Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 6th February 2025**
Time: **09:00 – 12:30**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 5th December 2024** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Action Tracker**	Update	Enclosure 5
6.	09:10	**Acting Chair's Report**	Assurance	Enclosure 6
7.	09:20	**Acting Chief Executive's Report**	Assurance	Enclosure 7
8.	09:30	**Staff Story, Wellbeing - Staff Mental Health** Adam Grundy, Head of Occupational Health	Assurance	Presentation
	Strategy and Culture			
9.	10:00	**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 Incidents and Investigations Overview / Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 9.1
	Operational / Strategy			
10.	10:30	**Q3 Review and Integrated Performance Report (IPR)** Report of the Executive Team	Consider	Enclosure 10
	BREAK (10 mins)			

	Time	Item	Status	Paper
	Governance			
11.	11:20	**Board Assurance Framework** Report of the Chief Executive	Approve	Enclosure 11
12.	11:30	**Well Led Review – Summary Report and Action Plan** Report of the Director of Corporate Affairs	Assurance	Enclosure 12
13.	11:40	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (28th January 2025) • Audit and Assurance Committee Report of the Committee Chair (16th January 2025) • Quality Committee Report of the Committee Chair (27th January 2025) • People Committee Report of the Committee Chair (28th January 2025) • Charitable Funds Committee Report of the Committee Chair (21st January 2025) • Partnerships and Communities Committee Report of the Committee Chair (21st January 2025)	Assurance Assurance Assurance Assurance Assurance Assurance	Enclosure 13.1 Enclosure 13.2 Enclosure 13.3 Enclosure 13.4 Enclosure 13.5 Enclosure 13.6
14.	12:15	**Outstanding Service – Community Diagnostic Centre, Site Heritage** James Thomas, Acting Deputy Medical Director	Assurance	Presentation
15.	12:25	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
16.	12:25	**Any Other Business**		
17.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **6th March 2025, Boardroom, King's Mill Hospital**		
18.		**Chair Declares the Meeting Closed**		
19.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		

	Time	Item	Status	Paper
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

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

Enc 05	• **Cost of IT in 5 Years Report**
Enc 09.1	• **Nursing Safe Staffing Paper**
Enc 09.1	• **Perinatal Safe Staffing Paper**
Enc 11	• **Significant Risks Report**
Enc 13.1	• **Finance Committee – previous minutes**
Enc 13.2	• **Audit and Assurance Committee – previous minutes**
Enc 13.3	• **Quality Committee – previous minutes**
Enc 13.4	• **People Committee – previous minutes**
Enc 13.5	• **Charitable Funds Committee – previous minutes**
Enc 13.6	• **Partnerships and Communities Committee – previous minutes**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 5th December 2024, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Acting Chair	GW
	Steve Banks	Non-Executive Director	SB
	Barbara Brady	Non-Executive Director	BB
	Andrew Rose-Britton	Non-Executive Director	ARB
	Neil McDonald	Non-Executive Director	NM
	Manjeet Gill	Non-Executive Director	MG
	Claire Hinchley	Acting Director of Strategy and Partnerships	CH
	Richard Mills	Chief Financial Officer	RM
	Simon Roe	Acting Medical Director	SR
	Rob Simcox	Director of People	RS
	Rachel Eddie	Chief Operating Officer	RE
	Phil Bolton	Chief Nurse	PB
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
In Attendance:	Kathy Smiley	Matron ACCU and CCOT	KS
	Paula Shore	Director of Midwifery	PS
	Sue Bradshaw	Minutes	
	Jess Baxter	Producer for MS Teams Public Broadcast	
	Rich Brown	Head of Communications	
Observers:	Darren Fernandes	Chief Registrar	
	Ian Holden	Public Governor	
	2 members of the public		
Apologies:	Aly Rashid	Non-Executive Director	AR
	Andy Haynes	Specialist Advisor to the Board	AH
	David Selwyn	Acting Chief Executive	DS

Item No.	Item	Action	Date
24/369	**WELCOME**		
1 min	The meeting being quorate, GW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
24/370	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
24/371	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Aly Rashid, Non-Executive Director, Andy Haynes, Specialist Advisor to the Board, and David Selwyn, Acting Chief Executive. It was noted Phil Bolton was attending the meeting in the capacity of Acting Chief Executive and Paula Shore was attending the meeting in the capacity of Chief Nurse.		
24/372	**PATIENT STORY - MARTHA'S RULE, THE FIRST PATIENT TO ACTIVATE MARTHA'S RULE**		
13 mins	KS joined the meeting. KS introduced the Patient Story, which highlighted the Trust's work in piloting Martha's Rule. GW felt it is good to see Martha's Rule 'in action'. GW noted two members of staff had used Martha's Rule to escalate concerns and queried how awareness of Martha's Rule can be increased to ensure all staff are aware they can use it. KS advised the Martha's Rule Team attend multiple forums to provide feedback. A report from the first three months of the pilot is currently being produced and this will be fed back to the teams involved. KS left the meeting.		
24/373	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 7th November 2024, the Board of Directors APPROVED the minutes as a true and accurate record.		
24/374	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/251.1, 24/316.2, 24/316.4, 24/345.2, 24/345.3, 24/346, 24/347.1 and 24/347.2 were complete and could be removed from the action tracker.		

	NM noted the deadline for three of the actions had been extended and queried what the reason for this was. PB advised in order to complete these actions, reports need to be presented to different sub-committees and, therefore, the date has been changed to fit in with committee work cycles.		
24/375	**ACTING CHAIR'S REPORT**		
4 mins	GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chair's perspective, highlighting Non-Executive Director (NED) recruitment, work of the Trust's volunteers, visit from Mansfield Town Football Club to mark World Prematurity Day, meetings with system partners and Board of Directors Time Out session. The Board of Directors were ASSURED by the report.		
1 min	**Council of Governors Highlight Report** GW presented the report, highlighting 15 Steps visits and approval of the reappointment of Steve Banks, NED, for a further three years. The Board of Directors were ASSURED by the report.		
24/376	**ACTING CHIEF EXECUTIVE'S REPORT**		
8 mins	PB presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chief Executive's perspective, highlighting recruitment for a Director of Improvement and Change, operational activity, extended opening hours for the Newark Urgent Treatment Centre (UTC), introduction of Automatic Number Plate Recognition (ANPR) system for car parking, single point-of-contact sexual health service, Community Diagnostic Centre (CDC) engagement event, visit to the Trust by the Regional Chief Midwife, Gaynor Armstrong, and Staff Survey. RS advised the Staff Survey closed on 29th November 2024. The final figures are awaited but currently the Trust has had just under 4,000 colleagues respond to the survey, which is the highest number of responses ever. The percentage of responses is higher than the 2023 Staff Survey. BB noted the extended opening hours of the UTC and queried if there is the same increase in patient demand as is evident in A&E at King's Mill Hospital. RE advised the increase in the number of walk-ins at the UTC has been greater than the increase in walk-ins at A&E, but it is not clear if this is due to the extended opening hours. Since the change in opening hours at the UTC, there are more people queuing in the morning. Therefore, the shift patterns are going to be reviewed to address this. The Board of Directors were ASSURED by the report.		

24/377	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
mins	**Maternity Update** ***Safety Champions update*** PS presented the report, highlighting quality improvement work, Friends and Family Test responses, Care Quality Commission (CQC) Maternity survey, Safety Champions Walkaround, visit to the Trust by the new Regional Chief Midwife, Staff Survey responses and focus on clinical excellence. MG requested a report be presented to a future Board of Directors meeting in relation to inequalities and equity of access issues and the actions the Trust is taking to address these. PS advised there is a lot of work ongoing in relation to this and the tools developed by the Trust's Governance Team provide some useful information. PB advised a report would be prepared for the Perinatal Assurance Committee for onward reporting to the Quality Committee. The Chair of the Quality Committee would then decide how this is reported to the Board of Directors. **Action** • **Report to be presented to the Perinatal Assurance Committee (and onwards to the Quality Committee) in relation to inequalities and equity of access issues in maternity.**	**PB**	**03/04/25**
	BB requested a trend line be added to all the graphs in the report. **Action** • **Trend line to be added to all graphs in future Safety Champions update reports.**	**PB**	**06/02/25**
	BB noted the number of emergency caesarean sections are increasing, as are the number of cases of induced labour, and queried if there is a link. PS advised if labour has to be induced, this increases the likelihood of a caesarean section or assisted delivery being required. With increased activity, this has also led to increased complexity. PS acknowledged the increase in the number caesarean sections and the reasons for this are being investigated. SB referenced the CQC survey and the assurance being sought in relation to follow up by GPs and queried if there was visibility of follow up by community health visitors. PS advised there was nothing in the free text comments about health visiting services, but the Trust works closely with teams, both post-natal and antenatal. There were some feedback comments for GPs which can be passed on via system working groups. SB queried if the standard for the number of community visits is being met. PS advised a minimum of three community midwifery visits is required and this is being met. There is a local area agreement which states the final discharge visit is not completed until the mother has		

	been seen by their health visitor. Visits by the community midwives are aligned with health visitor appointments. NM advised space management is becoming an issue for the maternity team, noting there are opportunities to drive the efficiency of the unit if space management was improved, which requires estates work, which comes at a cost. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance*** PS presented the report, highlighting an improvement in the number of massive obstetric haemorrhages and third and fourth degree tears, high levels of activity and suspension of maternity services. The Board of Directors were ASSURED by the report.		
24/378	**STRATEGIC OBJECTIVE 5 – SUSTAINABLE USE OF RESOURCES AND ESTATE**		
8 mins	**Financial Improvement Performance 2024 / 2025 Update** RM presented the report, advising financial efficiency is discussed at each meeting of the Finance Committee. RM highlighted the target, unweighted forecast, weighted forecast, current position, next steps and recurrent / non-recurrent savings. ARB acknowledged there is a drive to make savings, but expressed concern regarding recurrent versus non-recurrent savings. GW advised recurrent savings are now the important driver. RM advised there was an initial discussion at the Executive Team meeting on 27th November 2024 in relation to planning for 2025/2026 and there will be a report presented to the Executive Team on 11th December 2024 to set out the initial draft of the programme for 2025/2026. SB queried if other potential income streams were being considered as part of the 'forward look'. RM advised he would welcome any ideas for other income streams, noting there are contractual and space issues for any retail opportunities. The Board of Directors were ASSURED by the report.		
24/379	**STANDING FINANCIAL INSTRUCTIONS (SFIS) AND SCHEME OF DELEGATION**		
6 mins	RM presented the report, advising a full review of the Standing Financial Instructions (SFIs) and Scheme of Delegation (SoD) has been undertaken in line with the two-yearly review cycle. The changes made are detailed in the report. ARB confirmed the SFIs and SoD had been presented to the Audit and Assurance Committee, who are content with the changes made.		

	The Board of Directors APPROVED the Standing Financial Instructions (SFIs) and Scheme of Delegation.		
24/380	**ASSURANCE FROM SUB-COMMITTEES**		
15 mins	**Finance Committee** GW presented the report, highlighting the Financial Improvement Programme (FIP), Month 7 financial position, capital forecast assurance, Elective Recovery Fund (ERF), financial strategy, cash position and review of Board Assurance Framework (BAF) Principal Risk 4 (PR4) - Insufficient financial resources available to support the delivery of services and PR8 - Failure to deliver sustainable reductions in the Trust's impact on climate change. The Board of Directors were ASSURED by the report. **Audit and Assurance Committee** ARB presented the report, highlighting SFIs and clarification of the procurement process for Charitable Funds. The Board of Directors were ASSURED by the report. **Quality Committee** BB presented the report, highlighting an increase in catheter associated urinary tract infections (UTIs), lack of resources to ensure completion of medicines reconciliation, ongoing issues with water safety and positive assurance taken from the presentation and discussion around the mortality update and changes to Hospital Standardised Mortality Ratio (HSMR) methodology. GW felt it would be useful to present an update on HSMR to the Council of Governors. ARB noted the ongoing issues in relation to water safety and queried what additional actions could be taken to address this. PB advised engagement, processes and visibility has improved and mitigations are in place. However, there is a need for a long-term solution, but this is costly and will cause a lot of disruption within the organisation. There is a need to balance the risk. RM advised water safety is regularly discussed at various forums and options are reviewed. GW advised the issues have been raised with the Private Finance Initiative (PFI) provider and Skanska. However, there is also the need for cultural discipline from everyone in the Trust in terms of regularly turning taps on to flush them out. PB advised the Water Safety Group meets monthly and is attended by representatives from Skanska and the Trust. Better processes are in place and some outlets which are no longer used have been removed. A lot of proactive work has been undertaken. The Board of Directors were ASSURED by the report.		

	People Committee SB presented the report, highlighting Staff Survey, pharmacy workforce update and plans to further develop Freedom to Speak Up. The Board of Directors were ASSURED by the report.		
24/381	**OUTSTANDING SERVICE – SURGICAL SDEC**		
7 mins	A short video was played highlighting the work of Surgical Same Day Emergency Care (SDEC).		
24/382	**COMMUNICATIONS TO WIDER ORGANISATION**		
3 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Martha's Rule. • Implementation of ANPR system for car parking. • Thanks to staff for their ongoing hard work during times of operational pressure. • Visit to the Trust by the Regional Chief Midwife. • Surgical SDEC. • Extended opening hours of the UTC. • Staff Survey. • Work of the Trust volunteers. • Work to improve the Trust's financial position. • Encourage staff to access flu and Covid vaccinations. • Approval of SFIs and SoD.		
24/383	**ANY OTHER BUSINESS**		
1 min	GW expressed thanks to AR for his contribution to the work of the Trust, noting this is his last Board of Directors meeting.		
24/384	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 6th February 2025 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 10.30.		
24/385	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Acting Chair** **Date**		

24/386	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	GW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
24/387	**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.		

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PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
24/183.2	06/06/2024	Sub-committee annual reports to follow same format	Public Board of Directors	None	Apr-25	S Brook Shanahan			Grey
24/223	04/07/2024	Information in relation to the cost of maintaining the current IT landscape, and what the costs are likely to be in five years' time, to be reported to the Finance Committee.	Public Board of Directors	Finance Committee	06/02/2025	D Selwyn	N Turner	**Update 16/10/2024** Update to be provided to Finance Committee on 29th October 2024, with a full report to Finance Committee in January 2025 **Update 06/02/2025** Paper presented to the Finance Committee on 28th January 2025 and uploaded to the Reading Room for information. **Action - CLOSED**	Green
24/312	03/10/2024	Update on waiting times and the impact of inequalities to be provided to the Quality Committee.	Public Board of Directors	None	~~05/12/2024~~ 06/02/2025	R Eddie		**Update 25/11/2024** To be presented to Quality Committee in January 2025 **Update required**	Amber
24/313.1	03/10/2024	Rolling death rate for alcoholic liver disease to be included in future learning from deaths reports	Public Board of Directors	None	03/04/2025	S Roe			Grey
24/314.1	03/10/2024	Consideration to be given as to how the People Committee and Board of Directors can be provided with visibility of broader staffing groups, not covered in the Nursing, Midwifery and AHP Staffing report.	Public Board of Directors	People Committee	~~07/11/2024~~ 06/02/2025	R Simcox	R Cotterill	**Update 30/10/2024** On People Committee workplan for January 2025 **Update 23/01/2025** Item presented at Januaury 2025 People Committee regarding how the total workforce is viewed how this aligned to the 2024/25 Operational Workforce Plan and wll be part of on onward Workforce Planning **Action - CLOSED**	Green
24/314.2	03/10/2024	'Forward look' to be included in future Nursing, Midwifery and Allied Health Professions (AHP) Staffing bi-annual reports	Public Board of Directors	None	06/03/2025	P Bolton		**Update 28/01/2025** Included in Bi-Annual Board staffing paper going to March 2025 Board and will continue to be developed over the coming year **Action - CLOSED**	Green
24/314.3	03/10/2024	Results and learning from the annual leave audit, particularly in relation to overtaken leave, to be presented to the Quality Committee	Public Board of Directors	~~Quality Committee~~ People Committee	~~05/12/2024~~ 06/02/2025	S Roe		**Update 24/10/2024** SR confirmed this item should be presented to People Committee not Quality Committee **Update 27/11/2024** To be presented to People Committee in January 2025 **Update 23/01/2025** Item presented at the January 2025 People Committee **Action - CLOSED**	Green

24/314.4	03/10/2024	Tangible metrics for Freedom to Speak up in terms of impact to be requested from the National Guardians' Office	Public Board of Directors	None	06/02/2025	S Brook Shanahan	K Bosworth	**Update required**	Amber
24/345.1	07/11/2024	Cost of unused flu vaccinations to be investigated and included in the loses and special payments report to the Audit and Assurance Committee	Public Board of Directors	Audit & Assurance Committee	06/02/2025	R Mills / R Simcox	A Grundy	**Update 25/11/2024** Details to be provided to the Audit and Assurance Committee on 16/01/2025 **Update 30/01/2025** A paper was presented to the Audit and Assurance Committee in January which provided further information on the cost of unused flu vaccinations and the potential for financial write-offs. Further updates will be provided through the Audit and Assurance Committee as necessary for assurance and/or approval. **Action - CLOSED**	Green
24/347.3	07/11/2024	Performance review to be presented to the Board of Directors at the end of Q3	Public Board of Directors	None	06/02/2025	D Selwyn		**Update 13/01/2025** Included within the February 2025 Agenda	Green
24/377.1	05/12/2024	Report to be presented to the Perinatal Assurance Committee (and onwards to the Quality Committee) in relation to inequalities and equity of access issues in maternity.	Public Board of Directors	Quality Committee	03/04/2025	P Bolton			Grey
24/377.2	05/12/2024	Trend line to be added to all graphs in future Safety Champions update reports	Public Board of Directors	None	06/02/2025	P Bolton	P Shore	**Update 29/01/2025** Agreed to include SPC charts from review and revision of reports from April 2025. **Action - CLOSED**	Green

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chair's report	**Date:**	30 January 2025
Prepared By:	Rich Brown, Head of Communication		
Approved By:	Graham Ward, Acting Chair		
Presented By:	Graham Ward, Acting Chair		

Purpose

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

ATTFE = Academy Transformation Trust Further Education
FPPT = Fit & Proper Persons Tests
NED = Non-Executive Director

Executive Summary

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

Passing of Trust governor John Wood

Everyone at Sherwood was saddened to learn of the recent passing of one of the Trust's public governors, John Wood.

John, who lived in Mansfield all his life and had four grown-up children, had served on the Trust's Council of Governors since 2016 where he had been a key part of the Trust's work to engage the Trust's thousands of public members in helping to shape the services of their local hospitals. Over the years, John had also served as a school governor locally, as well as being involved in a number of local charities, committees and fundraising activities.

John passed away on Tuesday 31 December 2024 surrounded by his family.

Everyone at the Trust who knew John has such fond memories of him as someone who was always a great source of knowledge and advice in how he represented our Trust members over the years and I personally especially enjoyed our conversations during 15 steps visits to different areas across the Trust.

He will be dearly missed by all who knew him and our thoughts remain with his friends, family and colleagues at this difficult time. I am sure that I speak on behalf of everyone at Sherwood in passing my condolences to John's family and friends.

Updates on appointments to the Trust's Board of Directors

Further to my updates to the Trust's Board of Directors over recent months, our efforts have been continuing to recruit to a number of vacancies on the Trust's Board, as the Trust has sought to appoint two Non-Executive Directors and one Associate Non-Executive Director.

I am delighted to confirm that three appointments are planned to those roles, subject to final employment and Fit & Proper Persons Tests (FPPT) being finalised. Those appointments were approved subject to the completion of those final pre-appointment checks at an extraordinary meeting of the Trust's Council of Governors on 17 January 2025.

One appointment that has been confirmed is that of Richard Cotton, a Management Accountant who has spent most of his career in the private sector in a range of industries, including pharmaceuticals. He has also carried out a number of Non-Executive Director (NED) roles in the pharmaceutical and medical sectors.

Richard Cotton

His role and portfolio here at Sherwood will involve providing Board-level strategic financial leadership experience, joining the Trust's Finance and Partnerships & Communities Committees, where he will work with the rest of our Trust Board of Directors to strengthen the Trust's assurance, governance and forward planning processes.

I am sure that colleagues will join me in welcoming Richard to the Trust, with Richard due to join his first Public Meeting of our Board of Directors in February.

Two further appointments will be announced to the following roles, once vital pre-appointment checks have concluded satisfactorily. As a reminder, those roles are as follows:

- One clinically-qualified Non-Executive Director with extensive experience in primary care, secondary care, public health or social care to join the Quality and Finance Committees.
- One Associate Non-Executive Director with a focus on research and innovation, recognising the important role that these fields play in making great care happen here at Sherwood.

As a Trust Board, we are confident that each of those appointments will add real value, insight and leadership that will help further our Trust-wide efforts to *Improving Lives* of the communities we serve.

I look forward to being able to share more details of those vital appointments with the Trust's Board of Directors, our Trust colleagues and our communities as soon as I am able to do so.

Council of Governors election update

Efforts have been ongoing behind-the-scenes to prepare for the Trust's latest Council of Governor election, which is required to take place before the end of April 2025.

As a NHS Foundation Trust, Sherwood Forest Hospitals is required to hold Council of Governor elections to elect the governors who will ensure accountability, hold Non-Executive Directors to account and help ensure that the voices of the local communities we serve are considered in the running of our services.

This latest election will seek to appoint to 10 vacancies on the Trust's Council of Governors across the Trust constituency boundaries that were reconfigured when our Trust Constitution was last reviewed in 2024.

This election will seek to appoint to 10 vacancies in the following constituencies:

- Five vacancies in our 'Mansfield, Ashfield & surrounding wards' public constituency
- Two in our 'Newark & Sherwood & surrounding wards' public constituency
- One in our 'Rest of England' public constituency; and
- Two vacancies for Trust colleagues to serve as 'Staff' governors

Details (including the precise timeline for these elections) are now being finalised for those elections, which I look forward to being able to share with the Trust's Board of Directors over the coming weeks.

Recognising the difference made by our Trust Charity and Trust volunteers

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

In January alone, 380 Trust volunteers generously gave over 4,550 hours of their time to help make great patient care happen across the 30 services they have supported during the month.

During the month, four volunteers were presented with Long Service Awards, recognising their long service and dedication over five to 25 years.

Other notable developments from the Sherwood Forest Hospitals Charity and our Community Involvement team:

- Patients and staff at Newark Hospital are benefiting from the purchase of innovative new equipment thanks to generous donations from The Magnus Foundation.

  The Foundation donated £44,301 to Sherwood Forest Hospitals Charity over two years, which has been used to buy two waste management systems for the operating theatres at Newark Hospital.

  The Neptune Rover 3 waste management system collects, transports, and disposes of surgical waste fluid and will bring benefits to both patients and staff.

  An average of 19 minutes per procedure will be saved thanks to the new equipment, with the faster operating times leading to a better patient experience. The time saved will enable more operations to be performed in the department, which is great news for patients waiting to have their surgery at Newark Hospital.

  The introduction of the equipment also improves safety to staff by reducing their exposure to potentially infectious liquids and limiting the risk of manual handling injuries. It will also be safer for patients as it means that staff can monitor their fluid levels more effectively during a procedure.

- Profits from the Daffodil Cafe and fundraising stall have funded 19 projects to the value of £47,000 during the last three months.

  A couple of recently completed projects include supplying bespoke oak leaf badges for new Healthcare Assistants following a suggestion from the Shared Governance Council.

  Another project saw 24 sets of weighing scales purchased for the Diabetes Dietetics Team to support education of portion control for newly-diagnosed paediatric patients.

- During the month, we were also delighted to welcome students from Quarrydale Academy in Sutton-in-Ashfield, who visited the Breast Unit to donate mastectomy bags (which are worn over the shoulder to carry surgical drains following an operation) and heart-shaped cushions to make patients more comfortable, which they made during their textiles class.

Students from Quarrydale Academy present their donations

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

Other notable engagements during December and January:

- I attended the regular update calls with NHS England's Midlands Regional Director, Dale Bywater, in both December and January.

- I met with Nottinghamshire Healthwatch with the Trust's Acting Chief Executive, Dave Selwyn, to demonstrate our commitment to working together moving forwards – something we will be keen to explore over the months.

- Chairs and elected members from our NHS and local authorities across Nottingham and Nottinghamshire met on 19 December

- On 6 January 2025, I joined the Trust's Acting Chief Executive, Dave Selwyn, in a meeting with the Academy Transformation Trust Further Education (ATTFE) to explore how the Trust can look to work more closely with the college as another vital partner in our local education sector.

- I joined the Trust's Council of Governors Membership and Engagement Forum meeting on Tuesday 7 January to update the Trust's governors about the Trust's financial position and the planned Non-Executive Director appointments to our Trust's Board of Directors.

- I attended the NHS England (Midlands) operating model engagement event with Chairs and Chief Executives from across the region to consider the role that our Trust will play in the development and delivery of the new NHS 10-year plan.

- I joined the NHS Nottingham and Nottinghamshire Non-Executive Directors network meeting on 23 January

- I joined our quarterly meeting with colleagues from Newark and Sherwood District Council on Tuesday 28 January to discuss our continued partnership working.

- I have held regular catch-up meetings with our Trust's Lead Governor, Liz Barrett.

- I attended a planning guidance webinar with the NHS Chief Executive and the Secretary of State.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

- Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	30 January 2025
Prepared By:	Caroline Kirk, Communications Specialist		
Approved By:	Dr David Selwyn, Acting Chief Executive		
Presented By:	Dr David Selwyn, Acting Chief Executive		

Purpose

An update regarding some of the most noteworthy events and items since the last Public Board meeting from the Acting Chief Executive's perspective.	**Approval**	
	Assurance	**Y**
	Update	**Y**
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

Acronyms

ATTFE = Academy Transformation Trust Further Education (ATTFE)
BAF = Board Assurance Framework
CDC = Community Diagnostic Centre
CQC = Care Quality Commission
ED = Emergency Department
EMAS = East Midlands Ambulance Service NHS Trust
MSFT = Medically Safe for Transfer
ICS = Integrated Care System
MNVP = Maternity and Neonatal Voices Partnership
MRI = Magnetic Resonance Imaging
RSV = Respiratory Syncytial Virus
SAS = Specialist, Associate Specialist and Specialty
SEND = Special educational needs and disability
SSDEC = Surgical Same Day Emergency Care

Executive Summary
An update regarding some of the most noteworthy events and items over the past two months, shared on behalf of the Acting Chief Executive.

Operational updates

Overview of operational activity

We have continued to experience very significant demand and pressure on our urgent and emergency care pathways over the winter period, like much of the NHS.

At SFH, the urgent and emergency care demand growth continues to exceed regional and national positions, and we continue to work with our system partners to understand and mitigate for this. Our colleagues continue to work relentlessly in caring for our patients in as timely and dignified manner as possible in very challenging circumstances.

Many of the challenges have been publicised in the media as we have worked hard to convey a clear message to our local population that our services are under pressure and to attend ED appropriately, recognising several other available options.

Local system partners continue to work well together to maintain relatively low levels of patients within our hospitals who no longer require our specialist care (referred to as patients that are medically safe for transfer). This helps us to turn around our acute beds as quickly as possible, however, despite our efforts we are still seeing patients waiting 12 hours for admission within our ED.

In terms of planned care, we have continued to reduce the number of long wait patients, increased our performance against the (returning to prominence) incomplete 18-week RTT metric which is a constitutional standard to ensure patients receive non-emergency consultant-led treatment within 18-weeks of referral. We have also made significant progress improving our diagnostic waiting time (DM01) performance to now be above our operational plan position. Our cancer performance remains strong for the 28-day faster diagnostic standard with our main area of focus being on the 62-day treatment standard which we were just below the interim standard of 70% in November 2024 (latest reported position).

Our Integrated Performance Report provides more detail on areas of strong and challenged performance together with the key actions we are taking to improve the timeliness of care we offer to patients.

In December, King's Mill Hospital featured in a national ITV news report about a surge in flu patients in intensive care after NHS figures showed the number of people in hospital with flu had jumped by 41% in a week – this was four times higher than at the same point last year. Health leaders warned the situation could get "worse before it gets better" as Christmas and festive gatherings took place. ITV spoke to the partner of a previously fit and healthy 42-year-old father who had been placed on a breathing machine on our critical care unit, as a result of flu.

The Sky News team visited us at the start of January to speak with patients and colleagues about the challenges of winter pressures and also this year’s flu season. They interviewed one of our patients who recently recovered from flu, sharing her personal experience, as well as Respiratory Consultant Dr Mark Roberts, who highlighted the gravity of flu, ways to stay protected, and how our hospital is managing cases this winter.

Chief Nurse Phil Bolton also discussed discharges and the relationship between health and social care. This piece was broadcast just days before East Midlands Ambulance Service NHS Trust (EMAS) declared a critical incident for the first time as a result of significant patient demand, pressure within local hospitals, and flooding across the East Midlands.

Later in January we warned our local community that flu still posed a risk despite a drop in the number of patients hospitalised with the virus. Our hospitals continued to experience pressure from a range of respiratory viruses including flu, Covid-19 and Respiratory Syncytial Virus (RSV), as well as norovirus.

During December, the Trust treated 402 flu-positive patients – more than eight times the 47 people it treated in November. There were 50 patients with flu in King's Mill Hospital on 30 December, but by 15 January this figure had dropped to 14.

You can read more on our website at www.sfh-tr.nhs.uk/news/2025/january/flu-warning-despite-drop-in-hospital-cases.

Partnership updates

Leaders from health, social care, education and the third sector came together for an ICS event Lifting Our Gaze on 28th November. SFH was represented by Dr Helena Clements, Consultant Paediatrician, and Paula Longden, from the Strategy and Partnerships Team.

The event included learning from local successes in special educational needs and disability (SEND), integrated neighbourhood teams and collaborating with faith organisations. It highlighted key leadership messages about the benefits of achieving genuine coproduction, the importance of authenticity and passion, practical examples of how to build community connections and learning and sharing about what works in our local neighbourhoods.

It also provided all attendees with a vital networking, connecting and relationship-building opportunity that will support the continued development of the system during 2025 and beyond.

On the 27th January the Trust joined ATTFE, a community and educational partner, at its #InThisTogether stakeholder event to celebrate its successes from 2024 and learn more about its strategy for 2025 and beyond.

SFH Strategy and Partnership Team presented at the event, highlighting the benefits of collaborative working to both organisations which, in 2024, included promoting and celebrating volunteering within Sherwood and local community groups and providing opportunities for ATTFE learners to develop skills.

Read the latest ICS Newsletter at https://healthandcarenotts.co.uk/ics-newsletter-january-2025.

Other Trust updates

DAISY award winner

A huge well done to Demi Lee, Deputy Sister on Ward 23, who was presented with a DAISY award after being nominated by multiple colleagues.

Colleagues witnessed Demi grow from a newly-qualified nurse to her present role and consistently demonstrating the Trust's CARE values in everything she does.

Demi was described as going above and beyond to ensure patients are cared for physically and emotionally. They explained that she 'has a massive impact on the ward' and that Demi's 'kindness, compassion and leadership is exceptional' she is a 'good listener, hearing not only the words but also what lies behind the words'.

If you have received outstanding care yourself, or witnessed one of your colleagues delivering outstanding care and want to share your thanks, you can nominate a Nurse or Midwife by visiting the DAISY award page on our website at www.sfh-tr.nhs.uk/work-for-us/staff-recognition/daisy-awards/.

Sisters celebrate TULIP awards

A huge well done to our two latest TULIP award winners, sisters Georgia and Hayley!

Both are Health Care Assistants on Ward 12 at King's Mill Hospital and were presented with TULIP awards after receiving heart-warming nominations from a colleague and patient's relative.

Hayley joined SFH in 2020 and Georgia made a career change to join the team in 2022 when Hayley recommended the Trust as a great place to work.

Georgia received a touching nomination from a patient's family member who said: "Georgia was so kind and gentle with my mum, making sure she was not in pain, asking if she was feeling comfortable and explaining what she was going to do and why."
The family member explained that the care received made the patient feel "secure and safe in a stressful environment" and that Georgia "made a huge difference and helped [the patient's] recovery."

Hayley's nomination came from a colleague who described Hayley as "an absolute ray of sunshine" who goes "above and beyond every day for our patients."

Hayley gives her all to her role, even when not in work, including going to another hospital to visit a close relative and coming away with ideas on how to make improvements on the ward demonstrating "the lengths she will go to for the benefit of our patients. She is truly remarkable."

A massive thank you to you both for your excellent care and commitment to your role, colleagues and patients. You're a real credit to the Trust.

TULIP stands for Touching Unique Lives in Practice and is used to recognise the amazing work and care that our colleagues provide in and out of the hospital daily. Anyone can submit a recognition - colleagues, patients, and members of the public – via our website: www.sfh-tr.nhs.uk/work-for-us/staff-recognition/tulip-awards.

Specialist Anaesthetist receives two awards

Congratulations to Dr Rob Fleming, Specialist Anaesthetist at the Trust, who has been awarded with the Anniversary Medal and Kathleen Ferguson Award for Inclusivity by the Association of Anaesthetists.

The Kathleen Ferguson Award is awarded to those promoting diversity, equity and inclusion, while the Anniversary Medal is awarded to those who have held office or made significant contributions to the Association.

Dr Fleming has been acknowledged for being an advocate for Specialist, Associate Specialist and Specialty (SAS) doctors and for holding the Association Board's first dedicated SAS seat.

Specialist, Associate Specialist, and Speciality (SAS) doctors include doctors in permanent posts with at least four years' experience as a doctor, two of those in their relevant specialty.

The common route for a doctor is to continue in a formal training programme, working towards becoming a consultant or GP, which requires them to work across multiple organisations.

SAS doctors develop their career within one organisation, with many focusing more on direct patient care rather than clinical and non-clinical responsibilities required of a consultant. Others are involved in teaching, service development, research, or management and leadership.

SAS doctors work in all hospital specialties and include doctors working at every level. Specialists, like Rob, are senior and experienced doctors who work independently alongside consultants.
Rob has spent many years working as a national representative for SAS doctors, an often-overlooked group which contains a high number of international medical graduates working in the NHS.

After completing an initial period of training in Anaesthesia, Dr Fleming decided to continue his career as an anaesthetist outside of the more common training route. He became a Specialty Doctor in 2012 in Nottingham, moving to Sherwood Forest Hospitals in 2022 and progressed to become a Specialist Anaesthetist in 2023.
He is currently the interim lead for obstetric anaesthesia at the trust alongside other leadership and educational roles.

Neonatal unit benefits from donated games console

Thank you to the Emily Harris Foundation, who have purchased an interactive Medical Gaming Cart complete with an Xbox series S console and games. The cart is for use by the siblings and families of babies admitted to the Neonatal unit.

Clare Harris, Manager of the Emily Harris Foundation, decided to use funds from the Foundation to purchase the cart after she saw them being used on the children's ward at the hospital. It is hoped that the cart will help to give children visiting the ward a sense of normality and distraction from the hospital environment.

Promoting the NHS App

Drop-in sessions have been taking place regularly at our three hospital sites to promote the NHS App and Patients Know Best to our own colleagues, patients and visitors. You can find out more about our digital services on our website at www.sfh-tr.nhs.uk/for-patients-visitors/nhs-app/.

Children to benefit from Mansfield 103.2 FM's annual toy appeal

Thank you to local businesses and individuals who supported Mansfield 103.2's annual King's Mill Toy appeal. The appeal, which is in its 13th year, resulted in a huge number of toys being donated and more than £3,000 being raised for Children's Services.

Sexual Safety Charter

As signatories to the NHS Sexual Safety Charter, we are continuing to reaffirm our zero-tolerance approach to any unwanted, inappropriate, or harmful sexual behaviours in the workplace.

This commitment ensures staff feel safe, respected, and valued, creating an environment where everyone can thrive.
By prioritising safety and inclusivity, we're not only fostering a positive workplace culture but also making Sherwood Forest Hospital a great place to work.
Our current job vacancies are on our website at www.sfh-tr.nhs.uk/work-for-us/our-vacancies.

CQC Maternity Survey results 2023

The CQC Maternity Survey 2023 results identified several areas to improve on, and colleagues on the unit have been working hard to make changes and ensure a positive experience for all who stay on the maternity unit.

Changes include:

• Mandatory training for maternity staff on listening to women and supporting choice
• Introducing a Lead Midwife for induction of labour who has led multiple improvements to the service
• Increasing the number of drug trolleys available so birthing people are not waiting for pain relief
• Making our Lime Green infant feeding team available in the mornings to provide support on the wards
• Starting a Birth Afterthoughts Clinic

The results of the 2024 CQC Maternity Survey were released at the end of 2024, and we're pleased to say they have revealed extremely positive results for our maternity services. We'll be sharing details internally and externally shortly. Well done to all colleagues involved in contributing to these scores.

Hospital unit helps to speed up patients' treatment this winter

The Surgical Same Day Emergency Care (SSDEC) Unit at King's Mill Hospital, which helps to reduce waiting times and overnight hospital admissions, assessed more than 1,300 patients in its first six months.

The unit enables patients with urgent or emergency surgical conditions to be assessed, have a treatment plan in place and be discharged the same day, without the need for a hospital admission.

Common conditions assessed and treated on the unit are skin abscesses, symptomatic gallstones, wound-related problems, and most cases of acute abdominal pain.

Before the unit opened, on average around 70% of patients with surgical conditions spent more than four hours in the Emergency Department (ED), and now, this number is averaging at less than an hour.

The addition of the unit means that patients are seen in the right place as quickly as possible, and it also helps to free up space in the hospital's busy ED.

New MRI Hybrid Unit arrives

Christmas came early when our new MRI Hybrid Unit was delivered to King's Mill Hospital in December.

This new machine will have a very positive effect on the service we can provide for patients by increasing MRI capacity onsite, allowing us to image selected inpatients as well as out-patients in a more timely and efficient manner, aiding quicker diagnosis and increasing the number of patients that can be accommodated treated and discharged.

Phoenix team celebrates third anniversary

The Trust's Maternity Tobacco Dependency Treatment Service, the Phoenix team recently celebrated its three-year service milestone.

Since the Phoenix team was established, it has contributed to a reduction in smoking at the time of birth from 18.3% to just less than 10%.

To celebrate this fantastic achievement, a group of smoke-free babies who have benefitted from this service were invited to King's Mill Hospital's Faith Centre on Tuesday 26 November along with members of the Maternity and Neonatal Voices Partnership (MNVP) and the senior leadership team.

The families shared some anecdotes from their smoke-free journeys and gave some very positive feedback about the Phoenix team with one mum telling us "the team were so lovely, they motivated me to cut down and eventually quit all without any judgement."

A future action for the team will be to set up a peer support group, this has been based upon the families' suggestions for service improvement.

Mansfield Community Diagnostic Centre update

More than 50 people attended an event to mark Mansfield Community Diagnostic Centre (CDC) delivering 50,000 tests in its first year.

Patients, residents and NHS staff were among those who joined Mansfield Mayor Andy Abrahams to hear the latest about the project at Mansfield Community Hospital.

It also celebrated a significant milestone with a "first spade in the ground" ceremony, marking the official start of construction for Nottinghamshire's first purpose-built CDC.

Expect Respect, Not Abuse

Patients and visitors were reminded that hospital staff deserve respect and not abuse, as winter pressures began to intensify at Sherwood Forest Hospitals Emergency Department.

As the Trust faced increasing demand as winter approaches, we urged patients and visitors to treat hospital staff with respect, emphasising that abuse - whether verbal or physical - will not be tolerated.

We're encouraging Trust colleagues to report any incidents of physical or verbal abuse so that appropriate action can be taken, including refusing treatment or pursuing legal steps. Staff who report incidents will also be offered the support they deserve.

Trust risk ratings reviewed

The Board Assurance Framework (BAF) Principal Risk 7 – 'A major disruptive incident' – for which the Risk Committee is the lead committee, has been scrutinised by the Trust's Risk Committee. Committee members discussed the risk scores and assurance ratings but decided that they should remain unchanged.

Committee members also agreed to propose changes to the BAF assurance levels titles, the details of which will be included when the full and updated Board Assurance Framework (BAF) is presented at the Public Meeting of the Trust's Board of Directors in February.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Integrated Performance Report – 2024/25 Q3	**Date:**	6 February 2025
Prepared By:	Domain leads and Mark Bolton, Associate Director of Operational Performance		
Approved By:	Domains approved by lead Executive		
Presented By:	Domains to be presented by lead Executive		

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

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

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

Committees/groups where this item has been presented before

The Quality of Care and Timely Care domain reports were considered by the Quality Committee in January 2025. The final report was considered by the Executive Team on 29 January 2025.

Acronyms

All acronyms are defined within the paper.

Executive Summary

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

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

contains benchmarking data for the timely care domain to show our performance relative to other Trusts in England. The benchmarking element of the report is presently being expanded to cover other domains which will be included in the next report to Trust Board.

Maintaining good performance against some of the key indicators contained in the report has been challenging for the Trust during 2024/25 quarter three. We have continued to experience demand pressures on our urgent and emergency care pathway over the winter period like much of the NHS. This includes increased levels of infection as seen across the NHS and reflected in our Quality of Care domain report. This demand has placed pressure on our clinical teams and our services. The strain on our ED and our hospital inpatient bed base has caused a deterioration in several key performance metrics across all performance domains. Our staff have worked relentlessly to care for patients in as timely and dignified manner as possible in very challenging circumstances. Many of the challenges have been publicised in the media as we have worked hard to convey a clear message to our local population. The sustained pressure of high patient demand for many months has resulted in patient demand often exceeding the capacity of our hospitals and being above planned, and funded levels. To support patient care we have enacted escalation actions including our full capacity protocol; these actions place pressure on our people and the financial position of the Trust. Over winter we have needed to extend our full capacity protocol to include going two-over on our base wards at times of extreme pressure to ensure the clinical risk is shared across the Trust and not held within our Emergency Department (or with our partners at East Midlands Ambulance Service).

Despite the challenges there are areas where our performance compares favourably across the NHS and these successes are to be celebrated. We remain one of the top performing Trusts nationally for ambulance handover, a position we are proud of as it allows ambulance crews to respond to the needs of our local population. Our diagnostic DM01 performance in Dec-24 at just under 90% was our highest since 2021 as insourcing plans have helped reduce the significant 6-week backlog; this recovery has lifted us out of benchmarked lower quartile position nationally. Our value weighted activity for the Elective Recovery Fund has consistently exceeded the NHS England target with opportunities constantly being reviewed to care and treat as many patients as possible waiting for planned care.

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

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals

Integrated Performance Report

Reporting Period: 2024/25 Quarter 3

Integrated Scorecard

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

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

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

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

Category	At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD
Quality of Care	Safe	Falls with lapse in care	≤2	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1
		Falls per 1000 occupied bed days	≤6.63	≤6.63	✗ 6.9	✗ 7.3	✓ 6.1	✗ 6.7	✓ 6.2	✓ 5.8	✗ 6.7	✓ 6.3	✗ 6.7	✓ 5.9	✓ 6.2	✓ 6.3	✓ 6.0	✗ 7.4	✗ 7.3	✗ 6.9	✓ 6.5
		Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2
		MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1
		Cdifficile reported in month	≤13	≤13	1	3	5	✓ 9	4	4	5	✓ 13	4	3	4	✓ 11	7	4	6	✗ 17	✗ 41
		Ecoli blood stream infections (BSI) reported in month	≤22	≤22	3	5	3	✓ 11	5	1	4	✓ 10	3	5	2	✓ 10	4	6	0	✓ 10	✓ 30
		Klebsiella BSI reported in month	≤1	≤1	2	1	0	✗ 3	0	1	2	✗ 3	1	1	0	✗ 2	1	1	0	✗ 2	✗ 7
		Pseudomonas BSI reported in month	≤3	≤3	2	1	1	✗ 4	0	0	1	✓ 1	0	0	0	✓ 0	0	1	0	✓ 1	✓ 2
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care			0.2	0.2	0.1	0.2	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.2	0.1	0.0	0.1	0.1
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✗ 1	✗ 1	✗ 2	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 2	✗ 2	✗ 5
		Patient Safety Incident Investigations (PSII)			2	2	1	5	3	4	0	7	0	2	2	4	1	0	2	3	14
		Sepsis (metric to be defined)			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.1	✓ 1.1	✓ 0.8	✓ 1.0	✓ 0.7	✓ 1.5	✓ 0.9	✓ 1.0	✓ 1.5	✓ 0.8	✓ 0.8	✓ 1.0	✓ 0.8	✓ 0.8	✓ 0.4	✓ 0.7	✓ 0.9
		Compliments received in month			151	122	120	393	161	138	151	450	155	120	119	394	204	160	147	511	1355
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 108	✗ 107	✗ 105	✗ 105	✗ 104	✗ 103	✗ 102	✗ 102	✗ 102	✗ 102	✗ 103	✗ 103	✗ 103	✗ 103	✗ 101	✗ 103	✗ 103
		SHMI	≤100	≤100	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106
		Still birth rate	≤4.4	≤4.4	✓ 3.2	✗ 11.5	✓ 3.7	✗ 5.9	✓ 0.0	✓ 3.2	✓ 4.2	✓ 2.3	✓ 0.0	✗ 6.8	✗ 6.4	✓ 4.4	✓ 3.4	✗ 10.3	✓ 0.0	✗ 4.5	✓ 3.8
		Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✗ 3.2	✗ 1.1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.4
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 6.9	-	-	-	✓ 6.8	-	-	-	✓ 6.8	-	-	-	-	✓ 6.8
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 5.1%	✓ 4.7%	✓ 4.5%	✓ 4.7%	✓ 8.2%	✓ 8.0%	✓ 8.1%	✓ 8.1%	✓ 8.4%	✓ 7.7%	✓ 7.4%	✓ 7.9%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 8.3%	✓ 8.1%
		Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.5%	✓ 0.3%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.5%
		Appraisals	≥90%	≥90%	✗ 88.9%	✗ 88.3%	✗ 87.8%	✗ 88.3%	✗ 88.5%	✓ 90.1%	✗ 88.8%	✗ 89.1%	✓ 90.3%	✓ 90.0%	✗ 89.7%	✓ 90.0%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.2%	✗ 89.1%
		Mandatory & statutory training	≥90%	≥90%	✓ 91.0%	✓ 91.0%	✓ 92.0%	✓ 91.3%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.4%	✓ 91.3%	✓ 90.9%	✓ 91.2%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 91.1%	✓ 91.1%
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.0%	✗ 4.7%	✗ 4.3%	✗ 4.6%	✗ 4.3%	✗ 4.4%	✗ 4.7%	✗ 4.4%	✗ 4.9%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.8%	✗ 4.9%
		Total workforce loss	≤7.0%	≤7.0%	✗ 7.3%	✓ 6.9%	✓ 6.4%	✓ 6.9%	✓ 6.4%	✓ 6.4%	✓ 6.8%	✓ 6.5%	✓ 6.9%	✓ 6.3%	✓ 6.7%	✓ 6.6%	✓ 7.6%	✗ 7.8%	✗ 8.1%	✗ 7.8%	✓ 7.0%
		Flu vaccinations uptake (front line staff)	≥80%	≥75%	58.0%	58.0%	-	58.0%	-	-	-	-	-	-	-	-	35.3%	43.6%	47.1%	47.1%	47.1%
		Employee relations management	<12	<17	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✗ 15	✗ 19	✗ 20	✗ 20	✗ 21	✗ 20	✗ 19	✗ 20	✗ 18	✗ 19	✗ 20
	New Ways of Working	Bank usage			8.8%	7.7%	10.8%	9.1%	8.3%	10.3%	9.3%	9.3%	9.8%	10.3%	8.1%	9.4%	7.3%	7.8%	9.1%	8.0%	8.9%
		Agency usage	<3.7%	<3.2%	✗ 5.2%	✗ 4.7%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 4.6%	✗ 4.7%	✗ 4.6%	✗ 5.1%	✗ 4.2%	✗ 3.4%	✗ 4.2%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.5%	✗ 4.1%
		Agency (off framework)	≤6.0%	0.0%	✗ 0.1%	✗ 0.1%	✓ 0.0%	✗ 0.0%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✗ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.0%
		Agency (over price cap)	≤30.0%	≤40.0%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 55.1%	✗ 55.6%	✗ 59.7%	✗ 57.1%	✗ 60.3%	✗ 53.6%	✗ 55.5%	✗ 56.4%	✗ 45.1%	✗ 43.1%	✗ 47.9%	✗ 45.4%	✗ 53.1%
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✓ 95.6%	✗ 93.9%	✗ 94.6%	✗ 94.7%	✓ 96.6%	✓ 96.5%	✓ 95.1%	✓ 96.1%	✓ 95.6%	✓ 96.8%	✗ 93.5%	✓ 95.3%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 87.1%	✗ 92.8%
		Ambulance delays >60 mins	0.0%	0.0%	✗ 0.2%	✗ 0.2%	✗ 0.5%	✗ 0.3%	✗ 0.2%	✓ 0.0%	✓ 0.0%	✓ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.5%	✗ 0.6%
		ED 4-hour performance	≥76%	≥76%	✗ 65.7%	✗ 63.6%	✗ 72.2%	✗ 67.3%	✗ 74.2%	✗ 73.4%	✗ 70.9%	✗ 72.8%	✗ 71.7%	✓ 82.0%	✗ 73.6%	✗ 75.6%	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.8%	✗ 71.4%
		ED 12-hour length of stay performance	≤2%	≤2%	✗ 5.5%	✗ 5.1%	✗ 3.1%	✗ 4.5%	✗ 3.1%	✗ 2.2%	✗ 2.3%	✗ 2.5%	✗ 2.9%	✓ 0.9%	✗ 3.0%	✗ 2.3%	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.0%	✗ 3.3%
		SDEC rate	≥33%	≥33%	✓ 38.3%	✓ 38.1%	✓ 37.8%	✓ 38.1%	✓ 38.2%	✓ 37.7%	✓ 38.6%	✓ 38.2%	✓ 38.1%	✓ 41.3%	✓ 39.0%	✓ 39.4%	✓ 40.0%	✓ 39.4%	✓ 36.8%	✓ 38.7%	✓ 38.8%
		Adult G&A bed occupancy	≤92%	≤92%	✗ 97.9%	✗ 97.8%	✗ 96.5%	✗ 97.4%	✗ 93.6%	✗ 94.8%	✗ 94.7%	✗ 94.4%	✗ 95.5%	✗ 92.2%	✗ 93.8%	✗ 93.9%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 94.9%	✗ 94.4%
		Long length of stay (21+) occupied beds	≤Plan	≤Plan	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✗ 102.0	✓ 105.0	✓ 103.0	✓ 104.0	✓ 96.0	✓ 97.0	✓ 106.0	✓ 99.8	✓ 102
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 84	✗ 65	✗ 57	✗ 69	✗ 57	✗ 56	✗ 59	✗ 57	✗ 67
	Electives	Advice & guidance	≥16%	≥16%	✓ 24.3%	✓ 27.3%	✓ 25.4%	✓ 25.6%	✓ 24.5%	✓ 25.8%	✓ 22.0%	✓ 24.1%	✓ 25.2%	✓ 24.6%	✓ 22.3%	✓ 24.0%	✓ 24.7%	✓ 23.9%	✓ 24.4%	✓ 24.3%	✓ 24.1%
		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 5.7%	✓ 5.6%	✓ 5.3%	✓ 5.5%	✓ 6.0%	✓ 5.9%	✓ 5.9%	✓ 5.9%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.2%	✓ 6.0%	✓ 5.9%	✓ 6.1%	✓ 6.0%	✓ 6.0%
		Outpatient attends that are first or follow up with a procedure		≥Plan	43.2%	43.7%	43.8%	43.5%	✗ 43.3%	✗ 40.7%	✗ 43.9%	✗ 42.6%	✗ 42.2%	✗ 42.9%	✓ 43.1%	✗ 42.7%	✗ 41.5%	✗ 41.5%	✗ 41.1%	✗ 41.4%	✗ 42.2%
		Incomplete RTT waiting list	≤Plan	≤Plan	✗ 52,377	✗ 50,534	✗ 50,757	✗ 50,757	✗ 36,584	✗ 35,858	✗ 35,720	✗ 35,720	✗ 35,251	✗ 35,165	✗ 35,507	✗ 35,507	✗ 35,440	✗ 34,538	✗ 34,147	✗ 34,538	✗ 34,538
		Incomplete RTT pathways +52 weeks	≤Plan	≤Plan	✗ 1,759	✗ 1,662	✗ 1,591	✗ 1,591	✓ 1,312	✓ 1,162	✓ 1,177	✓ 1,177	✓ 1,080	✗ 1,019	✗ 870	✗ 870	✗ 786	✗ 709	✗ 569	✗ 709	✗ 709
		Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✓ 109	✓ 77	✗ 105	✗ 50	✗ 50	✗ 44	✗ 36	✗ 40	✗ 36	✗ 36
		Incomplete RTT pathways +78 weeks	0	0	✗ 17	✗ 12	✗ 5	✗ 5	✗ 2	✗ 1	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Diagnostics	Diagnostic DM01 backlog			3,659	3,344	3,430	3,430	3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	1,427	989	945	945	945
		Diagnostic DM01 performance under 6-weeks	≥99%	≥Plan	✗ 62.8%	✗ 68.1%	✗ 70.5%	✗ 70.5%	✓ 71.6%	✓ 72.7%	✗ 70.5%	✗ 70.5%	✗ 69.5%	✗ 70.2%	✗ 76.3%	✗ 76.3%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 89.4%	✓ 89.4%
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥75%	✓ 76.0%	✓ 82.9%	✓ 82.6%	✓ 80.6%	✓ 75.3%	✓ 79.8%	✓ 79.2%	✓ 78.2%	✓ 81.6%	✓ 81.6%	✓ 78.2%	✓ 80.5%	✓ 79.9%	✓ 78.4%	-	✓ 79.2%	✓ 79.3%
		Cancer 31-day treatment performance	≥96%	≥Plan	✗ 73.2%	✗ 80.0%	✗ 90.4%	✗ 81.4%	✓ 89.8%	✓ 87.5%	✓ 88.3%	✓ 88.6%	✓ 95.0%	✓ 91.1%	✓ 95.0%	✓ 93.8%	✓ 94.3%	✓ 89.8%	-	✗ 91.9%	✓ 91.3%
		Cancer 62-day treatment performance	≥85%	≥Plan	✗ 56.5%	✗ 54.7%	✗ 69.2%	✗ 60.4%	✓ 71.8%	✗ 56.3%	✓ 70.3%	✗ 66.1%	✓ 71.4%	✓ 67.9%	✓ 61.2%	✗ 67.0%	✗ 66.1%	✗ 69.7%	-	✗ 68.0%	✗ 66.9%
		Suspected cancer patients waiting over 62-days			88	57	59	59	100	80	81	81	75	99	95	95	98	86	92	86	86
Best Value Care	Finance	Income & expenditure against plan	≥£0.00m	≥£0.00m	✗ -£0.76	✓ £2.33	✗ -£12.76	✗ -£11.19	✗ -£0.02	✓ £0.02	✗ -£0.61	✗ -£0.61	✗ -£0.33	✗ -£0.31	✓ £0.44	✗ -£0.20	✗ -£0.18	✗ -£0.79	✗ -£0.09	✗ -£1.06	✗ -£1.87
		Financial Improvement Programme (FIP) against plan	≥£0.00m	≥£0.00m	✓ £1.27	✗ -£0.43	✓ £0.54	✓ £1.38	✗ -£0.55	✓ £1.48	✓ £0.66	✓ £1.59	✗ -£1.61	✗ -£1.38	✗ -£1.57	✗ -£4.56	✓ £4.90	✗ -£1.66	✗ -£0.20	✓ £3.04	✓ £0.07
		Capital expenditure against plan	≤£0.00m	≤£0.00m	✓ -£2.01	✓ -£0.88	✓ -£12.53	✓ -£15.42	✗ £1.61	✗ £2.07	✗ £1.39	✗ £5.07	✗ £1.55	✗ £1.28	✗ £1.27	✗ £4.10	✗ £1.16	✗ £1.01	✗ £1.92	✗ £4.09	✗ £13.26
		Cash balance	-	≥£1.45m	£1.80	£8.76	£4.74	£4.74	✗ £1.34	✓ £1.73	✓ £1.50	✓ £1.50	✗ £0.32	✗ £0.15	✗ £0.05	✗ £0.05	✓ £9.46	✓ £4.17	✗ £1.28	✗ £1.28	✗ £1.28
		Implied Productivity 2023/24 v 2024/25	-	3.1%	-	-	-	-	-	-	-	-	✓ 6.7%	✓ 5.2%	✓ 6.1%	✓ 6.1%	✓ 6.9%	-	-	✓ 6.9%	✓ 6.9%
		Value weighted elective activity	-	105%	113.2%	114.2%	127.1%	118.2%	✗ 103.5%	✓ 110.9%	✓ 112.0%	✓ 108.8%	✓ 108.8%	✓ 118.7%	✓ 118.5%	✓ 115.3%	✓ 119.1%	✓ 113.6%	✓ 114.4%	✓ 115.7%	✓ 113.3%
		Agency expenditure against plan	≥£0.00m	≥£0.00m	✗ -£1.36	✗ -£1.17	✗ -£1.09	✗ -£3.62	✗ -£0.18	✗ -£0.29	✗ -£0.29	✗ -£0.76	✗ -£0.39	✗ -£0.24	✓ £0.01	✗ -£0.62	✗ -£0.17	✗ -£0.09	✓ £0.14	✗ -£0.12	✗ -£1.50
		Reported agency spend			£1.47	£1.28	£1.21	£3.96	£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£1.18	£1.14	£0.90	£3.22	£10.63
		Reported bank spend			£3.36	£2.01	£3.69	£9.06	£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£2.36	£2.41	£2.61	£7.38	£22.96
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan	≤Plan	✗ 104.5%	✗ 111.1%	✗ 111.6%	✗ 109.0%	✗ 111.5%	✗ 106.8%	✗ 104.1%	✗ 107.3%	✗ 106.5%	✓ 96.7%	✗ 102.0%	✗ 101.7%	✗ 105.9%	✗ 107.4%	✗ 107.7%	✗ 107.0%	✗ 105.3%
		Non-elective admissions	≤Plan	≤Plan	✗ 119.9%	✗ 118.6%	✗ 116.0%	✗ 118.2%	✗ 111.3%	✗ 110.4%	✗ 103.3%	✗ 108.3%	✗ 105.5%	✗ 102.1%	✓ 99.1%	✗ 102.2%	✓ 98.1%	✓ 96.2%	✗ 103.3%	✓ 99.1%	✗ 103.1%
	Electives	Average daily elective referrals			314	327	304	315	343	340	325	336	348	320	347	338	374	350	-	362	343
		Outpatients - first appointment	≥Plan	≥Plan	✓ 108.3%	✓ 106.3%	✓ 109.7%	✓ 108.1%	✗ 99.3%	✗ 84.0%	✗ 94.0%	✗ 92.3%	✗ 90.5%	✗ 87.5%	✗ 96.0%	✗ 91.3%	✗ 82.9%	✗ 83.4%	✗ 78.2%	✗ 81.6%	✗ 88.3%
		Outpatients - follow up	≤Plan	≤Plan	✗ 107.5%	✗ 105.0%	✗ 106.2%	✗ 106.2%	✓ 100.0%	✗ 102.4%	✓ 94.1%	✓ 98.9%	✓ 99.1%	✓ 92.2%	✓ 97.2%	✓ 96.2%	✓ 97.2%	✓ 92.5%	✓ 92.0%	✓ 94.0%	✗ 96.3%
		Outpatients - procedures	≥Plan	≥Plan	✓ 121.7%	✓ 125.3%	✓ 123.0%	✓ 123.3%	✓ 133.0%	✓ 129.3%	✓ 114.4%	✓ 125.3%	✓ 122.7%	✓ 118.7%	✓ 139.0%	✓ 126.1%	✓ 139.9%	✓ 124.7%	✓ 139.9%	✓ 134.5%	✓ 128.4%
		Day case	≥Plan	≥Plan	✓ 100.2%	✓ 101.5%	✓ 109.8%	✓ 103.7%	✗ 96.3%	✗ 96.1%	✗ 96.0%	✗ 96.1%	✓ 102.7%	✓ 101.3%	✓ 100.0%	✓ 101.3%	✗ 95.8%	✓ 101.4%	✗ 97.1%	✗ 98.1%	✗ 98.6%
		Elective inpatient	≥Plan	≥Plan	✓ 101.9%	✓ 110.8%	✓ 129.3%	✓ 113.5%	✗ 92.5%	✗ 94.6%	✗ 90.0%	✗ 92.4%	✓ 84.0%	✗ 99.8%	✗ 96.7%	✗ 93.3%	✓ 108.0%	✓ 109.4%	✗ 97.9%	✓ 105.4%	✗ 97.0%
	Diagnostics	Diagnostics	≥Plan	≥Plan	✓ 102.6%	✓ 103.9%	✓ 106.8%	✓ 104.4%	✓ 102.6%	✓ 109.2%	✗ 98.1%	✓ 103.2%	✓ 104.9%	✓ 111.4%	✓ 112.5%	✓ 109.5%	✓ 120.5%	✓ 114.9%	✓ 114.6%	✓ 116.7%	✓ 109.8%

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Quality of Care

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Domain Summary: Quality of Care

Overview	Lead: Chief Nurse/Medical Director

In Oct-24 we reported our first MRSA bacteraemia for over two years; regionally Trusts are reporting an increase in cases. We have identified an increase in infections related to C-difficile and Gram-negative infections which is in line with what is being seen nationally. Infection, Prevention and Control (IPC) undertake rapid reviews for all hospital associated infections and had completed 223 at the end of Dec-24 with learning being shared as part of all divisional governance reports.

