MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 2nd May 2024**
Time: **09:00 – 12:45**
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 4th April 2024** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Action Tracker**	Update	Enclosure 5
6.	09:10	**Chair's Report**	Assurance	Enclosure 6
7.	09:15	**Chief Executive's Report**	Assurance	Enclosure 7
	Strategy			
8.	09:25	**Governance Approach to Strategy Delivery for 2024-2025, incorporating 2023/2024 Q4 Strategic Priorities Close Down** Report of the Interim Director of Strategy and Partnerships	Assurance	Enclosure 8
9.	09:40	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity Update** Report of the Director of Midwifery o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 9.1
10.	09:55	**Strategic Objective 3 – Empower and support our people to be the best they can be** • **Nursing, Midwifery and Allied Health Professions (AHP) Staffing 6 monthly report** Report of the Chief Nurse • **Medical Workforce Staffing – 6 monthly report** Report of the Medical Director	Assurance Assurance	Enclosure 10.1 Enclosure 10.2

	Time	Item	Status	Paper
11.	10:25	**Patient Story – Family Liaison – Supporting our patients** Emma Mutimer Hallgarth, Divisional Patient Experience Lead	Assurance	Presentation
	BREAK (10 mins)			
	Operational			
12.	10:55	**Integrated Performance Report (IPR)** Report of the Executive Team	Approve	Enclosure 12
	Governance			
13.	11:40	**Use of the Trust Seal** Report of the Director of Corporate Affairs	Assurance	Enclosure 13
14.	11:45	**Fit and Proper Person Test update** Report of the Director of Corporate Affairs	Assurance	Enclosure 14
15.	11:50	**Provider Licence Self-certification declaration** Report of the Director of Corporate Affairs	Approval	Enclosure 15
16.	12:00	**Committee Effectiveness Reviews** Report of the Director of Corporate Affairs	Assurance	Enclosure 16
17.	12:05	**Standing Financial Instructions (SFI) and Scheme of Delegation** Report of the Chief Financial Officer	Approval	Enclosure 17
18.	12:10	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) o Audit and Assurance Committee Annual Report • Finance Committee Report of the Committee Chair (last meeting) o Finance Committee Annual Report • Quality Committee Report of the Committee Chair (last meeting) • Partnerships and Communities Committee Report of the Committee Chair (last meeting)	Assurance Assurance Assurance Assurance	Enclosure 18.1 Enclosure 18.2 Enclosure 18.3 Enclosure 18.4
19.	12:30	**Outstanding Service - The Discharge Lounge - Getting our patients home safer and faster**	Assurance	Presentation
20.	12:35	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
21.	12:40	**Any Other Business**		
22.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **6th June 2024, Boardroom, King's Mill Hospital**		
23.		**Chair Declares the Meeting Closed**		

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

Board of Directors Information Library Documents

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

Enc 16	• **Committee Effectiveness Review – Audit and Assurance Committee**
Enc 16	• **Audit and Assurance Committee - TOR**
Enc 16	• **Audit and Assurance Committee – Workplan**
Enc 16	• **Committee Effectiveness Review – Finance Committee**
Enc 16	• **Finance Committee – TOR**
Enc 16	• **Finance Committee – Workplan**
Enc 16	• **Committee Effectiveness Review – Quality Committee**
Enc 16	• **Quality Committee – TOR**
Enc 16	• **Quality Committee - Workplan**
Enc 16	• **Committee Effectiveness Review – People Committee**
Enc 16	• **People Committee – TOR**
Enc 16	• **People Committee - Workplan**
Enc 16	• **Charitable Funds Committee – TOR**
Enc 16	• **Charitable Funds Committee – Workplan**
Enc 16	• **Partnerships and Communities Committee – TOR**
Enc 16	• **Partnerships and Communities Committee - Workplan**
Enc 18.1	• **Audit and Assurance Committee – previous minutes**
Enc 18.2	• **Finance Committee – previous minutes**
Enc 18.3	• **Quality Committee – previous minutes**
Enc 18.4	• **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 4th April 2024, in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Graham Ward	Non-Executive Director	GW
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Andrew Rose-Britton	Non-Executive Director	ARB
	Barbara Brady	Non-Executive Director	BB
	Aly Rashid	Non-Executive Director	AR
	Neil McDonald	Non-Executive Director	NM
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	David Selwyn	Medical Director	DS
	Richard Mills	Chief Financial Officer	RM
	Rob Simcox	Director of People	RS
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Claire Hinchley	Deputy Director of Strategy and Partnerships	CH
	Phil Bolton	Chief Nurse	PB
	Rachel Eddie	Chief Operating Officer	RE
In Attendance:	Paula Shore	Director of Midwifery	PS
	John Tansley	Clinical Director for Patient Safety	JT
	Alison Steel	Head of Research and Innovation	AS
	Lauren Brown	Matron	LB
	Sue Bradshaw	Minutes	
	Jess Baxter	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Joanne Wright	Divisional General Manager – Medicine Division	
	Ian Holden	Public Governor	
	Jamie Waller	Notts TV	
	2 members of the public		
Apologies:	None		

Item No.	Item	Action	Date
24/100	**WELCOME**		
1 min	The meeting being quorate, CW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
24/101	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
24/102	**APOLOGIES FOR ABSENCE**		
1 min	There were no apologies for absence.		
24/103	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 7th March 2024, the Board of Directors APPROVED the minutes as a true and accurate record.		
24/104	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/007, 24/042.1, 24/042.2 and 24/081.2 were complete and could be removed from the action tracker. *Action 24/081.1* – RM advised the NHS England (NHSE) report, outlining the growth in productivity, has been circulated to members of the Board of Directors and will be discussed at the April meeting of the Finance Committee.		
24/105	**CHAIR'S REPORT**		
1 min	CW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective, highlighting the work of the Trust's volunteers and support from the local community. The Board of Directors were ASSURED by the report.		
24/106	**CHIEF EXECUTIVE'S REPORT**		
23 mins	PR presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective, highlighting the high levels of demand within ED, noting the good performance in relation to ambulance handover times and an improvement in ED 4-hour wait performance despite the pressures, Quarter 3 Segmentation review, opening times		

	for the Urgent Treatment Centre (UTC) at Newark Hospital, industrial action update, Step Into The NHS event at West Notts College, entry into the pre-election period and the marking of Overseas NHS Workers Day. AR noted the 10% increase in ED attendances during February and March 2024, compared to the equivalent period in 2023, and queried what work has been undertaken in conjunction with the Integrated Care System (ICS) to identify the drivers for the increase. PR advised discussions have taken place through the A&E Delivery Board and there has been an increased focus on A&E waiting times during March 2024. RE advised this is an ongoing conversation. A deep dive into ED attendances was presented to the Finance Committee in February 2024 and the report was shared with members of the Board of Directors. Discussions are ongoing in relation to different approaches which can be taken by primary care. In addition, RE advised she is due to meet with the ICS and East Midlands Ambulance Service (EMAS) in relation to the 'drift' of ambulances to the Trust. AR queried if a formal audit had been completed, looking at cases and identifying patients who should have been seen by primary care, rather than in ED. Noting the ICS is paying for primary care services to be contracted in a certain way, there is a need to ensure that is the right model. RE advised an audit has been completed, but not recently. NEMS are providing the Primary Care (PC24) service at the 'front door' at King's Mill Hospital. Patients do attend ED, who could be dealt with elsewhere, but they are quickly streamed into PC24. PR advised, for the King's Mill site, the streaming into PC24 ensures the inappropriate presentations that were diverted from primary care, do not reach the ED pathway. DS advised the Trust has shared service data with the Primary Care Networks (PCNs) and the Primary Care Lead. Nigel Marshall, Adviser to the Medical Director at SFHFT, is undertaking some work looking at the interface between primary and secondary care. NM referenced the Quarter 3 (Q3) Segmentation Review letter from the Integrated Care Board (ICB), noting in the section about preventing ill health and reducing inequalities, there is an implication the Trust is reducing input into committees and, therefore, not enabling them to undertake system approaches to addressing inequalities. NM sought further information in relation to this. PR advised this is not recognised by the Trust, noting there may have been instances in Q3 when the Committee met and the Trust was unable to provide a participant. DS advised the Trust has a strong presence on the Health Inequalities Committee and is a substantial component of the Committee. BB felt the letter from the ICB draws out the different aspects of what will be a difficult year ahead. PR advised there is an opportunity for further discussion at the Board to Board meeting with the ICB in June 2024.		

	AH sought further information in relation to the comments in the people section of the ICB letter regarding surveys which have indicated reduced satisfaction with training and potential identification of bullying and harassment concerns. DS advised it is unclear if this refers to the General Medical Council (GMC) survey or a local survey. The Trust has a good record in terms of training and issues relating to bullying and harassment are flagged up. This is a constant focus and there is no evidence there is a problem. PR advised there are some points in the letter which require clarification in terms of data sources. This will be followed up with the ICB, with a request for the data sources to be clarified in the Q4 segmentation letter. **Action** • **Data sources in the ICB Quarter 3 Segmentation Review letter to be clarified.**	**PR**	**02/05/24**
	CW noted the comment in the Q3 Segmentation letter in relation to progress which is being made in terms of staff in senior leadership roles from a Black and Minority Ethnic (BME) background and felt it would be useful for the Board of Directors, and the wider public, to be sighted on what action is being taken. RS advised a report will be provided to the People Committee, who will then report back to the Board of Directors. **Action** • **Report to be provided to the People Committee in relation to the actions being taken to address diversity within the Trust, particularly people in senior leadership roles.**	**RS**	**06/06/24**
	NM noted the Trust has good plans in place for periods of strike action, but felt an area of concern is any action which is short of strike action as this may affect overtime, cross-cover, withdrawal of co-operation, etc. NM queried what plans the Trust has in place for this, noting there is a need to think differently. DS advised the Trust is awaiting information from the British Medical Association (BMA) as to what form future industrial action will take. PB advised the principles are similar when planning for any form of industrial action, for example, what activity cannot be continued, what needs to be stepped down, etc. RE reflected the most difficult period of strike action to date was when strike action by the consultants and junior doctors overlapped. AR queried if the costs of industrial action can be costed out in advance. PR advised the level of disruption and impact cannot be determined until it is known what form the industrial action will take. The Trust will look at each rota and how this will be covered. The same process used in previous periods of action will be followed to understand which shifts will be covered appropriately. BB expressed concern in relation to the training implications of continued industrial action.		

	DS advised the Trust has raised this issue locally and nationally. It was noted competencies are not time based. In addition to the impact on trainees, there will be an impact on specialist surgeons who have lists cancelled. CW expressed concern there is no apparent appetite to address this issue nationally. DS advised it is unclear if the issue is being considered nationally as no information is being fed back to trusts. DS advised he is not aware of any of the Royal Colleges reporting a difference in their pass rate. The Board of Directors were ASSURED by the report.		
24/107	**STRATEGIC PRIORITIES 2023/2024 QUARTER 3 UPDATE**		
11 mins	CH presented the report, which provides an update on progress at the end of Quarter 3, noting 17 priorities are on track and six priorities have actions underway to address delivery delays. A final update for 2023/2024 will be provided to the May meeting of the Board of Directors, including a close down of the 2019-2024 Trust Strategy. Not all of the 2023/2024 priorities will be closed by Quarter 4, as some continue to be a priority over multiple years. The approach to strategy delivery for 2024/2025 will be discussed at the Board of Directors workshop on 25th April 2024. NM queried if the objectives which require further work link into the ratings outlined in the ICB Quarter 3 Segmentation Review letter. PR advised there is some crossover. This report details the Trust's priorities for 2023/2024, as agreed at the start of the year. Some of these relate to the delivery of performance objectives and requirements from the planning guidance and others are priorities which were internally deemed to be important. These may also have been nationally reported indicators and, therefore, are picked up in the segmentation letter. ARB noted little progress has been made over the past three quarters in relation to medical workforce transformation and queried what actions are being taken to improve this position. GW noted work towards a sustainable model of urgent and emergency care and work to recover planned care services are also off track. CH advised, in terms of medical workforce transformation, there has been a focussed workstream in place over the past 6 months which is starting to put enabling actions in place which will start to reduce the use of temporary staffing and move towards greater substantive staffing. This is starting to make progress. An Improvement Cabinet has been established which will maintain the focus on this area. This is linked into how fragile services are managed. RE advised the Trust has delivered on the majority of actions set in terms of elective recovery and urgent care. However, progress has be thrown off track by periods of industrial action and the huge growth in demand for emergency care. Therefore, the anticipated outcomes have not come to fruition, despite being on track with the actions taken.		

	MG queried, in terms of working with ICB partners to reduce health inequalities, if the ICB Health Inequalities Investment and Innovation Fund remains paused. PR advised the pause on distributing further funds was for 2023/2024. The fund will continue as originally planned for 2024/2025. MG queried if the fund is available for 2024/2025, are there any agreed proposals for utilising the funding. CH advised the plans which were in place for 2023/2024, which were not funded while the funding was paused, will continue into 2024/2025. However, there will be no new schemes. The Health Inequalities Group will work up the cases for the next funding round. AH sought clarification on the close down process for the Trust's strategic objectives for 2023/2024. CH advised this will be discussed at the Board of Directors workshop on 25th April 2024. Work is underway to determine how the priorities from 2023/2024, which need to continue, will link into 2024/2025. The Board of Directors were ASSURED by the report.		
24/108	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
32 mins	PS joined the meeting. **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting the reintroduction of enabling birthing partners to stay overnight on the unit, introduction of the CardMedic translator app, NHS Resolution (NHSR) submission and the Saving Babies Lives Care Bundle. PS highlighted the Score Survey and Staff Survey. BB queried what feedback has been received from patients using the CardMedic translator app. PS advised patient feedback is being collated. Feedback from staff is that the app provides a rapid translation service. The app is not replacing face to face translation for planned appointments, but is a very useful tool in instances of unplanned activity. The app is very easy to use and the Trust is exploring if the app could be rolled out into different areas. The Board of Directors were ASSURED by the report. ***Maternity Perinatal Quality Surveillance*** PB presented the report, highlighting staffing and a reduction in massive obstetric haemorrhage. NM noted the upward trend in the number of maternity incidents resulting in low or no harm and queried if this was an area of concern. PS advised the Trust has a robust method in place for incidents to be reviewed. The increased number of incidents is partly due to increased activity. There has been no increase in moderate harm. Examples of incidents resulting in low or no harm are cases where additional		

	treatment was required or there was some area of learning. If an increase in the number of incidents resulting in moderate harm, or higher, became evident, a deep dive would be undertaken. PB advised the Trust is encouraging staff to report incidents, noting over the last two months there has been an increase in people reporting increased activity or staffing gaps. This helps to identify the mitigating actions which were taken, which in turn demonstrates to staff they have been listened to. NM queried, if the increase is due to better reporting, were incidents happening previously which were not reported. PB acknowledged there is a tendency to under-report across all areas. There is a need to ensure any issues are not normalised. PS advised there is a drive within maternity to provide feedback to staff and there are clear reporting mechanisms in place to enable this. PS advised she was confident the 'right things' are being reported and there is good staff engagement. Reporting of incidents enables any themes and trends to be identified, alongside service user feedback and staff feedback from surveys. This helps to identify areas requiring improvement. SB queried what the wait time is for an emergency caesarean section. PS advised there is a national standard for caesarean sections and they are categorised from 1-4, with Category 1 being within 30 minutes from the decision to deliver to the baby being born and Category 4 being elective caesarean sections. For reporting purposes the focus is on Categories 1-3. Any caesarean section which is performed outside of the timeframes is reported on Datix and the Trust puts all Category 1 caesarean sections on Datix to ensure monitoring of the time thresholds. PS advised she could recall two cases which were slightly out of timeframe, but this was by minutes due to the complexity of the case. There was no extended delay to delivery. AR noted third and fourth degree tears had increased in month and queried what action was being taken to address this. PS advised monthly reviews are undertaken and cases are reported on Datix. Consideration is given to the mode of birth, any ongoing complications, etc. All the patients have been reviewed and there was no or low harm. All the women are followed up by the Physiotherapy Service and there is ongoing care built in. If any concerns are identified in the future, the case would be revisited. Tears are a known outcome of obstetric care. CW queried if cases could be tracked over a period of time to provide assurance there are no long term issues. PS advised these women are also followed up by a neuro gynaecology obstetrician. Methods of performing an audit of ongoing appointments could be considered. PR queried if any harm identified through ongoing outpatients appointments would be recorded on the maternity incidents section of the Maternity Perinatal Quality Surveillance Scorecard. PS advised it would be raised as a new incident within the Gynaecology Service, rather than being reported as a maternity incident.		

	Action • **Method for tracking cases of third and fourth degree tears for any ongoing harm to be developed.** BB queried if an evaluation of the impact made by the establishment of the Lower Pelvic Floor Team has been completed. PS advised the Team has only just taken up post. PB advised the Team will report into the Maternity Assurance Committee once established. A report can be provided to the Quality Committee in approximately 4 months when data is available. **Action** • **Report to be provided to the Quality Committee in relation to the work of the Lower Pelvic Floor Team, particularly the impact of their work on third and fourth degree tears.** SB noted the maternity updates provided the Board of Directors with a deep dive into one area of the Trust's activity and queried if similar assurance relating to other services was provided to the Quality Committee. CW advised there has been a national focus on maternity services, resulting in the requirement for the Board of Directors to be sighted on the performance of the Maternity Service. PB advised it is a statutory requirement for updates on the Maternity Service to be provided directly to the Board of Directors. The Quality Committee workplan will be reviewed to ensure assurance is provided on other key areas. **Action** • **Quality Committee workplan to be reviewed to ensure appropriate assurance is provided on key services.** ARB noted the increasing activity levels and queried if the 'tipping point' is being reached in terms of resources being stretched too far. PS advised this is under constant review. The Birthrate Plus tool is aligned to the Trust's staffing model and the Trust is over-recruiting to posts due to a significant amount of maternity leave in maternity and neonatal services. Postcode data is being monitored. The Trust does still have capacity. However, an area of concern is when the Trust recently had a suspension of service, no other units were able to provide support. Therefore, there is a need to create a sustainable model at SFHFT. BB noted the Trust is currently at 80% of interventions implemented for Element 1 (Smoking) of Version 3 of the Saving Babies Lives Care Bundle. Noting the good work the Trust has undertaken in relation to smoking cessation, BB felt this figure would be higher. PS advised the requirement is to be over 70% compliant. Each month the Local Maternity and Neonatal System (LMNS) undertake an assessment of the Trust. The difficulty relates to the reporting of smoking. Therefore, this does not relate to the work the Trust is undertaking, but relates to the national standards for reporting, monitoring and how the data is collated.	**PB** **PB** **PB**	**02/05/24** **01/08/24** **06/06/24**

	NM noted the Trust is currently over-recruiting, based on a high absence rate within the Maternity Service, and queried what the expected acceptable absence rate is. PS acknowledged the rate of maternity leave is currently higher than expected. There is a need to consider the workforce profile of the service, which is currently an all female workforce and 65% of the workforce are aged under 30. Therefore, this leads to a higher likelihood of staff taking maternity leave. The Trust standard is a 0.5% uplift in the establishment figures for maternity leave, but there is a need to consider the workforce profile. This will be an ongoing challenge and while the interim steps are in place, there is a need to consider how this is managed in the longer term. NM sought clarification on what percentage of the absence is due to maternity leave and what is due to other reasons. PS advised the majority of absence is due to maternity leave. Shorter term sickness is managed through the use of bank staff. In terms of managing and helping to prevent longer term absences, pastoral support is in place and the Team has open access to clinical psychologists, noting maternity is a difficult area to work in. CW queried the use of the word 'ambition' when referring to the stillbirth rate. PS advised this relates to the national stance of reducing stillbirths and neonatal deaths by 2025 and is demonstrating the Trust is currently below the national threshold. The Board of Directors were ASSURED by the report. PS left the meeting.		
31 mins	**Learning from Deaths** JT joined the meeting DS presented the report, highlighting Summary Hospital-Level Mortality Indicator (SHMI), Hospital Standardised Mortality Ratio (HSMR), key clinical review into fractured neck of femur, 'surrogate' markers of improvement in relation to documentation and coding, the work of the Medical Examiner, Structured Judgement Review (SJR) process, Learning Disabilities Mortality Review (LeDeR) data, learning from coronial processes, increase in coronial work and changes to some coding by Dr Foster. SB sought clarification in relation to the process for cases being referred to the Coroner and queried if all cases referred to the Coroner result in an inquest, noting there were approximately 130 coronial matters in 2023. DS advised there are some deaths which have to be referred to the Coroner, for example, deaths resulting from trauma, industrial related disease, etc. In addition, if a clinician has any concerns about a case, these can be referred to the Coroner. Medical examiners will also make referrals to the Coroner, particularly if any concerns are raised by the family.		

	SB queried if the reason for the increase in coronial matters is known. DS advised this may be due to a number of factors, noting the appointment of a new Coroner in 2011, change to the coronial law system in 2013 and appointment of medical examiners in 2019/2020. This information has been shared with the Coroner, who has expressed the view the current caseload is what she should be seeing, noting this was not the case previously. MG noted the Trust has been issued with a Regulation 28 (Prevention of Future Deaths) Order, following a referral to the Coroner, and sought further information in relation to this. DS advised this is the legal Order by which the Trust has to answer any queries raised by the Coroner. There are usually a small number of specific points raised. The case referenced in the report relates to a patient who had Necrotising Fasciitis, which is a rare and difficult to diagnose condition. There were two questions raised, relating to developing and embedding Trust-wide Necrotising Fasciitis guidelines and mechanisms for 'sieving' medical facts and directing them to clinicians. NM noted the HSMR position is gradually improving and queried how this could be accelerated. DS advised HSMR is a rolling 12-month trend and, therefore, it will take some time to work through. However, there has been in an improvement in four out of the past six months. NM queried what positive actions have been taken over the past four months which have led to the improved position, and what additional actions can be taken to improve this position further. JT advised, given the current method for calculating HSMR, it is never going to be 100, unless the way palliative care services operate within the ICB are significantly changed. The Trust is making good progress in the areas which it can control, for example, the quality of the documentation. It was noted there is a complicated algorithm, with many factors, which produces the figures. There are strict rules relating to the coding of palliative care and a specialist palliative care doctor has to be involved in the patient's care in order to use this coding. The number of specialist palliative care doctors is limited. There are no concerns about the quality of end of life care, but it cannot be coded as such. The evidence from the SHMI is that deaths are within the as expected range. BB noted one of the variables in the algorithm relates to the fact the Trust serves a community with high levels of multiple deprivation and queried if using the index of multiple deprivation, instead of comorbidities coding, would resolve some of the issues. DS advised this is what Dr Foster are changing. BB queried if Dr Foster, or whichever provider is used going forward to provide the data, will look back and recalculate the figures based on the new algorithm so the Trust can see an accurate trend based on the current understanding of the variables. DS advised there are risks associated with changing the supplier of the data, as it will change the figures. It is not clear what the revised algorithm from Dr Foster will generate.		

