Sherwood Forest Hospitals
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: Thursday 3rd August 2023
Time: 09:00 – 12:30
Venue: Boardroom, King's Mill Hospital

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 6th July 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Action Tracker**	Update	Enclosure 5
6.	09:10	**Chair's Report**	Assurance	Enclosure 6
7.	09:15	**Chief Executive's Report**	Assurance	Enclosure 7
	Strategy			
8.	09:25	**2023/2024 Strategic Priorities Quarter 1 Update** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 8
9.	09:40	**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.	09:55	**Strategic Objective 3 – Empower and support our people to be the best they can be** • **Freedom to Speak Up (FTSU)** Report of the FTSU Guardian	Assurance	Enclosure 10.1
11.	10:15	**Patient Story – Behind the scenes of your operation** Caroline Robinson, Department Lead for Education, Operating Theatres	Assurance	Presentation

	Time	Item	Status	Paper
	BREAK (10 mins)			
	Operational			
12.	10:45	**IPR (Integrated Performance) Report – Quarterly** Report of the Executive	Consider	Enclosure 12
13.	11:30	**Board Assurance Framework (BAF)** Report of the Chief Executive	Approval	Enclosure 13
	Governance			
14.	11:40	**Use of the Trust Seal** Report of the Director of Corporate Affairs	Assurance	Enclosure 14
15.	11:40	**External Well-led Review Recommendations Progress Report** Report of the Director of Corporate Affairs	Assurance	Enclosure 15
16.	11:50	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • People, Culture and Improvement Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance Assurance Assurance	 Enclosure 16.1 Enclosure 16.2 Enclosure 16.3 Enclosure 16.4 Enclosure 16.5
17.	12:10	**Outstanding Service – Supporting young people with SEND (Special educational needs and disabilities) into employment**	Assurance	Presentation
18.	12:20	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
19.	12:25	**Any Other Business**		
20.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **7th September 2023, Boardroom, King's Mill Hospital**		
21.		**Chair Declares the Meeting Closed**		
22.		**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 12	• **IPR Charts**
Enc 13	• **Significant Risks**
Enc 16.1	• **Audit and Assurance Committee – previous minutes**
Enc 16.2	• **Finance Committee – previous minutes**
Enc 16.3	• **Quality Committee – previous minutes**
Enc 16.4	• **People, Culture and Improvement Committee – previous minutes**
Enc 16.5	• **Charitable Funds Committee – previous minutes**
Enc 19	• **Improvement Advisory Group Quadrant report**

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 6th July 2023 in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Graham Ward	Non-Executive Director	GW
	Barbara Brady	Non-Executive Director	BB
	Aly Rashid	Non-Executive Director	AR
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Andrew Rose-Britton	Non-Executive Director	ARB
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	Phil Bolton	Chief Nurse	PB
	Rob Simcox	Director of People	RS
	David Ainsworth	Director of Strategy and Partnerships	DA
	David Selwyn	Medical Director	DS
	Rachel Eddie	Chief Operating Officer	RE
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
In Attendance:	Jen Leah	Deputy Chief Financial Officer	JL
	Paula Shore	Director of Midwifery	PS
	Leanne Minett	Corporate Matron	LM
	Adele Bonsall	Dementia Nurse Specialist	AB
	Jane Little	Voluntary Services Administrator and Patient's daughter (patient story)	JLi
	Richard Walker	Chief Digital Information Officer	RW
	Morgan Thanigasalam	Clinical Lead for Digital Innovation and Transformation	MT
	Sue Bradshaw	Minutes	
	Jessica Baxter	Producer for MS Teams Public Broadcast	
Observers:	Kevin Stewart	Appointed Governor	
	Ian Holden	Public Governor	
	Ashton Green	Co-Chair of Youth Forum	
	Richard Brown	Head of Communications	
	Lyndsey Ball	Postgraduate Programme Quality Manager	
	1 member of the public		
Apologies:	Richard Mills	Chief Financial Officer	RM

Item No.	Item	Action	Date
23/208	**WELCOME**		
1 min	The meeting being quorate, CW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and any members of the public watching the live broadcast were able to submit questions via the live Q&A function.		
23/209	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
23/210	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Richard Mills, Chief Financial Officer. It was noted Jen Leah, Deputy Chief Financial Officer, was attending the meeting in place of Richard Mills.		
23/211	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 1st June 2023, the Board of Directors APPROVED the minutes as a true and accurate record.		
23/212	**MATTERS ARISING/ACTION LOG**		
2 min	The Board of Directors AGREED that actions 23/136, 23/172, 23/178.1, 23/178.2, 23/178.3 and 23/184 were complete and could be removed from the action tracker. Action 23/173.2 – DS confirmed AR has now visited the proposed site for the doctors' mess. An indicative timeline for the works is in place and work is progressing via the Capital Oversight Group. The Board of Directors AGREED this action was complete and could be removed from the action tracker.		
23/213	**CHAIR'S REPORT**		
3 mins	CW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective, highlighting events to mark the 75th birthday of the NHS, Staff Excellence Awards, governor elections and the news Andy Haynes, Specialist Advisor to the Board, is to receive an MBE. The Board of Directors were ASSURED by the report		

23/214	**CHIEF EXECUTIVE'S REPORT**		
6 mins	PR presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective, highlighting the tragic incident in Nottingham on 13th June 2023 and partners' response to this, the Trust's response to industrial action by junior doctors in June 2023 and preparations for further action in July 2023, delivery of key standards, achievement of bronze standard in a globally recognised accreditation scheme for clinical research, the third 'Step into the NHS' careers showcase event, progress in key capital schemes, continued success of the vaccination hub and extension to the current overnight closure of the Urgent Treatment Centre (UTC) at Newark Hospital. BB noted the comments in the NHS Oversight Framework 2022-23, Quarter 4 segmentation letter from Amanda Sullivan, Chief Executive of Nottingham and Nottinghamshire Integrated Care Board (ICB), in relation to the actions the Trust needs to take to progress from Segment 2 to Segment 1, with particular reference to the action "To be a key contributor to the wider system as an anchor institution", and sought further information in relation to this. PR advised the letter suggests the Trust is a good system partner which plays its role in supporting the community, etc. PR advised he feels the Trust is not being described as needing to do more in this regard, but to ensure it continues to be a good system partner. MG sought further information in relation to the health inequalities forum refenced in the letter from Amanda Sullivan. PR advised this relates to the Trust continuing to contribute to the wider agenda in relation to health inequalities. The Board of Directors were ASSURED by the report		
23/215	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
25 mins	PS joined the meeting **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting the Maternity Voices Champion role, Maternity Safety Champion walkarounds, maternity triage system, elective caesarean sections, reduction in agency usage, recruitment, forthcoming staff maternity leave and safety culture survey. PS advised there has been recent national attention regarding nitrous oxide, particularly within maternity services. The Trust commissioned its own review which provides assurance that currently staff are not exposed to high levels of harmful Entonox. However, the review recommended controls are put in place to monitor this. There will be a programme of estates work, education for staff and women and a clear monitoring plan, including devices for staff.		

	PB advised other areas of the Trust where Entonox is used will be included in this work. CW queried if the recent recruitment was linked to the 'Step into the NHS' events held in partnership with West Notts College. PS advised the Maternity Team had a 'stall' at the recent 'Step into the NHS' event in addition to a midwifery recruitment day on 12th May 2023. The Trust has appointed 20.6 whole time equivalent (WTE) midwives. This includes three Band 6 midwives, with the remainder being early career midwives. A cohort is due to start in September 2023, with a second cohort starting in January 2024. CW queried if the staff recruited were returners to work or if they were coming from other trusts. PS advised the majority are early career midwives, who are new into their roles. The majority of these are students trained by SFHFT. AR queried if there is the right balance between the number of front line clinical staff and the number of managers who ensure systems are correct. In addition, AR queried if staff understand each other's roles. PS advised the balance is correct and assurance in relation to this is provided by the Trust's recent Birthrate Plus report, which details the number of clinical midwives, support workers and specialist midwives. PS acknowledged there is still some work to do in relation to the understanding of each other's roles. PB advised all the team's matrons, up to and including PS, as Director of Midwifery, will work clinically if staffing or acuity requires this. AR noted more maternity patients are coming to SFHFT from Nottingham University Hospitals (NUH). Noting there is a time lag between receiving patients and resources being put in place to manage the increase, AR queried what actions are being put in place to manage this and what support is being provided by the Integrated Care System (ICS). PS advised the ICS are supportive and work is ongoing in relation to future planning for the Tomorrow's NUH programme. In terms of day to day work, the Trust is more active in terms of monitoring acuity and additional staff will be put in place as and when necessary. In addition, the Trust is being proactive in managing elective work to help ease pressure on emergency work. September and October are busy months in maternity and steps are taken to try to avoid arranging mandatory training during this period. The team monitors rosters and will put in additional staff as required. It has been identified peak attendances are between 4pm and 8pm. The Trust has introduced an additional shift to cover that period. PB advised he and DS sit on the executive partnership board of the Local Maternity and Neonatal System (LMNS) and will ensure areas such as funding allocations and mapping of activity are raised at that level. DS advised the LMNS are acutely aware of the situation and are very supportive. In terms of resources, the focus of colleagues within the system is currently on Nottingham. SFHFT is linked into the Tomorrow's NUH business case and the Trust has asked for a refresh of the data modelling linked to this.		

	MG queried if the Trust is compliant with the recommendations from the Kirkup report. PS advised the initial Kirkup report related to Morecombe Bay and the Trust has previously benchmarked against that report and has declared compliance with the initial seven Immediate and Essential Actions (IEAs) for Ockenden. The report into East Kent does not have metrics attached to it. Rather than identifying particular actions, the report identifies themes which are integrated into the 3-year plan for maternity. MG queried if the next report could provide a deeper dive into the equality of outcomes work. PB advised it has been agreed this will be reported through the Quality Committee. AH queried if the Maternity Team are happy with the current levels of support from non-obstetric services, for example, haematology, diabetes, etc. and will this support be able to keep pace as the number of births increase. PS advised the Team is happy with the level of support provided, but noted diabetic services are challenged, particularly the antenatal clinic. There are plans to provide an additional midwife to support that clinic, but there is more work to do in relation to health promotion and healthier start to pregnancy. Critical care colleagues are supportive in relation to the maternity agenda and have provided support with training. BB noted the new perinatal pelvic health service which has been established and queried if new staff have been recruited to support this service or if staff have been transferred from other areas. PS advised the service is staffed by existing staff who have been given additional time within their current roles to support the new service. The Board of Directors were ASSURED by the report ***Maternity Perinatal Quality Surveillance*** PB presented the report, highlighting obstetric haemorrhage, elective caesarean sections and home births service. DS queried if the obstetric haemorrhages are as a result of elective or emergency caesarean sections. PS advised this information is captured as part of the current thematic review. The caesarean section rate has increased and the Trust wishes to engage in the rotational thromboelastometry (ROTEM) trial. The Trust has requested this be a system wide trial. ARB noted the reference to progress in achievement of CNST10 and sought clarification what CNST10 is. PS advised this relates to the Maternity Incentive Scheme and NHS Resolution (NHSR) 10 steps to safety. The Trust was unable to declare full compliance for 2022/2023, but there is a clear programme of work to improve this position. The Board of Directors were ASSURED by the report PS left the meeting		

23/216	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
5 mins	**2023/2024 Capital Expenditure Plan** JL presented the report, advising the plan had been developed under the scrutiny of the Capital Oversight Group, in conjunction with the capital leads. The plan has been discussed in depth by the Trust Management Team (TMT) and was approved by the Finance Committee following detailed discussion. SB sought clarification in relation to the IT costs of £1.45m. JL advised the sub-total for IT detailed in the report relates to the business as usual capital programme, for example, the replacement cycle, updates, etc. The more significant IT scheme is the external funding for the Electronic Patient Record (EPR) system. SB noted the cost of IT from a capital perspective is more than half of the total capital spend and queried if that cost is increasing. JL advised the costs are relatively consistent with the expenditure in previous years and needs based on previous years. SB noted the costs of 'maintaining' IT and queried how much will be available to spend on improvements. DS advised this will be covered in more detail in the item relating to the Digital Strategy. However, there is a need to move away from using the terms IT and digital, advising projects are part of a whole hospital transformation programme and digital is the main driver for transforming and improving patient care. The Board of Directors APPROVED the 2023/2024 Capital Expenditure Plan		
23/217	**PATIENT STORY – CARING FOR OUR PATIENTS WITH DEMENTIA**		
16 mins	LM, AB and JLi joined the meeting LM and AB presented the Patient Story, which highlighted how the Trust cares for patients with dementia. CW thanked JLi for sharing her mother's story. PB queried if there was anything the Board of Directors could do to support the work of the Dementia Services Team. LM advised it would be useful for the Board of Directors to highlight the importance of dementia awareness training. Charitable Funds are doing a dementia appeal for this year, which puts dementia in the spotlight. The team would benefit from additional dementia specialist nurses. CW advised the Board of Directors have previously undertaken dementia awareness training, but it would be useful for this to be repeated. **Action** • **Dementia awareness training to be added to the Board of Directors workshop schedule**	**SBS**	**03/08/23**

	MG felt it was a powerful and touching story and queried if there was any learning from dementia services which is transferrable to other areas. JLi felt communication is key, advising not everyone who works on the wards has experience of dementia and staff do not always understand why communication breaks down. There is a need for more awareness from both a patient and family perspective. JLi felt all families should have the same level of support which was provided to her family. GW agreed support for families of patients with dementia is very important. SB queried if there was anything the Trust could do, in terms of wider system working, to support the experience of patients and families who do not need to come into hospital. LM advised, during the recent dementia week, the team had a stand in King's Mill Hospital and helped visitors who were newly diagnosed with dementia and were attending clinic appointments. As a result, consideration is being given to a quality and safety hub in the main entrance of King's Mill Hospital to highlight dementia and provide a signposting service, making use of services commissioned, for example, advisers from the Alzheimer's Society support the organisation. In terms of people living in care homes, the team are linking in with the ongoing work in relation to virtual wards to look at the dementia / delirium pathway to identify anything which can be done which is outward facing. LM advised she is meeting with a representative from the ICB on 7th July 2023 to identify any links with outward facing services to potentially reduce admission crisis. The team are also hoping to relaunch the carer passport. PB advised dementia needs to be a key priority for the Trust, but acknowledged there is a lot of work to do to ensure the increased demand is met through system working and linking services. AB advised one of the biggest challenges faced is when a patient comes into hospital with a dementia diagnosis, having been diagnosed in the community, and this is not known. There is no one place where this information is recorded, which necessitates staff having to trawl through various systems. DA advised Primary Care Networks (PCNs) have a register of patients identified as having dementia. He will discuss this issue with some of his contacts to ensure the Trust is sighted on the work of primary care and help reduce fragmentation. **Action** • **David Ainsworth to speak to contacts within Primary Care Networks regarding register of patients identified as having dementia** LM, AB and JLi left the meeting	**DA**	**03/08/23**

23/218	**DIGITAL STRATEGY**		
70 mins	RW and MT joined the meeting DS advised the report details the progress the Trust has made to date against the Digital Strategy 2020-2025 and provides the opportunity to consider the future direction. DS advised digital is a whole hospital transformation programme and is a key enabler to change. RW gave a presentation outlining the ongoing work in relation to digital, highlighting progress to date against the Digital Strategy, work in relation to the delivery of EPR, digital systems introduced and digital opportunities. A general discussion followed, during which the following points were raised: • Good example of a strategy • What update on progress could be provided to the carer who introduces the strategy document? o Frustration the Trust has not moved at the pace and scale which was hoped for. However, some good examples of what has been introduced can be evidenced. Real progress has been made in some areas, but there is a lot more to do. • Will the strategic objective themes in the strategy continue? There is a need to ensure continuity to enable true optimisation. o The strategy will not change, but it will have a thorough review once the Trust has signed an EPR contract • Need to deliver EPR • Initial focus has been on patient areas, with back-office functions being considered for the next iteration of the strategy • EPR needs to work for patients, with the data flowing from that • In terms of interoperability, within the Nottingham and Nottinghamshire system there is the Digital Notts Shared Care Records system which provides the ability for key data to flow in near real time. This system is linked to other areas using the same technology. However, there will always be a border and there is a national challenge for the NHS to enable absolute coverage. The NHS app will be the front door to electronic records for patients. • To move forward, the right infrastructure needs to be in place and this has to be working efficiently • Need to ensure the ratio of maintaining systems and making productive change for patients and clinicians is correct • Need to ensure patients who are unable to access services electronically are not excluded o Digital Notts is taking the lead on this work. They have undertaken research and run sessions in the community to help people who are digitally disadvantaged. It is important progress is not constrained by focussing on those who are unable to access services digitally, but it is equally important they are not left behind. o Digital will allow for people to be a proxy for other's electronic presence within the system. o More work to do in this area.		

	• Need to consider how data is used to drive improvement across the Trust
	  o Need more data sources within the 'data warehouse' to start to triangulate data
	• Need to grow the Digital Team and share resource across the system
	  o Need to ensure the Trust is not just increasing the number of people who can extract data. There is a need to move to a service which can provide real intelligence.
	• Need to consider what is missing in the strategy which would increase the pace and ambition of delivery
	• Need to ensure staff are engaged and are competent in using any new digital systems
	• The strategy is not about digital, but transformation. Therefore, more information on transformation is required
	• Gap analysis required to outline the current position compared to the position the Trust wants to reach
	• Has a cost comparison been undertaken in terms of the resourcing aspect, given observations taken will be entered onto the system at the bedside and artificial intelligence (AI) will look at scans, etc.
	  o The recently published NHS Workforce Plan takes this into account, majoring on AI
	  o Need to change some processes in the future which can be automated
	  o There is an assumption in the NHS Workforce Plan that technology will reduce the workload on clinicians
	• Need to raise the profile of digital within the organisation, highlighting it is a key infrastructure in terms of what can be done for patients
	• Digital is everyone's business
	• Useful to have further discussion at a future Board of Directors workshop
	
	Action
	
	• **Digital Strategy to be a topic for a future Board of Directors workshop**
	
	The Board of Directors were ASSURED by the report
	
	RW and MT left the meeting
		SBS	**03/08/23**

23/219	**STRATEGY 2024-29: OUR APPROACH TO ENGAGEMENT**		
22 mins	DA presented the report, highlighting the engagement exercise being undertaken, timeline and the approach to engagement. DA advised an initial questionnaire has been sent to 11,000 members of the public. From the limited initial responses received, some early themes are emerging relating to improving the delivery of services, delay in receiving digital letters and the provision of joined up care. MG queried what the objectives of engagement are. MG felt it important to acknowledge feedback from previous consultations and how that has helped shape the Trust's priorities, so people feel their voices are listened to.		

	DA advised the Trust is not undertaking a formal consultation with the public, but is undertaking local engagement with local people to ensure local voices are kept in mind when designing and delivering future care models. Acknowledging the possibility of 'consultation fatigue', the Trust is working with partners in the voluntary sector to help engage with the public. At a Place Based Partnership (PBP) level, consideration is being given to how public sector organisations engage with the local population to ask people once about the public sector offer, rather than multiple times. There is a lot of work to do in relation to this. MG queried how previous engagement which has taken place is being analysed so people feel the Trust has listened and acted on previous engagement and is now building on it. DA felt this is not necessarily built into the programme, but consideration will be given to how this can be achieved, possibly using feedback from the Patient Experience Team. There are several strands to how the Trust engages with the public and there is a need to think about a coherent way to manage this. **Action** • **Consideration to be given to how feedback from previous engagement opportunities is analysed and used to inform engagement in relation to the Trust's Strategy for 2024-2029** BB queried how the Trust is ensuing the engagement opportunities include the communities which are traditionally 'harder to reach'. BB felt the engagement should include what the public can do for the Trust, not just what the Trust can do for them. DA advised the future strategy needs to enable the Trust to know who lives in the local communities and local intelligence will be key to achieving this. The Trust has already reached out to Portland College, who care for and educate people who are neurodivergent. Once the information has been gathered, analysed and put into the strategy, the plan is to hold a compact with the local population to get the message across the Trust cannot be all things to all people in a world where demand and complexity is increasing, and finances are constrained. There is a need to be sensible and proportionate in relation to what future healthcare will look like. GW noted the messages highlighted from the engagement undertaken so far are as expected, indicating that what people want is already known to a large extent. GW felt the Trust will not gain much additional information and, therefore, should pull together the feedback which has already been received and progress the work to develop the strategy. DA advised while there is a need to learn from the past, things have changed since going through the Covid pandemic and demands on the Trust's services are changing. This is not a rolling programme of engagement, but is time limited. The engagement work is being run in parallel to developing the strategy. The Trust has only received 100 responses so far. Therefore, further engagement is required.	**DA**	**03/08/23**

	PR advised the Trust has not engaged in any earnest way since the development of the current 5-year strategy. PR acknowledged the Trust holds a lot of data, comments, etc. but there has been no conversation with the local community. Engagement will help inform the strategy which is being developed. GW felt there is a need to get the balance right between engagement and developing the strategy document. PR advised the Trust's future values and strategic objectives have already been agreed. This is the basis of any engagement being undertaken. DA advised some people who have responded to date have provided contact details, indicating they wish to continue to be involved. Therefore, as the strategy evolves the Trust can go back to those people and undertake a check and balance process as work progresses. The Board of Directors were ASSURED by the report		
23/220	**IG / DATA SECURITY PROTECTION TOOLKIT (DSPT) SUBMISSION**		
5 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 113 mandatory standard evidence items are now complete for the DSPT. It has been submitted with an overall compliance and the relevant certification has been received. During 2022/2023, there were six incidents requiring investigation, one of which was referred to the Information Commissioners Office. This has now been resolved with no further action taken. It was noted during 2022/2023, the Trust processed a total of 710 Freedom of Information (FOI) requests and 3,172 requests for access to patient records. SBS outlined some of the work priorities going forward. GW advised the internal auditors have provided their overall assessment on the DSPT as Moderate. This will be discussed further at next internal audit meeting. The Board of Directors were ASSURED by the report		
23/221	**USE OF TRUST SEAL**		
1 min	SBS presented the report, advising in accordance with Standing Order 10 and the Scheme of Delegation, which delegates authority for application of the Trust Seal to the directors, the Trust Seal was applied to the following documents: • Seal number 102 was affixed to a document on 13th June 2023 for Keir Construction Ltd. The document related to the refurbishment of Ward 3 at King's Mill Hospital.		

	• Seal number 103 was affixed to a document on 27th June 2023 for Keir Construction Ltd. The document related to comprising works to modular building by others and associated line structure. The Board of Directors NOTED the Use of the Trust Seal numbers 102 and 103.		
23/222	**ASSURANCE FROM SUB-COMMITTEES**		
4 mins	**Audit and Assurance Committee** GW presented the report, highlighting implementation of internal audit recommendations and counter fraud. GW advised the work in relation to 'no purchase order, no pay' will be monitored through the Finance Committee. **Finance Committee** ARB presented the report, highlighting the 2023/2024 Financial Plan submission. The Board of Directors were ASSURED by the reports		
23/223	**OUTSTANDING SERVICE – SUPPORTING OUR VETERANS AND ARMED FORCES COLLEAGUES**		
6 mins	A short video was played highlighting the work being undertaken to support veterans and Armed Forces colleagues within the Trust.		
23/224	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Patient story – caring for patients with dementia • Support for veterans and Armed Forces colleagues • Launch of maternity triage system • Compliance with Ockenden recommendations • Governor elections • Preparations for industrial action • Engagement activities in relation to the Trust strategy for 2024/2029 • Ambitions for digitally enabled transformation, being mindful of the potential impact on patients who are digitally excluded		
23/225	**ANY OTHER BUSINESS**		
	No other business was raised.		
23/226	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 3rd August 2023 in the Boardroom, King's Mill Hospital.		

	There being no further business the Chair declared the meeting closed at 12:10		
23/227	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Claire Ward **Chair** **Date**		

23/228	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
2 mins	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. Kevin Stewart, Appointed Governor, noted the election of new governors will provide an opportunity for governors to be more fully involved with engagement activities, particularly, at this stage, in relation to the Trust strategy. Ashton Green, Co-Chair of the Youth Forum, queried if there will be specific engagement on the strategy focussed on youth engagement and involvement. DA advised he would support Ashton in taking this forward through the Youth Forum.		
23/229	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

Key	
Red	Action Overdue
Amber	Update Required
Green	Action Complete
Grey	Action Not Yet Due

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
23/045	02/02/2023	Recommendations from the external well-led report to be reviewed in 6 months, including ensuring data in relation to gender and ethnicity is monitored	Public Board of Directors	None	03/08/2023	S Brook Shanahan		**On agenda for August meeting**	Green
23/173.1	01/06/2023	Triangulation between exception reports relating to working additional hours and patient safety incidents to be included in future Guardian of Safe Working reports	Public Board of Directors	None	07/09/2023	D Selwyn			Grey
23/173.3	01/06/2023	Future Equality and Diversity Annual Reports to have an increased focus on the patient perspective	Public Board of Directors	None	Jun-24	R Simcox			Grey
23/173.4	01/06/2023	Further analysis to be provided to the People, Culture and Improvement Committee regarding the Trust quality profile	Public Board of Directors	People, Culture and Improvement Committee	06/10/2023	R Simcox		**Update 15/06/2023** Item added to the September People, Culture and Improvement Committee agenda	Grey
23/217.1	06/07/2023	Dementia awareness training to be added to the Board of Directors workshop schedule	Public Board of Directors	None	03/08/2023	S Brook Shanahan		Added to workshop planner **Complete**	Green
23/217.2	06/07/2023	David Ainsworth to speak to contacts within Primary Care Networks regarding register of patients identified as having dementia	Public Board of Directors	None	03/08/2023	D Ainsworth		**Update 27/07/2023** Discussion with the PCN clinical lead. Further work to be undertaken at general practice level and individual patient level data. **Complete**	Green
23/218	06/07/2023	Digital Strategy to be a topic for a future Board of Directors workshop	Public Board of Directors	None	03/08/2023	S Brook Shanahan		Added to workshop planner **Complete**	Green
23/219	06/07/2023	Consideration to be given to how feedback from previous engagement opportunities is analysed and used to inform engagement in relation to the Trust's Strategy for 2024-2029	Public Board of Directors	None	03/08/2023	D Ainsworth		**Update 27/07/2023** There has been limited previous engagement work that will be relevant to the future strategy which reinforces the importance of the engagement presented at last board meeting. To provide some confidence in our baseline. **Complete**	Green

Public Board - Cover Sheet

Subject:	Chair's report	**Date:** 3rd August 2023	
Prepared By:	Rich Brown, Head of Communication		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chair's perspective.		**Approval**	
		Assurance	X
		Update	X
		Consider	

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

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
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

Cllr = Councillor

Executive Summary

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

Governor updates: Nine new governors appointed

In July, we were delighted to welcome a new group of governors to our Council of Governors, following this year's governor elections.

The election took place between Tuesday 13th June and Thursday 5th July, as thousands of the Trust's public and staff members were invited to cast their votes to appoint new governors in a total of nine advertised vacancies.

As a result of the elections, nine new governors were elected: five new governors were elected to the Trust's Rest of East Midlands public constituency, which covers Mansfield, Ashfield and the rest of the East Midlands.

They will join the Trust's current governors in ensuring that the Trust – which runs King's Mill, Mansfield Community and Newark Hospitals – continues to be one of the best places to work and receive care in the Midlands, according to the most recent National NHS Staff Survey. More than 1,360 votes were cast by Trust members across the constituencies.

The following governors were appointed to the Trust's Rest of East Midlands public constituency following the election:

- John Dove
- Pam Kirby
- Tracy Burton
- Steven Hunkin

A fifth public governor, Dean Wilson, was appointed as a 'governor designate' in the same constituency, to prepare for the ending of the term of office of Sue Holmes in November.

The following candidates were appointed unopposed after the trio applied to become governors for three vacancies in the Trust's Newark and Sherwood public constituency:

- Peter Gregory
- Karen Nadin
- Shane O'Neill

Samantha Musson, the Trust's Head of Therapy Services, was also elected as staff governor for the Trust after receiving 241 votes from her Sherwood Forest Hospitals colleagues.

I would like to place on record my thanks to all the candidates who put their names forward in this election; it was great to see such great engagement from our local community.

I congratulate each one of our new governors and I look forward to working with them all in their new roles over the coming months and years ahead.

I would also like to thank everyone who took the time to vote. I hope that your new governors will serve you well in the coming years.

Membership and governor updates: Update regarding our appointed governors

Following the recent local government elections, we have been delighted to welcome a new appointed governor from Mansfield District Council to our Council of Governors.

Cllr Angie Jackson – the Council's joint-portfolio holder for wellbeing, health and safer communities – has now joined our Trust's Council of Governors, as she takes over from Cllr Craig Whitby. We are grateful to Cllr Whitby for his hard work and dedication during his time as a governor.

Elsewhere, I am delighted to welcome back Cllr Linda Dales (Newark and Sherwood District Council) and David Walters (Ashfield District Council) as appointed governors to Sherwood for another term.

Our appointed governors from our local district councils will continue to work alongside our other appointed governors, who are Nikki Slack (West Nottinghamshire College), Kevin Stewart (Volunteers) and Cllr John Doddy (Nottinghamshire County Council).

I thank them for their continued service and I look forward to continuing to work with them all over the months and years ahead.

Reaffirming our commitment under the 'Dying to Work' pledge

Reaffirming our 'Dying to Work' pledge alongside Roz Norman, staff-side lead, and Rob Simcox, Director of People

In July, I was delighted to join Roz Norman, #TeamSFH's staff-side lead, and Rob Simcox, the Trust's Director of People, in reaffirming our commitment to support, protect and guide Trust colleagues who have received a terminal diagnosis.

There are many colleagues that will get some sort of serious illness at some point during their lives and their career. This will often take a toll on their professional lives, as well as the obvious impact it will have on them personally.

Juggling their personal circumstances also presents its own challenges, with people managing terminal diagnoses and long-term conditions often needing to take time off if they are unwell or need to attend medical appointments.

We also know people who suffer with terminal illness will become scared and be faced with emotional stress and challenges. This is why – as a Trust – we are committing to do all we can to support colleagues who have received a terminal diagnosis.

We will provide colleagues with job security, peace of mind and the right to choose the best course of action for themselves and their families to help support them through the unprecedented times with dignity and respect without excessive financial loss.