Two Patient Safety Incident Investigations (PSII) were commissioned by the Patient Safety Incident Response Group (PSIRG) in Dec-24, this followed an in-depth discussion during which representatives from the Integrated Care Board (ICB) were present. There is one confirmed coroner's investigation. During quarter three, four PSII's were signed off and the key learning points were identified (shared on slide nine).

During 2024/25 quarter three, we received 511 compliments, 381 concerns, 47 formal complaints, and closed 85, showing a 42% increase in response times /formal complaints. We continue to identify actions and themes that are tracked through the Patient Experience Committee.

There are eight off-track metrics during 2024/25 quarter three:

- **Category 3/4 Hospital Acquired Pressure Ulcers (HAPU) and ungradable pressure ulcers with lapses in care**: SFH reported two avoidable category three pressure ulcers.
- **Falls per 1000 occupied bed days:** falls rate for Nov-24 (7.4) and Dec-24 (7.3) was above the national average of 6.63 per thousand occupied bed days.
- **MRSA reported in month:** During quarter three we have reported one hospital-onset healthcare-associated (HOHA) and one community-onset healthcare-associated (COHA).
- **C-difficile reported in month:** During quarter three we have reported 17 HOHAs and 11 COHAs.
- **Klebsiella BSI reported in month:** We have reported two HOHAs and two COHAs.
- **Hospital Standardised Mortality Ratio (HSMR):** Latest 12-monthly rolling = 101.4 (Oct-23 to Sep-24); (quarter two report HSMR 122.14). Now as expected.
- **Summary Hospital-level Mortality Indicator (SHMI):** Latest reporting = 106.05 (Aug-23 to Jul-24); (quarter two report 105.96). Remains as expected.
- **Early neonatal deaths**: Four stillbirths (one in Oct- 24 and three in Nov-24), and no early neonatal deaths.

The following pages contain more detailed performance information across the quality of care domain.

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Scorecard: Quality of Care

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

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD
Safe	Falls with lapse in care	≤2	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1
	Falls per 1000 occupied bed days	≤6.63	≤6.63	✗ 6.9	✗ 7.3	✓ 6.1	✗ 6.7	✓ 6.2	✓ 5.8	✗ 6.7	✓ 6.3	✗ 6.7	✓ 5.9	✓ 6.2	✓ 6.3	✓ 6.0	✗ 7.4	✗ 7.3	✗ 6.9	✓ 6.5
	Never events	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 2
	MRSA reported in month	0	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✓ 0	✗ 1	✗ 1
	Cdifficile reported in month	≤13	≤13	1	3	5	✓ 9	4	4	5	✓ 13	4	3	4	✓ 11	7	4	6	✗ 17	✗ 41
	Ecoli blood stream infections (BSI) reported in month	≤22	≤22	3	5	3	✓ 11	5	1	4	✓ 10	3	5	2	✓ 10	4	6	0	✓ 10	✓ 30
	Klebsiella BSI reported in month	≤1	≤1	2	1	0	✗ 3	0	1	2	✗ 3	1	1	0	✗ 2	1	1	0	✗ 2	✗ 7
	Pseudomonas BSI reported in month	≤3	≤3	2	1	1	✗ 4	0	0	1	✓ 1	0	0	0	✓ 0	0	1	0	✓ 1	✓ 2
	HAPU (cat 2) per 1000 occupied bed days with a lapse in care			0.2	0.2	0.1	0.2	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.2	0.1	0.0	0.1	0.1
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✗ 1	✗ 1	✗ 2	✓ 0	✓ 0	✗ 1	✗ 1	✓ 0	✓ 0	✗ 2	✗ 2	✗ 5
	Patient Safety Incident Investigations (PSII)			2	2	1	5	3	4	0	7	0	2	2	4	1	0	2	3	14
	Sepsis *(metric to be defined)*																			
Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	✓ 1.1	✓ 1.1	✓ 0.8	✓ 1.0	✓ 0.7	✓ 1.5	✓ 0.9	✓ 1.0	✓ 1.5	✓ 0.8	✓ 0.8	✓ 1.0	✓ 0.8	✓ 0.8	✓ 0.4	✓ 0.7	✓ 0.9
	Compliments received in month			151	122	120	393	161	138	151	450	155	120	119	394	204	160	147	511	1355
Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	✗ 108	✗ 107	✗ 105	✗ 105	✗ 104	✗ 103	✗ 102	✗ 102	✗ 102	✗ 102	✗ 103	✗ 103	✗ 103	✗ 103	✗ 101	✗ 103	✗ 103
	SHMI	≤100	≤100	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106	✗ 106
	Still birth rate	≤4.4	≤4.4	✓ 3.2	✗ 11.5	✓ 3.7	✗ 5.9	✓ 0.0	✓ 3.2	✓ 4.2	✓ 2.3	✓ 0.0	✗ 6.8	✗ 6.4	✓ 4.4	✓ 3.4	✗ 10.3	✓ 0.0	✗ 4.5	✓ 3.8
	Early neonatal deaths per 1000 live births	≤1	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✗ 3.2	✗ 1.1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.4

Indicator in Focus: Falls per 1000 occupied bed days

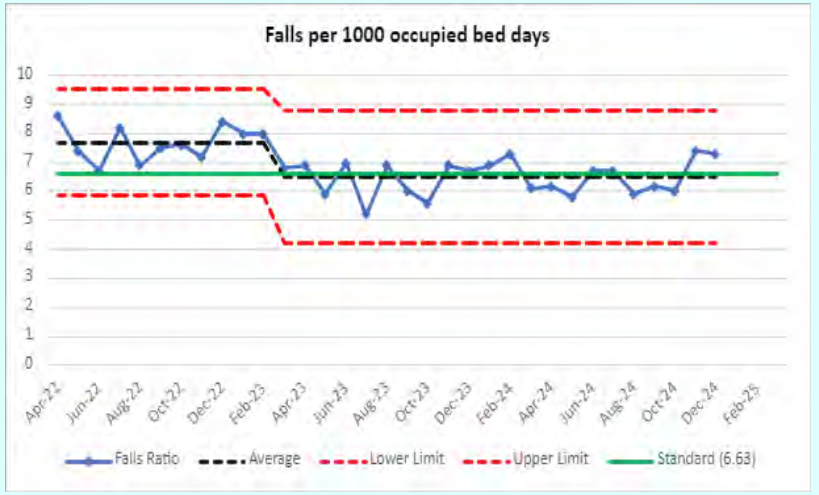
NHS
Sherwood Forest Hospitals
NHS Foundation Trust

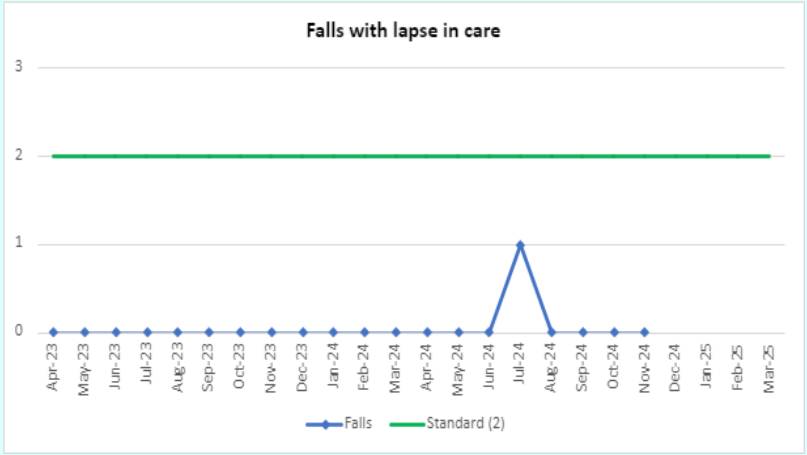
Overview and national position

Following a strong performance in Oct-24 the falls rate for Nov-24 (7.4) and Dec-24 (7.3) was above the national average of 6.63 per thousand occupied bed days, putting us off track for 2024/25 quarter three. This may be in part due to the continued high volume of people consistently accessing urgent care; the Trust has been in surge capacity and has at times used the Full Capacity Protocol (FCP).

In-depth investigations identified that there had been no falls where lapses in care have been identified. Actions and learning identified as part of the investigations is captured below.

Data





Root causes	Actions and timescale	Impact
Increase in number of falls in Dec-24, due to increase in surge capacity and implementation of FCP.	• Training on fundamentals of care for Healthcare Support Workers. • Training on essentials to role for Registered Nurses. • Training on focus days for preceptorship nurses.	• Staff up to date with falls information.
	• Focused support for wards that request additional training.	• To share relevant information for that area regarding recent incidents and how they can learn from them.
	• Thematic Falls review to be completed via the Patient Safety Incident Response Framework (PSIRF).	• To identify any lapses within care, looking retrospectively at incidents, to be shared via the Nottingham and Nottinghamshire Integrated Care System (ICS) falls group.
Seasonal increase in length of stay.	• Supporting wards with identifying repeat falls and providing education to patients to reduce risk of falling again.	• To reduce risk of repeat falls.

Indicator in Focus: MRSA, C-difficile and Klebsiella BSI

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

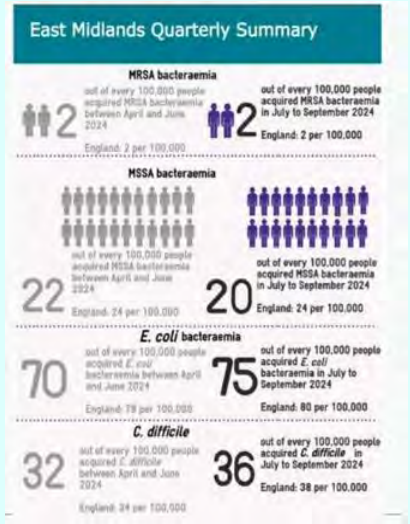
MRSA - The national trajectory has been set for the Trust at 0 (same for all organisations).
Quarter three: Reported one HOHA and one COHA. These are the first MRSA bacteraemia in over two years. Regionally, Trusts are seeing an increase in cases. Benchmarking against peer organisations shows that we are in the middle of the group, not an outlier.
C-difficile - The national trajectory has been set for the Trust at 65 (increase of eight from last year's trajectory).
Quarter three: Reported 17 HOHA and 11 COHAs. We have had 63 cases identified and are close to breaching our target. Regionally and nationally, Trusts are seeing an increase in cases, with the UKHSA releasing a briefing note in Dec-24 related to this increase with recommendations for reporting clusters and outbreaks and responding to any additional requests from UKHSA. Benchmarking against peer organisations shows that we are in the middle of the group, not an outlier.
Klebsiella - The national trajectory has been set for the Trust at 16. (reduction of six from last year's trajectory).
Quarter three: Reported two HOHA and two COHAs. There is currently a regional and national increase in cases, we have provided data on all cases to our Regional NHS England team to look for any wider themes. Benchmarking against peer organisations indicates that we continue to have the second lowest number of cases.

Root causes	Actions and timescale	Impact
MRSA: Wound related and one was a contaminated sample.	• Commenced work to ensure all wounds are reviewed and swabbed at time of admission. • Carry out a blood culture project to maintain correct procedures and ensure correct levels are obtained.	• Early identification of infections. • Reduction in contamination rate and better identification of infection.
C-difficile: Found to be unavoidable due to patients being treated with antibiotics for other infections.	• Commencing a review of C-difficile patients relating to the increase in use of high-risk antibiotics in the Trust. • Conducting quarterly thematic reviews of all cases.	• Raise awareness of antimicrobial stewardship. • To reduce case and improve practice.
Klebsiella: Two out of four of the bacteraemia were caused by urinary tract infections (UTIs).	• Integrated Care Board (ICB) review of gram-negative bacteraemia to be undertaken to review themes.	• Reduce number of infections.
	• Quarterly thematic reviews of all cases being undertaken by the Infection Prevention and Control (IPC) team.	• Identify areas for improvement and reduce infections.

Data

National Picture

Regional Picture



Indicator in Focus: Hospital Acquired Pressure Ulcers (HAPU)

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

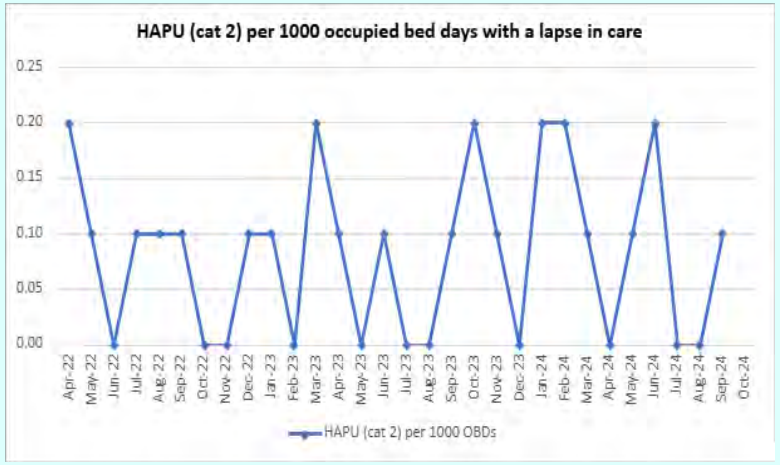
Overview and national position

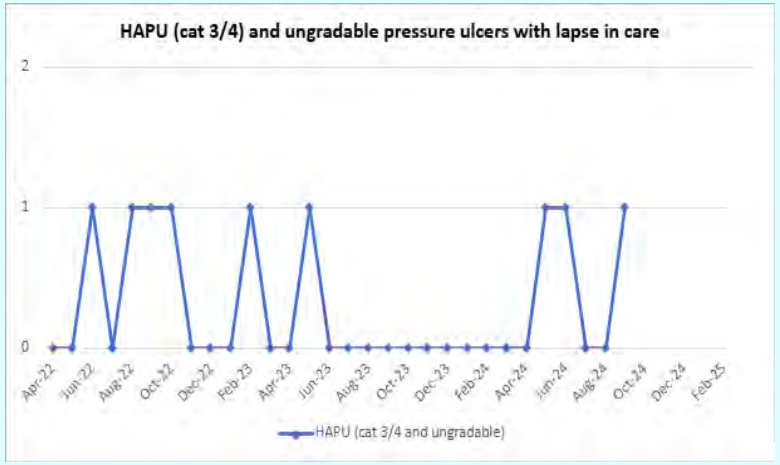
Pressure ulcers are in the 'top 10 harms' to patients (NHS England, 2024). Although there is no longer a national recommendation for identifying avoidable/unavoidable pressure damage, our position is that all Trust acquired pressure ulcers are investigated to identify learning.
Pressure ulcers are categorised as 'avoidable' where learning is identified or there is a lapse in care.
In 2024/25 quarter three, SFH has had two avoidable category three pressure ulcers:

- Ward 41 investigated new pressure damage on a patient's buttock who was admitted for general decline and chest sepsis, with pre-existing category four damage and osteomyelitis. A specialist air fluidised mattress was provided, which was found to be partially deflated on one occasion due to a missing cable.
- Short Stay Unit (SSU) have investigated bilateral heel category three damage to a patient with learning difficulties (LD). This gentleman had existing leg ulcerations to both lower legs, requiring bandaging. He had full time carers present during his admission.

Root causes	Actions and timescale	Impact
Ward 41: Despite regular skin checks being performed, these highlighted the presence of dressings to the existing ulceration; lapses found in recording his remaining skin condition. The investigation was unable to determine if the deflated mattress was a contributory factor.	• Ward leader is discussing identified lapses in skin checks with individual staff members involved. • Incident will be shared to facilitate learning by the Tissue Viability (TV) team within the 2025 Pressure Ulcer Prevention training for both Registered Nurses (RNs) and Healthcare Assistants (HCAs). Identified staff members from ward 41 are to attend this training. • Immediate learning from the incident has been shared with the ward team. • Ward 41 team did not have access to Orion to compare skin condition to previous photographs; this has been addressed, and the team can now access records	• Potential for similar incidents Trust-wide in inpatient areas. Learning to be shared from both incidents. Plans in place for the Tissue Viability team to present both incidents as case studies to facilitate learning Trust-wide.
SSU: Investigation found inconsistency and lack of skin checks to heels, inappropriate bandaging and no recorded dressing changes, delays in reporting and escalating damage once identified. The traffic light system for LD patients was not utilised.	• SSU Investigation is still ongoing; further information is to be added relating to lapses in use of the LD traffic light system. • Reflective statements have been requested from all RNs involved in this incident and the ward leader will consider file notes / further action according to responses. • Audits of pressure ulcer prevention documentation are ongoing with support from TV teams. • TV champions and identified staff members are to attend TV training on pressure ulcer prevention and leg ulcer management.	

Data





Indicator in Focus: Patient Safety Incident Investigations (PSII)

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

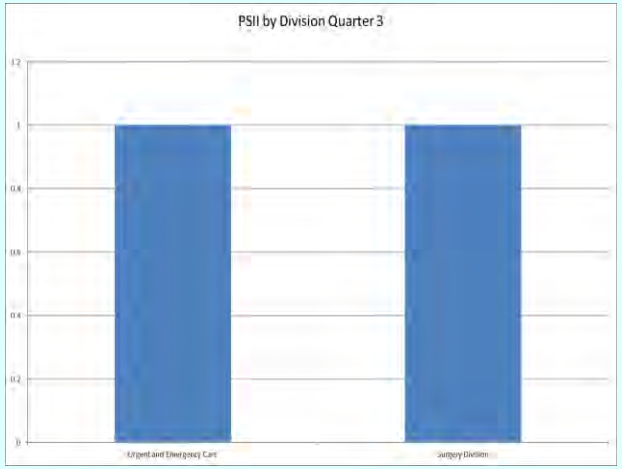
In line with SFH's Patient Safety Incident Response Plan during quarter three, two PSII's were commissioned by the Patient Safety Incident Response Group (PSIRG) following in-depth discussion during which the ICB were present.

PSII with potential coronial interest	MSNI investigation	Never Events
One of the patients have died and the case has been taken by the coroner. There is no inquest date listed at present.	None commenced	None reported in Quarter 3

During quarter three, there were four PSII's that were signed off and the key learning points were identified as follows:

1) Following concerns with management of sepsis, a PSII was completed which identified multiple actions including, sepsis training, information resources for employees, requirement for a medical sepsis lead and reviewing use of electronic handovers. It was agreed the full action plan would be monitored via Patient Safety Committee (PSC).
2) PSII completed following a theme of Mental Capacity Act (MCA) and Deprivation of Liberty (DoL) processes not being followed appropriately. There were multiple actions agreed; however, one key action was for the current provision for safeguarding services within SFH to be reviewed to provide a more comprehensive training programme, a robust audit and support to ward areas with patients with complex care needs. This will in turn support completion of the actions in relation to MCA and DoL documentation.
3) PSII completed and presented to the coroner in relation to abnormal results not being acted upon in a timely manner. Key Trust-wide generic learning included: A reconfiguration of how blood results are displayed on the ICE system is required to ensure results are grouped; and review the standard operating procedure (SOP) "Guidelines for telephoning abnormal results" to ensure staff groups who can receive urgent results are correct.
4) PSII completed in relation to an unexpected death linked with abnormal acute kidney injury (AKI) results not being identified during a resident doctor strike- this was presented to the coroner. Recommendations identified: 1)Review the "Patient 60 years and over Femur Fracture Multidisciplinary Integrated Care Pathway" booklet with a view to include a section for observations and bloods as is done on day one post-operation. 2) Future digital developments including the implementation of electronic patient records need to consider including the management and action for the receipt of abnormal clinical investigations.

Data



Root causes	Actions and timescale	Impact
Commissioned in Dec-24 following an unexpected cardiac arrest whereby there was a delay in obtaining an airway and utilising the defibrillator.	PSII commissioned, immediate learning identified: • Review defibrillator compatibility issues on Emergency Assessment Unit (EAU). • Safety communications regarding the equipment within EAU. • Clarify roles for cardiac arrests. • Learning around resuscitation trolleys to junior team.	PSII ongoing.
PSII commissioned following two incidents whereby there were concerns regarding documentation of surgical site.	PSII commissioner, immediate learning identified: • Communication to be sent to the team to include awareness for checking consent, imaging, carrying out the World Health Organisation (WHO) checklist, documentation and handovers.	PSII ongoing.

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

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

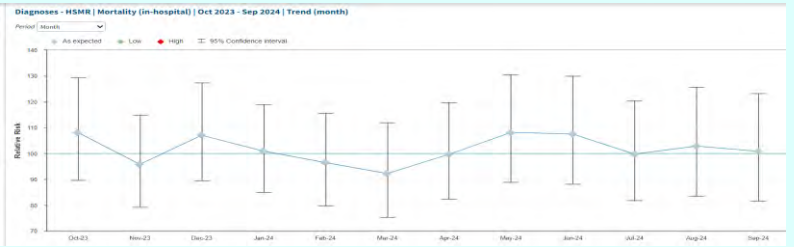
HSMR+ (Plus) - Latest 12-monthly rolling = 101.4 (Oct 23 – Sept 24); (Q2 report HSMR 122.14). **Now as expected.**
As of Nov 2024, Telstra implemented revised methodology, HSMR+ (Plus), to provide a "more robust" and equitable benchmarking tool
SHMI - Latest reporting = 106.05 (Aug 23- Jul 24); (Q2 report 105.96). **Remains as expected.**

Root causes	Actions and timescale	Impact
Data Quality Timely diagnosis, documentation, coding, co-morbidity capture	• Focus on documentation, accuracy (in relation to coded entries) and communication. • Work continues to develop a culture of "change" in relation to timely diagnosis, signposting and management, with increased focus on 'Getting it Right First Time (GIRFT)' and post-take ward round senior-decision making. • Specific review of specialty coding entries to ensure accurate reflection of activity.	HSMR (+) figure will not, necessarily, reflect until 12 months after action commenced.
Patient Management and Flow Clinical pathways, management bundles and effective signposting.	• Continued emphasis on senior decision making to support timely and effective management. • Review of pathways and how decisions and flow / signposting impact management. • Targeted reviews, as part of the wider Learning from Deaths (LfD) process, to investigate/ understand outlier areas and identify Trust opportunities for improvement. Highlighted/deep-dive areas include Alcohol Liver Disease (ALD), Anaemia (deficiency) and Intestinal Infection.	As above; forms part of overall working approach Reporting aids discussion, learning and helps identify further action / escalation.
Palliative Care Coding **(**Remains low, nationally)	• SFH continues to report low Specialist Palliative Care (SPC) coding but the difference between trust and national / peers is showing a converging trend. With HSMR+ not adapting for SPC coding, the importance of a separate focus remains. • Discussions continue, with local SPC provider, to identify opportunities for improvement, alongside direct support for clinical teams.	SPC low activity compared to overall. Requires Trust & ICB resource / investment.
Learning from Deaths (LfD) **Data Intelligence and Benchmarking** **External peer review and Wider accountability** **Collaboration**	• LfD continues to be the forum by which trends and outliers are discussed and reviewed. • Wide internal representation (inc. divisional / clinical specialty) alongside close working with Telstra (data analytics / HSMR+), for benchmarking analysis, triangulation and learning/action. • Monthly meeting with Telstra to ascertain trends, outliers and need for further reviews. • HSMR+ performance has followed a consistently lower trend than HSMR (-23.5pts average). • Crude rate continues to trend downwards; a similar trend with expected rates is under review. • Focus on re-identification, mortality reviews, reporting, patient segmentation, documentation. • The Trust are in the early stages of determining future 'benchmarking tool' requirements in the context of both Trust and wider / ICB opportunities. • Share mortality reporting and assurance measures with ICS colleagues to aid wider learning • Update presentation to Quality Committee (Nov 2024) including HSMR+ changes and impact • Awaiting next stage of quality dashboard development, hoped to summarise a range of key patient safety metrics. • "Interface Workstream" in place to support developing collaborative relationships, wider understanding and promote pathways for future working, locally and on ICS footprint.	Shared understanding and action with improved clinical engagement / ownership. Monitor HSMR+ over coming months to provide assurance of retrospective trends. Improved mortality review processes and understanding. Greater assurance and understanding. Whole pathway approach and system understanding.

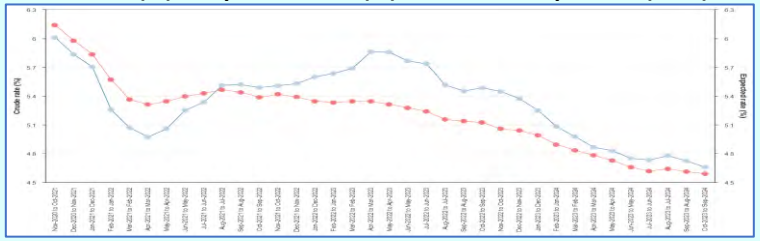
Data

HSMR+ 3 yearly (12 month rolling) trend

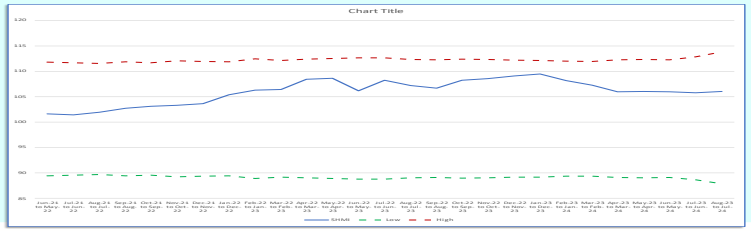
HSMR Single-Month Trend



Crude Rate (%) v Expected Rate (%) Oct 2021 – Sept 2024 (36m)



SHMI: Rolling 12 months (Latest- Aug 23-Jul 24)



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

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

In 2024/25 quarter three, there were four stillbirths (one in Oct- 24 and three in Nov-24), and no early neonatal deaths. Each case received an individual review as outlined below and has been reported through the Perinatal Mortality Review Tool (PMRT) process where they will receive a further review. All cases were reported within the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE) recommended timescales.

Stillbirths

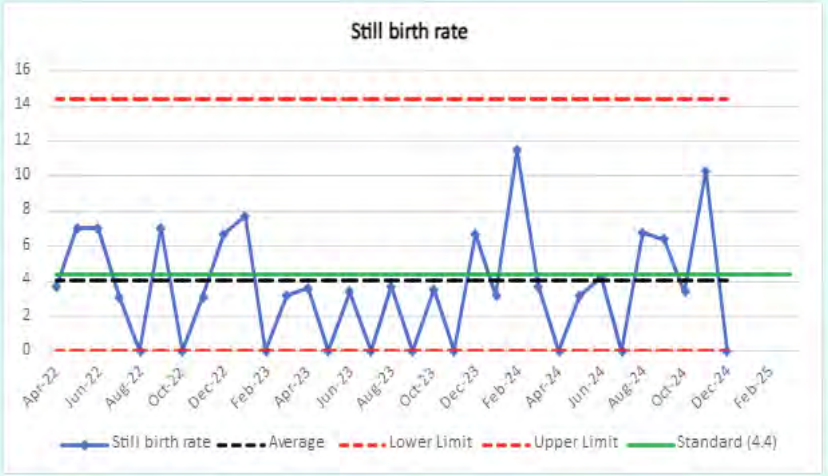
Oct-24:

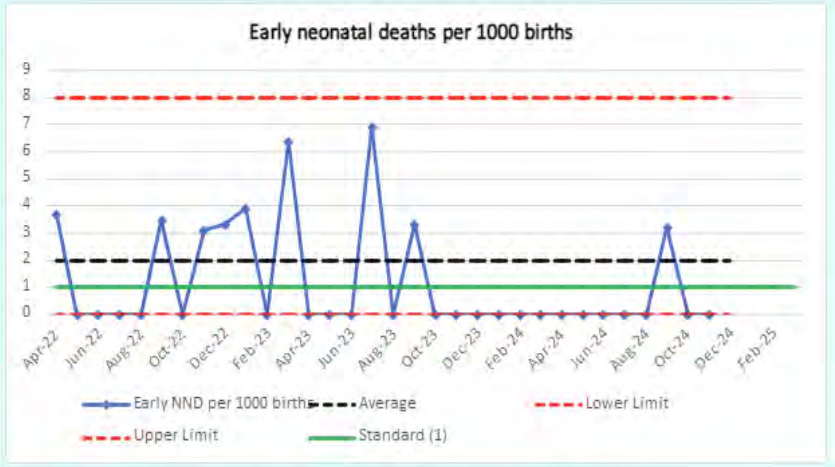
- Stillbirth at 24 weeks and four days gestation, attended triage with the first episode of altered fetal movements and unable to auscultate a fetal heart. No concerns were raised from parents or initial review.

Nov-24:

- Stillbirth at 28-week gestation, attended triage with a history of altered fetal movements for twenty-four hours, unable to auscultate a fetal heart. No concerns were raised.
- Stillbirth at 25 weeks and two days gestation, known oligohydramnios and intrauterine growth restriction, attended with altered fetal movements and no fetal heart present. Managed through the correct pathways with no initial concerns.
- Stillbirth at 27 week and three days gestation, attended triage with the first episode of altered fetal movements, unable to auscultate a fetal heart.

Data





Root causes	Early/ urgent learning identified	Impact
No early themes.	Review now to include postcode analysis to support depravation index analysis and any subsequent themes.	

Outstanding Care,
Compassionate People,
Healthier Communities

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People and Culture

Outstanding Care,
Compassionate People,
Healthier Communities

Sherwood Forest Hospitals
NHS Foundation Trust

Domain Summary: People and Culture

Overview	Lead: Director of People

It has been an extremely busy time across the hospital and within the ICS, with extra controls and governance mobilised at short notice to support our financial position for 2024/25. However, through 2024/25 quarter three we have noted positive performance across some People and Culture metrics. We are also finalising the development our People Strategy for 2025 to 2029.

Our planned whole time equivalent (WTE) position for Dec-24 shows that we are -0.9% (or -55.3 WTEs) under plan. We are over plan on substantive WTEs (+28.3 WTES) and under plan on Bank (-60.5 WTEs) and Agency (-23.0 WTEs). This variance is due to the Trust strategy on replacing 'temporary staffing' with substantive staff, which gives us more sustainability and lower costs across the workforce. We are projecting that we will deliver a position under plan for our total workforce numbers by Mar-25. Within our workforce efficiency programme, we are £1.82m over our plan for Dec-24 and are projecting an increase in the target from £13.9m to £17.0m.

Our Mandatory and Statutory Training (MaST) position is positive where we are continuing to report levels above the Trust standards. Vacancy and turnover rates sit below our standard. From Apr-24 to date, we have used zero 'off framework' agency. Appraisal levels in quarter three were 88.2%, marginally below the Trust target (90%). We have undertaken an audit around appraisals where we have received a high assurance level.

Over quarter three our sickness absence level is reported at 5.8% (2024/25 quarter two was 4.6%); this sits higher than Trust target (4.2%) and between the upper and lower statistical process control levels. During quarter three, have noted increases within staff reporting absence for cold, cough and influenza (5.3% increase) and in chest & respiratory problems (1.5% increase).

Our staff influenza vaccination take up is reported at 47.1%. This is lower than in previous years (55.9% in Dec-23), however we compare favourably to national NHS figures; 38.8% of eligible healthcare workers nationally having had an influenza vaccine.

Employee relations cases over the quarter have remained high (monthly average of 19); a marginal decrease from quarter two (20). This sits above our target (17), but within the statistical process control limits. The Trust has seen several formal disciplinary cases being concluded in quarter three.

We monitor our agency levels frequently. The reduction of this level is aligned with some of our efficiency programmes. Our current agency position for quarter three is reported at 3.5%, and for Dec-24 this is reported at 3.2%. When we exclude Elective Recovery Fund (ERF) schemes from the agency level, this reduces to 2.6%. Over the quarter we have seen zero 'off framework' workers. This reduction follows amended agency rules that came into force from Jul-24. During quarter three, 45.4% of total agency shifts filled were 'on framework' staff, but above the recommended NHS England price cap. During quarter three, significant work has commenced that aligns to our efficiency programme. This is outside our target and the NHSE expectation (40%). However, the work we have commenced is showing positive signs, and we are planning to hit this target by Mar-25.

The following pages contain more detailed performance information across the people and culture domain.

Outstanding Care,
Compassionate People,
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Scorecard: People and Culture

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

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD
Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	✓ 6.9	-	-	-	✓ 6.8	-	-	-	✓ 6.8	-	-	-	-	✓ 6.8
Growing the Future	Vacancy rate	≤8.5%	≤8.5%	✓ 5.1%	✓ 4.7%	✓ 4.5%	✓ 4.7%	✓ 8.2%	✓ 8.0%	✓ 8.1%	✓ 8.1%	✓ 8.4%	✓ 7.7%	✓ 7.4%	✓ 7.9%	✓ 8.4%	✓ 8.3%	✓ 8.1%	✓ 8.3%	✓ 8.1%
	Turnover in month	≤0.9%	≤0.9%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.4%	✓ 0.5%	✓ 0.3%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.6%	✓ 0.5%	✓ 0.5%	✓ 0.4%	✓ 0.5%	✓ 0.7%	✓ 0.5%	✓ 0.5%
	Appraisals	≥90%	≥90%	✗ 88.9%	✗ 88.3%	✗ 87.8%	✗ 88.3%	✗ 88.5%	✓ 90.1%	✗ 88.8%	✗ 89.1%	✓ 90.3%	✓ 90.0%	✗ 89.7%	✓ 90.0%	✗ 88.8%	✗ 86.9%	✗ 88.8%	✗ 88.2%	✗ 89.1%
	Mandatory & statutory training	≥90%	≥90%	✓ 91.0%	✓ 91.0%	✓ 92.0%	✓ 91.3%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.4%	✓ 91.3%	✓ 90.9%	✓ 91.2%	✓ 90.9%	✓ 90.7%	✓ 91.8%	✓ 91.1%	✓ 91.1%
Looking after our People	Sickness absence	≤4.2%	≤4.2%	✗ 5.0%	✗ 4.7%	✗ 4.3%	✗ 4.6%	✗ 4.3%	✗ 4.4%	✗ 4.7%	✗ 4.4%	✗ 4.9%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 5.6%	✗ 5.7%	✗ 6.1%	✗ 5.8%	✗ 4.9%
	Total workforce loss	≤7.0%	≤7.0%	✗ 7.3%	✓ 6.9%	✓ 6.4%	✓ 6.9%	✓ 6.4%	✓ 6.4%	✓ 6.8%	✓ 6.5%	✓ 6.9%	✓ 6.3%	✓ 6.7%	✓ 6.6%	✗ 7.6%	✗ 7.8%	✗ 8.1%	✗ 7.8%	✓ 7.0%
	Flu vaccinations uptake (front line staff)	≥80%	≥75%	58.0%	58.0%	-	58.0%	-	-	-	-	-	-	-	-	35.3%	43.6%	47.1%	47.1%	47.1%
	Employee relations management	<12	<17	✗ 20	✗ 17	✗ 21	✗ 19	✗ 20	✗ 23	✓ 15	✗ 19	✗ 20	✗ 20	✗ 21	✗ 20	✗ 19	✗ 20	✗ 18	✗ 19	✗ 20
New Ways of Working	Bank usage			8.8%	7.7%	10.8%	9.1%	8.3%	10.3%	9.3%	9.3%	9.8%	10.3%	8.1%	9.4%	7.3%	7.8%	9.1%	8.0%	8.9%
	Agency usage	<3.7%	<3.2%	✗ 5.2%	✗ 4.7%	✗ 4.2%	✗ 4.7%	✗ 4.6%	✗ 4.6%	✗ 4.7%	✗ 4.6%	✗ 5.1%	✗ 4.2%	✗ 3.4%	✗ 4.2%	✗ 3.6%	✗ 3.7%	✓ 3.2%	✗ 3.5%	✗ 4.1%
	Agency (off framework)	≤6.0%	0%	✓ 0.1%	✓ 0.1%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✗ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	0.0%
	Agency (over price cap)	≤30.0%	≤40.0%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.0%	✗ 55.1%	✗ 55.6%	✗ 59.7%	✗ 57.1%	✗ 60.3%	✗ 53.6%	✗ 55.5%	✗ 56.4%	✗ 45.1%	✗ 43.1%	✗ 47.9%	✗ 45.4%	✗ 53.1%

Indicator in Focus: Appraisals

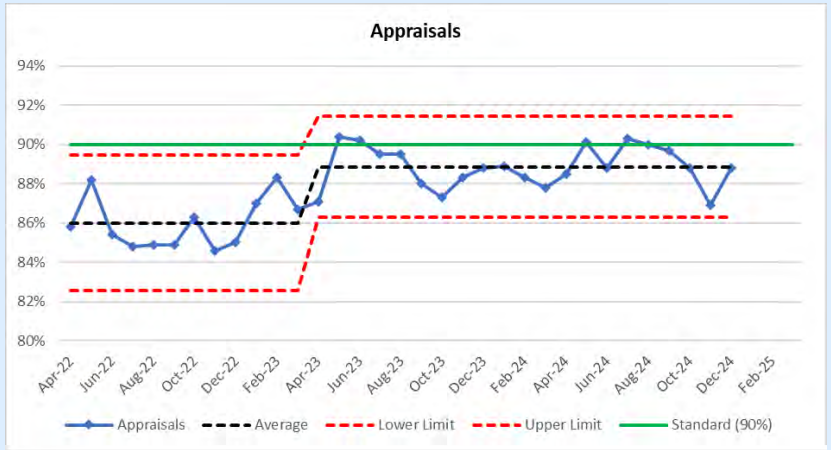
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Our appraisal level sits below the Trust target (90%). Over 2024/25 quarter three the compliance levels ranged from 86.9% to 88.8% which is standard process variation as shown on the adjacent statistical process control chart. Our year-to-date average performance is 89.1%.

Local benchmarking shows that the ICB provider appraisal level is reported at 83.1% (Nov-24). The NHS Corporate Benchmarking exercise indicates that over 2023/24 our appraisal compliance is in the upper quartile. The national median is reported at 81.6%, with the upper quartile performance at 86.9%.

Data



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

Indicator in Focus: Sickness Absence

Sherwood Forest Hospitals NHS Foundation Trust

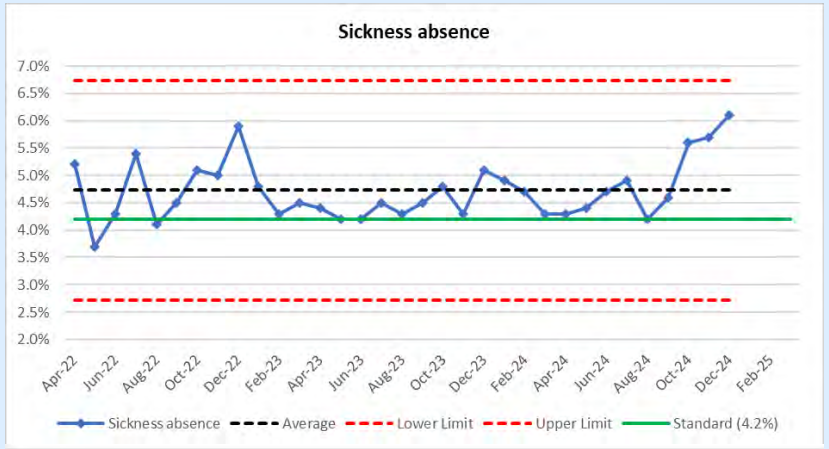
Overview and national position

During 2024/25 quarter three our overall sickness absence level was 5.8%. This sits above our target standard (4.2%). During the quarter, a gradual increase in the level is noted. The position for Dec-24 is reported at 6.1%. Our position for quarter three sits between the upper and lower statistical process control levels.

Between quarters two and three, we have noted increases with staff reporting absences related to Cold, Cough, Influenza (5.3% increase) and in Chest & Respiratory problems (1.5% increase).

Local benchmarking shows that the Integrated Care Board (ICB) provider sickness absence level is reported at 6.3% (Dec-24).

Data



Root causes

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

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

Actions and timescale

- All services are supported with one-to-one support from the Divisional People Lead teams with sickness absence management on a case-by-case basis and in line with policy where we will be re-focusing on fundamentals.
- A person-centred approach is taken in relation to sickness absence management.
- Sickness absence key performance indicators are monitored through People and Performance meetings, Service Line meetings and via Divisional Performance Reviews (DPRs).
- We have completed a deep dive into sickness that has been reviewed at our People Committee, within this will be an associated action plan is being developed for divisions that will be monitor via DPRs and People Cabinet.

Impact

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

Indicator in Focus: Flu Vaccinations

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

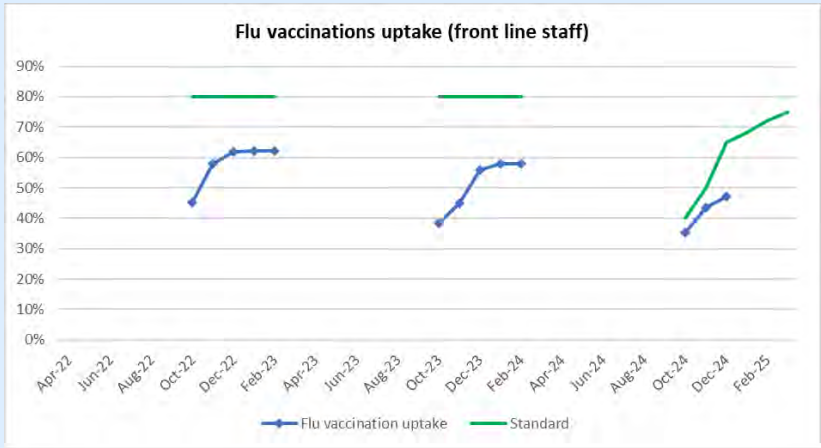
Our Staff Flu take up is reported at 47.1%, it is acknowledged that this is lower than in previous years (55.9% in Dec-23). Nationally the NHS is reporting lower figures with 38.8% of eligible healthcare workers having had a flu vaccine.

In the Midlands region the average uptake is 35.9% with SFH ranking 7th of 40 for highest uptake on 31 Dec-24. We have the highest uptake of providers across Nottinghamshire. In general, those with a higher uptake are smaller organisations with few exceptions.

We are actively promoting Flu vaccinations and linked this into Health and Wellbeing campaigns, aligned to the keeping well during winter programmes. The Occupational Health (OH) and Peer Vaccinator teams will continue to offer staff access to a flu vaccine up to the end of Mar-25 and the ICS Mobile Vaccine Unit will continue offering vaccines throughout Jan-25.

Recent surveys undertaken by our Communications team suggests colleagues are aware of how to get the vaccine and its importance; however, with the low uptake work is planned at SFH to understand why staff are choosing not to have the flu vaccination. The OH service is supporting a colleague undertaking masters level research to explore this. There is also potential for support from a Public Health Consultant from Nottinghamshire County Council to explore this issue.

Data



Root causes	Actions and timescale	Impact
Across the Trust we are actively promoted flu vaccinations and linking this into our Health and Wellbeing campaigns, which are aligned to our keeping well during winter programmes. Verbal reports from regional Occupational Health colleagues echoes the experience currently at SFH. Low staff engagement with flu vaccination which is mirrored by the national picture.	• Flu vaccine continues to be offered to all attendees to the Occupational Health department and the Peer Vaccinator teams continue to undertake roving clinics taking vaccination direct to staff in clinical areas. • We will also be reviewing where we have low compliance over differing lenses, so we can further target hard to reach groups. • Staff who receive their flu vaccine outside of SFH will have their vaccine added to the total at the end of the programme. Currently around 150 staff have notified the OH team to this effect.	• Increase vaccine uptake to reduce infection and spread across our workforce and our patients.

Indicator in Focus: Employee Relations Management

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

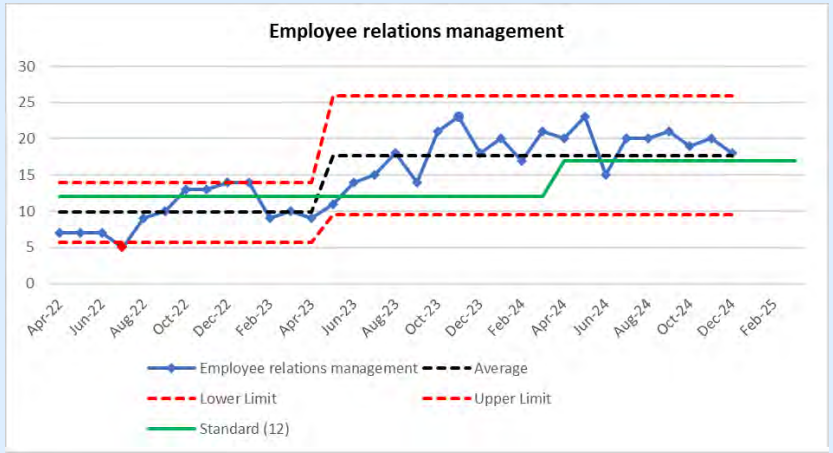
During 2024/25 quarter three the employee relations level has fluctuated between 18 and 20 cases, with the average of quarter three being 19 cases. The increased level of employee relations has primarily been related to formal disciplinary processes.

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

SFH is not an outlier in relation to employee relations casework, with other organisations reporting an ongoing increase in employee relations case management.

The 2023/24 NHS Corporate Benchmarking exercise reports our employee relation cases at 7.2 cases per 1000 headcount. This ranks us within the second quartile, with the national median being 9.5 cases; the lower quartile being between 6.6 and the upper quartile 16.7 cases.

Data



Root causes

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

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

Actions and timescale

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

Impact

- The work we undertake supports our workforce as are we move into 2024/25 quarter four. We do not expect this to reduce immediately.

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

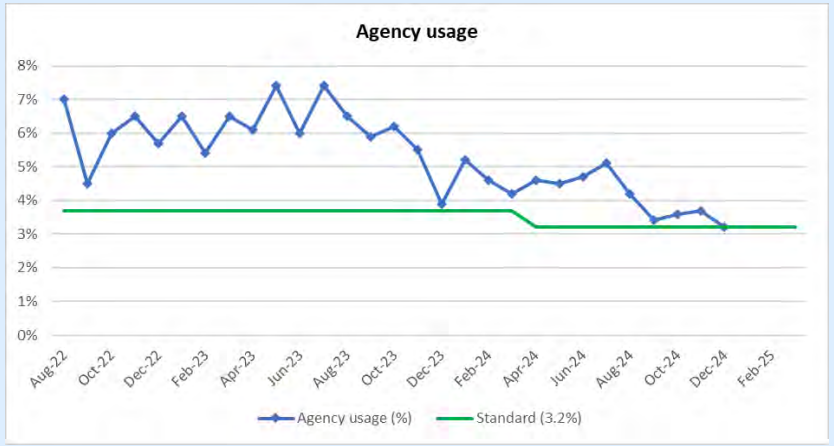
Sherwood Forest Hospitals NHS Foundation Trust

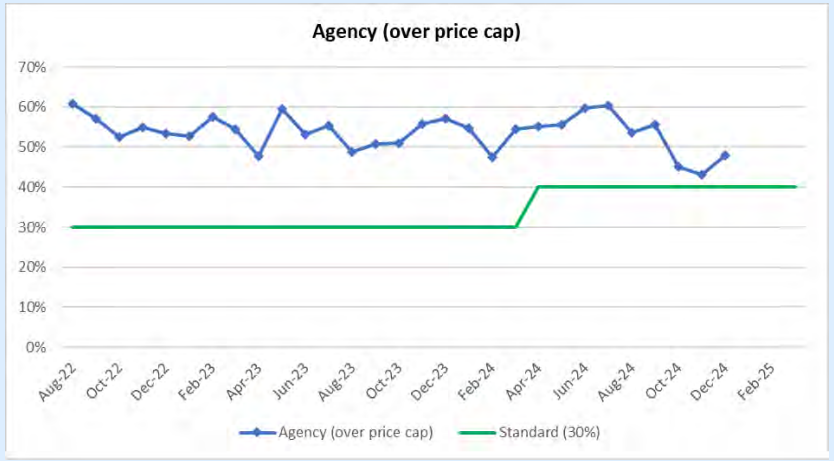
Overview and national position

Our current agency position for 2024/25 quarter three is reported at 3.5%, and for Dec-24 this is reported at 3.2%. When we exclude Elective Recovery Fund (ERF) schemes from the agency level this reduces to 2.6%. We have modelled this with plans over the 2024/25 period to sit around the NHS planning guidance and our target of 3.2%.

We are noting a gradual reduction to our 'on framework, over price cap' position, within quarter three we are reporting 45.4%, which shows a decrease from quarter two (56.4%). The reduction is aligned to our workforce efficiency programmes and the work we are undertaking on the 'on framework, over price cap', as key reductions in over price cap support reductions to the overall agency target.

Data





Root causes	Actions and timescale	Impact
As the data informs us, our biggest risk is medical and dental staff over the NHS England price cap; these are also impacted by some of our fragile services were there are national speciality shortages.	• During 2024/25 we have continued the significant work to reduce reliance on agency usage and support the financial recovery challenge.	• We have been actively filling medical roles and have had success in some key specialities, reductions are noted across the 2024/25 period.
	• We continue to advertise and fill medical posts, which has gradually reduced our agency level. We organise medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff, where possible, on to direct engagement contracts.	• Over the 2024/25 period, we are focusing on medical staff who are 'on framework', but over the NHS England price cap and are developing plans to exit these agency workers and replace with substantive roles.
	• A strict authorisation process for approval of shifts for Thornbury has been implemented in Nursing. Detailed reports illustrating areas using all agency, with Thornbury highlighted, are produced for the Deputy Chief Nurse.	

Outstanding Care,
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Healthier Communities

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Timely Care

Outstanding Care,
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Domain Summary: Timely Care

Overview	Lead: Chief Operating Officer

We continued to experience demand pressures on our urgent and emergency care pathway. These demand pressures were driven by 3% more ambulance arrivals and over 7% more Accident and Emergency (A&E) attends than the previous year across quarter three; exceeding the planned level of growth of 0.6%. The growth seen at Sherwood Forest Hospitals NHS Foundation Trust (SFH) is greater than the regional and national position. Our type one A&E attendance growth is upper quartile nationally (amongst the highest in the country); this growth is a real terms increase and is not driven by any counting or coding changes. As observed by the Nottingham and Nottinghamshire System Analytical Intelligence Unit (SAIU), there has been non-elective activity shift during 2024 between Nottingham University Hospitals NHS Trust (NUH) and SFH with more patients attending King's Mill Hospital (KMH) at SFH instead of Queen's Medical Centre (QMC) at NUH. A large part of the demand growth in mid-Nottinghamshire is accounted for by patients with digestive and respiratory infections and injuries. Nationally, this winter has been more challenging than last in terms of influenza with very high rates in December 2024. Benchmark ambulance handover performance is top of the second quartile nationally.

The demand pressures have placed continuous strain on our Emergency Department (ED) and our hospital inpatient bed base which has caused a deterioration during the quarter across several performance metrics including ambulance handover times, 4-hour emergency access and the percentage of patients with a stay in our ED of greater than 12 hours. Our staff have worked relentlessly to care for patients in as timely and dignified manner as possible in very challenging circumstances. Many of the challenges have been publicised in the media as we have worked hard to convey a clear message to our local population that our services are under pressure and to attend ED only when clinically necessary. Our local system partners have worked together well to maintain relatively low levels of Medically Safe for Transfer (MSFT) patients in our hospitals. Low MSFT patient numbers have been essential to maintain hospital patient flow and full capacity protocol actions have been in place to ensure the clinical risk is shared across the Trust.

In quarter three, we have continued to reduce the incomplete Referral to Treatment (RTT) waiting list and the number of 52-week waits. Our 65-week waits have now reduced to circa 40. We are slightly off plan on all three metrics, in part driven by the support we are offering across the system, together with the need to prioritise cancer pathways. We continue to work together as a system with patients being transferred between providers to support equity of access. Our diagnostics DM01 performance continues to improve significantly and is now 89.8%, the highest level since Dec-21, and has brought us mid-pack nationally (after being in the lowest quartile earlier in 2024). Our Echocardiography position has improved significantly and is now ahead of plan, largely due to insourcing that has gradually helped us to reduce the significant 6-week backlog. In early Jan-25, national guidance around reforming elective care was released. Within this guidance, there is a return of focus on the incomplete 18-week RTT metric with a drive for national performance to achieve 65%. Whilst we do not presently report this metric to Trust Board; we track it at our Planned Care Steering Group and will reintroduce it to this report for 2025/26. Our 18-week RTT position in Dec-24 was 63%, which means our target next year will be a 5% increase. Our national position for 18-weeks is in the top 35% of Trusts in England (middle of the second quartile).