	JT advised the procurement process is ongoing. The requirement to undertake a 'look back' can be added to the specification in order to generate accurate trend data. AH advised there is a clear relationship within the Trust between comorbidity coding and the HSMR, as measured by Dr Foster. AH noted the two coronial cases referenced in the report and queried if they were flagged up by the SJR process or the Medical Examiner and, if so, was the Quality Committee sighted on those cases. JT confirmed the paediatric case was reported to the Quality Committee. It was noted the coronial process lags significantly behind the Trust's internal process, hence actions being in place for both of these cases before the coronial process concluded. DS confirmed he had had brought both of these cases to the attention of the Board of Directors. The Board of Directors were ASSURED by the report. JT left the meeting.		
24/109	**STRATEGIC OBJECTIVE 2 – EMPOWER AND SUPPORT OUR PEOPLE TO BE THE BEST THEY CAN BE**		
9 mins	**Staff Survey** RS presented the report, highlighting response rate, performance in relation to the People Promise themes, regional and national benchmarking, next steps and support available to leaders. RS advised actions and progress will be tracked through the People Committee. SB confirmed the Staff Survey results and next steps have been discussed by the People Committee. There are some consistent themes which need to be an area of focus. AH left the meeting. ARB queried if there were any 'hotspots' within the organisation in terms of people who had not completed the survey. RS advised this is part of the ongoing analysis which is underway, which is also considering the correlation between the survey being received in paper or electronic format, staff groups, etc. Early indications are there was a better response rate where staff received the survey as a hard copy. This might be an area of learning to take forward for the next survey. GW noted staff experiencing physical violence is acknowledged, but felt emotional violence should also be noted. GW felt actions relating to leadership should be higher up the list of next steps being taken. BB queried how the results of the staff survey triangulate with information available from other sources. RS advised a heatmap is being developed, which will capture this triangulation. This will be discussed at June meeting of the People Committee. The Board of Directors were ASSURED by the report.		

24/110	**STRATEGIC OBJECTIVE 4 – CONTINUOUSLY LEARN AND IMPROVE**		
24 mins	AS joined the meeting. **Research Strategy – Annual Report** AS presented the report, highlighting recruitment, commercial research activity, finance, patient experience and progress against objectives, particularly the issues in relation to securing space for a Clinical Research Facility. GW felt it important to secure accommodation for the Clinical Research Facility as soon as possible. GW noted the expressions of interest (EOIs) which have to be submitted in relation to commercial research and felt it may be useful to approach a trust which has been successful in securing commercial work to critique SFHFT's EOIs. AS advised there has been an independent review of the Trust's EOIs by Chesterfield Royal Hospital and Northampton General Hospital, but acknowledged it may be useful to look at their EOIs. GW queried if there are any opportunities to work jointly with Chesterfield Royal Hospital. AS advised there has previously been a joint post between SFHFT and Chesterfield Royal Hospital in relation to midwifery research. RM advised the development of the new Clinical Research Facility was approved by the Finance Committee in December 2023. However, this has not progressed for several reasons. A different space has been identified. Noting the Board of Directors has committed to developing the Clinical Research Facility, AS should attend the space utilisation meeting on 7th April 2024 with the backing of the Board of Directors. MG sought assurance in relation to how research studies are selected in order to provide benefits for the Trust's patients and the local population. AS acknowledged impact on the local population of the research activities the Trust participates in is not always evident. However, the Trust is part of the ICS Research Partners Group and, therefore, research at the Trust is not standalone. Work is ongoing to look at how research is delivered across the system, part of which is looking at what patients see as important and then supporting people to develop studies. DS advised the Trust was significantly involved in Covid platform trials, which made a huge impact. The Board of Directors were ASSURED by the report. AS left the meeting		
24/111	**PATIENT STORY – THE COMMUNITY DIAGNOSTIC CENTRE – REDUCING WAITING TIMES FOR PATIENTS**		
10 mins	LB joined the meeting. LB presented the Patient Story, which highlighted the services currently being offered at The Community Diagnostic Centre (CDC).		

	CW queried how the Trust is ensuring the services being offered by the CDC are communicated to primary care, particularly GPs. LB advised she is working with the Communications Team to ensure the Trust keeps in contact with local partners, posters are displayed in GP surgeries, etc. Accelerated activity is also being offered at Newark Hospital, which has been very well received. BB queried how the Trust can ensure GPs do not stop providing their own in-house service and refer all patients to the CDC. LB advised this was already happening, noting at busy times there were queues within Clinic 3 at King's Mill Hospital. The Trust has tried to address this by offering an appointment system, alongside the walk-in offer, and working with GP practices to ensure they are seeing their patients where possible. LB left the meeting.		
24/112	**CLINICAL SERVICES STRATEGY**		
15 mins	DS presented the report, advising this is the first Clinical Services Strategy developed by the Trust. DS advised he was pleased with the messages and direction contained within the Strategy. The Strategy will lead to the Trust being more 'forward facing' and considering pathways not specialities, systems not organisations, the roll of the Trust in the community, health inequalities and innovation. Progress against the Strategy will be monitored and tracked via the Quality Committee. CH advised the development of the Strategy had been clinically driven. The Strategy will be owned by the Quality Committee. It is important to ensure all the sub-strategies link together. ARB queried who the Strategy will be promoted to. DS advised the overall Trust Strategy is for everyone and the Clinical Services Strategy is primarily for internal colleagues. This will be used as a sub-strategy to drive the change required to deliver the overall strategy. However, the Clinical Services Strategy will be shared with partners, particularly primary care colleagues. GW expressed the view it is unclear what the Strategy will deliver, what difference it will make and how success will be measured. NM felt the sub-strategies should contain the measurables, but felt this Strategy is more descriptive of the actions the Trust will take, rather than including the measures of success. DS advised this is how the Strategy had been designed, acknowledging there is more work to do in terms of dovetailing with other strategies. NM queried how updates on all strategies will be reported to the Board of Directors in a tangible way. CH advised this will be discussed at the Board of Directors workshop on 25th April 2024. BB felt the Strategy sets the direction of travel, noting the messages in relation to working outside of hospital walls.		

	MG felt the Strategy is a good document and sought assurance it will be deliverable. It is good to see the co-production. The Strategy sets the foundation, with the next step being to take evidence of need and developing that into tangible deliverables. DS advised engagement and co-production is the key to success. AH re-joined the meeting. PR advised this Strategy is a good starting point, and articulates the guiding principles and how, from a clinical services perspective, the overall Trust strategy will be delivered. PR acknowledged there is more work to do in terms of understanding the detail. The Strategy sets the tone internally for clinical services, but also demonstrates to external partners what the Trust's future direction is. The interface between primary and secondary care needs to be more effective and this Strategy will lead to conversations in relation to what the Trust expects collaboration to 'look like'. MG queried if the Trust has had sight of the ICS Clinical Strategy. DS advised there is no ICS Clinical Services Strategy in Nottinghamshire. The Board of Directors APPROVED the Clinical Services Strategy.		
24/113	**ANNUAL SIGN OFF OF DECLARATIONS OF INTEREST**		
7 min	SBS presented the report, advising Declaration of Interests is an annual requirement and the report reflects the work done during 2023/2024. The conflicts of interest register will be published on the Trust website and will include details of people who have registered an interest, people who have made nil declarations and details of people who are non-compliant. For 2023/2024 51 people are non-compliant, of 1,137 staff who are required to declare an interest. SBS highlighted the actions being taken to improve the position through 2024/2025, noting the requirement for Declarations of Interest to be completed by colleagues each year. MG advised the Audit and Assurance Committee monitors compliance with Declarations of Interest throughout the year. The Committee have asked for the single tender waiver template to be amended to identify any potential conflict of interest and for work to be undertaken to identify any other processes where there is potential for a conflict of interest. The Board of Directors APPROVED the annual Declarations of Interest report.		
24/114	**ASSURANCE FROM SUB-COMMITTEES**		
23 mins	**Audit and Assurance Committee** MG presented the report, highlighting single tender waivers and outstanding internal audit actions. The Board of Directors were ASSURED by the report.		

	Finance Committee GW presented the report, highlighting review of Board Assurance Framework (BAF) Principal Risk 8 (PR8 - Sustainable use of resources and estates), Month 11 financial position, risks in relation to income, capital expenditure, deep dive into the Financial Improvement Programme (FIP) and draft Financial Strategy. RM advised the CDC funding of £5.5M for 2023/2024 is unlikely to be received and, therefore, this will need to be reflected in the Month 12 accounts. The issue relating to the Derbyshire contract remains under negotiation at ICB level. DS queried if there is an opportunity to review the FIP process at an earlier time. GW advised work has been ongoing, but a deep dive has now been requested to help achieve something which is sustainable and deliverable. The deep dive will include an in depth look at the Trust's workforce. FIP should be an ongoing, rolling programme. ARB queried if there had been any response from the ICB in respect of funding for the CDC. RM advised this issue would affect the final financial outturn for SFHFT and Nottingham University Hospitals (NUH). It is disappointing the funding is not forthcoming, noting this is capacity the Trust has had in place for the benefit of patients in Nottinghamshire. CW acknowledged the capacity has been a benefit to patients. However, the Trust was expected to deliver the early benefits as a condition of bringing the CDC forward. The Trust took a financial risk putting the capacity in place and the funding has not been received. GW advised this issue has been flagged up and verbal assurance had been received, although nothing was received in writing. CW felt there is a wider challenge to reflect back to NHSE in terms of if there is a request to bring something forward which involves the Trust taking a financial risk, this needs to be followed through. **Action** • **The views of the Board of Directors in relation to the CDC funding issues to be fed back to NHSE.** The Board of Directors were ASSURED by the report. **Quality Committee** AR presented the report, highlighting Integrated Performance Report (IPR) timely care update, Patient Safety Incident Response Framework (PSIRF) report and review of BAF PR1, PR2 and PR5. The Board of Directors were ASSURED by the report. **People Committee** SB presented the report, highlighting Staff Survey, Violence and Aggression Improvement Plan, Gender Pay Gap report and review of BAF PR3.	**PR**	**02/05/24**

	MG queried if any work is underway in relation to the global competitiveness of recruitment. RS advised approaches to recruitment and retention is an item on the work plan for the People Committee. RS acknowledged there are ongoing external factors and it is a very competitive market. There is a need to utilise the Staff Survey as a principle of attraction. Recruitment to consultant roles over the past 12 months has been an improvement on previous years. CW felt it would be useful for data on retention rates to be reported, particularly international staff. SB advised the Committee received a report in relation to information obtained via exit interviews and also conversations with staff who were thinking of leaving the organisation. RS advised the Trust has secured national funding to support some of the People Promise exemplar work. PB advised the bi-annual staffing report was presented to the People Committee, which prompted a discussion in relation to retention of international staff. AR queried if the Trust could use its foundation trust status to insist newly recruited staff, particularly overseas recruits, remain with the Trust for a certain period of time. RS advised he would need to look into this carefully. **Action** • **Clarify if the Trust can use its foundation trust status to insist newly recruited staff, particularly overseas recruits, remain with the Trust for a certain period of time.** The Board of Directors were ASSURED by the report.	**RS**	**02/02/24**
24/115 4 mins	**OUTSTANDING SERVICE – MATERNITY SERVICES - WELCOMING PARTNERS AND SUPPORTERS TO STAY OVERNIGHT** A short video was played highlighting the provision for partners and supporters to stay overnight in the Maternity Unit.		
24/116 1 min	**COMMUNICATIONS TO WIDER ORGANISATION** The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Staff Survey results. • Development and success of research activity. • Development of the Community Diagnostic Centre and the impact on waiting times this will provide. • Approval of Clinical Services Strategy. • Requirement to complete annual Declaration of Interests. • Initiative to allow birthing partners to stay on the unit overnight.		
24/117	**ANY OTHER BUSINESS** No other business was raised.		

24/118	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 2nd May 2024 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:30		
24/119	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Claire Ward **Chair** **Date**		

24/120	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	CW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
24/121	**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
23/356.1	02/11/2023	Consideration to be given to how other significant roles, for example pharmacists and clinical scientists, can be included in future staffing reports to the Board of Directors	Public Board of Directors	None	~~02/05/2024~~ 06/06/2024	D Selwyn / P Bolton		**Update 17/04/2024** Clinical Support, Therapies & Outpatients (CSTO) presenting workforce paper to People Committee on 28th May 2024	Grey
24/039	01/02/2024	Divisional breakdown within Freedom to Speak Up (FTSU) Guardian report to be shown as a percentage of workforce in future reports.	Public Board of Directors	None	01/08/2024	S Brook Shanahan	K Bosworth		Grey
24/106.1	04/04/2024	Data sources in the ICB Quarter 3 Segmentation Review letter to be clarified	Public Board of Directors	None	02/05/2024	P Robinson		**Complete -** further information will be provided in the May Board of Directors meeting	Green
24/106.2	04/04/2024	Report to be provided to the People Committee in relation to the actions being taken to address diversity within the Trust, particularly people in senior leadership roles	Public Board of Directors	People Committee	01/08/2024	R Simcox		**Update 24/04/2024** Item to be presented at the July meeting of the People Committee	Grey
24/108.1	04/04/2024	Method for tracking cases of third and fourth degree tears for any ongoing harm to be developed	Public Board of Directors	None	06/06/2024	P Bolton	P Shore	**Update 24/04/2024** Director of Midwifery to work with the Trust Perinatal Pelvic Health Service Lead to look at options fot tracking.	Grey
24/108.2	04/04/2024	Report to be provided to the Quality Committee in relation to the work of the Lower Pelvic Floor Team, particularly the impact of their work on third and fourth degree tears.	Public Board of Directors	Quality Committee	04/07/2024	P Bolton	P Shore	**Update 17/04/2024** On agenda for June meeting of the Quality Committee	Grey
24/108.3	04/04/2024	Quality Committee workplan to be reviewed to ensure appropriate assurance is provided on key services	Public Board of Directors	Quality Committee	06/06/2024	P Bolton		**Update 17/04/2024** On agenda for April meeting of the Quality Committee	Grey
24/114.1	04/04/2024	The views of the Board of Directors in relation to the CDC funding issues to be fed back to NHSE	Public Board of Directors	None	02/05/2024	P Robinson		**Complete -** further information will be provided in the May Board of Directors meeting	Green
24/114.2	04/04/2024	Clarify if the Trust can use its foundation trust status to insist newly recruited staff, particularly overseas recruits, remain with the Trust for a certain period of time	Public Board of Directors	None	02/05/2024	R Simcox		**Update 18/04/2024** After reviewing this, this something which is diffcult to enforce and, therefore, the advice is not to specify any time period **Complete**	Green

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Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date:**	2nd May 2024
Prepared By:	Rich Brown, Head of Communication		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		

Purpose

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

AGM = Annual General Meeting
NICU = Neonatal Intensive Care Unit
#TeamSFH = Team 'Sherwood Forest Hospitals'

Executive Summary

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

Update on the regional Mayoral election for the East Midlands

Over the last few months, I have kept the Trust Board updated about my intention to stand as a candidate in this year's election to elect the first regional Mayor for the East Midlands who will represent the people of Derbyshire, Nottinghamshire, Derby and Nottingham.

That process is now well underway, with people across the East Midlands due to go to the polls on Thursday 2nd May 2024.

It is anticipated that the results of the election will be declared on Friday 3rd May 2024. I will update the Board of the result.

Hosting the Trust's first Governors' Conference

On Tuesday 16th April 2024, I was proud to join the Trust's Lead Governor, Liz Barrett, at King's Mill Hospital to host the Trust's first-ever *Governors' Conference*.

As a Foundation Trust, we are proud to have over 14,000 public members and 5,000+ staff members. This event was a fantastic opportunity to discuss how we can better engage and involve the Trust's governors and members in the Trust's work to Improve Lives in the communities we serve.

The event was also a great opportunity to understand how well we are engaging with our members already – and where we can go further to improve that engagement and ensure we are representing the views of all of the communities we serve.

Colleagues from the Trust's operational and nursing teams also joined the event to share detailed information on the Trust's Discharge and Patient Experience processes – two topics that are often raised with governors through their conversations with the members they represent.

An action plan will now be drawn-up to take that work forward. I look forward to updating the Trust's Board about this important work as it develops over the coming months.

Recognising the difference made by our Trust Charity and Trust volunteers

April was another busy month for our Trust's Community Involvement team.

We continue to see fantastic support for the Trust – both in how we encourage 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 April 2024, 380 Trust volunteers generously gave over 4,600 hours of their time to help make great patient care happen across the 36 services they have supported during the month.

Caption: Four recliners chairs are presented to Newark Hospital's Minster Ward

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

- The Friends of Newark Hospital have kindly purchased four recliner chairs for Minor Ops on Minster Ward using funds raised in coffee shops and fundraising stalls. Pictured above.

- The team co-ordinated the numerous donations of Easter eggs and gifts which were distributed to Childrens' Services and Health Care of the Elderly wards.

- We welcomed our regular fundraisers, the Mansfield Roadrunners Scooter Club, who arrived at King's Mill in a huge scooter convoy to deliver Easter eggs and a £500 donation to our Neonatal Intensive Care Unit (NICU).

- We offered a warm welcome to 10 new #TeamSFH volunteers who joined the Trust during the month and were officially inducted into the organisation.

- As well as welcoming new volunteers into the organisation, we have also presented a number of our volunteers with long service awards over the past month.

  One such presentation was made to Daffodil Cafe volunteer Kath, who received an award for her 15 years' service from the Trust's Deputy Divisional Manager from our Clinical Support, Therapies and Outpatient Division, Mandy Toplis. Pictured opposite.

- The mealtime assist volunteer role was launched on Sconce and Castle Wards at Newark Hospital, following bespoke training sessions from the Speech and Language Team.

- Volunteers continue to support training sessions for medical students using their acting skills to become the patient in a number of role-play scenarios. Pictured opposite.

I would like to reiterate my personal thanks to everyone who has given their time, money and support in other ways to support the Trust and our hard-working colleagues over the past month.

Other notable engagements:

- During the month, I joined Trust governors and colleagues in undertaking our latest '15 Steps' visit to Trust services. This month's event took place in the Trust's Colposcopy areas, which provided an essential opportunity for colleagues to showcase their achievements and highlight areas where we can further improve.

  I want to give a special mention to Sally in the department as it was clear from our visit how much she is valued by the team for her dedication to the patients and the services provided.

- I was delighted to be invited to the Annual General Meeting (AGM) of the League of Hospital Friends (Mansfield and Sutton).

  Over the last year, they have raised funds for the Trust which has helped to make great patient care happen here at Sherwood. Their contributions have helped to pay for presents for all inpatients who spent Christmas in hospital and a tabletop activity unit that will be used by all three wards at Mansfield Community Hospital.

  It was an enjoyable afternoon event and an opportunity to thank all the volunteers for their fundraising to support our patients.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date:**	2nd May 2024
Prepared By:	Rich Brown, Head of Communication		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		

Purpose		
An update regarding some of the most noteworthy events and items over the past month from the Chief Executive's perspective.	**Approval**	
	Assurance	**Y**
	Update	**Y**
	Consider	**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	Failure to achieve the Trust's financial strategy	
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

None

Acronyms

BAF = Board Assurance Framework
MP = Member of Parliament
NHS = National Health Service
PCN = Primary Care Network
#TeamSFH = Team 'Sherwood Forest Hospitals'

Executive Summary

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

Operational updates

King's Mill Hospital Discharge Lounge opens to help make every bed count

One of the most exciting developments in the Trust from the past month saw the opening of our new multimillion-pound Discharge Lounge at King's Mill Hospital, which opened its doors to its first patients on Monday 22nd April 2024.

The development has been part-funded thanks to investment from the Department of Health and Social Care to create a more positive and comfortable experience for patients once they have received the vital hospital care they need and are preparing to be discharged to wherever they call home.

The new lounge has been specially-designed to improve patient flow in our hospitals by providing increased capacity for 19 beds and around 22 chairs for patients who no longer require a hospital bed. The configuration of the lounge can be tailored, depending on the needs of patients in the lounge at the time.

By providing a comfortable space for patients to wait for the vital medication and transport they need, the Discharge Lounge will also help to ease pressures in our Emergency Department and our wards by ensuring that hospital beds can be freed-up as soon as possible for those that need them most.

We are delighted to be announcing this development here at Sherwood that will play a vital part in ensuring that our patients can access the care they need in the right place at the right time – a key part of our new Trust Strategy.

We look forward to sharing more information about this exciting development in this month's *Outstanding Service* video that we will showcase at this month's Public Board meeting.

Other Trust updates

Trust opens nominations for annual *Excellence Awards*

Sherwood Forest Hospitals is inviting patients and members of the public to show their appreciation and thank Trust colleagues for the care they and their loved ones have provided by making a nomination for this year's Trust *Excellence Awards*.

Our annual *Excellence Awards* celebrate individual colleagues, teams and volunteers who go above-and-beyond in their roles to make a positive impact on our services, patients, visitors and colleagues through the outstanding care they provide.

While the majority of awards are nominated by Trust colleagues, our 'People's Award' allows the local community who may have received care at one of the Trust's three sites the opportunity to nominate someone and show their appreciation.

The awards are an outstanding opportunity for patients and members of the local community to say 'thank you' to our hardworking Trust staff who have given them outstanding care over the year gone by.

Nominations are now open until midnight on Monday 13th May 2024 for the annual awards, which are entirely funded thanks to the generosity of our corporate and charity sponsors.

Members of the community can make their nominations via the *Excellence Awards* page on our Trust website at www.sfh-tr.nhs.uk/excellence. Paper nomination forms are also available by emailing sfh-tr.communications@nhs.net.

Specialist Admiral Nurse appointed to support families with Dementia

Sherwood Forest Hospitals has recently appointed its first Admiral Nurse in collaboration with Dementia UK, the specialist dementia nurse charity.

Georgina Goulding joined the Trust's Dementia Specialist team to provide life-changing support for families affected by all forms of dementia across our three hospital sites.

