MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 1st August 2024**
Time: **09:00 – 12:15**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Patient Story – Theo's Story** Paula Shore, Director of Midwifery	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 4th July 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 4 – Continuously learn and improve** • **NHS Impact** Report of the Acting Director of Strategy and Partnerships	Assurance	Enclosure 10.1
	BREAK (10 mins)			
	Operational			
11.	10:40	**Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 11

	Time	Item	Status	Paper
	Governance			
12.	11:20	**Board Assurance Framework (BAF)** Report of the Chief Executive	Approval	Enclosure 12
13.	11:30	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • People Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance Assurance Assurance	 Enclosure 13.1 Enclosure 13.2 Enclosure 13.3 Enclosure 13.4 Enclosure 13.5
14.	11:50	**Outstanding Service – Pathology - The team behind an outstanding service**	Assurance	Presentation
15.	12:00	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
16.	12:05	**Any Other Business**		
17.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **5th September 2024, Boardroom, King's Mill Hospital**		
18.		**Chair Declares the Meeting Closed**		
19.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

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

Enc 09	• **Nursing and Midwifery Safer Staffing Reports**
Enc 12	• **Significant Risks Summary**
Enc 13.1	• **Audit and Assurance Committee – previous minutes**
Enc 13.2	• **Finance Committee – previous minutes**
Enc 13.3	• **Quality Committee – previous minutes**
Enc 13.4	• **People Committee – previous minutes**
Enc 13.5	• **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 4th July 2024, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Acting Chair	GW
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Barbara Brady	Non-Executive Director	BB
	Aly Rashid	Non-Executive Director	AR
	Neil McDonald	Non-Executive Director	NM
	Andrew Rose-Britton	Non-Executive Director	ARB
	Andy Haynes	Specialist Advisor to the Board	AH
	David Selwyn	Acting Chief Executive	DS
	Claire Hinchley	Interim Director of Strategy and Partnerships	CH
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Phil Bolton	Chief Nurse	PB
	Simon Roe	Acting Medical Director	SR
In Attendance:	Debbie Kearsley	Deputy Director of People	DK
	Jen Leah	Deputy Chief Financial Officer	JL
	Chris Dann	Deputy Chief Operating Officer	CD
	Richard Clarkson	Divisional Director of Nursing for UEC	RC
	Nikki Turner	Chief Digital Information Officer	NT
	Paul Moore	Deputy Chief Digital Information Officer	PM
	Mark Bolton	Associate Director of Operational Performance	MB
	Sue Bradshaw	Minutes	
	Jess Baxter	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Rich Brown	Head of Communications	
	Deborah Dowsing	Communications Officer	
	Liz Barrett	Lead Governor	
	Ian Holden	Public Governor	
	Elly Holmes	NHS Professionals	
	Lauren Monaghan	Notts TV	
	1 member of the public		
Apologies:	Rob Simcox	Director of People	RS
	Richard Mills	Chief Financial Officer	RM
	Rachel Eddie	Chief Operating Officer	RE

Item No.	Item	Action	Date
24/212	**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.		
24/213	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
24/214	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Rob Simcox, Director of People, Richard Mills, Chief Financial Officer and Rachel Eddie, Chief Operating Officer. It was noted Debbie Kearsley, Deputy Director of People, was attending the meeting in place of Rob Simcox, Jen Leah, Deputy Chief Financial Officer, was attending the meeting in place of Richard Mills and Chris Dann, Deputy Chief Operating Officer, was attending the meeting in place of Rachel Eddie.		
24/215	**PATIENT STORY: THE EMERGENCY DEPARTMENT – TREATING PATIENTS WITH MENTAL HEALTH**		
15 mins	RC presented the Patient Story, which highlighted the case of a patient with mental health problems who had a prolonged stay in the Emergency Department. PB advised this is a powerful, but not uncommon story. The patient presented to ED in crisis and the Trust and system failed to respond promptly and offer them the right care, in the right place, at the right time. Lots of care was provided in ED and the team did a good job in ensuring the patient had access to food, showers and somewhere to rest. GW felt it was a powerful video which highlights the issue of getting the right care in the right place for patients with mental health problems. AH noted it is a story everyone will recognise and queried if the Trust tracks Section 2 patients and what the average delay is in getting them to a bed in the right place. PB advised patients are tracked and debriefs take place if there has been a prolonged stay in ED. System processes have improved, with calls taking place throughout the day and at weekends. However, there is evidence of a significant difference between weekdays and weekends. It is important to get the right people on the calls who can make decisions. The Trust is working to identify where and when the longest delays occur. The concern is the availability of beds, noting the bed stock for mental health services is reducing and patients are being sent further afield, away from family, for their care.		

	DS advised cases are reported to the Quality Committee and Strategic Executive Information System (StEIS) reports are completed to highlight cases. Noting the impact on the patient, there is also an impact on staff and other patients in the department. PB advised patients require at least 1:1 care, with some requiring 4:1 care, which has resource implications for ED. NM noted getting a care packing in place is quicker during the week than over a weekend and queried what actions can be taken to improve decision making capabilities at weekends. PB advised there is a need to have the right people on call who can make those decisions, acknowledging this is variable depending on what the substantive role is of people on call. Some of the issues are out of the Trust's control, particularly if the patient is from out of area. There is usually a better response, and ability to get the right people, even out of hours, from the Nottinghamshire system. The challenge is when the patient is from a different area, in this case Liverpool, who were dealing with their own patients, in their own system, as a priority. Delays still occur during the week, but it is more problematic at weekends. SB felt the answer should still have been within the Nottinghamshire system as the family wanted the patient to remain in this area. PB acknowledged this point, advising the longest stay patients should be taken into the most appropriate bed. However, in this case there were no beds in the local system. This is a challenge which needs to be raised at system level. MG noted it was positive to see the team working together. PB advised the Trust escalates cases appropriately. However, the response from the Integrated Care System (ICS) could be improved. The concern is the constraints, lack of facilities, beds, etc. to support patients with mental health problems. BB felt this case is an example of 'Cinderella Services' for patients with mental health problems. DS acknowledged there is a disconnect between the importance of mental health versus physical health, noting patients do not receive any treatment for their mental health while they are waiting in ED.		
24/216	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 6th June 2024, the Board of Directors APPROVED the minutes as a true and accurate record.		
24/217	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/106.2, 24/140 and 24/183.1 were complete and could be removed from the action tracker.		

24/218	**ACTING CHAIR'S REPORT**		
3 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 the contribution of volunteers at the Trust, particularly during National Volunteers Week. GW expressed thanks for donations to the Trust's Charity. The Board of Directors were ASSURED by the report.		
24/219	**ACTING CHIEF EXECUTIVE'S REPORT**		
22 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 actions required during the pre-election period, ongoing high levels of demand across the urgent and emergency care pathway, industrial action by the British Medical Association (BMA), ICS performance and assurance update, 2023/2024 Quarter 4 segmentation review letter, Martha's Rule pilot, recognition of Armed Forces Week, Community Diagnostic Centre (CDC) engagement event and review of Board Assurance Framework (BAF) risks. DS acknowledged the recent sentencing of Edward Finn, trainee doctor hosted by the Trust a number of years ago, and apologised to the patient and family affected. The Trust has conducted a robust internal review to understand how the strict measures which are in place to protect patients were breached, noting only Edward Finn knows how he committed these crimes, which are the ultimate betrayal of trust to patients, family and colleagues. SB felt there is no evidence of progress in the ICS update. DS acknowledged this and expressed the hope more tangible results will become evident as the updates and work mature. ARB noted activity levels are 10% above plan. If this trend continues, ARB queried how the Trust will manage this in terms of finance and patient care. DS felt there is the need to identify the reasons for the increased activity. NM noted the Trust's good performance in terms of ambulance turnaround times and queried what impact that is having on the Trust's workload and capacity, noting ambulance crews may choose to convey to King's Mill Hospital, rather than elsewhere, as they will be turned around quicker. CD advised, from the available data, the local population is driving the increased demand on ED. There is an increase in ambulance conveyances from the border of different catchment areas, noting typically the admission rate is higher for ambulance conveyances compared to walk-ins. This has an impact on the Trust's bed stock. This has been raised at a system level. DS advised where ambulances are coming from is kept under regular review.		

	MG queried what the underlying causes for increased activity are and what actions are being taken to address this at a system and organisational level. SR advised the issue has been raised with the system analytics unit who are undertaking some work to try to understand the drivers, as the Trust is seeing a disproportionate increase in demand compared to other providers, a significant portion of which is local activity. BB felt there is a need for the Trust to have good working relationships with primary care colleagues. AH felt there is a need to understand the demographics of the local population and identify if people are not accessing services which are available or if there are some services which are not available. GW expressed thanks to staff who covered shifts during the recent period of industrial action. The Board of Directors were ASSURED by the report.		
24/220	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
9 mins	**Maternity Update** ***Safety Champions update*** PB presented the report, highlighting the service user voice, rollout of Electronic Prescribing and Medicines Administration (EPMA) in the Maternity Department, staff engagement, regional maternity heatmap and work in relation to improving the triage process. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance*** PB presented the report, highlighting reduction of massive obstetric haemorrhage, home births service and recruitment event. There were no suspensions of service in May 2024. BB expressed the view that the number of third and fourth degree tears continues to be a concern. PB advised benchmarking information is available which highlights this is a national problem and the Trust benchmarks well compared to others. However, this does not justify the rates. There is still work to be done, including implementing the Obstetric Anal Sphincter Injury (OASI) care bundle. There is work underway at the Local Maternity and Neonatal System (LMNS), which will be reported through Quality Committee. There is a lot of focus on this issue both internally and nationally. AR expressed concern for the long term outcomes for patients who have suffered a third or fourth degree tears and asked for this information to be reported to the Quality Committee. PB reminded members of the Board of Directors of the review into third and fourth degree tears which is underway and confirmed the outcomes are included in that work. This will be reported to the Quality Committee.		

	NM noted third and fourth degree tears is a national issue and queried how this is linked into the training provided to trainee midwives. PB advised this links with the OASI care bundle. The Board of Directors were ASSURED by the report.		
24/221	**STRATEGIC OBJECTIVE 2 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE**		
18 mins	**Equality and Diversity Annual Report** DK presented the report, highlighting mandatory aspects and successes and work taken forward over the past year. It was acknowledged there is more work to do and progress will be reported to the People Committee. In addition, there is more work to do in relation to patients. It was noted an inequalities group has been established, which is a collaborative with system colleagues. BB felt the report did not contain much information relating to the patient aspect. BB queried what the added value is for staff who are part of the various staff networks. DK advised the staff networks provide a peer group for staff where they can share experiences and take the learning out into the wider organisation. The networks are an outward demonstration to the organisation that the diverse workforce of the Trust is valued. Steve Banks, Chair of the People Committee, is planning to meet with the chairs of the networks to discuss the value the networks add and what the Trust can do to further support the networks. BB felt the report could be improved by including feedback from members of the staff networks. SB felt there is a need to consider how the voice of the staff networks can be brought into discussions. DS advised there is reference in the Acting Chief Executive's report to the creation of an Armed Forces Staff Network, advising this has been very well received. MG queried what areas have been covered by the Equality Impact Assessments (EqIA) and what learning has been identified as a result. DK advised all policies, procedures, service changes, etc. should have an EqIA completed to identify anything which may disproportionately impact on protected characteristics. In terms of learning, there have been some practical issues identified, for example, improving access. MG felt it would be useful for more strategic information to be available, for example, numbers of EqIAs carried out, thematic areas, how they are helping to drive improvement, etc. MG queried if an EqIA had been carried out on the Trust Strategy. CH advised an EqIA had not been undertaken on the whole strategy as that is difficult to complete at a high level. However, where changes are proposed, EqIAs are undertaken. DK advised information in relation to the number of EqIAs undertaken, etc. can be sourced and reported to the People Committee.		

	Action • **Information in relation to the number of Equality Impact Assessments undertaken and their impact, etc. to be reported to the People Committee.** AR noted the total number of staff at the Trust has increased during 2023/2024, compared to 2022/2023, with about half of the increase being non-clinical staff. AR queried what work is being done to look at this, given the current financial constraints which the Trust is operating within. JL advised the non-clinical workforce is one of the areas of reflection within the transformation and efficiency programme. DS advised there is a series of workstreams relating to workforce changes where the Trust and the system is being held to account and investigated. This is looking into where the workforce growth is compared to pre-pandemic and the reasons for this. From a Trust perspective, there are some understandable reasons, for example, CDC growth, and Electronic Patient Records (EPR) work. GW felt it would be useful to have a Board of Directors Workshop to increase understanding of workforce, activity and finances. DK advised there is a need to triangulate information relating to workforce, finances and activity to ensure the Trust has the right workforce. MG felt there needs to be analysis of the workforce, noting it is not always as simple as clinical versus non-clinical staff. DK advised the non-clinical workforce can have a direct impact on clinical work and it is important to recognise this. DS advised every vacancy has to go through the vacancy control panel for approval and this is a robust process. **Action** • **Triangulation of information relating to workforce, activity and finances to be a topic for a future Board of Directors workshop.** The Board of Directors were ASSURED by the report.	**RS** **RM / RS / RE**	**03/10/24** **TBC**
24/222	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
6 mins	**2024/2025 Capital Expenditure Plan** JL presented the report, highlighting the sources of the Trust's capital resources, proposed process for prioritisation of capital spend, pre-committed spending and increase in capital spend for 2024/2025 compared to 2023/2024. BB queried how the capital expenditure plan will feed into the Trust's charitable funds. JL advised the prioritisation matrix helps to identify the 'want to dos', i.e. assets which are being enhanced, noting it is this area where the Charity can make the biggest difference to the Trust, acknowledging the Charity can only support areas which add value, rather than maintaining the current position.		

	The Board of Directors APPROVED the 2024/2025 Capital Expenditure Plan.		
24/223	**DIGITAL UPDATE**		
24 mins	NT and PM joined the meeting. PM presented the report, highlighting the growth in the senior leadership team for digital services, governance arrangements, EPR progress, Public Facing Digital Services (PFDS) and milestones in the Digital Strategy. ARB sought clarification in relation to the tender process for EPR. PM advised each organisation has to follow a full procurement process, noting the national programme, which had previously been established, no longer exists. DS advised there is a balance between buying a product which has been designed for the majority and buying a product which works for individual organisations, noting there are advantages and disadvantages of both approaches. GW advised there is a framework agreement the Trust can procure through, which is limited to organisations which can deliver the required system. SB queried what the current costs are to maintain the Trust's digital landscape and what the cost of change is. PM advised the capital programme, from an IT perspective, is focussed on maintenance and there are no plans to do anything vastly different due to EPR and other activities. When the full EPR business case is developed, the Trust will look to identify some of the opportunities, for example, some systems will be retired and, therefore, will not require upgrades, etc. DS advised there will be an internal and external focus in terms of where SFHFT positions itself, not just with NHIS but also across the Integrated Care Board (ICB). There will be a need to work together to create efficiencies. SB queried what the cost is (as a percentage of turnover) of maintaining the IT landscape currently and what it will be in five years' time. JL advised the current costs are as documented within the capital programme. In terms of getting the information as a percentage, this information can be obtained and will be reported to the Finance Committee. From the EPR business case perspective, the capital programme spend is unlikely to reduce as the spend will be on maintaining the new software for the future. The EPR business case will demonstrate savings in relation to workforce and the way the Trust operates. PM advised the overall cost of IT goes beyond EPR. For example, the Trust has just responded to the Model Hospital Corporate Return which gives an overarching cost of workforce and some of the technical elements. NT advised there is work to do to look at what the 'fast forward' looks like. In five years' time there may be opportunities across the ICS to further build on progress and provide collaborative services.		

	Action • **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.** NM advised he attended the first meeting of the EPR Programme Board and felt this was a very good meeting, noting a lot of work has been completed in terms of workload mapping, etc. The full business case will need the support of the Board of Directors and the Executive Team. There is a need to have the commitment of the Executive Team at the right level to enable decisions to be made in a timely manner. AH felt there is an important synergy between EPR and the data strategy and queried if the data strategy and the EPR programme are adequately aligning to get maximum benefit. PM advised currently the organisation is at a low position from a data and information perspective. To address this, the Trust has recently appointed a Head of Information to drive forward the agenda, noting this is a new role. The Trust is starting to make some improvements in terms of the technology the organisation is using and the ability to provide data. As part of the EPR procurement work, the Trust has detailed the importance of how to extract data from systems. There is a long way to go from a data and information point of view, but it is a core part of the EPR programme. DS advised the appointment to the Head of Information post was brought forward and expressed the view the terminology should be changed to Head of Intelligence. Historically the Trust has been chasing data. There will be a system repository for data and the Trust needs a support unit which provides the intelligence. MG noted the need for the end user to embrace the benefits and the new technology and queried if there was any learning from the 'tap and go', which has been delivered in Urgent and Emergency Care, regarding the realisation of benefits for the end user. PM advised the first role appointed to as part of the EPR programme was Head of People, which is in recognition of the change the organisation will undergo. This role is responsible for driving change and engagement. In addition, the Trust will be recruiting a Head of Operational Change to look at how to make improvements with users. The digital champions have done some good work and there is now a small number of very bought in staff. The next challenge will be looking at how to free up time to give people the ability to become involved. The Board of Directors were ASSURED by the report. NT and PM left the meeting.	**DS**	**05/09/24**

24/224	**INTEGRATED PERFORMANCE REPORT (IPR) ANNUAL REVIEW**		
15 mins	MB joined the meeting. MB presented the report, highlighting the indicators to be amended in the IPR for 2024/2025, the indicators to be removed, the indicators to be added, activity indicators to be moved from the Timely Care domain and consolidated into a separate activity section and the proposal to add benchmarking information from Quarter 2 (Q2). MG noted the proposal to increase the target for the vacancy rate from 6% to 8.5%, but with tighter caps on agency usage. MG queried if the target was stretching enough and if there were any risks to patient safety and availability of staff. DK advised the People Directorate were reporting different figures to the Finance Directorate. Therefore, the reason for the change is to ensure reporting is from one data source. In deciding the target, the last two years have been reviewed and the vacancy rate over the past two years has been calculated. 8.5% does represent a stretch target. Moving forward it is important to look at the vacancy rate on a month on month and quarterly basis in terms of how vacancies change. This will be key in terms of monitoring vacancies and understanding the impact that has on the Trust from a finance and patient safety perspective and also how this interrelates with agency usage. JL advised there has been an alignment of the start point of what the percentage is being benchmarked against. What is recognised in the finance ledger as being fully established and what has been recognised in HR as fully established has differed. Therefore, there is a need to ensure the start points are the same. AR queried if it is possible to include serious incidents which result in significant harm. PB confirmed this can be included. **Action** • **The number of serious incidents which result in significant harm to be included in the IPR report.** NM queried if the targets in relation to agency usage are a financial measure or a percentage. DK confirmed this is a percentage and is linked to the national guidance. NM noted in the Best Value Care domain the measure is agency expenditure against plan and expressed the view this should be total variable cost against plan. JL advised bank usage is reported in terms of number as a percentage, rather than cost as a percentage. **Action** • **Agency expenditure against plan to be reported in the IPR as total variable cost against plan.** SB sought clarification if staff turnover in month is planned or unplanned turnover.	**RE** **RE**	**01/08/24** **01/08/24**

	DK advised this is unplanned turnover, noting anything which is deemed as planned is taken out of the figures, for example, resident doctors. GW felt there should be more focus on productivity in the Best Value Care domain. JL advised the ambition is to build the implied productivity into the IPR and work is underway to establish what this will 'look like'. Currently a report is presented to the Finance Committee in relation to the productivity metrics and the ambition is that will continue. AH sought assurance that in relaxing the agency usage over price cap indicator, this will not create a tension with meeting the target for overall agency usage. JL advised it is important not to report the Trust is achieving the agency price cap through other measures, while agency usage remains the same. It is important to understand exactly what the agency spend is, what the drivers are and what is being done to reduce agency spend. DK advised agency usage over price cap was set at 30% in 2023/24, but this target was never achieved and it was over ambitious. An exercise has been undertaken to complete some triangulation and this suggests if 40% is achieved for agency usage over price cap, the target of 3.2% for overall agency usage will also be achieved. GW felt it would be useful to see the plan and trajectory for areas where improvements are required. MB advised the datasets include the plan values through to year end. Therefore, this information can be included within the graphs. The Board of Directors APPROVED the IPR indicators for 2024/2025, subject to the requested amendments being made. MB left the meeting.		
24/225	**IG / DATA SECURITY PROTECTION TOOLKIT (DSPT) SUBMISSION**		
4 mins	SBS presented the report, advising the report provides an overview of the Trust's compliance with the Information Governance (IG) and security agenda, both nationally and locally. All of the 108 mandatory standard evidence items are now complete for the DSPT. It was submitted with overall compliance and an auditor's opinion of substantial assurance. During 2023/24, three incidents were escalated as reportable to the Information Commissioners Office, none of which have resulted in action from the regulator as the Trust provided appropriate assurance. It was noted during 2023/2024, the Trust processed a total of 863 Freedom of Information (FOI) requests and 3,710 requests for access to patient records, noting this is a year on year increase. SBS acknowledged there is more work to do, particularly in relation to improving response times to FOI requests.		

	AH queried what the decline rate is for FOI requests and how the Trust benchmarks with other organisations. SBS advised very few requests are declined. No benchmarking information is available and it would be difficult to compare as each request is unique. However, this can be explored. **Action** • **Explore the possibility of producing benchmarking information for the number of FOI requests received and decline rates.** AH noted some people make multiple requests and queried what is being done to address this. SBS advised the Trust links up with partners in relation to this to ensure, where appropriate, there is a consistent approach to the responses. DS advised there will be opportunities in the digital world to address this, noting requests for the same information are often received by Nottingham University Hospitals (NUH), Nottinghamshire Healthcare Notts HC and ICB. Ways of requests being submitted via one portal are being actively explored. The Board of Directors were ASSURED by the report	**SBS**	**01/08/24**
24/226	**ASSURANCE FROM SUB-COMMITTEES**		
6 mins	**Audit and Assurance Committee** MG presented the report, highlighting annual reports, Internal Audit progress report and register of interests. The Board of Directors were ASSURED by the report. **Finance Committee** GW presented the report, highlighting the Financial Improvement Programme (FIP) and capital allocation. The Board of Directors were ASSURED by the report. **Quality Committee** AR presented the report, highlighting palliative care provision, increase in the number of complaints and potential links to litigation, Prevention of Future Deaths and Regulation 28 Report and serious incident themes. ARB queried if the increase in the number of complaints is a national trend. AR confirmed it is a national trend. GW queried if there were any themes emerging from the complaints received. PB advised a Patient Experience Committee has recently been established. In terms of themes, there has been an increase in complaints across all areas, particularly in relation to delays in appointments, access, etc. CD advised there is a 'ripple effect' in terms of delays to treatment caused by periods of industrial action.		

	The Board of Directors were ASSURED by the report.		
24/227	**OUTSTANDING SERVICE – OPUS MUSIC – MAKING MUSIC AN INTRINSIC PART OF HEALTHCARE**		
8 mins	A short video was played highlighting the work of the OPUS Musicians within the Trust.		
24/228	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Thanks to colleagues for maintaining essential services during periods of industrial action. • Martha's Rule pilot. • Armed Forces Network. • Value of staff networks. • Financial position. • Capital Plan commitments. • Patient story. • OPUS Musicians. • IPR update.		
24/229	**ANY OTHER BUSINESS**		
	No other business was raised.		
24/230	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 1st August 2024 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 11:40.		
24/231	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Chair** **Date**		

24/232	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	CW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
24/233	**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,
Compassionate People,
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
24/039	01/02/2024	Divisional breakdown within Freedom to Speak Up (FTSU) Guardian report to be shown as a percentage of workforce in future reports.	Public Board of Directors	None	~~01/08/2024~~ 03/10/2024	S Brook Shanahan	K Bosworth	**Update 15/07/2024** Report deferred to October Board meeting	Grey
24/108.2	04/04/2024	Report to be provided to the Quality Committee in relation to the work of the Lower Pelvic Floor Team, particularly the impact of their work on third and fourth degree tears.	Public Board of Directors	Quality Committee	~~04/07/2024~~ 03/10/2024	P Bolton	P Shore	**Update 17/04/2024** On agenda for June meeting of the Quality Committee **Update 20/06/2024** The Perinatal Pelvic Health Service paper will be presented at the August 2024 meeting of the Maternity Assurance Committee before presentation at the Quality Committee in September 2024	Grey
24/142.1	02/05/2024	Assurance and description of the establishment review process, methodology used and mandated national safe staffing requirements to provide assurance on the driver for the increase in nursing and midwifery staffing to be provided to the People Committee	Public Board of Directors	People Committee	01/08/2024	P Bolton		**Update 24/07/2024** A paper will be presented at the People Committee on 30th July 2024 **Complete**	Green
24/175	06/06/2024	Data in relation to usage of the Discharge Lounge to be included in the Integrated Performance Report (IPR)	Public Board of Directors	None	01/08/2024	R Eddie	M Bolton	**Update 24/07/2024** An additional slide has been included in the Timely Care section of the 2024/2025 Q1 IPR. **Complete**	Green
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
24/221.1	04/07/2024	Information in relation to the number of Equality Impact Assessments undertaken and their impact, etc. to be reported to the People Committee.	Public Board of Directors	People Committee	03/10/2024	R Simcox			Grey
24/221.2	04/07/2024	Triangulation of information relating to workforce, activity and finances to be a topic for a future Board of Directors workshop.	Public Board of Directors	None	TBC	R Simcox / R Mills / R Eddie		Added to Board Workshop Planner **Complete**	Green
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	05/09/2024	D Selwyn	N Turner		Grey
24/224.1	04/07/2024	The number of serious incidents which result in significant harm to be included in the IPR report	Public Board of Directors	None	01/08/2024	R Eddie	M Bolton	**Update 24/07/2024** A new metric called Patient Safety Incident Investigations (PSII) has been added to the Quality of Care section of the 2024/2025 Q1 IPR. An indicator in focus page is included the in IPR. **Complete**	Green

24/224.2	04/07/2024	Agency expenditure against plan to be reported in the IPR as total variable cost against plan	Public Board of Directors	None	01/08/2024	R Eddie	M Bolton	**Update 24/07/2024** Agency expenditure against plan is part of the Best Value Care section of the 2024/2025 Q1 IPR. Reported agency spend and reported bank spend have also been added to the Best Value Care section of the 2024/2025 Q1 IPR. **Complete**	Green
24/225	04/07/2024	Explore the possibility of producing benchmarking information for the number of FOI requests received and decline rates.	Public Board of Directors	None	01/08/2024	S Brook Shanahan		**Update 24/07/2024** A survey has been circulated to system and wider IG colleagues seeking this information. A summary of the responses received will be placed in the Board reading room. **Complete**	Green

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chair's report	**Date:**	1st August 24
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	
	Update	**Y**
	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
Y	**Y**	**Y**	**Y**	**Y**	**Y**

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

ADHD = Attention Deficit Hyperactivity Disorder
CEO = Chief Executive Officer
ICB = Integrated Care Board
ICS = Integrated Care System

Executive Summary

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

Meetings with other Chairs across the Nottingham and Nottinghamshire Integrated Care System

As part of my induction into my new role as the Trust's Acting Chair, I have been meeting with Chairs and other key stakeholders from across the Nottingham and Nottinghamshire Integrated Care System (ICS).

Those meetings have been a vital part of strengthening the Trust's relationships across the local health and care system, as part of the commitment to work collaboratively with partners in the community that is woven into our five-year Trust Strategy.

During June and July, I have held meetings with:

- Nick Carver (Chair, Nottingham University Hospitals)
- Amanda Sullivan (CEO Nottingham & Nottinghamshire ICB)
- Dale Bywater (Regional Director)
- Kathy McLean (Chair Nottingham & Nottinghamshire/Derby ICB)
- Suzy Brain-England (Chair, Doncaster & Bassetlaw)
- Sabrina Taylor (CEO, Healthwatch)
- Mahmud Nawaz (Chair, Chesterfield Royal Hospitals)
- Paul Devlin (Chair, Nottinghamshire Healthcare)

We have also enjoyed our most recent catch-up with colleagues from Newark and Sherwood District Council, where it has been great to see their focus on improving the health of their local population continuing. I also attended the Midlands Chairs Monthly Update Call.

I look forward to continuing those meetings to further strengthen those relationships over the coming weeks and months.

Recognising the difference made by our Trust Charity and Trust volunteers

July was another busy month for the 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.

New recliner chairs are presented to the Medical Day Case Ward at Newark Hospital

In July alone, 379 Trust volunteers generously gave over 4,600 hours of their time to help make great patient care happen across the 35 services they supported during the month.

Notable events from the Trust's Community Involvement team, our Sherwood Forest Hospitals Charity and our team of Trust volunteers over the past month have included:

- Our fundraising partners, the Friends of Newark Hospital, have provided funding to two schemes at Newark Hospital over the past month.

  Their first donation contributed to improvements to our Teledermatology service, which aims to provide a much faster diagnosis for patients with suspected skin cancer. That

funding has provided the service with patient seating and desks for the medical photographers who help run the service.

In addition, six recliner chairs have been provided to the Medical Day Case Unit at Newark Hospital to give patients extra comfort while receiving their treatment.

We are so grateful for their support in making improvements to our services.

- The Trust has welcomed eight new volunteers to the Trust during July, including Vaishali. Vaishali joined us as a volunteer at Newark Hospital to gain experience of hospital life to support her application to study medicine or biochemistry.

  We wish Vaishali and all our new volunteers a very warm welcome to #TeamSFH.

Vaishali has joined the Trust's team of dedicated at Newark Hospitals during July

- Colleagues on Ward 25, the children's ward at King's Mill Hospital, recently received a donation from a kind-hearted 11-year-old called Sam Jones.

  Sam has made it his mission to donate to 11 worthy charities in 11 months in memory of his dad, Tom Jones, who passed away from cancer in 2021.

Naming his fundraising efforts Sam's 11:11, Sam has attention deficit hyperactivity disorder (ADHD) and his mum, Nicola Jones, described this project a great way to focus his energy into something positive.

The project started with a sweet stall in his front garden, when he decided he wanted to donate money to cancer research. It has since grown to the 11:11 project, where he committed to donating money to a different charity of his choosing each month.

So far, he has raised over £9,000 in ten months, including a donation of £920 to the Children's Ward at King's Mill Hospital via the Sherwood Forest Hospitals Charity.

Those vital funds have been used to purchase a large amount of toys for the ward and craft materials for teenage mental health patients to be used as part of their therapy. Sam also gained a donation of books from *The Works*, which was gifted to the unit.

Sam Jones receives a certificate recognising his donations to Ward 25

The generous 11-year-old specified that £100 of the donation went to staff on the unit and this has been used to buy lots of lovely things for the staff room, such as new Tupperware and coffee pods for the coffee machine.

Sam is such an inspirational young man and his donation will make such a big difference to young people staying on the ward and the staff who provide the vital care there.

- We have also shared our grateful thanks to Judith, Angela and other members of the Newark Sewing Group (pictured below) who have kindly donated a large number of mastectomy cushions to provide patient comfort following surgery.

- David, one of the Trust's volunteers, was very happy to receive his 15-year long service award from Karen Meikle during July, pictured right.

  David is a constant support to our buggy and way-finder services, where he has proven himself to be totally committed to providing good care for our patients and visitors.

  We thank him for his continued outstanding service.

- The Theatres department at King's Mill Hospital was delighted to receive a Sound Ear Pro device, which was funded by the Sherwood Forest Hospitals Charity during the month.

  The equipment is used to detect noise levels in the area and help keep the recovery area a calm and peaceful environment for patients recovering from surgery.

This is just the latest example of the life-changing difference that the Sherwood Forest Hospitals Charity makes to improving patient and colleague experience here at Sherwood. We are grateful to them for their continued support.

Other notable engagements:

- I have taken part in my latest walkaround of the Trust alongside Roz Norman, the Trust's Staff Side representative. During that engagement, we visited the mattress sterilising, catering and medical engineering teams. I am grateful to everyone who welcomed us during our visits.
- During July, I also visited our Research and Innovation team who showed-off their brilliant work which includes designing the layout for the forthcoming ward area with beds and seating areas to help them to conduct more research within ward environments.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	1st August 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	
	Update	**Y**
	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
Y	**Y**	**Y**	**Y**	**Y**	**Y**

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

Committees/groups where this item has been presented before

Not applicable

Acronyms

BMA = British Medical Association
ICB = Integrated Care Board
IPR = Integrated Performance Report
MP = Members of Parliament
SDEC = Same Day Emergency Care

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, including industrial action updates

It has been another challenging month across our hospitals, where we continue to experience winter-like pressures across our services. Those challenges have seen the Trust enact its Full Capacity Protocol on multiple occasions during the month to ensure that additional hospital beds are available to ensure that patients can continue to access the care they need in as timely way as possible.