In outpatients, activity levels remain strong and favourable to plan for outpatient follow ups and procedures. We consistently exceed the 5% Patient Initiated Follow Up (PIFU) target and benchmark within the top quartile of trusts nationally. Advice and guidance performance remains well above target and stable over a long period of time.

In terms of our Cancer metrics, we continue our strong delivery of the national 28-day faster diagnostic standard, exceeding the national standard. We fell below plan in Nov-24 for the cancer 31-day standard for the first time this financial year due to challenges in our Breast service (plans are in place to improve oncology capacity and theatre scheduling). While we are behind our planning trajectory for the cancer 62-day treatment standard, in Nov-24 we were very close to meeting the 70% interim standard, and we are better than the England average position for the cancer 62-day standard.

The following pages contain more detailed performance information across the timely care domain.

Outstanding Care,
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Scorecard: Timely Care

Timely Care

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

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

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD	Latest Benchmark Position (Nov 24)
Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	✓ 95.6%	✗ 93.9%	✗ 94.6%	✗ 94.7%	✓ 96.6%	✓ 96.5%	✓ 95.1%	✓ 96.1%	✓ 95.6%	✓ 96.8%	✗ 93.5%	✓ 95.3%	✗ 93.7%	✗ 87.4%	✗ 80.6%	✗ 87.1%	✗ 92.8%	✓ 32 / 176
	Ambulance delays >60 mins	0.0%	0.0%	✗ 0.2%	✗ 0.2%	✗ 0.5%	✗ 0.3%	✗ 0.2%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.1%	✗ 1.7%	✗ 2.5%	✗ 1.5%	✗ 0.6%	✓ 43 / 176
	ED 4-hour performance	≥76%	≥76%	✗ 65.7%	✗ 63.6%	✗ 72.2%	✗ 67.3%	✗ 74.2%	✗ 73.4%	✗ 70.9%	✗ 72.8%	✗ 71.7%	✓ 82.0%	✗ 73.6%	✗ 75.6%	✗ 69.2%	✗ 66.5%	✗ 61.7%	✗ 65.8%	✗ 71.4%	✗ 94 / 141
	ED 12-hour length of stay performance	≤2%	≤2%	✗ 5.5%	✗ 5.1%	✗ 3.1%	✗ 4.5%	✗ 3.1%	✗ 2.2%	✗ 2.3%	✗ 2.5%	✗ 2.9%	✓ 0.9%	✗ 3.0%	✗ 2.3%	✗ 3.9%	✗ 4.8%	✗ 6.3%	✗ 5.0%	✗ 3.3%	✓ 59 / 176
	SDEC rate	≥33%	≥33%	✓ 38.3%	✓ 38.1%	✓ 37.8%	✓ 38.1%	✓ 38.2%	✓ 37.7%	✓ 38.6%	✓ 38.2%	✓ 38.1%	✓ 41.3%	✓ 39.0%	✓ 39.4%	✓ 40.0%	✓ 39.4%	✓ 36.8%	✓ 38.7%	✓ 38.8%	– 94 / 177
	Adult G&A bed occupancy	≤92%	≤92%	✗ 97.9%	✗ 97.8%	✗ 96.5%	✗ 97.4%	✗ 93.6%	✗ 94.8%	✗ 94.7%	✗ 94.4%	✗ 95.5%	✗ 92.2%	✗ 93.8%	✗ 93.9%	✗ 95.4%	✗ 94.7%	✗ 94.8%	✗ 94.9%	✗ 94.4%	– 93 / 177
	Long length of stay (21+) occupied beds	≤Plan	≤Plan	✗ 116	✗ 116	✗ 107	✗ 116	✗ 124	✓ 96	✓ 91	✓ 110	✓ 102	✓ 105	✓ 103	✓ 104	✓ 96	✓ 97	✓ 106	✓ 100	✓ 102	
	Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	✗ 93	✗ 105	✗ 101	✗ 98	✗ 91	✗ 64	✗ 71	✗ 75	✗ 84	✗ 65	✗ 57	✗ 69	✗ 57	✗ 56	✗ 59	✗ 57	✗ 67	
Electives	Advice & guidance	≥16%	≥16%	✓ 24.3%	✓ 27.3%	✓ 25.4%	✓ 25.6%	✓ 24.5%	✓ 25.8%	✓ 22.0%	✓ 24.1%	✓ 25.2%	✓ 24.6%	✓ 22.3%	✓ 24.0%	✓ 24.7%	✓ 23.9%	✓ 24.4%	✓ 24.3%	✓ 24.1%	
	Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	✓ 5.7%	✓ 5.6%	✓ 5.3%	✓ 5.5%	✓ 6.0%	✓ 5.9%	✓ 5.9%	✓ 5.9%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.2%	✓ 6.0%	✓ 5.9%	✓ 6.1%	✓ 6.0%	✓ 6.0%	✓ 14 / 135
	Outpatient attends that are first or follow up with a procedure		≥Plan	43.2%	43.7%	43.8%	43.5%	✗ 43.3%	✗ 40.7%	✗ 43.9%	✗ 42.6%	✗ 42.2%	✗ 42.9%	✓ 43.1%	✗ 42.7%	✗ 41.5%	✗ 41.5%	✗ 41.1%	✗ 41.4%	✗ 42.2%	
	Incomplete RTT waiting list	≤Plan	≤Plan	✗ 52,377	✗ 50,534	✗ 50,757	✗ 50,757	✗ 36,584	✗ 35,858	✗ 35,720	✗ 35,720	✗ 35,251	✗ 35,165	✗ 35,507	✗ 35,507	✗ 35,440	✗ 34,538	✗ 34,147	✗ 34,538	✗ 34,538	
	Incomplete RTT pathways +52 weeks	≤Plan	≤Plan	✗ 1,759	✗ 1,662	✗ 1,591	✗ 1,591	✓ 1,312	✓ 1,162	✓ 1,177	✓ 1,177	✓ 1,080	✗ 1,019	✗ 870	✗ 870	✗ 786	✗ 709	✗ 569	✗ 709	✗ 709	– 63 / 155
	Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	✗ 399	✗ 347	✗ 157	✗ 157	✓ 140	✓ 129	✓ 109	✓ 109	✓ 77	✗ 105	✗ 50	✗ 50	✗ 44	✗ 36	✗ 40	✗ 36	✗ 36	– 88 / 155
	Incomplete RTT pathways +78 weeks	0	0	✗ 17	✗ 12	✗ 5	✗ 5	✗ 2	✗ 1	✓ 0	✓ 0	✗ 2	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 1 / 155
Diagnostics	Diagnostic DM01 backlog			3,659	3,344	3,430	3,430	3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	1,427	989	945	945	945	
	Diagnostic DM01 performance under 6-weeks	≥99%	≥Plan	✗ 62.8%	✗ 68.1%	✗ 70.5%	✗ 70.5%	✓ 71.6%	✓ 72.7%	✗ 70.5%	✗ 70.5%	✗ 69.5%	✗ 70.2%	✗ 76.3%	✗ 76.3%	✓ 85.6%	✓ 89.8%	✓ 89.4%	✓ 89.4%	✓ 89.4%	– 69 / 135
Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥75%	✓ 76.0%	✓ 82.9%	✓ 82.6%	✓ 80.6%	✓ 75.3%	✓ 79.8%	✓ 79.2%	✓ 78.2%	✓ 81.6%	✓ 81.6%	✓ 78.2%	✓ 80.5%	✓ 79.9%	✓ 78.4%	-	✓ 79.2%	✓ 79.3%	– 70 / 133
	Cancer 31-day treatment performance	≥96%	≥Plan	✗ 73.2%	✗ 80.0%	✗ 90.4%	✗ 81.4%	✓ 89.8%	✓ 87.5%	✓ 88.3%	✓ 88.6%	✓ 95.0%	✓ 91.1%	✓ 95.0%	✓ 93.8%	✓ 94.3%	✗ 89.8%	-	✗ 91.9%	✓ 91.3%	✗ 104 / 133
	Cancer 62-day treatment performance	≥85%	≥Plan	✗ 56.5%	✗ 54.7%	✗ 69.2%	✗ 60.4%	✓ 71.8%	✗ 56.3%	✓ 70.3%	✗ 66.1%	✗ 71.4%	✓ 67.9%	✗ 61.2%	✗ 67.0%	✗ 66.1%	✗ 69.7%	-	✗ 68.0%	✗ 66.9%	✗ 86 / 133
	Suspected cancer patients waiting over 62-days			88	57	59	59	100	80	81	81	75	99	95	95	98	86	92	92	92	

Notes:

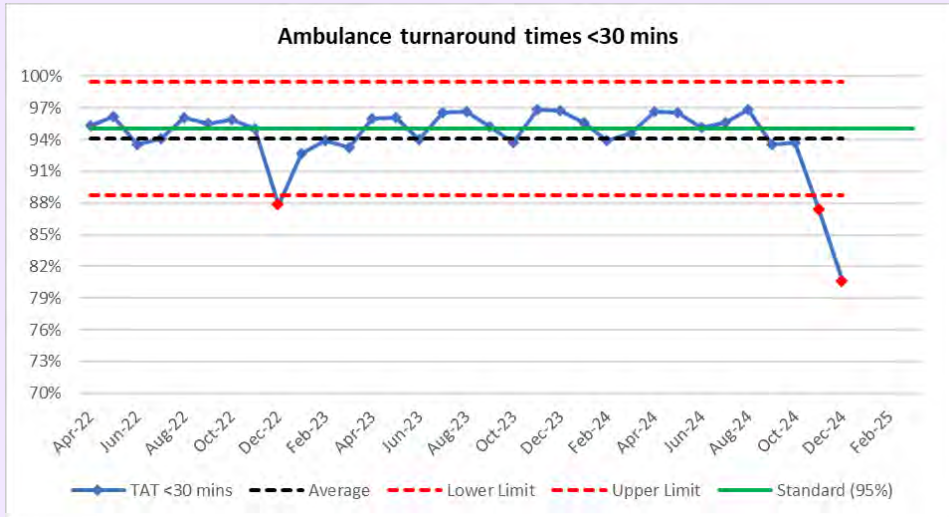
(1) Within the reported cancer treatment standards, we have aligned our reporting to match with the national cancer waiting time standards which remove auto upgrades. The reported position for the last two months for the cancer treatment standards can move as provisional cancer waiting time data is validated.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

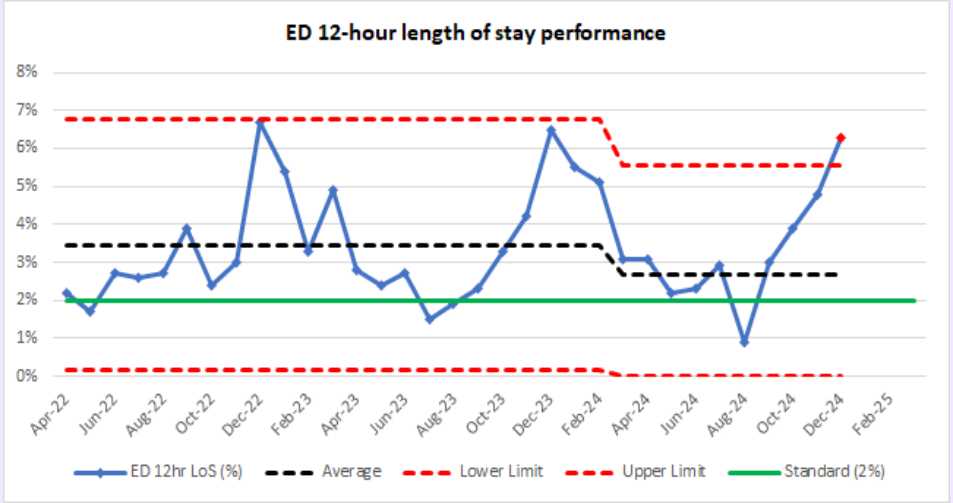
(2) As part of the IPR annual review undertaken in 2024/25 quarter one, we agreed to add benchmarking data to the timely care domain in the quarter two report. This has been added to the above scorecard and referenced as appropriate in the following pages.

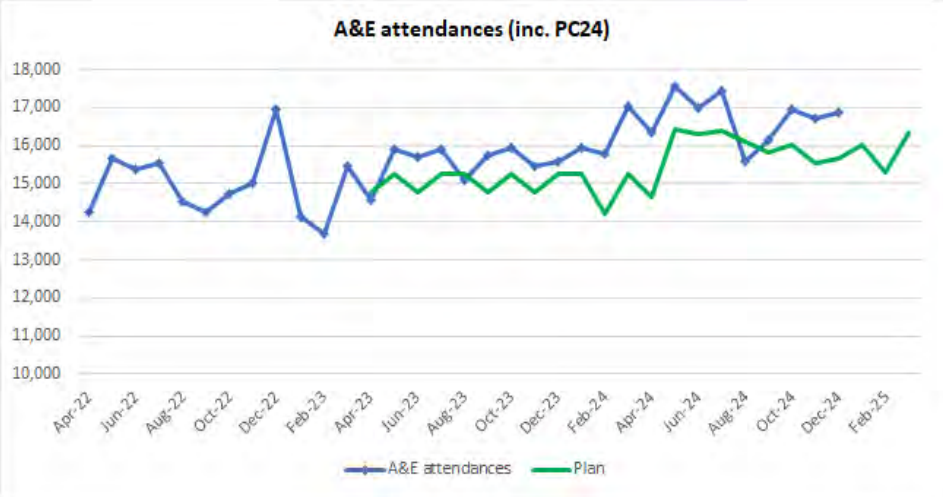
Indicators in Focus: Urgent Care – A&E (1/3)

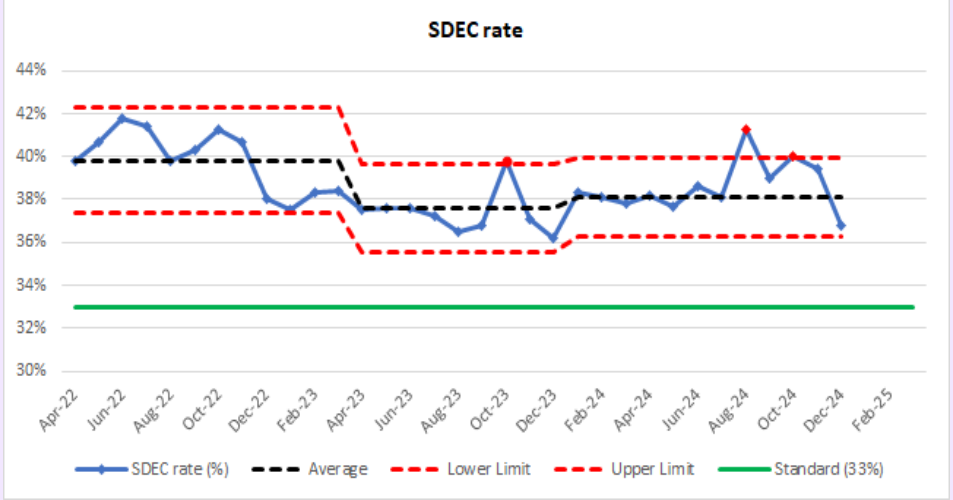
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

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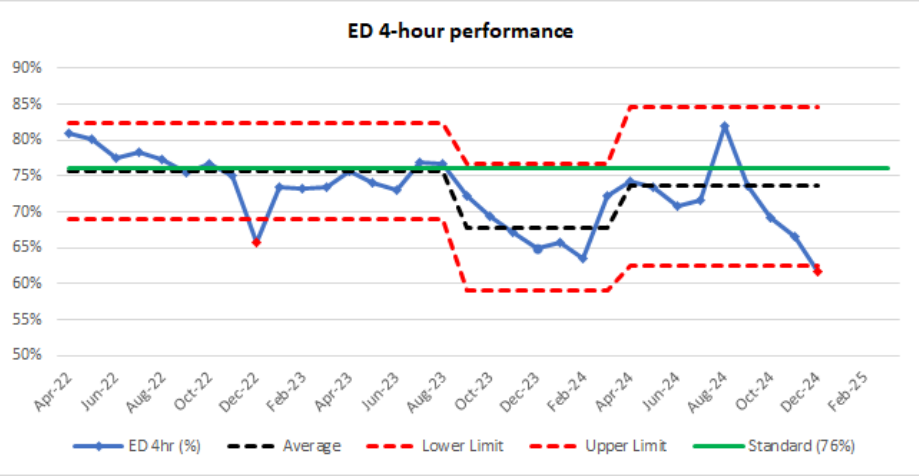
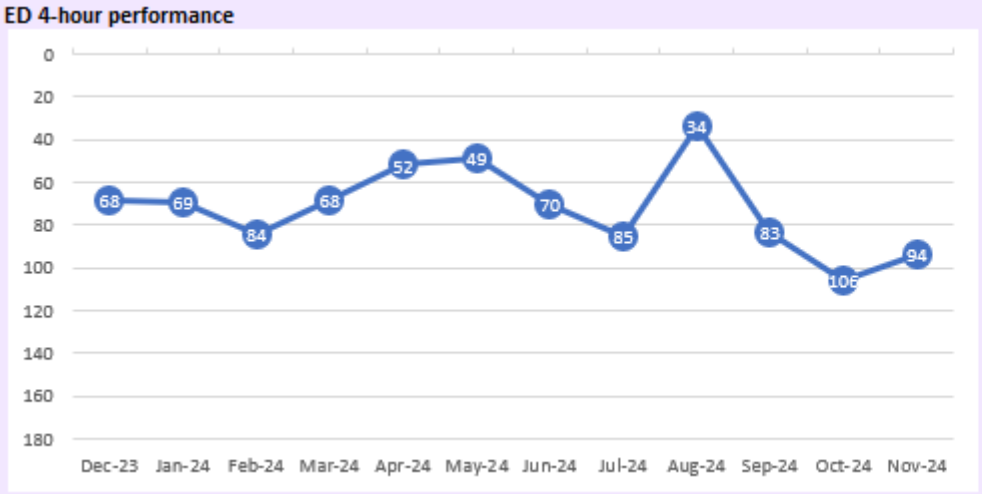
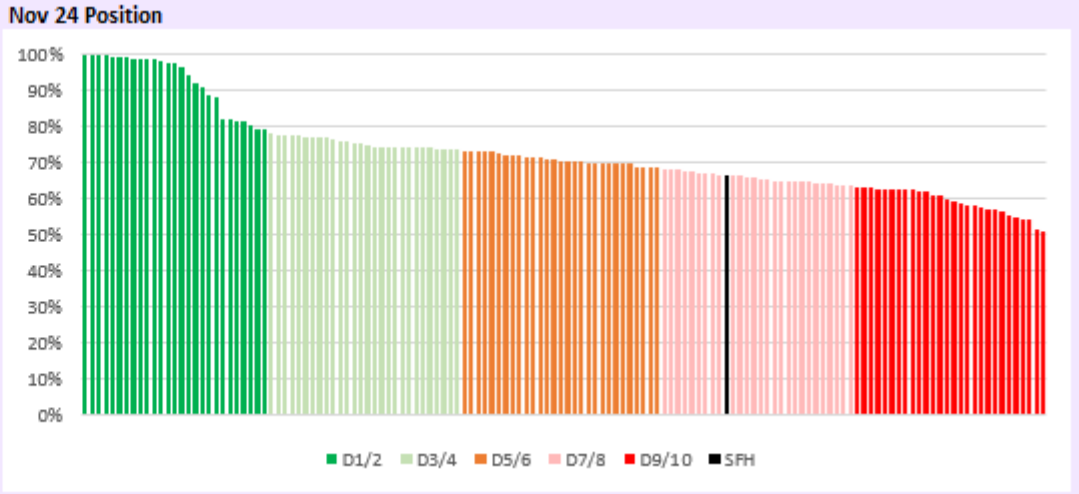


Overview and national position

- We have seen a deterioration in our ambulance handover position through quarter three due to a new clinical frailty scoring process. This is now improving as staff increase familiarity. However, we are significantly better than the East Midlands Ambulance Service (EMAS) average. Key messages to note are:
  - We are frequently best in Midlands and top quartile nationally for ambulance handovers.
  - EMAS average handover time 40 minutes, SFH 19 minutes.
  - A&E attends increased in quarter three to be 107% against planned levels. Type one attendance demand growth is in the upper quartile nationally (amongst the highest in the country). Type three Newark Urgent Treatment Centre attendance levels increased following the introduction of extended opening hours on 11 Nov-24, and the promotion of the service that came with the communication of it.
- The deterioration in 4-hour emergency access performance has seen us drop into the 3rd quartile (out of 4) nationally in Nov-24 (position for Dec-24 not published).

Benchmarking Position and Standings





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

Sherwood Forest Hospitals NHS Foundation Trust

Root causes	Actions and timescale	Impact

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

	• Optimise approach to Same Day Emergency Care (SDEC) for patients who would otherwise be admitted to hospital and develop frailty and respiratory Virtual Ward at scale to maximising opportunities for admission avoidance. • Criteria to Admit Lead trial post (now in post from beginning of Jan-25).	• Increase in patients through Frailty and Surgical SDEC. • Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our Emergency Department (ED). • Decrease in mean time in department for non-admitted patients identified with a Clinical Frailty Score (CFS) >6.
	• We are working with systems partners to better understand the increase in the number of Mental Health presentations in ED. There has been a reduction in Mental Health-related ED presentations in the last month.	• Reduce ED overcrowding and improve staff to patient ratio through reduction in 1:1s required.
Insufficient staffing to manage ED demand.	• Business case supported for four additional Consultants and two Speciality Doctors to support (but not fully mitigate) the increased demand and reduce variable pay costs. Consultant interviews are due in Feb-25. The two Speciality Doctors have been recruited and are awaiting a start date. • Reviewing case mix of patient presentations at Newark by hour, with the aim to return to 99% emergency access performance.	• Decrease in mean time in department for non-admitted patient to <180 mins. • Time to initial assessment for arrivals to A&E seen within 15 minutes to greater than 60%.
ED overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	• Robust frailty offer launched in Nov-24 as part of the winter plan. This includes an Acute Frailty Unit and pathways to support the transfer of patients out of ED and avoid admission. • Wards have begun to go two-over as part of our Full Capacity Protocol to accommodate more patients and thereby improve hospital flow and bedded capacity reducing clinical risk due to overcrowding in ED. • New Fit to Sit to open at end of Jan-25.	• Early identification of Frailty through Clinical Frailty Scale (CFS) score being recorded in our emergency Department (ED). • Decrease in mean time in department for non-admitted patients identified with a CFS >6.

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

Sherwood Forest Hospitals NHS Foundation Trust

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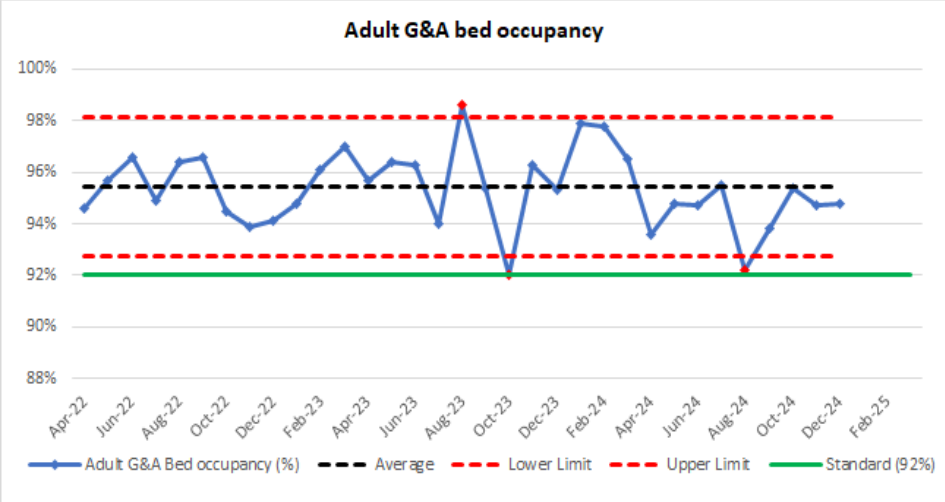

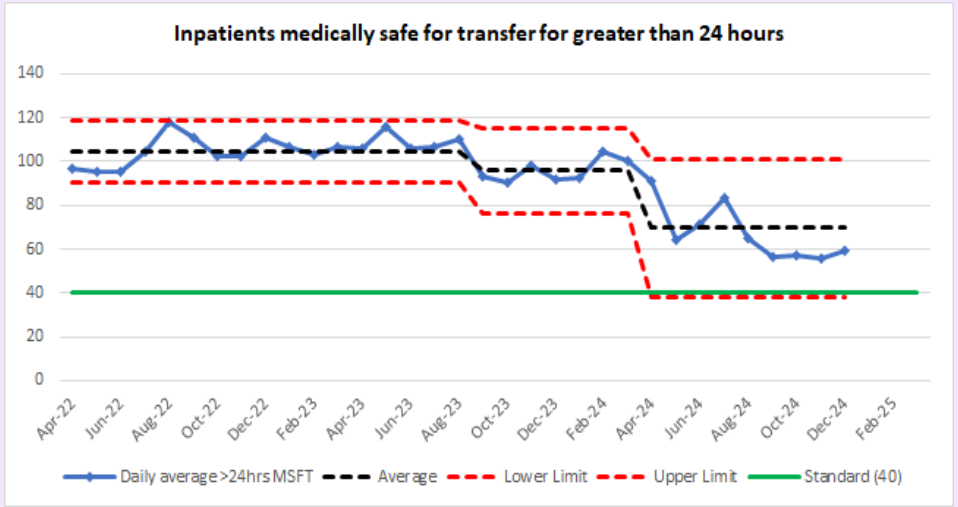

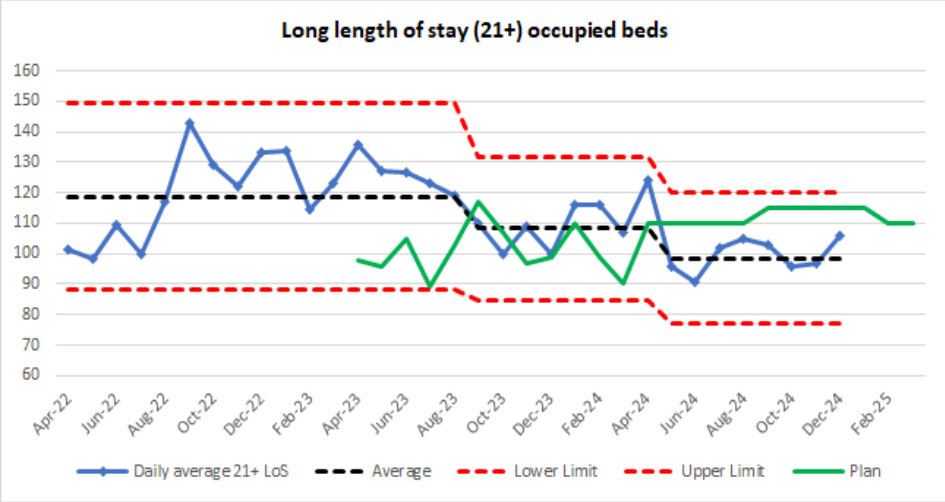

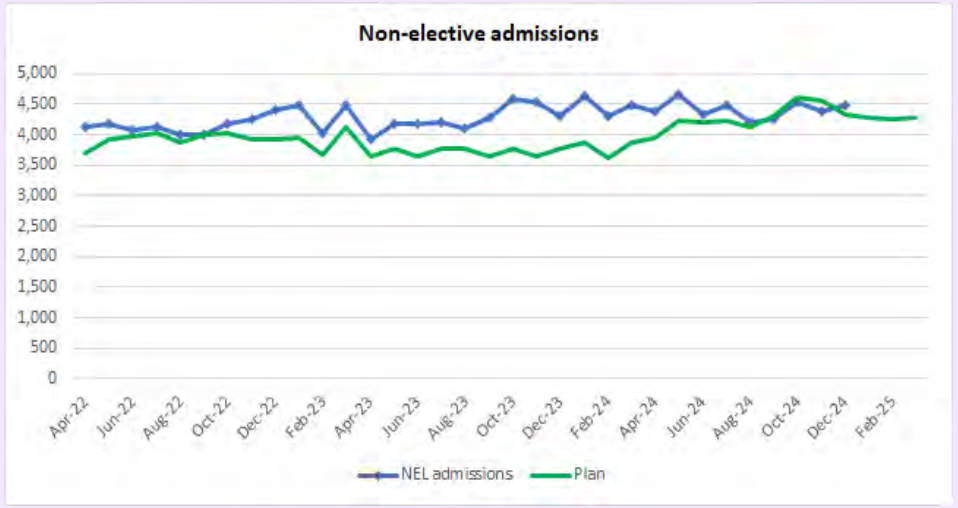

Indicators in Focus: Urgent Care – Hospital Flow (2/2)

NHS Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- Non-elective admission demand eased to be 0.9% below planned levels in quarter three, though this is still high. The year-to-date position is 3.1% above planned levels (our plan included 0.6% growth on 2023/24 levels). Our discharge levels have been strong particularly during Nov-24 and the first two weeks of Dec-24; however, the demand for beds remains high.
- The number of patients Medically Safe For Transfer (MSFT) over 24 hours reduced significantly to flag as a step-change on the statistical process control chart in quarters two. This lower observed level remained through quarter three as system partners continued to work closely to effectively transfer patients from the acute setting.
- The number of long stay patients has followed a similar trend to MSFT inpatient numbers due to similarities in the patient cohort with our position being better than our 2024/25 plan since May-24.

Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• Long length of stay (LOS) meetings embedded for both pre and post medically safe patients. • Dedicated ward Discharge Coordinators engage early with patients and families.	• LOS meetings identify opportunities for alternative pathways and early engagement with partner agencies to support discharge. • Early identification of potential barriers to discharge.
	• A programme 'Getting the Basics Right ' championed by the Chief Operating Officer and Medical Director continues to focus on board rounds and ward processes to support consistency of clinical documentation and clear recording of decisions.	• Review of discharge definitions including 'medically safe' will help us plan discharges in a timely way. Communication plan for winter, including training video for all ward-based or supporting staff, to ensure all staff aware of their role in supporting flow and discharge.
	• Completion of recruitment to nurse vacancies within the discharge team.	• Consistency of discharge nurses across wards will benefit patient and family conversations to support timely discharge.
Delays to post-medically safe discharge processes.	• Transfer of Care Hub continues to work well. Dedicated staff focus on Pathway 3 patients and those with housing and homelessness issues.	• Reduce discharge delays and reduce the number of medically safe patients in our hospitals.
	• The discharge team undertake a daily review of all patients that have been medically safe for greater than 24 hours to identify actions to support timely discharge.	• Improve LOS for complex discharges across our hospitals.
	• Review funding of Street Health service which is non recurrently funded until Apr-25. Liaising with current funders to agree next year's plan around this essential service to ensure continuity.	• Reduce delays in discharge processes for patients with complex housing issues supporting overall reduction in the number of medically safe inpatients.
	• Patient Transport Services (PTS) continue to be a challenge to timely discharge. Both EMED and Ambicorp conveyances now under both local and system-wide review.	• Identify opportunity for operational and financial efficiency. • Eliminate barriers to discharge and further reduction in (good progress already seen) the number of abandoned discharges.
Insufficient community capacity to meet supported discharge demand.	• Daily reviews and escalation of Derbyshire patients to identify barriers and develop solutions for patients awaiting discharge.	• Rapid resolution of complex issues through multi agency working to support continued reductions in number of supported patients waiting more than 24 hours for discharge.
	• Twice-daily review of patients awaiting Nottinghamshire packages of care (POC); there are issues around those who are non-weight bearers. There has been a change within adult social care, who now limit the number of POCs to the funded limit of 100 per week across the system; this means that we typically have seen these POCs exhausted by Friday, leaving patients in hospital over the weekend.	• Identify trends in delays to discharge to enable further conversations with system partners around best use of capacity to maximise flow.

Indicators in Focus: Outpatients (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

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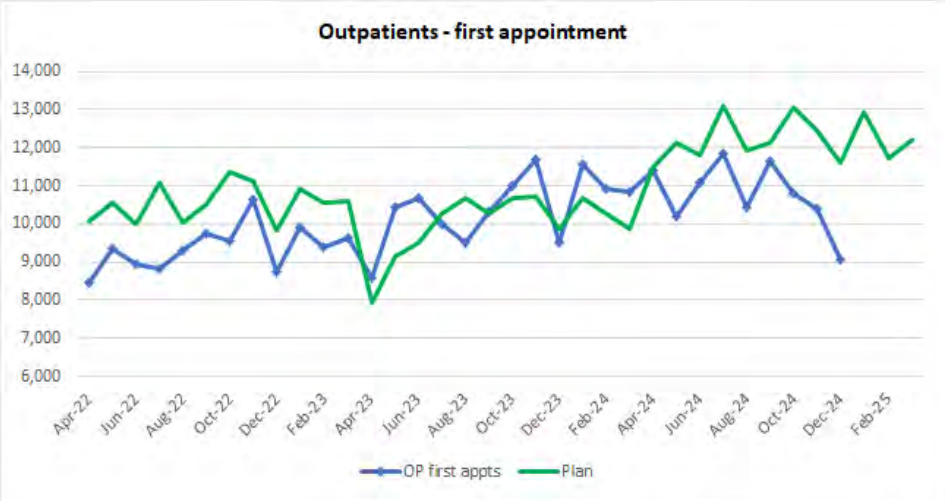

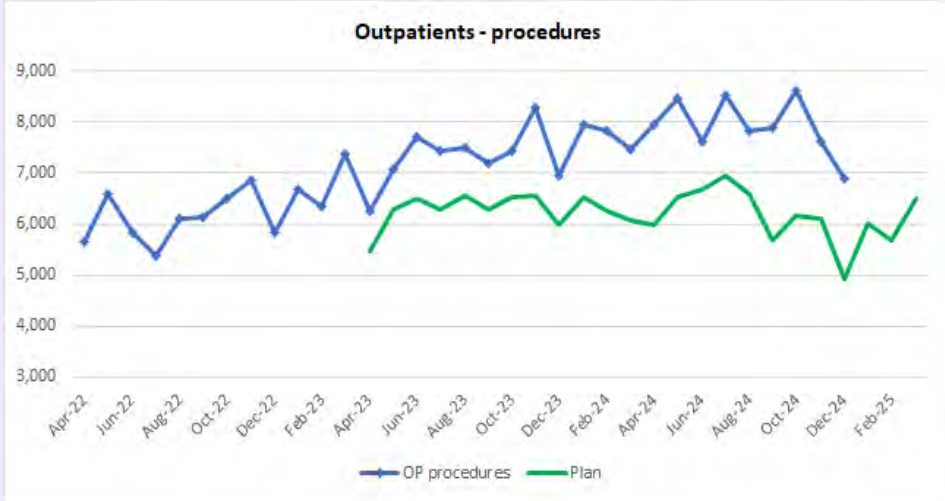

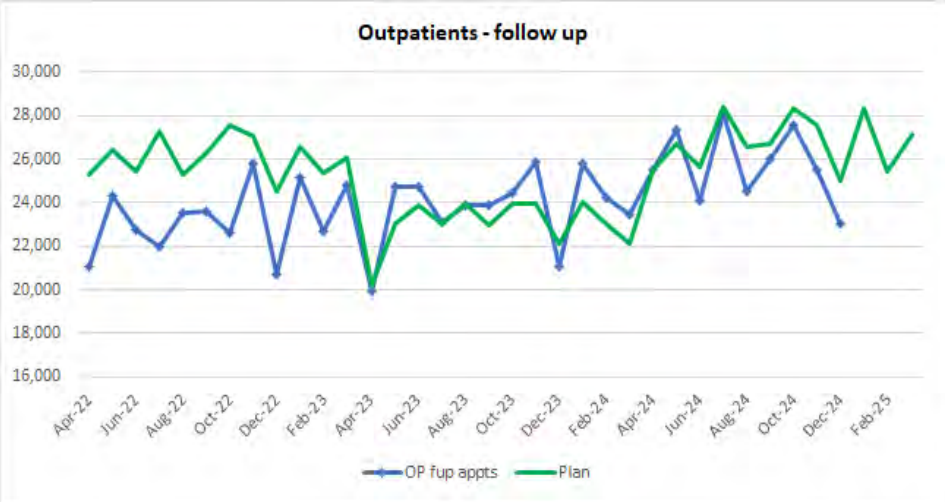

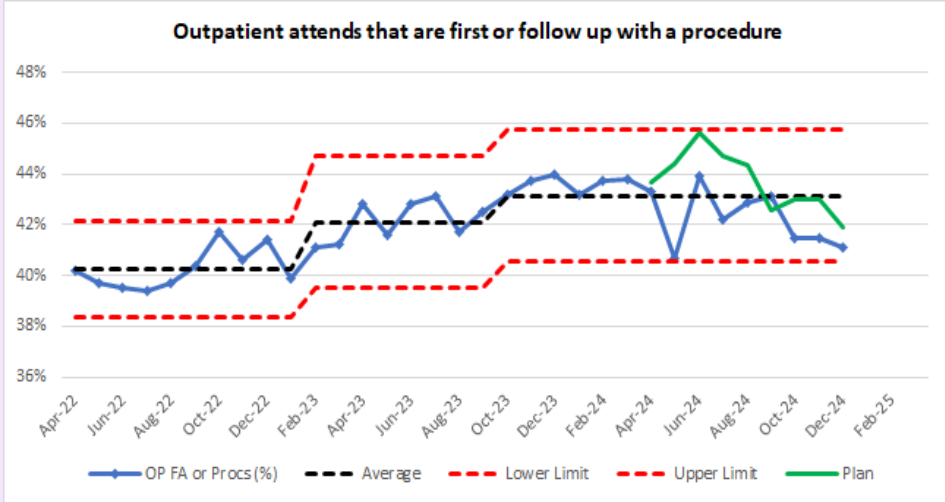

Indicators in Focus: Outpatients (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

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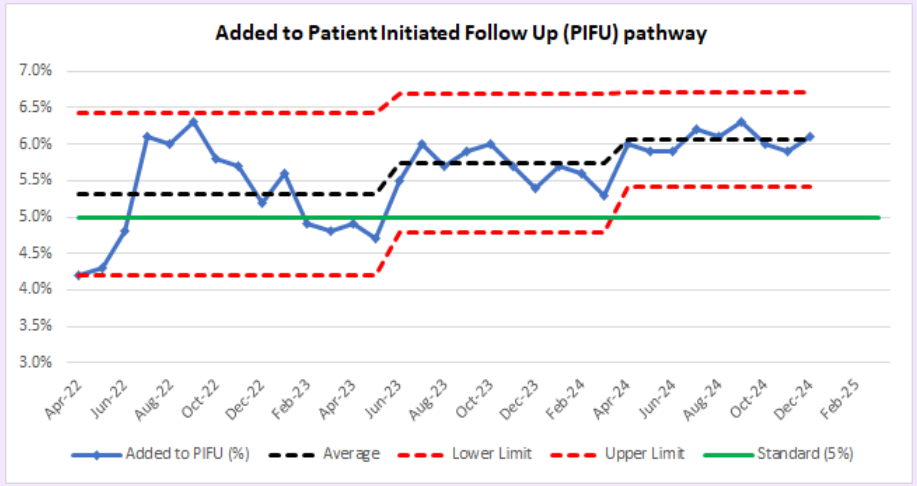
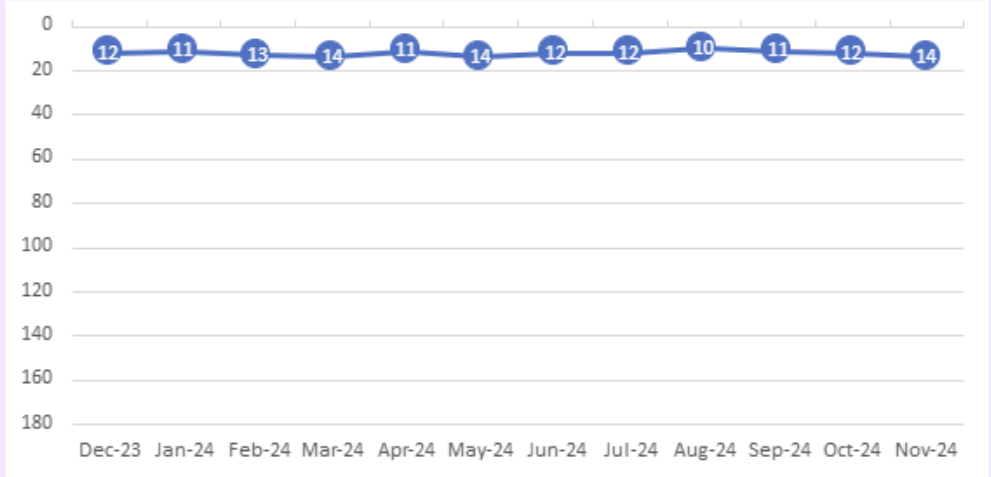


Overview and national position

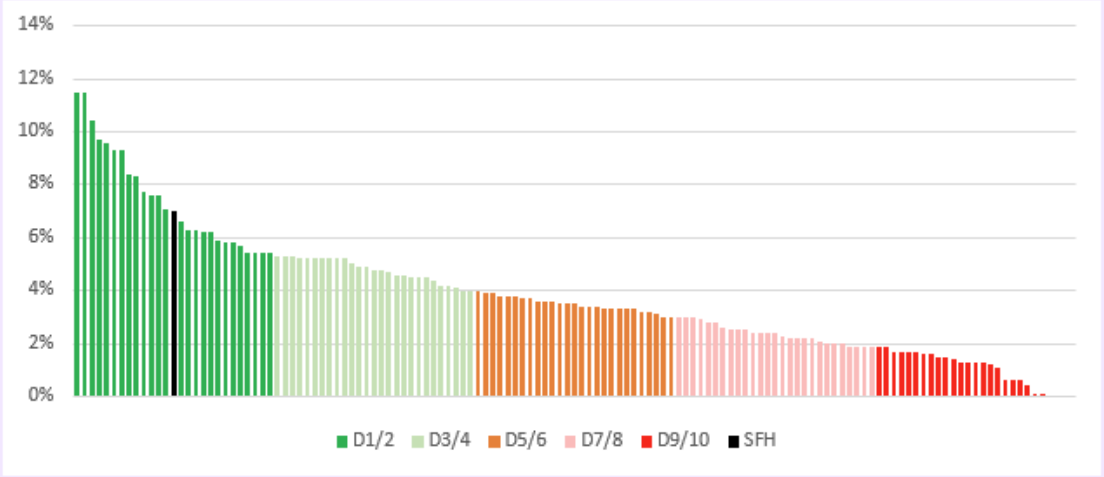
- We consistently perform above the 5% Patient Initiated Follow Up (PIFU) target and benchmark strongly (see below).
- Our volume of advice and guidance surpasses national targets, and we are responding to 98.2% of requests in less than five days.
- We have an outpatient improvement programme in place. Since the programme went live, it has delivered just over £0.5m in improvements (vs a plan of £120k) based on a circa 3% improvement in did not attend (DNA) rates and a circa 2% improvement in clinic utilisation. As of the middle of Jan-25, the programme is forecast to continue to over-deliver. Key schemes implemented through the programme are "Queuebuster", the "Room and Resource system" and text reminder optimisation.
- Trust outpatient first attendance and procedure activity levels have reduced throughout quarter three, though procedures remain well above plan. First appointments remain below plan. Reductions in December are always expected due to the Christmas holidays.
- Our outpatient follow up activity levels have been below our planned levels, which is positive in the context of the national ambition to reduce the volume of patients returning for follow up outpatient appointments.
- There are no specific escalations to raise for our outpatient metrics for this report.

Benchmarking Position and Standings

Added to Patient Initiated Follow Up (PIFU) pathway



Nov 24 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

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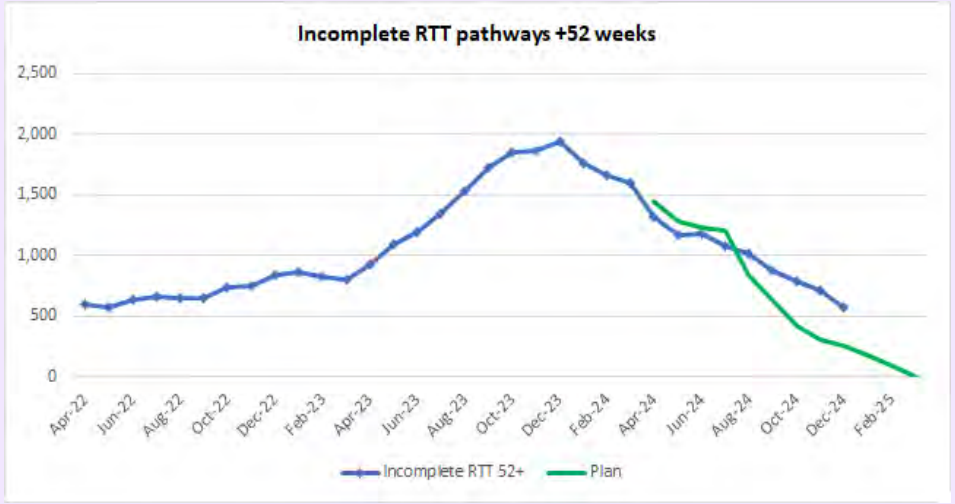
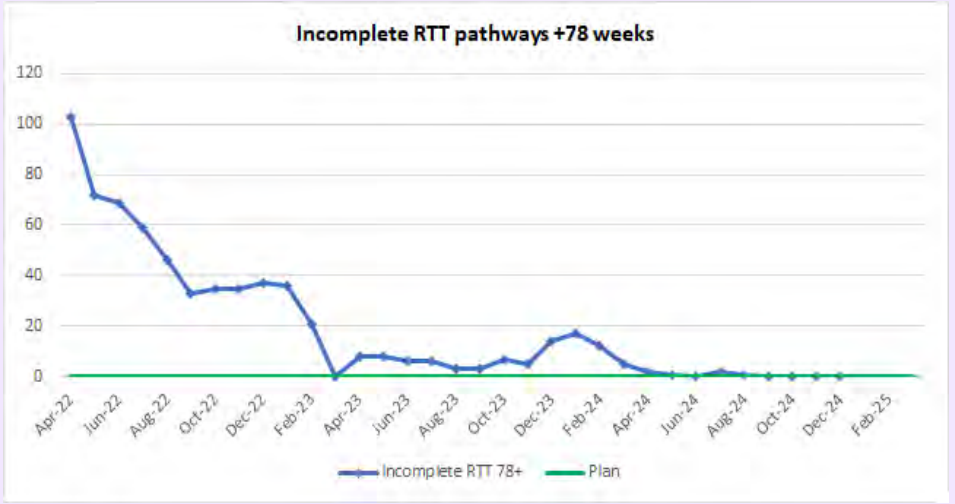
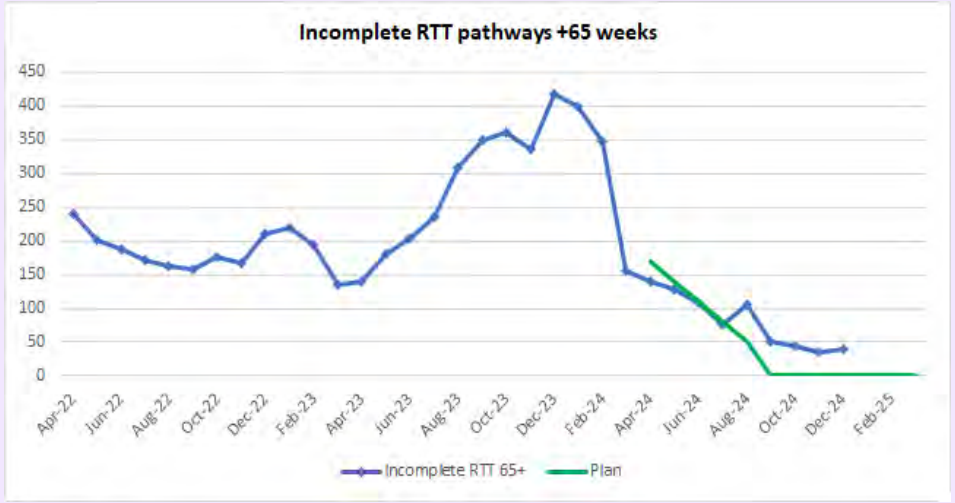
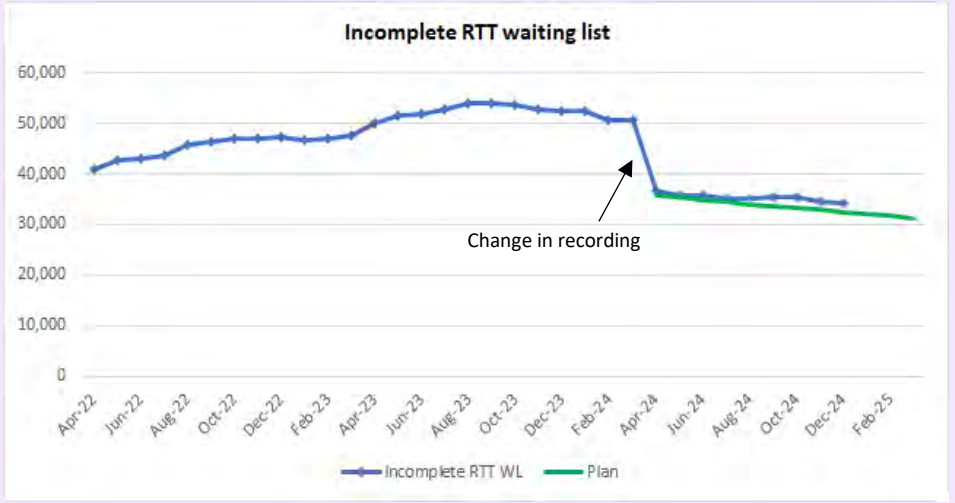








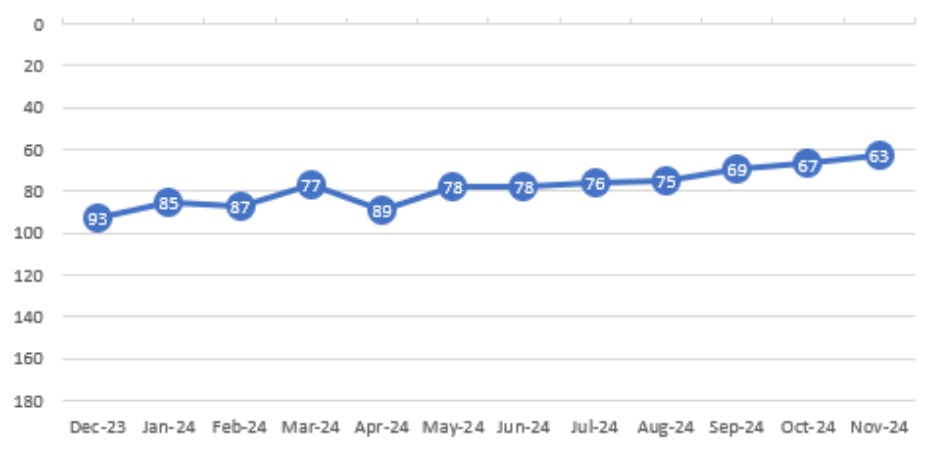
Indicators in Focus: Referral To Treatment (2/3)

Sherwood Forest Hospitals NHS Foundation Trust

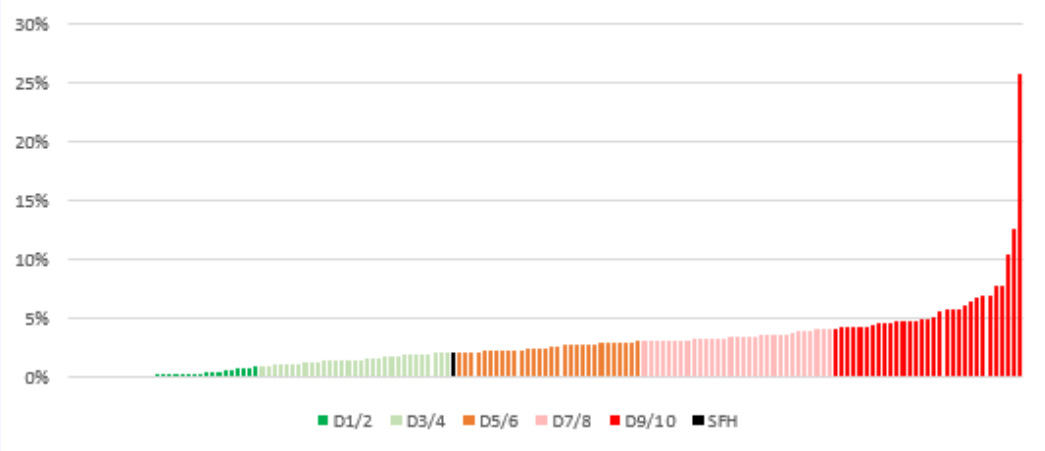
Data

Benchmarking Position and Standings

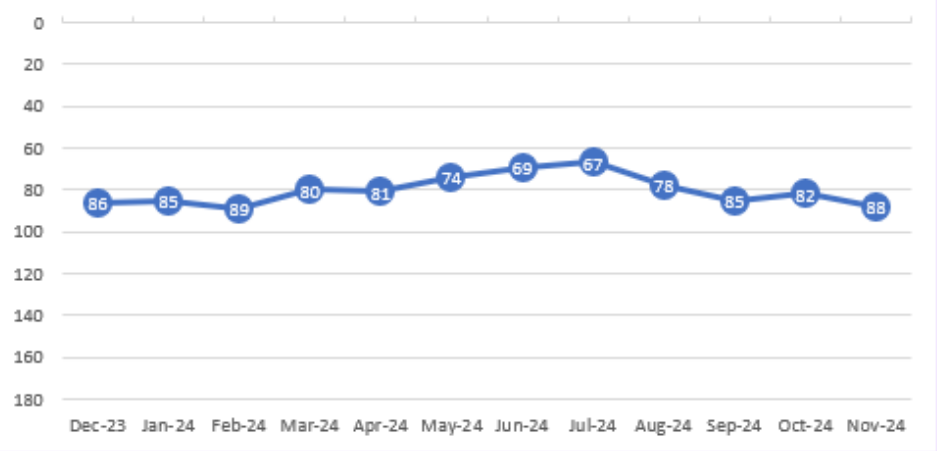
Incomplete RTT pathways +52 weeks



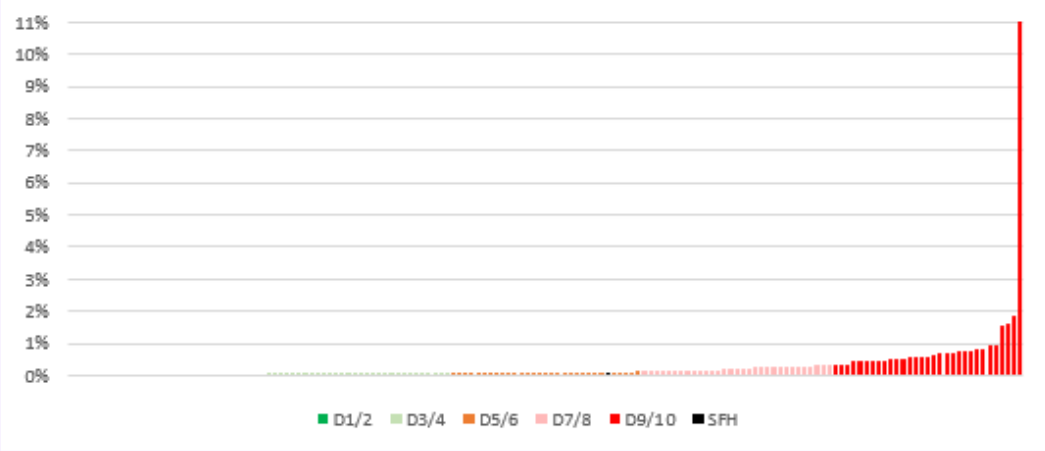
Nov 24 Position



Incomplete RTT pathways +65 weeks



Nov 24 Position



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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Referral to Treatment (RTT) waiting times across England has reduced slightly to 7.1 million. National reporting of long wait patients more than 52 weeks wait has reduced to 217,000 pathways. The emphasis within the planning guidance was to reduce the volume of long waiting pathways and overall Patient Tracking List (PTL) size.
- Following updated guidance for RTT reporting within the Waiting List Minimum Data Set (WLMDS), from apr-24 we stopped reporting our overdue review appointments within or PTL; this resulted in a significant step change (reduction) in our overall reported incomplete pathways size from approximately 52,000 pathways to 37,000. We are seeing a reduction in line with (however, marginally above) our plan.
- 78-week waits remained at zero throughout quarter three. We continue to operate with zero tolerance for the reminder of 2024/25.
- 65-week wait patient volumes have been plateaued at circa 40 throughout quarter three. The provision of system support created further challenges from the late summer period, specifically in ENT, which is a national trend. The requirement to facilitate reductions in Children's and Young Persons and clinically urgent pathways are contributing to this position.