Admiral Nurses are specialist dementia nurses that are continually supported and developed by Dementia UK. They are there for families with dementia when needed most; providing health advice, compassionate emotional and psychological support, and improving the quality of life for everyone involved.

Georgina will be working to improve awareness and knowledge among Trust colleagues for when they are caring for people who are living with dementia.

The Dementia Specialist Team already comprises a Specialist Dementia Nurse, Adele Bonsall, and Dementia Support Worker, Carol Hatton, who strive to provide excellent dementia care at Sherwood Forest Hospitals. The team aims to embed a culture of dementia care that puts the person and their loved ones at the forefront, as well as supporting and educating staff to enhance dementia care.

Dementia is an umbrella term for a range of progressive conditions that affect a person's ability to remember, think and speak. It can affect a person at any age but it's more common in people over the age of 65. One in two of us will be affected by dementia – either through caring for a loved one with the condition, developing it ourselves, or both. It is a huge and growing health crisis.

We are delighted to be working with Dementia UK to introduce this new role that will increase support for people living with dementia, their families and those caring for them. We are pleased to welcome Georgina to the team and look forward to the positive differences she will make.

We are looking forward to sharing more information about Georgina's appointment in an *Outstanding Service* video that will be shared with the Trust's Board at a future meeting.

#TeamSFH receives Interim Quality Mark for Preceptorship

On Monday 25th March 2024, Sherwood Forest Hospitals received the Interim Quality Mark for Preceptorship.

Over the last 12 months, we have been busy gathering evidence to demonstrate that our Preceptorship policy aligned with the 10 core criteria to enable us to become accredited.

In 2022, following the release of the National Preceptorship Framework, the Trust's Preceptorship Team reviewed the programme and considered all the recommendations, which include extension to Preceptorship from six months to one year. This has been a successful transition, with our newly-qualified Registered Nurses now completing The Edward Jenner Leadership in the second half of the programme.

The framework will help to continue to drive outstanding patient care here at Sherwood by providing a framework of good practice and providing a structured and supportive approach for our newly-qualified nursing colleagues to follow as they develop here at Sherwood.

Partnership updates

- Our Clinical Chairs met with Primary Care Network (PCN) Clinical Directors to build relationships and develop a plan for improving the primary secondary care interface, linked to the roll-out of the Trust's new *Clinical Strategy*.

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. The Committee has confirmed that there are no changes to the risk score.

The full and updated Board Assurance Framework (BAF) is next due to be presented at the Public Meeting of the Trust's Board of Directors in June 2024, with its presentation having been deferred from this month's meeting.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Trust Board - Cover Sheet

Subject:	2023/24 Qtr. 4 Strategic Priorities	**Date:**	2nd May 2024
Prepared By:	Kevin Gallacher, Associate Director Planning & Partnerships Claire Hinchley, Interim Director of Strategy and Partnerships		
Approved By:	Claire Hinchley, Interim Director of Strategy and Partnerships		
Presented By:	Claire Hinchley, Interim Director of Strategy and Partnerships		

Purpose		
To provide the final update to the Trust Board on the 2023/24 Strategic Priorities and conclude the 2019-2024 strategy.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Executive Team

Acronyms

BAF – Board Assurance Framework
BAU – Business As Usual
CQC – Care Quality Commission
EDI – Equality, Diversity, and Inclusion
EPR – Electronic Patient Record
ICS – Integrated Care System
NHSE – National Health Service England
SFH – Sherwood Forest Hospitals
Q1 or Qtr.1 - April to June
Q2 or Qtr. 2 - July to September
Q3 or Qtr. 3 - October to December
Q4 or Qtr. 4 - January to March.

Executive Summary

2023/24 was the final year of the Trust 2019-2024 strategy with the Trust's new 'Improving Lives' strategy, covering the period April 2024 to March 2029, approved by Trust Board in March 2024.

As part of introducing our new five-year strategy we acknowledged that we are proud of our achievements over the last five years and yet recognise people wanted more from us. Appendix 1 sets out the background to the 2019-24 strategy and some of our achievements during that time.

In addition to the developing the 'Improving Lives' strategy for 2024-2029, a new framework has also been put in place. This framework has a greater focus on the underpinning supporting strategies and the role of the Board Sub-Committee's in both gaining assurance on the delivery of the supporting strategies as well as providing assurance to the Board on their delivery. Taken together, ongoing delivery of the supporting strategies will contribute to the achievement of the overarching strategy and to 'Improving Lives'.

This paper updates and concludes the final year of the 2019-2024 strategy with the new framework operating from April 2024 onwards.

The attached paper summarises the position on a page at the end of March 2024 (Qtr. 4) including showing whether the 2023/24 in-year measures of success have been completed or are ongoing.

A more detailed update is also given providing information on the delivery of the measures of success during Qtr. 4 and a 2023/24 closedown statement. These updates have been discussed by the executive lead at the associated governance forums.

The closedown statement confirms whether all of the 2023/24 measures of success were completed or if elements of these have been carried forward into 2024/25. This statement also provides a brief overview of how any new actions associated with the 2023/24 priorities are being progressed into 2024/25 as business as usual.

Of the twenty-three priorities, seven, shown below, have individual measures that are not yet fully concluded and will continue into 2024/25. The remainder have completed all the measures of success set out for delivery in 2023/24.

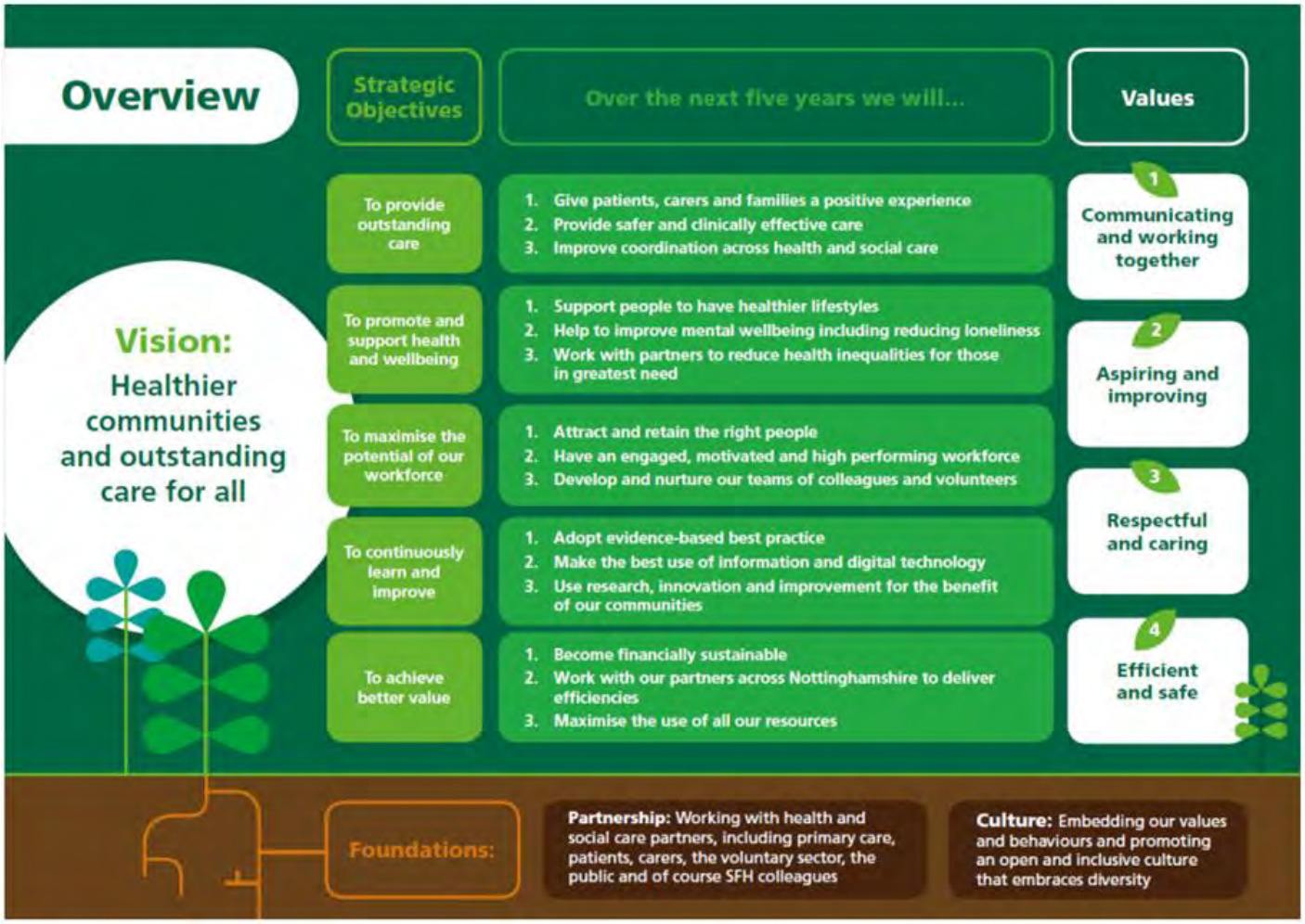
- 1.2a - Expand day case surgery services at Newark hospital
- 1.2b - Expand diagnostic services to Mansfield community hospital
- 2.2 - Agree our approach and programme of actions around health inequalities and prevention.
- 4.1a - Electronic prescribing implementation
- 5.1 - Establish an underpinning financial strategy.
- 5.2 - Deliver the objectives set out in the SFH green plan 2021-2026
- 5.3 - Develop a multi-year capital investment profile.

The Trust Board are asked to:

Note the update and the conclusion of the 2019-2024 strategy and approach.

Appendix 1: Concluding the 2019 2024 – Healthier Communities, Outstanding Care Strategy

In April 2019 the "Healthier Communities, Outstanding Care" strategy was launched which ran until March 2024. The graphic below provides a summary of the vision, strategic objectives and values:



The context in which the strategy was developed was different to that which we note in 2024. Covid-19 was unknown, the integrated care system concept was a pilot, Mid Notts were starting to work together in an integrated care partnership, the NHS long term plan had just been released and provider collaboratives were not something you had to be a part of.

Sherwood Forest Trust was performing well in terms of activity metrics and had met its financial control total for 4 years in a row. Staff survey results were starting to be positive with a second year of best engagement across the Midlands (rated ninth in the NHS for staff engagement) and the Trust had been rated as Outstanding by the CQC.

A significant delivery area of the strategy was a greater emphasis on mental wellbeing of colleagues which was key once the pandemic took hold.

A selection of examples of delivery from across the 5 year period of the strategy include:

- Launched 'Health Heroes' programme, equipping staff to promote health and wellbeing amongst colleagues.
- Continued making progress in digitising patient health records, replacing paper-based patient assessments with electronic ones.

- Reduced unnecessary patient visits to hospital, through redesigning our outpatient services.
- Exceeded our target for the number of apprentices in post.
- Offered funded tobacco treatment services to the majority of smokers admitted to our hospitals.
- Launched the Carers Passport for patients and their carers during Carers' Week.
- Rollout of Covid Vaccination Programme to the local population, with our vaccination team delivering 200,000 plus, doses since the start of the programme and at times delivering more than 1,200 doses a day.
- Expansion of services, including a new community diagnostic centre at Ashfield Health Village for Ophthalmology patients, additional scanning capacity from a Mobile Endoscopy Unit situated at King's Mill Hospital, and the expansion of surgical procedures at Newark Hospital.
- Introduced our new double cot for twin babies in our Neonatal Intensive Care Unit, allowing us to keep new-born children together, just like in the womb.
- Delivered full compliance against the ten safety actions set out by NHS Resolution to support the delivery of safer maternity care and been commended by the Chief Midwifery Officer for England as an exemplar Trust for our commitment to safety and care.
- Introduced a pilot whereby QR code posters (linking to relevant Trust-approved patient information leaflets) have been produced, to further improve effective patient communication.
- Strengthened our links with Primary Care, opening channels between GPs and the Trust, as part of the Integrated Care Board/Place-based Partnership Communications Group.
- Introduced 20 new Wellbeing Champions, with varied interests including physical activity, mental health, and menopause.
- Developed and published a Mental Health Strategy with Nottinghamshire Healthcare NHS Foundation Trust.
- Through 2021/22 we co-produced a regional Workforce Race, Equality and Inclusion Strategy and in February 2022 we launched our new anti-racism strategy, making a clear commitment to take effective action to create an anti-racist working environment.
- Declared a climate emergency, being one of only eight NHS organisations to do so, to recognise the affect climate change has on physical and mental health.
- Continued our progress to Pathway to Excellence accreditation.
- Introduced a high impact action plan to address inequity in recruitment and development for those from ethnic minority backgrounds, alongside partners within the Nottinghamshire ICS.
- Introduced a new staff network for carers in the organisation.

- Furthered our digital maturity through the rollout of our Electronic Prescribing and Medicines Administration (EPMA) system and the development of a business case for a new Electronic Patient Record (EPR) system.
- Strengthened system coordination through the development of a Provider Collaborative and Placed Based Partnerships.
- Expanded Day Case Surgery Services at Newark Hospital through the Transformation Investment fund (TIF).
- Expanded Diagnostic Services to Mansfield Community Hospital.
- Embedded and expanded virtual wards.
- Progressed Medical, Nursing, Allied Healthcare Workforce Transformation.
- Strengthened partnerships with the education sector to promote local employment opportunities and contribute to the wider determinants of health and well-being.
- Continued the Wellbeing champions focus on spread across the Trust focussing on menopause and physical activity.
- Driven improvements in our commitment to the green agenda which includes the planting of a HOPE orchard.
- Worked with partners external to the NHS, including councils and the voluntary sector to focus positive effort on improving the wider determinants of health.
- Delivered 111 babies smoke free at time of delivery through targeted help of expectant mothers which will have benefits on future healthy lifestyles.
- Developed an improvement faculty concept which will mobilise from next year
- Undertaken QSIR training across the organisation to increase capacity.
- Delivered a transformation programme across key priority areas including outpatients, operating theatres, and flow through the trust.
- SFH have exceeded the national ambitions (33%) and made significant progress in delivering Same Day Emergency Care (SDEC). SFH was able with the help of additional funding, to significantly invest in the creation of a dedicated Medical SDEC Unit.
- Learned from critical incidents through effective de-briefing of teams both internal and external across the system with our partners.
- 80% inpatient areas are now using electronic prescribing.
- Delivered a transformation programme at Newark Hospital, making it a valued and vibrant asset to the local population.
- Been a key partner in the Provider Collaborative, shaping the priorities and strengthening partnership working with the major providers in Nottingham and Nottinghamshire.
- Established a Transfer of Care Hub – bringing system partners together to drive reducing length of stay and a focus on medically safe for discharge cohorts.
- Attracted national funding to build a community diagnostic centre and a new operating theatre at Newark Hospital.

- Contributed to the local economy and businesses through employment offers, procurement opportunities and through a scheme to support people become work ready.

Summary

In summary, the 2019-2024 strategy delivered significant gains across each of the strategic objectives despite the pandemic response which would have been unforeseen at the time of its development. The pandemic has required a reset of services and patient care, including supporting our colleagues through longer term health and wellbeing challenges.

The context in which we deliver care has changed too, with the formalisation of the Integrated Care System and a statutory requirement to collaborate. The new 2024-29 strategy 'Improving Lives' is set within this changed context and it feels right that the strategic objectives and ambitions have been refreshed rather than newly created.

Despite the successes of the 2019 strategy, some of our progress has slowed and some of our plans have needed a rethink, our patients and local residents have more complex health issues, health inequalities are not improving and the national workforce challenge means we have to work differently to support us in continuing to deliver outstanding care.

The new strategy builds upon solid foundations of the 2019 strategy.

Outstanding Care, Compassionate People, Healthier Communities

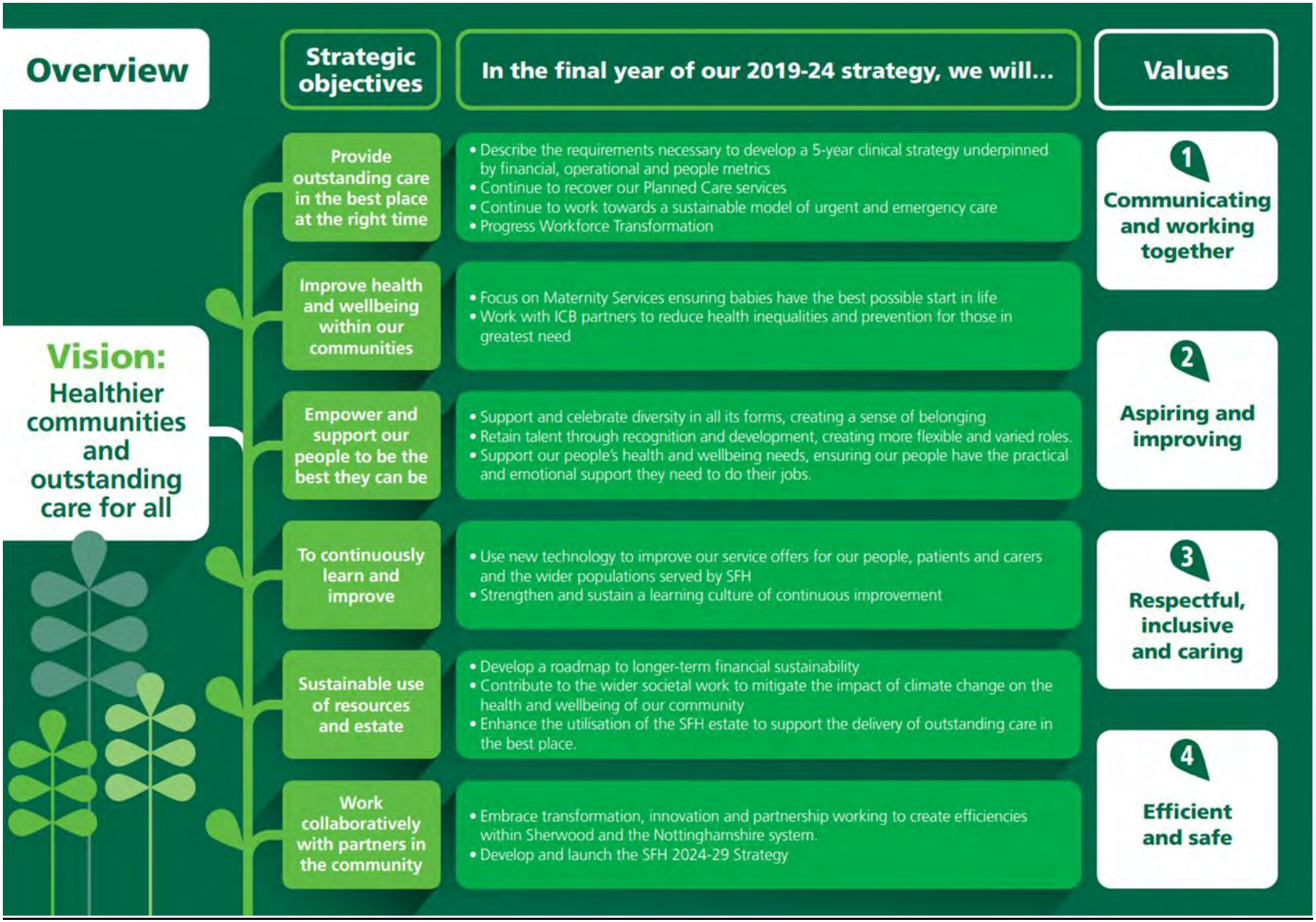
Sherwood Forest Hospitals NHS Foundation Trust

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

2023/24 Quarter 4 Update and Closedown

Outstanding Care, Compassionate People, Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust



1. Summary – 2023-24 Qtr. 4. 'Position on a Page'

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

Overall RAG Key

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

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

Overall RAG Key

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

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

Overall RAG Key

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

2. Detailed Quarter 4 Update

Ref	2023-24 Trust *Priority* and Deliverable	Executive Lead	SFH Governance	Measures of Success	Quarter 4 Update	2023/24 Closedown Statement
1.1a	*Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics* Work with Clinical Divisions to develop Clinical Service Strategies at Specialty and Divisional level, to inform a Trust level Clinical Strategy	Medical Director	Executive Team Meeting  **On Track** - no issues to note.	• By the end of July 2023 the ICS Joint Forward Plan will have been made available to the Divisions. • By end Qtr. 2. Divisional service lines will have produced a 2 year plan that describes where they are now and key issues and opportunities in the 1-2 Year and 3-5 Year time horizon ensuring that options for fragile services are fully understood. • By the end of Qtr. 3. have in place a Trust level Clinical Services Strategy that supports longer term alignment of estates, people, technological, and financial plans.	- The 2024-2029 Clinical Services Strategy has been approved by the Quality Committee and ratified by the Trust Board.	- The 2023/24 measures are complete. - The 'We Will' actions and the next steps during 2024/25 are set out in the Clinical Services Strategy and incorporated into business as usual (BAU).
1.1b	*Describe the requirements necessary to develop a 5-year clinical strategy underpinned by financial, operational and people metrics* 'Develop high level 5yr bed requirement model	Chief Operating Officer	Executive Team Meeting  **On Track** - no issues to note.	• By the end of Qtr. 3 have an initial 5 year model in place that is informed by Divisional Service Line Plans • By the end of Qtr. 4 refine bed model to reflect Trust level clinical strategy.	- As reported in the Q3 update an indicative 5-year view of the adult bed model was presented to the Trust Board time out session in Nov-23. The bed model shows growing demand and capacity mismatches without mitigating actions. The Clinical Services Strategy provides a high-level ambition of areas of focus. Our 2024/25 bed model has mitigations in terms of service change that provide a degree of mitigation to the capacity shortfalls.	- The 2023/24 measures are complete. - Annual bed modelling will continue as part of business-as-usual processes to support annual and winter planning with outputs reviewed by our Winter Planning Group and Divisional Leadership Team meeting. Bed modelling outputs will also form part of the Winter Plan that is presented to Trust Board in September and October each year.