Those pressures are being particularly hard-felt in our Emergency Department at King's Mill Hospital and our Urgent Treatment Centre at Newark Hospital, where the number of attendances to our Emergency Department has increased by 12% year-on-year during the first quarter of the financial year - 11% greater than planned. Those pressures have increased both from patients arriving by ambulance and self-attending our Urgent and Emergency Care department.

For non-elective admissions, where demand is 13% above plan and 14% compared to Q1 last year, 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, resulting in escalation actions in place to support patient care.

Despite the challenges, that are several areas where our performance compares favourably across the NHS and these successes are to be celebrated.

I am grateful to all our Trust and system colleagues who have worked to manage the pressures we have been facing across our services over the past month.

A more comprehensive statistical breakdown of the Trust's performance is due to be shared in the Integrated Performance Report (IPR) that is due to be presented later in this meeting.

Planning efforts are also well underway to prepare the Trust to deal with the additional seasonal pressures that we also see each year during winter, which will involve working closely with health and social care colleagues across the county to help manage those pressures together.

Industrial action update

Rising demand for our services has been compounded over the past month by multiple periods of industrial action that create additional complexity in managing the numbers of patients accessing our services.

During July, the Trust was affected by further periods of industrial action across its services - both from Medirest colleagues and from the industrial action called by the British Medical Association (BMA).

The most recent BMA industrial action took place between 7am on Thursday 27th June 2024 and 7am on Tuesday 2nd July 2024, resulting in 487 appointments, operations and procedures being postponed here at Sherwood to allow us to focus on providing safe urgent and emergency care to patients.

Despite those challenges, we managed to deliver 4,645 appointments, operations and procedures during that period. I am grateful to colleagues who worked to ensure that patients could continue to access the care they needed throughout that time.

Financially, the cost of the past year's industrial action now runs to over £8.9million here at Sherwood alone. That figure accounts for the spend to cover lost shifts, lost income opportunities and missed efficiency-saving opportunities. To date, the Trust has received £4.7million of national funding to mitigate the impact of this.

Separately, Medirest colleagues who are members of the GMB Union have engaged in multiple periods of industrial action, with the most recent due to take place between 6am on Thursday 1st August 2024 and 5.59am Saturday 3rd August 2024.

Operational planning has been continuing throughout the month to minimise the impact of that industrial action, as well as to plan for further periods of industrial action that may be called over the coming months.

We continue to hope for a speedy resolution to these national disputes that continue to have a real impact here at Sherwood and across our NHS and we watch with interest in the hope that the change in government will bring the resolution that we are all hoping for.

Integrated Care Board 'at a glance' report shared

The Nottingham and Nottinghamshire Integrated Care Board (ICB) has shared its monthly 'at a glance' report to give a high-level overview of performance and assurance across the Nottingham and Nottinghamshire health and social care system. Their report is included for information below.

The report highlights a number of areas of concern for the system which the Trust will continue to play its part in helping to manage and mitigate the impact of the risks highlighted, with Board oversight of these issues being maintaining through the Trust's Operational Performance Report that is due to be presented later in this meeting:

Integrated Care System
Nottingham & Nottinghamshire

At a glance
Status report July 2024

RED: Urgent, additional actions required, significant risks AMBER: Further actions required to manage identified risks, work in progress GREEN: on track, all required actions in place at the current time or plans in place

Managing today

Timely access to care
- Significant focus on UEC flow remains, but some encouraging improvements –continued improvements in 4 hour and 12-hour ED waits
- Ambulance handover recovery plan still needs further impact at NUH
- Focus on cancer waiting times and 78 week waits – zero 78-week waits achieved, some improvements in cancer waiting times

Quality of care
- Widespread quality concerns in NHT mental health services, with CQC Section 48 review ordered by the Secretary of State
- Improvement Oversight and Assurance Group in place - IOAG (NHT, ICB, NHSE), Integrated Improvement Plan under development, initial focus Section 48 Review
- Safety monitoring metrics in place
- Ockenden Review ongoing, CQC unannounced inspection undertaken

Primary Care
- Ongoing work to consider how flexibilities in use of resources could support general practice resilience
- GP potential industrial action a concern – ongoing engagement concerning potential impacts and mitigations

£
- Detailed 2024/5 operational plan submitted to NHSE – work ongoing to strengthen efficiency plans and identify further areas of improvement / flexibility
- QI system review held in June – significant gap in delivery confidence currently, with additional mitigations / delivery plan development during July
- NHSE requirement for all NHS systems to be back in balance by 31/3/26

Making tomorrow better

Population health / analytics
- Population of health outcomes framework underway to enable tracking of priority areas
- Review of SAIU priorities underway to support plan delivery and evolving ICB operating model (incorporating provider oversight)
- Outcomes metrics developed and endorsed by ICB Board

Inequalities
- Areas for targeted intervention identified in operational plan, approved by the ICB Board
- Health inequalities investment fund schemes identified, with slippage into 24/25
- Approach for 24/25 HIIF schemes to be developed
- Inequalities plan part of 24/25 plans

Transformation
- Transformation priorities developed as part of operational planning – frailty will be a key system priority
- Transformation delivery system approach initiated – first Transformation Delivery Group held and programme leads identified

Workforce
- Recruitment / agency controls strengthened to mitigate unaffordable growth and reduce temporary staffing costs
- Increased granularity across the system in terms of agency controls and bank spend – trajectories being developed as part of operational plan triangulation
- Review of vacancy control processes undertaken – revised whole system approach

Developing the ICS

Place Based Partnerships
- PBP determined priorities confirmed and being implemented
- Community transformation programmes embedding – built into whole system transformation programme
- 24/25 plans under development - will be linked to overall system plans

Integrated Care Partnership
- Ongoing delivery through HWB and operational plans
- Terms of Reference refreshed

Provider Collaborative
- Work plan under development – work areas identified
- Provider Leadership Board refining delivery plans and scope of back office and workforce initiatives (to complement other system working and identify lead areas)
- Development session with ICB Board held

Integrated Care Board
- Developing performance and financial oversight and assurance approach across the system – work commenced to embed new ways of working and align with ongoing statutory ICB duties
- ICS research strategy endorsed by the board

Partnership updates

Welcome to Mid Nottinghamshire's newly-elected Members of Parliament

As a Board, we would like to take this opportunity to formally welcome those Members of Parliament (MPs) who were elected and re-elected in the Mid Nottinghamshire area we serve during July's General Election.

As a Trust, we have always valued the relationships we have enjoyed with our local Members of Parliament and we are sure that will continue with them all over the course of the next parliament.

As a key employer and anchor organisation within their constituencies, the Acting Chair and I have taken the opportunity to write to them all following their election to share more about the Trust's work and to explore how we can work with them to address some of the challenges we will face together over the coming years.

Planned meeting with Newark MP over urgent treatment provision

One of the conversations that will be high on the list of the recently re-elected Member of Parliament for Newark, Robert Jenrick MP, is the provision of urgent healthcare in the Newark area.

Mr Jenrick wrote to the Acting Chair and I during July to discuss this important matter - an opportunity we have welcomed.

The Trust is now working with Mr Jenrick's Constituency Office to arrange a meeting to discuss the topic alongside colleagues from the Nottingham and Nottinghamshire Integrated Care Board (ICB).

Other Trust updates

Damien becomes first patient in the East Midlands to be treated with new Parkinson's drug

A patient here at King's Mill Hospital has become the first in the East Midlands to receive a life-changing new treatment for Parkinson's disease.

Damien Gath, 52, from Derby, underwent the treatment here at Sherwood, where we have been proud to become one of the first hospitals in the East Midlands to offer Produodopa - a new NICE-approved infusion therapy that is administered via a portable pump under the skin for patients with advanced-stage Parkinson's disease.

Mr Gath, who was first diagnosed 12 years ago and has been under the care of Sherwood Forest Hospitals since 2016, underwent treatment with new infusion therapy during July.

A breath-taking video of Damien making a cup of coffee 'before and after' receiving the treatment underlines just how life-changing the treatment is for him. You can watch that incredible video on the Trust's Facebook page here.

Produodopa is administered as a continuous infusion therapy, meaning the patient no longer experiences the fluctuations common in oral drugs caused as a dose of medication fades away and the next dose is not due. The portable drug infusion ensures a gradual release of medication, resulting in greater symptom management. Damien can also administer an additional dose when needed, offering greater personal control over his condition.

Damien reported that he was in considerable pain at night and was unable to sleep or even to turn over, experiencing significant fluctuations in his condition as the effect of the oral drugs were reduced during the night. Since beginning the infusion therapy, which he has been trained to administer himself at home, his quality of life has been transformed.

Teams at the Trust have worked hard to implement this new therapy as soon as it was approved for use by the NHS to ensure it was available for our patients - offering a shining example of the Trust bringing its *Improving Lives* vision to life.

I am grateful to everyone who has played their part in bringing this life-changing treatment to Sherwood.

Professor Sir Jonathan Van-Tam visits King's Mill Hospital

On Wednesday 24th July 2024, we were delighted to welcome Professor Sir Jonathan Van-Tam to King's Mill Hospital for a special visit to the Trust to mark the work we are doing to support the Armed Forces community.

During the visit, Professor Sir Jonathan Van-Tam - who played a leading role in the nation's pandemic response - officially unveiled a 'Veterans Aware' plaque at King's Mill Hospital that recognises the Trust's work to make the Trust a welcoming place to work and receive care for serving and former members of our Armed Forces and their families.

Sir Jonathan comes from a military family and is Honorary Colonel of the Army Cadet Force.

The plaque recognises the Trust achieving the gold standard accreditation - the highest available - from the Veterans Covenant Healthcare Alliance (VCHA), shows the strength of the Trust's commitment to ensuring that those who serve or have served in the Armed Forces and their families are treated fairly whenever they need the Trust's services. This commitment also covers all employees and volunteers across the Trust.

Speaking to members of the staff network, he praised the Trust for the work we are doing to put veterans on the map within the Trust and in the local area. and said he hoped the network goes from strength to strength.

He said it was important to recognise the sacrifice made by members of the Armed Forces and their families, as well as the contribution those with military experience make to civilian life.

During his visit, he also visited the Trust's Hospital Grand Round where he spoke to Trust colleagues about his career history, the challenges faced during the pandemic and how they were tackled, and the importance of good communication.

He also thanked SFH colleagues for their work during the pandemic, saying he knew how awful and traumatic the unprecedented situation was.

We are grateful to Professor Sir Jonathan Van-Tam for the time he took to visit us here at Sherwood.

Sherwood shows its support for Nottinghamshire PRIDE

During July, I joined the PRIDE march at King's Mill Hospital to show the Trust's enduring commitment to making our hospitals a great place to work and receive treatment for people from all backgrounds - including those from our LGBTQ+ communities.

I joined colleagues from across the Trust for the march on Tuesday 16 July ahead of Nottinghamshire PRIDE, while a separate march took place for colleagues at Newark Hospital on Tuesday 23rd July 2024.

#TeamSFH colleagues take part in the Trust's PRIDE march at Newark Hospital

Congratulations to all our Project SEARCH graduates

During July, we were extremely proud to congratulate the 2024 cohort of Project SEARCH interns at their recent graduation ceremony.

DFN Project SEARCH is a one-year transition to work programme for young adults with a learning disability or autism spectrum conditions - or both.

The scheme works hard to challenge and change cultures, demonstrating how young people with a learning disability can enrich the workforce, bring incredible skills and talent, encourage greater diversity, and meet a real business need.

This programme is currently running at our King's Mill and Mansfield Community Hospitals, where interns on the programme gain experience in three job rotations to explore a variety of career paths within the NHS - including in a range of hospitality, business admin, domestic services, pathology and other roles.

It has been an honour to see the progress our interns have been making - both in work and in developing their general life skills - over the last two years and to watch them progress to either work or volunteering.

I congratulate each of our graduates on their work, as well as thanking our Trust colleagues who have been so welcoming and supportive of the interns by offering their help, time and support to these young people.

New electric charging points for King's Mill Hospital

A number of additional electric car charging points have been installed at King's Mill Hospital over recent weeks, as the Trust works to further its environmental commitments and make more sustainable use of its resources and estates over the coming years.

A total of 24 new chargers have now installed in a staff car parking area (Car Park 11) at King's Mill Hospital to allow staff to charge their vehicles while on-shift. The new chargers, which are due to go-live over the coming weeks, will supersede the two chargers currently available for staff on-site.

The introduction of new electric car charging points at King's Mill follow the introduction of 16 new electric car parking spaces at Newark Hospital, which have been introduced as part of the opening of a new 80-space staff car park there in partnership with Newark and Sherwood District Council that is already helping to improve the car parking situation for staff and patients on-site.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Public

Subject:	Integrated Performance Report - 2024/25 Q1	**Date:**	1st August 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	Failure to achieve the Trust's financial strategy	✓
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

A version of the Quality of Care and Timely Care domain reports were considered by the Quality Committee on 22nd July 2024. Recommended updates have been made to the report.
The whole report was reviewed by the Executive Team on 24th July 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.

The key performance indicators for 2024/25 have been updated to reflect the IPR annual review that was considered by Trust Board in July 2024. There are a total of 67 indicators reported in the quarter one report. Two indicators remain under-development and will be added to a future report (outpatient attends that are first or follow up with a procedure and an implied productivity measure).

This report is for 2024/25 quarter one. 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 one. We have experienced very high urgent care demand which has exceeded planned levels. The surging accident and emergency attendance demand (11% above plan) and non-elective admission demand (13% above plan) 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 have been further periods of disruptive industrial action in 2024/25 quarter one from both our junior doctors and our Medirest colleagues as part of the ongoing pay dispute. Pay negotiations are outside of our control and we continue to respect our colleagues right to take industrial action and focus 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) and by the end of 2024/25 quarter one we have successfully eliminated referral to treatment patients waiting longer than 78-weeks. 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.

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 1

Integrated Scorecard

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

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	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	✓ 0
		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	✓ 6.3
		Never events	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1
		MRSA reported in month	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	✓ 13
		Ecoli blood stream infections (BSI) reported in month	≤22	≤22	✓ 0	✓ 6	✓ 5	✓ 11	✓ 3	✓ 5	✓ 3	✓ 11	✓ 5	✓ 1	✓ 4	✓ 10	✓ 10
		Klebsiella BSI reported in month (hospital onset)	≤1	≤1	✓ 1	✓ 1	✓ 1	✗ 3	✗ 2	✓ 1	✓ 0	✗ 3	✓ 0	✓ 1	✗ 2	✗ 3	✗ 3
		Pseudomonas BSI reported in month	≤3	≤3	✓ 0	✓ 1	✓ 1	✓ 2	✓ 2	✓ 1	✓ 1	✗ 4	✓ 0	✓ 0	✓ 1	✓ 1	✓ 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	0.1
		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	✗ 2
		Patient Safety Incident Investigations (PSII)			1	2	2	5	2	1	0	3	3	4	-	-	7
	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	✓ 1.0
		Compliments received in month			103	158	150	411	151	122	120	393	161	138	151	450	450
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 127	✗ 125	✗ 126	✗ 126	✗ 131	✗ 129	✗ 126	✗ 126	✗ 129	✗ 126	✗ 124	✗ 124	✗ 124
		SHMI	≤100	≤100	✗ 108	✗ 107	✗ 107	✗ 107	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 107
		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	✓ 0.0	✓ 1.2	✓ 1.2
		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
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 7.3	-	-	-	-	-	-	-	-	-
	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%	✓ 8.1%
		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%
		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%	✗ 88.4%
		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%	✓ 91.0%
	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%	✗ 4.4%
		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%	✓ 6.5%
		Flu vaccinations uptake (front line staff)	≥80%	≥80%	✗ 38.3%	✗ 44.8%	✗ 55.9%	✗ 55.9%	✗ 58.0%	✗ 58.0%	-	✗ 58.0%	-	-	-	-	-
		Employee relations management	<12	<17	✗ 21	✗ 23	✗ 18	✗ 21	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✗ 23	✗ 22	✗ 22
	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%	9.0%
		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%	✗ 4.7%
		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%
		Agency (over price cap)	≤30.0%	≤40.0%	✗ 51.0%	✗ 55.7%	✗ 57.0%	✗ 54.3%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 54.5%	✗ 54.1%	✗ 57.4%	✗ 55.4%	✗ 55.4%
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%	✓ 96.1%
		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%	✗ 0.1%
		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%	✗ 72.8%
		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%	✗ 2.5%
		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%	✓ 38.2%
		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%	✗ 94.4%
		Long length of stay (21+) occupied beds	≤Plan	≤Plan	✓ 100	✗ 109	✗ 100	✗ 103	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✓ 110
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 90	✗ 98	✗ 92	✗ 94	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 75
	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%	-	-	✓ 25.1%
		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%	✓ 6.0%	✓ 6.0%	✓ 6.0%
		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	✗ 35,720
		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	✓ 1,177
		Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 362	✗ 337	✗ 418	✗ 418	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✗ 109	✓ 109
		Incomplete RTT pathways +78 weeks	0	0	✗ 7	✗ 5	✗ 14	✗ 14	✗ 17	✗ 12	✗ 5	✗ 5	✗ 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	3,861
		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%	✗ 70.5%
	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%	-	-	✓ 77.7%
		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%	-	-	✓ 88.7%
		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%	-	-	✗ 64.0%
		Suspected cancer patients waiting over 62-days			89	86	89	89	76	50	52	52	80	69	70	70	70
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	✗ -£0.61
		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	✓ £1.59
		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	✗ £5.07
		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	£1.50
		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%
		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	✗ -£0.76
		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	£3.87
		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	£7.72
Activity (for context)	Urgent Care	A&E attendances	≤Plan	≤Plan	✗ 109.1%	✗ 109.1%	✗ 104.3%	✗ 107.5%	✗ 108.1%	✗ 112.3%	✗ 114.2%	✗ 111.5%	✗ 113.2%	✗ 111.5%	✗ 109.2%	✗ 111.2%	✗ 111.2%
		Non-elective admissions	≤Plan	≤Plan	✗ 121.4%	✗ 124.2%	✗ 114.1%	✗ 119.9%	✗ 119.9%	✗ 118.6%	✗ 116.0%	✗ 118.2%	✗ 111.4%	✗ 116.8%	✗ 110.8%	✗ 113.0%	✗ 113.0%
	Electives	Average daily elective referrals			310	316	260	295	314	327	304	315	343	340	325	336	336
		Outpatients - first appointment	≥Plan	≥Plan	✓ 102.9%	✓ 109.1%	✗ 96.4%	✓ 103.0%	✓ 108.3%	✓ 106.3%	✓ 109.7%	✓ 108.1%	✗ 99.3%	✗ 93.2%	✗ 93.1%	✗ 95.1%	✗ 95.1%
		Outpatients - follow up	≤Plan	≤Plan	✗ 102.1%	✗ 108.1%	✓ 95.1%	✗ 101.9%	✗ 107.5%	✗ 105.0%	✗ 106.2%	✗ 106.2%	✓ 100.0%	✓ 99.2%	✓ 93.0%	✓ 97.4%	✓ 97.4%
		Outpatients - procedures	≥Plan	≥Plan	✓ 113.9%	✓ 126.4%	✓ 116.0%	✓ 118.9%	✓ 121.7%	✓ 125.3%	✓ 123.0%	✓ 123.3%	✓ 133.0%	✓ 129.1%	✓ 115.1%	✓ 125.5%	✓ 125.5%
		Day case	≥Plan	≥Plan	✗ 86.7%	✓ 101.3%	✗ 91.8%	✗ 93.3%	✓ 100.2%	✓ 101.5%	✓ 109.8%	✓ 103.7%	✗ 96.3%	✗ 96.1%	✗ 95.4%	✗ 96.0%	✗ 96.0%
		Elective inpatient	≥Plan	≥Plan	✗ 86.8%	✓ 108.9%	✓ 107.1%	✓ 100.7%	✓ 101.9%	✓ 110.8%	✓ 129.3%	✓ 113.5%	✗ 92.5%	✗ 94.6%	✗ 92.9%	✗ 93.4%	✗ 93.4%
	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%	✓ 103.2%

Outstanding Care,
Compassionate People,
Healthier Communities

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Quality of Care

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Domain Summary: Quality of Care

Overview	Lead: Chief Nurse/Medical Director

In 2024/25 quarter one (Apr-Jun) there is a continued high volume of people accessing urgent care, with the Trust at surge capacity. This prolonged, unrelenting period of operational pressure impacts on our ability to provide good, safe patient care. Long waits for admission and overcrowding impact on our patients and staff within our Emergency Department (ED). The British Medical Association (BMA) Industrial Action (IA) has continued during quarter one with four days of action at the end of Jun-24. During quarter one we received 490 compliments, 435 concerns, 64 formal complaints, and we closed 541 concerns and 80 formal complaints. We continue to identify actions and themes which 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. All hospital associated infections have a rapid review completed to look at alternative root causes including waiting for procedures or recurrent infections. PSIRF does not impact or change current methods of mandatory reporting of key alert infections such as MRSA, E.coli, Pseudomonas aeruginosa, Klebsiella, MSSA bacteraemia's and C. difficile. There remains a zero tolerance for MRSA bacteraemia and thresholds in place for C. difficile and the Gram-Negative bacteraemia, national trajectories have not yet been released but are expected imminently.

The Trust has not had an MRSA bacteraemia for two years (and we are the only Trust in the region not to have had one this financial year). We have seen a reduction in the number of C. difficile cases compared with the same period last year and we are maintaining our trajectory for E.coli and Pseudomonas cases.

Seven Patient Safety Incident Investigations (PSIIs) were commissioned by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the Integrated Care Board (ICB) were represented. There is one confirmed coroner's investigation in relation to the delay in recognising a low magnesium PSII. This has been RAG-rated as red by the Trust legal team.

There are six indicators reported on as off track in 2024/25 quarter one:

- **Falls per 1000 occupied bed days**: Falls rate for Jun-24 was 6.7. This is slightly above the national target of 6.63; however, we remain on track for quarter one with a strong performance in Apr-24 and May-24.
- **Never Events:** Apr-24 we reported an incident relating to wrong site surgery in Dermatology. This was reported as a PSII and the investigation is underway.
- **The gram-negative blood stream infections:** Klebsiella. Three cases reported in 2024/25. We are currently benchmarking against our peer organisation as showing to have the second lowest number of cases with numbers of Klebsiella increasing in the region. Work is underway locally and at a system level to address the learning from reported cases.
- **Hospital Acquired Pressure Ulcers (HAPU):** Two avoidable category three pressure ulcers. The process for investigating pressure ulcers has been reviewed in line with Learning from Patient Safety Events (LFPSE). After action reviews (AAR) are completed for all hospital acquired pressure ulcers involving the Tissue Viability team, ward leaders, matrons and staff involved in the incident. AAR's continue to be presented and discussed at the monthly pressure ulcer panel meeting. Learning from incidents is shared widely by the Tissue Viability team. There is currently no national system in place for comparison; however, SFH pressure ulcer figures are significantly lower compared to data shared regionally by Tissue Viability colleagues.
- **HSMR:** Remains above expected but an overall downward trend has been sustained alongside individual month reporting remaining "as expected", despite re-basing and reported national data issues.
- **SHMI:** Continues to remain as expected.

Further details relating to Quality-of-Care metrics are included in the following pages.

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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	2024/25 YTD
Safe	Falls with lapse in care	≤2	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	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	✓ 6.3
	Never events	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1
	MRSA reported in month	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	✓ 13
	Ecoli blood stream infections (BSI) reported in month	≤22	≤22	✓ 0	✓ 6	✓ 5	✓ 11	✓ 3	✓ 5	✓ 3	✓ 11	✓ 5	✓ 1	✓ 4	✓ 10	✓ 10
	Klebsiella BSI reported in month (hospital onset)	≤1	≤1	✓ 1	✓ 1	✓ 1	✗ 3	✗ 2	✓ 1	✓ 0	✗ 3	✓ 0	✓ 1	✗ 2	✗ 3	✗ 3
	Pseudomonas BSI reported in month	≤3	≤3	✓ 0	✓ 1	✓ 1	✓ 2	✓ 2	✓ 1	✓ 1	✗ 4	✓ 0	✓ 0	✓ 1	✓ 1	✓ 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	0.1
	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	✗ 2
	Patient Safety Incident Investigations (PSII)			1	2	2	5	2	1	0	3	3	4	-	-	7
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	✓ 1.0
	Compliments received in month			103	158	150	411	151	122	120	393	161	138	151	450	450
Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 127	✗ 125	✗ 126	✗ 126	✗ 131	✗ 129	✗ 126	✗ 126	✗ 129	✗ 126	✗ 124	✗ 124	✗ 124
	SHMI	≤100	≤100	✗ 108	✗ 107	✗ 107	✗ 107	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 107
	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	✓ 0.0	✓ 1.2	✓ 1.2
	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

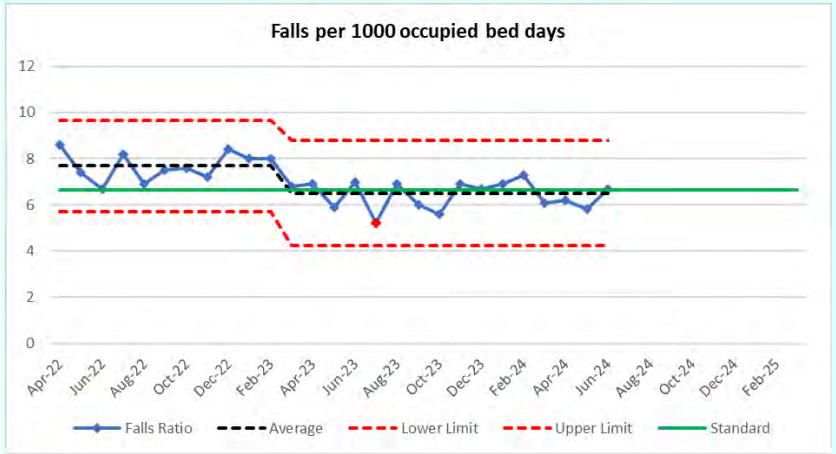
Indicator in Focus: Falls per 1000 occupied bed days

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The falls rate for Jun-24 is 6.7 this is slightly above the national target of 6.63 per thousand occupied bed days.
- Jun-24 saw an increase in falls with 142 overall and an increase in repeat falls.
- High volume of people accessing urgent care and high (albeit reducing) numbers of medically safe patients remain in acute beds.
- Community of Practice have pulled together data and summarised this through a report for Trusts. The next Community of Practice meeting will be held Sep-24
- There have been no lapses in care reported post falls (currently awaiting two to be discussed at PSIRG).
- One coronial inquest; awaiting date.

Data



Root causes	Actions and timescale	Impact
Increase in the number of inpatient falls for June 2024. There has been a limited falls service for May-24 and Jun-24.	• Recruitment for additional Falls Prevention Practitioner currently advertised.	• Sep-24
	• Implementation of After-Action Reviews post falls in line with PSIRF.	• Sep-24
	• Visual Acuity check is with the digital developers awaiting roll out plan.	• Ongoing
	• Training sessions planned for Falls Champions.	• Oct-24
	• Essential for role training commenced involving patient stories related to falls.	• Twice a month – ongoing
Nationally deconditioning of the population has been highlighted as a concern for the increase of falls.	• NNICS work continues to look at how Trusts are alerted about the history of falls when a patient is admitted. Working with the system and the digital team.	• Ongoing
	• Lying and standing blood pressure on Nervecentre (hospital information system), aligned to national recommendations. Training rolled out Trust-wide.	• Ongoing

Indicator in Focus: Never Events

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

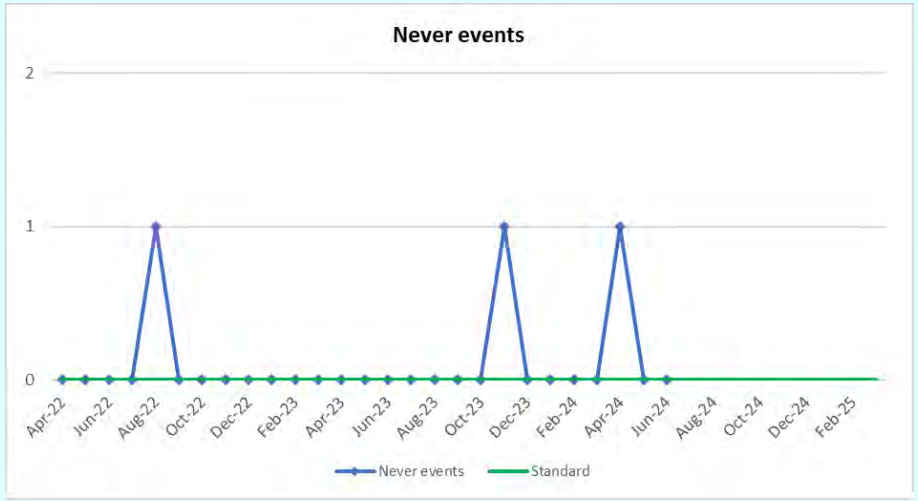
NHS England state that: “Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.” (Never Events policy and framework, Jan-18).

At the time of this report being produced the Provisional Never Events 2024/2025 data: 1 April 2024- 31 May 2024 has been published indicating there were 51 Never Events reported Nationally of which 6 were wrong skin lesion removed/ biopsy.

In Apr-24 SFH reported an incident relating to wrong site surgery in Dermatology:
Patient attended clinic for punch biopsies of two lesions one on the left cheek and the other was on upper lip. She attended ED later that day due to pain at the operation site. On removal of the wound dressing, the patient reported that the biopsy taken from her cheek was not the lesion for which the punch biopsy was planned - incorrect site skin lesion biopsy.
An external review has been commissioned and is being undertaken by colleagues from Nottingham University Hospitals NHS Trust (NUH). This had a target completion date of 10th Jul-24; however, the investigation is ongoing.

Root causes	Actions and timescale	Impact
The incident has been reported on Strategic Executive Information System (STEIS) and declared a Never Event. A formal investigation is being undertaken using an external investigator from NUH.	• Policies will need updating at a Trust and divisional level taking recommendations from National Safety Standards for Invasive Procedures (NATSSIPS) 2. • Moving forwards and until leaning has been identified and actions put in place these procedures and biopsies to be undertaken by substantive staff. • External review required – whilst waiting for the external review, look at the previous Never Event in Dermatology and establish whether environmental factors contributed to these. Surgery within Dermatology is performed outside of the theatres, using a clinical area. Is this contributing to a difference in the formality of a WHO? • Review human factors elements of the incident / process / cultural differences.	• Ongoing.