Root causes	Actions and timescale	Impact
Capacity in anaesthetics and across specialties such as ENT, General Surgery, and Orthopaedics (some of which is driven by system support).	• SFH supporting NUH patients across Ophthalmology, Audiology and Urology. Cross-provider support for ENT patients (NUH supporting SFH and SFH supporting NUH).	• Equalise waits across the system. This has impacted on reported positions for long waits at a provider level.
	• Increased capacity in Gastroenterology through insourcing and Endocrinology through locum appointment to reduce waits for first appointments.	• Patients referred to General Surgery at a shorter wait.
	• Insourcing provider identified, first list wc20/01 to increase ENT capacity. • Increase in cases on theatre lists being implemented following FourEyes meeting with ENT team. • Successful bid for additional equipment to increase Functional Endoscopic Sinus Surgery (FESS) capacity accepted and due to begin in eleven weeks as of 14 Jan-25.	• 1 list per week increase in ENT capacity to enable further reduction in long waits in a sustainable way. • Utilisation of sessions at 89.3% for the quarter • Will increase the volume of FESS that can be booked each week by up to 2 patients per week
	• Anaesthetic recruitment for four whole time equivalents (WTE) underway to support on-call rota cover. • Whilst trying to recruit, anaesthetic insourcing has been in place in quarter three.	• Enable reduction in theatre list cancellations due to anaesthetic availability, improving RTT waits.
Quality of data within our PTL. Patients potentially no longer needing or wanting treatment remaining on our waiting list.	• Investment in electronic patient-centred validation system (DrDoctor) to enable mass validation programme. Fully rolled out Nov-24 and under review.	• PTL will be 'clean' and represent only those patients genuinely waiting treatment. PTL reduction.

Indicators in Focus: Diagnostics

Sherwood Forest Hospitals NHS Foundation Trust

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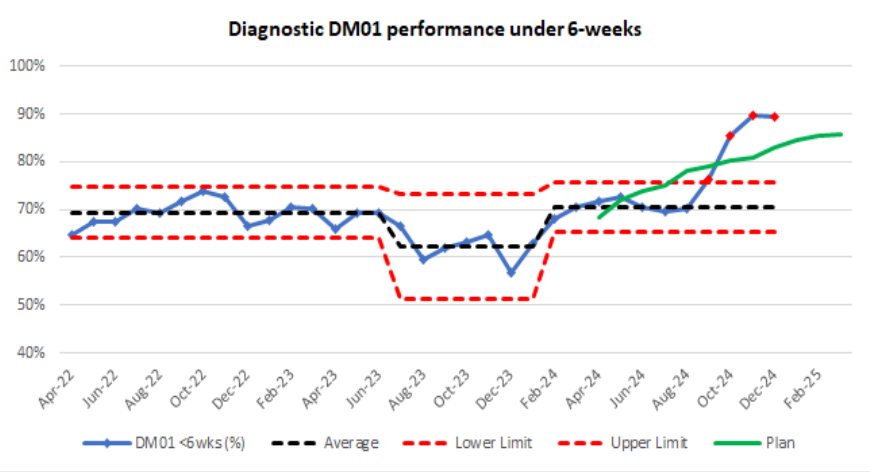
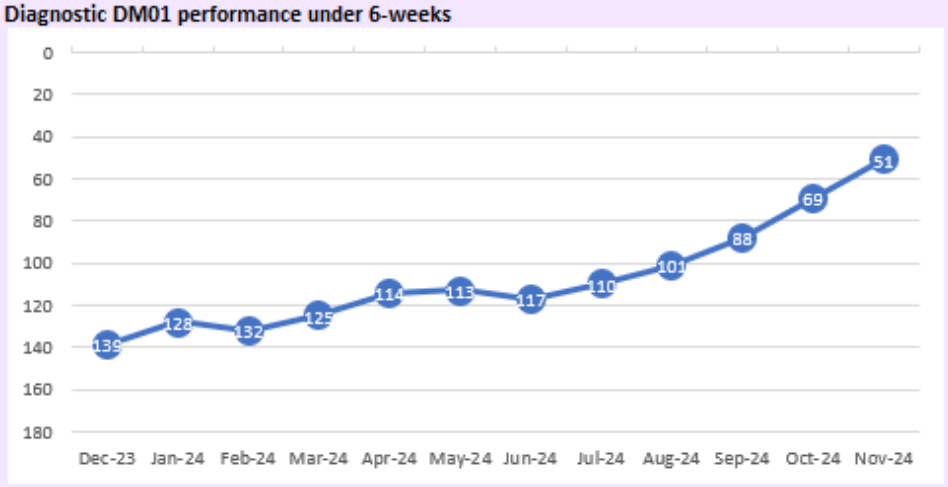
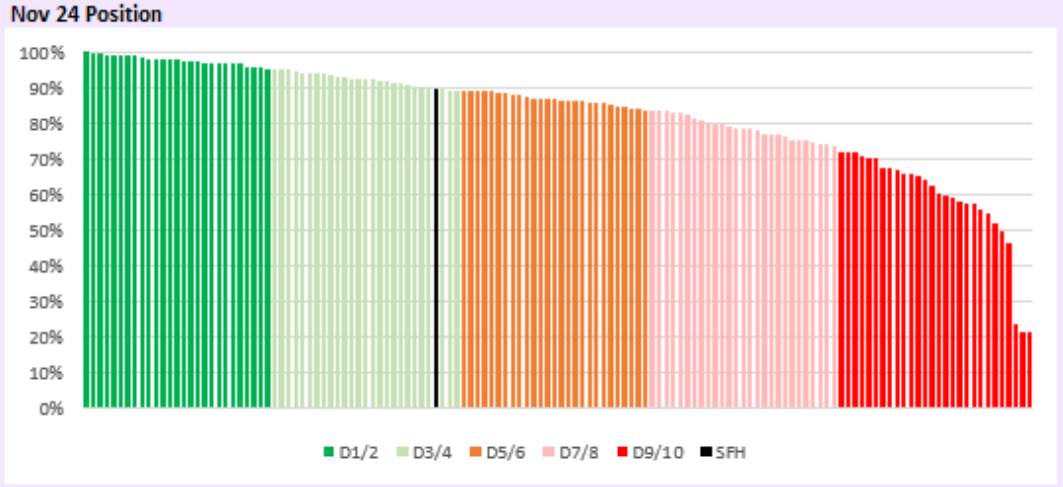


Overview and national position

- Diagnostic DM01 performance at SFH has improved significantly in quarter three, resulting in an improvement in our benchmarking position (see below). We have moved into the fourth decile having been towards the bottom of the pack at the start of 2024/25.
- Nationally, 80% of patients nationally were seen within 6-weeks against the interim national standard of 95% by Mar-25.
- We have observed sustained improvements in DM01 performance and in 6 and 13-week backlog levels since Jul-24. The local position at the end of Nov-24 improved to 89.8% of patients seen within 6-weeks; above the national position. The greatest improvements have been seen in Echocardiography and Computed Tomography (CT).
- Our focus is now on:
    - Audiology where the pressure has been driven by extra demand from patients taken in mutual aid. We are converting one-stop capacity to bookable DM01 slots.
    - CT Cardiac where the pressure has been partially driven by the targeted lung health check programme expansion. We have a new scanner which is due to be operational in Feb-25 and are being supported by the independent sector and by Doncaster and Bassetlaw Teaching Hospitals (DBTH) and NUH.
- This indicator has performed better than plan throughout 2024/25 quarter three.

Benchmarking Position and Standings





Indicators in Focus: Cancer (1/2)

Sherwood Forest Hospitals NHS Foundation Trust

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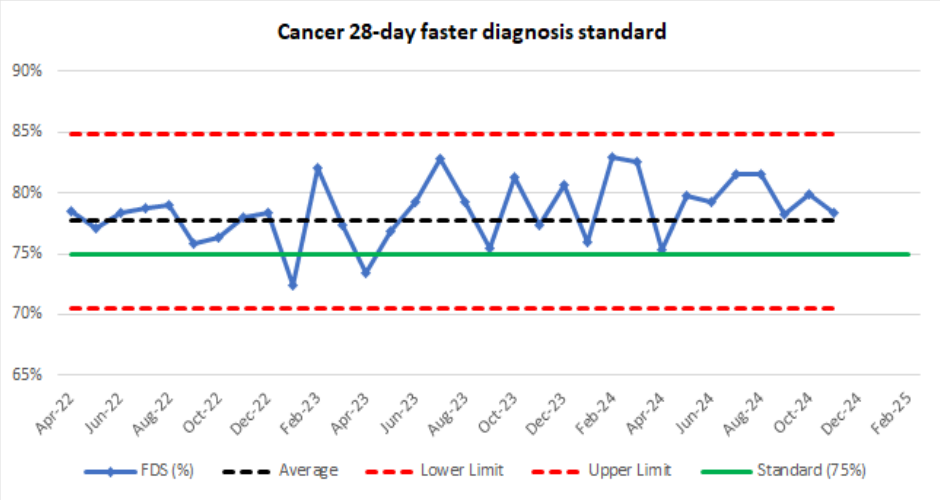

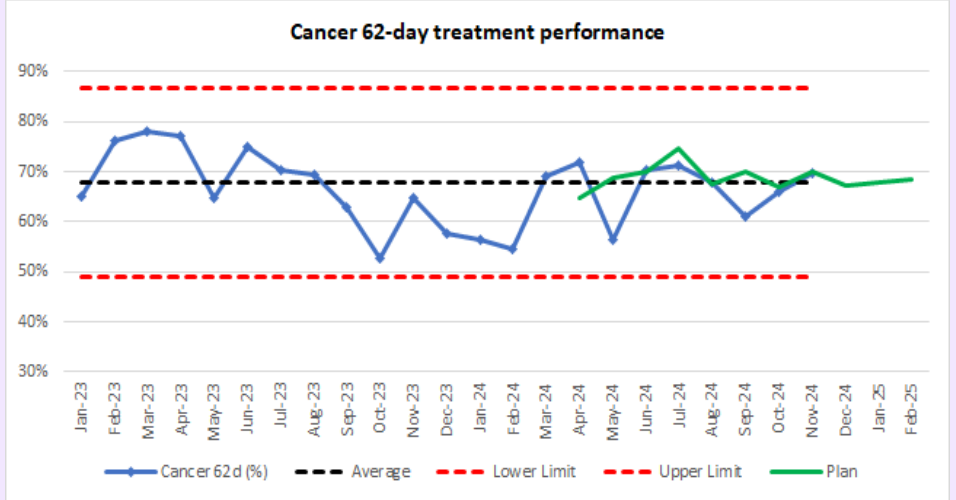

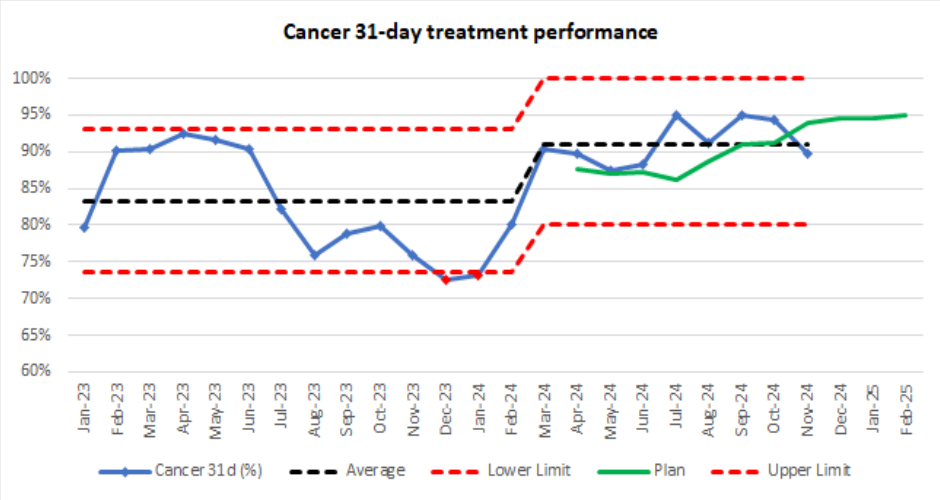

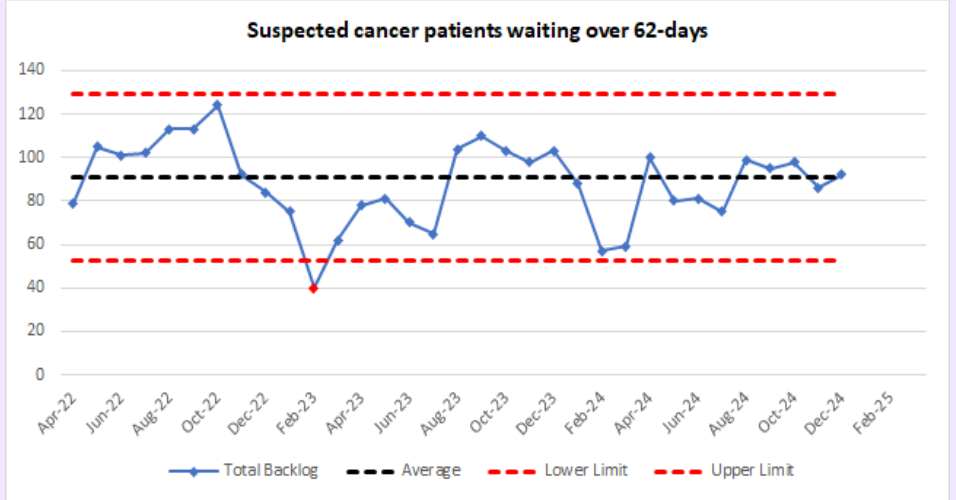

Revised national cancer waiting time standards launched in Oct-23 with the original 10 standards reduced to three. The 31-day and 62-day standards present validated month-end, published data against the new standards from Oct-23. The historical data is based on a proxy as these metrics did not exist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

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

Indicators in Focus: Cancer (2/2)

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

Considering the latest national data (Nov-24):

- Nationally, 28-day Faster Diagnosis Standard (FDS) is 77% against the 75% standard. SFH is performing better than the England position and above the national standard. In Nov-24 we ranked 76 out of 140 providers.
- Nationally, 31-day treatment performance (first treatment) is 91% against the 96% standard. SFH is performing just below the England position and the national standard. In Nov-24 we ranked 104 out of 140 providers.
- Nationally, 62-day performance is 69% against the interim 70% standard. SFH is performing better than the England position and in line with the interim national standard. In Nov-24 we ranked 94 out of 146 providers.

Root causes	Actions and timescale	Impact
62-day standard – all tumour sites except for skin, LGI gynaecology did not meet the interim 70% standard in Nov-24. Due to capacity, histology turnaround, patient complexity, fitness and patient engagement.	• Best practice timed pathway improvement groups in place for Head and Neck, Prostate, Lower GI, Breast , Upper GI and Teledermatology.	• Streamlining pathways towards best practice timed pathways to improve 28, 31 and 62-day performance.
	• CT Colon and Colonoscopy pathway and demand review.	• Improved 28, 31 and 62-day performance by reducing waits for diagnostic tests.
	• Lower GI demand and capacity modelling.	• Improved 28 and 62-day performance by increased timeliness of consultant decisions to progress next steps.
	• Successful funding for new scanner to increase capacity for CT Colons, working towards 2024/25 quarter four installation.	• Increased diagnostic capacity and improved FDS and 62-day.
	• Recruitment to additional Consultant Radiology capacity to increase capacity and reporting turnaround.	• Improved 28, 31 and 62-day performance by reducing waits for diagnostic tests and reports.
	• Additional Consultant capacity for histopathology.	• Improved histopathology turnaround and increased compliance with the 10-day standard.
31-day standard –Breast oncology and surgical capacity.	• Theatres transformation workstream to improve booking process and timely access to theatres. • Advanced planning of post chemo patient pathway operations. • Pooled consultant lists as appropriate to increase listing flexibility.	• Increase timely surgical capacity. • Improve 31-day performance.
	• Joint Oncology PTL with NUH.	• Equalise Oncology waits and improve 31-day performance.
Performance against 62-day standards will temporarily reduce as the backlog is cleared. Once the backlog is reduced, we will be in a more sustainable position for future delivery.		

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Best Value Care

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Domain Summary: Best Value Care

Overview	Lead: Chief Financial Officer

The financial plan for 2024/25 is to deliver a break-even plan. This changed in 2024/25 quarter two from a deficit plan of £14m due to non-recurrent deficit funding being provided by NHS England in 2024/25.

The quarter three position is a deficit to plan variance of £1.1m. This is a year-to-date deficit of £1.9m adverse to the break-even plan. The year-to-date (YTD) position accounts for the financial impact of industrial action; including £0.3m relating to the income lost as well as £0.2m of unplanned redundancy costs linked to the Covid Vaccination Service, £0.5m underfunded consultant pay award plus urgent and emergency care pressures.

The winter plan commenced in quarter three for 2024/25 and cost £0.6m. This is £0.4m less than the planned cost. The current full plan is forecast to be utilised of £2.3m.

The current forecast risk to delivery is £13.4m which is being taken through financial recovery and has been fully reviewed through the Executive team and Finance Committee with next steps and actions to be agreed.

Financial Improvement Programme (FIP) delivery in quarter three saw a significant shift from delivery in the first two quarters of the year with an over delivery against plan of £2.5m in quarter three. YTD £26.6m has been delivered against a target of £26.9m. Significant over delivery of vacancy factor is supporting the shortfall of recurrent schemes. The current unweighted forecast is for £43.0m with a risk adjusted forecast of £37.8m. Schemes continue to be worked on at pace supporting financial recovery.

The 2024/25 Capital Expenditure Plan was initially phased in equal twelfths across the financial year, due to delays in finalising allocations and plans across the Integrated Care System (ICS). Quarter three capital expenditure totalled £4.3m, which is £3.1m lower than initially planned. Following the Board approval of the final re-prioritised capital plan in Jul-24, a reprofiling exercise has been completed to align the forecast delivery dates. The current full year forecast is £2.5m less than the original plan due to re-phasing of nationally allocated Electronic Patient Record (EPR) funding into 2025/26.

Closing cash on 31 December was £3.0m, which is £1.3m favourable to plan. However, this masks an underlying pressure on available revenue cash resource, as it is being managed by extending payment terms to suppliers and has been supported by Revenue Support of £9.1m in year.

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

In 2024/25 quarter three, we have spent £3.2m on agency, which is £0.1m higher than the plan of £3.1m. This represents 3.5% of our total pay bill and exceeds the 3.2% NHS England target. However, this has been the lowest quarter of agency spend over the year. The main reasons for agency use are sickness and vacancies, while a proportion also related to ERF initiatives to increase activity and reduce patient waiting list backlogs.

The following pages contain more detailed performance information across the best value care domain.

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Scorecard: Best Value Care

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

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD
	Income & expenditure against plan	≥£0.00m	≥£0.00m	✗-£0.76	✓£2.33	✗£12.76	✗£11.19	✗-£0.02	✓£0.02	✗-£0.61	✗-£0.61	✗-£0.33	✗-£0.31	✓£0.44	✗-£0.20	✗-£0.18	✗-£0.79	✗-£0.09	✗-£1.06	✗-£1.87
	Financial Improvement Programme (FIP) against plan	≥£0.00m	≥£0.00m	✓£1.27	✗-£0.43	✓£0.54	✓£1.38	✗-£0.55	✓£1.48	✓£0.66	✓£1.59	✗-£1.61	✗-£1.38	✗-£1.57	✗-£4.56	✓£4.90	✗-£1.66	✗-£0.20	✓£3.04	✓£0.07
	Capital expenditure against plan	≤£0.00m	≤£0.00m	✓-£2.01	✓-£0.88	✓£12.53	✓£15.42	✗£1.61	✗£2.07	✗£1.39	✗£5.07	✗£1.55	✗£1.28	✗£1.27	✗£4.10	✗£1.16	✗£1.01	✗£1.92	✗£4.09	✗£13.26
	Cash balance	-	≥£1.45m	✓£1.80	✓£8.76	✓£4.74	✓£4.74	✗£1.34	✓£1.73	✓£1.50	✓£1.50	✗£0.32	✗-£0.15	✗£0.05	✗£0.05	✓£9.46	✓£4.17	✗£1.28	✗£1.28	✗£1.28
Finance	Implied Productivity 2023/24 v 2024/25	-	3.1%	-	-	-	-	-	-	-	-	✓ 6.7%	✓ 5.2%	✓ 6.1%	✓ 6.1%	✓ 6.9%	-	-	✓ 6.9%	✓ 6.9%
	Value weighted elective activity	-	105%	✓113.2%	✓114.2%	✓127.1%	✓118.2%	✗103.5%	✓110.9%	✓112.0%	✓108.8%	✓108.8%	✓118.7%	✓118.5%	✓115.3%	✓119.1%	✓113.6%	✓114.4%	✓115.7%	✓113.3%
	Agency expenditure against plan	≥£0.00m	≥£0.00m	✗-£1.36	✗-£1.17	✗-£1.09	✗-£3.62	✗-£0.18	✗-£0.29	✗-£0.29	✗-£0.76	✗-£0.39	✗-£0.24	✓£0.01	✗-£0.62	✗-£0.17	✗-£0.09	✓£0.14	✗-£0.12	✗-£1.50
	Reported agency spend			£1.47	£1.28	£1.21	£3.96	£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£1.18	£1.14	£0.90	£3.22	£10.63
	Reported bank spend			£3.36	£2.01	£3.69	£9.06	£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£2.36	£2.41	£2.61	£7.38	£22.96

Indicator in Focus: Income and Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust financial plan, which is a break-even position for 2024/25. This is aligned to the Trust's share of the 2024/25 Revenue Plan Limit set for the Nottingham & Nottinghamshire ICB by NHS England.
- The Trusts annual plan has moved from a deficit of £14m this year to a break-even position, due to non-recurrent deficit funding being provided by NHS England in 2024/25.
- The Trust has an adverse variance to plan of £1.1m in 2024/25 quarter three, and £1.9m year-to-date against the plan.

Root causes	Actions and timescale	Impact
Lost income due to industrial action relating to cancelled activity.	• The forecast includes an assumption that the lost income relating to industrial action is covered by supporting allocations later in the year, and that elective activity levels are accelerated through the year.	• Annual plan achievement.
Urgent and Emergency Care pressures.	• The forecast assumes current pressure from the Urgent Care pathway will be managed within the total trust position.	• Annual plan achievement.
Pay award	• Forecast assumes current pressure from the consultant pay award, which has not been fully funded will be managed in the total Trust position.	• Annual plan achievement.
Forecast risk	• Current forecast risk is £13.4m. A recovery plan has been taken to the Executive team and Finance Committee which sets out several key recovery actions to take place over the coming weeks. These are: income ERF income stretch, winter plan slippage to not be re-invested, cap on temporary pay, increased vacancy control panel grip and control, further grip and control on discretionary expenditure and a cap on insourcing and outsourcing. • Forecast assumes remaining pay awards are fully funded, and that winter pressures do not require any elective activity to be cancelled. The forecast excludes impact of band 2 to band 3 pay claim as we do not expect to be able to mitigate this. • Multiple contractual discussions are taking place with the ICB regarding funding for services, value-based commissioning and outcome from service reviews. This may cause a further risk in the current forecast. • Remainder of the year holds a risk of a reduced level of income being received including energy funding and non-recurrent revenue support received in quarter two.	• Annual plan achievement.

Data

Indicator in Focus: Financial Improvement Plan

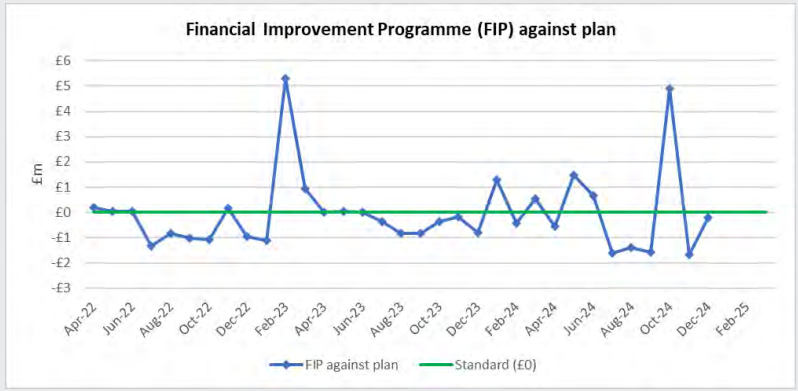
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the Trust Financial Improvement Plan (FIP).
- The Trust has a £38.4m efficiency programme for 2024/25, which is currently £0.3m behind plan.

Root causes	Actions and timescale	Impact
• Failure to identify schemes in time to deliver savings in line with the plan.	• Following the quarter two shortfall seen in delivery, this was pulled back throughout quarter three with a surplus against the plan of £2.5m. This gives a year-to-date efficiency delivery of £26.6m against a target of £26.9m, giving a deficit against the plan of £0.3m. • Regular financial efficiency meetings are in place with addition of the recovery plan now commencing throughout quarter four with focus on delivery of Trust control total. • New opportunities continue to be identified and quantified to move opportunities into delivery.	• Annual plan achievement.
• Resources to support delivery.	• Resources are in place to support each workstream and we now have a 'Specialist Advisor – Financial Recovery and Associate Director of Financial Recovery and Sustainability' in post. • The current weighted forecast is £37.8m against the plan of £38.4m. Financial recovery is supporting to close this gap.	• Annual plan achievement.

Data



Indicator in Focus: Capital Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

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

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

Data

Indicator in Focus: Cash Balance

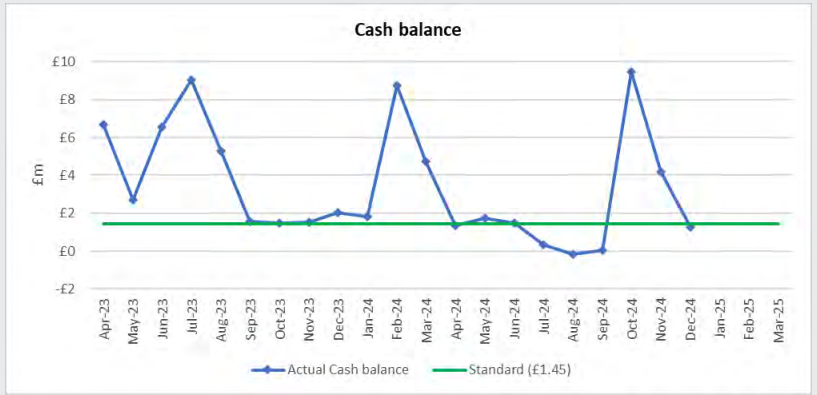
Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the minimum cash balance (£1.45m) as set by the Department of Health and Social Care (DHSC) as a condition of revenue cash support.
- At the end of 2024/25 quarter three, the cash position is £1.25m favourable to plan and was above the minimum cash balance.
- Plan required revenue borrowing Public Dividend Capital (PDC) cash support from DHSC of £14.0m. This has been replaced by revenue deficit support funding in quarter three.

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

Data



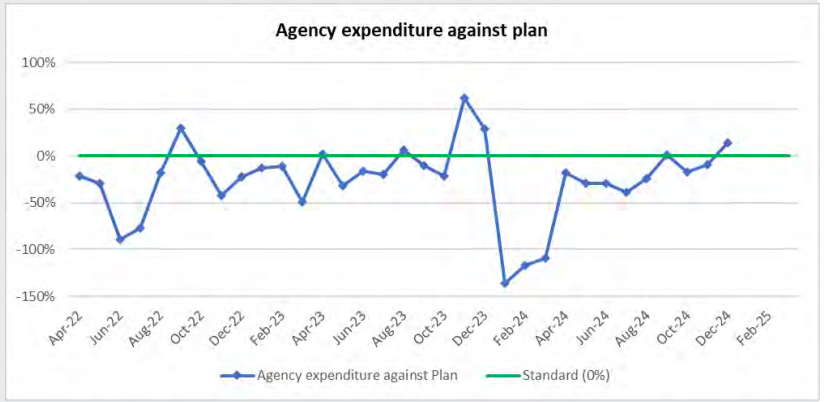
Indicator in Focus: Agency Expenditure Against Plan

Sherwood Forest Hospitals NHS Foundation Trust

Overview and national position

- The standard is the planned agency expenditure for 2024/25.
- The Trust has reported agency expenditure of £3.22m for 2024/25 quarter three; this is £0.12m adverse to the planned level of spend.
- Agency expenditure in quarter three accounts for 3.5% of our total pay bill and exceeds the 3.2% NHS England target. However, this is the lowest percentage we have seen over the current financial year and previous year.

Data



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

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Scorecard: Activity (for context)

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

At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD
Urgent Care	A&E attendances (inc. PC24)	≤Plan	≤Plan	✗104.5%	✗111.1%	✗111.6%	✗109.0%	✗111.5%	✗106.8%	✗104.1%	✗107.3%	✗106.5%	✓96.7%	✗102.0%	✗101.7%	✗105.9%	✗107.4%	✗107.7%	✗107.0%	✗105.3%
	Non-elective admissions	≤Plan	≤Plan	✗119.9%	✗118.6%	✗116.0%	✗118.2%	✗111.3%	✗110.4%	✗103.3%	✗108.3%	✗105.5%	✗102.1%	✓99.1%	✗102.2%	✓98.1%	✓96.2%	✗103.3%	✓99.1%	✗103.1%
Electives	Average daily elective referrals			314	327	304	315	343	340	325	336	348	320	347	338	374	350	-	362	343
	Outpatients - first appointment	≥Plan	≥Plan	✓108.3%	✓106.3%	✓109.7%	✓108.1%	✗99.3%	✗84.0%	✗94.0%	✗92.3%	✗90.5%	✗87.5%	✗96.0%	✗91.3%	✗82.9%	✗83.4%	✗78.2%	✗81.6%	✗88.3%
	Outpatients - follow up	≤Plan	≤Plan	✗107.5%	✗105.0%	✗106.2%	✗106.2%	✓100.0%	✗102.4%	✓94.1%	✓98.9%	✓99.1%	✓92.2%	✓97.2%	✓96.2%	✓97.2%	✓92.5%	✓92.0%	✓94.0%	✓96.3%
	Outpatients - procedures	≥Plan	≥Plan	✓121.7%	✓125.3%	✓123.0%	✓123.3%	✓133.0%	✓129.3%	✓114.4%	✓125.3%	✓122.7%	✓118.7%	✓139.0%	✓126.1%	✓139.9%	✓124.7%	✓139.9%	✓134.5%	✓128.4%
	Day case	≥Plan	≥Plan	✓100.2%	✓101.5%	✓109.8%	✓103.7%	✗96.3%	✗96.1%	✗96.0%	✗96.1%	✓102.7%	✓101.3%	✓100.0%	✓101.3%	✗95.8%	✓101.4%	✗97.1%	✗98.1%	✗98.6%
	Elective inpatient	≥Plan	≥Plan	✓101.9%	✓110.8%	✓129.3%	✓113.5%	✗92.5%	✗94.6%	✗90.0%	✗92.4%	✗84.0%	✗99.8%	✗96.7%	✗93.3%	✓108.0%	✓109.4%	✗97.9%	✓105.4%	✗97.0%
Diagnostics	Diagnostics	≥Plan	≥Plan	✓102.6%	✓103.9%	✓106.8%	✓104.4%	✓102.6%	✓109.2%	✗98.1%	✓103.2%	✓104.9%	✓111.4%	✓112.5%	✓109.5%	✓120.5%	✓114.9%	✓114.6%	✓116.7%	✓109.8%

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Appendix A: Integrated Scorecard & Graphs for each indicator

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

Appendix B: Benchmarking Guidance (1/2)

How can we use benchmarking?

Benchmarking can tell us:

Are we different?

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

How are we different?

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

Why are we different?

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

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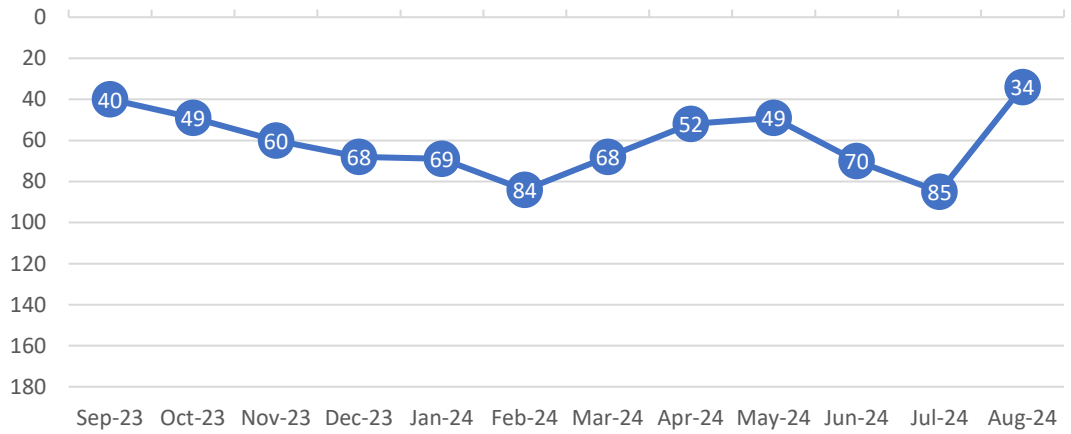
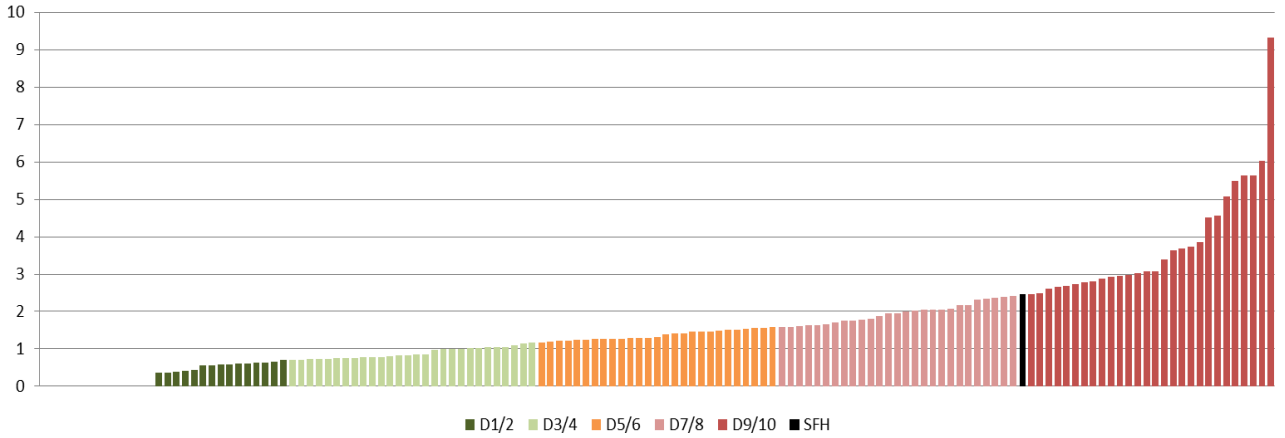
Appendix B: Benchmarking Guidance (2/2)

Reading the benchmarking charts:

The Trend Chart



The Bar Chart



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

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

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

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

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

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

December 2024 (Qtr 3)

Cover Page | Charts | Definitions

Integrated Report

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

Category	At a Glance	Indicator	2023/24 Standard	2024/25 Standard	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	2024/25 YTD
Quality of Care	Safe	Falls with lapse in care	≤2	≤2	0	0	0	0	0	0	0	0	1	0	0	1	0	0	0	0	1
		Falls per 1000 occupied bed days	≤6.63	≤6.63	6.9	7.3	6.1	6.7	6.2	5.8	6.7	6.3	6.7	5.9	6.2	6.3	6.0	7.4	7.3	6.9	6.5
		Never events	0	0	0	0	0	0	1	0	0	1	0	0	1	1	0	0	0	0	2
		MRSA reported in month	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	1	1
		Cdifficile reported in month	≤13	≤13	1	3	5	9	4	4	5	13	4	3	4	11	7	4	6	17	41
		Ecoli blood stream infections (BSI) reported in month	≤22	≤22	3	5	3	11	5	1	4	10	3	5	2	10	4	6	0	10	30
		Klebsiella BSI reported in month	≤1	≤1	2	1	0	3	0	1	2	3	1	1	0	2	1	1	0	2	7
		Pseudomonas BSI reported in month	≤3	≤3	2	1	1	4	0	0	1	1	0	0	0	0	0	1	0	1	2
		HAPU (cat 2) per 1000 occupied bed days with a lapse in care			0.2	0.2	0.1	0.2	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.2	0.1	0.0	0.1	0.1
		HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	0	0	1	0	1	0	1	1	2	0	0	1	1	0	0	2	2	5
		Patient Safety Incident Investigations (PSII)			2	2	1	5	3	4	0	7	0	2	2	4	1	0	2	3	14
		Sepsis (metric to be defined)			0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
	Caring	Complaints per 1000 occupied bed days	≤1.9	≤1.9	1.1	1.1	0.8	1.0	0.7	1.5	0.9	1.0	1.5	0.8	0.8	1.0	0.8	0.8	0.4	0.7	0.9
		Compliments received in month			151	122	120	393	161	138	151	450	155	120	119	394	204	160	147	511	1355
	Effective	HSMR (basket of 56 diagnosis groups)	≤100	≤100	108	107	105	105	104	103	102	102	102	102	103	103	103	103	101	103	103
		SHMI	≤100	≤100	108	109	109	109	109	108	107	107	106	106	106	106	106	106	106	106	106
		Still birth rate	≤4.4	≤4.4	3.2	11.5	3.7	5.9	0.0	3.2	4.2	2.3	0.0	6.8	6.4	4.4	3.4	10.3	0.0	4.5	3.8
		Early neonatal deaths per 1000 live births	≤1	≤1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	3.2	1.1	0.0	0.0	0.0	0.0	0.4
People and Culture	Belonging in the NHS	Engagement score	≥6.8%	≥6.8%	-	-	-	6.9	-	-	-	6.8	-	-	-	6.8	-	-	-	-	6.8
	Growing the Future	Vacancy rate	≤8.5%	≤8.5%	5.1%	4.7%	4.5%	4.7%	8.2%	8.0%	8.1%	8.1%	8.4%	7.7%	7.4%	7.9%	8.4%	8.3%	8.1%	8.3%	8.1%
		Turnover in month	≤0.9%	≤0.9%	0.4%	0.4%	0.4%	0.4%	0.5%	0.3%	0.6%	0.5%	0.5%	0.6%	0.5%	0.5%	0.4%	0.5%	0.7%	0.5%	0.5%
		Appraisals	≥90%	≥90%	88.9%	88.3%	87.8%	88.3%	88.5%	90.1%	88.8%	89.1%	90.3%	90.0%	89.7%	90.0%	88.8%	86.9%	88.8%	88.2%	89.1%
		Mandatory & statutory training	≥90%	≥90%	91.0%	91.0%	92.0%	91.3%	91.0%	91.0%	91.0%	91.0%	91.4%	91.3%	90.9%	91.2%	90.9%	90.7%	91.8%	91.1%	91.1%
	Looking after our People	Sickness absence	≤4.2%	≤4.2%	5.0%	4.7%	4.3%	4.6%	4.3%	4.4%	4.7%	4.4%	4.9%	4.2%	4.7%	4.6%	5.6%	5.7%	6.1%	5.8%	4.9%
		Total workforce loss	≤7.0%	≤7.0%	7.3%	6.9%	6.4%	6.9%	6.4%	6.4%	6.8%	6.5%	6.9%	6.3%	6.7%	6.6%	7.6%	7.8%	8.1%	7.8%	7.0%
		Flu vaccinations uptake (front line staff)	≥80%	≥75%	58.0%	58.0%	-	58.0%	-	-	-	-	-	-	-	-	35.3%	43.6%	47.1%	47.1%	47.1%
		Employee relations management	<12	<17	20	17	21	19	20	23	15	19	20	20	21	20	19	20	18	19	20
	New Ways of Working	Bank usage			8.8%	7.7%	10.8%	9.1%	8.3%	10.3%	9.3%	9.3%	9.8%	10.3%	8.1%	9.4%	7.3%	7.8%	9.1%	8.0%	8.9%
		Agency usage	<3.7%	<3.2%	5.2%	4.7%	4.2%	4.7%	4.6%	4.6%	4.7%	4.6%	5.1%	4.2%	3.4%	4.2%	3.6%	3.7%	3.2%	3.5%	4.1%
		Agency (off framework)	≤6.0%	0.0%	0.1%	0.1%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
		Agency (over price cap)	≤30.0%	≤40.0%	54.6%	47.4%	54.4%	52.0%	55.1%	55.6%	59.7%	57.1%	60.3%	53.6%	55.5%	56.4%	45.1%	43.1%	47.9%	45.4%	53.1%
Timely Care	Urgent Care	Ambulance turnaround times <30 mins	≥95%	≥95%	95.6%	93.9%	94.6%	94.7%	96.6%	96.5%	95.1%	96.1%	95.6%	96.8%	93.5%	95.3%	93.7%	87.4%	80.6%	87.1%	92.8%
		Ambulance delays >60 mins	0.0%	0.0%	0.2%	0.2%	0.5%	0.3%	0.2%	0.0%	0.0%	0.1%	0.2%	0.1%	0.2%	0.2%	0.1%	1.7%	2.5%	1.5%	0.6%
		ED 4-hour performance	≥76%	≥76%	65.7%	63.6%	72.2%	67.3%	74.2%	73.4%	70.9%	72.8%	71.7%	82.0%	73.6%	75.6%	69.2%	66.5%	61.7%	65.8%	71.4%
		ED 12-hour length of stay performance	≤2%	≤2%	5.5%	5.1%	3.1%	4.5%	3.1%	2.2%	2.3%	2.5%	2.9%	0.9%	3.0%	2.3%	3.9%	4.8%	6.3%	5.0%	3.3%
		SDEC rate	≥33%	≥33%	38.3%	38.1%	37.8%	38.1%	38.2%	37.7%	38.6%	38.2%	38.1%	41.3%	39.0%	39.4%	40.0%	39.4%	36.8%	38.7%	38.8%
		Adult G&A bed occupancy	≤92%	≤92%	97.9%	97.8%	96.5%	97.4%	93.6%	94.8%	94.7%	94.4%	95.5%	92.2%	93.8%	93.9%	95.4%	94.7%	94.8%	94.9%	94.4%
		Long length of stay (21+) occupied beds	≤Plan	≤Plan	116	116	107	116	124	96	91	110	102.0	105.0	103.0	104.0	96.0	97.0	106.0	99.8	102
		Inpatients medically safe for transfer for greater than 24 hours	≤40	≤40	93	105	101	98	91	64	71	75	84	65	57	69	57	56	59	57	67
	Electives	Advice & guidance	≥16%	≥16%	24.3%	27.3%	25.4%	25.6%	24.5%	25.8%	22.0%	24.1%	25.2%	24.6%	22.3%	24.0%	24.7%	23.9%	24.4%	24.3%	24.1%
		Added to Patient Initiated Follow Up (PIFU) pathway	≥5%	≥5%	5.7%	5.6%	5.3%	5.5%	6.0%	5.9%	5.9%	5.9%	6.2%	6.1%	6.3%	6.2%	6.0%	5.9%	6.1%	6.0%	6.0%
		Outpatient attends that are first or follow up with a procedure		≥Plan	43.2%	43.7%	43.8%	43.5%	43.3%	40.7%	43.9%	42.6%	42.2%	42.9%	43.1%	42.7%	41.5%	41.5%	41.1%	41.4%	42.2%
		Incomplete RTT waiting list	≤Plan	≤Plan	52,377	50,534	50,757	50,757	36,584	35,858	35,720	35,720	35,251	35,165	35,507	35,507	35,440	34,538	34,147	34,538	34,538
		Incomplete RTT pathways +52 weeks	≤Plan	≤Plan	1,759	1,662	1,591	1,591	1,312	1,162	1,177	1,177	1,080	1,019	870	870	786	709	569	709	709
		Incomplete RTT pathways +65 weeks	≤Plan	≤Plan	399	347	157	157	140	129	109	109	77	105	50	50	44	36	40	36	36
		Incomplete RTT pathways +78 weeks	0	0	17	12	5	5	2	1	0	0	2	1	0	0	0	0	0	0	0
	Diagnostics	Diagnostic DM01 backlog			3,659	3,344	3,430	3,430	3,569	3,584	3,861	3,861	4,295	3,634	2,558	2,558	1,427	989	945	945	945
		Diagnostic DM01 performance under 6-weeks	≥99%	≥Plan	62.8%	68.1%	70.5%	70.5%	71.6%	72.7%	70.5%	70.5%	69.5%	70.2%	76.3%	76.3%	85.6%	89.8%	89.4%	89.4%	89.4%
	Cancer	Cancer 28-day faster diagnosis standard	≥75%	≥75%	76.0%	82.9%	82.6%	80.6%	75.3%	79.8%	79.2%	78.2%	81.6%	81.6%	78.2%	80.5%	79.9%	78.4%	-	79.2%	79.3%
		Cancer 31-day treatment performance	≥96%	≥Plan	73.2%	80.0%	90.4%	81.4%	89.8%	87.5%	88.3%	88.6%	95.0%	91.1%	95.0%	93.8%	94.3%	89.8%	-	91.9%	91.3%
		Cancer 62-day treatment performance	≥85%	≥Plan	56.5%	54.7%	69.2%	60.4%	71.8%	56.3%	70.3%	66.1%	71.4%	67.9%	61.2%	67.0%	66.1%	69.7%	-	68.0%	66.9%
		Suspected cancer patients waiting over 62-days			88	57	59	59	100	80	81	81	75	99	95	95	98	86	92	86	86
Best Value Care	Finance	Income & expenditure against plan	≥£0.00m	≥£0.00m	-£0.76	£2.33	-£12.76	-£11.19	-£0.02	£0.02	-£0.61	-£0.61	-£0.33	-£0.31	£0.44	-£0.20	-£0.18	-£0.79	-£0.09	-£1.06	-£1.87
		Financial Improvement Programme (FIP) against plan	≥£0.00m	≥£0.00m	£1.27	-£0.43	£0.54	£1.38	-£0.55	£1.48	£0.66	£1.59	-£1.61	-£1.38	-£1.57	-£4.56	£4.90	-£1.66	-£0.20	£3.04	£0.07
		Capital expenditure against plan	≤£0.00m	≤£0.00m	-£2.01	-£0.88	-£12.53	-£15.42	£1.61	£2.07	£1.39	£5.07	£1.55	£1.28	£1.27	£4.10	£1.16	£1.01	£1.92	£4.09	£13.26
		Cash balance	-	≥£1.45m	£1.80	£8.76	£4.74	£4.74	£1.34	£1.73	£1.50	£1.50	£0.32	-£0.15	£0.05	£0.05	£9.46	£4.17	£1.28	£1.28	£1.28
		Implied Productivity 2023/24 v 2024/25	-	3.1%	-	-	-	-	-	-	-	-	6.7%	5.2%	6.1%	6.1%	6.9%	-	-	6.9%	6.9%
		Value weighted elective activity	-	105%	113.2%	114.2%	127.1%	118.2%	103.5%	110.9%	112.0%	108.8%	108.8%	118.7%	118.5%	115.3%	119.1%	113.6%	114.4%	115.7%	113.3%
		Agency expenditure against plan	≥£0.00m	≥£0.00m	-£1.36	-£1.17	-£1.09	-£3.62	-£0.18	-£0.29	-£0.29	-£0.76	-£0.39	-£0.24	£0.01	-£0.62	-£0.17	-£0.09	£0.14	-£0.12	-£1.50
		Reported agency spend			£1.47	£1.28	£1.21	£3.96	£1.27	£1.28	£1.32	£3.87	£1.44	£1.17	£0.93	£3.54	£1.18	£1.14	£0.90	£3.22	£10.63
		Reported bank spend			£3.36	£2.01	£3.69	£9.06	£2.25	£2.88	£2.59	£7.72	£2.75	£2.89	£2.22	£7.86	£2.36	£2.41	£2.61	£7.38	£22.96
Activity (for context)	Urgent Care	A&E attendances (inc. PC24)	≤Plan	≤Plan	104.5%	111.1%	111.6%	109.0%	111.5%	106.8%	104.1%	107.3%	106.5%	96.7%	102.0%	101.7%	105.9%	107.4%	107.7%	107.0%	105.3%
		Non-elective admissions	≤Plan	≤Plan	119.9%	118.6%	116.0%	118.2%	111.3%	110.4%	103.3%	108.3%	105.5%	102.1%	99.1%	102.2%	98.1%	96.2%	103.3%	99.1%	103.1%
	Electives	Average daily elective referrals			314	327	304	315	343	340	325	336	348	320	347	338	374	350	-	362	343
		Outpatients - first appointment	≥Plan	≥Plan	108.3%	106.3%	109.7%	108.1%	99.3%	84.0%	94.0%	92.3%	90.5%	87.5%	96.0%	91.3%	82.9%	83.4%	78.2%	81.6%	88.3%
		Outpatients - follow up	≤Plan	≤Plan	107.5%	105.0%	106.2%	106.2%	100.0%	102.4%	94.1%	98.9%	99.1%	92.2%	97.2%	96.2%	97.2%	92.5%	92.0%	94.0%	96.3%
		Outpatients - procedures	≥Plan	≥Plan	121.7%	125.3%	123.0%	123.3%	133.0%	129.3%	114.4%	125.3%	122.7%	118.7%	139.0%	126.1%	139.9%	124.7%	139.9%	134.5%	128.4%
		Day case	≥Plan	≥Plan	100.2%	101.5%	109.8%	103.7%	96.3%	96.1%	96.0%	96.1%	102.7%	101.3%	100.0%	101.3%	95.8%	101.4%	97.1%	98.1%	98.6%
		Elective inpatient	≥Plan	≥Plan	101.9%	110.8%	129.3%	113.5%	92.5%	94.6%	90.0%	92.4%	84.0%	99.8%	96.7%	93.3%	108.0%	109.4%	97.9%	105.4%	97.0%
	Diagnostics	Diagnostics	≥Plan	≥Plan	102.6%	103.9%	106.8%	104.4%	102.6%	109.2%	98.1%	103.2%	104.9%	111.4%	112.5%	109.5%	120.5%	114.9%	114.6%	116.7%	109.8%

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

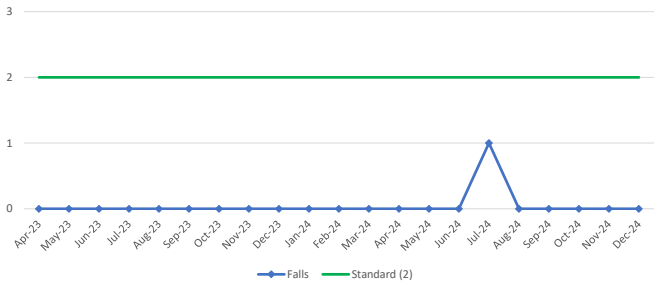
December 2024 (Qtr 3)

Cover Page | Definitions

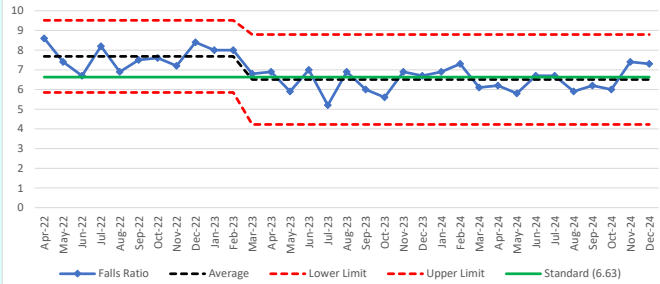
Charts

Quality of Care

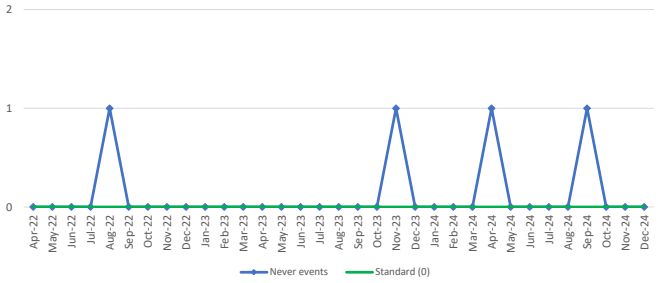
Falls with lapse in care



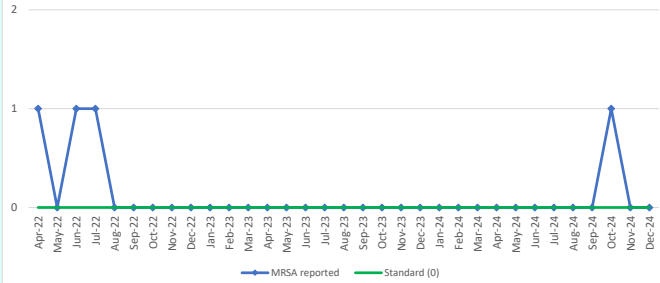
Falls per 1000 occupied bed days



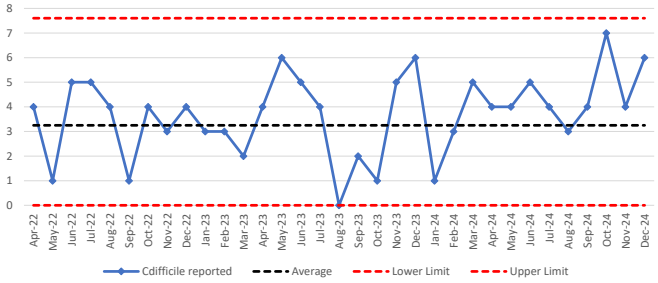
Never events



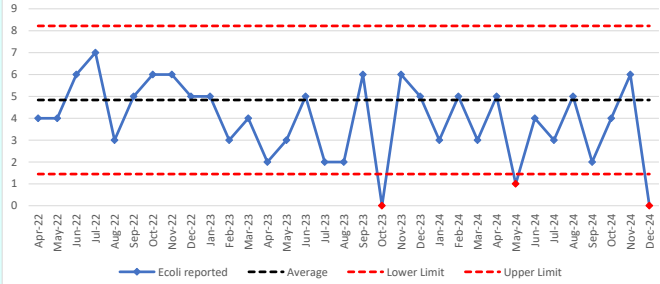
MRSA reported in month



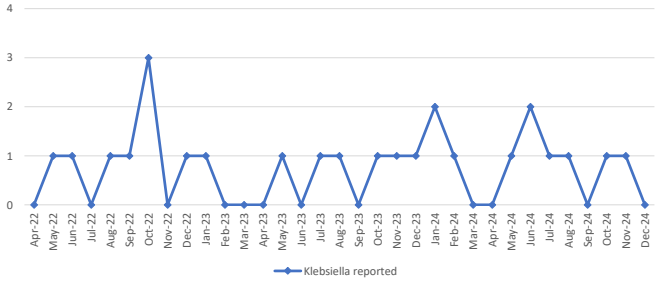
Cdifficile reported in month



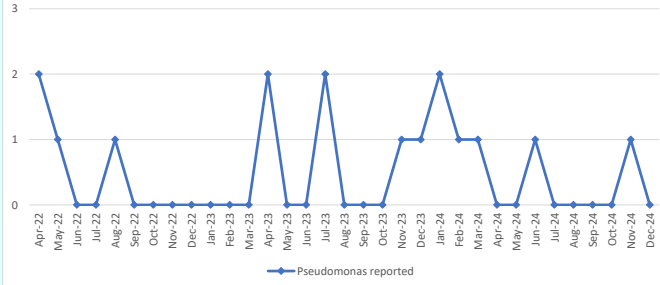
Ecoli blood stream infections (BSI) reported in month