As a Trust, this is something that we feel strongly about and want our colleagues to know we are here for them – no matter the situation.

Notable engagements:

- Supporting the Trust's PRIDE celebrations at King's Mill Hospital on Wednesday 26th July

- Continuing to represent Sherwood Forest Hospitals at the Nottingham and Nottinghamshire NHS's Provider Collaborative group meetings.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet

Subject:	Chief Executive's report	**Date:** 3rd August 2023	
Prepared By:	Rich Brown, Head of Communication		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective.		**Approval**	
		Assurance	Y
		Update	Y
		Consider	

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

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

Committees/groups where this item has been presented before

Not applicable

Acronyms

ATTFE = Academy Transformation Trust Further Education College
ICS = Integrated Care System
MNPBP = Mid Nottinghamshire Place-Based Partnership
PBP = Mid Nottinghamshire Place-Based Partnership
ICS = Nottingham and Nottinghamshire Integrated Care System

Executive Summary

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

Pressures: Industrial action

July has seen two further periods of industrial action affecting colleagues within Sherwood Forest Hospitals, with both having been called by the British Medical Association (BMA).

The first period of industrial action during the month affected our junior doctor colleagues and took place between 7am on Thursday 13th July to 7am on Tuesday 18th July. It was the longest single period of industrial action in the history of our NHS.

The second period of industrial action involved consultants, with that period of industrial action running between 7am on Thursday 20th July to 7am on Saturday 22nd July. This is the first time that consultants have taken industrial action in almost 50 years.

As a Trust, we know the importance of good pay and conditions in making great care happen across our hospitals and we respect colleagues' right to take industrial action to protect those most basic requirements.

On behalf of the Executive Team, I would like to thank colleagues from across #TeamSFH who worked to ensure that patients could continue to access the treatment they needed and deserved throughout that time.

We are also grateful to our patients and the wider communities we serve for their patience and understanding, as our hardworking colleagues have worked to keep essential services running and reschedule hundreds of appointments that were affected by these latest rounds of industrial action.

There is no escaping the fact that each period of industrial action has a significant impact on our services, with the financial costs alone continuing to run into hundreds of thousands of pounds.

The human cost of this industrial action is also not lost on us – both through the impact this has on colleagues' wellbeing and the delays this is causing for patients who are waiting to access the treatment they need and deserve.

During July, we watched the government's national announcement of pay offers with real interest and we share the views of our junior doctor and consultant colleagues in wanting to see a conclusion to this ongoing national dispute as soon as possible.

We also note that the BMA has already announced further provisional strike dates for its consultants on Thursday 24 and Friday 25 August, which will cause unique challenges ahead of a Bank Holiday period which always brings its own operational challenges.

The Trust's planning for those future periods of industrial action has already begun and we will, of course, keep the Board updated as those plans progress.

Welcoming the announcement of the national NHS Workforce Plan

Another major development over the past week was the announcement from the government and NHS England of the launch of the NHS Long-Term Workforce Plan, which sets a longer-term framework for how the NHS will look to protect its greatest asset over the coming years – its highly-skilled and hardworking people.

That strategy is an essential one in setting out how the NHS will look to train, attract, retain, development and safeguard our wellbeing to ensure that our NHS can continue to provide high-quality healthcare to them in the long-term.

As well as being an important development nationally, that work also brilliantly complements our own work to achieve those same aspirations here at Sherwood that we have within our Trust's own People Strategy.

Newark Hospital: Work begins on new and improved operating theatres

In July, we were delighted to get our first glimpse of our new-and-improved operating theatres that are currently being installed at Newark Hospital as part of our £5.6million plans to boost operating theatres capacity there.

Parts of the modular theatre, which will be known as Newark Elective Hub, were lifted into place by crane over the weekend of Saturday 8th July and Sunday 9th July.

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

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

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

The new theatre sessions will be targeted towards procedures delivered by orthopaedics, urology, and ear, nose and throat (ENT) surgery, which have the greatest backlogs. In addition, improvements to the existing minor operations suite will enable some procedures to take place there rather than in a theatre. This will free-up theatre space for procedures where an overnight stay is likely.

The improvements have been made possible thanks to funding from the NHS England's Targeted Investment Fund (TIF) following a successful bid. The money will also provide the required new theatre equipment and extra storage space, as well as improved changing and rest facilities for staff.

This is a really exciting time for Newark Hospital, our patients and colleagues. This project is just the latest aspect of our plans to make best use of the potential of the Hospital that will also see the expansion of car parking provision at the site over the coming months.

Caption: How the new theatres at Newark Hospital could look

Partnerships update: Place-Based Partnerships Working together to empower communities and reduce inequalities announced

In September, we are delighted that Sherwood Forest Hospitals will be supporting the Mid Nottinghamshire Place-Based Partnership's co-design event at the Mansfield Civic Centre.

The establishment of the Nottingham and Nottinghamshire Integrated Care System (ICS) has provided an opportunity to work differently across Nottingham and Nottinghamshire by bringing organisations together into Place Based Partnerships.

Sherwood Forest Hospitals is proud to be a part of the Mid Nottinghamshire Place-Based Partnership, serving the Mansfield, Ashfield, Newark and Sherwood areas of the county.

This event is being hosted by the Nottingham and Nottinghamshire ICS to explore what Place Based Partnerships are and how they are promoting integration across organisations and a real focus on and commitment to community empowerment to reduce inequalities and improve lives.

We are proud to be part of the event and I will, of course, update you on the outcome of that event in future updates to the Board.

Partnerships: Nottingham and Nottinghamshire Integrated Care System (ICS) Partnership Agreement

A Partnership Agreement, which describes how system partners across Nottingham and Nottinghamshire will work together, has been in place for a number of years. The document demonstrates the commitment to work effectively together for the benefit of all our communities and citizens.

The Agreement is currently being reviewed and refreshed and has been considered at the ICS Reference Group and the Provider Collaborative Charis and Chief Executives Group.

I will provide the final document to the Board when completed, this is expected to be at the October Board meeting.

Partnerships: Nottingham and Nottinghamshire Provider Collaborative Board update

The Provider Collaborative continues to develop, and I have attached a paper which is being received by all partner Trust Boards which describes recent work completed.

Each Trust Board is asked to:

- Acknowledge the ongoing process to develop the Provider Collaborative at Scale
- Invite reflections on progress from attendees of the Joint Board Development session
- Support the direction of travel and next steps.
-

Partnerships: Welcoming local councillors into our hospitals

The Trust has welcomed various newly-elected local councillors to tour our hospitals as part of their induction recently, following May's local government elections. With recent changes in political leadership, some of the health portfolio holders have also changed.

These visits will contribute to our open and transparent culture, as well as helping to ensure that we assist our councillors to have relationships and insights into local NHS provision for the communities they serve.

Partnerships: Strengthening our relationships with local education providers

Academy Transformation Trust Further Education College (ATTFE) held a focused meeting with us to explore building a long-term partnership which adds value to people who live in our area.

Two short term actions were agreed for progression over the next three months:

1. **An adult lifelong learning hub based at Newark Hospital as a spoke of the College**
   Impact expected: Making the hospital a vibrant asset for the wider community and opening up opportunities for colleagues to easily access learning.
2. **Offering Level 1 in Volunteering training to our volunteers**
   Impact expected: This will build the experience for future employers in those who use volunteering as a career steeping stone.

Risk ratings reviewed

The Board Assurance Framework (BAF) risks, for which the Risk Committee is the lead committee, have been scrutinised by the Trust's Risk Committee. The Committee has confirmed that there are no changes to the risk scores affecting the following areas:

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

The full and updated Board Assurance Framework (BAF) is due to be presented at our next public meeting of the Trust's Board of Directors in August 2023.

Appendix 1

Update on Nottingham and Nottinghamshire Provider Collaborative at Scale Common Paper for Trust Boards

1. Purpose of the paper

1.1. The purpose of this paper is to apprise Trust Boards on the recent work to continue to develop the Provider Collaborative, share feedback from the recent Joint Board Development session, update on the priorities for 2023/24 and set out next steps.

2. Executive Summary

2.1. The Nottingham and Nottinghamshire Provider Collaborative at Scale has now been operating for a year. Our last update to Boards (in March / April) detailed our work areas for 2023/24. In the first quarter of 2023/24 we have further scoped our work-streams and have built on our links with other parts of the system in order to align and co-ordinate our effort in these areas.

2.2. There is still more work to do in order to provide detailed quantification of the likely impact of these areas of work and to ensure that we are investing our energy in the right places.

2.3. This paper details the progress that has been made in Quarter 1 of 2023/24 and the next steps to develop the operating model for the Provider Collaborative at Scale.

3. Main Report Details

3.1. Joint Board Development Session

3.1.1. Members of the Provider Collaborative across the five organisations met on the 30 June 2023 to discuss progress to date, including on the two prioritised programmes of Workforce and Urgent Care, and to understand and explore options for governance structures to support joint working and decision making. 33 participants attended the workshop with all five organisations represented.

3.1.2. The scope, objectives and progress to date of the priority programmes of Workforce and Urgent Care were discussed during the session. Colleagues felt that more clarity was needed on the objectives of each of the work streams within the programmes, with defined goals set against timelines. Colleagues also felt that there needed to be discussions with the ICS/ICB and wider system partners to ensure there wasn't duplication of effort.

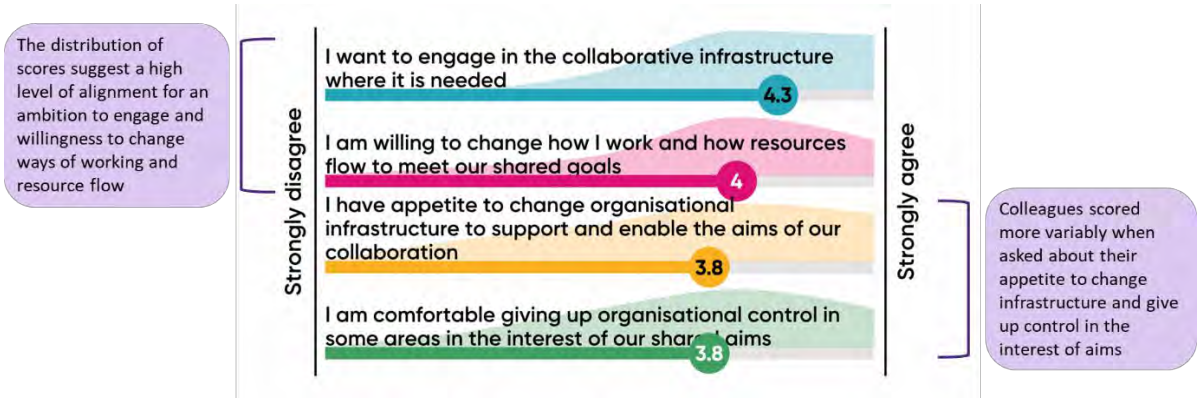
3.1.3. Governance was explored by learning what other Collaboratives in other ICSs are doing, i.e., their functions, and how they are doing it, i.e., their form. Colleagues agreed that the governance model should be kept simple to avoid hindering progress, and that our Collaborative should frame the governance model around what the organisations are trying to achieve together. In so doing it was agreed that it will be important to engage NEDs. It was also felt that resolving this was critical for further progress and to realise some of the ambitions that had been discussed in the session.

3.1.4. Colleagues reflected on the value of setting SMART objectives and committing to delivering at pace, ensuring all organisations are aligned on these. The next steps included:

- Working together to develop clearly defined SMART objectives for each of the prioritised programmes of work to be shared with Boards.

- Considering what the best form of governance is to support the work now, and how this might evolve in the future.
- Agreeing the roles and responsibilities within the Collaborative across executive and non-executive colleagues once governance arrangements are decided.
- Developing the "prospectus" documentation outlining defined objectives of priority programmes and the governance model for discussion with Boards.

3.1.5 The session closed by checking the alignment of colleagues through a mentimeter exercise to understand appetite for change. The below diagram shows the output of that discussion. Over the coming months, Trust Boards may wish to consider these statements as individual organisations so Board members who did not attend the session can reflect on their alignment.



3.2. **Distributed Executive Group:** At the end of July, our Distributed Executive Group meets for the first time. This group recreates an organisational executive with Directors representing their areas as opposed to their organisations. This group will help guide the collaborative, advise the Provider Leadership Board on delivery of programmes and areas of opportunity plus will give individuals from across our member organisations a role within the collaborative space.

3.3. **Work-streams:**

3.3.1 Urgent Care - We will deliver care improvements for our patients by streamlining Pathway 0 (simple discharge) pathways, providing consistency across the frailty pathway; and actively align and contribute to the system wide work on demand, capacity and flow, taking ownership and leadership for relevant elements. By aligning our work with system work, we will distinguish between partnership and delivery requirements and take account of regulatory assurance needs.

3.3.2 Workforce – We have four workstreams which will be delivered by March 2024:

- Delivery of a Talent Management Framework underpinned by a Leadership Programme; Nottingham(shire) Graduate Scheme; and a local 360°Feedback system across the Provider Collaborative.
- Embed a portability approach that ensures our staff / people can move across the provider collaborative with Mandatory Training, DBS checks, References and Pre-employment checks.
- Have a flexible workforce programme that puts the systems & processes in place to enable portability to happen.
- Deliver the NHS Workforce Plan by aligning, distinguishing and delivering provider responsibilities from national and ICS responsibilities.

3.4. **Prospectus:** It was also agreed in January that a 'prospectus' would be developed for the collaborative, setting out what the collaborative is and is not, why we exist, what our priorities are, how we will operate, what governance forms we will consider and how we will work and communicate with our partners. The prospectus will be shared with Trust Boards, along with an MOU for the collaborative from September for adoption once all five members have agreed.

3.5. Next Steps

3.5.1 **Mobilising our Priorities:** Work is now focused on expediting mobilisation and identifying the anticipated outcomes and added value for each priority. This intended impact will be shared with Trust Boards by September.

3.5.2 **Governance arrangements and the Prospectus:** The MOU and Prospectus are being developed and will be shared with Trust Boards by September. Agreeing the roles and responsibilities within the Collaborative across executive and non-executive colleagues will be considered in parallel to this work and be shared with Trust Boards in October once governance arrangements have been agreed.

3.5.3 **Communication and Engagement:** Work on the collaborative identity, name and branding is outstanding and we are out to advert to secure some short-term communications expertise to help us with this and mobilise the draft Communication and Engagement Plan.

4. Risks

4.1. As with any work programme, there are risks to the delivery of the work of the Provider Collaborative. Some of the key risks for us are detailed below:

4.2. **Capacity** - our member organisations are all under significant pressure both operationally and financially and therefore the capacity of people to engage in additional programmes of work is limited. We have discussed what we may need to stop doing in order to create this capacity, as well as how we get absolute clarity of roles and functions of different people/groups across the system, to remove any unnecessary duplication. Whilst we realise that some of those decisions are within the gift of our member organisations, some will need to be discussed more broadly across the system.

4.3. **Collaboration at all levels** – we have done lots of work with Boards and senior leaders of our member organisations but this work has not yet diffused throughout our organisations. We have more work to do in order to bring our colleagues and teams with us on this collaborative journey.

4.4. **Gaining credibility and managing expectations** - we are ambitious and believe in the opportunity to deliver collectively but we are balancing gaining credibility by showing that we can deliver something, alongside high expectations of the role that we could be playing in the system. We want to start with a small number of priorities and deliver them well, but want to ensure we are also capitalising on our opportunity to be a vehicle for strategic transformation. How we manage the pace and scale of our growth journey will be vital to our longer term success.

5. Recommendations

The Trust Boards are asked to:

- Acknowledge the ongoing process to develop the Provider Collaborative at Scale
- Invite reflections on progress from attendees of the Joint Board Development session
- Support the direction of travel and next steps.

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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

Quarter 1 Update

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Healthier Communities, Outstanding Care

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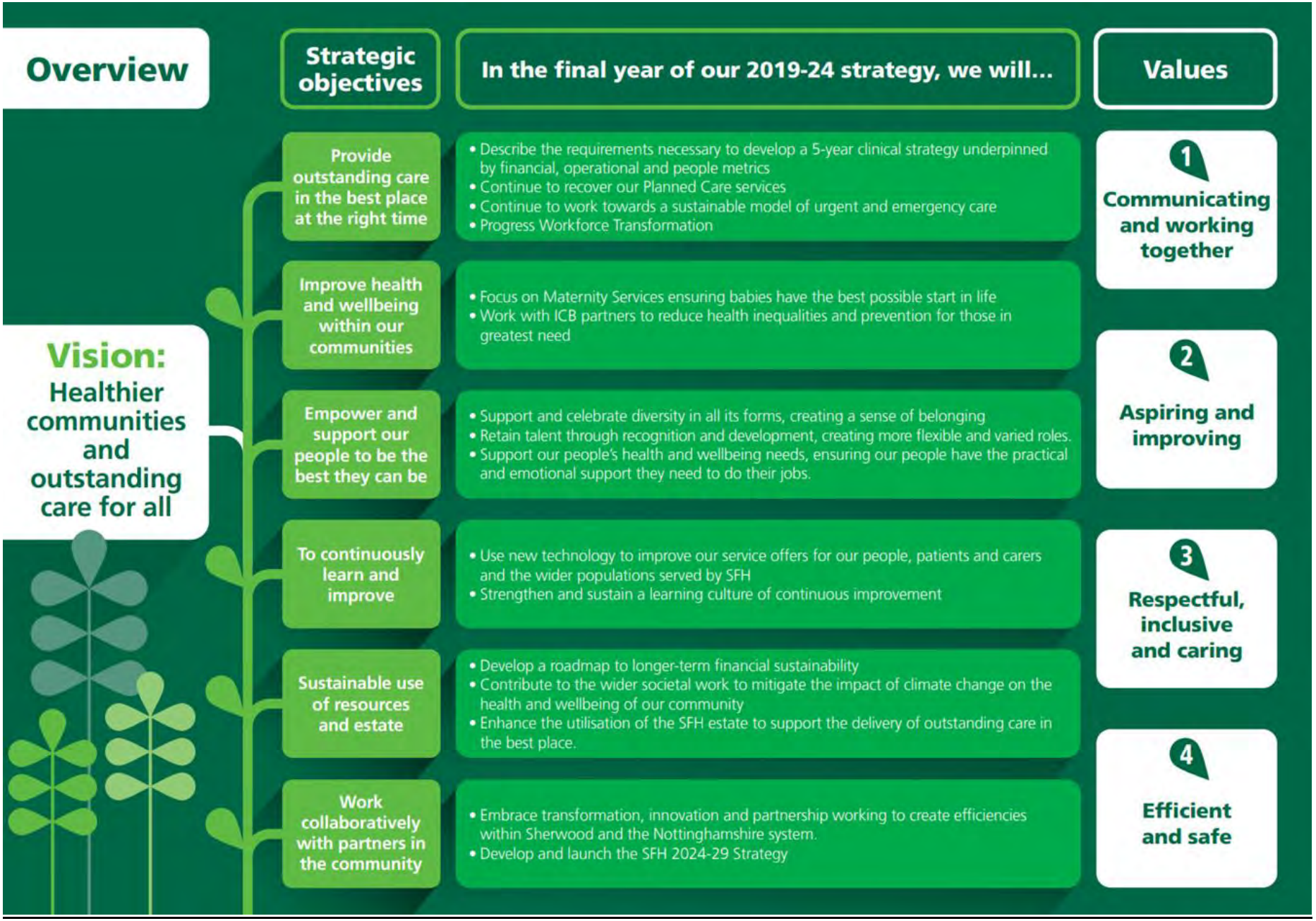


1. Summary – Qtr. 1. 'Position on a Page'

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

Overall RAG Key

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

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

Overall RAG Key

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

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

Overall RAG Key

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

2. Detailed Quarter 1 Update

Ref	2023-24 Trust *Priority* and Deliverable	Executive Lead	SFH Governance	Measures of Success	Quarter 1 Update
1.1a	*Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics* Work with Clinical Divisions to develop Clinical Service Strategies at Specialty and Divisional level, to inform a Trust level Clinical Strategy	Director of Strategy and Partnership	Executive Team Meeting  **On Track** – action underway to address minor issues	• By the end of July 2023 the ICS Joint Forward Plan will have been made available to the Divisions. • By end Qtr. 2. Divisional service lines will have produced a 2 year plan that describes where they are now and key issues and opportunities in the 1-2 Year and 3-5 Year time horizon ensuring that options for fragile services are fully understood. • By the end of Qtr. 3. have in place a Trust level Clinical Services Strategy that supports longer term alignment of estates, people, technological, and financial plans.	The ICS working with SFH and other Partners published the NHS Joint Forward Plan (JFP) on 30th June as Draft with formal approval mid July at which point this will be made available to Divisions and Service Lines. The NHS JFP represents the NHS component of the ICS Integrated Care Strategy and it will be within this context that service lines will be asked to develop their plans. Work is on target to co-produce and issue Guidance and Templates to Divisions/Service lines by the end of July to meet the Quarter 2 deadline. Industrial action and continuing operational pressures present a risk to this process during Qtr. 2.
1.1b	*Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics* 'Develop high level 5yr bed requirement model	Chief Operating Officer	Executive Team Meeting  **On Track** - no issues to note.	• By the end of Qtr. 3 have an initial 5 year model in place that is informed by Divisional Service Line Plans • By the end of Qtr. 4 refine bed model to reflect Trust level clinical strategy.	Work to be informed by service line plans that are being developed in Qtr. 2. Noted for action in Qtr. 3

1.2a	*Continue to recover our Planned Care services* 'Expand Day Case Surgery Services at Newark Hospital through the Transformation Investment fund (TIF)	Chief Operating Officer	Executive Team Meeting  **Off Track** – action underway to address major issues	• Service commencement by end of June 2023 • 90% of staff substantively in post by end of Qtr. 3. • By end of Qtr. 4 be achieving the monthly levels of activity required to meet the full year aspirations of the TIF submission.	Newark TIF development delayed due to building works. Modular theatre arrived on site early July. Works underway to mobilise facility with opening scheduled for October 2023. Surgical recruitment completed for all ward roles with theatre recruitment on track. Challenges in recruitment for some support services positions with alternative roles being explored.
1.2b	*Continue to recover our Planned Care services* 'Expand Diagnostic Services to Mansfield Community Hospital	Director of Strategy and Partnership	Executive Team Meeting  **Off Track** – action underway to address major issues	• Building works commenced by June 2023 • Staffing model and agreed development plan in place by Qtr. 2 (Feb 25 current go live date). • Mobile MRI service located on MCH site and fully operational by 1st December 2023	Building works delayed – pre demolition works (asbestos and lead paint removal) scheduled to commence in Qtr. 2 (August 2023). Construction scheduled to commence Qtr. 4 (January/February 2024). Initial Workforce modelling completed. Workplan to be presented to CDC Steering Group in August 2023. Key clinical roles (trainee endoscopist, cardiac and respiratory physiologist), paper being presented to Execs to seek support to recruit at risk – delays to recruitment will incur delay to university studies. Mobile MRI - Site visit to be completed on 12th July 2023 – options appraisal to be completed.
1.2c	*Continue to recover our Planned Care services* 'Achieve elective activity levels, backlogs and patient waiting times in line with the 2023/24 operational plan and supporting performance trajectories.	Chief Operating Officer	Executive Team Meeting  **Off Track** – action underway to address minor issues.	• Delivery of the following metrics in line with (or better than) plan: - Activity plans (Elective, Day Case, O/P) - PIFU - 52 and 65ww - Number of completed RTT pathways - 62-day cancer backlog - 28-day cancer FDS	Theatre and outpatient improvement programmes relaunched and underway. Working together with Nottingham University Hospitals (NUH) delivering mutual aid. Whilst this has resulted in us taking on some long wait patients in ENT; NUH are going to support our challenged position for Echocardiographs. At the end of month 2 our planned care activity levels were better than our original plan, however they are lower than the final stretch plan submission required to support the route to financial balance set

					out in the 2023/24 Trust plans. Industrial action continues to adversely impact on elective activity levels. PIFU average Qtr. 1 position better than the national target driven by a strong Jun-23 position. 52 and 62ww positions are worse than plan. The 62ww position is driven by ENT patients taken in mutual aid. Completed RTT pathways is better than our plan as a combined position for Apr & May-23. 62-day cancer backlog is better than our plan and significantly below the nationally set threshold for SFH. Cancer 28-day FDS is better than national target in May-23 following a dip in performance in Apr-23. Please see the Integrated Performance Report for further narrative on elective performance.
1.3	*Continue to work towards a sustainable model of urgent and emergency care* - Progress with the Optimising Patient Journey (OPJ) improvement programme - Expand use of Same Day Emergency Care (SDEC) within Surgery - Embed and expand virtual wards - Work with the ICB and system partners to facilitate system actions to reduce the number of Medically Safe For Transfer (MSFT) Patients who should not be in an acute hospital bed	Chief Operating Officer	Executive Team Meeting  **Off Track** – action underway to address major issues	• Increase the number of patients using SDEC. • Increase the number of patients on a virtual ward pathway. • Reduce number of >20 day length of stay patients. • MSFT patient numbers in line with ICS trajectory.	The Optimising the Patient Journey (OPJ) improvement programme being relaunched in line with the creation of the Improvement Faculty. Focus in Qtr 1 has been on identifying the priority work programmes; this work will be concluded by the end of Jul-23. SDEC rates have been stable in 2023. Surgical SDEC opening delayed due to building works preventing ward reconfigurations to enable the creation of the SDEC area. Frailty virtual ward commenced in May-23. Virtual ward (VW) use increased from 3 patients admitted on a VW in 2022/23 Qtr. 4 (sum of 34 days) to 12 patients in 2023/24 Qtr. 1 (sum of 116 days).

					Long length of stay patient numbers have reduced throughout Qtr. 1. These however remain above levels seen in 2022/23. To support further reductions bi-weekly long length of stay meetings are in place to review individual patient pathways. MSFT patient numbers have exceeded the ICS plan trajectory throughout Qtr. 1. An ICS Plan Delivery Group is in place providing further scrutiny on system-level urgent and emergency care delivery plans. Please see the Integrated Performance Report for further narrative on urgent and emergency care performance.
1.4a	*Progress Workforce Transformation* - Progress Medical Workforce Transformation	Medical Director	People, Culture and Improvement Committee  **Off Track** – action underway to address major issues	• Deliver Trust and ICB/ICS Agency Task Force Group measures • Specialties provide future workforce models by Qtr. 3 • Review NHSE workforce plan and put action plan in place in place within 2 months of publication.	Increased activity above plan has caused overspends on variable pay against plan The variable pay position remains under intense scrutiny via committee with established Divisional membership Activity Reports are now provided monthly to divisions along with a summary of potential saving opportunities and tracked through the MTP Ops Group Bespoke reporting has been developed to identify and understand variable hourly rates to support reducing medical agency expenditure. A Strategic Workforce Model to support long term medical staffing and reduce the use of agency workers is in development.