Data



Date reported	Detail	Division	Specialty
17/08/22	Removal of wrong skin mole – left scapula	Medicine	Dermatology
04/12/2023	Removal of wrong skin lesion - back	Medicine	Dermatology
16/04/2024	Removal of wrong skin lesion - face	Medicine	Dermatology

Indicator in Focus: Klebsiella BSI reported in month

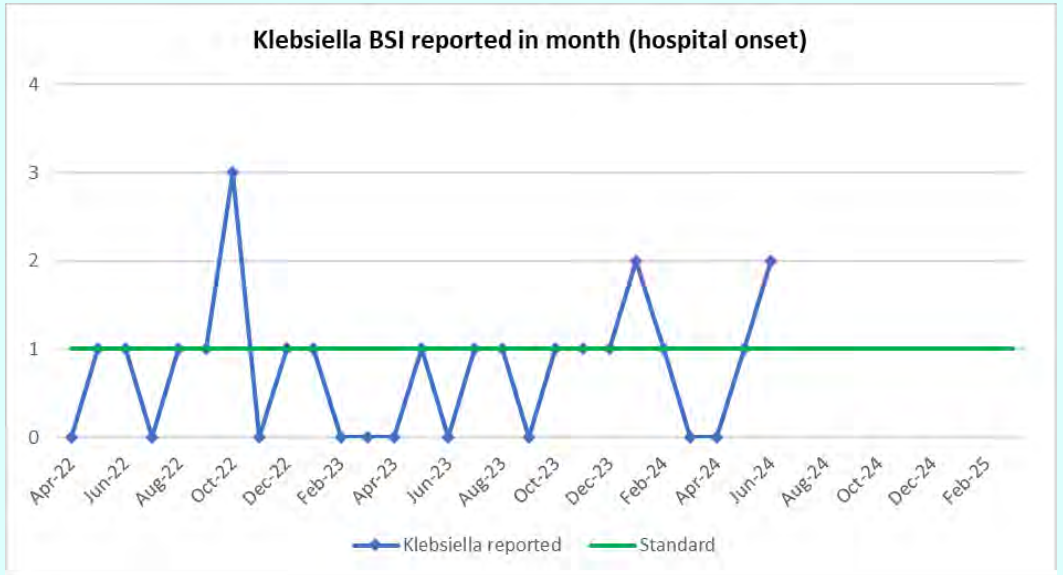
Sherwood Forest Hospitals NHS Foundation Trust

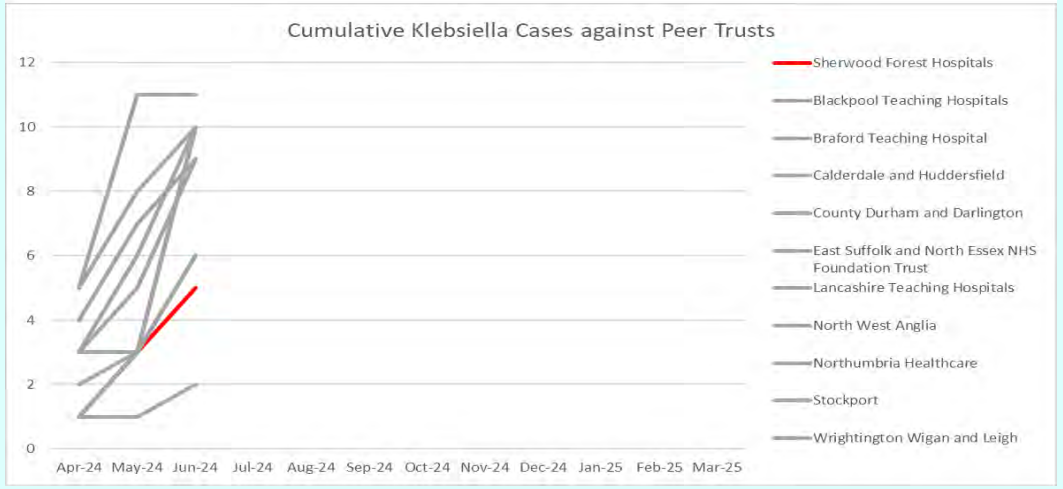
Overview and national position

The national trajectories have not yet been released, although it is believed they will be the same as last year and the Trusts for Klebsiella was 22. We have had five hospital associated cases during 2024/25 quarter one (three hospital onset and two community onset). When benchmarked against our peer trusts for all hospital associated cases we have the second lowest number of cases. Numbers of Klebsiella have been increasing in the region.

Root causes	Actions and timescale	Impact
Four out of five of the bacteraemia's were caused by Urinary Tract Infections (UTI'S), one related to a catheter.	• A UTI strategy is being developed at a system level (lead by ICB) to support work on reducing UTI's in the region. Currently out for comment and for ratification in Aug-24.	• To support with a region wide reduction in UTI's.
	• A UTI awareness campaign will be held in Aug-24.	• Raise awareness on how to prevent UTI's.
	• Urinary catheter project is underway to reduce the length of time catheters are in-situ.	• Reduce catheter UTI's.
Three of the five UTI's have had recurrent infections.	• A joint healthcare-associated infection (HCAI) review meeting has been commenced with the ICB Infection Prevention and Control team to discuss and review these types of cases to enable actions to be undertaken by both the General Practitioner (GP) and the Hospital.	• Joint working in the reduction of UTI's.

Data





Indicator in Focus: Hospital Acquired Pressure Ulcers (HAPU)

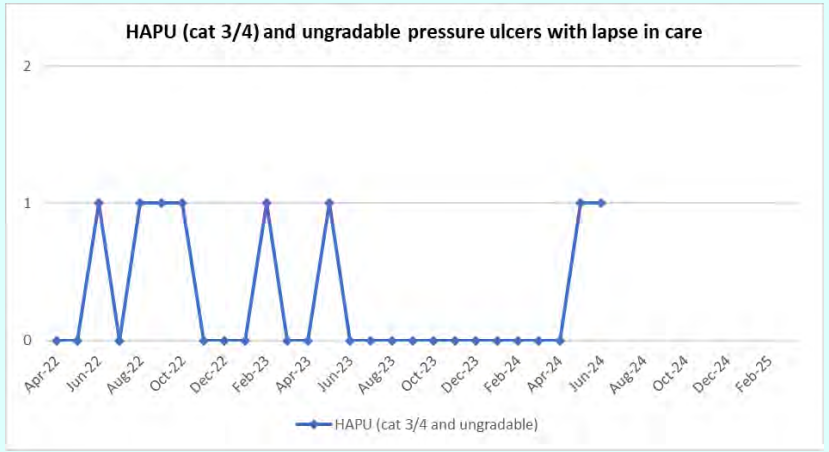
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Pressure ulcers are reported as 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 Trust position is that all Trust acquired pressure ulcers are investigated to identify learning. Pressure ulcers (PU) are categorised as having 'no lapses in care' or 'avoidable' where learning is identified.
In 2024/25 quarter one SFH has had two avoidable category three pressure ulcers:

- ED investigated a category three PU to a patient's wrist which was found on removal of a back-slab in theatre. The back slab had been applied two weeks prior to surgery in ED. The Orthopaedic Senior House Officer (SHO) had performed 'swell checks' below the back-slab prior to surgery.
- Ward 31 investigated new category three pressure damage to a patient's ischium. The patient was admitted with an existing complex category four PU to her sacral area. Multiple MDT meetings have taken place and the Safeguarding team are involved with this patient.

Data



Root causes	Actions and timescale	Impact
ED: No skin check recorded in ED prior to application of back-slab; no clear record regarding application of cast in ED.	• Communication and education in ED. • Review of skin check procedure prior to cast application in ED. • Review of how patients with vulnerable skin are identified pre and post cast application.	• Actions complete.
Swell checks performed on ward 12 by the SHO; However, no record noted of skin condition or developing PU.	• Incident to be shared and discussed at Orthopaedic divisional governance forums and learning to be disseminated to junior teams.	• Actions complete.
Ward 31: Omissions in wound assessments of ischial and sacral assessment.	• Audits and monitoring in place to increase percentage in compliance in fully completing wound assessments in line with policy and procedure. • Ward staff attending Tissue Viability training. • Risk management for patients making unwise decisions to be incorporated into Tissue Viability training. Tissue Viability team to advocate early use of high-risk immersion therapy mattresses.	• Actions complete. Ongoing monitoring.

Indicator in Focus: Patient Safety Incident Investigations (PSII)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

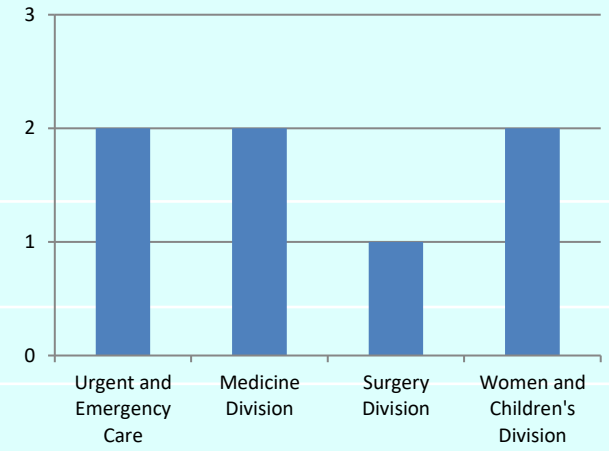
NHS England states that "A PSII offers an in-depth review of a single patient safety incident or cluster of incidents to understand what happened and how." In line with SFH's Patient Safety Incident Response Plan during 2024/25 quarter one, seven PSII's were commissioned by the Patient Safety Incident 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 seven patients have died; however ,there is currently only one confirmed coroner's investigation in relation to the magnesium delay in care PSII. This has been RAG-rated as red by the Trust legal team.	None commenced.	One - see earlier slide for details (not included in table below).

Data

Root causes	Actions and timescale	Impact
Possible missed Acute Kidney Injury (AKI) which was may have contributed to the death of the patient.	PSII commissioned, no immediate learning. Potential coronial involvement, however, not yet listed on Trust legal dashboard.	Ongoing investigation.
A repeat blood test indicative of magnesium levels of 0.3 (significantly below the reference range 0.7-1.0) was not reviewed and acted upon.	Legal team informed that PSII in progress. Urgent learning identified: •Urgent conversation to be had with the pathology labs around the immediate process for communicating and highlighting critically abnormal results. •Urgent communication is required to the wards around the handling of the critically abnormal results that are handed back and how these are communicated and acted on appropriately. •To consider whether the magnesium results can go at the top of the results page, so they are more easily noticeable	Immediate comms undertaken. PSII ongoing.
Reoccurring theme in relation to missed opportunities to identify patients who meet the criteria for a silver trauma CT scan and escalation to the trauma team.	PSII commissioned. Immediate learning: Emergency Department Governance Lead to cascade reminder of criteria for silver trauma with all departmental clinicians.	Learning cascaded PSII ongoing.
Hospital acquired C-Diff listed in part one of patient's death certificate.	Potential coronial involvement; however, not yet listed on Trust legal dashboard. No immediate learning identified.	Ongoing PSII.
Significant delay in a gynaecology patient returning to theatre for an emergency laparotomy.	Immediate review of initial surgery undertaken completed and concerns around technique used by the lead surgeon discussed within the team.	Ongoing PSII.
Near miss case whereby a patient was identified to have socks tied around their neck which were removed with a ligature cutter.	Immediate learning: Communications to all staff to ensure they are aware of where ligature cutters are located and where to obtain additional training on use of these if required.	Immediate learning completed PSII ongoing.

PSII by Division for Q1



Indicator in Focus: Summary Hospital-level Mortality Indictor (SHMI)

NHS Sherwood Forest Hospitals NHS Foundation Trust

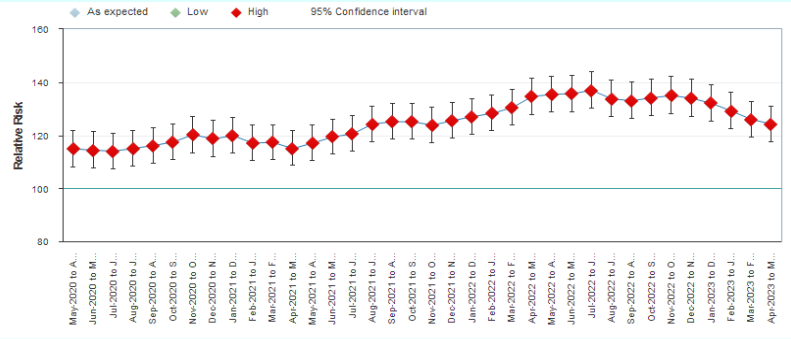
Overview and national position

HSMR- Latest 12-monthly rolling figure = 126.9 (Apr-23 to Mar-24). Remains above expected but an overall downward trend has been sustained alongside individual month reporting remaining "as expected", despite re-basing and reported national data issues.
SHMI- Latest **reporting** = 108.0 (May-24); this continues to remain as expected.

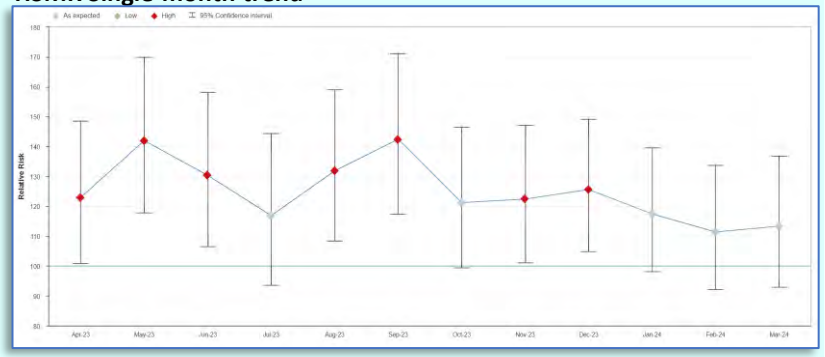
Root causes	Actions and timescale	Impact
Data Quality- Emphasis on timely diagnosis, documentation, coding and co-morbidity capture.	• Continued monitoring of documentation, specifically review of admission clerking workbook, alongside further divisional and individual meetings with an emphasis on accuracy and capture of co-morbidities and diagnosis. Promotion of culture to establish timely diagnosis, signposting and management.	Will take 12 months after action to see signs of impact.
Pathways and Patient Flow- Review of admission pathways, use of management bundles and signposting pathways.	• Continued emphasis on senior decision making to support timely and effective management, thereby enabling right care, first time and helping reduce unnecessary referrals or transfers of care. • Review of patient flow and how this may impact data capture and coding; including ED, SDEC, consultant episodes and inter-specialty. • Outlier reviews continue within context of HSMR reporting and Learning from Deaths, to identify Trust opportunities for improvement and acknowledgement of "system-wide" challenges.	As above; forms part of overall working approach.
Palliative Care Coding- **(**Remains lowest, nationally).	• Clinical review of Front Door Specialist Palliative Care (SPC) intervention, with local provider, to promote timely recognition of status and needs, ensure effective coding and capture of SPC activity, whilst identifying improvement opportunities and supporting clinical teams.	SPC low activity compared to overall. Requires Trust and ICB resource / investment.
Other areas: **Data Intelligence-** Benchmarking, analysis and triangulation of other intelligence (eg ME, ICS and BI). **External peer review / support-** **New Initiatives / Collaboration-** **Data Benchmarking**	• Close working with Telstra, provision of data analytics and wider benchmarking intelligence. Continued data interrogation, targeted reviews, internal audits and deep dives with focus on clinical ownership • Learning from Deaths (LfD) as the vehicle for review, monitoring and action. • HSMR methodology changes (HSMR+) are awaited (retrospective review has shown, what would be, a general improvement in HSMR) • Meeting with Dudley Group undertaken and planned visit to better understand approaches, review coding practice and gain support. • ICS-wide Patient Safety meetings with LfD as part of this. • "Interface Workstream" now in place and facilitating targeted work, alongside developing collaborative relationships and understanding. • Benchmarking tool tender process to ensure value and meets needs.	National data issues have led to reporting delays; now resolved. HSMR+ to be monitored until implementation. Benefits realisation are not anticipated until 12 months effect of any actions. Implementation awaited.

Data

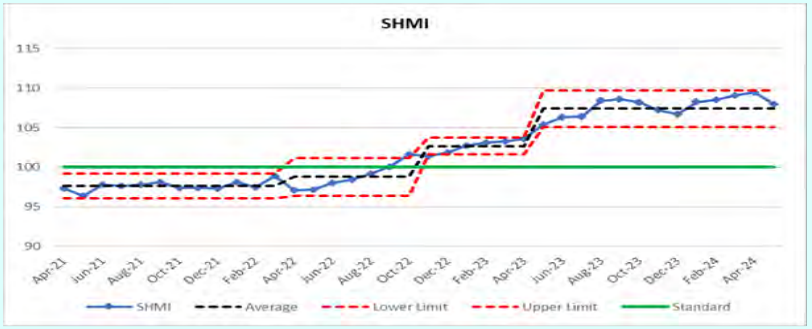
HSMR 3 yearly (12 month rolling) trend



HSMR Single-month trend



SHMI



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Compassionate People,
Healthier Communities

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People and Culture

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Domain Summary: People and Culture

Overview	Lead: Director of People

Between Apr-24 and Jun-24, it has been a busy time across the hospital and within the ICS, with 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.

Our Mandatory and Statutory Training (MaST) position is positive where 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 one (88.4%) sits marginally below the Trust target (90%), we have noted a static position in compliance over the last few quarters. During Jun-24 the level sits at 88.1%; however, this is still a strong level of performance. We have undertaken an audit around appraisals where we have received a high assurance level.

Over 2024/25 quarter one our sickness absence level is reported at 4.4% (2023/24 quarter four was 4.6%), this does sit higher than Trust target (4.2%) and sits between the upper and lower statistical process control levels.

There has been an increase with employee relations cases over the quarter (average 22). We have seen a marginal increase over the quarter with Jun-24 recorded at 23 cases, this sits above our target (17) and within the statistical process control limits. The Trust has seen several formal disciplinary cases being concluded between Apr-24 and Jun-24 and as a result there has been an increase in the number of appeals. This increase in appeals was anticipated.

Within Nottinghamshire our Integrated Care Board (ICB) has been flagged for high agency usage and we have a system programme to review our agency usage. Across the ICB we are active in this agency working group and we do understand where we have high usage within the Trust. We also have developed internal control meetings that are supporting our financial improvements. Our current agency position for quarter one is reported at 4.7%, when we exclude Elective Recovery Fund schemes from the agency level this reduces to 4.1%.

Over the quarter, of the agency shifts filled, we have seen very low levels of those filled by off framework workers over the last quarter and for May-24 and Jun-24 we have seen zero off framework. From Jul-24 new rules commence where the is an expectation to have a zero off framework usage.

During quarter one, 55.4% of total agency shifts filled were ‘on framework’ staff but above the recommended NHS England price cap. During the last quarter significant work has commenced that aligns to our 100 days plan and ambition to reduce our reliance on agency usage and financial recovery challenge. We are currently advertising a significant level of medical consultant posts and are confident this will directly impact on the levels of agency usage.

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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	2024/25 YTD
Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 7.3	-	-	-	-	-	-	-	-	-
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%	✓ 8.1%
	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%
	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%	✗ 88.4%
	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%	✓ 91.0%
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%	✗ 4.4%
	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%	✓ 6.5%
	Flu vaccinations uptake (front line staff)	≥80%	≥80%	✗ 38.3%	✗ 44.8%	✗ 55.9%	✗ 55.9%	✗ 58.0%	✗ 58.0%	-	✗ 58.0%	-	-	-	-	-
	Employee relations management	<12	<17	✗ 21	✗ 23	✗ 18	✗ 21	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✗ 23	✗ 22	✗ 22
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%	9.0%
	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%	✗ 4.7%
	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%
	Agency (over price cap)	≤30.0%	≤40.0%	✗ 51.0%	✗ 55.7%	✗ 57.0%	✗ 54.3%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 54.5%	✗ 54.1%	✗ 57.4%	✗ 55.4%	✗ 55.4%

Indicator in Focus: Appraisals

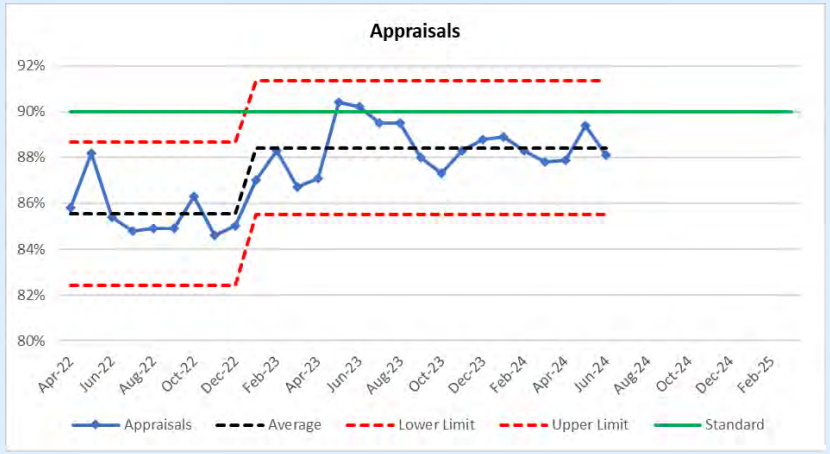
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Our appraisal level sits below the Trust target (90%), we have noted the appraisal level is at a similar level to 2023/24 quarters three and four. The 2024/25 quarter one average sitting at 88.4%. Over the quarter the level ranged from 87.9% to 88.1%. Although we are marginally under the standard this is still a strong level of performance.

Local benchmarking shows that the ICB provider appraisal level is reported at 86.1%. National levels within the model hospital are reported at 82.5% (Sep-23).

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 addition 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 how to report this via the Electronic Staff Record (ESR).	• Training and coaching managers on how to enter appraisals onto ESR is on 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 one our overall sickness absence level was 4.4%, this sits above our standard (4.2%). During the quarter, a gradual increase in the level is noted. The position for Jun-24 is reported at 4.7%. Our position for quarter one 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 5.2% (Mar-24).

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 out Full Capacity Protocol (FCP).

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

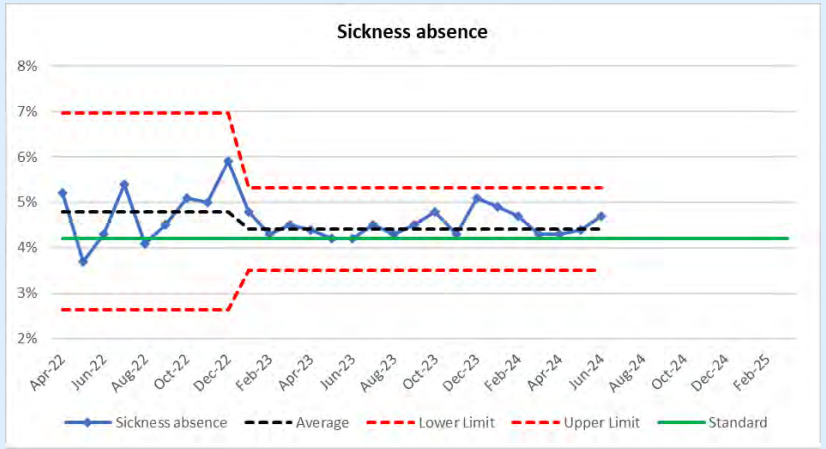
Actions and timescale

- 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.

Data



Indicator in Focus: Employee Relations Management

Sherwood Forest Hospitals NHS Foundation Trust

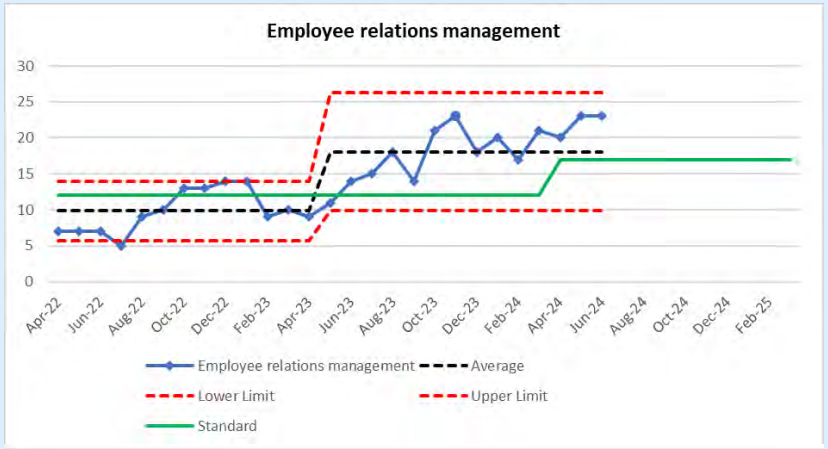
Overview and national position

Since Feb-24 we have seen a gradual increase to the employee relations cases, currently we are reporting 22 cases for 2024/25 quarter one.

During quarter one this level has fluctuated and in Jun-24 we reported 23 cases. Our current level sits above the standard and sits between the statistical process control levels.

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

Data



Root causes

The Trust has seen several formal disciplinary cases being concluded between Apr-24 and Jun-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 are we move into 2024/25 quarter two. 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)

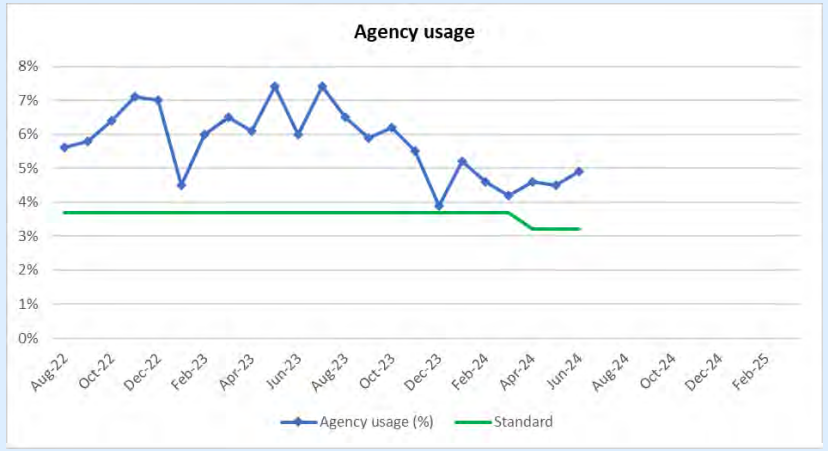
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Our overall agency position across 2024/25 quarter one was 4.7% (excluding Elective Recovery Fund initiatives this reduces to 4.1%), this does sit above the target level of 3.2%. We have modelled this with plans over the 2024/25 period to reduce to the NHS Planning guidance and our target of 3.2%.

The reduction to this is aligned to 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 were 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, the reduction are noted across the 2024/25 period.
	• We continue to advertise and fill medical posts, that 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 one (Apr-Jun) we continued to experience surging numbers of A&E attends (over 11% more than plan) and ambulance arrivals in Jun-24 were amongst the highest levels we have ever seen. Non-elective (NEL) admission demand was 13% above our plan (which included 0.6% growth on 2023/24 levels) meaning that pressures on our clinical teams and on our bed-base remained high despite Medically Safe for Transfer (MSFT) and long stay patient numbers being at some of the lowest levels we have seen outside of the peak pandemic periods of 2020 and 2021. 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, mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals. This mismatch in demand and capacity resulted in us starting the day on Operational Pressures Escalation Level (OPEL) 4 on 50 days during quarter one (14 in Apr-24, 17 in May-24 and 19 in Jun-24) 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 the challenges, 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. We have continued additional emergency department staffing schemes introduced in Mar-24 throughout quarter one to help manage the high attendance demand. We are working with our system partners to try and gather a more detailed understanding of the drivers of the high urgent care demand. Due to the actions taken, our 4-hour performance has remained stronger in quarter one than the winter period despite the increasing pressures caused by the sustained high demand.

In quarter one we had a further period of Industrial Action that resulted in curtailments in elective activity (particularly outpatients) which adversely impacts on our elective activity, backlog and performance metrics. Despite this, we have still managed to reduce the number of long waiting patients, delivering against the plans we set for 2024/25 at the end of the last financial year. We continue to work together as a system with patients being transferred between providers to support equity of access. We are benefiting from support from Nottingham University Hospitals (NUH) to help with our Echocardiograph position, one of our underperforming diagnostic tests, which together with insourcing plans is gradually helping us to reduce the significant backlog. 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 above plan for outpatient procedures. We have a stretching plan for outpatient first attends and are implementing our Getting It right First time (GIRFT) action plans together with insourcing to further improve our outpatient offer. We remain a strong performer in our provision of Advice and Guidance and have consistently exceeded the 5% Patient Initiated Follow Up (PIFU) target.

In terms of our Cancer metrics, we continue our strong delivery of the national 28-day faster diagnostic standard exceeding the national standard. At month two (May-24) we delivered against our planning trajectory for cancer 31-day treatments. Unfortunately, we are off track against our planning trajectory for the cancer 62-day treatment standard with our focus being on Lower GI recovery. We have further work to do to improve performance in the treatment phase of the pathway, with our benchmark position for both the 31-day and 62-day standards needing to improve.

Further details relating to Timely Care metrics are included in the following pages with metrics grouped together within the relevant care pathways.

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Scorecard: Timely Care

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

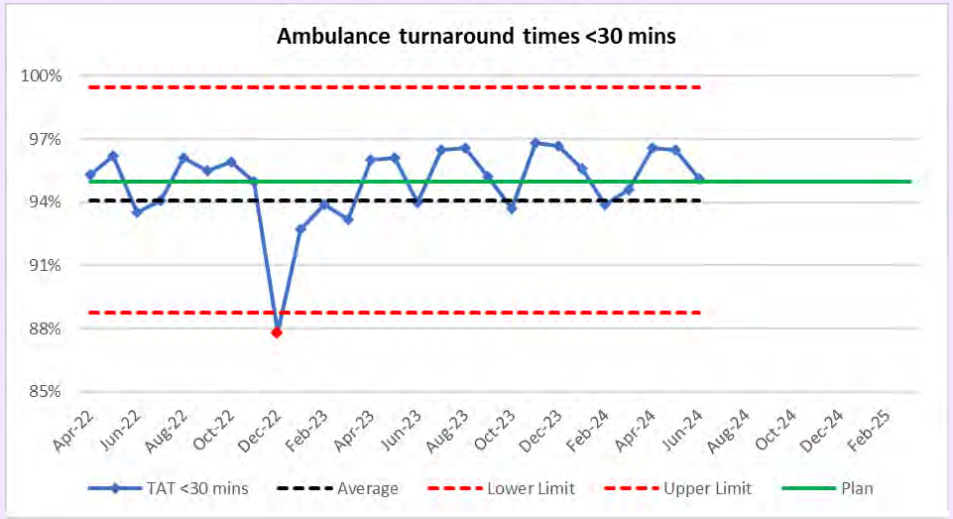
At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	2024/25 YTD
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✗ 93.7%	✓ 96.8%	✓ 96.7%	✓ 95.7%	✓ 95.6%	✗ 93.9%	✗ 94.6%	✗ 94.7%	✓ 96.6%	✓ 96.5%	✓ 95.1%	✓ 96.1%	✓ 96.1%
	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%	✗ 0.1%
	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%	✗ 72.8%
	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%	✗ 2.5%
	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%	✓ 38.2%
	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%	✗ 94.4%
	Long length of stay (21+) occupied beds	≤Plan	≤Plan	✓ 100	✗ 109	✗ 100	✗ 103	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✓ 110
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 90	✗ 98	✗ 92	✗ 94	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 75
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%	-	-	✓ 25.1%
	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%	✓ 6.0%	✓ 6.0%	✓ 6.0%
	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	✗ 35,720
	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	✓ 1,177
	Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 362	✗ 337	✗ 418	✗ 418	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✓ 109	✓ 109
	Incomplete RTT pathways +78 weeks	0	0	✗ 7	✗ 5	✗ 14	✗ 14	✗ 17	✗ 12	✗ 5	✗ 5	✗ 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	3,861
	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%	✗ 70.5%
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%	-	-	✓ 77.7%
	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%	-	-	✓ 88.7%
	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%	-	-	✗ 64.0%
	Suspected cancer patients waiting over 62-days			89	86	89	89	76	50	52	52	80	69	70	70	70

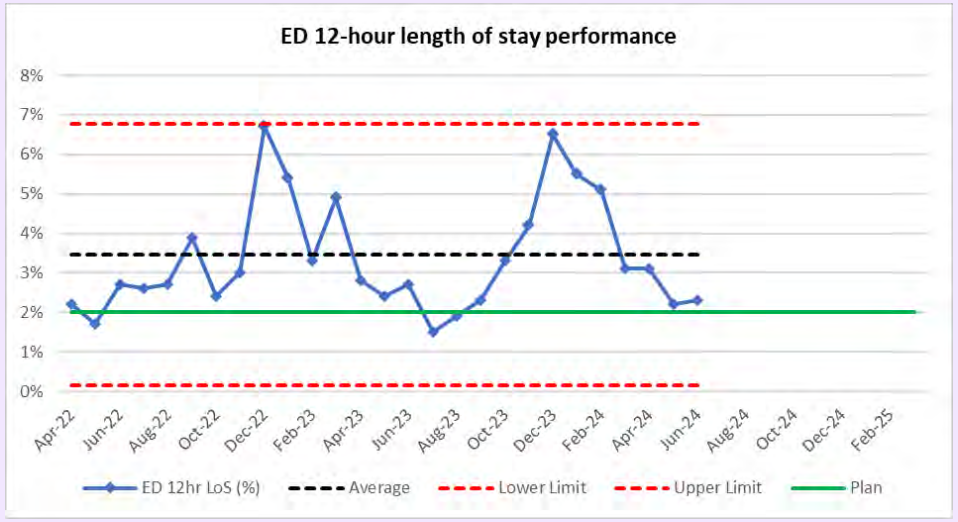
Note: Within the reported cancer treatment standards, we have aligned our reporting to match with the national cancer waiting time standards which remove auto upgrades. The reported position for the last two months for the cancer treatment standards can move as provisional cancer waiting time data is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

