU = Neonatal Intensive Care Unit
NTU = Nottingham Trent University
NUH = Nottingham University Hospitals
STEM = Science, technology, engineering and maths

Executive Summary

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

Non-Executive Director recruitment updates

A number of further changes are to be made to the Trust's Board of Directors over the coming months, as the Trust looks to appoint two Non-Executive Directors and one Associate Non-Executive Director.

The three roles we are looking to recruit to are as follows:

- One a financially qualified Non-Executive Director with board-level strategic financial leadership experience, drawn from a track record working in complex highly regulated sector(s). The successful candidate will be able to join the Audit and Assurance Committee or Finance Committee and be a part of the committee chair succession planning.
- One clinically qualified Non-Executive Director with extensive experience in primary care, secondary care, public health or social care to join the Quality Committee.
- One Associate Non-Executive Director with a focus on research and innovation, recognising the important role that these fields play in making great care happen here at Sherwood.

The first of those Non-Executive Director roles will be to backfill my own substantive position as a Trust Non-Executive Director, following my appointment to the role of Acting Chair. Longer-term, this appointment will replace my substantive position, recognising I will have served my maximum tenure at the point my time as Acting Chair comes to an end.

The second Non-Executive Director vacancy we are looking to appoint will be for a medically qualified individual to succeed our existing Non-Executive Director, Dr Aly Rashid, who has recently informed us of his intention to step-down at the end of his current term. We are grateful to Aly for his three years in post, where he has proven himself as an invaluable member of the Trust's Board and a great support to me personally during my time as Acting Chair. We wish him well in his next chapter.

Recruitment for all three positions is due to have begun by the time of our November meeting of our Board of Directors. I will, of course, keep the Trust's Board appraised of the latest developments concerning these important appointments.

College, university and hospitals show the power of partnership

The Trust's pioneering partnerships with local education providers continue to go from strength-to-strength – a fact we saw first-hand on a recent to visit to West Nottinghamshire College alongside our Acting Chief Executive and Nottingham Trent University (NTU) colleagues in October 2024.

We joined leaders at West Nottinghamshire College's Derby Road and Chesterfield Road campuses to see the state-of-the-art facilities that equip students to work in the health and care sectors.

Starting at Derby Road, we saw the college's recently upgraded Robin Hood Ward – a simulated clinical environment where T-Level Health students undertake practical learning in a realistic setting. The ward boasts the latest equipment including robotic patients with artificial intelligence to help learners practice their skills, and an interactive digital dissection table that teaches them about body and skeletal systems in 3D.

This was followed by a visit to NTU's Centre for Health and Allied Professions, located on the site, to see its own hi-tech virtual hospital wards where undergraduates are training to become the healthcare professionals of tomorrow.

Next was a visit to the college's computer science department to learn about the technology at students' disposal and the chance for them to move into IT roles within the health service. We were then shown the college's simulated nursery, where education and early years students experience a real-life environment.

At the Chesterfield Road campus, we saw construction work on the Future Tech Skills and Knowledge Exchange. Due to open in Summer 2025, the £8.8million hub will prepare students for jobs in emerging industries, with a strong focus on innovation and science, technology, engineering and maths (STEM) subjects.

Our visit ended with a tour of the sixth-form college on Chesterfield Road South and its suite of science laboratories for students on A-Level and diploma courses.

Joint working between the three organisations is already providing ever-increasing opportunities for people to train for rewarding occupations in the health and care sectors through further and higher education courses, apprenticeships and work placements.

Together, we have also run a series of *Step into the NHS* events aimed at promoting the various job roles available in the area's hospitals and the educational routes towards them.

In addition, college students with additional needs have the chance to undertake a year-long supported internship programme at King's Mill Hospital to gain confidence and employability skills so they are ready for the workplace.

Meanwhile, students on its T-Level in Health course are undertaking long-term industrial placements at the hospital, under the supervision of a nurse jointly employed by both partners, while the apprenticeship pathways also continue to grow.

Our visit was aimed at building upon our longstanding relationship with West Notts College and seeing the work we've been doing together to develop the T-Level training programme and the investment the college has made, along with its strong partnership with Nottingham Trent University.

We were very impressed by the developments that have taken place and the phenomenal difference that investment can make for the students of today and the workforce of tomorrow.

We are looking forward to continuing to develop this further to ensure that students have a seamless journey to a meaningful career.

Recognising the difference made by our Trust Charity and Trust volunteers

October 2024 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 2024 alone, 383 Trust volunteers generously gave over 4,600 hours of their time to help make great patient care happen across the 33 services they have supported during the month.

During the month, eight volunteers were presented with their Long Service Awards for service ranging from five to 20 years.

Pictured is cafe volunteer Lesley receiving her five-year award from the Trust's Director of Corporate Affairs, Sally Brook Shanahan.

Volunteer Lesley receives her five-year award from the Trust's Director of Corporate Affairs, Sally Brook Shanahan

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

- Facilitating a visit from Performance Health – a NHS medical supplies company who hosted a fundraising stall on-site for their 'Make a Difference' volunteering day in support of the Sherwood Forest Hospitals Charity.
- Working with ATTFE College, West Nottinghamshire College and Brunts' School to explore partnership opportunities for students to support with fundraising and community volunteering projects.
- Finalising the festive events plan, which includes a programme of visits from school carol singers across the Trust's three sites, as well as plans for Christmas Jumper Day, Twelve Days of Christmas raffle for staff, and obtaining funding for inpatient gifts.
- Supporting OPUS Healthcare Musicians with arrangements for the second staff engagement and training session at Mansfield Community Hospital. Ward and therapy staff and volunteers will be in attendance, together with representation from Critical Care who are keen to see how music can support patient recovery and therapy.
- Arranging publicity for charitable-funded projects such as the purchase of cot canopies for the Trust's Neonatal Intensive Care Unit (NICU). These will support babies' brain development by encouraging a dark and quiet environment to sleep.

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.

Notable engagements:

Notable engagements I have undertaken during October 2024 include:

- A productive Board-to-Board meeting with Nottingham University Hospitals (NUH) colleagues, where we explored how the two trusts can continue and extend their partnership working together.

- The Notts Healthier Together Leadership Board with Trust Chairs and Chief Executives from Nottinghamshire Healthcare and Nottingham University Hospitals (NUH). The meeting focused on collaboration in the interest of furthering system working around four key areas of: planned care; people and culture, looking at how we recruit better, look after our people and align our people processes; corporate services; and estates.

- Attending the Nottingham and Nottinghamshire Integrated Care Board's (ICB) bi-annual meeting with foundation trust governors from Nottinghamshire Healthcare and from Doncaster and Bassetlaw Teaching Hospitals. The event included a roundtable workshop to explore how trusts can move 'from acute to community' and 'from treatment to prevention'.

- Attending the Ashfield 'PLACE' Board on Wednesday 23rd October 2024.

- Attending the monthly meeting of the Chairs and elected members meeting on Thursday 24th October 2024.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	7th Nov 2024
Prepared By:	Rich Brown, Head of Communication		
Approved By:	David Selwyn, Acting Chief Executive		
Presented By:	David Selwyn, Acting Chief Executive		

Purpose

An update regarding some of the most noteworthy events and items over the past month from the Acting Chief Executive's perspective.	**Approval**	
	Assurance	**Y**
	Update	**Y**
	Consider	**Y**

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	
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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

CDC = Community Diagnostic Centre
CPR = Cardiopulmonary resuscitation
ICB = Integrated Care Board
MSK = Musculoskeletal
NHS = National Health Service
NIV = Non-Invasive Ventilation
PICS = Primary Integrated Community Services

Executive Summary

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

Operational updates

Overview of operational activity

Following a seasonal ease in Accident & Emergency attendance demand in August 2024, we have seen demand pressures increase as we moved into September to return to above-planned levels once again.

Demand for non-elective admission has consistently remained above planned levels throughout 2024/25, however in recent months the gap to plan has reduced.

These demand pressures have meant that our Urgent and Emergency Care pathway remains pressurised, with patients not always receiving timely care in the manner we would wish despite us implementing escalation actions. National benchmarking data suggests that similar Urgent and Emergency Care pressures are being felt across the country right now. We continue to benchmark well against a number of national targets and work continues to improve our ways of working and to strengthen our front door capability, despite much of the increased activity remaining currently unfunded.

Within our planned care pathway, outpatient, day case and diagnostic activity levels are favourable to plan. Our 'Referral to Treatment' waiting list size continues to reduce, albeit slightly behind our plan.

We have fallen behind our plan for our long-waiting elective patients, which is partly driven by patients being transferred to Sherwood Forest Hospitals as part of our Trust playing its part in supporting our local system colleagues.

Performance against the three main cancer performance standards were above plan in August 2024, which is the most up-to-date reporting period available.

A more comprehensive update on our operational performance is due to be presented to the Trust's Board in our latest Integrated Performance Report which will consider the Trust's 2024/25 quarter two performance, and a review of the first six months of the year, later in the agenda.

Over 50,000 tests delivered as Nottinghamshire's first Community Diagnostic Centre marks one-year milestone

The project to bring Nottinghamshire's first Community Diagnostic Centre (CDC) has celebrated delivering over 50,000 health checks and tests to local people - even before the first brick has been laid for the new purpose-built facility.

The tests include blood tests, X-rays, and MRI scans that are being offered as part of the project before the new purpose-built facility is eventually built alongside Mansfield Community Hospital in Stockwell Gate.

These additional tests have taken place across the Trust's King's Mill, Mansfield Community and Newark Hospitals, as well as from a specialist mobile unit at the Nottingham Road Clinic in Mansfield. Those tests have helped to reduce the time it takes for patients to be referred to help them receive an 'all clear' or diagnosis sooner.

Work is continuing to progress on the multimillion pound Community Diagnostic Centre scheme after the project received planning approval for its revised plans from Mansfield District Council in September 2024.

Anyone looking to find out more about the project can attend the Trust's latest public information event on Thursday 21st November 2024 from 8.30am to 12noon at Mansfield Community Hospital. Members of the public are invited to drop-in at any time during the event, where they will have the opportunity to speak with team members leading the CDC project, ask questions, and learn more about the latest developments.

Partnership updates

Successful community event held for patients under NHS care

More than 150 people attended a third community event aimed at supporting patients with their health and wellbeing during October 2024.

The event was organised by MSK Together – a partnership hosted by Sherwood Forest Hospitals NHS Foundation Trust which includes Nottinghamshire Healthcare NHS Foundation Trust, Nottingham University Hospitals NHS Trust, Primary Integrated Community Services (PICS) and NHS Nottingham and Nottinghamshire Integrated Care Board (ICB).

Taking place at Kirkby Leisure Centre, it was attended by residents of Mansfield, Ashfield, and Newark and Sherwood who are on under the care of the NHS for musculoskeletal (MSK) conditions which affect bones, joints, or muscles.

MSK conditions can significantly impact people's quality of life and ability to work and socialise, often existing with other health problems like obesity, chronic pain, depression, and physical inactivity.

The purpose of the event was to help those people access the wide range of help and support services available to them within the local area, as connecting people with local support networks empowers patients to proactively manage their health while they wait for the next step in their treatment journey.

Events such as this are so important as they support members of the community to take control of their own health and wellbeing, providing them with the practical advice and resources they need to manage this.

We are grateful to all of the partners we work with who helped to make this event such a success.

Other Trust updates

Celebrating the life-saving actions of one of our Trust nurses, Eleanor Pike

During October 2024, we celebrated the life-saving actions of one of our Trust colleagues who helped save the life of a local resident while off-duty.

Eleanor Pike, our Deputy Ward Sister in Ward 31 at King's Mill Hospital, was walking along the river in her hometown of Newark when she came across 83 year old Phil Seagar on the floor in the recovery position.

As he had hit his head and was covered in blood, the people with him hadn't realised that his heart had stopped, which Eleanor identified in seconds.

She performed CPR (cardiopulmonary resuscitation) on Phil for "what felt like ten minutes" and it later turned out that he had been clinically dead for a total of 15 minutes.

Due to Eleanor keeping the CPR going, the ambulance crew were able to shock him back to life.

Since the incident, the two have become firm friends, after a chance meeting between Eleanor's mum's friend and Phil's brother put them in touch with each other.

Eleanor described their initial meeting as being 'very emotional', with tears from them both. She now checks in with him on a weekly basis, even chauffeuring him from further hospital visits and says that Phil couldn't be more thankful to her for saving his life.

We are incredibly proud of Eleanor for putting her training into action – it's very different doing CPR beside the River Trent compared to in a hospital. We're delighted that it was successful and has given Phil more time with his family and friends.

Survival rates for people who have a cardiac arrest outside of a hospital setting are incredibly low. We encourage everyone to learn CPR and how to use a defib so that those having a sudden cardiac arrest have the best chance of surviving.

Cataract patients to benefit from new one-stop clinic

Patients who have cataracts are set to benefit from a new one-stop clinic which will reduce the need for multiple hospital visits ahead of surgery. The Trust's clinic at Ashfield Health Village in Kirkby-in-Ashfield will also help to reduce overall waiting times for surgery.

At the clinic, patients will see their consultant, have all the tests they need and, if all is well, they will be given a date for both their pre-op appointment and their operation. There are likely to be fewer cancellations because appointments are made to suit patients.

Previously, patients had to make multiple visits to hospital before they got a date for their surgery. The location at the health village has free parking and good access for patients, especially those with mobility problems, and its small size provides a calm and quiet environment.

Patients can be referred to the service via their optometrist or GP. Operations will continue to take place at either King's Mill Hospital or Newark Hospital.

The cataract clinic joins the ophthalmology community diagnostic centre already at Ashfield Health Village, which assesses patients who have conditions such as glaucoma, macular degenerative disease and diabetes.

The official opening of the clinic on Monday 30th September 2024 was attended by Trustees from the League of Friends (Mansfield and Sutton) who generously donated £58,844 to buy specialist equipment for the clinic. This includes a state-of-the-art instrument that accurately measures the eye in a non-invasive way, an ultrasound scanner, and a special microscope with a bright light attached to it that is used to look at different parts of the eye.

The one-stop cataract clinic will be a huge benefit to patients who will experience a quicker, smoother process, and means we can potentially see more patients.

As a Trust, we are very grateful to the League of Friends for providing equipment that will ensure patients receive gold standard care and a date for their surgery on the first visit for cataract referral.

Moving all cataract appointments to Ashfield Health Village creates more space at the main Trust for complex clinical cases, meaning we can maximise our resources and ultimately treat more patients.

Trust playing its part in nationwide RSV vaccination campaign

The Antenatal Vaccination Team administered their first vaccination for Respiratory Syncytial Virus or 'RSV' at King's Mill Hospital during October 2024.

Mansfield resident Morgan Panting is due to give birth on 16th November 2024 and decided to have the vaccine to ensure she protects the health of her future baby.

The RSV vaccine is now available during pregnancy to help reduce the severity of the RSV virus in newborns. The virus can cause respiratory illness which in some cases can have serious lifelong consequences or lead to death.

Giving the RSV vaccine from week 28 of pregnancy will temporarily boost antibody levels in the birthing parent, enabling them to transfer a high level of antibodies to their unborn child through the placenta, and this will protect the newborn baby against RSV in their first months of life.

This will also give the parent enough time to make the antibodies and transfer them to the unborn child, considering the possibility that the baby may be born prematurely.

RSV is a major respiratory virus that is common over the winter period, typically from November to February. While the symptoms are mild for many, RSV accounts for around 30,000 hospitalisations of children under 5 in the UK each year.

Expectant mothers and birthing people can speak to their midwife if they are pregnant and would like to have the vaccine.

***Celebrating Excellence* at Sherwood Forest Hospitals**

During October, the Trust hosted its second annual *Celebrating Excellence* conference as an opportunity for Nursing, Midwifery, Allied Health Professional and other colleagues to showcase some of the improvement projects that have been taking place across the Trust over the year gone by.

The morning was filled with a range of presentations from colleagues aimed at inspiring others to start their own improvement projects across the Trust, with projects included as part of the showcase including a Non-Invasive Ventilation (NIV) ward accreditation project and the benefits that have come following the opening of the Trust's Same Day Emergency Care surgical unit.

The event was a timely celebration of this work, ahead of the Trust's *Improvement Week* in early November, where the Trust's Improvement Faculty will be working with colleagues to start bring their own improvement ideas to life.

Trust risk ratings reviewed

The full Board Assurance Framework was presented to Risk Committee for oversight and it was agreed that discussions should take place with Lead Directors and Board Committee Chairs to describe metrics/deliverables to reduce scores (particularly risks scored at 20).

Risk Committee members scrutinised Principal Risk 7 – 'A major disruptive incident' – for which the Risk Committee is the lead committee. It was agreed that there should be no changes to the risk score or assurance ratings.

Board of Directors Meeting in Public - Cover Sheet

Subject:	**Emergency Preparedness Overview**	**Date:**	7th Nov 2024
Prepared By:	Mark Stone- Emergency Planning Officer		
Approved By:	Rachel Eddie – Chief Operating Officer (and Accountable Emergency Officer)		
Presented By:	Mark Stone- Emergency Planning Officer		

Purpose

The purpose of the paper is to provide an overview for the Board on the emergency preparedness workstream and the outcome of this year's annual compliance assessment against NHS England's Core Standards for Emergency Preparedness, Resilience and Response (EPRR) and in doing so provide assurance about the level of preparedness	**Approval**	
	Assurance	**x**
	Update	
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	Insufficient financial resources available to support the delivery of services	
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

RAC – Resilience Assurance Committee
EPO – Emergency Planning Officer
EPRR – Emergency Planning Resilience and Response
AEO – Accountable Emergency Officer
LHRP – Local Health Resilience Partnership
ICB = Integrated Care Board
BCMS – Business Continuity Management System

Executive Summary

The report aims to provide an overview of the Trusts' current state of emergency preparedness, through highlighting the improvement in its compliance rating against the national standard, the positive report into its upgraded BCMS and the levels of training compliance.

The Trust's main governance forum for EPRR is the Resilience Assurance Committee, which is chaired by the Chief, or Deputy Chief Operating Officer. The COO is also assigned as the

Accountable Emergency Officer (AEO) with responsibility for EPRR to the Board.

There have been excellent attendance levels at the RAC, across all disciplines and as captured in the following table:

Resilience Assurance Committee – Attendance Update Nov 2023 - Sept 2024		
Chief Operating Officer/Deputy Chief Operating Officer (Chair)	10 of 10	100%
Emergency Planning and Business Continuity Officer	10 of 10	100%
Risk and Assurance Manager	7 of 10	70%
Head of Communications	10 of 10	100%
EPRR Lead for Division of Urgent and Emergency Care – Divisional General Manger for UEC	10 of 10	100%
EPRR Lead for Division of Medicine - Divisional General Manager for Medicine	10 of 10	100%
EPRR Lead for Division of Surgery - Divisional General Manager for Surgery	9 of 10	90%
EPRR Lead for Division of Women and Children's – Divisional General Manager for Women's and Children's	9 of 10	90%
EPRR Lead for CSTO – Divisional General Manager for CSTO	10 of 10	100%
Associate Director of Estates & Facilities`	10 of 10	100%
EPRR Lead - NHIS Head of Corporate and Business Support	9 of 10	90%
Operations Manager – Central Nottinghamshire Hospitals Plc	10 of 10	100%
Contract Director – Medirest	9 of 10	90%
Senior General Manager – Skanska	10 of 10	100%

As a result, there have been no escalations to the Risk Committee in this regard.

Although we await the formal confirmation letter from NHS England, the Trust has improved its overall Core Standards compliance rating from "Partial" (82%) to "Substantial" (91%), with no areas deemed non-compliant. The overall outcome is described in the following table:

Final position – 2024 Core Standards Compliance

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	10	1	0
Command and control	2	1	1	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	7	3	0
CBRN	12	12	0	0
Total	62	56	6	0

The formal letter, addressed to the Chief Executive is expected on 15th November.

There is excellent completion rate on the RAC annual workplan, with only two exercises not yet delivered throughout a very busy year. That said, the Trust has engaged in more exercises than it has ever completed before and is compliant with the national standard in this respect.

The Trust trains all on-call staff before they are placed on a rota and this training is refreshed annually. Current training completion stands as follows:

Strategic (Gold) = 100%
Tactical (Silver) = 91%

There have been few declared EPRR incidents of note in 2024, but the Trust has successfully managed lengthy periods of industrial using the EPRR structures and processes.

The Risk of a major disruptive incident is captured within the Board Assurance Framework (PR7), and reviewed on a monthly basis by the AEO, the EPO and the Risk & Assurance Manager.

The Trust is committed to, and fully engages with, the principles of learning lessons from incidents and exercises.

The Business Continuity Management System has been improved and now provides “Significant” assurance to the Board. This was also reflected in the Core Standards outcome in the on Business Continuity domain.

The Board is asked to be updated and **ASSURED** by this overview report.

Public Board – Emergency Preparedness Update

November 2024

Introduction

The report will highlight the current status of the Trusts emergency preparedness, and the governance processes in place to ensure compliance with legal requirements and national standards.

It will cover;

- Resilience Assurance Committee (RAC) Attendance
- Governance Arrangements
- The EPRR Core Standards Submission
- Annual EPRR Workplan
- Training Compliance Levels
- Exercises Completed
- Incidents
- Risks Identified
- Lessons Learned

In doing so, the report should provide an overview of the current state of preparedness for incidents and emergencies.

RAC Attendance

RAC is Chaired by the Chief or Deputy Chief Operating Officer.

There is excellent attendance and engagement from all areas of the Trust, as depicted in the following table:

Resilience Assurance Committee – Attendance Update Nov 2023 - Sept 2024		
Chief Operating Officer/Deputy Chief Operating Officer (Chair)	10 of 10	100%
Emergency Planning and Business Continuity Officer	10 of 10	100%
Risk and Assurance Manager	7 of 10	70%
Head of Communications	10 of 10	100%
EPRR Lead for Division of Urgent and Emergency Care – Divisional General Manger for UEC	10 of 10	100%
EPRR Lead for Division of Medicine - Divisional General Manager for Medicine	10 of 10	100%
EPRR Lead for Division of Surgery - Divisional General Manager for Surgery	9 of 10	90%
EPRR Lead for Division of Women and Children's – Divisional General Manager for Women's and Children's	9 of 10	90%
EPRR Lead for CSTO – Divisional General Manager for CSTO	10 of 10	100%
Associate Director of Estates & Facilities`	10 of 10	100%

EPRR Lead - NHIS Head of Corporate and Business Support	9 of 10	90%
Operations Manager – Central Nottinghamshire Hospitals Plc	10 of 10	100%
Contract Director – Medirest	9 of 10	90%
Senior General Manager – Skanska	10 of 10	100%

In 2024 there have been no concerns to escalate in respect of attendance by any core member.

Governance

The Emergency Planning service within SFH currently consists of a full time Emergency Planning Officer and an Emergency Planning Support Officer, also full time.

It provides support to and facilitates the Resilience Assurance Committee (RAC), which is chaired by the Chief or Deputy Chief Operating Officer and has membership at a senior level across the organisations' both clinical and corporate areas.

The RAC reports and escalates into the Risk Committee which is Chaired by the Chief Executive, with monthly reports capturing the outputs from RAC.

Notts ICB and NHS England Midlands Region host the Local health Resilience Partnership (LHRP) which is a system wide forum, containing all of the health organisations in the Nottinghamshire area, and is attended on SFH's behalf by the Chief Operating Officer, who is the Trusts' Accountable Emergency Officer (AEO).

Notts ICB and NHS England scrutinise and cross-check our compliance against the national core standards annually, after which the final assessment and compliance rating for the organisation is reported to the Board of Directors in a public setting.

The EPRR Core Standards

The Trust is obliged by law to comply with its responsibilities as a category One responder under the Civil Contingencies Act (2004), they being:

a) To assess the risk of emergencies

b) To plan for emergencies

c) To develop business continuity management

d) To cooperate with other responders

e) To share information

f) To communicate (warning and informing)

In order to ensure compliance with the foregoing, NHS England has developed a set of core standards for emergency preparedness, across ten domains with which to examine individual organisations levels of compliance, which can be seen in the following table:

There are four levels of compliance available as follows:

Full Compliance = 100% compliant across all domains

Substantial Compliance = 89-99%

Partial Compliance = 77-88%

Non-Compliant = below 77%

Although we await the formal confirmation letter from NHS England, the Trust has improved its overall Core Standards compliance rating from **"Partial"** (82%) in 2022 and 2023, to "Substantial" (91%) in 2024, with no areas deemed non-compliant. The overall outcome is described in the following table.

The 2024 Core Standards Final Assessment:

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	10	1	0
Command and control	2	1	1	0
Training and exercising	4	4	0	0
Response	7	6	1	0
Warning and informing	4	4	0	0
Cooperation	4	4	0	0
Business Continuity	10	7	3	0
CBRN	12	12	0	0
Total	62	56	6	0

The areas not fully compliant are:

- CS13 - Pandemic Surge Plan – our existing copy was slightly overdue its formal review.
- CS21- Trained on call staff to maintain a Personal Development Portfolio – unable to evidence.
- CS26 – ability to run a virtual ICC – unable to evidence.
- CS47 – Business Continuity Plans – insufficient evidence in compliant standard (self-declared)
- CS50 – BCP weakness in performance monitoring (self-declared)
- CS53 – BCMS of commissioned suppliers/providers – insufficient evidence.

The EPO will work to improve the areas deemed partially compliant over the coming weeks and months, to progress further towards a Full Compliance rating.

The formal letter of confirmation, addressed to the Chief Executive, is expected on 15th November.

RAC Annual Workplan

The annual workplan is presented to the RAC in November each year for agreement/amendment as a schedule for the following year.

The workplan is designed around the core standards but will also incorporate any actions and learning from incidents and exercises and recommendations arising from the annual core standards assessment process. It will also set out plans for training and exercises throughout the year.

The RAC regularly reviews progress on the workplan and any significant challenge with completing any elements may be escalated to the Risk Committee via the monthly Quadrant report.

The workplan for 2024 was set out as follows and has been completed apart from two exercises:

1. The Mass Countermeasures exercise – this requires coordinating with system colleagues, but it was decided to carry out a regional evacuation exercise instead, so this will be deferred until 2025 and included in the Workplan.
2. Missing child exercise in maternity – due to severe operational pressures this has been postponed a couple of times. The EPO will continue to work with Divisional colleagues to make this event happen before the year end.

Otherwise there has been 100% completion rate against the plan (see Appendix 1).

Training Compliance

The priority task of the EPO is to ensure incident commanders at both Strategic (Gold) and Tactical (Silver) are trained to respond effectively to any incident. Additionally, a considerable monthly effort to train emergency department staff (at all levels) on being prepared for incidents, including the particular requirements to respond effectively to Chemical, Biological, Radiological, Nuclear (CBRN) or HazMat (hazardous materials) incidents.

All responders are provided with training in incident response and command and control prior to enrolment on to the on-call rotas. Training is refreshed annually and compliance levels for 2024 for incident commanders at both levels is currently as follows, which is exceptional when compared to peer organisations:

Strategic (Gold) = 100%

Tactical (Silver) = 91%

Exercises

In accordance with the NHS England EPRR Framework guidance the trust has an obligation to carry out exercises, as follows:

ICC Equipment test – every three months

Communications (Cascade test) exercise – every six months

Tabletop exercise – annually

Live Play exercise – every three years

ICC Command Post exercise – every three years

This is rigorously examined as part of the Trust core standards submission, and we are again fully compliant with this section, as more exercises are being conducted now than at any time in the past.

The Trust has conducted or taken part in the following exercises in line with the above:

- CBRN exercise at NUH (Exercise Triton)
- Equipment tested every two weeks
- Cyber resilience exercise (exercise Viper) with NHIS (tabletop).
- Measles presentation in ED (exercise Rasher) – live play.
- Water supply disruption exercise (exercise Dry Run) involving Severn Trent Water (tabletop).
- VIP Admission exercise Star Attraction (during election campaign) – live play.
- Trust wide business continuity exercise (exercise Trident with three scenarios) in tabletop format.
- Regional evacuation exercise (exercise Dynamo) in tabletop format.
- Site-wide power failure exercise (Blackstart) – live play.

The Trust has also carried two incident cascade tests (one in hours and one out of hours), with another two due in November.

Reports into all of the above are available on request.

All exercises are properly debriefed with agreed actions being captured and tracked through the RAC Action Log for completion.

Incidents

There have been no serious declared incidents through 2024, which is highly unusual and is perhaps a positive reflection on the resilience of our services.

It is worthy of note however that the Trust has managed extended periods of industrial action as EPRR events, using normal incident response processes and command and control arrangements.

The Trust has also recently had to deal with some malicious activity over its radio network making direct threats to the organisation. It has managed these through normal EPRR processes.

Risks Identified

Risks of a major disruptive incident are captured in and managed through the Board Assurance Framework, Principle Risk no.7.

This is reviewed on a monthly basis with the Trusts Risk & Assurance Manager, the Accountable Emergency Officer and the Emergency Planning Officer, and is currently rated as a 16, high risk, predominantly due to threat of cyber-attack.

Other than cyber, there are no high risks currently deemed a significant threat to the Trust.

Lessons Learned

In accordance with the Trusts Emergency Planning Policy, it is committed to learning lessons from incidents and exercises. This process is described within the policy and ensures a robust process is in place to ensure follow up actions are completed.

There is also a regional process in place for sharing lessons with partner organisations through submission of post incident and exercise reports, with oversight from NHS England.

The Trust wilfully engages with regional colleagues in sharing its lessons and acquiring those of other organisations.

Business Continuity Management System

The Trust has, throughout 2024, sought to upgrade its BCMS and bring into line with the NHS BC Toolkit, which itself is aligned to international standard ISO22301**.**

360 Assurance audited the upgraded BCMS in September 2024, and concluded that it should provide “Significant” assurance to the Trust Board.

Summary

Through the successful completion of its workplan, the number of exercises undertaken, training compliance levels, the smooth running of periods of industrial action and the assurances received from external partners, one can conclude that the Trust is well prepared to deal with incidents and emergencies.

The improvement in our core standards assessment is further evidence that the Trust is positively progressing in terms of its overall emergency preparedness and the Board is asked to be **Assured** by the contents of this report.

Report by Mark Stone

Emergency Planning Officer

October 2024

Appendix 1

EPRR Work Programme 2024

Item	Action	Lead	J	F	M	A	M	J	J	A	S
Governance											
Agree Meeting Schedule for 2023	Approve	Chair	✓								
Review RAC Terms of Reference	Approve	Chair		✓							
Create Collaboration Log and append to all reviewed plans	Create	Emergency Planning Officer	✓								
Six monthly assurance and performance progress report to be sent to the Risk Committee	Present	Chair					✓				
Update RAC action log	Update	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Update RAC attendance report	Update	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete EPRR Self-Assessment	Update	Emergency Planning Officer								✓	
EPRR Core Standard Self-Assessment to RAC	Approve	Emergency Planning Officer									
Annual EPRR Self-Assessment Report to Board	Approve	Chair									
Feedback from Regional Groups	Update	Chair	✓	✓	✓	✓	✓	✓	✓	✓	✓
Corporate/Divisional/Contracted Function Resilience Update											

Item	Action	Lead	J	F	M	A	M	J	J	A	S
Skanska	Present	Skanska Lead	✓						✓		
SFH Estates	Present	SFH Estates Lead	✓						✓		
Medirest	Present	Medirest Lead	✓						✓		
Urgent & Emergency Care	Present	UEC Lead		✓						✓	
Surgery	Present	Surgery Lead		✓						✓	
CSTO	Present	CSTO Lead			✓						✓
Women's and Children's	Present	W & C Lead			✓						✓
Medicine	Present	Medicine Lead				✓					
NHIS	Present	NHIS Lead				✓					
Training Activity											
Complete Training Needs Analysis to include EPO	Create	Emergency Planning Officer	✓								
Silver Command	Conduct	Emergency Planning Officer	✓		✓		✓		✓		✓
Gold Command	Conduct	Emergency Planning Officer				✓		✓			✓
Loggist	Conduct	Emergency Planning Officer	✓		✓		✓		✓		✓
CBRN/Major Incident Training with ED Staff	Conduct	Emergency Planning Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓
Principles of Health Command	Conduct	Strategic and Tactical Leads	✓	✓	✓	✓	✓	✓	✓	✓	✓
Exercise Activity											
Plan Trust wide Business Continuity Exercise	Plan	Emergency Planning Officer				✓					

Item	Action	Lead	J	F	M	A	M	J	J	A	S
Conduct Trust Wide BC Exercise	Test	Emergency Planning Officer						✓			
Plan Cyber Security Exercise	Plan	Emergency Planning Officer		✓							
Carry Out Cyber Security Exercise	Test	Emergency Planning Officer			✓						
Plan Mass Countermeasures Exercise	Plan	Emergency Planning Officer						✓			
Carry Out Mass Countermeasures	Test	Emergency Planning Officer						✗			
Carry Out Six-Monthly Cascade Test	Test	Emergency Planning Officer				✓					
Plan test of Missing Child Procedure	Plan	Emergency Planning Officer				✓					
Carry out test of Missing Child Procedure	Test	Emergency Planning Officer					✗				
Carry Out Blackstart test at KMH	Test	Estates Lead		✓	✓						
Carry OUT Blackstart Test at NWK	Test	Estates Lead		✓							
Carry Out Test of NHIS IRP	Test	Emergency Planning Officer					✓				
Business Continuity											
Divisions to conduct review of all BCP's and bring up to date	Update	Emergency Planning Officer		✓							

Item	Action	Lead	J	F	M	A	M	J	J	A	S
All Updated BCP's to be uploaded on to intranet site	Update	Emergency Planning Officer		✓							
All updated BCP's to be placed in Divisional folders and DNM Master Folder	Update	Emergency Planning Officer									
Arrange Meeting of the SWPG	Arrange	Emergency Planning Officer					✓				
Review BC Policy and present to Public Board	Review	Emergency Planning Officer									
Emergency Planning											
Complete Review of Actions from 2023 CSSA and prepare 2024 submission	Complete	Emergency Planning Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓
Complete Review of EMAS CBRN audit complete any outstanding actions	Complete	Emergency Planning Officer	✓	✓	✓						
Progress Mass Notification System with DSG	Progress	Emergency Planning Officer	✓		✓			✓			✓
Carry Out Radio and Battery Checks	Conduct	Emergency Planning Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓
Update Silver and Gold On-call Lists	Update	Emergency Planning Officer			✓			✓			✓

Item	Action	Lead	J	F	M	A	M	J	J	A	S
Review Stock and Serviceability of Radio Pagers	Review	EPO/Estates Lead			✓						✓
Conduct Stock and Serviceability Check on Mobiles at NWK	Review	Emergency Planning Officer	✓	✓	✓	✓	✓	✓	✓	✓	✓
Review Community/ National Risk Register and Escalate to Risk Committee any Appropriate Concerns	Review	Emergency Planning Officer			✓			✓			✓
Arrange for Ramgene Calibration	Arrange	Emergency Planning Officer									✓
Arrange for PRPS Suit Servicing	Arrange	Emergency Planning Officer			✓			✓			✓
Arrange CBRN Equipment Service	Arrange	Emergency Planning Officer						✓			
Arrange Decon Tent Service	Arrange	Emergency Planning Officer			✓						

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Trust Board Cover Sheet

Subject:	Half Year Performance Review	**Date:**	07/11/2024
Prepared By:	Andrew Graham, Deputy Chief Financial Officer Chris Dann, Deputy Chief Operating Officer Deborah Kearsley, Deputy Chief People Officer		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
To present Trust Board with an overview of H1 performance and an initial outlook for H2.	**Approval**	
	Assurance	
	Update	**X**
	Consider	

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

Identify which Principal Risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	**X**
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Insufficient financial resources available to support the delivery of services	**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

Trust Management Team
Finance Committee

Acronyms

H1 = 1st half of the financial year (April 24 to September 24)	ICB = Integrated Care Board
H2 = 2nd half of the financial year (October 24 to March 25)	SLAM = Service Line Activity Management
FYE = Full Year Effect	BPPC = Better Payment Practice Code
YTD = Year to Date	WTE = Whole Time Equivalent
YTG = Year to Go	A&E = Accident and Emergency
NHSE = NHS England	FDS = Faster Diagnosis Standard
PDC = Public Dividend Capital	SFH = Sherwood Forest Hospital NHS Foundation Trust
PFI = Private Finance Initiative	GI = Gastrointestinal
FOT = Forecast Out-Turn	SOP = Standard Operating Procedure
I&E = Income and Expenditure	MSFT = Medically Safe for Transfer
ERF = Elective Recovery Fund	
FIP = Financial Improvement Programme	

Executive Summary

The accompanying slides present the Trust Board with an overview of the organisational H1 position looking through the domains of finance, workforce, activity, and performance.

The Trust now has a H1 deficit of £0.8m. This deficit is following the non-recurrent deficit support funding (£13.6m) provided by NHSE.

The £0.8m deficit is being driven by

- £0.3m Industrial Action income loss
- £0.2m for redundancy costs on the vaccination service
- £0.3m for the impact of the consultant pay award not being fully funded

The unmitigated forecast for the financial year is £29.1m however there are a range of opportunities within the slides that look to mitigate this back to a break-even position in-line with the submitted plan to NHSE.

From a workforce perspective, our overall workforce, inclusive of Substantive, Bank, and Agency together the Trust was 0.6% or circa 32.3 WTE below plan, this is lower than Month 5 where the Trust was 0.03% above plan.

The Trust continues to see increasing levels of activity across all points of delivery, which is greater than the planned 0.6% growth that was included in our baseline for in 24/25. Despite the pressure this creates, the Trust has delivered relatively strong performance across several key metrics such as diagnostics and referral to treatment.

There are some positive measures reported under the quality of care domain such as the Trust have not had an MRSA bacteraemia for over two years, and the only organisation in the region to not have one this financial year. Our national inpatient survey demonstrated that 22 scores are in the top 20% range, 26 are in the intermediate-60%, and 1 is in the bottom 20%. There were some areas to learn and improve on which are demonstrated in the two never events and the coronial matters reported in H1.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Half Year Performance Review

Trust Board Meeting

H1 I&E Report

	YTD		
	Plan	Actual	Variance
Income:			
Clinical Income	243.76	244.21	0.45
Other Income	26.04	25.91	(0.13)
Total Income	**269.80**	**270.12**	**0.32**
Expenditure:			
Pay - Substantive	(149.15)	(142.69)	6.46
Pay - Bank	(10.92)	(15.59)	(4.67)
Pay - Agency	(6.01)	(7.39)	(1.38)
Pay - Other (Apprentice Levy and Non Execs)	(0.80)	(0.73)	0.07
Total Pay	(166.88)	(166.40)	0.47
Non-Pay	(84.14)	(85.79)	(1.62)
Depreciation	(7.88)	(7.78)	0.10
Interest Expense	(23.90)	(23.92)	(0.02)
PDC Dividend Expense	-	-	-
Total Non-Pay	(115.92)	(117.49)	(1.54)
Total Expenditure	**(282.80)**	**(283.89)**	**(1.10)**
Surplus/(Deficit)	**(13.00)**	**(13.77)**	**(0.78)**
Removal of PFI adjustment	12.99	12.99	-
Final Surplus/(Deficit)	**(0.00)**	**(0.78)**	**(0.78)**

- The Trust has a H1 deficit of £0.8m. This is being driven by
  - £0.3m Industrial Action income loss
  - £0.2m for redundancy costs on the vaccination service
  - £0.3m for the impact of the consultant pay award not being fully funded.
- The H1 plan is now at break-even following the non-recurrent deficit support funding (£13.6m) provided by NHSE.
- The Trust is also off plan on the efficiency programme at H1 by £2.9m but this is being mitigated with other non-recurrent measures such as prior year ERF overperformance.
- The H1 position still contains energy inflation funding from NHSE to the value of £3.0m (£6.0m FYE) which NHSE have recently highlighted as being a very high-risk assumption.
- Whilst H1 pay position is showing a marginal £0.5m underspend, there is a higher than planned reliance on temporary staffing expenditure to cover substantive roles.

24/25 Unmitigated Forecast

Category	Year to Date 2024/25 Actual £m	Year to Go (YTG) Actual £m	Forecast Out-turn Forecast £m	Movement Forecast £m
Clinical Income	244.21	227.07	471.28	(17.14)
Other Operating Income	25.30	25.90	51.20	0.60
Total Operating Income	**269.51**	**252.97**	**522.48**	**(16.54)**
Pay	(166.40)	(175.48)	(341.89)	(9.08)
Non Pay	(85.35)	(87.44)	(172.79)	(2.10)
EBITDA	**17.76**	**(9.96)**	**7.80**	**(27.72)**
				0
Operating Costs Excl. from EBITDA	(8.07)	(7.98)	(16.05)	0.09
Non Operating Income	0.50	0.79	1.29	0.28
Non Operating Expenditure	(23.92)	(5.18)	(29.10)	18.74
Surplus/(Deficit) on Accounts Basis	**(13.72)**	**(22.33)**	**(36.06)**	**(8.61)**
				0
Donated Asset Income	(0.15)	(0.15)	(0.30)	-
Donated Asset Depreciation	0.12	0.11	0.22	(0.01)
Gain / Loss on Disposal of Fixed Assets	(0.02)	0.01	(0.01)	0.03
Surplus/(Deficit) - ICS Achievement Basis	**(13.78)**	**(22.37)**	**(36.14)**	**(8.59)**
				0
IFRS16 PFI Adjustment	12.99	(5.96)	7.04	(18.95)
				0
Final Surplus/(Deficit)	**(0.78)**	**(28.32)**	**(29.11)**	**(27.54)**

- H2 assumes £16.5m less income than we have received in H1. The key drivers to this reduction are
  - Energy inflation funding not received
  - Non-Recurrent Revenue Support Received in H1
- H2 is forecasting £9.1m additional pay costs than we have incurred in H1. This is not linked to pay inflation. The key drivers of this increase are
  - Winter funding
  - Increased fill rate to vacant posts across operational and corporate areas
- H2 is forecasting £2.1m additional non-pay costs than we have incurred in H2. The expenditure increase will be linked to seasonality and increased consumables associated with ERF activity across H2
- This significant change in run rate is not sustainable for 24/25. Given the controls already in place, we need a refresh of the forecast at M7, especially when it comes to the £9.0m increase in pay level being forecast.

Financial Risk (outside of unmitigated forecast)

Risk Description	Internal/External	Notes
Pay Award Funding	External	Potential for adverse impact of Junior Doctor and Agenda for Change 24/25 pay awards. Currently anticipating both to be fully funded.
Winter (income loss)	Internal	Organisation is required to cancel elective activity due to emergency care pressures over winter
Band 2 to Band 3 pay settlement	External	Back dated national band 2 to band 3 uplift. Full impact is currently being worked through.
Contract disputes with the ICB	External	Multiple contractual discussions taking place with ICB regarding funding for services, value-based commissioning and outcome from service reviews. Potential double count of financial savings across N&N ICS.
Closed Loop Diabetes Pumps	External	NICE guidance changes driving a change in prescribing behaviours and cost is more than any national funding.
Delivery of Risk Adjusted Efficiency Forecast	Internal	We are currently assuming that our weighted forecast will be met within our current forecast. Any reduction to our weighted forecast achievement would worsen the unmitigated forecast position

Financial Recovery Plan Opportunities

Proposed Action	Proposal
Annual Leave Provision	To apply stricter controls around annual leave carry forward in 24/25 to allow full release of the current balance.
Medical Agency Review	To issue an agency expenditure limit for H2 for the organisation to prioritise resource accordingly and reduce expenditure
Increased scrutiny of vacancy control	Increased scrutiny of vacant posts and to review the categorisation of our services into the four levels
Discretionary Expenditure Controls	Continue recently introduced process for discretionary expenditure
Collaborative Procurement	Work with system partners to source best value contracts and supplies
ERF Income Achievement	Robust review of H2 ERF activity and income, ensuring all benefits from theatre and outpatient transformation is captured
De-risking the FIP plan	Work with PA consulting to de-risk the FIP plan across H2
Bank Expenditure Review	Continued work with system partners on bank rates and usage, with a view to reducing expenditure
Review of accounting policies	Trust to review accounting policies with system partners to ensure consistency of approach and seek any wider opportunities
Robust confirm and challenge on financial forecast	Given the above controls which are starting to take shape, a robust monthly forecast review is to take place to ensure ownership

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Workforce

Workforce Planning

- Overall, for Substantive, Bank, and Agency together the Trust was **0.6% or circa 32.3 WTE below plan**, this is lower than Month 5 where the Trust was 0.03% above plan.
- Trust **bank is 2.9% below plan** (12.2 WTE) and **agency WTEs are 23.9% (24.4 WTES) below plan**. Substantive workforce in month 6 is 0.1% (4.3 WTE) above plan, this increase demonstrates the work we are mobilising in substantivsing the workforce.
- Agency usage (3.5%) sits below our Trust planned figure (4.2%) and above the expected 3.2% NHSI target, and shows a decrease from Month 5. M6 position is reported at 3.5%, and without ERF reported at 2.8%.
- We have projected the winter plan into the planning assumptions, noting increases in bank and agency usage from November 24 to February 25.

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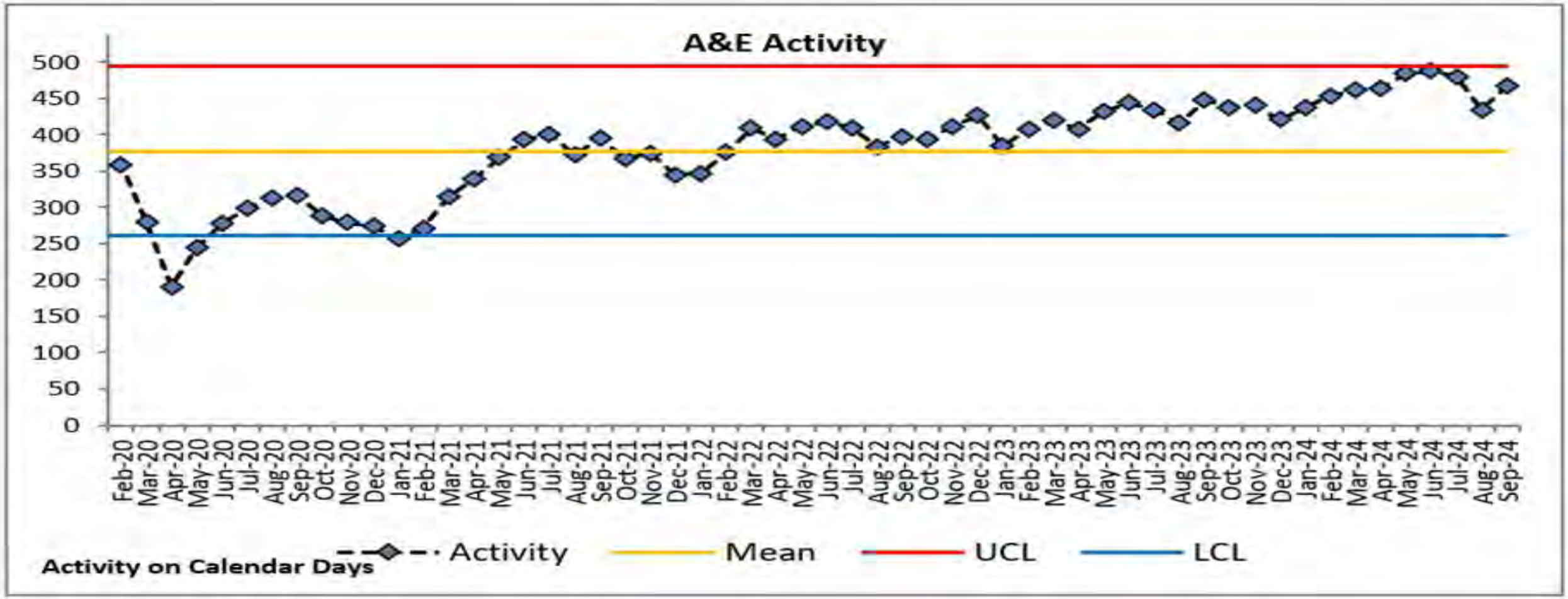
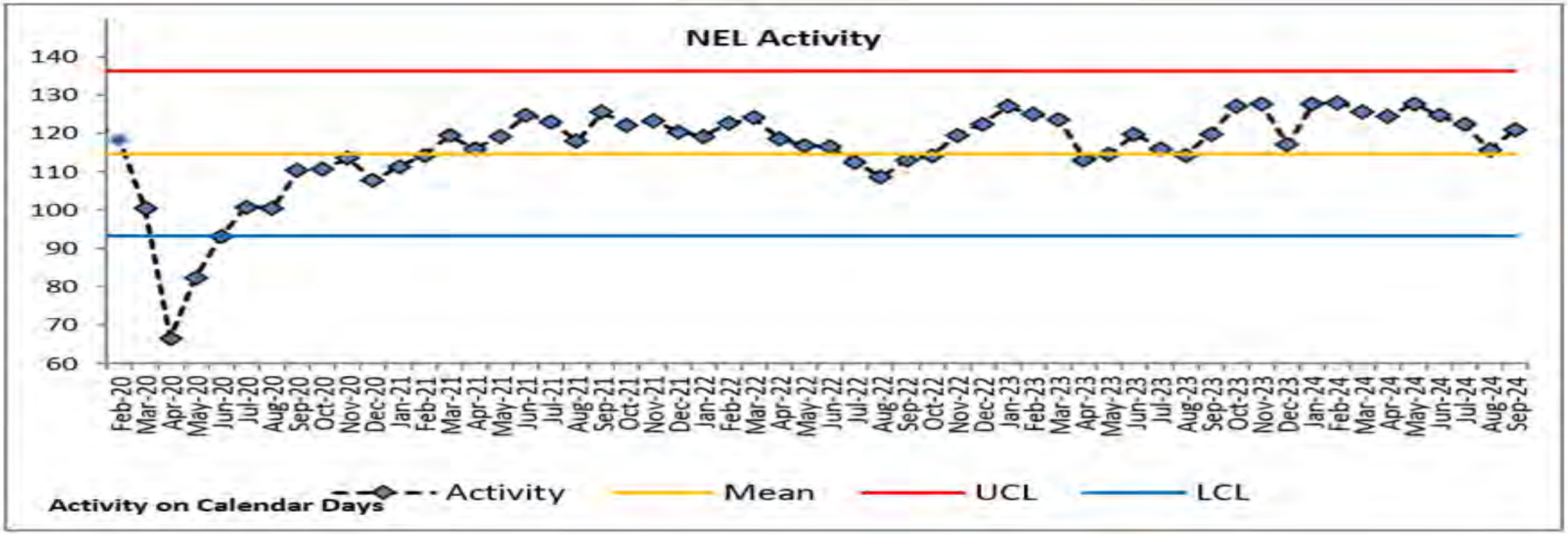
Activity

A&E Activity



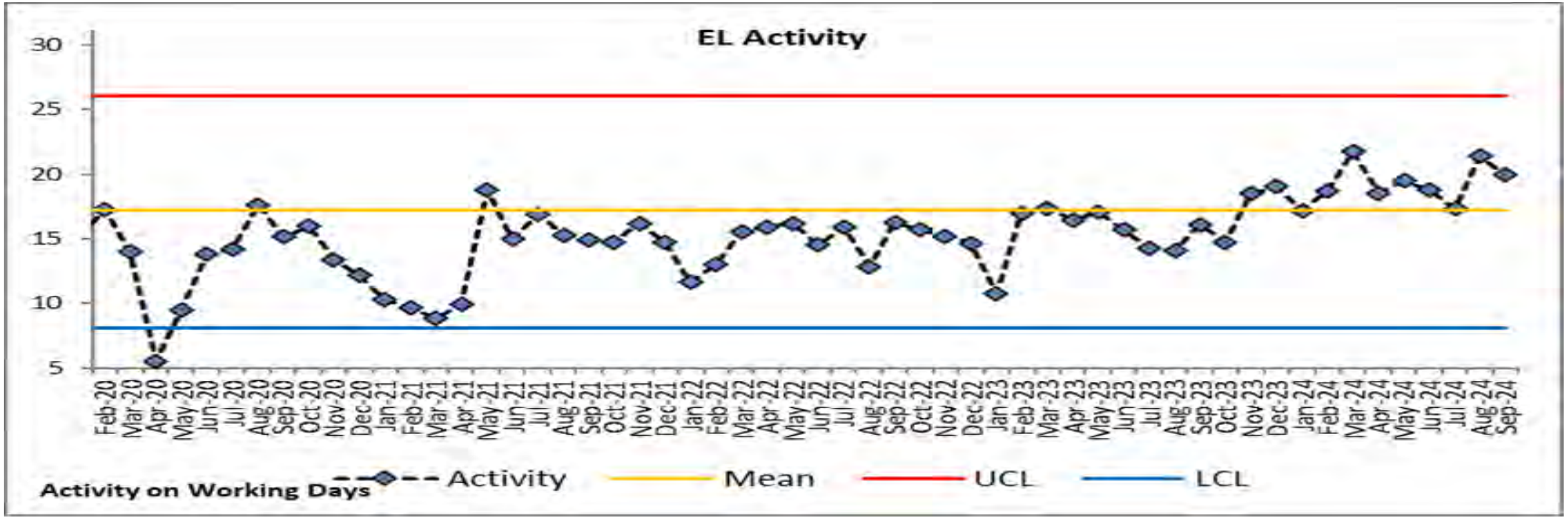
- Compared to September 2023, activity was 571 (4%) higher.
- Attendances per day in September 2024 = 467, compared to September 2019 = 381.

NEL Activity



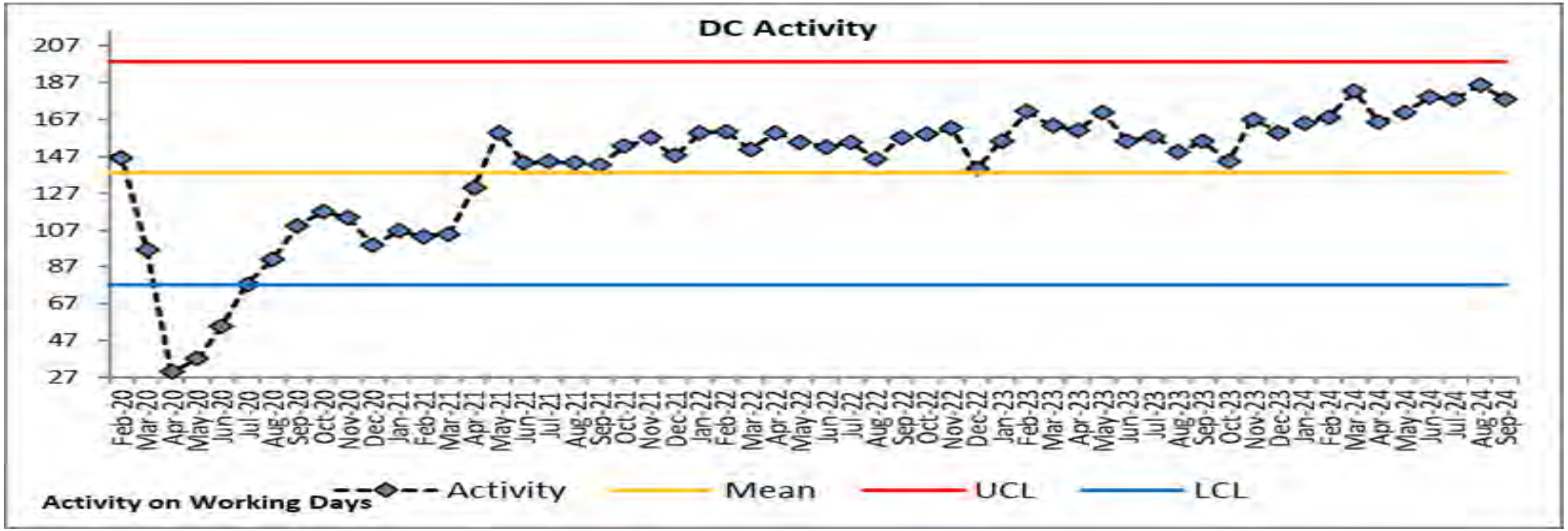
- Compared with September 2023, activity was 1% higher, with 30 more discharges.
- Discharges per day in September 2024 = 121, compared to September 2019 = 114.

EL Activity



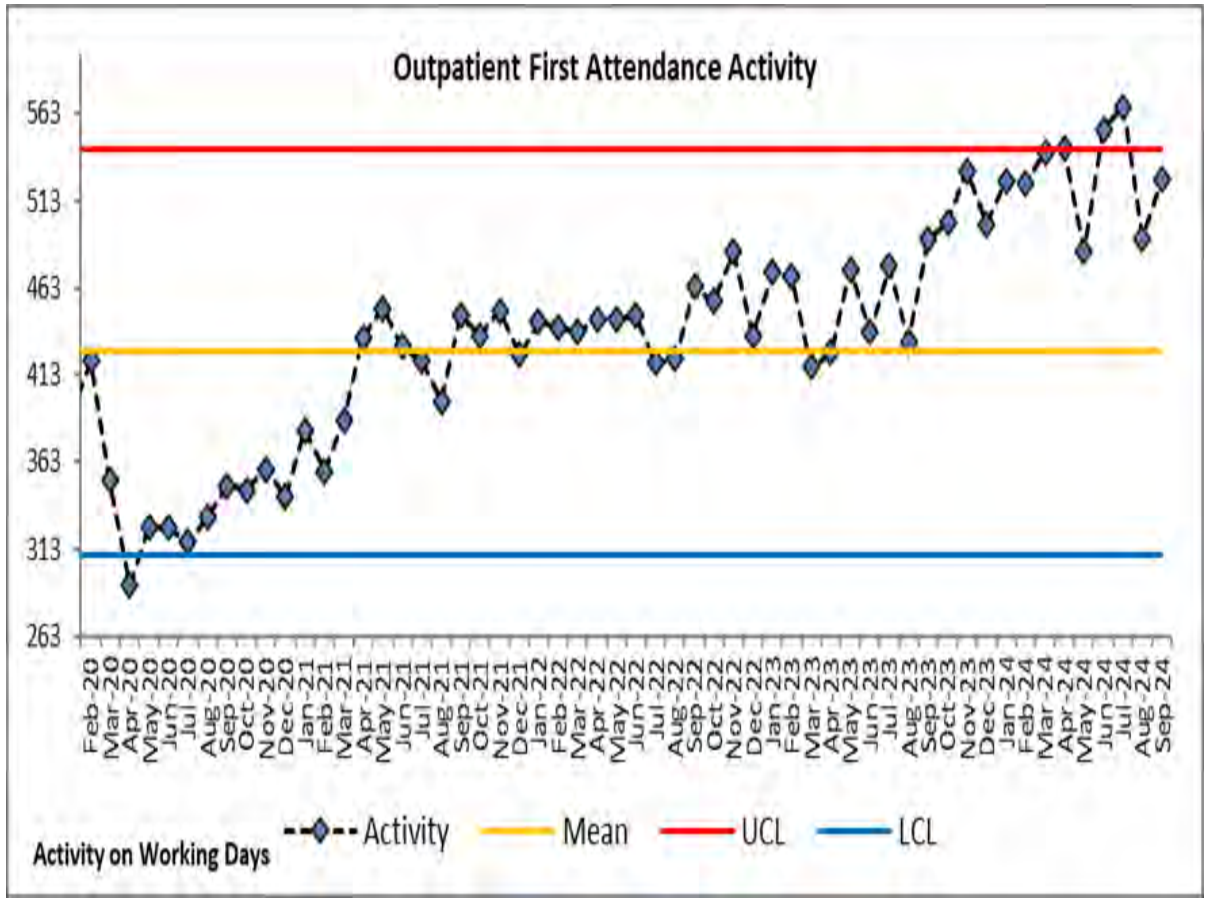
- Elective activity per working day has decreased compared to the previous month.
- Compared with September 2023, activity is 24% higher (81 spells).
- Discharges per working day in September 2024 = 20, compared to September 2019 = 18.

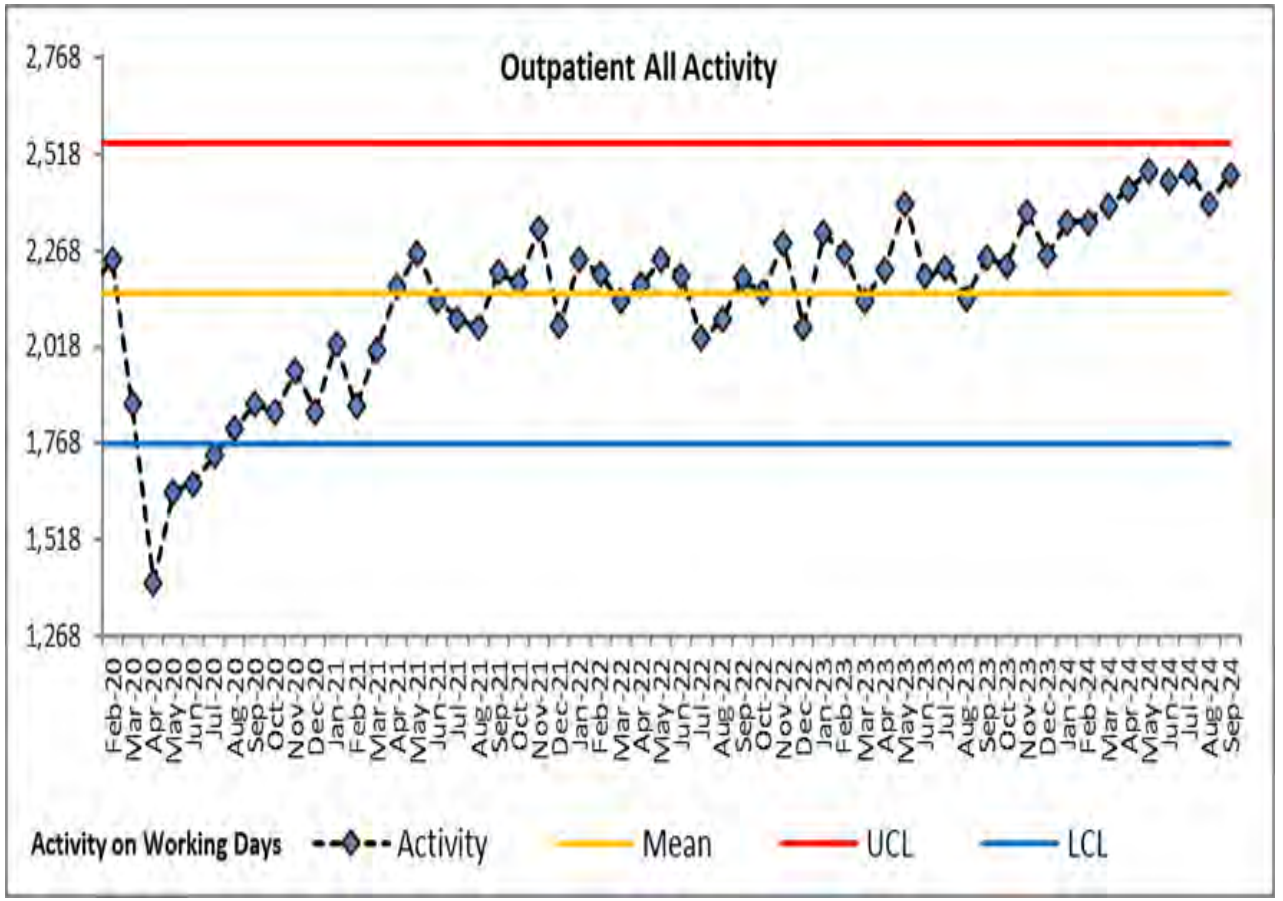
DC Activity



- Day case activity in September has decreased compared to the previous month.
- Compared with September 2023, activity is 15% higher (478 more spells).
- Attendances per working day in September 2024 = 179 compared to September 2019 = 133.