1.4b	*Progress Workforce Transformation* 'Progress Nursing, Midwifery & Allied Health Profession (NMAHP) workforce transformation	Chief Nurse	People, Culture and Improvement Committee  **On Track** - no issues to note.	• Movement to sustainable use of agency usage staring with off framework/off cap • Month on month reduction in agency usage • Reduction of vacancies focusing on Band 5 Registered Nurses • Develop Allied Health Professional (AHP) Job Planning by Qtr.3 to meet Carter Review recommendations. • Annual Establishment review against current capacity completed by end of Qtr. 3 and development of longer term review process	During Q1 we have seen a significant reduction in the use of Level 3 escalation agency usage across our services. Several improvement initiatives have been implemented whilst ensuring safe staffing remains a priority. Enhanced rates of pay remain in place in selected high-priority areas alongside the allocated on-arrival workforce. These are continuously reviewed to ensure safety is met and sustainability is achieved. Focused resolution continues with the band 5 registered nurse vacancy deficit. The Trust is continuing with international recruitment and a business case has been approved to support an additional 70 registered nurses over the coming months. To ensure the continued momentum for recruitment remains a key driver bespoke recruitment events are being coordinated by the corporate nursing team with a fundamental focus being placed on student nurse engagement. Three events have been held during Q1 with the successful appointment of 24 substantive registered nurses, one operating department practitioner, and one bank registered nurse. The senior corporate nursing team is also supporting clinical divisions with the recruitment of 80 WTE to the priority over establishment areas of Castle Ward, Lindhurst Ward, and Chatsworth Unit. Several successful recruitment sessions have taken place at Mansfield Community Hospital in recent weeks and 96% of the registered nursing workforce required for Lindhurst and Chatsworth Ward have had offers made with approximately 67% of the nonregistered workforce also receiving offers. Recruitment support will continue to be provided but with a realigned effort to support Castle in the coming months.
2.1	*Focus on Maternity Services ensuring babies have the best possible start in life*	Chief Nurse	Quality Committee	• Implementation of the single maternity oversight framework, completion of the CQC must do and should do actions.	For the Q1 update, assurance can be provided around the CQC "Must Do" actions in that the re-launch of triage was commenced on the 5th of June

	Work with the Local Maternity and Neonatal Services (LMNS) to equitably transform our maternity services through delivering a single delivery plan in line with the recommendations from the Ockenden and Kirkup review and CQC inspection.		 **On Track** - no issues to note.	• Ensure smoking at time of delivery becomes part of our 'Business as Usual' through planning for 2024-25. • Optimisation and stabilisation of the preterm infant principles introduced. • Implementation of NHSE guidance on Equity and Equality. • Annual Establishment review against birth rate plus completed by end of Qtr. 3 and development of longer term review process	23 with a clear plan for monitoring and embedding. The MAST remains above the 90% trust set threshold and the planned trajectory remains on track for the training year 23/24 The Three-Year Delivery Plan for Maternity and Neonatal Services (NHSE, 2023) was released on the 31st of March 23. The plan focuses upon four key themes: • Listening to and working with women and families with compassion • Growing, retaining and supporting our workforce • Developing and sustaining a culture of safety, learning and support • Standards and structures that underpin safer more personalised and more equitable care As a LMNS we have looked at local data and demand and have provisionally proposed an initial focus upon two key priority areas and aligned these to the ICS Integrated Care Strategy and the SFH priorities: • Embedding the voice of women, birthing people and families and ensuring key learning from service users is the main driver in transforming our maternity and neonatal services. This includes but is not limited to development of MVP and NVP • Equity as the lens through which we view all areas of the LMNS – ensuring equity across our services and local population, with a focus on experience as well as outcomes using t localized data for Nottingham and Nottinghamshire

2.2	*Work with ICB partners to reduce health inequalities and prevention for those in greatest need* agree our approach and programme of actions around Health Inequalities and prevention as a key strategic priority for the 24-29 strategy	Medical Director	Quality Committee  **Off Track** – action underway to address minor issues.	• Assessment of 5 Year ICS NHS Joint Forward Plan within 2 months of publication (expected 30th June) to align areas of focus for Health Inequalities • Commence Health Inequalities reporting to Quality Committee Qtr. 3 • Agree with Board our approach to Health Inequalities and prevention and identify any gaps Qtr. 3 • Work internally and with partners to develop SFH or Joint proposals that qualify for any new Health Inequalities Investment Funding (HIIF) by January 2024	SFH membership of ICS Health Inequalities Oversight Group has been confirmed. The ICB Health Inequalities and Innovation Investment Fund (HIIF) has been established and the JFP sets out further new funding for the HIIF over the 5 years of the plan. We have worked with system partners in developing 2023/24 HIIF proposals and formal confirmation of the first tranche of initiatives to be supported by this fund is expected in early August 2023. Proposals for 2024/25 will be developed as part of the 2024/25 planning process. Development work on ICS HI dashboard commenced ICB Joint Forward Plan signed off
3.1	*Support and celebrate diversity in all its forms, creating a sense of belonging.* 'Delivery of the "Belonging in the NHS" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, culture and Improvement Committee of the delivery of supporting actions • Evaluate impact of Staff Networks by Qtr. 3 • Evaluate 6 high impact actions by the end of Qtr. 4 • Deliver 'closing the gap' action plans to improve experiences for our people with protected characteristics by end of Qtr. 4.	Organisational Culture Heat Map in development, with key metrics agreed – populated in Q1 and will be piloted in Q2 in line with Divisional People Committees being established. Employee feedback programme currently in development including 'TOM' (Thinking of Moving) proposal in development. Refresh of Reward and Recognition programme complete with new brochure in place and consistent approach to long service milestones and long service retirement. Face to face long service presentations for 25 years + long service to commence in Q2. NHS EDI Improvement plan launched in June 2023 with clear focus and objectives relating to 6 high impact actions enabling an opportunity to do more and do it better. Self-assessment currently being undertaken. National Staff Survey 2023 actively being planned for prior to launch in October 2023. Draft communications plan in place to commence from

					August 2023 (soft launch) and higher profile comms from Sept 2023
3.2	*Retain talent through recognition and development, creating more flexible and varied roles.* 'Delivery of the "Growing for the Future" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Quarterly update to People Culture & Improvement Committee on where we are growing a future workforce. • Recruit 20 external apprentices by end of Qtr. 3 • Evaluate and further utilise the apprenticeship levy throughout 2023-24 (Ongoing) • Talent Management approach / Leadership Development programme implemented by the end of Qtr. 4	Performance against MAST compliance has significantly improved, currently sitting at 91%. Performance has been above our target of 90% for the past 3 months. Performance against the appraisal target is currently at 90% which is an improvement on the previous month. Presentation of an Allied Health Professional (AHP) Tactical Workforce Plan to People, Culture and Improvement Committee. This plan highlighted the AHP workforce profile, enabling trends and risks to be identified, thereby enabling supporting plans to be developed to mitigate short, medium and long terms risks. A new Leadership Development Framework has been designed and has been widely engaged during Q1. This will go to TMT for approval on 26th July and does seek a small amount of investment. This work links the development of SFH 'talent' but a formal SFH Talent Strategy will be developed in line with our work with system partners. The appraisal paperwork has been redesigned and piloted in Q1 and will launch in Q2, further action to improve quality including spot audits.
3.3	*Support our people's health and wellbeing needs, ensuring our people have the practical and emotional support they need to do their jobs.* Delivery of the "Looking after our people" supporting actions in year 2 of the Trusts People Strategy 2022-2025.	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Develop cultural insights to support improved experiences for our people at SFH (Ongoing/by Qtr4.)	Industrial action Wellbeing support in place across the Trust; Rest Rehydrate and Refuel message, offer of free snacks and drinks for all staff along with wellbeing walk arounds. Trust Health and Wellbeing strategy being developed with Wellbeing, Occupational Health and Health and Safety colleagues utilising the NHS Wellbeing framework. On track to be in place by Q3 2023. Fundamental Wellbeing needs audit taking place and will be completed by September 2023 to assess basic

				• Introduce a Health & Wellbeing Strategy by Qtr. 3 • Measure the effectiveness of our Health & Wellbeing offer including Vivup and Occupational Health by Qtr. 3	needs across the Trust and gaps to be identified such as limited to access to hot drink and food provision, hot drink facilities, access to water and rest areas etc. BHVA group review taken place in Q1 with a view to more focused new group being launched in Q2 TRIM practitioners have been trained during June with senior practitioner training in July. TRIM steering group meeting has commenced in Q1 and on track to roll out pilot during Q3 Review of Schwartz round offer – increased numbers in attendance by targeting rounds in existing forums e.g. nurse development day
4.1a	*Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH* Complete the first and commence the second stages of Electronic Prescribing implementation [1. Implementation, 2. stabilisation, 3. optimisation, 4. transformation]	Medical Director	Quality Committee  **Off Track** – action underway to address major issues	• Roll out EPMA to remaining areas by end of Qtr. 4 • Commence Stabilisation during Qtr2	EPMA rolled out to 80% Trust in patient areas as per Business Case Prioritisation agreed for next phase, 20% non-standard areas: paediatrics, maternity, critical care Funding agreed and allocated, resource yet to be identified EPMA stabilisation project adopted into Nervecentre working group Risk management process agreed for digital risks and will report into Risk Committee
4.1b	*Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH* Develop EPR (Electronic Patient Records) business case	Medical Director	Quality Committee  **On Track** - no issues to note.	• Submission of business case Qtr. 2 • Approval dependent commencement of recruitment Qtr. 3	Pre-market supplier engagement exercise launched, concluding August Draft business case ready to be populated with feedback from benefits reviews and pre-market engagement Benefits planning sessions progressing across stakeholders, concluding Q2 Approval dependant commencement of recruitment brought forward to Q2

					On track to submit OBC in October 2023 Slip from Q2 to early Q3 to comply with NHSE Frontline Digitisation funding requirements
4.2a	*Strengthen and sustain a learning culture of continuous improvement* Develop and embed the Patient safety Incident Response Framework (PSIRF)	Medical Director / Chief Nurse	Quality Committee **On Track** - no issues to note.	• Develop Patient Safety Incident response Framework (PSIRF) by end of Qtr. 2 • Implement PSIRF approach to match national patient safety framework during Qtr. 3 • In Qtr.4 set out the plan to embed this in 2024-25	The Components of PSIRF are set out below: Patient Safety Incident response planning – Complete Policy, planning and oversight – Patient Safety Incident Response plan written and awaiting sign off. Policy underway Competence and capacity – Investigator training underway. Oversight training scheduled for July Engagement and involvement of those affected by patient safety incidents – Family Liaison Officer recruited. 1 Patient Safety Partner recruited, and recruitment is ongoing. On track for a go live with PSIRF in Q2, ahead of schedule
4.2b	*Strengthen and sustain a learning culture of continuous improvement* To embed the Improvement Faculty within the Trust whose role will be to provide a centre of excellence for transformational and improvement support.	Director of Strategy and Partnership	People, Culture and Improvement Committee **On Track** - no issues to note.	• Fortnightly matrix meetings established from early Qtr. 1, incorporating all teams for whom improvement is a component of their role. • By the end of Qtr. 1 all aspects of the Trusts Transformation and Efficiency Programme to have been assessed by the Improvement Faculty to determine validity and deliverability. • By the end of Qtr. 2 a physical Improvement Faculty office to be created for the colocation	Fortnightly matrix meetings have been established – the 'Improvement Advisory Group'. These meetings commenced in May 2023. All aspects of the Trusts Transformation and Efficiency Programme have been assessed by the Improvement Faculty. As a result, three areas of the Programme are now subject to a 'stocktake' review. These reviews have all been led by the respective Executive Sponsor. The Improvement Faculty 'Hub' has now been

				of the Transformation and Improvement Teams plus hot desk availability for other teams involved in the Faculty's work. • By the end of Qtr. 4 an Initial (independent) review of the Improvement Faculty's impact will have been completed and reported to the Finance Committee.	created (which hosts the Transformation and Improvement Teams plus has hot desk availability).
5.1	*Develop a roadmap to longer-term financial sustainability* Establish an underpinning financial strategy to act as the foundation for the delivery of our new 2024-29 Strategy	Chief Financial Officer	Finance Committee **On Track** – action underway to address minor issues	• A Financial Resources Oversight Group will be established by the end of Qtr. 1. • Use of Resources reviews undertaken by the end of Qtr2, to better understand where and how we spend our resources. • By the end of Qtr. 3 multi-year divisional budgets will be established. • We will have investment plans and financial efficiency plans for 2024-25 and beyond in place by Qtr. 4. • Establishment of a Strategic Procurement plan alongside ICS partners.	Enhanced financial governance established in Q1, including: • Bi-monthly finance focussed Divisional Performance Review meetings • Bi-weekly CFO attendance at Divisional General Manager meetings • Drafted Divisional Finance Committee Terms of Reference The Terms of Reference for the Financial Resources Oversight Group are still to be confirmed considering the above forums being established. Strategic Procurement collaboration with ICS partners is progressing. Steps taken so far include: • A shared data portal where we can compare prices paid and review contract end dates across the ICS • Monthly meetings with the Heads of Procurement to discuss potential projects • Successful joint procurements in areas such as Pathology, IT and temporary staffing • Joint access to the Graduate Training Scheme to ensure that there are now three procurement graduate trainees across the system

					Future Strategic Procurement developments will include joint work plans, procurement strategies and sustainability strategies.
5.2	*Contribute to the wider societal work to mitigate the impact of climate change on the health and wellbeing of our community* Establish the Sustainability Development Steering Group and progress delivery of the objectives set out in the SFH Green Plan 2021-2026	Chief Financial Officer	Finance Committee  **On Track** - no issues to note.	• Improvements evidenced in key metrics (including energy and water consumption, waste and carbon emissions). • Annual Green Plan report to Board in Q3. • BAF PR8 score maintained or reduced. • Funding secured to progress Energy Reduction Projects.	Sustainable Development Strategy Group (SDSG) met w/c 26th June with revised, tighter, membership. SDSG approved Sustainable Development Operational Group (SDOG) Terms of Reference. Inaugural SDOG met w/c 3rd July. Net zero BAF PR8 score reviewed and workstream leads identified. SDOG updated on net-zero cases presented to Capital Resources Oversight Group (CROG) for investment. Work progressing on due diligence of the Public Sector Decarbonisation Scheme application to determine deliverability.
5.3	*Enhance the utilisation of the SFH estate to support the delivery of outstanding care in the best place.* Complete a comprehensive space utilisation review of all Trust sites to underpin delivery of the Estates Strategy, develop a multi-year capital investment programme, and work with system partners to find solutions to long-standing estate challenges.	Chief Financial Officer	Finance Committee  **On Track** - no issues to note.	• Refreshed Space Utilisation Group operational and assessment of all SFH estate completed by Qtr. 4, to identify potential solutions that support delivery of the emerging Clinical Service Strategies. • Completion of the key capital schemes in line with planned timescales and budgets. • Multi-year capital investment programme in place. • Business cases prepared for future development opportunities.	Space Utilisation report for Newark Hospital has concluded. The findings and opportunities have been shared with the Site Leadership team for review. First meeting held w/c 10th July to discuss opportunities and Project Initiation Documents (PIDs) required to progress. Substantive Space Utilisation Officer out to advert w/c 15th July 2023. Working groups established for key capital schemes, with updates reported through Executive Team and Capital Resources Oversight Group (CROG).

					Proposal for multi-year capital investment plan supported at Trust Management Team (TMT) and scheduled for Finance Committee consideration (July 2023).
6.1a	*We will embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.* Delivery of the "New Ways of Working and delivering care" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework. • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Delivery tactical people plans by Qtr. 1 • Develop workforce transformation to deliver Newark Transformation Investment Funding (TIF) by July 23 and Mansfield Community Diagnostics Centre (CDC) by Qtr. 2 • Design and understand interfaces between People and Transformation programmes to support financial improvements by end of Qtr. 4.	We have revised the metrics in the SOF for 2023/24 and are due to report on these in July 23, these developed metrics will allow us to give a focus and clarity on our people metrics Where we have noted variance against statistic norms we will continue to report, and where needed conduct 'deep dives' to explore underlying issues We have developed tactical people profiles that we will present in Julys DLT, and send out to all services lines, these will be used in conjunction with the development the division clinical strategies We have recruited to all post (except 2 pharmacy post) Services has put rota mitigations in place while we continue to support recruitment across these difficult to recruit posts.
6.1b	*We will embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.* As a Nottingham and Nottinghamshire provider collaborative we will identify and deliver opportunities to improve how we work together with colleagues and services outside of SFH.	Director of Strategy and Partnership	Executive Team Meeting  **Off Track** – action underway to address minor issues.	• 2023-24 Provider Collaborative at Scale (PC@S) Prospectus agreed during Qtr. 1 • PC@S Maturity Matrix Completed and action Plan in place by Qtr. 2 • 2023-24 PC@S areas of focus refreshed and agreed for 2024-25 by the end of December 2023	The description of the Provider Collaborative at Scale, its priorities and its mission statement have been agreed for the prospectus however work is ongoing within the system to develop the underpinning detail for the delivery of the Urgent Care and People priorities which is required to finalise the prospectus. It is expected that this system clarity will be in place by September and that following this the prospectus will be published.

6.2	*Develop and launch the SFH 2024-29 Strategy* Through engagement with our People, Board, Council of Governors, Patient & Carers, the wider community we serve and our partners we will put in place a strategy that reflects our populations needs and contributes to our social, partner and regulatory agendas.	Director of Strategy and Partnership	Executive Team Meeting  **On Track** - no issues to note.	• Engagement plan in place by the end of May 2023 • Draft 'Consultation' Strategy completed for 5th October Board • Board Approval of Strategy - 4th Jan 24 • Clear set of priorities and actions for Year 1 agreed with Board during Qtr. 4 (updated annually) • 2024-29 Strategy launched Qtr. 4 2024	Engagement commenced June 2023 initially with Trust Membership and subsequently expanded to other groups in line with plan. Agreement made to move date for Draft Strategy from 5th October Board to the Trust Board Time Out on 25th October to allow more time for consideration of the Draft. Drafting of the plan will reflect engagement feedback and set out the Trust ambitions with further engagement and feedback sought on the draft strategy following discussion at the Board Time Out.

Board of Directors Meeting in Public - Cover Sheet

Subject:	2023/24 Priorities - Qtr1	**Date: 3rd August 2023**	
Prepared By:	Kevin Gallacher, Associate Director Planning and Partnerships		
Approved By:	**David Ainsworth, Director of Strategy and Partnerships**		
Presented By:	**David Ainsworth, Director of Strategy and Partnerships**		
Purpose			
To provide an update on the delivery of the 2023/24 SFH Strategic Priorities.		**Approval**	
		Assurance	**X**
		Update	
		Consider	

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

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

Committees/groups where this item has been presented before

Executive Team Meeting

Acronyms

BAF – Board Assurance Framework
BHVA – Bullying, Harassment, Violence and Aggression
CFO – Chief Financial Officer
CROG – Capital Resources Oversight Group
CQC – Care Quality Commission
DLT – Divisional Leadership Team
EDI – Equality, Diversity, and Inclusion
ENT – Ear Nose and Throat
EPR – Electronic Patient Record
EPMA – Electronic Prescribing and Medicines Administration
FDS – Faster Diagnosis Standard
HI – Health Inequalities
ICB – Integrated Care Board
ICS – Integrated Care System
IT – Information Technology
LMNS – Local Maternity and Neonatal System
MAST – Management and Supervision Tool
MSFT – Medically Safer For Transfer
MTP – Medical Transformation Programme
MVP – Maternity Voice Partnership
NHSE – National Health Service England

NUH – Nottingham University Hospitals
NVP – Neonatal Voice Partnership
OBC – Outline Business Case
PIFU – Patient Initiated Follow Up
PR – Principal Risk
RTT – Referral to Treatment
SDEC – Same Day Emergency Care
SDOG - Sustainable Development Operational Group
SDSG – Sustainable Development Strategy Group
SFH – Sherwood Forest Hospitals
SOF – System Oversight Framework
TMT – Trust Management Team
TRIM – Trauma Risk Management
Q1 or Qtr1 - April to June
Q2 or Qtr2 - July to September
Q3 or Qtr3 - October to December
Q4 or Qtr4 - January to March.

Executive Summary

The Trust's Strategic Priorities for 2023/24 were agreed at the Trust Board meeting in April 2023. The table below provides an update on progress at the end of Quarter 1 with fifteen priorities on track and a further eight with actions underway to address minor or major issues.

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

The attached paper provides a narrative update against each priority for quarter 1. For the items off track, all have plans to bring back on track with the main reason being as slight (but recoverable) slippage in anticipated delivery timescales.
1.2a – Modular theatre arrived on site early July. Opening scheduled for October 2023
1.2b – Building works delayed. Due to commence Jan/Feb 2024, workforce plan due August 2023
1.3 – Conclusion of priority programmes of work refresh to be presented end of July. IPR has further performance data
1.4a – Overspend against variable pay versus plan. Bespoke reporting has been developed to support improved scrutiny and mitigating actions. Strategic workforce model in development
4.1a – EPMA rolled out to 80% of Trust with remaining 20% prioritised but awaiting resource identification

This report will continue to be developed for Quarter 2 to ensure assurance can be provided for the priorities off track including an improved summary of actions underway to improve the position. This information will be taken from sub-committee and associated meeting minutes.

The Board is asked to:

Note the update.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – Q1 2023-2024	**Date:** 3rd August 2023	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Executive Team		
Presented By:	Paul Robinson, CEO		
Purpose			
To provide assurance to the Board regarding the Performance of the Trust as measured in the Integrated Performance Report		**Approval**	
		Assurance	
		Update	
		Consider	X

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

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

Committees/groups where this item has been presented before

Executive Team 26th July 2023

Acronyms

SOF – Single Operating Framework

Executive Summary

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

This report is for Quarter 1 2023/24. Rather than being RAG rated, the performance indicators identified on the report are marked as "met" or "not met" via a green tick and red cross, respectively. A graph is provided for each standard that is not met that identifies trends.

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

There are a total of 64 indicators reported on the Q1 IPR report, of those 31 are rated as met, and 33 are rated as not met. These are reported by individual Domains as follows:

Quality Care

Of the total 14 indicators, 10 are rated as met and 4 as not met for Quarter 1.

People and Culture

Of the total 11 indicators, 6 are rated as met and 5 as not met for Quarter 1. .

Timely Care

Of the total 34 indicators, 13 are rated as met and 21 as not met for Quarter 1.

Best Value Care

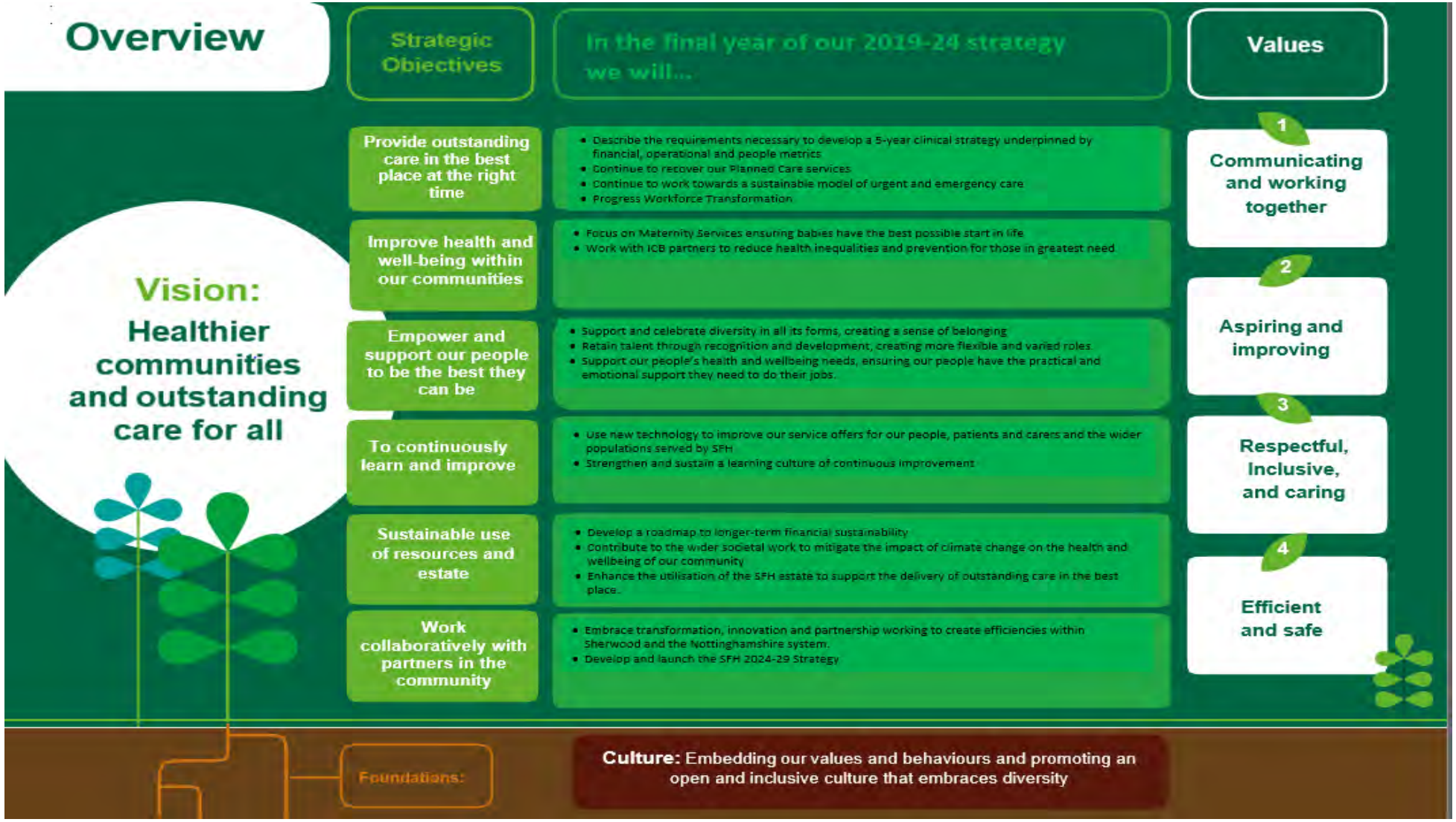
Of the total 5 indicators, 2 are rated as met and 3 as not met for Quarter 1.

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

Recommendation

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

Appendix 1


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

Mid-Nottinghamshire Integrated Care Partnership

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Integrated Performance Report

Reporting Period: Q1 2023/24

Inspected and rated Good
CareQuality Commission

Integrated Performance Report – Q1 – Domain Summary

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Quality Care	During Q1 the Organisation has remained extremely busy, with prolonged periods of operational pressure and consequential long waits in the Emergency Department; however, there have been less periods spent in prolonged escalation or Opel 4 than the last quarter. This has been mainly due to the continuation of maintaining all additional escalation bed capacity open. Despite the decision now made to substantively recruit to the majority of this, it presently continues to rely on temporary and additional staffing to maintain safe staffing levels whilst recruitment progresses. There continue to be large numbers of patients medically safe for discharge awaiting in our inpatient wards, and medical outliers continue in surgical beds. Regular and relentless periods of Industrial Action have occurred throughout the quarter. Trust Board is well sighted of our planning, response and the impact of activity of Industrial Action. Our focus has been to ensure the safety and care of our emergency and in-patient pathways. The operational and managerial impact of planning and dealing with recurrent periods of Industrial Action, cannot be overstated. Safety metrics and incidents have been carefully reviewed during disruption. No additional obvious patient harm has yet been identified though this would not consider potential harm from late diagnosis or decision making due to lost out patient appointments. The ongoing focus on fall prevention, with a proactive focus on avoiding deconditioning, prevention measures and increased mobilisation, has delivery some positive impact with a reduction of falls across Q1. There are three domains during Q1 which will be reported on as off track: • Clostridium difficile reported in month The national picture for Cdiff has deteriorated with an increase in cases. There is a both a local and regional focus on causation which is thought to be related increased use of antibiotics in community. A regional summit has been convened to examine the trend and share best practice. Our review process is being widened for identified hospital acquired infection to include community and previous admissions. When occupied bed days are used to refine statistics, we report a trend toward lower cases per 1000 bed days. Further Detail is provided in the slide set. • Case finding question, or diagnosis of dementia or delirium Our compliance has improved considerably in recent years although we fall below the high standard of 90%. We continue to focus on care for people living with dementia and have successfully engaged with Dementia UK to introduce Admiral Nursing to the Trust. We continue to be supported in our charity with the Dementia Appeal and funding for interactive devices for people who might benefit from this. Detail is provided below. We have recently undertaken a review of service provision which has reported through our quality governance forums. • HSMR (and 12-month rolling position) continues to see a rising trend and is above expected, driven by crude rates rising (Latest month Mar-23 = 4.3), with expected rates remaining relatively stable, therefore seeing a divergence between observed and expected. In addition, key factors driving the HSMR trend are understood and significantly scrutinised via Quality Committee. These include palliative care, documentation (including coding and co-morbidities) and patient flow/ attributed spells within the hospital. A few elements with no data or unvalidated data are included and will be rectified by Q2.	MD, CN

Integrated Performance Report – Q1 – Domain Summary

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
People & Culture	**People & Culture Strategy** During the quarter we have launched our People & Culture Strategy, we have set our focus areas for 2022-2025 around 4 delivery pillars that are aligned to the national people promise. Our action plans will be delivered through our operational sub-cabinets, with highlight reports to our People Cabinet, and reported through the Trusts People, Culture and Improvement Committee. We have delivered on all our Q1 objectives. We have seen continued events of **Industrial Action** held by the British Medical Association (BMA), there were junior doctors strikes held between 11-15 April (80.1% loss), 14-17 June 2023 (73.4% loss). Within July there we 2 episodes of industrial action, 13-18 July for junior medical staff (77.0%) loss and consultants (31.5% loss). It is indicated that there will be a further episode of consultant industrial action in 24 & 25 August 2023 and we are ware the BMA are re-balloting junior medical staff. Over the last three months we have seen a gradual increase in the Trust **vacancy** level, over the quarter this is recorded at 7.5% (Q4 – 3.8%), with the rate for June 2023 at 8.0%. This increase is due to an increase in the establishment levels, that have artificially increased the vacancy level. This increase can be noted around the growth around filling to our substantive bed base and growth associated with the additional Newark Theatre. Supporting our vacancy reductions, we are active in recruitment and have recent held successful recruitment fairs and careers event and continue to have a really active and engaged programme that has scheduled events over the next few months. Our **Appraisal** and **Mandatory and Statutory Training (MaST)** position is really positive where we are reporting above the Trust targets. Over Q1 our **sickness absence** level is reported at 4.2% and over the last few months has shown a gradual decrease to a level of 4.2% in June 2023. Sickness does sit equivalent the Trust target (4.2%) and between the upper and lower SPC levels. There has been an increase with **employee relations** cases over the quarter (n.40) with June recorded at 15 cases, and this sits above our target (n.12) and towards the upper SPC limit. Whilst there has been an increase in the number of formal cases we have seen an increase in support required for Managers relating to informal concerns in relation to perceived breaches of our CARE values and teams and individuals working together. There have been several formal cases that have been ongoing across April, May and June with a number concluding as we move into July. We are aware that across Nottinghamshire our ICB has been flagged for high **agency usage** and we have a system programme to review our agency usage. Across the ICB we are active in this agency working group and we do understand where we have high usage within the Trust. Our overall agency position is reported at 5.4%, although this does sit above the target level of 3.7% this has been impacted by the junior medical industrial action episodes. During quarter 1, 53.3% of total agency shifts filled were 'on framework' staff but **above the recommended NHSE price cap**, we have set a target of 30% for this metric, the majority of this sits with our medical workforce (98.6%). Over the year we aim to move towards this target. Additionally, of the agency shifts filled we have seen low levels of those filled by off framework workers over the last quarter (April – June 2023). To note there has been 3 off framework agency workers, with June 2023 reporting zero. The last time the Trust achieved this was in June 2020. We have arranged medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles	DOP

Integrated Performance Report – Q1 – Domain Summary

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Timely care	In 2023/24 Q1 (Apr-Jun) our services have continued to operate under pressure much like many acute Trusts across the country. The combination of admission demand, length of stay pressures and mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals. This mismatch in demand and capacity resulted in us starting the day on OPEL 4 on 35 days during Q1 (spread across all months). At times, patients experienced delays to admission due to a lack of beds. In response to these pressures, we enacted escalation actions and, where necessary, our full capacity protocol. Despite the challenges, we continued to provide strong ambulance handover; benchmarked well in terms of our four-hour performance (3rd best in region); and have a strong medical Same Day Emergency Care (SDEC) offer exceeding national targets. When looking across the suite of Integrated Performance Report (IPR) metrics; although a number of the timely care metrics are struggling, the quality of care metrics on the whole remain strong indicating that patient care remains good. Following the launch of the Improvement Faculty earlier in the year, the Optimising Patient Journey (OPJ) programme is being relaunched with the focus to date in 2023/24 being the identification of priority work programmes. Whilst the interplay between emergency and elective pathways continues to create challenges, the instances of industrial action resulted in curtailments in elective activity which adversely impacted on our elective activity, backlog and performance metrics. The national requirements to meet zero 78-week waiters has not been met. At the end of Jun-23 we had four 78-week wait patients for a variety of clinical and capacity-related reasons (see relevant escalation page). We have successfully increased the number of first outpatient and daycase procedures to above planned levels with further expansion later in 2023/24 as our Targeted Investment Fund (TIF) development opens at Newark hospital in autumn 2023. We continue to work together as a system with patients being transferred between providers as part of mutual aid arrangements; this has resulted in us inheriting some long wait patients. Over the summer we will receive some support to help with our Echocardiograph position; one of our struggling diagnostic tests. As a quarterly position we delivered the 5% Patient Initiated Follow Up (PIFU) target. Whilst we continue to see in the region of 15% of outpatients non-face-to-face, we recognise that we have further work to ensure that we make full benefit of remote outpatient attendances; embedding the learnings from the height of the pandemic. Our outpatient improvement programme is maturing and we are relaunching our theatre improvement programme. Key metrics relating to the delivery of timely cancer care are generally strong especially when benchmarked. Like other organisations we have seen growth in Cancer two-week referrals following a similar increasing trend seen over the last decade. Our two week wait performance remains above the national target. We continue our strong delivery of the national 28-day faster diagnostic standard with our ICS being one of the best in the Midlands region. The number of two-week wait suspected cancer patients waiting over 62 days for treatment is better than both our local target and the target set by the national team to be achieved by Mar-24. Our 62-day performance was very strong at the start of Q1 in Apr-23; however, reduce to be in line with recent mean values in May-23. Further details relating to underperforming metrics are included in the escalation pages. Within the escalation pages we have grouped some of the metrics together within the relevant care pathways.	COO