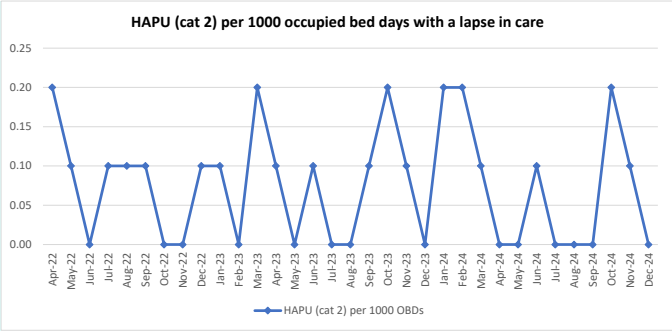


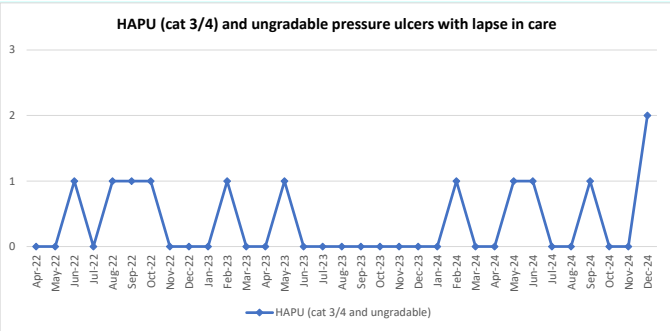
Klebsiella BSI reported in month

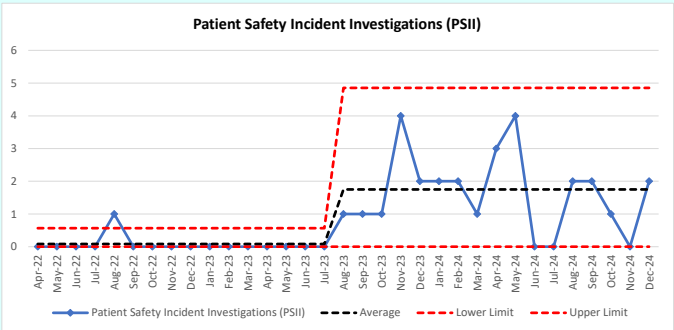


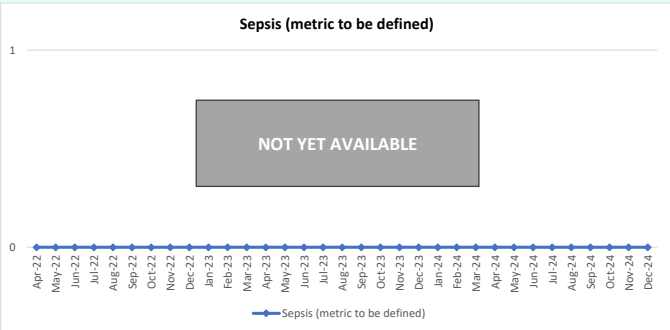
Pseudomonas BSI reported in month

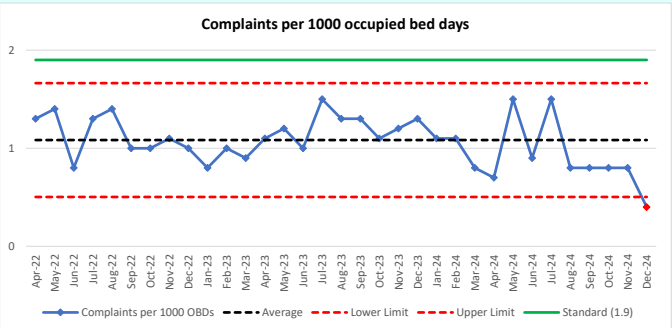


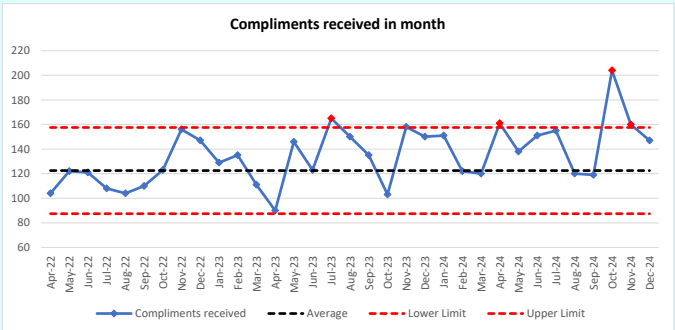

HAPU (cat 2) per 1000 occupied bed days with a lapse in care
HAPU (cat 2) per 1000 OBDs

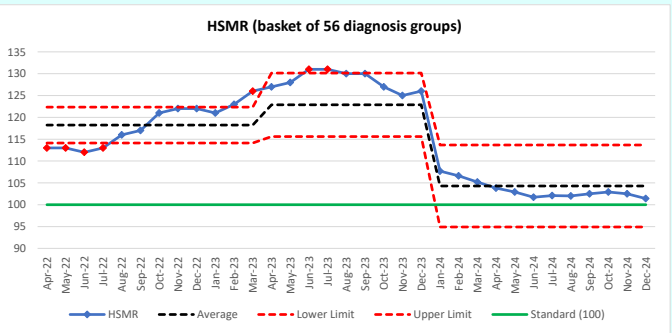

HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care
HAPU (cat 3/4 and ungradable)

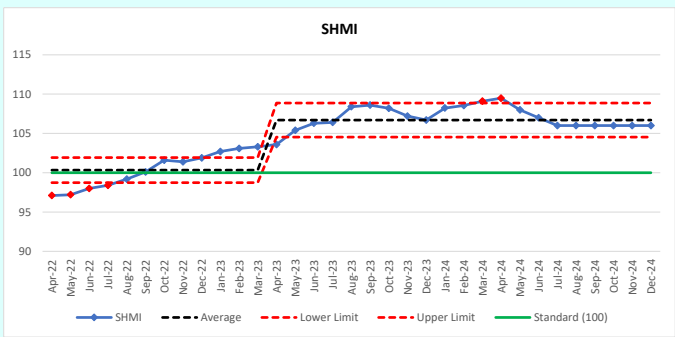

Patient Safety Incident Investigations (PSII)
Patient Safety Incident Investigations (PSII)
Average
Lower Limit
Upper Limit

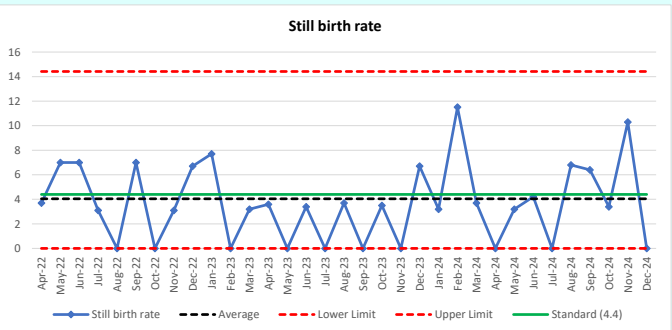

Sepsis (metric to be defined)
NOT YET AVAILABLE
Sepsis (metric to be defined)

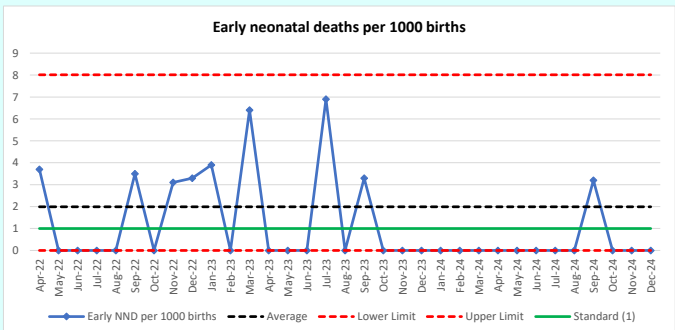

Complaints per 1000 occupied bed days
Complaints per 1000 OBDs
Average
Lower Limit
Upper Limit
Standard (1.9)


Compliments received in month
Compliments received
Average
Lower Limit
Upper Limit


HSMR (basket of 56 diagnosis groups)
HSMR
Average
Lower Limit
Upper Limit
Standard (100)

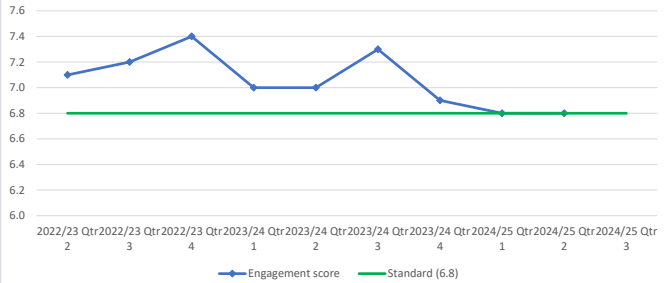

SHMI
SHMI
Average
Lower Limit
Upper Limit
Standard (100)


Still birth rate
Still birth rate
Average
Lower Limit
Upper Limit
Standard (4.4)

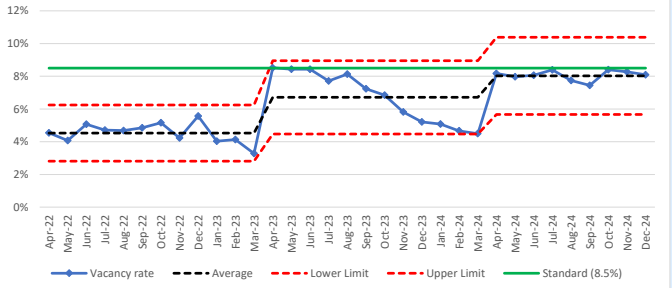

Early neonatal deaths per 1000 births
Early NND per 1000 births
Average
Lower Limit
Upper Limit
Standard (1)

People and Culture

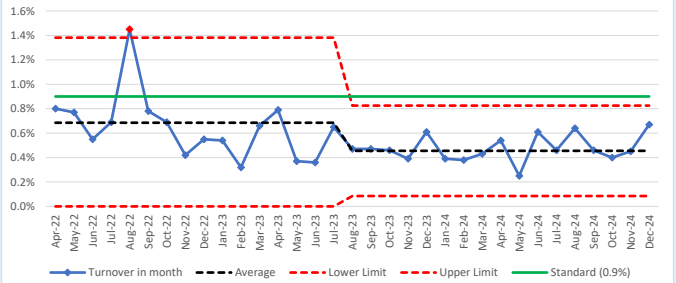
Engagement score



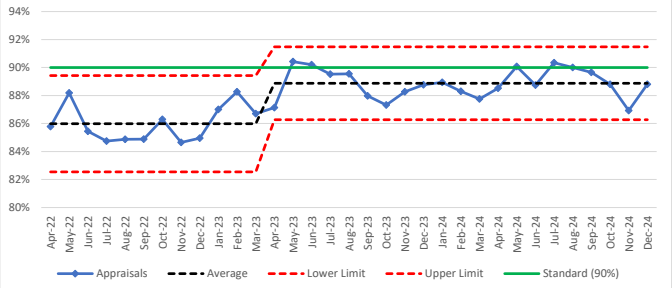
Vacancy rate



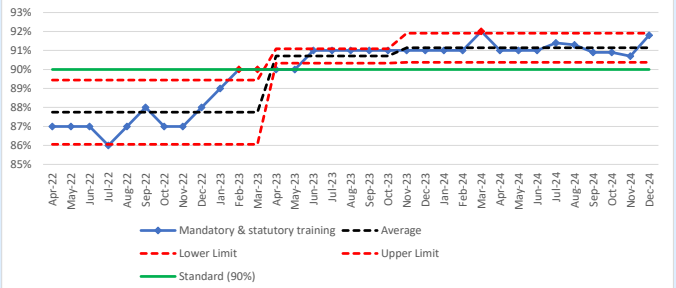
Turnover in month



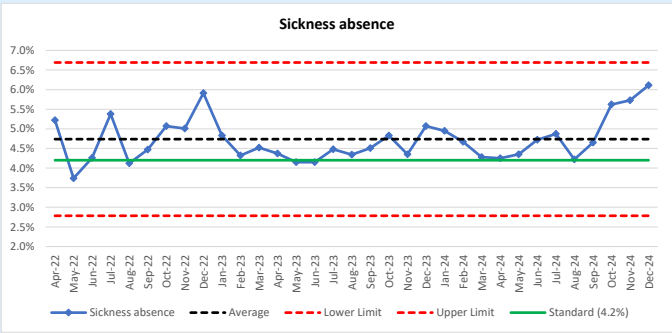
Appraisals



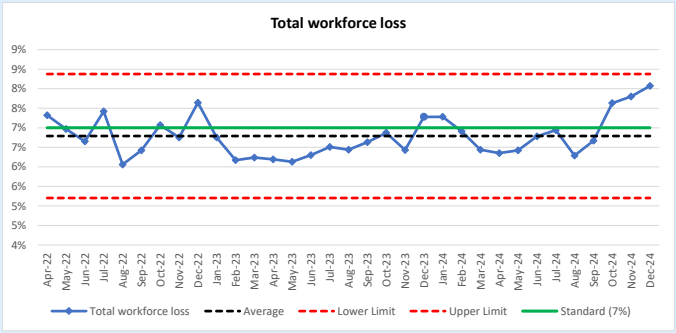
Mandatory & statutory training



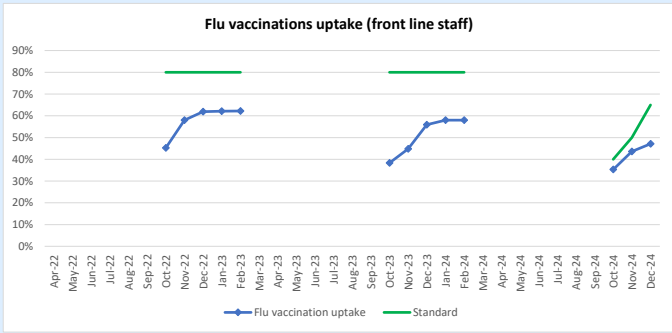
Sickness absence

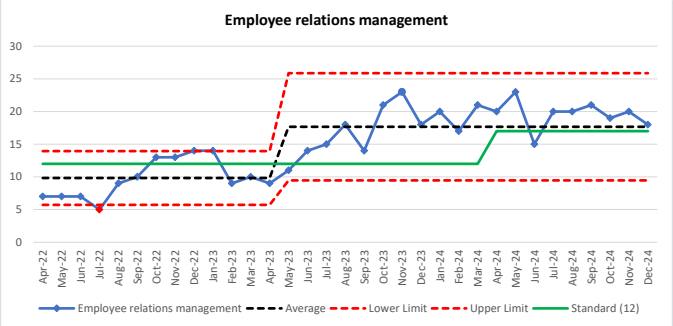


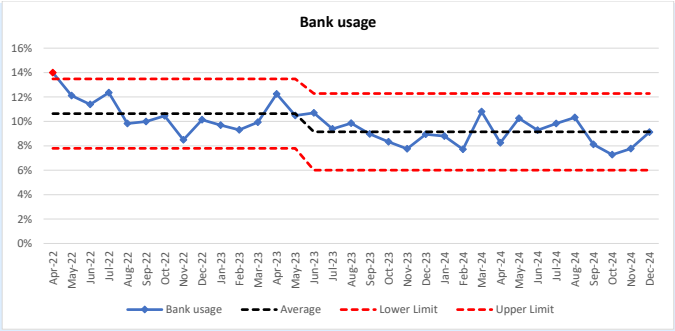
Total workforce loss

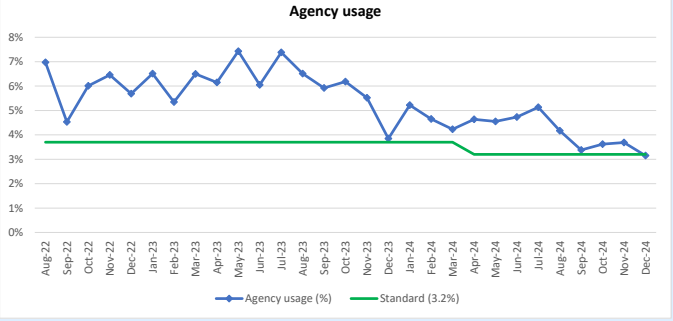


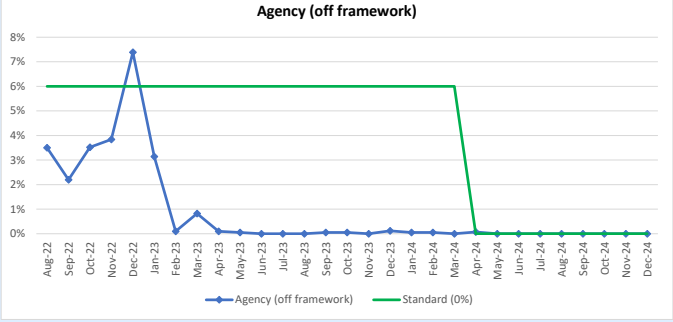
Flu vaccinations uptake (front line staff)

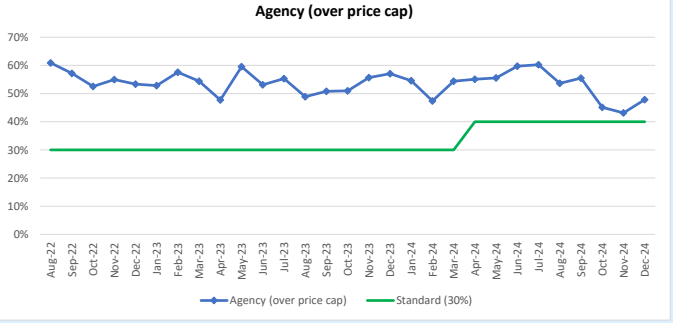



Employee relations management
30
25
20
15
10
5
0
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24
Employee relations management
Average
Lower Limit
Upper Limit
Standard (12)


Bank usage
16%
14%
12%
10%
8%
6%
4%
2%
0%
Apr-22 May-22 Jun-22 Jul-22 Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24
Bank usage
Average
Lower Limit
Upper Limit

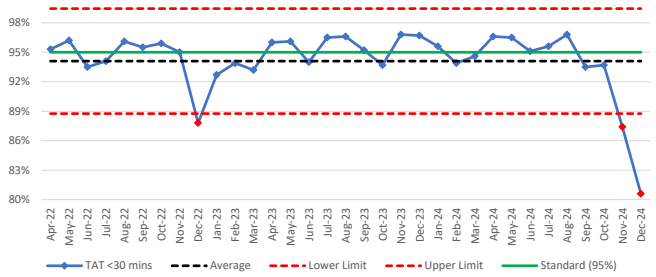

Agency usage
8%
7%
6%
5%
4%
3%
2%
1%
0%
Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24
Agency usage (%)
Standard (3.2%)


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

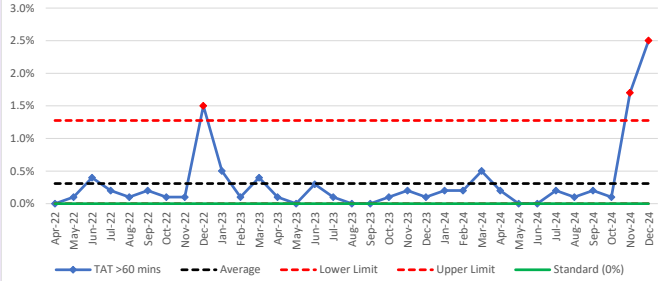

Agency (over price cap)
70%
60%
50%
40%
30%
20%
10%
0%
Aug-22 Sep-22 Oct-22 Nov-22 Dec-22 Jan-23 Feb-23 Mar-23 Apr-23 May-23 Jun-23 Jul-23 Aug-23 Sep-23 Oct-23 Nov-23 Dec-23 Jan-24 Feb-24 Mar-24 Apr-24 May-24 Jun-24 Jul-24 Aug-24 Sep-24 Oct-24 Nov-24 Dec-24
Agency (over price cap)
Standard (30%)

Timely Care

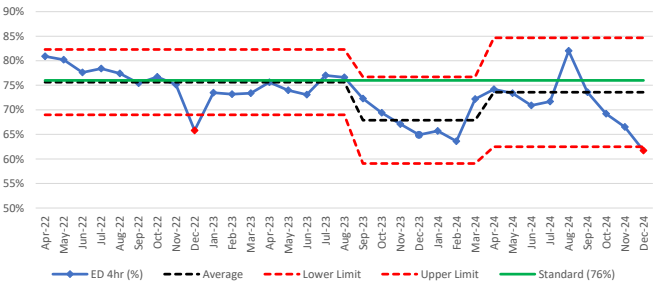
Ambulance turnaround times <30 mins



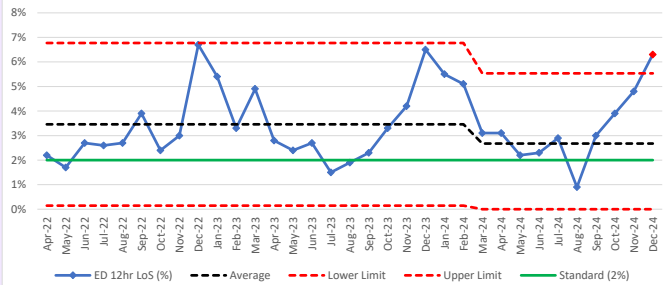
Ambulance delays >60 mins



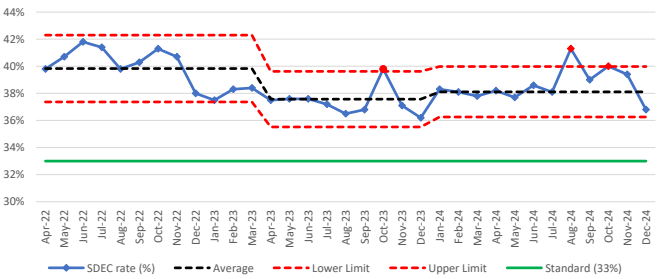
ED 4-hour performance



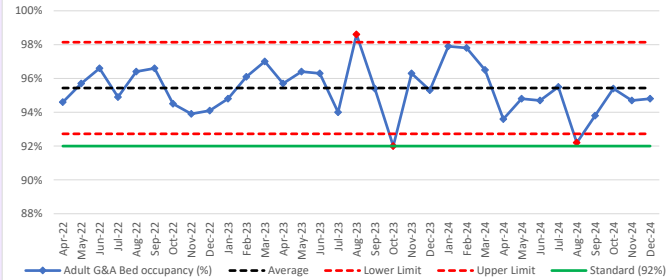
ED 12-hour length of stay performance



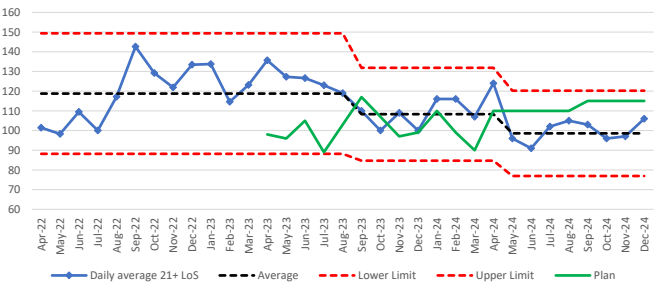
SDEC rate



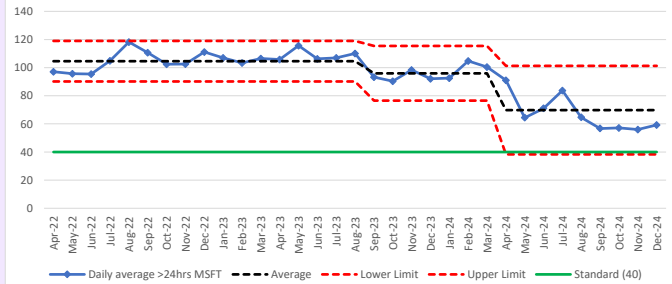
Adult G&A bed occupancy

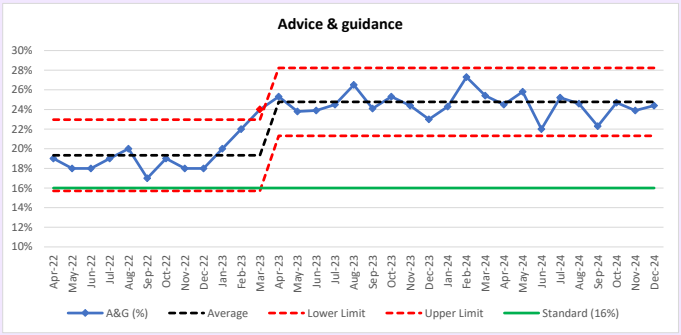


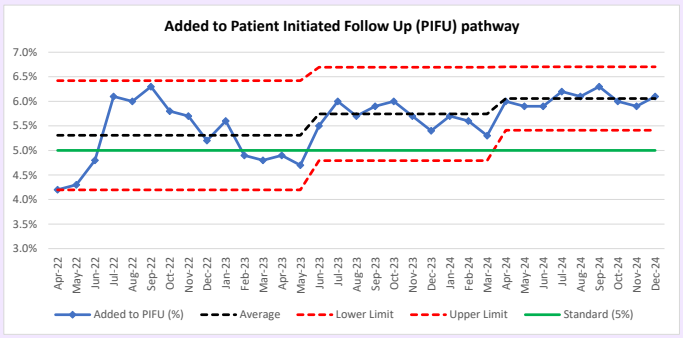
Long length of stay (21+) occupied beds

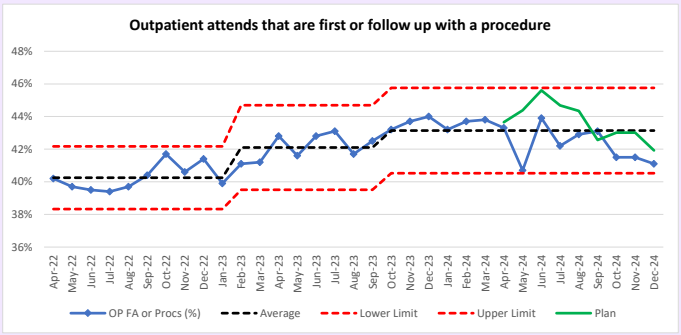


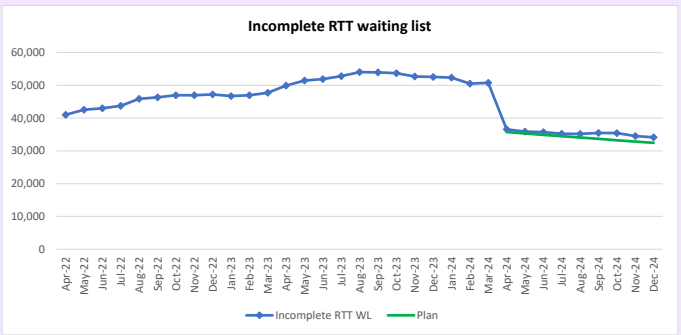
Inpatients medically safe for transfer for greater than 24 hours

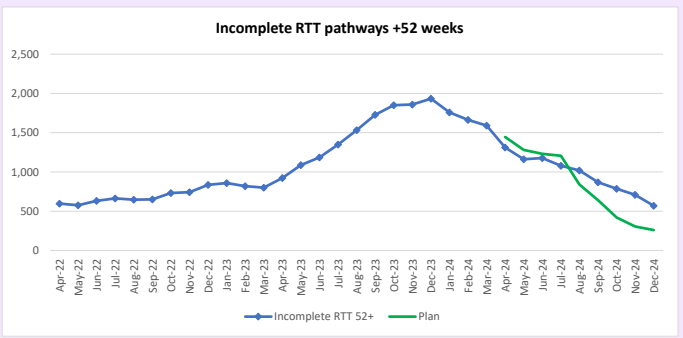


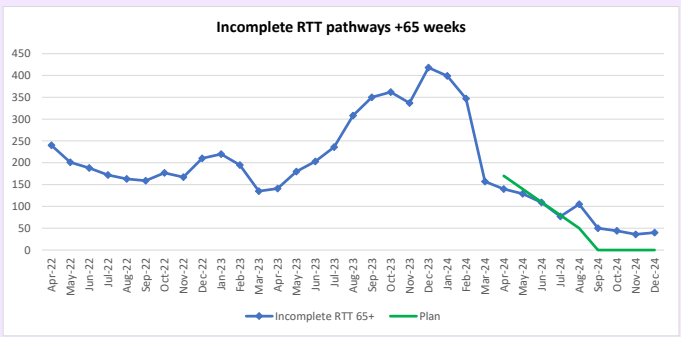

Advice & guidance
A&G (%)
Average
Lower Limit
Upper Limit
Standard (16%)

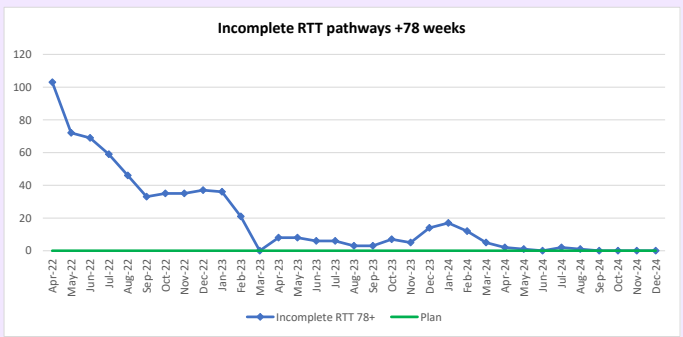

Added to Patient Initiated Follow Up (PIFU) pathway
Added to PIFU (%)
Average
Lower Limit
Upper Limit
Standard (5%)

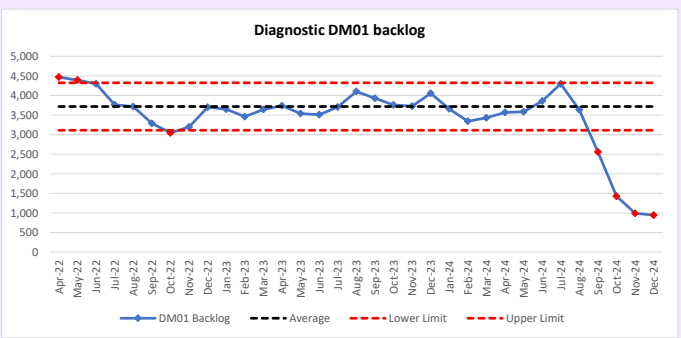

Outpatient attends that are first or follow up with a procedure
OP FA or Procs (%)
Average
Lower Limit
Upper Limit
Plan

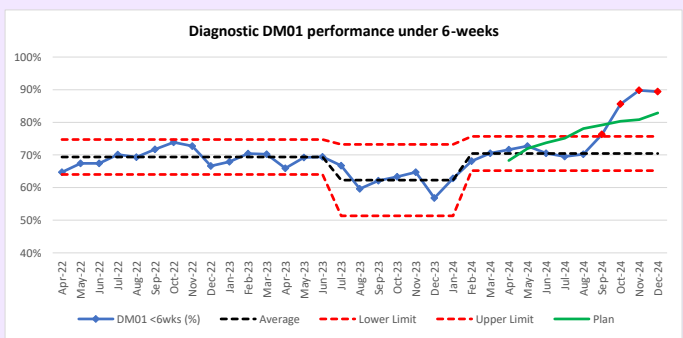

Incomplete RTT waiting list
Incomplete RTT WL
Plan

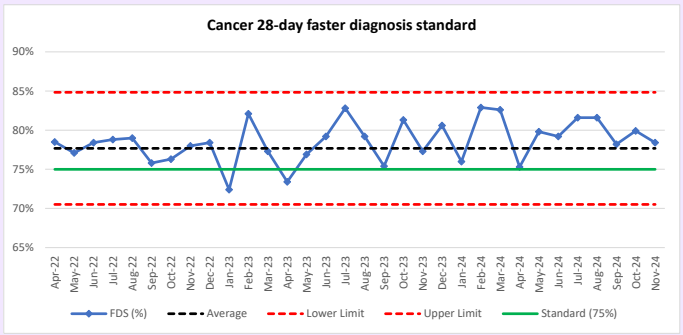

Incomplete RTT pathways +52 weeks
Incomplete RTT 52+
Plan

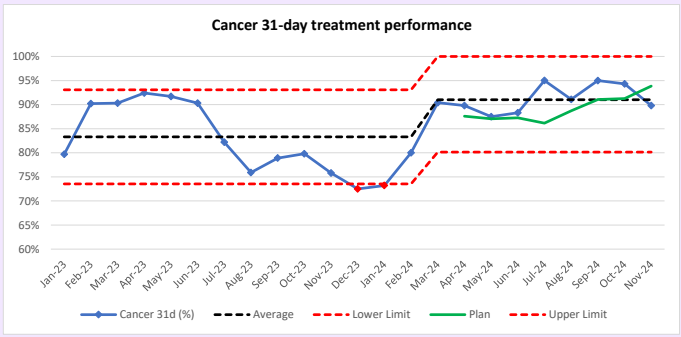

Incomplete RTT pathways +65 weeks
Incomplete RTT 65+
Plan

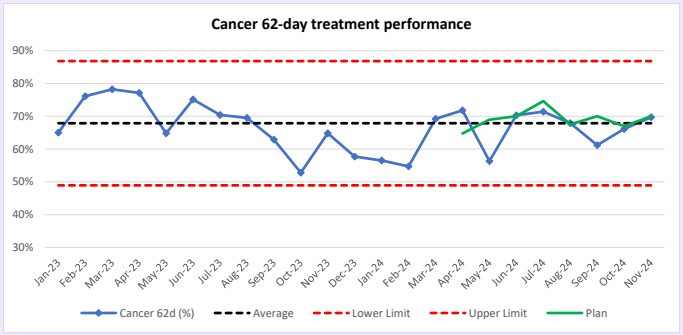

Incomplete RTT pathways +78 weeks
Incomplete RTT 78+
Plan

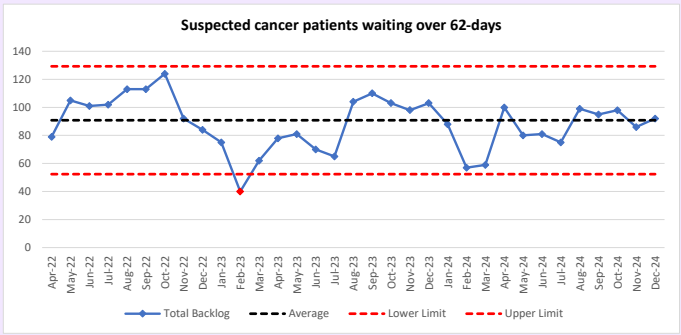

Diagnostic DM01 backlog
DM01 Backlog
Average
Lower Limit
Upper Limit


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

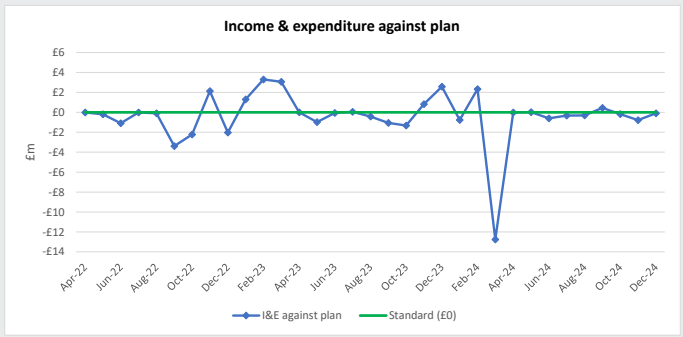


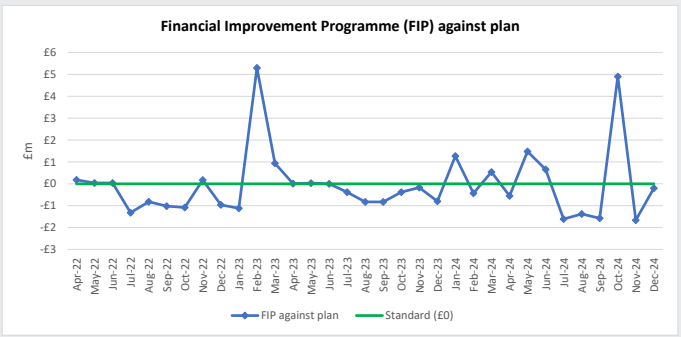


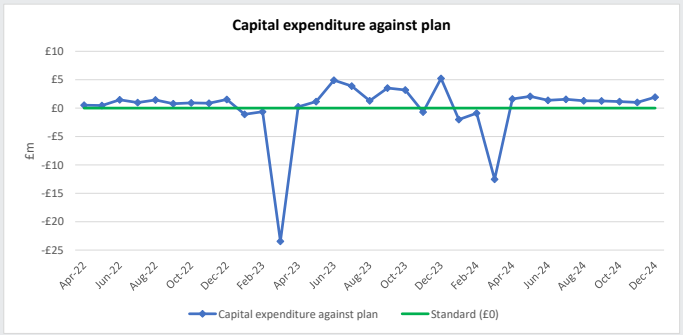


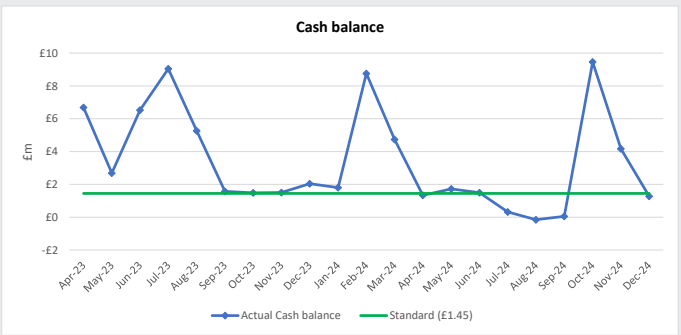


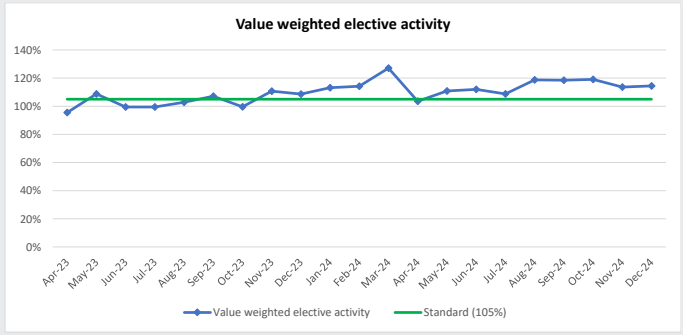
Best Value Care

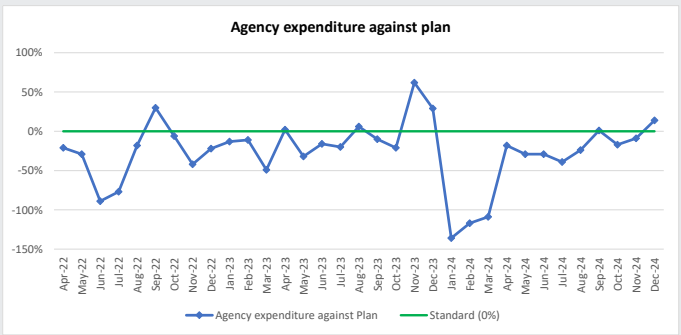


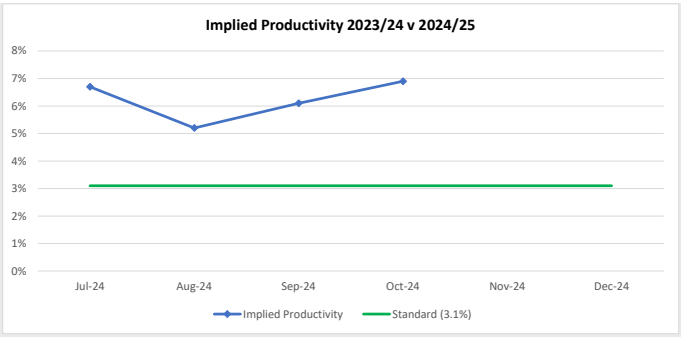


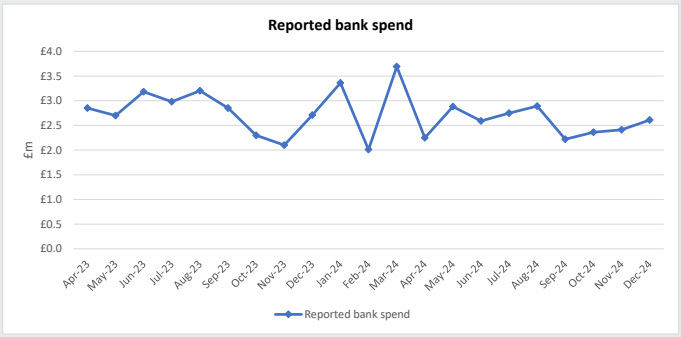




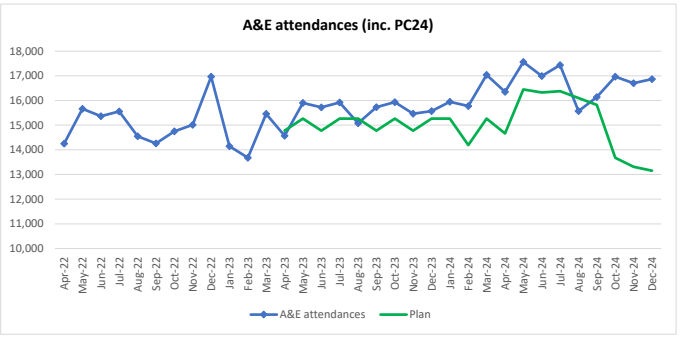


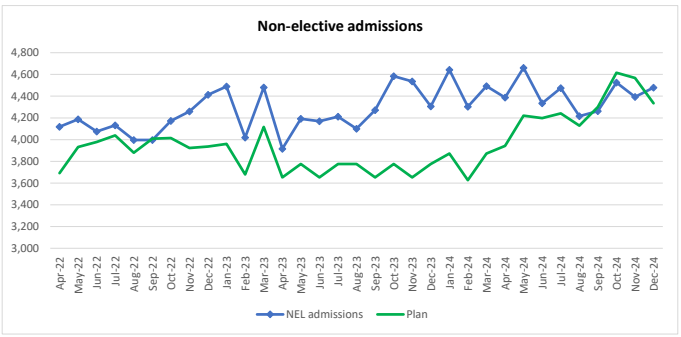


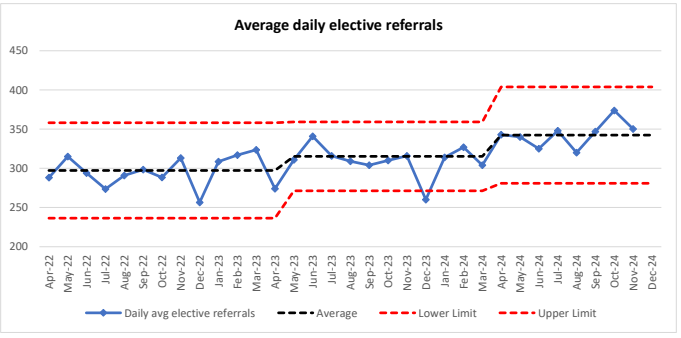


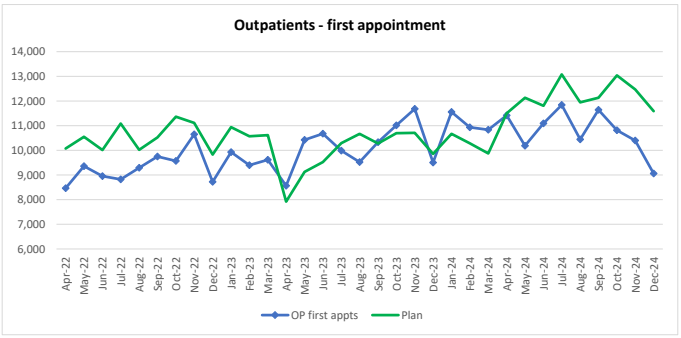


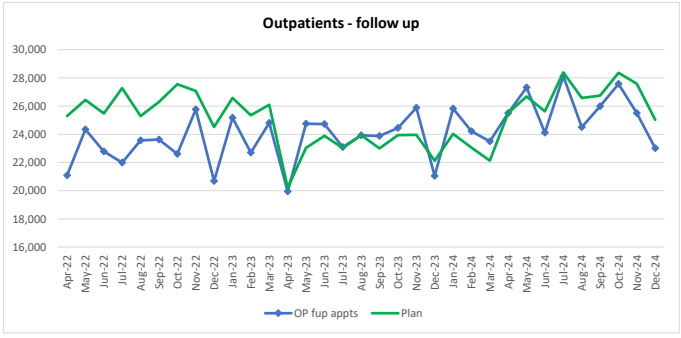
Activity (for context)

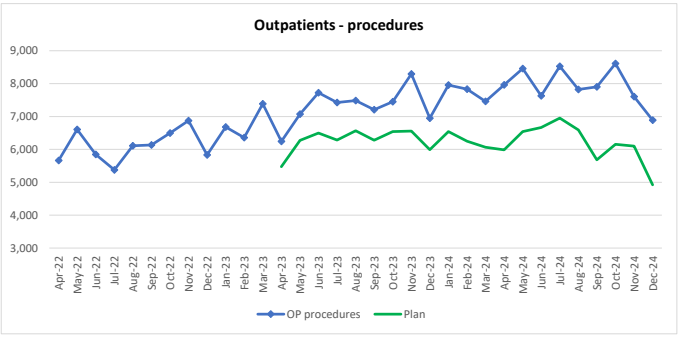


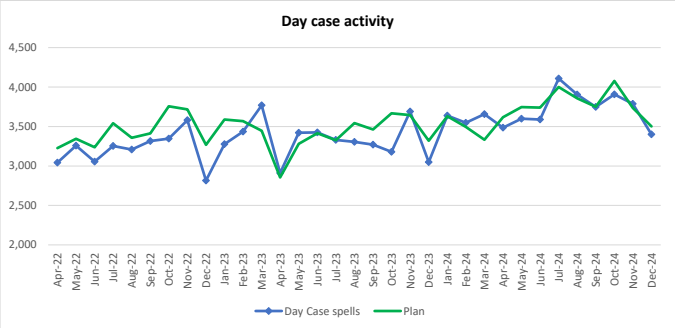


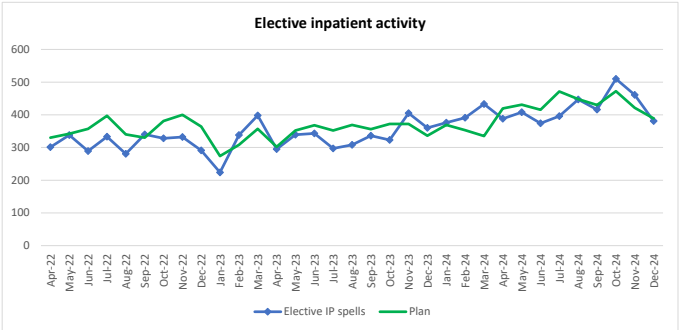


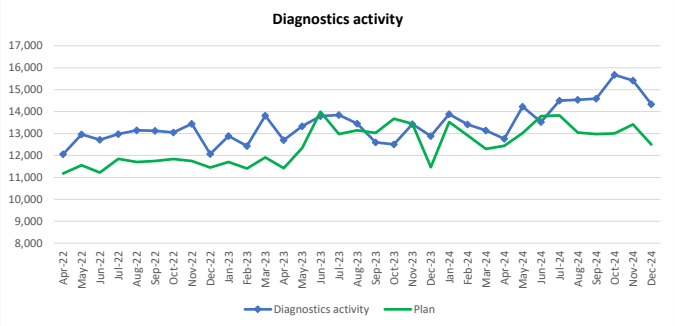







Day case activity
4,500
4,000
3,500
3,000
2,500
2,000
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Day Case spells
Plan


Elective inpatient activity
600
500
400
300
200
100
0
Apr-22
May-22
Jun-22
Jul-22
Aug-22
Sep-22
Oct-22
Nov-22
Dec-22
Jan-23
Feb-23
Mar-23
Apr-23
May-23
Jun-23
Jul-23
Aug-23
Sep-23
Oct-23
Nov-23
Dec-23
Jan-24
Feb-24
Mar-24
Apr-24
May-24
Jun-24
Jul-24
Aug-24
Sep-24
Oct-24
Nov-24
Dec-24
Elective IP spells
Plan


Diagnostics activity
17,000
16,000
15,000
14,000
13,000
12,000
11,000
10,000
9,000
8,000
Apr-22
May-22
Jun-22
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Oct-24
Nov-24
Dec-24
Diagnostics activity
Plan

Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report 2024/25

December 2024 (Qtr 3)

Timely Care Benchmarking

Nov-24

At a Glance	Indicator	Source	Rate	Rank	Of	Decile
Urgent Care	Ambulance turnaround times <30 mins	Summary Emergency Department Indicator Table (SEDIT)	87.9%	32	176	2
	Ambulance delays >60 mins	Summary Emergency Department Indicator Table (SEDIT)	1.7%	43	176	3
	ED 4-hour performance	NHS England A&E Attendances and Emergency Admissions	66.5%	94	141	7
	ED 12-hour length of stay performance	Summary Emergency Department Indicator Table (SEDIT)	7.6%	59	176	4
	SDEC rate	Summary Emergency Department Indicator Table (SEDIT)	35.8%	94	177	6
	Adult G&A bed occupancy	Summary Emergency Department Indicator Table (SEDIT)	95.6%	93	177	6
Electives	Added to Patient Initiated Follow Up (PIFU) pathway	Model Hospital	7.0%	14	135	2
	Incomplete RTT pathways +52 weeks	RTT waiting times data	2.1%	63	155	5
	Incomplete RTT pathways +65 weeks	RTT waiting times data	0.1%	88	155	6
	Incomplete RTT pathways +78 weeks	RTT waiting times data	0.0%	1	155	1
Diagnostics	Diagnostic DM01 performance under 6-weeks	Diagnostics Waiting Times and Activity data	85.5%	69	135	6
Cancer	Cancer 28-day faster diagnosis standard	Cancer Waiting Times standards	78.4%	70	133	6
	Cancer 31-day treatment performance	Cancer Waiting Times standards	89.8%	104	133	8
	Cancer 62-day treatment performance	Cancer Waiting Times standards	69.7%	86	133	7

Sherwood Forest Hospitals NHS Foundation Trust

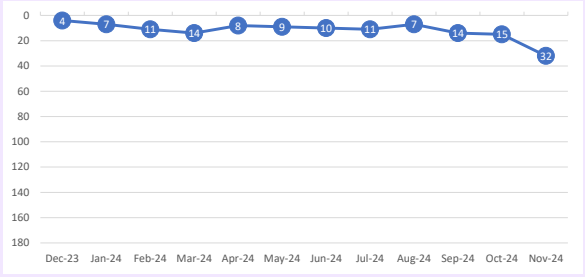
Integrated Performance Report 2024/25

December 2024 (Qtr 3)

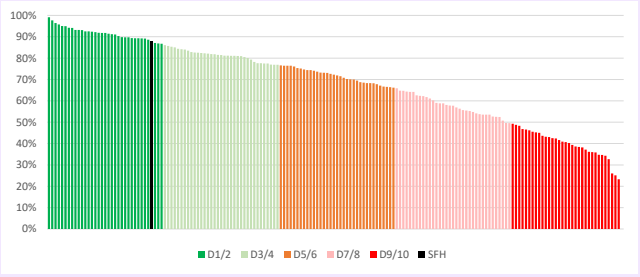
Timely Care Benchmarking Charts

Timely Care Benchmarking

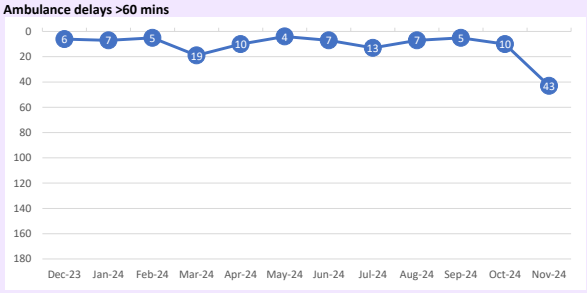
Ambulance turnaround times <30 mins



Nov 24 Position



Ambulance delays >60 mins



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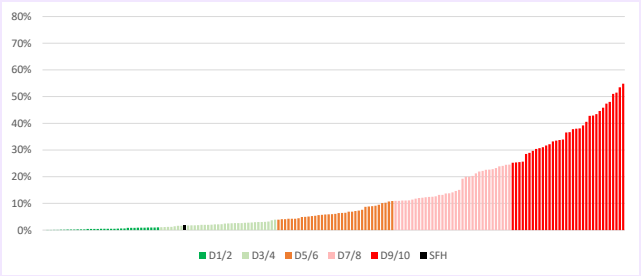
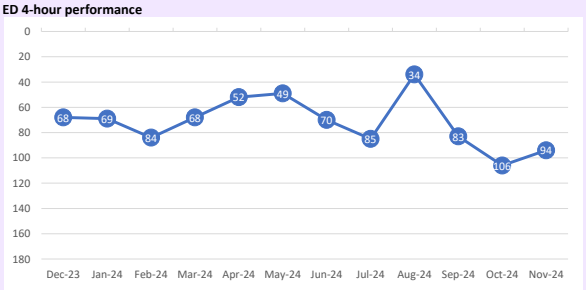


ED 4-hour performance



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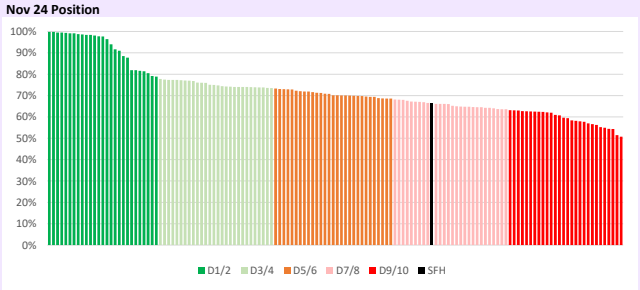
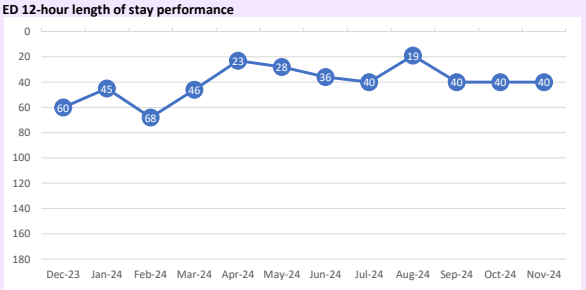


ED 12-hour length of stay performance



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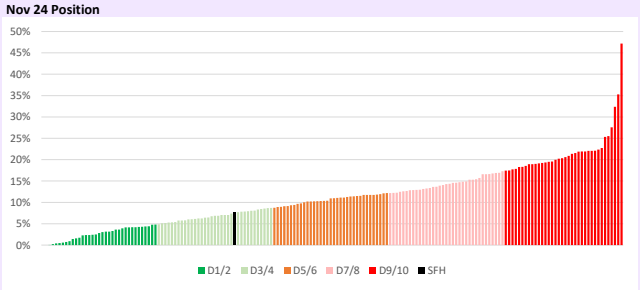
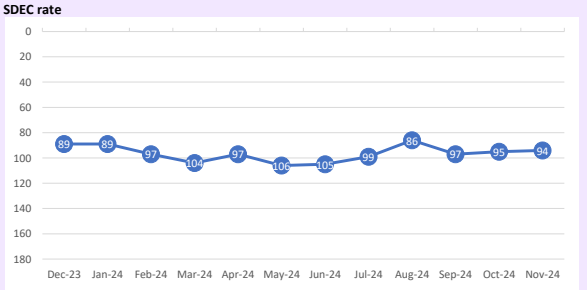


SDEC rate



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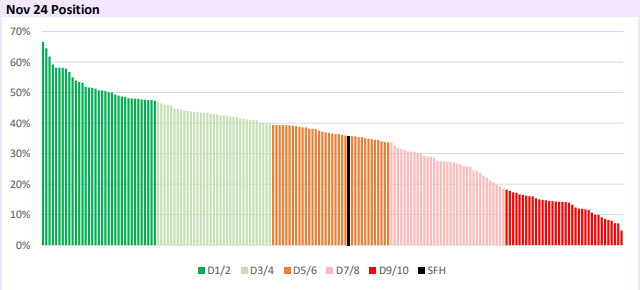
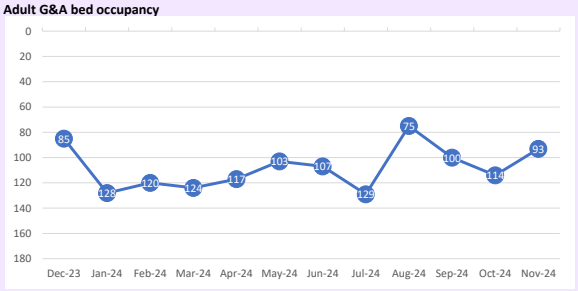
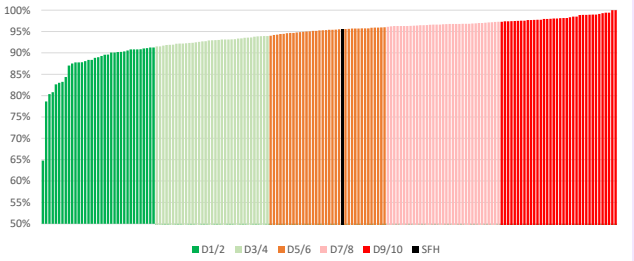