Outpatient Activity





- Compared with September 2023, outpatient first activity was 7% higher (700 more attendances in month per working day).
- Outpatient first attendances per working day in September 2024 = 525, compared to September 2019 = 395.
- Total Attendances per working day in September 2024 = 2,466 compared to September 2019 = 2,130.

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Operational Performance

Cancer

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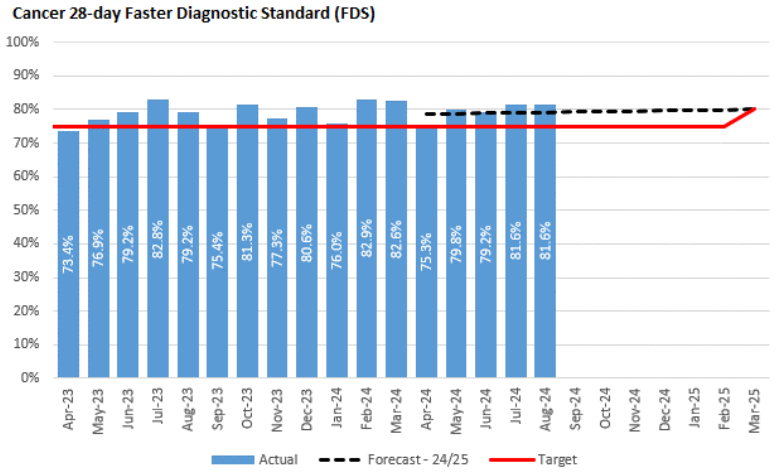

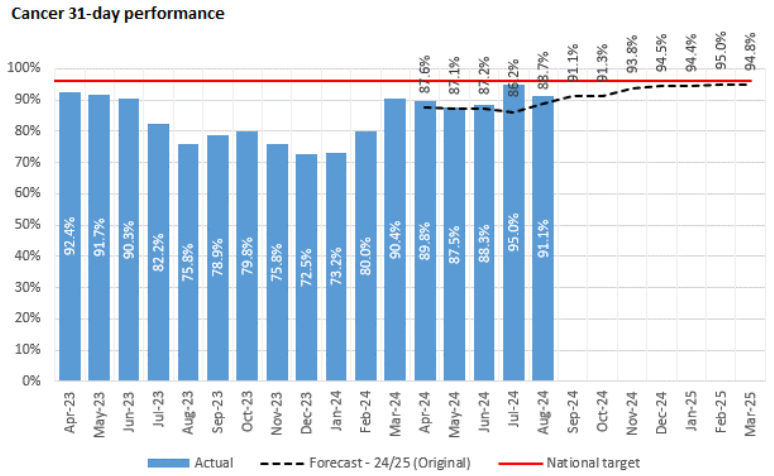

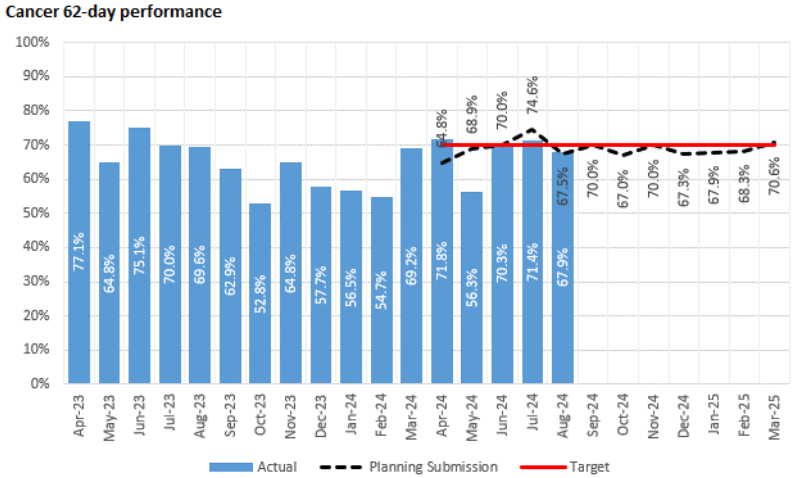

Progress during 2024/25 H1

- Throughout H1, we have achieved the **Cancer 28-Day Faster Diagnosis Standard and 31-day performance standard** in line with our operational plan forecast.
- **Cancer 62-day performance** has been strong from Jun-24 to Aug-24. While we fell short of our ambitious operational plan in Jul-24, our performance remained above the current national target of 70%.
- SFH is performing above the **national average** for 28-day FDS performance, but slightly below **national average** for cancer 31-day and 62-day performance.
- The two biggest tumour sites impacting **31-day performance** are Lower GI and Urology. **Lower GI** has been above plan during Jun-24 and Jul-24. **Urology** remains just below a plan of 100%. **Skin** has been the greatest contributor to improved 31-day performance and delivery of our recovery trajectory, achieving the national standard in Aug-24 for the first time this financial year.
- **Skin** has achieved consistently high **cancer 62-day performance** through H1, while **Upper GI** has improved significantly from 50% to 85% in Aug-24.

Priority areas of focus and 2024/25 H2 outlook

- There is a growing 62-day backlog in **Head & Neck** that is impacting on 62-day performance due to diagnostic capacity. This is being addressed, with additional local radiology capacity and mutual aid.
- The **Lung 62 backlog has increased** and impacted performance due to complex pathways and an increased requirement for interval diagnostics (at 3 months,) with patients remaining on the cancer pathway. However, Lung are compliant with the Best Practice Timed pathway.
- Our operational plan suggests that **Lower GI** is expected to **dip in 31-day performance** until Dec-24, but will rise in the following months to **achieve 95% by year-end**.
- **Improving histology turnaround** impacting on pathway delays across all tumour sites is a key focus. A SOP to mitigate current challenges is being developed and will be operationalised in H2.
- Reducing waits for diagnostic tests and increasing reporting turnaround for all pathways, in particular CT colon and US FNA, is a key focus and will be achieved through increased capacity and mutual aid.

Diagnostics

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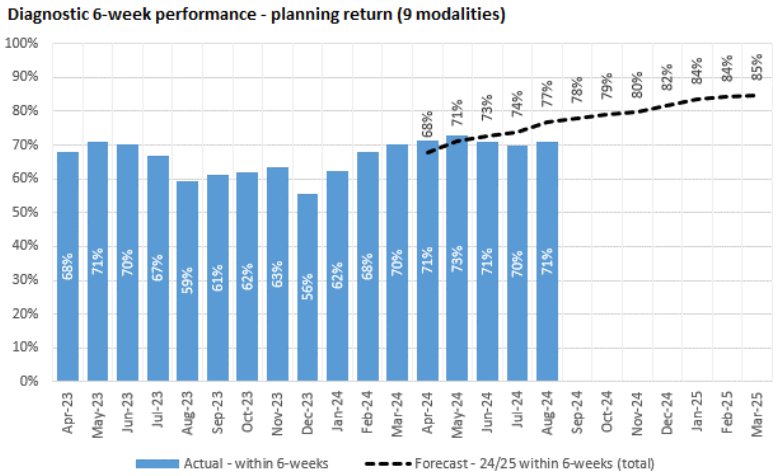

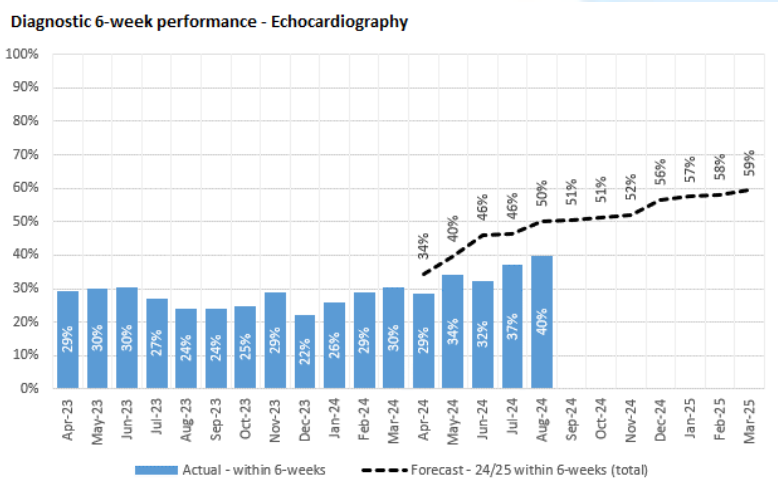

Progress during 2024/25 H1

- During H1, our **performance against the Diagnostic 6-week standard** has remained relatively stable against a requirement to improve performance month-by-month. In Aug-24, we were circa 6% below plan.
- **Echocardiography** was the biggest challenge through H1, though has been improving, and has achieved above plan in the last two weeks (at the time of writing).In real terms - this takes performance from 28.6% to 56.7% (unvalidated). This progress has been reflected in the 13-week backlog, which has dropped from 1,695 to 131 through H1.
- **Computed Tomography** has observed a decrease in performance of ~10% during H1, diverging consistently from a rising operational plan. Deviation from plan has been significantly affected by delays in operationalisation of a new CT Cardiac scanner.
- Recent challenges have been observed in **Audiology and Non-Obstetric Ultrasound**. A significant driver of Audiology performance relates to system support provided to NUH as agreed through SOG. Performance decreases seen in Non-Obstetric Ultrasound have been driven by rising demand, Doppler referral increases, and staffing challenges.

Priority areas of focus and 2024/25 H2 outlook

- Improvements seen in **Echocardiography** are anticipated to continue through the remainder of the year, with plans in place to recover CDC activity, put on additional ‘stress Echo’ sessions, continue to utilise a fifth room at King’s Mill Hospital with additional locum support.
- Echocardiography 13ww waiters are expected to be eliminated by end of Oct with a primary focus on 'stress echo' which carries the greatest risk due to being a single consultant service.
- **Non-Obstetric Ultrasound** performance is showing early signs of improvement back towards plan, with extra Doppler scanning clinics initiated to mitigate increased referral demand, and maximisation of CDC capacity being monitored.
- The new **CT Cardiac scanner** is now set to go online in Feb-25. To mitigate this, system support from Doncaster and Bassetlaw Teaching Hospitals, Nottingham University Hospitals and the independent sector support is in place, while extra CT activity at weekends at Newark campus is being provided. A request to Chesterfield for support is also being considered.
- **Sleep** will see improved performance throughout H2 as a process for inpatient sleeps on the discharge lounge is agreed and they operationalise their ERF bid to increase capacity.

Referral to Treatment

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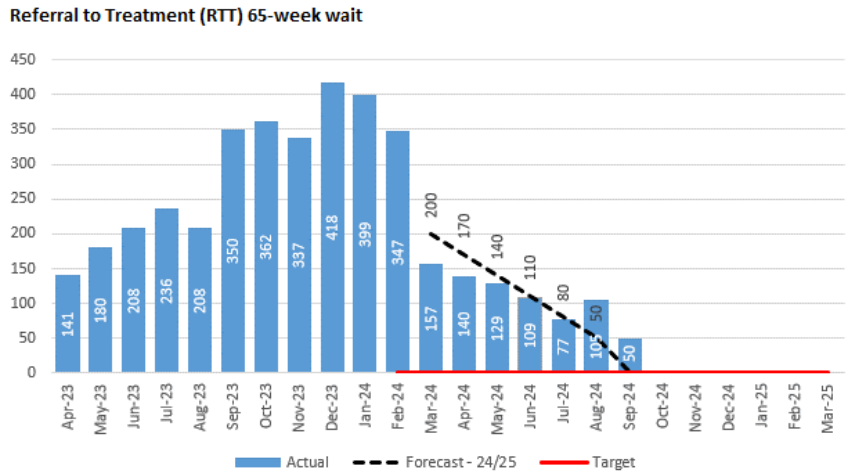

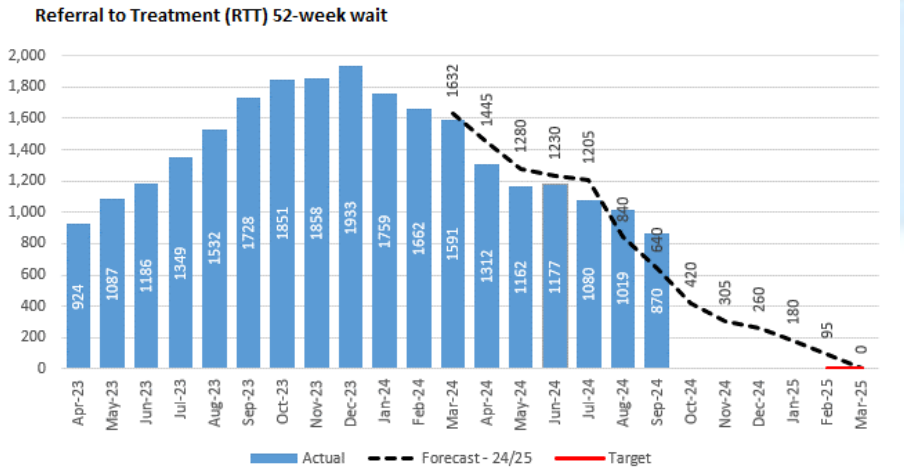

Progress during 2024/25 H1

- **78ww backlog was eliminated in H1 –** a risk of 'drop ins' remain from active validation
- **65ww backlog** has reduced during H1, falling from 157 to 50. However, our operational plan committed to eliminating 65ww by the end of H1, which we have not achieved.
- The two specialties with the largest 65ww backlog **are ENT and General Surgery**, accounting for over 40 patients on the backlog.
- **ENT 65ww backlog has been adversely impacted** by a demand and capacity mismatch that is seen at regional and national level. SFH is also providing system support for NUH. Capacity required for high number of 52ww CYP patients.
- **52ww backlog** has reduced significantly in H1 from 1,591 to 870. However, this is behind plan with anticipated reductions in Aug-24 not fully realised. ENT is the biggest driver of this position.
- Significant 52ww **backlog improvements** have been observed in **Gastroenterology, Endocrinology and Orthopaedics**. However, Orthopaedics remains slightly behind plan.
- Hit plan to minimise DNA rates in Sept to 6% - additional income of ~£0.5m YTD

Priority areas of focus and 2024/25 H2 outlook

- Excluding **ENT, General Surgery, patient choice and complex pathways** all services are forecasting an elimination of 65ww by the end of October
- **Focus remains on ENT and General Surgery to reduce and eliminate 65ww's.** Insourcing capacity for ENT is being implemented November alongside an ongoing anaesthetic contract, which is improving session utilisation. Virtual review clinics in place to improve timeliness of patient removal from pathway. Pre-operative assessment PTL in place to ensure patients ready for surgery.
- Expectation to **eliminate 52ww** in line with operational plan by the end of the year. Plans to achieve this include:
  - Ensure all patients in the 52ww cohort have attended a First outpatient appointment by December 31st
  - Contacting patients through DrDoctor to ensure the waiting list is accurate. Expansion of Central Validation team to reflect Total incomplete PTL size.
  - Continue to access System Support from NUH, other acute providers in region and the Independent Sector.
- Continued focus on theatre utilisation / booking & POA processes through FEI programme
- Ability to identify and operationalise new ERF schemes at pace – in line with H1

Urgent and Emergency Care

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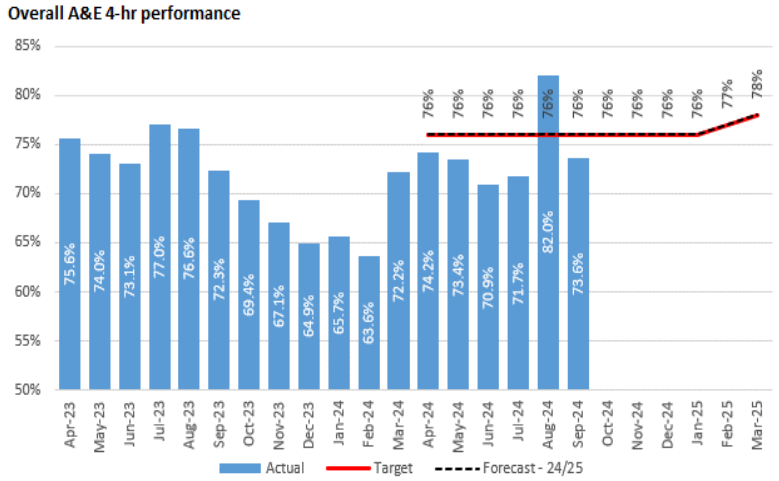

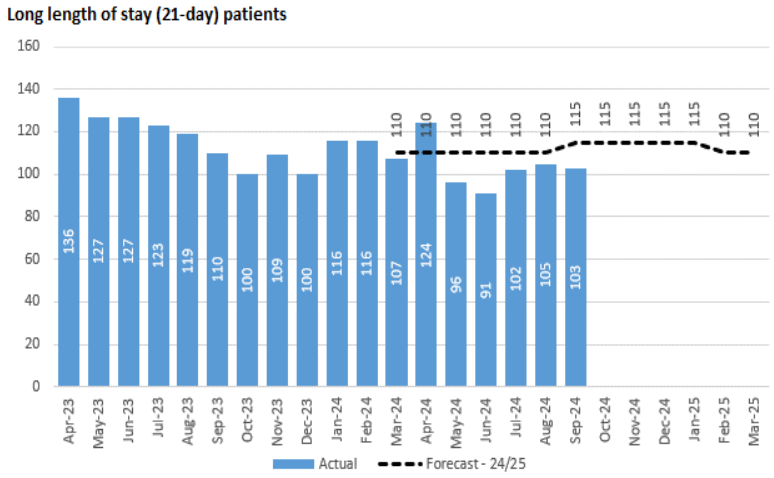

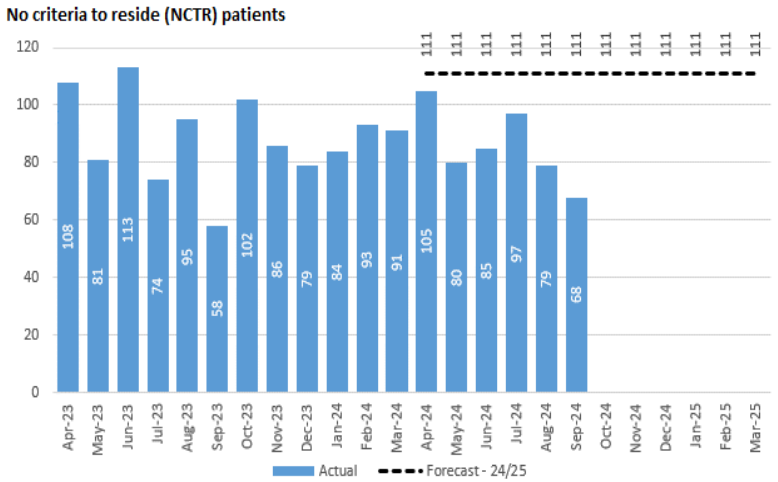

Progress during 2024/25 H1

- **A&E 4-hour performance** delivered a step change improvement in Mar-24 after enhancing the medical and nursing staffing teams in ED to support the rise in attendance demand. This improved position has been sustained in 2024/25; however, our performance has been consistently below our ambitious (and compliant) operational plan throughout H1, apart from in Aug-24. Apr-24 to Jul-24 attendance levels were 10% higher than the equivalent period last year. Type 1 attendances were 11.2% higher. Newark Type 3 attendances were 12.6% higher.
- Aug-24 saw a **significant increase in 4-hour performance** at the same time as a reduction in attendances during the school summer holidays.
- **Long length of stay (LLOS)** levels have remained at circa 100 patients since May-24, inside operational plan following a challenging Apr-24. Lower levels of medically safe for transfer (MSFT) patients will be contributing to this position and supporting the reduced use of Ashmere Care Home group beds (from 27 in H1 2023/24 to 17 in H1 2024/25).
- **No criteria to reside (NCTR, also known as MSFT)** levels have reduced in Q2 to 68 patients, following a rise to 97 in Jul-24. Throughout H1, SFH has continued to track well inside of the operational plan. Our new Discharge Lounge which opened in Apr-24 and expanded Discharge Coordinator team are supporting improved patient flow.

Priority areas of focus and 2024/25 H2 outlook

- Despite improved 4-hour performance in Aug-24, **significant pressures** and challenges to performance and A&E crowding are expected during winter, with a bed model peak forecast **bed gap of 48 beds** during Jan-25.
- Agreed **winter plans** being mobilised to ensure this bed gap and resultant pressure on A&E is minimised. Expansions to SDEC services, focus on frailty and other flow improvement plans are particularly key.
- **Dynamic rostering** to be trialled in Oct-24 to match predicted attendances with appropriate levels of A&E staffing, with a view to implement through H2.
- **LLOS and NCTR positions** expected to remain inside operational plan levels through H2 and our ambition is to keep medically safe over 24hrs no higher than 50 as we know that delayed discharge negatively impacts both those delayed and those awaiting a bed.
- A particular focus will be placed on both reducing internal delays and abandoned discharges and robust management of external demand to reduce the potential impact of the bed gap referenced above.

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Quality of Care

Quality of care

Sherwood Forest Hospitals NHS Foundation Trust

Overview	Lead: Chief Nurse/Medical Director

During H1, we received 901 compliments, 864 concerns, 125 formal complaints, and closed 129 formal complaints. We continue to identify actions and themes that are tracked through the Patient Experience Committee.

The Patient Safety Incident Response Framework (PSIRF) is now well embedded in the Trust and from Apr-24, Infection Prevention and Control (IPC) is aligned with the PSIRF model. The Patient Safety Incident Response Plan has been refreshed and approved by the Patient Safety Committee. It will be presented to Quality Committee for final ratification.

The Trust has not had an MRSA bacteraemia for over two years (we are the only Trust in the region not to have had one this financial year). National targets for infection prevention and control were released in August; we have had increases for CDiff to 65 (24 cases in H1) and Pseudomonas BSI to 14 (1 case in H1) and reductions for Klebsiella BSI to 16 (5 cases in H1) and Ecoli BSI to 83 (20 cases in H1). Infection Prevention Control (IPC) have commenced undertaking rapid reviews for all hospital associated infections and had completed 125 at the end of August with learning being shared as part of all divisional governance reports. There have been two reported CDiff deaths and investigations have taken place for both which have identified that both patients received the appropriate treatment and care.

National Inpatient Survey 2024:Compared to the other sector organisations, 22 scores are in the top 20% range, 26 are in the intermediate-60%, and 1 is in the bottom 20%. Areas where the Trust scores well include privacy & dignity, cleanliness and availability of drinks. Areas for improvement include opportunity to feedback on quality of care, information on medicines at time of discharge, support from Health & Social care following discharge and family involvement in discussions about discharge. The trust has received the Maternity inpatient survey, it is currently embargoed and we are working through themes/ free text comments to look at a plan for sharing.

During H1, 11 Patient safety incident investigations (PSII) were commissioned by the Patient Safety Incident Response Group (PSIRG); this followed an in-depth discussion during which the ICB were present. There were two confirmed coroner's investigations in relation to a delay in recognition and treatment of a low magnesium and the delay in cardiology processes and task list issues - RAG rated red by the Trust legal team. Further information in relation to the patient involved in the Never Event related to retained drill fragment has been requested by the coroner.

Falls per 1000 occupied bed days - The falls rate for H1 is 6.3; this is slightly below the national target of 6.63.

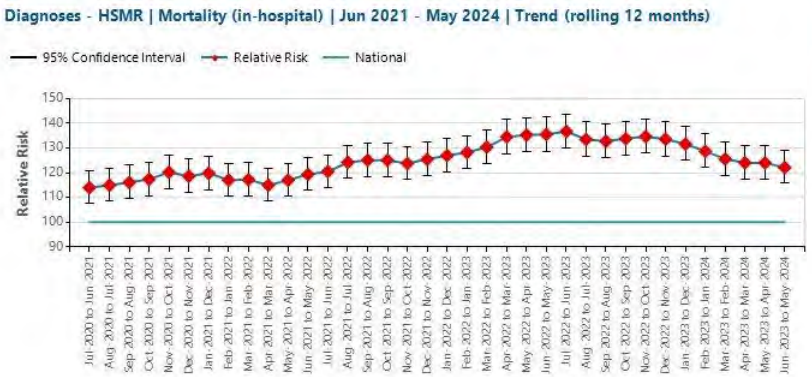
There are four domains during H1 which will be reported as off track for H1:
Never Events – in H1 we reported 2 Never Events (wrong site surgery in dermatology, and retained drill fragment following orthopaedic surgery)
Category 3/4 Hospital acquired pressure ulcers (HAPU) and ungradable pressure ulcers with lapses in care - SFH has had three avoidable category 3 pressure ulcers in H1
Early neonatal deaths per 1000 live births - rate increased to 3.2 in September, but H1 rate 0.6 is within target
Hospital Standardised Mortality Ratio (HSMR)- Latest 12-monthly rolling figure= 122.14 (Jun-23 – May-24); (quarter one report 126.9). Remains above expected but a continued downward trend, alongside individual month reporting remaining "as expected" (Note- awaited changes to HSMR+ methodology).
Summary Hospital-level Mortality Indicator (SHMI)- Latest reporting = 105.96 (May 23- Apr 24); (quarter one report 108.0). Remains as expected.

Further detail relating to mortality indicators, Never Events and regulatory activity is described on the following slide.

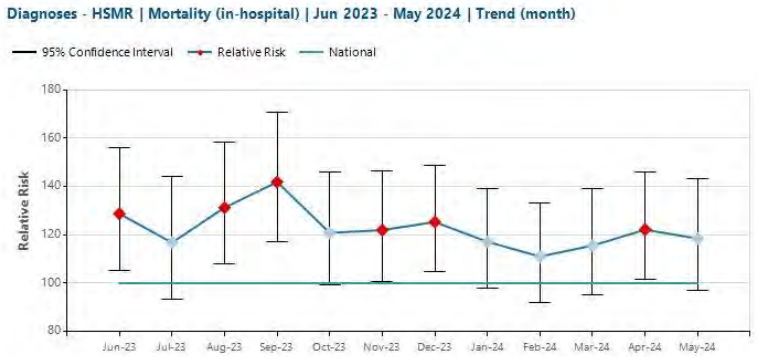
Quality of care

Sherwood Forest Hospitals NHS Foundation Trust

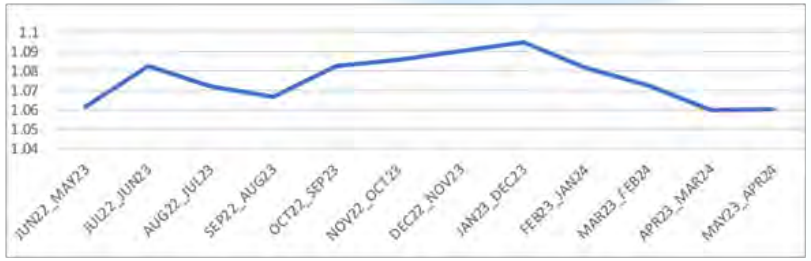
HSMR 3 yearly (12 month rolling) trend



HSMR single month trend



SHMI: Rolling 12 months (Latest May 23- Apr 24)



Mortality Indicators

HSMR- Latest 12-monthly rolling figure= 122.14 (Jun 23 – May 24); (Q1 report 126.9). Remains above expected but a continued downward trend, alongside individual month reporting remaining "as expected" (Note- awaited changes to HSMR+ methodology)
SHMI- Latest reporting = 105.96 (May 23- Apr 24); (Q1 report 108.0). Remains as expected.
Work on root causes continues focussing on:
Data Quality- Emphasis on timely diagnosis, documentation, coding and co-morbidity capture.
Pathways and Patient Flow- Review of admission pathways, use of management bundles and effective signposting.
Palliative Care Coding- Remains lowest, nationally. Discussion with local SPC provider to identify opportunities for improvement.
Learning from deaths – Representation from ME service, divisional leads, ICS and BI. Close working with Telstra. Actions include data interrogation, targeted reviews/ deep dives and audit.
Data Intelligence- HSMR+ (plus) is due to "go live" Q3 2024; it is understood, changes in methodology mean an improved HSMR+ and trend when compared to HSMR and expected values.
External peer review - Visit to Dudley Group Hospitals (DGH) undertaken 1st October with an emphasis on Learning from Deaths and to review processes, approaches to engagement and coding practice.
Wider accountability – Meeting with ICB medical director Sept 24 to review HSMR, assurance measures, coding practices. Development of quality dashboard.

Never events / Coronial process / CQC

Never events: In Apr-24 SFH reported an incident relating to wrong site surgery in Dermatology: A patient attended for a punch biopsy but there was an incorrect site skin lesion biopsy.
An external review has been commissioned and is being undertaken by colleagues from Nottingham University Hospitals NHS Trust (NUH). The investigation is ongoing.
In September 2024 SFH reported an incident when following a surgical procedure, it was identified that a drill bit used during the procedure had broken. Upon review of the image intensifier, it has been confirmed that the broken drill bit can be seen in the patient's elbow which had not been recognised prior to completion of the surgery. It is not thought that this incident contributed to the patient's death and a structured judgement review (SJR) has been commissioned to look at the episode of care.

Coronial matters: The Trust has responded to 4 Prevention of Future Deaths reports, 2 related to the management of sepsis and 2 related to ante-partum haemorrhage. Significant work has been undertaken to review pathways related to sepsis within ED. A new sepsis lead has been appointed. Maternity colleagues have revised guidelines around APH and undertaken additional learning related to this.

CQC: During the last 6 months the Trust has had 2 visits from CQC, including an unannounced visit to ED to review sepsis pathways and a visit to our nuclear medicine department. The Trust has received initial written feedback from both visits. Both visits identified areas of good practice. Formal reports are awaited.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – 2024/25 Q2	**Date:**	7th November 2024
Prepared By:	Domain leads and Mark Bolton, Associate Director of Operational Performance		
Approved By:	Domains approved by lead Executive		
Presented By:	Domains to be presented by lead Executive		

Purpose		
To provide assurance to Trust Board regarding the performance of the Trust as measured in the Integrated Performance Report (IPR).	**Approval**	
	Assurance	✓
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	Insufficient financial resources available to support the delivery of services	✓
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

An earlier version of the Quality of Care and Timely Care domain reports were considered by the Quality Committee in October 2024. The final report was shared with the Executive Team on 29 October 2024.

Acronyms

All acronyms are defined within the paper.

Executive Summary

The Integrated Performance Report (IPR) provides the Board with assurance regarding the performance of the Trust in respect of the performance indicators allocated under the following domains: Quality of Care, People and Culture, Timely Care and Best Value Care. Key activity metrics are provided as context to support all domains.

In this report we have introduced benchmarking data within the timely care domain report. Appendix A contains the full benchmarking data (table and charts) for the timely care domain. Appendix B contains benchmarking guidance to provide further, useful context. Adding more formal benchmarking data to the IPR was discussed and agreed as part of the IPR annual review that was considered by Trust Board in July 2024.

This report is for 2024/25 quarter two. Performance indicators are marked as "met" or "not met" using a green tick and red cross respectively where a standard or plan value exists. The main report includes domain summaries that provide the opportunity to celebrate successes and identify areas of challenge. The indicators in focus pages provide an overview against each underperforming indicator together with details of the root causes and actions being taken to improve performance. The integrated scorecard is included at the start of the report and in appendix A. Appendix A also includes graphs for each indicator that identify trends over a two-year period and, where appropriate, the plan for the remainder of 2024/25.

Maintaining good performance against some of the key indicators contained in the report has been challenging for the Trust during 2024/25 quarter two. We have continued to experience very high urgent care demand which has exceeded planned levels and has placed pressure on our clinical teams and our services. This pressure has been sustained for many months with patient demand often exceeding the capacity of our hospitals with escalation actions in place to support patient care.

There was a further period of disruptive industrial action at the start of quarter two from our resident doctors as part of the pay dispute with the government that is now resolved. Our focus during strike action is on maintaining the delivery of services to our local population.

Despite the challenges there are several areas where our performance compares favourably across the NHS and these successes are to be celebrated. We are pleased to report that we have not had a MRSA bacteraemia for two years (we are the only Trust in the region to achieve this). We also remain one of the top performing Trusts nationally for ambulance handover, a position we are proud of as it allows ambulance crews to respond to the needs of our local population. During Aug-24 we saw a seasonal ease in the surging A&E attendance demand. This ease in demand enabled our 4-hour emergency access performance to improve to the highest level since Feb-22. Our diagnostic DM01 performance in Sep-24 was our highest since Dec-21 as insourcing plans have helped reduce the significant 6-week backlog.

Trust Board is requested to comment on the report, celebrate successes, and be assured that actions are in place to improve performance in challenged areas.

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals

Integrated Performance Report

Reporting Period: 2024/25 Quarter 2

Integrated Scorecard

The Integrated Scorecard together with graphs for all indicators is included in appendix A.

The graphs present monthly data typically from Apr-22. Where appropriate, the graphs are statistical process control (SPC) charts.

Performance is assessed as met/did not meet the standard set for the financial year. Where the metric is being assessed against plan; details of the plan are included in the graphs in the appendix.

Green tick = target met/exceeded; Red cross = target not met

Category	At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD
Quality of Care	Safe	Falls with lapse in care	≤2	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 1	✓ 1
		Falls per 1000 occupied bed days	≤6.63	≤6.63	✓ 5.6	✗ 6.9	✗ 6.7	✓ 6.4	✗ 6.9	✗ 7.3	✓ 6.1	✗ 6.7	✓ 6.2	✓ 5.8	✗ 6.7	✓ 6.3	✗ 6.7	✓ 5.9	✓ 6.2	✓ 6.3	✓ 6.3
		Never events	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1	✗ 2
		MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
		Cdifficile reported in month	≤13	≤13	✓ 1	✓ 5	✓ 6	✓ 12	✓ 1	✓ 3	✓ 5	✓ 9	✓ 4	✓ 4	✓ 5	✓ 13	✓ 4	✓ 3	✓ 4	✓ 11	✗ 24
		Ecoli blood stream infections (BSI) reported in month	≤22	≤22	✓ 0	✓ 6	✓ 5	✓ 11	✓ 3	✓ 5	✓ 3	✓ 11	✓ 5	✓ 1	✓ 4	✓ 10	✓ 3	✓ 5	✓ 2	✓ 10	✓ 20
		Klebsiella BSI reported in month	≤1	≤1	✓ 1	✓ 1	✓ 1	✗ 3	✗ 2	✓ 1	✓ 0	✗ 3	✓ 0	✓ 1	✗ 2	✗ 3	✓ 1	✓ 1	✓ 0	✗ 2	✗ 5
		Pseudomonas BSI reported in month	≤3	≤3	✓ 0	✓ 1	✓ 1	✓ 2	✓ 2	✓ 1	✓ 1	✗ 4	✓ 0	✓ 0	✓ 1	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care	0	0	0.2	0.1	0.0	0.1	0.2	0.2	0.1	0.2	0.0	0.1	0.2	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	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✗ 2	✓ 0	✓ 0	✗ 1	✗ 1	✗ 3
		Patient Safety Incident Investigations (PSII)			1	4	2	7	2	2	1	5	3	4	0	7	0	2	2	4	11
		Sepsis (metric to be defined)			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.1	✓ 1.2	✓ 1.3	✓ 1.2	✓ 1.1	✓ 1.1	✓ 0.8	✓ 1.0	✓ 0.7	✓ 1.5	✓ 0.9	✓ 1.0	✓ 1.5	✓ 0.8	✓ 0.8	✓ 1.0	✓ 1.0
		Compliments received in month			103	158	150	411	151	122	120	393	161	138	151	450	155	120	119	394	844
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 127	✗ 125	✗ 126	✗ 126	✗ 131	✗ 129	✗ 126	✗ 126	✗ 129	✗ 126	✗ 124	✗ 124	✗ 124	✗ 122	✗ 124	✗ 124	✗ 124
		SHMI	≤100	≤100	✗ 108	✗ 107	✗ 107	✗ 107	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106
		Still birth rate	≤4.4	≤4.4	✓ 3.5	✓ 0.0	✗ 6.7	✓ 3.3	✓ 3.2	✗ 11.5	✓ 3.7	✗ 5.9	✓ 0.0	✓ 3.2	✓ 4.2	✓ 2.3	✓ 0.0	✗ 6.8	✗ 6.4	✓ 4.4	✓ 3.4
		Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✗ 3.2	✗ 1.1	✓ 0.6
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 7.3	-	-	-	✓ 6.9	-	-	-	✓ 6.8	-	-	-	-	-
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 6.9%	✓ 5.8%	✓ 5.2%	✓ 6.0%	✓ 5.1%	✓ 4.7%	✓ 4.5%	✓ 4.7%	✓ 8.2%	✓ 8.0%	✓ 8.1%	✓ 8.1%	✓ 8.4%	✓ 7.7%	✓ 7.4%	✓ 7.9%	✓ 8.0%
		Turnover in month	≤0.9%	≤0.9%	✓ 0.5%	✓ 0.4%	✓ 0.6%	✓ 0.5%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.5%	✓ 0.2%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%
		Appraisals	≥90%	≥90%	✗ 87.3%	✗ 88.3%	✗ 88.8%	✗ 88.1%	✗ 88.9%	✗ 88.3%	✗ 87.8%	✗ 88.3%	✗ 87.9%	✗ 89.4%	✗ 88.1%	✗ 88.4%	✗ 89.9%	✗ 89.7%	✗ 89.5%	✗ 89.7%	✗ 89.1%
		Mandatory & statutory training	≥90%	≥90%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 92.0%	✓ 91.3%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.4%	✓ 91.3%	✓ 90.9%	✓ 91.2%	✓ 91.1%
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 4.8%	✗ 4.3%	✗ 5.1%	✗ 4.8%	✗ 4.9%	✗ 4.7%	✗ 4.3%	✗ 4.6%	✗ 4.3%	✗ 4.4%	✗ 4.7%	✗ 4.4%	✗ 4.9%	✗ 4.2%	✗ 4.6%	✗ 4.6%	✗ 4.5%
		Total workforce loss	≤7.0%	≤7.0%	✓ 6.9%	✓ 6.4%	✗ 7.3%	✓ 6.9%	✗ 7.3%	✓ 6.9%	✓ 6.4%	✓ 6.9%	✓ 6.4%	✓ 6.4%	✓ 6.8%	✓ 6.5%	✓ 6.9%	✓ 6.3%	✓ 6.7%	✓ 6.6%	✓ 6.6%
		Flu vaccinations uptake (front line staff)	≥80%	≥75%	✗ 38.3%	✗ 44.8%	✗ 55.9%	✗ 55.9%	✗ 58.0%	✗ 58.0%	-	✗ 58.0%	-	-	-	-	-	-	-	-	✗ 0.0%
		Employee relations management	<12	<17	✗ 21	✗ 23	✗ 18	✗ 21	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✗ 15	✗ 19	✗ 20	✗ 20	✗ 21	✗ 20	✗ 20
	New Ways of Working	Bank usage			8.3%	7.8%	8.9%	8.3%	8.8%	7.7%	10.8%	9.1%	8.2%	10.3%	8.6%	9.0%	9.8%	10.3%	8.1%	9.4%	9.2%
		Agency usage	<3.7%	<3.2%	✗ 6.2%	✗ 5.5%	✗ 3.9%	✗ 5.2%	✗ 5.2%	✗ 4.6%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 4.5%	✗ 4.9%	✗ 4.7%	✗ 5.4%	✗ 4.4%	✗ 3.5%	✗ 4.4%	✗ 4.6%
		Agency (off framework)	≤6.0%	0.0%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✗ 0.1%	✗ 0.1%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%
		Agency (over price cap)	≤30.0%	≤40.0%	✗ 51.0%	✗ 55.7%	✗ 57.0%	✗ 54.3%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 55.1%	✗ 55.6%	✗ 59.7%	✗ 57.1%	✗ 60.3%	✗ 53.4%	✗ 53.4%	✗ 55.6%	✗ 56.4%
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✓ 96.8%	✓ 96.7%	✓ 95.7%	✓ 95.6%	✗ 93.9%	✗ 94.6%	✗ 94.7%	✓ 96.6%	✓ 96.5%	✓ 95.1%	✓ 96.1%	✓ 95.6%	✓ 96.8%	✗ 93.5%	✓ 95.3%	✓ 95.7%
		Ambulance delays >60 mins	0.0%	0.0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.5%	✗ 0.3%	✗ 0.2%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.1%
		ED 4-hour performance	≥76%	≥76%	✗ 69.4%	✗ 67.1%	✗ 64.9%	✗ 67.2%	✗ 65.7%	✗ 63.6%	✗ 72.2%	✗ 67.3%	✗ 74.2%	✗ 73.4%	✗ 70.9%	✗ 72.8%	✗ 71.7%	✗ 82.0%	✗ 73.6%	✗ 75.6%	✗ 74.2%
		ED 12-hour length of stay performance	≤2%	≤2%	✗ 3.3%	✗ 4.2%	✗ 6.5%	✗ 4.7%	✗ 5.5%	✗ 5.1%	✗ 3.1%	✗ 4.5%	✗ 3.1%	✗ 2.2%	✗ 2.3%	✗ 2.5%	✗ 2.9%	✓ 0.9%	✗ 3.0%	✗ 2.3%	✗ 2.4%
		SDEC rate	≥33%	≥33%	✓ 39.8%	✓ 37.1%	✓ 36.2%	✓ 37.7%	✓ 38.3%	✓ 38.1%	✓ 37.8%	✓ 38.1%	✓ 38.2%	✓ 37.7%	✓ 38.6%	✓ 38.2%	✓ 38.1%	✓ 41.3%	✓ 39.0%	✓ 39.4%	✓ 38.8%
		Adult G&A bed occupancy	≤92%	≤92%	✓ 92.0%	✗ 96.3%	✗ 95.3%	✗ 94.6%	✗ 97.9%	✗ 97.8%	✗ 96.5%	✗ 97.4%	✗ 93.6%	✗ 94.8%	✗ 94.7%	✗ 94.4%	✗ 95.5%	✗ 92.2%	✗ 93.8%	✗ 93.9%	✗ 94.1%
		Long length of stay (21+) occupied beds	≤Plan	≤Plan	✓ 100	✗ 109	✓ 100	✗ 103	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✓ 102.0	✓ 105.0	✓ 103.0	✓ 104.0	✓ 103
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 90	✗ 98	✗ 92	✗ 94	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 84	✗ 65	✗ 57	✗ 69	✗ 72
	Electives	Advice & guidance	≥16%	≥16%	✓ 25.3%	✓ 24.4%	✓ 23.0%	✓ 24.3%	✓ 24.3%	✓ 27.3%	✓ 25.4%	✓ 25.6%	✓ 24.5%	✓ 25.8%	✓ 22.0%	✓ 24.1%	✓ 25.2%	-	-	-	-
		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 5.7%	✓ 5.4%	✓ 5.7%	✓ 5.7%	✓ 5.6%	✓ 5.3%	✓ 5.5%	✓ 6.0%	✓ 5.9%	✓ 5.9%	✓ 5.9%	✓ 6.2%	✓ 6.1%	✓ 6.5%	✓ 6.3%	✓ 6.1%
		Outpatient attends that are first or follow up with a procedure		≥Plan	43.2%	43.7%	44.0%	43.6%	43.2%	43.7%	43.8%	43.5%	✗ 43.3%	✗ 40.7%	✗ 43.9%	✗ 42.6%	✗ 43.6%	✗ 42.2%	✓ 42.7%	✗ 42.9%	✗ 42.7%
		Incomplete RTT waiting list	≤Plan	≤Plan	✗ 53,708	✗ 52,717	✗ 52,569	✗ 52,569	✗ 52,377	✗ 50,534	✗ 50,757	✗ 50,757	✗ 36,584	✗ 35,858	✗ 35,720	✗ 35,720	✗ 35,251	✗ 35,165	✗ 35,507	✗ 35,507	✗ 35,507
		Incomplete RTT pathways +52 weeks	≤Plan	≤Plan	✗ 1,851	✗ 1,858	✗ 1,933	✗ 1,933	✗ 1,759	✗ 1,662	✗ 1,591	✗ 1,591	✓ 1,312	✓ 1,162	✓ 1,177	✓ 1,177	✓ 1,080	✗ 1,019	✗ 870	✗ 870	✗ 870
		Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 362	✗ 337	✗ 418	✗ 418	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✓ 109	✓ 77	✗ 105	✗ 50	✗ 50	✗ 50
		Incomplete RTT pathways +78 weeks	0	0	✗ 7	✗ 5	✗ 14	✗ 14	✗ 17	✗ 12	✗ 5	✗ 5	✗ 2	✗ 1	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0
	Diagnostics	Diagnostic DM01 backlog			3,761	3,726	4,055	4,055	3,659	3,344	3,430	3,430	3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	2,558
		Diagnostic DM01 performance under 6-weeks	≥99%	≥Plan	✗ 63.3%	✗ 64.7%	✗ 56.8%	✗ 56.8%	✗ 62.8%	✗ 68.1%	✗ 70.5%	✗ 70.5%	✓ 71.6%	✓ 72.7%	✗ 70.5%	✗ 70.5%	✗ 69.5%	✗ 70.2%	✗ 76.3%	✗ 76.3%	✗ 76.3%
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥75%	✓ 81.3%	✓ 77.3%	✓ 80.6%	✓ 79.7%	✓ 76.0%	✓ 82.9%	✓ 82.6%	✓ 80.6%	✓ 75.3%	✓ 79.8%	✓ 79.2%	✓ 78.2%	✓ 81.6%	✓ 81.6%	-	-	-
		Cancer 31-day treatment performance	≥96%	≥Plan	✗ 79.8%	✗ 75.8%	✗ 72.5%	✗ 75.9%	✓ 73.2%	✗ 80.0%	✓ 90.4%	✓ 81.4%	✓ 89.8%	✓ 87.5%	✓ 88.3%	✗ 88.6%	✓ 95.0%	✓ 91.1%	-	-	-
		Cancer 62-day treatment performance	≥85%	≥Plan	✗ 52.8%	✗ 64.8%	✗ 57.7%	✗ 58.6%	✗ 56.5%	✗ 54.7%	✗ 69.2%	✗ 60.4%	✓ 71.8%	✗ 56.3%	✓ 70.3%	✗ 66.1%	✗ 71.4%	✓ 67.9%	-	-	-
		Suspected cancer patients waiting over 62-days			89	86	89	89	76	50	52	52	80	69	70	70	68	87	83	83	83
Best Value Care	Finance	Income & expenditure against plan	≥£0.00m	≥£0.00m	✗ -£1.33	✓ £0.82	✓ £2.58	✓ £2.07	✗ -£0.76	✓ £2.33	✗ -£12.76	✗ £11.19	✗ -£0.02	✓ £0.02	✗ -£0.61	✗ -£0.61	✗ -£0.33	✗ -£0.31	✓ £0.44	✗ -£0.20	✗ -£0.81
		Financial Improvement Programme (FIP) against plan	≥£0.00m	≥£0.00m	✗ -£0.38	✗ -£0.17	✗ -£0.80	✗ -£1.35	✓ £1.27	✗ -£0.43	✓ £0.54	✓ £1.38	✗ -£0.55	✓ £1.48	✓ £0.66	✓ £1.59	✗ -£1.61	✗ -£1.38	✗ -£1.57	✗ -£4.56	✗ -£2.97
		Capital expenditure against plan	≤£0.00m	≤£0.00m	✗ £3.19	✓ -£0.70	✗ £5.23	✗ £7.72	✓ -£2.01	✓ -£0.88	✗ -£12.53	✓ -£15.42	✗ £1.61	✗ £2.07	✗ £1.39	✗ £5.07	✗ £1.55	✗ £1.28	✗ £1.27	✗ £4.10	✗ £9.17
		Cash balance	-	≥£1.45m	✓ £1.49	✓ £1.51	✓ £2.04	✓ £2.04	✓ £1.80	✓ £8.76	✓ £4.74	✓ £4.74	✗ £1.34	✗ £1.73	✓ £1.50	✓ £1.50	✗ £0.32	✗ -£0.15	✗ £0.05	✗ £0.05	✓ £1.50
		Implied Productivity 2023/24 v 2024/25	-	3.1%	-	-	-	-	-	-	-	-	-	-	-	-	✓ 6.7%	-	-	-	-
		Value weighted elective activity	-	105%	✗ 99.6%	✓ 110.7%	✓ 108.6%	✓ 106.3%	✓ 113.2%	✓ 114.2%	✓ 127.1%	✓ 118.2%	✗ 103.5%	✓ 110.9%	✓ 112.0%	✓ 108.8%	✓ 108.8%	✓ 118.7%	✓ 118.5%	✓ 115.3%	✓ 112.1%
		Agency expenditure against plan	≥£0.00m	≥£0.00m	✗ -£0.21	✓ £0.62	✓ £0.29	✓ £0.70	✗ -£1.36	✗ -£1.17	✗ -£1.09	✗ -£3.62	✗ -£0.18	✗ -£0.29	✗ -£0.29	✗ -£0.76	✗ -£0.39	✗ -£0.24	✓ £0.01	✗ -£0.62	✗ -£1.38
		Reported agency spend			£1.67	£0.72	£1.07	£3.46	£1.47	£1.28	£1.21	£3.96	£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£7.41
		Reported bank spend			£2.30	£2.10	£2.71	£7.11	£3.36	£2.01	£3.69	£9.06	£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£15.58
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan	≤Plan	✗ 104.4%	✗ 104.7%	✗ 102.0%	✗ 103.7%	✗ 104.5%	✗ 111.1%	✗ 111.6%	✗ 109.0%	✗ 111.5%	✗ 106.8%	✗ 104.1%	✗ 107.3%	✗ 106.5%	✓ 96.7%	✗ 102.0%	✗ 101.7%	✗ 104.5%
		Non-elective admissions	≤Plan	≤Plan	✗ 121.4%	✗ 124.2%	✗ 114.1%	✗ 119.9%	✗ 119.9%	✗ 118.6%	✗ 116.0%	✗ 118.2%	✗ 111.3%	✗ 110.4%	✗ 103.3%	✗ 108.3%	✗ 105.5%	✗ 102.1%	✗ 101.3%	✗ 103.0%	✗ 105.6%
	Electives	Average daily elective referrals			310	316	260	295	314	327	304	315	343	340	325	336	348	320	-	-	-
		Outpatients - first appointment	≥Plan	≥Plan	✓ 102.9%	✓ 109.1%	✗ 96.4%	✓ 103.0%	✓ 108.3%	✓ 106.3%	✓ 109.7%	✓ 108.1%	✗ 99.3%	✗ 84.0%	✗ 94.0%	✗ 92.3%	✗ 90.5%	✗ 86.0%	✗ 90.9%	✗ 89.2%	✗ 90.7%
		Outpatients - follow up	≤Plan	≤Plan	✗ 102.1%	✗ 108.1%	✓ 95.1%	✗ 101.9%	✗ 107.5%	✗ 105.0%	✗ 106.2%	✗ 106.2%	✓ 100.0%	✗ 102.4%	✓ 94.1%	✓ 98.9%	✓ 99.1%	✓ 93.0%	✓ 95.1%	✓ 95.8%	✓ 97.3%
		Outpatients - procedures	≥Plan	≥Plan	✓ 113.9%	✓ 126.4%	✓ 116.0%	✓ 118.9%	✓ 121.7%	✓ 125.3%	✓ 123.0%	✓ 123.3%	✓ 133.0%	✓ 129.3%	✓ 114.4%	✓ 125.3%	✓ 122.7%	✓ 115.7%	✓ 136.5%	✓ 124.4%	✓ 124.8%
		Day case	≥Plan	≥Plan	✗ 86.7%	✓ 101.3%	✗ 91.8%	✗ 93.3%	✓ 100.2%	✓ 101.5%	✓ 109.8%	✓ 103.7%	✗ 96.3%	✗ 96.1%	✗ 96.0%	✗ 96.1%	✓ 102.7%	✓ 101.3%	✓ 100.0%	✓ 101.3%	✗ 98.8%
		Elective inpatient	≥Plan	≥Plan	✗ 86.8%	✓ 108.9%	✓ 107.1%	✓ 100.7%	✓ 101.9%	✓ 110.8%	✓ 129.3%	✓ 113.5%	✗ 92.5%	✗ 94.6%	✗ 90.0%	✗ 92.4%	✗ 84.0%	✗ 99.8%	✗ 96.9%	✗ 93.4%	✗ 92.9%
	Diagnostics	Diagnostics	≥Plan	≥Plan	✗ 91.5%	✗ 99.9%	✓ 112.4%	✓ 100.6%	✓ 102.6%	✓ 103.9%	✓ 106.8%	✓ 104.4%	✓ 102.6%	✓ 109.2%	✗ 98.1%	✓ 103.2%	✓ 104.9%	✓ 111.4%	✓ 112.5%	✓ 109.5%	✓ 106.4%

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Quality of Care

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Domain Summary: Quality of Care

Overview	Lead: Chief Nurse/Medical Director

During 2024/25 quarter two, we received 411 compliments, 429 concerns, 61 formal complaints, and closed 49 formal complaints. We continue to identify actions and themes that are tracked through the Patient Experience Committee.

The Patient Safety Incident Response Plan has been refreshed and approved by the Patient Safety Committee. It will be presented to Quality Committee for final ratification. The Trust has not had an MRSA bacteraemia for over two years (we are the only Trust in the region not to have had one this financial year). National targets for infection prevention and control were released in Aug-24; we have had increases for CDiff to 65 and Pseudomonas to 14 and reductions for Klebsiella to 16 and Ecoli to 83. Infection Prevention Control (IPC) have commenced rapid reviews for all hospital associated infections and had completed 125 at the end of Aug-24 with learning being shared as part of all divisional governance reports. There have been two reported CDiff deaths, and investigations have taken place for both which have identified that both patients received the appropriate treatment and care.

Two Patient Safety Incident Investigations (PSII) were commissioned by the Patient Safety Incident Response Group (PSIRG) in Aug-24 and two PSII's were commissioned in Sep-24; this followed an in-depth discussion during which representatives from the Integrated Care Board (ICB) were present. There is one confirmed coroner's investigation in relation to the delay in Cardiology processes and task list issues, which has been RAG-rated red by the Trust Legal Team. Further information in relation to the patient involved in the Never Event has been requested by the coroner. It is not thought that this incident contributed to the patient's death, and a Structured Judgement Review (SJR) has been commissioned to look at the episode of care. The falls per 1,000 occupied bed days rate for Jul-24 is 6.7; this is slightly above the national target of 6.63. We remain on track for quarter two.

There are five off-track metrics during 2024/25 quarter two:

- **Never Events**: In Sep-24, we reported an incident relating to a 'retained surgical instrument/ part of a surgical instrument' reported as a PSII – investigation underway.
- **Category 3/4 Hospital Acquired Pressure Ulcers (HAPU) and ungradable pressure ulcers with lapses in care**: SFH has had one avoidable category 3 pressure ulcer.
- **Hospital Standardised Mortality Ratio (HSMR)**: Latest 12-monthly rolling figure= 122.14 (Jun-23 – May-24); (quarter one report 126.9). Remains above expected but a continued downward trend, alongside individual month reporting remaining "as expected" (awaited changes to HSMR+ methodology).
- **Summary Hospital-level Mortality Indicator (SHMI)**: Latest reporting = 105.96 (May 23- Apr 24); (quarter one report 108.0). Remains as expected.
- **Early neonatal deaths**: There were four stillbirths and one early neonatal death in quarter two.

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Scorecard: Quality of Care

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD
Safe	Falls with lapse in care	≤2	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 1	✓ 1
	Falls per 1000 occupied bed days	≤6.63	≤6.63	✓ 5.6	✗ 6.9	✗ 6.7	✓ 6.4	✗ 6.9	✗ 7.3	✓ 6.1	✗ 6.7	✓ 6.2	✓ 5.8	✗ 6.7	✓ 6.3	✗ 6.7	✓ 5.9	✓ 6.2	✓ 6.3	✓ 6.3
	Never events	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1	✗ 2
	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Cdifficile reported in month	≤13	≤13	✓ 1	✓ 5	✓ 6	✓ 12	✓ 1	✓ 3	✓ 5	✓ 9	✓ 4	✓ 4	✓ 5	✓ 13	✓ 4	✓ 3	✓ 4	✓ 11	✗ 24
	Ecoli blood stream infections (BSI) reported in month	≤22	≤22	✓ 0	✓ 6	✓ 5	✓ 11	✓ 3	✓ 5	✓ 3	✓ 11	✓ 5	✓ 1	✓ 4	✓ 10	✓ 3	✓ 5	✓ 2	✓ 10	✓ 20
	Klebsiella BSI reported in month	≤1	≤1	✓ 1	✓ 1	✓ 1	✗ 3	✗ 2	✓ 1	✓ 0	✗ 3	✓ 0	✓ 1	✗ 2	✗ 3	✓ 1	✓ 1	✓ 0	✗ 2	✗ 5
	Pseudomonas BSI reported in month	≤3	≤3	✓ 0	✓ 1	✓ 1	✓ 2	✓ 2	✓ 1	✓ 1	✗ 4	✓ 0	✓ 0	✓ 1	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care			0.2	0.1	0.0	0.1	0.2	0.2	0.1	0.2	0.0	0.1	0.2	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	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✗ 1	✗ 2	✓ 0	✓ 0	✗ 1	✗ 1	✗ 3
	Patient Safety Incident Investigations (PSII)			1	4	2	7	2	2	1	5	3	4	0	7	0	2	2	4	11
	Sepsis *(metric to be defined)*																			
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.1	✓ 1.2	✓ 1.3	✓ 1.2	✓ 1.1	✓ 1.1	✓ 0.8	✓ 1.0	✓ 0.7	✓ 1.5	✓ 0.9	✓ 1.0	✓ 1.5	✓ 0.8	✓ 0.8	✓ 1.0	✓ 1.0
	Compliments received in month			103	158	150	411	151	122	120	393	161	138	151	450	155	120	119	394	844
Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 127	✗ 125	✗ 126	✗ 126	✗ 131	✗ 129	✗ 126	✗ 126	✗ 129	✗ 126	✗ 124	✗ 124	✗ 124	✗ 122	✗ 124	✗ 124	✗ 124
	SHMI	≤100	≤100	✗ 108	✗ 107	✗ 107	✗ 107	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106
	Still birth rate	≤4.4	≤4.4	✓ 3.5	✓ 0.0	✗ 6.7	✓ 3.3	✓ 3.2	✗ 11.5	✓ 3.7	✗ 5.9	✓ 0.0	✓ 3.2	✓ 4.2	✓ 2.3	✓ 0.0	✗ 6.8	✗ 6.4	✓ 4.4	✓ 3.4
	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 3.2	✗ 1.1	✓ 0.6

Indicator in Focus: Never Events

NHS Sherwood Forest Hospitals NHS Foundation Trust

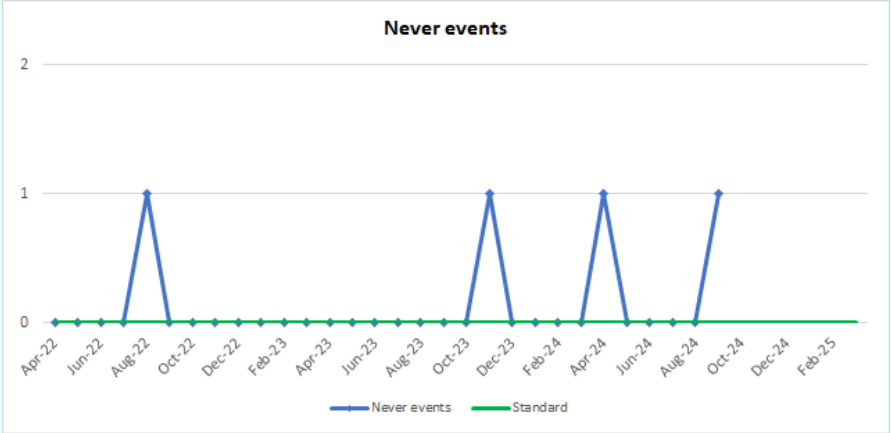
Overview and national position

NHS England definition of a Never Event is: “Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.”

At the time of this report being produced, the Provisional Never Events 2024/25 data: 1 Apr-24 - 31 Jun-24 has been published, indicating there were 120 Never Events reported nationally, of which 3 were ‘retained surgical instrument/ part of surgical instrument’.

In Sep-24, SFH reported an incident when following a surgical procedure, it was identified that a drill bit used during the procedure had broken. Upon review of the image intensifier, it has been confirmed that the broken drill bit can be seen in the patient’s elbow which had not been recognised prior to completion of the surgery. A Patient Safety incident investigation has been commissioned.

Data



Root causes	Early/ urgent learning identified	Impact
The incident has been reported on Transfer of Strategic Executive Information System (STEIS) and declared a Never Event. A formal investigation is being undertaken.	Following identification of the incident immediate action has been taken and drill bits are now single use pending a formal divisional review of how process can be strengthened to prevent broken drill bits going unidentified. It has been confirmed that additional drill bits have been ordered to ensure there are no supply issues. In addition, at the end of procedures the user of the drill now holds the drill bit up and confirms it is intact with another member of staff in the operating theatre as an additional visual check.	Ongoing

Date reported	Detail	Division	Speciality
04/12/2023	Removal of wrong skin mole	Medicine	Dermatology
16/08/2024	Removal of wrong skin mole	Medicine	Dermatology
10/09/2024	Retained part of Instrument	Surgery	Orthopaedics

Indicator in Focus: Hospital Acquired Pressure Ulcers (HAPU)

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Overview and national position

Pressure ulcers are in the 'top 10 harms' to patients (NHS England, 2024). Although there is no longer a national recommendation for identifying avoidable/unavoidable pressure damage, the current SHF Trust position is that all Trust acquired pressure ulcers are investigated to identify learning. Pressure ulcers are categorised as 'avoidable' where learning is identified or having 'no lapses in care'.