Integrated Performance Report – Q1 – Domain Summary

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Best Value care	**Income & Expenditure:** • The reported financial position or Q1 highlights some of the challenges facing the Trust in meeting the planning ambition to deliver a breakeven financial position • The Trust reported a deficit of £4.9m for the Q1 period, this represents an adverse variance to plan of £1.05m. The period saw the continuation of many of the challenges faced in the previous year with the level of capacity open and high demand for beds. The level of patients medically fit for discharge has remained at levels above those assumed in the 2023/24 annual plan • The costs of additional capacity remains the largest element of the adverse variance to plan, with £3.28m spent in Q1 on escalation capacity and some continuation of winter schemes which is above levels assumed in planning. • The Q1 position also sees unplanned costs relating to the Industrial action, with a direct financial impact that includes costs of covering gaps and an estimation of lost income relating to cancelled activity. • Q1 saw the assumed income brought forwards for CDC April-June element of £1.4m which was planned for later in the year • Although FIP is favourable to plan, this largely relates to non recurrent underspends and is measured against a very low level of FIP planned for the period. • The outturn position is currently forecast to breakeven with risks given the continuation of additional capacity open and continued industrial action. **Capital Expenditure & Cash:** • Capital expenditure of £1.50m has been reported for the Q1 period, with 2023/24 outturn expenditure currently forecast at £39.27m. The forecast is being re-worked to account for expected changes in ERF and CDC planned expenditure. • The cash balance at the end of Q1 stands at £6.53m, which is £0.72m higher than planned. **Agency Expenditure:** • The Trust reported agency expenditure of £4.64m during Q1, with 2023/24 outturn expenditure forecast at £14.57m. **Elective Recovery Fund (ERF):** • ERF is higher than our initial plans set out, however is £0.5m short of stretch plans agreed and submitted.	CFO

Integrated Performance Report – Q1 – Scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Care

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Safe	Falls per 1000 OBDs	≤6.63	✗ 6.9	✓ 5.9	✗ 7.0	✓ 6.6	✓ 6.6
	Never events	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	MRSA reported in month	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Cdifficile reported in month	≤13	✓ 4	✓ 6	✓ 5	✗ 15	✗ 15
	Ecoli BSI reported in month	≤22	✓ 2	✓ 3	✓ 5	✓ 10	✓ 10
	Klebsiella BSI reported in month	≤1	✓ 0	✓ 1	✓ 0	✓ 1	✓ 1
	Pseudomonas BSI reported in month	≤3	✓ 2	✓ 0	✓ 0	✓ 2	✓ 2
	HAPU (cat 2) per 1000 OBDs with a lapse in care		0.1	0.0	0.1	0.1	0.1
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Venous Thromboembolism (VTE) risk assessments	≥95%	Not yet available				
Caring	Case finding question, or diagnosis of dementia or delirium	≥90%	✗ 82.1%	✗ 84.8%	✗ 86.2%	✗ 84.4%	✗ 84.4%
	Complaints per 1000 OBDs	≤1.9	✓ 1.1	✓ 1.2	✓ 1.0	✓ 1.1	✓ 1.1
	Compliments received in month		90	146	123	359	359
Effective	HSMR (basket of 56 diagnosis groups)	≤100	✗ 126.8	✗ 127.8	✗ 130.6	✗ 130.8	✗ 130.6
	SHMI	≤100	✗ 106.25	✗ 106.4	-	-	✗ 106.4
	Still birth rate	≤4.4	✓ 3.6	✓ 0.0	✓ 3.4	✓ 2.2	✓ 2.2
	Early neonatal deaths per 1000 live births	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0

Integrated Performance Report – Q1 – Scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

People and Culture

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Belonging in the NHS	Engagement Score	≥6.8%	-	-	-	✓ 6.9	✓ 6.9
Growing the Future	Vacancy rate	≤6.0%	✗ 6.9%	✗ 7.4%	✗ 8.0%	✗ 7.5%	✗ 7.5%
	Turnover in month	≤0.9%	✓ 0.79%	✓ 0.37%	✓ 0.36%	✓ 0.51%	✓ 0.51%
	Appraisals	≥90%	✗ 87.1%	✓ 90.4%	✓ 90.2%	✗ 89.3%	✗ 89.3%
	Mandatory & Statutory Training	≥90%	✓ 90.0%	✓ 90.0%	✓ 91.0%	✓ 90.3%	✓ 90.3%
Looking after our People	Sickness Absence	≤4.2%	✗ 4.4%	✓ 4.2%	✓ 4.2%	✓ 4.2%	✓ 4.2%
	Total Workforce Loss	≤7.0%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.2%	✓ 6.2%
	Flu vaccinations uptake - front line staff	≥80%	-	-	-	-	0.0%
	Employee Relations Management	<12	✓ 11	✗ 14	✗ 15	✗ 13	✗ 13
New Ways of Working	Agency (Off Framework)	≤6.0%	✓ 0.1%	✓ 0.1%	✓ 0.0%	✓ 0.0%	✓ 0.0%
	Agency (Over Price Cap)	≤30.0%	✗ 47.7%	✗ 59.6%	✗ 53.1%	✗ 53.3%	✗ 53.3%
	Agency Usage (%)	<3.7%	✗ 5.7%	✗ 6.5%	✗ 5.4%	✗ 5.9%	✗ 5.9%

Integrated Performance Report – Q1 – Scorecard

Timely Care (1/2)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Urgent Care	Ambulance turnaround times <15 mins (%)	≥65%	✗ 44.6%	✗ 48.0%	✗ 41.7%	✗ 44.8%	✗ 44.8%
	Ambulance turnaround times <30 mins (%)	≥95%	✓ 96.0%	✓ 96.1%	✗ 94.0%	✓ 95.4%	✓ 95.4%
	Ambulance delays >60 mins (%)	0.0%	✗ 0.1%	✓ 0.0%	✗ 0.3%	✗ 0.2%	✗ 0.2%
	ED 4 hour performance (%)	≥76%	✗ 75.6%	✗ 74.0%	✗ 73.1%	✗ 74.2%	✗ 74.2%
	Mean waiting time in ED (in minutes)	≤200	✗ 209	✗ 212	✗ 217	✗ 213	✗ 213
	ED 12 hour LoS performance (%)	≤2%	✗ 2.8%	✗ 2.4%	✗ 2.7%	✗ 2.6%	✗ 2.6%
	ED 12 hour DTA breaches	0	✗ 84	✗ 84	✗ 78	✗ 246	✗ 246
	Number of A & E attendances against plan	≤Plan	✓ 14,571	✗ 15,900	✗ 15,720	✗ 46,191	✗ 46,191
	Number of NEL admissions against plan	≤Plan	✓ 3,429	✓ 3,587	✓ 3,643	✓ 10,659	✓ 10,659
	SDEC activity (%)	≥33%	✓ 37.5%	✓ 37.6%	✓ 37.6%	✓ 37.5%	✓ 37.5%
	Adult G&A bed occupancy (%)	≤92%	✗ 95.7%	✗ 96.4%	✗ 96.3%	✗ 96.1%	✗ 96.1%
	Long length of stay (21+) occupied beds	≤Plan	✗ 136	✗ 127	✗ 127	✗ 130	✗ 130
	Inpatients MSFT >24 hours	≤40	✗ 106	✗ 116	✗ 106	✗ 109	✗ 109

Integrated Performance Report – Q1 – Scorecard

Timely Care (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Electives	Average daily referrals		274	311	-	-	293
	Elective inpatient activity against plan	≥Plan	✗ 295	✗ 339	✗ 343	✗ 977	✗ 977
	Daycase activity against plan	≥Plan	✓ 2,908	✓ 3,421	✓ 3,426	✓ 9,755	✓ 9,755
	Outpatients - first appointment against plan	≥Plan	✓ 10,131	✓ 12,349	✓ 12,316	✓ 34,796	✓ 34,796
	Outpatients - follow up against plan	≤Plan	✗ 22,687	✗ 28,059	✗ 27,812	✗ 78,558	✗ 78,558
	Remote attendances (%)	≥25%	✗ 14.9%	✗ 15.6%	✗ 14.9%	✗ 15.1%	✗ 15.1%
	Added to PIFU (%)	≥5%	✗ 4.9%	✗ 4.7%	✓ 5.6%	✓ 5.1%	✓ 5.1%
	Advice & guidance (%)	≥16%	✓ 25.3%	✓ 23.7%	✓ 21.9%	✓ 23.5%	✓ 23.5%
	Completed admitted RTT pathways against plan	≥Plan	✗ 910	✓ 1,179	✓ 1,163	✓ 3,252	✓ 3,252
	Completed non-admitted RTT pathways against plan	≥Plan	✗ 6,453	✓ 8,908	✓ 9,257	✗ 24,618	✗ 24,618
	Incomplete RTT waiting list against plan	≤Plan	✗ 49,956	✗ 51,459	✗ 51,946	✗ 51,946	✗ 51,946
	Incomplete RTT pathways +52 weeks against plan	≤Plan	✗ 924	✗ 1,087	✗ 1,186	✗ 1,186	✗ 1,186
	Incomplete RTT pathways +65 weeks against plan	≤Plan	✓ 141	✗ 180	✗ 208	✗ 208	✗ 208
	Incomplete RTT pathways +78 weeks	0	✗ 8	✗ 8	✗ 6	✗ 6	✗ 6
	Incomplete RTT pathways +104 weeks	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Diagnostics	Diagnostics activity against plan	≥Plan	✓ 12,704	✓ 13,335	✗ 13,795	✓ 39,834	✓ 39,834
	Diagnostic DM01 Waiting List		10,952	11,476	11,462	11,462	11,462
	Diagnostic DM01 Backlog		3,737	3,538	3,508	3,508	3,508
	Diagnostic DM01 <6 weeks	≥99%	✗ 65.9%	✗ 69.2%	✗ 69.4%	✗ 68.2%	✗ 68.2%
Cancer	Two week wait Cancer Referrals		1,417	1,527	-	-	2,944
	Cancer 2 week wait performance (%)	≥93%	✓ 93.4%	✓ 96.0%	-	-	✓ 94.8%
	Faster Diagnosis Standard (%)	≥75%	✗ 73.4%	✓ 76.9%	-	-	✓ 75.2%
	First definitive cancer treatments		115	124	-	-	239
	Cancer 31 day treatment performance (%)	≥96%	✗ 93.0%	✗ 91.1%	-	-	✗ 92.1%
	Cancer 62 day performance (%)	≥85%	✗ 76.3%	✗ 63.7%	-	-	✗ 69.1%
	2ww patients waiting >62 days for treatment	≤Plan	✓ 58	✓ 58	✓ 55	✓ 55	✓ 55

Integrated Performance Report – Q1 – Scorecard

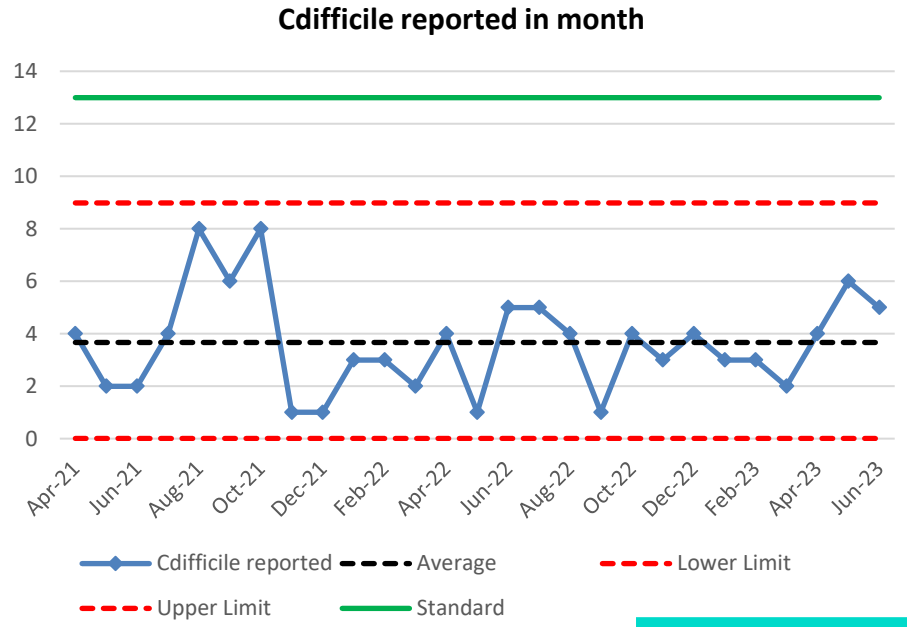
Sherwood Forest Hospitals
NHS Foundation Trust

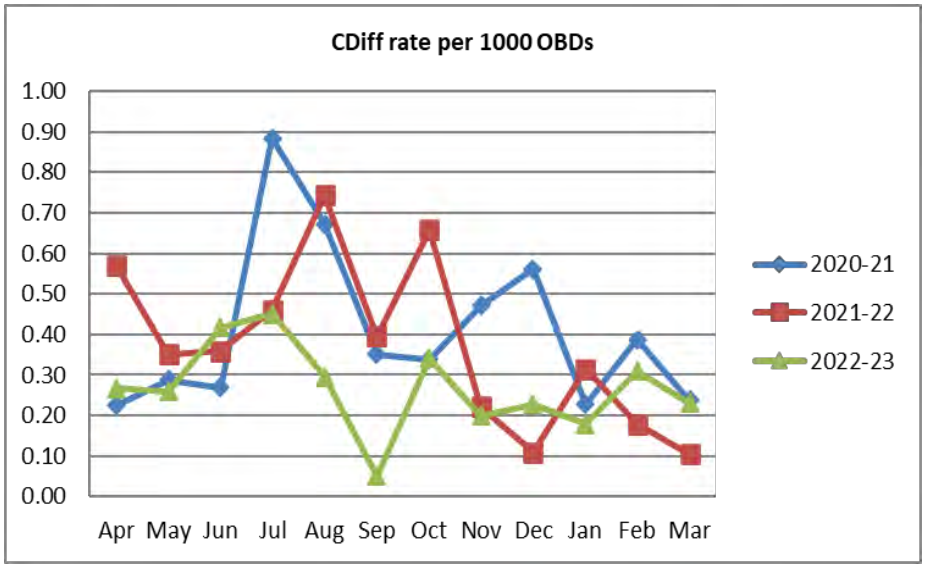
Best Value care

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Finance	Income & expenditure against plan (£m)	≥£0.00m	✓ £0.00	✗ -£0.98	✗ -£0.06	✗ -£1.04	✗ -£1.04
	Financial Improvement Programme (FIP) against plan (£m)	≥£0.00m	✓ £0.01	✓ £0.03	✓ £0.00	✓ £0.04	✓ £0.04
	Capital expenditure against Plan (£m)	≤£0.00m	✗ £0.23	✗ £1.15	✗ £6.71	✗ £8.09	✗ £8.09
	Cash balance against Plan (£m)	≥£0.00m	✗ -£8.73	✓ £4.35	✓ £5.10	✓ £0.72	✓ £0.72
	Agency expenditure against Plan (£m)	≥£0.00m	✓ £0.02	✗ -£0.32	✗ -£0.16	✗ -£0.46	✗ -£0.46

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Cdifficile reported in month	≤13	✓ 4	✓ 6	✓ 5	✗ 15	✗ 15

Sherwood Forest Hospitals
NHS Foundation Trust





National position & overview

- This year our trajectory has been set at 57
- Nationally there has been an increase in CDiff cases and organisations trajectories are going to be difficult to meet.
- We have reviewed our cases on rates per occupied bed days for the last 3 years which shows last year we had our lowest rates during this time.
- Regional summit has been convened to examine themes and share best practice. This will be reported into IPCC.

Root causes	Actions	Impact/Timescale
The root cause of the CDiff cases have been unavoidable due to patients being treated with antibiotics for other infections	• Attend the regional NHSE collaborative day • Expand the RCA process to review further back in the patients history to identify any changes we can make to prevent the patients initial infection. • Work closely with the community IPC Team to review the above cases and identify areas for improvement. • Antimicrobial Pharmacy support has been maintained to monitor community prescribing • Decant Deep cleaning at NH and MCH nearing completion and plans in place for KM at DLT this month	28th July 2023 September 2023 September 2023

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Case finding question, or diagnosis of dementia or delirium	≥90%	✖ 82.1%	✖ 84.8%	✖ 86.2%	✖ 84.4%	✖ 84.4%

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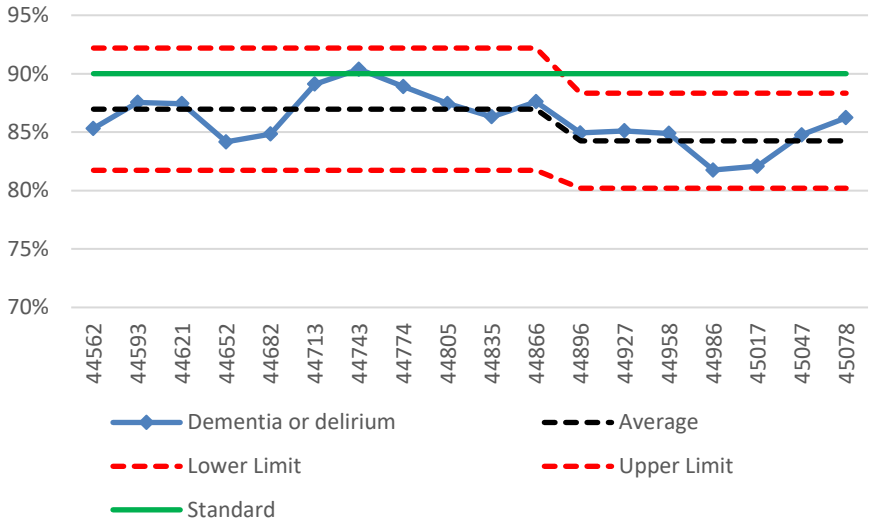
Case finding question, or diagnosis of dementia or delirium



National position & overview

- Following an initial dip in compliance for this metric when a Nervecentre electronic version of the audit data was developed and introduced, this has improved as both Nursing and Medical staff can now complete the assessment
- In 2019 it was agreed that nursing staff could also complete the assessment, and after a period of education, guidance, and support the percentages improved.
- In April 2020 at the start of the pandemic national reporting on dementia assessments was initially paused until June 2021,
- In June 2021 following a national consultation and questionnaire the decision was made to close the return nationally, although we have continued to monitor here at Sherwood Forest.
- During the period we have collected data locally our percentage rate has maintained a standard of greater than 80%.
- Following a review undertaken by the UK Government national screening committee a decision was made that it is not currently recommended for this condition.

Root causes	Actions	Impact/Timescale
It is recognised and documented that DAR data should be more practical, quality-focused, and less burdensome	• As the NHSI consultation identified these points, it is proposed that the focus on the percentage of dementia assessments is changed to reflect the new progress priorities. Which include a renewed emphasis of the identification of delirium, a drawing together of measures that help signal the quality of care for people with dementia and delirium aligned to the Dementia Well Pathway and finally capture and use existing data, already routinely collected taking a staged approach to address short or medium and longer term requirements.	An adaption of the screening tool to capture delirium, using the 4AT on Nervecentre. Agreement would be needed and then developed with the team. Using the data collected as part of the National Dementia Audit to identify areas for development. Report due for 22-23 and learning will be shared. The next audit commences August 2023 Working alongside the ward assurance team to improve the compliance and in turn increase awareness and identification of patients on the wards.
Delirium is known to be one of the most common complications in hospitalised older adults.	• The proposal is to change the focus from dementia assessments to avoiding, identifying, and treating delirium with the aim of avoiding harm to patients, reducing length of stay and providing quality care.	With support and commitment there is an ability to have a significant impact on the percentage of patients affected by delirium. Through education at all levels and to all health professionals, knowledge and awareness can be achieved to both treat and prevent delirium occurrence.

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
HSMR (basket of 56 diagnosis groups)	≤100	✗ 126.8	✗ 127.8	✗ 130.6	✗ 130.8	✗ 130.6
SHMI	≤100	✗ 106.25	✗ 106.4	-	-	✗ 106.4

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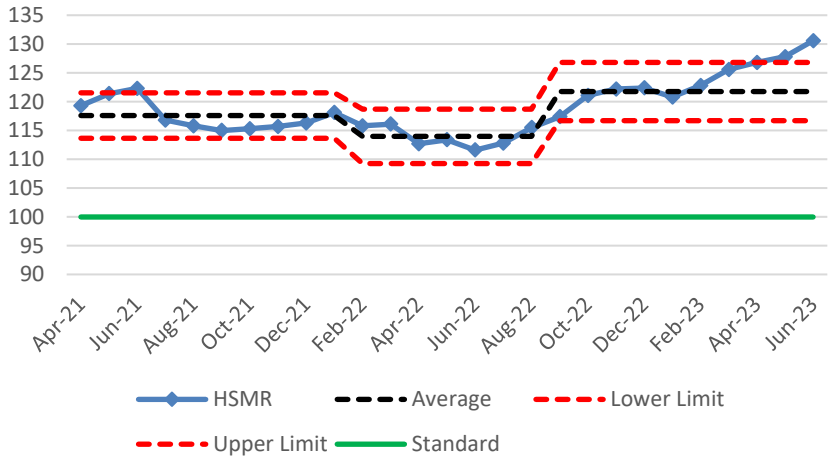
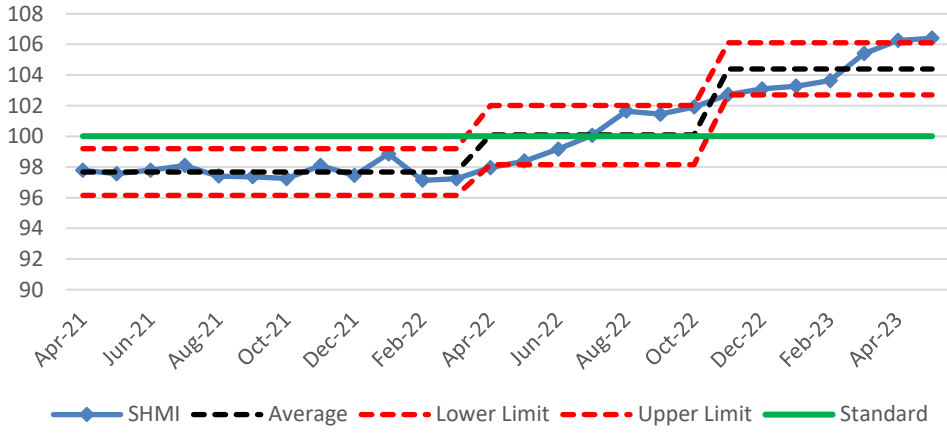
HSMR (basket of 56 diagnosis groups) rolling 12 months



SHMI



Overview

HSMR remains off track as expected, recognising this represents a 12-month rolling position.
Key factors driving the HSMR trend include palliative care, documentation (including coding and co-morbidities) and patient flow/ attributed consultant spells within the hospital. Our crude mortality rates are sitting at peak covid activity and it is noted that National crude rates have also seen a general increase in this reporting period.

The work programme tackling these includes improving our palliative care provision, admission workbook redesign and targeted case review, undergoes regular scrutiny via Quality Committee. The months of disruptive Industrial Action are noted to significantly impact the clinical focus, on this work.
Our Learning from Deaths programme remains the vehicle for identifying and delivering clinical change across our patient pathways.

Our SHMI remains as expected but has seen a marginal rise. It is thought this supports the understanding that factors, other than Palliative Care are contributing to the overall position seen. Work on this is incorporated in the programme as mentioned above.

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Vacancy rate	≤6.0%	✖ 6.9%	✖ 7.4%	✖ 8.0%	✖ 7.5%	✖ 7.5%

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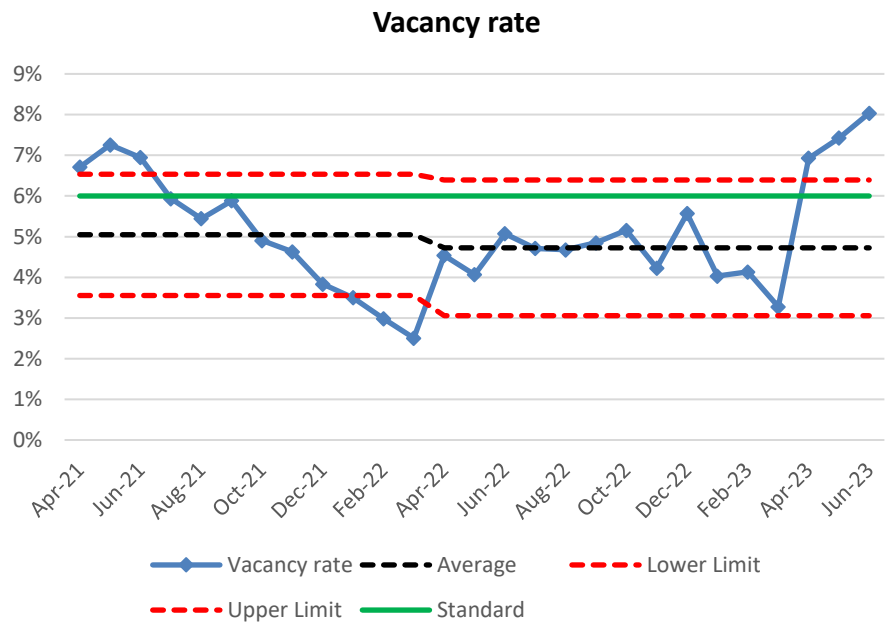

National position & overview

Since April 2023 we have seen a gradual increase in the Trust vacancy level, currently this is recorded at 8.0%, This sits above our agreed Trust (6.0%). The quarterly total is reported at 7.5%, with the 12-month average is 5.3%.

Local benchmarking shows that the ICB provider vacancy level is reported at 11.5%.

This increase can be noted around the growth around filling to our substantive bed base and growth associated with the additional Newark Theatre

Root causes	Actions	Impact/Timescale
During April we normally see an increase in the establishment levels, which then generates an increase in the vacancy levels. This is aligned to the additional budget being added into the financial establishment, during the year we have previously shown recruitment success in closing this gap. This increase includes the increased budget for the additional staff associated with the surge bed base work.	To support the acuity of the hospitals, known growth and our ambition to reduce vacancies we have held various recruitment fairs to show case roles and Sherwood Forest, these have been very success and we have appointed a number of staff, initially these have been fed into bank roles, however we are successful in converting these to substantive vacancies. We do hold regular workforce planning meetings with each Service Line to understand hard-to-fill posts and discuss if any alternative solutions can be identified to address resourcing difficulties. Our People Partners do support to progress any new JDs through job evaluation to reduce slippage on vacancies.	Over the next few months we do anticipate the overall vacancy level to reduce as we do have an approximate 40 day recruitment lag time.

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Appraisals	≥90%	✗ 87.1%	✓ 90.4%	✓ 90.2%	✗ 89.3%	✗ 89.3%

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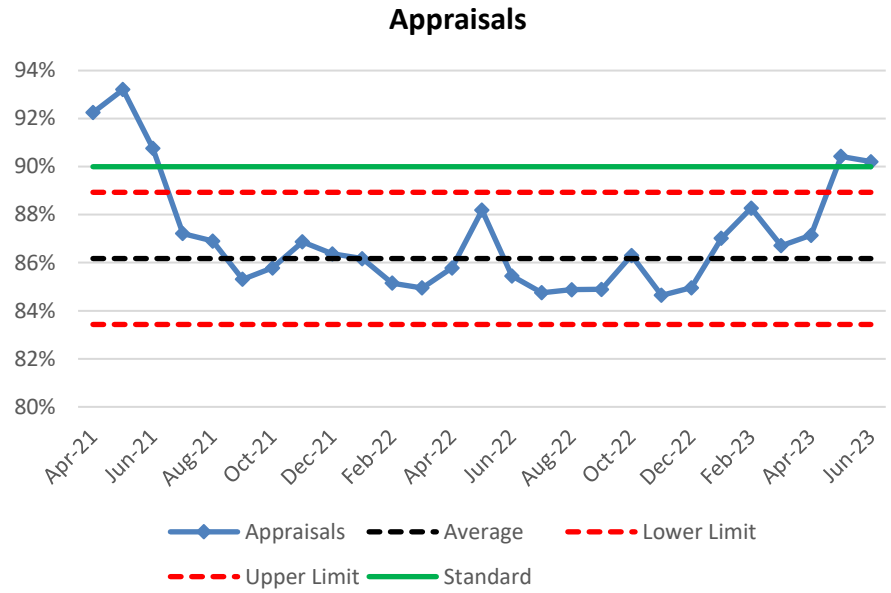

National position & overview

The charts below express that our appraisal level sits at the same level as the Trust target (90%) and we have seen a gradual increase in the appraisal level. We have noted that the overall quarterly position is below the Trust Target, however we are seeing a greatly improved position.

Local benchmarking shows that the ICB provider appraisal level is reported at 85%.

Root causes	Actions	Impact/Timescale
As stated we have seen an increase in the overall appraisal level over the last few months, this increase does coincide with the re-instatement of pay progression.	Service lines with low appraisal rates are supported to develop action plans to work on improving appraisal compliance. In addition, Service Lines are sighted on non-compliance rates and assurance is sought via Performance meetings on improving compliance. There are specific case conversations take place during monthly People & Performance reviews	We envisage that there will be a gradual increase to our overall levels over the next few months .