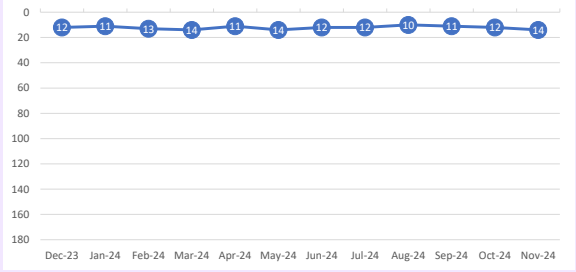
Adult G&A bed occupancy



Nov 24 Position



Added to Patient Initiated Follow Up (PIFU) pathway



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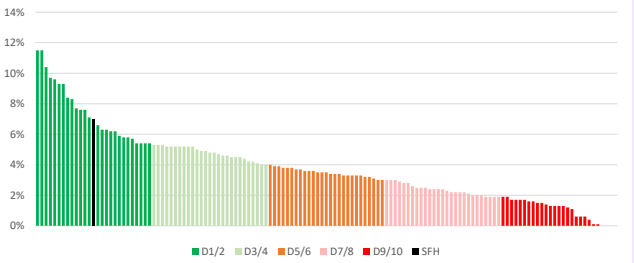
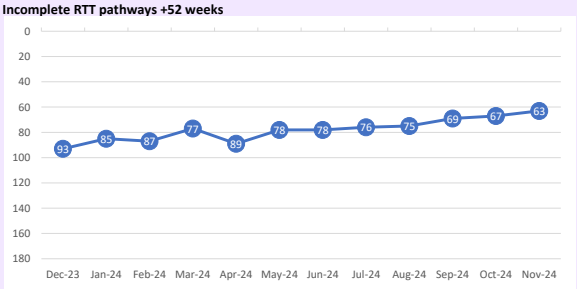
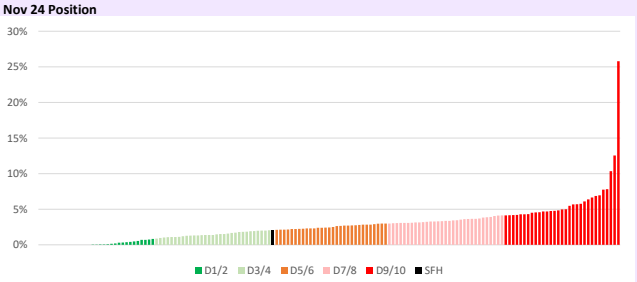


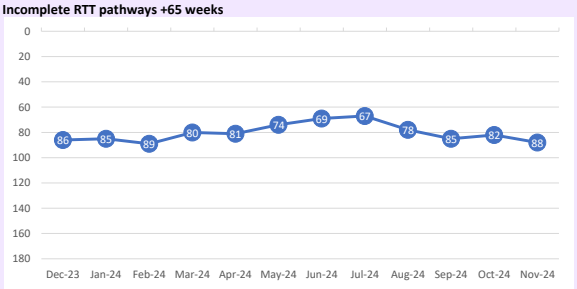
Incomplete RTT pathways +52 weeks



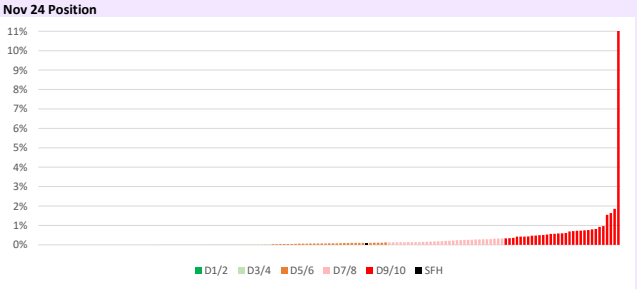
Nov 24 Position



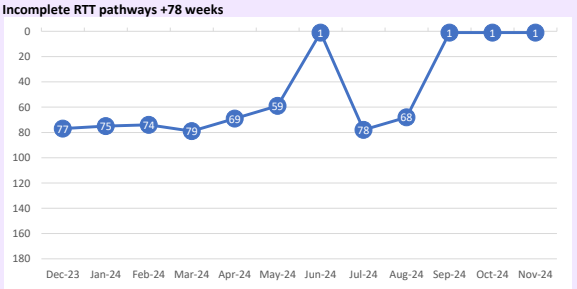
Incomplete RTT pathways +65 weeks



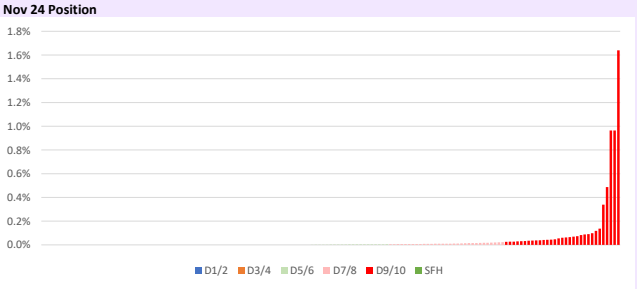
Nov 24 Position



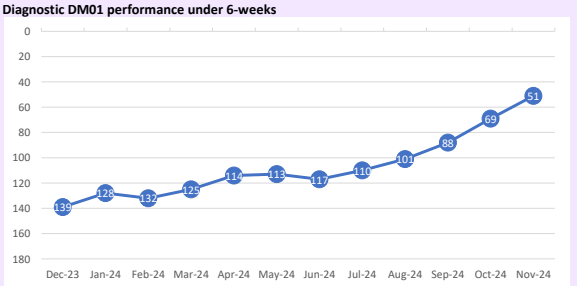
Incomplete RTT pathways +78 weeks



Nov 24 Position



Diagnostic DM01 performance under 6-weeks



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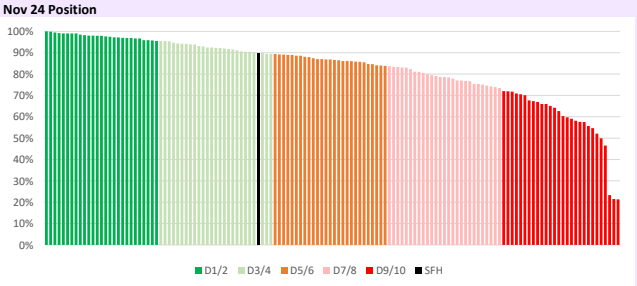
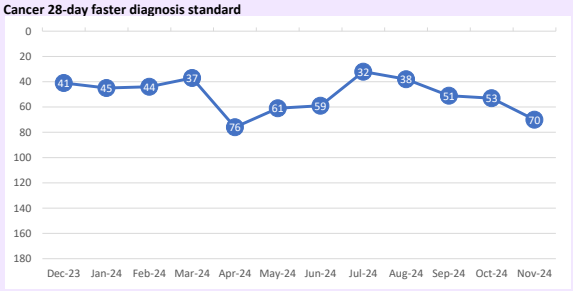
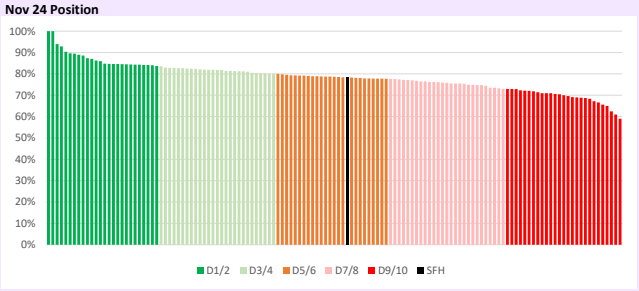


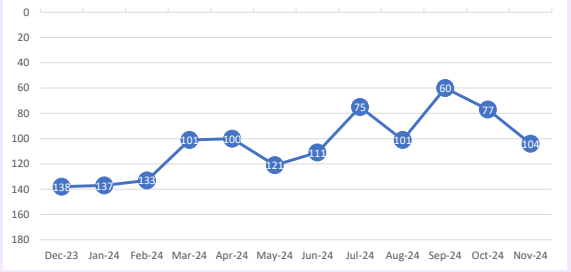
Cancer 28-day faster diagnosis standard



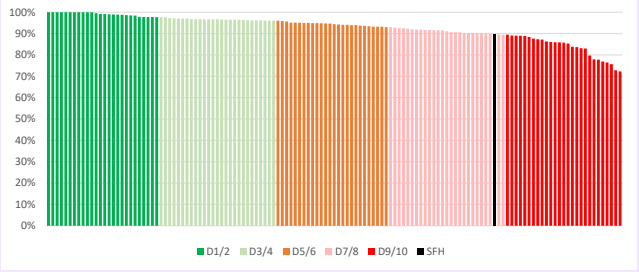
Nov 24 Position



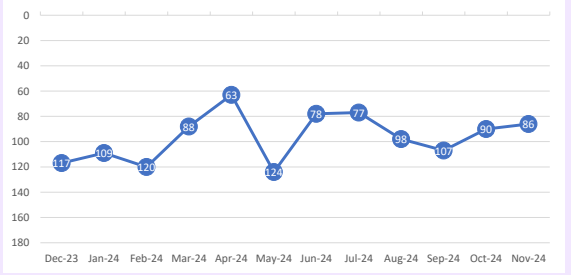
Cancer 31-day treatment performance



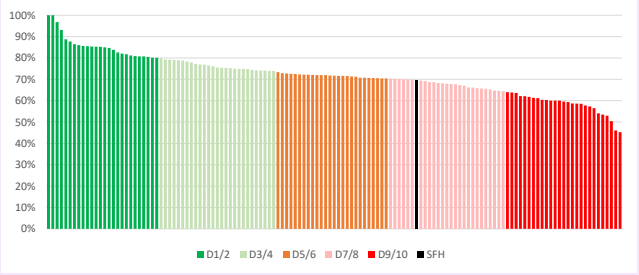
Nov 24 Position



Cancer 62-day treatment performance



Nov 24 Position



Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Q3 Review	**Date:**	6 February 2025
Prepared By:	Andrew Graham, Deputy Chief Financial Officer		
Approved By:	Richard Mills, Chief Financial Officer		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
To present the Board with an overview of Quarter 3 performance from a finance, workforce and activity perspective.	**Approval**	
	Assurance	
	Update	**X**
	Consider	

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

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

Committees/groups where this item has been presented before
Executive Team

Acronyms	
ICB – Integrated Care Board ICS – Integrated Care System	Q3 – Quarter 3 (Oct-24 to Dec-24) YTD – Year-to-Date

Executive Summary

The accompanying slides present the Trust Board with an overview of the organisational Q3 position looking through the domains of finance, workforce and activity.

Key Points:

- The Trust has reported a deficit of £7.3m to the end of December 2024, with a Quarter 3 deficit of £6.5m.
- At the end of Q3, we are showing that for our total workforce we are 0.9% (or 55.3 WTEs) below plan, driven by a reduction in agency and bank.
- High levels of activity have continued through Quarter 3, with more demand than the same period last year.

The Board of Directors are asked to note the contents of the update.

Outstanding Care,
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Healthier Communities

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Q3 Review

Trust Board Meeting

Outstanding Care,
Compassionate People,
Healthier Communities

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NHS Foundation Trust

Finance

M9 YTD I&E Report

ICS Achievement Basis, All values £'m	YTD		
	Plan	Actual	Variance
Income:			
Clinical Income	369.49	369.41	(0.07)
Other Income	40.11	42.10	1.99
Total Income	**409.60**	**411.51**	**1.91**
Expenditure:			
Pay - Substantive	(233.19)	(223.76)	9.43
Pay - Bank	(17.02)	(23.01)	(5.99)
Pay - Agency	(9.11)	(10.62)	(1.51)
Pay - Other (Apprentice Levy and Non Execs)	(1.20)	(1.15)	0.04
Total Pay	(260.52)	(258.54)	1.98
Non-Pay	(126.34)	(132.19)	(5.84)
Depreciation	(11.82)	(11.67)	0.15
Interest Expense	(26.38)	(26.42)	(0.04)
PDC Dividend Expense	-	-	-
Total Non-Pay	(164.53)	(170.28)	(5.73)
Total Expenditure	**(425.05)**	**(428.82)**	**(3.77)**
Surplus/(Deficit)	**(15.46)**	**(17.31)**	**(1.86)**
Removal of PFI adjustment	10.05	10.05	-
Final Surplus/(Deficit)	**(5.40)**	**(7.26)**	**(1.86)**

- The Trust has a Q3 deficit of £7.3m which is £1.9m adverse to the planned deficit of £5.4m. This is being driven by
  - £0.3m relates to Industrial Action as a result of income lost noting the impact of expenditure was supported in month 6,
  - £0.2m for redundancy costs on the vaccination service
  - £1.4m for funding shortfalls associated with commissioned services and they pay award.
- We have achieved £26.6m of efficiency savings which although is slightly behind plan at M9 by £0.3m, this is £7m higher than we reported at the same period in 23/24.
- The Trust pay position is £2.0m underspent at Month 9, however the Trust is still utilising bank and agency to offset substantive posts.
- Non-Pay expenditure is showing a £5.7m overspend however £2.8m of this relates to high-cost drugs and devices therefore is off set with additional income. A further £1.2m is associated with pass through costs of system licenses and the remaining links to additional activity levels.

Q3 Position

ICS Achievement Basis, All values £'m	Quarter 3		
	Plan	Actual	Variance
Income:			
Clinical Income	125.73	125.20	(0.52)
Other Income	14.07	16.19	2.12
Total Income	**139.80**	**141.39**	**1.60**
Expenditure:			
Pay - Substantive	(84.05)	(81.10)	2.95
Pay - Bank	(6.10)	(7.39)	(1.29)
Pay - Agency	(3.10)	(3.22)	(0.12)
Pay - Other (Apprentice Levy and Non Execs)	(0.40)	(0.42)	(0.02)
Total Pay	(93.64)	(92.13)	1.51
Non-Pay	(42.22)	(46.41)	(4.22)
Depreciation	(3.94)	(3.89)	0.05
Interest Expense	(2.48)	(2.50)	(0.02)
PDC Dividend Expense	-	-	-
Total Non-Pay	(48.63)	(52.80)	(4.20)
Total Expenditure	**(142.28)**	**(144.93)**	**(2.69)**
Surplus/(Deficit)	**(2.48)**	**(3.54)**	**(1.09)**
Removal of PFI adjustment	(2.94)	(2.94)	-
Final Surplus/(Deficit)	**(5.42)**	**(6.48)**	**(1.09)**

- Within Q3, the Trust has delivered a deficit of £6.5m which is £1.1m more than planned.
- Although the Trust has a break-even plan for the year, the phasing of the efficiency programme, backloaded over the later months, is driving a deficit plan in Q3. The phasing profile over Q4 is to deliver a surplus to get to that break-even position.
- The Trust has received £1.6m more income than planned in Q3. This is due to recouping the additional non-pay costs that are on a pass-through basis however this is offset by a shortfall in clinical income for which the Trust is still providing those services.
- We have seen an underspend on pay to the value of £1.5m when compared to plan but pay costs are higher than previous quarters due to the timing of the pay award and the backdated payments.
- Non-Pay expenditure was £4.2m more than expected and can be explained due to a significant increase in high-cost drugs, devices and pass through IT costs. The spike in high-cost drugs is due to NICE guidance changes.

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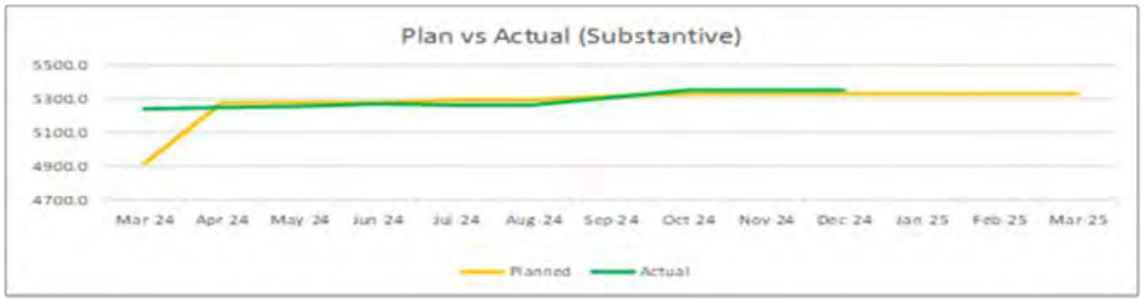
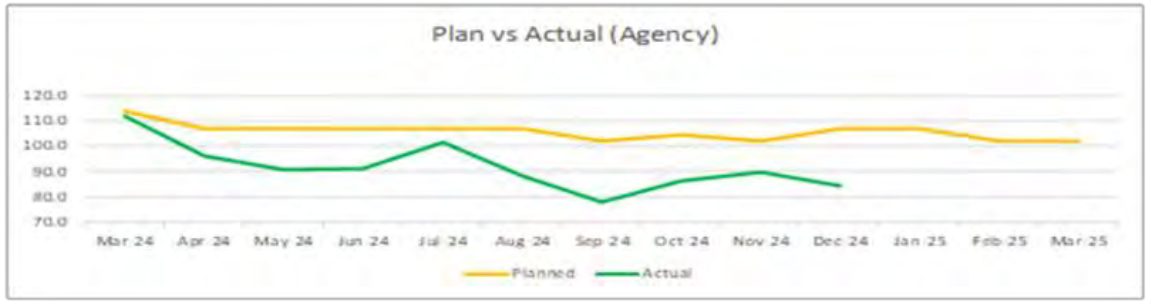
Workforce

Workforce (Plan versus Actual)

At a Glance	Indicator	Apr-24	May-24	Jun-24	2024/25 Qtr 1	Jul-24	Aug-24	Sep-24	2024/25 Qtr 2	Oct-24	Nov-24	Dec-24	2024/25 Qtr 3	Jan-25	Feb-25	Mar-25	2024/25 Qtr 4	2024/25 YTD
Workforce	Plan vs Actual (Subs)	-0.5%	-0.4%	0.0%	-0.3%	-0.5%	-0.5%	-0.1%	-0.4%	0.5%	0.5%	0.5%	0.5%					-0.1%
	Plan vs Actual (Bank)	-9.8%	-14.0%	-6.1%	-9.9%	0.8%	9.1%	-2.9%	2.3%	3.7%	-11.4%	-13.5%	-7.0%					-3.8%
	Plan vs Actual (Agency)	-10.2%	-15.1%	-14.7%	-13.3%	-5.1%	-17.5%	-23.9%	-15.5%	-17.6%	-12.3%	-21.5%	-17.1%					-14.5%
	Plan vs Actual (Total)	-1.4%	-1.7%	-0.8%	-1.3%	-0.5%	-0.1%	-0.7%	-0.4%	0.4%	-0.6%	-0.9%	-0.4%	-100.0%	-100.0%	-100.0%		-0.7%





- At the end of Q3, we are showing that for our total workforce we are 0.9% (or 55.3 WTEs) below plan.
- Substantive staff 0.5% (or 28.3 WTEs) are above plan. Agency staff are -21.5% (or -23 WTEs) and Bank staff are reported at 13.5% (or 60.5 WTEs) below plan.
- The current trajectory is to be on plan by March 2025, we are expecting the substantive, bank and agency staffing levels to follow the planned trajectory and show a reduction after winter.

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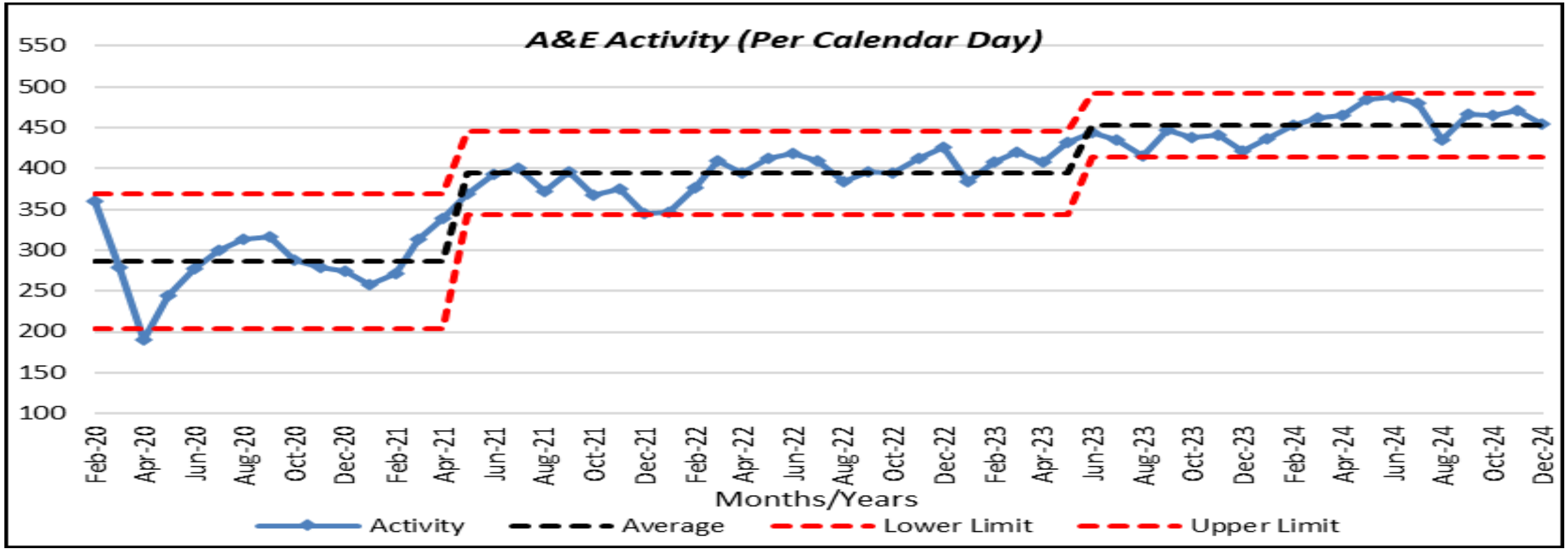
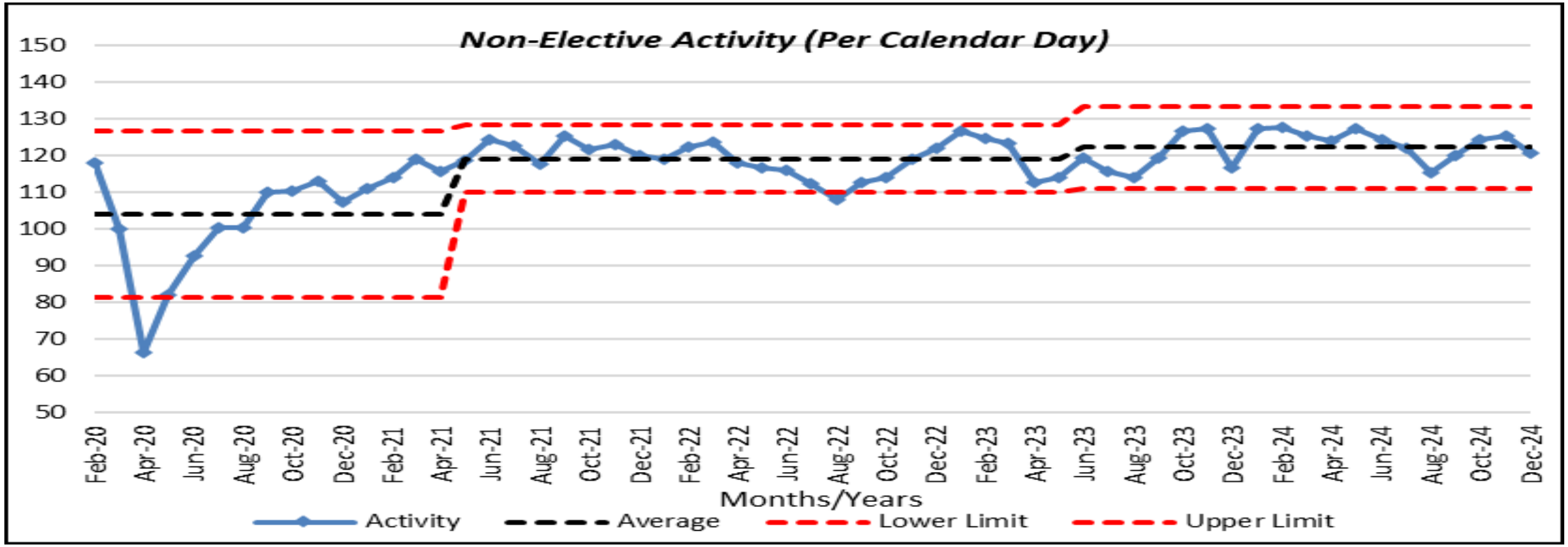
Activity

A&E Activity



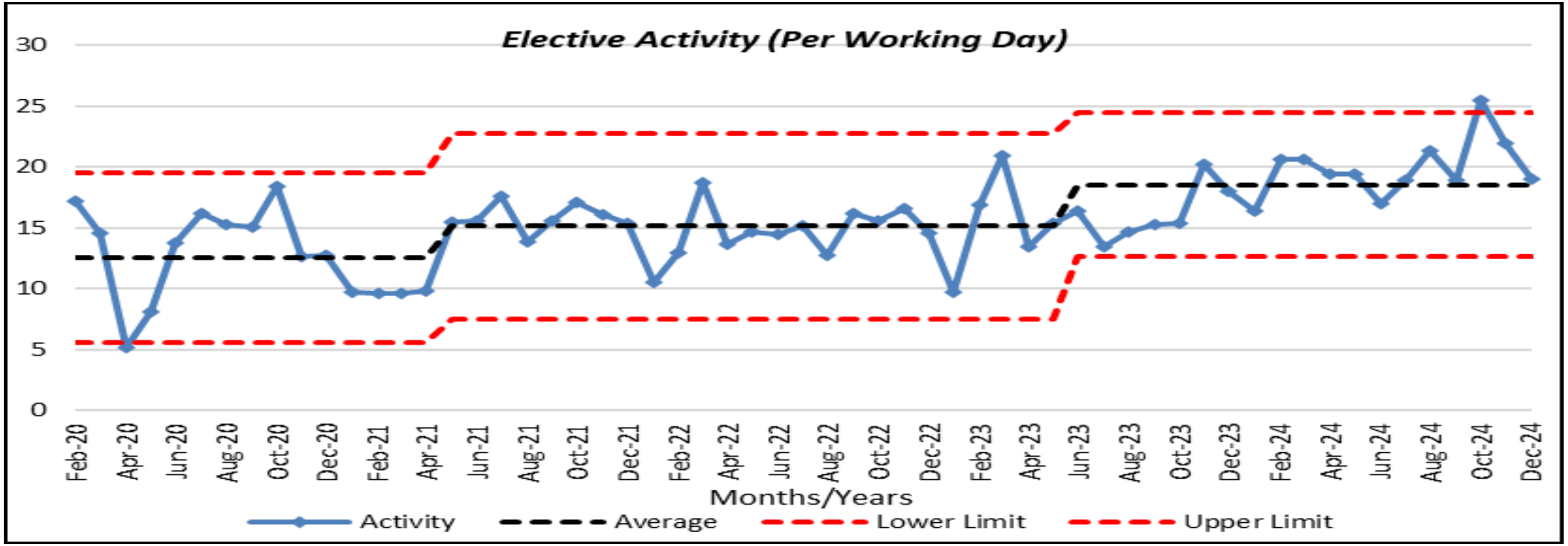
- A & E activity slightly decreased per calendar day in December compared with November.
- Attendances per day were 455 in December compared to 471 in November.
- Compared to December 2023, activity was 1,038 (8%) higher.
- Attendances per day in December 2024 = 455, compared to December 2019 = 377.

NEL Activity



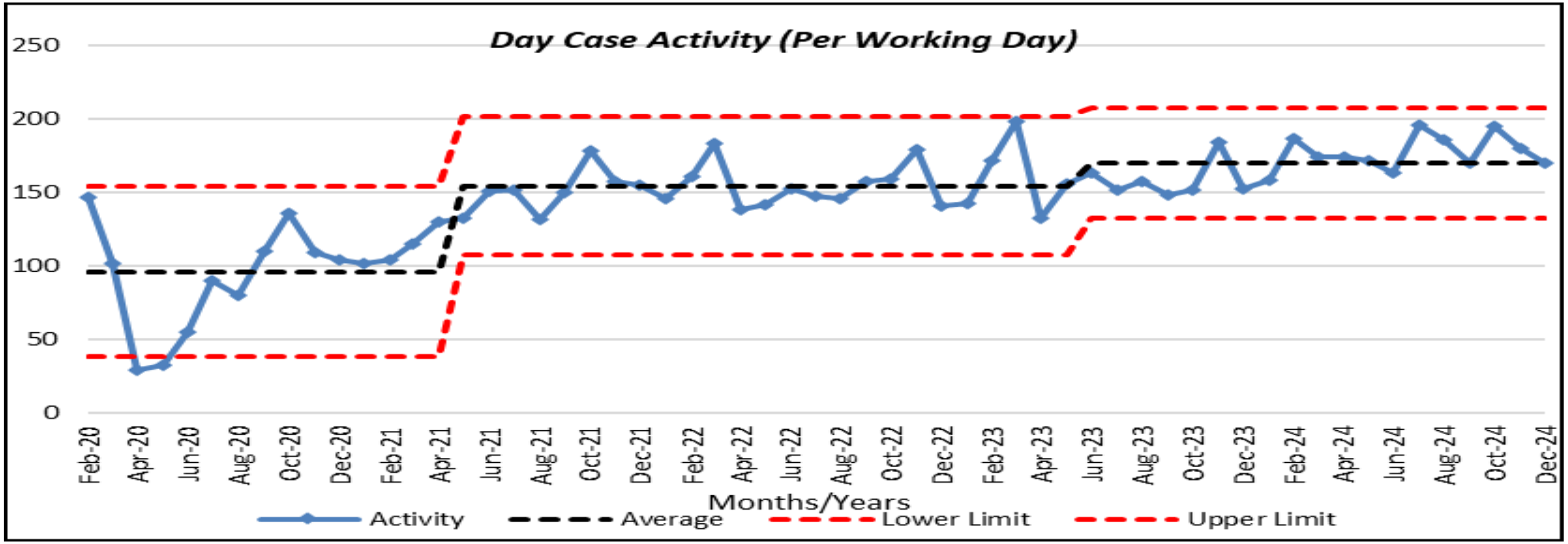
- Non-Elective activity per day in December decreased compared with November.
- Discharges per day were 121 in December compared with 126 in November.
- Compared with December 2023, activity was 3% higher, with 126 more discharges.
- Discharges per day in December 2024 = 121, compared to December 2019 = 124.

EL Activity



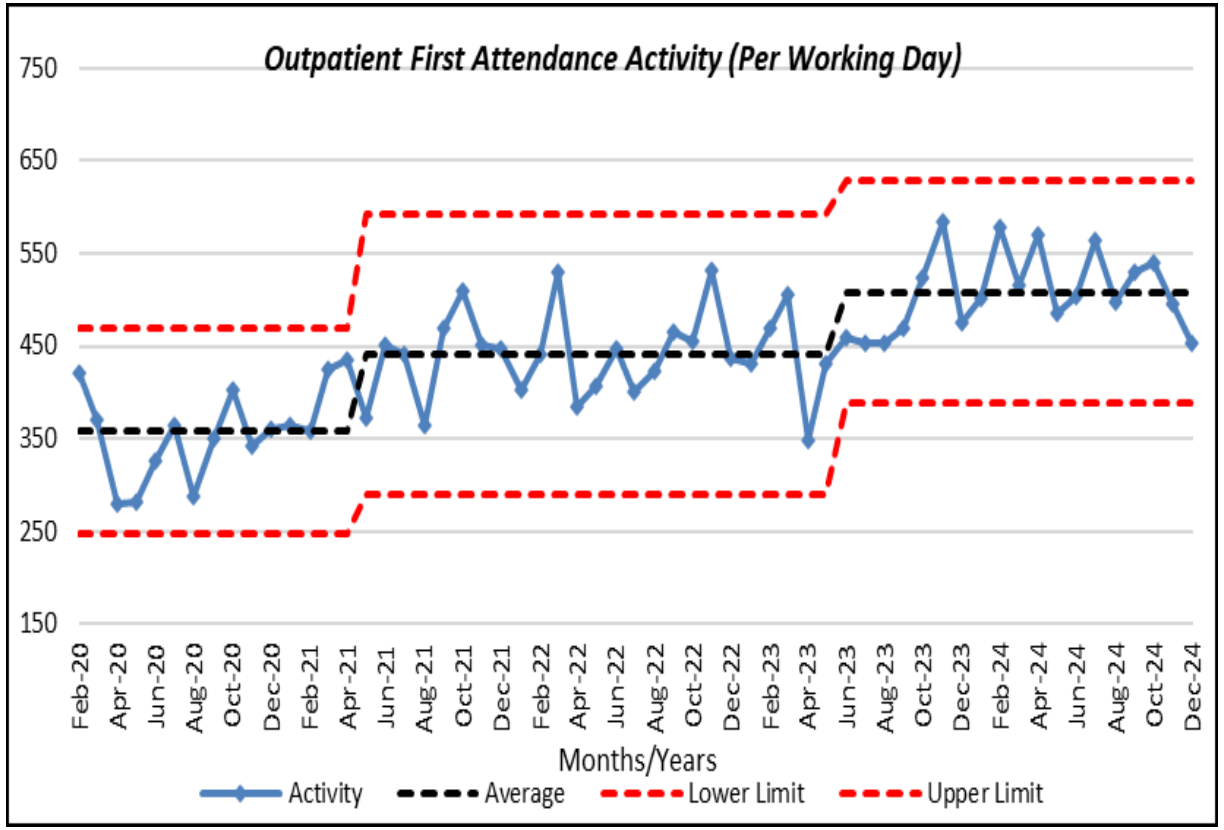
- Elective activity per working day has decreased compared to the previous month.
- Discharges per day were 19 in December and 22 in November.
- Compared with December 2023, activity is 6% higher (21 spells).
- Discharges per working day in December 2024 = 19, compared to December 2019 = 22.

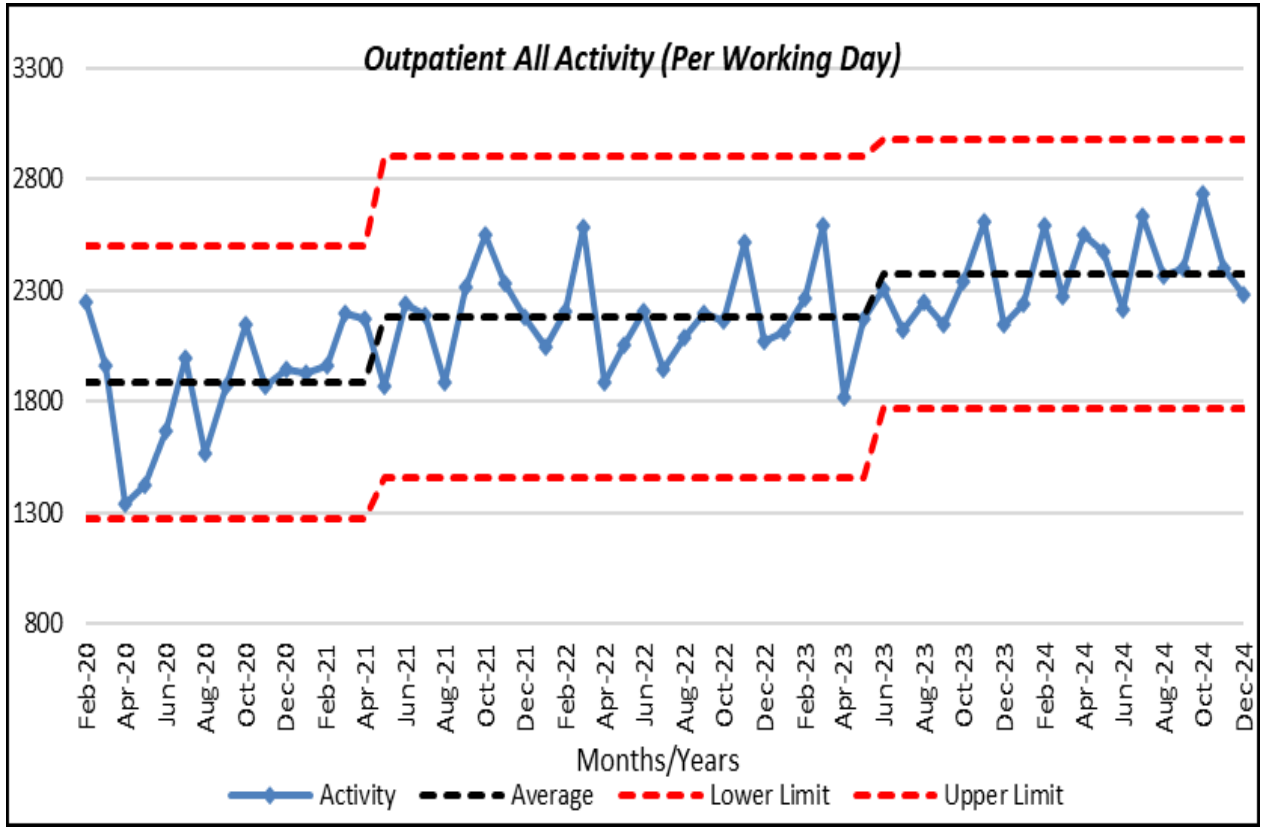
DC Activity



- Day case activity in December has decreased compared to the previous month.
- Discharges per day were 170 in December and 180 in November.
- Compared with December 2023, activity is 12% higher (353 more spells).
- Attendances per working day in December 2024 = 170 compared to December 2019 = 152.

Outpatient Activity





- Outpatient first attendances in December decreased compared to November. Attendances per day were 453 in December and 495 in November.
- Compared with December 2023, activity was 5% lower (446 less attendances in month per working day). Attendances per working day in December 2024 = 453, compared to December 2019 = 419.
- All Outpatient Attendances per day decreased compared with November. Outpatient procedures and follow ups per day were 5% lower than in November.
- Total Attendances per working day in December 2024 = 2,283 compared to December 2019 = 2,343.

Board Assurance Framework (BAF): January 2025

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~~ Significant 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~~ Moderate 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~~ the Committee is not assured that the current risk treatment strategy fully addresses the gaps in assurance or control

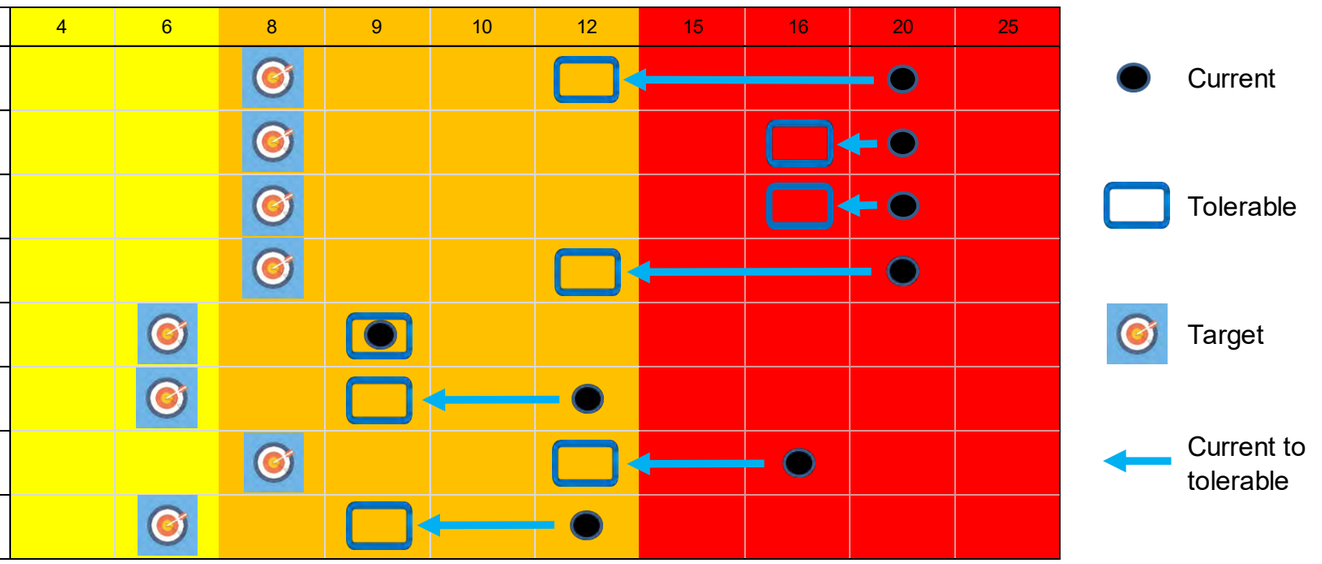
Red = ~~Negative~~ Limited assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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

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

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

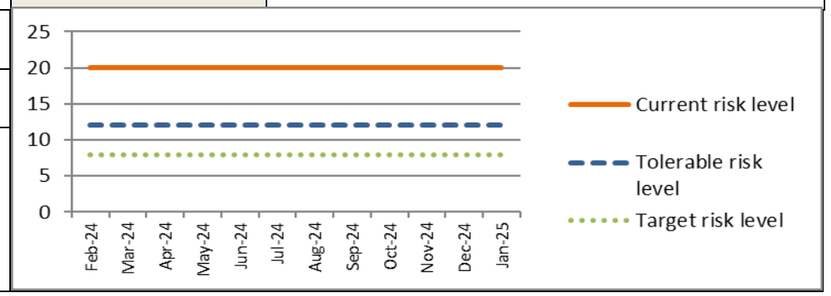
		Lead Director	Lead Committee
PR1	**Significant deterioration in standards of safety and care**	Medical Director Chief Nurse	Quality
PR2	**Demand that overwhelms capacity**	Chief Operating Officer	Quality
PR3	**Critical shortage of workforce capacity and capability**	Director of People	People
PR4	**Insufficient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



Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Recognised deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead directors	Medical Director Chief Nurse	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	3. Possible	2. Unlikely		
Last reviewed	27/01/2025	**Risk rating**	**20. Significant**	**12. High**	**8. Medium**		
Last changed	27/01/2025						

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



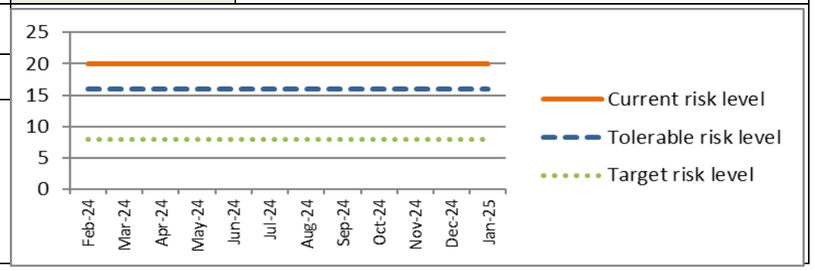
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to maintain patient safety and quality of care leading to increased incidence of avoidable harm and poor patient experience	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ IPR metric reviewed annually and agreed by Board ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Patients Safety Incident Response Framework (PSIRF) ▪ Review, oversight and learning from patient safety incidents Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC quarterly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy ▪ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight ▪ Digital Strategy Group ▪ Enhanced actions to full capacity protocol	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 Inability to re-provide MDT or other outpatients ~~appointments~~ in a timely way, impacting on ~~cancer~~ patient pathway metrics and overall patient care Financial restraints may lead to impacts on ability to maintain patient care and safety, including the ability to recruit temporary staffing Insufficient capacity, particularly beds, to maintain safe standards of care	Review the existing reporting metrics used to monitor patient safety and identify improvements to ensure consistency of the values used across different reports across governance groups, including the development of a quality dashboard **SLT Lead:** Medical Director / Chief Nurse **Progress:** Review completed – developing dashboard **Timescale:** ~~November 2024~~February 2025 Monitoring of fill rates and quality impact **SLT Lead:** Medical Director / Chief Nurse **Timescale:** ~~December 2024~~May 2025 Review of bed capacity and conversion of unconventional bed space **SLT Lead:** Medical Director / Chief Nurse **Timescale:** February 2025	**Management:** Learning from deaths Report to Quality Committee and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board quarterly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee Reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC - Sepsis report to Quality Committee and Patient Safety Committee quarterly Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports; Digital risks reported to Risk Committee 6-monthly and DSG monthly **Risk and compliance:** Quality Dashboard and IPR to Quality Committee bi-monthly; Quality Account Report qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC quarterly; Significant Risk Report to RC monthly; Exception reporting to System Quality Committee bi-monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of: - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)	~~Unmitigated risk associated with the continuation and escalation of industrial action, the lack of progress towards a negotiated solution and the impact across professional groups who inevitably step up to provide cover in service gaps~~ Palpable harm to staff due to work pressures, and the longevity and impact of the ongoing demands Running at OPEL4 for a protracted length of time and full capacity protocol, exceeding full capacity protocol and system-wide critical incidents Full capacity protocol does not fully address bed capacity requirements during winter	~~Positive~~ Moderate ~~No change since April 2020~~Last changed January 2025

Board Assurance Framework (BAF): January 2025

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 ▪ Reintroduction of enhanced respiratory virus testing during winter ▪ Public communications re: norovirus and infectious diseases ▪ Infectious disease identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions	FIT mask testing compliance rate below required rate Influenza vaccination uptake is below target levels	Increase compliance to target rate **Progress:** Fit Testing Data is now included in Divisional Performance Review Packs Compliance increased, but not yet to target rate, and targeting high-risk clinical areas **SLT Lead:** Director of People / Chief Nurse **Timescale:** ~~October 2024~~January 2025 Communications to staff around the importance of vaccinations **SLT Lead:** Medical Director / Chief Nurse **Timescale:** throughout winter 2024/25 Review influenza vaccination programme to understand the reasons for low take-up **SLT Lead:** Director of People **Timescale:** August 2025	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; Integrated Performance Report to Board monthly; IPC Clinical audits in IPC Committee report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan: UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; Annual Maternity incentive scheme assessment, which incorporates 10 safety elements, regional monthly heat map and progress towards the Three-Year Delivery Plan		Significant Last changed November 2022

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care							**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	27/01/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	27/01/2025								

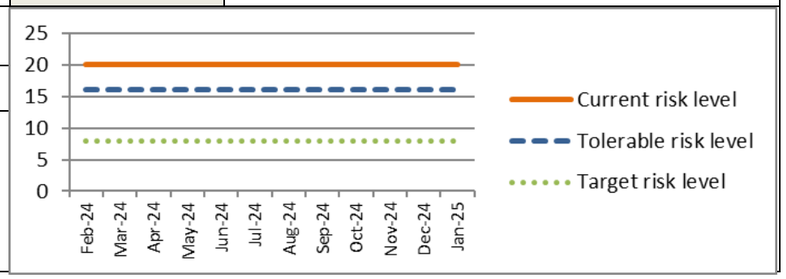


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population and increasing complexity of health needs • Further waves of admissions driven by Covid-19, flu or other infectious diseases • Increased acuity leading to more admissions and longer length of stay	▪ System programme boards with responsibility for oversight and delivery of transformation programmes ▪ UEC Improvement Programme focussing on internal flow, and Getting the Basics Right with internal oversight at the Emergency Care Steering Group ▪ Trust leadership of and attendance at ICS UEC Delivery Board ▪ Emergency admission avoidance schemes across the system under oversight of the Urgent and Emergency Care (UEC) Board and the System Oversight Group ▪ SFH Medical and Surgical Same Day Emergency Care (SDEC) services in place (and expanding in winter 2024/25) to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care and SDEC direct access – regular meetings with Nottingham Emergency Medical Services (NEMS) ▪ Trust and System escalation policies and processes, including Operational Pressures Escalation Level (OPEL) Framework and Full Capacity Protocol ▪ Inter-professional standards across the Trust to ensure we complete today's work today ▪ SFH annual capacity plan with specific focus on the Winter period via the Winter Planning Group ▪ Referral management systems shared between primary and secondary care ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Planned Care Steering Group with oversight of performance and improvement activities (including work of the Cancer Steering Group) ▪ System support in place (mutual aid) with regular meetings via the System Elective Hub	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions that are part of our full capacity protocol e.g. opening surge capacity, reducing elective operating, bedding patients in alternative areas i.e. day case	Continuation of March 2024 Emergency Department schemes to support non-admitted breach reduction **SLT Lead:** Chief Operating Officer **Timescale:** throughout Q1 and Q2, and continuing into Q3 Trial of frailty SDEC co-located within ~~Discharge Lounge~~Medical Day Case **Progress:** Part of 2024/25 Winter Plan, opened in November 2024 **SLT Lead:** Chief Operating Officer **Timescale:** ~~Commence October 2024~~March 2025 Winter Plan to be agreed and implemented **Progress:** First draft approved by Trust Board in September 2024. Final draft to be approved in October 2024, then immediate implementation **SLT Lead:** Chief Operating Officer **Timescale:** ~~October 2024~~Complete Full Capacity Protocol refreshed, signed off and implemented, including two-over beds on wards **SLT Lead:** Chief Operating Officer **Timescale:** ~~January 2025~~ Complete Undertake an options appraisal to increase bedded capacity **SLT Lead:** Chief Operating Officer **Timescale:** October 2025	**Management:** Performance management reporting arrangements between Divisions, Service Lines, Executive Team on an at least bi-monthly basis, and Board quarterly **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Integrated Performance Report including national rankings to Board quarterly **Independent assurance:** Performance Management Framework internal audit report Jun 22; Operational Planning internal audit report Jul 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25	Some transformation schemes overseen by the System programme boards are not currently preventing increases in the number of patients presenting to SFH 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:** throughout 2025	Moderate Last changed September 2024

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Constraints in availability of hospital bed capacity caused by elevated numbers of ~~MFFD~~ MSFT (medically ~~fit for discharge~~safe for transfer) patients remaining in hospital	▪ Engagement in ICB Discharge Operational Steering Group ▪ Multidisciplinary Transfer of Care Hub in place that undertakes twice-daily reviews of patients awaiting Nottinghamshire packages of care ▪ Full use of our bed base across our 3 sites with further capacity purchased from Ashmere Group Care Homes (at reduced levels in 2024) ▪ Improved use of NerveCentre to facilitate timely patient discharge ▪ Re-introduction of Discharge Co-ordinators across inpatient wards	~~Lack of consistent achievement of the mid-Notts threshold for MSFT patients of 40~~	Right-size pathway 2 and pathway 3 bedded capacity required for rehabilitation and re-enablement across the ICS to reduce length of stay and MSFT **Progress:** agreement made with ICS that the current footprint of P2 bedded capacity is right sized to meet demand, with no expectation to reduce length of stay further **SLT Lead:** Chief Operating Officer **Timescale:** ~~October 2024~~Complete Roll out a series of one-minute videos that explaining the basic but essential elements of patient flow **SLT Lead:** Chief Operating Officer **Timescale:** ~~December 2024~~Complete	**Management:** Daily and weekly themed reporting of the number of MSFT patients in hospital beds - reports into the ICS UEC Delivery Board and ICS Demand and Capacity Group monthly **Risk and compliance:** Exception reporting on the number of MSFT into the Trust Board via the Integrated Performance Report quarterly, which is showing positive progress in 2024/25 Q1 and Q2	Challenges in the provision of the ICS-commissioned transport contract to deliver timely patient discharge Supplement the contract with commissioners with locally commissioned additional transport services **SLT Lead:** Chief Operating Officer **Timescale:** June 2025	~~Inconclusive~~ Significant ~~No change since threat added in January 2022~~ Last changed January 2025
Failure of Primary Care to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ICS risk register / BAF entry relating to operational failure of General Practice ▪ Weekly System Oversight Group meetings across ICS~~, including Primary Care~~ ▪ ICS Primary Care Strategy Group, with responsibility for overseeing delivery of the Primary Care Access Recovery Plan ▪ Nottingham Emergency Medical Services-run 24/7 primary care service within our Emergency Department			**Management:** Routine mechanism for sharing of ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand; ICS reports available on the System Analytical Intelligence Unit portal	Adverse impact due to potential GP collective action Monitor and review the potential impact of GP collective action **SLT Lead:** Chief Operating Officer **Timescale:** Throughout 2025	Moderate 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	▪ System programme boards with responsibility for oversight and delivery of transformation programmes ▪ Engagement in relevant Integrated Care System (ICS) groups/boards ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Mechanism in place to agree peripheral and full diverts of patients via EMAS ▪ Regular meetings in place with EMAS and commissioners to review and discuss appropriate flow of patients to our hospitals			**Management:** A&E attendance demand report (including post code analysis of ambulance conveyance) to Finance Committee Feb 24, and shared with System partners **Independent assurance:** Weekly reports provided by NHSE Regional Team showing performance against key Urgent and Emergency Care metrics; System Analytical Intelligence Unit (SAIU) Drivers of Urgent Care Demand report Sep 24; System Analytical Intelligence Unit report on changes in Emergency Care Demand to System Urgent & Emergency Care Delivery Board Jan 25	Lack of control over the flow of patients from the surrounding area, including decisions by EMAS to undertake strategic conveyancing Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** ~~Ongoing during 2024~~throughout 2025	~~Positive~~ Moderate Last changed ~~November 2022~~January 2025
~~Growth in demand for care in our maternity services (population growth and increase in out of area referrals)~~	~~▪ Over-established midwifery~~ ~~▪ Additional antenatal clinics based on overtime/bank~~ ~~▪ Maternity assurance group (monthly)~~ ~~▪ Director of Midwifery providing Board-level oversight~~	~~Physical capacity/estate will be insufficient should growth trends continue in the coming years~~		~~**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings)~~ ~~**Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)~~		~~Significant~~ ~~New threat added January 2023~~

Board Assurance Framework (BAF): January 2025

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**	Empower and support our people to be the best they can be
Lead committee	People	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**5. Very likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	28/01/2025	**Risk rating**	**20. Significant**	**16. Significant**	**8. Medium**				
Last changed	28/01/2025								

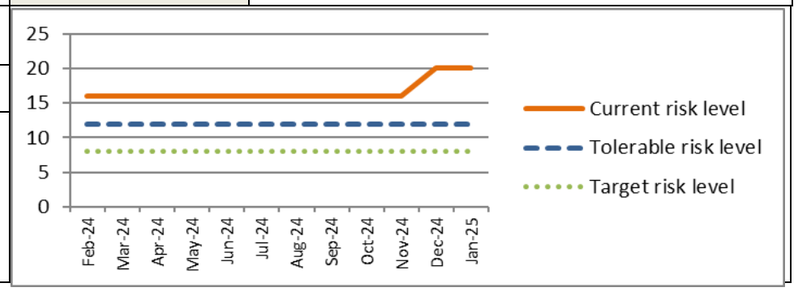
Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff, resulting in critical workforce gaps in some clinical and non-clinical services	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Activity, Workforce and Financial plan ▪ 5-year strategic workforce plan supported by associated Tactical People Plans ▪ ICS People and Culture Strategy (2019 to 2029) and Delivery Group ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels; Activity Manager to support activity plans and utilisation of consultant job planning ▪ Education partnerships with formal agreements in place with West Notts College and Nottingham Trent University ▪ Director of People attendance at ICS People and Culture Board ▪ Workforce planning for system work stream ▪ Medical Transformation Board ▪ Nursing & Midwifery Transformation Board ▪ ICB Agency Reduction Group ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Communication of daily SitReps (Situation Reports) for workforce gaps ▪ CDC Workforce Group ▪ CDC Steering Group ▪ People Promises Exemplar Organisation	Workforce gaps across key areas such as Medical, Nursing, AHP and Maternity, which may impact on the quality and standard of care Lack of consistency across the system about recruitment and retention, creating competition and not maximising opportunities Inability to achieve the system workforce efficiency programme target	Deliver the People Strategy – Year 3 priorities and objectives **SLT Lead:** Director of People **Timescale:** March 2025 Work with provider collaborative colleagues to deliver the Vanguard programme in relation to workforce portability / passporting recruitment KPIs **SLT Lead:** Director of People **Progress:** Pilot for resident doctors ~~to~~ commenced in November **Timescale**: ~~November 2024~~March 2025 Deliver the plan to replace premium pay and agency staff with substantive workforce **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to People Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People and Culture to People Committee; Recruitment & Retention report monthly; Strategic People Plan to People Committee May24; Employee Relations Quarterly Assurance Report to People Committee; People Plan updates to People Committee bi-monthly; Leadership Development Strategy Assurance Report to People Committee quarterly; NHSE Planning – Workforce Perspective Report to People Committee May 24 **Risk and compliance:** Risk Committee significant risk report monthly; HR & Workforce planning report Risk Committee; IPR – Workforce Indicators to People Cabinet (monthly) - quarterly to Board; Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Recruitment of agency staff audit report Jun 23; Appraisals internal audit report Jun 24	Impact of the Trust workforce financial efficiency programme with enhanced controls regarding recruitment and a reduction in bank rates of pay (from 11th November 2024) Periodic review of the impact of cost and recruitment restrictions on staff safety and staffing levels **SLT Lead:** Director of People **Timescale:** March 2025 Potential impact of industrial unrest due to the job matching and profile review for Nursing and Midwifery staff Develop a working group to review the profiles and job descriptions **SLT Lead:** Director of People **Timescale:** March 2025 Engage with regional groups to ensure consistency of approach principles **SLT Lead:** Director of People / Chief Nurse **Timescale:** March 2026	Moderate Last changed September 2024