1.2a	*Continue to recover our Planned Care services* 'Expand Day Case Surgery Services at Newark Hospital through the Transformation Investment fund (TIF)	Chief Operating Officer	Executive Team Meeting  **On Track** – action underway to address minor issues.	• Service commencement by end of June 2023 • 90% of staff substantively in post by end of Qtr. 3. • By end of Qtr. 4 be achieving the monthly levels of activity required to meet the full year aspirations of the TIF submission.	- The new theatre opened at Newark hospital in Nov-23 as part of our Targeted Investment Fund (TIF) development to support our elective pathway. - The main constraint to fully utilise the theatre capacity at Newark is Consultant Anaesthetists where we have a 35% workforce gap across the SFH services. We mitigate these gaps through Waiting List Initiatives. There are other outstanding posts to recruit into for Newark theatres which are out to advert; however, these posts are not presently a rate limiting factor. - The three other elements of TIF (upgrading medical day-case unit, minor operations suite and the procedure room) are now scheduled to open in Apr-24. - Activity levels are lower than the NHS England agreed plan because of delays in the TIF facilities being operational. We have a revised activity plan that we are working to agree with NHS England.	- Ongoing – delivery through BAU - Our Planned Care Steering Group oversees key actions and data relating our outpatient, diagnostic, elective inpatient, day-case and cancer services. - The Planned Care Steering Group will oversee the completion of the TIF capital works and monitoring of impact which is being managed by the Surgical, Anaesthetics and Critical Care division.

1.2b	*Continue to recover our Planned Care services* 'Expand Diagnostic Services to Mansfield Community Hospital	Director of Strategy and Partnership	Executive Team Meeting  **On Track** – action underway to address minor issues.	• Building works commenced by June 2023 • Staffing model and agreed development plan in place by Qtr. 2 (Feb 25 current go live date). • Mobile Magnetic resonance imaging (MRI) service located on MCH site and fully operational by 1st December 2023	- The Community Diagnostic Centre (CDC) Phase 1 delivered a total of 16,588 additional tests between Oct 2023 -31st March 2024. - The workforce model is validated, and a mobilisation plan developed. - CDC Phase 1 will continue in 2024/25.	- Ongoing – delivery through BAU - The 2024/25 submitted activity plan to NHSE is: o Phlebotomy - 11,180 tests o Ultrasound – 5,060 scans o Echo -3,233 scans - Next steps: o Demolition – to commence June 2024 o Phase 2a – refurbishment to go live March 2025 o Phase 2b – Main CDC – October 2025 o Phase 3 – Andrology/x-ray winter 25/26
1.2c	*Continue to recover our Planned Care services* 'Achieve elective activity levels, backlogs and patient waiting times in line with the 2023/24 operational plan and supporting performance trajectories.	Chief Operating Officer	Executive Team Meeting  **On Track** - no issues to note.	• Delivery of the following metrics in line with (or better than) plan: - Activity plans (Elective, Day Case, O/P) - PIFU - 52 and 65ww - Number of completed RTT pathways - 62-day cancer backlog - 28-day cancer FDS	- The ongoing instances of Industrial Action (IA) have resulted in curtailments in elective activity which adversely impacted on our elective activity, backlog, and performance metrics. Despite IA we exceeded our planned activity levels in Q4 across outpatients, diagnostics, day-case and elective inpatient services and made positive progress across the suite of planned care metrics (hence improved RAG status). - Patient Initiated Follow Up (PIFU) remains consistently better than the 5% target. - Cancer 62-day backlog position reduced in Q4 to meet our end of year target which was significantly better than the NHS England fair shares	- The 2023/24 measures are complete. - Our Planned Care Steering Group oversee key actions and data relating our outpatient, diagnostic, elective inpatient, day-case and cancer services. - Planned care performance data with associated narrative for all the metrics of success is included in the the quarterly Integrated Performance Report.

					allocation. - Cancer 28-day cancer Faster Diagnostic Standard (FDS) performance remains consistently better than the national standard. - In Q4 we saw our Referral To Treatment (RTT) long waits (52ww and 65ww) month-end position improve with further focus planned for 24/25 in line with national planning guidance ambitions.	
1.3	*Continue to work towards a sustainable model of urgent and emergency care* - Progress with the Optimising Patient Journey (OPJ) improvement programme - Expand use of Same Day Emergency Care (SDEC) within Surgery - Embed and expand virtual wards - Work with the ICB and system partners to facilitate system actions to reduce the number of Medically Safe For Transfer (MSFT) Patients who should not be in an acute hospital bed	Chief Operating Officer	Executive Team Meeting  **On Track** - no issues to note.	• Increase the number of patients using SDEC. • Increase the number of patients on a virtual ward pathway. • Reduce number of >20 day length of stay patients. • MSFT patient numbers in line with ICS trajectory.	- A work programme has been agreed and is in place supported by the Improvement Faculty which supplements improvement work underway across our divisional teams. - Medical Same Day Emergency Care (SDEC) continues to be well utilised with our overall SDEC rate exceeding the 33% national standard. Surgical SDEC goes live in Apr-24 with the plan to expand the offering incrementally. Frailty SDEC will be delivered in new Discharge Lounge facility when it opens in Apr-24. - Virtual ward utilisation has increased as services expanded in Q2 with activity at strong levels. - MSFT and long stay patient levels typically remain lower in Q4 than in Q1 and Q2. Non-elective attendance and admission demand has been high resulting in the benefits of reduced	- The 2023/24 measures are complete. - The positive progress we have made in the measures of success are reflected in an improved reported RAG position. However, it is also acknowledged that further focus will continue in 24/25 and beyond to support the delivery of a sustainable model of urgent and emergency care. - Our Emergency Care Steering Group oversee key actions and data relating our urgent and emergency care services. - Urgent and emergency care performance data with associated narrative for the metrics of success is included in the the quarterly Integrated Performance Report.

					Medically Safe for Transfer (MSFT) and long stay patients not translating into improved patient flow through our hospitals. Work continues to improve discharge process data to help identify and resolve bottlenecks in the process.	
1.4a	*Progress Workforce Transformation* - Progress Medical Workforce Transformation	Medical Director	Finance Committee  **On Track** - no issues to note.	• Deliver Trust and ICB/ICS Agency Task Force Group measures. • Specialties provide future workforce models by Qtr. 3 • Review NHSE workforce plan and put action plan in place in place within 2 months of publication.	- Amalgamation and enhanced format of Medical Transformation Programme Board. - Core workstream reducing medical agency cost and agency utilisation audit. - Focus on activity manger, annual leave, and study leave.	- The 2023/24 measures are complete. - Now established within business as usual and will be closely monitored as part of delivering the Trust 2024/25 Operational Plan.
1.4b	*Progress Workforce Transformation* 'Progress Nursing, Midwifery & Allied Health Profession (NMAHP) workforce transformation	Chief Nurse	Finance Committee  **On Track** - no issues to note.	• Movement to sustainable use of agency usage staring with off framework/off cap • Month on month reduction in agency usage • Reduction of vacancies focusing on Band 5 Registered Nurses • Develop Allied Health Professional (AHP) Job Planning by Qtr.3 to meet Carter Review recommendations. • Annual Establishment review against current capacity completed by end of Qtr. 3 and development of longer-term	- Sustained improvement continues with bank utilisation increasing to 81% and agency usage equating to 10 % of all requested filled. Agency provider contracts have been reviewed and updated. - The band 5 vacancy rate remained unchanged for Q4 at 11%. Student nurse engagement and recruitment continues, and we are looking to placed 18 qualified apprenticeship Registered Nurses into posts over the coming weeks. - All band 5 Allied Health professionals (AHPs) will have an electronic job plan by 31st March 2024. This equates to 28% of the AHP workforce. The	- The 2023/24 measures are complete. - While the 2023/24 actions set out have been completed workforce transformation will continue as a priority for 2024/25 due to the national fragility surrounding nursing workforce vacancies. Monthly divisional vacancy tracking will continue to be monitored through the NMAHP Transformation Group. - During 2024/25 the scope of job planning will also evolve to incorporate Clinical Nurse specialists.

				review process	secondment into AHP job planning has been extended to ensure full realisation of job planning across the wider workforce. - The annual establishment reviews have been completed and in line with national policy drivers.	
2.1	*Focus on Maternity Services ensuring babies have the best possible start in life* Work with the Local Maternity and Neonatal Services (LMNS) to equitably transform our maternity services through delivering a single delivery plan in line with the recommendations from the Ockenden and Kirkup review and CQC inspection.	Chief Nurse	Quality Committee **On Track** - no issues to note.	• Implementation of the single maternity oversight framework, completion of the CQC must do and should do actions. • Ensure smoking at time of delivery becomes part of our 'Business as Usual' through planning for 2024-25. • Optimisation and stabilisation of the preterm infant principles introduced. • Implementation of NHSE guidance on Equity and Equality. • Annual Establishment review against birth rate plus completed by end of Qtr. 3 and development of longer term review process	- The Single Maternity Oversight (SMO) Framework is embedded. Oversight and assurance is through peer review, working with and supporting stakeholders from MNVP/LMNS through attendance at Speciality Governance and Safety Champions meetings. - Equity and Equality work continues into 24/25 cross system to meet the needs of our service users through embedding a robust escalation policy with a focus on mutual aid. - Preterm Birth lead has commenced in post working collaboratively across the system.	- The 2023/24 measures are complete. - This sits in business as usual during 2024/25 with further actions to implement the three year delivery plan for maternity and neonatal services underway. - The annual review and workforce strategy are aligned to the Local Maternity and Neonatal System (LMNS) transformation plan. - Recurrent funding is in place for 2024/25 for key roles; further review to commence with focus on recruitment and retention for 2024/25 and development of the wider Public Health agenda, bereavement care and perinatal pelvic health.
2.2	*Work with ICB partners to reduce health inequalities and prevention for those in greatest need* agree our approach and programme of actions around	Medical Director	~~Quality Committee~~ Partnership and Communities Committee	• Assessment of 5 Year ICS NHS Joint Forward Plan within 2 months of publication (expected 30th June) to align areas of focus for Health Inequalities • Commence Health Inequalities	- The Deputy Medical Director is the chair of SFH Health Inequalities Steering Group (HISG) which is now meeting regularly. - The Health Inequalities stocktake	- Ongoing – delivery through BAU - Now established as business as usual with reporting into the Trust's newly established Partnership and Communities Committee where our

	Health Inequalities and prevention as a key strategic priority for the 24-29 strategy		 **On Track** - no issues to note.	reporting to Quality Committee Qtr. 3 • Agree with Board our approach to Health Inequalities and prevention and identify any gaps Qtr. 3 • Work internally and with partners to develop SFH or Joint proposals that qualify for any new Health Inequalities Investment Funding (HIIF) by January 2024	close to completion. - System Analysis and Intelligence Unit presentations made to the HISG and the SFH Partnerships and Community Committee (P&CC). - ICB established Digital Inequalities Group is chaired by the SFH Medical Director.	approach to any gaps identified, following the completion of the Health Inequalities (HI) stocktake, will be agreed.
3.1	*Support and celebrate diversity in all its forms, creating a sense of belonging.* 'Delivery of the "Belonging in the NHS" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, culture and Improvement Committee of the delivery of supporting actions • Evaluate impact of Staff Networks by Qtr. 3 • Evaluate 6 high impact actions by the end of Qtr. 4 • Deliver 'closing the gap' action plans to improve experiences for our people with protected characteristics by end of Qtr. 4.	- Culture Heat map developed and embedded across Trust. Induction, milestones events embedded. Appraisal process rolled out. Feedback asked for. Milestone process fully embedded across the Trust including long service presentation with Board. Divisional support with reward and recognition improved. Trust recognised nationally for staff engagement. - Review of staff networks undertaken. An Executive Pledge has been drafted to clarify the support from our Board and Executive Team. Launch: May 2024 - Successful delivery against 8 of 14 High Impact Actions from the EDI Improvement Plan 23/24. - GPGR, WRES and WDES action plans reviewed and to date, 6 have been achieved, 6 remain on track.	- The 2023/24 measures are complete. - Continued development through BAU to include National Staff Survey 2023 results. - Working group established to review exit interviews and thinking of moving conversation via People Promises Manager in 2024/25.

3.2	*Retain talent through recognition and development, creating more flexible and varied roles.* 'Delivery of the "Growing for the Future" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Quarterly update to People Culture & Improvement Committee on where we are growing a future workforce. • Recruit 20 external apprentices by end of Qtr. 3 • Evaluate and further utilise the apprenticeship levy throughout 2023-24 (Ongoing) • Talent Management approach / Leadership Development programme implemented by the end of Qtr. 4	- We have successfully recruited 26 apprentices into the organisation since the project began up until 31st March 2024. We did this through direct engagement with department leads to identify opportunities. - We continue to promote the use of apprenticeships across the organisation with planned activity during National Apprenticeship week in March. - A new guidance document has been produced for managers and apprentices which also includes a new retention process which sets out support for apprentice and expectations for managers ahead of the apprenticeship end date. - In Q3 the Sherwood Talent approach was developed outlining plans for the next 2-3 year which are split into 4 categories Attraction and Recruitment, Identification and Planning, Develop and Retain, Sharing and Learning. We also continue to work alongside the ICS to design and shape the system strategy.	- The 2023/24 measures are complete - Develop apprenticeship pathway documents aligned to staff groups e.g., Nursing, AHPs, Midwives etc. - Work closely with our location Education Providers, particularly West Notts College and Nottingham Trent University to ensure there are local offers for the apprenticeships that we need and that learners are directed to the Trust. - Identify further apprenticeship opportunities using intelligence data – focus on Band 2 roles that could be apprentices or trainee posts with an aligned apprenticeship for Band 5 and above. - The implementation of the Talent approach has been added to year 3 of the People Strategy.
3.3	*Support our people's health and wellbeing needs, ensuring our people have the practical and emotional support they need to do their jobs.* Delivery of the "Looking after our people" supporting	Director of People	People, Culture and Improvement Committee  **On Track** - no	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions	- Culture Heat map developed and embedded across Trust. - Assessment against NHSE Health & Wellbeing framework complete. Health and Wellbeing (H&WB) Improvement Plan created focussing on a core set of key improvements.	- The 2023/24 measures are complete. - Continued development to include National Staff Survey 2023 results. - H&WB Improvement Plan to be refreshed for 2024/2025. Key improvement actions to form part of

	actions in year 2 of the Trusts People Strategy 2022-2025.		issues to note.	• Develop cultural insights to support improved experiences for our people at SFH (Ongoing/by Qtr4.) • Introduce a Health & Wellbeing Strategy by Qtr. 3 • Measure the effectiveness of our Health & Wellbeing offer including Vivup and Occupational Health by Qtr. 3	- Effectiveness of H&WB offer assessed following 360 audit in 2023/24 and initial improvement ideas identified as part of People Strategy development, for example: o Focussed communications to Clinical colleagues o Enhanced wellbeing offer to colleagues going through an people process (Employee Relations) o Support to colleagues who experience violence and aggression – as outlined within the Violence & Aggression (V&A) Improvement Plan which was drafted in Q3.	the People Strategy 2024/2025 update. - Linked to H&WB Improvement Plan. Trauma Risk Management (TRiM) model to be reviewed as part of V&A Improvement Plan. V&A plan to be launched in May 2024, comms plan in development.
4.1a	*Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH* Complete the first and commence the second stages of Electronic Prescribing implementation [1. Implementation, 2. stabilisation, 3. optimisation, 4. transformation]	Medical Director	Quality Committee **Off Track** – action underway to address minor issues.	• Roll out Electronic Prescribing and Medicines Administration (EPMA) to remaining areas by end of Qtr. 4 • Commence Stabilisation during Qtr2	- The vacant EPR Pharmacy lead position, having been vacant for 12 months following completion of EPMA Stage 1, has now been appointed too and will be in post for Q1 24/25. - At present the current project activities is on the delivery of EPMA to Maternity with a proposed date of delivery of June 2024. - ED and Outpatients remain out of scope at this current time.	- Ongoing – delivery through BAU - Paediatric and Intensive Care Unit timeframes will be reviewed during Q2 2024/25 in line with the EPR procurement.

4.1b	*Use new technology to improve our service offers for our people, patients and carers and the wider populations served by SFH* Develop EPR (Electronic Patient Records) business case	Medical Director	Quality Committee  **On Track** - no issues to note.	• Submission of business case Qtr. 2 • Approval dependent commencement of recruitment Qtr. 3	- EPR roles progressing via Vacancy Control Panel and TRAC as per workforce timeline. - Planned attendance at NHSE EPR Launchpad, Board Assurance session	- The 2023/24 measures are complete. - EPR in final stages of national approval. Following this it will be subject to the Cabinet approval process.
4.2a	*Strengthen and sustain a learning culture of continuous improvement* Develop and embed the Patient safety Incident Response Framework (PSIRF)	Medical Director / Chief Nurse	Quality Committee  **On Track** - no issues to note.	• Develop Patient Safety Incident response Framework (PSIRF) by end of Qtr. 2 • Implement PSIRF approach to match national patient safety framework during Qtr. 3 • In Qtr.4 set out the plan to embed this in 2024-25	- The Patient Safety Incident Response Plan (PSIRP) has been extended until October 2024 to allow for inclusion of the data for the first year of implementation. - The first PSIRF Oversight group was held in Q4 looking at Q3 data. This reported into the Quality Committee providing assurance that incidents have been reviewed in line with PSIRF, and that Duty of Candour is complied with. The oversight group will continue to meet quarterly.	- The 2023/24 measures are complete. - The Development and implementation of PSRIF has been well received by trust staff, partners and the ICB. With its implementation we have continued to strengthen our culture of continuous improvement and support for staff. - The 2024 – 2026 PSIRP is underway and will outline the priorities moving forwards. -
4.2b	*Strengthen and sustain a learning culture of continuous improvement* To embed the Improvement Faculty within the Trust whose role will be to provide a centre of excellence for transformational and improvement support.	Director of Strategy and Partnership	Quality Committee  **On Track** - no issues to note.	• Fortnightly matrix meetings established from early Qtr. 1, incorporating all teams for whom improvement is a component of their role. • By the end of Qtr. 1 all aspects of the Trusts Transformation and Efficiency Programme to have been assessed by the Improvement Faculty to determine validity and deliverability.	- The 'Improvement Advisory Group' (IAG) (matrix meeting) continues to meet monthly. IAG meetings continue to be well attended. - All aspects of the Trusts Transformation and Efficiency Programme have been assessed by the Improvement Faculty. Work has commenced during Qtr. 4 to determine the 2024/25 priority areas. - The Improvement Faculty 'Hub' is fully operational and continues to facilitate	- The 2023/24 measures are complete. - The improvement faculty is now fully embedded within business as usual within the Trust.

				• By the end of Qtr. 2 a physical Improvement Faculty office to be created for the colocation of the Transformation and Improvement Teams plus hot desk availability for other teams involved in the Faculty's work. • By the end of Qtr. 4 an Initial (independent) review of the Improvement Faculty's impact will have been completed and reported to the Finance Committee.	greater collaborative working. - The Improvement Faculty has been subject to significant review during 2024/25. Regular reports on the efficacy and impact of the faculty have been presented to the Trusts Quality Committee, Finance Committee, Trust Management Team, and Executive Director Team. In addition, an Internal Audit has recently commenced, focusing specifically on the financial improvement aspect of the faculty's work plan.	
5.1	*Develop a roadmap to longer-term financial sustainability* Establish an underpinning financial strategy to act as the foundation for the delivery of our new 2024-29 Strategy	Chief Financial Officer	Finance Committee  **On Track** – action underway to address minor issues.	• A Financial Resources Oversight Group will be established by the end of Qtr. 1. • Use of Resources reviews undertaken by the end of Qtr2, to better understand where and how we spend our resources. • By the end of Qtr. 3 multi-year divisional budgets will be established. • We will have investment plans and financial efficiency plans for 2024-25 and beyond in place by Qtr. 4. • Establishment of a Strategic Procurement plan alongside ICS partners.	- A Financial Recovery Cabinet is in operation and meeting monthly. - A Financial Resources Oversight Group is established and meeting monthly. - A medium-term financial plan, including stretch financial recovery targets to deliver multi-year budgets which return spending to control total limits in the medium term, is in production. - Stretch savings targets to formulate into deliverable financial savings plans for 2024/25 have been agreed by the Trust Management Team (TMT) - All ICS partners procurement work plans data is now on the Atamis database. Working groups have convened to analyse the data and a joint work plan has been developed.	- Ongoing – delivery through BAU - Improvement cabinet to oversee efficiencies in 2024/25. - Financial Strategy for 2024-29 to be launched in July 2024 - The ICS partners will be jointly assessed against the Level 2 procurement standards in November 2024

5.2	*Contribute to the wider societal work to mitigate the impact of climate change on the health and wellbeing of our community* Establish the Sustainability Development Steering Group and progress delivery of the objectives set out in the SFH Green Plan 2021-2026	Chief Financial Officer	Finance Committee  **Off Track** – action underway to address minor issues.	• Improvements evidenced in key metrics (including energy and water consumption, waste and carbon emissions). • Annual Green Plan report to Board in Q3. • BAF PR8 score maintained or reduced. • Funding secured to progress Energy Reduction Projects.	- Key metrics are reviewed through Estates & Facilities Governance Group, with KPIs also shared at Risk Committee. - BAF PR8 score has been maintained however, noted that further assurance and controls to be developed. - A case for investment in the sustainability team has been submitted during Q4 as part of the planning round. - Application submitted to Public Sector Low Carbon Skills Fund (Phase 5), seeking a grant to support decarbonisation initiatives on our estate. - The Trust Sustainability Lead is engaging with all Green Plan workstream leads to refresh expectations and reporting.	- Ongoing – delivery through BAU - A report on the Green Plan progress and future steps is scheduled for a Trust Management Team discussion in July 2024.
5.3	*Enhance the utilisation of the SFH estate to support the delivery of outstanding care in the best place.* Complete a comprehensive space utilisation review of all Trust sites to underpin delivery of the Estates Strategy, develop a multi-year capital investment programme, and work with system partners to find	Chief Financial Officer	Finance Committee  On Track – action underway to address minor issues.	• Refreshed Space Utilisation Group operational and assessment of all SFH estate completed by Qtr. 4, to identify potential solutions that support delivery of the emerging Clinical Service Strategies. • Completion of the key capital schemes in line with planned timescales and budgets. • Multi-year capital investment programme in place.	- Space Management Utilisation Group established and meeting monthly. Space Allocation approach and process presented to Trust Management Team in March 2024. - 2023/24 Capital Programme resources fully utilised. - Innovative Space allocation software has been rolled out for the Newark Hospital site following completion of the TIF estates scheme. Consideration	- Ongoing – delivery through BAU - Year-end review of Estates capital programme at April Capital Oversight Group, with Communications to be shared on delivery highlights and patient benefits. - Capital prioritisation workshop (April 2024).

	solutions to long-standing estate challenges.			• Business cases prepared for future development opportunities.	to be sought for roll out across KMH pending funding. - Early considerations for post PFI settlement investment decant options underway with Project Co.	
6.1a	*We will embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.* Delivery of the "New Ways of Working and delivering care" supporting actions in year 2 of the Trusts People Strategy 2022-2025	Director of People	People, Culture and Improvement Committee  **On Track** - no issues to note.	• On-going monitoring and review of impact through the People Metrics on the Single Oversight Framework. • Quarterly exception reporting by the People, Culture and Improvement Committee of the delivery of the supporting actions • Delivery tactical people plans by Qtr. 1 • Develop workforce transformation to deliver Newark Transformation Investment Funding (TIF) by July 23 and Mansfield Community Diagnostics Centre (CDC) by Qtr. 2 • Design and understand interfaces between People and Transformation programmes to support financial improvements by end of Qtr. 4.	- Tactical people plans developed and distributed across the Trust. - Continued to support workforce planning for Mansfield Community Diagnostics Centre (CDC). We have revalidated the CDC workforce model and will be developing a long-term workforce model/plans during Q1 2025/26. - Delivered our initial 100-day plan aligned to the route to balance and reducing unnecessary costs, considering revisions to nursing headroom to reduced variable pay costs. Also developed annual workforce plan with triangulation to finance and activity measures. - Progressing review on change forms looking at internal new starters and terminations.	- The 2023/24 measures are complete. - Quarterly Tactical People Plan reports to be shared with service lines as BAU throughout 2024/25. - Development and implementation of workforce plan for CDC including operational resourcing plans and people plans for CDC modalities. - Links to optimisation of systems we use within the People Directorate. ESR / e-Forms being considered. - Further work to be completed including development of a mechanism to monitor actual vs plan, plus an evaluation of 2024/25 planning round for areas of learning.