Indicator	Standard	Apr-23	May-23	Jun-23	Qtr 1
Agency (Over Price Cap)	≤30.0%	✖ 47.7%	✖ 59.6%	✖ 53.1%	✖ 6.5%
Agency Usage (%)	<3.7%	✖ 5.7%	✖ 6.5%	✖ 5.4%	✖ 6.5%

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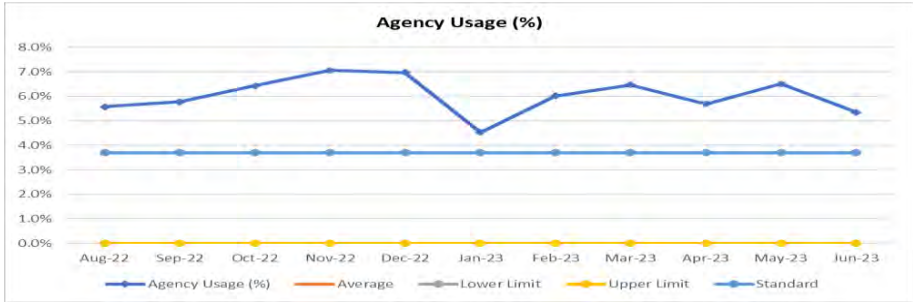

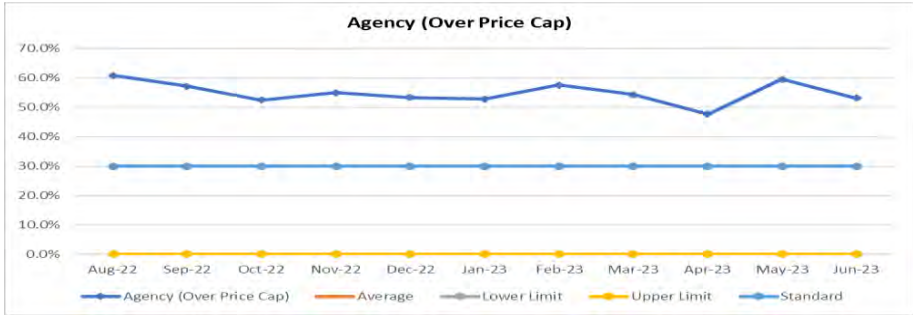

National position & overview

Our overall agency position is reported at 5.4%, although this does sit above the target level of 3.7%, and on framework over price cap is reported at 53.3% and is above our target 30.0%. This has been impacted by the junior medical industrial action episodes.

We are aware that across Nottinghamshire our ICB has been flagged for high agency usage and we have a system programme to review our agency usage. Across the ICB we are active in this agency working group and we do understand where we have high usage within the Trust. The table below expresses this.

Local benchmarking shows that the ICB provider agency level is reported at 5.5%, with the percentage over price cap at 41.8%, however there is a relationship with off frame work where the ICS figures is 10% (SFH report 0%).

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

Urgent Care: ED metrics (1/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Ambulance turnaround times <15 mins (%)	≥65%	✗ 44.6%	✗ 48.0%	✗ 41.7%	✗ 44.8%	✗ 44.8%
Ambulance delays >60 mins (%)	0.0%	✗ 0.1%	✓ 0.0%	✗ 0.3%	✗ 0.2%	✗ 0.2%
ED 4 hour performance (%)	≥76%	✗ 75.6%	✗ 74.0%	✗ 73.1%	✗ 74.2%	✗ 74.2%
Mean waiting time in ED (in minutes)	≤200	✗ 209	✗ 212	✗ 217	✗ 213	✗ 213
ED 12 hour LoS performance (%)	≤2%	✗ 2.8%	✗ 2.4%	✗ 2.7%	✗ 2.6%	✗ 2.6%
ED 12 hour DTA breaches	0	✗ 84	✗ 84	✗ 78	✗ 246	✗ 246
Number of A & E attendances against plan	≤Plan	✓ 14,571	✗ 15,900	✗ 15,720	✗ 46,191	✗ 46,191

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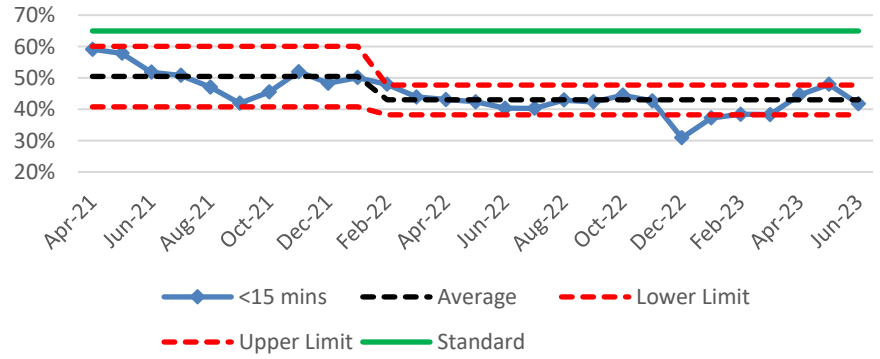
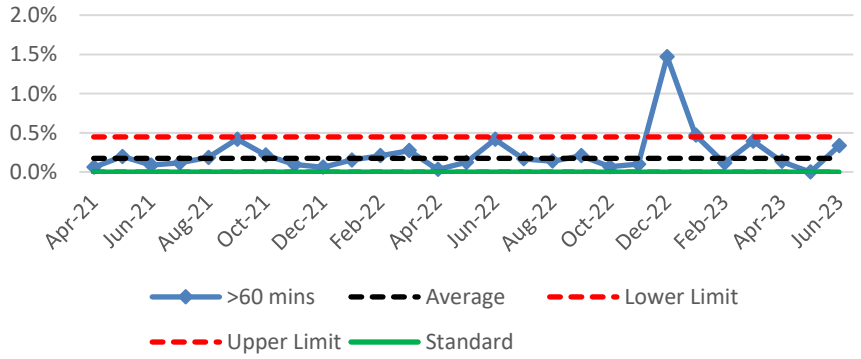
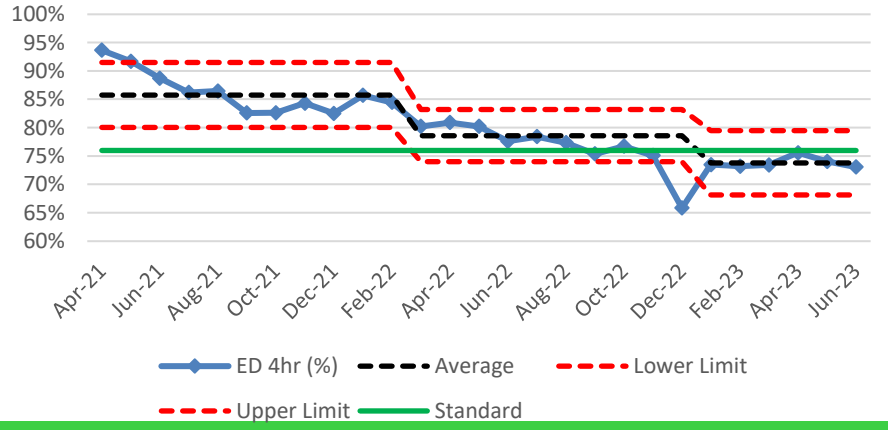
Ambulance turnaround times <15 mins (%)



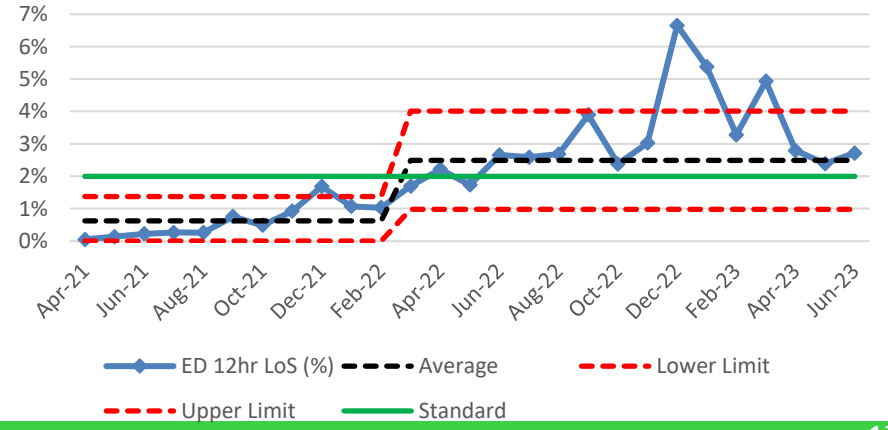
Ambulance delays >60 mins (%)



ED 4 hour performance (%)



ED 12 hour LoS performance (%)



Urgent Care: ED metrics (2/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Ambulance turnaround times <15 mins (%)	≥65%	✗ 44.6%	✗ 48.0%	✗ 41.7%	✗ 44.8%	✗ 44.8%
Ambulance delays >60 mins (%)	0.0%	✗ 0.1%	✓ 0.0%	✗ 0.3%	✗ 0.2%	✗ 0.2%
ED 4 hour performance (%)	≥76%	✗ 75.6%	✗ 74.0%	✗ 73.1%	✗ 74.2%	✗ 74.2%
Mean waiting time in ED (in minutes)	≤200	✗ 209	✗ 212	✗ 217	✗ 213	✗ 213
ED 12 hour LoS performance (%)	≤2%	✗ 2.8%	✗ 2.4%	✗ 2.7%	✗ 2.6%	✗ 2.6%
ED 12 hour DTA breaches	0	✗ 84	✗ 84	✗ 78	✗ 246	✗ 246
Number of A & E attendances against plan	≤Plan	✓ 14,571	✗ 15,900	✗ 15,720	✗ 46,191	✗ 46,191

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National position & overview

- Our ambulance handover position is significantly better than the EMAS average.
  - Average regional handover time for EMAS 25.5 mins (King's Mill: 17.3 mins, Newark: 7 mins).
  - 16.5% of regional EMAS ambulance handovers were over 30 minutes (SFH 4.6% in Q1).
  - 5.6% of regional EMAS ambulance handovers were over 60 minutes (SFH 0.2% in Q1).
- 4-hr benchmark position is 3rd in Midlands region (with the best performing Trust at 77.4%).
- 4-hr benchmark position 44th nationally out of 120 providers submitting data – upper quartile performance is 77% versus SFH performance of 74.2% in Q1.
- 12-hr benchmark position 61st nationally out of 120 providers submitting data – upper quartile performance is 0 breaches versus SFH performance of 246 in Q1.
- ED attends 5% year to date increase compared to 2022/23 and 12% increase compared to 2019/20.

Root causes	Actions	Impact/Timescale
• ED attendance demand.	• Develop new, expanded Fit to Sit area to create additional capacity collocated with majors to support enhanced patient flow and improved staffing model. • Develop surgical SDEC and expand medical SDEC direct access. • Develop Discharge Lounge pathways in line with new location due to open in October 2023.	• October 2023 - Reduce 12hr LOS performance <2%.
• ED clinician decision-making capacity.	• Recruitment in line with ED business case. • New Clinical rotas in place from 4 August 2023.	• Reduce mean time in ED <200min from August 2023. • Improve 4 hr performance >=76% from August 2023.
• ED overcrowding driven by bed capacity pressures and mismatches in admission and discharge times.	• Optimising Patient Journey (OPJ) programme relaunched. • Please see the following slides.	• New priority workstreams in place in Q2.

Urgent Care: Hospital flow metrics (1/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Adult G&A bed occupancy (%)	≤92%	✗ 95.7%	✗ 96.4%	✗ 96.3%	✗ 96.1%	✗ 96.1%
Long length of stay (21+) occupied beds	≤Plan	✗ 136	✗ 127	✗ 127	✗ 130	✗ 130
Inpatients MSFT >24 hours	≤40	✗ 106	✗ 116	✗ 106	✗ 109	✗ 109

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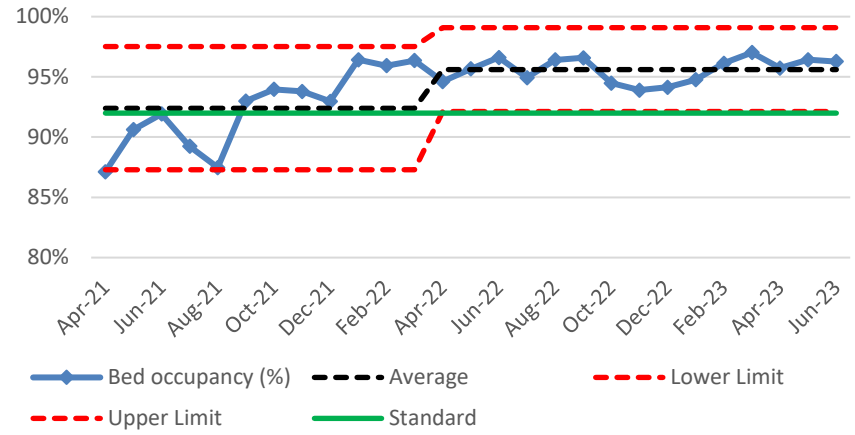
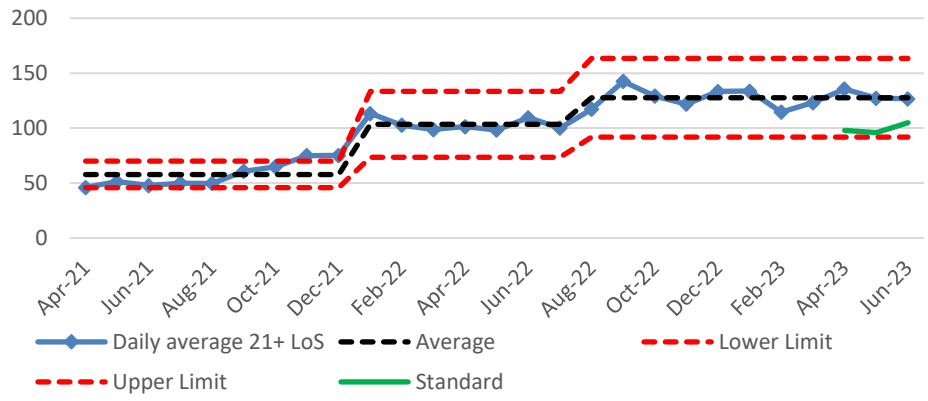
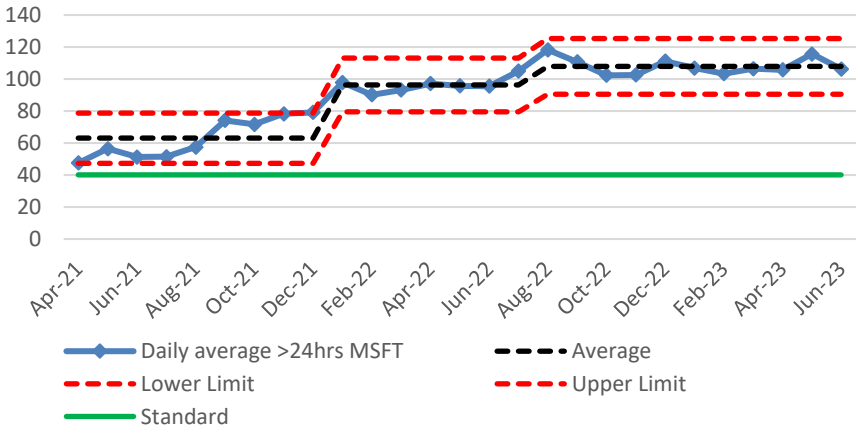
Adult G&A bed occupancy (%)



Long length of stay (21+) occupied beds



Inpatient MSFT >24 hours



National position & overview

- The number of open beds in 2023/24 Q1 reduced from 2022/23 Q4 highs in line with lower use of surge areas. However, all the wards open during 2022/23 remain in use in 2023/24 Q1. Sherwood Community Unit moved into Mansfield Community Hospital (MCH) in early Q1 bringing all three MCH wards into use.
- Our hospitals continue to operate at bed occupancy levels significantly higher than best practice 92%; like many other Trusts nationally. Lower bed occupancy supports stronger 4-hour performance (as experienced in mid-July 2023).
- The number of patients Medically Safe For Transfer (MSFT) over 24 hours has been relatively stable over the past year when viewed as a monthly average following a step change in August 2022. The local position remains significantly above the agreed threshold both in term of the 2023/24 plan value and the 2022/23 national planning guidance ambition (latter standard used on the chart).
- The number of long stay patients have followed a similar trend to MSFT inpatient numbers with process steps changes being experienced at the same points in time (as seen in the graphs) due to similarities in the patient cohort.

Urgent Care: Hospital flow metrics (2/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Adult G&A bed occupancy (%)	≤92%	✗ 95.7%	✗ 96.4%	✗ 96.3%	✗ 96.1%	✗ 96.1%
Long length of stay (21+) occupied beds	≤Plan	✗ 136	✗ 127	✗ 127	✗ 130	✗ 130
Inpatients MSFT >24 hours	≤40	✗ 106	✗ 116	✗ 106	✗ 109	✗ 109

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Root causes	Actions	Impact/Timescale
• Length of Stay (LOS) challenges (partly driven by the medically safe position as the pre-medically safe LOS has reduced since the start of 2023) • The Trust continues to experience delays in the discharge of patients who are MSFT with a detrimental effect on acute capacity and flow.	• Continue to utilise SDEC and streaming pathways to avoid admission where possible with planned expansion of surgical SDEC later in 2023/24. SDEC rate in excess of national target. • Continued efforts to transfer patients onto both existing and new Virtual Wards. • Bi-weekly long length of stay reviewing meetings. • Optimising the Patient Journey (OPJ) improvement programme under review with new priorities to be agreed in August 2023. • System discharge to assess programme. • Transfer of Care hub MDT pathway 1-3 referral reviews three-times daily. • Daily attendance at system calls to ensure appropriate challenge to partners. • System discharge lead (and deputy) supporting us to map and improve internal discharge processes.	• Actions ongoing throughout 2023/24 with aim of balancing bed occupancy with operational performance whilst aiming to contribute to the financial 'route to balance' plan. • Surgical SDEC implementation interlinked with the King's Mill Hospital ward reconfigurations which are subject to feasibility and capital approval. Aim to maintain SDEC rate >33% throughout 2023/24. • Frailty virtual ward launched in 2023/24 Q1 with expansion planned for end of Q2 into Q3.

Electives: Activity metrics (1/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Elective inpatient activity against plan	≥Plan	✗ 295	✗ 339	✗ 343	✗ 977	✗ 977
Outpatients - follow up against plan	≤Plan	✗ 22,687	✗ 28,059	✗ 27,812	✗ 78,558	✗ 78,558
Remote attendances (%)	≥25%	✗ 14.9%	✗ 15.6%	✗ 14.9%	✗ 15.1%	✗ 15.1%
Completed non-admitted RTT pathways against plan	≥Plan	✗ 6,453	✓ 8,908	✓ 9,257	✗ 24,618	✗ 24,618

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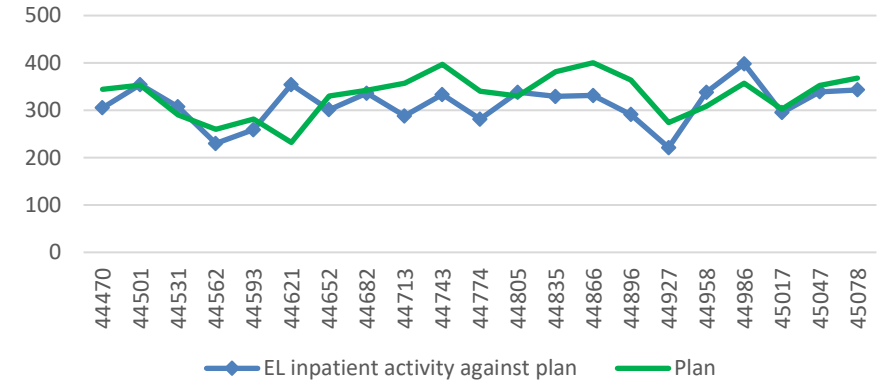
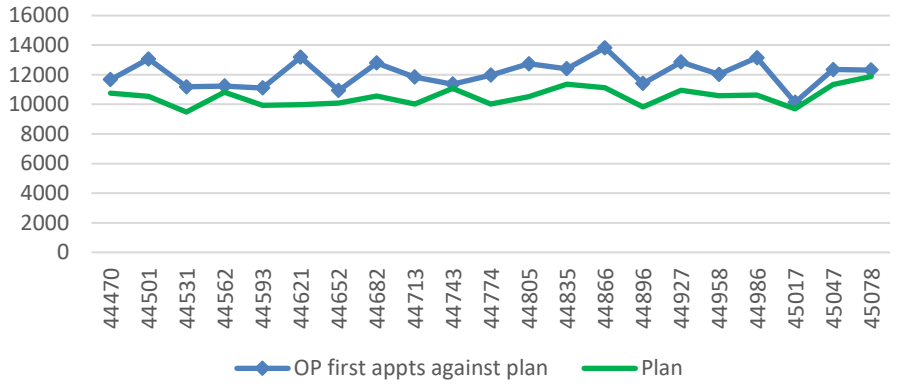
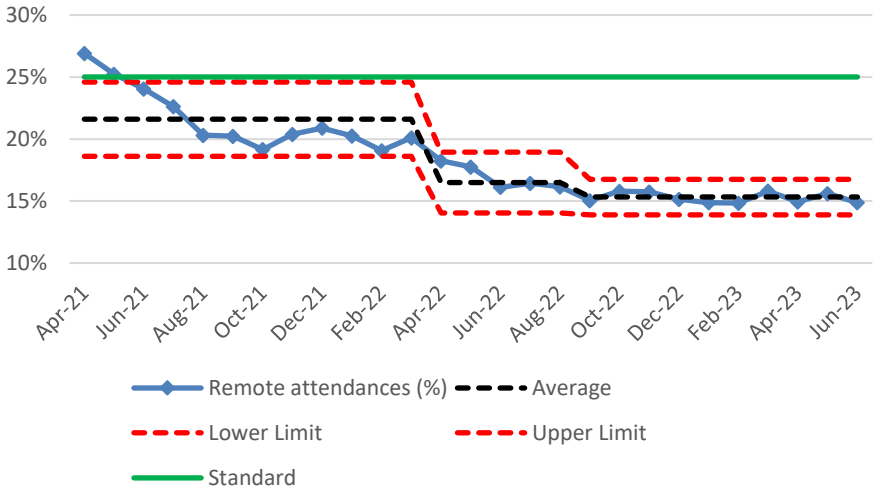
Elective inpatient activity against plan



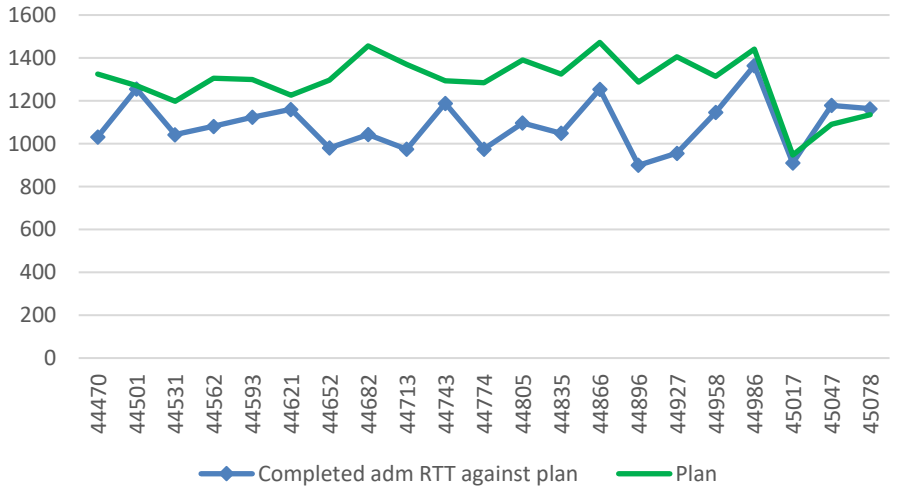
Outpatients - first appointment against plan



Remote attendances (%)



Completed admitted RTT pathways against plan



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Completed non-admitted RTT pathways against plan	≥Plan	✗ 6,453	✓ 8,908	✓ 9,257	✗ 24,618	✗ 24,618

NHS Forest Hospitals NHS Foundation Trust

National position & overview

- Elective inpatient activity against plan delivered in Feb-23 and Mar-23. Ongoing industrial action aversely impacts on our ability to deliver planned activity levels; specifically in outpatients.
- SFH (and the system) submitted a non-compliant plan against the outpatient follow-up reduction target of 25% in the 2022/23 and 2023/24 planning rounds.
- The virtual appointments agenda remains an area of underperformance across the Trust. The Operational Planning Guidance indicated that at least 25% of outpatient appointments should be delivered remotely via telephone or video consultation. SFH are currently delivering 15% which has been as stable position over the past 10 months.
- Non admitted RTT against plan off track in Apr-23; which has driven the overall quarterly underperformance (delivered in May-23 and Jun-23). In Apr-23 the bank and school holidays together with industrial action resulted in underperformance.

Root causes	Actions	Impact/Timescale

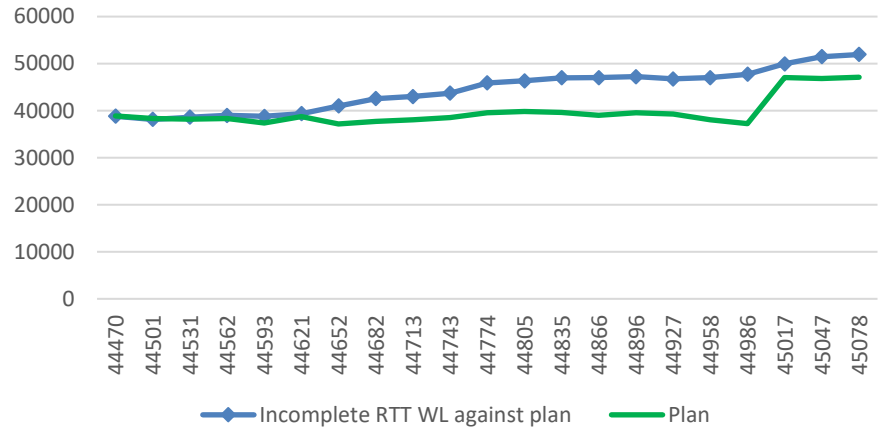
• Industrial action impacting the delivery of activity levels against plan.
• PIFU pathways are not in place for all specialities.
• Remote attendance below target due to clinician preference to see patients face-to-face.
• Demand for new and follow-up outpatient services. The Trust continues to have a significant overdue review list. Ophthalmology, Gastroenterology, Cardiology and ENT are the specialties which represent 50% of the Trust's total.
	• Continue to operationally manage the impact of industrial action with a focus on what we can deliver whilst ensuring clinical prioritisation.
	• Outpatient improvement and transformation programme in place with a focus on:
	  ◦ Increasing the number of services offering Referral Assessment Services (RAS) to direct patients to the most appropriate next steps at point of referral e.g. straight to test.
	  ◦ Link with specialties where there may be opportunity to either introduce PIFU where it is not currently in place, or to increase/expand its use. Surgery have been identified to explore pilot.
	• Based on national guidance, developing a toolkit to assess suitability and appetite for each speciality to understand current virtual attendance position, potential trajectories, challenges and risks.
		• Ongoing
		• End of Q3
		• During 23/24
		• Toolkit completed end of Q1 – next steps are to work with teams on opportunities.