In 2024/25 quarter two SFH has had one avoidable category 3 pressure ulcer:

- RSU investigated new category 3 pressure damage to a patient's heel. This 83-year-old gentleman also sustained category 2 damage to his hallux and category 1 damage around his toes. The patient was frail and general condition was deteriorating, patient has since died. Anti-embolic stockings (AES) were prescribed after stopping Warfarin due to a raised International Normalised Ratio (INR). Unfortunately, a diagnosis of significant peripheral vascular disease (PVD) had not been acknowledged within the admission details. The prescription for AES was discontinued on Electronic Prescribing and Medicines Administration (EPMA), however the stockings were left in place for a further five days and removed when the damage was found by a Registered Nurse.

Root causes

- Lapses in recognising diagnosis of PVD and prescribing of AES in patient with contra-indication.
- Lapses in skin checks and failure to remove stockings after prescription was stopped.
- Lapses in communication to ensure stockings were removed when the prescription was stopped.

Actions and timescale

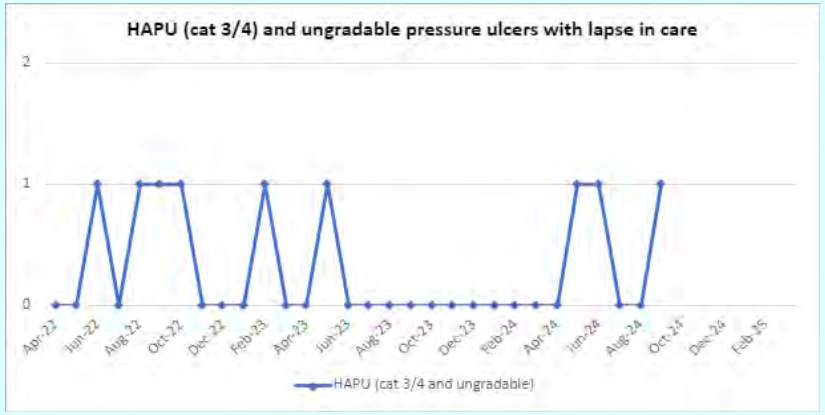
All actions to be completed through Oct-Dec 24:

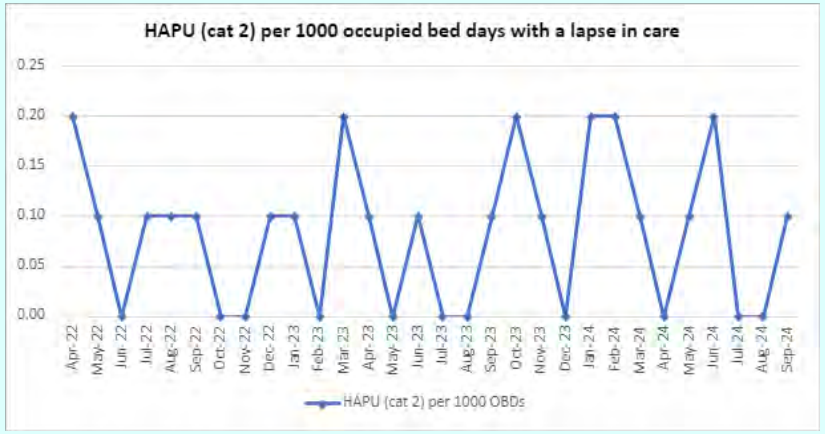
- Lead respiratory consultant to review VTE assessment procedure on Nervecentre and VTE prescribing with EPMA team.
- Review of staff involved in the incident and nursing reflective statements obtained and discussed (completed). Consideration given to staff involved in previous incidents.
- Ward nursing documentation to be audited.
- Learning board to be produced to highlight management of patients in AES and contra-indications for use.
- Incident shared at Respiratory and Medical divisional governance, COEC, Safety and staffing meetings, Tissue Viability (TV) champions.
- Incident to be incorporated into 2025 TV education.

Impact

- AES used in all divisions therefore learning to be shared Trust-wide.

Data





Indicator in Focus: Patient Safety Incident Investigations (PSII)

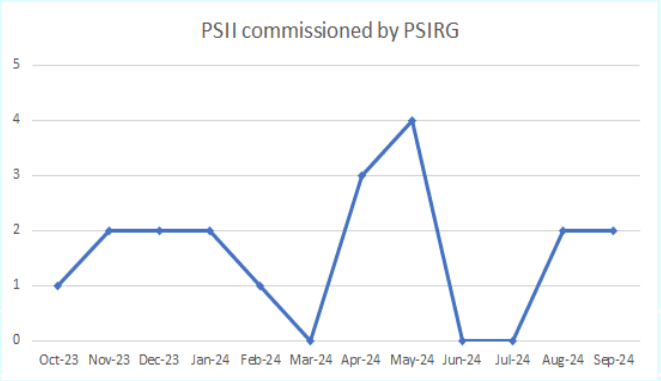
Sherwood Forest Hospitals NHS Foundation Trust

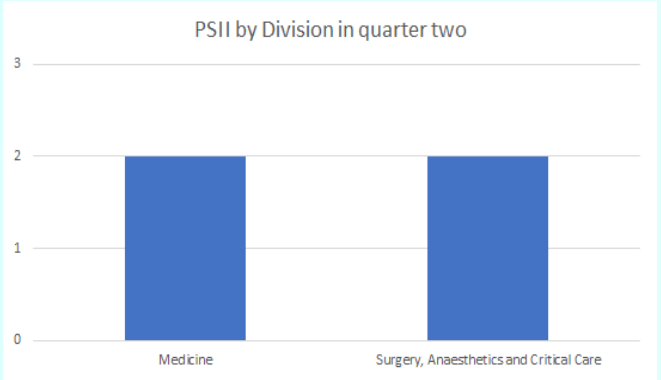
Overview and national position

NHS England states that "A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how."
In line with SFH's Patient Safety Incident Response Plan during quarter two, four PSII's were commissioned by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the ICB were present.

PSII with potential coronial interest	MSNI investigation	Never Events
Three of the four patients have died however, there is currently only one confirmed coroner's investigation into Cardiology delay in care PSII. This has been RAG rated as red by the Trust Legal Team.	None commenced	1- see slide 5 for details (Not included in table below)

Data





Root causes	Actions and timescale	Impact
Commissioned in Aug-24: Review current process: task lists, referrals, paper systems as there is a theme of concern around these in Cardiology. Review of process to ensure that it is in line with guidance and meeting the needs of service and our patients.	PSII commissioned, no immediate learning. Coronial involvement.	Ongoing investigation
Delay in cancer diagnosis resulting in more extensive surgery. The PSII was commissioned to investigate the management of diagnostic results and the cancer tracking processes.	Delays in review of the partial booking list at the time of the incident was due to administration capacity and this has been addressed and the booking list streamlined. At the time of the incident there was a backlog of filing which has been addressed.	PSII ongoing
Commissioned in Sep-24: Healthcare-associated infection CDiff acquired during admission.	Rapid review undertaken: Ensure indication listed for antibiotics. All policies and procedures were carried out as per protocol. Staff to continue to follow. IPC guidelines and management of patients with loose stools.	PSII ongoing

Indicator in Focus: Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI)

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

HSMR: Latest 12-monthly rolling figure= 122.14 (Jun 23 – May 24); (Q1 report 126.9). Remains above expected but a continued downward trend, alongside individual month reporting remaining "as expected". (Note- awaited changes to HSMR+ methodology).

SHMI: Latest reporting = 105.96 (May 23- Apr 24); (Q1 report 108.0). Remains as expected.

Crude Rate: Previously higher crude rate, suggested as being a driver of HSMR (by Telstra), has seen a downward trend over recent months.

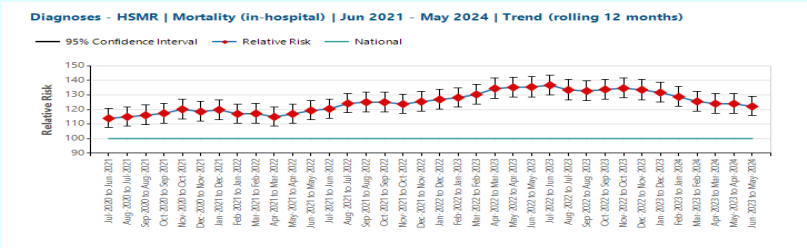
Root causes	Actions and timescale	Impact
Data Quality- Timely diagnosis, documentation, coding, co-morbidity capture	• Monitoring of documentation; emphasis on accuracy, capture of co-morbidities and diagnosis. • Working, specifically with senior clinical colleagues and decision makers, to develop a culture of "change" in relation to timely diagnosis, signposting and management, with an increased focus on post-take ward round decision making.	HSMR (+) figure will not, necessarily, reflect until 12 months after action commenced.
Patient Flow- Clinical pathways, management bundles and effective signposting.	• Continued emphasis on senior decision making to support timely and effective management. • Review of patient flow and pathways to establish how this impacts coding and data and whether this provides a true reflection of activity. • Targeted reviews, as part of the wider Learning from Deaths (LfD) process, to understand "outlier areas and identify Trust opportunities for improvement.	As above; forms part of overall working approach
Palliative Care Coding- (Remains low, nationally)	• Clinical review of Front Door Specialist Palliative Care (SPC) intervention and End Of Life (EOL). • Discussion with local SPC provider to identify opportunities for improvement, support clinical teams and consider system intervention to enhance patient journey and care.	SPC low activity compared to overall. Requires Trust & ICB resource / investment.

Learning from Deaths (LfD)-	• LfD continues to be the vehicle by which trends are reviewed, discussed and action instigated.
	  • Includes representation from ME service, divisional leads, ICS and BI
	  • Close working with Telstra (data analytics / HSMR provider), for benchmarking analysis, supporting triangulation and subsequent advice / signposting.
	  • Actions include data interrogation, targeted reviews / deep dives and audit.
	  • Continued strong emphasis on the need for clinical ownership and responsibility.
		Shared understanding and action with improved clinical engagement and "ownership" from teams.

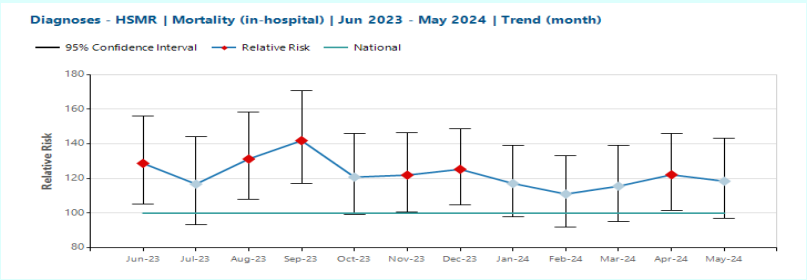
Data Intelligence and benchmarking-	• 12m renewal of Telstra contract to allow further review of needs and wider / ICB discussion. • HSMR+ (plus) is due to "go live" quarter three; it is understood, changes in methodology mean an improved HSMR+ and trend when compared to HSMR and expected values.	HSMR+ to be monitored until full implementation
External peer review-	• Visit to Dudley Group Hospitals (DGH) undertaken 1 Oct-24 with an emphasis on Learning from Deaths and to review processes, approaches to engagement and coding practice.	Development of improved mortality review processes.
Wider accountability-	• Meeting with ICB Medical Director (19 Sep-24) to review HSMR, assurance measures and consider approach to Learning from Death, both as an organisation and on ICS footprint. • Development of quality dashboard which will summarise a range of key patient safety metrics ongoing – (draft to Quality Committee in Nov-24)	Greater assurance and understanding
Collaboration-	• "Interface Workstream" in place to support developing collaborative relationships, wider understanding and promote pathways for future working, locally and on ICS footprint.	Whole pathway approach and system understanding.

Data

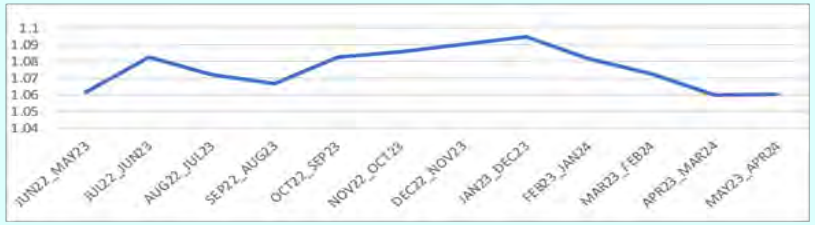
HSMR 3 yearly (12 month rolling) trend



HSMR Single-month trend



SHMI: Rolling 12 months (Latest- May 23-Apr 24)



HSMR- Crude Rate (12m) v Relative Risk)

Indicator in Focus: Still Birth Rate & Early Neonatal Deaths per 1000 live births

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

In 2024/25 quarter two, there were four stillbirths (two in Aug-24 and two in Sep-24), and one early neonatal death. Each case received an individual review as outlined below and has been reported through the PMRT process where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

Aug-24:

- Stillbirth at 37 weeks and 5 days gestation, inpatient with recurrent reduced movements and pregnancy induced hypertension, re-presented following discharge home with a further episode of reduced movements and an IUFD was identified. Reviewed through weekly review meeting and all care appropriate, Perinatal Mortality Review Tool (PMRT) review ongoing. Postmortem examination accepted – results pending.

- Stillbirth at 30 weeks and 3 days gestation. Attended with reduced fetal movements and an intrauterine fetal death (IUFD) was identified. PMRT review completed to draft pending results. Scan pathways were incorrect antenatally. Postmortem examination accepted – awaiting results.

Sep-24:

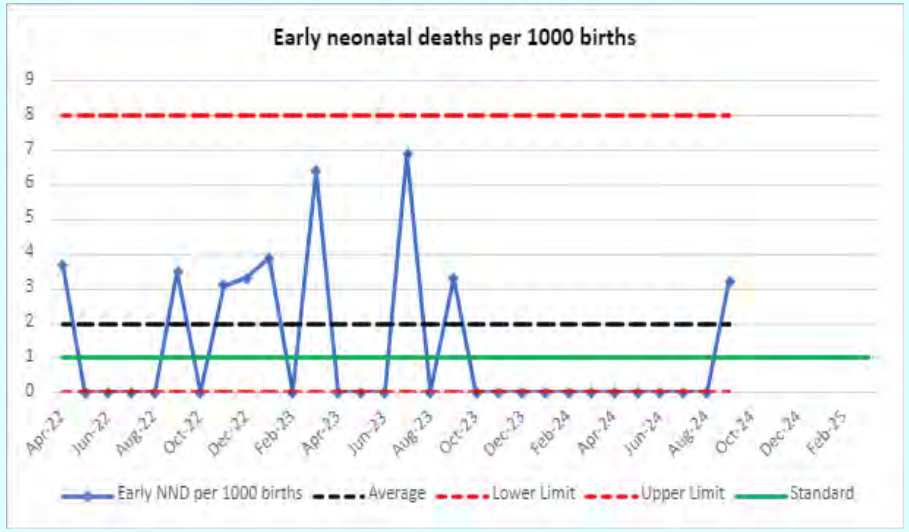
- Twin pregnancy, IUFD of Twin 2 diagnosed at 29 weeks and 5 days gestation, progressed to Stillbirth at 34 weeks and 1 day gestation. Twin 1 was born in good condition and remains alive and well. On review, correct scan pathways were not followed. PMRT review ongoing, postmortem examination declined.

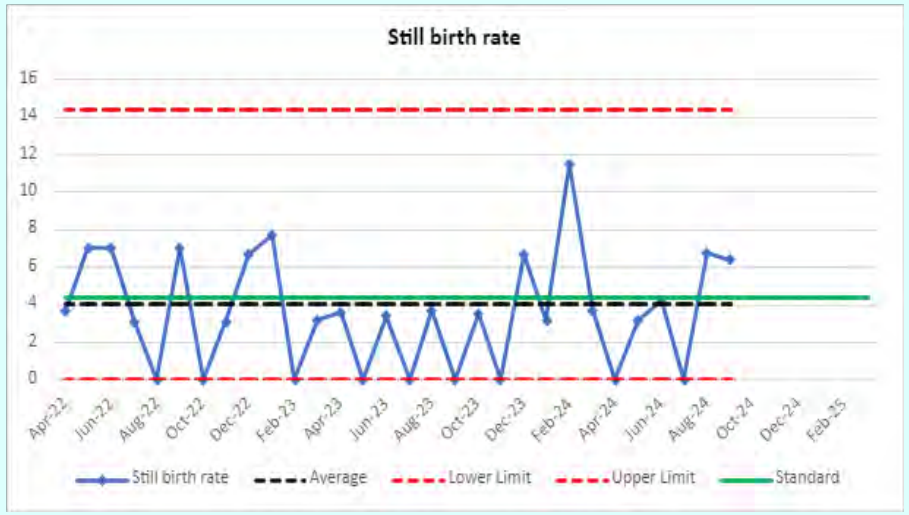
- Stillbirth at 24 weeks and 6 days gestation. Attended for a planned scan, no fetal heart identified on scan. PMRT ongoing. Postmortem examination accepted – results pending.

- 25 weeks and 1 day gestation, presented in advanced pre-term labour and rapidly gave birth, baby was transferred to a tertiary unit by 6 hours of age and sadly passed away 17 days later. Cultures grew pseudomonas. PMRT reported and led by the tertiary unit. Trust review through PMRT and graded our care involvement as A (*'The review group concluded that there were no issues with care identified up the point that the baby was born.')*

Root causes	Early/ urgent learning identified	Impact
Incorrect scan pathways was a theme across two of the cases and in previous reviews.	Cases presented to Divisional rapid review meeting. Although the scan pathways did not impact on the outcome in these cases, it was recognised as a theme and a cluster review was commissioned.	Cluster review - Ongoing

Data





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People and Culture

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Domain Summary: People and Culture

Overview	Lead: Director of People

In 2024/25 quarter two, our hospitals and the wider Integrated Care System (ICS) remained busy, with a spell of industrial action; requiring extra controls and governance needing to be mobilised at short notice to support our financial position. However, over the quarter we have noted some positive performance across people and culture metrics. We have also commenced the development our People Strategy from 2025 to 2029.

Our Mandatory and Statutory Training (MaST) position is positive; we are continuing to report levels above the Trust standards. Vacancy and turnover rates sit below our standard. During May-24 and Jun-24, we have used zero off-framework agency.

Appraisal level for 2024/25 quarter two (89.7%) sits marginally below the Trust target (90%), and over the quarter we have noted a strong and constant performance level. We have undertaken an audit around appraisals, where we have received a high assurance level.

Over 2024/25 quarter two our sickness absence level is reported at 4.6% (2024/25 quarter one was 4.4%); this sits higher than the Trust target (4.2%); however, within the statistical process control limits.

Employee relations cases over the quarter have remained at a steady level (average 20). We have seen a marginal increase from quarter one (recorded at 19). This sits above our target (17), but within the statistical process control limits. The Trust has seen the conclusion of several formal disciplinary cases between Jul-24 and Sep-24. As a result, there has been an increase in the number of appeals. This increase in appeals was anticipated.

We monitor our agency levels frequently and the reduction of this level is aligned with some of our efficiency programmes. Our current agency position for quarter two is reported at 4.4%. For Sep-24, this is reported at 3.5%. When excluding Elective Recovery Fund schemes from the agency level, this reduces to 2.8%. Over the quarter we have seen zero off-framework workers; this reduction follows amended agency rules that came into force from Jul-24.

During quarter two, 55.7% of total agency shifts filled were ‘on-framework’ staff and above the recommended NHS England price cap. During the last quarter, significant work has commenced that aligns to our efficiency programme. Over the quarter we have seen the level drop from 60.3% to 53.4%. This is above our target and the NHS England expectation (40%). However, the work we have commenced is showing positive signs and we are planning to hit this target by Mar-25.

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Scorecard: People and Culture

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD
Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 7.3	-	-	-	✓ 6.9	-	-	-	✓ 6.8	-	-	-	-	-
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 6.9%	✓ 5.8%	✓ 5.2%	✓ 6.0%	✓ 5.1%	✓ 4.7%	✓ 4.5%	✓ 4.7%	✓ 8.2%	✓ 8.0%	✓ 8.1%	✓ 8.1%	✓ 8.4%	✓ 7.7%	✓ 7.4%	✓ 7.9%	✓ 8.0%
	Turnover in month	≤0.9%	≤0.9%	✓ 0.5%	✓ 0.4%	✓ 0.6%	✓ 0.5%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.5%	✓ 0.2%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.5%
	Appraisals	≥90%	≥90%	✗ 87.3%	✗ 88.3%	✗ 88.8%	✗ 88.1%	✗ 88.9%	✗ 88.3%	✗ 87.8%	✗ 88.3%	✗ 87.9%	✗ 89.4%	✗ 88.1%	✗ 88.4%	✗ 89.9%	✗ 89.7%	✗ 89.5%	✗ 89.7%	✗ 89.1%
	Mandatory & statutory training	≥90%	≥90%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 92.0%	✓ 91.3%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.4%	✓ 91.3%	✓ 90.9%	✓ 91.2%	✓ 91.1%
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 4.8%	✗ 4.3%	✗ 5.1%	✗ 4.8%	✗ 4.9%	✗ 4.7%	✗ 4.3%	✗ 4.6%	✗ 4.3%	✗ 4.4%	✗ 4.7%	✗ 4.4%	✗ 4.9%	✓ 4.2%	✗ 4.6%	✗ 4.6%	✗ 4.5%
	Total workforce loss	≤7.0%	≤7.0%	✓ 6.9%	✓ 6.4%	✗ 7.3%	✓ 6.9%	✗ 7.3%	✓ 6.9%	✓ 6.4%	✓ 6.9%	✓ 6.4%	✓ 6.4%	✓ 6.8%	✓ 6.5%	✓ 6.9%	✓ 6.3%	✓ 6.7%	✓ 6.6%	✓ 6.6%
	Flu vaccinations uptake (front line staff)	≥80%	≥75%	✗ 38.3%	✗ 44.8%	✗ 55.9%	✗ 55.9%	✗ 58.0%	✗ 58.0%	-	✗ 58.0%	-	-	-	-	-	-	-	-	✗ 0.0%
	Employee relations management	<12	<17	✗ 21	✗ 23	✗ 18	✗ 21	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✓ 15	✗ 19	✗ 20	✗ 20	✗ 21	✗ 20	✗ 20
New Ways of Working	Bank usage			8.3%	7.8%	8.9%	8.3%	8.8%	7.7%	10.8%	9.1%	8.2%	10.3%	8.6%	9.0%	9.8%	10.3%	8.1%	9.4%	9.2%
	Agency usage	<3.7%	<3.2%	✗ 6.2%	✗ 5.5%	✗ 3.9%	✗ 5.2%	✗ 5.2%	✗ 4.6%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 4.5%	✗ 4.9%	✗ 4.7%	✗ 5.4%	✗ 4.4%	✗ 3.5%	✗ 4.4%	✗ 4.6%
	Agency (off framework)	≤6.0%	0%	✓ 0.0%	✓ 0.0%	✓ 0.1%	✓ 0.1%	✓ 0.1%	✓ 0.1%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	0.0%
	Agency (over price cap)	≤30.0%	≤40.0%	✗ 51.0%	✗ 55.7%	✗ 57.0%	✗ 54.3%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 55.1%	✗ 55.6%	✗ 59.7%	✗ 57.1%	✗ 60.3%	✗ 53.4%	✗ 53.4%	✗ 55.6%	✗ 56.4%

Indicator in Focus: Appraisals

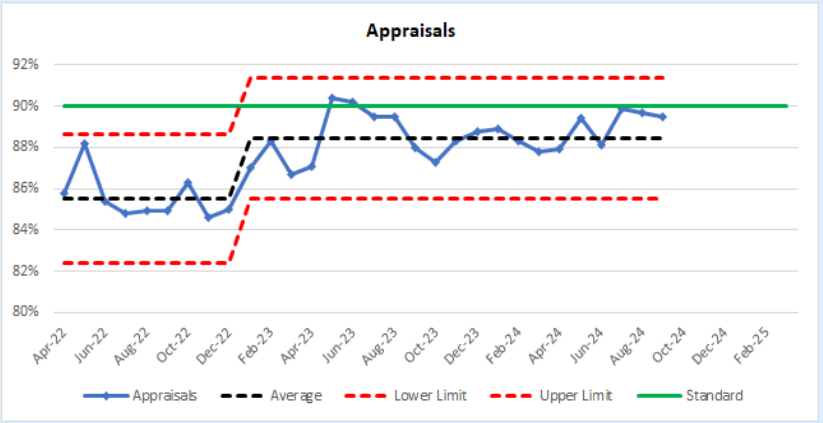
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Our appraisal level sits below the Trust target (90%). We are showing a really strong performance within appraisal compliance with the quarter two average at 89.7%, and the year-to-date average at 89.1%. Over the quarter, the compliance levels ranged from 89.9% to 89.5%.

Local benchmarking shows that the ICB provider appraisal level is reported at 84.3% (Aug-24). The NHS Corporate Benchmarking exercise indicates that over 2023/24, our appraisal compliance is in the upper quartile. The national median is reported at 81.6%, with the upper quartile reported at 86.9%.

Data



Root causes	Actions and timescale	Impact
Patient demand and hospital acuity has impacted on compliance.	• Service lines with low appraisal rates are supported to develop trajectories for improvement. • In addition, service lines are sighted on non-compliance rates and assurance is sought via monthly service line performance meetings. This is additional to monthly People and Performance review meetings within each department.	• Appraisal compliance levels to gradually increase, with an ambition to see levels of 90%.
In some instances, we have received feedback that managers have raised concerns on how to report this via the Electronic Staff Record (ESR).	• Training and coaching managers on how to enter appraisals onto ESR is in place along with a “how to” video guide to support our written user guidance.	

Indicator in Focus: Sickness Absence

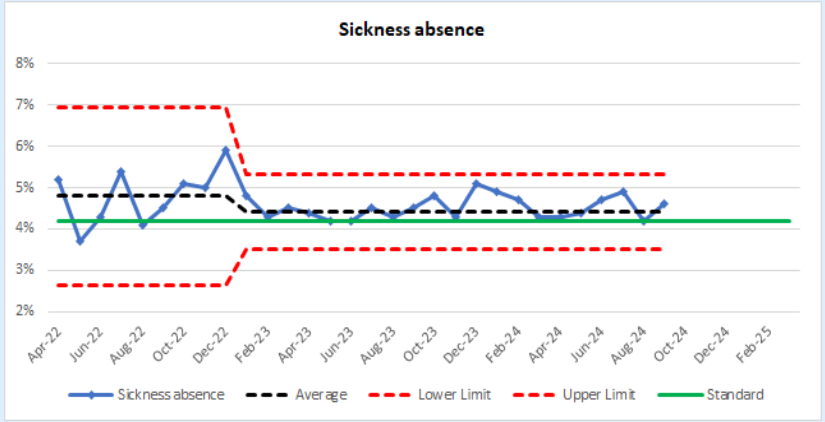
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

During 2024/25 quarter two, our overall sickness absence level was 4.6%; this sits above our standard (4.2%). The position for Sep-24 is reported at 4.6%. Our position for quarter two sits between the upper and lower statistical process control levels.

Local benchmarking shows that the Integrated Care Board (ICB) provider sickness absence level is reported at 5.0% (Aug-24).

Data



Root causes

Our sickness level is reflective of the acuity of the hospital, including being on a high Operational Pressures Escalation Level (OPEL) and at times implementing our Full Capacity Protocol (FCP).

We are noting an increase in length of absences due to the impact of NHS waiting and treatment times.

Actions and timescale

- All services are supported with one-to-one support from the Divisional People Lead teams with sickness absence management on a case-by-case basis and in line with policy.
- Sickness absences key performance indicators are monitored through People and Performance meetings, Service Line meetings and via Divisional Performance Reviews (DPRs).
- A person-centred approach is taken in relation to sickness absence management.

Impact

- We actively manage sickness cases through a person-centred approach and are aware of outside influences that are contributing to an elevated sickness level.

Indicator in Focus: Employee Relations Management

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

During 2024/25 quarter two, the employee relations level fluctuated between 20 and 21 cases, with the average of quarter one being 19 cases.

The increased level of employee relations has primarily been related to formal disciplinary processes.

There are several other cases which have proceeded under a Some Other Substantial Reason (SOSR) process. These cases relate to safeguarding concerns, which are of a sensitive nature and/or where there has been third party involvement. This includes colleagues working under Agenda for Change and Medical and Dental terms and conditions. Continued actions are being put in place to ensure training and support is available for all colleagues involved in employee relations matters with specific Trust psychological support to the Employee Relations and Divisional People Lead teams.

SFH is not an outlier in relation to Employee Relations casework with other organisations reporting an ongoing increase in Employee Relations case management.

The 2023/24 NHS Corporate Benchmarking exercise reports our employee relation cases at 7.2 cases per 1,000 headcount. This ranks us within the second quartile, with the national median being 9.5 cases. The lower quartile is reported at 6.6 and the upper quartile is at 16.7 cases.

Data

Root causes

The Trust has seen several formal disciplinary cases being concluded between Jul-24 and Sep-24 and, as a result, there has been an increase in the number of appeals. This increase in appeals was anticipated.

Disciplinary investigations are the key Employee relations reason within the quarter.

Actions and timescale

- All cases are managed using Just Culture Principals and take a person-centred approach with additional training taking place.
- Partnership working continues with Staff Side representatives, Clinical colleagues and People Directorate colleagues in management of cases.
- Enhanced wellbeing support has been developed to support colleagues who are part of any employee relations process.
- Person-centred approach is in place in relation to Sickness Absence management.
- Specialist panel advisers from Safeguarding and included in all safeguarding hearings.
- Re-emphasis on an informal resolution to incidents, concerns and adverse events, where possible.

Impact

- The work we undertake supports our workforce as we move into 2024/25 quarter three. We do not expect this to reduce immediately; however, we hope this returns to the average level of 2023/24 quarters three and four.

Indicator in Focus: Agency Usage (including off framework and over price cap)

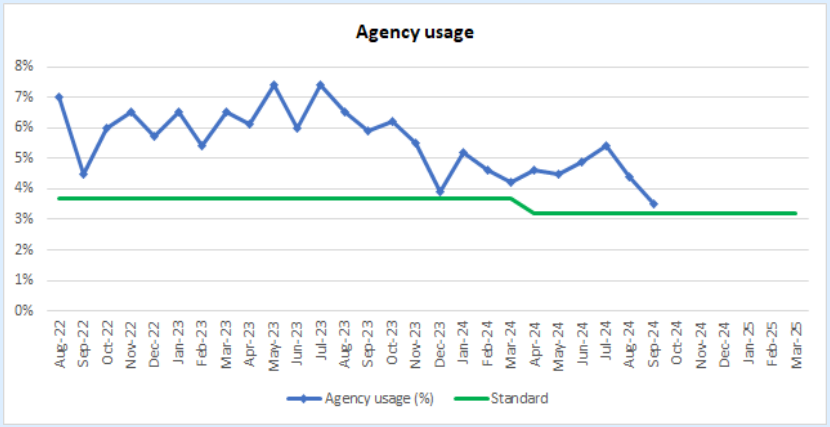
Sherwood Forest Hospitals NHS Foundation Trust

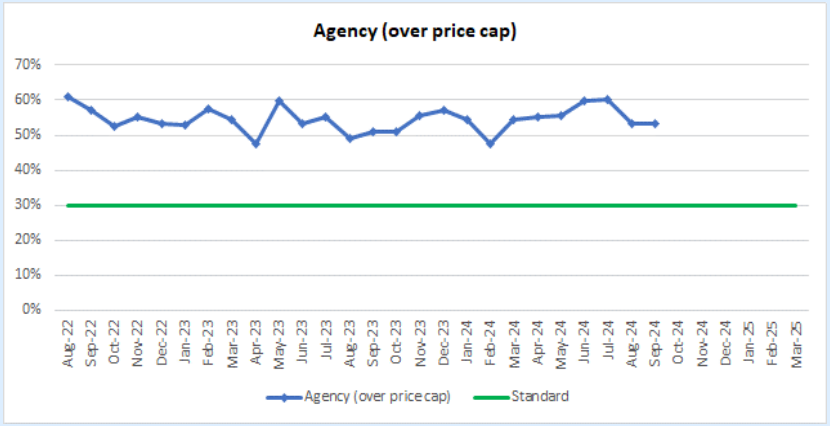
Overview and national position

Our current agency position for 2024/25 quarter two is reported at 4.4%, and for Sep-24 this is reported at 3.5%. When excluding Elective Recovery Fund (ERF) schemes from the agency level, this reduces to 2.8%. We have modelled this with plans over the 2024/25 period to reduce to the NHS planning guidance and our target of 3.2%.

We are noting a gradual reduction to our 'on-framework, over price cap' position. Within quarter two, we are reporting 55.7%, which shows a decrease from quarter one (57.1%). The reduction to this is aligned to our workforce efficiency programmes and the work we are undertaking on the 'on-framework, over price cap', as key reductions in over price cap support reductions to the overall agency target.

Data





Root causes	Actions and timescale	Impact
As the data informs us, our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services, where there are national speciality shortages.	• During 2024/25, we have continued the significant work to reduce reliance on agency usage and support the financial recovery challenge.	• We have been actively filling medical roles and have had success in some key specialities; reductions are noted across the 2024/25 period.
	• We continue to advertise and fill medical posts, which has gradually reduced our agency level. 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.	• Over the 2024/25 period we are focusing on medical staff who are on framework, but over the NHS England price cap, and are developing plans to exit these agency workers and replace with substantive roles.
	• 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.	

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Timely Care

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Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

In 2024/25 quarter two, we continued to experience surging numbers of A&E attends above plan during quarter two (1.7%), though not at the margin above plan observed in quarter one (7.3%). Compared to 2023/24 quarter two, attends increased by 5.6%. We saw a significant reduction in attends during Aug-24 during the school summer holidays (3% below plan), resulting in improved performance in A&E for Aug-24, with 4-hour performance above plan and national target, and among the highest national levels. Our type one attendance demand growth is upper quartile nationally (amongst the highest in the country). We have refreshed our planned A&E activity levels for the remainder of the year to resolve an error with the original plan. This is reflected in this report, has been communicated to the ICB, and will be monitored going forward.

Non-elective admission demand eased to be 3% above planned levels in quarter two, with a year-to-date position of almost 6% above planned levels. These elevated levels resulted in pressures on our clinical teams and on our bed-base, despite Medically Safe for Transfer (MSFT) patient numbers being at some of the lowest post-pandemic levels. The pressure on our services has been sustained for many months, much like many acute Trusts across the country. The combination of high attendance and admission demand, and mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals, resulting in us often starting the day at our highest level of escalation, with patients experiencing delays to admission due to a lack of beds. In response to these pressures, we enacted escalation actions and, at times, our full capacity protocol. Despite these pressures, the Getting It Right First Time (GIRFT) Emergency Medicine Index of patient flow (GEMI) ranking at SFH is 14; this ranks us 6th best in England for flow in A&E. We continued to provide strong ambulance handover, consistently performing as one of the best in the country; and have a strong medical Same Day Emergency Care (SDEC) offer exceeding national targets.

In quarter two, we have continued to reduce the incomplete RTT waiting list and the number of 52-week waits. We also continue to reduce our 65-week waits, although we are slightly off plan, in part driven by the support we are offering across the system, together with the need to prioritise cancer pathways and staff availability over the holiday period. We continue to work together as a system with patients being transferred between providers to support equity of access. Our DM01 performance is now 76.5%, the highest level since Dec-21. Our Echocardiography position has improved significantly and is now ahead of plan, largely due to insourcing plans that have gradually helped us to reduce the significant 6-week backlog. We are also receiving Echocardiography support from Nottingham University Hospitals (NUH). We are providing support to NUH across ENT, Ophthalmology and Urology. Further support offers continue to be reviewed.

In outpatients, activity levels remain strong and favourable to plan for outpatient follow ups and procedures. We consistently exceed the 5% Patient Initiated Follow Up (PIFU) target and benchmark within the top 15 Trusts nationally (10th best in Aug-24). In Sep-24, we exceeded our plan for the first time in 2024/25 against the new outpatient metric measuring the proportion of outpatient attends that are first or follow up with a procedure.

In terms of our Cancer metrics, we continue our strong delivery of the national 28-day faster diagnostic standard, exceeding the national standard. As of Aug-24, we have consistently delivered against our planning trajectory for cancer 31-day treatments. We also delivered against our planning trajectory for the cancer 62-day treatment standard in Aug-24 after falling off-track in Jul-24, though we fell below the interim standard of 70%. However, we are better than the England average position for the cancer 62-day standard.

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Scorecard: Timely Care

Timely Care

Green tick = target met/exceeded; Red cross = target not met

Green tick = Best performing 40%
Amber dash = Middle performing 20%
Red cross = Worst performing 40%

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD	Latest Benchmark Position (Aug 24)
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✓ 96.8%	✓ 96.7%	✓ 95.7%	✓ 95.6%	✗ 93.9%	✗ 94.6%	✗ 94.7%	✓ 96.6%	✓ 96.5%	✓ 95.1%	✓ 96.1%	✓ 95.6%	✓ 96.8%	✗ 93.5%	✓ 95.3%	✓ 95.7%	✓ 7 / 173
	Ambulance delays >60 mins	0.0%	0.0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.5%	✗ 0.3%	✗ 0.2%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.1%	✓ 7 / 174
	ED 4-hour performance	≥76%	≥76%	✗ 69.4%	✗ 67.1%	✗ 64.9%	✗ 67.2%	✗ 65.7%	✗ 63.6%	✗ 72.2%	✗ 67.3%	✗ 74.2%	✗ 73.4%	✗ 70.9%	✗ 72.8%	✗ 71.7%	✓ 82.0%	✗ 73.6%	✗ 75.6%	✗ 74.2%	✓ 34 / 140
	ED 12-hour length of stay performance	≤2%	≤2%	✗ 3.3%	✗ 4.2%	✗ 6.5%	✗ 4.7%	✗ 5.5%	✗ 5.1%	✗ 3.1%	✗ 4.5%	✗ 3.1%	✗ 2.2%	✗ 2.3%	✗ 2.5%	✗ 2.9%	✓ 0.9%	✗ 3.0%	✗ 2.3%	✗ 2.4%	✓ 19 / 174
	SDEC rate	≥33%	≥33%	✓ 39.8%	✓ 37.1%	✓ 36.2%	✓ 37.7%	✓ 38.3%	✓ 38.1%	✓ 37.8%	✓ 38.1%	✓ 38.2%	✓ 37.7%	✓ 38.6%	✓ 38.2%	✓ 38.1%	✓ 41.3%	✓ 39.0%	✓ 39.4%	✓ 38.8%	– 86 / 173
	Adult G&A bed occupancy	≤92%	≤92%	✓ 92.0%	✗ 96.3%	✗ 95.3%	✗ 94.6%	✗ 97.9%	✗ 97.8%	✗ 96.5%	✗ 97.4%	✗ 93.6%	✗ 94.8%	✗ 94.7%	✗ 94.4%	✗ 95.5%	✗ 92.2%	✗ 93.8%	✗ 93.9%	✗ 94.1%	– 75 / 178
	Long length of stay (21+) occupied beds	≤Plan	≤Plan	✓ 100	✗ 109	✗ 100	✗ 103	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✓ 102	✓ 105	✓ 103	✓ 104	✓ 103	
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 90	✗ 98	✗ 92	✗ 94	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 84	✗ 65	✗ 57	✗ 69	✗ 72	
Electives	Advice & guidance	≥16%	≥16%	✓ 25.3%	✓ 24.4%	✓ 23.0%	✓ 24.3%	✓ 24.3%	✓ 27.3%	✓ 25.4%	✓ 25.6%	✓ 24.5%	✓ 25.8%	✓ 22.0%	✓ 24.1%	✓ 25.2%	-	-	-	-	✓
	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 6.0%	✓ 5.7%	✓ 5.4%	✓ 5.7%	✓ 5.7%	✓ 5.6%	✓ 5.3%	✓ 5.5%	✓ 6.0%	✓ 5.9%	✓ 5.9%	✓ 5.9%	✓ 6.2%	✓ 6.1%	✓ 6.5%	✓ 6.3%	✓ 6.1%	✓ 10 / 134
	Outpatient attends that are first or follow up with a procedure		≥Plan	43.2%	43.7%	44.0%	43.6%	43.2%	43.7%	43.8%	43.5%	✗ 43.3%	✗ 40.7%	✗ 43.9%	✗ 42.6%	✗ 43.6%	✗ 42.2%	✓ 42.7%	✗ 42.9%	✗ 42.7%	
	Incomplete RTT waiting list	≤Plan	≤Plan	✗ 53,708	✗ 52,717	✗ 52,569	✗ 52,569	✗ 52,377	✗ 50,534	✗ 50,757	✗ 50,757	✗ 36,584	✗ 35,858	✗ 35,720	✗ 35,720	✗ 35,251	✗ 35,165	✗ 35,507	✗ 35,507	✗ 35,507	
	Incomplete RTT pathways +52 weeks	≤Plan	≤Plan	✗ 1,851	✗ 1,858	✗ 1,933	✗ 1,933	✗ 1,759	✗ 1,662	✗ 1,591	✗ 1,591	✓ 1,312	✓ 1,162	✓ 1,177	✓ 1,177	✓ 1,080	✗ 1,019	✗ 870	✗ 870	✗ 870	– 75 / 156
	Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 362	✗ 337	✗ 418	✗ 418	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✓ 109	✓ 77	✗ 105	✗ 50	✗ 50	✗ 50	– 78 / 156
	Incomplete RTT pathways +78 weeks	0	0	✗ 7	✗ 5	✗ 14	✗ 14	✗ 17	✗ 12	✗ 5	✗ 5	✗ 2	✗ 1	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	– 68 / 156
Diagnostics	Diagnostic DM01 backlog			3,761	3,726	4,055	4,055	3,659	3,344	3,430	3,430	3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	2,558	
	Diagnostic DM01 performance under 6-weeks	≥99%	≥Plan	✗ 63.3%	✗ 64.7%	✗ 56.8%	✗ 56.8%	✗ 62.8%	✗ 68.1%	✗ 70.5%	✗ 70.5%	✓ 71.6%	✓ 72.7%	✗ 70.5%	✗ 70.5%	✗ 69.5%	✗ 70.2%	✗ 76.3%	✗ 76.3%	✗ 76.3%	✗ 101 / 134
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥75%	✓ 81.3%	✓ 77.3%	✓ 80.6%	✓ 79.7%	✓ 76.0%	✓ 82.9%	✓ 82.6%	✓ 80.6%	✓ 75.3%	✓ 79.8%	✓ 79.2%	✓ 78.2%	✓ 81.6%	✓ 81.6%	-	-	-	✓ 38 / 141
	Cancer 31-day treatment performance	≥96%	≥Plan	✗ 79.8%	✗ 75.8%	✗ 72.5%	✗ 75.9%	✗ 73.2%	✗ 80.0%	✗ 90.4%	✗ 81.4%	✓ 89.8%	✓ 87.5%	✓ 88.3%	✓ 88.6%	✓ 95.0%	✓ 91.1%	-	-	-	✗ 101 / 141
	Cancer 62-day treatment performance	≥85%	≥Plan	✗ 52.8%	✗ 64.8%	✗ 57.7%	✗ 58.6%	✗ 56.5%	✗ 54.7%	✗ 69.2%	✗ 60.4%	✓ 71.8%	✗ 56.3%	✓ 70.3%	✗ 66.1%	✗ 71.4%	✓ 67.9%	-	-	-	✗ 98 / 141
	Suspected cancer patients waiting over 62-days			89	86	89	89	76	50	52	52	80	69	70	70	68	87	83	83	83	

Notes:

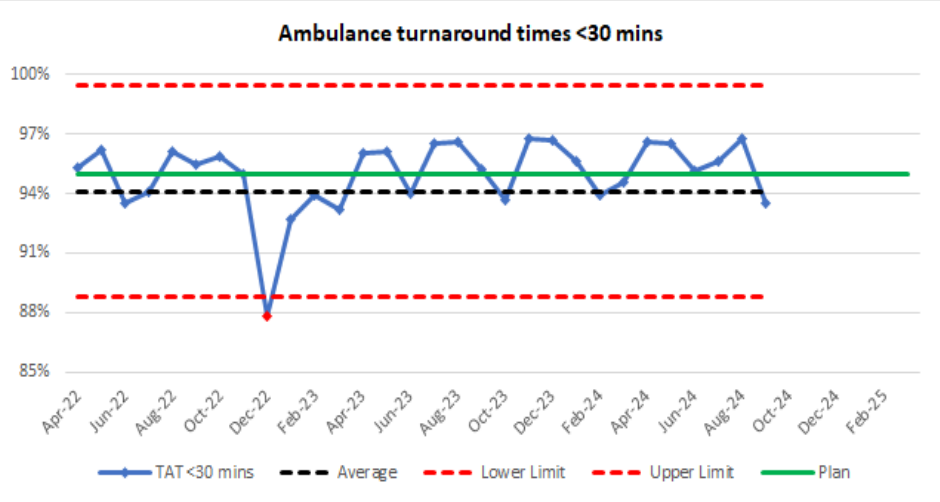
(1) Within the reported cancer treatment standards, we have aligned our reporting to match with the national cancer waiting time standards which remove auto upgrades. The reported position for the last two months for the cancer treatment standards can move as provisional cancer waiting time data is validated. We align the reported position in the Integrated Performance Report to the national reported position.

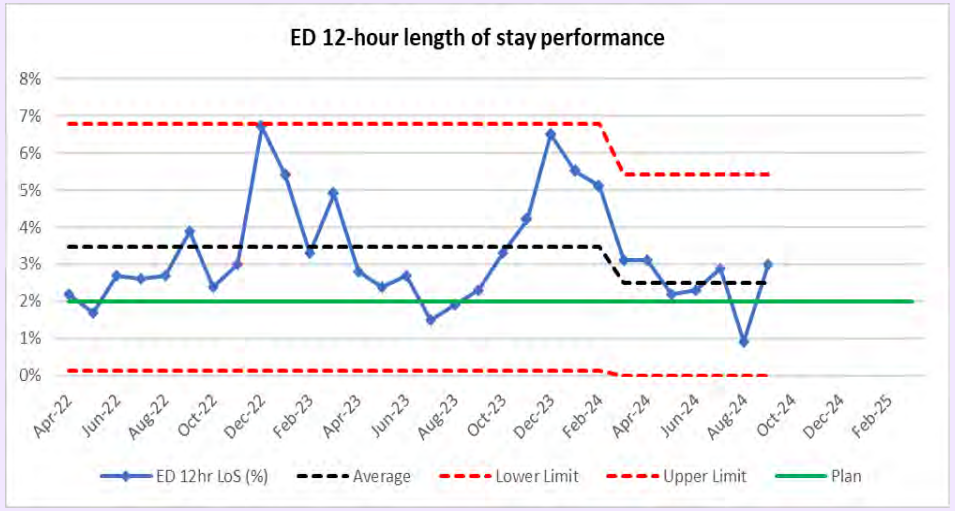
(2) As part of the IPR annual review undertaken in 2024/25 quarter one, we agreed to add benchmarking data to the timely care domain in the quarter two report. This has been added to the above scorecard and referenced as appropriate in the following pages. If Trust Board are happy with the way benchmarking data has been presented, we will expand into the other domains in future reports. Appendix B to the IPR includes some guidance on benchmarking.

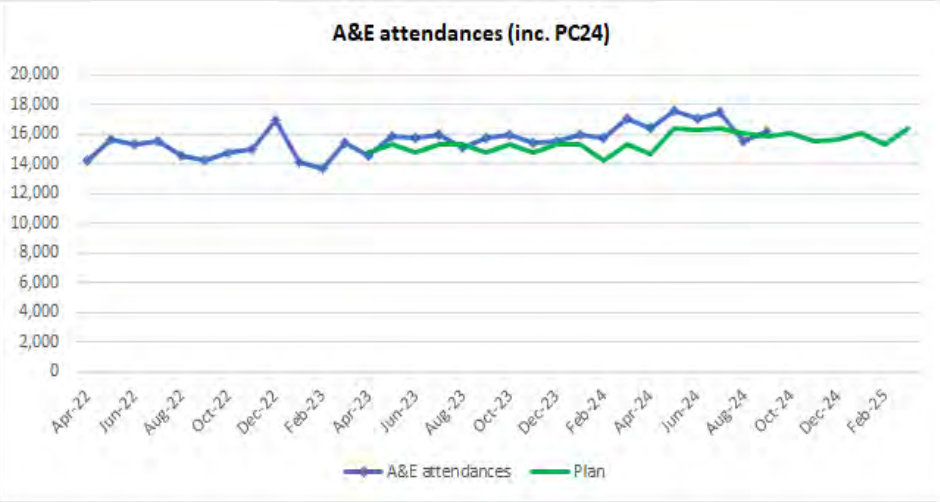
Indicators in Focus: Urgent Care – A&E (1/3)

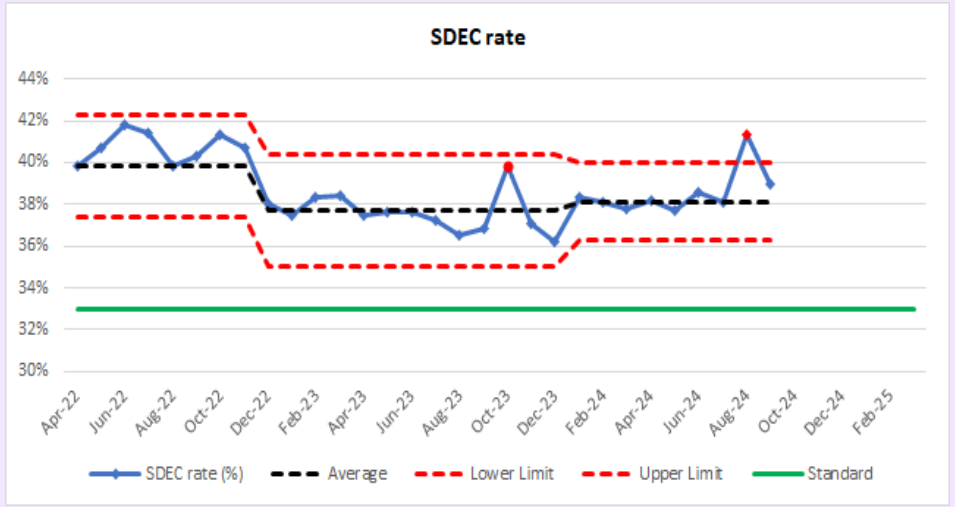
Sherwood Forest Hospitals NHS Foundation Trust

Data









Indicators in Focus: Urgent Care – A&E (2/3)

Sherwood Forest Hospitals NHS Foundation Trust

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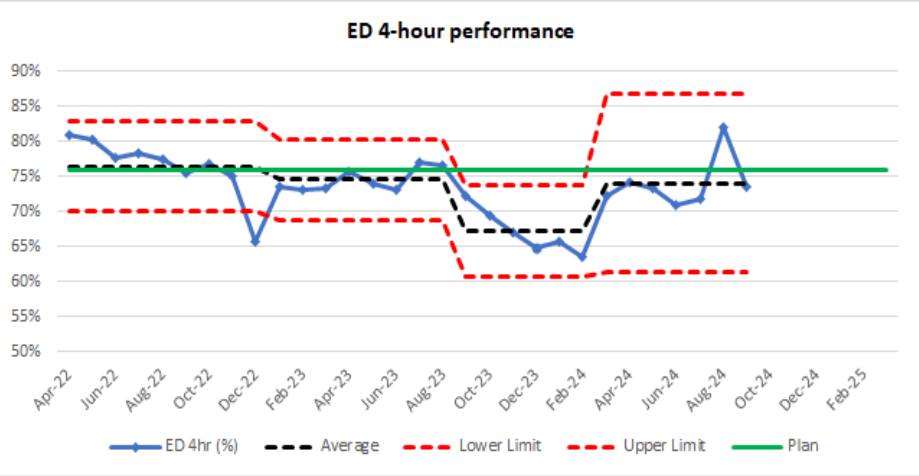
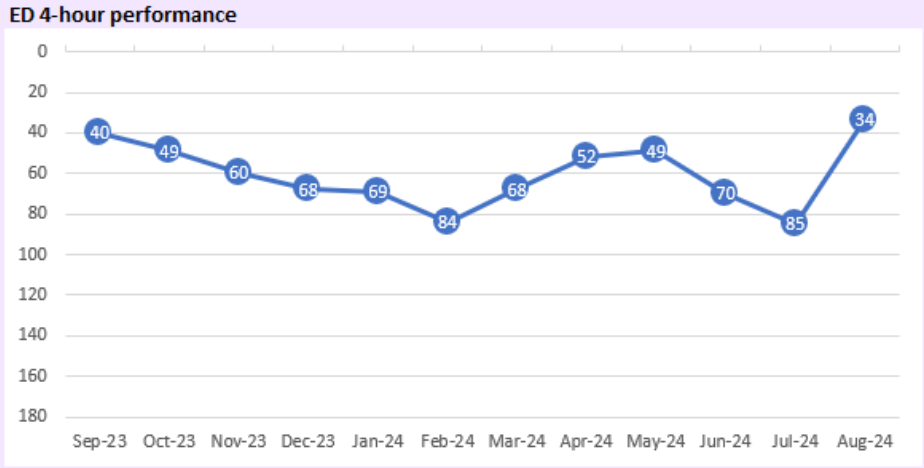
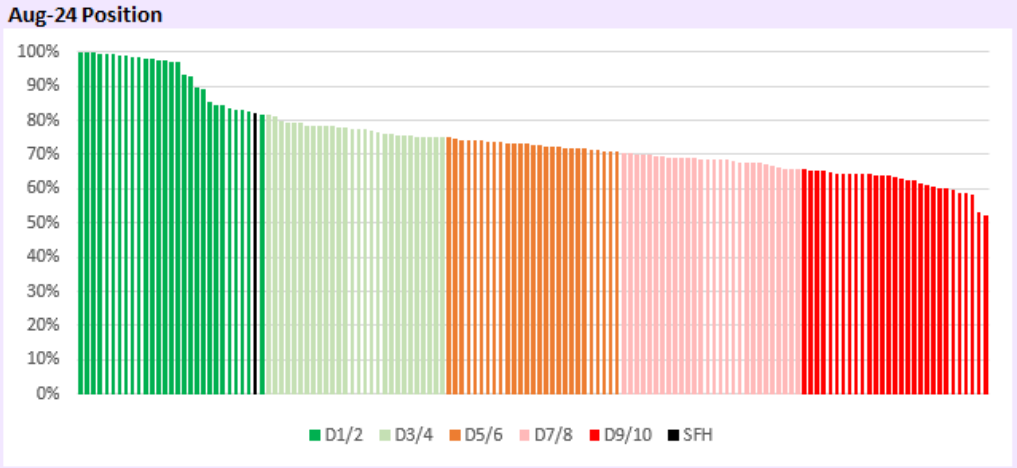


Overview and national position

- Our ambulance handover position is significantly better than the East Midlands Ambulance Service (EMAS) average and amongst the best nationally (6th best average time):
  - Frequently best in Midlands, within top 10 nationally for ambulance handovers.
  - EMAS average handover time 35 minutes, SFH 15 minutes.
  - A&E attends dropped in Sep-24 to be 102% against planned levels. This remains at a low level of growth when compared to quarter one and is driven by type three PC24 attendance levels being consistently below plan. Note: the plan included 0.6% growth on 2023/24 levels. Type one attendance demand growth is in the upper quartile nationally (amongst the highest in the country).
  - Expectation that as the planned activity over winter remains relatively static, we may see big variances against planned levels of attendances.
- The Getting It Right First Time (GIRFT) Emergency Medicine Index of patient flow (GEMI) ranking at SFH is 14; this ranks us 6th best in England in A&E.
- Our strong Aug-24 4-hour emergency access performance resulted in our benchmark position improving to be top quartile. This evidences that when demand falls within manageable levels, we have strong systems and processes to deliver timely patient care.





Indicators in Focus: Urgent Care – A&E (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact

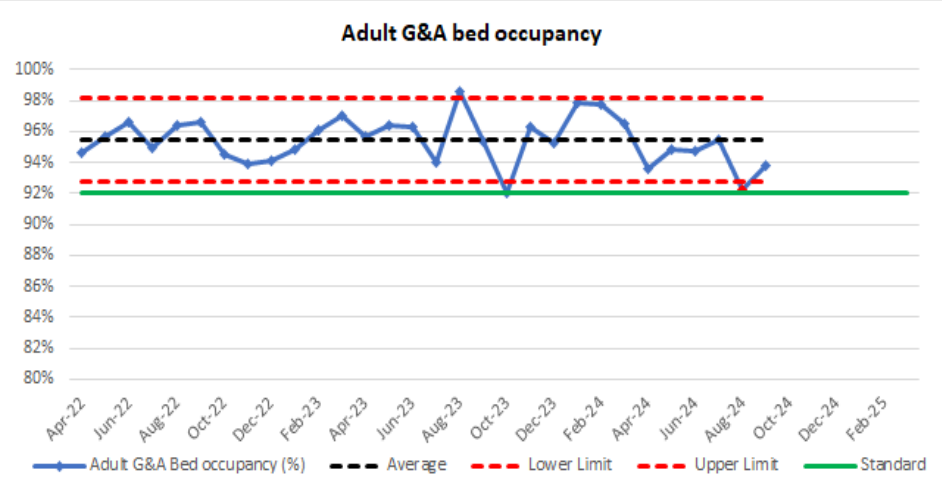
Increased ED attendance demand.	• Admission and attendance avoidance with system partners to include:
	  – Focus on frailty attendances – call before you convey, use of urgent care response teams.
	  – Develop pathways out of the Urgent Care Co-ordination Hub.
	  – Review all category 3 activity for missed opportunities. Category 3 activity is urgent patients but not life-threatening (category 1) or emergency calls (category 2).
	  – Review of attendance demand with system partners for walk in attendances and ambulance conveyance with postcode analysis to try and identify the drivers for increased demand.
	• Extension of Newark Urgent Treatment Centre (UTC) opening hours – commencing 11 Nov-24.
		• Reduction in out of area conveyances.
		• Reduction in category 3 ambulance conveyances.
		• Reduction in over 65-year-olds where length of stay is one day plus.

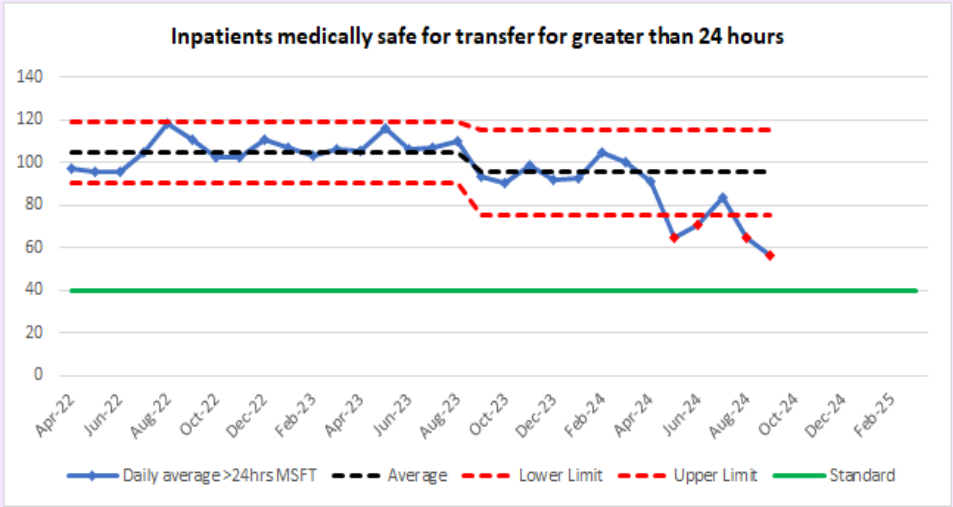
	• Optimise approach to Same Day Emergency Care (SDEC) for patients who would otherwise be admitted to hospital and develop frailty and respiratory Virtual Ward at scale to maximising opportunities for admission avoidance. • Criteria to Admit Lead trial post (externally funded for 3 months).	• Increase in patients through Frailty and Surgical SDEC. • Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our Emergency Department (ED). • Decrease in mean time in department for non-admitted patients identified with a Clinical Frailty Score (CFS) >6.
	• We are working with systems partners to better understand the increase in the number of Mental Health presentations in ED.	• Reduce ED overcrowding and improve staff:patient ratio through reduction in 1:1s required.
Insufficient staffing to manage ED demand.	• Business case supported for four additional Consultants and two Speciality Doctors to support (but not fully mitigate) the increased demand and reduce variable pay costs. • Agency and bank fill of additional ED shifts until substantive appointment.	• Decrease in mean time in department for non-admitted patient to <180 mins. • Time to initial assessment for arrivals to A&E seen within 15 minutes to greater than 60%.
ED overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Develop robust frailty offer as part of the winter plan to trial an Acute Frailty Unit and pathways to support the transfer of patients out of ED and avoid admission.	• Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our emergency Department (ED). • Decrease in mean time in department for non-admitted patients identified with a CFS >6.
	• Improved overall hospital flow.	• See next slides.