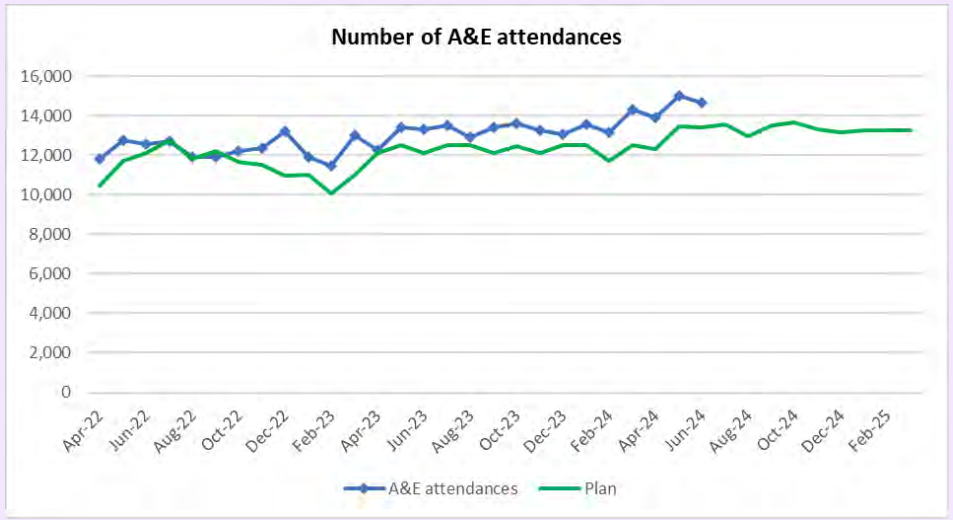
Indicators in Focus: Urgent Care – A&E (1/2)

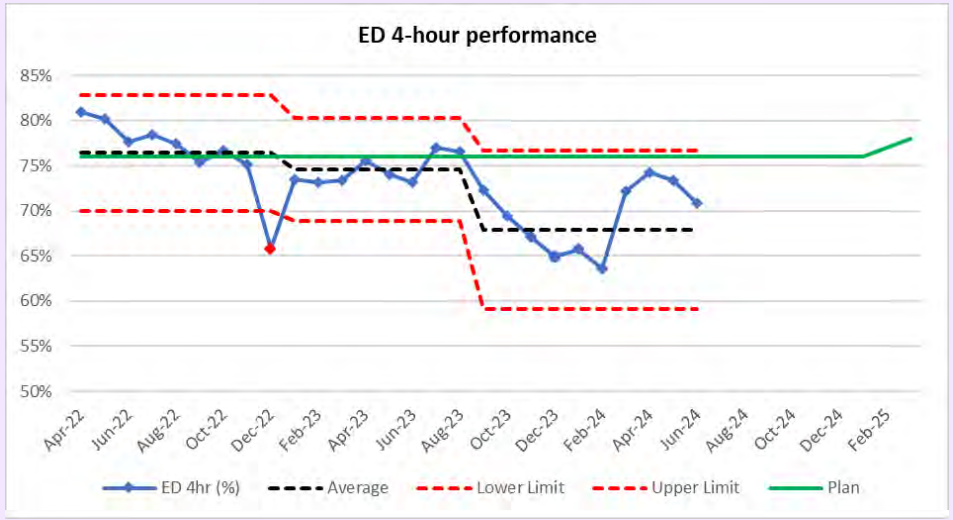
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

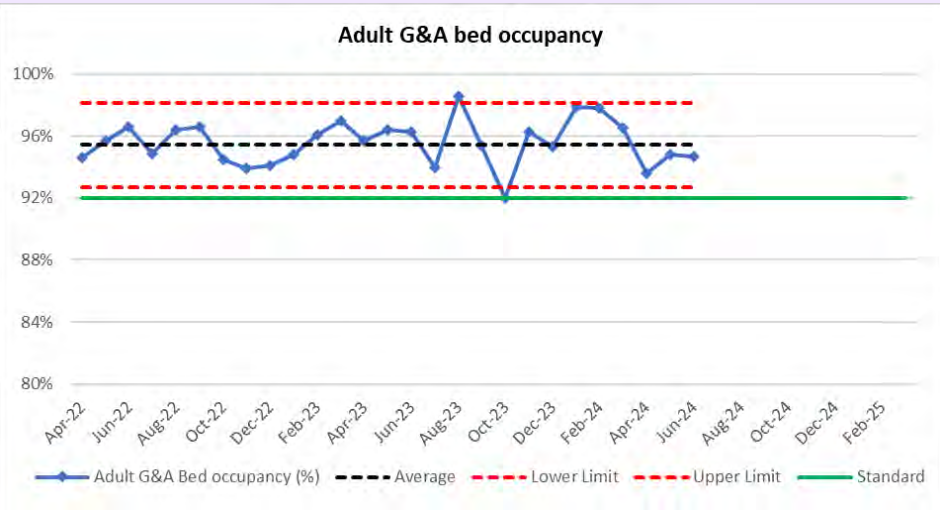
- Our ambulance handover position is significantly better than the East Midlands Ambulance Service (EMAS) average and amongst the best nationally:
  - Frequently best in Midlands, within top 10 nationally for ambulance handovers less than 30 mins, and the only Trust in England with 0% over 60 minutes in May and Jun-24.
  - EMAS average handover time 35 minutes, SFH 15 minutes.
- Accident and Emergency (A&E) attends over 111% of planned levels in 2024/25 quarter one (plan included 0.6% growth on 2023/24 levels). Our type one attendance demand growth is upper quartile nationally (amongst the highest in the country).
- Our 4-hour benchmark position in Jun-24 was 67th nationally out of 121 providers.
- 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.

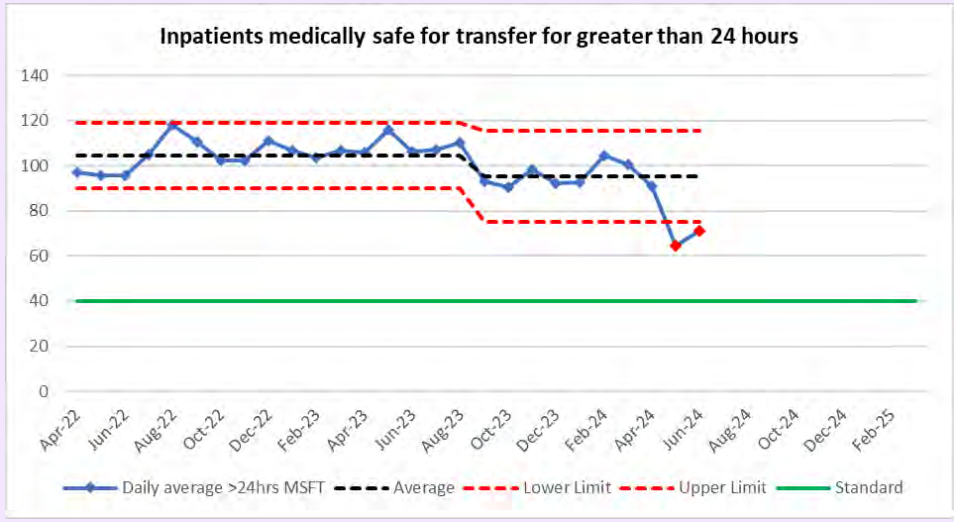
Root causes	Actions and timescale	Impact
Increased ED attendance demand.	• Admission and attendance avoidance with system partners to include: – Focus on frailty attendances – call before you convey, use of urgent care response teams. – Develop pathways out of the Urgent Care Co-ordination Hub. – Review 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.	• Reduction in out of area conveyances. • Reduction in category 3 ambulance conveyances. • Reduction in over 65-year-olds where length of stay 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.	• Increase in patients through Frailty 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 CFS >6.
Insufficient staffing to manage ED demand.	• Review staffing at local organisations and comparison of King's Mill Hospital ED productivity. • Continuation of additional staffing schemes throughout quarter two and business case to be developed to identify options to close the capacity gap in response to continued increase in demand. • Agency fill of additional ED shifts.	• 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%. • Reduction in non-admitted breaches and increased 4-hour performance to 76% with plan to increase to 78% by Mar-25.
ED overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Develop robust frailty offer as part of new Discharge Lounge pathways to support the transfer of patients out of ED.	• Improve patient experience as patients will be waiting to leave from discharge lounge rather than ED.
	• Improved overall hospital flow.	• See next two slides.

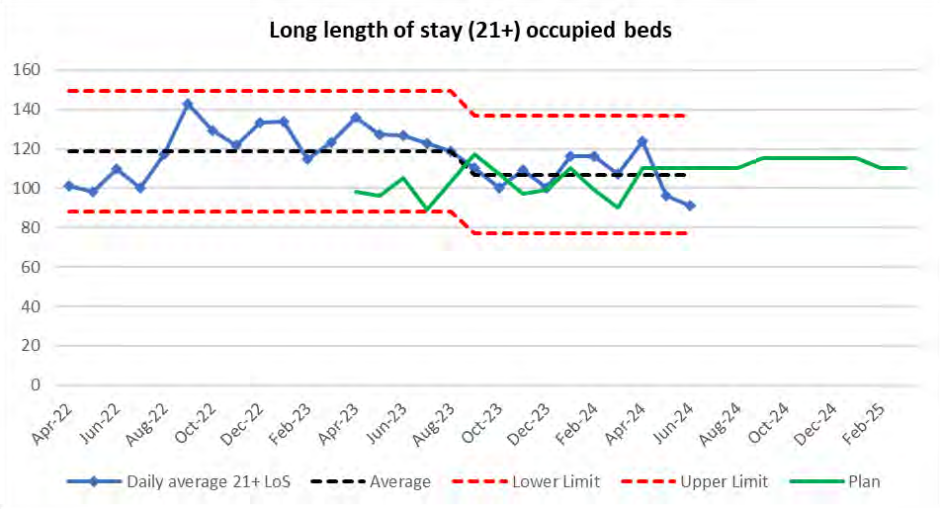
Indicators in Focus: Urgent Care – Hospital Flow (1/3)

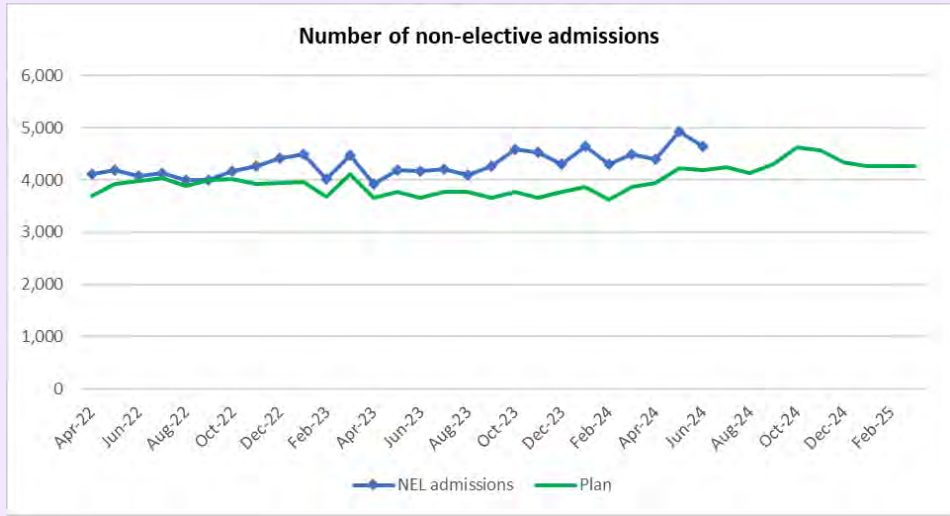
Sherwood Forest Hospitals NHS Foundation Trust

Data









Indicators in Focus: Urgent Care – Hospital Flow (2/3)

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 one was above planned levels at 113% (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. 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 in May and Jun-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 across King's Mill, Mansfield Community Hospital and Newark Hospital wards.	• LOS meetings identify opportunities for utilising virtual wards and early identification of potential barriers to discharge to support reduced LOS.
	• In 2024/25 quarter one a new team of discharge coordinators has been deployed to dedicated wards prioritising wards with the highest number of supported discharges. These coordinators work with ward and hub staff supporting patients and their families with complex discharge planning.	• Enhanced discharge coordination will support successful discharge planning from point of admission to reduce length of stay.
Delays to post-medically safe discharge processes.	• Transfer of Care Hub continues to work well. The hub undertakes a daily review of all patients that have been medically safe for greater than 24 hours to identify actions to support timely discharge.	• Reduce discharge delays and reduce the number of medically safe patients in our hospitals.
	• New team member in the Transfer of Care hub who is focusing on securing pathway three placements.	• Reduce delays in the pathway three discharge processes supporting an overall reduction in the number of medically safe patients in our hospitals.
	• We continue to see a high number of patients with complex housing issues. Age UK and local authorities are supporting resolving housing issues. We have a strong relationship with a local housing maintenance services company that supports preparing patients homes to be suitable for discharge.	• Reduce delays in the pathway one discharge processes for patients with complex housing issues supporting an overall reduction in the number of medically safe patients in our hospitals.
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. We have AmbiCorp contract in place to mitigate for a lack of commissioned PTS capacity to meet discharge demand. Ongoing system conversation about contracting arrangements for the future.	• Eliminate barriers to discharge and reduce the number of abandoned discharges.
Insufficient community capacity to meet supported discharge demand (with a specific focus on out of area patients).	• We continue to see delays to discharge for patients requiring packages of care and placements in Derbyshire. We have a daily review meeting with Derbyshire to discuss and escalate patients waiting for 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.

Indicators in Focus: Urgent Care – Hospital Flow (3/3)

Sherwood Forest Hospitals NHS Foundation Trust

Discharge Lounge

Following the completion of capital works in Apr-24, our new discharge lounge opened. Initially, when the discharge lounge transferred to the new facility it was open Monday to Friday during daytime hours. In early May-24, we transitioned to a trial of 24/7 opening.

The new discharge lounge can cater for patients that are ambulatory and able to sit in a chair/recliner and patients that need to remain in a bed. In our old discharge lounge, we could only care for patients that were ambulatory. Within the larger discharge lounge foot-print we can accommodate patients waiting on transport from other areas of the hospital e.g. our Emergency Department.

The adjacent graph shows the total weekly number of patients leaving King's Mill Hospital via the discharge lounge. The number of patients going through our discharge lounge has more than doubled (from circa 120 patients per week to between 250 and 290 patients per week). We continue our communications with wards to encourage early in the day transfer of patients to the discharge lounge to help bridge the gap between the peak time of admission and peak time of discharge.

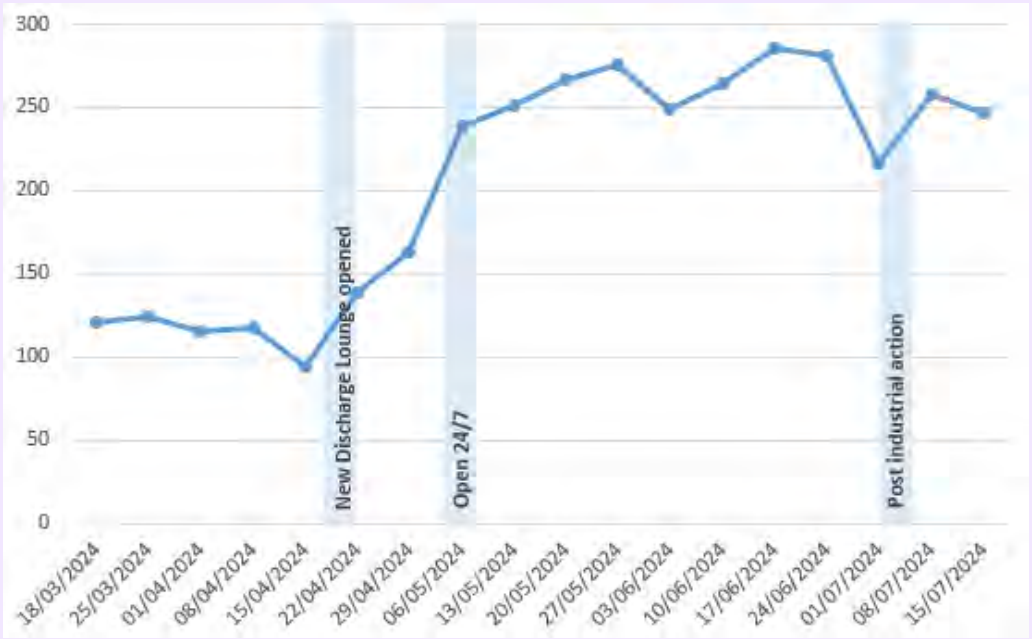
Staff feedback has been exceptionally positive in terms of the working environment and the future potential to expand services that are offered. However, staff have raised concerns around the reliance on bank and agency staff to cover the shifts and how this adds further pressure on those substantive members of staff on shift. Our nursing staff have also raised that having a dedicated Flow Co-ordinator would help release the nursing colleagues to spend more time to care for patients reducing the administration burden of tracking patients and updating hospital computer systems. We have taken this feedback onboard and are formulating a proposal for a future workforce model based on Observational Audits supported by the Improvement Faculty.

Patient feedback has been positive and following the daily Divisional Leadership Team walkarounds we are working on revamping the friends and family feedback we receive to generate more useful insight.

In Jul-24 a Trust Governor has visited to speak directly to patients regarding their Discharge experience and we have created a QR code to obtain staff feedback after each shift to inform future development of the service.

Data

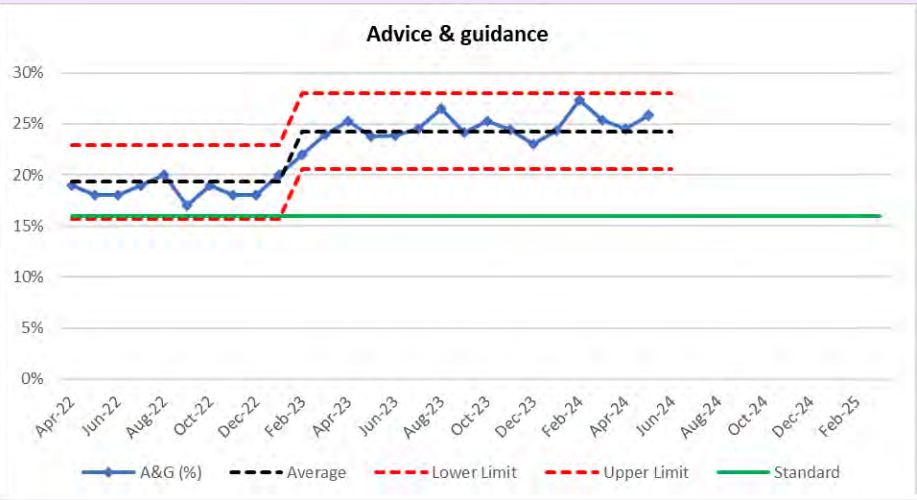
Weekly number of patients transferred to the Discharge Lounge

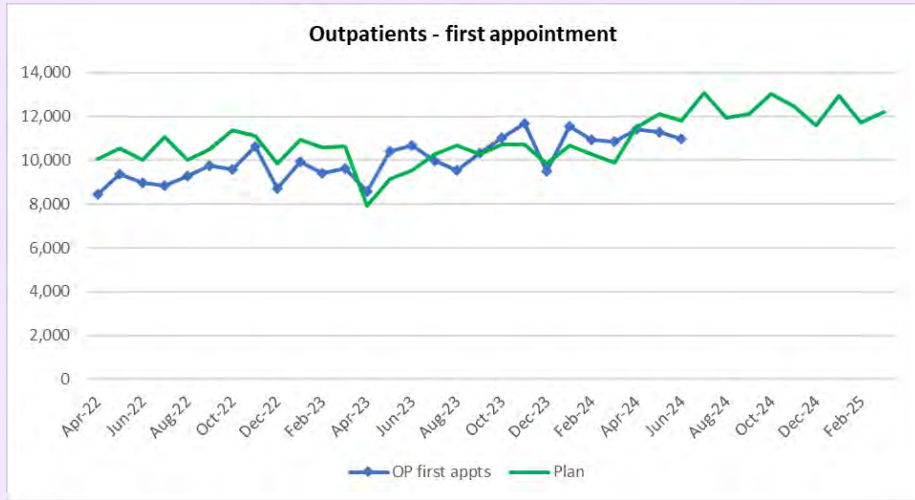


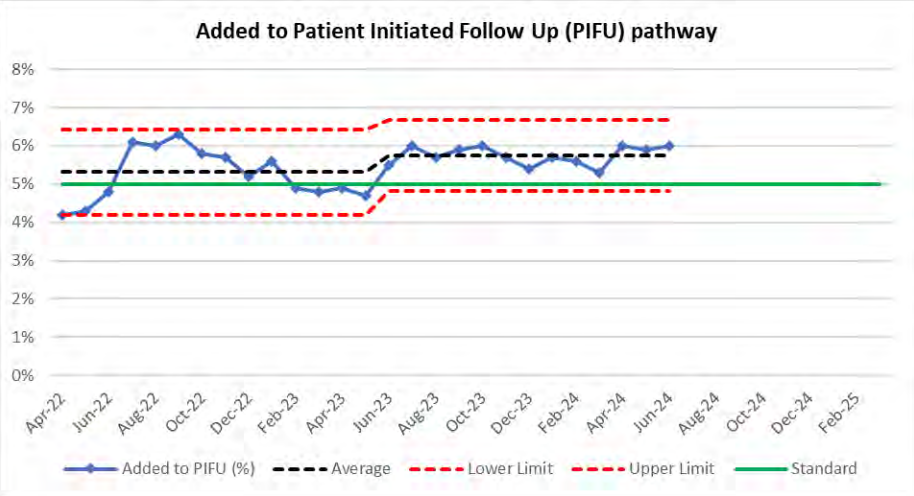
Indicators in Focus: Outpatients (1/2)

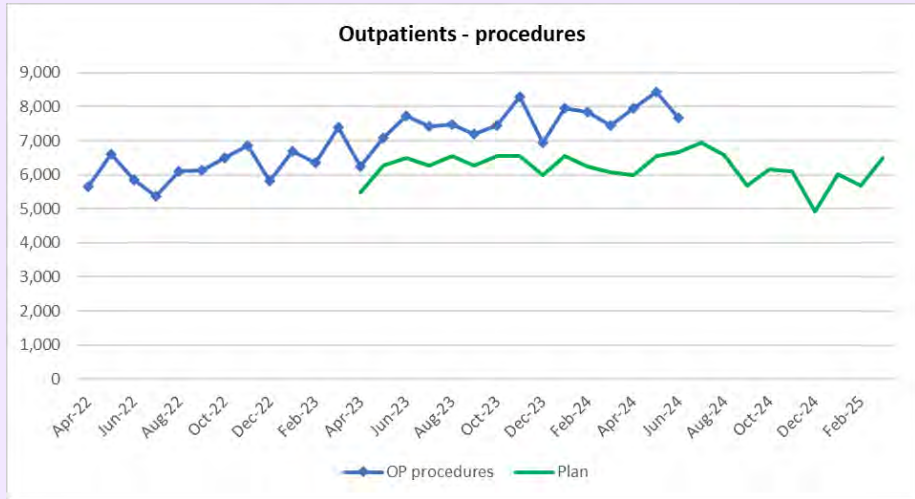
Sherwood Forest Hospitals NHS Foundation Trust

Data









Indicators in Focus: Outpatients (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

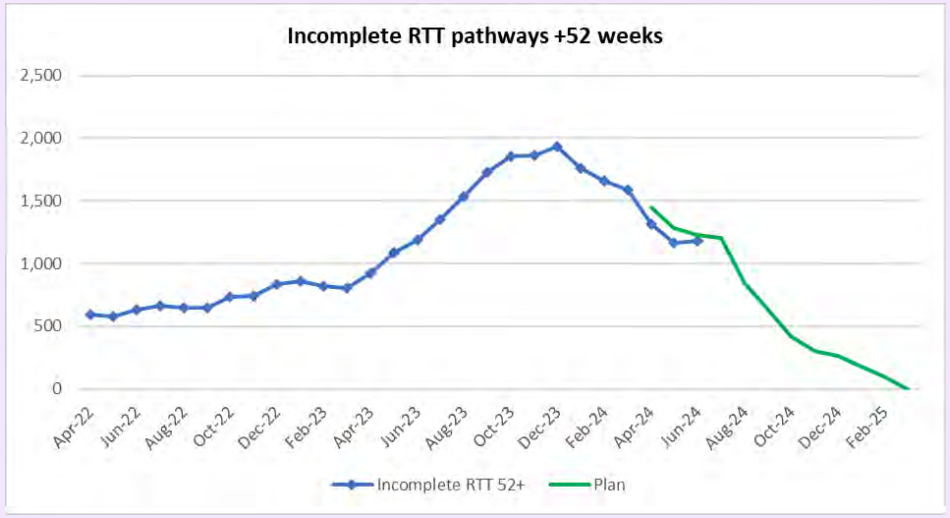
- We consistently perform above the 5% Patient Initiated Follow Up (PIFU) target and in recent benchmark data we were within the top ten nationally.
- Our volume of advice and guidance surpasses national targets, and we are responding to 95% of requests in less than five days.
- Trust outpatient first attendance activity levels have remained at strong levels throughout 2024; however, we have a very ambitious plan, and we need to deliver a further rise in the remainder of the year.
- 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.
- Outpatient procedure volumes are consistently exceeding planned levels. We have a new planning guidance metric that considers the proportion of outpatient attends that are first or follow up with a procedure. This metric is being added to our Integrated Performance Report scorecard and is not available at time of writing this report. However, high levels of outpatient procedures will support delivery against this new ambition.

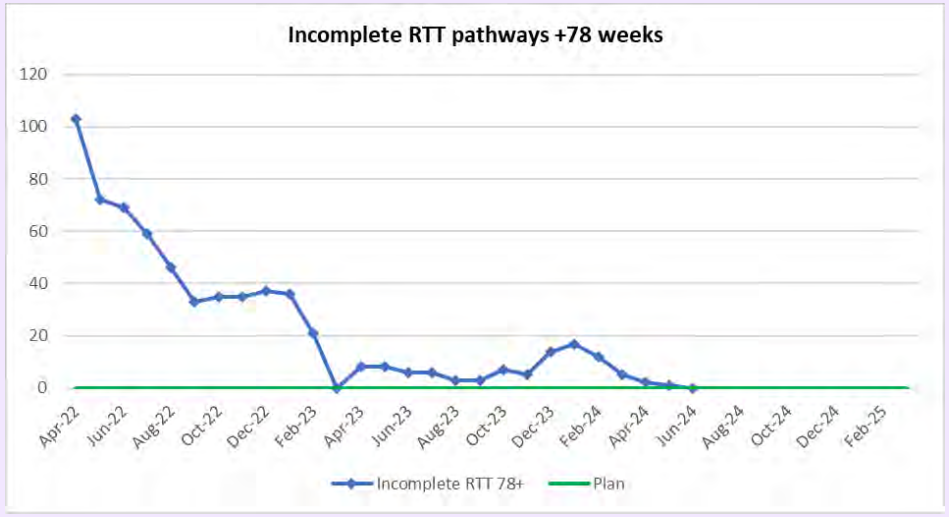
Root causes	Actions and timescale	Impact
Lack of physical clinic space to increase activity levels.	• Outpatient team review of all clinic space to ensure fit for generic use.	• Flexibility of space across the organisation.
	• Electronic system introduce in 2024/25 quarter one to support clinic booking across the trust.	• Improved utilisation of the clinic space and increased activity.
	• GIRFT (Getting It Right First Time) Further Faster toolkits were launched in 2023/24 quarter four to all divisions to support improvement programme and identify productivity opportunities. Action plans developed in quarter one and will be delivered in the rest of 2024/25.	• Improvement across all outpatient metrics including DNA rates (that have improved in 2024/25 quarter one), reducing overdue reviews, and increasing first outpatient activity.
Staffing constraints to deliver planned activity levels.	• Insourcing in Gastroenterology to increase outpatient volumes.	• Insourcing to deliver circa 3,000 appointments per year.
	• Use of locums to support increased outpatient volumes as part of the Elective Recovery Fund (ERF).	• ERF outpatient schemes to deliver over 13,000 new appointments in 2024/25.
Industrial Action (IA) impacting the delivery of planned care activity levels due to medical workforce being redeployed to support urgent and emergency care pathways.	• Continue to operationally manage instances of IA with a focus on what we can deliver whilst ensuring clinical prioritisation.	• Minimise the number of patients who have their outpatient appointments delayed during IA.

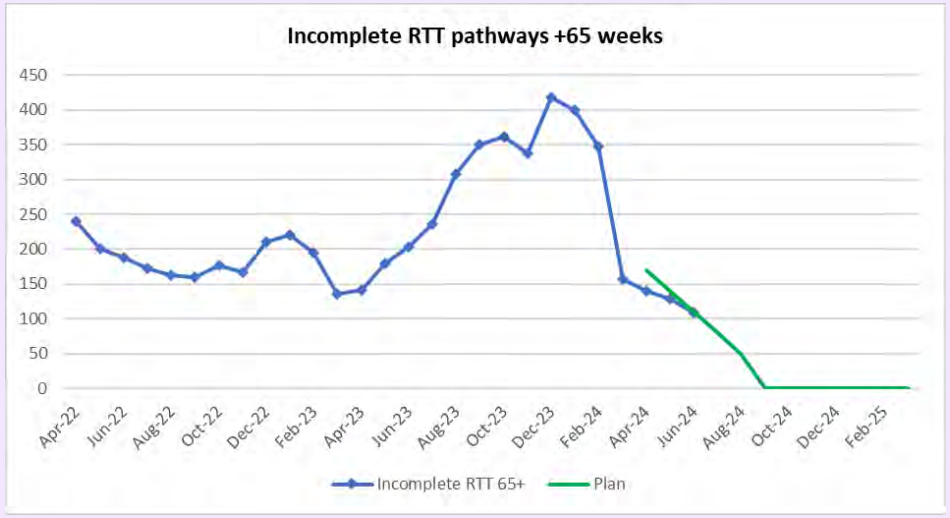
Indicators in Focus: Referral To Treatment (1/2)

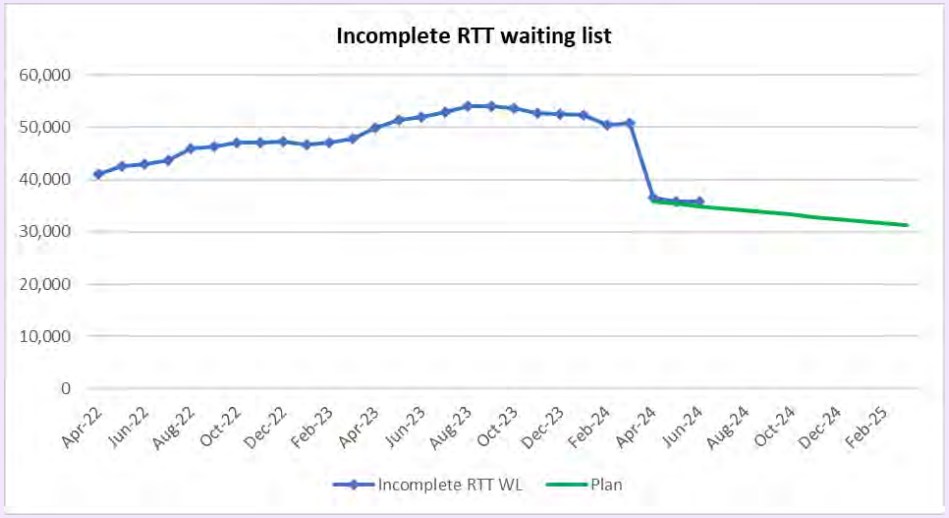
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Referral to Treatment (RTT) waiting times across England has stabilised at 7.6 million. Nationally reporting of long wait patients more than 52 weeks wait remains at circa 307,000 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 2024/5 quarter one and 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 and we remain on target to deliver zero 65-week wait patients by the end of quarter two. We have a few challenged specialties, predominantly ENT, Cardiology and General Surgery and the provision of system support could create further challenges towards the late summer period.
- Despite the ongoing pressures of Industrial Action (IA), we are performing well against our plan for no patients waiting longer than 52-weeks for treatment by the end of Mar-25.

Root causes	Actions and timescale	Impact
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 to enable mass validation programme.	• PTL will be 'clean' and represent only those patients genuinely waiting treatment. Reduction in overall PTL size.
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 and Urology. We are about to commence transferring Audiology and MRI patients in summer 2024. • System support by Nottingham University Hospitals to see Sherwood Forest Hospitals patients waiting for Echocardiography. There are plans to transfer Endocrinology and Vascular patients in summer 2024.	• Equalise waits across the system. This could adversely impact on reported positions for long waits at a provider level.
Industrial Action (IA) impacting the delivery of planned care activity levels due to medical workforce being redeployed to support urgent and emergency care pathways.	• Continue to operationally manage instances of IA with a focus on what we can deliver whilst ensuring clinical prioritisation.	• Minimise the number of patients who have their planned care delayed during IA. • Focus on treating patients in order of clinical priority.