Electives: Waiting list metrics (1/2)

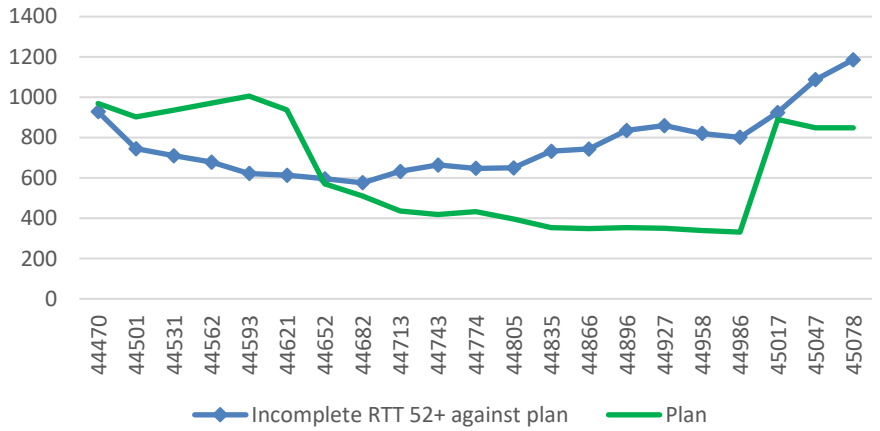
Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Incomplete RTT waiting list against plan	≤Plan	✗ 49,956	✗ 51,459	✗ 51,946	✗ 51,946	✗ 51,946
Incomplete RTT pathways +52 weeks against plan	≤Plan	✗ 924	✗ 1,087	✗ 1,186	✗ 1,186	✗ 1,186
Incomplete RTT pathways +65 weeks against plan	≤Plan	✓ 141	✗ 180	✗ 208	✗ 208	✗ 208
Incomplete RTT pathways +78 weeks	0	✗ 8	✗ 8	✗ 6	✗ 6	✗ 6

NHS Forest Hospitals NHS Foundation Trust

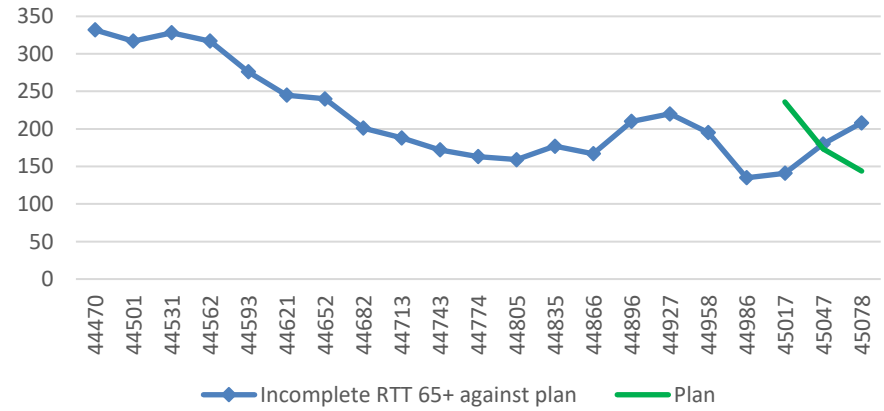
Incomplete RTT waiting list against plan



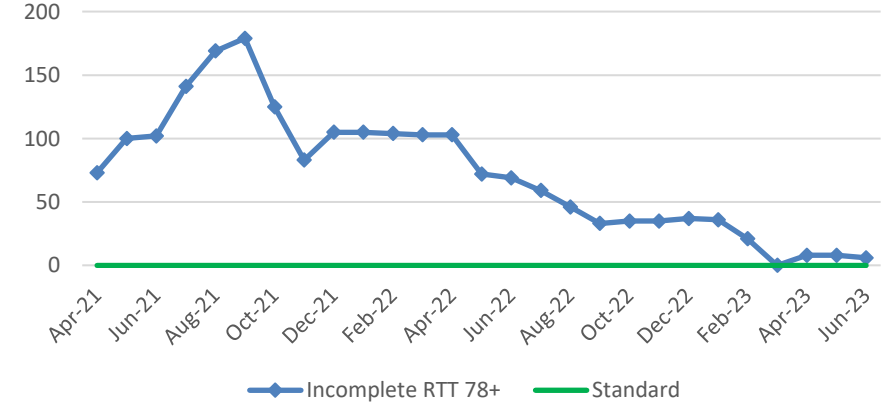
Incomplete RTT pathways +52 weeks against plan



Incomplete RTT pathways +65 weeks against plan



Incomplete RTT pathways +78 weeks



Electives: Waiting list metrics (2/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Incomplete RTT waiting list against plan	≤Plan	✗ 49,956	✗ 51,459	✗ 51,946	✗ 51,946	✗ 51,946
Incomplete RTT pathways +52 weeks against plan	≤Plan	✗ 924	✗ 1,087	✗ 1,186	✗ 1,186	✗ 1,186
Incomplete RTT pathways +65 weeks against plan	≤Plan	✓ 141	✗ 180	✗ 208	✗ 208	✗ 208
Incomplete RTT pathways +78 weeks	0	✗ 8	✗ 8	✗ 6	✗ 6	✗ 6

NHS Forest Hospitals NHS Foundation Trust

National position & overview

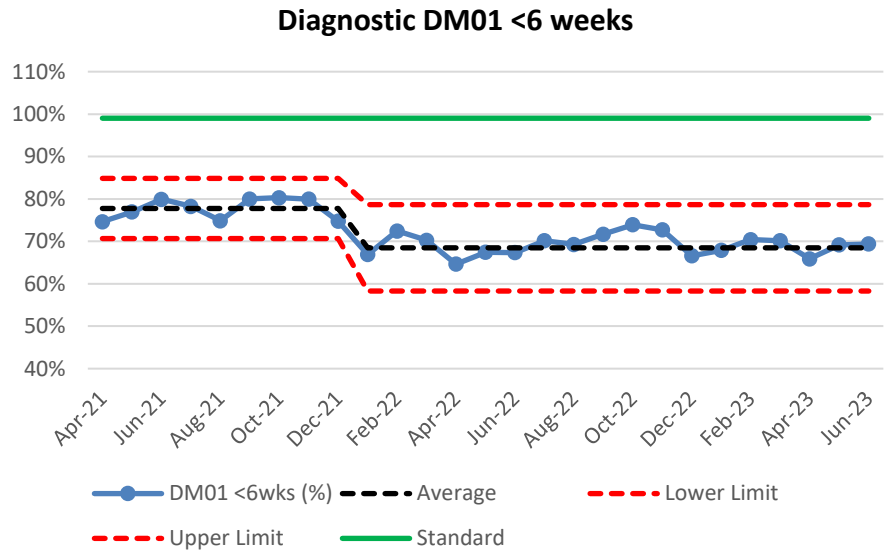
- Referral to treatment (RTT) waiting times across England continues to rise. Prior to the pandemic in Feb-20 there were nationally circa 4 million people on the waiting list, this has grown to circa 7.5 million by May-23.
- At SFH the RTT waits pre-pandemic was 26,000 patients and has continued to grow to just over 51,900 at the end of Jun-23. The rate of increase has varied post-pandemic with ongoing increase in 2023/24 Q1.
- The national requirement was to have no patients on an RTT pathway waiting greater than 78 weeks by end of Mar-23. At SFH there were 4 patients waiting over 78 weeks at the end of Jun-23 – one due to the patient choosing to wait for treatment, one with complexity not well enough to proceed, one patient that we took as mutual aid and one due to capacity
- While the actuals are behind trajectory the 65 week wait total cohort (considering those patients forecast to breach) is ahead of plan for Mar-24 delivery of the national requirement.

Root causes	Actions	Impact/Timescale
• Workforce capacity issues e.g. anaesthetic cover for elective lists. • Reduction in treatment levels during the Covid-19 pandemic. • National focus on long waiting patients (78+ weeks), including provision of mutual aid. • Physical space and infrastructure to enable increased activity required to recover the position. • Availability of cardiology diagnostic tests and delays in reporting.	• Clinical validation and review of all 65-week wait cohort patients. • Daily tracking of all patients to prevent 78-week breaches. • Use of additional clinics and theatre lists, outsourcing services (e.g. ophthalmology cataract referrals) and insourcing services to increase capacity. • Continued use of private sector for routine elective procedures. • Options paper to address increasing demand for technical and administrative validation of the full Patient Tracking List (PTL) in line with increased size of the PTL. • Newark Targeted Investment Fund (TIF) development to expand procedures in Gynaecology and ENT and support the transfer of activity from King's Mill to Newark to release capacity for more complex, long waiting patients. • Mutual aid being provided by NUH for cardiology diagnostics and weekend working.	• The first six actions are ongoing in 2023/24. • 2023/24 Q2. • Opening scheduled for Oct-23. • Due to commence Sep-23

Diagnostics

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Diagnostic DM01 <6 weeks	≥99%	✖ 65.9%	✖ 69.2%	✖ 69.4%	✖ 68.2%	✖ 68.2%

NHS Forest Hospitals NHS Foundation Trust



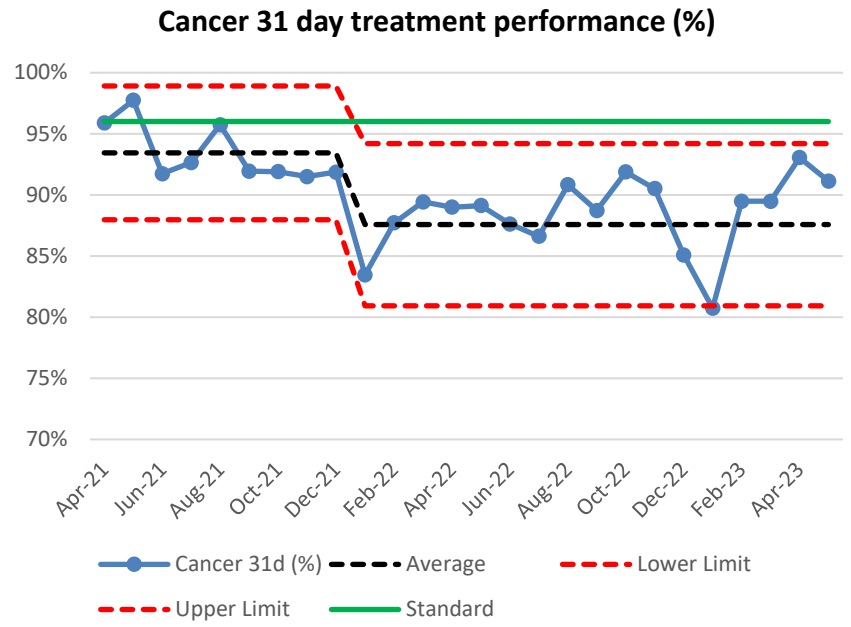
National position & overview

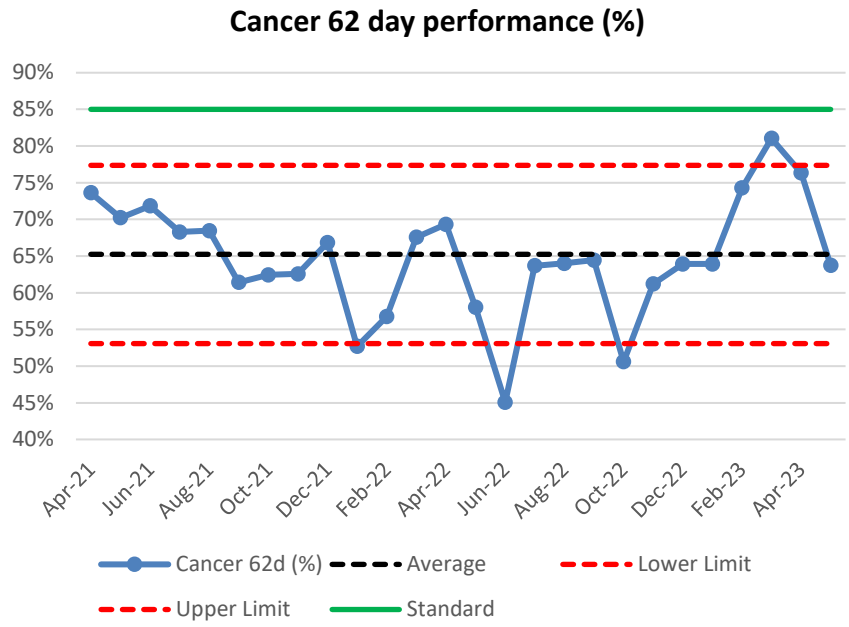
- Nationally, the total number of patients waiting six weeks or more from referral for one of the 15 key diagnostic tests at the end of May-23 was 409,700. This was 25.9% of the total number of patients waiting at the end of the month against the national standard of less than 1%.
- Across Sherwood there were a total of 11,476 patients waiting for DM01 reportable diagnostic tests of which a total of 3,538 patients were waiting greater than 6 weeks.

Root causes	Actions	Impact/Timescale
Our most challenged diagnostic modalities are:		
• Sleep studies	• Additional weekend sessions. • Paediatric pathway development to move from inpatient to home sleep studies.	Ongoing By end of Q3
• Echo due to increased demand.	• Additional weekend sessions. • Mutual aid pathway – transferring 30 per month to another provider. • Recruitment to vacancies.	Ongoing Sep-23 Underway
• Endoscopy	• In session utilisation and validation. • Recruitment to locums and vacancies.	Jul-23 Underway – by end of Q3
• MRI inpatient capacity	• Prioritisation of 2ww and long waiters – use of mobile capacity.	Ongoing
• CT Cardiac capacity and backlog – increased demand	• Additional capacity – 1 day per month, 14 patients.	Jul-23

Cancer (1/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Cancer 31 day treatment performance (%)	≥96%	93.0%	91.1%	-	92.1%	92.1%
Cancer 62 day performance (%)	≥85%	76.3%	63.7%	-	69.1%	69.1%





National position & overview

Considering the latest national data (Apr-23):

- Nationally 31 day treatment performance (1st treatment) is 90% against the 96% standard; Midlands combined 87.7%. Sherwood Forest position is performing above the Midlands position; however, below the England position and national standard.
- Nationally 62 day performance (urgent GP suspected cancer) 61% against the 85% standard; Midlands combined 53.1%. Sherwood Forest position is performing above the Midlands and England position; however, below the national standard.
- Whilst 62 day performance is challenged our 62 day backlog continues to be ahead of our operational plan trajectory.
- 2 week wait performance has been consistently above the 93% national standard from Jan to May-23 and predicted to achieve in Jun-23.
- The Faster Diagnosis Standard (FDS) of 75% was achieved in May-23 at 76.9% and predicted to achieve in Jun-23.

Cancer (2/2)

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Cancer 31 day treatment performance (%)	≥96%	✗ 93.0%	✗ 91.1%	-	✗ 92.1%	✗ 92.1%
Cancer 62 day performance (%)	≥85%	✗ 76.3%	✗ 63.7%	-	✗ 69.1%	✗ 69.1%

NHS Forest Hospitals NHS Foundation Trust

Root causes	Actions	Impact/Timescale
Continued backlog across multiple tumour sites impacting 62 day performance.	• Tumour site recovery actions plans that include recruitment as necessary. • Review of clinical Capacity Bid to East Midlands cancer alliance for funding recently approved. Q2&3 operationalisation of actions to commence pathway changes.	Ongoing Q3
Late tertiaries and treatment capacity at tertiary centres.	• Liaison with tertiary centres. • IPT transfer process review and collation of learning to identify actions/mitigations to increase timeliness of IPT where clinically possible.	Ongoing Jul & Aug-23
Patient volume within our Skin tumour site.	• Development of tele-dermatology and straight to biopsy service. Bid to East Midlands cancer alliance for funding recently approved. Q2&3 operationalisation of actions to commence pathway changes, including recruitment of staff and purchase of kit.	Q4 impacting 2 week wait; 31 day first treatment

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Income & expenditure against plan (£m)	≥£0.00m	✓ £0.00	✗ -£0.98	✗ -£0.06	✗ -£1.04	✗ -£1.04

Sherwood Forest Hospitals
NHS Foundation Trust

Standard & overview

- The standard is the Trust financial plan which is a breakeven position for 2023/24
- The Trust has reported a year to date deficit position of £4.88m for Q1 which is £1.04m adverse to the planned deficit position of £3.84m

Root causes

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

Actions

- CDC income brought forward from Q4 to be phased throughout the year ahead of plan
- Divisions undertaking pipeline FIP review to provide assurance
- Recovery plans being worked through
- Enhanced Financial Governance

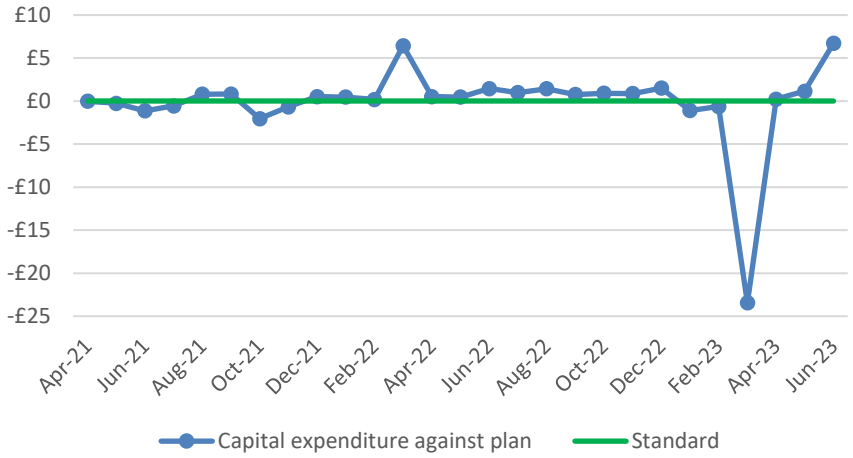
Impact/Timescale

- Financial position has been discussed at Executive team and with General Managers of recent weeks with further discussions planned in July.
- Over Q1 we have enhanced our financial governance through establishment of finance focussed Divisional Performance Reviews and Divisional governance structures are being strengthened to include Divisional Finance Committees.
- Current Trust forecast is aligned to the planned breakeven position.

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Capital expenditure against Plan (£m)	£0.00m	✗ £0.23	✗ £1.15	✗ £6.71	✗ £8.09	✗ £8.09

Sherwood Forest Hospitals
NHS Foundation Trust

Capital expenditure against plan



Standard & overview

- Standard is the plan
- Significant variance to plan due to the phasing of EPR and Mansfield CDC.
- Plan requires capital borrowing support of £6.49m, which presents a risk to the forecast expenditure if not approved, due to cash position of the Trust

Root causes	Actions	Impact/Timescale
Variance is primarily being driven by CDC and EPR.	• Discussion are ongoing with NHSE/ICB to reprofile the expenditure and associated borrowing relating to CDC and EPR. • Capital leads reforecasting planned expenditure profile for 2023/24. • Monthly monitoring via Capital Resources Oversight Group. • Capital loan currently being prepared to be submitted beginning of August.	Risk to capital plan delivery and cash until capital borrowing confirmed. If rejected would require capital spend to be halted in year, due to availability of funds. If EPR and CDC reprofiling across years is not agreed, would create significant risk and pressure in ensuring utilisation in 2023/24.

Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	2023/24 YTD
Agency expenditure against Plan (£m)	≥£0.00m	✓ £0.02	✗ -£0.32	✗ -£0.16	✗ -£0.46	✗ -£0.46

Sherwood Forest Hospitals
NHS Foundation Trust

Standard & overview

- The standard is the planned agency spend
- The Trust has reported agency expenditure of £4.64m or Q1, this is £0.46m adverse to the planned spend of £4.18m

Root causes

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

Actions

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

Impact/Timescale

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

Board Assurance Framework (BAF): July 2023

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

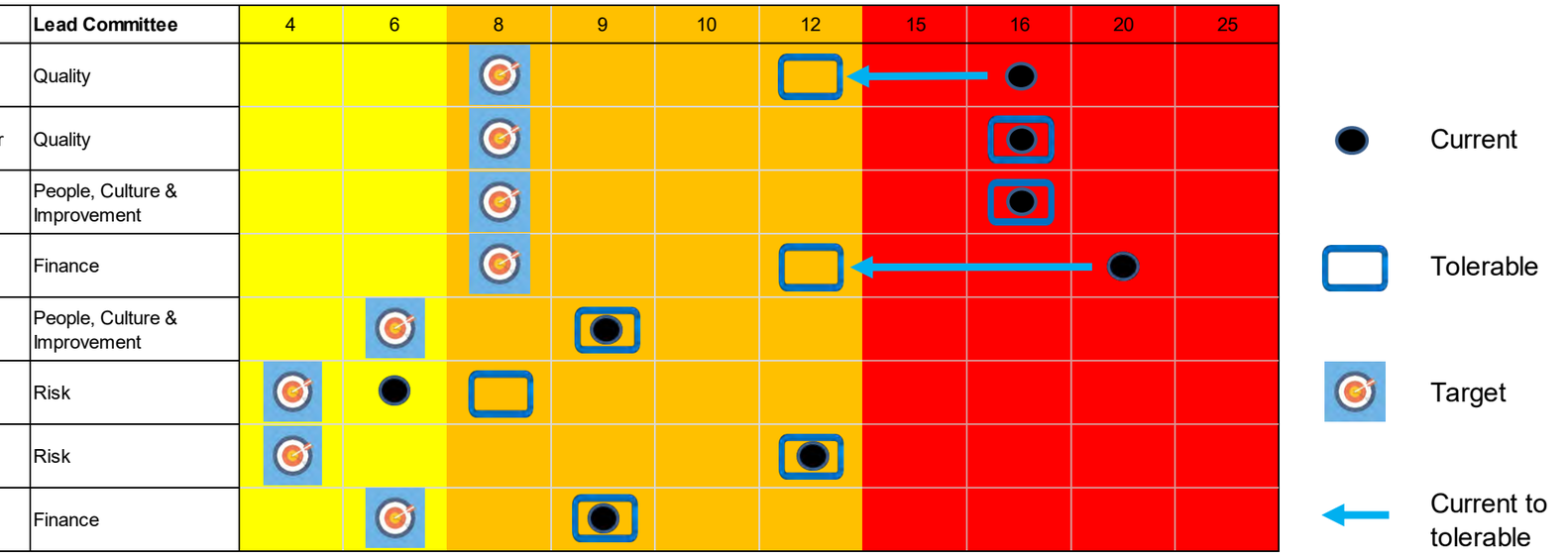
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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

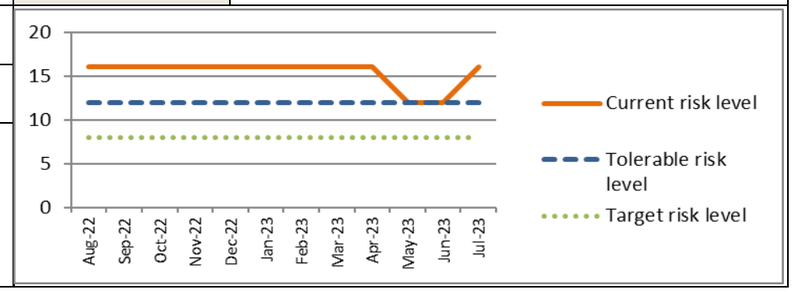
Likelihood score and descriptor					
	Very unlikely 1	**Unlikely 2**	**Possible 3**	**Somewhat likely 4**	**Very likely 5**
Frequency How often might/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally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

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

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



Board Assurance Framework (BAF): July 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes							**Strategic objective**	1. To provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Lead director	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	~~3. Possible~~4. High	3. Possible	2. Unlikely				
Last reviewed	20/07/2023	**Risk rating**	~~12. High~~16. Significant	**12. High**	**8. Medium**				
Last changed	20/07/2023								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to maintain patient safety and quality of care leading to increased incidence of avoidable harm and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ ~~Review, oversight and learning from patient safety incidents~~ ▪ ~~Scoping and sign-off process for incidents and SIs~~ ▪ Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC ~~Bi-monthly~~ 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	Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care Difficulty in maintaining the safety of our existing in-patients during prolonged periods of industrial action Inability to re-provide MDT or appointments in a timely way impacting on cancer pathway metrics and overall patient care	Review of informatics function and development of informatics strategy **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~Complete –~~March 2024 Progress: business case ~~submitted, currently un~~supported and progressing with recruitment Oversee the ePMA project board to resolve identified issues with eTTOs, critical medicines and allergy documentation **SLT Lead:** Medical Director **Timescale:** September 2023	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board qrtly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports **Risk and compliance:** Quality Dashboard and SOF to PSC Monthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC bi-monthly; Significant Risk Report to RC monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)	Unmitigated risk associated with the continuation and escalation of industrial action, the lack of progress towards a negotiated solution and the impact across professional groups who inevitably step up to provide cover in service gaps	Positive No change since April 2020

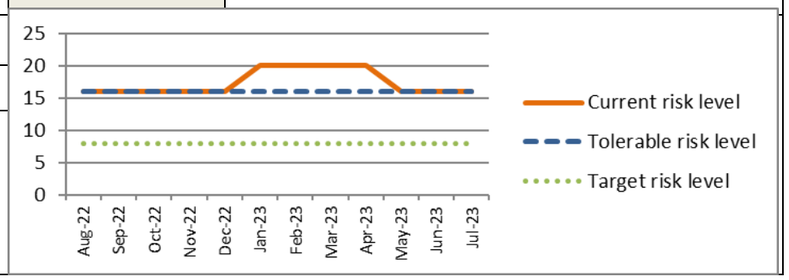
Board Assurance Framework (BAF): July 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Public communications re: norovirus and infectious diseases ▪ Coronavirus identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions ▪ Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements			**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; CQC Maternity Review Dec 22		Positive Last changed November 2022

Board Assurance Framework (BAF): July 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	4. Somewhat likely	2. Unlikely		
Last reviewed	20/07/2023	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**		
Last changed	20/07/2023						

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

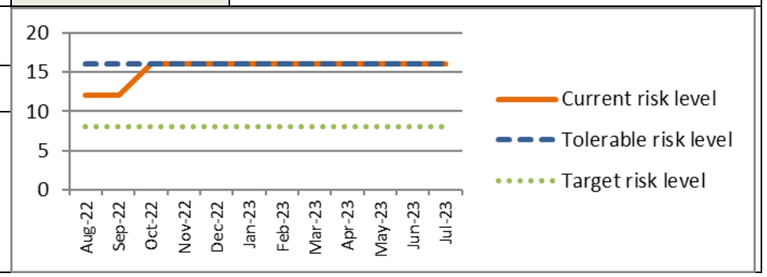


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • Further waves of admissions driven by Covid-19, Flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ SFH Same Day Emergency Care service in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care – regular meetings with NEMS ▪ Trust and System escalation policies and processes, including Full Capacity Protocol and Pandemic Surge Plan ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Inter-professional standards across the Trust to ensure we complete today's work today e.g. turnaround times such as diagnostics are completed within 1 day ▪ SFH annual capacity plan with specific focus on the Winter period ▪ Patient pathways, some of which are joint with NUH ▪ Referral management systems shared between primary and secondary care ▪ Optimising Patient Journey Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Elective Steering Group to steer the recovery of elective waiting times ▪ Emergency Steering Group to steer improvement across the emergency pathway ▪ Winter Planning group ▪ ~~Incident Control Team~~	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions e.g. reducing elective operating, bedding patients in alternative areas i.e. daycase	Develop delivery plans with system partners ~~for the 4 areas of focus to mitigate demand pressures~~ under the oversight of the ICS Plan Delivery Group **SLT Lead:** Chief Operating Officer **Timescale:** July 2023 Planning documents for 23/24 to identify clear demand and capacity gaps/bridges to be presented to Board in September and October 2023 **SLT Lead:** Chief Operating Officer **Timescale:** October 2023	**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; ~~Winter Plan considered by Board in Oct 22; Planning documents for 23/24 to identify clear demand and capacity gaps/bridges;~~ Waiting list update to TMT as required ~~; Super Surge Plan considered by Board in Feb 22;~~ Bed model outcomes to Exec Team Feb 23 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; ~~Single Oversight Framework Integrated Monthly~~ Integrated Performance Report including national rankings to Board **Independent assurance:** Performance Management Framework internal audit report Jun 22		Positive Last changed December 2020
Reductions in availability of hospital bed capacity caused by increasing 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 ▪ ~~Opening~~ Use of additional beds ▪ ~~Sherwood Care Home transferred to MCH Apr 23~~ ▪ Mansfield Community Hospital ~~Nov 22~~ (3 wards) ▪ Use of Ashmere	Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 22	Delivery of ICS Discharge to Assess Business Case **SLT Lead:** Chief Operating Officer **Timescale:** throughout 23/24 Virtual ward programme implementation **SLT Lead:** Chief Operating Officer **Timescale:** expanding throughout 23/24	**Management:** Daily and weekly themed reporting of the number of MFFD patients in hospital beds. Reports into the system CEOs group; ICS UEC Delivery Board and ICS Demand and Capacity Group **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the ~~SOF~~Integrated Performance Report	~~Further refinements to MFFD reporting to ensure a single and shared version of the truth within the Trust and between system partners~~ **SLT Lead:** Chief Operating Officer **Timescale:** ~~Continual review and improvement to June 2023~~Complete	Inconclusive No change since threat added in January 2022

Board Assurance Framework (BAF): July 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly Chief Officer calls across ICS, including Primary Care ▪ ~~Mid Notts ICP represented at weekly Incident Control Team meeting~~			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand	Lack of visibility in primary care demand and capacity **Action:** Continue to push via ICS UEC Delivery Board and ICS Demand and Capacity Group the importance of system-wide oversight of demand and capacity **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development. ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors			**Risk and compliance:** NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area **Action:** Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Positive Last changed November 2022
Growth in demand for care in our maternity services (population growth and increase in out of area referrals)	▪ Over-established midwifery by 10% from 2021/22 ▪ Additional antenatal clinics based on overtime/bank ▪ ~~Recruited additional consultants (12 in 2020 to 14 at time of writing)~~ ▪ Maternity assurance group (monthly) ▪ Director of Midwifery providing Board-level oversight	Midwifery staffing vacancies (gap of 5.6% WTE against establishment) No increase in junior medical staffing Nursing gaps in neonatal unit No standalone junior out-of-hours on-call for neonatal (as per critical care review) Physical capacity/estate will be insufficient should growth trends continue in the coming years	Maternity and Neonatal service review document in development **SLT Lead:** Chief Operating Officer **Timescale:** Q~~1~~2 23/24	**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings) **Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)		Positive New threat added January 2023

Board Assurance Framework (BAF): July 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care							**Strategic objective**	3. Create an environment for all our colleagues to thrive
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	4. Somewhat likely	2. Unlikely				
Last reviewed	25/07/2023	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**				
Last changed	25/07/2023								

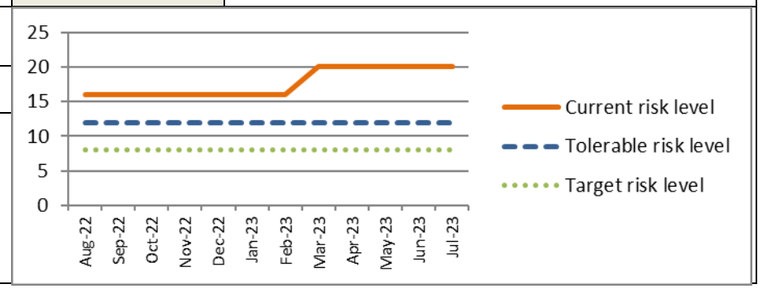
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff due to market factors, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Activity, Workforce and Financial plan ▪ 5-year strategic workforce plan supported by associated Tactical People Plans ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of Consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Communication of daily SitReps (Situation Reports) for workforce gaps	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, which may impact on the quality and standard of care Lack of consistency across the system with regard to recruitment and retention, creating competition and not maximising opportunities	Deliver the People, Culture and Improvement Strategy – Year 2 **SLT Lead:** Director of People **Timescale:** March 2024 Work with the Chief People Officer to form a provider collaborative forum for recruitment and retention **SLT Lead:** Director of People **Progress:** Retention Lead post recruited to at ICB, and provider collaborate workforce programmes being worked up **Timescale**: ~~June~~November 2023	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to PCI Committee Jun 22; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to PCI Committee bi-monthly; Leadership Development Strategy Assurance Report to PCI Committee Jun 22 **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators to People Cabinet (Monthly) - Quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Pre-employment Checks internal audit report Feb 21 – significant assurance; HSJ Award for Acute Trust of the Year 2021; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr 21	Staff mental health issues as a result of psychological trauma Train Trauma Risk Management practitioners to provide psychological support following traumatic events **SLT Lead:** Deputy Director of People **Timescale:** August 2023	Positive Last changed June 2022

Board Assurance Framework (BAF): July 2023

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement, which could lead to a detremental impact on patients and service users	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Welbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users	Develop and embed staff network groups to address inequalities in staff inclusivity **SLT Lead**: Director of People **Timescale**: ~~June 2023~~Complete Undertake a review in accordance with the National Improvement Plan and highlight associated actions **SLT Lead**: Director of People **Timescale**: September 2023 Violence and Aggression Working Group to establish an action plan in related to the V&A agenda **SLT Lead:** Director of People **Timescale:** Oct 2023	**Management:** Staff Survey Action Plan to Board May 23; Staff Survey Annual Report to Board Apr 23; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board Sep 22; Quarterly Assurance reports on People Cabinet to People Culture and Improvement Committee; Wellbeing report to People, Culture and Improvement Committee Dec 22; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug22; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr23; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr22; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar23; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22	Potential impact of cost-of-living issues on staff morale and wellbeing Potential industrial action up to and including strike action from all NHS unions, affecting all system partners	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): July 2023