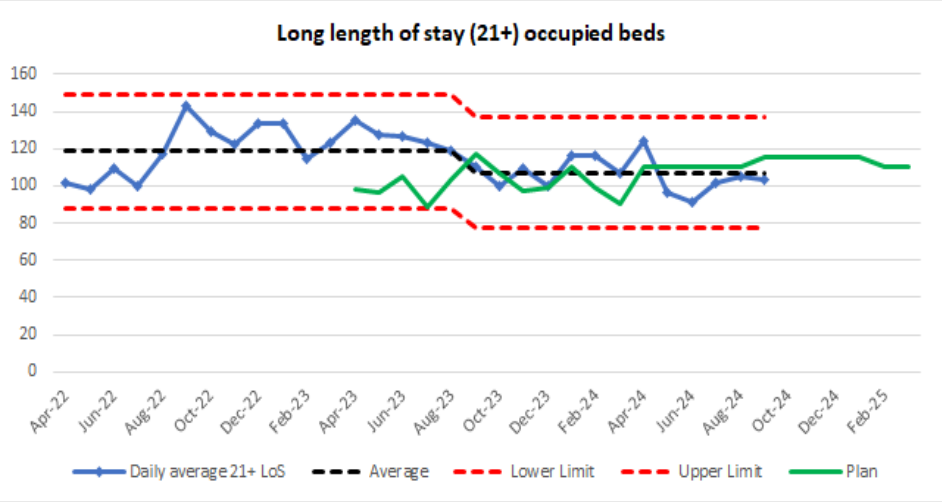
Indicators in Focus: Urgent Care – Hospital Flow (1/2)

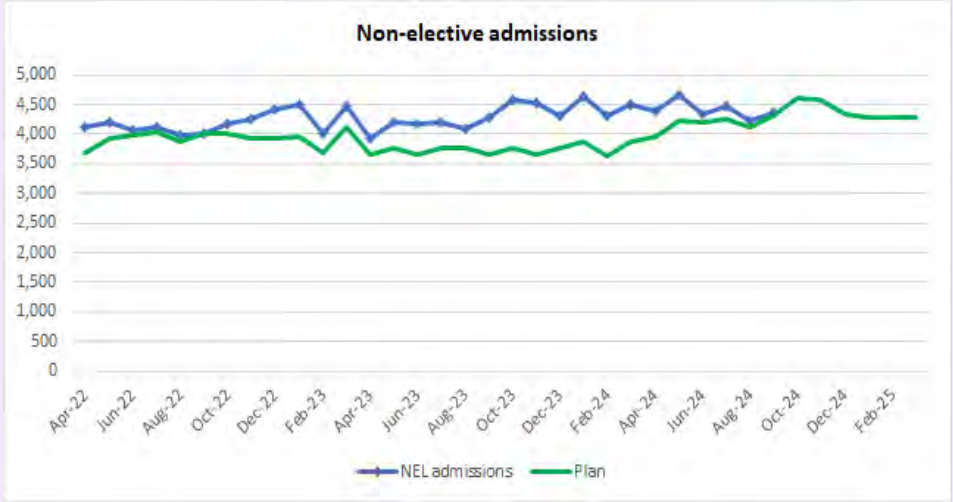
Sherwood Forest Hospitals NHS Foundation Trust

Data









Indicators in Focus: Urgent Care – Hospital Flow (2/2)

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

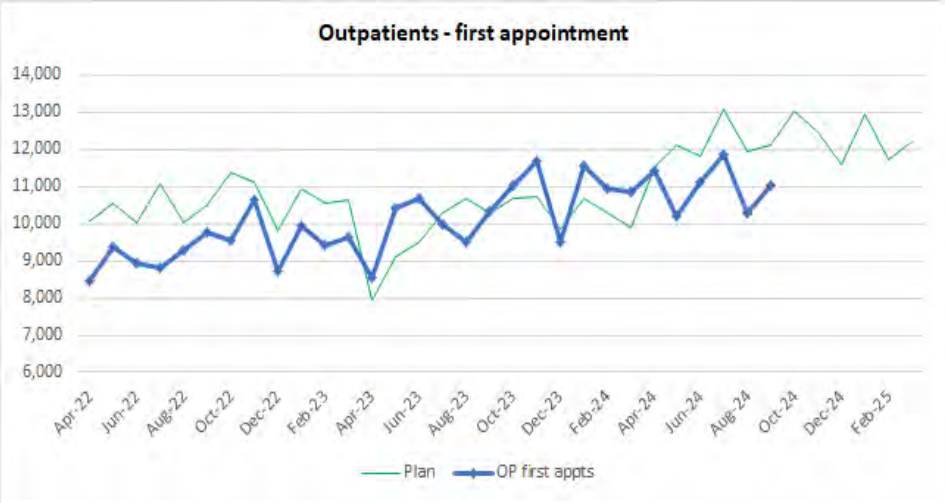
- Non-elective admission demand has continued to be high throughout 2024, and in 2024/25 quarter two was above planned levels by 3.0% (our plan included 0.6% growth on 2023/24 levels). Our discharge levels have been strong; however, the demand for beds remains high.
- The number of patients Medically Safe For Transfer (MSFT) over 24 hours reduced significantly to flag as special cause variation on the statistical process control chart in quarter two. This reduction is a combination of a recording practice change (whereby patients receiving ongoing rehabilitation and reablement under the nationally recognised discharge pathway two in our peripheral bed base are no longer considered medically safe until their rehabilitation and/or reablement is complete) and genuine improvement in internal and system discharge processes.
- The number of long stay patients has followed a similar trend to MSFT inpatient numbers due to similarities in the patient cohort with our position being better than our 2024/25 plan since May-24.

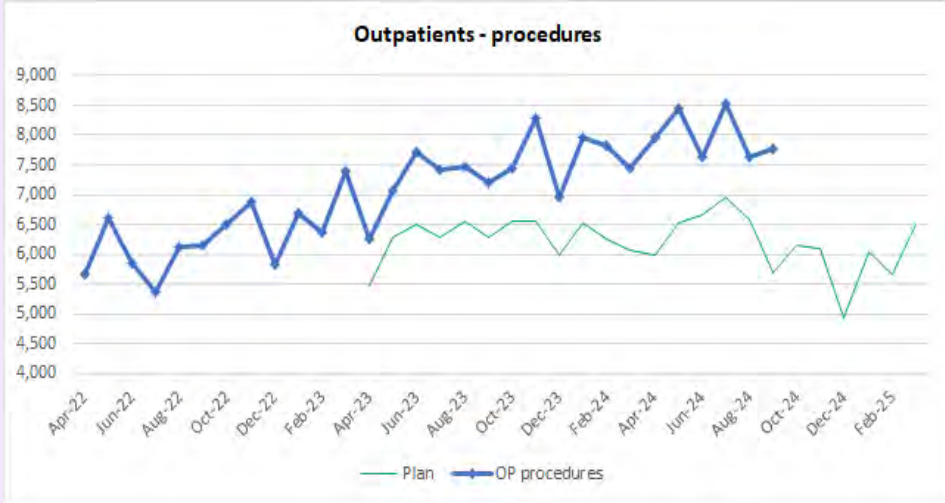
Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• Long length of stay (LOS) meetings embedded for both pre and post medically safe patients. • Dedicated ward Discharge Coordinators engage early with patients and families.	• LOS meetings identify opportunities for alternative pathways and early engagement with partner agencies to support discharge. • Early identification of potential barriers to discharge.
	• A programme 'Getting the Basics Right ' championed by the Chief Operating Officer and Medical Director continues to focus on board rounds and ward processes to support consistency of clinical documentation and clear recording of decisions.	• Review of discharge definitions including 'medically safe' will help us plan discharges in a timely way. Communication plan for winter, including training video for all ward-based or supporting staff, to ensure all staff aware of their role in supporting flow and discharge.
	• Continued recruitment to nurse vacancies within the discharge team.	• Consistency of discharge nurses across wards will benefit patient and family conversations to support timely discharge.
Delays to post-medically safe discharge processes.	• Transfer of Care Hub continues to work well. Dedicated staff focus on Pathway 3 patients and those with housing and homelessness issues.	• Reduce discharge delays and reduce the number of medically safe patients in our hospitals.
	• The discharge team undertake a daily review of all patients that have been medically safe for greater than 24 hours to identify actions to support timely discharge.	• Improve LOS for complex discharges across our hospitals.
	• Review funding of Street Health service which is non recurrently funded until April 2025. Liaising with current funders to agree next year's plan around this essential service to ensure continuity of service.	• Reduce delays in discharge processes for patients with complex housing issues supporting overall reduction in the number of medically safe inpatients.
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. Both EMED and Ambicorp conveyances now under both local and system wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge and further reduction in (good progress already seen) the number of abandoned discharges.
Insufficient community capacity to meet supported discharge demand.	• Daily reviews and escalation of Derbyshire patients to identify barriers and develop solutions for patients awaiting discharge.	• Rapid resolution of complex issues through multi agency working to support continued reductions in number of supported patients waiting more than 24 hours for discharge.
	• Twice-daily review of patients awaiting Nottinghamshire packages of care (POC); there are issues around those who are non-weight bearers.	• Identify trends in delays to discharge to enable further conversations with system partners around best use of capacity to maximise flow.

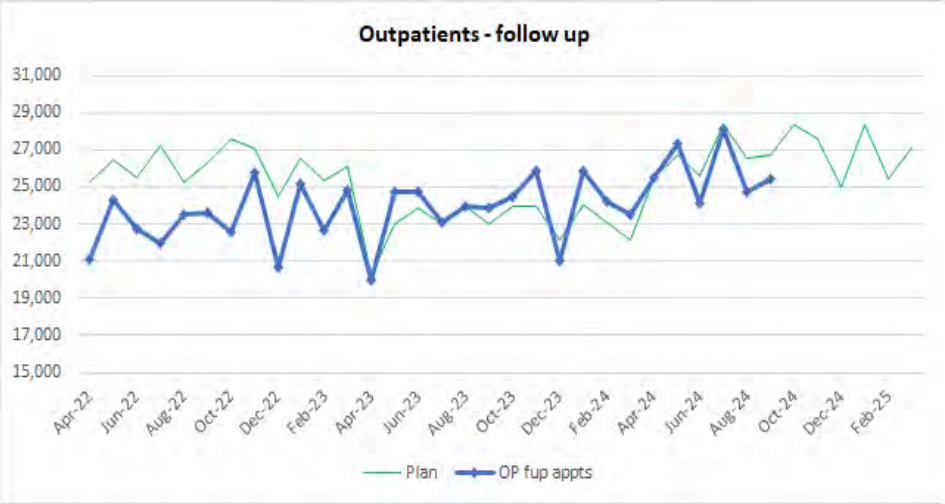
Indicators in Focus: Outpatients (1/2)

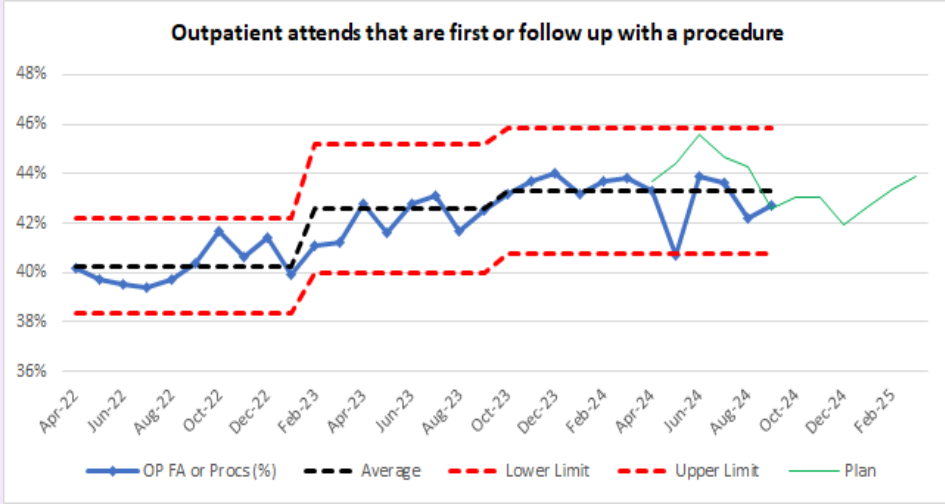
Sherwood Forest Hospitals NHS Foundation Trust

Data









Indicators in Focus: Outpatients (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

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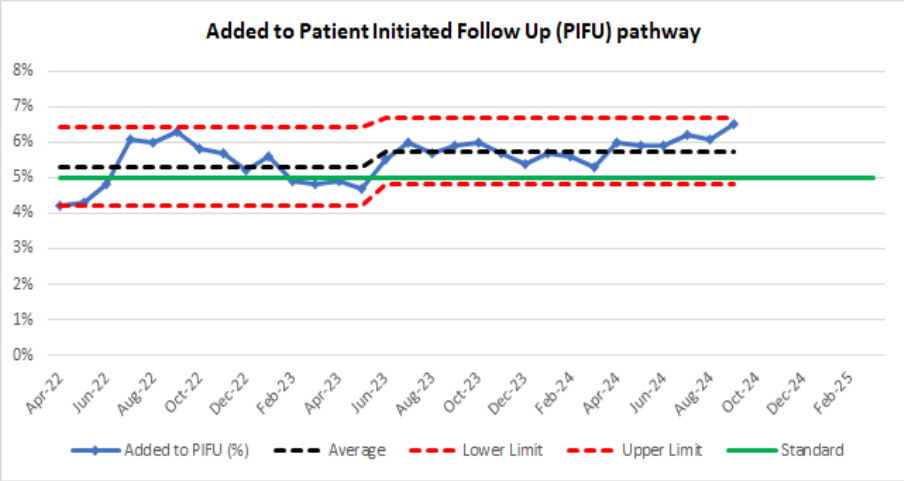
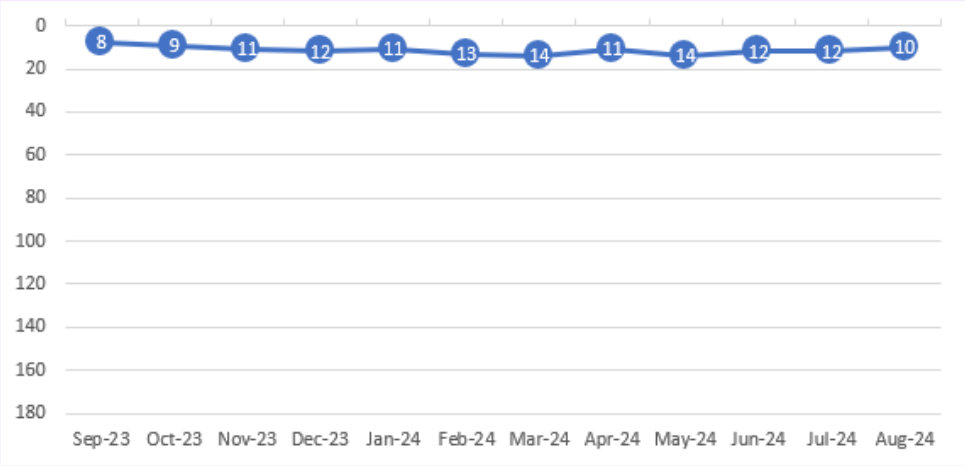


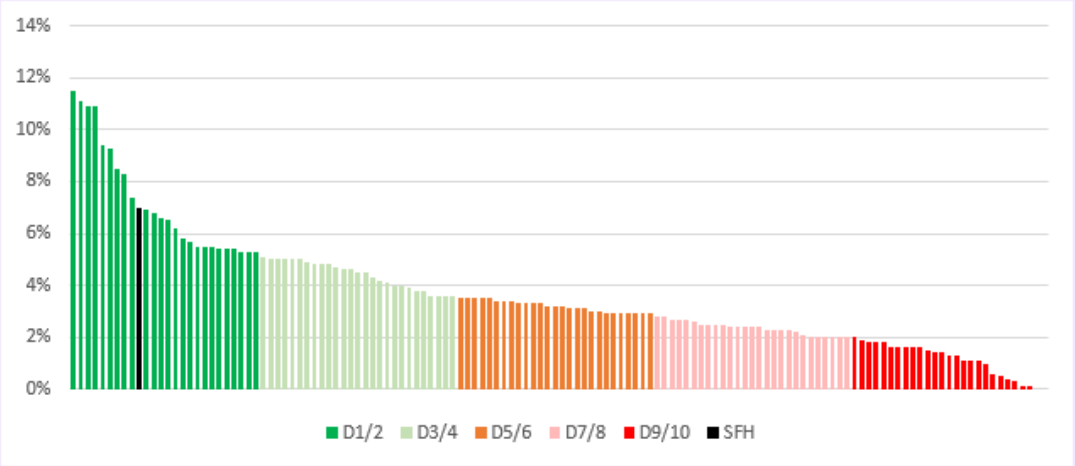
Overview and national position

- We consistently perform above the 5% Patient Initiated Follow Up (PIFU) target and benchmark strongly (see below).
- Our volume of advice and guidance surpasses national targets, and we are responding to 97.6% of requests in less than five days.
- We have an outpatient improvement programme in place. Since the programme went live, it has delivered just over £0.5m in improvements (vs a plan of £71,000) based on a circa 3% improvement in DNA (did not attend) rates and a circa 2% improvement in clinic utilisation. As of the middle of Oct-24, the programme is forecast to continue to over-deliver. Key schemes implemented through the programme are "Queuebuster", the "Room and Resource system" and text reminder optimisation.
- Trust outpatient first attendance and procedure activity levels have increased through 2024/25.
- Our outpatient follow up activity levels have been below our planned levels, which is positive in the context of the national ambition to reduce the volume of patients returning for follow up outpatient appointments.
- There are no specific escalations to raise for our outpatient metrics for this report.

Added to Patient Initiated Follow Up (PIFU) pathway



Aug-24 Position



Indicators in Focus: Referral To Treatment (1/3)

Sherwood Forest Hospitals NHS Foundation Trust

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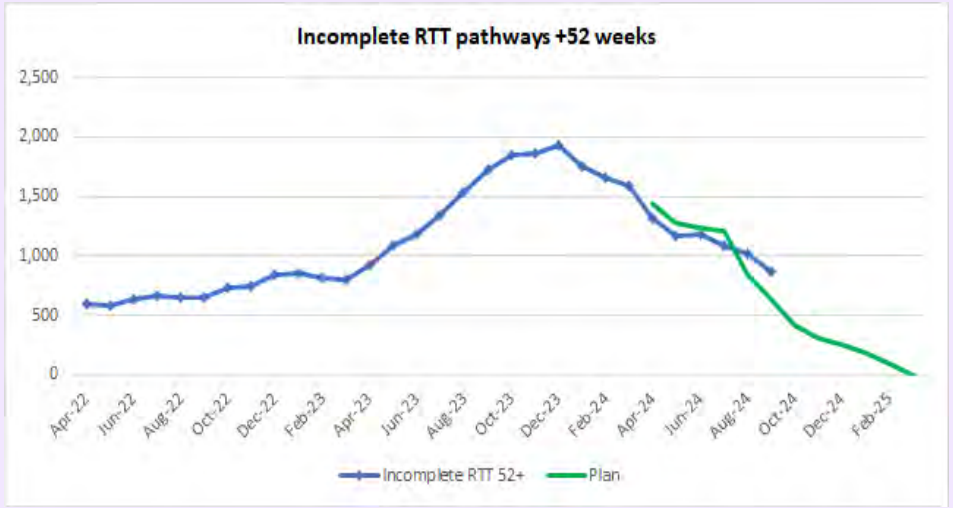
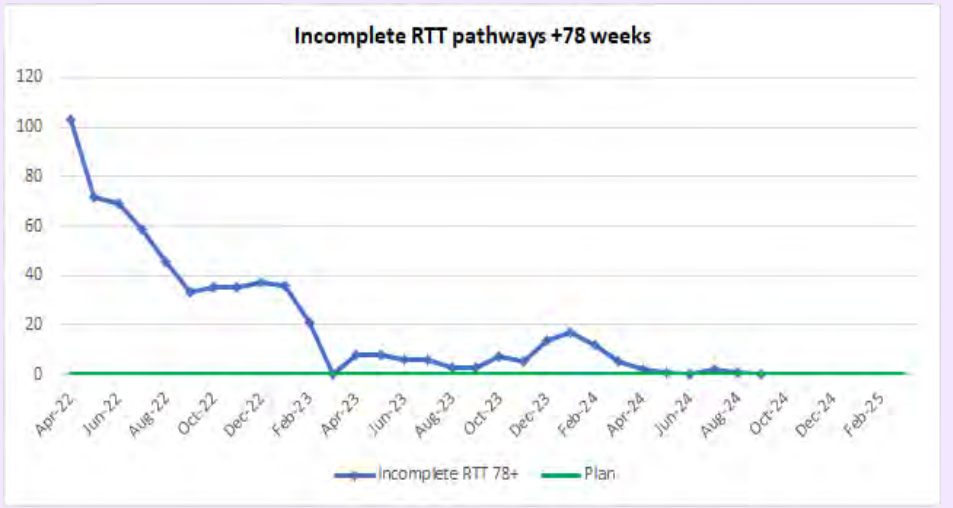
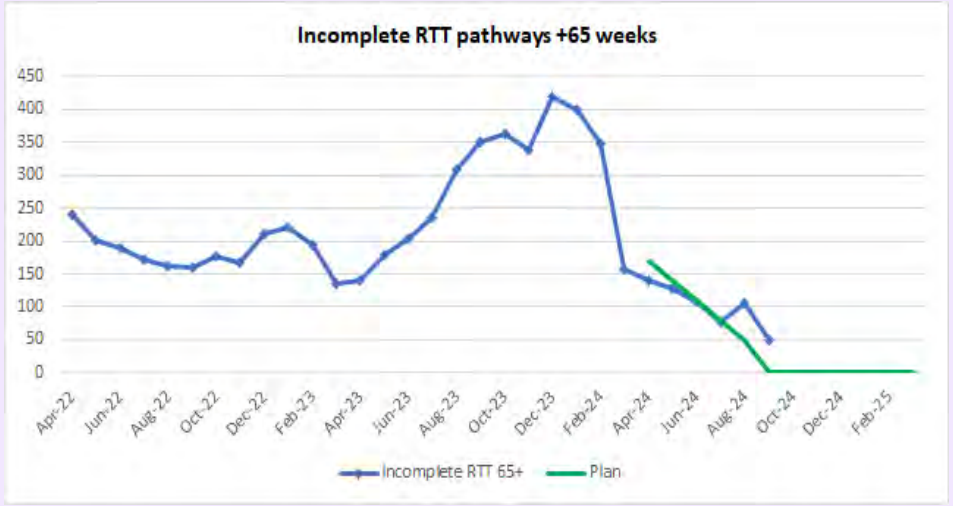
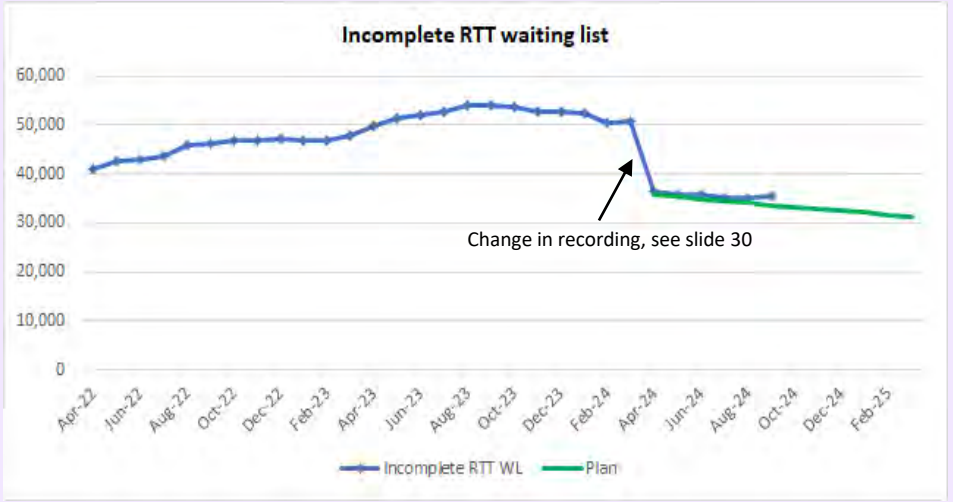






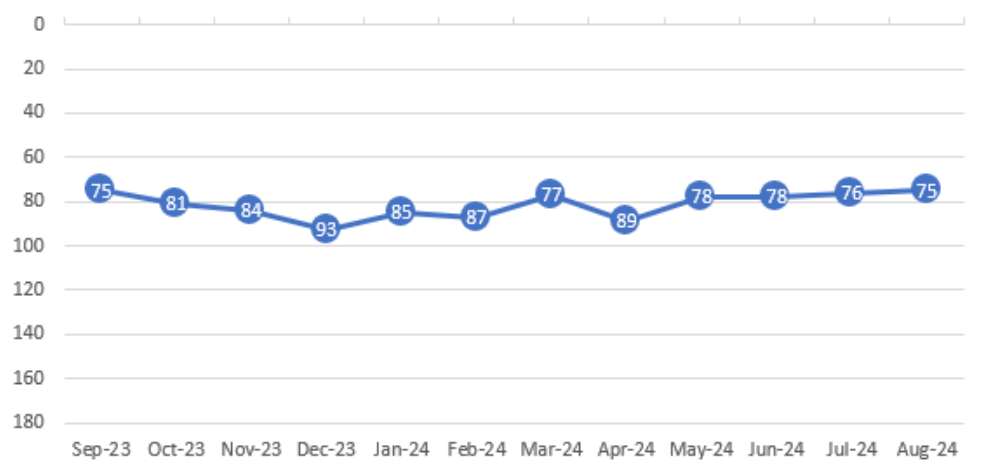


Indicators in Focus: Referral To Treatment (2/3)

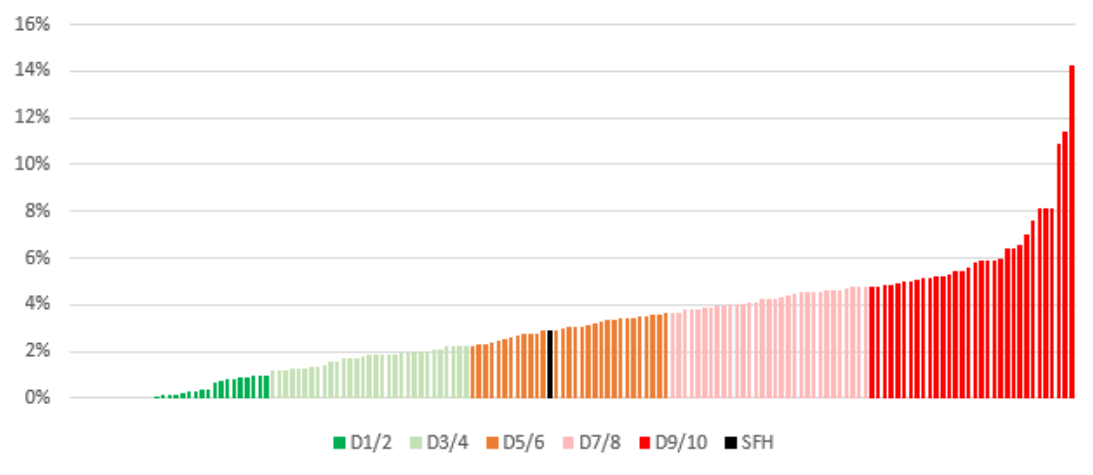
Sherwood Forest Hospitals NHS Foundation Trust

Data

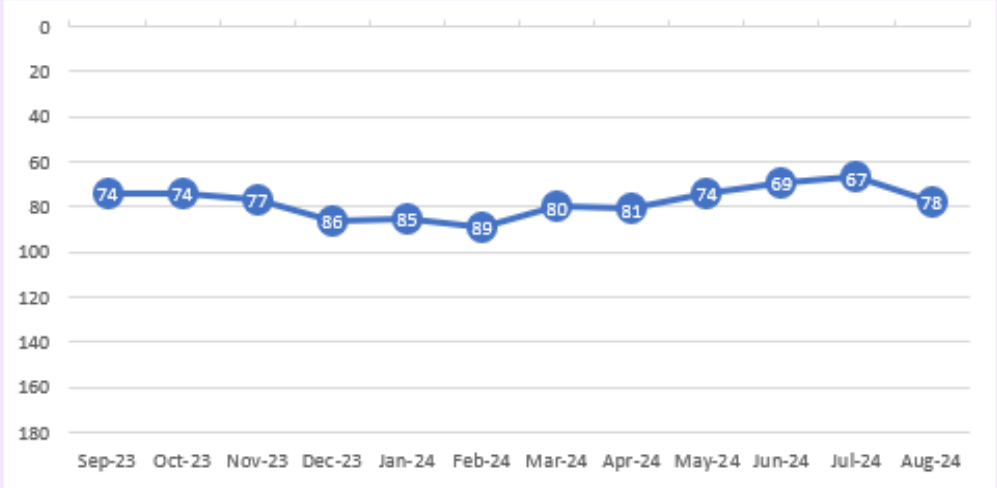
Incomplete RTT pathways +52 weeks



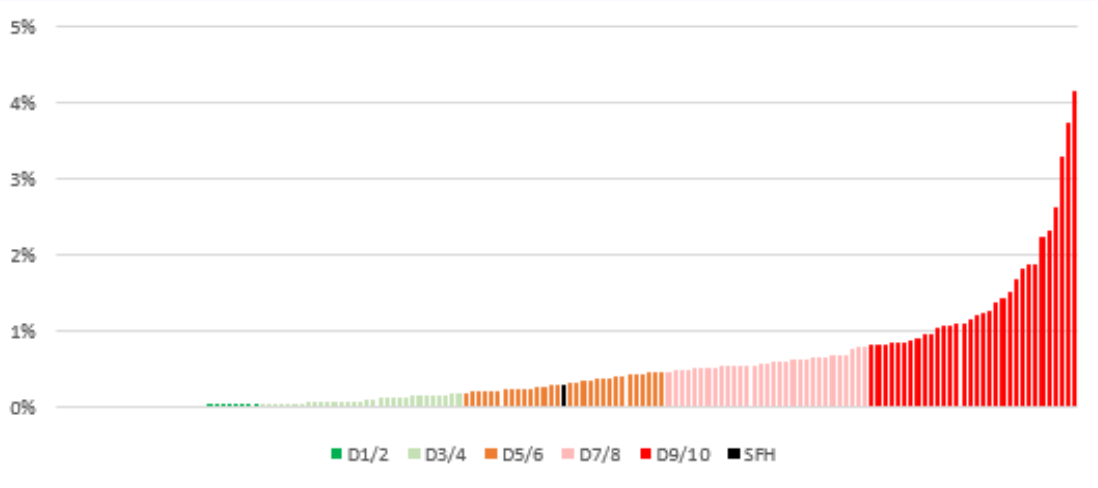
Aug-24 Position



Incomplete RTT pathways +65 weeks



Aug 24 Position



Indicators in Focus: Referral To Treatment (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Referral to Treatment (RTT) waiting times across England has stabilised at 7.6 million. National reporting of long wait patients more than 52 weeks wait has reduced to 290,000 pathways. The emphasis within the planning guidance for referral to treatment focuses on continuing to reduce the volume of long waiting pathways and overall Patient Tracking List (PTL) size.
- Following updated guidance for RTT reporting within the Waiting List Minimum Data Set (WLMDS), we no longer report our overdue review appointments within or PTL. From Apr-24, this resulted in a significant step change (reduction) in our overall reported incomplete pathways size from approximately 52,000 pathways to 37,000. We are seeing a reduction in line with (however, marginally above) our plan.
- 78-week waits were eliminated from the end of 2024/25 quarter one. However, in Jul-24, one patient breached due to complexity of pathway and patient engagement issues. In Aug-24, one patient breached due to requiring a rare diagnostic test at another provider to proceed for surgery that was cancelled multiple times due to unforeseen circumstances (kit and solution were not available). Despite this, we are looking to continue with zero tolerance for the reminder of 2024/25.
- 65-week wait patient volumes have been in line with our 2024/25 plan, the position deteriorated in Aug-24 as the provision of system support created further challenges towards the late summer period, specifically in ENT, which is a national trend. At the end of Sep-24 there were 50 patients waiting over 65 weeks.

Root causes	Actions and timescale	Impact
Inequity of waits for treatment across the system meaning that patients may need to transfer between providers altering reported positions.	• System support by Sherwood Forest Hospitals to see Nottingham University Hospital patients across ENT, Ophthalmology, Audiology, Urology and MRI.	• Equalise waits across the system. This could adversely impact on reported positions for long waits at a provider level.
	• System support by Nottingham University Hospitals to see Sherwood Forest Hospitals patients waiting for Echocardiography.	
Capacity in ENT and General Surgery due to prioritisation of cancer pathways, and late inter consultant referrals from Gastroenterology and Endocrinology.	• Continue to review patients booked weekly to ensure booking in clinical priority and then order of wait.	• Focus on treating patients in order of clinical priority.
	• Increased capacity in Gastroenterology through insourcing and Endocrinology through locum appointment to reduce waits for first appointments.	• Patients referred to General Surgery at a shorter wait.
Quality of data within our PTL. Patients potentially no longer needing or wanting treatment remaining on our waiting list.	• Investment in electronic patient-centred validation system (DrDoctor) to enable mass validation programme. Partial launch from Sep-24 full roll out by the end of quarter two.	• PTL will be ‘clean’ and represent only those patients genuinely waiting treatment. Reduction in overall PTL size.

Indicators in Focus: Diagnostics

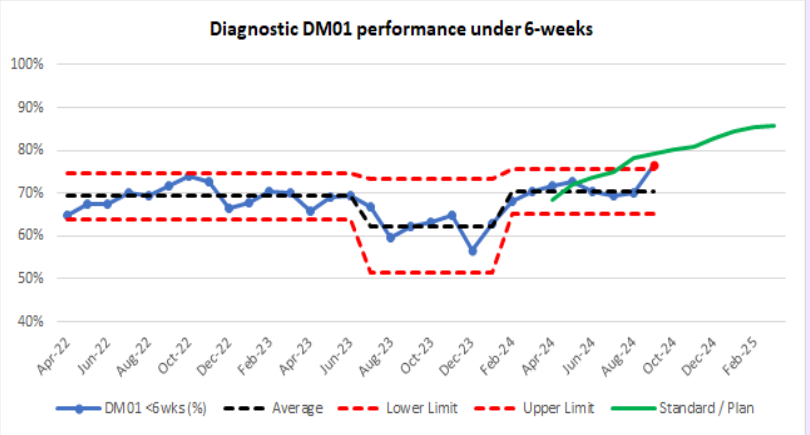
NHS Sherwood Forest Hospitals NHS Foundation Trust

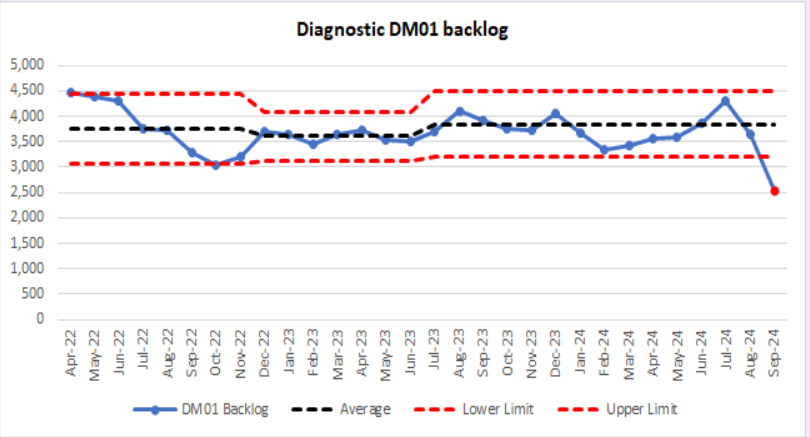
Overview and national position

- 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-24 was just over 373,100. This meant that 76% of patients nationally were seen within 6-weeks against the interim national standard of 95% by Mar-25.
- We have observed significant improvements in DM01 performance and in 6 and 13-week backlog levels over the last two months. The local position at the end of Sep-24 improved to 76.5% of patients seen within 6-weeks (Sep-24 awaiting publication); in line with the national position.
- Across SFH at the end of Sep-24 there were just over 10,800 patients waiting for DM01 reportable diagnostic tests, down from a peak of circa 14,000 in Jul-24. Of these, circa 2,500 patients were waiting greater than 6-weeks, down from a peak of circa 4,300. The greatest quarter two improvements have been seen in Echocardiography.
- The DM01 13-week backlog has seen a significant reduction, from 1,837 in Apr-24 to 387 patients waiting at the end of Sep-24.

Root causes	Actions and timescale	Impact
Echocardiography backlog and insufficient workforce to meet demand. Equipment and physical space are constraining backlog recovery alongside the workforce challenges.	• Enhanced pay rates paper submitted for Echo Physiologists to increase volunteers for additional weekend working.	• 64 patients per month from Jul-24 to end of Mar-25.
	• Insourced activity at King's Mill and Newark Hospitals.	• 110-130 cases per week.
	• Insourced activity delivered at Mansfield Community Hospital in a newly equipped facility.	• 60 cases per week.
	• System support from Nottingham University Hospitals since Aug-23.	• 7 cases per week.
	• The combined impact of the above mitigations will support gradual backlog reduction.	• Sep-24 DM01 performance strongest position since Dec-21.
CT Cardiac increase in demand (50% since 2022-23) further driven by the targeted lung health check programme expansion.	• Successful funding for new scanner to increase capacity for targeted lung health check expansion and CT Cardiac capacity, working towards 2024/25 quarter three installation.	• Up to 20 CT Cardiac cases per day.
	• Mutual support arrangements in place with NUH and Doncaster and Bassetlaw Teaching Hospitals (DBTH).	• 12 scans per week (8 NUH and 4 DBTH).
	• Additional capacity provided by the independent sector.	• 15 scans per month.

Data

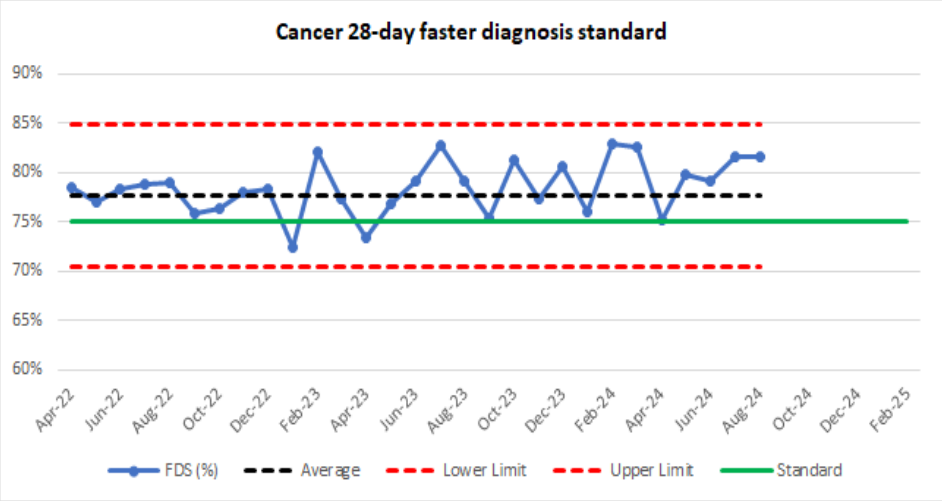


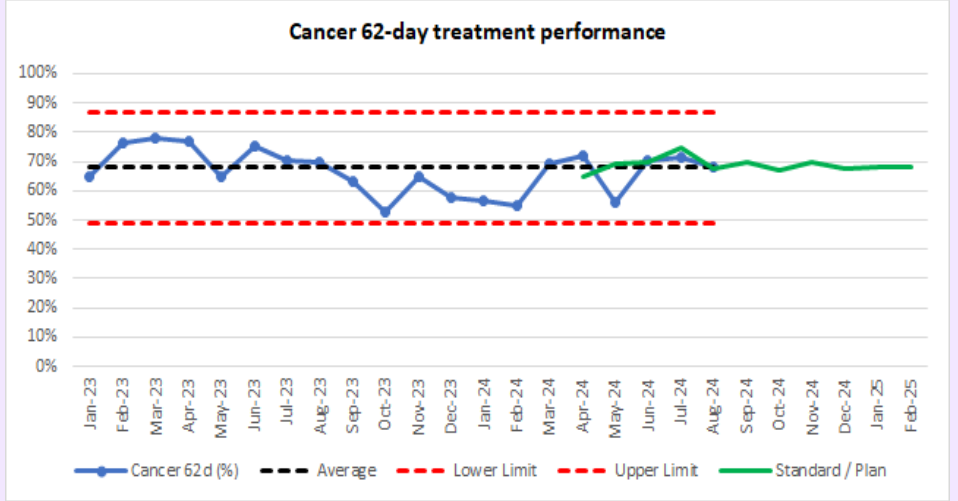


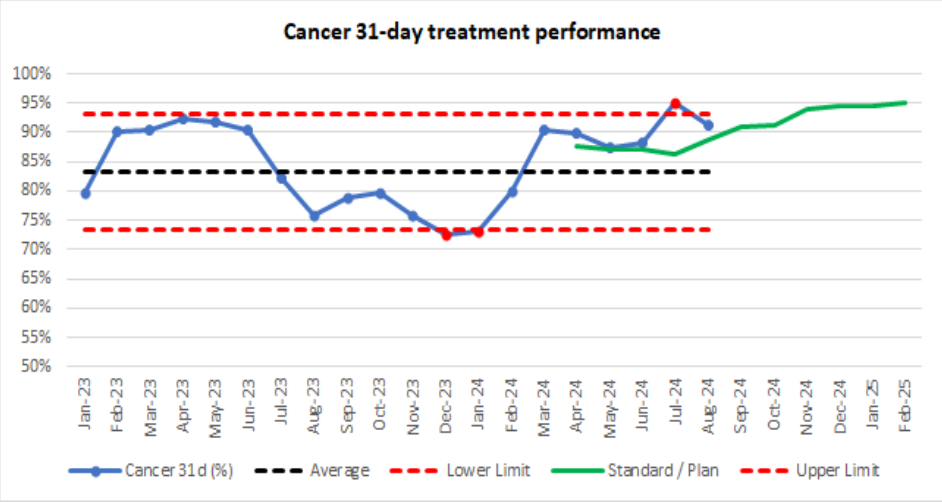
Indicators in Focus: Cancer (1/2)

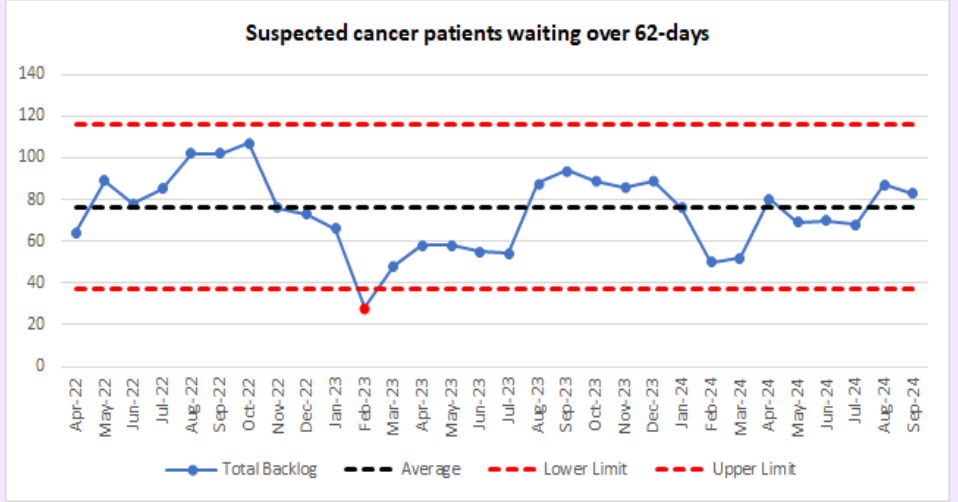
Sherwood Forest Hospitals NHS Foundation Trust

Data









Revised national cancer waiting time standards launched in Oct-23 with the original 10 standards reduced to three. The 31-day and 62-day standards present validated month-end, published data against the new standards from Oct-23. The historical data is based on a proxy as these metrics did not exist pre-Oct-23; as such the Jan-23 to Sep-23 data should be used as a guide and does not reflect the month-end, validated and published data.

We have aligned our reporting of the 31-day and 62-day treatment standards to match with the national cancer waiting time standards which remove auto upgrades. The reported position for the last two months for the cancer treatment standards can move as provisional cancer waiting time data is validated. We align the reported position in the Integrated Performance Report to the national reported position.

Indicators in Focus: Cancer (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Considering the latest national data (Aug-24):

- Nationally, 28-day Faster Diagnosis Standard (FDS) is 82% against the 75% standard. SFH is performing better than the England position and above the national standard. In Aug-24 we ranked 38 out of 141 providers.
- Nationally, 31-day treatment performance (first treatment) is 91% against the 96% standard. SFH is performing just below the England position and the national standard. In Aug-24 we ranked 101 out of 141 providers.
- Nationally, 62-day performance is 68% against the interim 70% standard. SFH is performing just below the England position and the national standard. In Aug-24 we ranked 98 out of 141 providers.

Root causes	Actions and timescale	Impact
62-day standard – All tumour sites except for skin and Upper GI. Due to capacity, histology turnaround, patient complexity, fitness and patient engagement.	• Best practice timed pathway improvement groups in place for Head and Neck, Prostate, Lower GI, Breast , Upper GI and Teledermatology	• Streamlining pathways towards best practice timed pathways to improve 28, 31 and 62-day performance.
	• Daily clinical reviews being undertaken within Gynaecology and Urology.	• Improved 28 and 62-day performance by increased timeliness of consultant decisions to progress next steps.
	• Recruitment to additional Consultant Radiology capacity to increase capacity and reporting turnaround.	• Improved 28, 31 and 62-day performance by reducing waits for diagnostic tests and reports.
	• Daily nurse triage to review results to determine patient discharge, consultant face to face or daily virtual review commenced Jul-24.	• Reduced number of Consultant clinical reviews required and increase timeliness of clinical reviews.
	• Endoscopy direct line bookable appointments for Lower GI.	• Reduce number of days lost to appointment booking and increase patient engagement and compliance with test. Increase timeliness of test turnaround.
	• Lower GI patient information video launched.	• Improve engagement and increase test compliance.
	• Successful funding for new scanner to increase capacity for CT Colons, working towards 2024/25 quarter three installation.	• Increased diagnostic capacity and improved FDS and 62-day.
	• Recruitment to additional Consultant Radiology capacity to increase capacity and reporting turnaround.	• Improved 28, 31 and 62-day performance by reducing waits for diagnostic tests and reports.
	• Additional Consultant capacity for histopathology.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
31-day standard – Skin and Lower GI surgical capacity.	• Audit of all 31-day breaches in LGI commenced Oct-24 to inform action plan. • LGI demand and capacity modelling underway to 'rightsize' theatre capacity. • Theatres transformation workstream to improve booking process and timely access to theatres for Breast and LGI.	• Increase timely surgical capacity • Improve 31-day performance.
	• Locum Consultant appointed in Skin.	• 31-day performance achieved >96% in Aug-24.

Performance against 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.

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Best Value Care

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Domain Summary: Best Value Care

Overview	Lead: Chief Financial Officer

The Financial Plan for 2024/25 is to deliver a break-even plan. This has changed in 2024/25 quarter two from a deficit plan of £14.0m due to non-recurrent deficit funding being provided by NHS England in 2024/25. The quarter two position is a deficit to plan variance of £0.2m. This is a year-to-date deficit of £0.8m adverse to the break-even plan. This accounts for the financial impact of industrial action; including £0.3m relating to the income lost as well as £0.2m of unplanned redundancy costs linked to the Covid Vaccination Service and £0.3m underfunded consultant pay award. The costs of managing the continued emergency and non-elective demand pressures faced over the quarter two period included capacity costs of £3.5m, compared to a quarter two plan of £3.5m. Although this spend is on plan for bedded capacity the non-bedded capacity element has seen a cost pressure in quarter two of £0.1m due to agreed schemes to enhance ED staffing. The forecast for the remainder of the year aligns to the break-even plan, which includes an assumption that the lost income relating to industrial action is addressed and assumes full efficiency delivery. The current forecast risk to delivery is being reviewed through a stocktake of the first two quarters. This stocktake is being fully reviewed through Trust Management Team (TMT) and Finance Committee for next steps and actions to be agreed.

Financial Improvement Programme (FIP) delivery in quarter two is £7m against a plan of £11.5m. The £4.5m adverse variance to plan largely relates to unachieved divisional FIP, which is being partly offset by an over delivery on non-recurrent vacancy factor slippage. The current unweighted forecast is for full FIP delivery, however the risk adjusted forecast is not at the same level. Schemes continue to be worked on at pace to de-risk and progress schemes.

The 2024/25 Capital Expenditure Plan was initially phased in equal twelfths across the financial year, due to delays in finalising allocations and plans across the Integrated Care System (ICS). Quarter two capital expenditure totalled £3.74m, which is £3.65m lower than initially planned. Following the Board approval of the final re-prioritised capital plan in Jul-24, a reprofiling exercise has been completed to align the forecast delivery dates. The current full year forecast is £2.5m less than the original plan due to re-phasing of nationally allocated Electronic Patient Record (EPR) funding into 2025/26.

Closing cash on 30 September was £1.5m, which is £12k adverse to plan. However, this masks an underlying pressure on available revenue cash resource, as it is being supported by Revenue Support.

Value weighted elective activity in quarter two was 116% against the baseline, which exceeds the NHS England target of 105%. The Trust has set an ambitious Elective Recovery Fund (ERF) plan for 2024/25, and further work is being undertaken to identify opportunities to improve the levels of value weighted elective activity as the year progresses.

In 2024/25 quarter two, we have spent £3.5m on agency, which is £0.6m higher than the plan of £2.9m. This represents 4.2% of our total pay bill and exceeds the 3.2% NHS England target. The main reasons for agency use are sickness and vacancies, while a proportion also related to ERF initiatives to increase activity and reduce patient waiting list backlogs.

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Scorecard: Best Value Care

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD
Finance	Income & expenditure against plan	≥£0.00m	≥£0.00m	✗-£1.33	✓£0.82	✓£2.58	✓£2.07	✗-£0.76	✓£2.33	✗£12.76	✗£11.19	✗-£0.02	✓£0.02	✗-£0.61	✗-£0.61	✗-£0.33	✗-£0.31	✓£0.44	✗-£0.20	✗-£0.81
	Financial Improvement Programme (FIP) against plan	≥£0.00m	≥£0.00m	✗-£0.38	✗-£0.17	✗-£0.80	✗-£1.35	✓£1.27	✗-£0.43	✓£0.54	✓£1.38	✗-£0.55	✓£1.48	✓£0.66	✓£1.59	✗-£1.61	✗-£1.38	✗-£1.57	✗-£4.56	✗-£2.97
	Capital expenditure against plan	≤£0.00m	≤£0.00m	✗£3.19	✓-£0.70	✗£5.23	✗£7.72	✓-£2.01	✓-£0.88	✓£12.53	✓£15.42	✗£1.61	✗£2.07	✗£1.39	✗£5.07	✗£1.55	✗£1.28	✗£1.27	✗£4.10	✗£9.17
	Cash balance	-	≥£1.45m	✓£1.49	✓£1.51	✓£2.04	✓£2.04	✓£1.80	✓£8.76	✓£4.74	✓£4.74	✗£1.34	✓£1.73	✓£1.50	✓£1.50	✗£0.32	✗-£0.15	✗£0.05	✗£0.05	✓£1.50
	Implied Productivity 2023/24 v 2024/25	-	3.1%	-	-	-	-	-	-	-	-	-	-	-	-	✓6.7%	-	-	-	-
	Value weighted elective activity	-	105%	✗99.6%	✓110.7%	✓108.6%	✓106.3%	✓113.2%	✓114.2%	✓127.1%	✓118.2%	✗103.5%	✓110.9%	✓112.0%	✓108.8%	✓108.8%	✓118.7%	✓118.5%	✓115.3%	✓112.1%
	Agency expenditure against plan	≥£0.00m	≥£0.00m	✗-£0.21	✓£0.62	✓£0.29	✓£0.70	✗-£1.36	✗-£1.17	✗-£1.09	✗-£3.62	✗-£0.18	✗-£0.29	✗-£0.29	✗-£0.76	✗-£0.39	✗-£0.24	✓£0.01	✗-£0.62	✗-£1.38
	Reported agency spend			£1.67	£0.72	£1.07	£3.46	£1.47	£1.28	£1.21	£3.96	£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£7.41
	Reported bank spend			£2.30	£2.10	£2.71	£7.11	£3.36	£2.01	£3.69	£9.06	£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£15.58

Indicator in Focus: Income and Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust financial plan, which is a break-even position for 2024/25. This is aligned to the Trust's share of the 2024/25 Revenue Plan Limit set for the Nottingham & Nottinghamshire ICB by NHS England.
- The Trusts annual plan has moved from a deficit of £14m this year to a break-even position, due to non-recurrent deficit funding being provided by NHSE in 2024/25.
- The Trust has an adverse variance to plan of £0.2m in 2024/25 quarter two, and £0.8m year-to-date against this break-even plan.

Root causes	Actions and timescale	Impact
Lost income due to industrial action relating to cancelled activity.	• The forecast includes an assumption that the lost income relating to industrial action is covered by supporting allocations later in the year, and that elective activity levels are accelerated through the year.	• Annual plan achievement.
Capacity spend over-commitment against the planned allocation.	• The forecast assumes any overspends against the non-bedded capacity e.g. bed waiters are reduced back to budgeted levels.	• Annual plan achievement.
Pay award	• Forecast assumes current pressure from the consultant pay award, which has not been fully funded will be managed in the total Trust position; and that pay awards due in Oct-24 and Nov-24 do not cause further cost pressures.	• Annual plan achievement.
Forecast Risks	• Assumes remaining pay awards are fully funded, and that winter pressures do not require any elective activity to be cancelled. The forecast excludes impact of band 2 to band 3 pay claim as we do not expect to be able to mitigate this. • Multiple contractual discussions are taking place with the ICB regarding funding for services, value-based commissioning and outcome from service reviews. This may cause a risk in current forecast • Remainder of the year holds a risk of a reduced level of income being received including energy funding and non-recurrent revenue support received in quarter two. • Financial recovery actions are being reviewed with executive leads.	• Annual plan achievement.

Data

Indicator in Focus: Financial Improvement Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust Financial Improvement Plan.
- The Trust has a £38.4m Efficiency Programme for 2024/25, which is currently £2.85m behind plan.

Root causes	Actions and timescale	Impact
• Failure to identify schemes in time to deliver savings in line with the plan.	• In quarters one and two, we have an efficiency shortfall of £2.9m. • Regular financial efficiency meetings are in place with addition of the phase two support from an external company, which has recently been brought in to support with de-risking our FIP programme. • New opportunities continue to be identified and quantified to move opportunities into delivery. • Work is underway to determine options for increasing capacity across all aspects of the efficiency programme. • Targeted work is underway with external support to triage, quantify and validate pipeline schemes.	• Annual plan achievement.
• Scheme recurrency	• Of the £12.6m efficiency delivered to date, only £2m has been delivered on a recurrent basis, with £10.6m delivered on a non-recurrent basis. The reliance on non-recurrent efficiency delivery will only provide us with higher targets to deliver in 2025/26. • The current weighted forecast is £26.6m against the plan of £38.4m leaving us with an efficiency shortfall of £11.8m at the end of Mar-25. This shortfall in performance will drive us away from our financial plan in the second half of the year and will need mitigating.	• Annual plan achievement.

Data

Indicator in Focus: Capital Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the 2024/25 Capital Expenditure Plan. Following the Board approval of the final re-prioritised capital plan in Jul-24, a reprofiling exercise will be completed to align to forecast delivery dates.
- The current forecast is £2.5m less than the original plan due to re-phasing of nationally allocated Electronic Patient Record (EPR) funding into 2025/26.
- The plan requires capital borrowing support from the Department of Health and Social Care (DHSC), which presents a risk due to timing of spend compared to receipt of Public Dividend Capital (PDC) support.
- There are known overspends in relation to capital schemes agreed in the 2023/24 plan, which need to be managed in-year against the 2024/25 allocation.

Root causes	Actions and timescale	Impact
Outturn variance across schemes driven by the re-phasing of EPR and reallocation of plan to cover known overspends.	• Agreed re-phasing of EPR.	
	• Reprioritised 2024/25 Capital Expenditure Plan agreed by the Board in Jul-24.	
	• Allocation agreed with Integrated Care System (ICS) partners for 2024/25.	
Requirement for Public Dividend Capital (PDC) to support plan £13.35m.	• PDC request prepared and submitted in Aug-24 in relation to the agreed 2024/25 capital plan.	• No agreement in place for PDC, current spending is at risk. • Risk that the application will not be approved, which would adversely impact of cash and delivery of Capital Plan.

Data

Indicator in Focus: Cash Balance

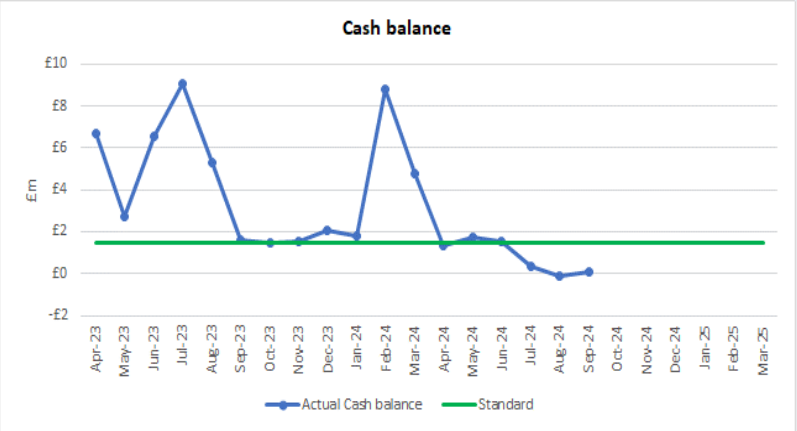
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the minimum cash balance (£1.45m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of 2024/25 quarter two the cash position is £0.012m lower than planned but remains above the minimum cash balance.
- Plan required revenue borrowing Public Dividend Capital (PDC) cash support from DHSC of £14.0m. This will be replaced by revenue deficit support funding in quarter three.

Root causes	Actions and timescale	Impact
Standard is the plan and the minimum cash balance required by DHSC of £1.45m as part of our support.	• Management of available cash balances to accounts payable payments due. • Prioritisation matrix of supplier payments agreed at the Trust Management Team.	• Requirement to ensure minimum balance is met/ maintained.
Plan and actual required revenue borrowing PDC cash support from DHSC and 2024/25 forecast indicates a further requirement for working capital support.	• Plan and actual required revenue borrowing PDC cash support from DHSC and 2024/25 forecast indicates a further requirement for revenue support. • Revenue support application submitted for 2024/25 quarters one and two. • PDC request submitted Aug-24 in relation to the agreed 2024/25 capital plan.	• Extended payment terms to suppliers. • Failure to achieve Better Payment Practice code.

Data



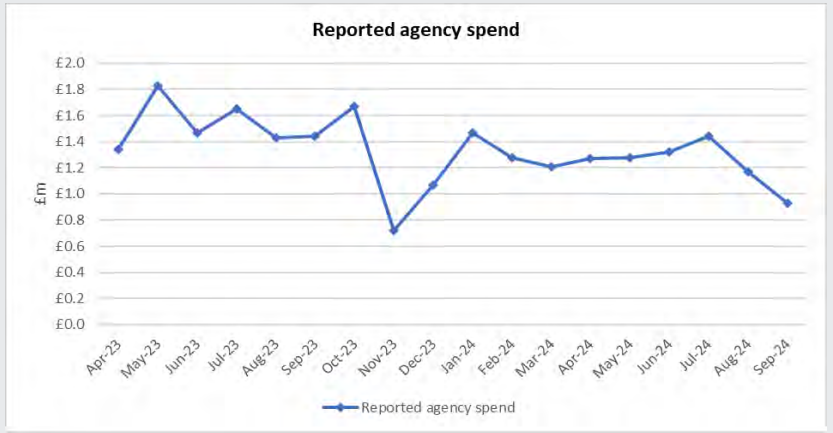
Indicator in Focus: Agency Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the planned agency expenditure for 2024/25.
- The Trust has reported agency expenditure of £3.5m for 2024/25 quarter two; this is £0.6m adverse to the planned level of spend.
- Agency expenditure in quarter two accounts for 4.2% of our total pay bill and exceeds the 3.2% NHS England target.

Data



Root causes	Actions and timescale	Impact
Level of vacancies and sickness.	• Enhanced financial governance focus on agency spend and compliance at Divisional Performance Reviews and Divisional Finance Committees. • Medical posts being filled and reviewed at medical specialty groups.	• Reduced agency run rate to achieve financial plan.
	• All medical agency bookings that are above cap to be reviewed at weekly vacancy control panels. There are still shifts filled over cap but this has begun to reduce in quarter two.	
	• From Jul-24, the use of off-framework agencies is not permitted. Any exceptions are to be approved by the Chief Executive Officer. All internal escalation forms have been updated to reflect this. • Quarter two saw zero off-framework shifts covered.	

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Scorecard: Activity (for context)

Green tick = target met/exceeded; Red cross = target not met

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD
Urgent Care	A&E attendances (inc. PC24)	≤Plan	≤Plan	✗104.4%	✗104.7%	✗102.0%	✗103.7%	✗104.5%	✗111.1%	✗111.6%	✗109.0%	✗111.5%	✗106.8%	✗104.1%	✗107.3%	✗106.5%	✓96.7%	✗102.0%	✗101.7%	✗104.5%
	Non-elective admissions	≤Plan	≤Plan	✗121.4%	✗124.2%	✗114.1%	✗119.9%	✗119.9%	✗118.6%	✗116.0%	✗118.2%	✗111.3%	✗110.4%	✗103.3%	✗108.3%	✗105.5%	✗102.1%	✗101.3%	✗103.0%	✗105.6%
Electives	Average daily elective referrals			310	316	260	295	314	327	304	315	343	340	325	336	348	320	-	-	-
	Outpatients - first appointment	≥Plan	≥Plan	✓102.9%	✓109.1%	✗96.4%	✓103.0%	✓108.3%	✓106.3%	✓109.7%	✓108.1%	✗99.3%	✗84.0%	✗94.0%	✗92.3%	✗90.5%	✗86.0%	✗90.9%	✗89.2%	✗90.7%
	Outpatients - follow up	≤Plan	≤Plan	✗102.1%	✗108.1%	✓95.1%	✗101.9%	✗107.5%	✗105.0%	✗106.2%	✗106.2%	✓100.0%	✗102.4%	✓94.1%	✓98.9%	✓99.1%	✓93.0%	✓95.1%	✓95.8%	✓97.3%
	Outpatients - procedures	≥Plan	≥Plan	✓113.9%	✓126.4%	✓116.0%	✓118.9%	✓121.7%	✓125.3%	✓123.0%	✓123.3%	✓133.0%	✓129.3%	✓114.4%	✓125.3%	✓122.7%	✓115.7%	✓136.5%	✓124.4%	✓124.8%
	Day case	≥Plan	≥Plan	✗86.7%	✓101.3%	✗91.8%	✗93.3%	✓100.2%	✓101.5%	✓109.8%	✓103.7%	✗96.3%	✗96.1%	✗96.0%	✗96.1%	✓102.7%	✓101.3%	✓100.0%	✓101.3%	✗98.8%
	Elective inpatient	≥Plan	≥Plan	✗86.8%	✓108.9%	✓107.1%	✓100.7%	✓101.9%	✓110.8%	✓129.3%	✓113.5%	✗92.5%	✗94.6%	✗90.0%	✗92.4%	✗84.0%	✗99.8%	✗96.9%	✗93.4%	✗92.9%
Diagnostics	Diagnostics	≥Plan	≥Plan	✗91.5%	✗99.9%	✓112.4%	✓100.6%	✓102.6%	✓103.9%	✓106.8%	✓104.4%	✓102.6%	✓109.2%	✗98.1%	✓103.2%	✓104.9%	✓111.4%	✓112.5%	✓109.5%	✓106.4%

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Appendix A: Integrated Scorecard & Graphs for each indicator

The Integrated Scorecard together with graphs for all indicators is included as a separate file.