6.1b	*We will embrace transformation, innovation and partnership working to create efficiencies within Sherwood and the Nottinghamshire system.* As a Nottingham and Nottinghamshire provider collaborative we will identify and deliver opportunities to improve how we work together with colleagues and services outside of SFH.	Director of Strategy and Partnership	Executive Team Meeting  **On Track** - no issues to note.	• 2023-24 Provider Collaborative at Scale (PC@S) Prospectus agreed during Qtr. 1 • PC@S Maturity Matrix Completed and action Plan in place by Qtr. 2 • 2023-24 PC@S areas of focus refreshed and agreed for 2024-25 by the end of December 2023	- The Nottinghamshire Provider Collaborative at Scale (PC@S) purpose, priorities and mission statement have been drafted and agreed. - The 2024/25 areas of focus have been agreed as People and Culture and Corporate Services. Work to fully scope this out was undertaken during Qtr.4 and will continue into early 2024/25.	- The 2023/24 measures are complete. - The PC@S Distributed Executive Group (DEG) continues to meet and is established within our system working Business as Usual. - Work to further develop the action plans to underpin our identified work programmes, 'areas of focus', continues into 2024/25 with the DEG continuing to consider how we maximise the impact of our collaboration and to ensure we are aligned and have clarity of the purpose of this work.
6.2	*Develop and launch the SFH 2024-29 Strategy* Through engagement with our People, Board, Council of Governors, Patient & Carers, the wider community we serve and our partners we will put in place a strategy that reflects our populations needs and contributes to our social, partner and regulatory agendas.	Director of Strategy and Partnership	Executive Team Meeting  **On Track** - no issues to note.	• Engagement plan in place by the end of May 2023 • Draft 'Consultation' Strategy completed for 5th October Board • Board Approval of Strategy - 4th Jan 24 • Clear set of priorities and actions for Year 1 agreed with Board during Qtr. 4 (updated annually) • 2024-29 Strategy launched Qtr. 4 2024	- The Sherwood Forest Hospitals Trust 'Improving Lives' Strategy was launched on 7th March 2024.	- The 2023/24 measures are complete. - 2024/25 is year 1 of the new 5 year 'Improving Lives' strategy and work will continue to ensure that this is a 'live' document throughout the live of the strategy as part of BAU.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Public

Subject:	Integrated Performance Report – Q4 2023-2024	**Date:**	2nd May 2024
Prepared By:	Domain leads and Neil Wilkinson, Risk & Assurance Manager		
Approved By:	Executive Team		
Presented By:	Paul Robinson, Chief Executive		

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

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

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

Committees/groups where this item has been presented before

Executive Team - 24th April 2024

Acronyms

Executive Summary

The Integrated Performance Report (IPR) provides the Board with assurance regarding the performance of the Trust in respect of the performance Indicators allocated to four domains: Quality Care, People and Culture, Timely Care and Best Value Care.

This report is for Quarter 4 2023/24. The performance indicators identified on the report are marked as "met" or "not met" via a green tick and red cross, respectively. Further details, including trends and actions to improve, are provided for each standard that is not met.

Maintaining good performance against the key indicators contained in the report has been challenging for Trust during the quarter, and for the NHS. In this winter period urgent care demand has been at its highest ever levels and there have been periods of disruptive Industrial Action. However, the Trust's performance compares favourably across the NHS in key areas.

There are a total of 61 indicators reported on the Q4 IPR report (65 in Q3), of those 26 are rated as met (27 in Q3), and 35 are rated as not met (38 in Q3). These are reported by individual Domains as follows:

Quality Care
Of the total 16 indicators (16 in Q3), 9 are rated as met (11 in Q3) and 7 as not met for Quarter 4 (5 in Q3).

People and Culture
Of the total 11 indicators (11 in Q3), 5 are rated as met (5 in Q3) and 6 as not met for Quarter 4 (6 in Q3).

Timely Care
Of the total 29 indicators (33 in Q3), 9 are rated as met (8 in Q3) and 20 as not met for Quarter 4 (25 in Q3).

Best Value Care
Of the total 5 indicators (5 in Q3), 3 are rated as met (3 in Q3) and 2 as not met for Quarter 4 (2 in Q3).

Domain	Total indicators		Met		Not met	
	Q4	Q3	Q4	Q3	Q4	Q3
Quality Care	16	16	9	11	7	5
People and Culture	11	11	5	5	6	6
Timely Care	29	33	9	8	20	25
Best Value Care	5	5	3	3	2	2
Total	**61**	**65**	**26**	**27**	**35**	**38**

Recommendation

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

Mid-Nottinghamshire Integrated Care Partnership

NHS Sherwood Forest Hospitals NHS Foundation Trust

Integrated Performance Report

Reporting Period: Q4

2023/24

Inspected and rated Good

CareQuality Commission

Domain Summary: Quality Care

Sherwood Forest Hospitals NHS Foundation Trust

Overview	Lead
2023/24 Q4 (Jan - Mar) There is a continued high volume of people consistently accessing urgent care, with the Trust at surge capacity. This prolonged, unrelenting period of operational pressure impacts on our ability to provide good, safe patient care. We continue to see long waits for admission beds and over-crowding and patient and staff impact, within the Emergency Department. The 2023 BMA Industrial Action has continued during Q4. The Patient Safety Incident Response Framework (PSIRF) is now well embedded in the Trust and during Q4 4 Patient Safety Incident Investigations (PSII) were commissioned. Themed under: 1 - Treatment & Care to include concerns over appointments, admission, transfer & discharge 1 - Delays in care 2 - Communication - Consent / DoLS / MCA The First PSIRF Oversight Group was held in February with good attendance from the Divisions, ICB representation and one of Patient Safety Partner's (PSP's) was also present. The divisions each gave an overview of any matters of concern, key risks, work on-going and positive assurances to highlight. The divisional reports presented varied in relation to content and a discussion was held on how, moving forwards, these reports can be more closely aligned. Duty of Candour compliance remains 100% Q4 has seen the falls rate per 1000 bed days for January & February above the national average, this can in part be attributed to a high number of medically safe patients remaining in acute beds due to reduced capacity for community care and ability to discharge. When compared to December 2022 data this represents a decrease in overall falls and although we were off track for the quarter we remained on track for the annual target. Themes and trends are explored and provision of bespoke training from Falls Prevention Practitioners (FPP) continues. Project work with the digital team to ensure assessments such as lying and standing blood pressure and visual acuity are aligned to national guidance is underway as is the use of AMAT for audits of falls risk assessments and bed rail assessments, providing assurance of compliance to policy. Comprehensive investigation of all falls continues to report no of lapses in care. As an organisation we have seen an improvement with our gram negatives blood stream infections compared with the last financial year and continue to compare cases against our Peer Trusts and the regional Hospital Trusts, we also review against our position as an ICB. Venous Thromboembolism (VTE) risk assessments are on track for Q4. Work is ongoing around VTE with the link from assessment to a prescription and timing for further assessments. There are 5 domains during Q4 which will be reported on as off track: • The Gram Negative blood stream infections: For our Klebsiella trajectory this year we have a target of 22 and our end of year position is 16 cases this is a reduction of 5 cases from last year (see graph 9) showing a good improvement. Currently benchmarking against our peer organisations we are showing to have the second lowest number of cases, for our Pseudomonas trajectory this year we have a target of 10 and our end of year position shows we breached this with 15 cases, at the same time last year we were on 13 cases • Falls per 1000 bed days • Case finding question, or diagnosis of dementia or delirium: Our compliance has improved considerably, with the percentage rate consistently >80%, we expect this improvement to continue. • HSMR remains "higher-than-expected" (126.3), recognising this represents a 12-month rolling position (representing the period January 2023-December 2023) Our in-month HSMR for December 2023 which is the latest reported month is 116.2 which is "within expected". There is no validated HSMR data after Dec 23. • SHMI remains "as expected" at 108.6 for the rolling 12-month period November 22 to October 2023. The upward trend we were concerned about in the last update did not continue and has begun to reverse. There is no SHMI data after October 23.	MD, CN

Scorecard: Quality Care

Sherwood Forest Hospitals NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	2023/24 YTD
Safe	Falls with lapse in care	≤2	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Falls per 1000 OBDs	≤6.63	✗ 6.9	✓ 5.9	✗ 7.0	✓ 6.6	✓ 5.2	✗ 6.9	✓ 6.0	✓ 6.1	✓ 5.6	✗ 6.9	✗ 6.7	✓ 6.4	✗ 6.9	✗ 7.3	✓ 6.1	✗ 6.7	✓ 6.5
	Never events	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1
	Hospital acquired infection MRSA > 48 hours	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
	Hospital acquired infection C difficile > 48 hours	≤13	✓ 4	✓ 6	✓ 5	✗ 15	✓ 4	✓ 0	✓ 2	✓ 6	✓ 1	✓ 5	✓ 6	✓ 12	✓ 1	✓ 3	✓ 0	✓ 4	✗ 37
	Hospital acquired infection Ecoli BSI > 48 hours	≤22	✓ 2	✓ 3	✓ 5	✓ 10	✓ 2	✓ 2	✓ 6	✓ 10	✓ 0	✓ 6	✓ 5	✓ 11	✓ 3	✓ 5	✓ 3	✓ 11	✗ 42
	Hospital acquired infection Klebsiella BSI > 48 hours	≤1	✓ 0	✓ 1	✓ 0	✓ 1	✓ 1	✓ 1	✓ 0	✗ 2	✓ 1	✓ 1	✓ 1	✗ 3	✗ 2	✓ 1	✓ 0	✗ 3	✗ 9
	Hospital acquired infection Pseudomonas BSI > 48 hours	≤3	✓ 2	✓ 0	✓ 0	✓ 2	✓ 2	✓ 0	✓ 0	✓ 2	✓ 0	✓ 1	✓ 1	✓ 2	✓ 2	✓ 1	✓ 1	✗ 4	✗ 10
	HAPU (cat 2) per 1000 OBDs with a lapse in care		0.1	0.0	0.1	0.1	0.0	0.0	0.1	0.0	0.2	0.1	0.0	0.1	0.2	0.2	0.2	0.2	0.1
	HAPU (cat 3/4) and ungradable pressure ulcers with lapse in care	0	✓ 0	✗ 1	✓ 0	✗ 1	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✗ 1
	Venous Thromboembolism (VTE) risk assessments	≥95%	✗ 92.4%	✗ 94.6%	✗ 94.4%	✗ 93.8%	✓ 95.0%	✗ 94.7%	✗ 94.2%	✗ 94.6%	✓ 95.6%	✗ 94.9%	✗ 94.5%	✓ 95.0%	✗ 94.7%	✗ 94.6%	✓ 95.9%	✓ 95.0%	✗ 94.6%
Caring	Case finding question, or diagnosis of dementia or delirium	≥90%	✗ 82.1%	✗ 84.8%	✗ 86.2%	✗ 84.4%	✗ 88.1%	✗ 84.9%	✗ 83.7%	✗ 85.6%	✗ 83.5%	✗ 85.4%	✗ 86.6%	✗ 85.2%	✗ 84.8%	✗ 84.5%	✗ 84.0%	✗ 84.4%	✗ 84.9%
	Complaints per 1000 OBDs	≤1.9	✓ 1.1	✓ 1.2	✓ 1.0	✓ 1.1	✓ 1.5	✓ 1.3	✓ 1.3	✓ 1.4	✓ 1.1	✓ 1.2	✓ 1.3	✓ 1.2	✓ 1.1	✓ 1.1	✓ 0.8	✓ 1.0	✓ 1.2
	Compliments received in month		90	146	123	359	165	150	135	450	103	158	150	411	151	122	120	393	1613
Effective	HSMR (basket of 56 diagnosis groups)	≤100	✗ 127	✗ 128	✗ 131	✗ 131	✗ 131	✗ 130	✗ 130	✗ 130	✗ 127	✗ 125	✗ 126	✗ 126	✗ 131	✗ 129	✗ 126	✗ 126	✗ 126
	SHMI	≤100	✗ 104	✗ 105	✗ 106	✗ 106	✗ 106	✗ 108	✗ 109	✗ 109	✗ 108	✗ 107	✗ 107	✗ 107	✗ 108	✗ 109	✗ 109	✗ 109	✗ 109
	Still birth rate	≤4.4	✓ 3.6	✓ 0.0	✓ 3.4	✓ 2.2	✓ 0.0	✓ 3.7	✓ 0.0	✓ 1.2	✓ 3.5	✓ 0.0	✗ 6.7	✓ 3.3	✓ 3.2	✗ 11.5	✓ 3.7	✗ 5.9	✓ 3.1
	Early neonatal deaths per 1000 live births	≤1	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✗ 6.9	✓ 0.0	✗ 3.3	✗ 3.5	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.0	✓ 0.9

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

Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

There is a national increase in the rates of Gram negative blood stream infections with trajectories set out by NHS England being difficult to achieve. A full review of all Hospital onset Healthcare associated (HOHA) and Community onset healthcare associated (COHA) blood stream infections is being undertaken by the IPC team

E-coli.

- This year's trajectory is set at 86.
- The trust has ended the year with 86 patients who have isolated E-coli which is on the target. There is an even split of 42 HOHA and 44 COHA infections.
- The ICB has the highest rates of E-coli blood stream infections within the Country

Pseudomonas Aeruginosa.

- This year's trajectory is set at 10, the trust have breached this trajectory with 15 cases identified this year. With a split of 10 HOHA and 5 COHA. A high number of our peer organisation have also breached their trajectory.

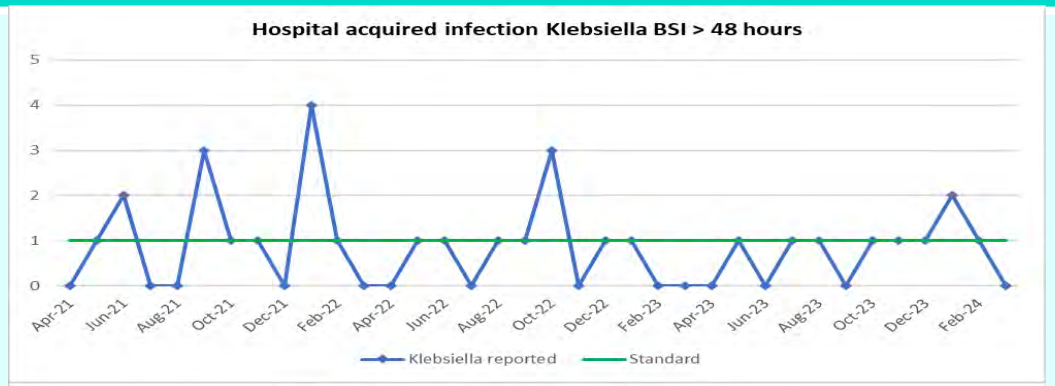
Klebsiella.

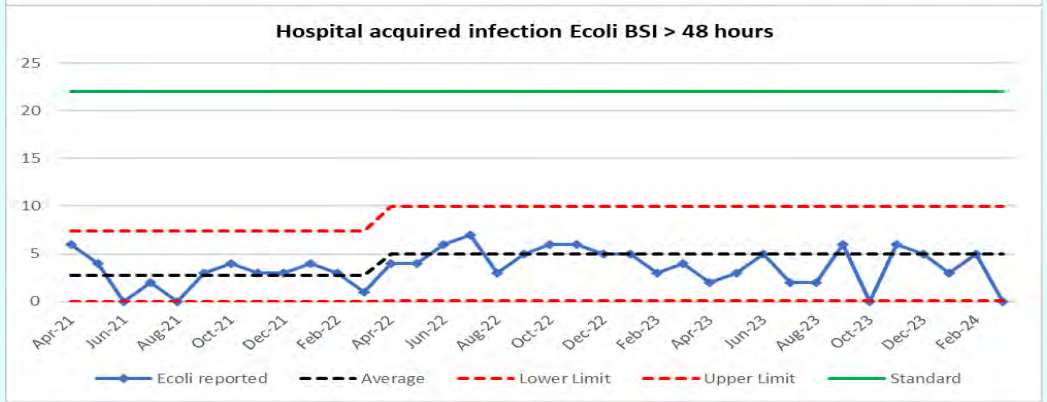
- This year's trajectory is set at 22.
- Although the trust is over its standard of less than 1 per quarter, the trust overall position for the year is 16 cases identified, this has improved by 5 cases from last year when we recorded 21.

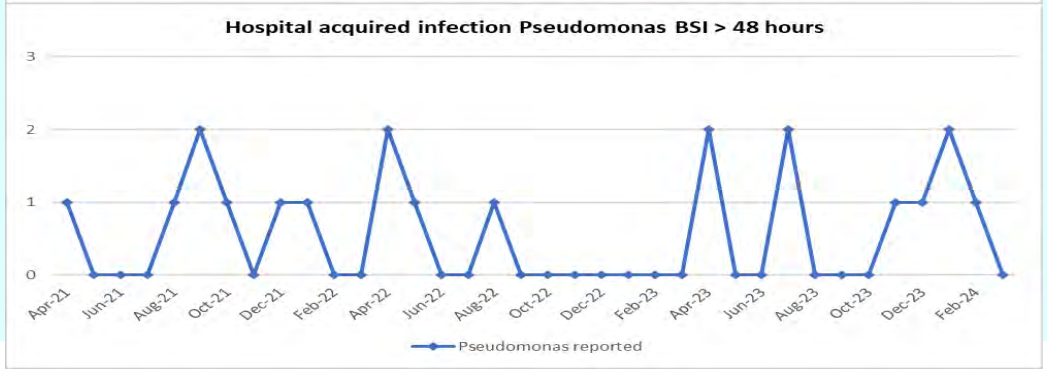
As an organisation we have seen an improvement with our gram negatives blood stream infections compared with the last financial year.

Root causes	Actions	Impact/Timescale
Over 50% of our gram negative infections are related to urinary tract infections.	• To have a regional focus on reducing urinary tract infections including the use of urinary catheters. • To develop an ICB urinary tract infection strategy	October 2024 May 2024

Data







Indicators in Focus: Quality Care – Falls

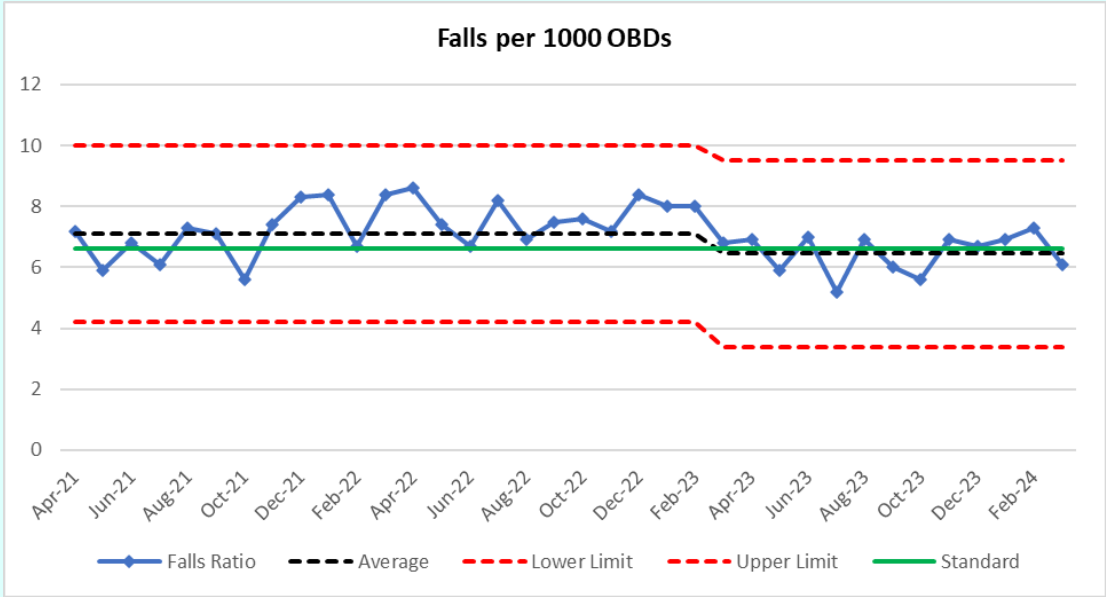
Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

- The falls rate for February 2024 is 7.59 which is above the national average of 6.63 per thousand bed days, comparable to 7.95 in February 2023 this is a decrease in overall falls.
- March 2024 has shown a decrease at 6.25 – the lowest since October 2023
- No reports of lapses in care.
- There is a continued high volume of people consistently accessing urgent care, with the Trust at surge capacity.
- Patients' length of stay remains increased

Root causes	Actions	Impact/Timescale
Increase in the number of inpatient falls for February 2024	Patients who have fallen more than twice are seen by the FPP and recommendations suggested. Falls with harm are scoped all scoped by the FPP and presented with any concerns to governance scoping meetings. Themes are explored and escalated at governance meetings with any actions taken as required. Monthly data is sent to all ward /dept areas for awareness and discussion at ward /dept level. Bespoke education by the Falls PP is provided as required Project work with the digital team to ensure assessments such as lying and standing blood pressure and visual acuity are aligned to national guidance. Continued clinical visibility across all 3 sites by the Fall PP	All actions ongoing, with a view of the digital work being live by May 2024. Ongoing monthly reports / data for awareness .