Indicators in Focus: Diagnostics

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 Apr-24 was just over 376,000. This meant that 77% of patients nationally were seen within 6-weeks against the interim national standard of 95% by Mar-25. The local position at the end of Apr-24 was 72.7% of patients seen within 6-weeks; below the national position.
- Across SFH at the end of Jun-24 there were just over 13,000 patients waiting for DM01 reportable diagnostic tests of which circa 3,800 patients were waiting greater than 6-weeks. Most patients are awaiting Echocardiography.

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.	
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.
Cystoscopy waiting list management and processes causing increase in overall diagnostic patient tracking list size since Sep-23.	• Review of rota planning and additional capacity took place in Jul-24.	• Lists fully utilised to achieve zero patients over 13 weeks by Sep-24.
	• Training teams and updating training and supporting documentation throughout Jul-24.	• Increased accuracy in patient tracking list and validation.

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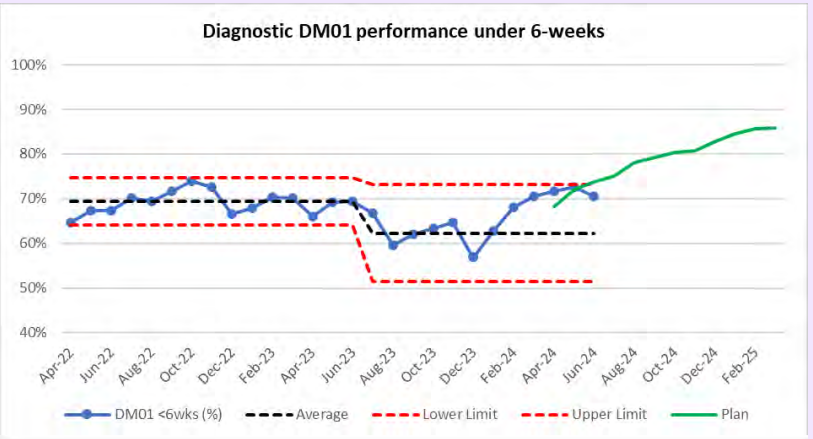
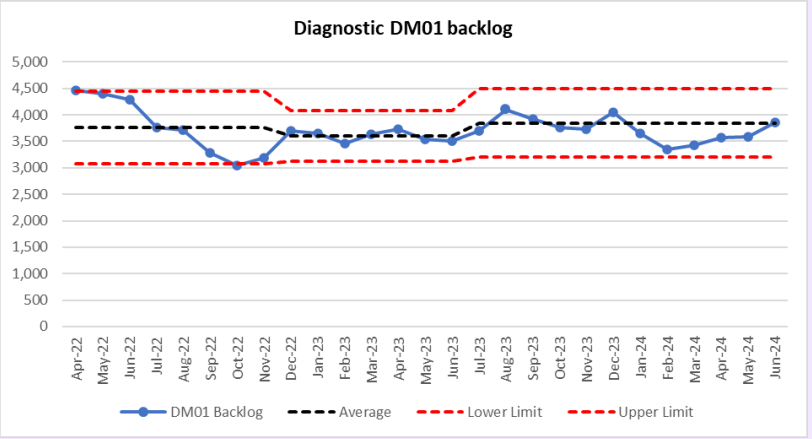
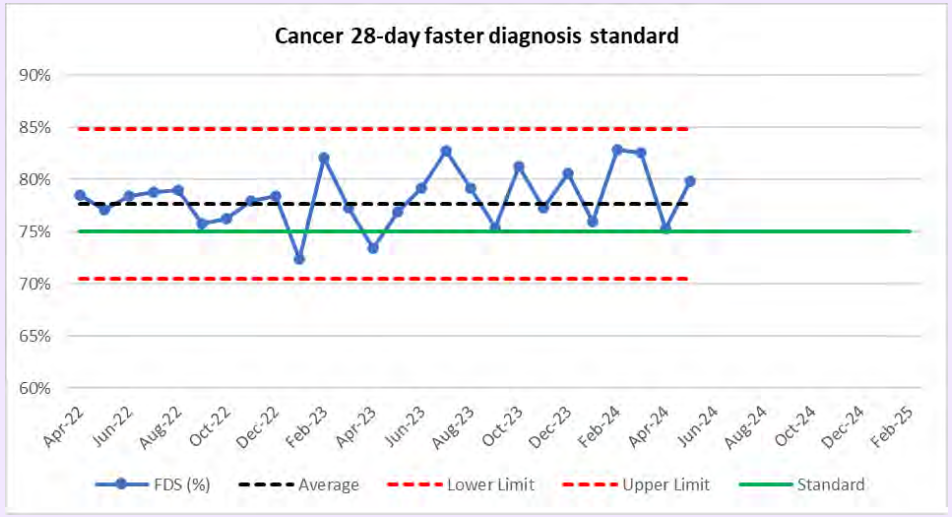


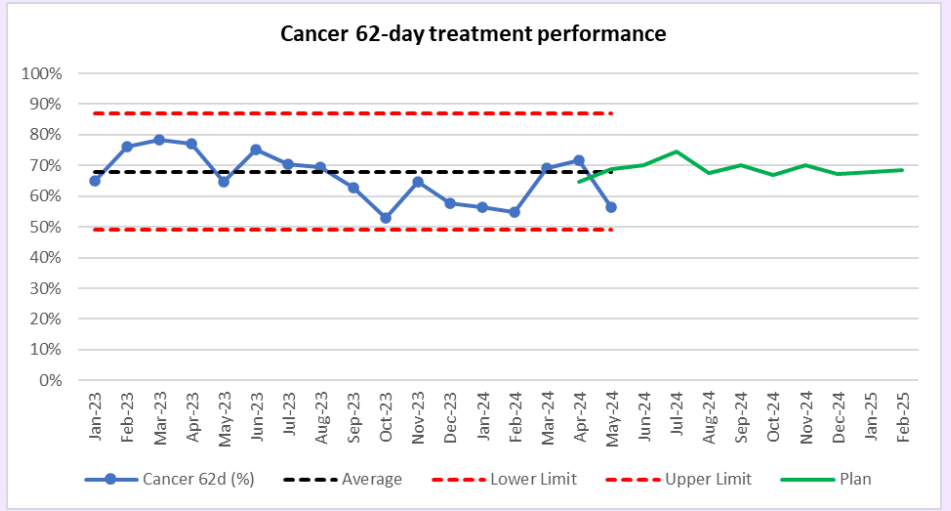


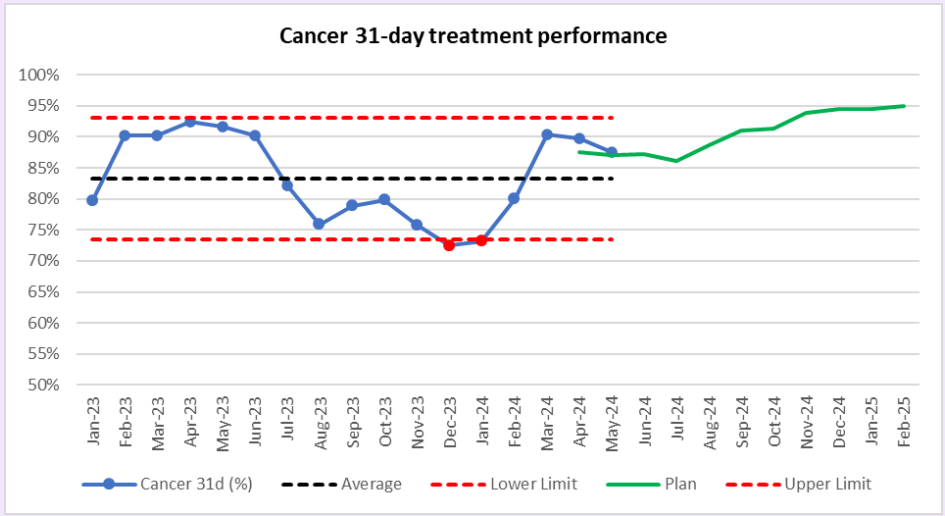
Indicators in Focus: Cancer (1/2)

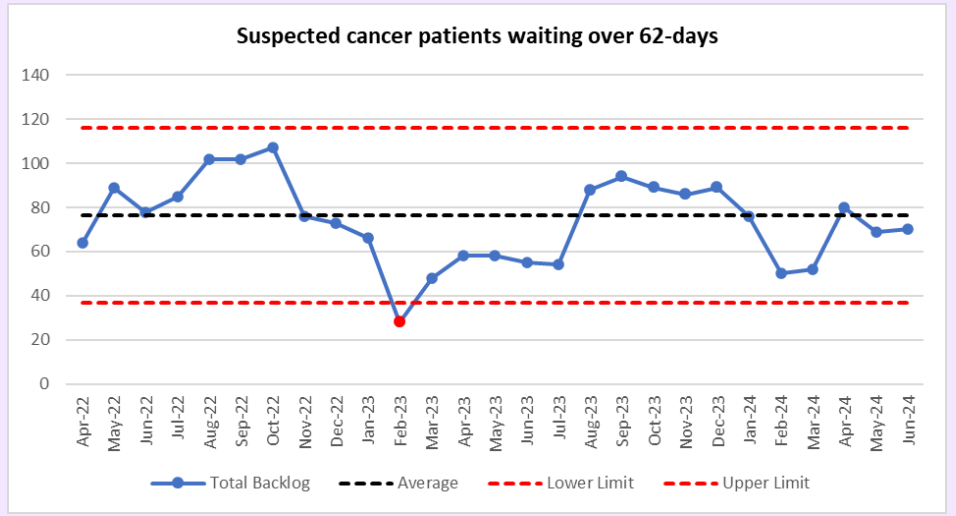
Sherwood Forest Hospitals NHS Foundation Trust

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 (May-24):

- Nationally Faster Diagnosis Standard (FDS) is 76.4% against the 75% standard. Our position is performing better than the England position. In May-24 we ranked 61st out of 142 providers nationally.
- Nationally 31-day treatment performance (first treatment) is 91.8% against the 96% standard. Our performance is below the England position and the national standard. In May-24 we ranked 121st out of 141 providers nationally.
- Nationally 62-day performance is 65.8% against the interim 70% standard. Our performance is below the England position and interim standard. In May-24 we ranked 124th out of 149 providers nationally.

Root causes	Actions and timescale	Impact
62-day standard - Lower GI has workforce challenges, high referral demand and difficulties with patient engagement.	• Locum consultant Colorectal sessions were provided in Jun-24 to create additional routine capacity to free up colorectal cancer consultants. The Consultant role is now substantive.	• Increased capacity to improve FDS, 31-day and 62-day performance. Additional capacity per week: two clinics, half day theatre session and one endoscopy session per week.
	• Patient information video filming complete and process for sign off underway. The video will be launched in Jul-24.	• Improve engagement and increase test compliance.
	• Daily nurse triage to review results to determine patient discharge, consultant face to face or daily virtual review commencing Jul-24.	• Improved FDS and 62-day - reduced number of consultant clinical reviews required and increase timeliness of clinical reviews.
	• Nurse-led face to face clinics commenced Jul-24.	• Reduced number of patients requiring consultant face to face capacity.
	• 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.
31-day standard - Skin tumour site referral demand.	• Tele-dermatology King's Mill Hospital trial complete and fully operational. Service commenced at Newark Hospital.	• 137 patients seen via tele-dermatology in Jun-24, reducing the number of face-to-face appointments to 235. First seen average reduced from 12 to 6 days for tele-dermatology patients compared to those requiring a face-to-face appointment.
	• Insourcing options being reviewed to support routine activity to release clinical time for complex cancer patients.	• To be confirmed.
Industrial Action (IA) impacting the delivery of tumour site activity levels and pathway development.	• Continue to operationally manage instances of IA with a focus on what we can deliver whilst ensuring clinical prioritisation to minimise the number of cancer patients who have their pathway delayed.	• 14 outpatient appointments and one daycase cancelled from the recent Jun/Jul-24 period. All rescheduled within one week.

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

Income and Expenditure

- The Financial Plan for 2024/25 is to deliver a deficit of £14.0m. This is aligned to the Trust's share of the 2024/25 Revenue Plan Limit set for the Nottingham and Nottinghamshire ICB by NHS England.
- The 2024/25 quarter one position is a deficit of £11.0m, which is £0.6m adverse to the planned deficit of £10.4m for this period. This accounts for the financial impact of industrial action (£0.2m relating to the expenditure impact and £0.2m because of income lost) as well as £0.2m of unplanned redundancy costs linked to the Covid Vaccination Service.
- The costs of managing the continued emergency and non-elective demand pressures faced over the quarter one period included capacity costs of £3.9m, compared to a year-to-date plan of £3.6m. This overspend has been offset by underspends on other divisional budgets in the period.
- The forecast for the remainder of the year aligns to the delivery of the £14.0m planned deficit. It includes an assumption that the costs and lost income relating to industrial action are covered by supporting allocations later in the year, and that elective activity levels are accelerated through the year. The forecast also assumes full efficiency delivery and that the overspends on escalation capacity are managed back to budgeted levels.

Financial Improvement Programme

- The 2024/25 quarter one Financial Improvement Programme (FIP) delivery is £5.5m against a plan of £3.9m. The £1.6m favourable variance to plan largely relates to vacancy control. However, if we continue to deliver at the existing run rate of £5.5m per quarter the annual achievement would be £16.5m below the annual FIP target of £38.5m. There is a sustained focus on the identification and implementation of additional efficiency schemes across the organisation.

Capital

- 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 one capital expenditure totalled £3.0m, which is £5.0m lower than initially planned. 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.

Cash

- Closing cash on 30 June was £1.50m, which is £20k 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

- Value weighted Elective activity in quarter one was 108.8% against the baseline, which exceeds the NHS England target of 105.0%. 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.

Agency

- In 2024/25 quarter one we have spent £3.9m on agency, which is £0.8m higher than the plan of £3.1m. This represents 4.7% 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	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	✗-£0.61
	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	✓£1.59
	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	✗£5.07
	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	✓£1.50
	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%
	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	✗-£0.76
	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	£3.87
	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	£7.72

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 deficit position of £14.0m 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 Trust has an adverse variance to plan of £0.6m in 2024/25 quarter one, reporting a deficit of £11.0m against a plan of £10.4m.

Root causes	Actions and timescale	Impact
Unfunded costs and lost income due to industrial action, including the costs of covering staffing gaps and an estimate of lost income relating to cancelled activity.	• The forecast includes an assumption that the costs and lost income relating to industrial action are covered by supporting allocations later in the year, and that elective activity levels are accelerated through the year.	• Annual plan achieved.
Escalation spend over-commitment against the planned allocation.	• The forecast assumes any overspends are reduced back to budgeted levels.	• 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 July 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 manged 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 July 2024.	
	• Allocation agreed with Integrated Care System (ICS) partners for 2024/25.	
Requirement for Public Dividend Capital (PDC) to support plan £13.6m.	• PDC request to be prepared and submitted in July 2024 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.

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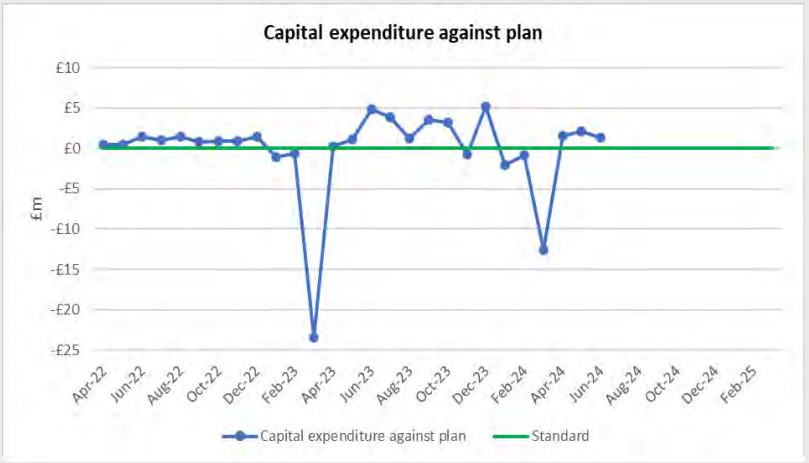

Indicator in Focus: Cash Balance

NHS 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 quarter one the cash position is £0.20m lower than planned but remains above the minimum cash balance.
- Plan and actual required revenue borrowing Public Dividend Capital (PDC) cash support from DHSC of £14.0m.

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 suppler 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 revenue 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 to be prepared and submitted Jul-24 in relation to the agreed 2024/25 capital plan.	• Extended payment terms to suppliers. • Failure to achieve Better Payment Practice code

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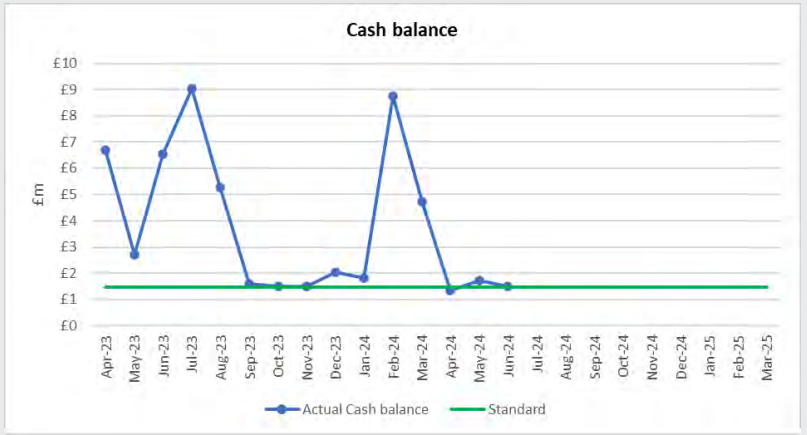

Indicator in Focus: Agency Expenditure Against Plan

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 £3.9m for 2024/25 quarter one; this is £0.8m adverse to the planned level of spend.
- Agency expenditure accounts for 4.7% of our total pay bill and exceeds the 3.2% NHS England target.

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. • All medical agency bookings that are above cap to be reviewed at weekly vacancy control panels. • From July 2024 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.	• Reduced agency run rate to achieve financial plan.

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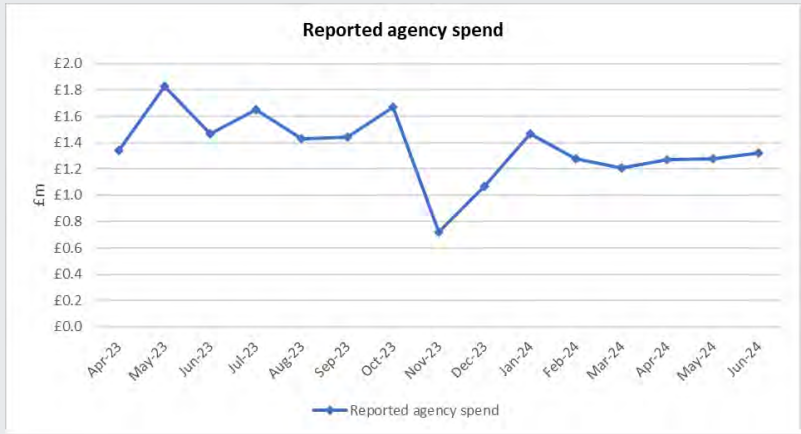

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Scorecard: Activity (for context)

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	2024/25 YTD
Urgent Care	A&E attendances	≤Plan	≤Plan	✗109.1%	✗109.1%	✗104.3%	✗107.5%	✗108.1%	✗112.3%	✗114.2%	✗111.5%	✗113.2%	✗ 111.5%	✗109.2%	✗111.2%	✗111.2%
	Non-elective admissions	≤Plan	≤Plan	✗121.4%	✗124.2%	✗114.1%	✗119.9%	✗119.9%	✗118.6%	✗116.0%	✗118.2%	✗111.4%	✗ 116.8%	✗110.8%	✗113.0%	✗113.0%
Electives	Average daily elective referrals			310	316	260	295	314	327	304	315	343	340	325	336	336
	Outpatients - first appointment	≥Plan	≥Plan	✓102.9%	✓109.1%	✗ 96.4%	✓103.0%	✓108.3%	✓106.3%	✓109.7%	✓108.1%	✗99.3%	✗ 93.2%	✗93.1%	✗95.1%	✗ 95.1%
	Outpatients - follow up	≤Plan	≤Plan	✗102.1%	✗108.1%	✓ 95.1%	✗101.9%	✗107.5%	✗105.0%	✗106.2%	✗106.2%	✓100.0%	✓ 99.2%	✓ 93.0%	✓ 97.4%	✓ 97.4%
	Outpatients - procedures	≥Plan	≥Plan	✓113.9%	✓126.4%	✓116.0%	✓118.9%	✓121.7%	✓125.3%	✓123.0%	✓123.3%	✓133.0%	✓ 129.1%	✓115.1%	✓125.5%	✓125.5%
	Day case	≥Plan	≥Plan	✗ 86.7%	✓101.3%	✗ 91.8%	✗ 93.3%	✓100.2%	✓101.5%	✓109.8%	✓103.7%	✗96.3%	✗ 96.1%	✗ 95.4%	✗ 96.0%	✗ 96.0%
	Elective inpatient	≥Plan	≥Plan	✗ 86.8%	✓108.9%	✓107.1%	✓100.7%	✓101.9%	✓110.8%	✓129.3%	✓113.5%	✗92.5%	✗ 94.6%	✗ 92.9%	✗ 93.4%	✗ 93.4%
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%	✓103.2%

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

June 2024 (Qtr 1)

Cover Page | Charts | Definitions

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	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	✓ 0
		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	✓ 6.3
		Never events	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1
		MRSA reported in month	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	✓ 13
		Ecoli blood stream infections (BSI) reported in month	≤22	≤22	✓ 0	✓ 6	✓ 5	✓ 11	✓ 3	✓ 5	✓ 3	✓ 11	✓ 5	✓ 1	✓ 4	✓ 10	✓ 10
		Klebsiella BSI reported in month (hospital onset)	≤1	≤1	✓ 1	✓ 1	✓ 1	✗ 3	✗ 2	✓ 1	✓ 0	✗ 3	✓ 0	✓ 1	✗ 2	✗ 3	✗ 3
		Pseudomonas BSI reported in month	≤3	≤3	✓ 0	✓ 1	✓ 1	✓ 2	✓ 2	✓ 1	✓ 1	✗ 4	✓ 0	✓ 0	✓ 1	✓ 1	✓ 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	0.1
		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	✗ 2
		Patient Safety Incident Investigations (PSII)			1	2	2	5	2	1	0	3	3	4	-	-	7
	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	✓ 1.0
		Compliments received in month			103	158	150	411	151	122	120	393	161	138	151	450	450
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 127	✗ 125	✗ 126	✗ 126	✗ 131	✗ 129	✗ 126	✗ 126	✗ 129	✗ 126	✗ 124	✗ 124	✗ 124
		SHMI	≤100	≤100	✗ 108	✗ 107	✗ 107	✗ 107	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 107
		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	✓ 0.0	✓ 1.2	✓ 1.2
		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
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 7.3	-	-	-	-	-	-	-	-	-
	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%	✓ 8.1%
		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%
		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%	✗ 88.4%
		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%	✓ 91.0%
	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%	✗ 4.4%
		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%	✓ 6.5%
		Flu vaccinations uptake (front line staff)	≥80%	≥80%	✗ 38.3%	✗ 44.8%	✗ 55.9%	✗ 55.9%	✗ 58.0%	✗ 58.0%	-	✗ 58.0%	-	-	-	-	-
		Employee relations management	<12	<17	✗ 21	✗ 23	✗ 18	✗ 21	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✗ 23	✗ 22	✗ 22
	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%	9.0%
		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%	✗ 4.7%
		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%
		Agency (over price cap)	≤30.0%	≤40.0%	✗ 51.0%	✗ 55.7%	✗ 57.0%	✗ 54.3%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 54.5%	✗ 54.1%	✗ 57.4%	✗ 55.4%	✗ 55.4%
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%	✓ 96.1%
		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%	✗ 0.1%
		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%	✗ 72.8%
		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%	✗ 2.5%
		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%	✓ 38.2%
		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%	✗ 94.4%
		Long length of stay (21+) occupied beds	≤Plan	≤Plan	✓ 100	✗ 109	✗ 100	✗ 103	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✓ 110
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 90	✗ 98	✗ 92	✗ 94	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 75
	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%	-	-	✓ 25.1%
		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%	✓ 6.0%	✓ 6.0%	✓ 6.0%
		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	✗ 35,720
		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	✓ 1,177
		Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 362	✗ 337	✗ 418	✗ 418	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✓ 109	✓ 109
		Incomplete RTT pathways +78 weeks	0	0	✗ 7	✗ 5	✗ 14	✗ 14	✗ 17	✗ 12	✗ 5	✗ 5	✗ 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	3,861
		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%	✗ 70.5%
	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%	-	-	✓ 77.7%
		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%	-	-	✓ 88.7%
		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%	-	-	✗ 64.0%
		Suspected cancer patients waiting over 62-days			89	86	89	89	76	50	52	52	80	69	70	70	70
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	✗ -£0.61
		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	✓ £1.59
		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	✗ £5.07
		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	£1.50
		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%
		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	✗ -£0.76
		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	£3.87
		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	£7.72
Activity (for context)	Urgent Care	A&E attendances	≤Plan	≤Plan	✗ 109.1%	✗ 109.1%	✗ 104.3%	✗ 107.5%	✗ 108.1%	✗ 112.3%	✗ 114.2%	✗ 111.5%	✗ 113.2%	✗ 111.5%	✗ 109.2%	✗ 111.2%	✗ 111.2%
		Non-elective admissions	≤Plan	≤Plan	✗ 121.4%	✗ 124.2%	✗ 114.1%	✗ 119.9%	✗ 119.9%	✗ 118.6%	✗ 116.0%	✗ 118.2%	✗ 111.4%	✗ 116.8%	✗ 110.8%	✗ 113.0%	✗ 113.0%
	Electives	Average daily elective referrals			310	316	260	295	314	327	304	315	343	340	325	336	336
		Outpatients - first appointment	≥Plan	≥Plan	✓ 102.9%	✓ 109.1%	✗ 96.4%	✓ 103.0%	✓ 108.3%	✓ 106.3%	✓ 109.7%	✓ 108.1%	✗ 99.3%	✗ 93.2%	✗ 93.1%	✗ 95.1%	✗ 95.1%
		Outpatients - follow up	≤Plan	≤Plan	✗ 102.1%	✗ 108.1%	✓ 95.1%	✗ 101.9%	✗ 107.5%	✗ 105.0%	✗ 106.2%	✗ 106.2%	✓ 100.0%	✓ 99.2%	✓ 93.0%	✓ 97.4%	✓ 97.4%
		Outpatients - procedures	≥Plan	≥Plan	✓ 113.9%	✓ 126.4%	✓ 116.0%	✓ 118.9%	✓ 121.7%	✓ 125.3%	✓ 123.0%	✓ 123.3%	✓ 133.0%	✓ 129.1%	✓ 115.1%	✓ 125.5%	✓ 125.5%
		Day case	≥Plan	≥Plan	✗ 86.7%	✓ 101.3%	✗ 91.8%	✗ 93.3%	✓ 100.2%	✓ 101.5%	✓ 109.8%	✓ 103.7%	✗ 96.3%	✗ 96.1%	✗ 95.4%	✗ 96.0%	✗ 96.0%
		Elective inpatient	≥Plan	≥Plan	✗ 86.8%	✓ 108.9%	✓ 107.1%	✓ 100.7%	✓ 101.9%	✓ 110.8%	✓ 129.3%	✓ 113.5%	✗ 92.5%	✗ 94.6%	✗ 92.9%	✗ 93.4%	✗ 93.4%
	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%	✓ 103.2%

Sherwood Forest Hospitals NHS Foundation Trust

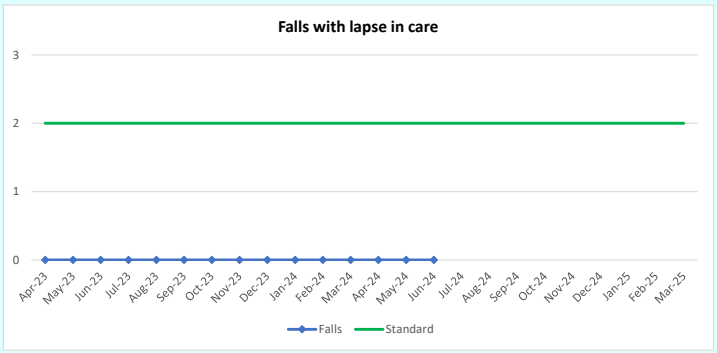
Integrated Performance Report 2024/25

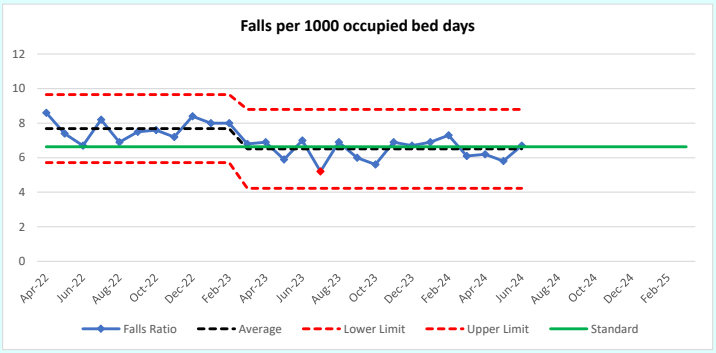
June 2024 (Qtr 1)