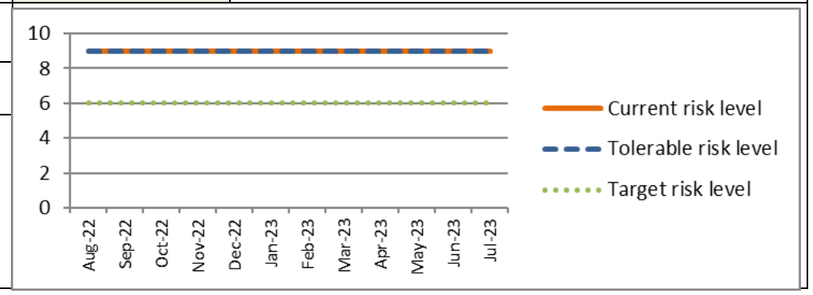
Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**	5. Sustainable use of resources and estate
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
Lead director	Chief Financial Officer	**Consequence**	4. High	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	5. Very likely	3. Possible	2. Unlikely				
Last reviewed	25/07/2023	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**				
Last changed	25/07/2023								



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ ~~Transformation and Efficiency Cabinet, FIP planning processes and PMO coordination of delivery~~Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ ~~COVID-19 related funding application process in place at Trust level~~ ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Capital Resources Oversight Group overseeing capital expenditure plans. ▪ Enhanced financial governance established, including bi-monthly finance-focussed Divisional Performance Review meetings. Divisional Finance Committees are also being established	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework Revenue business case process may not adequately represent the longer-term priorities and potential consequences of future years	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** 2023/24 financial plan in development Longer-term financial strategy to be finalised during 2023/24 as part of strategic priorities, in line with clinical and operational strategies **SLT Lead:** Chief Financial Officer **Timescale:** March 2024 Review and implement enhanced business case process for 2023/24 planning and in-year prioritisation **Progress:** Business case process for 2023/24 planning completed – process for in-year prioritisation post-planning to be confirmed; however limited resources mean that business cases are currently paused and managed through the risk management framework **SLT Lead:** Chief Financial Officer **Timescale:** ~~June 2023~~September 2023	**Management:** CFO's Financial Reports and Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ICS finance report to Finance Committee (monthly); Capital 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 ~~Transformation & Efficiency Cabinet updates to Executive Team~~ **Risk and compliance:** Risk Committee significant risk report Monthly **Independent assurance**: Deloitte audit of COVID-19 expenditure; External Audit Year-end Report ~~2021/22~~2022/23 Internal Audit reports: - Key Financial Systems - Asset Register Jan 22 - Improving NHS financial sustainability Dec 22		Positive Last changed July 2022
ICB system deficit results in a negative financial impact to the Trust	▪ Full participation in ICB planning ▪ SFH plan consistency with ICB and partner plans ▪ ICB DoFs Group ▪ ICB Operational Finance Directors Group ▪ ICB Financial Framework ▪ ICB Agency Reduction Group (Chaired by SFH CFO)	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **SLT Lead**: Chief Financial Officer **Timescale:** March 2024 (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board		Positive Last changed July 2022

Board Assurance Framework (BAF): July 2023

Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care							**Strategic objective**	4: To continuously learn and improve
Lead committee	People, Culture & Improvement	**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	25/07/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	25/07/2023								

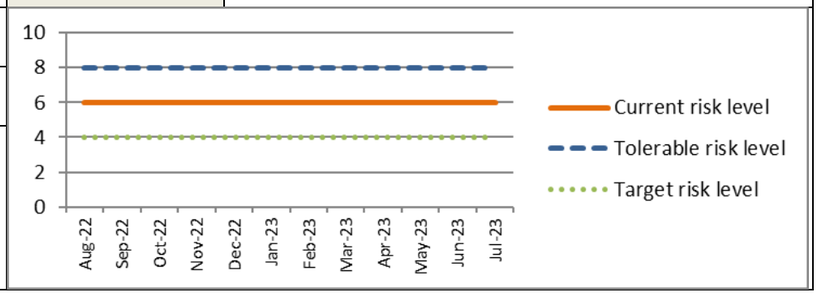


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform ▪ Improvement Faculty	The improvement function needs to be ~~defined and~~ organisationally embedded following the restructure	Development of an ideas platform within the remit of the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~June 2023~~Complete Structured programme of engagement and communications to be developed and delivered **SLT Lead:** Director of Strategy and Partnerships **Timescale:** September 2023	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** SOF Culture and Improvement indicators; SFH Trust Priorities to Board quarterly **Independent assurance:** Internal Audit of FIP/ QIPP processes Sep 21; 360 assessment in relation to Clinical Effectiveness - report May 2022`	Lack of capacity for colleagues to engage with improvement Consider ways to provide the capacity to progress improvement activity **SLT Lead:** Director of Strategy and Partnerships **Timescale:** ~~June 2023~~Complete ~~**Progress:** the transformation programme has now been designed and integrated with strategic priorities and FIP to reduce the number of things we ask the organisation to focus on and to make connections across multiple layers of our business. This will assist in a reduction of meetings and programme reviews. Thereby releasing headspace Improvement Faculty launched 4th May~~ Promote the training an ongoing support available to all colleagues via the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** September 2023	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): July 2023

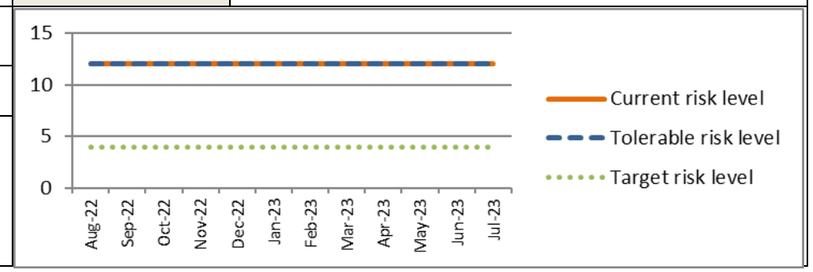
Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of Strategy and Partnerships	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely		
Last reviewed	11/07/2023	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**		
Last changed	11/07/2023						

Strategic objective	6. Work collaboratively with partners in the community



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP annual work plan • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSE • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans through the joint forward plan • Full alignment of organisational priorities with system planning • Independent chair for ICP • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative • ICS System Oversight Group • SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services (both formally established on 1st July 2022) • ~~Mid-Notts~~ New Place-based Partnership (PBP) leadership arrangements in place • PBP priorities and work plan agreed for 2023/24 • ~~Mid-Notts Place Executive~~New PBP executive providing oversight and leadership		A shadow provider collaborative executive team is due to meet in July and will be responsible for overseeing the work programme. This will provide a single responsible group with delivery accountability	**Management:** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board **Risk and compliance:** Significant Risk Report to RC monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities, which limits our ability to care for patients in the right place, at the right time	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ Clinical Directors and PCN Directors clinical partnership working ▪ A new health inequalities fund has been launched across the ICS targeting funding towards prevention activities	The needs of the population will not be fully understood or aligned to our clinical services until the ICS Clinical Services Strategy is implemented	Refreshed ICS Clinical Services Strategy led by the ICB Medical Director **SLT Lead:** Medical Director **Timescale:** September 2023 Desktop analysis of service lines is underway in preparation for meetings with clinical teams	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place		Positive Last changed October 2022

Board Assurance Framework (BAF): July 2023

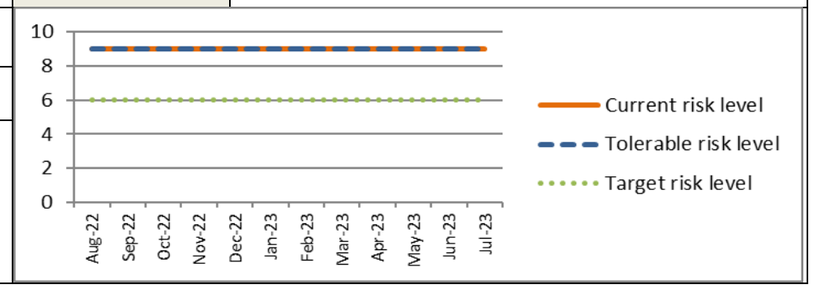
Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community							**Strategic objective**	1: To provide outstanding care in the best place at the right time
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**3. Possible**	3. Possible	1. Very unlikely				
Last reviewed	11/07/2023	**Risk rating**	**12. High**	**12. High**	**4. Low**				
Last changed	09/05/2023								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ Cyber news – circulated to all NHIS partners ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead	Systems connected to the network are not all supported by the respective software suppliers, so are not receiving the latest security updates	Ensure all systems have support in place, or the cyber risk is assessed and appropriately mitigated **SLT Lead:** Chief Digital Information Officer **Timescale:** May 2023	**Management:** Data Security and Protection Toolkit submission to Board Jul 22- compliant on 108/109 elements; Hygiene Report to Cyber Security Board monthly; Cyber Security Assurance Highlight Report to Cyber Security Board monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine **Risk and compliance:** **Independent assurance**: ISO 27001 Information Security Management Certification; TIAN / 360 Assurance Cyber Security Survey - The impact of Covid-19 on the NHS Dec 20; CCG Cyber Security Report Mar 21- Significant Assurance; 360 Assurance NHIS Governance and Interface audit – limited assurance; 360 Assurance Data Security and Protection Toolkit audit Jul 22 –moderate assurance; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan 22		Inconclusive Last changed February 2023
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Water Safety Update Report to Risk Committee Jul 20; Patient Safety Concerns report to QC March 21; Hard and soft FM assurance reports **Risk and compliance:** Monthly Significant Risks Report to Risk Committee **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct22) – Substantial Assurance; Water Safety report (WSP) to Joint Liaison Committee Oct 19; WSP report – hard FM independent audit; MEMD ISO 9001:2015 Recertification Mar 21; British Standards Institute MEMD Assessment Report Feb 22		Positive Last changed March 2023

Board Assurance Framework (BAF): July 2023

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

Board Assurance Framework (BAF): July 2023

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

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

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date**: 3rd August 2023	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Paul Robinson, Chief Executive		

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

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

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

Committees/groups where this item has been presented before

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

Acronyms

See below

Executive Summary

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

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

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

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

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

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

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

Schedule of BAF reviews since last received by the Board of Directors on 1st June:

- Quality Committee: PR1 and PR2 – July
- People, Culture and Improvement Committee: July
- Finance Committee: PR4 and PR8 – July
- Risk Committee: PR6 and PR7 – June and July

PR1, PR2, PR3 and PR4 remain significant risks; PR1 and PR4 are above their tolerable risk ratings.

The risk score for PR1 was recently increased following a lengthy and difficult discussion about uncertainty around the ongoing industrial action.

At the June Risk Committee meeting a reduction in the current likelihood score (to 2) for PR6 was considered, but it was decided not to reduce the score due to the lack of clarity of the benefits.

Board members are requested to:

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

Acronyms used in the Board Assurance Framework

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

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

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Public - Cover Sheet

Subject:	Application of Trust Seal	**Date**: 3rd August 2023	
Prepared By:	Laura Webster, Corporate Secretariat Team Leader		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		
Purpose			
This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal, ensuring transparency and accountability in its application.		**Approval**	
		Assurance	X
		Update	
		Consider	

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

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

Committees/groups where this item has been presented before

N/A

Acronyms

None

Executive Summary

In accordance with Standing Order 10 and the delegated authority in the Scheme of Delegation, the Sherwood Forest Hospitals (NHS) Foundation Trust Official Seal has been affixed to the following documents:

Seal number 104

Between:
Sherwood Forest Hospitals NHS FT and Nottinghamshire Hospitals Plc ("Project Co")

Details of the contact:
Nottingham Hospitals PFI Project – Indemnity Letter Trust Works Variation Enquiry TVE0685 (Discharge Lounge). Arrangements for the conversion of Old Ward 3 o create a new Discharge Lounge to be delivered at King's Mill Hospital.

Signed/Sealed by the Chief Financial Officer and the Director of Corporate Affairs
Dated: 7th July 2023

Seal number 105

Between:

Sherwood Forest Hospitals NHS FT and Nottinghamshire Hospitals Plc ("Project Co")

Details of the contact:

Nottingham Hospitals PFI Project – Indemnity Letter Trust Works Variation Enquiry TVE0683A (Newark TIF Project). Arrangements for a modular laminar flow theatre and internal repurposing and reconfiguration of Theatre Spaces to be delivered at Newark General Hospital.

Signed/Sealed by the Chief Financial Officer and the Director of Corporate Affairs
Dated: 7th July 2023

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

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	External Well-Led Review – Recommendations, Progress Report	**Date:** 3rd August 2023	
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

The purpose of this paper is for the Board to receive assurance about progress towards meeting the recommendations identified in the final report from the Grant Thornton Well Led Review conducted in March 2022	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Executive Team

Acronyms

Executive Summary

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

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

The initial report detailing the 15 recommendations was presented to Board in April 2022 with further updates in August 2022 and February 2023.

This report provides progress against those recommendations, noting 13 are complete (an increase of two since the last report) and two remain outstanding (Actions 13 and 15). A progress report on each is provided below with both, requiring discussion and agreement by the Board.

Board of Directors Meeting in Public

Subject: External Well-led Review – Recommendations, Progress Report
Date: 27th July 2023
Author: Sally Brook Shanahan, Director of Corporate Affairs

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

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

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

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

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

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

This report provides progress against those recommendations, noting 13 are complete and two remain outstanding. Progress reports are provided for the two which remain outstanding (Recommendations 13 and 15):

Recommendation 13: **Data Quality Strategy**

The recommendation noted the Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG).

However, the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore, the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed.

The Trust is currently in the process of moving to a more integrated approach, where data quality is owned and monitored across the wider governance structure.

It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework, but this process is not yet fully documented, and roles and responsibilities need to be clarified.

It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed.

The Review recommended that once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.

Progress update July 2023:

The Patient Information and Data Assurance Group (PIDAG) is in place. The Chief Digital Information Officer is chairing. That enables the detailed work that is necessary in the field of data quality. Bringing the various teams together under the digital structure is also enabling closer working and a focus on data standards, quality, and completeness. All developments or configuration changes will be reviewed by PIDAG. The appointment of a Head of Information Services will provide professional oversight to this area going forward.

Recommendation 15: **Continuous Improvement**

The recommendation noted **t**he Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this.

The Review recommended Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use.
Outcomes of quality improvement projects should be celebrated through the Trust's services.

Progress update July 2023:

The Q1 (2023/24) ambition was to deliver a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and/or transformation. The Improvement Faculty launched as planned on 4th May 2023 and has brought together a number of existing teams, including the Improvement Team, Transformation Team and PMO to create a centre of excellence.
The Faculty's work plan is based on the following four pillars:
a. Pillar 1 - Improving Capability, Engagement and Culture – Building 'The Sherwood Way'
b. Pillar 2 - Evaluating New Ideas and Providing Solutions
c. Pillar 3 - Programme and Project Delivery
d. Pillar 4 - Programme Monitoring, Evaluation and Assurance
There are several large-scale transformation programmes for which the Faculty are providing coordinated support (Pillar 3). These include the Optimising Patient Journey (OPJ) Programme, Planned Care Programme (including Theatres, Outpatients and Diagnostics), a series of Workforce Programmes, several Capital Programmes and a number of Financial Improvement Programmes.

All large-scale transformation programmes have robust governance arrangements in place, have completed PIDs and identified senior leadership in place.

The remaining pillars are under development and will continue to be shaped and delivered during Q2 including strengthening the organisation's vision for improvement and developing in line with NHS Impact (national improvement direction) across ICS partners.

Development of the Improvement and Innovation strategy, as an enabler to the Trust strategy, will fully implement and embed the recommendation.

Recommendation

The Board is asked to note the progress updates about Recommendations 13 and 15 and that further assurance is required before their closure. This will be provided in the next update due in February 2024.

No.	Risk	Recommendation	Action	Lead		Timeline
KLOE 1. – Is there the leadership capacity and capability to deliver high quality, sustainable care?						
1	**Medium**	**Internal v external priorities** The Director of Human Resources is a joint post with Nottinghamshire Healthcare NHS Foundation Trust. However, due to the way the portfolio of work is arranged and the existence of a strong deputy this appears to and is reported to work well. The Director of HR is also prominent in the Integrated Care System (ICS) leading the people agenda and this workload needs to be regularly reviewed to ensure it remains manageable. **Recommendation:** As external priorities become more apparent in the establishment of the ICS a watching brief should be reviewed to ensure executives continue to have sufficient bandwidth to undertake their portfolio of work.	All joint posts with Nottinghamshire Healthcare have ceased **Complete**	Chief Executive Officer	**Complete**	June 2022
2	**Low**	**Succession planning** The Trust had undertaken a formal succession planning exercise for its executive roles in 2019, and this is best practice. It is important to refresh this periodically and this	A report will be presented to the Nomination and Remuneration Committee **Progress update:** Draft report presented to	Chief Executive Officer	**Complete**	September 2022

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

		existing NEDs who have missed the opportunities to undertake face to face activities				
KLOE 2 – is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?						
4	**Low**	**Quality Strategy** A new Quality Strategy is in development. A working draft version was presented at the November 2021 Quality Committee. The new strategy will run from 2022-2025 and has four campaigns on delivery quality care: 1. Create a positive practice environment to support the delivery of safest and most effective care 2. Excellent patient experience for users and the wider community 3. Strengthen and sustain a culture of continuous quality improvement and learning 4. Deliver high quality care through kindness and supporting each other It is not clear however how the third campaign links to the improvement techniques and training that are currently being rolled out in the Trust and this should be made more explicit **Recommendation** The Quality Strategy should more explicitly document the quality	Updated Quality Strategy approved by Quality Committee in September 2022, to include quality improvement methodology and linkages to the People, Culture and Improvement Strategy. Indicators provided in the Advancing Quality Programme will track delivery of the strategy	Chief Nurse	**Complete**	September 2022

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

		FTSU Champion role and this may encourage medical staff to speak up if they have concerns. The FTSU Guardian does not meet with the Guardian of Safe Working Hours and this would be a useful link. **Recommendation:** The FTSU Guarding should arrange to meet periodically with the Guardian of Safe Working Hours as there are linkages with these roles.				
7.	**Low**	**Awareness of detriment** It is important to ensure that people do not suffer detriment as a result of speaking up. Currently, following the closure of a case, the FTSU Guardian sends out a short four question email to staff who have raised concerns, however the response rate is low and the questions do not adequately assess if there has been any detriment. **Recommendation:** The FTSU Guardian should formalise a process to contact staff who have raised concerns three to six months following closure of the case to discuss how they are and if they have suffered detriment as a result of speaking up	A formal process to contact staff who have raised concerns to ascertain if they have suffered detriment has been developed and implemented **Complete**	Director of Corporate Affairs	**Complete**	June 2022

8.	**Low**	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation:** The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.	**Progress update July 2023**: At its meeting on 2nd February 2023 the Board of Directors agreed this recommendation could be closed, and requested a review take place in 6 months' time to ensure the data is monitored. A report will be brought to the October 2023 Board.	Director of Corporate Affairs and Executive Medical Director	**Complete**	September 2022
KLOE 4 – Are there clear responsibilities, roles and systems of accountability to support good governance and management?						
9.	**Low**	**Highlight report to the Board of Directors** There is variance in the quality of reporting the work of the Committees to the Board. A more common approach using a quadrant style reporting could more effectively identify key issues and action taken. **Recommendation:** Committee Chairs should consider	A quadrant template has been developed and has been implemented from April Committees. **Complete**	Director of Corporate Affairs	**Complete**	June 2022

		the use of a quadrant style report to present at the Board meeting. Headings of the 4 quadrants are commonly: • Matters of concern or key risks to escalate • Major actions commissioned / work underway • Positive assurances to provide • Decisions made				
10.	**Low**	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation:** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.	Committee Chairs have observed all key meetings which feed into their committee	Director of Corporate Affairs	**Complete**	September 2022
11.	**Low**	**People, Culture and Improvement Committee** The Chair of the Committee does not routinely meet with the Lead Executive for this Committee, more ad-hoc arrangements occur. Setting up a scheduled arrangement would	A schedule of regular meetings prior to committee meeting will be developed and implemented **Complete**	Director of People	**Complete**	June 2022

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

		All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.				
	KLOE 6 – Is appropriate and accurate information being effectively processed, challenged and acted on					
13.	**Medium**	**Data Quality Strategy** The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However, the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore, the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. The Trust is currently in the process of moving to a more integrated approach, where data quality is owned and monitored across the wider governance structure. It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework, but this process is not yet fully documented, and roles and	**Progress update July 2023:** The Patient Information and Data Assurance Group (PIDAG) is in place. The Chief Digital Information Officer is chairing. That enables the detailed work that is necessary in the field of data quality. Bringing the various teams together under the digital structure is also enabling closer working and a focus on data standards, quality, and completeness. All developments or configuration changes will be reviewed by PIDAG. The appointment of a Head of Information Services will provide professional oversight to this area going forward.	Executive Medical Director		December 2022

		responsibilities need to be clarified. It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed. **Recommendation :** Once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.				
14.	**Low**	**Data Quality Assurance Indicators** The Trust does not at present utilise a Data Quality Assurance Indicator. A data quality traffic light or kite mark could be used to appear next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based. **Recommendation:**	**Progress update July 2023:** We recognise the importance of providing assurance on the quality of data and highlighting potential risks. Identifying appropriate kite marks would involve a full review of each key performance indicator with engagement from operational and clinical colleagues, focusing on the four domains:	Director of Corporate Affairs	**On-Going**	On-Going

		The Trust should consider the use of Data Quality Assurance Indicators to inform users of any data quality risks attached to the data that might impact decision making.	timeliness, completeness, validity, process. Once set up there would be an ongoing requirement to review regularly to ensure any changes in data quality and risks are reflected.			
	KLOE 7. – Are people who use services, the public, staff and external partner engaged and involved to support high quality sustainable services?					
	We have not made any recommendations in this area as the Trust is already working on issues identified.					
	KLOE 8. – Are there robust systems and processes for learning, continuous improvement and innovation?					
15.	**Medium**	**Continuous Improvement** The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff	**Progress update July 2023** The Q1 (2023/24) ambition was to deliver a centrally located, single point of contact for all colleagues and teams seeking help and advice on any aspect of improvement, change management and/or transformation. The Improvement Faculty launched as planned on 4th May 2023 and has brought together a number of existing teams, including the Improvement Team, Transformation Team and PMO to create a centre of excellence.	Director of Strategy and Partnerships	**On-Going**	September 2022

		not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation:** Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.	The Faculty's work plan is based on the following four pillars: a. Pillar 1 - Improving Capability, Engagement and Culture – Building 'The Sherwood Way' b. Pillar 2 - Evaluating New Ideas and Providing Solutions c. Pillar 3 - Programme and Project Delivery d. Pillar 4 - Programme Monitoring, Evaluation and Assurance There are several large-scale transformation programmes for which the Faculty are providing coordinated support (Pillar 3). These include the Optimising Patient Journey (OPJ) Programme, Planned Care Programme (including Theatres, Outpatients and Diagnostics), a series of Workforce Programmes, several Capital Programmes and a number of Financial Improvement Programmes. All large-scale transformation			

			programmes have robust governance arrangements in place, have completed PIDs and identified senior leadership in place. The remaining pillars are under development and will continue to be shaped and delivered during Q2 including strengthening the organisation's vision for improvement and developing in line with NHS Impact (national improvement direction) across ICS partners. Development of the Improvement and Innovation strategy, as an enabler to the Trust strategy, will fully implement and embed the recommendation.			

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

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

Purpose		
To update the Board on our progress as maternity and Neonatal Safety Champions.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

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

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

Committees/groups where this item has been presented before

- Nursing and Midwifery AHP Committee 27/06/2023
- Maternity Assurance Committee 27/07/2023

Acronyms

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

Executive Summary

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

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

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

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

1.Service User Voice

July has seen the start of our new Maternity Voice Champion (MVP) volunteer Emma. As part of the "*Walk the Patch*" this month, Emma had her orientation to Acute Maternity areas. To support the ongoing work around the experience of birthing people undergoing an elective caesarean section, Emma spent time obtaining feedback from birthing people who have used this service.

Emma spoke with five women in total, the positives they shared about their care were as below;

> Very happy with care. Felt preparation was good. Happy the day of the caesarean was confirmed and kept.
>
> Really positive. Very impressed with support from midwife.
>
> Happy with support and care. Feels everything is being done that can be.
>
> Positive about all care. Had understood everything that was happening and happy with everything.
>
> Very happy with care. Felt everything went well and to plan.

Emma also explored what we could have done to make the experience better, as detailed below. The below themed points around communication and timing of discharge will be actioned through the Postnatal Forum.

> Two previous experiences of delay in discharge and worried this might happen again.
>
> Partner was not able to stay and wasn't aware that this was the case as had previously been in a side room so had partner stay with last baby.
>
> Awaiting discharge but unsure when that will be.
>
> Wasn't aware of changes to visiting and thought it was only 2 visitors. (ward manager spoke to women to explain visiting immediately following the feedback)
>
> Wasn't aware when discharge would be.

2.Staff Engagement

The planned MNSC walk round happened on the 4th of July visiting the Neonatal Unit, Sherwood Birthing Unit and the Maternity Ward. We were joined this month by our new Divisional General Manager, Matthew Warrilow, this month. Staff reported that activity was high although the staffing levels supported this. We spoke further to staff about the recent Digital walk round and the issues flagged by the team and what the Digital Transformation Unit are doing to address these.

The Maternity Forum ran on the 3rd of July 2023, with colleagues joining from all areas across the division. Staff were looking forward to the upcoming Staff Excellence Awards (5th of July) as many across the Division had received nominations. The team were updated on the up-and-coming plans for the noted increased in maternity leave and how the Senior Leadership Team had plans in place to support this. An update was also provided into the progress of the Entonox Report, in that

a Trust Wide Task and Finish Group had been set up to support the response and that an email explain the report and actions would be sent to all staff soon.

3. Governance Summary

Three Year Maternity and Neonatal Plan:

Further to the previous updates, the governance team have met with colleagues from the LMNS to look at the approach to the below priorities, with a request that each site now looks at their data/ information as to how these will be prioritised.

1.Embedding the voice of women, birthing people and families – and ensuring key learning from service users is the main driver in transforming our maternity and neonatal services. This includes but is not limited to development of MVP and NVP

2. Equity as the lens through which we view all areas of the LMNS – ensuring equity across our services and local population, with a focus on experience as well as outcomes, looking at localized data for Nottingham and Nottinghamshire.

Ockenden:

We have started the preparations for the planned Ockenden Oversight visit for October 2023, the team are continuing to collate the evidence to support the embedding of the 7IEA's. This report is viewed at the MNSC quarterly.

NHSE have confirmed that the system is not required to report compliance against Ockenden II. However, NHSE have suggested local Trust actions plans are developed and progressed to deliver the IEAs set out in Ockenden II. SFH completed this work and have been advised to review their delivery plans.

NHSR:

The NHSR Year 5 task and finish group is underway, with the named safety action leads meeting fortnightly. A mapping exercise has been undertaken to plan the evidence review through the extended Maternity Assurance Committee meeting in Q3 prior to the final submission in February 2024. This fortnightly meeting produces a flash report which is cited through MNSC, MAC and onwards to Quality Committee.

Saving Babies Lives:

NHSE visited the Trust on the 26th of June to film the work of the Tobacco Dependency Team, our early implementer site for the NHS LTP maternity model. They filmed staff and a family as part of the national launch for Saving Babies Lives care bundle v3 as a good case example.

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle (SBLCB) v2. On-going progress is reported externally quarterly to NHSE via the Midlands Maternity Clinical Network. Discussed at MNSC and shared as part of the reading room is the monthly data for the SBLCB taken from Badgernet, which is showing an improving position and is being used for governance papers through division.

CQC:

Following the "Good" rating from the planned 3-day visit from the Care Quality Commission (CQC) an action plan has bee approved by the Quality Committee on the 13th of April 2023 and the two

"Must do" actions are progressing. The progress of these and the commencing of the "Should do" actions will be discussed through Maternity Assurance Committee.

The "must do" action for mandatory training has been completed for the training year 2022/23. For the training year 2023-24 the completion rate remains at 91.8%, above the Trust target.

The second "Must do" relates to triage, which live re-launched on the 5th of June, work continues to embed this change.

4. Quality Improvement

As part of the national Maternity and Neonatal Safety Improvement Programme work and outlined in previous papers, we have had a drive around specific target areas. An update shared through the safety champions meeting is the early breast milk data for July, which showed an improvement with 87.5% of babies born before 34 weeks receiving breast milk within 24 hours of birth (previous rates outlined remained around 30%). This has been achieved through the below actions and will be monitored through the MNSC.

Discuss colostrum collecting with anyone with a chance of preterm birth in ANC, PDC and Community

Offer colostrum packs to parent in the IOL suite or on the ward

Facilitate hand expressing within 2 hours of birth on SBU

Ensure packs are readily made up

5.Safety Culture

We now commenced the first wave of the culture survey; the survey is live and we are awaiting the results. Plans are in place for the debriefing element.

In addition to this the Division Quadrumvirate are also booked onto the Perinatal Culture and Leadership 'Quad' Programme in Q3 this year. This initial introductory meeting has occurred, and we are in a strong position, given the current culture work and plans as these feature as part of the programme.