Data



Indicators in Focus: Quality Care – HSMR and SHMI

National position & overview

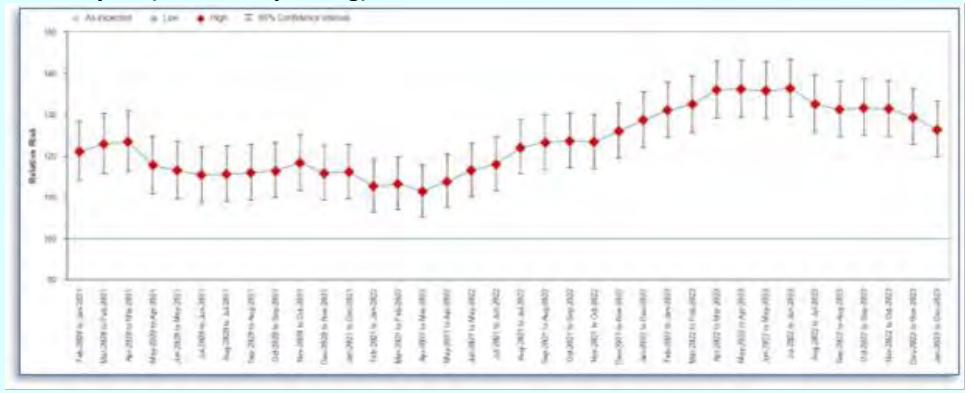
HSMR- Latest 12-monthly rolling figure= 126.3. Remains above expected but both 12 month-rolling and individual month reporting have seen recent trend of improvement, with 4 out of 6 of the latest individual months being as expected

SHMI- Latest report = 108.6 and remains as expected.

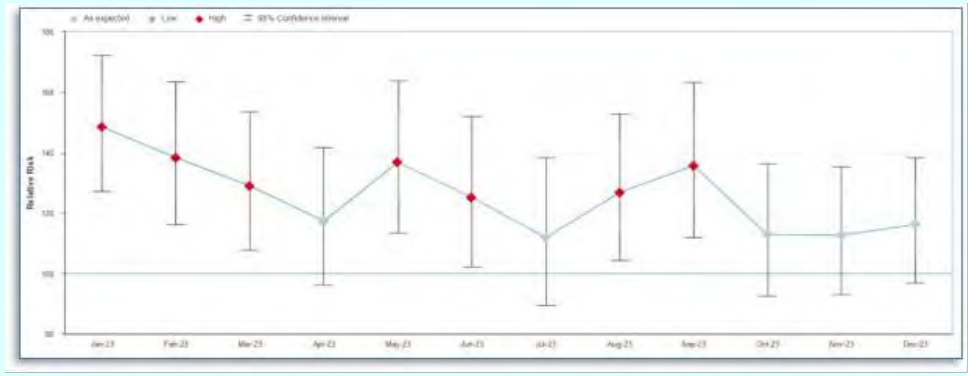
Root causes	Actions	Impact / Timescale
Data Quality- Emphasis on timely diagnosis, documentation, coding and co-morbidity capture	Educational meetings and divisional presentations undertaken, to highlight importance of documentation and coding, alongside revision of admission clerking booklet.	Will take 12 months after action to see signs of impact
Pathways and Patient Flow- Review of admission pathways, use of management bundles and signposting pathways	Focus on enhancing senior decision making, mitigating inappropriate consultant transfers of care and supporting timely management • Eg SDEC, evaluation of consultant episodes and specialty ownership; review of outlier groups (eg ALD) to identify Trust opportunities for improvement and "system-wide" challenges.	As above; forms part of overall working approach
Specialist Palliative Care (SPC) Coding- Remains lowest, nationally.	Working with local provider to identify opportunities and support clinical teams; focus on timely (early) recognition of status and needs, coding and capture of SPC activity, alongside system-wide provision	SPC is of low activity compared to overall. Requires Trust & ICB resource / investment.
Other areas: **Data Intelligence-** Close working with data provider (Telstra), triangulation with other intelligence (eg ME service and BI) and feeding into LfD	Initial data interrogation, targeted reviews and deep dives with focus on ownership by clinical teams and subsequent reporting into LfD. Notification, from Telstra, of intended changes to several areas related to HSMR methodology, including Palliative Care coding	Will take at least 12 months after commencing actions to see signs of benefit realisation.
External peer review / support-	Recent connection with Dudley Group, having been on similar journey and offer of support	
New Initiatives and Collaboration-	"Interface Workstream" to develop improved understanding, education, collaborative relationships and system-wide approaches to effective management	
Internal data review / audit-	Alongside clinical support, identification of opportunities for improvement in co-morbidity capture	
Data Benchmarking-	Evaluation of current tools and procurement / tender exercise to ensure best value and meets needs for Trust as a whole.	

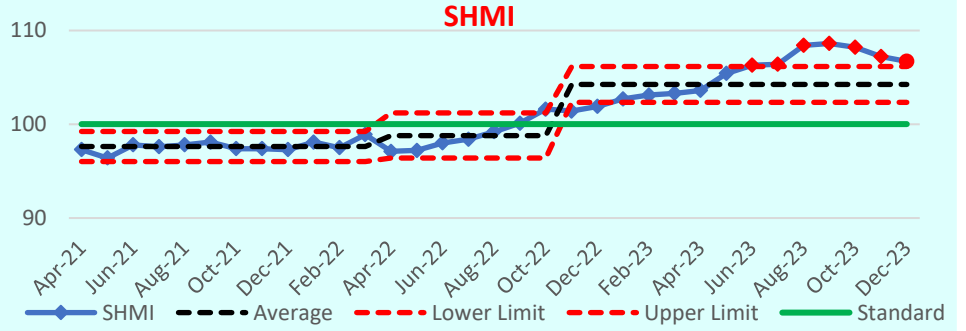
Data

HSMR 3 year (12 monthly rolling) trend



HSMR Single Month Trend





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

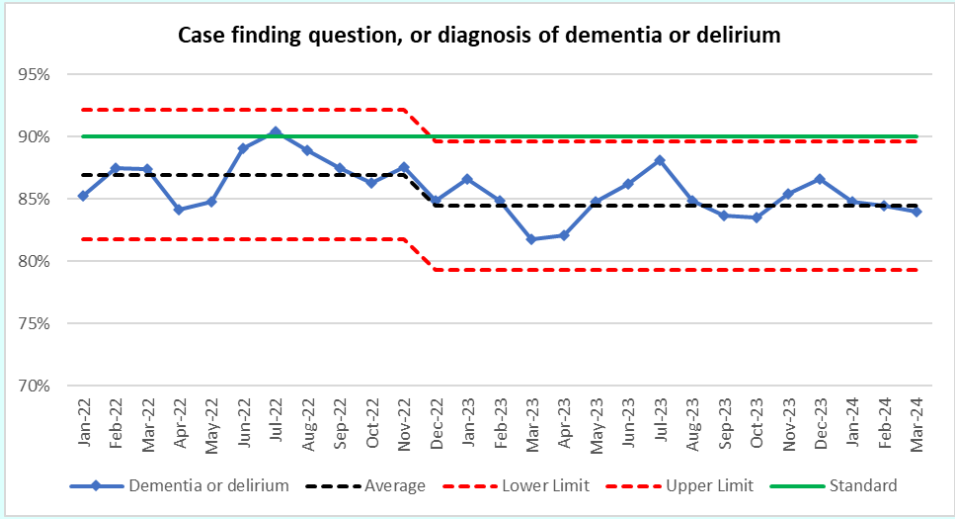
Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- All patients 65 years + admitted to the Trust for 72 hours and above are required to have a Dementia screen completed, this incorporates the SQiD screening for delirium. The screen is completed by both Nursing and Medical staff and is supported by the Dementia Team. This has seen an increase in compliance with the percentage rate consistently >80%.
- Dementia screening is no longer reported nationally (stopped since 2020) due to the pandemic and then following a consultation process, reporting has continued at Sherwood Forest Hospitals.
- Delirium assessments scores are required as part of the data submitted for the Yearly National Audit of Dementia, the team continue to focus and educate on the impact Delirium can have on a patient's journey including mortality, patient experience and length of stay.
- Following the recruitment of the Admiral Nurse, the Standard Operating Policy has been completed.
  Digital work with nervecentre to be launched April/May 24, includes lying and standing blood pressures and visual acuity.

Root causes	Actions	Impact/Timescale
Whilst we have achieved compliance >80% of Dementia screening, we have not reached the Trust target of >90%	• Emphasis on identifying patients with delirium and supporting patients with dementia, including their carers as part of the 'Dementia Well Pathway'. • Tier 1 Dementia training to be reinstated on the Mandatory programme • Consider Tier 2 training for Dementia champions • Review of current Dementia service provision	Underway Tier 1 training reinstated Tier 2 training for Dementia champions - underway Underway – working with Improvement Faculty (biannual update to PSC)

Data



Domain Summary: People and Culture

Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead
During the quarter we have seen continued events of **Industrial Action** held by the British Medical Association (BMA), there were a mix of Junior Doctors and Consultant strikes held between 3-9th January 2024 (Juniors 82% loss) and 24-28th February 2024 (Junior - 65% loss). We have undertaken the National Staff Survey, and the results are extremely positive, with the Trust ranked as the best NHS Acute Trust nationally for staff morale, staff engagement and in the best midlands to work for and for patients receiving standards of care staff would want for friends and family. Over the last three months we have seen a decrease in the Trust **vacancy** level, over the quarter this is recorded at 3.1% (Q2 – 3.7%), with the rate for March 2024 at 2.9%. Our **Mandatory and Statutory Training (MaST)** position is really positive where we are continuing to report levels above the Trust targets. Our final **Flu vaccine** reporting level was 58.9%**,** nationally there was an ambitions target of 80%. It is acknowledged that this is lower than in previous years (61.9%), however nationally the NHS are reporting lower figures, 43.0% of eligible healthcare workers nationally having had a flu vaccine. **Appraisal** level for quarter 4 (88.3%) sits below the Trust target (90.0%), we have noted a static position in compliance over quarter 4. During March 2024 the level sits at 87.8%, however, this is still a strong level of performance. During quarter 3 we have re-launched and embedded our revised appraisal paperwork, and during quarter 4 we are asking for feedback on this to ensure this works for our managers and employees. Trajectories for improvement in areas of low compliance have been set Over quarter 4 our **sickness absence** level is reported at 4.6% (Q3 – 4.8%), this is a seasonally expected level but does sit higher than Trust target (4.2%) and between the upper and lower SPC levels. During quarter 4 we are seeing a reduce absence level. There has been an increase with **employee relations** cases over the quarter (ave. 19). We have seen a marginal increase over the quarter with March 2024 recorded at 21 cases, this sits above our target (n.12) and above the upper SPC limit. Previously there have been a high level of grievance cases however in recent months we have seen an decrease in these but an increase in formal disciplinaries. Stage 2 Sickness absence cases remain consistent. We are aware that across Nottinghamshire our ICB has been flagged for high **agency usage** and we have a system programme to review our agency usage. Across the ICB we are active in this agency working group and we do understand where we have high usage within the Trust. We also have developed internal control meetings that are supporting our financial improvements. Our current agency position is reported at 4.2%, when we exclude ERF schemes from the agency level this reduces to 3.3% for March 2024. The quarterly position reported at 4.7% (exc ERF 3.8%) , although this does sit above the target level of 3.7% this has been impacted by the junior medical industrial action episodes and we have seen a reduction over the quarter. During quarter 4, 52.1% of total agency shifts filled were 'on framework' staff but **above the recommended NHSE price cap**, we have set a target of 30% for this metric, the majority of this sits with our medical workforce (98.6%). During the last quarter significant work has commenced that aligns to our 100 days plans and ambition to reduce our reliance on agency usage and financial recovery challenge. We are currently advertising a significant level of medical consultant posts and are confident this will direct impact on the levels on our agency usage. Additionally, of the agency shifts filled we have seen very low levels of those filled by **off framework** workers over the last quarter (January – March 2024). To note there has been 0.1% off framework agency workers. We have arranged medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff, where possible, on to direct engagement contracts. As an example, we have had success with Intensive Care and Anaesthetics and are scoping out where we have risk and are developing a programme to enable these discussions and associated actions to be delivered. We are also working closely with Remedium looking at longer term medical workforce plans.	DOP

Scorecard: People and Culture

Sherwood Forest Hospitals NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	2023/24 YTD
Belonging in the NHS	Engagement Score	≥6.8%	-	-	-	✓ 7.0	-	-	-	✓ 7.0	-	-	-	✓ 7.0	-	-	-	-	-
Growing the Future	Vacancy rate	≤6.0%	✗ 6.9%	✓ 5.8%	✗ 6.6%	✗ 6.5%	✓ 5.4%	✓ 5.3%	✓ 5.4%	✓ 5.4%	✓ 4.0%	✓ 3.4%	✓ 3.6%	✓ 3.7%	✓ 3.4%	✓ 2.9%	✓ 2.9%	✓ 3.1%	✓ 4.6%
	Turnover in month	≤0.9%	✓ 0.80%	✓ 0.40%	✓ 0.40%	✓ 0.50%	✓ 0.70%	✓ 0.50%	✓ 0.50%	✓ 0.50%	✓ 0.50%	✓ 0.40%	✓ 0.60%	✓ 0.50%	✓ 0.40%	✓ 0.40%	✓ 0.43%	✓ 0.41%	✓ 0.50%
	Appraisals	≥90%	✗ 87.1%	✓ 90.4%	✓ 90.2%	✗ 89.3%	✗ 89.5%	✗ 89.5%	✗ 88.0%	✗ 89.0%	✗ 87.3%	✗ 88.3%	✗ 88.8%	✗ 88.1%	✗ 88.9%	✗ 88.3%	✗ 87.8%	✗ 88.3%	✗ 88.7%
	Mandatory & Statutory Training	≥90%	✓ 90.0%	✓ 90.0%	✓ 91.0%	✓ 90.3%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 91.0%	✓ 92.0%	✓ 91.3%	✓ 90.9%
Looking after our People	Sickness Absence	≤4.2%	✗ 4.4%	✓ 4.2%	✓ 4.2%	✓ 4.2%	✗ 4.5%	✗ 4.3%	✗ 4.5%	✗ 4.4%	✗ 4.8%	✗ 4.3%	✗ 5.1%	✗ 4.8%	✗ 4.9%	✗ 4.7%	✗ 4.3%	✗ 4.6%	✗ 4.5%
	Total Workforce Loss	≤7.0%	✓ 6.2%	✓ 6.1%	✓ 6.3%	✓ 6.2%	✓ 6.5%	✓ 6.4%	✓ 6.6%	✓ 6.5%	✓ 6.9%	✓ 6.4%	✗ 7.3%	✓ 6.9%	✗ 7.3%	✓ 6.9%	✓ 6.4%	✓ 6.9%	✓ 6.6%
	Flu vaccinations uptake - front line staff	≥80%	-	-	-	-	-	-	-	-	✗ 38.3%	✗ 44.8%	✗ 55.9%	✗ 55.9%	✗ 58.0%	✗ 58.0%	-	✗ 58.0%	✗ 51.0%
	Employee Relations Management	<12	✓ 9	✓ 11	✗ 14	✓ 11	✗ 15	✗ 18	✗ 14	✗ 16	✗ 21	✗ 23	✗ 18	✗ 21	✗ 20	✗ 17	✗ 21	✗ 19	✗ 17
New Ways of Working	Agency (Off Framework)	≤6.0%	✓ 0.1%	✓ 0.1%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✓ 0.1%	✓ 0.1%	✓ 0.1%	✓ 0.1%	✓ 0.0%	✓ 0.1%	✓ 0.0%
	Agency (Over Price Cap)	≤30.0%	✗ 47.7%	✗ 59.6%	✗ 53.1%	✗ 53.3%	✗ 55.3%	✗ 48.9%	✗ 50.8%	✗ 51.5%	✗ 51.0%	✗ 55.7%	✗ 57.0%	✗ 54.3%	✗ 54.6%	✗ 47.4%	✗ 54.4%	✗ 52.1%	✗ 53.0%
	Agency Usage (%)	<3.7%	✗ 6.1%	✗ 7.4%	✗ 6.0%	✗ 6.5%	✗ 7.4%	✗ 6.5%	✗ 5.9%	✗ 6.6%	✗ 6.2%	✗ 5.5%	✗ 3.9%	✗ 5.2%	✗ 5.2%	✗ 4.6%	✗ 4.2%	✗ 4.7%	✗ 5.7%

Indicators in Focus: People and Culture – Appraisals

Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

The charts below expresses that our appraisal level sits below the Trust target (90%), we have noted a reduction in the appraisal level during quarter 4 , and this has remained at the same level as seen in quarter 3. The quarter 4 average sitting at 88.3%. During March 2024 the level has decreased to 87.8%, Although we are marginally under the standard this is still a strong level of performance and over the quarter we are showing an improved level.

Local benchmarking shows that the ICB provider appraisal level is reported at 82.6%. National levels within the model hospital are reported at 80.9% (October 2023).

Root causes

As stated, we have seen a static position in the overall appraisal level over the last few months, we are marginally below the standard and this lower level reduction does align to the acuity of the hospital.

In some instances, we have received feedback that managers have raised concerns how to report this via ESR.

Capacity and industrial action has also had an impact on compliance

Actions

Service lines with low appraisal rates are supported to develop trajectories for improvement in areas of low compliance have been set

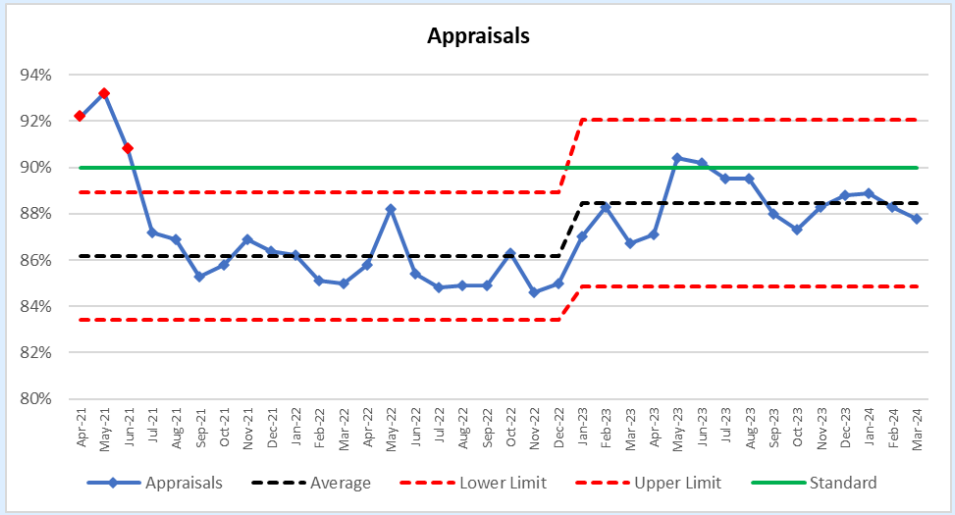
In addition, Service Lines are sighted on non-compliance rates and assurance is sought via monthly service line performance meetings. This is addition to monthly People and Performance review meetings within each department

Training and coaching managers on how to enter appraisals onto ESR is on place along with “A how to” video guide to support our written user guidance.

Impact/Timescale

As we move into 2024/2025 we expect Appraisal compliance levels-to gradually increase, with an ambition to see levels of 90%

Data



Indicators in Focus: People and Culture – Sickness Absence

Sherwood Forest Hospitals NHS Foundation Trust

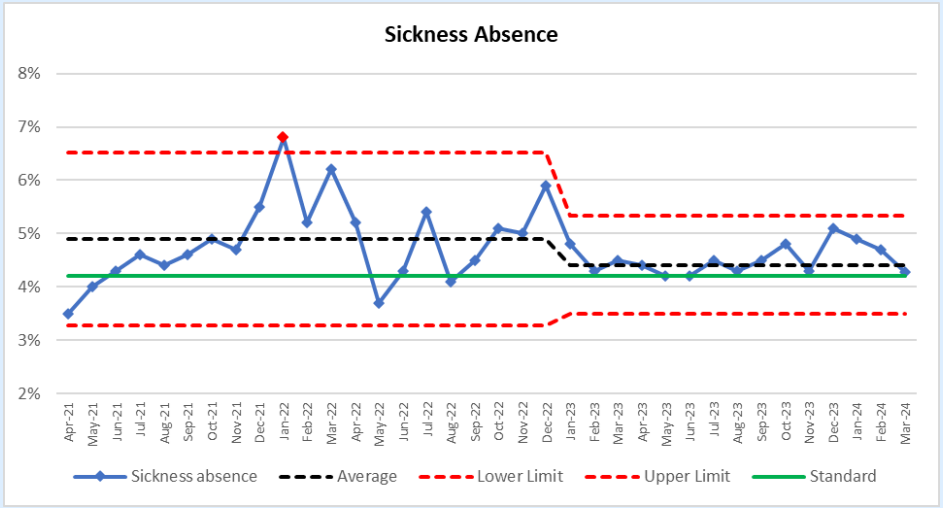
National position & overview

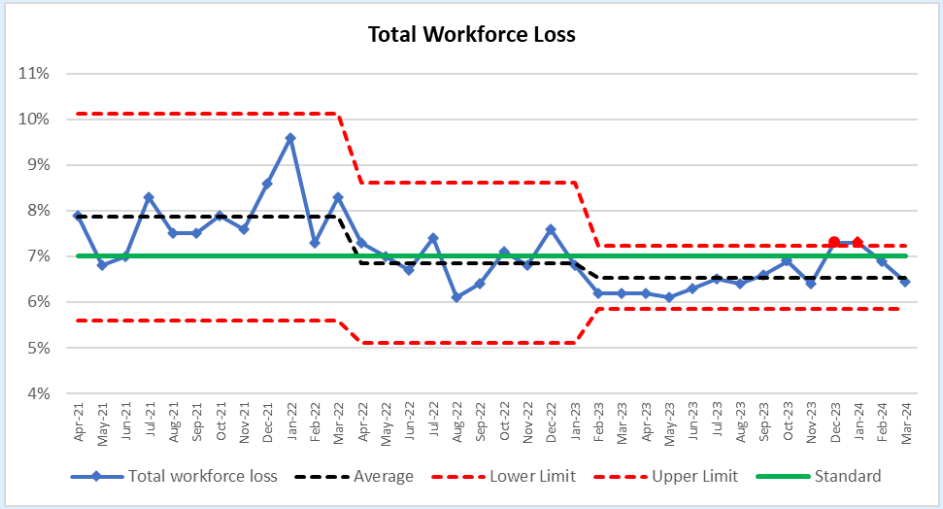
During quarter 4 our overall sickness absence level has been reported 4.6%, this sits above our standard (4.2%), during the quarter a gradual reduction in the level is noted. The position for March 2024 is reported at 4.3%. Sickness is seasonal and we do expect a higher level during quarter 3 and gradually reducing during quarter 4. Our position for quarter 4 sits between the upper and lower SPC levels.