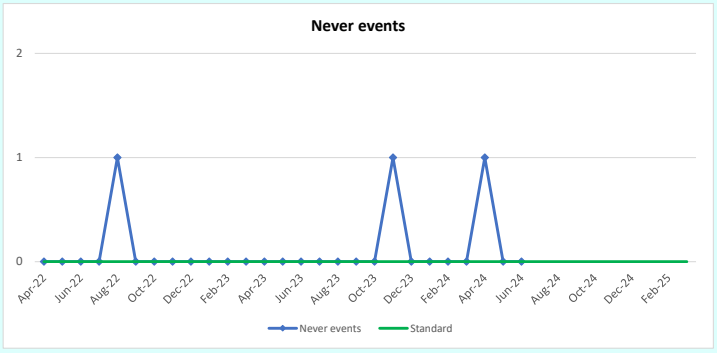
Cover Page | Definitions

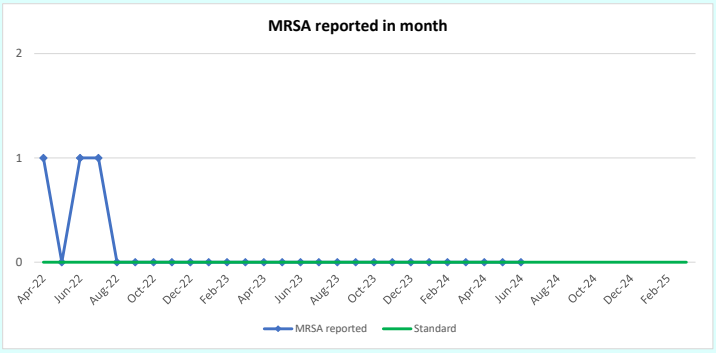
Charts

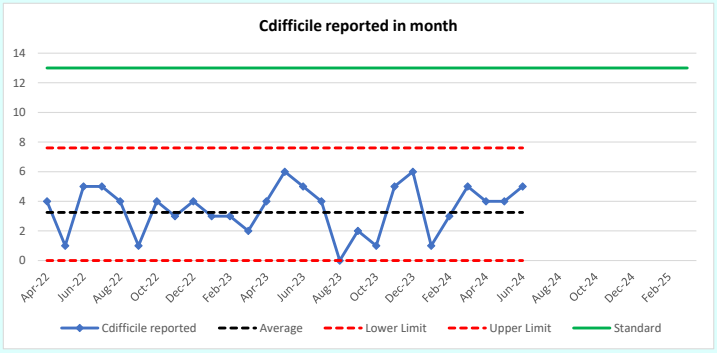
Quality of Care

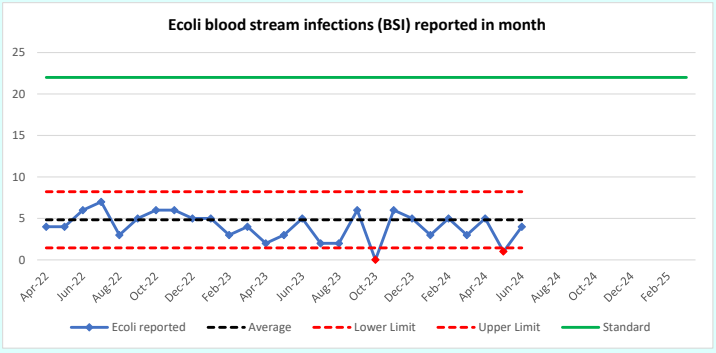


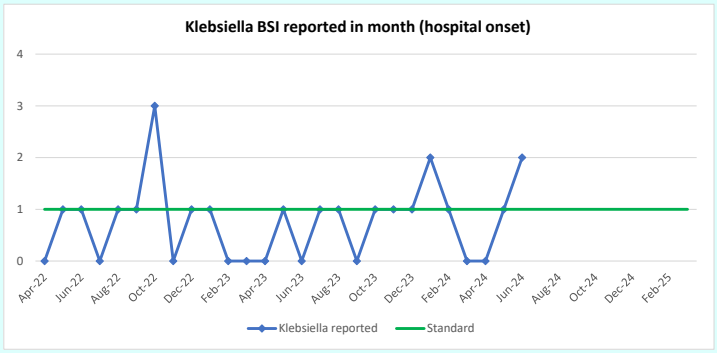


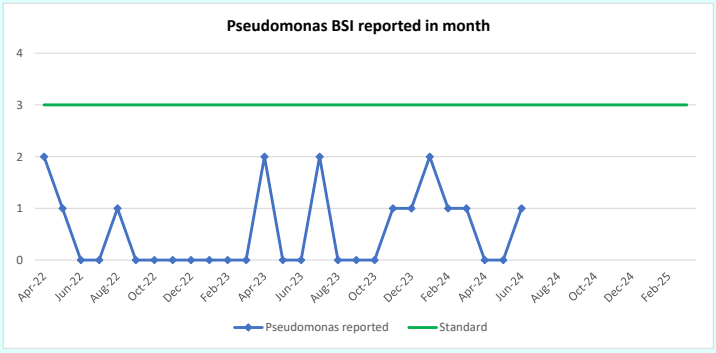


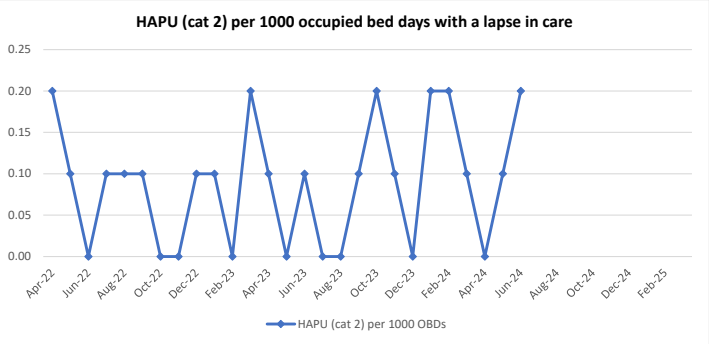


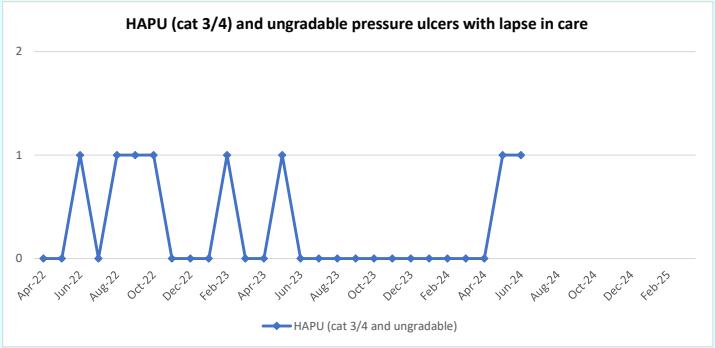


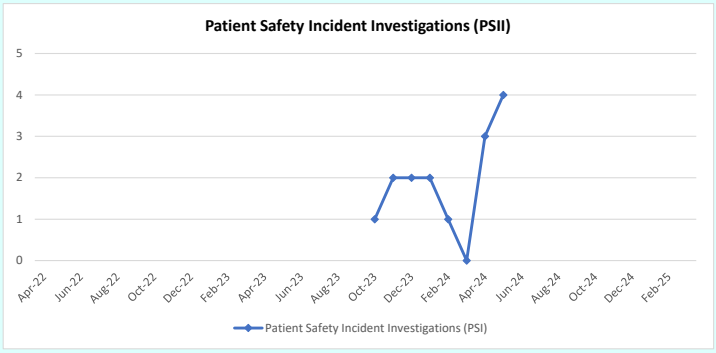


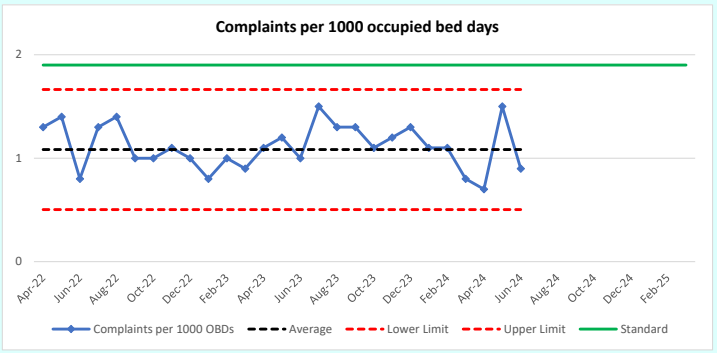


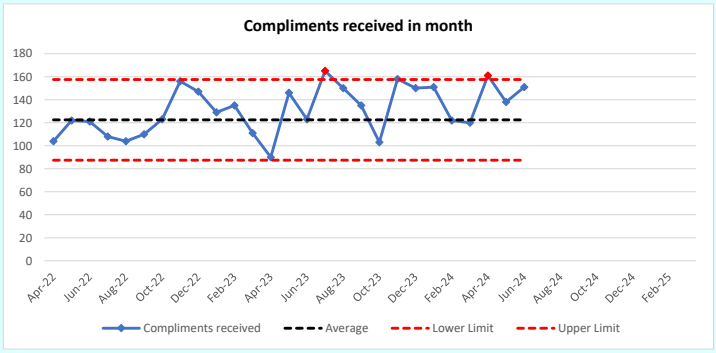


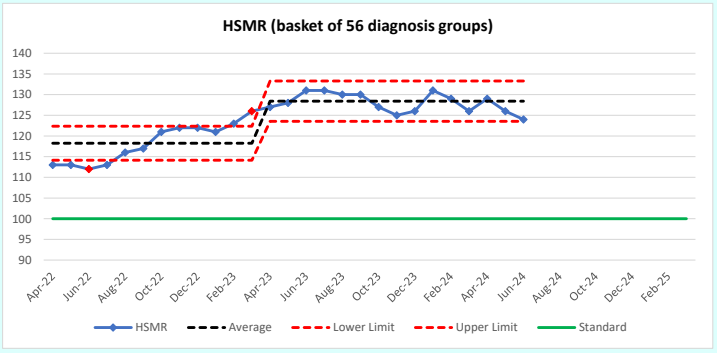

HAPU (cat 2) per 1000 occupied bed days with a lapse in care
0.25
0.20
0.15
0.10
0.05
0.00
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
HAPU (cat 2) per 1000 OBDs

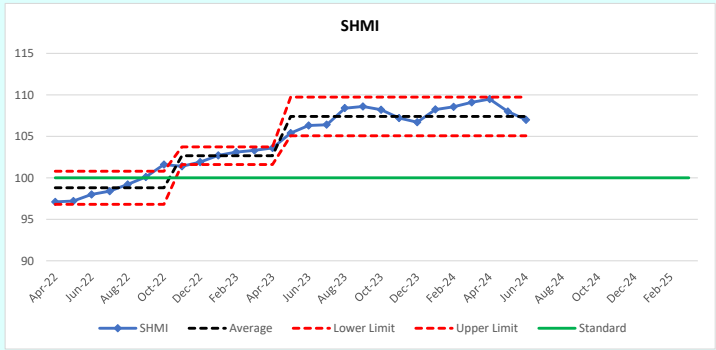

HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care
2
1
0
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
HAPU (cat 3/4 and ungradable)

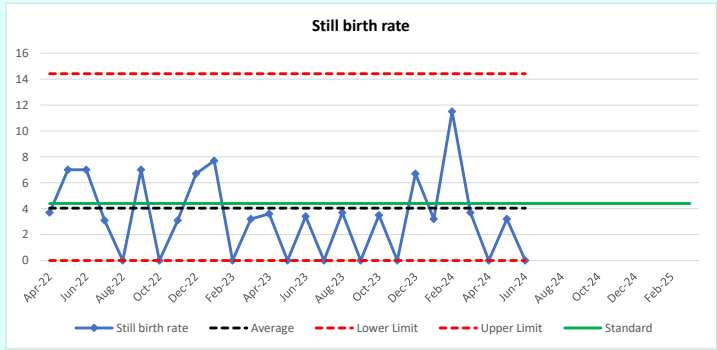

Patient Safety Incident Investigations (PSII)
5
4
3
2
1
0
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
Patient Safety Incident Investigations (PSI)

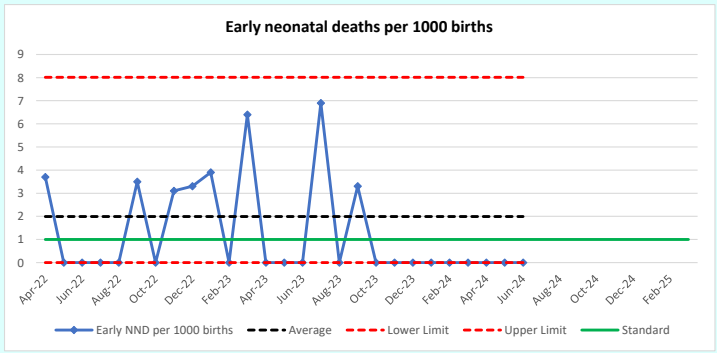

Complaints per 1000 occupied bed days
2
1
0
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
Complaints per 1000 OBDs
Average
Lower Limit
Upper Limit
Standard


Compliments received in month
180
160
140
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 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
Compliments received
Average
Lower Limit
Upper Limit


HSMR (basket of 56 diagnosis groups)
140
135
130
125
120
115
110
105
100
95
90
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
HSMR
Average
Lower Limit
Upper Limit
Standard

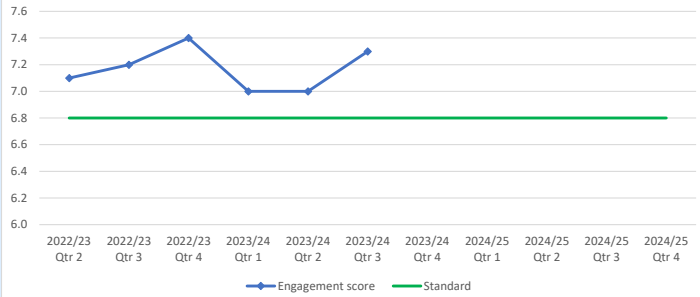

SHMI
115
110
105
100
95
90
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
SHMI
Average
Lower Limit
Upper Limit
Standard


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

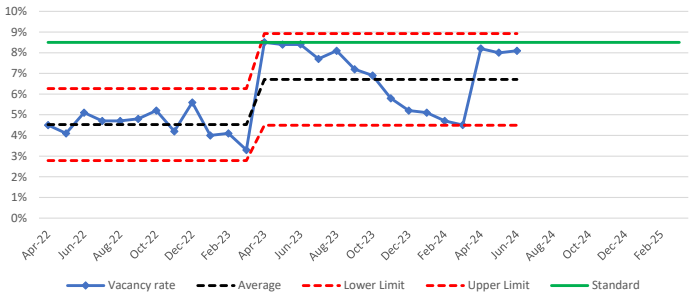

Early neonatal deaths per 1000 births
9
8
7
6
5
4
3
2
1
0
Apr-22 Jun-22 Aug-22 Oct-22 Dec-22 Feb-23 Apr-23 Jun-23 Aug-23 Oct-23 Dec-23 Feb-24 Apr-24 Jun-24 Aug-24 Oct-24 Dec-24 Feb-25
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard

People and Culture

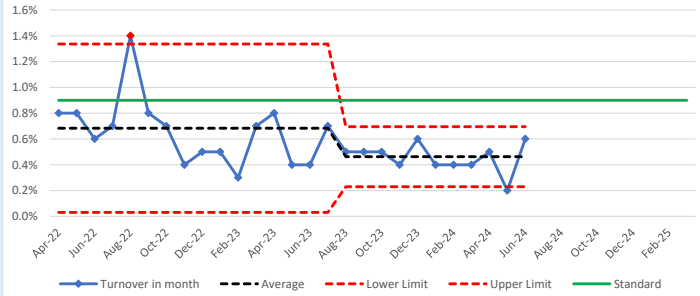
Engagement score



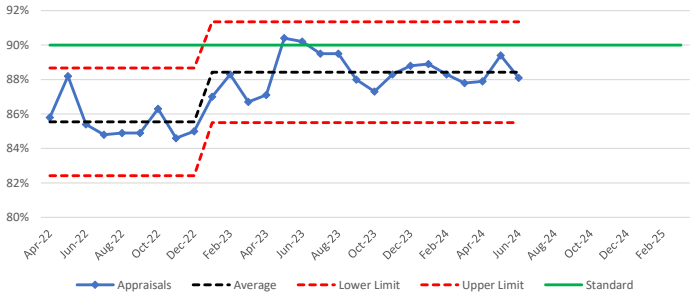
Vacancy rate



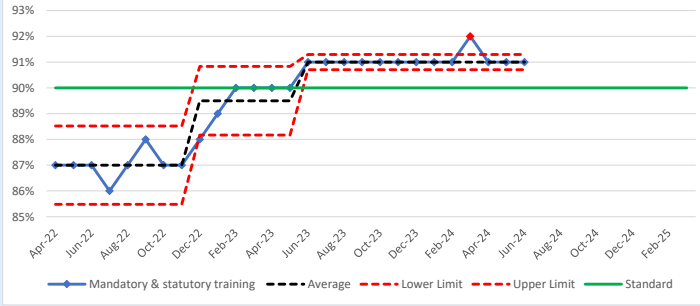
Turnover in month



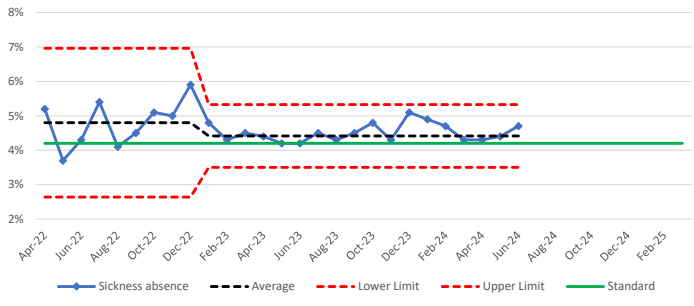
Appraisals



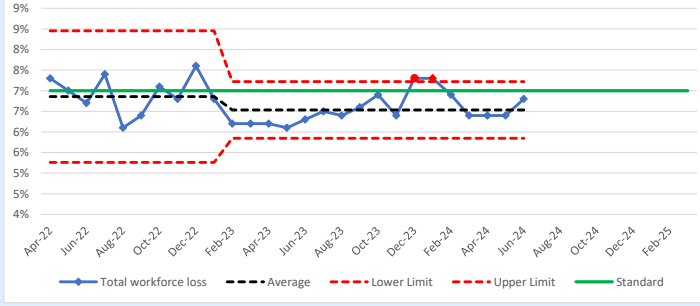
Mandatory & statutory training



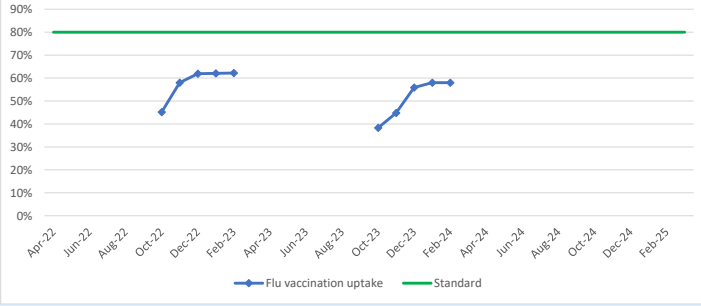
Sickness absence

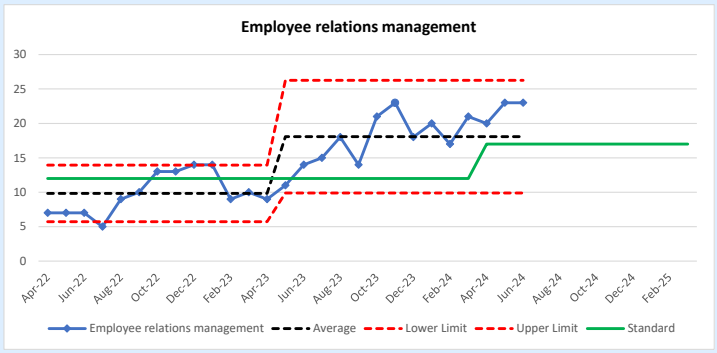


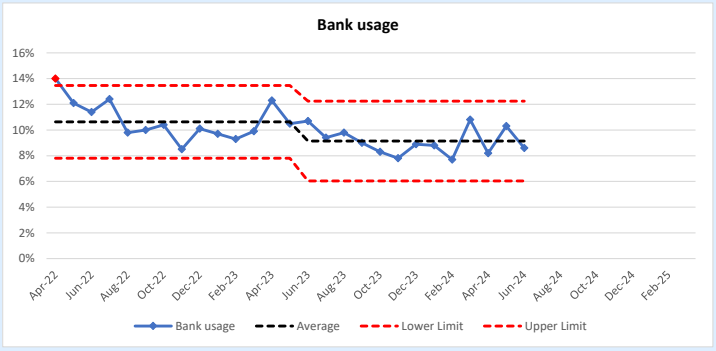
Total workforce loss

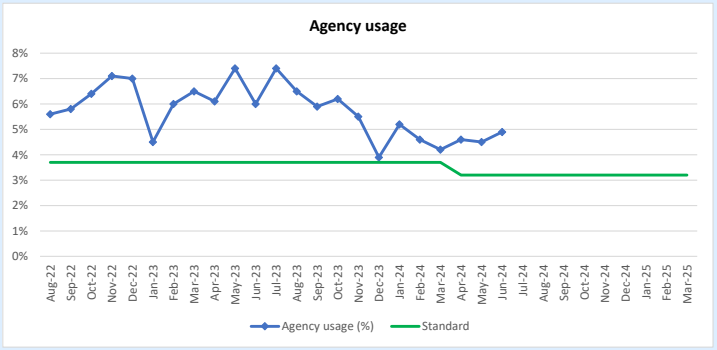


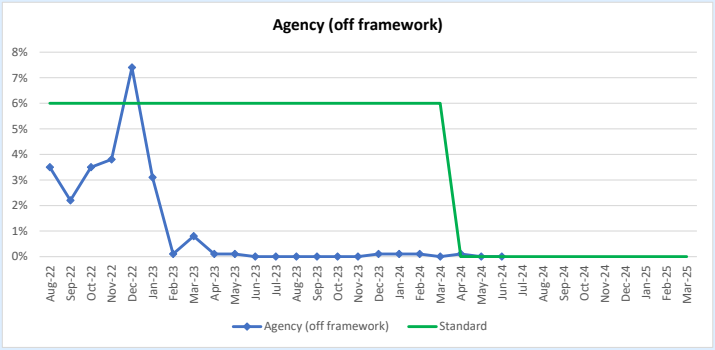
Flu vaccinations uptake (front line staff)

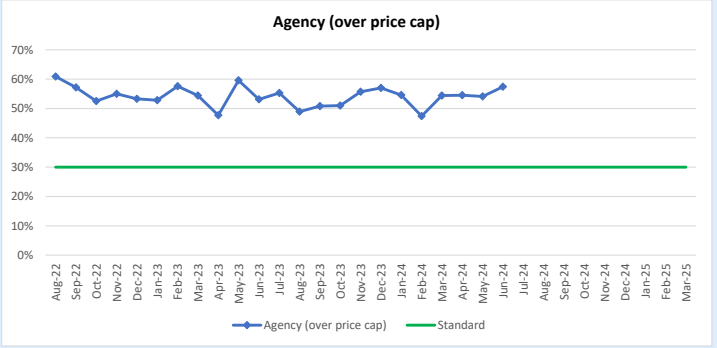



Employee relations management
30
25
20
15
10
5
0
Apr-22
Jun-22
Aug-22
Oct-22
Dec-22
Feb-23
Apr-23
Jun-23
Aug-23
Oct-23
Dec-23
Feb-24
Apr-24
Jun-24
Aug-24
Oct-24
Dec-24
Feb-25
Employee relations management
Average
Lower Limit
Upper Limit
Standard


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

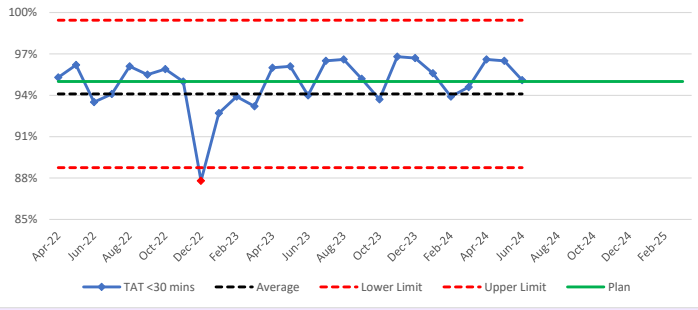

Agency usage
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Agency usage (%)
Standard


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

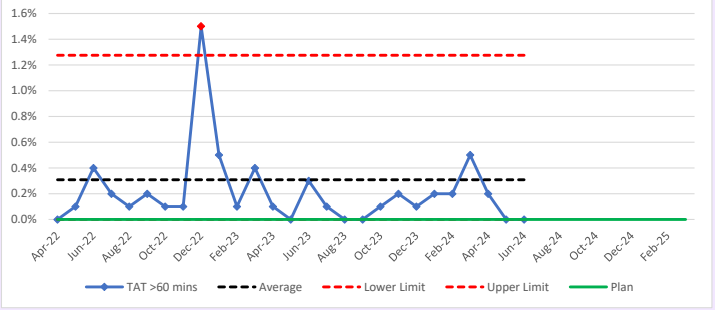

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Jan-25
Feb-25
Mar-25
Agency (over price cap)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

Timely Care

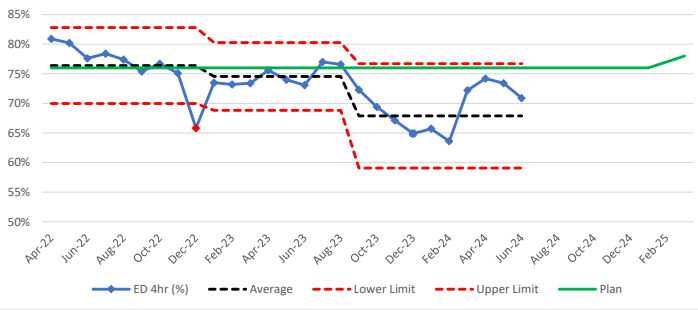
Ambulance turnaround times <30 mins



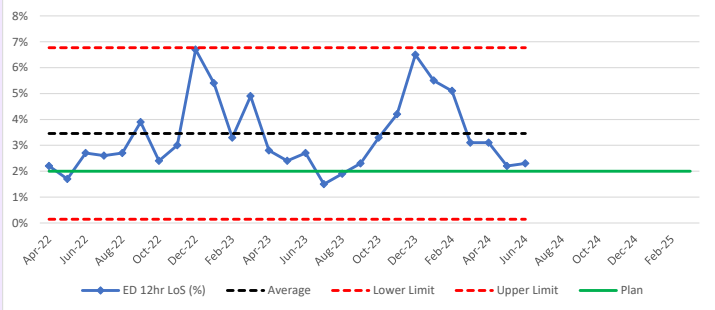
Ambulance delays >60 mins



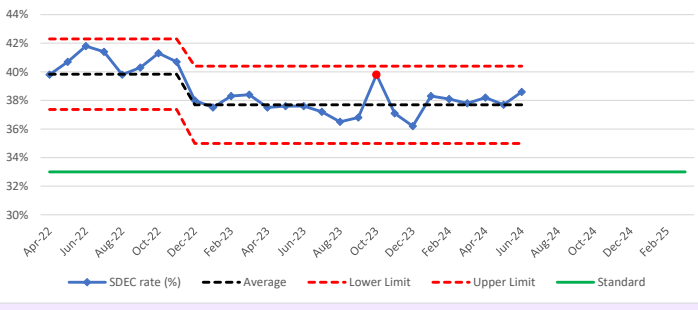
ED 4-hour performance



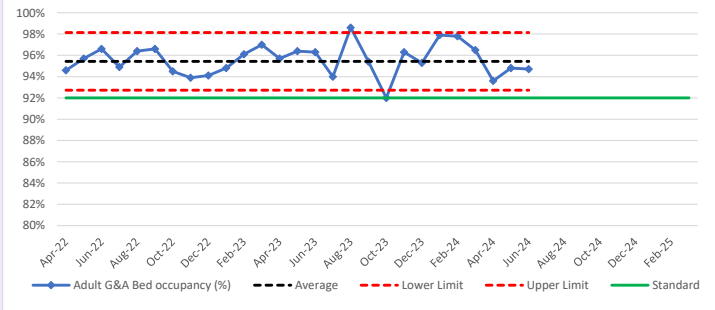
ED 12-hour length of stay performance



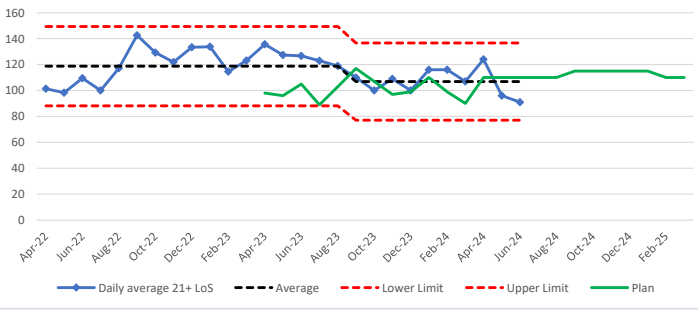
SDEC rate



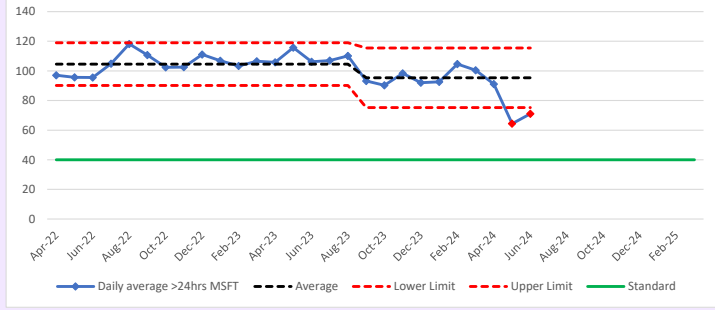
Adult G&A bed occupancy



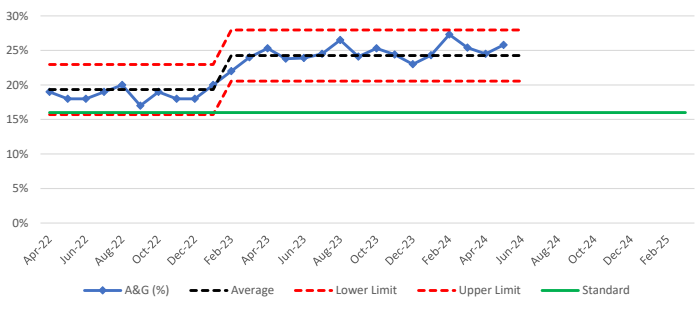
Long length of stay (21+) occupied beds



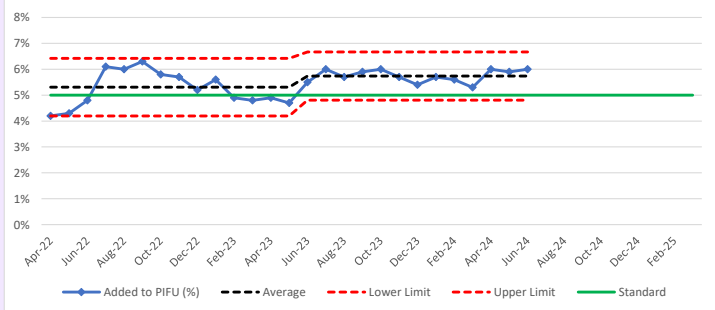
Inpatients medically safe for transfer for greater than 24 hours

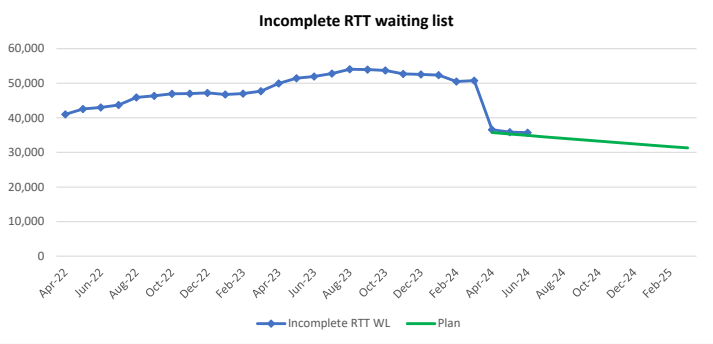


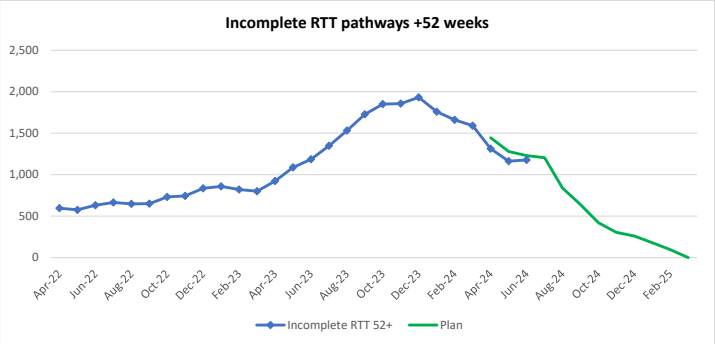
Advice & guidance

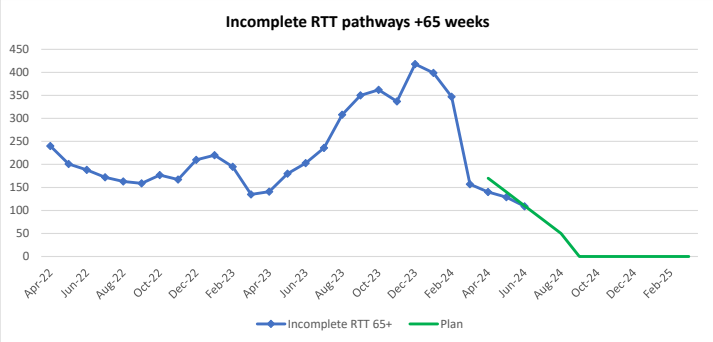


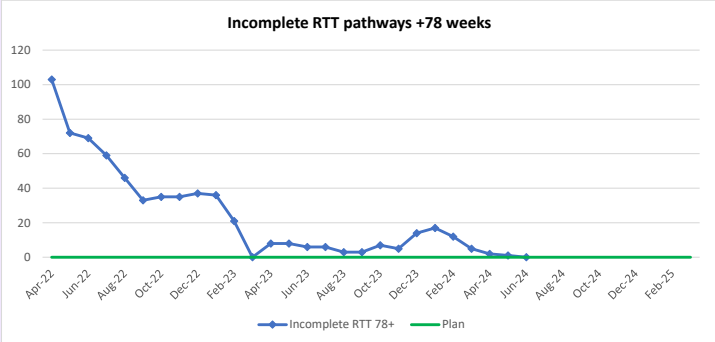
Added to Patient Initiated Follow Up (PIFU) pathway