Appendix One

NHSR Maternity Incentive Scheme year 5 – Flash Report @ 10/07/2023

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Reporting to: Divisional Triumvirate Meeting / Maternity Assurance Committee / Service Line	Operational Lead: Samantha Cole
Report Date: 10th July 2023	Clinical Leads: Paula Shore / Srini Vindla
Completed by: Samantha Cole	DGM: Matt Warrilow

Key Actions Completed

- Safety action leads and teams established
- All initial meetings held working through guidance and identifying any gaps / concerns
- Futures platform created and evidence folders created
- Safety action compliance tracker shared with MAC 28th June 2023 and at Safety Champions on 4th July 2023
- First fortnightly drop in session with leads held 6th July 2023
- Requested clarification on safety action 3 regarding babies to include part c
- Requested clarification on safety action 10 to confirm HSIB / MNSI / CQC are one entity
- Agreed MAC dates to go through evidence for each safety action
- Extended MAC sessions

NHSR Maternity Incentive Scheme Compliance Tracker

SA	Safety Action Name	Safety Action ask	SA Teams	Tracking RAG Rating position by month: May 23	Jun 23	Jul 23	Aug 23	Sep 23	Oct 23	Nov 23	Dec 23
1	Perinatal Mortality	Are you using the National Perinatal Mortality Review tool to review perinatal deaths to the required standard?	[illegible]								
2	MSDS	Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	[illegible]								
3	Transitional care services	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	[illegible]								
4	Clinical Workforce	Can you demonstrate an effective system of clinical workforce planning to the required standard?	[illegible]								
5	Midwifery Workforce	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	[illegible]								
6	Saving Babies Lives	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies Lives Care Bundle Version Three?	[illegible]								
7	Listening & coproduction	Listen to women, parents and families using Maternity and Neonatal services and coproduce services with users	[illegible]								
8	Training	Can you evidence the following 3 elements [illegible] local training plans and 'in house', one day multi professional training?	[illegible]								
9	Board Assurance	Can you demonstrate that there are robust processes in place to provide assurance to the Board on Maternity and Neonatal safety and quality issues?	Paula Shore								
10	HSIB/NHSR Early notification	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) scheme?	[illegible]								

Next actions to be completed

General

- Safety action leads to arrange separate meetings with teams to start evidence collection / planning / setting actions to progress
- Review of futures interaction and evidence gathering at each fortnightly catch up

Safety Action specific

- SA1 – SC to add deadline dates/RAG within PMRT tracker on each timeframes to aid timely data collection
- SA2 – Team to do a 'dummy' run checking CQIMs / ethnic category collection following July's MSDS submission to highlight any potential DQ issues that can be addressed in advance of Octobers submission
- SA3 – Team to work on an action plan to implement TC Pathway to go to MAC August/Sept, also reviewing policies
- SA4 – SC to be given access to CLW rota to evidence adherence to Anaesthetic medical workforce. Sc to contact SR regarding Neonatal workforce evidence
- SA5 – LB to look at plan to address the findings of the table top exercise of BirthRate+
- SA6 – SS to request that RN ensures that the SBLCBv3 national tracker wording matches to NHSR ask
- SA7 – SC to contact MVNP for evidence relating to establishment, infrastructure and funding.
- SA8 – SC to upload TNA plans to futures. Team to work through local training plan for implementation of V2 of core competency framework. Plan for adhoc emergency scenario to be conducted
- SA9 – PS to gain evidence that non-exec and exec safety champions have registered on dedicated Futures workspace by 1st August 2023 (was 1st July 2023 in original guidance)
- SA10 – SS to prepare templates to collect qualifying cases

Maternity Perinatal Quality Surveillance model for August 2023

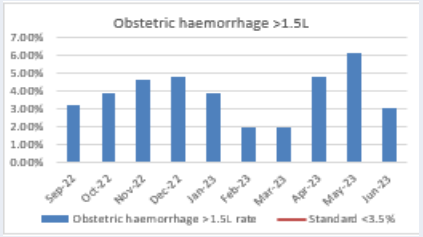
CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

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 3.1%)

- Decrease in cases from previous months, thematic review of cases ongoing.



Elective Care

Elective Caesarean (EL LSCS)

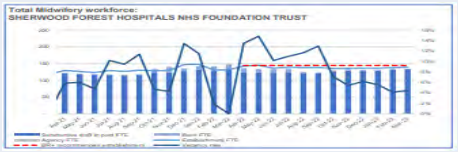
- Work continues around variation.
- Service user feedback obtained

Induction of Labour (IOL)

- IOL, delays improved lead band 6 commenced to support the MDT meetings and exploration of outpatient IOL

Midwifery Workforce

- Current vacancy rate 4.2% (blue line), recruited into -expected start dates in Sept 23
- Risk due to high number of expected Maternity Leave-paper for People Committee prepared.



Staffing red flags (Jun 2023)

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

Suspension of Maternity Services

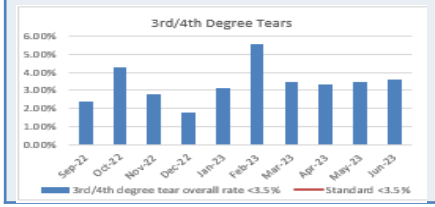
- 1 suspension of services during June

Home Birth Service

- 33 Homebirth conducted since re-launch
- Potential risk to service outlined within the paper going to People Committee

Third and Fourth Degree Tears (Jun 3.6%)

- Slight percentage increase in June
- New Perinatal Pelvic Health Service formed, SFH have key membership and aligns to NHS long term plan.



Stillbirth rate (4.0/1000 births)

- One stillbirth reported in June, escalated to PSIRG and for Divisional Investigation
- Rate remains below the national ambition of 4.4/1000 births

Maternity Assurance

NHSR	Ockenden
• Bid funding received. • Working commenced flash reports to MAC/QC • Submission due 2nd of Feb 2024	• Initial 7 IEA- 100% compliant • Next regional insight visit planned for Oct 23

Incidents reported Jun 2023 (85 no/low harm, 0 moderate or above)

Most reported	Comments
Emergency LSCS and MOH	MOH remains the most frequently reported. Slight increase in EM LSCS in June
Triggers x 9	1 incident required higher escalations
0 incidents reported as 'moderate'	

Other

- SBLCB, remain compliant, new lead in post, version 3 launched working on the Divisional action plan.
- Entonox working group established key action plan, assurance around current exposure but risk to current levels of control. Focus on education, estates and monitoring plan, work underway.
- All staffing incidents were related to acuity and activity. 5 Datix submitted for staffing regarding acuity during the time period of the unit suspension.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	55%	54%	43%	56%	56%	55%	60%	60%	50%	
3rd/4th degree tear overall rate	<3.5%	2.18%	2.40%	4.30%	2.80%	1.80%	3.10%	5.60%	3.50%	3.30%	3.50%	3.60%	
3rd/4th degree tear overall number		46	4	8	6	2	5	9	6	6	7	6	
Obstetric haemorrhage >1.5L number		59	9	9	14	14	5	5	5	13	19	9	
Obstetric haemorrhage >1.5L rate	<3.5%	3.24%	3.20%	3.90%	4.60%	4.80%	3.90%	2.00%	2.00%	4.80%	6.10%	3.10%	
Term admissions to NICU	<6%	3.62%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	3.40%	3.40%	2.50%	
Stillbirth number		8	2	0	2	2	2	0	1	1	0	1	
Stillbirth rate	<4.4/1000	4.63	3.300			3.240			4.000			2.200	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:24	
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	1:26	
Number of compliments (PET)		0	2	2	2	3	2	3	3	6	9		
Number of concerns (PET)		9	1	2	1	1	1	1	1	1	2		
Complaints		11	0	0	0	0	0	0	0	0	0		
FFT recommendation rate	>93%		91%	89%	90%	90%	89%	91%	91%	91%	90%		

External Reporting	Standard	Total/ average	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Trend
Maternity incidents no harm/low harm		595	96	72	80	79	64	70	64	70	77	85	
Maternity incidents moderate harm & above		0	0	0	0	0	0	0	0	0	3*	0	
Findings of review of all perinatal deaths using the real time monitoring tool	Jun-23	PMRT- One reportable case in June, the case was escalated through PSIRG and is having a Divisional investigaiton alongside PMRT review which is currently ongoing.											
Findings of review all cases eligible for referral to HSIB	Jun-23	No cases met reportable threasholds in May. One case currently active (early neonatal death reported in March). Two cases revived in 2023, one with no safety recommendations, one with 3 relating to escaltions, clinical and risk assessment. Action plans have been comeplted and are monitered through governance											
Service user voice feedback	Jun-23	New role commenced in post within the ICB of the Maternity and Neonatal Independent Senior Advocate to support SFH.											
Staff feedback from frontline champions and walk-abouts	Jun-23	MNSC on the 6th June, feedback around the EL LSCS list, detailed in the exception report. Positive re - aunch of Triage and clear plans for embedding articulated.											
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	
Progress in Achievement of CNST 10	<4 <7 7 & above												

Board of Directors Meeting in Public

Subject:	Freedom To Speak Up	**Date:**	3rd August 2023
Prepared By:	Kerry Bosworth – Freedom To Speak Up Guardian		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Kerry Bosworth – Freedom To Speak Up Guardian		

Purpose		
The purpose of this paper is to provide an update to the SFH Board on the Freedom to Speak Up Agenda within the Trust and provide assurance about the Speaking Up service.	**Approval**	
	Assurance	**x**
	Update	**x**
	Consider	

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

Principal Risk		
PR1	Significant deterioration in standards of safety and care	**x**
PR2	Demand that overwhelms capacity	
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

Acronyms

Abbreviations used-
SFH – Sherwood Forest Hospitals
EDI – Equality, Diversity & Inclusion
FTSUG - Freedom To Speak Up Guardian
FTSU - Freedom To Speak Up
NGO - National Guardians Office
OD - Organisational Development
OH - Occupational Health
NSS - National Staff Survey
NHSE - NHS England
JSPF – Joint Staff Partnership Forum
AHP – Allied Healthcare Professional
SID – Senior Independent Director
MDT – Multidisciplinary Team

Executive Summary

This report provides a review of speaking up cases for Q4 2022/23 and Q1 2023/24 and assurance in relation to the FTSU provision at SFH. It includes the themes and concerns raised in line with the NGO defined categories. Learning and improvement actions taken from concerns are reported and highlighted

with a case study. National updates are also included, together with performance against the NSS, in the raising concerns domains.

During Q4 2022/23 and Q1 2023/24 there were 60 concerns raised with the FTSU Guardian. People profiles are included.

FTSU is represented across all the Divisions. Nursing/ Midwifery and Admin/Clerical colleagues have raised the most concerns.

Worker Safety & Wellbeing and Inappropriate Behaviours and Attitudes are the categories to which most concerns align. Examples include poor behaviours in teams from leaders and/or colleagues, Trust Care Values not being upheld, staff feeling unsupported and uncared for in processes and when raising concerns and when attempting to reach a resolution locally.

Patient Safety and Quality concerns involve patients cared for in areas that lack experience / skills to best care for the patient, impact on patient experience and wellbeing of staff caring in these circumstances and challenges in maintaining quality of care in MDTs.

EDI concerns surrounding colleagues with disabilities have increased.

Actions taken include:

Concerns regarding disabilities have been supported by the People Team and the EDI Lead, for training and education purposes.
FTSU will feature within the new Leadership Development Framework – supporting lessons learnt from FTSU cases, in a programme directed towards new and existing leaders to improve line manager response and support for concerns.
Cases of Bullying & Harassment have executive oversight and the FTSUG continues to meet regularly with the CEO and Director of People.
Proactive involvement of FTSUG alongside teams and leaders actively engaging in listening and improvement work – some Divisions have asked for listening support.

The SFH Speak Up policy has been ratified by JSPF this month and has incorporated the National Freedom To Speak Up Policy (NHSE), which all providers are required to adopt by January 2024.

The NGO has created a FTSU Sub Score to replace the FTSU Index which calculates a score for each organaisation against the national average for the 4 speak up questions in the NSS. The national average for 2022 NSS is 6.4 (out of 10); SFH's score is 6.9 . For Acute/Acute Community Trusts category this puts SFH in the top 5 nationally and joint first locally.

A case study is highlighted, to demonstrate the approach to the resolution of concerns, providing an alternative escalation approach to support individuals with speaking up and enacting improvements.

Freedom To Speak Up

SFH Board Report – July 2023

Kerry Bosworth FTSU Guardian

Sherwood Forest Hospitals NHS Foundation Trust

Purpose

This report provides a review of speaking up cases for Q4 2022/23 and Q1 2023/24 and the assurance of the FTSU provision at SFH. Included is the learning and improvement actions taken from concerns, highlighted with a case study.

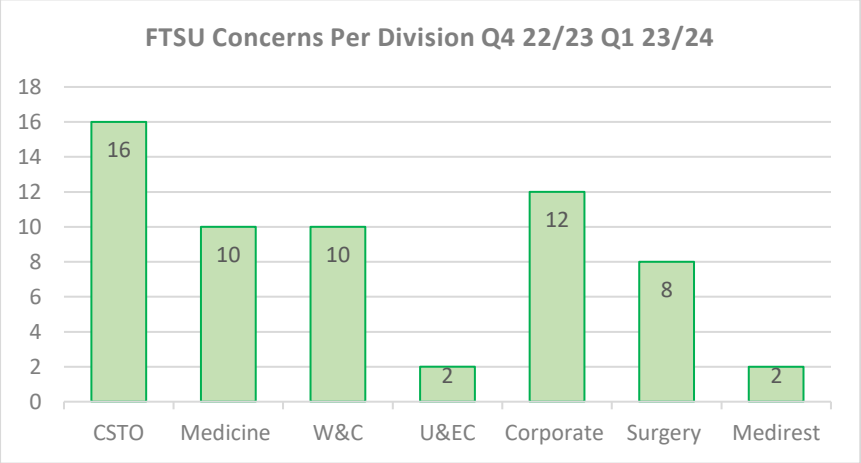
Overview

During Q4 22/23 and Q1 23/24 there were 60 concerns raised with the FTSU Guardian.

The number of colleagues raising concerns through FTSU demonstrates consistent engagement with FTSU as a route for raising concerns.

Out of the 60 concerns raised in the above periods, 43 were raised openly, 16 were raised confidentially (known to FTSUG only) and there was 1 anonymous concern.
The majority of concerns are now escalated openly to those in a position to support and follow up FTSU concerns, suggesting colleagues feel increased trust and psychological safety in speaking up.

All Divisions are represented in using FTSU , demonstrating awareness of FTSU across the organisation .



People Profile

Nursing & Midwifery and Admin/Clerical colleagues have raised the most concerns through both quarters; also represented are medical, clinical service and technical support teams and AHP colleagues. There has been an increase in Q1 2023/24 of concerns raised from medical and AHP colleagues which is welcomed as these groups historically have been less represented in FTSU at SFH.

EDI Information

The majority of concerns raised are from females. Ethnicity is predominantly white British however Indian, other Asian origin and dual ethnicity origin are also represented in both quarters .To increase visibility and awareness amongst ethnic minority colleagues the FTSUG

now has a regular session with new International Educated Nurses cohorts and also has regular engagement with the Ethnic Minority Staff Network to promote speaking up. The network Co-Chair is a FTSU Champion and therefore promotes speaking up regularly.

There have been 10 colleagues with disabilities raising concerns which is an increase from previous quarters.

Themes from Q4 2022/23 & Q1 2023/24

Patient Safety & Quality (6 Concerns)

- Unsafe care – expected to care and work in areas unfamiliar with
- Acuity - unable to provide expected level of care and cohorts of patients are of a different speciality – not usual patient cohort hence lack of knowledge and skills
- Behaviours in teams undermine safety processes
- Unchallenged behaviours impact quality and team working
- Work environment not conducive to quality care for patients

Bullying & Harassment (10 Concerns)

- Bullying from a colleague
- Bullying from a line manager
- Bullying culture within a team - unmanaged behaviours , poor leadership

Attitudes and Behaviours within B&H

- Racism – microaggressions in work environment
- Ableism –microagressions and lack of leadership awareness of disability and equality policies and support
- Leadership – manipulation , favouritism and power imbalance when speaking up

Worker Safety or Wellbeing (25 concerns)

- Poor leadership related to use of and understanding of HR processes . Guidance and policies not followed. Informal processes to resolve concerns not worked – limited options and limited impact
- Poor experience of being in a HR process – length of time / not a priority, feeling ostracised, feeling uncared for. Wellbeing affected by being in the process
- Unchallenged behaviours have impact on team and individuals – unresolved or feel unsupported. Options aren't favourable to engage with. Futile in reporting
- Impact of poor work experience on wellbeing, colleagues feeling taking sickness is only option especially when concerns are about relationships at work

Elements Of Other Inappropriate Attitudes or Behaviours (19 Concerns)

- Incivility
- Misogyny – conscious bias and unconscious bias undermining female workers
- Gaslighting behaviours
- Leadership poor response to raising concerns – poor options offered. Leaders unable to challenge poor behaviours
- Leadership styles – care values used as a threat but not exhibiting the values themselves
- Favouritism – interview panels not inclusive, 'friends interviewing friends', career development not equal opportunities.

- Leadership – lack of support in job re-evaluation processes and impact
- Inappropriate language relating to disability.

Detriment For Speaking Up

Following a case of detriment for speaking up raised in this period , this was escalated to the FTSU Executive and FTSU SID . An investigation led by the SID for FTSU was conducted and concluded that no detriment had occurred from speaking up.

FTSU Learning & Triangulation

Concerns regarding patient safety have been escalated to the relevant executive and senior divisional leads, some feeding into current improvement projects within divisional plans.

Concerns around bullying and harassment have been escalated to the senior People Team. Review of the concerns with line managers to improve line manager performance and offer resolutions. Unresolved B&H concerns have executive oversight and/or in HR processes. Concerns raised regarding disabilities have been triangulated with the EDI Lead for wider organisational learning and themes raised at the WAND Staff Network. The senior people team have supported conversations with line managers and colleagues with disabilities to improve the response to the nature of these concerns.

The majority of concerns fall into the Worker Safety or Wellbeing category, closely followed by Elements of Inappropriate Attitudes or Behaviours. Many concerns feature colleague's experiences in HR processes or the inefficacy of resolutions to behavioural concerns. Many of these workers come under SFH business and administration teams and it is noted that some affected colleagues are not sighted to direct regular communication with their line managers, some unclear who they are managed by and structure of leadership. They are more likely to have an offsite /WFH manager, who manage a considerable number of colleagues which may contribute to this nature of concern. These concerns have been raised to the People Team and divisional people teams are able to offer advice and guidance to colleagues who this is applicable to.

Wellbeing teams and OH have been asked to receive some of the concerns affecting health to support colleagues and there is a direct referral route between FTSU and these services to support colleagues who feel unable to do this via their line manager.

Leadership barriers remains a constant theme in FTSU concerns. Escalation is usually to the senior People Team. Individual mediation has been offered in some circumstances. Grievance policies are offered but rarely used due to fear or futility perceptions. Recognising this, FTSU now has input and presence in more of our leadership training and education programmes , with planned further involvement this year as the new Leadership Development Plan launches. This will not only be for new leaders but existing leaders.

NHSEI continues to recommend that all workers have mandated Speak Up, Listen Up & Follow Up training . As an entry step to this , FTSU will be presenting some content from this training within the Leadership Development Programme, launched this year.

The FTSUG continue to have regular meetings with the Director of People and Chief Executive Officer to share themes and progress .

The FTSUG has been working proactively to support individual divisions to help engage with their workforce and foster a culture of speaking up for improvement. The CSTO Division has proactively approached the FTSUG to ask for support in raising concerns and understanding

in their teams, in response to its NSS results. Successfully this has demonstrated to their team that speaking up is important but that FTSU can run alongside usual escalation routes to give colleagues options of who to talk to.

Case Review

Colleague raised concerns regarding behaviours of some colleagues within the MDT that could impact patient pathway decision making

Themes were –

- Concerns about patient safety and quality
- Behaviours were around incivility and professionalism
- Colleague had challenged the behaviour but felt this could happen to others less confident to respond.
- Leadership – raised with their line manager but unsure as to who to raise to further as involved MDT working and unaware of structures etc. Felt Datix not right tool for escalating concerns about behaviours
- Workload – high acuity meant unsure this could be presented at any governance / leadership meetings
- Felt Trust Values were not central to the behaviour experienced
- Felt some fear in speaking up and concerned about impact

FTSU Actions and Follow Up

- FTSUG ensured wellbeing and assurance that speaking up would be safe
- Appropriate Executive was escalated to and reassurance in response enabled the person to feel safe to share
- Action was taken to feed this into existing improvement project already underway regarding this pathway and enabled the concern raiser to be part of that , by arranging them to meet with the senior project lead and share their experiences for improvement
- Executive overview enabled creation of this opportunity and learning without having to navigate direct challenges to the colleagues from the concern raiser
- Positive feedback from the concern raiser after the conclusion of their escalation . Felt listened to and appropriate action taken in regard to the concern

FTSU Assurance at SFH

National Staff Survey Results 2022

SFH is above the national average for all the speak up questions and gives encouragement that colleagues feel able to have their say.

The NGO released their analysis of the NHS Staff Survey in June 2023 Fear & Futility - What does the Staff Survey tell us about speakingup in the NHS ? June 2023

Nationally there were declines on all questions relating to raising concerns, particularly related to raising concerns about clinical practice and the follow up question to this, which asks about confidence in the organisation addressing these concerns. There has been reflection of this trend in SFH results for these questions but still bench mark well above the national average. There is less shift down in the questions relating to speaking up about ***anything*** causing

concerns and the response to this. Again SFH bench marks well above the national average and could be an indicator that confidence in raising concerns around culture is present.

The NGO has created a FTSU Sub Score to replace the FTSU Index which calculates a score for each organaisation against the national average for the 4 speak up questions in the NSS.The national average for 2022 NSS is 6.4 (out of 10) ; SFH score is 6.9 . For Acute/Acute Community Trusts category this puts SFH in the top 5 nationally

The revised SFH Speak Up Policy has been approved at JSPF. The new policy incorporates the NHSE Freedom To Speak Up Policy launched last year which is mandated for all providers to adopt by Jan 2024.

New Champions have been recruited this quarter increasing the Champion numbers to 27. New Champions have been recruited from under represented teams and areas. This will increase visibility of FTSU.

FTSU Feedback

Feedback from those who use FTSU remains positive . This is requested via MS Forms but mainly consists of personal email feedback to the FTSUG.

Recent feedback -

"Very supportive and straightforward process. Was able to explain my thoughts without judgement."

"Felt listened to and gave me the confidence to be able to speak to the person I needed to without doing the wrong thing."

"Very easy to access and discuss, for providing support and then checking back in with me".

"Always a scary feeling, when you just don't know where to turn to, and who will listen and help. You did. Things have turned around for us. Thank you for all your time and input for us

Recommendation

The SFH Board is asked to receive assurance from the report regarding the Freedom to Speak Up agenda

Freedom To Speak Up

SFH Board Report – July 2023

Kerry Bosworth FTSU Guardian

Sherwood Forest Hospitals
NHS Foundation Trust

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

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

Subject:	Audit & Assurance Committee (AAC) Report	**Date:** 20th July 2023	
Prepared By:	Graham Ward – AAC Chair		
Approved By:			
Presented By:	Graham Ward – AAC Chair		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ Clinical Audit – The team is now at full strength, but they now need engagement and a clinician to overview/sponsor	▪ Procurement Annual Report – to include a section on the contract management benefits next year.
Positive Assurances to Provide	**Decisions Made**
▪ Counter Fraud – Very useful update that included benchmarking data and actions taken by SFH as a consequence of previous fraud investigations. ▪ Internal Audit – 2023/24 implementation rate increased to 85%. ▪ Data Security & Protection Toolkit – recommendations and agreed actions were discussed on this moderate assurance internal audit report and progress against actions noted. ▪ Risk Committee – committee assured by the work undertaken at the Risk Committee. ▪ Contract Management – the good progress made in implementing contract management was noted ▪ Procurement Annual Report – committee was assured by the work undertaken and results delivered by Procurement over the last year and planned for this current year. A particular note was made on the increased collaborative procurements being undertaken.	▪ Single Tender Waivers – approved. ▪ Losses & Special Payments – below approval threshold but nevertheless approved for completeness.

▪ Register of Interests Report – progress noted, though there are still 473 employees who haven't registered yet (43.4%).	

Comments on Effectiveness of the Meeting

- All papers were of a high quality and clear which helped the meeting run smoothly.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Chair's Highlight Report to Trust Board

Subject:	Finance Committee meeting	**Date:** 25th July 2023	
Prepared By:	Richard Mills, Chief Financial Officer		
Approved By:	Andrew Rose-Britton, NED Chair of Finance Committee		
Presented By:	Andrew Rose-Britton, NED Chair of Finance Committee		
Purpose			
The paper summarises the key highlights from the Finance Committee meeting held on 25th July 2023		**Assurance**	**Sufficient**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Board Assurance Framework Principal Risk 4 (Delivery of Financial Strategy) remains at a score of 20 (Significant), which exceeds the tolerable level. • The Quarter 1 financial position is adverse to plan, with numerous risks to delivery of the 2023/24 full-year plan, at both Trust and System level.	• Further evaluation of the Emergency Department Staffing Business Case to be presented at November Committee meeting. • Joint Procurement Strategy to be discussed as a future agenda item. • Further assurance sought on the development and implementation of robust FIP schemes to ensure delivery of the 2023/24 plan. • Forecast outturn scenario modelling to be developed and discussed at the next meeting.
Positive Assurances to Provide	**Decisions Made**
• Board Assurance Framework Principal Risk 8 (Impact on Climate Change) remains at a score of 9 (Medium), in-line with the tolerable level. • Post-implementation review of the Emergency Department Staffing Business Case, approved in November 2022, demonstrated positive progress against the objectives of the case. • A good understanding of upcoming projects demonstrated through the Procurement Forward View agenda item. • An initial 5-Year Capital Plan has been developed, which provides a roadmap for future investment into the SFH estate, equipment and IT. • Positive steps have been taken in Q1 towards the delivery of the 2023/24 Strategic Priorities reportable to the Finance Committee.	Approval granted for: • Public Sector Decarbonisation Scheme (subject to confirmation of funding and Board ratification).

• A Sustainability Development Strategic Group (SDSG) has been established, to provide further impetus to the delivery of the SFH Green Plan.	

Comments on Effectiveness of the Meeting
Good and effective discussion based on clear and informative papers. Agreed that monthly frequency of meetings is helpful in the context of the financial risks facing the organisation.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Quality Committee - Chair's Highlight Report to Trust Board

Subject:	Quality Committee	**Date: 20th July 2023**	
Prepared By:	Barbara Brady – Non - Executive Director		
Approved By:	Barbara Brady – Non - Executive Director		
Presented By:	Barbara Brady – Non - Executive Director, Chair of Quality Committee		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ SFHT an outlier for alcoholic liver disease in HSMR data from Dr Foster	▪
Positive Assurances to Provide	**Decisions Made**
▪ Clinical Audit ▪ Impact of Newark UTC overnight closure ▪ Significant assurance from Data Quality Framework audit ▪ Infection prevention and control ▪ Maternity all recommendation in response to recent CQC visit completed	▪ Patient safety Incident Response Plan recommended for approval ▪ Board Assurance Framework o PR1 -current exposure to rise to 16 as a result of likelihood score rising to 4 o PR 2 – no change to overall current exposure with further mitigations developed
Comments on Effectiveness of the Meeting	
▪ Excellent discussion, confirming and challenging through the meeting	

Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

People, Culture & Improvement Committee Chair's Highlight Report to Trust Board

Subject:	People, Culture & Improvement Committee Highlight Report	**Date:** 25th July 2023	
Prepared By:	Manjeet Gill, Non-Executive Director		
Approved By:	Rob Simcox, Director of People		
Presented By:	Manjeet Gill, Non-Executive Director		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Assurance by way of update reports were provided on industrial action, this included mitigations. However, factors such as uncertainty about future actions and goodwill means that there is a gap in control. This was reflected in the BAF ratings for PR3. The likelihood rating was increased to highly likely and gaps in assurance. • The increase in the number of challenged services, presented risks and assurance was given on actions being taken to stabilise. Assurance was also provided through the quality Committee and reports to Board. • The vacancy rate has increased from 6% to 7.7% in Quarter 1, due to investments made in key clinical services, assurance were provided to the approaches being taken to reduced the increased rates. • The Freedom to Speak Up report presented positive engagement with the process and identified themes such as an uptick in colleagues with a disability, feeling they were not being treated appropriately and getting the support for an inclusive culture.	• Ongoing assurance on recruitment and plans to address the fragile and more challenged services to reduce vacancy rates. • Assurance to illustrate the work of the improvement faculty by way of the Theatres programme was welcomed. • Further assurance and how that assurance was provided was requested for the Improvement work, in the following areas: 1. The improvement and transformation strategies 2. The patient and people focus – what were the strategic aims and measures to achieve these aims. Patient voice was one element. 3. How hearts and minds were addressed, forms of engagement and buy in to achieve more clinically led efficiencies and improvements. 4. The five improvement themes and 17 programmes, monitoring progress and impact. 5. The smaller projects not part of the main programmes. 6. The softer elements of the improvement work.

Positive Assurances to Provide	Decisions Made
• The Step into NHS Careers event, leading to positive local interest, recruitment and more reach into the local community, to develop more tailored careers pathways. • Q1 reports on progress made in People Strategy; Trust Strategic Priorities; Strategic workforce plan; Culture and Engagement and Equality, Diversity and Inclusion. • Positive assurance on recruitment to the Pharmacy workforce, gave an excellent example of focus on evidence and creative ways to address vacancies. Myth busting and creativity was recognised, and assurance sought on how this learning could be transferable to other areas of vacancies. • An appraisal process that has been co-produced, with staff, and is now a tool , that is much more about supporting development and good performance was presented. • A Leadership programme that addressed all levels of leadership, including aspiring talent was positively received as helping to reinforce the culture and values of the Trust as well as develop future leaders. • An example of a tactical workforce plan was presented for the AHP workforce demonstrating future challenges to the occupation and solution in place to mitigate these.	• BAF agreed for PR3 with an increase in risk and gaps is controls highlighted, due to uncertainty of future industrial action and its impact, later in the summer. • The July update of PR5 was agreed, with a decision to request further plans to improve controls, presented to September's Committee.

Comments on Effectiveness of the Meeting
Committee effectiveness discussion looked at the number of items on the agenda and whether we needed a six weekly meeting rather than bi-monthly to cover the range of assurance being sought. This was likely to increase as more detailed assurance was sought for improvement.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Charitable Funds Committee - Chair's Highlight Report to Trust Board

Subject:	Charitable Funds	**Date: 27th July 2023**	
Prepared By:	Barbara Brady – Non - Executive Director		
Approved By:	Barbara Brady – Non - Executive Director		
Presented By:	Barbara Brady – Non - Executive Director, Vice Chair of Charitable Funds		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪	▪ Summary document in support of the Annual Report ▪ Policy regarding external fundraising in public areas within SFHT estates. ▪ Scheme of delegation
Positive Assurances to Provide	**Decisions Made**
▪ Financial position ▪ Community involvement headline report ▪ NHS Charities Covid-19 recovery grant applied for	o
Comments on Effectiveness of the Meeting	
▪ Good discussion enabled by succinct and informative papers	