Local benchmarking shows that the ICB provider sickness absence level is reported at 5.4% (February 2024). National levels within the model hospital are reported at 4.9% (October 2023).

Root causes	Actions	Impact/Timescale
Our sickness level show seasonal variations, and are reflective of the acuity of the hospital, specifically norovirus and increase in respiratory short term absences. We are noting an increase in length of absences due to the impact of NHS waiting and treatment times.	All services are supported with 121 support from the Divisional People Lead teams with sickness absence management on a case by case basis and in line with policy. Sickness absences KPIs are monitored through People and Performance meetings, Service Line meetings and via Divisional Performance Reviews (DPRs). A person centred approach is taken in relation to Sickness Absence management Coaching is in place for management of absences along with training session delivery.	We actively manage sickness cases through a person centred approach and are aware of outside influences that are contributing to an elevated sickness level.

Data





Indicators in Focus: People and Culture – Employee Relations

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

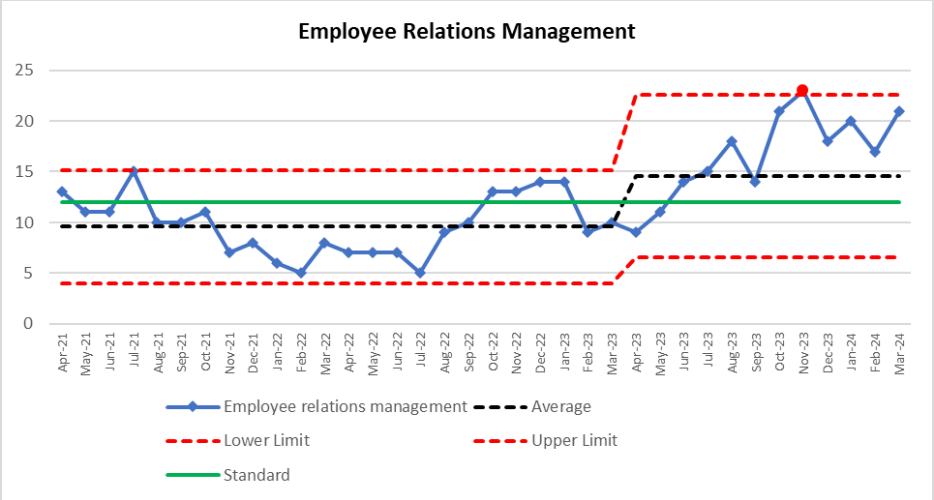
Since April 2023 we have seen a gradual increase to the employee relations cases, currently we are reporting 19 cases for quarter 4.

During quarter 4 this level has fluctuated and in In March 2024 we have noted a increase in the overall number of cases to 21.

Our current level sits above the standard and sits between the SPC levels.

Root causes	Actions	Impact/Timescale
Within Q3 and Q4, the Trust has seen a number of formal grievances being concluded, but a marked increase in the number of appeals within Q4. The number of appeals is currently submitted to the Trust are higher than seen throughout 23/24. Previously there have been a high level of grievance cases however in recent months we have seen an decrease in these but an increase in formal disciplinaries. These mainly relate a rise in Attitude and Behaviours but also in Safeguarding concerns outside of the workplace. Stage 2 Sickness absence cases remain consistent. Local intelligence suggests that Sherwood is not an outlier in relation to Employee Relations casework with other organisations reporting a significant increase in Employee Relations cases.	All cases are managed using Just Culture Principals and taking a person centred approach with additional training taking place New policies and procedures have been devised to help support both colleagues and managers Existing policies and procedures have been refined to help support. 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 ER process Person centred approach is in place in relation to Sickness Absence management Specialist panel advisers from Safeguarding and included in all safeguarding hearings. Re emphasis an informal resolution to incidents, concerns and adverse events, where possible.	As we move to 2024/2025 we do not expect case levels to significantly decrease but it is hoped to return to average levels

Data



Indicators in Focus: People and Culture – Agency Usage

Sherwood Forest Hospitals
NHS Foundation Trust

National position & overview

Our overall agency position across the quarter is reported at 4.7% (excluding ERF this reduces to 3.8%), this does sit above the target level of 3.7%. Our March 2024 position is reported at 4.2% (excluding ERF reduces to 3.3%).

On framework, over price cap is reported at 52.1% and is above our target 30.0%. These metrics have been impacted by the BMA industrial action episodes and acuity of the hospital.

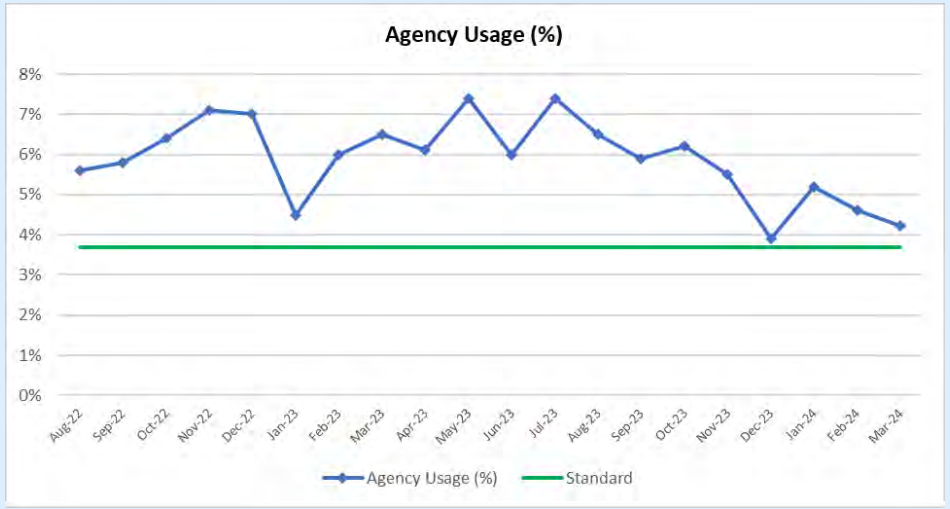
Local benchmarking shows that the ICB provider agency level is reported at 3.7%, which is the NHSE Target. For 2024/25 the NHSE target will reduce to 3.2%.

Over the 2023/24 period we have seen a constant reduction in our agency level, showing a reduction from Q1 (6.5%) to Q4 position at 4.7%, and as noted above with ERF this closely aligns to the expected agency level (3.7%).

Our plans over 23/24 were to exit long term locum roles, which we have been undertaking successfully. Over the 24/25 period we will be focusing on those locum who are 'on framework' and 'over price cap', with plans to replace with substantive roles, this will further reduce our 'over price cap' compliance leave and reduce the agency usage level.

Root causes	Actions	Impact/Timescale
As the data informs us our biggest risk is medical & dental staff over the NHSE price cap, these are also impacted by some of our fragile services were there are national speciality shortages.	During the last 2 quarters significant work has commenced that aligns to our 100 days plans and ambition to reduce our reliance on agency usage and financial recovery challenge. Over 2023/24 we have advertised and filled medical posts, that has gradually reduced our agency level. We organise medical speciality groups where there is a focus on agency spend and vacancies, with a view to support our service lines in filling these roles substantively, if not moving staff, where possible, on to direct engagement contracts. A strict authorisation process for approval of shifts for Thornbury has been implemented in Nursing. Detailed reports illustrating areas using all Agency with Thornbury highlighted are produced for the Deputy Chief Nurse.	We have been actively filling medical roles and have had success in some key specialities, the reduction are noted across the 2023/24 period. Over the 24/25 period we are focusing on medical staff who are on framework, but over the NHSE price cap and are developing plans to exit these agency workers and replace with substantive roles.

Data



Indicators in Focus: People and Culture – Flu Vaccinations

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

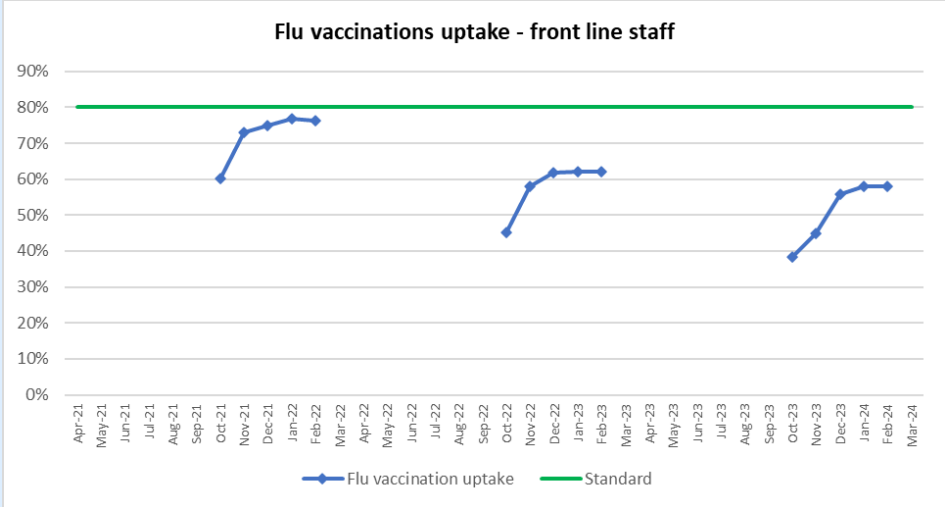
Our Staff Flu take up is reported at 58.9%, it is acknowledged that this is lower than in previous years (61.9% - Dec 22), however nationally the NHS are reporting lower figures, 38.5% of eligible healthcare workers nationally having had a flu vaccine.

The flu programme has now closed for 2023/24, however we did actively promote Flu vaccinations and linked this into our Health & Wellbeing campaigns, aligned to the keeping well during winter programmes.

Looking forward into 2024/25 we will review what went well across the programme and plan how we can maintain or increase our overall level.

Root causes	Actions	Impact/Timescale
Across the Trust we actively promoted Flu vaccinations and linked this into our Health & Wellbeing campaigns, this was aligned to the keeping well during winter programmes. To promote the take up across SFH we adopted different measures and where possible took the vaccines to staff. We did note that the acuity of the hospital has had an impact on vaccination levels. 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.	Before the next flu period we will be reviewing what went well over the flu period and look how we can develop improvements to attempt to increase of vaccinations compliance. We will also be reviewing are where we have low compliance over differing lenses, so we can further target hard to reach groups.	Programme ended 29th February 2024.

Data



Domain Summary: Timely Care

Sherwood Forest Hospitals
NHS Foundation Trust

Overview	Lead
In 2023/24 Q4 (Jan-Mar) seasonal pressures continued with surging numbers of A&E attends (at times over 11% greater than plan) and ambulance arrivals at the highest levels since the summer of 2022. Non-elective admission demand was more than 3% above our plan meaning that pressures on our bed base remained high despite Medically Safe for Transfer (MSFT) and long stay patient numbers being lower than in Q1 and Q2. The pressure on our services has been sustained for many months, much like many acute Trusts across the country. The combination of high attendance and admission demand, length of stay pressures and mismatches in admission and discharge times meant that, at times, patient demand exceeded the capacity of our hospitals. This mismatch in demand and capacity resulted in us starting the day on OPEL 4 on 55 days during Q4 (19 in Jan-24, 17 in Feb-24 and 19 in Mar-24) with patients experiencing delays to admission due to a lack of beds. In response to these pressures, we enacted escalation actions and at times our full capacity protocol. Despite the challenges, we continued to provide strong ambulance handover consistently performing as one of the best in the country; and have a strong medical Same Day Emergency Care (SDEC) offer exceeding national targets. In Mar-24 we increased focus on the 4-hour access target in line with a national focus to support timely patient care and to decongest our Emergency Department. Our efforts delivered a 9%-point improvement in 4-hour performance between Feb-24 and Mar-24. The subsequent pages highlight several key actions being taken to improve timely care, some of which are divisionally-led. Whilst the interplay between emergency and elective pathways continues to create challenges, it has been the ongoing instances of Industrial Action (early Jan-24 and late Feb-24 in Q4) that have resulted in curtailments in elective activity which adversely impact on our elective activity, backlog and performance metrics. In 2023/24 we had 10 instances of Junior Doctor Industrial Action. The national requirement to meet zero 78-week waiters continues to be missed due to a mixture complexity or patient choice with five patients waiting greater than 78-weeks at the end of Mar-24. The number of 65-week waiting patients has reduced during Q4 with further work required in 2024/25 Q1 and Q2 to ensure no patients are waiting more than 65-weeks unless due to patient choice. We continue to work together as a system with patients being transferred between providers as part of mutual aid arrangements. We are benefiting from some mutual aid to help with our Echocardiograph position, one of our underperforming diagnostic tests, which together with insourcing plans is gradually helping us to reduce the significant backlog. In Outpatients, activity levels remain strong and above plan. We have consistently exceeded the 5% Patient Initiated Follow Up (PIFU) target. We continue to see in the region of 15% of outpatient non-face-to-face; we recognise that we have further work to ensure that we make full benefit of remote outpatient attendances; embedding the learnings from the height of the pandemic. In terms of our Cancer metrics, we continue our strong delivery of the national 28-day faster diagnostic standard exceeding the national standard. In Q4 we have successfully reduced the number of two-week wait patients waiting over 62-days for treatment delivering against our original 23/24 planning trajectory for the end of Mar-24. Further details relating to timely care metrics are included in the following pages with metrics grouped together within the relevant care pathways.	COO

Scorecard: Timely Care – Urgent Care

Sherwood Forest Hospitals NHS Foundation Trust

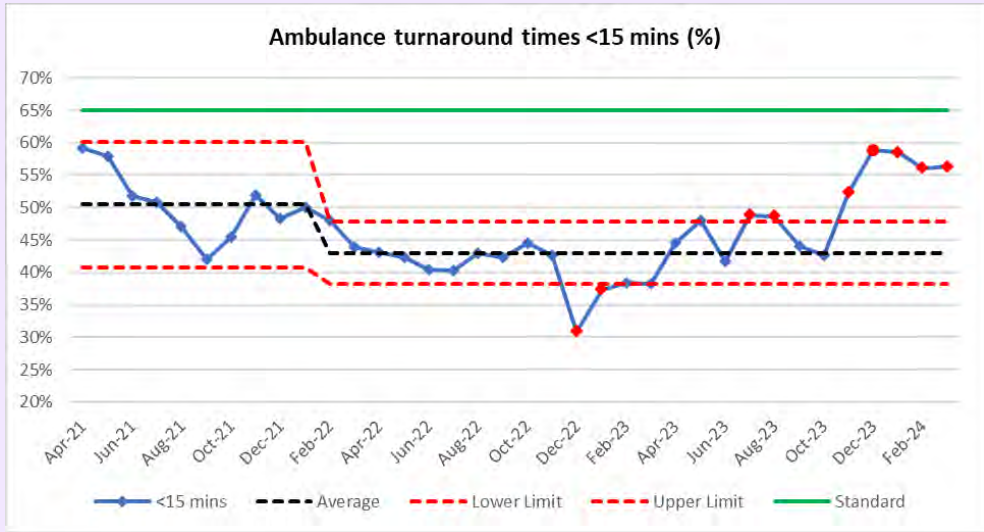
Green tick = target met/exceeded; Red cross = target not met

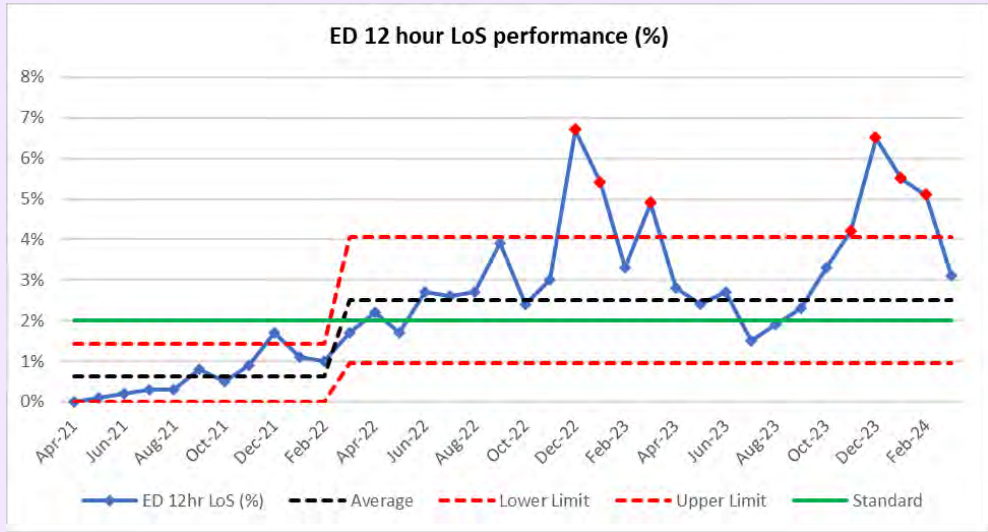
At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	2023/24 YTD
Urgent Care	Ambulance turnaround times <15 mins (%)	≥65%	✗ 44.6%	✗ 48.0%	✗ 41.7%	✗ 44.8%	✗ 48.8%	✗ 48.7%	✗ 44.0%	✗ 47.2%	✗ 42.7%	✗ 52.3%	✗ 58.8%	✗ 51.4%	✗ 58.5%	✗ 56.1%	✗ 56.3%	✗ 57.0%	✗ 50.2%
	Ambulance turnaround times <30 mins (%)	≥95%	✓ 96.0%	✓ 96.1%	✗ 94.0%	✓ 95.4%	✓ 96.5%	✓ 96.6%	✓ 95.2%	✓ 96.1%	✗ 93.7%	✓ 96.8%	✓ 96.7%	✓ 95.7%	✓ 95.6%	✗ 93.9%	✗ 94.6%	✗ 94.7%	✓ 95.5%
	Ambulance delays >60 mins (%)	0.0%	✗ 0.1%	✓ 0.0%	✗ 0.3%	✗ 0.2%	✗ 0.1%	✓ 0.0%	✓ 0.0%	✓ 0.0%	✗ 0.1%	✗ 0.2%	✗ 0.1%	✗ 0.1%	✗ 0.2%	✗ 0.2%	✗ 0.5%	✗ 0.3%	✗ 0.2%
	ED 4 hour performance (%)	≥76%	✗ 75.6%	✗ 74.0%	✗ 73.1%	✗ 74.2%	✓ 77.0%	✓ 76.6%	✗ 72.3%	✗ 75.3%	✗ 69.4%	✗ 67.1%	✗ 64.9%	✗ 67.2%	✗ 65.7%	✗ 63.6%	✗ 72.2%	✗ 67.3%	✗ 70.9%
	Mean waiting time in ED (in minutes)	≤200	✗ 209	✗ 212	✗ 217	✗ 213	✓ 199	✓ 199	✗ 218	✗ 205	✗ 236	✗ 247	✗ 269	✗ 251	✗ 259	✗ 265	✗ 228	✗ 250	✗ 230
	ED 12 hour LoS performance (%)	≤2%	✗ 2.8%	✗ 2.4%	✗ 2.7%	✗ 2.6%	✓ 1.5%	✓ 1.9%	✗ 2.3%	✓ 1.9%	✗ 3.3%	✗ 4.2%	✗ 6.5%	✗ 4.7%	✗ 5.5%	✗ 5.1%	✗ 3.1%	✗ 4.5%	✗ 3.4%
	ED 12 hour DTA breaches	0	✗ 84	✗ 84	✗ 78	✗ 246	✗ 32	✗ 58	✗ 65	✗ 155	✗ 125	✗ 147	✗ 284	✗ 556	✗ 244	✗ 144	✗ 109	✗ 497	✗ 1,454
	Number of A & E attendances against plan	≤Plan	✓ 98.6%	✗ 104.1%	✗ 106.4%	✗ 103.1%	✗ 104.3%	✓ 98.8%	✗ 106.5%	✗ 103.1%	✗ 104.4%	✗ 104.7%	✗ 102.0%	✗ 103.7%	✗ 104.5%	✗ 111.1%	✗ 111.6%	✗ 109.0%	✗ 104.7%
	Number of NEL admissions against plan	≤Plan	✓ 93.9%	✓ 95.0%	✓ 99.8%	✓ 96.2%	✓ 97.0%	✓ 95.5%	✓ 99.9%	✓ 97.4%	✗ 105.1%	✗ 105.8%	✓ 97.3%	✗ 102.7%	✗ 103.4%	✗ 103.6%	✗ 102.0%	✗ 103.0%	✓ 99.8%
	SDEC activity (%)	≥33%	✓ 37.5%	✓ 37.6%	✓ 37.6%	✓ 37.5%	✓ 37.2%	✓ 36.5%	✓ 36.8%	✓ 36.9%	✓ 39.8%	✓ 37.1%	✓ 36.2%	✓ 37.7%	✓ 38.3%	✓ 38.1%	✓ 37.8%	✓ 38.1%	✓ 37.6%
	Adult G&A bed occupancy (%)	≤92%	✗ 95.7%	✗ 96.4%	✗ 96.3%	✗ 96.1%	✗ 94.0%	✗ 98.6%	✗ 95.4%	✗ 96.0%	✓ 92.0%	✗ 96.3%	✗ 95.3%	✗ 94.6%	✗ 97.9%	✗ 97.8%	✗ 96.5%	✗ 97.4%	✗ 96.0%
	Long length of stay (21+) occupied beds	≤Plan	✗ 135.6	✗ 127.3	✗ 126.7	✗ 130.0	✗ 123.0	✗ 119	✓ 110	✗ 118	✓ 100	✗ 109	✗ 100	✗ 103	✗ 116	✗ 116	✗ 107	✗ 116	✗ 117
	Inpatients MSFT >24 hours	≤40	✗ 106	✗ 116	✗ 106	✗ 109	✗ 107	✗ 110	✗ 93	✗ 104	✗ 90	✗ 98	✗ 92	✗ 94	✗ 93	✗ 105	✗ 101	✗ 98	✗ 102