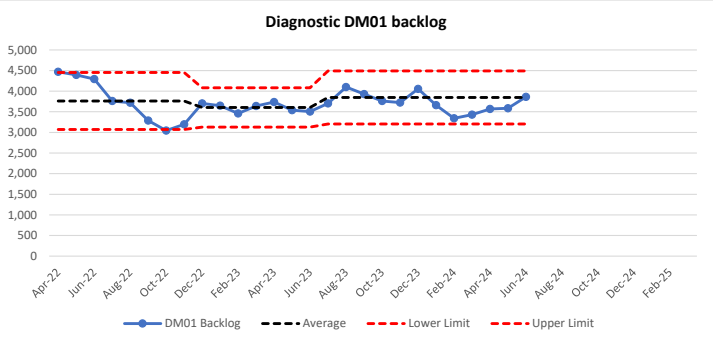


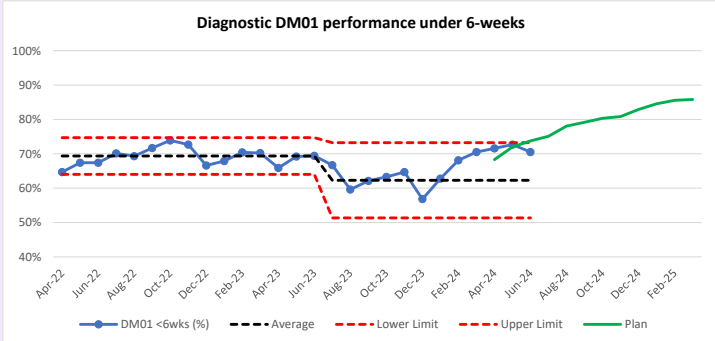

Incomplete RTT waiting list
Incomplete RTT WL
Plan

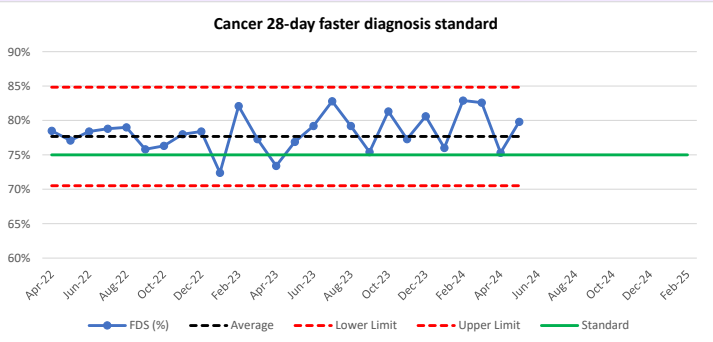

Incomplete RTT pathways +52 weeks
Incomplete RTT 52+
Plan

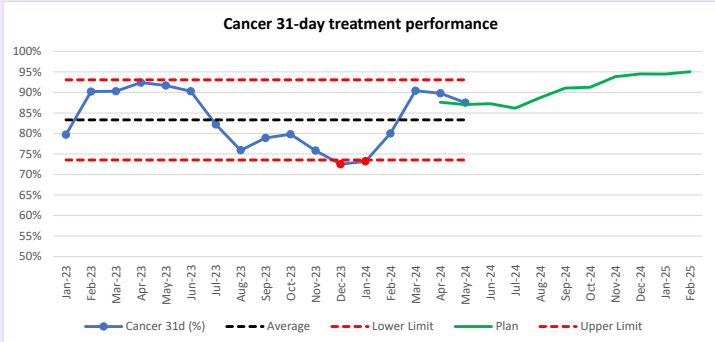

Incomplete RTT pathways +65 weeks
Incomplete RTT 65+
Plan

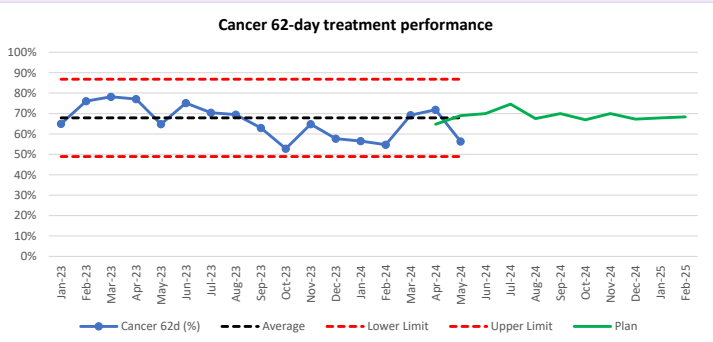

Incomplete RTT pathways +78 weeks
Incomplete RTT 78+
Plan

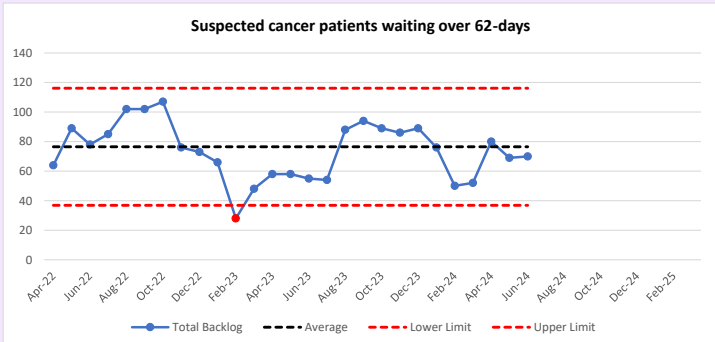

Diagnostic DM01 backlog
DM01 Backlog
Average
Lower Limit
Upper Limit


Diagnostic DM01 performance under 6-weeks
DM01 <6wks (%)
Average
Lower Limit
Upper Limit
Plan


Cancer 28-day faster diagnosis standard
FDS (%)
Average
Lower Limit
Upper Limit
Standard

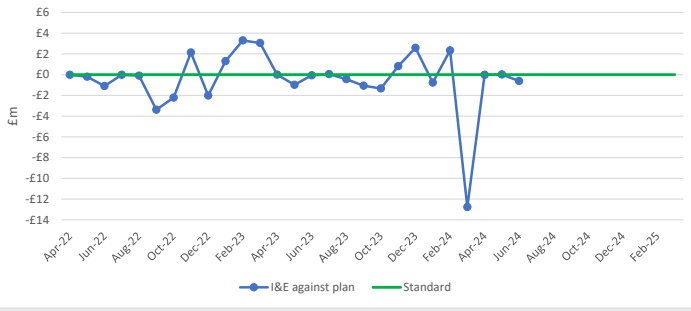

Cancer 31-day treatment performance
Cancer 31d (%)
Average
Lower Limit
Plan
Upper Limit


Cancer 62-day treatment performance
Cancer 62d (%)
Average
Lower Limit
Upper Limit
Plan

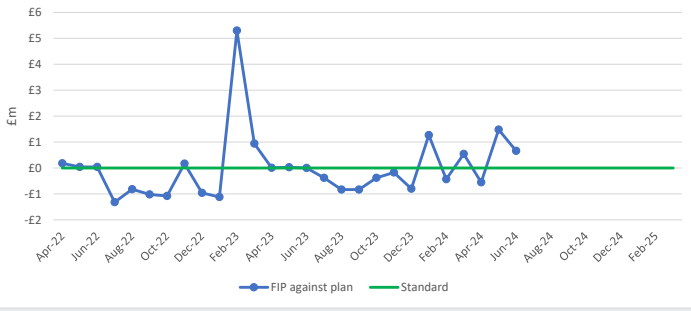

Suspected cancer patients waiting over 62-days
Total Backlog
Average
Lower Limit
Upper Limit

Best Value Care

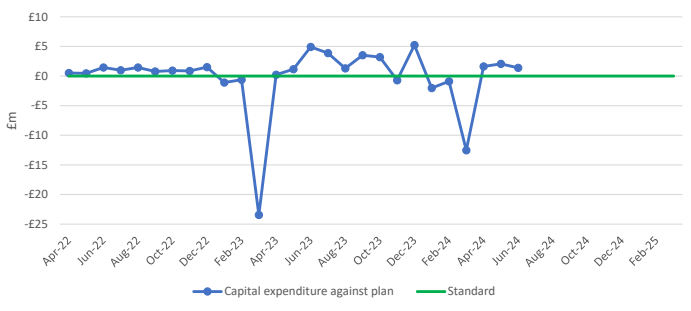
Income & expenditure against plan



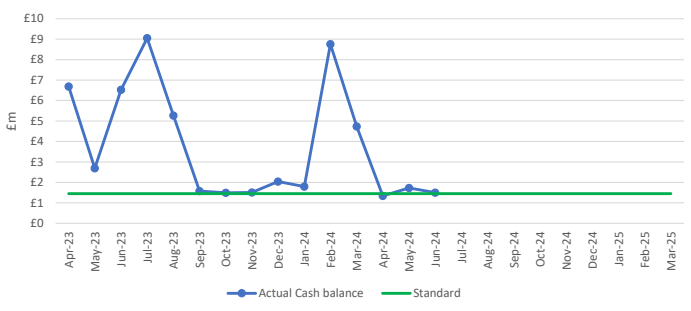
Financial Improvement Programme (FIP) against plan



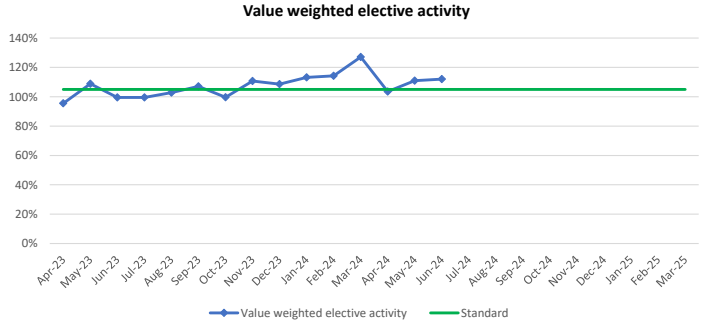
Capital expenditure against plan



Cash balance

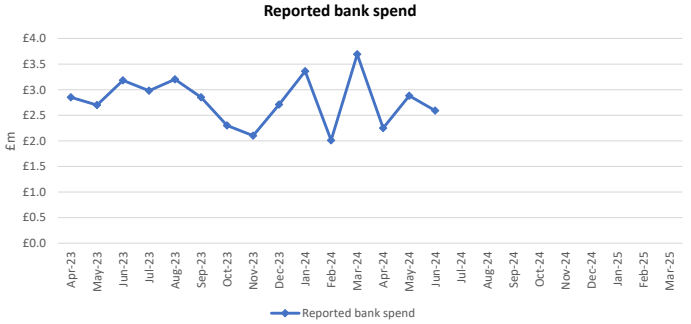


Value weighted elective activity

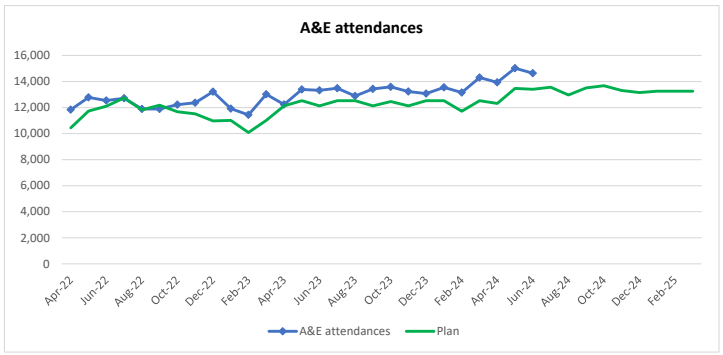


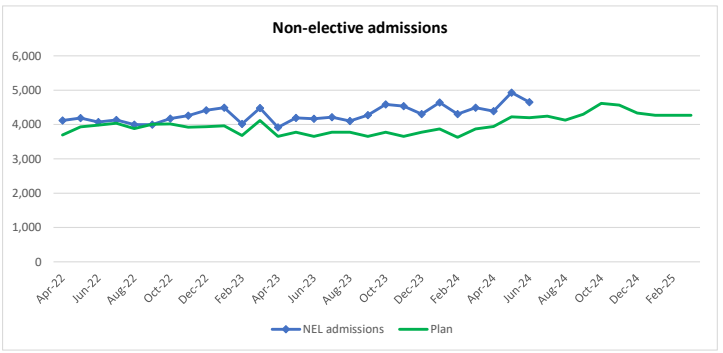
Reported agency spend

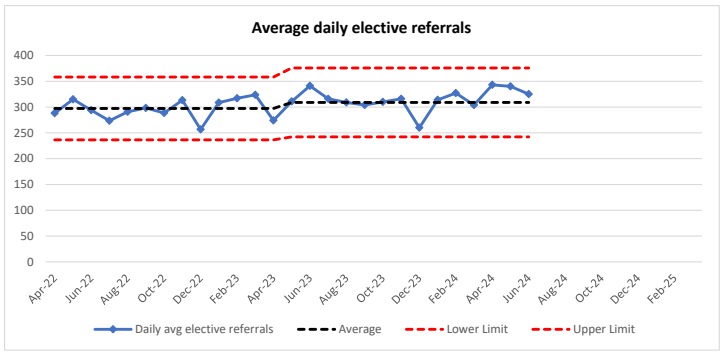
Reported bank spend

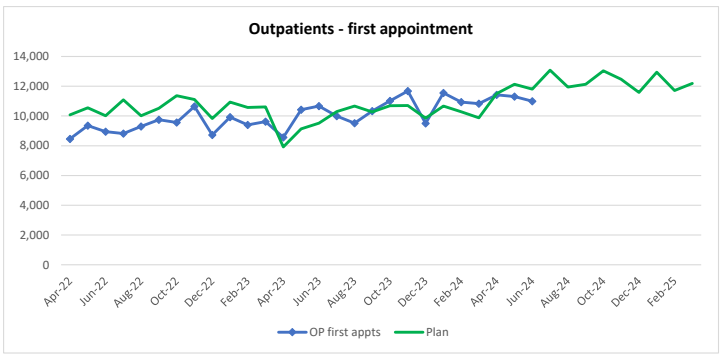


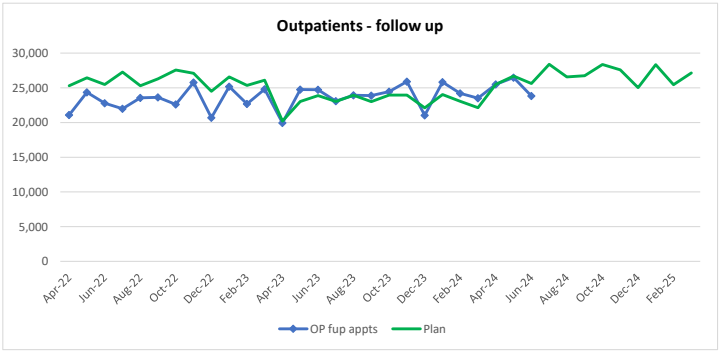
Activity (for context)

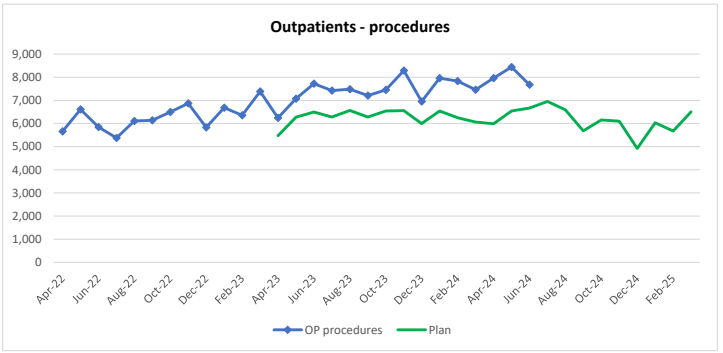


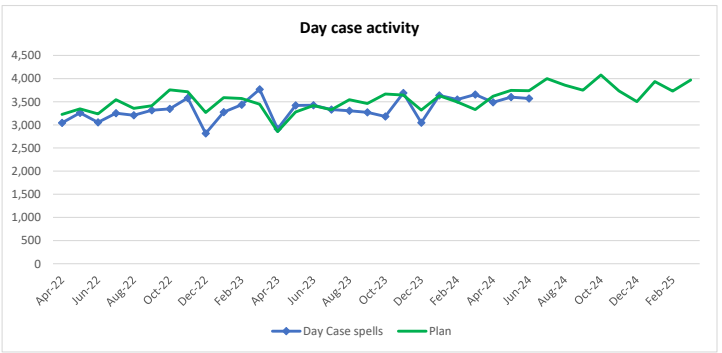


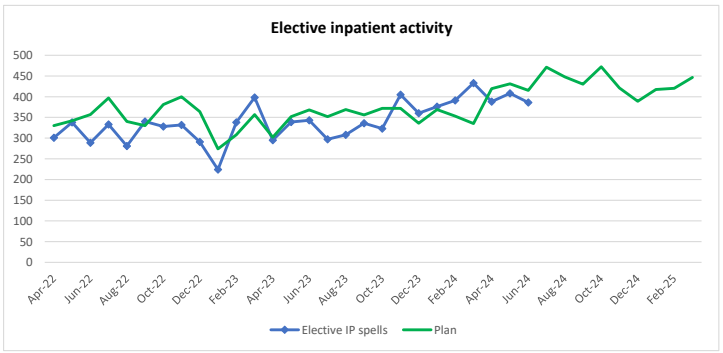


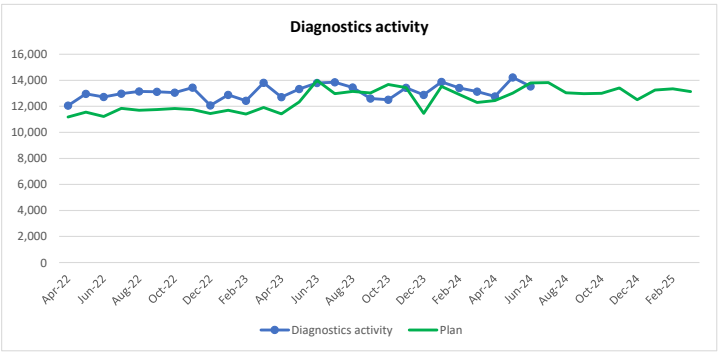












Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public – Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date:**	1st August 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	Failure to achieve the Trust's financial strategy	✓
PR5	Inability to initiate and implement evidence-based Improvement and innovation	✓
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	✓
PR7	Major disruptive incident	✓
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	✓

Committees/groups where this item has been presented before

Lead Committees review individual principal risks at each formal meeting (Quality Committee; People 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 6th June:

- Quality Committee: PR1 and PR2 – July; PR5 – June and July
- People Committee: PR3 – July
- Finance Committee: PR4 and PR8 – July
- Partnerships and Communities: PR6 – none
- Risk Committee: PR7 – June and July

At the April Board workshop, it was agreed that PR6 needs a re-write to reflect the current position. However, the Partnership & Communities Committee has not met since the Board workshop, so this is scheduled to be discussed at their August meeting.

The People Committee meeting is scheduled for 30th July, so the proposed changes have not been discussed by the Committee at the time of writing this report.

PR1, PR2, PR3 and PR4 remain significant risks; PR7 is proposed to increase to significant to reflect the current cyber threats to 3rd party suppliers.

PR1, PR2, PR3, PR4 and PR8 are all above their tolerable risk ratings. If the PR7 score increase is approved this will also be above its tolerable level.

Board members are requested to:

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

Acronyms used in the Board Assurance Framework

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

Acronym	Description
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): July 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

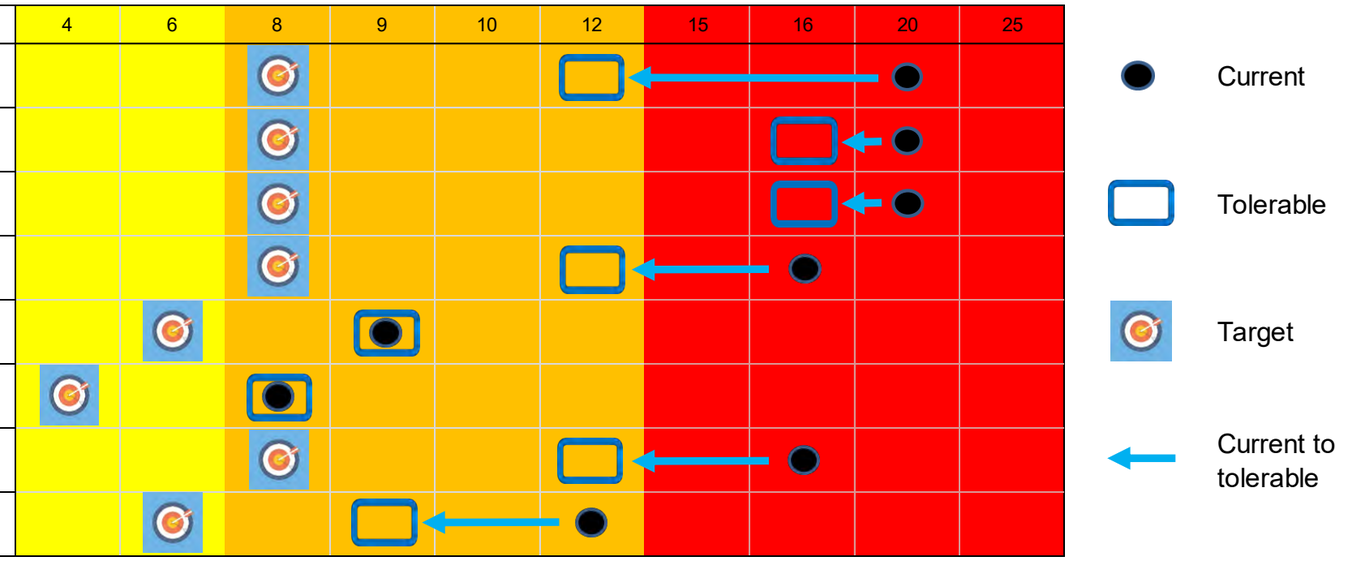
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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:

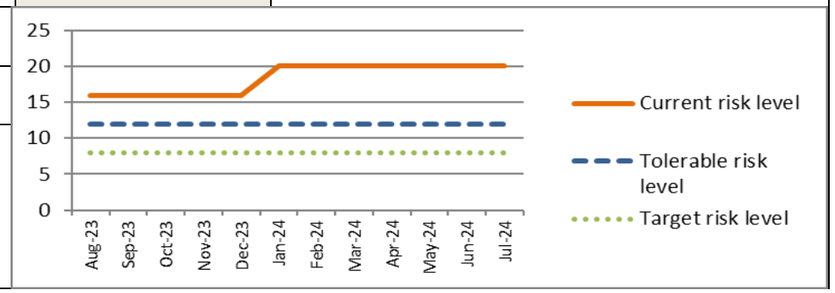
		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People
PR4	**Failure to achieve the Trust's financial strategy**	Chief Financial Officer	Finance
PR5	**Inability to initiate and implement evidence-based improvement and innovation**	Director of Strategy and Partnerships	Quality
PR6	**Working more closely with local health and care partners does not fully deliver the required benefits**	Director of Strategy and Partnerships	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): July 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						
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	22/07/2024	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**		
Last changed	22/07/2024						

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



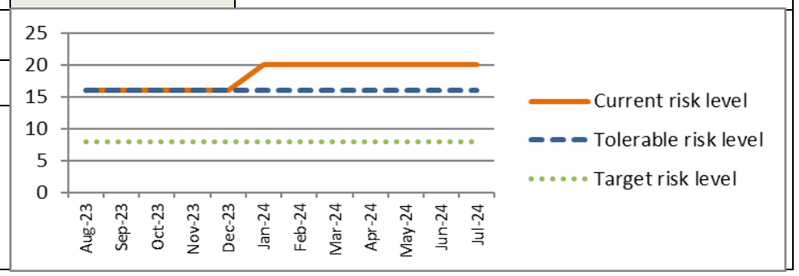
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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**
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	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:** ~~Chief Digital Information Officer~~Medical Director / Chief Nurse **Timescale:** September 2024	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board 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 (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports; Digital risks reported to Risk Committee 6-monthly and DSG monthly **Risk and compliance:** Quality Dashboard and ~~SOF~~ IPR to ~~PSC~~ Quality Committee bi-m~~M~~onthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC ~~bi-monthly~~ 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 ~~ICB PSIRF process awaiting go-live~~	Positive No change since April 2020

Board Assurance Framework (BAF): July 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 ▪ ~~Coronavirus~~ Infection 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 ▪ ~~Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements~~	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 **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	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; ~~SOF~~ Integrated Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; 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): July 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**
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm	Provide outstanding care in the best place at the right time
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	22/07/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**			
Last changed	22/07/2024							



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 to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with NEMS ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework~~,~~ and Full Capacity Protocol ~~and Pandemic Surge Plan~~ ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ 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 ~~▪ Cancer Services Steering Group~~ ~~▪ New oversight and additional actions in place to deliver the '4-hour sprint'~~	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. daycase	Utilising the outputs from the process mapping, as a system we are implementing improvements to SFH discharge information and processes including the re-introduction of discharge co-ordinators **SLT Lead:** Chief Operating Officer **Timescale:** ~~June 2024~~Complete ~~**Progress:** Action progressing well, with further developments to be delivered in 2024/25 Q1~~ Open a Surgical Same Day Emergency Care facility at KMH to enable ambulatory care instead of admission **Progress:** Trial commenced April 2024 **SLT Lead:** Chief Operating Officer **Timescale:** ~~June 2024~~ Complete 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 Trial of frailty SDEC co-located with Discharge Lounge **Progress:** Trial commenced 2024 **SLT Lead:** Chief Operating Officer **Timescale:** End Q~~1~~2 – then decision to end or make substantive 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) has been shared by the SAIU in July 2024 **SLT Lead:** Chief Operating Officer **Timescale:** throughout Q2	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board quarterly ~~on an at least bi-monthly basis~~; ~~'4-hour sprint' report to Executive Team weekly~~ **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board quarterly **Independent assurance:** Performance Management Framework internal audit report Jun 22		Positive Last changed December 2020

Board Assurance Framework (BAF): July 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 ~~opened at SFH Oct 22~~ ▪ Full ~~U~~use of ~~additional beds~~our bed base across our 3 sites ~~Mansfield Community Hospital (3 wards) Newark General Hospital (2 wards)~~ with further capacity purchased ~~Use of~~from Ashmere Group Care Homes ▪ Improved use of NerveCentre to facilitate timely patient discharge	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	**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		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 ~~Chief Officer~~ System Oversight Group meetings~~calls~~ 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 Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS			**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	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	Positive Last changed November 2022

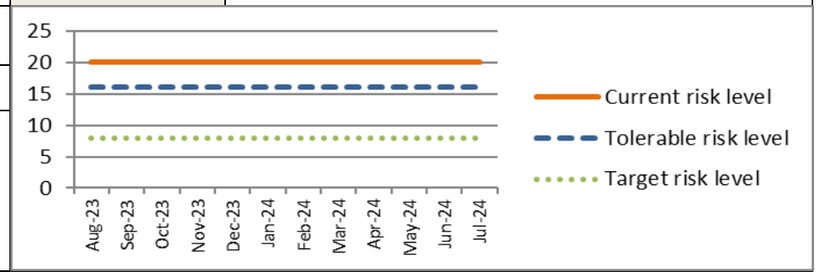
Board Assurance Framework (BAF): July 2024

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 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): July 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	22/07/2024	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**		
Last changed	22/07/2024						

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 **Timescale**: September 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; 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 **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		Positive Last changed June 2022

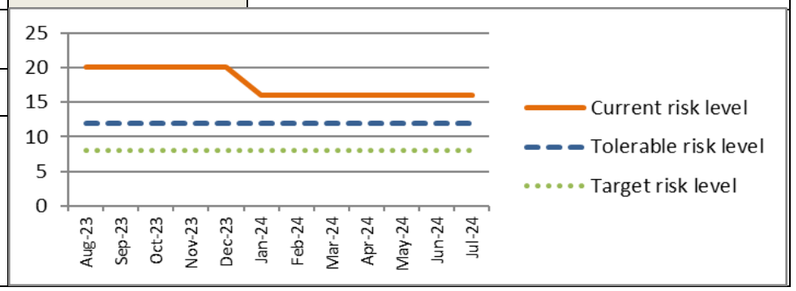
Board Assurance Framework (BAF): July 2024

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 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 **Timescale**: September 2024 Develop and implement a Sexual Safety Policy and process **SLT Lead:** Director of People **Timescale:** December 2024	**Management:** Staff Survey Action Plan to Board May 23; Staff Survey Annual Report to Board Apr 23; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board Oct 23; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, Culture and Improvement Committee Dec 22; People Plan updates to People Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug 23; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr 23; Assurance Report to People Committee quarterly; NHS Long Term Workforce Plan to People and Culture Committee Sep 23; 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; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22	Potential impact of cost-of-living issues on staff morale and wellbeing Industrial action up to and including strike action from all NHS unions, affecting all system partners ~~Co-ordinated~~ Potential strike action by ~~consultants, SAS doctors and~~ junior doctors ~~– on strike days Christmas Day cover only~~ Industrial action by Medirest staff	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): July 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						
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	23/07/2024	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	23/07/2024						

Strategic objective	Sustainable use of resources and estate

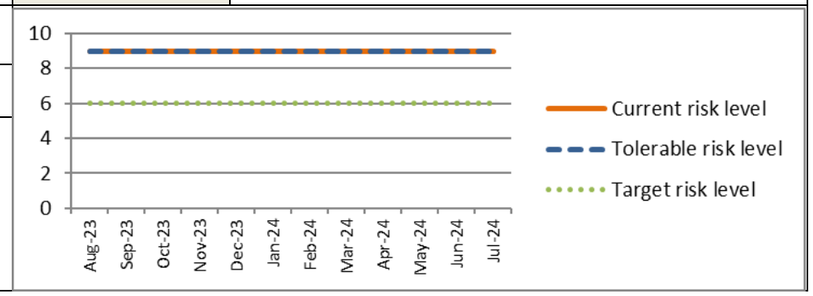


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
~~A reduction in funding or change in financial trajectory or unexpected event resulting in a requirement to reduce the scale of the financial deficit, without having an adverse impact on patient care~~ Regulatory action due to a failure to deliver NHS England financial targets	~~Working capital support through agreed PDC arrangements~~ ▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual ~~financial plan and~~ budgets~~,~~ based on available resources and stretching financial improvement targets ~~Improvement Faculty established to support the development and delivery of transformation and efficiency schemes~~ ▪ 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 ~~Close working with ICB partners to identify system-wide planning, transformation and cost reductions~~ ~~Development of a three-year Transformation and Efficiency Programme covering 2022-25~~ ▪ Monthly Provider Finance Return and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ~~Capital Resources Oversight Group (CROG) overseeing capital expenditure plans~~ ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established in most divisions ~~Financial Recovery Cabinet (monthly) and Financial Recovery Plan workstreams established~~ ▪ NHSE Financial controls self-assessment completed and working group set up to undertake improvement actions ~~Financial re-forecast undertaken in line with NHSE process~~ ▪ Financial Resources Oversight Group (FROG) established and meeting monthly. ▪ Vacancy Control panels ~~established~~in place	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 Financial Recovery Plan required to demonstrate a route to a break-even financial position by March 2026	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~~, annual planning for 2024/25 in progress~~ **SLT Lead:** Chief Financial Officer **Timescale:** ~~July~~ September 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. **SLT Lead:** Chief Financial Officer **Timescale:** August 2024 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. • August 2024 – Turnaround Director appointed • September 2024 – Financial Recovery Plan confirmed • October 2024 – Associate Director of Financial Recovery and Sustainability appointed	**Management:** ~~CFO's Financial Reports and Transformation & Efficiency Summary (Monthly);~~ Monthly Finance Report to Finance Committee Quarterly~~;~~ ~~Strategic Priority Report to Board~~ Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); ~~Capital Resources Oversight Group quadrant reports to Execs; Divisional Performance Reviews and Divisional Finance Reviews (monthly); Divisional risk reports to Risk Committee bi-annually; Monthly Agency reports to Trust Management Team; Financial Recovery Cabinet quadrant reports to Finance Committee (Monthly)~~ NHSE updates to Finance Committee; Monthly variable pay reports to Trust Management Team **Risk and compliance:** ~~Risk Committee significant risk report monthly~~ **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report ~~2022/23~~2023/24 Internal Audit reports: - ~~Key Financial Systems - Asset Register Jan 22~~ - 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) ~~- Key Financial Systems – Accounts Payable and Treasury and Cash Management Mar 24~~ - ~~Financial Ledger and Reporting Mar 24~~	Nottinghamshire system selected for NHSE initiated Investigation and Intervention Process (I&I). **Lead:** Chief Financial Officer **Timescale:** December 2024	Positive Last changed January 2024

Board Assurance Framework (BAF): July 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
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			**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 ~~restrictions~~ disinvestment in SFH ~~funding~~	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ~~ICB~~ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ~~ICB~~ICS Financial Recovery Group meeting weekly ▪ ICS System Opportunities Group meets bi-weekly, with SFH representation ▪ ~~ICB~~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 ▪ ~~Full participation in ICB planning~~ ▪ ~~SFH plan consistency with ICB and partner plans~~ ▪ ~~ICB Agency Reduction Group (Chaired by SFH CFO)~~ ▪ ~~NHSE Re-forecasting Process~~	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**: Chief Financial Officer **Timescale:** September 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. **Lead:** Chief Financial Officer **Timescale:** September 2024	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 Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report	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
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 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 2024	**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