Appendix B: Benchmarking Guidance (1/3)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

- Looking at the available evidence, is there a difference between our organisation and other comparable organisations?
- Evidence can be qualitative or quantitative (focus of this will be on quantitative).

How are we different?

- Does the evidence show that we are better or worse than comparators?
- Are we significantly different, or is the difference just normal variation?
- Can we easily explain the difference?

Why are we different?

- What are the better performing Trusts doing differently to us?
- Look at data for correlations of performance.
- Review any literature available relating to those organisations e.g. Benchmarking Network good practice compendiums.
- Contact other organisations.

Outstanding Care,
Compassionate People,
Healthier Communities

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Sherwood Forest Hospitals
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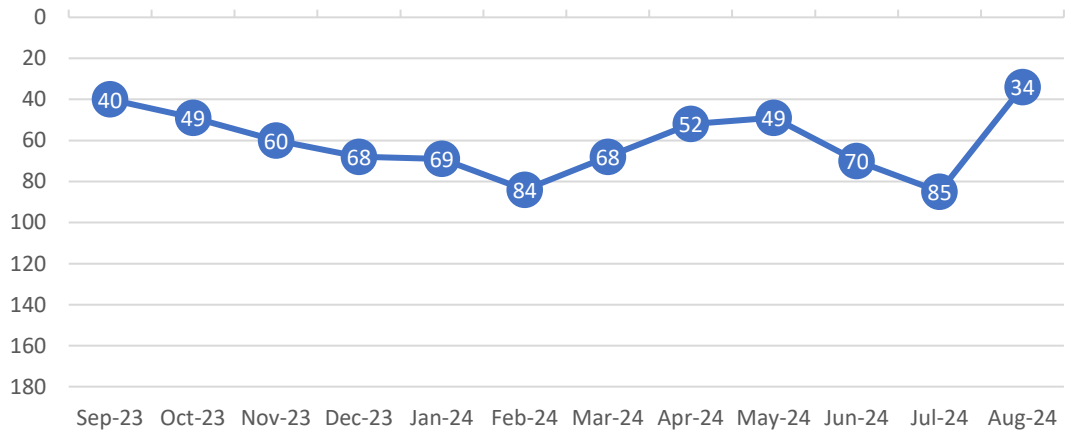
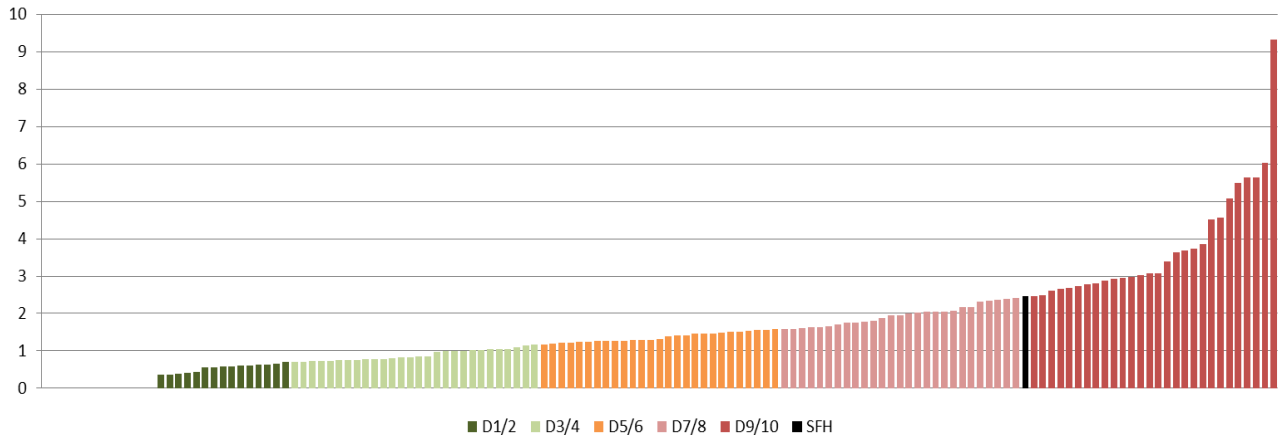
Appendix B: Benchmarking Guidance (2/3)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



The trend chart shows the SFH position relative to other Trusts nationally over time.

This gives us an indication if changes to our own rates are internally driven i.e. something the Trust is doing differently, or if the changes are related to wider environmental factors that will impact every Trust.

In the case of these charts, a lower number is always considered to be the better performing i.e. the chart shows our rank with 1 being the best in the country.

The bar chart shows the SFH position compared to other acute Trusts nationally; each bar represents a Trust, with the different colours each representing two deciles, or 20% of Trusts nationally (dark red being the worst performing 20%, dark green being the best performing) with SFH coloured black.

This allows us to see the comparative spread of performance, and the gap from the SFH position to the national average (median).

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Appendix B: Benchmarking Guidance (3/3)

Peer Groups are a group of Trusts that share similar characteristics with one another. Benchmarking against peers can give a more realistic position. For example:

- Size
- Locality
- Demographics
- Student staff (teaching verses non-teaching)
- Staff mix
- Specialty-specific

SFH peers (from NHS Peer Finder):

Code	Organisation name	Organisation Type	Absence Rate	Age 0-15	Age 60-74	Attendances	CCGs	Day beds	Degree of specialisation	Deprivation	Diagnosis	DTO
RK5	Sherwood Forest Hospitals NHS Foundation Trust	Acute - Medium	3.9%	11.5%	24.2%	893,175	197	94.0%	20,570.8	25.7	21.2%	69
RNQ	Kettering General Hospital NHS Foundation Trust	Acute - Small	4.5%	11.7%	24.3%	557,360	199	92.2%	8,045.6	19.6	23.3%	50
RWY	Calderdale and Huddersfield NHS Foundation Trust	Acute - Large	3.8%	12.8%	21.1%	904,590	198	85.6%	37,741.3	24.9	21.1%	38
RNS	Northampton General Hospital NHS Trust	Acute - Medium	4.5%	11.2%	23.8%	928,285	198	98.3%	28,354.4	18.4	20.6%	50
RFS	Chesterfield Royal Hospital NHS Foundation Trust	Acute - Small	4.6%	10.3%	22.8%	639,535	193	0.0%	-2,132.5	22.0	19.9%	22
RWP	Worcestershire Acute Hospitals NHS Trust	Acute - Large	4.1%	8.8%	26.5%	1,242,600	199	92.1%	112,225.9	17.6	20.0%	63
RFF	Barnsley Hospital NHS Foundation Trust	Acute - Small	4.3%	12.5%	22.0%	588,855	193	99.2%	-10,572.6	28.6	22.7%	3
RCF	Airedale NHS Foundation Trust	Acute - Small	4.3%	12.7%	22.7%	360,580	192	95.3%	-24,804.9	21.1	21.6%	14
RXW	Shrewsbury and Telford Hospital NHS Trust	Acute - Large	4.4%	9.2%	25.0%	1,056,320	197	85.4%	155,738.4	19.8	16.9%	23
RLT	George Eliot Hospital NHS Trust	Acute - Small	4.2%	9.0%	24.7%	438,300	194	100.0%	-32,895.4	21.6	23.6%	33
RXF	Mid Yorkshire Hospitals NHS Trust	Acute - Large	4.7%	12.0%	21.7%	1,263,370	201	71.4%	130,189.8	27.1	16.2%	1,11

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

September 2024 (Qtr 2)

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Integrated Report

Green tick = target met/exceeded; Red cross = target not met

Category	At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	2024/25 YTD
Quality of Care	Safe	Falls with lapse in care	≤2	≤2	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
		Falls per 1000 occupied bed days	≤6.63	≤6.63	5.6	6.9	6.7	6.4	6.9	7.3	6.1	6.7	6.2	5.8	6.7	6.3	6.7	5.9	6.2	6.3	6.3
		Never events	0	0	0	1	0	1	0	0	0	0	1	0	0	1	0	0	1	1	2
		MRSA reported in month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
		Cdifficile reported in month	≤13	≤13	1	5	6	12	1	3	5	9	4	4	5	13	4	3	4	11	24
		Ecoli blood stream infections (BSI) reported in month	≤22	≤22	0	6	5	11	3	5	3	11	5	1	4	10	3	5	2	10	21
		Klebsiella BSI reported in month	≤1	≤1	1	1	1	3	2	1	0	3	0	1	2	3	1	1	0	2	5
		Pseudomonas BSI reported in month	≤3	≤3	0	1	1	2	2	1	1	4	0	0	1	1	0	0	0	0	1
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care			0.2	0.1	0.0	0.1	0.2	0.2	0.1	0.2	0.0	0.1	0.2	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	0	0	0	0	0	0	0	0	0	1	1	2	0	0	1	1	3
		Patient Safety Incident Investigations (PSII)			1	4	2	7	2	2	1	5	3	4	0	7	0	2	2	4	11
		Sepsis (metric to be defined)			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	1.1	1.2	1.3	1.2	1.1	1.1	0.8	1.0	0.7	1.5	0.9	1.0	1.5	0.8	0.8	1.0	1.0
		Compliments received in month			103	158	150	411	151	122	120	393	161	138	151	450	155	120	119	394	844
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	127	125	126	126	131	129	126	126	129	126	124	124	124	122	124	124	124
		SHMI	≤100	≤100	108	107	107	107	108	109	109	109	109	108	107	107	106	106	106	106	106
		Still birth rate	≤4.4	≤4.4	3.5	0.0	6.7	3.3	3.2	11.5	3.7	5.9	0.0	3.2	4.2	2.3	0.0	6.8	6.4	4.4	3.4
		Early neonatal deaths per 1000 live births	≤1	≤1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.2	1.1	0.6
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	7.3	-	-	-	6.9	-	-	-	6.8	-	-	-	-	-
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	6.9%	5.8%	5.2%	6.0%	5.1%	4.7%	4.5%	4.7%	8.2%	8.0%	8.1%	8.1%	8.4%	7.7%	7.4%	7.9%	8.0%
		Turnover in month	≤0.9%	≤0.9%	0.5%	0.4%	0.6%	0.5%	0.4%	0.4%	0.4%	0.4%	0.5%	0.2%	0.6%	0.5%	0.5%	0.6%	0.5%	0.5%	0.5%
		Appraisals	≥90%	≥90%	87.3%	88.3%	88.8%	88.1%	88.9%	88.3%	87.8%	88.3%	87.9%	89.4%	88.1%	88.4%	89.9%	89.7%	89.5%	89.7%	89.1%
		Mandatory & statutory training	≥90%	≥90%	91.0%	91.0%	91.0%	91.0%	91.0%	91.0%	92.0%	91.3%	91.0%	91.0%	91.0%	91.0%	91.4%	91.3%	90.9%	91.2%	91.1%
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	4.8%	4.3%	5.1%	4.8%	4.9%	4.7%	4.3%	4.6%	4.3%	4.4%	4.7%	4.4%	4.9%	4.2%	4.6%	4.6%	4.5%
		Total workforce loss	≤7.0%	≤7.0%	6.9%	6.4%	7.3%	6.9%	7.3%	6.9%	6.4%	6.9%	6.4%	6.4%	6.8%	6.5%	6.9%	6.3%	6.7%	6.6%	6.6%
		Flu vaccinations uptake (front line staff)	≥80%	≥75%	38.3%	44.8%	55.9%	55.9%	58.0%	58.0%	-	58.0%	-	-	-	-	-	-	-	-	0.0%
		Employee relations management	<12	<17	21	23	18	21	20	17	21	19	20	23	15	19	20	20	21	20	20
	New Ways of Working	Bank usage			8.3%	7.8%	8.9%	8.3%	8.8%	7.7%	10.8%	9.1%	8.2%	10.3%	8.6%	9.0%	9.8%	10.3%	8.1%	9.4%	9.2%
		Agency usage	<3.7%	<3.2%	6.2%	5.5%	3.9%	5.2%	5.2%	4.6%	4.2%	4.7%	4.6%	4.5%	4.9%	4.7%	5.4%	4.4%	3.5%	4.4%	4.6%
		Agency (off framework)	≤6.0%	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
		Agency (over price cap)	≤30.0%	≤40.0%	51.0%	55.7%	57.0%	54.3%	54.6%	47.4%	54.4%	52.0%	55.1%	55.6%	59.7%	57.1%	60.3%	53.4%	53.4%	55.6%	56.4%
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	93.7%	96.8%	96.7%	95.7%	95.6%	93.9%	94.6%	94.7%	96.6%	96.5%	95.1%	96.1%	95.6%	96.8%	93.5%	95.3%	95.7%
		Ambulance delays >60 mins	0.0%	0.0%	0.1%	0.2%	0.1%	0.1%	0.2%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%
		ED 4-hour performance	≥76%	≥76%	69.4%	67.1%	64.9%	67.2%	65.7%	63.6%	72.2%	67.3%	74.2%	73.4%	70.9%	72.8%	71.7%	82.0%	73.6%	75.6%	74.2%
		ED 12-hour length of stay performance	≤2%	≤2%	3.3%	4.2%	6.5%	4.7%	5.5%	5.1%	3.1%	4.5%	3.1%	2.2%	2.3%	2.5%	2.9%	0.9%	3.0%	2.3%	2.4%
		SDEC rate	≥33%	≥33%	39.8%	37.1%	36.2%	37.7%	38.3%	38.1%	37.8%	38.1%	38.2%	37.7%	38.6%	38.2%	38.1%	41.3%	39.0%	39.4%	38.8%
		Adult G&A bed occupancy	≤92%	≤92%	92.0%	96.3%	95.3%	94.6%	97.9%	97.8%	96.5%	97.4%	93.6%	94.8%	94.7%	94.4%	95.5%	92.2%	93.8%	93.9%	94.1%
		Long length of stay (21+) occupied beds	≤Plan	≤Plan	100	109	100	103	116	116	107	116	124	96	91	110	102.0	105.0	103.0	104.0	103
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	90	98	92	94	93	105	101	98	91	64	71	75	84	65	57	69	72
	Electives	Advice & guidance	≥16%	≥16%	25.3%	24.4%	23.0%	24.3%	24.3%	27.3%	25.4%	25.6%	24.5%	25.8%	22.0%	24.1%	25.2%	-	-	-	-
		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	6.0%	5.7%	5.4%	5.7%	5.7%	5.6%	5.3%	5.5%	6.0%	5.9%	5.9%	5.9%	6.2%	6.1%	6.5%	6.3%	6.1%
		Outpatient attends that are first or follow up with a procedure		≥Plan	43.2%	43.7%	44.0%	43.6%	43.2%	43.7%	43.8%	43.5%	43.3%	40.7%	43.9%	42.6%	43.6%	42.2%	42.7%	42.9%	42.7%
		Incomplete RTT waiting list	≤Plan	≤Plan	53,708	52,717	52,569	52,569	52,377	50,534	50,757	50,757	36,584	35,858	35,720	35,720	35,251	35,165	35,507	35,507	35,507
		Incomplete RTT pathways +52 weeks	≤Plan	≤Plan	1,851	1,858	1,933	1,933	1,759	1,662	1,591	1,591	1,312	1,162	1,177	1,177	1,080	1,019	870	870	870
		Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	362	337	418	418	399	347	157	157	140	129	109	109	77	105	50	50	50
		Incomplete RTT pathways +78 weeks	0	0	7	5	14	14	17	12	5	5	2	1	0	0	2	1	0	0	0
	Diagnostics	Diagnostic DM01 backlog			3,761	3,726	4,055	4,055	3,659	3,344	3,430	3,430	3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	2,558
		Diagnostic DM01 performance under 6-weeks	≥99%	≥Plan	63.3%	64.7%	56.8%	56.8%	62.8%	68.1%	70.5%	70.5%	71.6%	72.7%	70.5%	70.5%	69.5%	70.2%	76.3%	76.3%	76.3%
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥75%	81.3%	77.3%	80.6%	79.7%	76.0%	82.9%	82.6%	80.6%	75.3%	79.8%	79.2%	78.2%	81.6%	81.6%	-	-	-
		Cancer 31-day treatment performance	≥96%	≥Plan	79.8%	75.8%	72.5%	75.9%	73.2%	80.0%	90.4%	81.4%	89.8%	87.5%	88.3%	88.6%	95.0%	91.1%	-	-	-
		Cancer 62-day treatment performance	≥85%	≥Plan	52.8%	64.8%	57.7%	58.6%	56.5%	54.7%	69.2%	60.4%	71.8%	56.3%	70.3%	66.1%	71.4%	67.9%	-	-	-
		Suspected cancer patients waiting over 62-days			89	86	89	89	76	50	52	52	80	69	70	70	68	87	83	83	83
Best Value Care	Finance	Income & expenditure against plan	≥£0.00m	≥£0.00m	-£1.33	£0.82	£2.58	£2.07	-£0.76	£2.33	-£12.76	-£11.19	-£0.02	£0.02	-£0.61	-£0.61	-£0.33	-£0.31	£0.44	-£0.20	-£0.81
		Financial Improvement Programme (FIP) against plan	≥£0.00m	≥£0.00m	-£0.38	-£0.17	-£0.80	-£1.35	£1.27	-£0.43	£0.54	£1.38	-£0.55	£1.48	£0.66	£1.59	-£1.61	-£1.38	-£1.57	-£4.56	-£2.97
		Capital expenditure against plan	≤£0.00m	≤£0.00m	£3.19	-£0.70	£5.23	£7.72	-£2.01	-£0.88	-£12.53	-£15.42	£1.61	£2.07	£1.39	£5.07	£1.55	£1.28	£1.27	£4.10	£9.17
		Cash balance	-	≥£1.45m	£1.49	£1.51	£2.04	£2.04	£1.80	£8.76	£4.74	£4.74	£1.34	£1.73	£1.50	£1.50	£0.32	-£0.15	£0.05	£0.05	£1.50
		Implied Productivity 2023/24 v 2024/25	-	3.1%	-	-	-	-	-	-	-	-	-	-	-	-	6.7%	-	-	-	-
		Value weighted elective activity	-	105%	99.6%	110.7%	108.6%	106.3%	113.2%	114.2%	127.1%	118.2%	103.5%	110.9%	112.0%	108.8%	108.8%	118.7%	118.5%	115.3%	112.1%
		Agency expenditure against plan	≥£0.00m	≥£0.00m	-£0.21	£0.62	£0.29	£0.70	-£1.36	-£1.17	-£1.09	-£3.62	-£0.18	-£0.29	-£0.29	-£0.76	-£0.39	-£0.24	£0.01	-£0.62	-£1.38
		Reported agency spend			£1.67	£0.72	£1.07	£3.46	£1.47	£1.28	£1.21	£3.96	£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£7.41
		Reported bank spend			£2.30	£2.10	£2.71	£7.11	£3.36	£2.01	£3.69	£9.06	£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£15.58
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan	≤Plan	104.4%	104.7%	102.0%	103.7%	104.5%	111.1%	111.6%	109.0%	111.5%	106.8%	104.1%	107.3%	106.5%	96.7%	102.0%	101.7%	104.5%
		Non-elective admissions	≤Plan	≤Plan	121.4%	124.2%	114.1%	119.9%	119.9%	118.6%	116.0%	118.2%	111.3%	110.4%	103.3%	108.3%	105.5%	102.1%	101.3%	103.0%	105.6%
	Electives	Average daily elective referrals			310	316	260	295	314	327	304	315	343	340	325	336	348	320	-	-	-
		Outpatients - first appointment		≥Plan	102.9%	109.1%	96.4%	103.0%	108.3%	106.3%	109.7%	108.1%	99.3%	84.0%	94.0%	92.3%	90.5%	86.0%	90.9%	89.2%	90.7%
		Outpatients - follow up		≤Plan	102.1%	108.1%	95.1%	101.9%	107.5%	105.0%	106.2%	106.2%	100.0%	102.4%	94.1%	98.9%	99.1%	93.0%	95.1%	95.8%	97.3%
		Outpatients - procedures		≥Plan	113.9%	126.4%	116.0%	118.9%	121.7%	125.3%	123.0%	123.3%	133.0%	129.3%	114.4%	125.3%	122.7%	115.7%	136.5%	124.4%	124.8%
		Day case		≥Plan	86.7%	101.3%	91.8%	93.3%	100.2%	101.5%	109.8%	103.7%	96.3%	96.1%	96.0%	96.1%	102.7%	101.3%	100.0%	101.3%	98.8%
		Elective inpatient		≥Plan	86.8%	108.9%	107.1%	100.7%	101.9%	110.8%	129.3%	113.5%	92.5%	94.6%	90.0%	92.4%	84.0%	99.8%	96.9%	93.4%	92.9%
	Diagnostics	Diagnostics		≥Plan	91.5%	99.9%	112.4%	100.6%	102.6%	103.9%	106.8%	104.4%	102.6%	109.2%	98.1%	103.2%	104.9%	111.4%	112.5%	109.5%	106.4%

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

September 2024 (Qtr 2)

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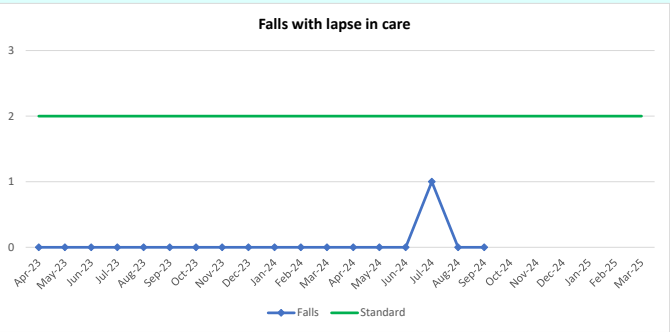
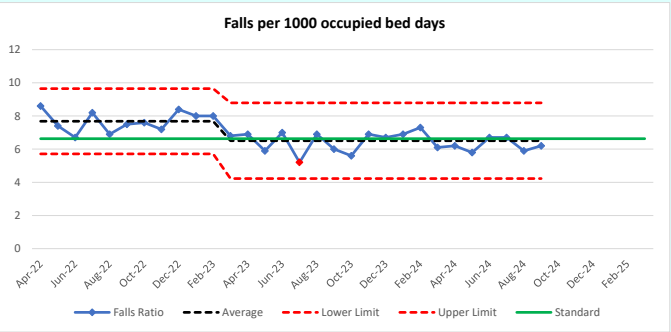
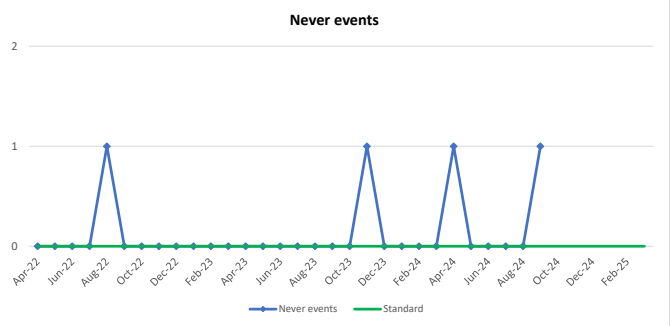
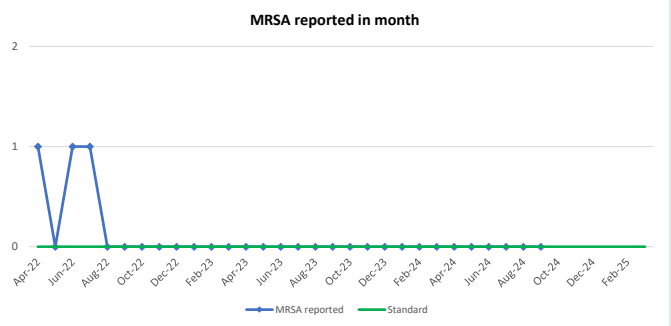
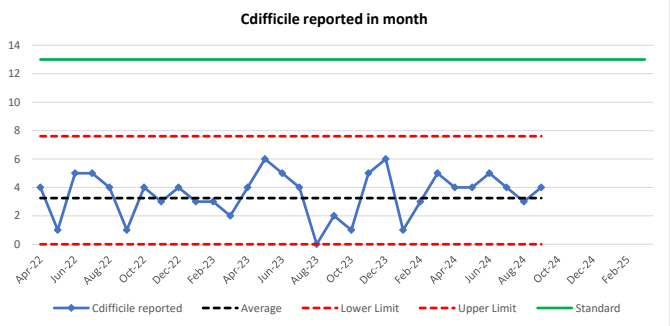
Quality of Care

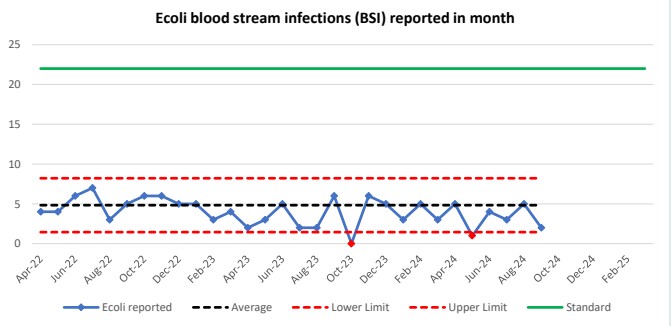


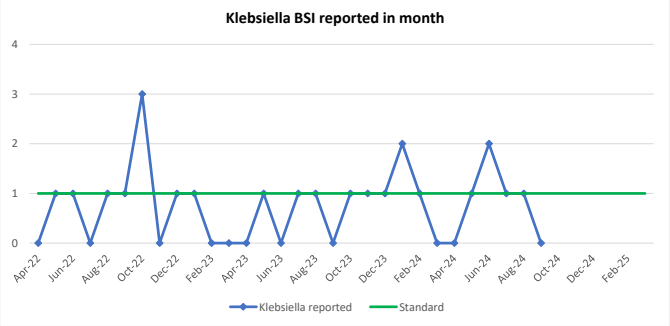


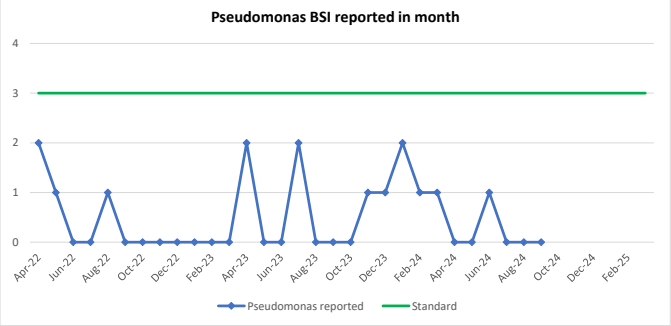


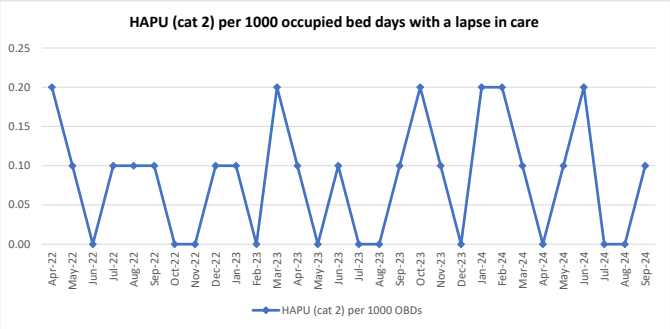


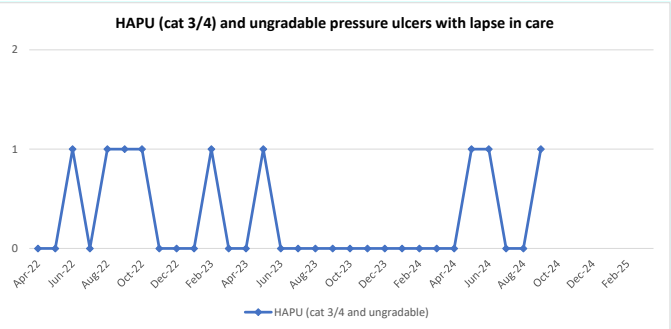


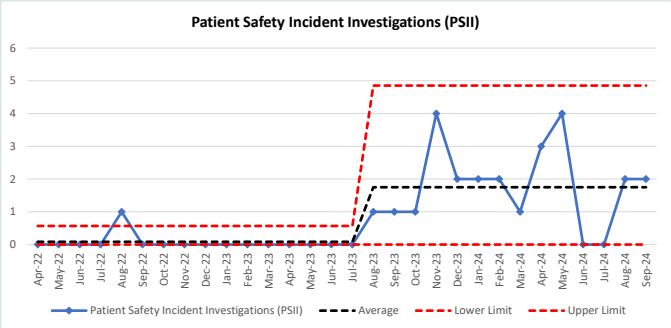


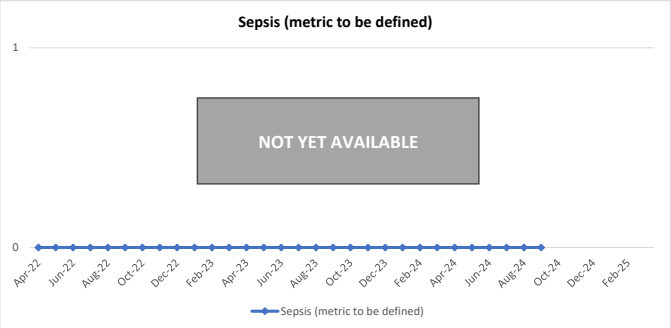


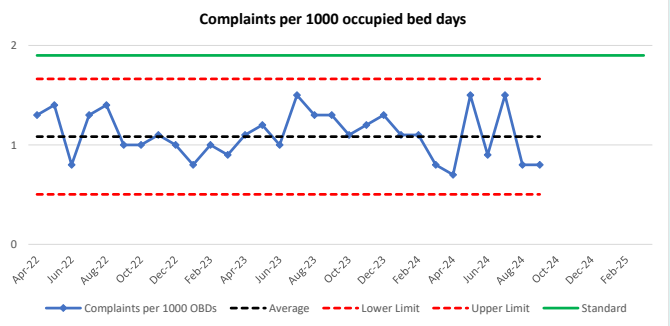


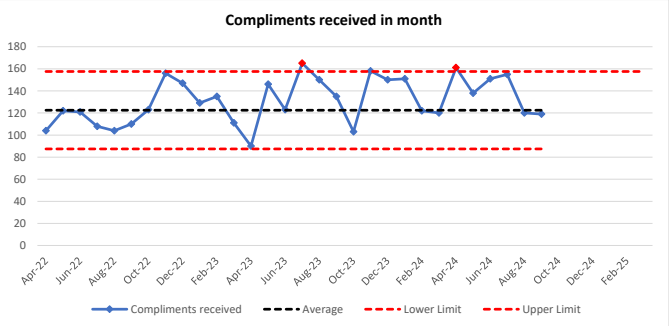

HAPU (cat 2) per 1000 occupied bed days with a lapse in care
HAPU (cat 2) per 1000 OBDs

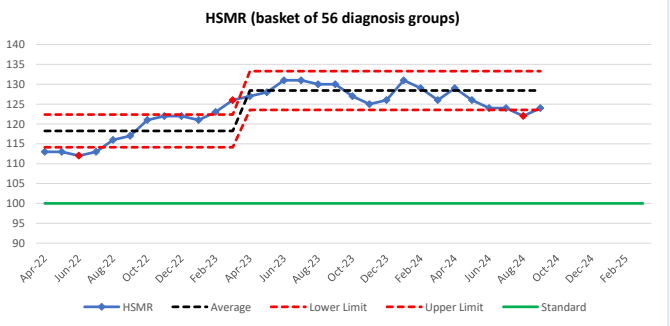

HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care
HAPU (cat 3/4 and ungradable)

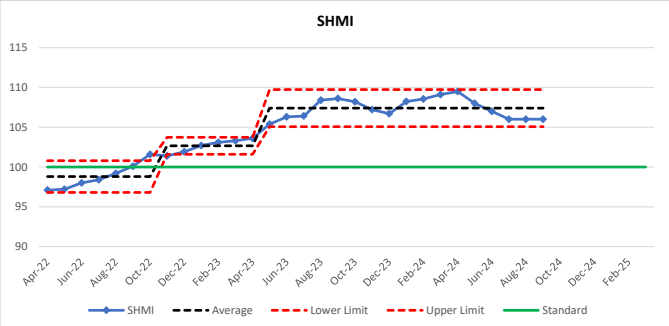

Patient Safety Incident Investigations (PSII)
Patient Safety Incident Investigations (PSII)
Average
Lower Limit
Upper Limit

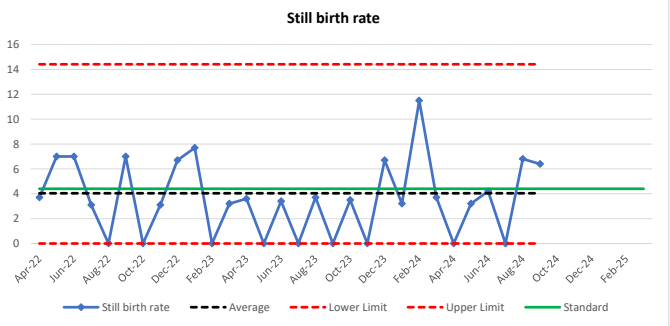

Sepsis (metric to be defined)
NOT YET AVAILABLE
Sepsis (metric to be defined)

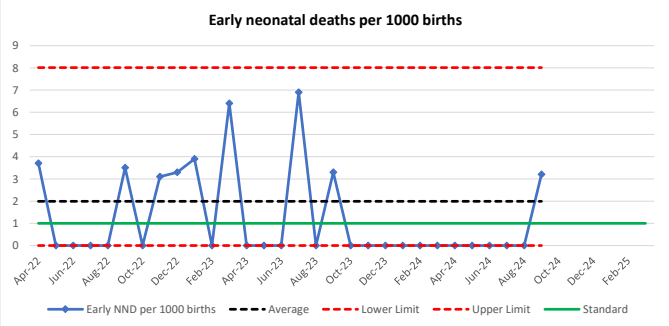

Complaints per 1000 occupied bed days
Complaints per 1000 OBDs
Average
Lower Limit
Upper Limit
Standard


Compliments received in month
Compliments received
Average
Lower Limit
Upper Limit


HSMR (basket of 56 diagnosis groups)
HSMR
Average
Lower Limit
Upper Limit
Standard

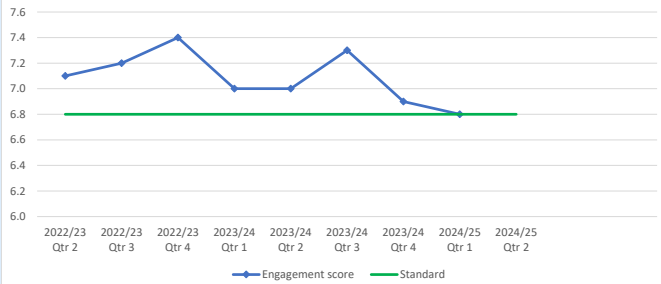

SHMI
SHMI
Average
Lower Limit
Upper Limit
Standard


Still birth rate
Still birth rate
Average
Lower Limit
Upper Limit
Standard

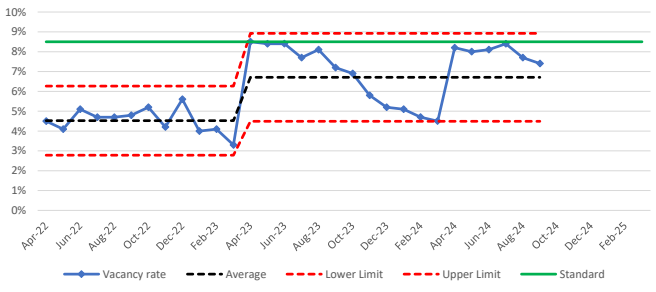

Early neonatal deaths per 1000 births
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard

People and Culture

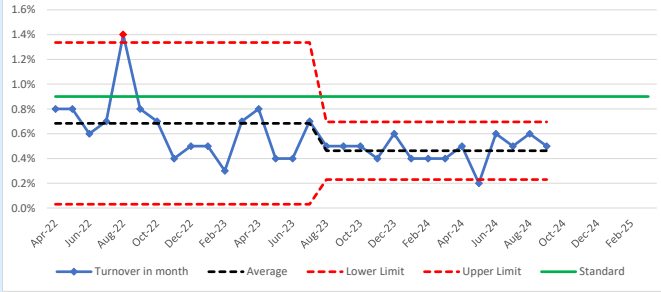
Engagement score



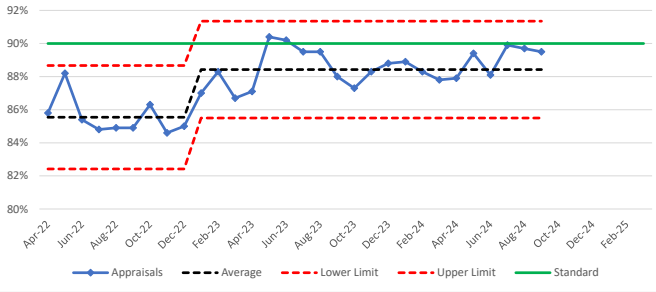
Vacancy rate



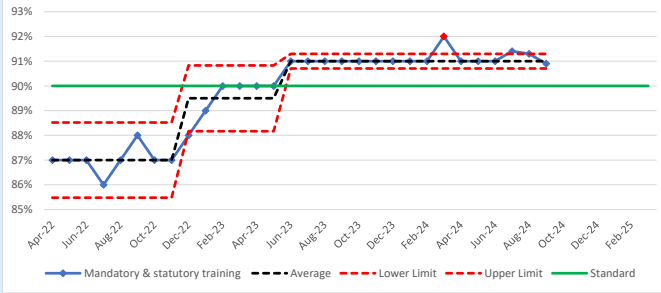
Turnover in month



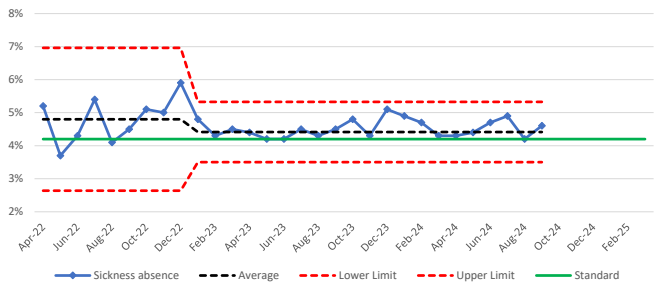
Appraisals



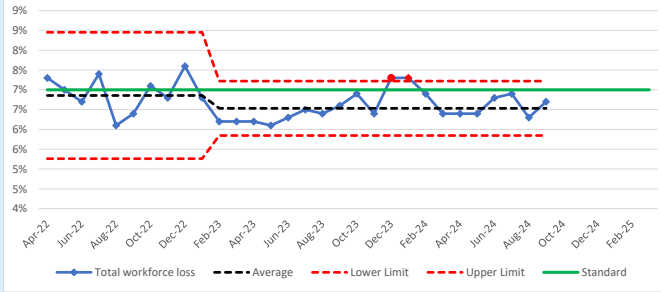
Mandatory & statutory training



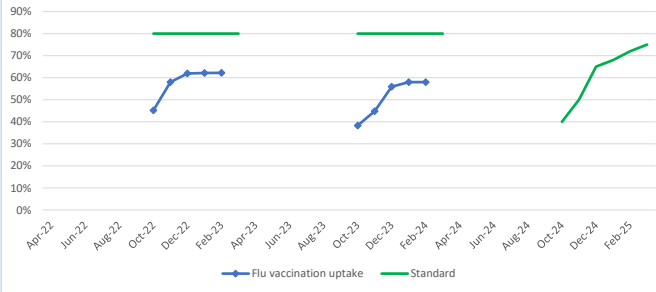
Sickness absence

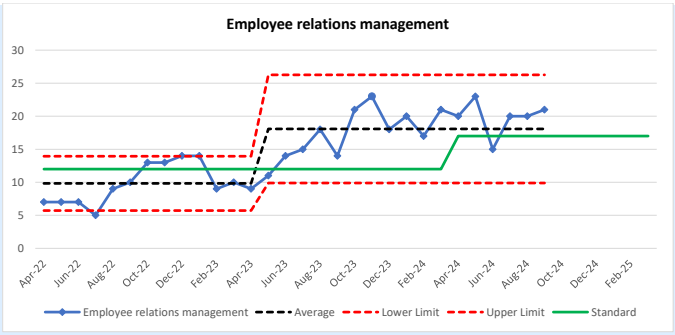


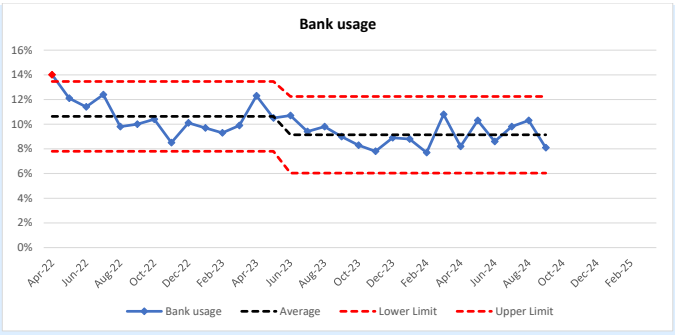
Total workforce loss

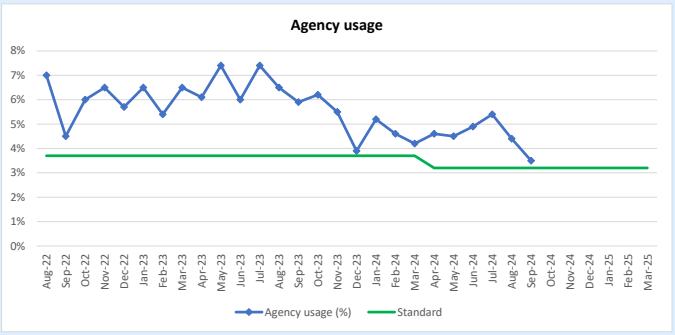


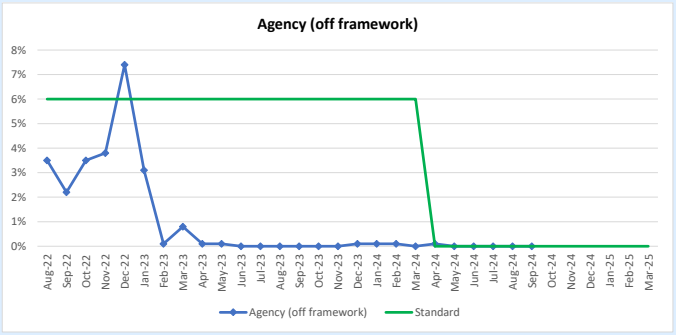
Flu vaccinations uptake (front line staff)

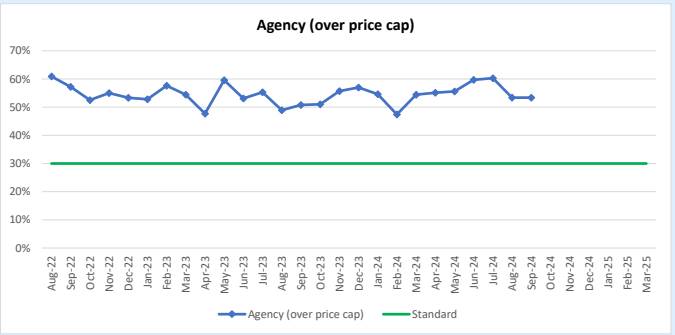



Employee relations management
30
25
20
15
10
5
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Employee relations management
Average
Lower Limit
Upper Limit
Standard


Bank usage
16%
14%
12%
10%
8%
6%
4%
2%
0%
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Bank usage
Average
Lower Limit
Upper Limit

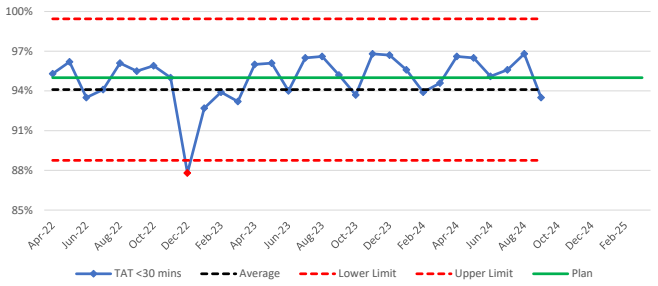

Agency usage
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Agency usage (%)
Standard


Agency (off framework)
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Agency (off framework)
Standard

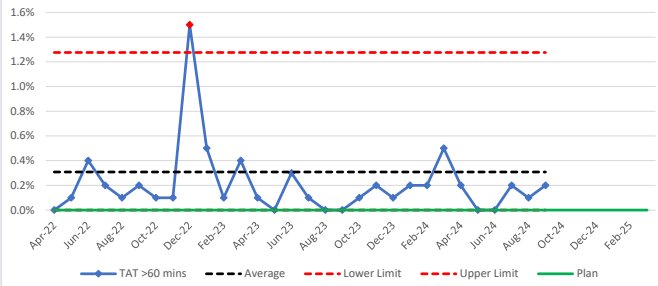

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Agency (over price cap)
Standard

Timely Care

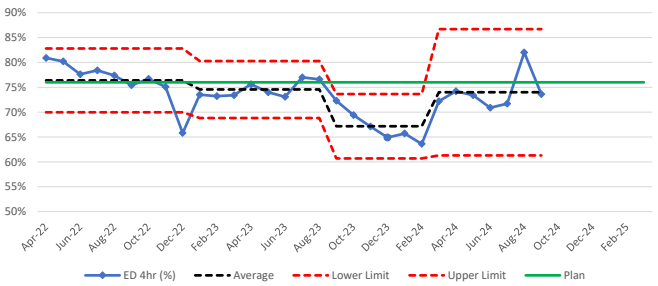
Ambulance turnaround times <30 mins



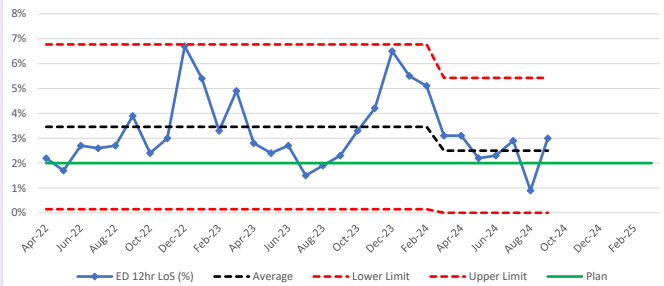
Ambulance delays >60 mins



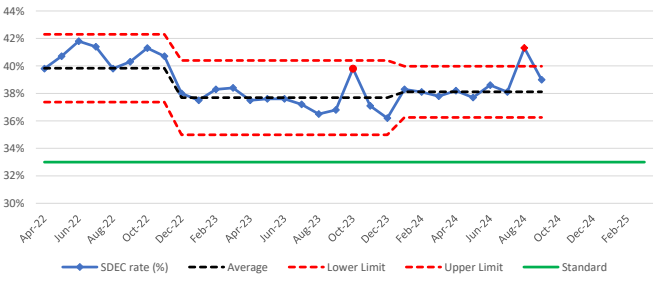
ED 4-hour performance



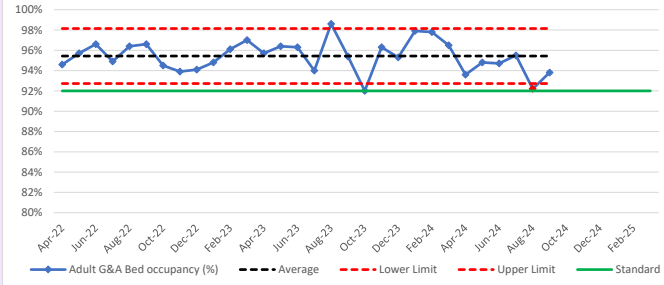
ED 12-hour length of stay performance



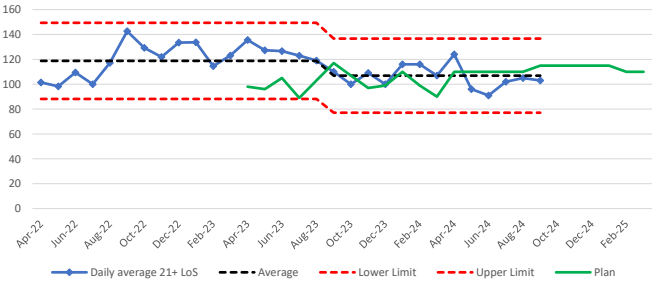
SDEC rate



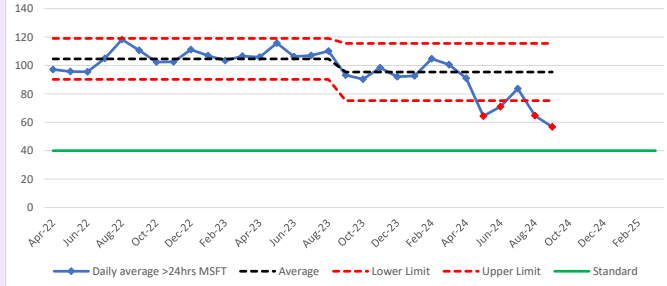
Adult G&A bed occupancy

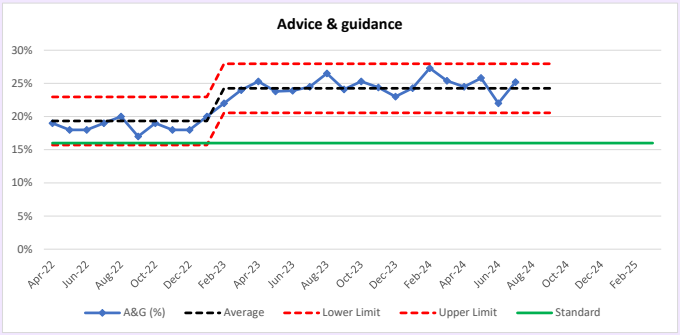


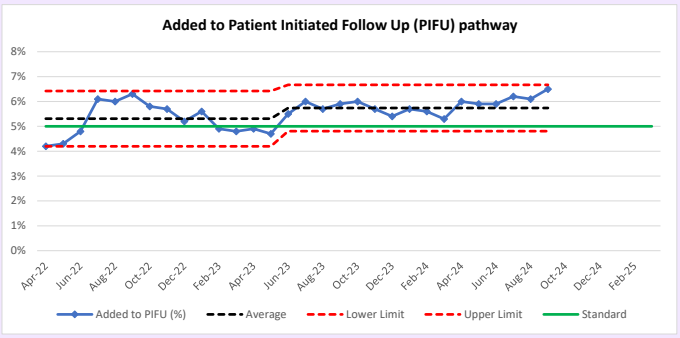
Long length of stay (21+) occupied beds

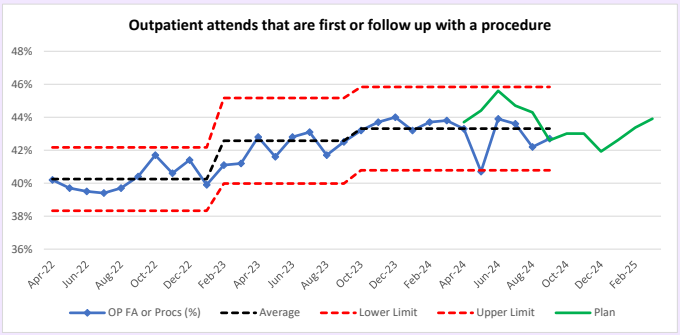


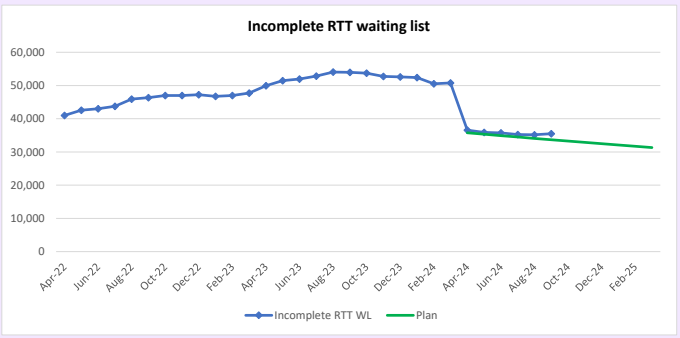
Inpatients medically safe for transfer for greater than 24 hours

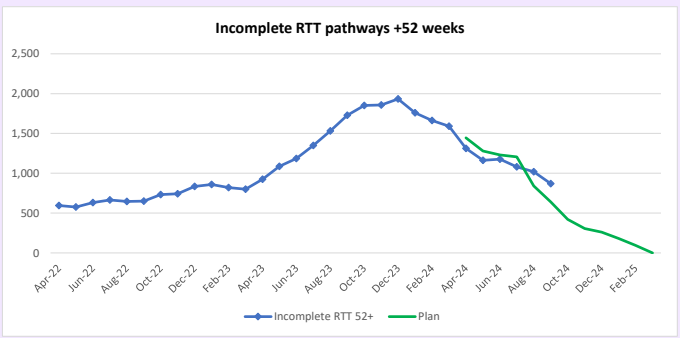


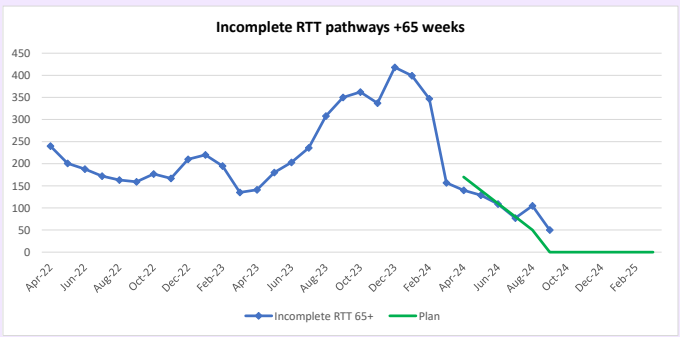

Advice & guidance
30%
25%
20%
15%
10%
5%
0%
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
A&G (%)
Average
Lower Limit
Upper Limit
Standard

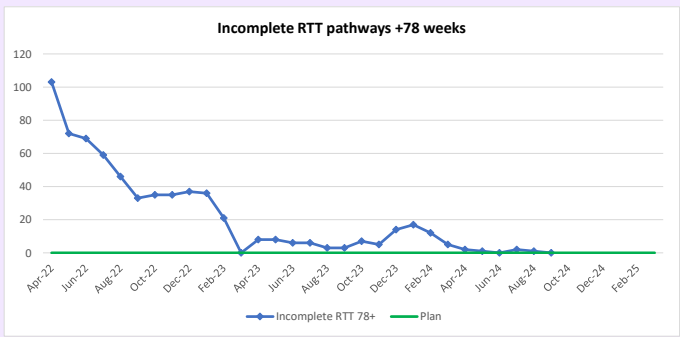

Added to Patient Initiated Follow Up (PIFU) pathway
8%
7%
6%
5%
4%
3%
2%
1%
0%
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Added to PIFU (%)
Average
Lower Limit
Upper Limit
Standard


Outpatient attends that are first or follow up with a procedure
48%
46%
44%
42%
40%
38%
36%
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
OP FA or Procs (%)
Average
Lower Limit
Upper Limit
Plan


Incomplete RTT waiting list
60,000
50,000
40,000
30,000
20,000
10,000
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Incomplete RTT WL
Plan


Incomplete RTT pathways +52 weeks
2,500
2,000
1,500
1,000
500
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Incomplete RTT 52+
Plan


Incomplete RTT pathways +65 weeks
450
400
350
300
250
200
150
100
50
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Incomplete RTT 65+
Plan


Incomplete RTT pathways +78 weeks
120
100
80
60
40
20
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
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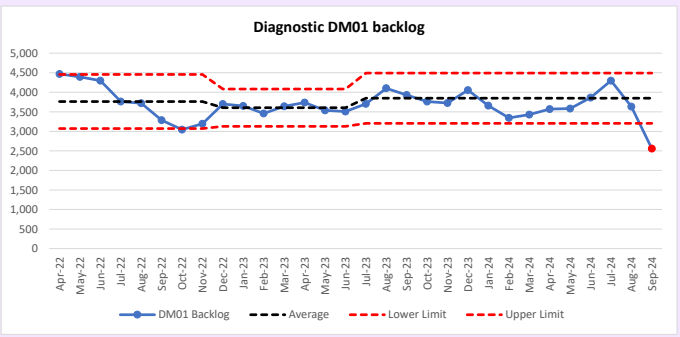
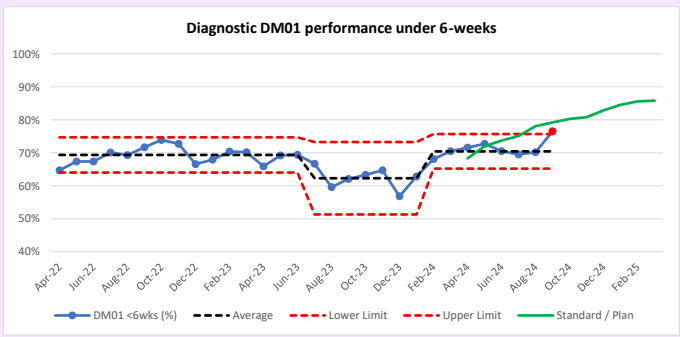
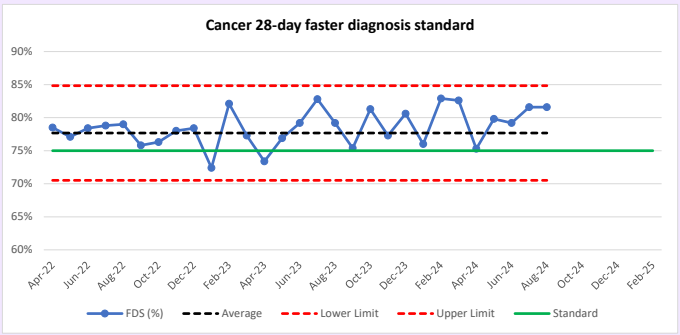
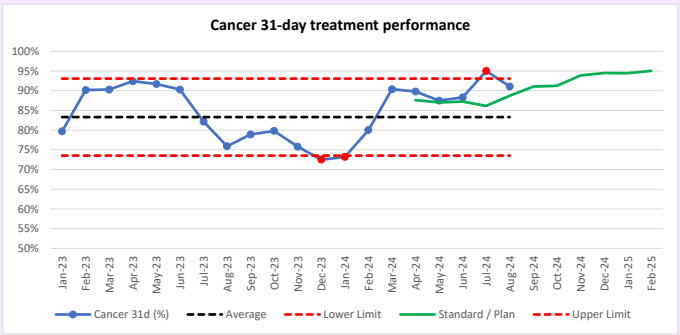
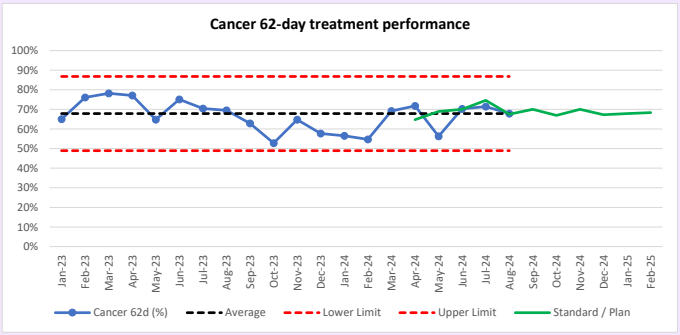
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Incomplete RTT 78+
Plan

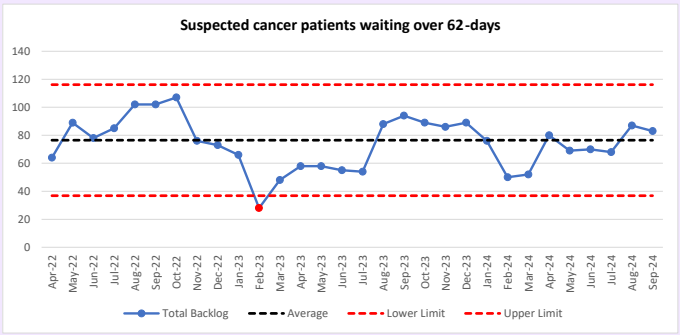

Diagnostic DM01 backlog
5,000
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
DM01 Backlog
Average
Lower Limit
Upper Limit


Diagnostic DM01 performance under 6-weeks
100%
90%
80%
70%
60%
50%
40%
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
DM01 <6wks (%)
Average
Lower Limit
Upper Limit
Standard / Plan