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A significant loss of workforce productivity arising from a short-term reduction in staff availability or reduction in morale and engagement	▪ People Strategy 2022-2025 ▪ People Cabinet ▪ Chief Executive's blog / Staff Communication bulletin / Weekly #TeamSFH Brief ▪ Engagement events with Staff Networks (BAME, LGBTQ+, WAND, Carers, Women in Sherwood Wellbeing Champions) ▪ Schwartz rounds ▪ Learning from COVID ▪ Key recognition milestones and events ▪ Annual Staff Excellence / Admin Awards ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and Restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff wellbeing support ▪ Staff counselling / Occ Health support including dedicated Clinical Psychologist for staff ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, system and the wider community ▪ Winter Wellness Campaign ▪ Sexual safety working group ▪ Violence Prevention and Reduction Working Group	Inequalities in staff inclusivity and wellbeing across protected characteristics groups Continued staff exposure to violence and aggression by patients and service users Concerns over sexual safety in the workplace	Include actions to address inequalities in staff inclusivity within the new People Strategy **SLT Lead:** Director of People **Timescale:** April 2025 Develop and Implement the Violence Prevention and Reduction action plan **SLT Lead:** Director of People **Timescale:** March 2025 Review with Provider Collaborative Colleagues wellbeing offers and identify areas of duplication and gaps, developing recommendations for delivery at a system level – vanguard programme **SLT Lead:** Director of People **Progress:** ICB have commissioned Arden and Gem (CSU) to produce a report to identify gaps and create an action plan **Timescale**: ~~January 2025~~Complete People Promises work taking forward a plan to address sexual safety in the workplace **SLT Lead:** Director of People **Timescale:** March 2025	**Management:** Staff Survey Action Plan to Board Apr 24; Staff Survey Annual Report to Board Apr 24; Equality and Diversity Annual Report Jul 24; WRES and WDES report to People Committee Jul 24; Quarterly Assurance reports on People Cabinet to People Committee; Wellbeing report to People, Committee Mar 24; People Plan updates to People Committee quarterly; Leadership Report to People Committee Jul 24; Diversity in the Trust – Senior Leadership Roles report to People Committee May 24; Violence and Aggression Improvement Plan to People Committee Mar 24 **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Jul 24; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to People Committee May 24; NHS Long Term Workforce Plan to People and Culture Committee Sep 23 and Strategic Workforce Plan update to People Committee May 24; Health and Wellbeing Campaign presented to People and Culture Committee Sep 23; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar24; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22; Staff Wellbeing internal audit report Jan 24	Potential impact of cost-of-living issues, and the impending job matching and profile review for Nursing and Midwifery staff, on staff morale and wellbeing	Significant Last changed September 2024

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 4: Insufficient financial resources available to support the delivery of services** Financial funding allocated to and generated by the Trust does not cover the costs of services provided						**Strategic objective** Sustainable use of resources and estate
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action
Lead director	Chief Financial Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 5. Very likely	3. Possible	2. Unlikely		
Last reviewed	28/01/2025	**Risk rating**	~~16~~20. **Significant**	**12. High**	**8. Medium**		
Last changed	28/01/2025						



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Regulatory action due to a failure to deliver NHS England financial targets	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ Annual budgets based on available resources and stretching financial improvement targets ▪ Scheme of Delegation, Standing Financial Instructions and Executive oversight of commitments ▪ Budgetary Control Procedure Document, delivery of budget holder training workshops and monthly financial reporting ▪ Monthly Provider Finance Return and escalation meetings with NHSE as necessary ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Divisional Performance Reviews (bi-monthly) ▪ Divisional Finance Committees established in most divisions	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Financial Recovery Plan required to demonstrate financial sustainability by March 2026 in line with NHSE direction. Longer-term financial plan in development as part of strategic priorities, in line with clinical and operational strategies. Update scheduled for Finance Committee in October 2024~~ Finance Strategy presented at January Finance Committee for approval, and to be presented to Board in March **SLT Lead:** Deputy Chief Financial Officer **Timescale:** ~~October 2024~~March 2025	**Management:** Monthly Finance Report to Finance Committee Quarterly; Quarterly Integrated Performance Report to Board; ICS finance report to Finance Committee (monthly); NHSE updates to Finance Committee; Monthly variable pay reports to Trust Management Team; divisional representation at Finance Committee on a cyclical basis; Financial Efficiency reports to Executive Team weekly **Risk and compliance:** **Independent assurance**: NHS England Financial Controls Assessment (Sep 23); External Audit Year-end Report 2023/24 Internal Audit reports: - Improving NHS financial sustainability (Dec 22) - Key Financial Systems – Pay Expenditure (Jul 23) - Financial Governance - Financial Ledger and Reporting (Mar-24) - Budget Setting, Reporting and Monitoring (Jun-24) - Operational Planning (Jun-24) - Financial Improvement Plan – Efficiency & Productivity (Jun-24) - System Financial Controls (Jun-24)	Nottinghamshire system selected for NHSE initiated Investigation and Intervention Process (I&I) **Progress:** ~~Phase 1 (Investigation) report issued and discussed at Finance Committee and Board of Directors.~~ Phase 2 ~~commenced 16th September for a 12 week period~~concluded with close-down report presented to January Finance Committee. SFH evaluation to February Finance Committee. **Lead:** Chief Financial Officer **Timescale:** ~~December 2024~~March 2025	~~Positive~~ Moderate Last changed January ~~2024~~2025
	▪ NHSE Financial controls self-assessment completed and working group set up to undertake improvement actions ▪ Financial Resources Oversight Group (FROG) established and meeting monthly ▪ Vacancy Control panels in place ▪ Updated guidance on Discretionary Spend introduced ▪ Weekly 'Grip & Control Arbitration' panels established ▪ Financial Recovery Cabinet (monthly) and Financial Efficiency Review (weekly) meetings established	Risk adjusted efficiency forecast falls short of the annual target of £38.5m Financial Recovery Plan required to demonstrate a route to a break-even financial position by March 2026	De-risking programme underway on all schemes to increase confidence in delivery of the 2024/25 target. **Progress:** Weekly Financial Efficiency Oversight meetings and monthly Financial Recovery Cabinet established. Weekly reports shared with the Executive Team. As of 10th January, risk-adjusted forecast equates to 98.3% of target. **SLT Lead:** Chief Financial Officer **Timescale:** Ongoing with a target of December 2024 for a risk-adjusted forecast that meets the target Financial Recovery workstreams to be established, plan to be developed and appointments of Associate Director of Financial Recovery and Sustainability to be made **Progress:** ~~Initial workstreams set out and~~ Associate Director of Financial Recovery and Sustainability ~~role~~ recruited ~~(start date October 2024)~~			

Board Assurance Framework (BAF): January 2025

Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (Are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
			Financial Recovery Plan for Q4 (including difficult decisions list) presented to January Finance Committee **SLT Lead:** Chief Financial Officer **Timescale:** March 2025 • ~~September 2024 – Financial Recovery Plan confirmed~~ • ~~September 2024 – Further resourcing requirements confirmed~~ • ~~October 2024 – Associate Director of Financial Recovery and Sustainability appointed~~ Develop a Financial Recovery Plan for 2025/26 **SLT Lead:** Chief Financial Officer **Timescale: March 2025**			
Cash availability leads to delays in paying suppliers and workforce	▪ Daily cash flow forecasts prepared ▪ Cash Management Policy to protect cash balances and establish prioritisation of payments ▪ NHS England process followed to access Revenue Support PDC ▪ Regular liaison with NHSE to support cash applications ▪ Financial Improvement Programme in place to deliver cash-releasing efficiencies ▪ Budgetary control processes and Scheme of Delegation in place to prevent overspends ▪ No Purchase Order, No Pay policy in place ▪ Escalation process to CFO/Deputy CFO for suppliers indicating restrictions on supply ▪ Weekly creditors report reviewed by Deputy CFO ▪	~~2024/25 Revenue Support applications have not been supported in full by NHSE~~	Meeting to be arranged with NHSE representatives to understand the risk and appeals process **Lead:** Deputy Chief Financial Officer **Timescale:** ~~October 2024~~Complete	**Management:** Monthly Finance Report to Finance Committee includes details on cash flow, debtors and creditors **Independent assurance**: NHS England Financial Controls Assessment (Sep 23) Internal Audit reports: - Key Financial Systems – Accounts Payable and Treasury and Cash Management (Mar-24) - Financial Governance – Financial Ledger and Reporting (Mar-24)		~~Positive~~ Limited ~~New threat added July 2024~~Last changed January 2025
ICB system financial performance challenge leads to disinvestment in SFH	▪ 2024/25 Financial Plan agreed with NHSE and ICB, in line with NHSE Revenue Control Limit ▪ ICS Directors of Finance Group established and attended by SFH Chief Financial Officer ▪ ICS Financial Recovery Group meeting weekly ▪ ICS System Opportunities Group meets bi-weekly, with SFH representation ▪ ICS Operational Finance Directors Group established and attended by SFH Deputy Chief Financial Officer ▪ ICB Financial Framework ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Sustainability reviews to be completed through Q1/Q2 of 2024/25 to establish a route to sustainability~~Update to be provided in November 2024 with timeline for launch to be confirmed **SLT Lead**: Deputy Chief Financial Officer **Timescale:** ~~November 2024 (dependant on NHSE/I and ICB Guidance)~~March 2025	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board **Independent assurance**: System Financial Controls Internal Audit report (Jun 24)	Impact of ICS partner financial recovery actions on SFH to be assessed Progress: Increasing prevalence of ICB savings that impact on SFH finances – CEO and CFO taking action to understand and mitigate this risk ~~Letter sent from the CFO to ICB confirming the SFH stance on actions that may adversely impact the Trust's financial position – awaiting response~~ **Lead:** Chief Financial Officer **Timescale:** Ongoing as recovery actions are developed	~~Positive~~ Moderate Last changed ~~July 2022~~ January 2025

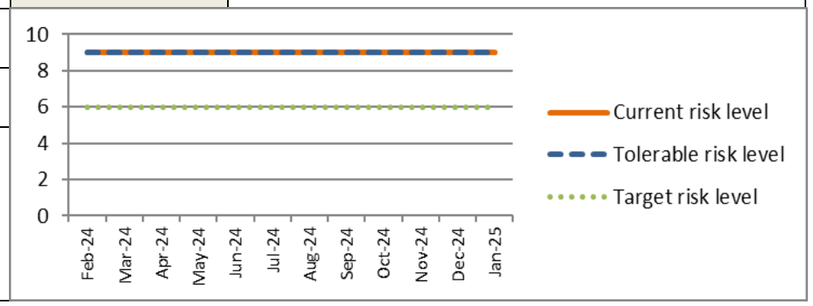
Board Assurance Framework (BAF): January 2025

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
Insufficient capital resources to fund required infrastructure	▪ Capital Resources Oversight Group (CROG) overseeing capital expenditure plans ▪ Capital Prioritisation process established ▪ ICS Capital Management meetings in place to monitor spend and highlight risks			**Management:** Board approved 2024/25 Capital Expenditure Plan; Capital Resources Oversight Group highlight reports to Trust Management Team; Divisional risk reports to Risk Committee (bi-annually); Monthly Finance Report to Finance Committee includes details on capital expenditure **Risk and compliance:** Monthly Risk Committee significant risks report **Independent assurance**: Capital Internal Audit report Jul 24	Further Internal Audit of capital expenditure process to be undertaken by 360 Assurance to provide independent assurance. **Lead:** Head of Financial Services **Timescale:** ~~December 2024~~March 2025	Significant New threat added July 2024
Reliance on non-recurrent funding and efficiencies threatens long-term sustainability of services	▪ Improvement Faculty established to support the development and delivery of transformation and efficiency schemes ▪ Weekly Financial Efficiency update report to the Executive Team (and Monthly to Trust Management Team), detailing recurrent and non-recurrent savings ▪ Weekly Financial Efficiency Oversight meetings established ▪ Financial Recovery Cabinet in place to support longer-term decision making	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **Progress:** ~~Longer-term financial in development as part of strategic priorities, in line with clinical and operational strategies, annual planning for 2024/25 in progress~~Finance Strategy presented at January Finance Committee for approval, and to be presented to Board in March **SLT Lead:** Chief Financial Officer **Timescale:** ~~September 2024~~March 2025 Planning and budget setting principles to be agreed to enable recurrent delivery of schemes currently deemed non-recurrent **SLT Lead:** Deputy Chief Financial Officer **Timescale:** March 2025	**Management:** Monthly Finance Report to Finance Committee includes details on financial efficiency; Divisional Performance Reviews (bi-monthly); Divisional risk reports to Risk Committee bi-annually; Improvement Cabinet highlight reports to Trust Management Team and Finance Committee **Independent assurance**: Internal Audit reports: - Improving NHS financial sustainability (Dec-22) - Financial Improvement Plan – Efficiency and Productivity (Jun-24)		Significant New threat added July 2024

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of capacity, capability and agility to optimise strategic and operational opportunities to improve patient care						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Acting 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	27/01/2025	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	27/01/2025						

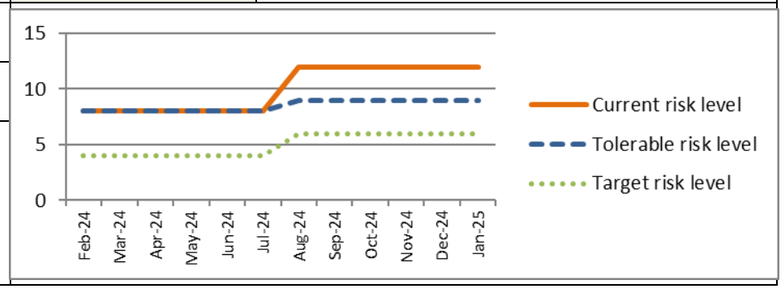
Strategic objective	Continuously learn and improve



Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (Evidence that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of embedded improvement culture across the Trust resulting in suboptimal efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy – overview of strategic digital improvement ▪ People Strategy – overview of strategic people development ~~▪ People Committee~~ ▪ Quality Strategy – overview of strategic quality development ▪ Quality Committee - Executive Director oversight on all aspects of quality ▪ Leadership development programmes - opportunity for Trust leaders to gain improvement skills ▪ Talent management map ▪ Strategy & Partnerships Cabinet – Executive Director oversight on all aspects of Improvement activity ▪ Ideas generator platform - easy-to-access mechanism to seek improvement support and advice ▪ Improvement Faculty - Single point of contact for all colleagues seeking improvement support ~~▪ Financial Recovery Programme~~ ▪ Financial Recovery Cabinet - Provides Executive Director oversight on all aspects of financial improvement activity ▪ Trust Board 'Improvement Showcase' - Increased awareness of improvement activity and sharing of good practice ▪ Quality, Service Improvement and Redesign Networks - informal forums to share knowledge, skills and experience	Continuous Quality Improvement Strategy not yet approved	Develop a process for clinical input for public and colleague engagement in improvement and transformation activities **Progress:** Process under development with the support of key stakeholders Recruited to key roles to support the process and plans in place to complete the documented process. To be reviewed to encompass the pending recommendations in the Darzi report **SLT Lead:** Acting Director of Strategy and Partnerships **Timescale:** February 2025 Develop and roll out a Continuous Improvement Strategy **Progress:** Paused until the new Improvement Director is in post **SLT Lead:** Acting Director of Strategy and Partnerships **Timescale:** April 2025	**Management:** Monthly Transformation and Efficiency report to FC; Improvement report to Quality Committee bi-monthly; NHS Impact Self-Assessment **Risk and compliance:** Strategic Priorities report to Board quarterly **Independent assurance:** 360 assessment in relation to Clinical Effectiveness - report May '22; Financial Improvement Plan - Efficiency and Productivity internal audit Jul 24		Moderate Last changed October 2022

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 6: Working more closely with health, care and educational partners, does not deliver the Trust's Improving Lives strategic objectives**							**Strategic objective**	Work collaboratively with partners in the community
Lead committee	Partnerships and Communities	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Acting Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	21/01/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	21/01/2025								



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**
Competing priorities within SFH could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Alignment of Trust's Strategy with the ICS Joint Forward Plan ▪ Clinical Services Strategy established guiding principles and priorities ▪ Partnership Strategy and delivery plan with oversight on delivery by Strategy and Partnership Cabinet ▪ People Strategy identifies key people partnership priorities and priority partners ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Partnership database and annual evaluation ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities and agreed actions	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Reflect constrained resources in plans and strategies for Years 2 to 5 **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Timescale:** February 2025	**Management:** ~~2023/24 strategy reporting (the "dials") to Board quarterly~~ Strategy and Partnership Cabinet chair's report to PCC ~~bi—monthly~~ Provider collaborative effectiveness updates to PCC ~~every four months~~ Partnership Delivery Plan updates to Strategy and Partnership Cabinet ~~monthly~~ Supporting strategy reporting to relevant sub committees ~~quarterly~~ 6-monthly MNPBP highlight reports to ~~Strategy and Partnership Cabinet and~~ Health Inequalities Steering Group quarterly Monthly HISG chair's report to Strategy and Partnership Cabinet ~~monthly~~ **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 2025

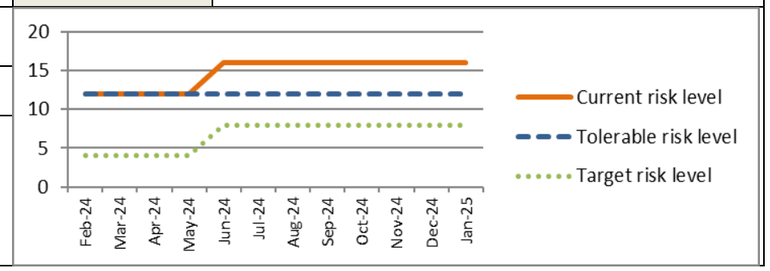
Strategic threat (What might cause this to happen)	Primary risk controls (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to 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
	▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources					
Competing priorities within our partners could result in a lack of commitment or contribution of resources to those partnerships that could contribute to the delivery of the Trust's priorities	▪ Trust's five-year strategy, Improving Lives, outlines strategic deliverables to focus Trust resources ▪ Partnerships and Communities Committee oversight ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ Nottingham and Nottinghamshire Integrated Care System (ICS) priority aim of integration by default and continued engagement with Nottingham and Nottinghamshire Integrated Care Partnership (ICP) and the ICS planning and governance arrangements ▪ Quarterly ICS performance review with NHSE ▪ Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ Full alignment of organisational priorities with system planning ▪ ICS Finance Directors Group, ICS Planning Group and ICS System Oversight Group act as assurance and escalation route ▪ SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services ▪ Nottingham(shire) Provider Collaborative at Scale (NNPC) annual plan and programme resource. Oversight through the NNPC Distributed Executive Group and governance structure ▪ East Midlands Acute Providers (EMAP) Network annual plan and programme resource. Oversight of delivery and risks through the Chief Executive Forum and Executive Group ▪ Primary secondary care interface annual plan and oversight through the Interface Group with representatives from SFH and general practice ▪ Mid-Nottinghamshire Place-Based Partnership (MNPBP) annual place plan setting priorities, aligning resources and agreeing actions ▪ Established PBP leadership arrangements in place of which SFH is a committed member including Mid-Nottinghamshire PBP Executive providing oversight and leadership ▪ Membership of and engagement with the three Place Boards in Ashfield, Mansfield and Newark and Sherwood agree plans, oversee delivery and agree shared resources ▪ Formal partnership arrangements with Vision West Notts College and Universities of Nottingham	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Reflect constrained resources in plans and strategies for Years 2 to 5 **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Timescale:** February 2025	**Management:** Partnership Delivery Plan updates to Strategy and Partnership Cabinet MNPBP highlight reports to ~~Strategy and Partnership Cabinet and~~ Health Inequalities Steering Group as appropriate HISG chair's report to Strategy and Partnership Cabinet Monthly highlight reports from Notts Provider Collaborative to SFH executive lead East Midlands Acute Providers monthly update reports to EMAP Executive Group **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 2025

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
Limited SFH partnership engagement capacity could result in a missed opportunity to bring in a wider patient and citizen voice to shape future healthcare services	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the Mid-Nottinghamshire PBP (MNPBP) and the district level Place Boards. ▪ ICS Clinical Services Strategy and Quality Strategy set priority re coproduction and personalised care ▪ ICS Health and Equality Strategy ▪ Nottingham and Nottinghamshire Joint Forward Plan, supporting workstreams and delivery group supporting partnership working ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ SAIU dashboards and themed reports to focus on key priority areas for inputs and provide assurance of outputs and outcomes ▪ Clinical Directors and PCN Directors clinical partnership working ▪ Partnerships and Communities Committee (PCC) oversees delivery and receives assurance ▪ Partnership canvas tool structuring the planning and execution of partnerships ▪ SFH Health Inequalities Steering Group (HISG) linked to Mid Notts Health Inequalities Oversight Group to build relationships, share population health information and agree priorities and ICS Health Inequalities Steering Group, which facilitates sharing of patient/citizen voice and provides oversight of delivery	Workforce capacity to progress key partnership workstreams in provider collaboratives and place partnerships to progress clinical service strategy priorities on fragile services, workforce and health inequalities	Investigate opportunities to expand workforce capacity within the systems financial constraints **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Reflect constrained resources in plans and strategies for Years 2 to 5. **SLT Lead:** Director Strategy and Partnerships **Timescale:** ~~December 2024~~Complete Engage with the provider collaboratives strategic reviews to determine priorities **SLT Lead:** Director Strategy and Partnerships **Timescale:** February 2025	**Management:** Strategy and Partnership Cabinet chair's report to PCC Partnership Delivery Plan updates to Strategy and Partnership Cabinet Supporting strategy reporting to relevant sub committees MNPBP highlight reports to ~~Strategy and Partnership Cabinet and~~ HISG as appropriate HISG chair's report to Strategy and Partnership Cabinet **Independent assurance**: None currently in place		Significant Threat updated August 2024

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community							**Strategic objective**	Provide outstanding care in the best place at the right time
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Chief Executive Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	14/01/2025	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	14/01/2025								

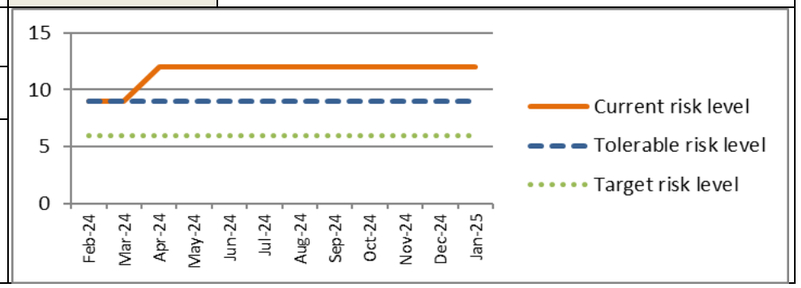


Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ National Cyber Security Centre updates to Cyber Delivery Group ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Devices that have failed to take the most recent security patch checked after 21 days of inactivity – disabled after 28 days ▪ Major incident response plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead			**Management:** Data Security and Protection Toolkit submission to Board Jul 23- compliant on all 113 elements; DSPT updates to Information Governance Committee bi-monthly and Risk Committee 6-monthly; Hygiene Report to Cyber Security Board bi-monthly; Cyber Security Assurance Highlight Report to Cyber Security Board bi-monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine Mar 22; NHIS Cyber Strategy approved at DSG May 24 **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance**: ISO 27001 Information Security Management Certification (NHIS) Mar24; 360 Assurance Data Security and Protection Toolkit audit Jun 23 – moderate assurance; Cyber Essentials Plus accreditation (NHIS) Dec 23	NHS-targeted cyber-attacks continue to be increased and there are inherent risks which are almost impossible to mitigate ~~Not fully assured that all business continuity processes are robust and fully tested in the event of prolonged system downtime~~ Review and test IT and business continuity processes **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~December 2024~~Complete ~~Insufficient Board oversight of the risk and impact of cyber security~~ Cyber threat to be fully addressed at a Board Workshop **SLT Lead:** Chief Executive Officer **Timescale:** ~~October 2024~~Complete	~~Moderate~~ Limited Last changed ~~March 2024~~January 2025
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Policy ▪ Health Technical Memorandum governance structure ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR	~~Gaps in controls and processes identified in the 2022 Fire Safety Management audit~~	Finalise and issue the Trust Fire Safety Strategy documents **Progress:** Gaps in controls addressed – documents to be considered by the Operational Fire Safety Group in February **SLT Lead:** Chief Financial Officer **Timescale:** ~~December 2024~~February 2025	**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Fire Safety reports to Risk Committee quarterly **Risk and compliance:** Significant Risks Report to Risk Committee monthly **Independent assurance:** Premises Assurance Model to Executive Team Oct 22; EPRR Core standards compliance rating (Oct22) – Substantial Assurance; MEMD ISO 9001:2015 Recertification (3-year) Mar 21; British Standards Institute MEMD Assessment Report Feb 22; External cladding report to Executive Team Jan 24; ARUP Fire Surveys included in Annual Fire Safety report to Risk Committee Apr 24; ARUP Milestone 2 (Fire) Reports issued in draft July 2024 for review	Inconclusive evidence of buildings cladding and structures compliance with fire regulations Determine the remedial work required to ensure that the cladding is compliant with fire regulations **Progress:** It has now been agreed by Project Co. that the existing cladding will be replaced in full, programme currently being updated to take into account the new Building Safety Act. Program is on track due for completion June 2025. **SLT Lead**: Associate Director of Estates & Facilities	Moderate Last changed March 2024

Board Assurance Framework (BAF): January 2025

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
	▪ Independent Authorising Engineer (Water) and other HTM Specialties ▪ Major incident response plan in place				**Timescale:** ~~October 2024~~June 2025 Trust actions required from the ARUP Milestone 2 (Fire) Report **Progress:** An overarching risk assessment ~~is to be~~ produced for each site highlighting the common themes/issues that have come out of the draft report and to be discussed with all areas. ~~ARUP fee proposal received – CNH approaching other companies for costs~~ Execs ~~to be~~ briefed on the ARUP findings on 4th September. Awaiting final version from CNH following Trust comments. **SLT Lead**: Associate Director of Estates & Facilities **Timescale:** ~~October 2024~~February 2025	
Severe restriction of service provision due to a significant operational incident or other external factor	▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, ICS, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies, including new Business Continuity Management system ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Major incident response plan in place ▪ Industrial Action Group ▪ Annual Core Standards Process (NHSE & ICB), with follow up report to Board ▪ Annual CBRN Audit (EMAS) ▪ Three-yearly internal audit of EPRR arrangements with report to Board ▪ Incident Response and command and control training to all tactical and strategic leads across the organisation carried out annually ▪ Testing and exercising of service level plans carried out annually ▪ Health Risk Management Group for EPRR	~~The current Business Continuity Management System (BCMS) does not meet the requirements of the Core Standards~~	Embed the updated BCMS within all divisions **SLT Lead**: Chief Operating Officer **Timescale:** ~~December 2024~~Complete	**Management:** Industrial Action debrief report to Executive Team Mar 23, and following each subsequent period of industrial action; Monthly Quadrant Report into Risk Committee **Independent assurance:** EPRR Core standards compliance rating ~~2023~~2024 – ~~Partial~~Substantial Compliance; EPRR Business Continuity internal audit report Nov 24 – Significant assurance; CBRN Audit carried out in March 2024 by EMAS	Improve compliance rating with Core Standards from “Partial” to “Substantial” **SLT Lead**: Chief Operating Officer **Timescale:** ~~October 2024~~Complete	Significant New threat added May 2023

Board Assurance Framework (BAF): January 2025

Principal risk (What could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable							**Strategic objective**	Improve health and wellbeing within our communities
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action		
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	22/11/2021	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	28/01/2025	**Risk rating**	**12. High**	**9. Medium**	**6. Low**				
Last changed	28/01/2025								

Strategic threat (What might cause this to happen)	**Primary risk controls** (What controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (Are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community (may be due to capacity and/or capability)	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Sustainability Development Operational Group (SDOG) and Sustainability Development Strategy Group (SDSG) ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support ▪ Process in place for gathering and reporting statistical data ▪ Adoption of NHS Net Zero building standard 2023 for all works from October 2023 ▪ Awareness to, and applications for, funding sources both internally and externally such as the Public Sector Decarbonisation Scheme and grants from Salix Ltd ▪ Annual Travel Survey ▪ Display energy certificates ▪ Building Research Establishment Environmental Assessment Methodology ▪ Net Zero Strategy ▪ Regular updates through Comms on the screen savers (included lighting, bees, waste etc.)	~~Dedicated capacity to implement ideas for change~~ Insufficient capital resource available to realise Trust ambition Support from our PFI partners in developing 'green' solutions	Additional resource **Progress**: Junior Energy Manager Apprentice and Sustainability Apprentice are being worked up for advertisement in Autumn 2024 **Lead**: Hard FM Manager **Timescale:** ~~October2024~~Complete CROG Scheme Bids: Ensure there are sufficient schemes developed and feasibilities undertaken to ensure the validity of the bids that are to be taken forward to Business Case Level **Progress:** Several CROG applications rejected due to lack of funds. Considering external EV & Solar 'rental' schemes but progress has been impeded by IFRS16 considerations. Attended Geothermal meetings but awaiting advice via Heat Decarbonisation Plan on the best system for SFH **Lead:** Sustainability Officer **Timescale:** ~~March 2025~~Complete PFI Partners: Engage with our PFI provider and relevant parties to develop a combined energy reduction plan associated with the financial close out of the deed, retained estate upgrades, lifecycle developments and how all these aspects will support SFH in its energy/sustainability targets. **Progress:** Awaiting PFI settlement & changes in Skanska personnel **Lead:** Sustainability Officer **Timescale:** ~~October2024~~January 2025	**Management:** Green updates provided routinely to Finance Committee via SDSG **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Car Parking Strategy: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~December 2024~~April 2025 Travel Plan: To be developed for the long-term solution to KMH, MCH and NH **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~December 2024~~April 2025 Display Energy Certificates Review all certificates and what actions need to be taken to improve the Energy Efficiency of the buildings. **Lead:** Sustainability officer **Timescale:** ~~September 2024~~Complete Energy / Sustainability Business Cases: Ensure business case schemes are all worked up and ready to be issued if further funding becomes available through various government routes **Lead:** Sustainability officer **Timescale:** ~~November 2024~~Complete ICS identified SFH had very poor LED lighting as a percentage nationally **Progress:** Skanska have now commenced LED lighting upgrades. To be monitored via E&F Monthly KPI Dashboard **Lead:** Sustainability officer **Timescale**: ~~To Be Agreed with Skanska~~Complete	Moderate Last changed December 2023

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public – Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date:**	6th February 2025
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	David Selwyn, Acting Chief Executive Officer		

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

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

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

Committees/groups where this item has been presented before

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

Acronyms

See below

Executive Summary

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

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

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

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

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

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

Schedule of BAF reviews since last received by the Board of Directors on 7th November:

- Quality Committee: PR1, PR2 and PR5 – November and January
- People Committee: PR3 – November and January
- Finance Committee: PR4 and PR8 – November, December and January
- Partnerships and Communities: PR6 – January
- Risk Committee: PR7 – November, December and January

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

BAF lead directors have been asked for their views on the appropriateness of the term 'Inconclusive assurance', and the outcomes were discussed at the January Risk Committee meeting, with the following agreed:

Amend the assurance levels titles:

- Positive → Significant
- Inconclusive → Moderate
- Negative → Limited

This would also align with the assurance levels used by 360 Assurance in their audit reports.

The descriptors for the levels have also been reviewed, and the consensus is that the only descriptor needing to change would be:

from the current:

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

to:

Moderate assurance: the Committee is not assured that the current risk treatment strategy fully addresses the gaps in assurance or control

Risk Committee members also propose the assurance level for the threat of our cash availability in PR4 be changed to moderate (previously inconclusive) assurance from positive. This was proposed as a change when PR4 was presented to the January Finance Committee meeting, and subsequently agreed.

The proposed changes to assurance ratings were included in BAF reports to January meetings of the respective Board committees, and have been made on the attached BAF entries, including on threats where the rating has been increased or reduced to reflect the current position.

For comparison, the assurance descriptions used by other organisations within our area are:

	Current assurance title				
	Significant	Full	Moderate	Limited	Weak
Nottinghamshire Healthcare	✓			✓	✓
Nottingham University Hospitals	✓			✓	
Chesterfield Royal Hospital	✓			✓	
Queen Elizabeth Hospital King's Lynn		✓	✓	✓	

Derby & Burton and University Hospitals of Leicester do not state assurance levels on their BAF.

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 changes to the assurance ratings
- Approve the BAF subject to any further changes identified

Acronyms used in the Board Assurance Framework

Acronym	Description
AHP	Allied Health Professional
BAF	Board Assurance Framework
BAME	Black, Asian and minority ethnic
BSI	British Standards Institution
CAS	Central Alerting System
CBRNe	Chemical, biological, radiological, nuclear, explosive
CFO	Chief Financial Officer
CQC	Care Quality Commission
CYPP	Children and Young People's Plan
DoF	Director of Finance
DPR	Divisional Performance Report
ED	Emergency Department
EoLC	End of Life Care
ePMA	Electronic Prescribing and Medicines Administration
EPRR	Emergency Preparedness, Resilience and Response
ERIC	Estates Return Information Collection
eTTO	Electronic To Take Out (medications)
FC	Finance Committee
FIP	Financial Improvement Plan
FM	Facilities Management
GIRFT	Getting it Right First Time
HQIP	Healthcare Quality Improvement Partnership
HSE	Health and safety Executive
HSIB	Healthcare Safety Investigation Branch
HSJ	Health Service Journal
ICB	Integrated Care Board
ICP	Integrated Care Partnership
ICS	Integrated Care System
IGAF	Information Governance Assurance Framework
IPC	Infection prevention and control
JAG	Joint Advisory Group
LGBT	Lesbian, gay, bisexual and trans

Acronym	Description
MEMD	Medical Equipment Management Department
MFFD	Medically fit for discharge
MHRA	Medicines & Healthcare products Regulatory Agency
MSFT	Medically safe for transfer
NEMS	NEMS Community Benefit Services (formerly Nottingham Emergency Medical Services)
OD	Organisational development
PC&IC	People, Culture and Improvement Committee
PCI	People, Culture and Improvement
PFI	Private Finance Initiative
PHE	Public Health England
PLACE	Patient-Led Assessments of the Care Environment
PMO	Programme Management Office
PPE	Personal protective equipment
PSC	Patient Safety Committee
PSC	Patient Safety Culture
QC	Quality Committee
QIPP	Quality, Innovation, Productivity and Prevention
SDEC	Same Day Emergency Care
SFFT	Staff Friends and Family Test
SI	Serious incident
SLT	Senior Leadership Team
SOF	Single Oversight Framework
TIAN	The Internal Audit Network
TMT	Trust Management Team
TTO	To Take Out (medications)
UEC	Urgent and Emergency Care
UKAS	United Kingdom Accreditation Service
UKHSA	UK Health Security Agency
WAND	We’re Able aNd Disabled
WDES	Workforce Disability Equality Standard
WRES	Workforce Race Equality Standard

Grant Thornton

Sherwood Forest Hospitals NHS Foundation Trust

Developmental Well Led Governance Review

January 2025

Grant Thornton

FAO: Sally A Brook Shanahan
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(**the Trust, the Addressee, you**)

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24 January 2025

Dear Sally

Sherwood Forest Hospitals NHS Foundation Trust – Well-Led Governance Review final report

We have pleasure in enclosing a copy of our final report in accordance with your instructions dated 11 September 2024. This document (the Report) has been prepared by Grant Thornton for Sherwood Forest Hospitals NHS Foundation Trust in connection with the developmental Well-Led Governance review (the **Purpose**).

We stress that the Report is confidential and prepared for the Addressee only. We agree that an Addressee may disclose our Report to its professional advisers in relation to the Purpose, or as required by law or regulation, the rules or order of a stock exchange, court or supervisory, regulatory, governmental or judicial authority without our prior written consent but in each case strictly on the basis that prior to disclosure you inform such parties that (i) disclosure by them is not permitted without our prior written consent, and (ii) to the fullest extent permitted by law we accept no responsibility or liability to them or to any person other than the Addressee.

The Report should not be used, reproduced or circulated for any other purpose, in whole or in part, without our prior written consent, such consent will only be given after full consideration of the circumstances at the time. These requirements do not apply to any information, which is, or becomes, publicly available or is shown to have been made so available (otherwise than through a breach of a confidentiality obligation).

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Addressee for our work, our Report and other communications, or for any opinions we have formed. We do not accept any responsibility for any loss or damages arising out of the use of the Report by the Addressee(s) for any purpose other than in relation to the Purpose.

The data used in the provision of our services to you and incorporated into the Report has been provided by third parties. We have not verified the accuracy or completeness of any such data. There may therefore be errors in such data which could impact on the content of the Report. No warranty or representation as to the accuracy or completeness of any such data or of the content of the Report relating to such data is given nor can any responsibility be accepted for any loss arising therefrom.

Period of our fieldwork

Our fieldwork was performed in the period between 23 September 2024 and 13 November 2024. We have not performed any fieldwork since 13 November 2024 and, in agreement with the addressees of this Report, our Report may not take into account matters that have arisen since then. If you have any concerns in this regard, please do not hesitate to let us know.

Scope of work and limitations

Our work focused on the areas set out in our scope of work. Our assessment of the affairs of the Trust does not constitute an audit in accordance with Auditing Standards and no verification work has been carried out by us; consequently we do not express an opinion on the figures included in the Report.

The scope of our work has been limited both in terms of the areas of the business and operations which we have assessed and the extent to which we have assessed them. There may be matters, other than those noted in the Report, which might be relevant in the context of the Purpose and which a wider scope assessment might uncover.

Forms of report

For your convenience, the Report may have been made available to you in electronic as well as hard copy format, multiple copies and versions of the Report may therefore exist in different media and in the case of any discrepancy the final signed hard copy should be regarded as definitive.

General

The Report is issued on the understanding that the management of the Trust have drawn our attention to all matters, financial or otherwise, of which they are aware which may have an impact on our Report up to the date of signature of this Report. Events and circumstances occurring after the date of our Report will, in due course, render our Report out of date and, accordingly, we will not accept a duty of care nor assume a responsibility for decisions and actions which are based upon such an out of date Report. Additionally, we have no responsibility to update this Report for events and circumstances occurring after this date.

Notwithstanding the scope of this engagement, responsibility for management decisions will remain solely with the directors of the Trust and not Grant Thornton. The directors should perform a credible review of the recommendations and options in order to determine which to implement following our advice.

Contacts

If there are any matters upon which you require clarification or further information please contact Peter Saunders on 07967 914925.

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Introduction

Boards are responsible for all aspects of performance and governance of the organisation. The role of the Board is to set strategy, lead the organisation, oversee operations, and to be accountable to stakeholders in an open and effective manner.

The Francis report led to major changes in the regulatory regime. It has also resulted in even closer working relationships between the bodies responsible for regulation and oversight of Foundation Trusts, particularly around the sharing of information and intelligence.

It is in this spirit regulators committed to developing an aligned framework for making judgements about how well led NHS providers are.

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

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality, sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

Sherwood Forest Hospitals NHS Foundation Trust (SFH) provides healthcare across the community to 500,000 people in Mansfield, Ashfield, Newark, Sherwood and parts of Derbyshire and Lincolnshire. The Trust has over 6,000 employees across three hospitals – King's Mill, Newark and Mansfield Community, and has well established relationships with partners in health and social care through the Mid Nottinghamshire Integrated Care Partnership. The Trust is a member of the Nottingham and Nottinghamshire Integrated Care System (ICS).

In May 2020, the Trust was rated as Good overall following its Care Quality Commission (CQC) inspection. King's Mill Hospital, where 90% of services are based, was rated Outstanding by the CQC. Newark Hospital and Mansfield Community Hospital were both rated Good.

This review was commissioned in line with NHSEI guidance that all NHS Trusts should undertake a review of its governance arrangements every 3-5 years. The Trust's previous developmental Well-Led review was undertaken in 2021/22.

This Well-Led review is an important assessment for the Trust. It provides the opportunity for the Trust to fully understand the strengths and weaknesses of current governance arrangements and implement recommended development plans and actions at an appropriate pace. It is also required to advise NHSEI of any material governance concerns that have arisen from the review and the action plan in response to these concerns.

Our approach

This report sets out the findings from our independent review of leadership and governance arrangements at the Trust against NHSEI's Well-Led Framework (June 2017). **We emphasise that our review was limited to the scope outlined in the Framework, and did not assess whether clinical services provided by the Trust are safe, effective, caring or responsive**.

For each of the 8 Well-Led framework key questions, we have assessed the Trust and assigned a rating using the NHSEI four-point scoring methodology detailed below:

Rating	Definition	Evidence
GREEN	Meets or exceeds expectations.	Many elements of good practice and there are no major omissions.
AMBER/GREEN	Partially meets expectations but confident in management's capacity to deliver 'Green' performance within a reasonable timeframe.	Some elements of good practice, has no major omissions. Robust action plans to address perceived shortfalls with proven track record of delivery.
AMBER/RED	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe.	Some elements of good practice, has no major omissions. Action plans to address perceived short falls are in an early stage of development with limited evidence of track record of delivery.
RED	Does not meet expectations.	Major omissions in quality governance identified. Significant volume of action plans required and concerns on management capacity to deliver.

It is important to note that the CQC have updated the Well-Led framework under its Single Assessment Framework (SAF) in April 2024. As part of the set up of the review, we mapped the revised SAF with the NHSEI developmental guidance to ensure areas were aligned and could be used to support any assessment CQC may undertake using the SAF. We agreed with the Trust that the review would not cover the environmental sustainability area of the SAF as this does not directly map to the current developmental framework.

We undertook our work between 23 September 2024 and 13 November 2024.

Our approach to delivering the scope of the review was limited to:

- Conducting a desktop review of key supporting evidence;
- Conducting 60-to-90-minute non-attributable, structured interviews with the Trust Executive Team, NEDs and divisional leaders;
- Observing private and public Trust Board meetings, as well as a range of Committee and Divisional governance meetings;
- Interviewing external stakeholders, including ICS leaders; and
- Delivering a Board development session on key development areas, held on 13 November 2024.

We have only raised issues and recommendations where these have been confirmed through multiple sources and triangulated with evidence.

A full list of interviews held is included in Appendix A, and a list of meetings observed is included in Appendix B.

We would like to thank all of the individuals at the Trust who have supported the completion of this review.

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Summary findings

Overall conclusion

Sherwood Forest Hospitals NHS Foundation Trust is a well-led Trust. Compared to the last developmental review completed in 2021/22, the Trust has maintained strong assessments in the majority of the areas covered by the Well-led KLOEs and has delivered on most of the actions agreed as part of that previous review. The Trust has strong governance processes which contain many elements of good practice. Our review did not identify any significant development areas and for those development areas we did identify, the Trust were aware of them and already in the process of discussing and implementing actions to address them.

Given contextual changes and challenges outlined below, it is a testament to the Trust's strong processes and leadership that it has been able to maintain the assessments when many other trusts will have struggled with their impact. The development areas identified are largely as a consequence of these changes.

Context

There are some important contextual points which have impacted on the assessments compared to the previous review:

- Transitional period for leadership – there have been significant changes to the Board, both Executive and Non-Executive, with many acting up arrangements, including the Chair and Chief Executive. There are also some recognised gaps in skills and experience with the Board. This is likely to continue in the short-term with posts currently advertised for Non-Executives and Executive roles.
- Challenges within the wider system – partners in the Nottingham and Nottinghamshire ICS have had a number of high-profile challenges on quality, operational and financial performance of services.
- Financial pressures and scrutiny – increasing financial challenges at the Trust and the wider system mean they are currently under the NHS E Financial Investigation and Intervention regime and receiving support to improve financial performance.

Good practice

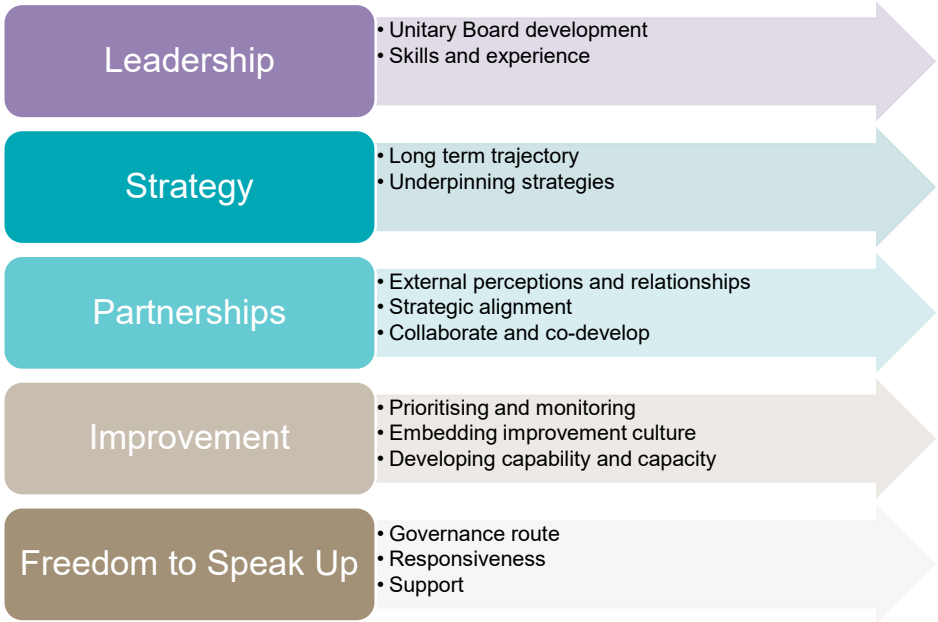
The review identified the continuation and operation of many good practice areas across the framework including:

- ✓ Trusted, supportive and open leadership style
- ✓ Succession planning evident and delivering in leadership roles
- ✓ Development and mentoring programmes for all staff levels
- ✓ Strong and deep affinity across the organisation to its CARE values
- ✓ Effective divisional performance management
- ✓ Board strategically focussed
- ✓ Warm and welcoming culture
- ✓ Risk recognition and management processes embedded.

Summary

Key development areas

Key development areas, which align directly to the relevant CQC SAF updated well-led areas, cover:



Next steps

Following a development planning workshop with the Board we have co-developed plans on all key areas and prioritised actions and recommendations based on these discussions alongside other lower priority areas identified during the review.

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Summary: KLOE ratings

The table to the right summarises our assessment of the Trust's performance against the 8 developmental Well-Led KLOEs. Our summary conclusions against each KLOE are presented on the following pages, highlighting key areas of development.

The table also shows the ratings from the previous Well-Led review undertaken in 2021/22, with the 2024 review showing a consistent rating for 7 of the 8 KLOEs, with only KLOE 7 (Engagement) deteriorating.

The far-right column shows how the revised CQC Single Assessment Framework (SAF) aligns to the developmental Well-Led KLOEs, with those in red being identified as the key areas of development during our assessment.

We have not undertaken any work in relation to the environmental sustainability CQC criteria as agreed with the Trust.

NHS Well-Led framework					CQC SAF
#	KLOE	2022 rating	2024 rating	Trend	CQC Well Led category
1	Leadership	AMBER/GREEN	AMBER/GREEN	↔	Capable, compassionate and inclusive leaders
2	Vision and Strategy	AMBER/GREEN	AMBER/GREEN	↔	Shared direction and culture Freedom to speak up Workforce equality, diversity and inclusion
3	Culture	AMBER/GREEN	AMBER/GREEN	↔	
4	Governance and management	GREEN	GREEN	↔	Governance, management and sustainability
5	Risk management	GREEN	GREEN	↔	
6	Information and data quality	AMBER/GREEN	AMBER/GREEN	↔	
7	Engagement	GREEN	AMBER/GREEN	↓	Partnerships and communities
8	Improvement and innovation	AMBER/RED	AMBER/RED	↔	Learning, improvement and innovation

Environmental sustainability

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KLOE 1: Leadership

AMBER/GREEN

Overview

The Board is in a transitional phase, having experienced significant change over the last 12 months with a number of 'acting' posts in place, including the Chair and Chief Executive. During our review we found:

- Despite the relative inexperience of the leadership team, both individually and collectively, **staff had a high level of confidence and trust** in them and the leadership team has **continued to provide stability and continuity during this period of change**. This is testament to the effective succession planning that the Trust has invested in to support emerging talent within the Trust, which has successfully delivered stability following key Board changes. Further transition is imminent, as the Trust seeks to make a number of substantive appointments at Executive and Non-Executive level.
- **Strong divisional leadership** with **effective development programmes in place**.
- Board members and senior divisional leaders were consistent in their understanding of the issues and priorities for the quality and sustainability of care.
- Leaders demonstrated an acute awareness of issues that fell within their remits during committees and meetings, however, information sharing outside of committees amongst NEDs could be strengthened to improve their holistic understanding of the Trust.
- **Leaders were visible throughout the organisation**, with executives having an open-door policy. We heard this was more variable amongst the NEDs due to competing demands on their limited time.
- Staff viewed the leadership as compassionate (NHS Staff Survey).
- The skills and experience of the Chair and the NED group are evident, and this is reflected in **the respectful but robust challenge and support observed during Committee and Board meetings**.

Areas for development

Unitary Board development

- The Chair and CEO should design a structured Board development plan to include actions and activities that support effective onboarding and integration of the new NEDs and other directors. The plan should include protected time to invest in "team development" and softer skills to ensure the Trust maintains a unitary Board.
- The Chair and NEDs should agree the schedule of regular NED group catch-ups, given the context of new NED member appointments over the next few months.

Skills and experience

- There remains recognised gaps at Board level covering the areas of improvement, transformation and research. The Trust is recruiting to a Director of Improvement and Change and NED recruitment is planned. The Chair and CEO should consider how experience and skills gaps can be closed as part of the ongoing Executive and NED recruitment process and as part of the board development programme.

KLOE 2: Vision and Strategy

AMBER/GREEN

Overview

During 2024/25 the Trust developed its 2024-2029 Strategy: Improving Lives, which set out the overarching vision and strategy of the Trust.

- In line with good practice **the Trust engaged extensively in developing the strategy**, with 6,000 staff at workshops and events and 14,000 Trust members, governors and partners. NEDs, Executive and Divisional Leaders felt able to provide challenge.
- NEDs observed that the strategy is grounded, realistic and deliverable, but is not as ambitious as they would like. However, we acknowledge that developing long term strategic direction is difficult in the context of the current transient leadership arrangements, operational and financial challenges and the lack of an agreed direction across the wider system.
- **The Board demonstrated a strong strategic focus**, with a clear emphasis on patient care, however, the Trust must ensure sufficient headspace is created for long term strategic planning and sufficient capacity for delivery.
- The Trust is committed to working with partners, however, there is a lack of strategic coherence across the system. The Trust should work with partners in the system (and beyond) to define their respective longer-term role.

A number of underpinning strategies support the overarching strategy, some of which are still under development, and in particular, a clear strategy for financial sustainability.

- Without underpinning strategies, it can be difficult to translate strategies into delivery and actions for staff - although 77.17% of NHS Staff Survey (2023) respondents indicated that their team has shared objectives.
- Divisional leaders noted that individual specialisms undertake work on their priorities over the next 3-5 years, however, there is a risk that this is done in silo without an overarching divisional strategy to ensure alignment within and across divisions. As underpinning/divisional strategies are developed, the Trust should ensure that delivery is monitored, with clear accountability for delivery.

Areas for development

Long term trajectory

- The Trust should develop a longer-term, strategic view of its role in the system, supporting the development of its population health and the supporting pillars of the NHS 10-year plan. This should be aligned to its partnership plans and strategy to understand what it can achieve as a Trust and what will be more effective in working with others.

Underpinning strategies

- Supporting underpinning/aligned divisional strategies need to be further developed to deliver the Trust's current and longer-term trajectory. In particular, the Trust should further develop a longer-term financial sustainability strategy which builds on the work being undertaken under the NHS E Investigation and Intervention regime.

KLOE 3: Culture

AMBER/GREEN

Overview

The Trust has a **strong culture**, which is warm and welcoming. It is centred around people, aiming to deliver the best for patients and staff alike. During 2023 the Trust refreshed and relaunched their CARE values which further demonstrates its ongoing commitment to them. Throughout our interviews and from our observations of the meetings and Committees we attended, it was evident that these values underpin the culture of the Trust and are at the centre of the Trust's behaviours and expectations. Those we spoke to were proud to work for the Trust. They felt well-supported and valued.

The Trust's 2023 **NHS Staff Survey** results, which achieved a 62% response rate, are testament to the Trust's positive culture. SFH was named best nationally in the NHS Staff Survey for:

- ✓ Staff morale (rated 6.52 out of 10 by Trust staff)
- ✓ Engagement, which is based on a number of factors around motivation, involvement and advocacy for the Trust's work (7.32 out of 10)
- ✓ Staff feeling able to access the right learning and development opportunities when they need them, with 70.1% of staff agreeing.
- ✓ Teams having freedom in how to do their work (66.2%)
- ✓ Staff feeling that their work is valued by the organisation (40.7%).

Freedom to Speak Up (FTSU) is well-established within the Trust with a full time Guardian in place and an increasing number of concerns being raised, supported by 70% of NHS Staff Survey respondents who felt safe to speak up about anything that concerns them.

Areas for development - Freedom to Speak Up (FTSU)

Governance route

- The FSTU Guardian provides assurance to a number of Committees, however, the FTSU agenda lacks a forum for focussed discussion, as well as identification and investigation of organisational-wide issues. It is recommended that the Trust establishes a focussed forum for the FTSU agenda and that a clear governance route to the Board is established.

Responsiveness

- Whilst the majority of people feel secure raising concerns, less people are confident that concerns will be addressed. The Trust should seek to increase confidence in their ability to respond to concerns effectively.

Support

- The FTSU agenda is well supported at Board level, however, CQC guidance notes the responsibility of leaders to investigate concerns and share learning across the organisation. This requires buy-in and engagement across the organisation. We note this is variable, particularly at divisional level. It is recommended that divisional leaders form part of the FTSU forum noted above.
- Individuals must be appropriately supported to ensure they are able to resolve concerns when raised. It is recommended that development needs are identified, and training is provided to support any gaps in expertise. Consideration should also be given to the frequency of such training.

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KLOE 4: Governance and management

GREEN

Overview

The Trust has **robust and effective governance structures and processes** in place:

- Staff were **clear on their roles and accountabilities,** and we observed a **good understanding of the delineation between Executive and Non-Executive Director roles**.
- The Board and its Committees have up-to-date and appropriate terms of reference (ToR) (approved in 2024) and those we observed operated in line with the ToR. Each Committee also undertook a self-assessment of its effectiveness during 2024. This is good practice and should continue to be undertaken on a regular basis.
- The Board Committee membership is designed to allow cross-membership of Executive Directors and NEDs which enables consideration of the impact of decisions on adjacent portfolios. NEDs are also able to sit in any Committee meetings, and we have noted examples of them doing so to gain a better understanding of important matters.

There are clear reporting and escalation routes:

- **Quadrant reporting is now fully embedded** across all Board Committees and the Council of Governors' meetings, which enables items to be recommended for consideration by other Committees.
- Bi-monthly Divisional Performance Review (DPR) meetings are held with all five Divisions, they are clearly structured and delivered effectively. Quadrant reports feed through the governance structure, with a combined quadrant report covering all divisional DPR meetings presented to TMT.
- The Boards and Committee meetings we attended were effective and in line with the terms of reference.

Areas for development

Duplication of information

- We identified some duplication of information and reporting across committees meaning some areas/information was seen multiple times rather than relying on clear responsibilities of Committees and sharing via cross-membership and quadrant reporting.

Embed, clarify and strengthen financial governance

- Financial governance and reporting arrangements below committee level have been updated in 2024/25 and there was a lack of clarity over the sustainability and embeddedness of arrangements, including reporting arrangements into the Improvement Cabinet and Finance Committee.

Operational performance

- The Trust has moved to quarterly IPR reports at Board level. While this enables Board meetings to operate strategically, key operational performance measures are not shared routinely with the Board.

KLOE 5: Risk management

GREEN

Overview

The Trust has **well established Risk Management processes** in place.

- The Board Assurance Framework (BAF) is well managed and maintained. It has eight principal risks (PR) and each of these are assigned to a Lead Director and to a Lead Committee, allowing the Board to maintain effective oversight of strategic risks through a regular process of formal review. Each paper presented to a Board Committee is accompanied by a cover paper which highlights the items linkage to principal risks.
- We observed a sound understanding of the Trust's key risks with all those interviewed, as well as a disciplined approach to managing those risks at Board Committees.
- All five clinical Divisional leaders demonstrated a good understanding of their risks and the way issues are raised, documented and escalated as appropriate.
- Risks were effectively managed in DPR meetings. Where further action was required, accountability and timelines were clear, with appropriate support offered from leadership.

The Nottingham and Nottinghamshire system is in the NHS England 'Investigation and Intervention' process with a focus on finding ways to rapidly improve financial performance. Many interviewees commented on the stringent focus on financial challenges facing the Trust and the system. Leadership are aware that this needs to be balanced with quality to ensure patient outcomes are not compromised.