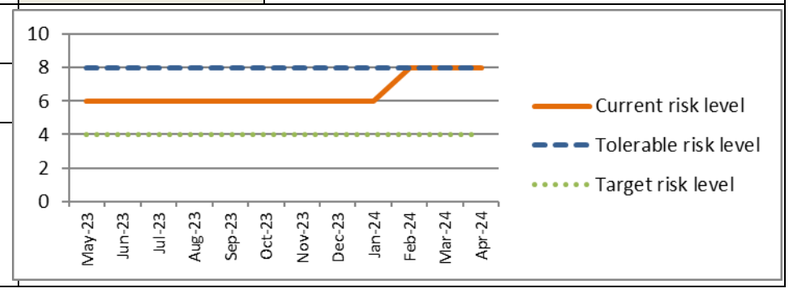
Board Assurance Framework (BAF): July 2024

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	22/07/2024	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	22/07/2024								

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 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:** ~~May~~ July 2024 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 **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~May~~ August 2024 Develop and roll out a Continuous Improvement Strategy **Progress:** Strategy developed for approval by the Strategy and Partnership Cabinet in July, then immediate roll-out **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~May~~ August 2024	**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): July 2024

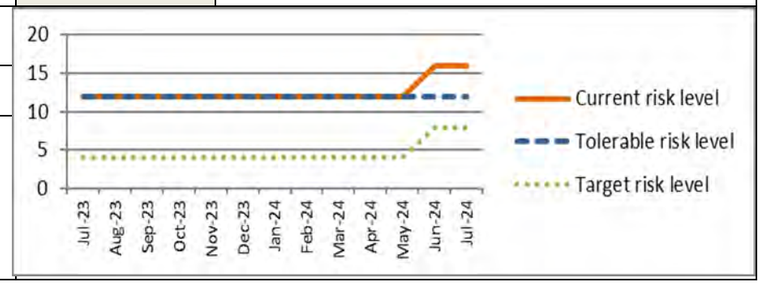
Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working							**Strategic objective**	Work collaboratively with partners in the community
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**4. Somewhat likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	11/04/2024	**Risk rating**	**8. Medium**	**8. Medium**	**4. Low**				
Last changed	11/04/2024								



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**
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; mid-; 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 ▪ Clinical Services strategy ▪ Health Inequalities Working Group			**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): July 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							**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Chief Executive Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	~~**3. Possible**~~ **4. Somewhat likely**	3. Possible	~~1. Very unlikely~~ 2. Unlikely				
Last reviewed	09/07/2024	**Risk rating**	~~**12. High**~~ **16. Significant**	**12. High**	~~**4. Low**~~ **8. Medium**				
Last changed	11/06/2024								

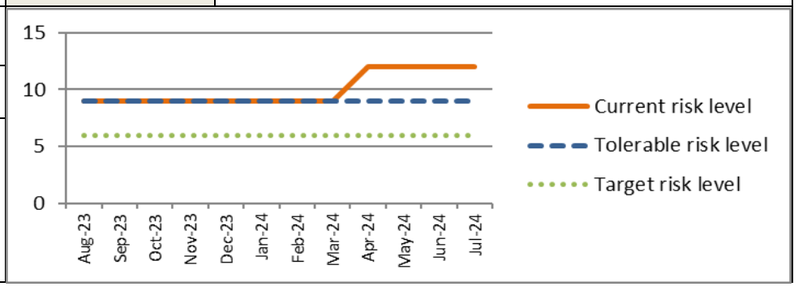


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required 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**
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	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) ▪ 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 2024 Complete the actions within the Fire Audit action plan **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** August 2024	**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	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:** ~~March~~ September 2024	Inconclusive Last changed March 2024

Board Assurance Framework (BAF): July 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**
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 ~~winter~~ weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident 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 ~~annual~~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	**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): July 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	23/07/2024	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	23/07/2024								

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 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:** ~~June~~ August 2024 Review of Green Plan Quarterly Energy and Sustainability Report to SDOG **Progress:** Data and information now readily available and now needs to show how we utilise this to inform our decisions on capital etc, **Lead:** Sustainability Officer **Timescale:** July 2024 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	**Management:** Green updates provided routinely to Finance Committee **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	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 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 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

Board Assurance Framework (BAF): July 2024

			Progress: Review of all aspects of the Green Plan have been undertaken and this is currently being reviewed by the EFM team. **Lead:** Associate Director of Estates and Facilities **Timescale:** July 2024 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 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. **Lead:** Sustainability Officer **Timescale:** July 2024 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. **Lead:** Sustainability Officer **Timescale:** August 2024		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 Decarbonisation Plan: Submission to Phase 5 Public Sector Low Carbon Skills Fund to produce our decarbonisation plan **Progress:** Bid Submitted May 2024 **Lead:** Sustainability officer **Timescale:** TBC following the outcome of the bid submission	

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	1 August 2024
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens.		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens, Philip 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**		

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

Committees/groups where items have been presented before

- Nursing and Midwifery AHP Committee
- Maternity Assurance Committee

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity Voice Champion (MVP)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)
- Saving Babies Lives Care Bundle (SBLCB)

Executive Summary

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

- build the maternity safety movement in your service locally, working with your maternity

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

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

Apology

As Maternity and Neonatal Safety Champions we would like to offer our deepest condolences to the families of Baby Arlo Lambert and Baby Theodore Bradley. In both cases, areas of care have been identified that could and should have been better and for this we are truly sorry.

We are committed as safety champions to ensure that improvements are made in the areas of care as identified by His Majesty's Coroners Miss L Bower and Dr E Didcock.

We will closely monitor the action plans, provide support for the resource required and challenge, when needed. We want to assure both families that we have taken the learning to improve and inform our future practice.

Summary of Maternity and Neonatal Safety Champion (MNSC) work for July 2024

1.Service User Voice

On the 18th of July 2024, as part of the planned MVP Trust Update meeting, we had the opportunity to meet with our new MVP Volunteer for SFH. Emma has been through a recruitment process and training now and is looking forward to spending time at the organisation.

A key deliverable this month from the MVP and the Trust has been through the MVP identifying that nationally the free text report for the annual CQC survey had been made available but neither SFH or NUH had access to this. Through joint working this has now been made available and the team leading on the survey feedback will now build these comments into the action plan.

2.Staff Engagement

The planned MNSC walk round, and Maternity Forum took place on the 11th of July 2024. The MNSC spoke with colleagues across the MDT with a key theme from all staff being the reflections following a recent coronal case.

As part of the walk round, open, and honest discussion were held into the case and subsequent actions with assurance from the teams regarding the culture elements outlined. As MNSC we will be closely cited to the action plan for the Regulation 28 report, which we will ensure is cascaded to all staff.

The forum later that day further provided the opportunity for open and honest feedback, which was provided. Actions were taken away by the Director of Midwifery which strengthened the current immediate actions in place following the Coronal case and information shared at that inquest.

3.Governance Summary

Three Year Maternity and Neonatal Plan:
The Maternity Safety Team continue to work with the LMNS, the first joint meeting with NUH and the LMNS was held at the end of June 2024 from which a template has been developed. We are working through this template but from the initial review we can provide assurance for the majority of this template. Escalation will be made to the MNSC regarding any areas that may be potential risk.

Ockenden:
The action plans continue through following the annual Ockenden insight visit report from our visit in October 2023. The visit findings supported the self-assessment completed by the Trusts. Area's have been identified from the visit to strengthen the embedding of the immediate and essential actions, progress has been made as a system around the bereavement provision, notable with the counselling support available for families as a system which is a feature of the Three-Year plan. This is being progressed now through the systems Transformation Committee.

The request from the independent maternity review at Nottingham regarding a data sharing agreement (DSA), has been presented to the Digital Committee and now requires progressing to the Information Governance Board, due to be held in July 2024. Until the DAS has been approved any request are being taken through the access to health records for review.

NHSR:
The task and finish group for the year 6 Maternity Incentive Scheme is established now and meeting fortnightly to work through the evidence upload needed.

Several national changes have been communicated and the team have updated their work plan accordingly. Presented to the MNSC is the risk around the Transitional Care staffing, an action plan will be drafted to support the submission for this year.

Saving Babies Lives:
SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) in version 2 and following the uploaded evidence submitted to the regional teams we have received confirmation that we have achieved the agreed over 70% of compliance for version 3 (SFH currently at 87%). Work continues to ensure that we aim for full compliance within the agreed time thresholds.

Key area of focus is to support the newest element within the version 3 of the bundle which focuses upon the diabetes service.

CQC:
Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) the evidence has been rated as "green" through the QC, further is needed for these actions to become embedded. The "Must-Do" progress will be tracked through the MNSC. The Trust Mandatory training remains above the 90% threshold and a standardised triage system is in place. The triage task and finish group continue to present through the MNSC meeting.

A revised peer review programme has commenced, initial in maternity to review set areas which would be incorporated within the CQC programme.

4. Quality Improvement
Colleagues in our Neonatal Unit are celebrating after they were awarded the prestigious Baby Friendly Award by the UNICEF UK Baby Friendly Initiative. Following an extremely competitive application process, the neonatal unit was one of 18 from across the UK to be selected for the initiative and was very lucky to

receive a range of support and opportunities over a three-year period to achieve their accreditation by 2024. Achieving this status is a key deliverable for the three-year plan, which we have reached before the target of 2027.

The Baby Friendly Initiative is a global programme which aims to transform healthcare for babies, their mothers, and families as part of a wider global partnership between UNICEF and the World Health Organization (WHO). In the UK, the Baby Friendly Initiative works with public services to better support families with feeding and developing close, loving relationships to ensure that all babies get the best possible start in life. The award is given to health facilities/hospitals/universities after an assessment by a UNICEF UK team has shown that recognised best practice standards are in place.

The award comes after the unit achieved their stage three Baby Friendly Accreditation just two years after the starting their baby friendly journey. The team have worked extremely hard to achieve all three stages of the accreditation process in a short period of time after initially receiving their certificate of commitment in April 2022, then going on to achieve stage one in July 2022 and stage two in late 2023.

5.Safety Culture

As part of the perinatal cultural workplan, drawing on the three themes of communication, leadership and health and wellbeing. Significant progress has been made towards the “You Said- Together We Did” campaign across the services, within a plan discussed at the Divisional People Committee as to how this is communicated widely.

Another element which will be incorporated into the Perinatal Quad Cultural work is the issues raised following the recent Coroners inquest, as part of the immediate action an anonymous survey will be circulated to review the concerns report by individuals during the inquest to understand if these are wider issues. These focus on the enhanced rate of pay and night working.

Maternity Perinatal Quality Surveillance model for July 2024

Sherwood Forest Hospitals
NHS Foundation Trust

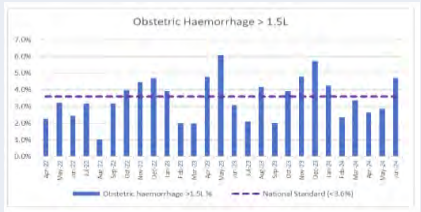
CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

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

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

Massive Obstetric Haemorrhage (Jun 4.7%%)

- Increase in MOH incident this month, reviewed through MDT meeting- no themes, trends or immediate action needed.
- LMNS PQSG meeting to align the PSIRP plans



Elective Care

Elective Caesarean (EL LSCS)

- First MDT scheduling meeting commenced for LSCS- positively received.

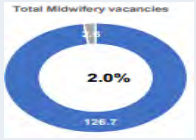
Induction of labour (IOL)

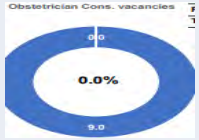
- Outpatient training commenced, awaiting data/ feedback for further updates.

Midwifery & Obstetric Workforce

Current vacancy rate (PWR data)

- Midwifery workforce 2%, vacancy fully recruited- awaiting start dates.
- MSSW recruitment successful- now in post. Band 4 MSSW trainer role appointed substantively , supported by external funds.
- No obstetric vacancy





Staffing red flags (Jun 2024)

- 7 staffing incident reported in the month,
- No harm related staffing incident, increase noted in short term sickness

Suspension of Maternity Services

- One suspension of service due to high acuity and capacity.

Home Birth Service

- 68 homebirth conducted since re-launch,
- Emerging risk to service due to expected maternity leave- 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 (3.1 /1000 births)

- One stillbirth reported in June. Reviewed through PMRT only at present.
- For 2023/2024 the rate per 1000 births is 2.3. This rate remains below the national threshold of 4.4/1000

Maternity Assurance

NHSR	Ockenden
• Year 6 MIS now live • Initial risk no mitigated. • Fortnightly task and finish group progressing	• Initial 7 IEA- 100% compliant • System reporting for Three-Year plan in development

Incidents reported Jun 2024 (102 no/low harm, 0 moderate or above*)

MDT reviews	Comments
Triggers x 14	

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

Other:

- PFD received for Antepartum Haemorrhage and Trust response to statement collation. Working group established to progress response.

Maternity Perinatal Quality Surveillance scorecard

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Maternal Perinatal Quality Surveillance Scorecard

Quality Metric	Standard	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	Trend
1:1 care in labour	>95%	100.00%	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%	
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%	
3rd/4th degree tear overall number		79	8	6	6	7	9	4	5	8	3	11	8	4	
Obstetric haemorrhage >1.5L number		127	6	11	6	11	15	17	13	6	9	9	9	11	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	2.90%	4.70%	
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%	
Stillbirth number		10	0	1	0	0	0	2	1	2	1	0	1	1	
Stillbirth rate	<4.4/1000				1.700			2.300			3.100			2.300	
Rostered consultant cover on SBU - hours per week	60 hours	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	
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	
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	
Number of compliments (PET)		38	2	3	3	4	4	3	2	3	4	5	4	1	
Number of concerns (PET)		9	1	1	1	2	0	1	1	1	1	0	0	4	
Complaints		6	0	1	1	1	0	0	1	0	0	1	1	0	
FFT recommendation rate	>93%		89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	91%	91%	

External Reporting	Standard	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	Trend
Maternity incidents no harm/low harm		1339	86	85	107	130	158	94	148	102	102	95	130	102	
Maternity incidents moderate harm & above		10	0	1	3	2	2	1	1	0	0	0	0	0	
Findings of review of all perinatal deaths using the real time monitoring tool	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	Two live cases, intrapartum stillbirth and HIE 3 following a shoulder dystocia. Both draft reports have been received and are under review.													
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													
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	Y	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	
Progress in Achievement of CNST 10	<4 <7 7 & above														

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NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	NHS Impact	**Date:**	1st August 2024
Prepared By:	Claire Hinchley, Acting 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 provide an introduction to NHS Impact and share initial plans for developing an improvement culture across SFH.	**Approval**	
	Assurance	
	Update	**Y**
	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
			Y		

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

Committees/groups where this item has been presented before

N/A

Acronyms

CQIS – Continuous Quality Improvement Strategy
NHS IMPACT – Improving Patient Care Together
QSIR – Quality Service Improvement and Redesign
SFH – Sherwood Forest Hospitals NHS Trust

Executive Summary

NHS Impact

NHS IMPACT (Improving Patient Care Together) is the new, single, shared NHS improvement approach. By creating the right conditions for continuous improvement and high performance, systems and organisations can respond to today's challenges, deliver better care for patients and give better outcomes for communities.

NHS Impact is a whole NHS offer to create an improvement culture. The last attempt at mass-improvement was undertaken by the Modernisation Agency in the early 2000's. This earlier approach trained patient facing colleagues in improvement but it was found that when they returned to their work, their organisations were not culturally ready for the improvement journey and development to continue, and the skill set was lost.

NHS Impact has taken this learning and seeks instead to focus on leadership behaviours especially at Board level related to improvement. They believe this approach will support the development of an improvement culture across the NHS. They recognise that many Board members now did not gain experience of the Modernisation Agency and improvement skill sets have diminished.

Improvement culture is both a mindset and a methodology. It is leadership behaviours, skills & capability and sharing of knowledge.

NHS Impact self-assessment

All Trusts were asked to complete an NHS Impact self-assessment tool to baseline current performance against 5 domains and 22 statements. It is also a requirement of the 2024/25 planning round.

5 domains:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding into management systems and processes

The Trust completed the assessment with a group of multi-professional colleagues through the Improvement Advisory Group late last year, the outcomes of which are included in the appendix. The scoring indicates the Trust as being in a 'starting' or 'developing' position across the domains which benchmarks similarly across Nottinghamshire's other healthcare providers.

Outcomes of the self-assessment

Development and engagement of a Continuous Quality Improvement Strategy (CQIS) which uses the domains of the self-assessment to create a plan has been the focus of delivery since the initial assessment. It is due to be finalised over the summer and has received positive engagement and feedback.

A further focus on the resource required to deliver improvement has required a rethink of skill set and capacity of colleagues. The improvement faculty provides facilitated improvement expertise to challenging programmes of work, however there are numerous requests for improvement support across the organisation that are currently not resourced.

Over 200 colleagues working within SFH services have received Quality Improvement and Service Redesign (QSIR) training through our training partners across the Nottinghamshire ICS. Plans are in place to develop this cohort of people into a network to provide support to less complex improvement projects and ensure improvement becomes everybody's business. There are pockets of positive engagement of QSIR trained colleagues into local improvement pieces of work that we can learn from and develop a consistent approach across the Trust.

A delivery plan against each of the domains is in development with the intention of nurturing an improvement culture that improves the lives of our patients and our people.

Recommendations:

The Board are asked to:

- NOTE the self-assessment process and current starting point
- NOTE the development of a strategy and resource delivery plan

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NHS Impact self-assessment

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Outcomes of NHS IMPACT Self-Assessment – Summary

NHS IMPACT (Improving Patient Care Together) requested healthcare providers undertake a self-assessment tool to develop the skills and techniques to deliver continuous improvement. NHS IMPACT's five components underpin a systematic approach that includes:

- Building a shared purpose and vision
- Investing in people and culture
- Developing leadership behaviours
- Building improvement capability and capacity
- Embedding improvement into management systems and processes

The development of these domains will support the Trust to adopt and share best practice. It will inform the way we work across services and create the conditions in which continuous improvement is the 'go to' method for tackling clinical, operational and financial challenges. This will be key in terms of changing the organisational culture.

Summary:

- It provides us with opportunities to improve. In addition, during the self-assessment, colleagues from across different disciplines started to identify opportunities. It has therefore stimulated the right level of discussion.
- We have shared our outcomes with Notts partner Organisations whose scores are broadly similar.
- The self-assessment exercise has informed the draft Continuous Quality Improvement Strategy. This will help in terms of managing and monitoring the outcome of specific, targeted activity. Our baseline position will be used to demonstrate improvements.
- Several domains will have progressed since the initial assessment was undertaken, we need to re-measure our progress later this year.

For reference, NHS IMPACT scoring criteria can be found here: NHS England » NHS IMPACT (Improving Patient Care Together) self-assessment

Outcomes of NHS IMPACT Self-Assessment (1)

Question	Score	Definition
Building a shared purpose and vision 1.Board and executives setting the shared purpose and vision.	Starting	We are starting to develop a shared vision aligned to our improvement methodology, although only known by a few. Our organisational goals are not yet aligned with the vision and purpose in a single, strategic plan.
2. Improvement work aligned to organisational priorities.	Starting	Our organisational purpose, vision, values and strategic priorities are in development, but not yet widely communicated to staff. Organisational goals are yet to be defined in a way that enables them to be cascaded to all our teams.
3. Co-design and collaborate - celebrate and share successes.	Starting	We are at the early stages of working out what quality or continuous improvement means in our context and how we will apply it systematically. So far engagement has been largely focused on senior leadership.
4. Lived experience driving this work (patients, staff, communities.	Starting	There is an aspiration or stated commitment to engage people using services, unpaid carers, staff and the community in further design of our shared purpose and vision, but it is not yet fully worked through or systematic.
Investing in people and culture 5. Pay attention to the culture of improvement.	Starting	There is an aspiration or stated commitment at Board level to establish an improvement culture, but it is yet to be worked through even at Board and Executive level.
6. What matters to staff, people using services and carers.	Starting	Our ways of understanding what matters most to staff, people using services and unpaid carers tend to be reliant on formal mechanisms (e.g. surveys) and the link to improvement is not strong or systematic.

Outcomes of NHS IMPACT Self-Assessment (2)

Question	Score	Definition
7. Enabling staff through a coaching style of leadership.	Developing	There is an organisational endorsement of a coaching-style of leadership, but it is not applied systematically (e.g. through leadership training). There are some good examples of how a coaching-based approach can bring about improvement, and this is increasingly recognised and encouraged. Staff are often supported to make changes when doing improvement activities.
8. Enabling staff to make improvements.	Developing	Some staff and teams feel able to make improvements (e.g. if they have been trained or are supported by a central team). There may be learning locally but it is generally not shared across teams and departments.
Developing leadership behaviours 9. Leadership and management development strategy.	Starting	Our Board, senior leaders and line managers are not yet trained in a consistent and defined improvement approach which they are expected to apply and role model.
10. Leadership and management values and behaviours.	Developing	Leadership values and behaviours are agreed across our organisation.
11. Leadership and management acting in partnership.	Developing	Most of our leaders work in partnership with their fellow leaders and managers.
12. Board development to empower collective improvement leadership.	Starting	Our Board discusses improvement at Board meetings, but it is not a regular occurrence.
13. ‘Go and see’ visits.	Starting	Some senior leaders spend time on the ‘shop floor’ from time to time to engage directly with staff and teams but it is not routine or widely practiced.

Outcomes of NHS IMPACT Self-Assessment (3)

Question	Score	Definition
Building improvement capability and capacity 14. Improvement capacity and capability building strategy.	Starting	We do not have a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams. We have some use of external resources.
15. Clear improvement methodology training and support.	Starting	No single improvement methodology has been adopted and only limited sharing of improvement gains/learning is cascaded beyond the immediate area where improvement is underway.
16. Improvements measured with data and feedback.	Starting	Our organisational approach to reviewing and tracking progress against goals has yet to be defined, at present improvement doesn't feature in whole organisational measures.
17. Co-production.	Starting	We have small discrete teams with relevant skills operating independently from one another labelled as clinical governance, service development, clinical audit or transformation, that are working in silos reporting to various directors with no lived experience partners co-producing improvement.
18. Staff attend daily huddles.	Starting	Any huddles are only traditional shift change clinical handovers.
Embedding into management systems and processes 19. Aligned goals.	Developing	Our department goals may involve up or downstream departments; we do not share improvement planning across departments. Our business planning is an activity conducted at board and senior leadership level to produce goals that are cascaded top-down to the rest of the organisation.

Outcomes of NHS IMPACT Self-Assessment (4)

Question	Score	Definition
20. Planning and understanding status.	Developing	Our business planning and performance management processes give the Board and senior managers reasonable visibility of status and progress against our goals. There are some routines for selecting and prioritising improvement work. Although we have some resource available there is no defined process for prioritising and allocating resource.
21. Responding to local, system and national priorities.	Starting	We do not yet have a coordinated or consistent management approach to how we respond to changing needs, address problems or deliver against our plans. Instead, it is perceived as reactive or firefighting.
22. Integrating improvement into everything we do.	Starting	Improvement is seen as separate to the day-to-day delivery of services. Our performance management system is seen as separate from any improvement activity or methods we apply and may be sending conflicting signals within the organisation.

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Audit and Assurance Committee Chair's Highlight Report to Board

Subject:	Audit and Assurance Committee	**Date:**	**18th July 2024**
Prepared By:	Manjeet Gill – Chair of Audit and Assurance Committee		
Approved By:	Manjeet Gill		
Presented By:	Manjeet Gill		
Purpose:			
		Assurance	**Substantial Assurance**

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Delivery of Trust Strategy – Concern about capacity to deliver strategy, improvements and innovation. Especially to meet the requirements of the externally supported financial efficiency work commissioned by the ICB in line with national direction. **Fracture Liaison Database –** Further assurance is sought via Quality Committee regarding this database. It is a mandated requirement and assurance needed for the plans and timescales to put this in place.	Progress on Due Diligence work for procurement and contract management including the opportunities around the Dynamic Purchasing Systems to open up the Frameworks, stronger procedures around Single tender waivers, and revisiting the processes around "No PO No Payment" about all of which a progress update report will be brought to the Committee in 3 months' time. Assurance on the Mental Health review and delivery of our Mental Health Strategy. Assurance to be provided by NHIS on timescales for completing the Network Data Security Policy.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Substantial Assurance provided from the Internal Audit Progress report against the 2024/25 Plan (including the new presentation of reports to show the strength of cumulative assurance), Register of Interests update, Non-clinical policies update, completion of outstanding Internal Audit Actions, Counter Fraud Progress report and Non-Clinical Audits. Assessment by 360 Assurance of the final submission of the Data Security Protection Toolkit provides substantial (high) assurance. Risk Committee report provided good assurance overall noting the	Losses and special payments (x3) noted and approved. Assured on the Board Assurance Framework process. Noted PR4 will be considered by the Finance Committee at its meeting on 23rd July 2023.

substantial Assurance from the work around Digital risk management, in particular. Substantial Assurance on the strengthening of due diligence processes for contract management, procurement and single tender waivers. Moderate Assurance opinion following the Internal Audit for FIP with assurance on the actions being taken to address recommendations. Limited Assurance opinion following the Internal Audit for Safeguarding. Assured on the actions being taken to implement the Audit recommendations.	

Comments on effectiveness of the meeting

Substantial Assurance on the Committee's Effectiveness including the quality and balance of the reports. Governor observers were asked for feedback with one pointing out that it felt to him that the Trust is now being reactive rather than proactive in relation to the delivery of its Strategy.

Items recommended for consideration by other Committees

Quality Committee to seek assurance on timescales for completion of Fracture Liaison Database and Clinical Audit Planning Process update.

Note: this report does not require a cover sheet due to sufficient information provided.

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Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:**	1st August 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 Finance Committee meeting of 23rd July 2024.		**Assurance**	Significant

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway

• Month 3 Financial Performance (to NOTE):
  o £0.6M adverse to plan
  o Delivered planned FIP, BUT still a significant gap to find
  o Behind on ERF
  o Grant Thornton review progressing well and Investigation & Intervention Review (I&I) by PA (on behalf of ICB as part of national review) about to commence.
  o ICB YTD actuals at £59M deficit (£2.4M adverse variance)
• PFI Update (to NOTE) – Hard FM service continues to underperform.
• Internal Audit Report on Financial Improvement and Productivity (to NOTE) – Moderate Assurance with 3 medium and 5 low risk recommendations. All agreed and in process of being implemented.
	• FIP – More detailed plan to be presented next month, including final outcomes of GT review.
	• Improvement Cabinet – The role and terms of reference to be reviewed.
	• Internal Audit Report on System Financial Controls – follow up report to be prepared on status of the 37 (of 80) self-assessed controls classed as 'Not complete and in place' to be presented to the next meeting.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
• Grant Thornton Review – Progress noted and good discussion on areas to focus on for FIP. • PA I&I Review – Agreed that scope of review will be helpful in further verifying work being undertaken, but also potentially identifying other opportunities within both the Trust and the ICS. • Month 3 Financial Performance – Deficit and variance to plan discussed. • Procurement – Annual Report and Contracts Forward Plan presented and reviewed. Assured by continued progress and cross organisation work being undertaken by the department.	• BAF – PR4 (Financial Sustainability), agreed to maintain risk score at 16, but to monitor closely as reviews are completed and FIP plan further developed. PR8 (Sustainable Reductions in Trust's Impact on Climate Change), agreed to maintain risk score at 12 and to review as plans to improve control implemented during July and through to September.

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

- To Audit Committee that the two Internal Audit Reports were thoroughly discussed and implemented of recommendations will be monitored.

Note: this report does not require a cover sheet due to sufficient information provided.

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Quality Committee Chair's Highlight Report to the Trust Board of Directors

Subject:	Quality Committee	**Date**	**Monday 22nd July 2024**
Prepared By:	Aly Rashid, Non-Executive Director/Chair		
Approved By:	Aly Rashid, Non-Executive Director/Chair		
Presented By:	Aly Rashid, Non-Executive Director/Chair		
Purpose:			
Assurance report to Board		**Assurance**	**Substantial Assurance**

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
- **62 Day- Cancer Performance and the tension between cancer waits and funding.** - **Fragile Services- Cardiology, Haematology and Stroke and establishment of working groups.** - **Limited Assurance provided in relation to the 360 Safeguarding Final Report. Noting updates to be provided to QC against ongoing actions.**	
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Positive assurance provided through the Cancer Services Annual Report. - Update in relation to the Electronic Patient Record (EPR) noted for information. - Updated in relation to improvement hot topic noted for information. - Positive Assurance from the PSC and PAC updates. - Assurance provided against the Maternity PFD actions underway. - Update received in response to challenged services.	- Approval of the IPR for Timely Care submission to the BOD. - Approval of the IPR for Quality Care submission to the BOD. - Approval of PR's 1, 2 and 5 of the Board Assurance Framework with no changes to the risk scores outlined.
Comments on effectiveness of the meeting	
Positive meeting held with in depth explanations and discussions in response to papers provided.	
Items recommended for consideration by other Committees	

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People Committee Chair's Highlight Report to Board

Subject:	People Committee Chair's Highlight Report	**Date:**	31st July 2024
Prepared By:	Steve Banks, Non Executive Director		
Approved By:	Steve Banks, Non Executive Director		
Presented By:	Steve Banks, Non Executive Director		
Purpose:			
To update the Board on the People Committee highlights following conversation held at the July meeting		**Assurance**	**Significant**

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• The ongoing context of strike action, increased demand and intense financial pressures impacting on the wellbeing and engagement of people in the Trust. • The lack of system capacity for patients with mental health concerns continues to lead to inappropriate lengths of stay in Urgent Care in unsuitable conditions. • Despite much positive assurance from the Thelwell self-review, some governance challenges exist	• Fragile services are being increasingly supported across the system and by the East Midlands Acute Providers network (EMAP)
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Much positive assurance was provided including from: • The actions following the significant assurance 360 report and the people promise. • The development of the cultural heat map evolving due to divisional requests • 360 audit findings re appraisals • People strategy progress	PR3 of the BAF was reviewed. • Due to continuing strike action and risk of further action the ratings remain unchanged and the threat of loss of work force productivity continues to have inconclusive assurance.

• Workforce Race Equality Standard progress, although national ambition for senior roles was challenged with further work planned at the next committee • Workforce Disability Equality Standard progress • Nursing and Midwifery Establishment review process • Health and Safety Update	

Comments on effectiveness of the meeting

Governor observation that Committee worked very effectively, with high quality input and some quite challenging conversations

Items recommended for consideration by other Committees

Productivity, agency and bank usage require working across People and Finance committees to ensure FIP targets are met

Note: this report does not require a cover sheet due to sufficient information provided.

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Charitable Funds Committee (CFC) Chair's Highlight Report to Board of Directors

Subject:	Charitable Funds Committee Report	**Date:**	1st August 2024
Prepared By:	Andrew Rose-Britton, CFC Chair		
Approved By:	Andrew Rose-Britton, CFC Chair		
Presented By:	Andrew Rose-Britton, CFC Chair		
Purpose:			
To provide an overview of the key discussion items from the Charitable Funds Committee meeting of 23rd July 2024.		**Assurance**	

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Project to re-scope End of Life rooms still not finalised in terms of cost or timescales	• To further develop and investigate fund raising options. • To finalise the launch of the Breast Service appeal for the 50% balance of funding required. • To review resources needed to promote charity work. • To look to develop Corporate and Staff engagement. • Review meeting arrangements including periodic meetings in person, including at Newark, and including development meetings in the schedule so members can see charity funded projects in action.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• Operational Group Quadrant gave positive assurances. • Community Involvement headline report well received. • The general direction of the Charity development plan was discussed, and the direction of travel was supported. • Market summary and investment portfolio	• To purchase a pair of Neptune 3 Rovers (a closed waste management system) utilising the grant funding from the Magnus Foundation. • To support the suggestion of a Green Champion category in the Annual Excellence Awards and to consider the suggestion to hold a Green "Dragons' Den". • To extend the duration of committee meetings to 2 hours. • To arrange a meeting of the Charity Trustees to appraise them of the updated appeal fund raising target

Comments on effectiveness of the meeting
Full engagement of the committee members, good discussion and decisions made.
Items recommended for consideration by other Committees
None.

Note: this report does not require a cover sheet due to sufficient information provided.