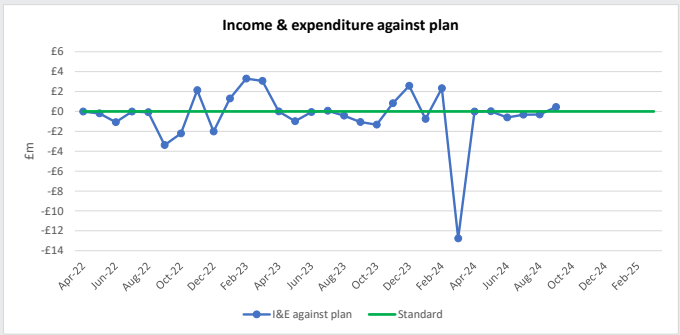


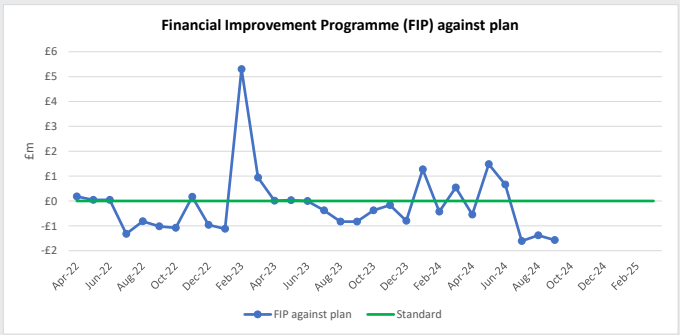


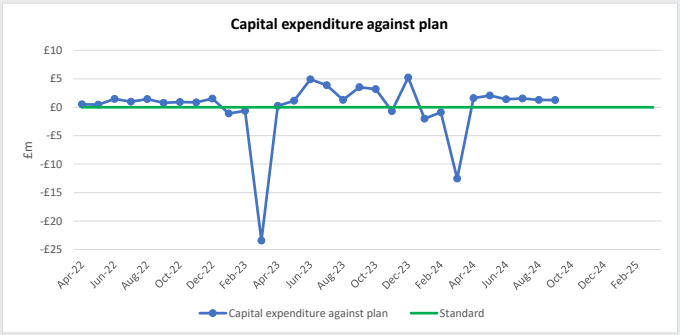


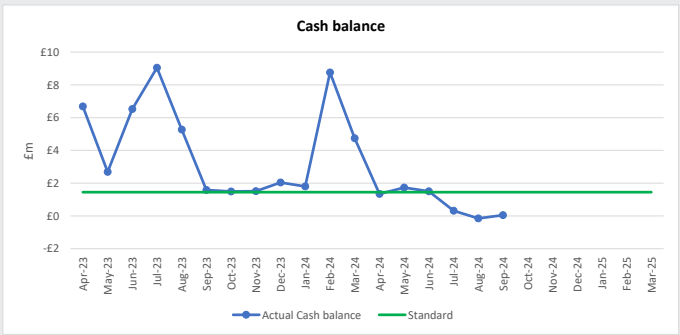


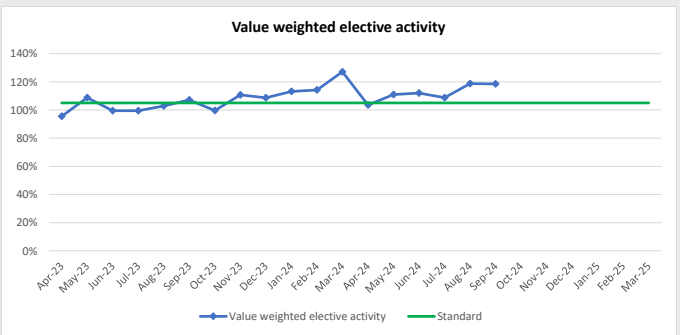
Best Value Care

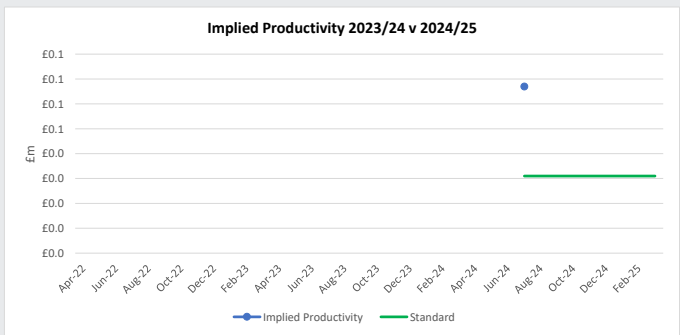


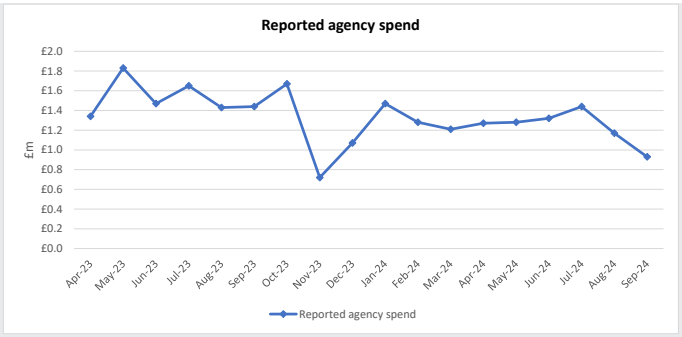


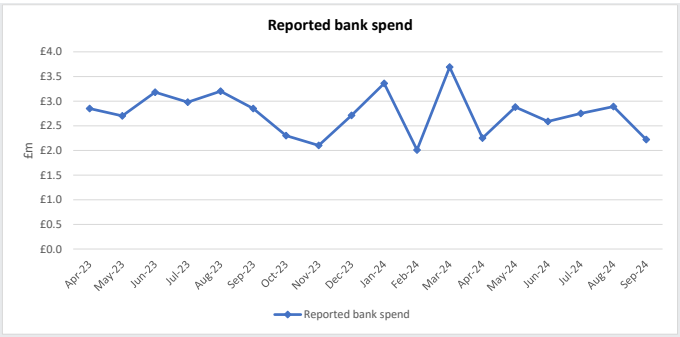




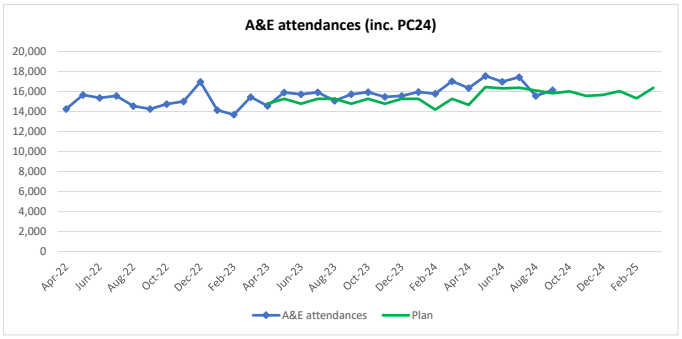


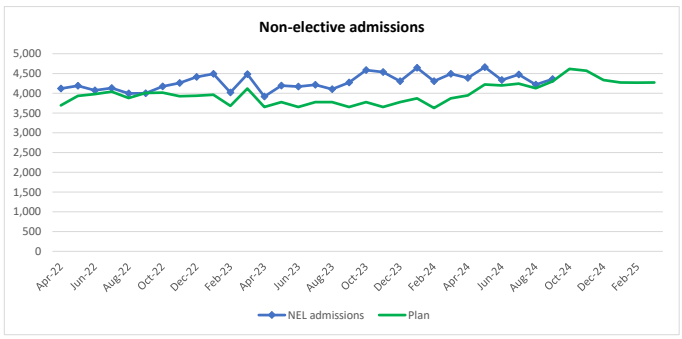


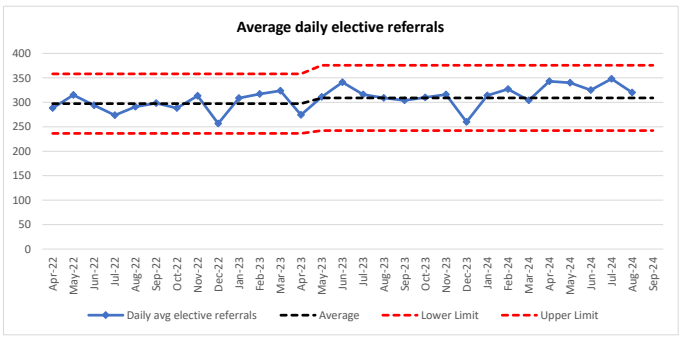


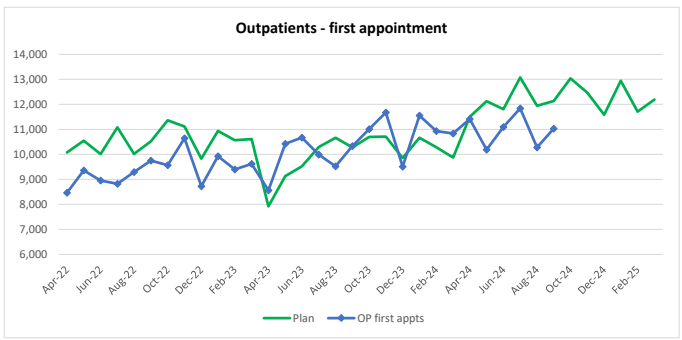


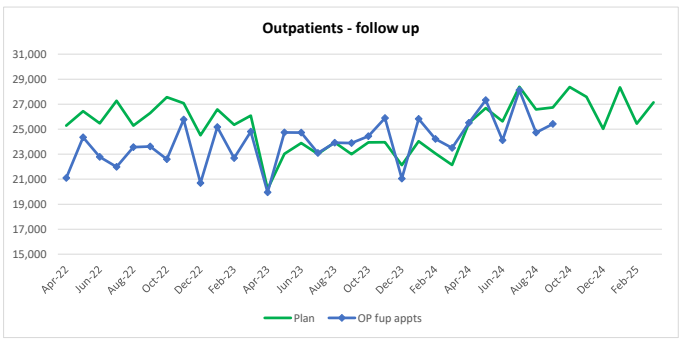
Activity (for context)

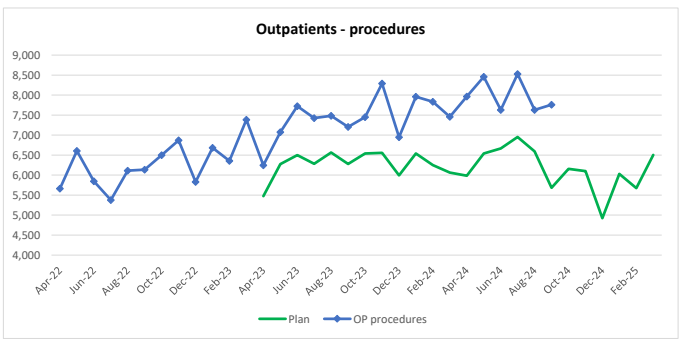


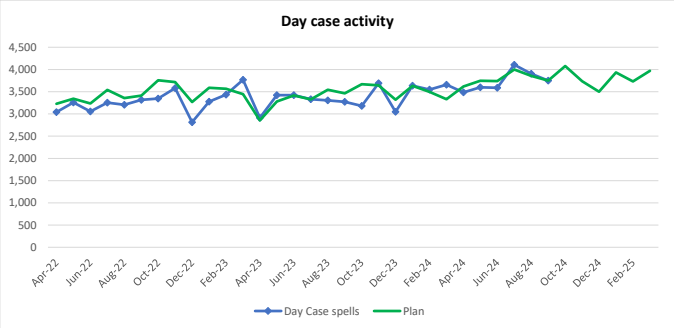


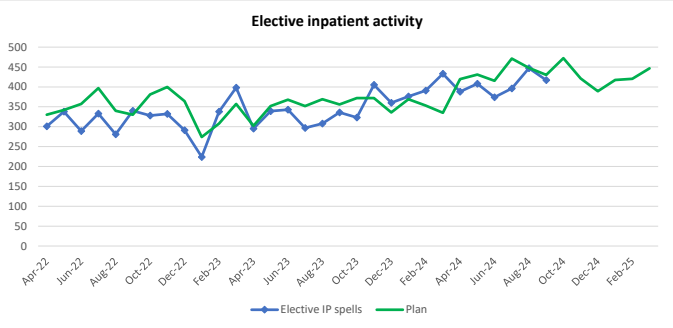


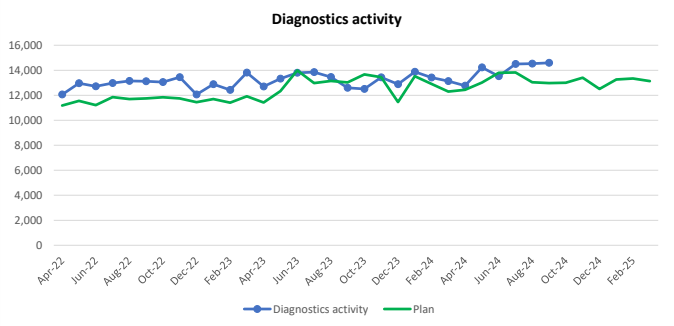







Day case activity
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Day Case spells
Plan


Elective inpatient activity
500
450
400
350
300
250
200
150
100
50
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Elective IP spells
Plan


Diagnostics activity
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Apr-22
Jun-22
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Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Diagnostics activity
Plan

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

September 2024 (Qtr 2)

Timely Care Benchmarking

At a Glance	Indicator	Source	Rate	Rank	Of	Decile
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	97.4%	7	173	1
	Ambulance delays >60 mins	Summary Emergency Department Indicator Table (SEDIT)	0.1%	7	174	1
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	82.0%	34	140	2
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	1.4%	19	174	2
	SDEC rate	Summary Emergency Department Indicator Table (SEDIT)	35.9%	86	173	5
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	91.7%	75	178	5
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	7.0%	10	134	1
	Incomplete RTT pathways +52 weeks	RTT waiting times data	0.0%	75	156	5
	Incomplete RTT pathways +65 weeks	RTT waiting times data	0.0%	78	156	5
	Incomplete RTT pathways +78 weeks	RTT waiting times data	0.0%	68	156	5
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	70.0%	101	134	8
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	81.6%	38	141	3
	Cancer 31-day treatment performance	Cancer Waiting Times standards	91.1%	101	141	8
	Cancer 62-day treatment performance	Cancer Waiting Times standards	67.9%	98	141	7

Sherwood Forest Hospitals NHS Foundation Trust

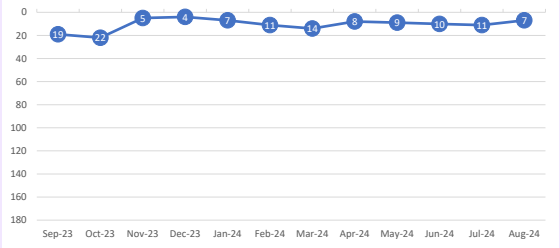
Integrated Performance Report 2024/25

September 2024 (Qtr 2)

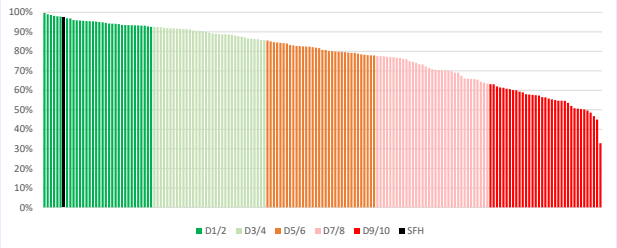
Timely Care Benchmarking Charts

Timely Care Benchmarking

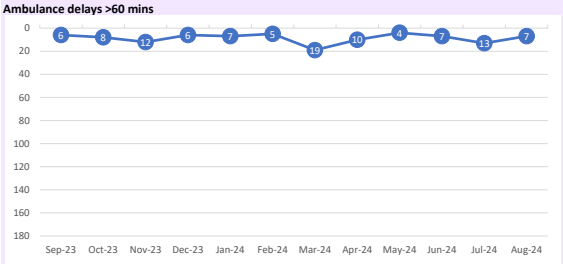
Ambulance turnaround times <30 mins



Aug 24 Position



Ambulance delays >60 mins



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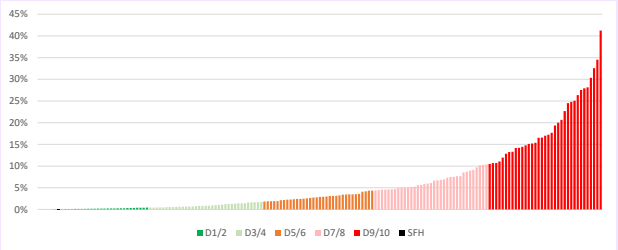
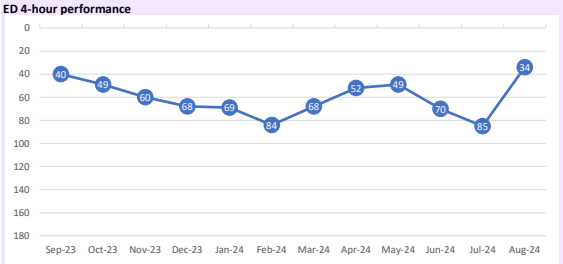


ED 4-hour performance



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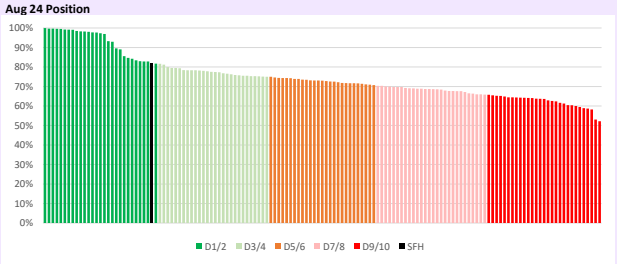
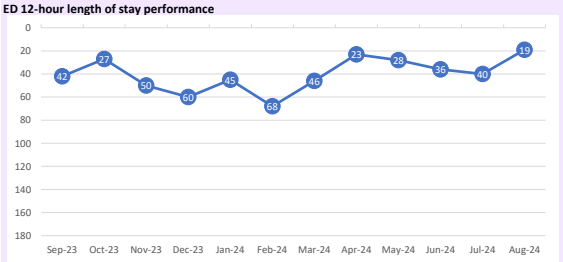


ED 12-hour length of stay performance



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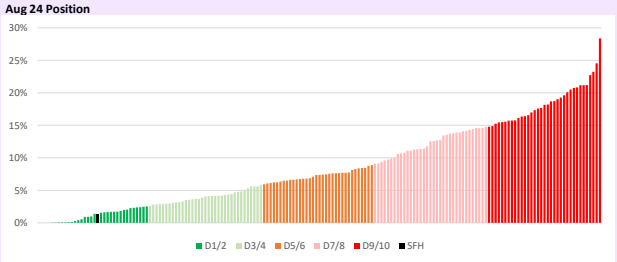
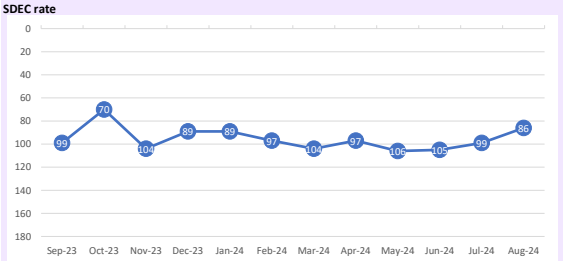
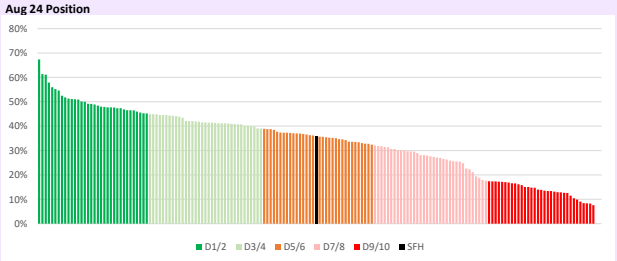


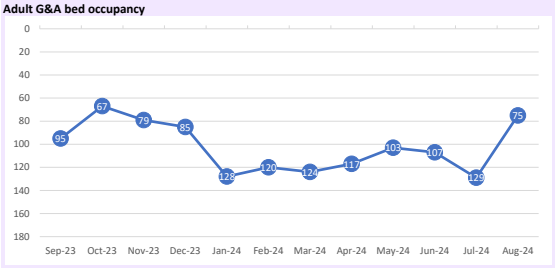
SDEC rate



Aug 24 Position



Adult G&A bed occupancy



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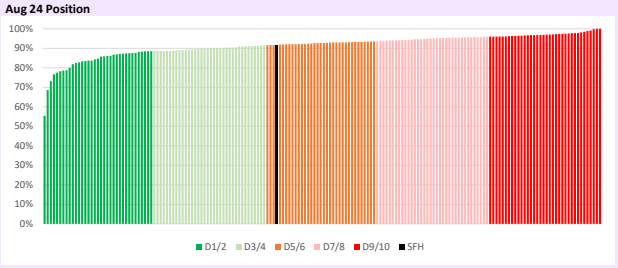
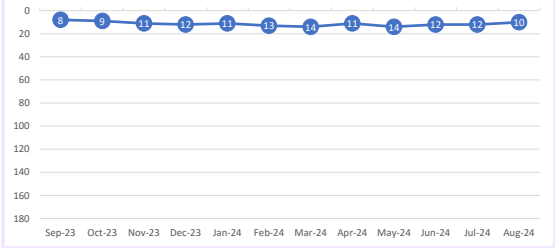


Added to Patient Initiated Follow Up (PIFU) pathway



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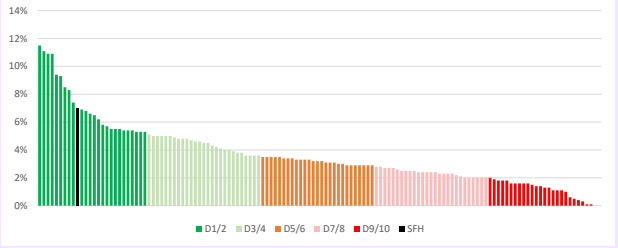
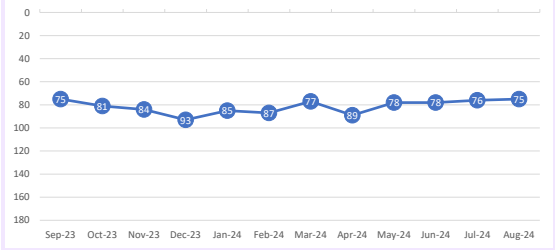
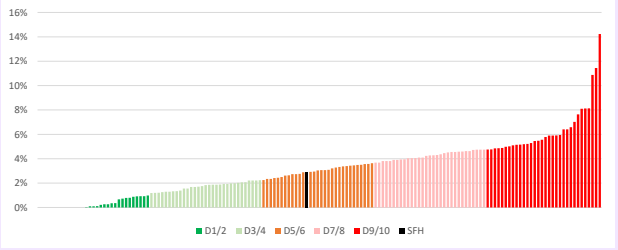


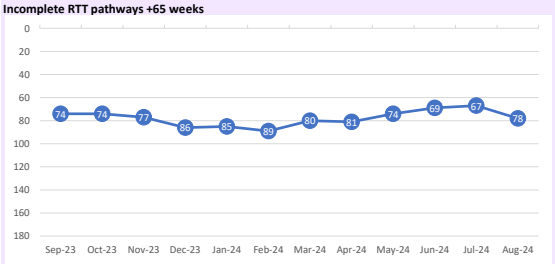
Incomplete RTT pathways +52 weeks



Aug 24 Position



Incomplete RTT pathways +65 weeks



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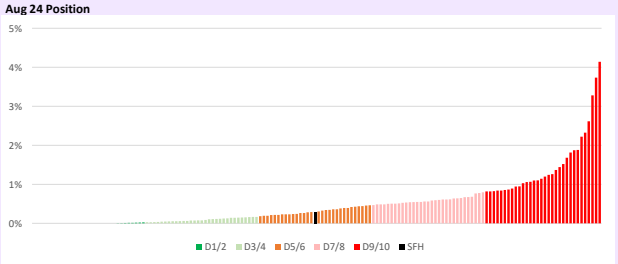
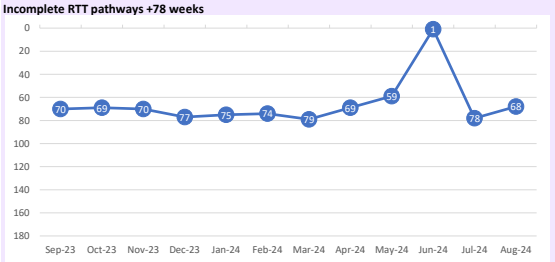


Incomplete RTT pathways +78 weeks



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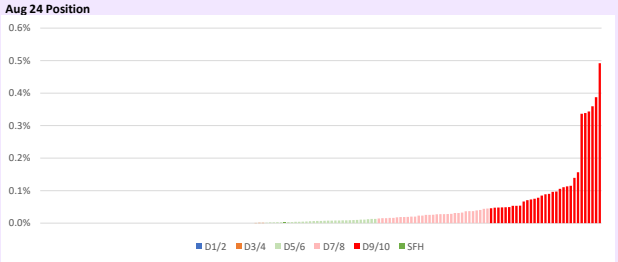
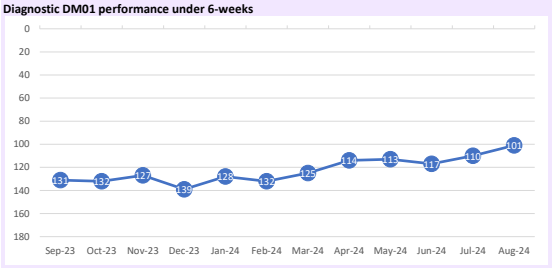
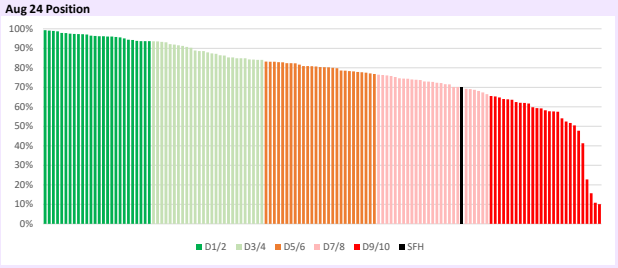


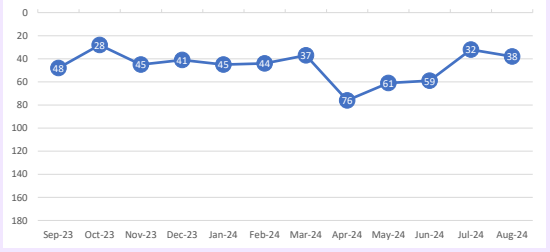
Diagnostic DM01 performance under 6-weeks



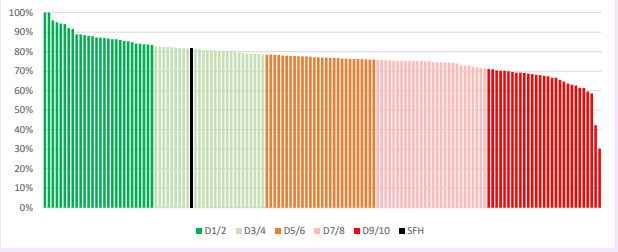
Aug 24 Position



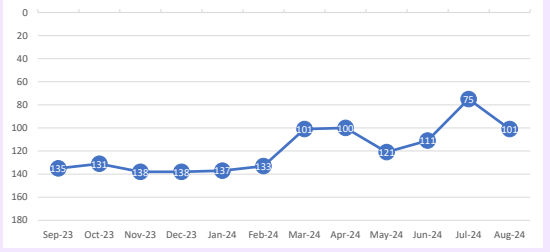
Cancer 28-day faster diagnosis standard



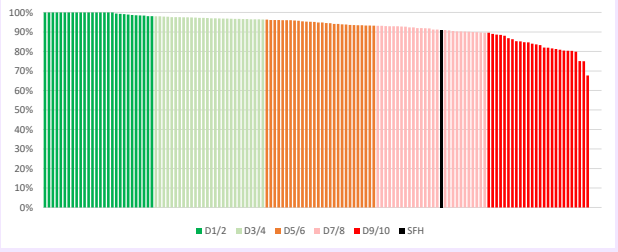
Aug 24 Position



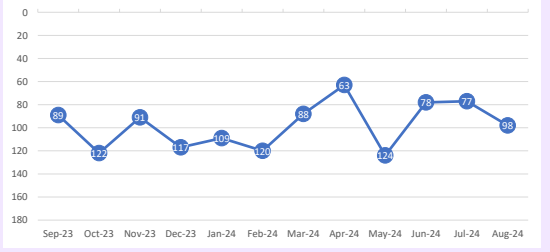
Cancer 31-day treatment performance



Aug 24 Position



Cancer 62-day treatment performance



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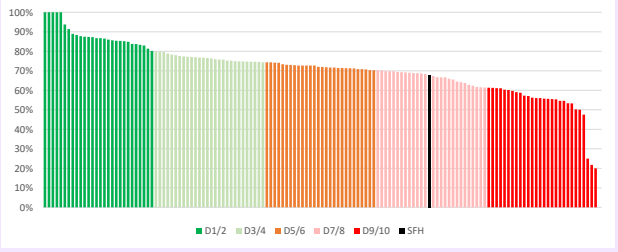


Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Public Board of Directors - Cover Sheet

Subject:	Improving Lives strategy – 6 months progress	**Date:**	07/11/2024
Prepared By:	Paula Longden, Associate Director of Strategy and Partnerships		
Approved By:	Claire Hinchley, Acting Director of Strategy and Partnerships		
Presented By:	Claire Hinchley, Acting Director of Strategy and Partnerships		

Purpose		
To review progress of delivering the Improving Lives strategy in the first 6 months since launch.	**Approval**	
	Assurance	
	Update	**X**
	Consider	

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

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Insufficient financial resources available to support the delivery of services	
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

All supporting strategies have been presented to their relevant Committee during September and October 2024

Acronyms

DNA – did not attend (the appointment)
MECC - making every contact count
NHS IMPACT – improving patient care together (NHS improvement approach)

Executive Summary

The Trust's five year 'Improving Lives' strategy was approved and launched on 1 April 2024. This is the first update of delivery towards the six strategic objectives for the period April to September 2024.

The Improving Lives vision of delivering consistently outstanding care by compassionate people, leading to healthier communities is underpinned by six strategic objectives:

- Strategic objective 1 – Provide outstanding care in the best place at the right time
- Strategic objective 2 – Empower and support our people to be the best they can be
- Strategic objective 3 – Improve health and wellbeing within our communities
- Strategic objective 4 – Continuously learn and improve
- Strategic objective 5 – Sustainable use of resources and estate

- Strategic objective 6 – Work collaboratively with partners in the community

Five supporting strategies set out principles and actions that deliver against these objectives and collectively achieve the Improving Lives strategy. The supporting strategies are:

- Clinical services strategy
- Quality strategy
- People plan
- Partnership strategy
- Finance strategy

The supporting strategies have been reviewed in Board committees during September and October against expected progress, and this has been amalgamated into demonstrating delivery of the overarching Trust strategy 'Improving Lives'.

The following report provides a summary of progress against each strategic objective during the first six months since launch.

Despite challenges faced by many NHS organisations in 'managing today' whilst maintaining a focus on 'making tomorrow better', the Trust has many achievements to be proud of. Every strategic objective has moved forwards and made improvements to the lives of our patients, our people and the local population.

During the next six months, there will be a refresh of the quality strategy and the people plan, and the finance strategy will be finalised which will further align to delivery of the Trust strategy.

A further review of progress and impact of the strategy's deliverables will be presented in May 2025.

Board is asked to NOTE progress made in the first 6 months of the five-year strategy.

Introduction

The Trust's five year 'Improving Lives' strategy was approved and launched on 1 April 2024. This is the first summary of delivery towards the six strategic objectives for the period April to September 2024.

The Improving Lives vision of delivering consistently outstanding care by compassionate people, leading to healthier communities is underpinned by six strategic objectives:

- Strategic objective 1 – Provide outstanding care in the best place at the right time
- Strategic objective 2 – Empower and support our people to be the best they can be
- Strategic objective 3 – Improve health and wellbeing within our communities
- Strategic objective 4 – Continuously learn and improve
- Strategic objective 5 – Sustainable use of resources and estate
- Strategic objective 6 – Work collaboratively with partners in the community

The Trust's supporting strategies set out principles and actions that deliver against these objectives and collectively achieve the Improving Lives strategy. The supporting strategies are:

- Clinical services strategy
- Quality strategy
- People plan
- Partnership strategy
- Finance strategy

The following section of the report provides a summary of progress against each strategic objective.

Strategic objective 1 – Provide Outstanding care in the best place at the right time

In our journey to be rated outstanding across all of our services, the Trust has taken steps to be at the forefront of service provision with innovative, safe and efficient healthcare.

Service developments and achievements focused on improving patient care and experience include:

- Being the first Trust in the Midlands to administer a new Parkinson's drug which made significant impact on our patients life and ability to complete daily tasks. This development received worldwide media interest
- The new discharge lounge providing purpose-built accommodation for our patients waiting to leave the hospital. Patient activity has doubled since the service transferred to its new environment
- Implementation of Vantage pharmacy system which provides timely tracking of samples throughout the department resulting in a better response for patients
- The Trust has achieved new and maintained existing nationally-recognised accreditations across divisions and specialties including, in pathology services, cellular pathology, clinical chemistry and clinical microbiology[1] and, in maternity services, the Baby friendly initiative
- Preparing for the electronic patient record working alongside clinical teams to map opportunities that digital working and digital records will bring
- The Trust is 6th best in England for its performance in emergency department patient flow and for ambulance handovers, meaning our patients are assessed and treated as early as possible in the right place
- The Trust has issued 167 carers passports to ensure our carers are identified and supported by our specialist teams

Strategic objective 2 – Empower and support our people to be the best they can be

Making the Trust a great place to work and belong is a key focus of our People Strategy.

[1] *ISO 15189:2012 Medical laboratories – requirements for quality and competence (assessed by the United Kingdom Accreditation Service)*

Improvements have been made to services provided by the People Directorate, aligned to the four delivery pillars of the NHS People Plan.

Looking after our people

- The Trust has commenced its 'Expect respect, not abuse' campaign, with the initial focus on supporting colleagues who experience violence and aggression from patients and service users and now expanding to promote sexual safety
- Development of a health and wellbeing survey to canvass staff on their knowledge of the health & wellbeing offer, exploring barriers to engagement

Belonging in the NHS

- The Trust has developed and successfully piloted exit interviews and 'thinking of moving' conversations to identify reasons why people leave the organisation and to support retention, a key initiative of the People Promise Exemplar programme
- Delivery of the Equality, Diversity & Inclusion Improvement Plan has prompted a relaunch of the Trust's staff networks and recruitment of inclusive recruitment champions

Growing for the future

- Working towards its strategic aim to be the local employer of choice, the Trust has continued with its Step into the NHS programme of events, is developing strategic partnerships with Vision West Nottinghamshire College and has enhanced its work experience offer with a 25% increase in offered placements since April 2024
- The coaching and mentoring network is under development with communications going live in October 2024

New ways of working and delivering care

- Workforce plans and recruitment to the Trust's new Community Diagnostics Centre services at Mansfield Community Hospital continue to be supported
- Revised processes have been developed utilising efficiencies in our electronic staff record and health roster systems, with the aim of removing duplications in processes

Strategic objective 3 – Improve health and wellbeing within our communities

The Trust will ensure that every contact counts and is committed to improving health and wellbeing within those people who work and live in our local population.

The Trust is taking action to address health inequalities:

- Digital 'flag' now in place for patients with cancer who also have a learning disability enabling adjustments to be made in their care
- Creation of a health inequalities steering group, which has agreed priority areas of focus over the rest of the year
- Cultural competency training delivered in women and children's division which supports our people to engage effectively with people from different cultures and countries in a way that best meets their needs
- A focus on reducing DNAs (Did Not Attend the appointment) with a health inequalities lens to identify different approaches to the way we manage our patient appointments

- Working with our partners to deliver MECC (Making Every Contact Count) training within the Trust to raise competencies and look at different ways to provide each contact

Strategic objective 4 – Continuously learn and improve

To embed a strong culture of continuous improvement the Trust has:

- Embedded improvement culture through mechanisms such as the Patient Safety Incident Response Framework, which seeks to identify learning from incidents
- Completed a self assessment against improvement domains set out in NHS IMPACT's national tool which puts us on a journey of improvement across the organisation
- Appointed a citizen improvement partner to engage the patient voice in improvement programmes
- Delivered improvement ambassador awards to our People who have demonstrated great service improvement projects in their area of work that have positively impacted on patient care
- Delivered a successful Celebrating Excellence event which showcases the outcomes of improvement through our nursing, midwifery, allied health professionals and pharmacy colleagues
- Promoted patient engagement through the in-patient survey to identify real time improvements

Strategic objective 5 – sustainable use of resources and estate

To deliver the best possible care for the community we serve, and using our resources wisely the Trust has:

- Focussed on core financial controls, assurance and pace of improvement with the aim for financial breakeven in 2026 and a contribution to the ICS financial position
- Eliminated the use of desflurane across the Trust supporting delivery of our Green Plan
- Added additional electric vehicle charging points and a new bus stop to promote sustainable and greener travel
- Worked with clinical fellows to develop further plans for decarbonisation and competencies for the workforce to tackle the impacts of climate change

Strategic objective 6 – Work collaboratively with partners in the community

The Trust has a long history of working in partnership, recognising delivery of the strategic objectives cannot be achieved by the Trust alone. The Trust has developed several relationships into deliverable partnerships including:

- Focussed work within provider collaboratives to build resilience in fragile services
- Commenced a collaborative programme of work with primary care to respond to problems that occur when patients move to and from the Trust's care to general practice

- Working closely with Vision West Nottinghamshire College to increase work experience and apprenticeships, and aligning a practice development nurse to work with students at the college, which is improving professional behaviours
- Developed a partnerships canvas to model the Trust's partnerships and the value exchanged through working in collaboration

Summary

Despite challenging circumstances faced by many NHS organisations across England in the first 6 months of this year, the Trust has achieved lots to be proud of towards delivering the strategy of Improving Lives.

In the next 6 months, there will be a refresh of several supporting strategies which will enhance deliverables for future years. Progress continues to be made in measuring the impact and outcomes of delivery, with a view of gaps and risks to delivery due at the first-year review.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public – Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date:**	7th November 2024
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	David Selwyn, Acting Chief Executive Officer		

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

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	Insufficient financial resources available to support the delivery of services	✓
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 Committee; Finance Committee; Partnerships & Communities 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.

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 1st August:

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

PR1, PR2, PR3, PR4 and PR7 remain significant risks. All risks except PR5 are above their tolerable risk ratings.

Discussions are taking place with Lead Directors and Board Committee Chairs to describe metrics/deliverables that may reduce risk scores.

PR6 has been re-written to reflect the current position.

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
CBRNe	Chemical, biological, radiological, nuclear, explosive
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
PHE	Public Health England

Acronym	Description
PLACE	Patient-Led Assessments of the Care Environment
PMO	Programme Management Office
PPE	Personal protective equipment
PSC	Patient Safety Committee
PSC	Patient Safety Culture
QC	Quality Committee
QIPP	Quality, Innovation, Productivity and Prevention
SDEC	Same Day Emergency Care
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

Board Assurance Framework (BAF): October 2024

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

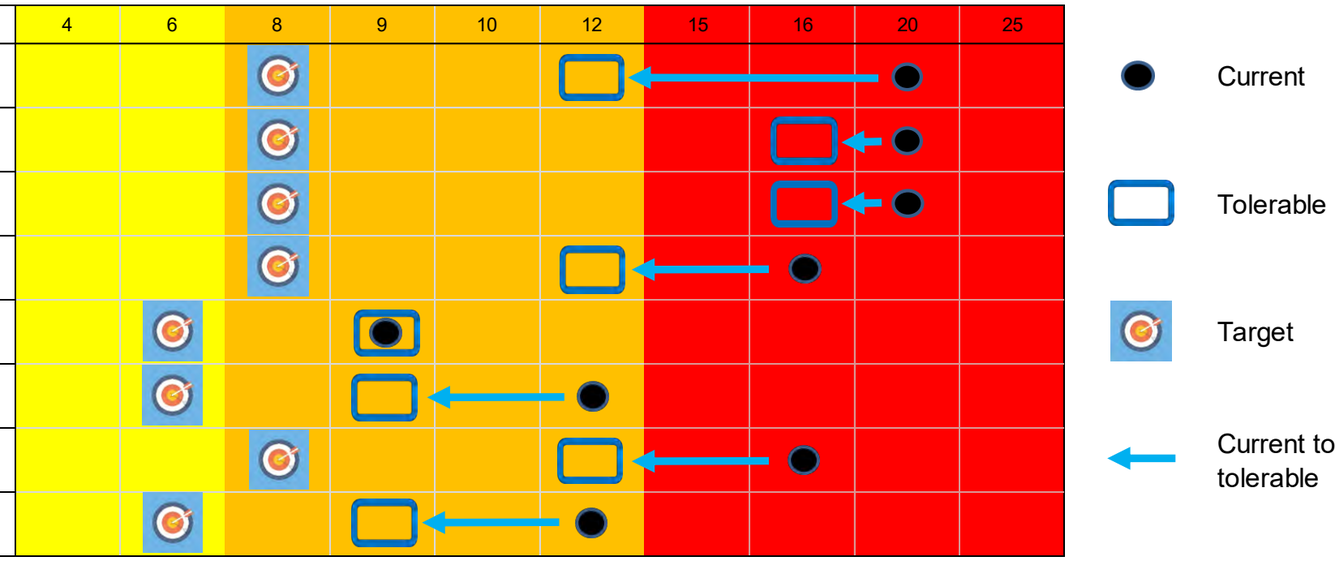
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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					

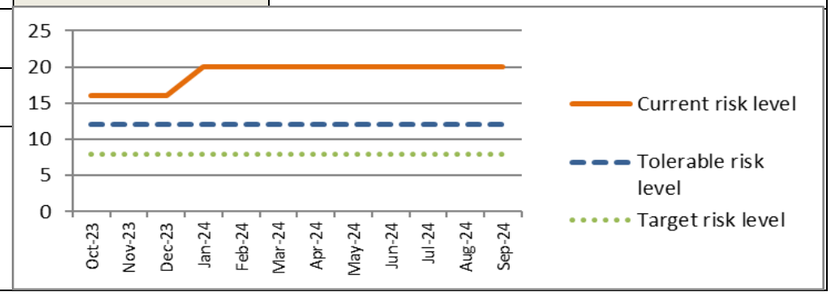
This BAF includes the following Principal Risks (PRs) to the Trust's strategic priorities and the risk scores:

		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People
PR4	**Insufficient financial resources available to support the delivery of services**	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	Partnerships and Communities
PR7	**Major disruptive incident**	Chief Executive Officer	Risk
PR8	**Failure to deliver sustainable reductions in the Trust's impact on climate change**	Chief Financial Officer	Finance



Board Assurance Framework (BAF): October 2024

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							**Strategic objective**	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 directors	Medical Director Chief Nurse	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	3. Possible	2. Unlikely				
Last reviewed	23/09/2024	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**				
Last changed	23/09/2024								



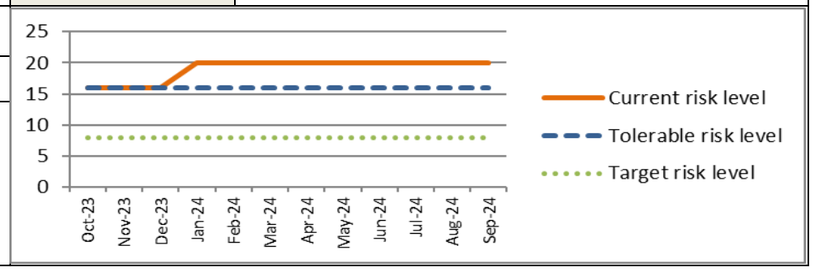
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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 ▪ IPR metric reviewed annually and agreed by Board ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Patients Safety Incident Response Framework (PSIRF) ▪ 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 Financial restraints may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing	Review the existing reporting metrics used to monitor patient safety and identify improvements to ensure consistency of the values used across different reports across governance groups, including the development of a quality dashboard **SLT Lead:** Medical Director / Chief Nurse **Progress:** Review completed – developing dashboard **Timescale:** ~~September~~ November 2024 Monitoring of fill rates and quality impact **SLT Lead:** Medical Director / Chief Nurse **Timescale:** December 2024	**Management:** Learning from deaths Report to Quality Committee and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board quarterly 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 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 IPR to Quality Committee bi-monthly; Quality Account Report qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC quarterly; Significant Risk Report to RC monthly; Exception reporting to System Quality Committee bi-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 Palpable harm to staff due to work pressures, and the longevity and impact of the ongoing demands Running at OPEL4 for a protracted length of time and full capacity protocol, exceeding full capacity protocol and system-wide critical incidents	Positive No change since April 2020

Board Assurance Framework (BAF): October 2024

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 ▪ Infectious disease 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	FIT mask testing compliance rate below required rate	Increase compliance to target rate **Progress:** Fit Testing Data is now included in Divisional Performance Review Packs Compliance increased, but not yet to target rate, and targeting high-risk areas **SLT Lead:** Director of People / Chief Nurse **Timescale:** October 2024 Establish a FIT testing task and finish group **SLT Lead:** IPC Nurse Consultant **Timescale:** ~~August 2024~~Complete	**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; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee 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; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan		Positive Last changed November 2022

Board Assurance Framework (BAF): October 2024

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**	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**	**5. Very likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	23/09/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	23/09/2024								



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 and increasing complexity of health needs • 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 under oversight of the Urgent and Emergency Care (UEC) Board and the System Oversight Group ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place (and expanding) to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with Nottingham Emergency Medical Services (NEMS) ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework and Full Capacity Protocol ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ SFH annual capacity plan with specific focus on the Winter period via the Winter Planning Group ▪ Referral management systems shared between primary and secondary care ▪ UEC Improvement Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Planned Care Steering Group ▪ Emergency Care Steering Group	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our full capacity protocol e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Continuation of March 2024 Emergency Department schemes to support non-admitted breach reduction **SLT Lead:** Chief Operating Officer **Timescale:** throughout Q1 and ~~continuing into~~ Q2, and continuing into Q3 Trial of frailty SDEC co-located with Discharge Lounge **Progress:** ~~Trial commenced 2024~~Part of 2024/25 Winter Plan **SLT Lead:** Chief Operating Officer **Timescale:** ~~End Q2 – then decision to end or make substantive~~Commence October 2024 Provide input and support to the System Analytical Intelligence Unit (SAIU) who are undertaking a system-wide diagnostic to try to identify the drivers to increased urgent care demand **Progress:** ~~First draft of the report (which excludes hospital date)~~ Report completed and has been shared by the SAIU in July 2024 **SLT Lead:** Chief Operating Officer **Timescale:** ~~throughout Q2~~Complete Winter Plan to be agreed and implemented **Progress:** First draft approved by Trust Board in September 2024. Final draft to be approved in October 2024, then immediate implementation **SLT Lead:** Chief Operating Officer **Timescale:** October 2024	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board quarterly **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; Operational Planning internal audit report Jul 24		~~Positive~~ Inconclusive Last changed ~~December 2020~~ September 2024

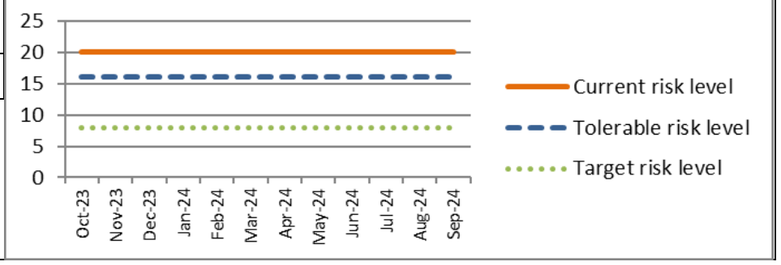
Board Assurance Framework (BAF): October 2024

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**
Constraints in availability of hospital bed capacity caused by 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 in place that undertakes twice-daily reviews of patients awaiting Nottinghamshire packages of care ▪ Full use of our bed base across our 3 sites with further capacity purchased from Ashmere Group Care Homes (at reduced levels in 2024) ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Re-introduction of Discharge Co-ordinators across inpatient wards	Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 40	Right-size pathway 2 and pathway 3 bedded capacity required for rehabilitation and re-enablement across the ICS to reduce length of stay and MFFD **SLT Lead:** Chief Operating Officer **Timescale:** October 2024 Roll out a series of one-minute videos that explaining the basic but essential elements of patient flow **SLT Lead:** Chief Operating Officer **Timescale:** December 2024	**Management:** Daily and weekly themed reporting of the number of MFFD patients in hospital beds - reports into the 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, which is showing positive progress in 2024/25 Q1 and Q2		Inconclusive No change since threat added in January 2022
Failure of Primary Care 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 System Oversight Group meetings across ICS, including Primary Care ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan ▪ Nottingham Emergency Medical Services-run 24/7 primary care service within our Emergency Department			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand; ICS reports available on the System Analytical Intelligence Unit portal		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 relevant Integrated Care System (ICS) groups/boards~~, and assuming a leading role in Integrated Care Provider development~~ ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS ▪ Regular meetings in place with EMAS and commissioners to review and discuss appropriate flow of patients to our hospitals			**Management:** A&E attendance demand report (including post code analysis of ambulance conveyance) to Finance Committee Feb 24, and shared with System partners **Independent assurance:** Weekly reports provided by NHSE Regional Team showing performance against key Urgent and Emergency Care metrics; System Analytical Intelligence Unit (SAIU) Drivers of Urgent Care Demand report Sep 24	Lack of control over the flow of patients from the surrounding area, including decisions by EMAS to undertake strategic conveyancing 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 2024 Review volume of patients attending the Trust from peripheral post codes to ensure a consistent approach to ambulance conveyance **Progress:** initial findings have shown an increase of patients from the Hucknall and Alfreton areas **SLT Lead:** Chief Operating Officer **Timescale:** ~~throughout Q2~~Complete	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	Physical capacity/estate will be insufficient should growth trends continue in the coming years		**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 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care						
Lead committee	People	**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	24/09/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	24/09/2024						

Strategic objective	Empower and support our people to be the best they can be



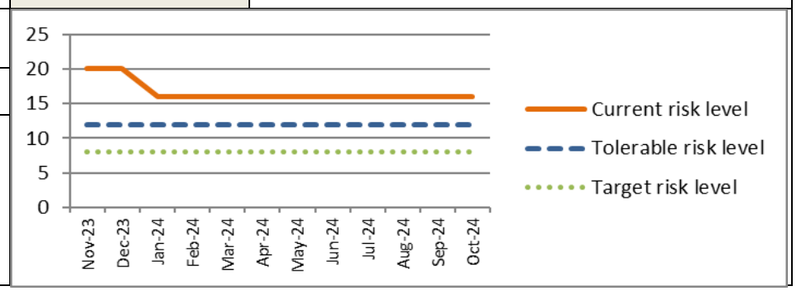
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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, 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 ▪ ICS People and Culture Strategy (2019 to 2029) and Delivery Group ▪ 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 ▪ Medical Transformation Board ▪ Nursing & Midwifery Transformation Board ▪ ICB Agency Reduction Group ▪ 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 ▪ CDC Workforce Group ▪ CDC Steering Group ▪ People Promises Exemplar Organisation	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 about recruitment and retention, creating competition and not maximising opportunities Inability to achieve the system workforce efficiency programme target	Deliver the People Strategy – Year 3 priorities and objectives **SLT Lead:** Director of People **Timescale:** March 2025 Work with provider collaborative colleagues to deliver the Vanguard programme in relation to workforce portability / passporting recruitment KPIs **SLT Lead:** Director of People **Progress:** Pilot for resident doctors to commence in November **Timescale**: ~~September~~ November 2024 Deliver the plan to replace premium pay and agency staff with substantive workforce **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to People Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People ~~& Inclusion~~ and Culture ~~& Improvement~~ to People Committee; Recruitment & Retention report monthly; Strategic People Plan to People~~, Culture and Improvement~~ Committee May ~~23~~24; Employee Relations Quarterly Assurance Report to People Committee; People Plan updates to People Committee bi-monthly; Leadership Development Strategy ~~Assurance Report to PCI Committee Jul 23;~~ Assurance Report to People Committee quarterly; NHSE Planning – Workforce Perspective Report to People Committee May 24 **Risk and compliance:** Risk Committee significant risk report monthly; HR & Workforce planning report Risk Committee; IPR – 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; Recruitment of agency staff audit report Jun 23; Appraisals internal audit report Jun 24	Impact of the Trust workforce financial efficiency programme with enhanced controls regarding recruitment and a reduction in bank rates of pay Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels **SLT Lead:** Director of People **Timescale:** March 2025	~~Positive~~ Inconclusive Last changed ~~June 2022~~ September 2024

Board Assurance Framework (BAF): October 2024

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	▪ 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 ▪ Winter Wellness Campaign ▪ Sexual safety working group ▪ Violence Prevention and Reduction Working Group	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users Concerns over sexual safety in the workplace	Develop an action plan from the outcomes of the National 2023 Staff Survey **SLT Lead:** Director of People **Timescale:** ~~September 2024~~Complete Include actions to address inequalities in staff inclusivity within the new People Strategy **SLT Lead:** Director of People **Timescale:** April 2025 Develop and Implement the Violence Prevention and Reduction action plan **SLT Lead:** Director of People **Timescale:** March 2025 Review with Provider Collaborative Colleagues wellbeing offers and identify areas of duplication and gaps, developing recommendations for delivery at a system level – vanguard programme **SLT Lead:** Director of People **Progress:** ICB have commissioned Arden and Gem (CSU) to produce a report to identify gaps and create an action plan **Timescale**: ~~September 2024~~January 2025 Develop and implement a Sexual Safety Policy and process **SLT Lead:** Director of People **Timescale:** ~~December 2024~~Complete People Promises work taking forward a plan to address sexual safety in the workplace **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Staff Survey Action Plan to Board ~~May 23~~ Apr 24; Staff Survey Annual Report to Board Apr ~~23~~24; Equality and Diversity Annual Report ~~Jun 22~~ Jul 24; WRES and WDES report to ~~Board Oct 23~~ People Committee Jul 24; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, ~~Culture and Improvement~~ Committee ~~Dec 22~~ Mar 24; People Plan updates to People Committee quarterly; Leadership Report to People Committee Jul 24; Diversity in the Trust – Senior Leadership Roles report to People Committee May 24; Violence and Aggression Improvement Plan to People Committee Mar 24 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board ~~Aug 23~~ Jul 24; 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~~ People Committee May 24; ~~Assurance Report to People Committee quarterly;~~ NHS Long Term Workforce Plan to People and Culture Committee Sep 23~~;~~ and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar ~~23~~24; 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; Staff Wellbeing internal audit report Jan 24	Potential impact of cost-of-living issues on staff morale and wellbeing ~~Industrial action up to and including strike action from all NHS unions, affecting all system partners~~ ~~Potential strike action by junior doctors~~ ~~Industrial action by Medirest staff~~	~~Inconclusive~~ Positive Last changed ~~October 2022~~ September 2024

Board Assurance Framework (BAF): October 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Insufficient financial resources available to support the delivery of services** Financial funding allocated to and generated by the Trust does not cover the costs of services provided							**Strategic objective**	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**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	29/10/2024	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	29/10/2024								



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**
Regulatory action due to a failure to deliver NHS England financial targets	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established in most divisions ▪ NHSE Financial controls self-assessment completed and working group set up to undertake improvement actions ▪ Financial Resources Oversight Group (FROG) established and meeting monthly. ▪ Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Weekly 'Grip & Control Arbitration' panels established ▪ Financial Recovery Cabinet (monthly) and Financial Efficiency Review (weekly) meetings established	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework ~~Shortfall in schemes identified to deliver the £38.5m efficiency target included in the 2024/25 Financial Plan~~ Risk adjusted efficiency forecast falls short of the annual target of £38.5m	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** Financial Recovery Plan required to demonstrate financial sustainability by March 2026 in line with NHSE direction. Longer-term financial plan in development as part of strategic priorities, in line with clinical and operational strategies. Update scheduled for Finance Committee in October 2024 **SLT Lead:** Chief Financial Officer **Timescale:** ~~September~~October 2024 Rapidly identify and implement efficiency schemes to meet the 2024/25 Financial Plan **Progress:** ~~Weekly Financial Efficiency Oversight meetings established and 'Plan B' list in development. Grant Thornton 6-weeks diagnostics exercise near completion~~ Overall plan now exceeds the 2024/25 target **SLT Lead:** Chief Financial Officer **Timescale:** ~~August 2024~~Complete De-risking programme underway on all schemes to increase confidence in delivery of the 2024/25 target. **Progress:** Weekly Financial Efficiency Oversight meetings and monthly Financial Recovery Cabinet established. Weekly reports shared with the Executive Team. **SLT Lead:** Chief Financial Officer **Timescale:** Ongoing with a target of December 2024 for a risk-adjusted forecast that meets the target	**Management:** Monthly Finance Report to Finance Committee Quarterly; Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); NHSE updates to Finance Committee; Monthly variable pay reports to Trust Management Team; divisional representation at Finance Committee on a cyclical basis **Risk and compliance:** **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2023/24 Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Key Financial Systems – Pay Expenditure (Jul 23) - Financial Governance - Financial Ledger and Reporting (Mar-24) - Budget Setting, Reporting and Monitoring (Jun-24) - Operational Planning (Jun-24) - Financial Improvement Plan – Efficiency & Productivity (Jun-24) - System Financial Controls (Jun-24)	Nottinghamshire system selected for NHSE initiated Investigation and Intervention Process (I&I) **Progress:** Phase 1 (Investigation) report issued and discussed at Finance Committee and Board of Directors. Phase 2 commenced 16th September for a 12 week period **Lead:** Chief Financial Officer **Timescale:** December 2024	Positive Last changed January 2024

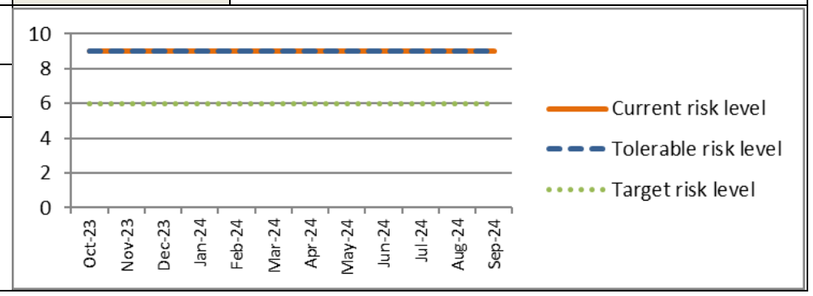
Board Assurance Framework (BAF): October 2024

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
		Financial Recovery Plan required to demonstrate a route to a break-even financial position by March 2026	Financial Recovery workstreams to be established, plan to be developed and appointments of ~~Financial Turnaround Director and~~ Associate Director of Financial Recovery and Sustainability to be made **Progress:** Initial workstreams set out and Associate Director of Financial Recovery and Sustainability role recruited (start date October 2024) **SLT Lead:** Chief Financial Officer **Timescale:** • July 2024 – Workstreams established (Complete) • ~~August 2024 – Turnaround Director appointed~~ • September 2024 – Financial Recovery Plan confirmed • September 2024 – Further resourcing requirements confirmed • October 2024 – Associate Director of Financial Recovery and Sustainability appointed			
Cash availability leads to delays in paying suppliers and workforce	▪ Daily cash flow forecasts prepared ▪ Cash Management Policy to protect cash balances and establish prioritisation of payments ▪ NHS England process followed to access Revenue Support PDC ▪ Financial Improvement Programme in place to deliver cash-releasing efficiencies ▪ Budgetary control processes and Scheme of Delegation in place to prevent overspends ▪ No Purchase Order, No Pay policy in place		2024/25 Revenue Support applications have not been supported in full by NHSE Meeting to be arranged with NHSE representatives to understand the risk and appeals process **Lead:** Deputy Chief Financial Officer. **Timescale:** October 2024	**Management:** Monthly Finance Report to Finance Committee includes details on cash flow, debtors and creditors **Independent assurance**: NHS England Financial Controls Assessment (Sep 23) Internal Audit reports: - Key Financial Systems – Accounts Payable and Treasury and Cash Management (Mar-24) - Financial Governance – Financial Ledger and Reporting (Mar-24)		**Positive** New threat added July 2024
ICB system financial performance challenge leads to disinvestment in SFH	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ICS Financial Recovery Group meeting weekly ▪ ICS System Opportunities Group meets bi-weekly, with SFH representation ▪ ICS Operational Finance Directors Group established and attended by SFH Deputy Chief Financial Officer ▪ ICB Financial Framework ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions	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 **Progress:** Sustainability reviews to be completed through Q1/Q2 of 2024/25 to establish a route to sustainability **SLT Lead**: Deputy Chief Financial Officer **Timescale:** ~~September~~ November 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun-24)	Impact of ICS partner financial recovery actions on SFH to be assessed **Progress:** Increasing prevalence of ICB savings that impact on SFH finances – CEO and CFO taking action to understand and mitigate this risk Letter sent from the CFO to ICB confirming the SFH stance on actions that may adversely impact the Trust's financial position – awaiting response **Lead:** Chief Financial Officer **Timescale:** ~~September 2024~~ Ongoing as recovery actions are developed	Positive Last changed July 2022
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks			**Management:** Board approved 2024/25 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team; Divisional risk reports to Risk Committee (bi-annually); Monthly Finance	Further Internal Audit of capital expenditure process to be undertaken by 360 Assurance to provide independent assurance. **Lead:** Head of Financial Services **Timescale:** December 2024	**Positive** New threat added July 2024

Board Assurance Framework (BAF): October 2024

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
				Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report **Independent assurance**: Capital Internal Audit report Jul 24		
Reliance on non-recurrent funding and efficiencies threatens long-term sustainability of services	▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Weekly Financial Efficiency update report to the Executive Team (and Monthly to Trust Management Team), detailing recurrent and non-recurrent savings ▪ Weekly Financial Efficiency Oversight meetings established ▪ ~~Improvement~~ Financial Recovery Cabinet in place to support longer-term decision making	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** 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:** ~~July~~ September 2024 Planning and budget setting principles to be agreed to enable recurrent delivery of schemes currently deemed non-recurrent **SLT Lead:** Deputy Chief Financial Officer **Timescale:** March 2025	**Management:** Monthly Finance Report to Finance Committee includes details on financial efficiency; Divisional Performance Reviews (bi-monthly); Divisional risk reports to Risk Committee bi-annually; Improvement Cabinet highlight reports to Trust Management Team and Finance Committee **Independent assurance**: Internal Audit reports: - Improving NHS financial sustainability (Dec-22) - Financial Improvement Plan – Efficiency and Productivity (Jun-24)		**Positive** New threat added July 2024