- Quality Impact Assessments (QIA) are required for new initiatives; however, we heard that these are not universally completed. Going forwards it will be imperative that QIAs are completed so decision makers are fully informed and able to make decisions which are balanced.

Area for development

- Quality Impact Assessments must be mandated and universally applied as initiatives are developed to address the current Trust and system financial challenges.

KLOE 6: Information and data quality

AMBER/GREEN

Overview

Performance and quality information and reports form a significant part of Board and Committee standing agendas.

- **Good coverage of quality and sustainability** was presented across the meetings we observed.
- **Staff feel well supported in terms of the information they receive**. Information we reviewed was of high quality, up to date and presented in a way that was easy to read with good narrative to support any anomalies or areas off target.
- Divisions reported their activity and performance in reports (generated from the same templates) during our attendance at their Performance Reviews and reporting styles appear to be well established.
- Executives reported being updated daily on operational matters which allow them to respond quickly to changing/emerging events.
- Board members were positive about the presentation of data at Board and Board Committees. Information is well presented and complete.

The Trust's Integrated Performance Reports (IPR) provides a ward-to-board reporting and monitoring structure.

- Routine reports are issued on a monthly basis from a single data source to ensure consistency of reporting and interpretation. Relevant metrics are presented at Board Committees.
- The IPR report is comprehensive, covering all portfolios in one report, and highlights areas of exception at the beginning with good narrative to support and explain the metrics.

Areas for development

Improvements to IPR

- It is good practice for Trusts to implement a performance indicator assessment process. A number of Trusts prepare Data Quality Assurance Indicators or Kite Marks to support members' review and assessment of performance indicator information reported in integrated performance reports. At present, the Trust does not have a data quality kitemark system in place although we note this was recommended in its last Well Led review. Internal Audit has also made a recent recommendation in this area. The Trust should consider the use of such a system to inform users of any data quality risks attached to the data that might impact decision making.
- The Trust could make more use of peer and national benchmarking information within the IPR to provide wider and additional context on the Trust performance against KPIs.

KLOE 7: Engagement

AMBER/GREEN

Overview

The Trust engages effectively with its staff. In the 2023 NHS Staff Survey, it achieved a response rate of 62% and the best results nationally for staff engagement and morale.

An example of the Trust engaging extensively was in developing their 2024-2029 Strategy: Improving Lives. This included 6,000 staff at workshops and events, 14,000 Trust members, 400 volunteers, and engagement with system partners.

The Trust is viewed as an **active participant of the Nottingham and Nottinghamshire Integrated Care System**. Executive Directors and other senior leaders interviewed were able to articulate their roles in the ICS and their engagement with other stakeholders locally.

SFH contributed to the Joint Forward Plan (JFP), a 5-year delivery plan created by partners in the ICS which ensures progress is made towards the ICS Strategy. SFH's strategy responds to all of the principles and aims within the JFP - whilst retaining the requirements that meet their local population's health needs and their vision of outstanding care, provided by compassionate people, enabling healthier lives.

There was **evidence of wider partnership working**, in particular with academic and research establishments such as West Nottinghamshire College, and local authorities. Operational and clinical leaders have also had initial discussions with organisations outside of the immediate system and sector on joint working.

The Trust has established a Partnership and Communities Committee recognising the importance to plan and monitor activities.

Areas for development

External perceptions & relationships

- We know from our conversations with external parties that there is a perception that the Trust has stepped back from collaborating with system partners. This may be as a result of transition and changes at Board level and the financial challenges at the Trust and the wider system. The Trust should recognise this perception and push its participation in system working, particularly at PLACE level.

Strategic alignment

- Further work needs to be done at system level to ensure the Trust's plans and future direction align with the ICB and system strategy and lead on development where appropriate.

Collaboration and co-develop

- We heard that the current financial climate has given rise to a more 'contractual' and performance management relationship with the ICB, with a focus on individual financial matters rather than working collaboratively. The Intervention and Investigation financial regime is providing the basis for development of system plans.

KLOE 8: Improvement and innovation

AMBER/RED

Overview

SFH recognises the need to adopt a robust, well-embedded and systematic continuous quality improvement approach to service delivery at all levels of the organisation.

- Whilst there is considerable improvement activity at the Trust through the established Improvement Faculty such as Continuous Improvement, Pathways to Excellence, Advancing Quality programme, clinical research and clinical audit, **activities are fragmented and there is not a Trust-wide approach and strategy or consistent approach to improvement**.
- The Trust has recently undertaken an NHS IMPACT (Improving Patient Care Together) Self-Assessment, which was presented to the Board in August 2024. The assessment indicated that while **there are examples of improvements happening across the Trust, they tend to be local and not shared more widely.**
- The Trust uses benchmarking data where possible to review its services, and we observed some use of this in reports. The Trust works jointly with a number of other providers in some specialties, and this is mutually beneficial to take stock of systems and processes used to deliver care.
- Annual Staff Excellence Awards celebrate outstanding performance from colleagues and teams across the Trust. Improvement Awards are given to staff to recognise their contributions to the Trust's improvement journey.

Areas for development

Prioritise and monitor

- Given the current operating environment and the continued focus on the Trust's financial position (through the the Investigation and Intervention regime), it has been difficult for individuals at the Trust to have headspace for other improvement work. We have heard consistently throughout interviews that there is a currently a focus on financial improvement across the Trust and there is a need to invest sufficient time and resources to develop and prioritise achievement of longer-term improvements.

Embedding improvement culture

- Improvement is still seen as being separate from day-to-day activities, rather than being integrated with it. The Trust must look to embed improvement as part of the Trust's everyday culture. There is a lack of shared understanding of what is meant by improvement and its role in supporting transformation.

Developing capability and capacity

- The Trust recognises a need to develop/broaden the skill set to enable improvement. Currently, there is not a structured training or capability building approach for improvement skills. Training is ad hoc and focused on small central teams.

Recommendations

The following pages set out the recommendations arising from our review. Our recommendations reflect the current status and maturity of Trust arrangements, the development session we had with the Board on 13 November 2024 as well as good and best practice we have observed elsewhere.

Ref.	Development Area	Recommendation	Priority
KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?			
R1.1	Unitary Board development	We recommend the Chair and CEO should design a structured Board development plan to include actions and activities that support effective onboarding and integration of the new NEDs and other Directors. The plan should include protected time to invest in “team development” and softer skills to strengthen unitary Board working, particularly given the planned Board changes over the next few months.	Medium
R.1.2	Unitary Board development	The Chair and NEDs should agree a schedule of regular NED group catch-ups.	Low
R1.3	Skills and experience	The Chair and CEO should consider how experience and skills gaps can be closed as part of the ongoing Executive and NED recruitment process and as part of the planning of the Board development programme.	Medium
KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?			
R2.1	Long term trajectory	The Trust should develop a longer-term, strategic view of its role in the system, supporting the development of its population health and the supporting pillars of the NHS 10-year plan. This should be aligned to its partnership plans and strategy to understand what it can achieve as a Trust and what will be more effective in working with others.	High
R2.2	Underpinning strategies	The Trust should further develop its supporting underpinning/aligned divisional strategies to deliver the Trust’s current and long-term trajectory. In particular, the Trust needs to develop a longer-term financial sustainability strategy which builds on the work being undertaken under the Investigation and Intervention regime.	High

Recommendations

Ref.	Development Area	Recommendation	Priority
KLOE 3: Is there a culture of high quality, sustainable care?			
R3.1	Freedom to Speak Up (FTSU) - Governance	The FSTU Guardian provides assurance to a number of Committees, however, the FTSU agenda lacks a forum for focussed discussion, as well as identification and investigation of organisational-wide issues. We recommend that the Trust: • Reviews and streamlines the governance route to Board, ensuring accountability at Committee level is clearly set out. • Establishes a focussed forum for the FTSU agenda (for example a FTSU sub-cabinet) and consider representation from divisional leads to strengthen divisional oversight and buy-in. • Consider the introduction of a time limited period for the role of the FTSU Champions, with options to extend if both parties agree.	Medium
R3.2	Freedom to Speak Up (FTSU) – Responsiveness	The Trust should seek to improve confidence in the FTSU process by: • Reviewing concerns raised to understand trends and activity, and use this information to redesign and promote pathways, reinforced by clear support for managers to enable resolution. • Establishing a FTSU triage system to determine how concerns of varying nature will be dealt with, including setting an expected response and resolution timeframe. This should be communicated to staff so there is a mutual understanding.	Medium
R3.3	Freedom to Speak Up (FTSU) – Support	The Trust should seek to improve the sharing of learning as part of the FTSU process by: • Developing a clear FTSU communications plan, to include promotion of the FTSU process, the sharing of success stories and promote other existing escalation routes. • Review and identify training requirements for Trust managers to empower and support managers to resolve concerns raised by their staff.	Medium

Recommendations

Ref.	Development Area	Recommendation	Priority
KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?			
R4.1	Duplication of information	We recommend the Trust reviews the reporting of information to Board and Committees to reduce the amount of duplicate reporting.	Low
R4.2	Financial Governance	We recommend the financial governance and reporting arrangements below Board Committee level are reviewed to the ensure that the arrangements are sustainable and there is clarity regarding reporting into the Improvement Cabinet and Finance Committee.	High
R4.3	Operational Performance	The Trust should review and agree how appropriately detailed information on Trust performance/issues is shared with NEDs between Committee meetings, to ensure NEDs are kept up to date in a timely manner.	Low
KLOE 5: Are there clear and effective processes for managing risks, issues and performance?			
R5.1	Quality impact assessments	We recommend that the Trust ensures Quality Impact Assessments are mandated and universally applied and completed alongside the development of initiatives to address the current Trust and system financial challenges.	Medium
KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?			
R6.1	Integrated Performance Report (IPR)	The Trust should consider strengthening the IPR to include: • A data quality kite mark system to inform users of any data quality risks attached to the data that might impact decision making. • Use of peer and national benchmarking information within the IPR to provide wider and additional context on the Trust's performance.	Medium

Recommendations

Ref.	Development Area	Recommendation	Priority
KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?			
R7.1	External perceptions and relationships	We recommend the Trust continues to proactively push being an active player in the system. In particular, this should include further strengthening system working and approach with the ICB on financial improvement. We recommend the Trust take clear leadership responsibilities on key areas of system development plans and at PLACE level.	High
R7.2	Strategic alignment	We recommend the Trust fully engages with the ICB on the development of strategic plans and underpinning strategies.	High
R7.3	Collaboration	We recommend the Trust work jointly with partners (system and wider) to co-develop and deliver plans and strategies which support the delivery of agreed long term plans. The Partnerships and Communities Committee should monitor actions and ensure strategic alignment.	Medium
KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?			
R8.1	Prioritise and monitor	We recommend the Trust establish buy-in and support from the Board on the Trust improvement strategy and approach. This would include agreeing key improvement priorities and what can be achieved by when, and setting out key terms and definitions (e.g. improvement – quality, operational and financial, transformation, multi-year etc)	Medium
R8.2	Developing capability and capacity	We recommend the Trust review how it can ringfence clinical and operational staff time to ensure improvement work is given more priority and focus.	High

Recommendations

Ref.	Development Area	Recommendation	Priority
KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?			
R8.3	Embedding Improvement Culture	The Trust should consider how all senior leaders at the Trust can input into the Trust improvement programme and activities, to drive and support delivery and send a message that improvement work is a responsibility of all leaders.	Medium
R8.4	Embedding Improvement Culture	The Trust should develop a clear and detailed plan to share learning from improvement projects and agree the approach to widely communicate improvement activities.	Medium
R8.5	Embedding Improvement Culture	We recommend the Trust revisit and reset governance processes and groups for developing and monitoring improvement work across the Trust. This would include consideration of the role of the Financial Improvement Cabinet/Improvement Cabinet and Quality and Safety Committee.	High

Appendix A - Interviewees

Interviewees

Category	Interviewees
Trust Board members	• Graham Ward (Acting Trust Chair and Chair of Finance Committee) • Barbara Brady (NED Chair of Partnership Committee, and Vice Chair) • Steve Banks (NED Chair of People Committee) • Manjeet Gill (NED Chair of Audit and Assurance Committee) • Aly Rashid (NED Chair of Quality Committee) • Andrew Rose-Britton (NED Chair of the Charitable Funds Committee) • Neil McDonald (NED, Maternity Champion) • Dave Selwyn (Acting CEO) • Phil Bolton (Chief Nurse) • Rachel Eddie (Chief Operating Officer) • Richard Mills (Chief Finance Officer) • Simon Roe (Acting Medical Director) • Rob Simcox (Director of People) • Sally Brook Shanahan (Director of Corporate Affairs) • Claire Hinchley (Acting Director of Strategy and Partnerships)
Other internal stakeholders	• Steven Jenkins (Divisional General Manager – UEC) • Joanne Wright (Divisional General Manager – Medicine) • Jo Fort (Divisional General Manager - Surgery) • Matthew Warrilow (Divisional General Manager - Women and Children) • Adam Littler (Divisional General Manager (CTSO) • Kerry Bosworth (FTSU Guardian) • Mark Bolton (Associate Director of Operational Performance)
External stakeholders	• Tim Guyler (NUH Assistant Chief Executive and Director of Integration) • Claire Page (Internal Audit 360 Assurance) • Richard Walton (External Audit KPMG) • Liz Barrett (SFH Lead Governor) • Amanda Sullivan (Nottingham and Nottinghamshire ICB Chief Executive) • Marcus Pratt (Nottingham and Nottinghamshire ICB Interim Director of Finance)

Appendix B – Meeting observations

Meeting observations

Category	Meeting
Trust Board and Board Committees	• Trust Board • Audit and Assurance Committee • Finance Committee • People Committee • Partnership and Communities Committee
Executive and Divisional meetings	• Women's and Children Performance Review Meeting • Medicine Performance Review Meeting • Surgery Performance Review Meeting • UEC Performance Review Meeting • CSTO Performance Review Meeting

Sherwood Forest Hospitals
NHS Foundation Trust

Well-Led Review 2024
Action plan for development areas

KEY:

ACE	Acting Chief Executive
DCE	Deputy Chief Executive
COO	Chief Operating Officer
DoI	Director of Improvement
DDSP	Deputy Director of Strategy & Partnerships
DoP	Director of People
DoCA	Director of Corporate Affairs
FTSUG	Freedom to Speak Up Guardian

Actions – Leadership

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
1	Unitary Board development	The Chair and ACE/DCE should design a structured board development plan to include actions and activities that support effective onboarding and integration of the new NEDs and other directors. The plan should include protected time to invest in "team building" and softer skills to ensure the Trust maintains a unitary board.	Chair and ACE/DCE	ACE/ DCE	31/10/2025		People
2	Unitary Board development	Review and agree how appropriately detailed information on Trust performance/issues is shared with NEDs between committee meetings, to ensure NEDs are kept up to date in a timely manner.	ACE/DCE	ACE/ DCE and COO	30/06/2025		People
3	Unitary Board development	The Chair and NEDs should agree the schedule of regular NED group catch-ups, given the context of new NED member appointments over the next few months.	Chair	DoCA	30/06/2025		People
4	Skills and experience	The Trust's effective succession planning arrangements have ensured that the Board has remained stable following key Board changes over the last year. There remain recognised gaps at board level covering the areas of improvement, transformation and research. The Trust is recruiting to a	DoP	All Exec Dirs.	31/10/2025		People

No.	Area of Development	Action	Action Lead	Task Lead(s)	Delivery Date	Progress Update	Committee sign off
		Director of Improvement and NED recruitment is planned. The Chair and ACE/DCE should consider how experience and skills gaps can be closed as part of the ongoing Executive and NED recruitment process and as part of the board development programme.					

Actions – Improvement

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	Prioritise and monitor	Establish buy in and support from the Board on the Trust improvement strategy and approach. This would include agreeing key improvement priorities and what can be achieved by when, and setting out key terms and definitions (e.g. improvement – quality, operational and financial, transformation, multi-year etc)	Chair	All Exec Dirs.	31/05/2026		Strategy and Partnerships
2	Embedding improvement culture	Revisit and reset governance processes and groups for developing and monitoring improvement work across the Trust. This would include consideration of the role of the Financial Improvement Cabinet/Improvement Cabinet and Quality and Safety Committee.	DoI	All Exec Dirs.	31/05/2026		Strategy and Partnerships
3	Embedding improvement culture	The Trust should develop a clear and detailed plan to share learning from improvement projects and agree the approach widely communicate improvement activities.	DoI	DDSP	31/05/2026		Strategy and Partnerships
4	Embedding improvement culture	The Trust should consider how all senior leaders at the Trust can input into the Trust improvement programme and activities, to drive and support delivery and send a message that improvement work is a responsibility of all leaders.	DoI	All Exec Dirs.	31/05/2026		Strategy and Partnerships
5	Developing capability and capacity	The Trust should consider how it can ringfence clinical and operational staff time to ensure improvement work is given more priority and focus.	DoI	DDSP	31/05/2026		Strategy and Partnerships

Actions – Strategy

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	Long term trajectory	Build a clear and detailed plan based on the Board development day sessions to build longer term strategy	ACE/DCE	DoI DDSP	31/10/2025		Strategy and Partnerships
2	Long term trajectory	Link actions into three pillars of NHS plan alongside ICB plans and strategy, in particular PLACE based delivery.	ACE/DCE	DoI DDSP	31/10/2025		Strategy and Partnerships
3	Long term trajectory	Identify and release capacity to develop strategy, considering broader input/leadership at Board level and wider organisation.	ACE/DCE	DoI DDSP	31/10/2025		Strategy and Partnerships
4	Long term trajectory	Establish governance processes and groups for monitoring delivery, development and engagement of strategy.	ACE/DCE	DoI DDSP	31/10/2025		Strategy and Partnerships
5	Underpinning strategies	Reset, align and further develop underpinning strategies that enable the delivery of the longer-term strategy.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships
6	Underpinning strategies	Develop a long-term financial strategy that demonstrates the financial sustainability of the Trust which links into the system plans and strategy.	ACE/DCE	CFO	31/05/2026		Finance
7	Underpinning strategies	Ensure clinical, operational, workforce and financial strategies are further developed and aligned.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships

Actions – Partnerships

No.	Area of Development	Action	Action Lead	Task Lead(s)	Due Date	Progress Update	Committee sign off
1	External perceptions and relationships	Continue to push as being active player in system and develop system working and approach with ICB on financial improvement in particular.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships
2	External perceptions and relationships	Take leadership responsibilities on key areas of system development plans and pushing PLACE.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships
3	Strategic alignment	Use development of long-term strategy as basis of discussion, direction and leadership on system and ICB plans.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships
4	Strategic alignment	Fully engage with ICB on development of strategic plans and underpinning strategies.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships
5	Collaborate and co-develop	Work jointly with partners (system and wider) to co-develop and deliver plans and strategies which support the delivery of agreed long term plans.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships
6	Governance	Use the Partnerships and Communities Committee to monitor actions and ensure strategic alignment.	ACE/DCE	DoI DDSP	31/05/2026		Strategy and Partnerships

Actions – Freedom to Speak Up

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
1	Governance route	Review and streamline the governance route to Board for FTSU ensuring accountability at Committee level is clear.	DoCA	DoCA	30/06/2025		People
2	Governance route	Create time and space for discussion of FTSU concerns e.g. FTSU sub-cabinet.	DoCA	DoCA	31/08/2025		People
3	Governance route	Divisional leads to sit on this sub-cabinet (along with Executive Lead) to secure buy in from divisions which is currently variable. Consider whether the Executive Lead should be within the triumvirate to strengthen engagement across the divisions.	DoCA	DoCA	30/06/2025		People
4	Governance route	Consider implementing a tenure for the FTSU Guardian and Champion role, with an option to extend if both parties agree.	DoCA	DoCA	31/05/2025		People

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
5	Responsiveness	Review concerns raised to understand trends and activity and use this intelligence to redesign and promote pathways supported by clear support for managers to enable resolution.	DoCA	DoCA	30/09/2025		People
6	Responsiveness	Develop a communications plan – to include promotion of FTSU, sharing of success stories, and also promote other existing routes.	DoCA	DoCA	30/09/2025		People
7	Responsiveness	Establish a triage system to determine how concerns of varying natures will be dealt with, including expected response and resolution timeframes. This should be communicated to staff so there is a mutual understanding.	DoCA	DoCA	30/09/2025		People
8	Responsiveness	Identify training requirements for managers and determine frequency to empower and support managers to resolve concerns.	DoCA	DoCA	30/09/2025		People

No.	Area of Development	Action	Action Owner	Task Lead	Due Date	Progress Update	Committee sign off
9	Support	Ensure appropriate training is provided to managers to ensure they are supported in listening to and resolving concerns raised.	DoCA	DoP	30/09/2025		People
10	Support	Divisional buy-in/engagement through FTSU sub-cabinet – this will provide opportunity to close feedback loops, identify trends and share learning more widely.	DoCA	DoCA	31/06/2025		People
11	Support	Consider how to make best use of FTSU Champions – e.g. signpost, triage, cover/alternative point of contact for FTSUG.	DoCA	FTSUG	30/09/2025		People

KEY:

ACE	Acting Chief Executive
DCE	Deputy Chief Executive
DoI	Director of Improvement
DDSP	Deputy Director of Strategy & Partnerships
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DoCA	Director of Corporate Affairs
FTSUG	Freedom to Speak Up Guardian

Board of Directors Meeting in Public - Cover Sheet

Subject:	Well-Led Review – Report	**Date:**	6th February 2025
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	David Selwyn, Acting Chief Executive		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To report the findings from the Developmental Well Led Governance Review undertaken by Grant Thornton and agree the action plan and the associated progress monitoring arrangements.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

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

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	Insufficient financial resources available to support the delivery of services	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	**X**
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

Board of Directors Meeting in Private – 2nd January 2025

Acronyms

SFH = Sherwood Forest Hospitals
DPR = Divisional Performance Review
ICB = Integrated Care Board
ICS = Integrated Care System
KLOE = Key lines of enquiry
CQC = Care Quality Commission
SAF = Single Assessment Framework
NHSE = NHS England
NED = Non-Executive Director
CEO = Chief Executive Officer
FTSU = Freedom to Speak Up
NGO = National Guardians Office
ToR = Terms of Reference
BAF = Board Assurance Framework
PR = Principal Risk
QIA = Quality Impact Assessment
IPR = Integrated Performance Reports
JFP = Joint Forward Plan

Executive Summary

This purpose of this paper is to set out the findings from the independent developmental well led review of the Trust's leadership and governance conducted by Grant Thornton UK LLP against NHS England's well led framework guidance for developmental reviews of leadership and governance (June 2017). It is important to note that the CQC updated the well-led framework under its SAF in April 2024. As part of the set up of the review, Grant Thornton mapped the revised SAF with the NHSE developmental guidance to ensure areas were aligned and could be used to support any assessment CQC may undertake using the SAF. It was agreed that the review would not cover the environmental sustainability area of the SAF as that does not map across to the current developmental framework.

This paper also has attached to it an action plan in response to the developmental actions identified to the report's findings.

The review was limited to the scope outlined in the framework guidance and did not assess whether clinical services provided by the Trust are safe, effective, caring or responsive. The summary of the review that is appended to this paper has been prepared on behalf of Grant Thornton UK LLP and is published with consent.

Overall conclusion

The report's overall conclusion is that Sherwood Forest Hospitals NHS Foundation Trust continues to be a well-led Trust. Compared to the last developmental review completed in 2021/22, the Trust has maintained strong assessments in the majority of the areas covered by the well-led KLOEs and has delivered on most of the actions agreed as part of that previous review. The Trust has strong governance processes which contain many elements of good practice. The review did not identify any significant development areas and for those development areas it did identify, the Trust was aware of them and already in the process of discussing and implementing actions to address them.

Given the contextual changes and challenges recorded below, the review noted it is a testament to the Trust's strong processes and leadership that it has been able to maintain the assessments when many other trusts will have struggled with their impact. The report goes on to remark that the development areas identified are largely as a consequence of those changes.

Context

There are some important contextual points which have impacted on the assessments compared to the previous review including:

- The Trust being in a transitional period for leadership during which there have been significant changes to the Board, both Executive and Non-Executive, with many acting up arrangements, including the Chair and Chief Executive. There are also some recognised gaps in skills and experience with the Board. This is likely to continue in the short-term with posts currently advertised for Non-Executives (to which successful appointments have now been made) and Executive roles.
- Challenges within the wider system with partners in the Nottingham and Nottinghamshire ICS having a number of high-profile challenges on quality, operational and financial performance of services.
- Financial pressures and scrutiny including increasing financial challenges at the Trust and the wider system resulting in the Trust's inclusion in the NHS E Financial Investigation and Intervention regime and the Trust receiving support to improve its financial performance.

Good practice

The review identified the continuation and operation of many good practice areas across the framework including:

- ✓ Trusted, supportive and open leadership style
- ✓ Succession planning evident and delivering in all leadership roles
- ✓ Development and mentoring programmes for all staff levels
- ✓ Strong and deep affinity across the organisation to its CARE values
- ✓ Effective divisional performance management
- ✓ Board strategically focussed
- ✓ Warm and welcoming culture
- ✓ Risk recognition and management processes embedded.

Action Plan

The action plan sets out those for the five key development areas - Leadership, Improvement, Strategy, Leadership and Freedom to Speak Up - including the allocated action and task leads, the due date and the Committee for sign off.

It is proposed that progress reporting to Board is scheduled to coincide with the groups of action due dates in July 2025, November 2025 and June 2026, with an additional report in February 2026 to provide assurance that the final actions are on track for timely completion.

Recommendations

The Board is asked:

- To receive the summary of the Developmental Well Led Governance Review undertaken by Grant Thornton, and
- To agree the action plan and the dates proposed for reports on progress to be presented to the Board.

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report and Perinatal Scorecard	**Date:**	6 February 2025
Prepared By:	Sarah Ayre Head of Midwifery, Rachael Giles Deputy Divisional Director of Nursing, Women's and Children's Division		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women and Childrens, Phillip Bolton, Executive Chief Nurse		

Purpose		
To update the Board of Directors on our progress as Maternity and Neonatal Safety Champions	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

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

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

Committees/groups where items have been presented before

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

Acronyms

MNSC - Maternity and Neonatal Safety Champion
MNVP - Maternity and Neonatal Voice Champion
PAC - Perinatal Assurance Committee
CQC - Care Quality Commission
LMNS - Local Maternity and Neonatal System
PMA - Professional Midwifery Advocate
IOL - Induction of Labour
PDC - Pregnancy Day Care
NICU - Neonatal Intensive Care Unit
MSW/MCA - Maternity Support Workers/Maternity Care Assistants
HoM - Head of Midwifery
DDoN- Deputy Director of Nursing

Executive Summary

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

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

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

Maternity and Neonatal Safety Champion (MNSC) oversight December 2025

Maternity

1 Staff Engagement

The planned monthly MNSC Safety Champions Walk around took place on Friday 10th January 2025. A focus was made upon the Neonatal Unit noting the staffing concerns and actions plans in place around the Transitional Care Unit, further details of this are provided later in the paper. The MNSC spoke with members of staff across the multidisciplinary team who felt supported by the measures in place and these actions will be monitored on a daily through a huddle and the senior leadership team within division. The next MNSC walk round is planned for Monday 3rd February 2025.

The Maternity Forum is planned for the end of January 2025, an update will be provided in the next paper. It is agreed for now that this will continue as Maternity specific however the Deputy Head of Nursing and CYP Matron will review what the neonatal teams would like to embed moving into 2025 as a similar platform to aid communication and celebrating excellence through the work, they are undertaking with the Quad+3 programme.

2 Service User Feedback

2.1 Complaints

No formal complaints have been received for Maternity this month. In addition, all outstanding actions for midwifery staff following incidents have been completed to date.

2.2 Compliments/ Concerns

This month we have received 6 compliments all praising the staff. 2 concerns have been raised, one about cleanliness on the ward and one about timing of medicine administration. These have all been shared with the appropriate staff involved.

2.3 Friend and Family Test

Response Option	Responses	Percentage
1 - Very good	45	68.18%
2 - Good	10	15.15%
3 - Neither good nor poor	4	6.06%
4 - Poor	4	6.06%
5 - Very poor	3	4.55%
6 - Don't know	0	0.00%

We are proud and are always happy to welcome the positive comments and feedback we receive around the services we provide. Overall, this data and information demonstrates we provide a good standard of care, however sadly on occasion we do not get it right and as a senior team, receiving this feedback and understanding and addressing these experiences is key to us improving and ensuring a consistent standard of care for all service users.

Working closely with the MNVP, ensuring women, birthing individuals and their families can escalate safely and effectively when not receiving the very best care, so that we can address their experience immediately, will be the focus of the senior team for 2025.

Free text comments this month include:

> My worries were heard and midwives helped me make important decisions when I didn't understand properly. And yes the midwife and student midwife who stayed with me the entire night were exceptional and made the experience entertaining and fun

> I had an elective c section and the theatre staff were amazing! I was anxious about the procedure. Our little girl had some difficulties after she was born but staff were incredible in keeping me calm and explaining what was happening.
> The maternity ward staff were also amazing, everyone involved offered great care and I cannot thank them enough.

> I felt like nobody knew what my birth plan was, had to ask for an epidurals top up because it wore off but after a shift change my midwife was the best I could ask for she was wonderful.

> Outstanding care from all health care workers even when they were seriously overstretched.

> The staff were not friendly and ruined my experience as a first time mum, I asked for pain relief 3 times after having an episiotomy which was never given. I asked for a clean down and pads to sit on as I had bled through everything and was in agony wearing knickers, I was told so many times they'd provide these and never did. I had to self discharge as I ended up having a panic attack and left alone without any help.

This feedback will be shared with all staff and a focused Ward / Team level approach will be adopted to addressing and improving any factors identified to contributing to poor service user experience.

3 Culture

3.1 PositiviTEATrolleys

We hosted a week of PositiviTEA Trolleys in November 2024, recognising the vital and varied roles that our Maternity Support Workers undertake across our Maternity Services. These daily tea trolleys were hosted by several members of the senior leadership team and have now become a monthly endeavour due to their popularity.

Christmas Eve, Head of Midwifery Sarah Ayre and Divisional General Manager Matthew Warrilow hosted a division wide tea trolley and then on New Years Eve, Director of Midwifery/Divisional Director of Nursing Paula Shore, joined by Maternity Matron Melanie Johnson and Deputy Divisional Manager Lisa Walker also undertook a Division wide tea round.

January 2025's PositiviTea Trolleys are planned for the end of the month, and we will be extending an invite to our MNVP colleagues to join us.

3.2 Collaboration

Head of Midwifery, Sarah Ayre and Clinical Lead, Miss Maddock-Khan will be working together throughout 2025 to understand and respond to the experience our Obstetric colleagues report of having worked within maternity services. This work will form part of the Quad+3 programme and will be disseminated Divisionally once established. We will report via MNSC.

3.3 Staff Council

The new Staff Council was launched in December that will be reporting into the Trust Shared Governance Council.

4 Safety Culture

4.1 NHSE Perinatal Culture and Leadership Programme

The next session chaired by Korn Ferry to ensure a thematic analysis of the data collected is planned for Tuesday 4th February 2025 and we are pleased to welcome NED Neil McDonald to this session. The programme concludes on 15th March 2025 and a paper around what we have learnt and what we have and are achieving will be required through PAC by the end of April 2025 and we will continue to update and provide assurance on the impact of our initiatives through PAC.

4.2 CQC Action Plan

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

4.3 Three Year Maternity and Neonatal Delivery Plan

We continue to collaborate with the LMNS on the 4 main themes and 12 objectives of the 3-year delivery plan. The collaborative LMNS mapping process against this plan is currently being overseen by Sarah Ayre Head of Midwifery for SFH. Once the LMNS formally request evidence and assurance, we will fix an agenda item at PAC to share our status against the plan.

4.4 NHSR

The Task and Finish group for the Maternity Incentive Scheme (MIS) Year 6 meets fortnightly to work through the evidence upload needed to meet each of the 10 Safety Actions, chaired by Speciality General Manager Sam Cole in collaboration with Operations Manager Jess Devlin. Currently 2 of the safety actions have been presented for sign off at PAC – SA2 and SA4 and the remaining 8 are assessed as AMBER which is defined as ‘on target with evidence to be submitted and reviewed.’

4.5 Ockenden

The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan embedded within Maternity. The visit’s findings supported the self-assessment completed by the Trust. Area’s have been identified from the visit to strengthen the embedding of the immediate and essential actions however, important to note the continuing progress as a system around bereavement care provision, specifically with the counselling support.

The plan is to revisit the maternity self-assessment tool created by NHSE in July 2021, in the new year to benchmark progress and will be undertaken by Head of Midwifery Sarah Ayre and Consultant Midwife Gemma Boyd and presented at PAC in February 2025. The National Maternity Self- Assessment Tool provides support to all trusts seeking to improve their maternity service rating from ‘requires improvement’ to ‘good’, as well as a supporting tool to support trusts looking to benchmark their services against national standards and best practice guidance.

4.6 CQC National Survey

Conducted in February 2023 - Our action plan is overseen by Consultant Midwife Gemma Boyd, and we remain in an active phase of embedding quality improvements, as reported.

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

CQC Survey 2025 - We have received the posters ready to share across the service for the next survey and we will be working as a senior team over the coming weeks to formulate and embed next steps on engaging our service users with this work, alongside our MNVP colleagues.

4.7 MBRRACE-UK:
Saving Lives, Improving Mothers' Care 2024 - Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2020-22, full report can be accessed below. Quality and Safety Lead Midwife Hannah Lewis is currently benchmarking against the report and her updates will be shared via PAC once completed.

Neonatal

5 Workforce

5.1 Nursing Staffing Update
Further to critical staffing escalations and whilst ensuring the safety of our neonatal services, with immediate effect, we have redeployed the nurses assigned to Transitional Care to work within our NICU. Monday 13th January 2025 staff from both NICU and TC will be NICU staff, so the unit will be staffed at 6 registered nurses + 2 support workers. TC babies and NICU capacity will be discussed at an 08:30 huddle with NIC/ Maternity /Medical team/ Senior leadership as per the guidance attached to where they are cared for and this is huddle is support by the below guidance.

NTC update Jan 24 final version 12.12.24.

Transitional care huddle.doc

We are actively recruiting into both the NICU and NTC vacancies. Interviews are in place for 16.1.25 and 29.1.25. We have had good applications for all posts and confident we will recruit. The ongoing long-term sickness is being managed and support by our divisional people partners.

5.2 Consultant Staffing Update
The rota will be changing to a 1 in 7 rotas instead of 1 in 13 for Neonatal Consultants - first steps are to go to 9-5pm neonatal hot weeks and get all consultants onto a 1 in 13 rota so they are all doing the minimum of 4 hot weeks a year as per BAPM. Then consider moving to split rotas in the future if it is mandated / workload / skill mix requires us to - the network have suggested this however the BAPM guidance hasn't mandated currently so working towards this.

6 Engagement Activity
6.1 3D tours
The 3D tours have been funded and support by the Neonatal Operational Delivery Network (ODN) in the East Midlands. On Wednesday 8th January 2025, the ODN lead showcased the 3D tour video for both the staff and parent / family platform. 30 minutes sessions ran through the day and all staff invited to drop-in sessions. We received positive feedback from staff who attended, and this included the NVP lead. The Communication team will now ensure the final sign off is completed and then this is available for SFH to

use. The 3D tour will be accessed via a QR code that we will use on leaflets, internet, Badgernet App and notice boards throughout the trust.

6.2 Criticool machine

LMNS funding / charity to support with Therapeutic hypothermia has been shown to be of benefit in the management of neonatal hypoxic ischaemic encephalopathy. Servo-controlled management of induced hypothermia in the neonate can be facilitated using the Criticool Cooling System prior to and during the neonatal transport episode to protect from brain damage. -£19,926.00

7 East Midlands Neonatal Peer Review 2024

On 4th May 2024, NICU at SFH received a visit from the East Midlands Neonatal Network. The report was issued to the trust on 1 August 2024 and the delay in providing the report was due to unforeseen capacity within the ODN Team. The peer reviews provide the Network management team with the opportunity to benchmark the services against the national standards, to highlight any areas for improvement, and to recognise any areas of notable achievement.

Positive Achievements:

- Neonatal BFI Stage 2 and working towards Stage 3 – achieved since review.
- The Trust now have a dedicated preterm lead midwife and preterm support worker.
- The service now has a governance lead nurse in post.
- The training and development programme is enhanced from previous review.
- Additional consultant in post for paediatrics/neonates.
- Excellent links and relationships between the Trust clinical team and the management teams.
- Excellent bereavement facilities.
- ANNP recruited.
- PNA available.
- Cohesive team working
- The LMNS is involved in a daily huddle to discuss OPEL position for maternity and neonatal services.
- The Emily Harris Foundation continues to provide invaluable support to the service which is highly commendable.
- Homecare phototherapy service now in place.
- ‘Bite Size’ videos which detail how to deal with common scenarios and ‘Bite Size’ teaching after the ward round.

An action plan to support the review was presented to the Patient Safety Committee on the 13th of January 2024 to provide oversight and assurance to trust. These actions focused around the configuration of the unit and pharmacy support. Both have extensive workstream underway, have been risk assessed and mitigations are in place.

8 Cultural Conversation

As part of the ongoing Quad Programme of work, Korn Ferry held their initial session on the 12th of December 2024 with NICU and NTC staff. Informed session was well attended and staff very engaging. We are waiting for specific feedback from this.

New perinatal PMA input – session held and December 2024 Feedback –

“The teams were really engaged and enthused about the session. Ruth was able to attend to support in her first duty as our new perinatal PMA and offer some good ideas and input. Fantastic that the new PMA role

is already making a difference to our neonatal teams and am very excited to see how the partnership strengthens and continues".

This role will support the ongoing cultural work within the division.

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Maternity Perinatal Quality Surveillance Model for Jan 2025

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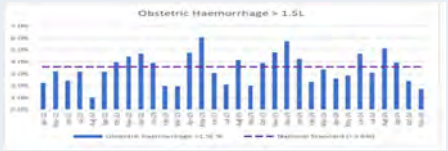
Exception report based on highlighted fields in monthly scorecard using Dec 2024 data (Slide 2)

3rd/4th Degree Tear – 3.7% (Dec 24)

- Rate reduced. No significant trends identified from previous month's review.

Postpartum Haemorrhage 5.2% (Dec 24)

- Increase in cases this month, review found increase in secondary PPH and will be monitored.



Stillbirth Rate (3.8/1000 births YTD)

- PMRT –No reportable cases for December

Patient Experience

- No complaints received in December.
- 6 Compliments received.
- 2 Concerns raised and addressed at a local level. These focused on the cleanliness of the ward and the timeliness of administration of analgesia.

Friends and Family Test (FFT)

Overall response rate 83.3%- lower response rate continues across service- to review current process.

Workforce – vacancy rate 8%

Maternity

- 1 Obstetric Consultant vacancy from end of Dec advertised – interviews planned for Feb 2025.
- Midwifery – intense period of recruitment planned following proposed new establishment has an increased headroom, noting the sustained workforce absence through maternity leave.
- Maternity Support Workers – band 2 to band 3 project to be completed early in 2025

Neonatal

- Significant nursing challenges due to staff absence through maternity and sickness. Local plan enacted to support.
- No Neonatal Consultant vacancy.

Staffing Red Flags

Suspension of Maternity Services

- 1 suspension of service in December

Home Birth Service

- Risk to service due to expected parenting leave mitigated.

Triage

- Noted reduction in DATIX submitted around delays in BSOTS in Triage in December. Working group continues.

IOL

- New lead in post to focus on QI work around improving delays.

Saving Babies Lives Care Bundle (SBLCB v3)

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)	NHS Resolution Maternity Incentive Scheme
Element 1	Smoking in pregnancy	Partially Implemented	80%	Partially Implemented	80%	CNST Met
Element 2	Fetal growth restriction	Partially Implemented	95%	Partially Implemented	95%	CNST Met
Element 3	Reduced fetal movements	Partially Implemented	50%	Partially Implemented	50%	CNST Met
Element 4	Fetal monitoring in labour	Fully Implemented	100%	Fully Implemented	100%	CNST Met
Element 5	Preterm birth	Partially Implemented	96%	Partially Implemented	96%	CNST Met
Element 6	Diabetes	Partially Implemented	83%	Partially Implemented	83%	CNST Met
All Elements	TOTAL	Partially Implemented	91%	Partially Implemented	91%	CNST Met

Maternity Assurance

NHSR

- Year 6 MIS now live
- Initial risk - no mitigations
- Final sign off planned for 23rd of Jan 25 before presenting to Quality Committee.

National Reporting

- Ockenden - Initial 7 IEA- 100% compliant
- 3 yr. delivery plan – system plan in development

Incidents reported Dec 2024; 131 (131no/low harm, 0 moderate or above*)

MDT reviews	Comments
Triggers x 16	No themes identified

*No Incidents reported as 'moderate or above' from the cases reviewed.

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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		

Quality Metric	Standard	Running Total/ average	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			51%	53%	47%	56%	49%	49%	48%	48%	46%	48%	46%	44%	54%	51%	
3rd/4th degree tear overall rate	<3.5%	3.50%	5.10%	2.40%	3.00%	5.00%	2.10%	6.00%	4.50%	3.00%	2.80%	4.70%	3.90%	0.70%	7.10%	3.70%	
3rd/4th degree tear overall number		88	9	4	5	8	3	11	8	4	4	7	6	1	12	6	
Obstetric haemorrhage >1.5L number		147	15	17	13	6	9	9	9	11	9	15	12	7	5	10	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	2.90%	4.70%	3.10%	5.10%	3.90%	2.40%	1.70%	5.00%	
Term admissions to NICU	<6%	3.10%	3.00%	3.10%	3.00%	2.80%	3.80%	2.60%	4.00%	2.90%	4.70%	4.00%	3.90%	3.60%	3.30%	2.10%	
Stillbirth number		16	0	2	1	2	1	0	1	1	0	2	2	1	3	0	
Stillbirth rate	<4.4/1000			2.300			3.100			2.300			4.400			3.8	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:22	1:22	1:23	1:22.18	1.22.10	1.22.10	
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	1:23	1:23	1:24	1:22.75	1:22.18	1:22.18	
Number of compliments (PET)		40	4	3	2	3	4	5	4	1	2	2	1	2	1	6	
Number of concerns (PET)		12	0	1	1	1	1	0	0	4	1	0	4	0	1	2	
Complaints		5	0	0	1	0	0	1	1	0	1	1	0	0	0	0	
FFT recommendation rate	>93%		91%	90%	90%	90%	90%	90%	91%	91%	88%	89%	84%	89%	84%	83%	

External Reporting	Standard	Running Total/ average	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Trend
Maternity incidents no harm/low harm		1772	158	94	148	102	102	95	130	102	125	169	115	159	142	131	
Maternity incidents moderate harm & above		7	2	1	1	0	0	0	0	0	2	1	0	0	0	0	
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	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	1	1	0	0	0	0	0	
Progress in Achievement of MIS YEAR 6	<4 <7 7 & above																

Findings of review of all perinatal deaths using the real time monitoring tool	Dec-24	No reportable cases within the month of December. Live tracker comiutes to moninter cases with the NHSR timeframes.
Findings of review all cases eligible for referral to MNSI	Dec-24	No reportable cases, no live case currently with MNSI.
Service user voice feedback	Dec-24	Ongoing engagement with the MNVP and LMNS to look at CQC Annual Nationl Survey action plan.
Staff feedback from frontline champions and walk-abouts	Dec-24	Focus upon the Neonatal Unit and Staffing, daily huddle implemented and working well.

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Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:**	6 February 2025
Prepared By:	Graham Ward – FC Chair		
Approved By:			
Presented By:	Graham Ward – FC Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee meetings of 17 December 2024 and 28 January 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• Workforce (to NOTE) – The Band 2 to 3 Review is likely to have an initial cost of £2.2M (which is being provided for) and an ongoing impact of up to £750K per annum. • Workforce (for ACTION) – There is potential for further material changes financially which may arise from a review of Bands 4 to 9. This is being pushed for local resolution, but the **recommendation is for Board to escalate and request national intervention.** • Month 9 Financial Position (to NOTE) – At the end of Month 9 the Trust has a deficit of £7.3M (an adverse variance to plan of £1.9M). The forecast outturn for the year has a risk range from a deficit £2.2M at best to a worst-case position of £14.7M. It is important all grip and control effort continues and this is carried into 2025/26. • Cash (to NOTE) – Cash continues to be a major issue with all recent NHSE support requests having been turned down. • Financial Planning (to NOTE) – due to the low current recurrent savings the starting point prior to the 2025/26 FIP programme is for a deficit of in excess of £60M (11% of costs).	• Financial Strategy – Further update to be presented to the Committee in February, with final version to be presented to Board at its March meeting. • Surgery Division – Support to be given on strategic options development. • Procurement – Further work to be undertaken on reviewing equipment maintenance contracts to identify potential for consolidation and VFM improvements.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
• Surgery Division – Noted deep dive presentation in December and concern over Anaesthetic Consultant vacancies (35%), plus forecast overspend of £2.1M for 2024/25. • Clinical Support Therapies & Outpatients Division – Noted deep dive presentation in January and excellent performance on their FIP programme together with the reductions in DNA rates down to 6% (from a peak of 8.1% in Oct 2023) and planned at 5% by March 2025. • NHIS Performance – Noted that forecast expenditure and income had been reduced to support savings requirements at all customers. Request to review opportunity for making some of the reductions recurrent. • Digital Landscape – Received a helpful paper outlining the current cost of the Trust's digital infrastructure (hardware and software), together with a predicted position in 5 years incorporating known changes. Agreed that this would act as a good base position to work from for any future business cases. • Procurement Forward View – Received and noted.	• Aseptic Dispensing Unit – Business case approved at December meeting • ICB IT Equipment Purchase – Business case agreed to be recommended to Board for approval subject to confirmation of funding from the ICB. • BAF – Agreed at December meeting to increase PR4 (Insufficient Financial Resources) risk rating from 16 to 20, this was endorsed in January's meeting. No change was proposed for PR8 (Sustainability) at a current risk rating of 12.

Comments on effectiveness of the meeting

All papers were of a high quality and clear which helped the meeting run smoothly and promoted good constructive challenge and discussion.

Items recommended for consideration by other Committees

- None identified

Progress with Actions

Number of actions considered at the meeting – 13 (December) 14 (January)
Number of actions closed at the meeting – 6 (December) 9 (January)
Number of actions carried forward – 7 of which 4 are not yet due (December) 5 all of which are not yet due(January)
Any concerns with progress of actions – No

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

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Audit and Assurance Committee Chair's Highlight Report to Board

Subject:	Audit and Assurance Committee	**Date:**	**16th January 2025**
Prepared By:	Manjeet Gill – Chair of Audit and Assurance Committee		
Approved By:	Manjeet Gill – Chair of Audit and Assurance Committee		
Presented By:	**Manjeet Gill** – Chair of Audit and Assurance Committee		
Purpose:			
		Assurance	**Substantial Assurance**

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Positive Assurance by management on the proposed actions for the Mental Capacity Act and Deprivation of Liberty Safeguards (Limited Assurance Audit Report). However, the Committee questioned the level of ongoing and visible assurance to Board considering the ongoing risks to patients and Trust.	Claire Page of 360 Internal Audit, reviewing governance in terms of our role in the ICS and system working. Further system wide audits, including Quality Impact Assessments. Clarity to be sought on whether the system-wide Quality Impact Assessment Group will report into SFH Quality Committee. Planning for 2025/26 Internal Audit underway with draft programme to be presented to March 2025 Committee for approval. Fire Safety Audit progressing and report by end of January. Review of Committee's Annual Workplan to enhance the reporting around losses and special payments to include focus on specific losses on a rolling basis such as pharmacy, workforce and bad debt write-off.

Positive Assurances to Provide	Decisions Made *(include BAF review outcomes)*
Substantial Assurance for: - The Internal Audit Progress report, 3 reviews in progress. - Register of Interests with a request to be made to those non-compliant to explain reason; - Progress with outstanding Internal Audit Actions (70% compliance on first follow-up); - Timely reviews of Non-Clinical Policies; - Single Tender Waivers (including positive results and impact of the No Purchase Order No Pay process); - Losses and Special Payment reports. Positive Assurance on: - Pharmacy waste and actions taken. - External audit progress report and note of change in system manager. - Annual Reports (including AGS), together with the Annual Accounts timetable and plan. - Risk Committee quadrant report. - No issues of internal controls were shared from the Board Sub-Committees.	**Escalate the MCA and DOLS assurance concerns to Board and to consider whether reporting and tracking should be via the Safeguarding Report to Quality Committee.** **Approved the Committee Maturity Assessment Action Plan** **Approved the Committee Effectiveness Self-Assessment** **Agreed that regular reports on pharmacy waste and other specific items be presented as part of the regular losses report on a rolling basis.**
Comments on effectiveness of the meeting	
Items recommended for consideration by other Committees	
Progress with Actions	
Number of actions considered at the meeting - 9 Number of actions closed at the meeting – 5 Number of actions carried forward – 4 (3 not yet due) Any concerns with progress of actions – No	

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

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

Subject:	Quality Committee	**Date**	**Monday 27th January 2025**
Prepared By:	Barbara Brady, Non-Executive Director/Chair		
Approved By:	Barbara Brady, Non-Executive Director/Chair		
Presented By:	Barbara Brady, Non-Executive Director/Chair		
Purpose:			
Assurance report to the Trust Board of Directors following the Quality Committee Meeting			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
- **Cardiology Deep Dive, good progress with some outstanding concerns remaining: Outpatient Follow-ups, Anaesthetic Support for Cardioversions and Right Sizing of Workforce. Actions are underway.** - **Requirement for formal visibility of progress on improvement plan relating to Mental Capacity and Deprivation of Liberty** - **Discussion regarding the ongoing challenge of how to avoid normalisation of actions taken over winter to respond effectively to unprecedented demand.** - **Ongoing issue of how QIA on changes are undertaken and reported at a system level. (Process for QIA at individual organisation level is not the issue**	- Cardiology- Further discussions re Clinical Nurse Specialist Workforce and Job Planning to ensure maximum nursing and medical engagement. - Escalation of MCA/DoLS limited assurance report to the ICB System Quality Committee for further review and discussion to be included within the quarterly report to the Quality Committee. - Further work commissioned to include visibility of System Quality Terms of Reference, Methodology and Meeting Minutes so this can feed into QC on a regular basis. - Reporting on the process and outputs from system wide QIA to feed into workplan of Quality committee - Further discussion to take place at Partnerships Committee regarding reporting on Health Inequalities in order to ensure quality of care aspects are considered at QC and partnership aspects at Partnership committee
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- All outstanding actions for QC 2024 were closed. - Assurance gained from the Cardiology Deep Dive and action underway. - Positive assurance gained from the Radiation Safety Committee Annual Report 2023/24 and notable changes to reporting structure.	- Quarterly Safeguarding Committee update to come to the QC to allow more visibility of MCS/DoLS. - Approval of the Quality Committee Annual Report ahead of presentation to the Board of Directors.

Further discussion to be held regarding applicability to the People Committee and assurance provision going forward. - Assurance gained against actions underway for the Limited Assurance Report into MCA/DoLS. - Positive Assurance gained from the Integrated Performance Reports for Timely and Quality care. - Positive assurance in relation to the update on wating times & impact of inequalities. - Positive Assurance gained from the PSC, NMAHP, Quality Strategy and PAC report to include the NHSR MIS Yr6 Position. - Positive Assurance in relation to the CQC update and NICE report. - Positive discussion held in relation to maintaining focus and oversight on quality of care & experience in pressurised services. Report to also be provided to the Board of Directors. - Updated noted on progress of actions relating to challenged/fragile services.	- Approval of the BAF Principal Risks; 1, 2 and 5 with no changes proposed to the current risk scores. Specific threat regarding maternity services a component of PR2 has been removed. - SAIU to be requested for BOD Development Session to deliver presentation relating to Demand Analysis.

Comments on effectiveness of the meeting

Really good meeting excellent level of reports provided, and healthy discussion held with valued input from the ICB.

Items recommended for consideration by other Committees

Partnerships and Community Committee- Frequency of Reporting Health Inequalities to Quality Committee to be agreed.

Progress with Actions

Number of actions considered at the meeting - 4
Number of actions closed at the meeting – 3
Number of actions carried forward - No actions were carried forward
Any concerns with progress of actions – No
If Yes, please describe –

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People Committee Chair's Highlight Report to Board

Subject:	Chair's Report	**Date:**	28th January, 2025
Prepared By:	Steve Banks Non-Executive Director		
Approved By:	Steve Banks Non-Executive Director		
Presented By:	Steve Banks Non-Executive Director		
Purpose:			
For Assurance			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• The Bi-Annual safe staffing report for Nursing, Midwifery and AHP's report contains concerns particularly in relation to Midwifery and AHP establishments. • Re-banding of Clinical Support Workers and National Job Matching Profiles for Nursing and Midwifery staff both carry significant financial and employee satisfaction risks	• People Strategy for 2025 – 2029 is on track for Board approval in April • Staff survey outcomes awaited • Action plan agreed to support staff and bring sickness levels back to target approved with a further update on actions at the March Committee • Improvements to Governance of FSTU agenda underway
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
There was much positive assurance provided including: • Maternity case ER lessons learned • Understanding of and action to clarify medical staff annual leave • FTSU governance improvements and report • Medical Workforce Bi-annual report.	The following decisions were made: • FTSU Cabinet TORs approved to tighten governance • BAF thoroughly discussed and agreed no change, however action to consider what circumstances would reduce the Principal Risk 3 from 20 to 16

Comments on effectiveness of the meeting
No observer present, but papers were of good quality, as was the debate
Items recommended for consideration by other Committees
Finance Committee have already seen papers on re-banding and job matching profiles
Progress with Actions
Number of actions considered at the meeting - 3 Number of actions closed at the meeting – 3 Number of actions carried forward - 0 Any concerns with progress of actions – NO If Yes, please describe –

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

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Charitable Funds Operational Group Chair's Highlight Report to Charitable Funds Committee

Subject:	Charitable Funds Committee update	Date:	21 January 2025
Prepared By:	Andrew Rose-Britton		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose:			
To provide an overview of the key discussion items from the Charitable Funds Committee on the 21 January 2025.			

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
Hospital Charity Lottery timeline and initial outlay.	End-of-life work for two wards being started. Hospital lottery progressing well, initial draw planned for May 2025. Payroll giving progressing.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Community Involvement Headline report. Update on End-of-Life project. Charity development and future fund-raising activities. Financial position. Investment update.	The request for 36 Pain drivers at a cost of £44K was approved (to support end-of-life patients). To continue to report Charitable Funds continue to be reported in non-consolidated form in the Trust's Annual Report and Accounts. To renew membership of "NHS Charities Together". To invite Rathbones, investment advisors, to review the Charites investment strategy at the June 2025 Corporate Trustee meeting. CF Committee meeting in July 2025 to be held in person.
Comments on effectiveness of the meeting	
Good challenge and discussion around key items. Reports well researched and presented.	
Items recommended for consideration by other Committees	
Corporate Trustee meeting: To recommend the Trust continues to report Charitable Funds in non-consolidated form in the Trust's Annual Report and Accounts.	

Progress with Actions
Number of actions considered at the meeting - 3 Number of actions closed at the meeting – 3 Number of actions carried forward - 0 Any concerns with progress of actions – No (actions progressing but not yet closed) If Yes, please describe

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

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Partnership and Communities Committee Chair's Highlight Report to the Trust Board

Subject:	Partnership and Communities Highlight Report	**Date:**	21st January 2025
Prepared By:	Barbara Brady, Non-Executive Director/Chair		
Approved By:	Barbara Brady, Non-Executive Director/Chair		
Presented By:	Barbara Brady, Non-Executive Director/Chair		
Purpose:			
Assurance report to the Board of Directors			

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
At a system level some services which are bring delivered collaboratively are being subjected to a review process with little detail or understanding how decisions will be made in the context of system impacts e.g. MSK Transformational change in the system is currently not evident in plans, particularly concerning in the light of our need to achieve sustainability Continuing concerns regarding resources to support collaboration and governance arrangements e.g. Nottinghamshire Healthier Together	Plan of work for Health Inequalities agreed and scheduled for feedback at April's committee meeting Ongoing development of the Partnership canvas which is seeking to capture and understand all the partnerships the Trust is currently involved with. The next version will include explicit cross reference to the 10 yr plan Revision of terms of reference to ensure these capture how each of the strategic objectives are supported by collaboration/partnership work
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Partnership approach to sustainable Stroke services Clear priorities for Health inequalities work and support plan of action Partnership plan development Role of SFHT as Anchor organisation particularly with regard to workforce/people aspects	Approval of the BAF with no changes recommended to the score for PR6

Comments on effectiveness of the meeting
Good discussion enabled by papers
Items recommended for consideration by other Committees
People/workforce aspects of Anchor work
Progress with Actions
Number of actions considered at the meeting - 3 Number of actions closed at the meeting – 3 Number of actions carried forward - 0 Any concerns with progress of actions – No If Yes, please describe –

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