Board Assurance Framework (BAF): October 2024

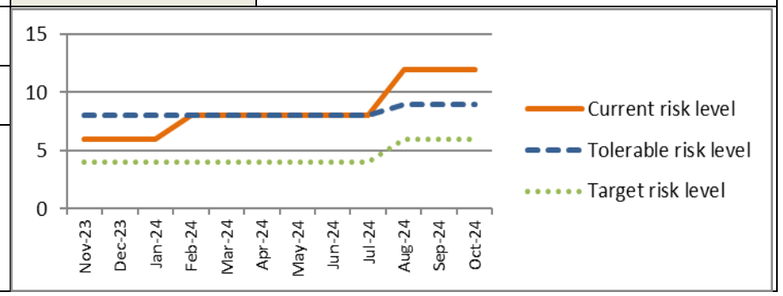
Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of capacity, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective**	Continuously learn and improve
Lead committee	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	23/09/2024	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	23/09/2024								

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 embedded improvement culture across the Trust resulting in suboptimal efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People Strategy ▪ People Committee ▪ Quality Strategy ▪ Quality Committee ▪ Leadership development programmes ▪ Talent management map ▪ Strategy & Partnerships Cabinet ▪ Ideas generator platform ▪ Improvement Faculty ▪ Financial Recovery Programme ▪ ~~Improvement~~ Financial Recovery Cabinet	Continuous Quality Improvement Strategy not yet approved	Continue communications to promote further engagement while the Continuous Improvement Strategy is being developed **Progress:** attendance at various meetings, with others planned **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~July 2024~~Complete Develop a process for clinical input for public and colleague engagement in improvement and transformation activities **Progress:** Process under development with the support of key stakeholders Recruited to key roles to support the process and plans in place to complete the documented process. To be reviewed to encompass the pending recommendations in the Darzi report **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~August 2024~~February 2025 Develop and roll out a Continuous Improvement Strategy **Progress:** ~~Strategy developed for approval by the Strategy and Partnerships Cabinet in July, then immediate roll-out~~Paused until the new Improvement Director is in post **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~August 2024~~April 2025	**Management:** Monthly Transformation and Efficiency report to FC; Improvement report to Quality Committee bi-monthly; NHS Impact Self-Assessment **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:** 360 assessment in relation to Clinical Effectiveness - report May '22		Inconclusive Last changed October 2022

Board Assurance Framework (BAF): October 2024

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~~ Working more closely with health, care and educational partners, does not deliver the Trust's Improving Lives strategic objectives** ~~Influencing the wider determinants of health and improving our collective financial position requires close partnership working~~						
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Acting Director of Strategy and Partnerships	**Consequence**	~~2. Low~~ 3. Moderate	~~2. Low~~ 3. Moderate	~~2. Low~~ 3. Moderate	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	4. Somewhat likely	~~4. Somewhat likely~~ 3. Possible	2. Unlikely		
Last reviewed	22/10/2024	**Risk rating**	~~8. Medium~~ 12. High	~~8~~9. Medium	~~4~~6. Low		
Last changed	22/10/2024						

Strategic objective	Work collaboratively with partners in the community



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
~~Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care~~	~~• Mid-Nottinghamshire Integrated Care Partnership~~ ~~• Mid-Nottinghamshire PBP Executive~~ ~~• Mid-Nottinghamshire PBP annual work plan~~ ~~• Nottingham and Nottinghamshire Integrated Care System Board~~ ~~• Continued engagement with PBP 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 PBP plans through the joint forward plan~~ ~~• Full alignment of organisational priorities with system planning~~ ~~• Independent chair for PBP~~ ~~• 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~~ ~~• New Place-based Partnership (PBP) leadership arrangements in place~~ ~~• 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~~ ~~• Partnerships and Communities Committee~~	~~Lack of control over staffing, and therefore service provision, by other system providers of services at SFH~~ ~~PBP priorities and work plan not agreed for 2024/25~~	~~Review service level agreements in contract management processes~~ ~~**SLT Lead:** Director of Strategy and Partnerships~~ ~~**Timescale:** July 2024~~ ~~PBP priorities and work plan to be agreed for 2024/25~~ ~~**Progress:** priorities agreed, work plan to be finalised~~ ~~**SLT Lead:** Director of Strategy and Partnerships~~ ~~**Timescale:** June 2024~~	~~**Management:** Strategic Partnerships Update to Board; 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 Risks Report to Risk Committee monthly~~ ~~**Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance~~		~~Inconclusive~~ ~~Last changed February 2024~~
~~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~~ ~~• 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~~ ~~• Partnerships and Communities Committee~~ ~~• Trust Strategy – Improving Lives~~			~~**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 2024

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
	~~Clinical Services strategy~~ ~~Health Inequalities Working Group~~					
Competing priorities within SFH could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Alignment of Trust's Strategy with the ICS Joint Forward Plan ▪ Clinical Services Strategy established guiding principles and priorities ▪ Partnership Strategy and delivery plan with oversight on delivery by Strategy and Partnership Cabinet ▪ People Strategy identifies key people partnership priorities and priority partners ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Partnership database and annual evaluation ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (PBP) annual place plan setting priorities and agreed actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024 Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	**Management:** 2023/24 strategy reporting (the "dials") to Board quarterly Strategy and Partnership Cabinet chair's report to PCC bi—monthly Provider collaborative effectiveness updates to PCC every four months Partnership Delivery Plan updates to Strategy and Partnership Cabinet monthly Supporting strategy reporting to relevant sub committees quarterly MNPBP highlight reports to Strategy and Partnership Cabinet and HISG quarterly HISG chair's report to Strategy and Partnership Cabinet monthly **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Threat updated August 2024
Competing priorities within our partners could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services,	Investigate opportunities to expand workforce capacity within the systems financial constraints. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	**Management:** Partnership Delivery Plan updates to Strategy and Partnership Cabinet MNPBP highlight reports to Strategy and Partnership Cabinet and HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet		Positive Threat updated August 2024

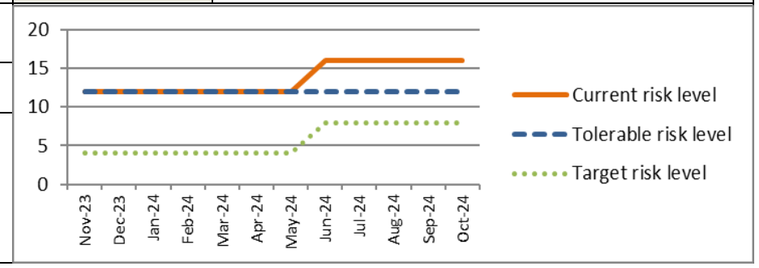
Board Assurance Framework (BAF): October 2024

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
	Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure. ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (PBP) annual place plan setting priorities, aligning resources and agreeing actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources ▪ Formal partnership arrangements with Vision West Notts College and Universities of Nottingham	workforce and health inequalities	Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	Monthly highlight reports from Notts Prov Collab to SFH executive lead EMAP monthly update reports to EMAP Executive Group **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		
Limited SFH partnership engagement capacity could result in a missed opportunity to bring in a wider patient and citizen voice to shape future healthcare services	▪ 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 PBP (MNPBP) and the district level Place Boards. ▪ ICS Clinical Services Strategy and Quality Strategy set priority re coproduction and personalised care ▪ ICS Health and Equality Strategy ▪ Nottingham and Nottinghamshire Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ SAIU dashboards and themed reports to focus on key priority areas for inputs and provide assurance of outputs and outcomes ▪ Clinical Directors and PCN Directors clinical partnership working ▪ Partnerships and Communities Committee (PCC) oversees delivery and receives assurance ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ SFH Health Inequalities Steering Group (HISG) linked to Mid Notts Health Inequalities Oversight Group to build relationships, share population health information and agree priorities and ICS Health Inequalities Steering Group, which facilitates sharing of patient/citizen voice and provides oversight of delivery	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024 Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** December 2024	**Management:** Strategy and Partnership Cabinet chair's report to PCC Partnership Delivery Plan updates to Strategy and Partnership Cabinet Supporting strategy reporting to relevant sub committees MNPBP highlight reports to Strategy and Partnership Cabinet and HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet **Independent assurance**: None currently in place		Positive Threat updated August 2024

Board Assurance Framework (BAF): October 2024

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Chief Executive Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely		
Last reviewed	08/10/2024	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	08/10/2024						

Strategic objective	Provide outstanding care in the best place at the right time

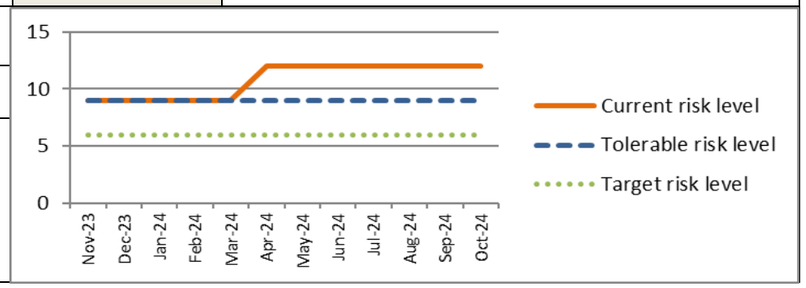


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ National Cyber Security Centre updates to Cyber Delivery Group ▪ 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 response plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead			**Management:** Data Security and Protection Toolkit submission to Board Jul 23- compliant on all 113 elements; DSPT updates to Information Governance Committee bi-monthly and Risk Committee 6-monthly; 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; NHIS Cyber Strategy approved at DSG May 24 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar24; 360 Assurance Data Security and Protection Toolkit audit Jun 23 – moderate assurance; Cyber Essentials Plus accreditation (NHIS) Dec 23	Not fully assured that all business continuity processes are robust and fully tested in the event of prolonged system downtime Review and test IT and business continuity processes **SLT Lead:** Chief Digital Information Officer **Timescale:** December 2024 Insufficient Board oversight of the risk and impact of cyber security Cyber threat to be fully addressed at a Board Workshop **SLT Lead:** Chief Executive Officer **Timescale:** October 2024	Inconclusive Last changed March 2024
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 ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Policy ▪ Health Technical Memorandum governance structure ▪ 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) and other HTM Specialties ▪ Major incident response plan in place	Gaps in controls and processes identified in the 2022 Fire Safety Management audit	Finalise and issue the Trust Fire Safety Strategy documents **SLT Lead:** Chief Financial Officer **Timescale:** ~~June~~ December 2024 Complete the actions within the Fire Audit action plan **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** ~~August~~ September ~~2024~~ Complete	**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Fire Safety reports to Risk committee quarterly **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; MEMD ISO 9001:2015 Recertification (3-year) Mar 21; British Standards Institute MEMD Assessment Report Feb 22; External cladding report to Executive Team Jan 24; ARUP Fire Surveys included in Annual Fire Safety report to Risk Committee Apr 24; ARUP Milestone 2 (Fire) Reports issued in draft July 2024 for review	Inconclusive evidence of buildings cladding and structures compliance with fire regulations Determine the remedial work required to ensure that the cladding is compliant with fire regulations **Progress:** It has now been agreed by Project Co. that the existing cladding will be replaced in full, programme currently being updated to take into account the new Building Safety Act. **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** ~~September~~ October 2024 Trust actions required from the ARUP Milestone 2 (Fire) Report	Inconclusive Last changed March 2024

Board Assurance Framework (BAF): October 2024

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
					Progress: An overarching risk assessment is to be produced for each site highlighting the common themes/issues that have come out of the draft report and to be discussed with all areas. ~~Awaiting~~ ARUP fee proposal received – CNH approaching other companies for costs Execs to be briefed on the ARUP findings ~~in August 2024~~ on 4th September. **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** ~~August 2024~~ October 2024	
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, ICS, 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 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 response plan in place ▪ Industrial Action Group ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three-yearly internal audit of EPRR arrangements with report to Board ▪ Incident Response and command and control training to all tactical and strategic leads across the organisation carried out annually ▪ Testing and exercising of service level plans carried out annually ▪ Health Risk Management Group for EPRR	The current Business Continuity Management System (BCMS) does not meet the requirements of the Core Standards	Roll out an updated BCMS to align with the national standards and include associated training **SLT Lead**: Chief Operating Officer **Timescale:** ~~June 2024~~Complete Embed the updated BCMS within all divisions **SLT Lead**: Chief Operating Officer **Timescale:** December 2024	**Management:** Industrial Action debrief report to Executive Team Mar 23, and following each subsequent period of industrial action; Monthly Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating 2023 – Partial Compliance; CBRN Audit carried out in March 2024 by EMAS	Improve compliance rating with Core Standards from "Partial" to "Substantial" **SLT Lead**: Chief Operating Officer **Timescale:** October 2024	Positive New threat added May 2023

Board Assurance Framework (BAF): October 2024

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**	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**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	29/10/2024	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	29/10/2024								

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 (may be due to capacity and/or capability)	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Operational Group (SDOG) and Sustainability Development Strategy Group (SDSG) ▪ 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 ▪ Annual Travel Survey ▪ Display energy certificates ▪ Building Research Establishment Environmental Assessment Methodology ▪ Net Zero Strategy ▪ Regular updates through Comms on the screen savers (included lighting, bees, waste etc.)	Education of ~~Board and~~ staff at all levels Dedicated capacity to implement ideas for change Insufficient capital resource available to realise Trust ambition Support from our PFI partners in developing 'green' solutions	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:** ~~July 2024~~Complete Proposal to ICB partners for collaborative approach and resource **Progress:** The ICS Infrastructure Strategy (January 2024) makes explicit reference to a system wide solution to consistent sustainability reporting and need for resource across the system to realise the ICS and provider ambitions. **Lead:** Chief Financial Officer **Timescale:** ~~August 2024~~Complete Additional resource **Progress**: Junior Energy Manager Apprentice and Sustainability Apprentice are being worked up for advertisement in Autumn 2024 **Lead**: Hard FM Manager **Timescale:** October 2024 Review of Green Plan Quarterly Energy and Sustainability Report to SDOG **Progress:** Data and information now readily available and now need to show how we utilise this to inform our decisions on capital etc, **Lead:** Sustainability Officer **Timescale:** ~~July 2024~~Complete	**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Car Parking Strategy: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~September~~ December 2024 Travel Plan: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~September~~December 2024 Display Energy Certificates Review all certificates and what actions need to be taken to improve the Energy Efficiency of the buildings. **Lead:** Sustainability officer **Timescale:** September 2024 Energy / Sustainability Business Cases: Ensure business case schemes are all worked up and ready to be issued if further funding becomes available through various government routes **Lead:** Sustainability officer **Timescale:** November 2024 Review of Performance on Sustainability Matters: - Yearly Energy and Sustainability Report to Trust Board (July 2024) - TMT Session on progress on the Green Plan (June 2024) - Annual Travel Survey 2024 - Regular review of how our staff travel to work	Inconclusive Last changed December 2023

			Quarterly Review of all outstanding actions within the Green Plan and when they are planned to be completed (including year up to 2026) to SDOG **Progress:** ~~Review of all aspects of the Green Plan have been undertaken and this is currently being reviewed by the EFM team.~~ Green Plan – review planned for March 2025 & E&F strategy should take into account what is still outstanding, ready for refreshed SFH Green Plan in 2026 **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~July 2024~~Complete Capital Bid Reviews: Further detail to be implemented into the process to show actual savings that are applied to capital schemes and how this impacts the overall trust financial position. **Progress:** Development of key metrics that would be included as part of the business case template for completion. **Lead:** Chief Financial Officer **Timescale:** ~~July 2024~~Complete CROG Scheme Bids: Ensure there are sufficient schemes developed and feasibilities undertaken to ensure the validity of the bids that are to be taken forward to Business Case Level **Progress:** ~~Solar Panels, Geothermal, Electric Vehicle Charging Points all currently being reviewed.~~ Several CROG applications rejected due to lack of funds. Considering external EV & Solar 'rental' schemes but progress has been impeded by IFRS16 considerations. Attended Geothermal meetings but awaiting advice via Heat Decarbonisation Plan on the best system for SFH **Lead:** Sustainability Officer **Timescale:** ~~July 2024~~March 2025 PFI Partners: Engage with our PFI provider and relevant parties to develop a combined energy reduction plan associated with the financial close out of the deed, retained estate upgrades, lifecycle developments and how all these aspects will support SFH in its energy/sustainability targets. **Progress:** ~~Awaiting completion of the settlement, key principles on sustainability, carbon and energy reduction to be set out when the works are undertaken.~~ Awaiting PFI settlement & changes in Skanska personnel **Lead:** Sustainability Officer **Timescale:** ~~August~~ October2024		and how this can be improved with alternative methods (additional bus stops on site was completed 23/24) **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~July 2024~~Complete Decarbonisation Plan: Submission to Phase 5 Public Sector Low Carbon Skills Fund to produce our decarbonisation plan **Progress:** ~~Bid Submitted May 2024~~ LCSF5 bid rejected **Lead:** Sustainability officer **Timescale:** ~~TBC following the outcome of the bid submission~~Complete ICS identified SFH had very poor LED lighting as a percentage nationally **Progress:** Skanska have now commenced LED lighting upgrades. To be monitored via E&F Monthly KPI Dashboard **Lead:** Sustainability officer **Timescale**: To Be Agreed with Skanska	

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	7 November 2024
Prepared By:	Sarah Ayre Head of Midwifery, Women and Childrens		
Approved By:	Phillip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women and Childrens, Phillip Bolton, Executive 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	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X	**X**	**X**	**X**	**X**	**X**

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

Committees/groups where items have been presented before

- Nursing and Midwifery AHP Committee
- Perinatal Assurance Committee (PAC)
- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- DPR
- Perinatal Forum
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- Birmingham Symptom Specific Obstetric Triage System (BSOTS)
- Care Quality Commission (CQC)
- Domestic Violence (DV)
- Fetal Alcohol Spectrum Disorder (FASD)
- Induction of Labour (IOL)

- Local Maternity and Neonatal System (LMNS)
- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Perinatal Assurance Committee (PAC)
- Pregnancy Day Care (PDC)
- Sherwood Birthing Unit (SBU)
- Transitional Care (TC)

Executive Summary

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

- Build the maternity and neonatal safety movement in your service locally, working with your clinical network safety champions, 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 perinatal team working to deliver safe, personalised care.
- act as a conduit to share learning and best practice from national and international research and local investigations and 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 September/October 2024

1. Service User Voice

On 27th September 2024 we welcomed the MNVP team to our Kings Mill Hospital maternity site for the 15 Steps service user initiative. We await their formal feedback, however, initial feedback provided on the day by the MNVP is reported by the Deputy Head of Midwifery as per below:

Postnatal Ward / Transitional Care

All staff were welcoming, kind and appeared happy. Atmosphere was calm and peaceful. Lack of a leaflet explaining TC care to mums. Signage around TC needs to have some additional languages added (talked about some QR codes added to posters) Postnatal ward needs more 'You said, we did' type of posters etc to share changes with families. Lack of poster showing staff so visitors can understand the uniform for each member of staff.

Antenatal Clinic / Pregnancy Day Care

All staff were welcoming, kind and appeared happy. Atmosphere was calm and peaceful. The signage about waiting time in clinic had nothing written in the 'minutes wait 'section. If there is no wait, can we write '0'. Only noted domestic violence information for patients and visitors in one toilet through whole of Maternity Unit. Need to frost the glass wall between the scan waiting area and corridor (from a previous visit following a woman stating she felt she was being watched walking up to quiet room after a poor outcome.)

Bereavement Suite

Acknowledged this is an excellent facility for our families. Please can a selection of the leaflets that are outside the door be put into a folder and available in the room. Can we source a new sofa bed as very poor condition. Can we look at some books about loss if there are not any for visiting siblings.

SBU/ Triage

All staff were welcoming, smiling, and stopped to talk. Partners felt involved in the care. No information on walls in SBU for women re: breastfeeding. Also need to think about different languages again on information. The new board on SBU is blank. No drinking water for women in triage waiting area/could also put up a sign saying available on request? Found a leaflet about FASD that did not explain the acronym on the leaflet. The BSOTS notice board not very well set out, no information about a red patient which may explain to women why there is a wait on times. Information too low down to appear important / to be read. No leaflets around for women to read while waiting. Could put signs up reminding women how to access leaflets on Badgernet.

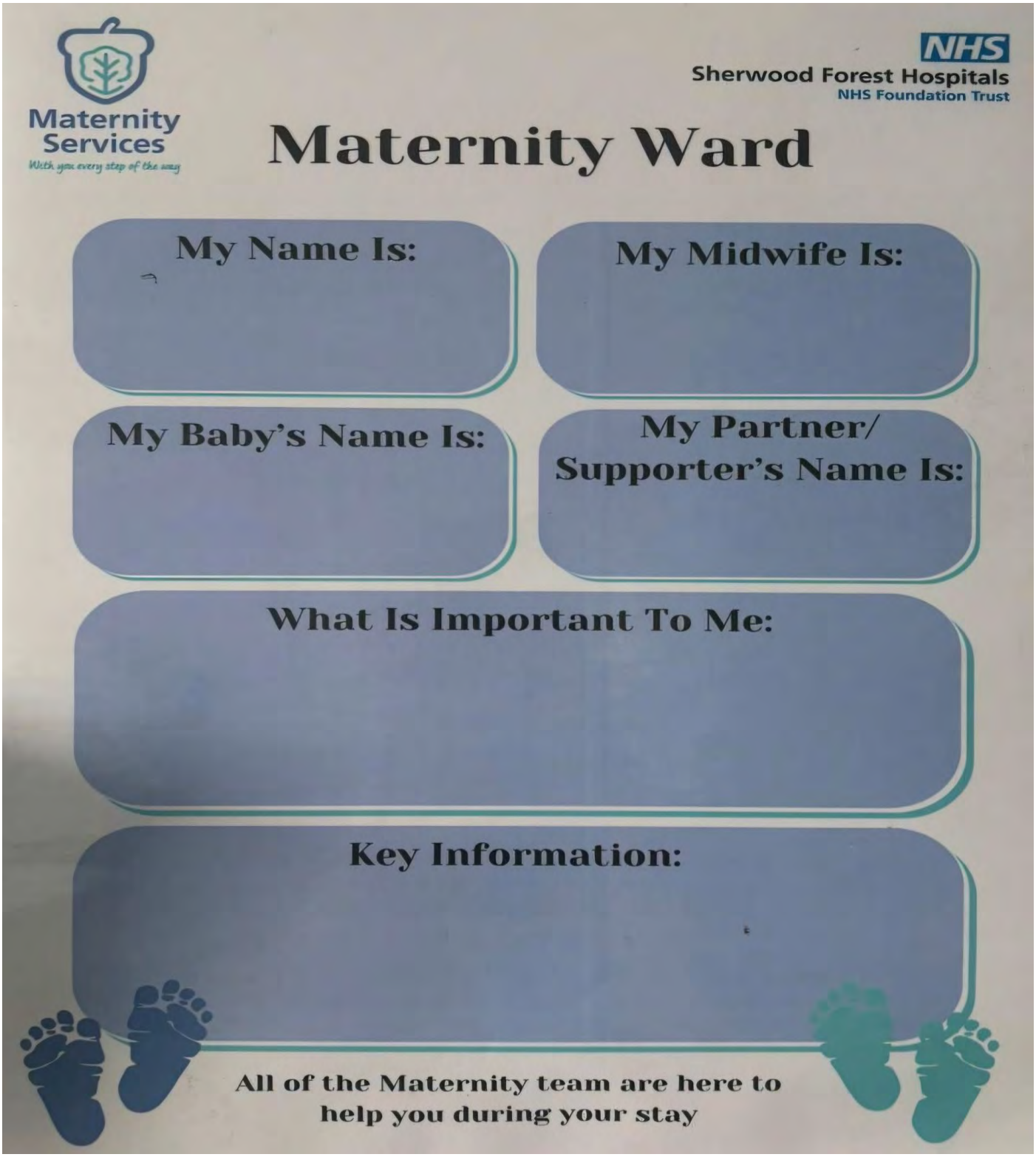
NNU

Minimal info in other languages. Information about card medic not up in the area. The general route into the

The Divisional SLT have been able to address most actions since receiving the informal feedback and will provide assurance against the formal feedback once received. The next MNSC meeting is planned for 30th December 2024.

You Said We Did

Our MNVP have been collaborating with maternity staff on setting and managing realistic expectations for service users; focusing in September on information around postnatal care when on the ward and what to expect around receiving pain medication, mealtimes, and mobilising post theatre admission. As part of this work the ward have implemented new notice boards at the bedside as per the picture below:



Utilisation and the impact of these boards on service user experience will be audited by Ward Leads and presented at MNSC meeting in December 2024.

Neonatal Services feedback remains predominantly positive with no specific escalations received for September.

On 2nd October 2024 our MNVP provided an updated focused work plan for 2024-2026 based around 2 clear objectives; Listening to the voices of women and families and working with Maternity & Neonatal Service Providers.

Our Consultant Midwife, Deputy Director of Nursing and Head of Midwifery will ensure collaboration and support for this plan and any escalation/highlights will continue to be presented via our MNSC meeting.

2. Staff Engagement
The planned monthly MNSC Safety Champions Walk around took place on Tuesday 8th October 2024. In support of our new Non-Executive Director for Women and Childrens, Neil McDonald's request to observe and understand the pregnancy journey as experienced by our service users, this month's focus is starting the journey through our varied intrapartum care services.

Neil McDonald, Phil Bolton Chief Nurse and Paula Shore, Director of Midwifery and Divisional Director of Nursing, also welcoming Matt Warrilow back to work, spent time talking to the teams who support the Induction of Labour, Triage and Birthing services to understand the process, but also asked 'what it is like to work in these areas'.

It was clear to the MNSC how increased activity and complexity was impacting staff and they noted the proposed solutions in place to support, such as the Elective Caesarean Sections List moving away from SBU to general theatres whilst also introducing outpatient IOL via PDC. The team also spoke about ideas they had within their own areas to make changes which could positively impact capacity and flow, alongside quality and safety and improve staff experience. The MNSC spoke with staff about the support needed for these changes and took away an action to work with colleagues from the Estates team around shared areas, particularly on SBU, to look at potential alternative provision for storage space.

The next MNSC walk round is planned for the 5th of November 2024 and will focus more specifically on our elective section pathway.

The Maternity Forum held in September mostly highlighted the continued low morale of our midwives and support workers following the impact of the two PFDs received earlier this year. Identifying and accessing the correct support for individuals and ensuring we listen remains a key priority of all leaders within Maternity.

The next Maternity Forum is planned for 19th November 2024. Maternity launched its very first Staff Council on 23rd October. Organised and supported by our MDT staff, representatives will attend monthly at the Maternity Forum to strengthen staff voice direct to our Trust Executives and will ensure an open and transparent approach to Ward to Board to Ward communication – a frequent request of our staff for many months.

Staff Voice - Round up
In acknowledgement of the various and multiple approaches to staff engagement and improving staff experience, Consultant Midwife Gemma Boyd has designed an overall action log. As this document has embedded evidence, we are unable to share during the normal channels with Board of Directors, but this document can be shared if requested.

This document helps shape our SLT priorities and next steps and is reviewed monthly at the SLT meeting chaired by the Head of Midwifery.

3. Quality and Safety

Risk
An improved process around managing and reviewing the Maternity Risk register will commence from November 2024. A focused Risk meeting will commence to review the register with key stakeholder's, chaired by the Quality and Safety Lead Midwife and her team. Owners will be required to attend to provide updates on actions, and escalations will be made to Divisional Governance. A robust highlight report from this meeting will be presented at Service Line, MNSC and PAC meetings.

Quality Improvement
Maternity
Divisional Strategy Next steps: Review of our key objectives and ambitions for 25/27 is underway, benchmarking progress and being overseen via the senior triumvirate at our weekly Senior Management Team (SMT) meeting.

Planned Care Lead Midwife: Recruitment into this new role to support developments and improvements in our elective care pathways and outpatient inductions is in progress.

Neonatal
Transitional Care (MIS Yr. 6, Safety Action 3) – Task and Finish group to be launched to support embedding of the service, relaunch of SOP and staff roles and responsibilities. Workforce review completed. Collaboration across Maternity and Neonatal leadership team to undertake the work streams identified.

4. Safety Culture
NHSE Perinatal Culture and Leadership Programme
With the aim of nurturing and growing our safety culture, enabling psychologically safe working environments, whilst continuing to build compassionate leadership, 4 of our senior leaders attended a series of workshops and action learning sets over the last 12 months, as part of a national programme focused on Cultural Safety led by NHSE. We are now engaging with an external agency to process our SCORE survey results and benchmark our actions to date against desired outcomes.

As part of our approach to addressing the SCORE survey themes, the Quad have formed Perinatal Staff Experience Team (PeSET) with support from the Head of Midwifery. Once the next stage has been completed by Kornferry, objectives can be agreed and next steps formed into an action plan, which will be shared through MNSC meeting and escalations made at PAC.

CQC Action Plan
The Should Do Action plan based on the CQC visit 2023 has been completed and embedded. However, we will continue to monitor success and additional actions through the peer review process, and further action plans will be presented through PAC. The Quality and Safety Lead Midwife has oversight for this action plan.

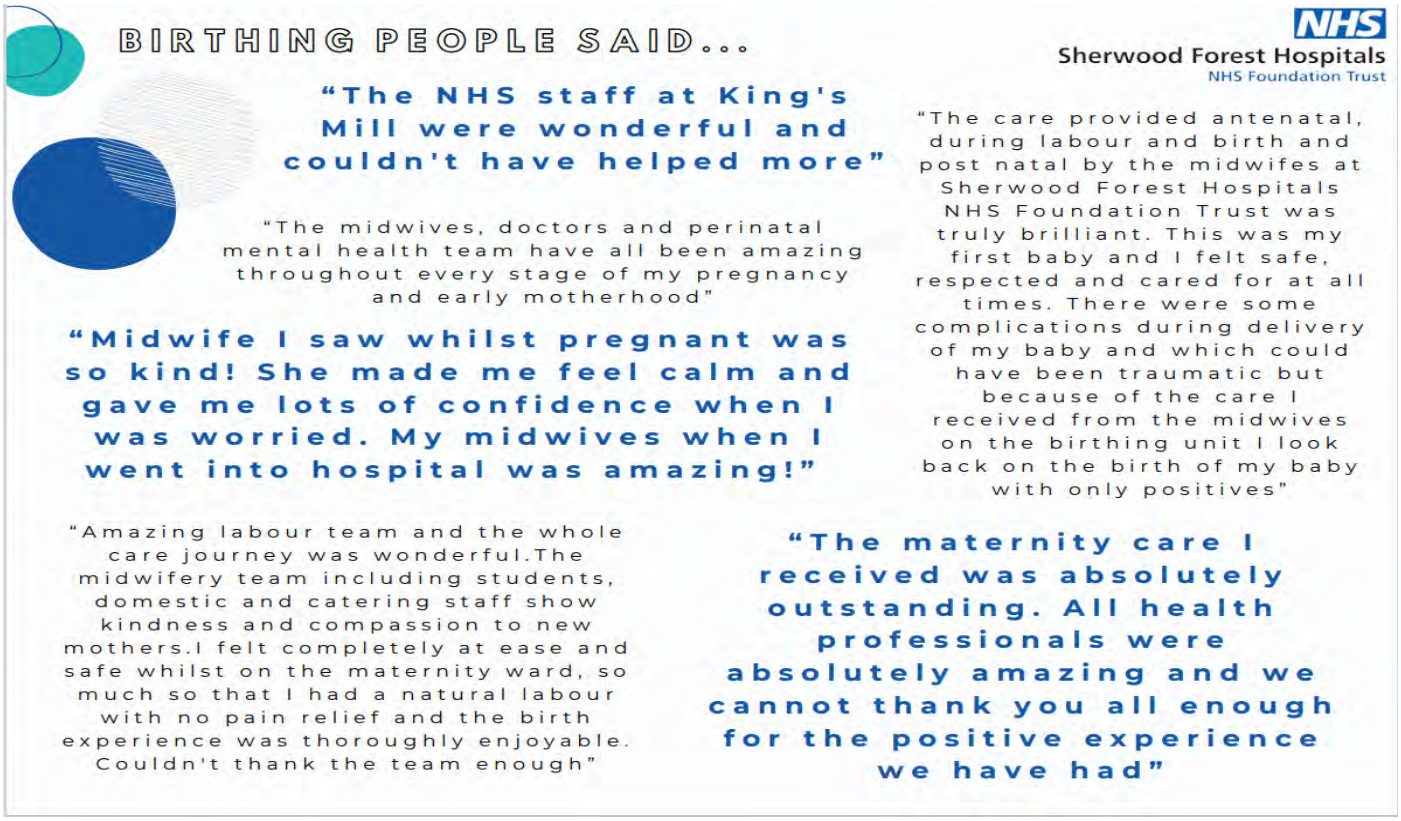
Peer Review Action Plan
Maternity Services Peer review was undertaken in September 2024. It identified both good practices and areas for improvement. The main report will be shared once the Peer Review Team have completed a full review of the documents provided as part of the request for information. Once received and actions agreed, the plan will be presented though MNSC and PAC for oversight and assurance.

Three Year Maternity and Neonatal Delivery Plan:
We continue to collaborate with the LMNS on the 4 main themes and the 12 objectives of the delivery plan. This document presents the 3-year delivery plan's technical guidance and will shape the oversight and assurance that we meet all aspects of the delivery plan. The mapping process against this plan is currently being overseen by the Head of Midwifery. Once the LMNS formally request evidence and assurance, we will fix an agenda item at Perinatal Assurance Committee to share our status against the plan.

NHSR
The Task and Finish group for the Maternity Incentive Scheme (MIS) Year 6 is now established, meeting fortnightly to work through the evidence upload needed to meet each of the 10 Safety Actions, chaired by the Speciality General Manager in collaboration with the Operations Manager. Currently all actions are assessed as AMBER which is defined as 'on target with evidence to be submitted and reviewed.'

Ockenden
The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan embedded within Maternity. The visit's findings supported the self-assessment completed by the Trust. Area's have been identified from the visit to strengthen the embedding of the immediate and essential actions however, important to note the continuing progress as a system around bereavement care provision, specifically with the counselling support. This is being progressed now through the systems Transformation Committee attended by the Head of Midwifery and Consultant Midwife.

CQC National Survey
Conducted in February 2023, some of the free text received is noted below prepared by the Consultant Midwife. Our action plan is overseen by our Consultant Midwife, and we remain in an active phase of embedding quality improvements, as reported.



Conducted in 2024 - It is noted that women and birthing individuals were asked for the first time within the national CQC survey about the care received by their GPs and the 6–8-week routine postnatal appointment. Our Consultant Midwife is working with the LMNS to discuss how we can collaborate, share, and assure these actions that sit in primary care. The results and free text are currently embargoed and so further updates, and our action plan will be shared though PAC once we can share all information.

MBRRACE-UK:
Saving Lives, Improving Mothers' Care 2024 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22. The full report can be accessed as follows. https://www.npeu.ox.ac.uk/mbrrace-uk/reports/maternal-reports/maternal-report-2020-2022

Our Quality and Safety Lead Midwife is currently benchmarking against the report and her updates will be shared via PAC once completed.

Maternity Perinatal Quality Surveillance model for Oct 2024

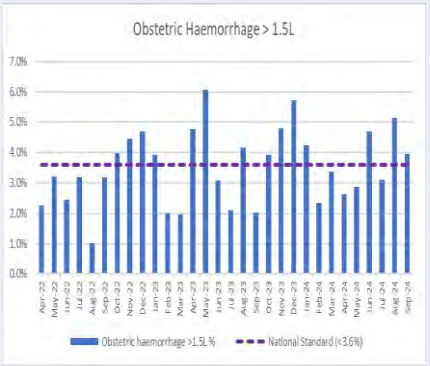
CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

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

Exception report based on highlighted fields in monthly scorecard using Sept 2024 data (Slide 2)

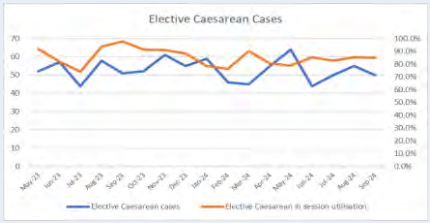
Massive Obstetric Haemorrhage (Sept 3.9%)

- MOH surveillance continues, reviewed through MDT meeting- no themes, trends or immediate action needed.

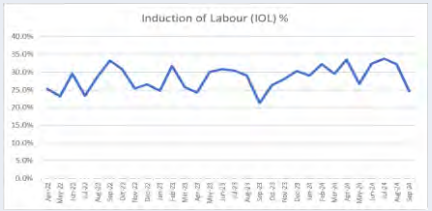


Elective Care

Elective Caesarean (EL LSCS)



IOL



Midwifery & Obstetric Workforce

Current vacancy rate

- Midwifery/support worker vacancy 7.3%
- Mandatory Compliance 92.4%
- Sickness rate overall 7.0%
- Parenting leave unavailability 6.5%
- No obstetric vacancy

FFT response rate

- Poor response rate continues across service, collaboration with MNVP to understand why and action plan to address to be created from November 2024

Staffing red flags

- 12 staff related incidents reported in the month: 2 needlestick, 2 poor staffing/no breaks, 2 suspension of services, 2 staff behaviour

Suspension of Maternity Services

Home Birth Service

- Emerging risk to service due to expected parenting leave and resignations - divisional review underway

Saving Babies Lives

Saving Babies Lives Care Bundle Version 3

	LMNS validated % of interventions fully implemented	
All elements	87	✓
Element 1 - Smoking	80	✓
Element 2 - Fetal Growth Restriction	95	✓
Element 3 - Reducted fetal movements	50	✓
Element 4 - Fetal monitoring	100	✓
Element 5 - Preterm birth	85	✓
Element 6 - Diabetes	83	✓
Overall implementation level	Partially implemented - CNST (yr 5) met	

Stillbirth rate (4.4 /1000 births YTD)

- PMRT – no reportable cases for September.

PET – 4 complaints

- Increase in concerns/complaints received in September – however care was provided May-Aug.
- Awaiting launch of new process/response templates from PET

Maternity Assurance

NHSR	National Reporting
• Year 6 MIS now live • Initial risk - no mitigations • Fortnightly task and finish group progressing	• Ockenden - Initial 7 IEA- 100% compliant • 3 yr delivery plan – system plan in development • CQC Plan – actions embedded; Peer Review action plan underway

Incidents reported Sept 2024; 115 (115 no/low harm, 0 moderate or above*)

MDT reviews	Comments
Triggers x 12	No themes identified

*0 Incidents reported as 'moderate or above' from the cases reviewed. Cases awaiting review at time of writing report.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Maternal Perinatal Quality Surveillance Scorecard

Quality Metric	Standard	Running Total/ average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			56%	56%	55%	55%	51%	53%	47%	56%	49%	49%	48%	48%	46%	48%	46%	
3rd/4th degree tear overall rate	<3.5%	3.50%	4.60%	4.50%	3.50%	3.90%	5.20%	2.40%	3.00%	5.00%	2.10%	6.00%	4.50%	3.00%	2.80%	4.70%	3.90%	
3rd/4th degree tear overall number		79	8	6	6	7	9	4	5	8	3	11	8	4	4	7	6	
Obstetric haemorrhage >1.5L number		127	6	11	6	11	15	17	13	6	9	9	9	11	9	15	12	
Obstetric haemorrhage >1.5L rate	<3.5%	3.50%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	2.90%	4.70%	3.10%	5.10%	3.90%	
Term admissions to NICU	<6%	3.10%	5.40%	3.40%	3.40%	3.70%	3.00%	3.10%	3.00%	2.80%	3.80%	2.60%	4.00%	2.90%	4.70%	4.00%	3.90%	
Stillbirth number		10	0	1	0	0	0	2	1	2	1	0	1	1	0	2	2	
Stillbirth rate	<4.4/1000				1.700			2.300			3.100			2.300			4.400	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:22	1:22	1:23	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:23	1:23	1:24	
Number of compliments (PET)		38	2	3	3	4	4	3	2	3	4	5	4	1	2	2	1	
Number of concerns (PET)		9	1	1	1	2	0	1	1	1	1	0	0	4	1	0	4	
Complaints		6	0	1	1	1	0	0	1	0	0	1	1	0	1	1	0	
FFT recommendation rate	>93%		89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	91%	91%	88%	89%	84%	

External Reporting	Standard	Running Total/ average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Trend
Maternity incidents no harm/low harm		1339	86	85	107	130	158	94	148	102	102	95	130	102	125	169	115	
Maternity incidents moderate harm & above		10	0	1	3	2	2	1	1	0	0	0	0	0	2	1	0	
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	0	1	1	0	0	
Progress in Achievement of MIS YEAR 6	<4 <7 7 & above																	
Findings of review of all perinatal deaths using the real time	Mar-24	PMRT case are within reporting timeframes inline with MIS, deadline met. Risk to MIS Year 6 mitigated with system plan.																
Findings of review all cases eligible for referral to MNSI	Mar-24	PMRT case are within reporting timeframes inline with MIS, deadline met. Risk to MIS Year 6 mitigated with system plan.																
Service user voice feedback	Mar-24	New MVP roles started, Tara and Emma to support 15 steps work.																
Staff feedback from frontline champions and walk-abouts	Mar-24	Multiple discussion following Coronal case, actions taken by team as detailed in MNSC paper																

CQC RATINGS (date of inspection 22 November 2022)	OVERALL: GOOD	WELL-LED good	RESPONSIVE good	SAFE requires improvement	CARING good	EFFECTIVE good

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet

Subject:	Occupational Health Staff Flu and COVID-19 Vaccination Campaign Plan 2024/25 Season	**Date:**	7 November 2024
Prepared By:	Victoria Kirkbride – Deputy Head of Occupational Head/Deputy Lead Nurse / Adam Grundy – Head of Occupational Health and Wellbeing/Lead Nurse		
Approved By:	Deborah Kearsley – Deputy Director of People		
Presented By:	Robert Simcox – Director of People		

Purpose

To provide an update and assurance on the SFH Staff Flu Vaccination Campaign plan for 2024/25 season and the agreed plans to provide access to a COVID-19 vaccine on site for staff.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	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	**X**
PR4	Insufficient financial resources available to support the delivery of services	
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

HCW – Healthcare Worker
CQUIN – Commissioning for Quality and Innovation
aQIV – Adjuvanted Quadrivalent Influenza Vaccine
QIVc – Cell Based Quadrivalent Influenza Vaccine
OH – Occupational Health
SFH – Sherwood Forest Hospitals
ICS – Integrated Care System

Executive Summary

This report sets out the plan agreed by the Sherwood Forest Hospitals NHS Foundation Trust Staff Flu Vaccination Group.

The report acknowledges the importance of the flu vaccination campaign and notes the uptake form 2023/24. The report notes that although there is no recognised CQUIN target for flu this cycle the group have agreed an internal target of 75% frontline staff uptake.

There is detailed information on the vaccines chosen this year with the main vaccine being egg free and available for colleagues aged 18 – 64. A vaccine will be available from Occupational Health specifically for staff aged 65+.

The approach for this year is set out in the report acknowledging that a more traditional approach will be taken with pop up 'grab a jab' clinics being run as well as roaming occupational health clinics and support from peer vaccinators. The campaign will also aim to target high traffic areas as well as opportunistic events such as mandatory training.

Monthly prize draws will be included in the incentive package as well as incentives for peer vaccinators.

The end of the report contains the National assurance checklist.

Vaccine uptake progress to date (24th October 2024)

The following gives an overview of the uptake so far at SFH:

Total vaccines given to SFH staff (All): **2276**

Total vaccines given to SFH frontline staff: **1656**

Uptake by profession:

Staff Group	Count	Vaccinated	Uptake %
Doctors	782	239	30.6%
Qualified Nurse	1798	577	32.1%
Other Professional Qualified Clinical staff	604	215	35.6%
Support to clinical staff	1578	625	39.6%
Total front line staff uptake	**4762**	**1656**	**34.8%**
Non front line staff	1442	620	43.0%
Total Staff	**6204**	**2276**	**36.7%**

Uptake by division:

Rank	Divisional	Numbers	Uptake %
1	Corporate	256	40.1%
2	CSTO	372	30.7%
3	Medicine	378	28.3%
4	Surgery	333	26.3%
5	Urgent & Emergency Care	175	26.1%
6	Women & Children's	138	22.5%

In addition to the plans relating to staff flu vaccination the paper goes on to outline the agreed plan for providing SFH staff with access to a COIVD-19 vaccine on site.

The focus of this is the arrangement for a mobile vaccine unit to come to Sherwood Forest Hospitals NHS Foundation Trust sites (Kings Mill and Newark Hospitals) to provide on site access

for staff.

A robust communications programme will also be released to ensure staff are aware of the national booking system to make arrangements for a COVID-19 vaccine and to make them aware of the other locations in the County where they can access a COVID-19 vaccine.

In addition to this the demand for COVID-19 vaccine amongst staff will be monitored and should demand exceed what we expect at this point conversations will be revisited to explore community pharmacy holding pop up clinics at SFH to deliver COVID-19 vaccine to staff.

Recommendation

Trust Board are asked to take assurance from the paper in relation to the Trust's approach to the annual people vaccination programme for flu and COVID-19.

Staff Influenza Vaccination Programme at Sherwood Forest Hospitals 2024-25

2024/25 season Healthcare worker (HCW) flu vaccination approach with completed best practice management checklist – for public assurance via Trust boards by November 2024.

Introduction

The annual flu campaign is firmly embedded within the culture of the Trust, with a track record of front-line staff uptake that is consistently well above the national average year on year.

The 2023/24 HCW flu vaccination campaign resulted in a 58.9% front line staff uptake – although a lower uptake than historically for the Trust this was still significantly higher than the national average (42.8%) and locally in when compared to other Nottinghamshire NHS Trusts.

The is no CQUIN target for 2024/25. We have agreed on an internal target of 75% of front-line staff uptake. However, we want every single member of staff to be offered the opportunity to be vaccinated against flu.

The potential for significant co-circulation of flu and other respiratory viruses could substantially affect the pressure on the NHS from winter 2024 to 2025.

This means that the 2024/25 HCW flu vaccination programme remains a very important priority this year to reduce morbidity and mortality associated with influenza, and to reduce hospitalisations during a time when the NHS and social care may also be managing winter viral infection outbreaks.

Vaccine

6000 cell-based egg free vaccines (Quadrivalent Inactivated Seasonal Influenza Vaccine (QIVc)) have been ordered as well as 300 vaccines that will be available for over 65s (Adjuvanted Quadrivalent Influenza Vaccine (aQIV)). Both vaccines are manufactured by Seqirus and will not have traditional brand names but be known as described above.

The flu vaccine was delivered on Wednesday 11th September 2024. Clinics officially commenced on 16th September 2024 however vaccines began to be administered opportunistically from Thursday 12th September 2024.

QIVc egg free vaccine will be available for Peer Vaccinators to use however the vaccine intended for 65 years and over (aQIV) will only be available from the Occupational Health Team. The aQIV vaccine is not egg free.

Approach for 2024/25 season.

The approach will be based on previous seasons as this has historically proved very successful.

- Annual flu vaccination programme will be led by OH.
- The organisation and co-ordination of the campaign will be achieved via a Trust HCW flu vaccination group chaired by the Deputy Head of OH
- The campaign will be supported by a strong and innovative Communication strategy which includes using Trust staff in publicity material.

- Trained teams of peer vaccinators spread throughout the Trust will proactively vaccinate colleagues.

- OH will aim to provide a large number of the very successful drop in 'grab a jab' pop up flu clinics.
    - Grab a jab clinics will be held in high traffic staff areas.
    - OH and peer vaccinators will attend opportunistic events throughout the season to offer vaccination (e.g.at mandatory update training for front line staff)
    - Any staff member who attends OH for any reason during the flu season will be offered a flu vaccine.

- The following incentives will be offered:

    - Every staff member who has the jab before Christmas will be entered into a monthly prize draw to win a prize (donated by Unison Dukeries Branch).
    - Ward/peer vaccinators are also incentivised – when they have vaccinated 50 colleagues a £20 high street voucher can be claimed.

Weekly uptake rates will be communicated to the Trust, starting from the 2nd week of October 2024.

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Staff COVID-19 Vaccination Programme at Sherwood Forest Hospitals 2024-25

Introduction

Vaccination is a high priority action for the NHS, to protect our people from serious illness and to support NHS resilience.

In August 2024, the Joint Committee on Vaccination and Immunisation (JCVI) advised that health and social care service providers may wish to consider whether vaccination provided as an occupational health programme to frontline health and social care workers is appropriate in future years; and that ahead of such considerations, health departments may choose to continue to extend an offer of vaccination to frontline health and social care workers and staff working in care homes for older adults in autumn 2024.

Previous COVID-19 vaccination programmes have been facilitated via the vaccination hub which was on the King's Mill Hospital site. This facility closed in the spring of 2024.

As outlined notification for the COVID-19 vaccination was not received until 21 August 2024. Acknowledging the financial and logistical challenges to offering the vaccine in house through the existing Occupational Health Service it was agreed that where staff would like to access the vaccine SFH will work with partners at the ICS to provide opportunities to access the vaccine on site. The Trust will also ensure a robust Communications approach to sign posting staff to the available options.

Mobile Vaccination Unit

Discussion have taken place with the ICS around the opportunity for SFH to host a mobile vaccine unit at Kings Mill and Newark Hospitals. The mobile vaccine unit is commissioned by the ICS to support the increasing of vaccine uptake across Nottingham and Nottinghamshire to all eligible individuals.

The mobile vaccine unit carries a range of vaccine including COVID-19 vaccine. The ICS has agreed the following dates for a mobile vaccine unit to attend SFH sites and as part of this any SFH staff who would like to be vaccinated against COVID-19 can do so:

- **Friday 8/11 Newark Hospital**
- **Monday 11/11/Kings Mill Hospital**
- **Thursday 21/11 Kings Mill Hospital**
- **Monday 25/11 Kings Mill Hospital**
- **Friday 6/12 Kings Mill Hospital**
- **Monday 9/12 Newark Hospital**
- **Tuesday 10/12 Kings Mill Hospital**
- **Thursday 19/12 Kings Mill Hospital**

The vaccine unit will be positioned at the front of the Kings Mill Hospital site, in easy reach of the main entrance and bus stops to ensure both staff and the public can find the unit and access it with eases. At Newark Hospital the unit will be positioned in the main front car park again within easy reach of the main entrance and bus stops on the main road.

National Booking Offer

Along side providing access on site to the COVID-19 vaccine the Trust will also ensure, through a robust Communications campaign, that staff are aware of how to access the COVID-19 vaccine through the National Booking Offer. This may prove to be more convenient for some colleagues.

The Trust have also requested details from the ICS about other locations for the Mobile Vaccine Unit across the county to again provide as much information as possible to staff wishing to access the COVID-19 vaccine.

Ongoing discussions

In addition to the above the possibility of engaging a local community pharmacy to run COVID-19 vaccine clinics at KMH has been discussed. At the time of writing there is some reluctance from the community pharmacy group around this as they feel these clinics would not be well attended. It has been agreed at this point to push the mobile vaccine unit and wider community offer to staff at SFH. Uptake through the onsite offers will be monitored and should demand exceed initial expectations the idea to engage community pharmacy on site will be revisited.

Recommendation

Trust Board are asked to take assurance from the paper in relation to the Trust's approach to the annual people vaccination programme for flu and COVID-19.

Appendix 1 – Healthcare worker flu vaccination best practice management checklist – for public assurance via Trust boards by November 2024

A	**Committed leadership**	**Trust self-assessment**
A1	Board record commitment to achieving the ambition of vaccinating all front-line healthcare workers	Yes – planned commitment to be recorded at Trust Management team meeting
A2	Trust has ordered and provided the quadrivalent (QIV) flu vaccine for healthcare workers	Yes – 6000 cell-based QIV and 300 adjuvanted QIV vaccines ordered. Planned delivery W/C 16 September 2024.
A3	Board receives an evaluation of the flu programme 2023/24, including data, successes, challenges and lessons learnt	Yes – summary of last year's flu programme presented to Board
A4	Agree on a board champion for flu campaign	Yes – Chief Nurse
A5	All board members receive flu vaccination and publicise this	Yes – to take place at October Trust Board meeting (3rd October 2024)
A6	Flu team formed with representatives from all directorates, staff groups and trade union representatives	Yes – long established group reconvened with trade union representation
A7	Flu team to meet regularly from September 2024	Yes – group will meet regularly from August 2024
B	**Communication plan**	
B1	Rationale for the flu vaccination programme and facts to be published – sponsored by senior clinical leaders and trades unions	Yes – Comms strategy in place to commence mid - September
B2	Drop-in clinics and mobile vaccination schedule to be published electronically, on social media and on paper.	Yes – OH availability given to Comms for publication via social media and dedicated Intranet page
B3	Board and senior managers having their vaccinations to be publicised	Yes – To be arranged for next available board meeting
B4	Flu vaccination programme and access to vaccination on induction programmes	Yes – all front-line staff throughout flu season are offered flu vaccination at induction
B5	Programme to be publicised on screensavers, posters, and social media.	Yes – Comms strategy in place to commence mid - September
B6	Weekly feedback on percentage uptake for directorates, teams, and professional groups	Yes – uptake percentages to be communicated from mid-October

C	**Flexible accessibility**	
C1	Peer vaccinators, ideally at least one in each clinical area to be identified, trained, released to vaccinate, and empowered.	Yes – established peer vaccinator model in place and will be mobilised again this year.
C2	Schedule for easy access drop-in clinics agreed.	Yes – drop-in clinics will be co-ordinated across the Trust in a number of accessible areas.
C3	Schedule for 24-hour mobile vaccinations to be agreed.	Yes – peer vaccinators often work a range of hours across the shift spectrum which will increase availability.
D	**Incentives**	
D1	Board to agree on incentives and how to publicise this	Yes – Incentives agreed and publicised as part of communication plan
D2	Success to be celebrated weekly	Yes - Weekly uptake will be celebrated through CEO blog and staff bulletin along with monthly prize draw winner communications

POLICY

Reference	Business Continuity Policy (BCP0519)		
Approving Body	Board of Directors		
Date Approved	November 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	July 2024		
Version	Version 8		
Summary of Changes from Previous Version	Updating to incorporate consultation document, and inclusion of Business Continuity Plan checklist		
Supersedes	Version 6		
Document Category	Business Continuity		
Consultation Undertaken	NHS Midlands Region Nottingham and Nottinghamshire Integrated Care System Resilience Assurance Committee		
Date of Completion of Equality Impact Assessment	25th June 2024		
Date of Environmental Impact Assessment (if applicable)	25th June 2024		
Legal and/or Accreditation Implications	Civil Contingencies Act 2004 Health and Social Care Act 2012 NHS EPRR Core Standards NHSE EPRR Framework		
Target Audience	All service leads, Business Support Managers, Resilience Assurance Committee, EPRR leads		
Review Date	June 2025		
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

APPENDICES

CONSULTATION

The plan has been circulated internally to all divisional, department and corporate leads at all three Trust hospital sites.

The following Collaborative Planning Form outlines the external organisations with whom the plan has been shared and any comments received.

Collaborative Planning Form

Purpose: To evidence that plans and arrangements have been developed in collaboration with relevant stakeholders, including, where appropriate, emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.

Title of policy/plan: Business Continuity Policy

Date of review: June 2024

Issued for collaboration (date): 5th July 2024

Partners consulted:

Organisation	Consulted Yes/No	Comments Received Yes/No	Comments included in policy/plan Y/N Including detail
NHSE Region	Y	Y	
Notts ICB	Y	Y	
NUH	Y		
EMAS	Y		
Bassetlaw	Y		
Notts Healthcare	Y		
NEMS	Y		
Notts CityCare	Y		
Police	N		
Fire Service	N		

Date of next review: June 2025

1.0 INTRODUCTION

1.1 Sherwood Forest Hospitals NHS Foundation Trust (SFH) 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. SFH is an Acute Trust which operates from three sites:

- King's Mill Hospital in Sutton-in-Ashfield
- Newark General Hospital and Urgent Treatment Centre
- Mansfield Community Hospital

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. As part of the Trust commitment to align its BCMS with recognised standards it will adopt the NHS England Business Continuity Toolkit, which aligns with the ISO22301 standard.

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. Plans will need to be exercised and reviewed regularly.

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:

- A continued process of Risk Assessment based on knowledge of the organisation and the likely threats to it.
- An assessment of the impact those risks would have should they materialise, including longer term risks, such as climate change.
- 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.
- Regular independent audit of the BCMS, with follow up report to the Board.

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**
- **SFH Business Continuity Management Framework**

2.0 POLICY STATEMENT

2.1 The Trust is committed to 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 the 1st July 2024 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, as listed in section 1.1

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.

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

3.8 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. Funding for the EPRR/BCMS resources is provided within the overall budget of the Chief Operating Officer (AEO).

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;

- Recommend the Business Continuity Policy, for approval by the Board.
- Ensure that the Business Continuity Management System is appropriately resourced, managed and embedded within the culture of the organisation.
- Receive a regular update reports from the Resilience Assurance Committee 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, Directors 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.
- Annually produce and agree with the Resilience Assurance Committee a work plan for the updating, testing and review of Business Continuity plans.
- Update RAC regularly in respect of the plan review process and any risks/escalations.

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. The training schedule will be included in the Annual Workplan and regularly reviewed by the Resilience Assurance Committee. All training is captured and recorded on the Trust electronic training records log.
- 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.

6.7 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.

6.8 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.

6.8.1 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 approved at the following:

Group	Date
Resilience Assurance Committee	25th July 2024
Risk Committee	13th August 2023
Public Board	November 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 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.)

Such threats should be captured on the relevant divisional or corporate risk register.

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

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 **Appendices 3 & 4** (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 will 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 7**. 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
e) in order to capture learning

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) A Business Impact Analysis has been carried out using the required Trust template (Appendix 3).
3) A Risk Assessment has been completed with clear mitigations outlined (see Appendix 4). Risk scores should aim to comply with the Trust target risk scores, as follows:

Risk Type	Risk Appetite	Target Risk
Patient Harm	Minimal	Low
Public Harm	Minimal	Low
Staff Harm	Minimal	Low
Services	Cautious	Medium
Reputation/Regulatory Action	Cautious	Medium
Finances	Cautious	Medium

4) Workable, easy to use Action Cards have been developed.as per Appendix 6.
5) Properly structured BC Plans have been produced, in line with the BC Toolkit and which align to ISO22301(see Appendix 7)
6) 20% of the plans been tested annually.
7) 95% of the plans are up to date at any time of review.
8) 100% of the plans have been written by a staff member trained on producing BC Plans.
9) The Trust will aim for an overall target 90% compliance rate for all areas in all of the foregoing points.
10) This will be regularly subject to independent audit, minimally every three years.

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 BCMS	Author, Ward / Service, Dept Managers, EPO, Resilience Assurance Committee	Annual review and report to Risk Committee followed independent formal audit every 3 years	Review annually and audit every three years	Author, Resilience Assurance Committee, Risk Committee 360 Assurance
Compliance with the KPI's	Author, Ward / Service, Dept Managers, EPO, Resilience Assurance Committee	Monthly RAC meetings update. Regular update reports into Risk Committee. Annual EPRR Core Standards Self-Assessment	6-monthly and annually	EPO RAC Risk Committee External Partners (ICB/NHSE) 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. Reports every six months to NHSE.	Six monthly, 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. Training will be recorded on the Trust electronic register.

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

10.3 Following approval, the Emergency Planning Team will make this Policy 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

- Civil Contingencies Act 2004
- NHS Act
- Health and Care Act 2022
- NHS EPRR Framework (Guidance)
- ISO 22301

Related SFHFT Documents:
SFH – Incident Response Plan
SFH – Corporate Risk Register
Risk Management and Assurance Policy
Emergency Planning Policy
BCMS Framework Document

12.0 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
13.7 APPENDIX SEVEN - BC PLAN CHECKLIST

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: 24th June 2024			
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:
24th June 2024

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

1. Service Details Purpose: to gather basic details about your service

Directorate		Service Manager	Claire Haywood
Service/ Team/ Function		Manager responsible for BC	
Does service support MI response		Contact Information	

2. Impact Assessment

Purpose: to assess how quickly an incident disrupting your service would damage the hospital and your Service.

Nursing Team Shortages (-50%)

4 hrs	1
8 hrs	1

Impact Guide	
1	Insignificant cost increase/schedule slippage, unsatisfactory patient experience not directly related to patient care, locally resolved complaint, short term low staffing level, temporarily reduces service quality (< 1 day), Small loss <£1,000, Minor non-compliance with standards, Rumours
2	<5% over budget/schedule slippage, Minor injury or illness requiring first aid treatment, Increase in length of stay 1-3 days, unsatisfactory patient experience, Justified complaint peripheral to clinical care, reduces service quality, Loss <£5,000, Non–compliance with standards, Local Media interest. Minor effect on staff morale
3	5-10% over budget/schedule slippage, Mismanagement of patient care, short term effects, in crease in length of stay (< than a week), Justified complaint involving lack of appropriate care, Loss < £100,000, Local Media – long term. Significant effect on staff morale

24 hrs	2
48 hours +	3
Your Service Priority is	Low
Your Recovery Time Objective is	24 hours

4	10-25% over budget/schedule slippage, Serious mismanagement of patient care, long term effects, in crease in length of stay (> than a week), Justified multiple complaints, Loss < £500,000, Enforcement action, Low rating, Non-compliance with core standards, National Media < 3 days
5	25% over budget/schedule slippage, Death or permanent incapacity, Totally unsatisfactory patient outcome or experience, Multiple claims or single major claim, Loss > £500,000, Prosecution, Zero rating, Severely Critical Report, National Media > 3 days. MP concern (Question in House)

3. Resources Purpose: to determine what your service needs to recover after an incident

Function	Resources					Dependents/Notes/Critical Periods
	Inputs from	Outputs to	Support Services	Management Services	IT Systems	

Staff Breakdown					
Role/Type	Usual Number		Specific Requirements of role		

Key Partners and Contractors				
Organisation Name	Impact of Failure	Time Needed	BCP Seen	Test Evidence

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)

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.

13.7 Appendix 7:- Business Continuity Plan Checklist

Cover Document

- Name of Trust
- Name of Document and Logo.

Plan Administration and Maintenance

- Version control and distribution list
- Security classification
- Document author and business continuity accountable officer
- Review date and schedule
- Exercising and testing schedule
- Plan approval and distribution information
- Planned review of BC Plan should documented for audit and assurance purposes.

Introduction

- Aim of the plan
- Objectives of the plan
- Scope of the plan
- List of legal and regulatory requirements for BC as well as associated guidance
- Key plans linked to the business continuity plan

Roles and Responsibilities within the Plan

- Identification of key roles and responsibilities within the plan (include who has authority to invoke the procedures)
- Individual responsibilities and authorities of team members.
- Prompts for immediate action any specific decisions the team may need to make e.g. activating an alternative site.

Business Impact Analysis and Risk Assessment Outputs

- BC risk assessment and treatment
- Prioritised activities including Recovery Time Objective (RTO) / Maximum Tolerable Period of Disruption (MTPoD)
- Resource requirements for priority services
  - People
  - Premises
  - Technology
  - Information
  - Supplies

Plan Activation

- What are the triggers for activation/standby with appropriate incident response levels
- Activation procedures including implementation procedures i.e. invocation of continuity solutions and team mobilisation structures.
- Escalation procedures
- Stand down procedures
- There should be a relationship between business continuity plans and the organisations incident plans. This is because if a business continuity incident occurred that lead to a critical incident there would only be one level of command and control.

Incident Response

- Incident response procedures/command and control
- Incident response structure (incident response teams and single points of contact)
- A relationship between both the BC plan and incident response plan should be considered e.g. if a BC incident occurred that leads to a critical incident there would only be one level of command and control.
- Action Cards (may be in an annex of the plan)
- Incident Coordination Centre facilities (primary and backup)
- Logging of decision making
- Decision support checklists

Recovery

- BC and recovery strategies
- Debrief/post incident reports/action plans

Communications

- Internal and external comms procedures
- Procedures for warning and informing public
- Info sharing procedures aligned to IG standards
- Media management

Annexes

- Reference to Business Impact Analysis
- Contact directory (Internal and External)
- Internal and external interdependencies
- Reporting tools (e.g. sitrep template)
- Template meeting agenda/s
- Action cards
- Any mutual aid agreement

Emergency Planning Policy

POLICY

Reference	MS/009/2024
Approving Body	Resilience Assurance Committee
Date Approved	25th July 2024
Issue Date	1st August 2024
Version	MS/009/03-24
Summary of Changes from Previous Version	Numerous changes to capture suggestions made in the EPRR Core Standards evidence gathering process
Supersedes	MS/008/02-23
Document Category	Emergency Planning
Consultation Undertaken	Resilience Assurance Committee
Date of Completion of Equality Impact Assessment	June 2024
Date of Environmental Impact Assessment (if applicable)	June 2024
Legal and/or Accreditation Implications	Civil Contingencies Act 2004 NHS England EPRR Framework Guidance 2022 Health and Care Act 2022
Target Audience	Incident Command Teams (Gold, Silver & Bronze) Communications Team Local Partner Agencies
Review Date	1st June 2025
Sponsor (Position)	Chief Operating Officer
Author (Position)	Mark Stone – Emergency Planning Officer
Lead Division/ Directorate	Corporate
Lead Specialty/ Service/ Department	Emergency Planning
Position of Person able to provide Further Guidance/Information	Emergency Planning Officer

Associated Documents/ Information	**Date Associated Documents/ Information was reviewed**
None	

CONTENTS

APPENDICES

Version Control

Name of Document	Updated Version	Amendment Made	Made/ Approved By	Notes
Emergency Planning Policy	MS/009/03-24	**See record of amendments**	**RAC – 25th July 2024**	

Record of Amendments

Page 1 – Updated version control & review dates.
Page 4 – Section 1.0 add “or serious Trust-wide Business Continuity Incident. This could be a sudden onset, rising tide, cloud on the horizon type incident, or even a Chemical, Biological, Radiological or Nuclear (CBRN) or HAZMAT (Hazardous Material) incident”, to paragraph 5.
Page 5 - Section 2.0 change second paragraph to “In order to deliver this, the Board is committed to maintaining a dedicated EPRR asset within the organisation, which it will review on a regular basis, and for which it will provide adequate funding and resources to ensure it is able to discharge its responsibilities and to ensure it has both the required competencies and capacity. Funding for the Emergency Planning workstream will sit within the domain of the Chief Operating Officer’s overall budget”.
Page 6 – Section 4.2 – change to: “The Chief Operating Officer is nominated by the CE to act as the Accountable Emergency Officer as required by the NHS Act”.
Page 10 – Section 6.2 – add Business Continuity and Critical Incident definitions.
Page 15 – section 7.0 – amend “three yearly” to “annually” in all relevant areas

CONSULTATION

The plan has been circulated internally to all divisional, department and corporate leads at all three Trust hospital sites.

The following Collaborative Planning Form outlines the external organisations with whom the plan has been shared and any comments received.

Collaborative Planning Form

Purpose: To evidence that 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.

Title of policy/plan: Emergency Planning Policy

Date of review: June 2024

Issued for collaboration (date): 5th July 2024

Organisation	Consulted Yes/No	Comments Received Yes/No	Comments included in policy/plan Y/N Including detail
NHSE Region	Y	Y	Numerous comments adopted throughout
Notts ICB	Y	N	
NUH	Y		
EMAS	Y		
Bassetlaw	Y		
Notts Healthcare	Y		
NEMS	Y		
Notts CityCare	Y		
Police	N		
Fire Service	N		

Date of next review: June 2025

1.0 INTRODUCTION

The Civil Contingencies Act 2004 (CCA) places a number of statutory duties on NHS organisations which are classed as either Category 1 or Category 2 Responders.

As a Category 1 Responder, Sherwood Forest Hospital NHS Foundation Trust (SFHFT) is required to prepare for emergencies in line with its responsibilities under the CCA.

Other requirements are captured in the CQC Outcome 6(D) and HIS Operating Framework, as well as the NHS Standard Contract (section 30) which stipulates all staff will comply included in NHS Core Standards for EPRR and the associated NHS EPPR Framework.

This Policy outlines how SFHFT will meet the duties set out in legislation and associated guidelines, as well as any other issues identified by way of risk assessments and identified capabilities.

This Policy is not intended to be used for the response to a Major Incident in those circumstances staff should refer to the Trusts' **Incident Response Plan** which details the Trusts operational response to a Major, Critical or serious Trust-wide Business Continuity Incident. This could be a sudden onset, rising tide, cloud on the horizon type incident, or even a Chemical, Biological, Radiological or Nuclear (CBRN) or HAZMAT (Hazardous Material) incident.

The policy should be read in conjunction with the Trusts' Business Continuity Policy and Incident Response Plan.

2.0 POLICY STATEMENT

The primary purpose of this policy is to optimise the safety of SFH patients, its staff and visitors to its premises, as a result of a serious incident.

SFHFT has a responsibility to ensure that it is capable of managing risks at corporate and service level and responding to Critical or Major Incidents of any scale in a way that delivers optimum care and assistance to the victims, that minimises the consequential disruption to healthcare services and that it brings about a speedy return to normal levels of functioning.

Aligning with the Trust strategic objectives:

To continuously learn and improve, and

To work collaboratively with partners in the community,

SFHFT will meet this responsibility through:

- Building upon the existing strengths of current multi-agency and Health Trusts co-ordination and co-operation in Emergency Planning, Resilience and Response.

- Fully integrating with partner agencies' emergency arrangements, in particular providing Mutual Aid in supporting Nottinghamshire Integrated Care System and other Acute Trusts with receiving Emergency Departments and other local NHS Providers (MOU).

- Reviewing the Trusts state of readiness and operability to deal with a Major, Critical or Business Continuity Incident, with the assistance of new and improved partnerships, to ensure the Trusts capability to handle any new kind and potential magnitude of threat.

- Ensuring that plans for Business Continuity (BC) are in place right across the organisation, with special emphasis on critical functions.

- Engendering a culture within SFHFT to make emergency preparedness, resilience and response an intrinsic element of management and operations.

- Having a process in place for learning from incidents and exercises from both within the Trust and from external agencies.

- Ensuring there is a process in place to monitor the RAC annual workplan with regular update reports provided to the Risk Committee.

- Embedding a culture of continuous improvement in line with recognised business continuity standards.

- Regularly reviewing risks to the organisation and its critical functions, as captured in Principal Risk no.7 on the Board Assurance Framework.

- Working with partners in identifying risks to the community and escalating where appropriate to LHRP/LRF.

- Ensuring that EPRR is adequately resourced and given appropriate access to funding.

In order to deliver this, the Board is committed to maintaining a dedicated EPRR asset within the organisation, which it will review on a regular basis, and for which it will provide adequate funding and resources to ensure it is able to discharge its responsibilities and to ensure it has both the required competencies and capacity. Funding for the Emergency Planning workstream will sit within the domain of the Chief Operating Officer's overall budget.

The policy has also been subject to Equality and Environmental Impact Assessments. No issues were identified as a result of these checks and the policy has been registered having a "Low" impact (see appendices one and two).

3.0 DEFINITIONS/ ABBREVIATIONS

Acronym	Term/Definition
AEO	Accountable Emergency Officer
BCMS	Business Continuity Management System
BCP	Business Continuity Plan
BoD	Board of Directors
RC	Risk Committee
CQC	Care Quality Commission
CBRN	Chemical, Biological, Radiological & Nuclear
CCA	Civil Contingencies Act - 2004
CE	Chief Executive
CRR	Community Risk Register
DH	Department of Health
EPRR	Emergency Preparedness, Resilience and Response
EMAS	East Midlands Ambulance Service
EPO	Emergency Planning Officer
ICB	Integrated Care Board
NHSE	NHS England
LHRP	Local Health Resilience Partnership
LRF	Local Resilience Forum (Nottinghamshire)
MOU	Memorandum of Understanding
NHS	National Health Service
RAC	Resilience Assurance Committee
SFHFT	Sherwood Forest Hospitals NHS Foundation Trust

4.0 ROLES AND RESPONSIBILITIES

The following roles and responsibilities relate to how SFHFT and key individuals will prepare for emergencies.

Emergency response roles and responsibilities are provided in the Trust's generic Incident Response Plan.

4.1 Chief Executive

The Chief Executive (CE) has overall responsibility for emergency planning and is accountable to the Trust's Board of Directors for ensuring systems are in place to facilitate an effective Major Incident response. The CE will:

Ensure that the Chief Operating Officer is nominated as the Accountable Emergency Officer (Executive Lead for Emergency Preparedness).

4.2 Accountable Emergency Officer

The Chief Operating Officer is nominated by the CE to act as the Accountable Emergency Officer as required by the NHS Act.

The Accountable Emergency Officer will:

- Chair the Trust's Resilience Assurance Committee, or delegate to another person of competence, as per its Terms of Reference.
- Work closely with the EPO to implement the Emergency Planning Policy.
- Prepare and submit, with the assistance of the EPO, an annual report to the Trust Board summarising the current state of preparedness.
- Attend meetings of the Local Resilience Forum (LRF) if requested or send a nominated deputy.
- Attend meetings of the Local Health Resilience Partnership (LHRP) as SFH Executive level representative.
- To ensure EPRR training is delivered across the organisation in accordance with the training needs analysis.
- To review the EPRR resource and funding on a regular basis.
- Ensure, with the assistance of the EPO, that an on-call rota is developed and maintained for the provision of Senior Manager availability to respond to incidents at both tactical and strategic levels.
- In conjunction with the Trust's Medical Director, will sign off the mass casualty dispersal figures for SFH as part of the Trusts' response to a regional mass casualty incident.

In his/her absence, the Deputy Chief Operating Officer will assume these responsibilities.

4.3 Emergency Planning Officer

The main duties of the EPO are:

- To ensure the Trust is prepared to respond to incidents and emergencies.
- To advise the Executive Team and/or the Risk Committee of emerging and/or escalating risks and threats, as and when required.
- To provide assurance to the Board about Trust preparedness and the working of the Resilience Assurance Committee, including progress on the RAC Annual Workplan, via a formal Trust Board Report not less than annually.
- To develop tests and exercises of trust-wide and service level plans
- To provide on-going training to all relevant staff.
- To ensure relevant plans, policies and procedures are kept up to date.
- To represent the Trust on external meetings, training and exercises related to emergency preparedness.

- To lead the process of learning from incidents which occur within the Trust and those which occur within partner agencies
- Provide training and expertise in specific risk areas, such as CBRN (Chemical, Biological, Radiological, Nuclear)

4.4 Resilience Assurance Committee (RAC)

The Resilience Assurance Committee is a multi-disciplinary team representing all key areas of the Trust who have responsibility for emergency response, including all divisions, specific clinical areas and other departments. Their role is:

- To develop the organisations statutory responsibility as a Category 1 Responder to plan and respond to a major incident/incidents or emergencies and manage recovery within the context of the Civil Contingencies Act 2004 (CCA) and NHS Guidance through robust planning and associated activities.

- To provide objective assurance to the Executive that systems and processes are in place to ensure emergency preparedness and that any resource implications are identified to enable the Trust to discharge its legal responsibilities.

- To provide a forum for, the exchange of information and discussion and debate concerning strategic, operational, educational, clinical and professional issues relating to emergency preparedness.

4.5 The Risk Committee (RC)

The role of the Risk Committee is to ensure the Trust Board of Directors are kept informed of EPRR matters escalated from the RAC and to provide support in resolving issues. New policies related to Emergency Planning and Business Continuity Management should be approved by the Risk Committee.

The Risk Committee will manage EPRR risks in accordance with the Trust's Risk Management and Assurance Policy.

4.6 Generic Trust Roles and Responsibilities

The following generic roles and responsibilities have been identified within the EPRR guidance.

- To mobilise and direct healthcare resources within the hospital at short notice.
- To sustain patient care in the hospital throughout the duration of a Major or Critical Incident.
- To ensure clinicians, nursing and other staff can respond to an incident.
- To assess the effects of an incident on and consider the needs of vulnerable care groups, such as children, dialysis patients, elderly, medically dependent or physically or mentally disabled.

- Plan to harness and effectively utilise the widest range of resources needed to treat any casualties transported to hospital by EMAS or Self Presenters.
- Have systems and facilities in place to ensure the health safety and welfare of all staff during a Major or Critical Incident.
- Provide suitable and sufficient training arrangements to ensure the competence of staff in performing emergency planning roles.
- In preparing for emergencies, it is essential to develop and embed a culture of resilience within the organisation. As such, emergency preparedness should be a consideration for all of the Trust's staff.
- To ensure that the Trust completes and submits situation reports in line with system requirements and agreed battle rhythm, and that such reports are completed on up to date report templates and signed off by an Executive.

Reporting Templates are appended to this policy:

SBAR = Appendix 3 (for Critical and Business Continuity Incident declarations)
METHANE = Appendix 4 (for Major Incident declarations)

4.7 CBRN Trained Staff

- Will support the Trust response to a CBRN incident
- Ensure their training on CBRN is up to date
- Will be familiar with the Equipment, where it is stored, how to access it and how it is to be used.

4.8 Trust Staff will:

- Ensure that they are familiar with the arrangements detailed in the Trust's Incident Response Plan and related documents.
- Ensure that they are familiar with their roles and responsibilities.
- Undertake training commensurate with their emergency response role.

5.0 APPROVAL

The Policy, which has several amendments resulting from previous feedback from external agencies and in readiness for the NHS Core Standards for EPRR self-assessment review of 2024. These amendments are set out on page 3.

This updated policy was approved at the RAC in July 2024, and will be ratified at Trust Board.

6.0 DOCUMENT REQUIREMENTS

The Trust has statutory duties as a Category 1 responder, under the CCA to assess local risks and put in place emergency plans, co-operating with other local responders to enhance co-ordination and efficiency.

The Trust is also required to have in place contingency plans that allow it to continue to provide services during a Major Incident, so far is practicable and to recover from the additional pressure that an incident would place on the organisation.

6.1 Statutory Duties / Risk Register

The Civil Contingencies Act (2004) delivers a single statutory framework for civil protection in the United Kingdom capable of meeting the challenges of the 21st century.

The Act is separated into two substantive parts:

- Part 1: focuses on local arrangements for civil protection, establishing a statutory framework of roles and responsibilities for local responders.
- Part 2: focuses on emergency powers, establishing a modern framework for the use of special legislative measures that might be necessary to deal with the effects of the most serious emergencies.

The Act defines an Emergency as:

'An event or a situation which threatens serious damage to human welfare in a place in the UK, the environment of a place in the UK, or war, or terrorism which threatens serious damage to the security of the UK'

The definition is concerned with the consequences rather than the course or source.

The Trust manages risks through a process of local risk assessment, and interaction with regional partners regularly reviewing the community and national risk registers, through the Local Health Resilience Partnership and the Health Risk Management Group.

Risks which are identified as prevalent are captured on the Trust's DATIX risk management system.

Principle Risk no.7 on the Board Assurance Framework highlights the risk of a serious untoward incident affecting the Trust, and is regularly reviewed by the Accountable Emergency Officer, Emergency Planning Officer and Risk & Assurance Manager. This review is presented to the Risk Committee each month.

6.2 Definitions:

NHS Major Incident

The Cabinet Office, and the Joint Emergency Services Interoperability Principles (JESIP), define a Major Incident as an event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder agency. In the NHS this will cover any occurrence that presents serious threat to the health of

the community or causes such numbers or types of casualties, as to require special arrangements to be implemented. For the NHS, this will include any event defined as an emergency. A Major Incident may involve a single agency response, although it is more likely to require a multi-agency response, which may be in the form of multiagency support to a lead responder. The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although a Major Incident is unlikely to affect all responders equally. The decision to declare a Major Incident will always be made in a specific local and operational context. There are no precise, universal thresholds or triggers. Where Local Resilience Forums (LRFs) and responders have explored these criteria in the local context and ahead of time, decision makers will be better informed and more confident in making that judgement.

NHS Critical Incident

Any localised incident where the level of disruption results in an organisation temporarily or permanently losing its ability to deliver critical services; or where patients and staff may be at risk of harm. It could also be down to the environment potentially being unsafe, requiring special measures and support from other agencies, to restore normal operating functions. A Critical Incident is principally an internal escalation response to increased system pressures/disruption to services.

NHS Business Continuity Incident

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

An event or occurrence that disrupts, or might disrupt, an organisation's normal service delivery, to below acceptable predefined levels. This would require special arrangements to be put in place until services can return to an acceptable level. Examples include surge in demand requiring temporary re-deployment of resources within the organisation, breakdown of utilities, significant equipment failure or hospital acquired infections. There may also be impacts from wider issues such as supply chain disruption or provider failure.

The Trust has statutory duties as a Category 1 responder, under the CCA to assess local risks and put in place emergency plans, co-operating with other local responders to enhance co-ordination and efficiency.

The Trust is also required to have in place contingency plans that allow it to continue to provide services during a Major Incident, so far is practicable and to recover from the additional pressure that an incident would place on the organisation.

Local Health Resilience Partnerships (LHRPs) with responsibility for EPRR across all relevant health bodies in Nottinghamshire have been established and are the forum for coordination, joint working and planning.

NHS organisations are required to nominate Accountable Emergency Officer (SFHFT – Chief Operating Officer) to assume executive responsibility and leadership at service level for EPRR.

The Act places six statutory obligations on Category 1 Responders:

- Duty to Plan for Emergencies
- Duty to Assess Risk
- Business Continuity Management
- Duty to cooperate
- Duty to share information
- Duty to communicate

6.3 Planning for Emergencies

As a Category 1 Responder, the Trust has a duty to prepare and maintain plans to respond to emergencies.

The Trust will develop, disseminate and maintain an Incident Response Plan detailing how the organisation will respond to an emergency, including:

- Definition of Major Incident and increase in Emergency Department thresholds
- Activation, notification and stand-down procedures
- Roles and responsibilities
- Control and coordination arrangements
- Communication arrangements
- Response activities
- Standard operating procedures
- Recovery arrangements

Where appropriate, the Trust will develop, disseminate and maintain specific emergency plans for identified hazards and threats, e.g. Severe Weather, Infectious Disease, Pandemic or CBRN Plan.

All emergency plans will be validated by tests and exercises conducted where possible within 12 months of the publication of the arrangements.

6.4 Risk Assessment

The Trust has assessed risks contained within the Community Risk Register and Local Health Resilience Partnership (LHRP) risk register and has included the impact of a Major Incident on

the Corporate Risk Register and within the Board Assurance Framework (BAF), under Principal Risk 7.

Where appropriate the Trust will develop specific plans to manage risks with a high likelihood of occurring, or those which would have a serious impact on the delivery of its services.

The process for reporting escalating and managing risks is captured in the Trust Risk Management and Assurance Policy.

6.5 Business Continuity Management System

As a Category 1 responder, the Trust has a duty to develop and maintain arrangements to ensure continuity of service whilst responding to an emergency is it internal or external.

The Trust recognises ISO 22301 as the definitive guidance for Business Continuity Management and is committed to working towards this standard.

In accordance with ISO 22301, the Trust will develop, disseminate and maintain business continuity policies, strategies and plans and work to embed a culture of business continuity management and continuous improvement across the organisation.

Through debriefing both local and regional incidents and planned exercises a formal process of learning will continue to be embedded across the Trust. Lessons will be captured in a post incident/ exercise report by the EPO. The report will contain recommendations for improvement and will be passed for approval to the RAC. Once approved at the RAC, the recommendations will be assigned to the relevant service leads and placed on the RAC Action Tracker, through which they will be monitored up to completion. Should the recommended actions require a sufficient amount of work for individuals or teams over a period of time, it will be placed on the RAC Annual Workplan, through which its updates to RAC can be planned and monitored.

This process demonstrates the Trust commitment to its strategic objective to continuously learn and improve.

All suppliers of essential services and equipment to the Trust must have a BCMS process in place.

The Trust is committed to ensuring the robustness of its supplies of equipment and services. To this end it will endeavour to exclusively utilise suppliers from the NHS Procurement Framework, or indeed NHS Supply Chain itself. This ensures that the companies from whom it procures have robust business continuity processes in place.

6.6 Cooperation

As a Category 1 responder the Trust has a duty to cooperate with other Category 1 and 2 responders within the local area.

The Trust recognises the Nottinghamshire LRF as the principal mechanism for multi-agency cooperation.

As the Trust is a Foundation Trust its contract is with the ICB, but the Trust will endeavour to cooperate with other providers in emergency planning matters.

NHS England coordinates the EPRR across all relevant health bodies in Nottinghamshire. A Local Health Resilience Partnership (LHRPs) has been established and is the forum for coordination, joint working and planning.

6.7 Information Sharing

As a Category 1 Responder, the Trust has a duty to share information requested by other Category 1 Responders.

Information requests between NHS organisations within the East Midlands Health Community will be addressed informally through the Resilience Assurance Committee.

Where informal requests for information cannot be resolved within the business of the RAC, they will be escalated to the Risk Committee and/or be referred to the Accountable Emergency Officer.

Where informal requests for information cannot be resolved within the business of the Risk Committee, a formal request for information will need to be made under the provisions of the CCA using the pro-forma supplied in the statutory guidance document 'CCA Emergency Preparedness'.

Information sharing will be based on the Caldicott Principles:

1. Justify the purpose
2. Use only when necessary
3. Use minimum amount of information required
4. Access based on a strict "need to know" basis
5. Everyone who has access is aware of responsibilities
6. All staff should comply with data protection law
7. Duty to share information is as important as protecting confidentiality
8. Inform patients and service users of how their information is used

6.8 Communication (Warning & Informing)

As a Category 1 responder the Trust has a responsibility for advising the public of risks before an emergency by warning and keeping the public informed in the event of an emergency.

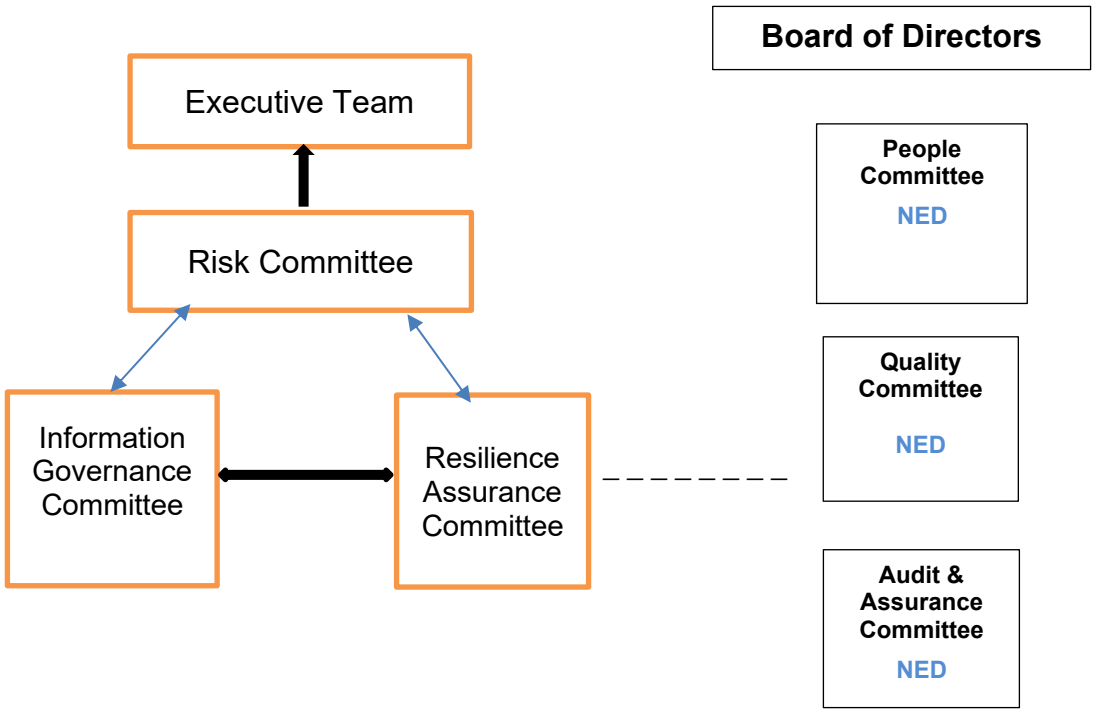
The NHS England acts on behalf of the Trust for communications within the LRF Nottinghamshire Communications Sub group. The Trust along with the ICB will develop, disseminate and maintain arrangements for communicating with the public before and during an emergency. The Trust will work with the ICB and NHS England when developing messages for the public.

These arrangements will be included in the Trust's Incident Response Plan.

6.9 EPRR Structure

Fig 1

SFH – Organisational Structure for EPRR



7.0 MONITORING COMPLIANCE AND EFFECTIVENESS

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, Department Managers, EPO, Resilience Assurance Committee	Formal Review on an annual basis and in line with Trust Risk Assessment and local / national guidance	Annually	Author, Resilience Assurance Committee, Risk committee
Monitoring Incidents and Learning	EPO, Resilience Assurance Committee Risk Committee	Activity within the Incident De-brief process and in line with the Procedure	Annually or after any serious incidents	Emergency Planning Office reporting to the Resilience Assurance committee

Monitoring Compliance:

The Trust's Chief Executive will be responsible for ensuring that the Trust has effective arrangements in place to respond to a major incident or emergency. The Chief Operating Officer has been delegated as the Accountable Emergency Officer

- The monitoring and enforcement of compliance with the duties and statutory provisions of the CCA will be undertaken through mainstream performance monitoring arrangements.
- Within the Trust, the Accountable Emergency Officer will ensure that annual reports are submitted to the board outlining the current state of preparedness.
- Comply with any requests from Internal Audit, ICB or NHS England.
- Comply with any requirements under the CQC's emergency preparedness standard.

8.0 TRAINING AND IMPLEMENTATION

Training:

The Trust will identify individuals by a Training Needs Analysis, staff who have specific responsibilities when responding to an emergency and ensures that they are given adequate and appropriate training, in line with recognised best practise to enable them to discharge their roles.

The Trust recognises the need for collaboration with other Trusts and partner agencies in organising, running and participating in exercises.

The Trust will, in partnership with other organisations within the Local Health Resilience Partnership, support the joint training strategy for the effective delivery of emergency preparedness and response training.

Formal training will take place within the Trust as determined by the Resilience Assurance Committee, which includes input on mandatory training sessions and exercises.

Informal guidance, advice and support can be provided on an 'as and when needed' basis to small groups or on an individual basis to meet identified needs. Please contact the Emergency Planning Officer to arrange.

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

A training needs analysis has identified the following requirement for the Trust Strategic (Gold) commanders:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
SHC01	Strategic Health Commander Portfolio Workbook	Every 3 years			
SHC02	Principles of Health Command – Strategic Health Commander	Every 3 years			
SHC03	Legal Awareness Training	Every 3 years			
SHC04	Defence Contribution to Resilience (or equivalent)	Every 3 years	Optional		
SHC05	MAGIC or Magic-Lite course	Every 3 years	Optional		
SHC06	Media Training/Awareness	Every 3 years			
SHC07	Working with your loggist	Every 3 years			

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
SHC08	Business Continuity Awareness	Every 3 years	AEO only		
SHC09	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually			
SHC10	Local Resilience Forum Awareness	Every 3 years	Optional		
SHC11	Specialist Asset Awareness	Every 3 years	Optional		
SHC12	EPRR Communications Awareness (initially through training and then annually through exercise application)	Annually			
SHC13	Incident Response Plan/ Command & Control familiarisation (inc through exercise application)	Annually			
SHC14	Writing a Strategy (inc. through exercise application)	Annually			
SHC15	Chair a Strategic Level Meeting	Annually			
SHC16	Act as a Strategic Health Commander at an incident or exercise	Annually			
SHC17	Act as a Strategic Health Commander at an Incident or Exercise with Multi-agency Partners	Annually	Optional		
SHC18	Accountable Emergency Officers – Role & Expectations	Every 3 years	AEO only		

Incident commanders are required to maintain a training portfolio as personalised evidence of this training.

The following table describes the training requirements identified in a TNA for all Tactical (Silver) commanders, who should also maintain a personal training portfolio:

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
THC01	Tactical Health Commander Portfolio Workbook	Every 3 years			
THC02	Principles of Health Command – Tactical Health Commander	Every 3 years			
THC03	Legal Awareness Training	Every 3 years	Optional	Optional	
THC04	Working with your loggist	Every 3 years			

Portfolio Reference	Requirements	Frequency	Provider	ICB	Region
THC05	Joint Decision-Making Awareness (initially through training and then annually through exercise application)	Annually			
THC06	Local Resilience Forum Awareness	Every 3 years	Optional		
THC07	Specialist Asset Awareness	Every 3 years	Optional		
THC08	EPRR Communications Awareness (initially through training and then annually through exercise application)	Annually			
THC09	Incident Response Plan/Command & Control familiarisation (inc. through exercise application)	Annually			
THC10	Writing a Tactical Plan (inc. through exercise application)	Annually			
THC11	Chair a Tactical Level Meeting	Annually			
THC12	Act as a Tactical Health Commander at an incident or exercise	Annually			
THC13	Act as a Tactical Health Commander at an Incident or Exercise with Multi-agency Partners	Annually	Optional		

Green boxes indicate mandatory requirement

The TNA also identified a need to train a sufficient cadre of log-keepers in line with national guidance.

Exercises:

In line with the NHS Core Standards for EPRR, the Trust will test its emergency arrangements through:

- Live exercises run at least every three years.
- Table-top exercises run at least every year.
- Communications tests run at least every six months.
- Command post exercises run at least every three years.

9.0 Impact Assessments

- This document has been subject to an Equality Impact Assessment, see completed form at Appendix 1
- This document has been subject to an Environmental Impact Assessment, see completed form at Appendix 2

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

Evidence Base:

Civil Contingencies Act 2004

NHS Act

Health and Care Act 2022

NHS EPRR Framework (Guidance)

Related SFHFT Documents:

- SFH – Incident Response Plan
- SFH – Corporate Risk Register
- Board Assurance Framework
- CBRN Plan
- Pandemic Surge Plan
- Business Continuity Policy

11.0 APPENDICES

Appendix 1	Equality Impact Assessment
Appendix 2	Environmental Impact Assessment
Appendix 3	SBAR Template
Appendix 4	METHANE Template

APPENDIX ONE - EQUALITY IMPACT ASSESSMENT FORM (EQIA)

Name of service/policy/procedure being reviewed: Violence and Aggression			
New or existing service/policy/procedure: Policy			
Date of Assessment: 24th June 2024			
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 for this version, in that all previous principles remain in accordance with previous version (which was subject to consultation) and this version is primarily a reformat and codification of agreed practices. None

What data or information did you use in support of this EqIA?
Trust policy approach to availability of alternative versions.

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 *(Delete as appropriate)*

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

Signature:

Date: 24th June 2024

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

Appendix 3 – SBAR Template

Organisation name			
Site name(s) affected			
Date of report	Dd mmm yyyy	Time of report	24hr
Type of incident declared		Business Continuity/Critical Incident	
Date declared	Dd mmm yyyy	Time declared	24hr
Completed by (name, role)			
Exec Sign off by (name, role)		Executive level director sign off required	
Signature		Please include electronic signature	

Element	Prompts	Description
S	**Situation** Clearly and briefly describe the current situation.	
B	**Background** Provide clear, relevant background information on the incident including: • Timings • Media • Exact situation	
A	**Assessment** State your assessment of the situation based on the situation and background. Include impacts to the hospital and services	
R	**Recommendations** Explain the actions being taken by the organisation to standdown from the incident/situation alongside any support required of partner agencies, ICB or NHS England	

Integrated Care Board only		
Additional system actions/ commentary		
Sign off	(name)	(role)
Signature		

Appendix 4 – METHANE Template

Organisation name			
Site name(s) affected			
Date of report	Dd mmm yyyy	Time of report	24hr
Type of major incident			
Date declared	Dd mmm yyyy	Time declared	24hr
Completed by (name, role)			
Exec Sign off by (name, role)		Executive level director sign off required	
Signature		Please include electronic signature	

M	Major incident	Has a Major Incident been declared? **YES/NO** *(If no, then complete ETHANE message or SBAR)*	
E	Exact Location	What is the exact location or area of incident	
T	Type of Incident	What kind of incident is it?	
H	Hazards	What hazards or potential hazards can be identified?	
A	Access	What are the best routes for access and egress?	
N	Number of casualties	How many casualties are there and what condition are they in?	
E	Emergency Services	Which and how many emergency responder assets/personnel are required or are already on-scene?	

Integrated Care Board only		
Additional system actions/ commentary		
Sign off	(name)	(role)
Signature		

Both SBAR and METHANE Documents are held in the ICC cupboard. They will be completed by an assigned member of the HICT and signed off by the Strategic (Gold) commander. Signed copies will be sent to Notts ICB EPRR team and copies saved and stored by the Emergency Planning Team.

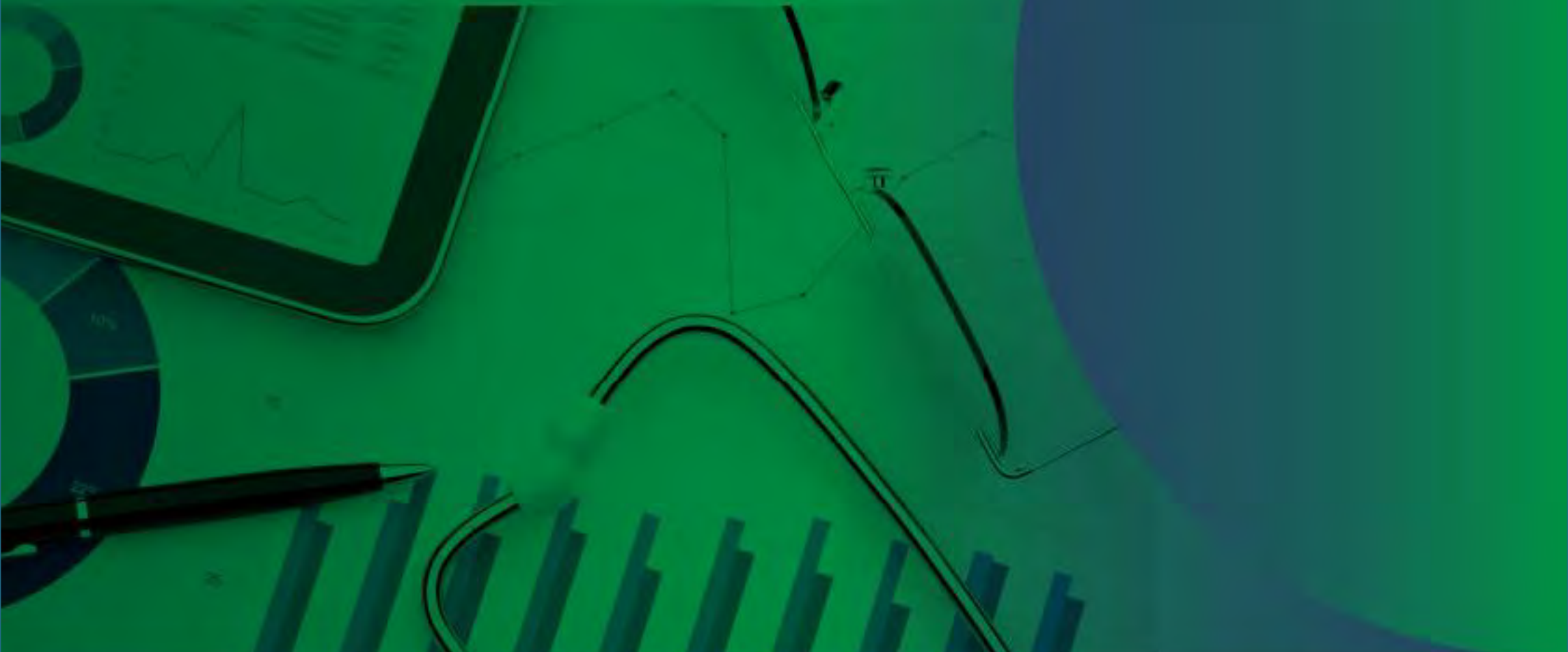
Business continuity

Sherwood Forest Hospitals NHS Foundation Trust

31 October 2024

2425/SFHFT/XX

Final draft report



Contents

Distribution

Name, Job Title	For action	For information
Rachel Eddie, Chief Operating Officer	✓	
Sally Brook Shanahan, Director of Corporate Affairs	✓	
Mark Stone, Emergency Planning Officer	✓	
Donna Bates, Emergency Planning Support Officer	✓	

The report has also been shared with the organisation's standard distribution list for internal audit reports.

Executive summary

Introduction and background

NHS England has developed Core Standards for Emergency Preparedness, Resilience and Response (EPRR). On an annual basis, organisations are required to complete a self-assessment against each of the Standards.

For 2023, the Trust self-assessed at a 'partial compliance' rating overall; it self-assessed as fully complaint against six out of the 10 Standards in the business continuity domain, and partially compliant against the remaining four (Standard 46 – business impact analysis/assessment (BIA), Standard 47 – business continuity plans (BCP), Standard 50 – Business Continuity Management Systems (BCMS) monitoring and evaluation, and Standard 51 – business continuity audit). At the time of our review, the Trust was finalising its EPRR Core Standards submission for 2024, self-assessing as substantial.

In August 2024, NHSE set out its programme of mandated business continuity tests. NHS organisations need to work together to plan, exercise and report on their capabilities within 7 themes, which are to be undertaken in turn on a yearly basis from October 2024. In response to this NHSE programme of mandated business continuity tests, the Trust advised us that these are going to be added to the annual workplan for the Resilience Assurance Committee (RAC).

Our risk assessment process aligns with the ISO 31000 principles and generic guidelines on risk management. The risk matrix we use, along with definitions of different opinion levels, is available on our website. We consider elements of governance, risk management, control and culture in compliance with PSIAS and findings have been categorised in accordance with this.

Audit objective

The overall aim of our review was to provide an independent assurance opinion in respect of the Trust's business continuity arrangements.

Audit opinion

Significant assurance	There is a generally sound framework of governance, risk management and control designed to meet the objectives of the system under review, and controls are generally being applied consistently. Our opinion is limited to the controls examined and samples tested as part of this review.

Summary findings and actions

The Trust has a Business Continuity Policy, Emergency Planning Policy and Business Continuity Management System (BCMS) in place.

Executive summary

Roles and responsibilities of individuals are clearly set out in key documents, and there is a clear governance structure in place supporting business continuity which is operating effectively overall, with reporting via the Resilience Assurance Committee (RAC) which reports upwards to the Risk Committee. This is supplemented by reporting to Board level via the annual EPRR report and Risk Committee quadrant reporting into the Audit and Assurance Committee.

At the time of our review, the Trust is in the process of implementing a new template for its business continuity plans. We have reviewed the template, confirming that it aligns with the NHSE business continuity toolkit. The Trust has provided two early draft BC plans which include a business impact analysis (BIA). We have seen that these align with the new template.

Through discussion with the Trust, we have been advised that business continuity tests are carried out on a tabletop thematic basis. We have been provided examples of post exercise reports, confirming that these are carried out around themes. Learning is also captured through post incident reports which are overseen through RAC.

Summary of actions

	High	Medium	Low	Advisory	Total
Proposed actions	0	3	3	0	6
Agreed	0	3	3	0	6

Follow up

Individual actions agreed in this report will be followed up via our online action tracking system, Pentana. Action owners are responsible for ensuring actions are completed by the agreed implementation dates and for providing relevant supporting evidence.

The expected evidence required to demonstrate implementation is included in the report. It is possible that alternative evidence may be provided by the Trust; we will assess whether alternative evidence addresses the risk identified.

Actions not completed by their agreed date are regularly reported to the Audit and Assurance Committee and impact on the organisation's Head of Internal Audit Opinion.

Supporting documentation review

The Trust has the following policies in place which are relevant to the business continuity framework:

- Business Continuity Policy (BC policy)
- Emergency Planning Policy (EP policy)
- Business Continuity Management System Framework (BCMS Framework).

Documentation availability

Both the Business Continuity Policy and the Emergency Planning Policy are available on the Trust's intranet and the public-facing website within the 'Business Continuity and Emergency Planning' section in the 'Policies and Procedures' area of the intranet and public website.

Through discussion with the Trust's Emergency Planning Officer, we have been advised that the BCMS will be posted onto the Trust's intranet and public-facing website when training on the BCMS is completed across the organisation.

Documentation review and approval

We reviewed the latest versions of the policies available from the intranet and public-facing website, confirming the approval and review dates. The policies were approved by the Resilience Assurance Committee (RAC). Both policies are due to be ratified by the Board in November 2024.

The versions of the policies available are due for review in June 2025.

Roles and responsibilities

Individual roles and responsibilities

Through review of the key Trust policies and BCMS Framework, we have seen that the following key roles and responsibilities are defined:

- Accountable Emergency Officer (AEO) – confirmed from review of documentation that the AEO role sits with the Chief Operating Officer
- Operational leads – confirmed that the BC Policy and the BCMS detail the roles of the operational leads, covering the divisional lead responsibilities for the oversight, production, and maintenance of plans and action cards in their area

- Service level leads – outlined in the BC Policy that Heads of Service, and Ward and Departmental Managers will have input in the development of BC plans and action cards
- Emergency Planning and Business Continuity Officer – the responsibilities of the role are clearly defined within the BC Policy.

Strategic oversight – Board and Risk Committee

Board

The EPRR Core Standards state that 'The AEO must provide reports to the public board on EPRR activity no less frequently than annually and must publicly state its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements'.

We have seen through review of Board papers for November 2023 that the Board received an annual report detailing the position against the EPRR core standards, including aspects covering business continuity, in line with expectations detailed in the Core Standards.

Risk Committee

The Trust's BC Policy outlines the responsibilities of the Risk Committee to approve the BC Policy, ensure that business continuity is appropriately resourced, managed, and embedded and receive an annual Resilience Assurance Report.

Through review of Risk Committee papers, we have confirmed that the Committee received an annual report from RAC in November 2023. This preceded the current arrangement for monthly quadrant reports to be reported to the Risk Committee, which started from May 2024 onwards.

Risk Committee reports into the Audit and Assurance Committee (AAC) through quadrant reports. Whilst the reporting mechanism provides a basis for reporting to AAC, we have not seen any business continuity escalations from Risk Committee to AAC between July and September 2024.

1 Strategic oversight of business continuity (governance issue)
Finding: Through review of the Risk Committee's Terms of Reference, we have not seen that it outlines the roles and responsibilities of the Committee in relation to business continuity. The Business Continuity Policy outlines the roles and responsibilities of the Committee, however, these are not reflected in the Terms of Reference.

Detailed report

1 Strategic oversight of business continuity (governance issue)	
The Risk Committee receives regular monthly quadrant reports from the Resilience Assurance Committee (RAC) detailing key information from RAC. Previously, the Risk Committee received twice yearly reports. The Risk Committee work plan that we have reviewed does not reflect the updated process for reporting from RAC to the Risk Committee. At present, there is not routine reporting on business continuity at Board Committee level, resulting in minimal oversight from Non-Executive Directors; at some organisations, responsibility for this is included within the audit committee's Terms of Reference.	
Risk: If the strategic oversight of business continuity is not clearly defined and operating, the Trust will not have regular independent oversight of the business continuity framework taking place.	**Medium** (Impact x likelihood) 3 x 3
Action 1.1: The Trust to update the Terms of Reference for the Risk Committee to clearly outline the Committee's role and responsibilities concerning business continuity in line with the expectations detailed in the Business Continuity Policy.	**Responsible officer**: Sally Brook Shanahan, Director of Corporate Affairs **Implementation by date**: 31 March 2025
Action 1.2: The Trust to update the Risk Committee work plan to ensure it aligns with the current reporting arrangements from the Resilience Assurance Committee.	**Responsible officer**: Sally Brook Shanahan, Director of Corporate Affairs **Implementation by date**: 31 March 2025
Action 1.3: To provide for Non-Executive Director scrutiny, the Trust to review whether the Audit and Assurance Committee should have a role in relation to oversight of EPRR and business continuity and Terms of Reference to be updated accordingly.	**Responsible officer**: Sally Brook Shanahan, Director of Corporate Affairs **Implementation by date**: 31 March 2025

1 Strategic oversight of business continuity (governance issue)
Evidence required to demonstrate implementation of action: • Action 1.1 – updated Terms of Reference for Risk Committee. • Action 1.2 – updated Risk Committee work plan. • Action 1.3 – confirmation of amended reporting arrangements for business continuity and, if appropriate, updated and approved Audit and Assurance Committee Terms of Reference.
Management response: Agreed.

Operational oversight – Resilience Assurance Committee

The Trust's Resilience Assurance Committee has operational-level oversight of arrangements defined in the Civil Contingencies Act (2004) and the EPRR Standards. The Committee meets monthly, reporting to the Risk Committee. The meeting is chaired by the Chief Operating Officer, with the Deputy Chief Operating Officer acting as deputy chair. We confirmed from the Terms of Reference that the quoracy/attendance requirements, responsibilities, and communication links were all appropriate.

We observed the meeting held on 25 July 2024, noting that the meeting was quorate. We noted that some items on the work plan were not covered (see finding 3 – these were areas that appeared operational). The input from divisional representatives was limited in the meeting, with input primarily being from the Deputy Chief Operating Officer as the Chair and the Emergency Planning Officer.

We confirmed that monthly escalation quadrant reports were reported to the Risk Committee during the period tested, including an annual report in November 2023 as per the work plan (see finding 1 regarding the Risk Committee work plan).

We have confirmed that an ongoing attendance log is maintained which is included as part of the meeting paper packs.

2 Resilience Assurance Committee quorum (governance issue)
Finding: We reviewed papers and minutes of the Resilience Assurance Committee between May 2023 and June 2024 to confirm meeting quoracy. We identified that two of the 11 meetings were not quorate:

2 Resilience Assurance Committee quorum (governance issue)	
• 28 March 2024 – Meeting was missing representation from one division (Surgery Division) • 18 April 2024 – Meeting was missing representation from one division (Women and Children's Division). Through review of minutes, we have not seen confirmation in minutes that the meetings were quorate, including confirmation if agenda items were required to be deferred or stood down.	
Risk: If meetings of the Resilience Assurance Committee are not quorate, there is a risk that key individuals will not be involved in oversight of business continuity and wider resilience arrangements, impacting on the effectiveness of the Trust's response to business continuity incidents.	**Low** (Impact x likelihood) 2 x 2
Action 2.1: The Trust to document within Resilience Assurance Committee minutes if the meeting was not quorate, including noting within the minutes if agenda items have to be deferred due to meetings not being quorate.	**Responsible by officer**: Mark Stone, Emergency Planning Officer *Supported by Donna Bates, Emergency Planning Support Officer* **Implementation by date**: 31 October 2024
Evidence required to demonstrate implementation of action: • Action 2.1 – evidence of Resilience Assurance Committee minutes which detail confirmation of quorum checks having taken place and, if applicable, record deferred items.	
Management response: Agreed.	

3 Resilience Assurance Committee work plan (governance issue)

Finding:

We have reviewed the work plan for the Resilience Assurance Committee against the papers from May 2023 to June 2024. We have seen that the work plan includes a number of items that appear to be operational in nature:

Emergency Planning		
Complete Review of Actions from 2023 CSSA and prepare 2024 submission	Complete	Emergency Planning Officer
Complete Review of EMAS CBRN audit complete any outstanding actions	Complete	Emergency Planning Officer
Progress Mass Notification System with DSG	Progress	Emergency Planning Officer
Carry Out Radio and Battery Checks	Conduct	Emergency Planning Officer
Update Silver and Gold On-call Lists	Update	Emergency Planning Officer
Review Stock and Serviceability of Radio Pagers	Review	EPO/Estates Lead
Conduct Stock and Serviceability Check on Mobiles at NWK	Review	Emergency Planning Officer
Review Community/ National Risk Register and Escalate to Risk Committee any Appropriate Concerns	Review	Emergency Planning Officer
Arrange for Ramgene Calibration	Arrange	Emergency Planning Officer
Arrange for PRPS Suit Servicing	Arrange	Emergency Planning Officer
Arrange CBRN Equipment Service	Arrange	Emergency Planning Officer
Arrange Decon Tent Service	Arrange	Emergency Planning Officer

We have been advised by the Emergency Planning Officer that these items would not constitute papers being brought to the Committee, rather they are a checklist of items to be completed as part of the Emergency Planning Officer role.

Risk: If the work plan for the Resilience Assurance Committee also includes operational tasks, the work plan will not be reflective of the expected papers and updates to be presented to the Committee which could impact on the effectiveness of the Committee.	**Low** (Impact x likelihood) 3 x 2
Action 3.1: The Trust to separate out the work plan for the Resilience Assurance Committee into the papers/updates to be presented to the Committee and the operational tasks expected to be carried out for emergency planning.	**Responsible officer**: Mark Stone, Emergency Planning Officer **Implementation by date**:

3 Resilience Assurance Committee work plan (governance issue)	
	31 January 2025
Evidence required to demonstrate implementation of action: • Action 3.1 – updated Resilience Assurance Committee work plan which reflects items expected to be presented to the Committee, and not operational checks to be carried out by the Emergency Planning Officer.	
Management response: Agreed. The Trust is looking to review the work plan going forwards to ensure that criteria for reporting to RAC are being more clearly defined.	

Service level business continuity plans

Availability of plans

All the Trust's business continuity plans and action cards are available from the Business Continuity section of the intranet. We were advised by the Emergency Planning Officer that hard copies of plans are held in locations within the relevant divisions, along with the Emergency Planning Officer retaining copies of all plans within the Duty Nurse Manager's Room and the Incident Control Centre.

Business continuity plan template

The Trust has recently developed a new template for its business continuity plans. We reviewed the Trust's business continuity plan template against the guidance from the NHS England Business Continuity Toolkit, confirming that the template aligns with the requirements of NHS England.

At the time of review, Divisions are developing plans in the new template. We were provided with two draft business continuity plans developed using the Trust's new template for the Urgent and Emergency Care Division and Women and Children's Division. Through reviewing the plans against the Trust template, we have confirmed that the plans are mostly consistent with the template. The draft templates provided were missing some appendices detailed in the Trust template, however, the Emergency Planning Officer has outlined that not all plans will require all the appendices detailed in the template to be included, for example, in instances where divisions are following Trust-wide lockdown procedures.

The Deputy Chief Operating Officer has set a deadline for new plans to be provided by Divisions in line with the updated Trust template by 17

October 2024. Furthermore, the Emergency Planning Officer has established a sub-group of RAC, which is responsible for oversight of the delivery of updated plans.

Business impact analysis template

The Trust has recently introduced a new business impact analysis (BIA) template. We have been provided with examples of BIAs that have been completed in line with the new template for the following areas:

- Antenatal Clinical and Pregnancy Day Care (Women and Children's Division)
- Acute Medicine – Discharge Lounge (Urgent and Emergency Care Division)

Through review of the BIAs provided, we have confirmed that they align to the Trust's template document.

Testing of business continuity plans

The Trust utilises a thematic tabletop approach to testing of business continuity arrangements rather than testing all plans. We have seen an example of a post exercise report for 'Exercise Rasher', outlining the outcome of testing in the event of a regional and national outbreak of measles. We have seen that the Trust is currently in the process of reporting the post exercise report for its recent 'Exercise Trident' through RAC and Risk Committee. The exercise included participation from across the Trust in multiple scenarios to test its plans to respond to a variety of incidents.

The approach taken by the Trust is consistent with the EPRR core standard for business continuity, requiring that organisations should carry out at least an annual tabletop exercise.

Learning from business continuity incidents

The Trust's Business Continuity Policy outlines that monitoring and learning from incidents is through the incident debrief process, with debriefs expected to always take place following an incident. Through discussion with the Emergency Planning Officer, we were advised that the Trust utilises post incident reports, with actions shared and monitored through the Resilience Assurance Committee to facilitate learning from incidents.

We reviewed evidence of post incident reporting for the following incidents, taken from the incident register provided by the Emergency Planning Officer:

Incident	Date of incident	Comments
Flooding in ED, PC24, Minors and entrance to Ward 25	12 June 2023	Post incident report provided.
Water ingress – multiple areas	20 – 21 October 2023	Post incident report provided.
IT incident, Rhapsody system not working	29 – 30 November 2023	No post incident report provided. The Trust has advised that due to internal pressures as a result of NHS industrial action, debrief report was not produced for this incident.

For the two incidents that had post incident reports (PIRs), we confirmed that they were reported to the RAC for oversight. We have seen that all actions included on the PIR for the November 2023 IT incident were recorded on the RAC action tracker, and implementation was monitored throughout subsequent meetings.

We have seen that post incident and exercise reports are monitored through RAC and subsequent escalation to Risk Committee as part of routine quadrant reports.

4 Learning from incidents (control issue)	
Finding: Through review of the post incident reports for two incidents from the Trust's Incident Register, we identified that actions are recorded on the reports. However, the actions recorded are not SMART. For one of the incidents reviewed (Water ingress – multiple areas (October 2023)), we have not seen that actions from the incident were recorded on the action tracker for the Resilience Assurance Committee. The Trust does not have a template for debriefing reports. The Trust has advised that the NHS England regional team is developing a model to allow for a consistent approach to reporting following incidents, with the Trust expected to follow future guidance from NHSE.	
Risk: If the Trust does not have a consistent approach to debriefing and learning following a business continuity incident, actions may not be deployed consistently, and learning may not be shared effectively within the organisation impacting on the effectiveness of the Trust's response to business continuity incidents.	**Low** (Impact x likelihood) 2 x 3

4 Learning from incidents (control issue)	
Action 4.1: The Trust to implement a template for business continuity incident debrief reports and debrief action tracking to ensure consistent post incident reporting and SMART actions, in line with future guidance from the NHSE regional team. Updated post incident reports should be overseen through the governance structure for business continuity.	**Responsible officer**: Mark Stone, Emergency Planning Officer **Implementation by date**: 31 Mach 2025
Evidence required to demonstrate implementation of action: • Action 4.1 – example of a template for business continuity debrief reports and an example of a debrief report aligned with the template, as well as an example action tracker, including processes for reporting through RAC and/or Risk Committee.	
Management response: Agreed.	

Appendix A: Audit scope

Scope area	Audit testing
Policy review	We reviewed the Trust's Business Continuity Policy, Emergency Planning Policy, and its recently developed BCMS Framework, to establish the control framework for business continuity at the Trust.
Roles and responsibilities	We: • established via review of relevant documents and by inquiry whether roles and responsibilities of key individuals for oversight of the business continuity framework are clearly defined and operating effectively. • reviewed relevant reports presented to the Board and relevant assurance committees to ensure appropriate Board-level oversight. • evaluated the scope of work and effectiveness of the Resilience Assurance Committee, through review of papers and minutes and through observation of one meeting.
Service level business continuity plans	At the time of review, the Trust is implementing a new business continuity plan template which aligns with the template from the NHS England Business Continuity Toolkit. We have been able to test two draft plans in the new Trust template. We tested the Trust's business continuity plan template against the NHSE guidance, confirming that it is consistent. We have sought to understand the process for testing of current plans, confirming if they are accessible to staff.
Learning from business continuity incidents	We evaluated how the Trust identified and disseminated lessons learnt from business continuity incidents via review of a sample of recent incidents which impacted the Trust's ability to deliver core services.
Limitations of scope: The scope of our work was limited to the areas identified in the agreed Terms of Reference. This review has not replicated the EPRR Core Standards assurance process. Our review excluded business continuity arrangements in relation to the Trust's informatics service and its arrangements in relation to 'cyber security'. Our review of IT systems was limited to the extent to which loss of IT systems has been considered as part of business impact assessments. We have not tested whether approve business continuity plans comply with the Trust template as, at the time of our review, no approved plans had been produced using the new template, we have reviewed two draft plans against the new Trust template. We have commented on the template plan having compared it to the template from the NHS England Business Continuity Toolkit.	

Appendix B: 360 Assurance standing information

Risk matrix and opinion levels

Risks contained within this report have been assessed using a standard 5x5 risk matrix. The score has been determined by consideration of the impact the risk may have, and its likelihood of occurrence, in relation to the system's objectives. The two scores have then been multiplied in order to identify the risk classification of low, medium, high or extreme.

The audit opinion has been determined in relation to the objectives of the system being reviewed. It takes into consideration the volume and classification of the risks identified during the review.

Our risk matrix and audit opinions are available to view in full on our website.

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Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:** 7th November 2024	
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 informal Finance Committee meeting of 29th October 2024.		**Assurance**	Significant

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• 2025/26 Planning (to NOTE) – In response to 2025/26 planning communications from the ICB concerns have been expressed over the potential operational and financial implications of the potential ICB savings schemes and to request additional funding to reflect the increased levels of emergency activity. • FIP (to NOTE) - FIP requirement of £38.5M. Programme continues to be developed but there is still a £7.55M weighted financial gap. • H1 Financial Position (to NOTE) – At the end of Month 6 the Trust has an adverse variance to plan of £0.8M.	• NHIS – Agreed that future reporting and governance to be reviewed. • Digital Options – Committee recommended that a future Board Development Meeting should include a discussion on digital options. • FT Commercial Opportunities – To be discussed further as part of the Board Time-Out in November. • Insourcing/Outsourcing Contracts – Consideration to be given on how best to provide support and focus to divisions on these contracts. • Finance Strategy – focussed discussion to be held at the next meeting. • Sustainability – more work to look at how the green agenda can be resourced and developed further.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• NHIS Performance – Continued good performance acknowledged for the first 6 months.	• Microsoft Agreements – Agreed to recommend approval to Board. • Phase 2 I&I Support – Approved proposal.

• Digital Landscape Update – Helpful paper tabled outlining our current position and the next steps. To be followed up with a forecast of the potential future financial implications. • Medicine Division Presentation – First of the divisional deep dives. Was noted that there are ongoing pressures because of the growth in activity being significantly above the planned 0.6%. • Procurement – forward plan discussed and agreed future oversight of Insourcing and Outsourcing contracts. • PFI – Continued progress on settlement deed noted. Target of reaching a Settlement Agreement ready for approval processes has moved back to late November though. • National Cost Collection – Update received confirming required submission made and that benchmark data will be used to explore further FIP potential.	• BAF – Agreed that overall risk score should remain at 16.

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.

Items recommended for consideration by other Committees

- None identified

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Partnerships and Communities Chair's Highlight Report to Board of Directors

Subject:	Partnerships and Communities Committee Quadrant Report	**Date:**	7th November 2024
Prepared By:	Barbara Brady, Non-Executive Director and Committee Chair		
Approved By:	Barbara Brady, Non-Executive Director and Committee Chair		
Presented By:	Barbara Brady, Non-Executive Director and Committee Chair		
Purpose:			
To provide an overview of the key discussion items from the committee meeting on the 22nd October 2024		**Assurance**	**Moderate**

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Ongoing concerns regarding capacity to engage and support partnership work. ***Need to constantly prioritise work in light of competing priorities.***	Development of 'Partnership Canvas', the document which will captures how partnerships are contributing to our Strategic Objectives including being explicit about the 'added value' achieved by working in partnership
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Ongoing development and maturity of the Primary/secondary care interface work. Digital and health inequalities, development of work to tackle this agenda. New Highlight report which captures the breadth or work showing progress, risks and next steps. Developing work on Health inequalities recognising there will be a needed for further prioritisation given capacity issues. Stocktake on work programme with EM Provide collaborative will generate a revised and refined work programme.	BAF – PR6, current exposure at 12 (high)
Comments on effectiveness of the meeting	
This committee and its agenda is maturing and this is reflected in the improved level of assurance. Good discussions and challenge as appropriate.	

Items recommended for consideration by other Committees
Digital Inequalities for discussion at Finance, People and Quality committees due to the cross-cutting nature of this issue. **Primary and secondary car interface for discussion at Quality Committee due to the potential impact on quality of care**

Note: this report does not require a cover sheet due to sufficient information provided.

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Charitable Funds Committee Chair's Highlight Report to Board of Directors

Subject:	Charitable Funds Committee Update	**Date:**	22nd October 2024
Prepared By:	Andrew Rose-Britton		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose:			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
The Board to note the change in the direction of travel of the Charity in the context of the proposal to launch a Charity Lottery.	To identify and review potential new projects for the Charity. To review the procurement guidelines that are applicable to the Charity. To note the progress with the End of Life rooms project.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Charity Operational Group Quadrant report. Community Involvement headline report. Project & Fundraising update. Project Evaluation forms. Charity development plan Financial update. Investment plan.	Not to proceed with the Breast Services Appeal. The Charity's Annual accounts 2023/24 and letter of representation to be recommended to the Corporate Trustee for approval at its meeting on 7th November 2024. To progress with the launch of a Charity Lottery subject to the agreement of the Corporate Trustee. To progress Payroll giving. Following their annual reviews, updates to the Charitable Funds Finance Policy and the Charity Privacy Policy were approved.
Comments on effectiveness of the meeting	
Good, positive and effective discussion	
Items recommended for consideration by other Committees	
Audit Committee: Procurement guidelines.	