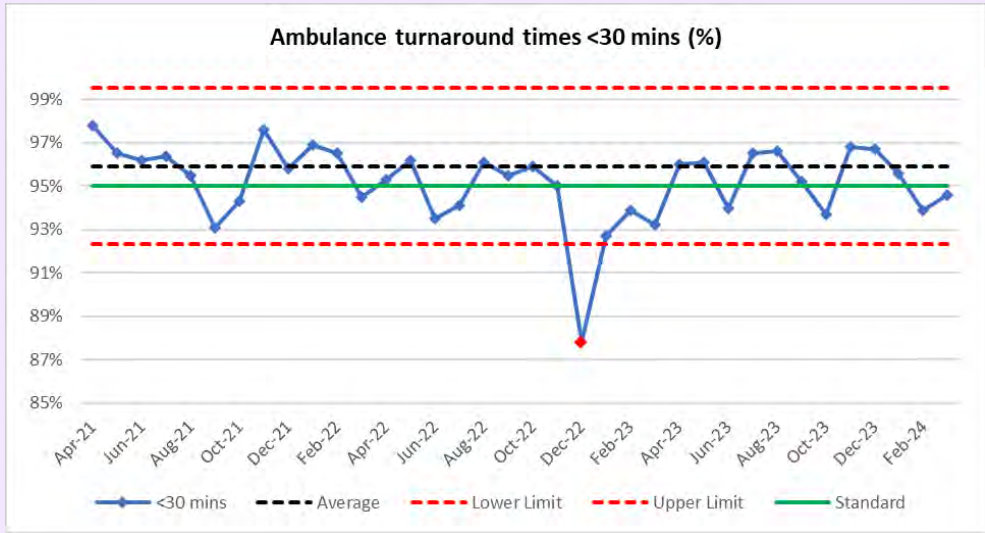
Indicators in Focus: Timely Care – ED metrics (1/2)

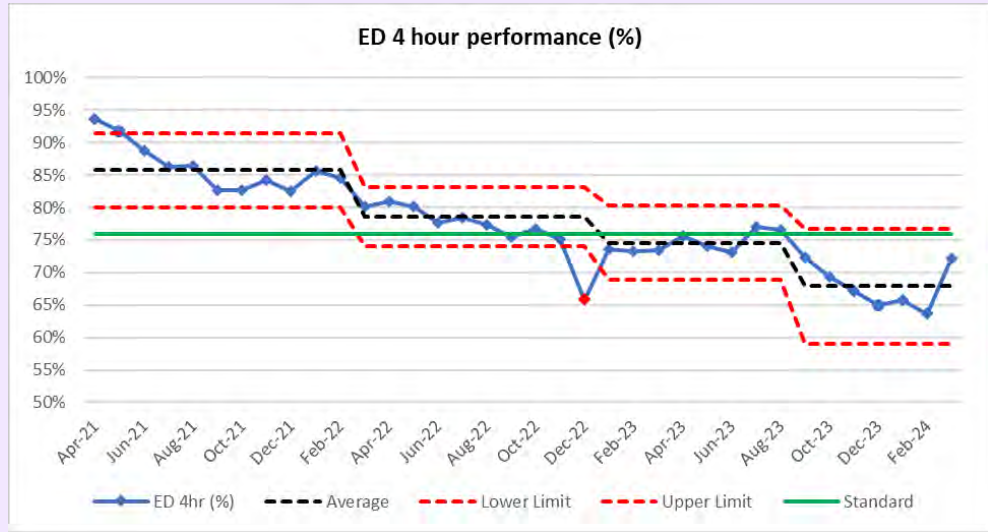
Sherwood Forest Hospitals
NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

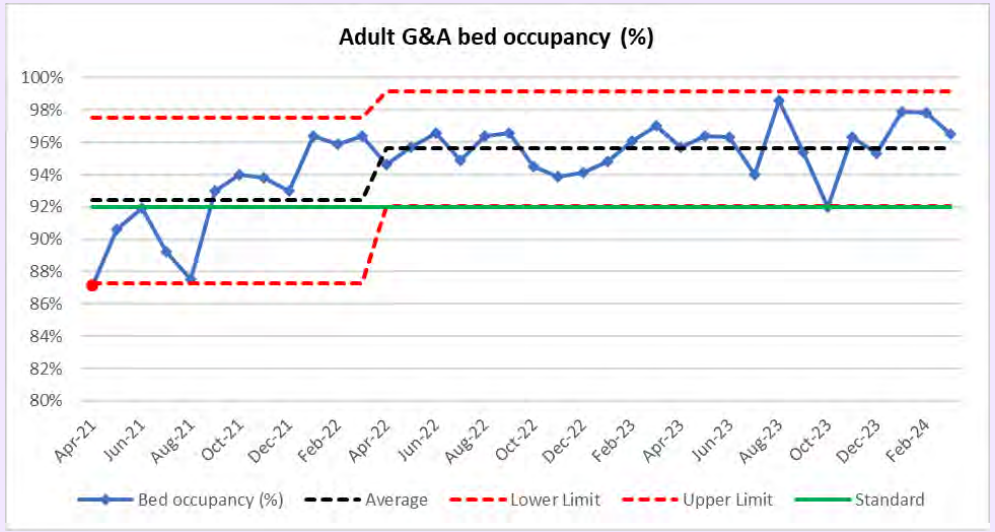
- Our ambulance handover position is significantly better than the East Midlands Ambulance Service (EMAS) average and amongst the best nationally:
  - Frequently best in Midlands and within top 10 nationally for Ambulance handovers less than 30 mins.
  - EMAS average handover time 44 minutes, SFH 15 minutes.
- 4-hour and 12-hour benchmark position has improved in Mar-24 as additional actions were put in place to support increased demand. Exact position to be confirmed once Mar-24 benchmark data is published.
- ED Attends 15% more in Feb-24 than Feb-23 and 11% more than planned levels. This places us in the top third of Trusts nationally in terms of the level of attendance growth.

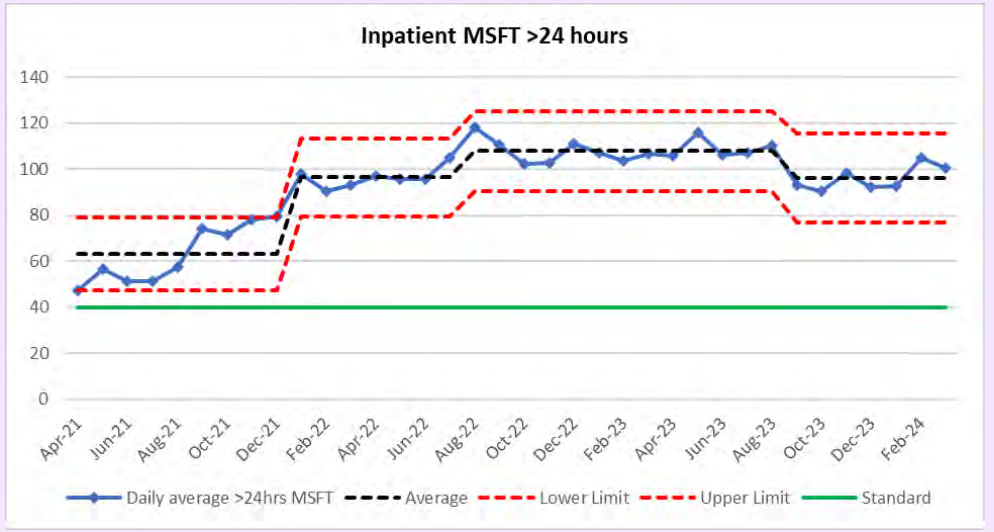
Root causes	Actions and timescale	Impact
Increased ED attendance demand.	Expand hospital Same Day Emergency Care (SDEC) services through: • Frailty SDEC in the new Discharge Lounge currently scheduled to open 6 May in line with the Discharge Lounge trial of 24/7 working. • Surgical SDEC trial commences 8 April 2024.	• Reduction in Frail patients in ED by 20 hours per day. • Increase in SDEC will support decongestion of Emergency Department and reduce the average time spent in department supporting improved 4-hour performance.
	• Review of attendance variance with partners (ICB / EMAS) for walk in attendances and ambulance with postcode analysis	• Reduction in out of area conveyances
Insufficient staffing to manage ED demand.	• Senior Nurse Initial Triage. • Additional senior decision makers based on attendance and breach analysis. • 24/7 Band 7 registered nurse to provider oversight and leadership for quality and performance from 1 April 2024. • Command centre updated to give oversight of live daily performance. • Daily huddles and validation of breaches.	• Average (mean) time in Department - non-admitted patient reduction to <180 mins. • Time to initial assessment for arrivals to A&E % seen within <= 15 minutes greater than 60% in Q4. • Reduction in non-admitted breaches and increased 4-hour performance by 6% from Feb-24 to Mar-24.
	Develop new, expanded 'Fit to Sit' area with the 12 spaces currently situated in Minors moving to be collocated with Majors to support enhanced patient flow and with an improved staffing model. Timescale to be determined following completion of estates scoping work.	• Reduction in overcrowding in ED and timely transfer from ED.
ED overcrowding driven by bed capacity pressures and mismatches in admission and discharge demand.	Develop Discharge Lounge pathways to support the transfer of patients out of ED e.g for patients awaiting transport from May-24 (when discharge lounge is open 24/7).	• Improve patient experience as patients will be waiting to leave from discharge lounge rather than the Emergency Department.
	Improved overall flow.	• See next two slides.

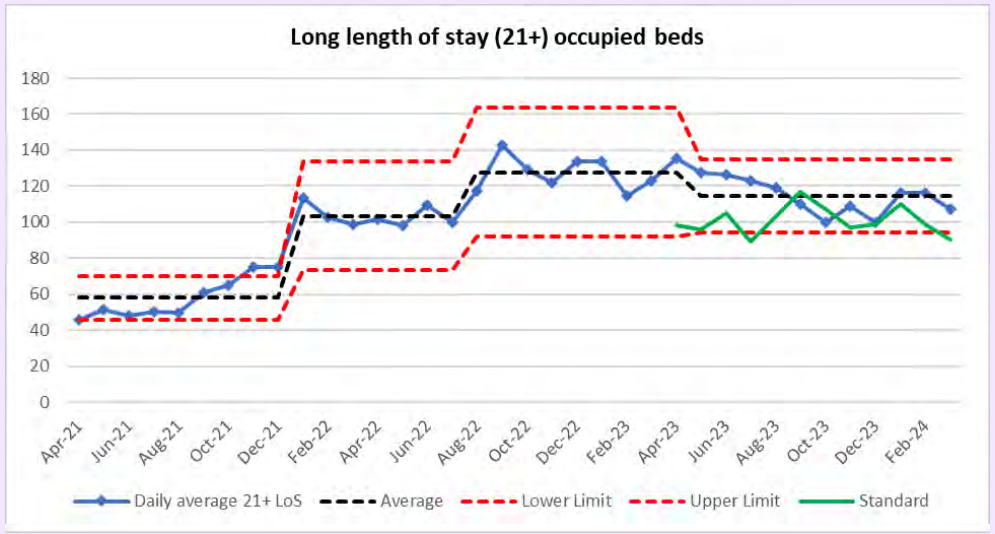
Indicators in Focus: Timely Care – Hospital flow metrics (1/2)

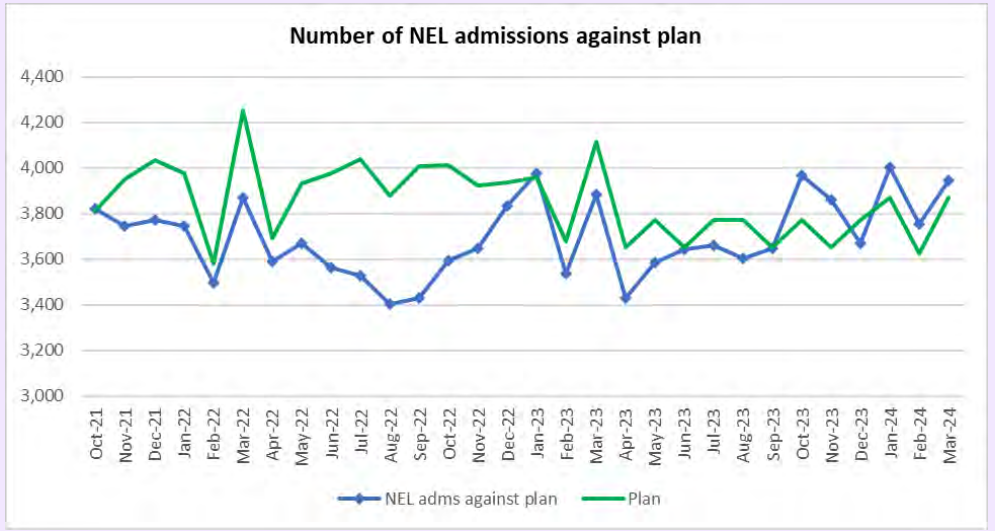
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Non-elective admission demand has been high in Q4, above our planned levels by circa 3-4%. Our discharge levels have been strong; however, the demand for beds remains high.
- Despite the winter plan increasing our capacity, we continue to operate at bed occupancy levels greater than 97%. Our bed occupancy is routinely higher than the Midlands average (typically 94-95%) and the planning guidance ambition of 92%.
- The number of patients Medically Safe For Transfer (MSFT) over 24 hours increased marginally in Q4 however remains lower than Q1 and Q2. The improved local position remains above the agreed threshold both in terms of the 2023/24 plan value and the 2022/23 national planning guidance ambition (latter standard used on the chart).
- The number of long stay patients have followed a similar trend to MSFT inpatient numbers due to similarities in the patient cohort. We have less long stay patients than the Midlands regional average (13-15% of our bed based compared with 16-17% regional average).

Root causes	Actions and timescale	Impact
Delays to pre-medically safe processes on inpatient wards.	• Board and ward round improvement programmes support our daily focus on timely discharge. The focussed programme with the Stroke wards continues and a new one with Ward 32 (medical outliers) has commenced. • Long length of stay (LOS) meetings for pre-medically safe patients on acute wards gathering momentum.	• Delivery of today's work today and early identification of potential discharge barriers will lead to reduced LOS. • LOS meetings for pre medically safe patients identify opportunities for utilising virtual wards and early identification of potential barriers to discharge.
	• Nervecentre improvements are ongoing, and use of the live flow dashboards is being embedded with ward teams and discharge staff. • A new team of discharge coordinators have been recruited and trained. From Apr-24, they will start to be deployed to dedicated wards, embedding in the ward teams and working with patients and families.	• The new Nervecentre dashboards are helping to better identify where patients are in their hospital journey and how we can prevent delays to their discharge. • Enhanced discharge coordination will support successful discharge planning from point of admission.
Delays to post-medically safe discharge processes.	• Opening of a new Discharge Lounge (19 beds and 22 chairs) on 22 Apr-24 with aspiration to move patients within 30 minutes of being identified as a definite discharge on Nervecentre.	• Facilitate timely flow through the hospital by freeing up beds earlier in the day to enable admissions. Estimate to release 6-8 base ward beds.
	• Transfer of Care Hub continues to work well. We now have a regular member of the team from Age UK as well as the Home from Hospital Service situated in the Hub which supports the solution of several potential barriers to discharge. We continue to see a higher than previous number of patients with complex housing issues which we are discussing with the ICB to identify potential solutions.	• Focus on key themes in reducing delays for specific patient groups. • This will continue the downward trend in the number of long stay patients and the average LOS for the trust.
	• A 3-month trial with EMED patient transport service commences on 8 April booking patient discharges into time-specific slots.	• Eliminate barriers to discharge and reduce the number of abandoned discharges. • Improve allocation of vehicles and process on inpatient wards.
Insufficient community capacity to meet supported discharge demand (with a specific focus on out of area patients)	• We continue to see delays to discharge for patients requiring packages of care and placements in Derbyshire. We have been unable to secure a member of their team physically in the hub but now hold regular progress reviews with them to expedite timely discharges. • There is a growing concern around discharging Pathway 1 patients with health needs which is leading to an increased number of delays. CHC are setting up a forum to discuss with the ICB. • Daily escalation of Derbyshire discharge problems via refined reporting mechanisms.	• Rapid resolution of complex issues through multi agency working to support continued reductions in number of supported discharges waiting more than 24 hours for discharge.

Scorecard: Timely Care – Electives, Diagnostics and Cancer

Sherwood Forest Hospitals NHS Foundation Trust

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

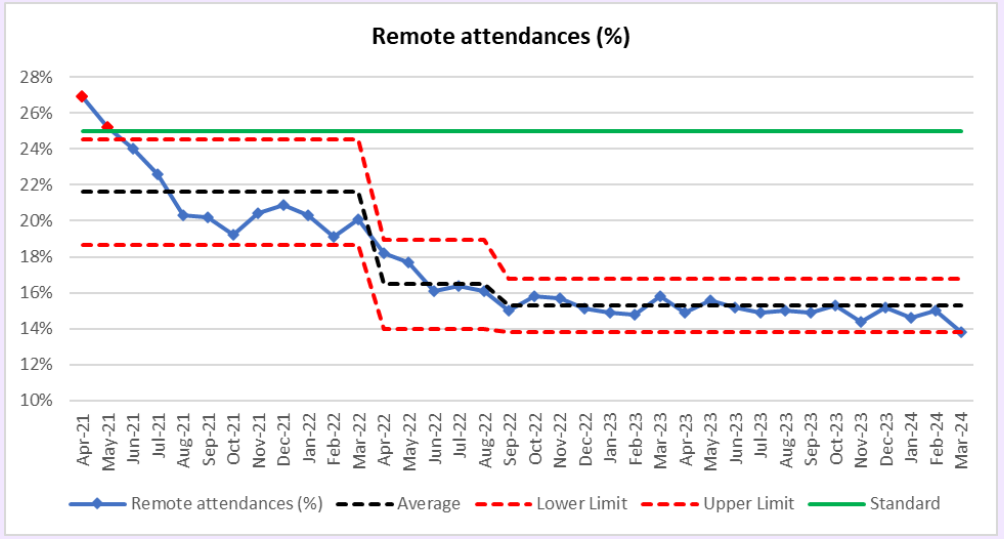
At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4	2023/24 YTD
Electives	Advice & guidance (%)	≥16%	✓ 25.3%	✓ 23.8%	✓ 23.9%	✓ 24.3%	✓ 24.5%	✓ 26.5%	✓ 24.1%	✓ 25.0%	✓ 25.3%	✓ 24.4%	✓ 23.0%	✓ 24.3%	✓ 24.3%	✓ 27.3%	✓ 25.6%	✓ 25.7%	✓ 24.8%
	Remote attendances (%)	≥25%	✗ 14.9%	✗ 15.6%	✗ 15.2%	✗ 15.3%	✗ 14.9%	✗ 15.0%	✗ 14.9%	✗ 14.9%	✗ 15.3%	✗ 14.4%	✗ 15.2%	✗ 14.9%	✗ 14.6%	✗ 15.0%	✗ 13.8%	✗ 14.5%	✗ 14.9%
	Added to PIFU (%)	≥5%	✗ 4.9%	✗ 4.7%	✓ 5.5%	✓ 5.0%	✓ 6.0%	✓ 5.7%	✓ 6.0%	✓ 5.9%	✓ 6.0%	✓ 5.7%	✓ 5.6%	✓ 5.8%	✓ 5.7%	✓ 5.6%	✓ 5.4%	✓ 5.6%	✓ 5.6%
	Average daily referrals		274	311	341	309	316	309	304	305	310	316	260	295	314	327	-	-	-
	Outpatients - first appointment against plan	≥Plan	✓ 104.4%	✓ 108.8%	✓ 105.3%	✓ 106.2%	✓ 104.9%	✗ 95.7%	✓ 104.5%	✓ 101.6%	✓ 105.4%	✓ 115.9%	✓ 105.2%	✓ 108.9%	✓ 112.5%	✓ 111.1%	✓ 111.8%	✓ 111.8%	✓ 107.1%
	Outpatients - follow up against plan	≤Plan	✗ 108.6%	✗ 115.8%	✗ 112.2%	✗ 112.3%	✗ 109.9%	✗ 109.5%	✗ 113.2%	✗ 110.8%	✗ 112.1%	✗ 118.1%	✗ 106.2%	✗ 112.3%	✗ 116.9%	✗ 116.5%	✗ 117.4%	✗ 116.9%	✗ 113.1%
	Daycase activity against plan	≥Plan	✓ 101.9%	✓ 104.3%	✓ 100.4%	✓ 102.2%	✓ 100.1%	✗ 93.3%	✗ 94.3%	✗ 95.8%	✗ 86.8%	✓ 101.2%	✗ 91.7%	✗ 93.3%	✓ 100.2%	✓ 101.5%	✓ 109.2%	✓ 103.5%	✗ 98.6%
	Elective inpatient activity against plan	≥Plan	✗ 97.7%	✗ 96.3%	✗ 93.2%	✗ 95.6%	✗ 84.4%	✗ 83.5%	✗ 94.4%	✗ 87.4%	✗ 86.8%	✓ 108.9%	✓ 107.4%	✓ 100.8%	✓ 102.4%	✓ 110.8%	✓ 131.6%	✓ 114.5%	✗ 99.6%
	Completed admitted RTT pathways against plan	≥Plan	✗ 910	✓ 1,179	✓ 1,163	✓ 3,252	✗ 1,044	✗ 1,033	✗ 1,072	✗ 3,149	✗ 993	✓ 1,206	✗ 951	✗ 3,150	✗ 1,082	✗ 954	✓ 1,117	✗ 3,153	✗ 12,704
	Completed non-admitted RTT pathways against plan	≥Plan	✗ 6,453	✓ 8,908	✓ 9,257	✗ 24,618	✗ 8,402	✗ 8,207	✓ 9,214	✗ 25,823	✓ 9,209	✓ 9,821	✗ 7,696	✓ 26,726	✓ 9,509	✗ 8,718	✓ 8,579	✓ 26,806	✗ 103,973
	Incomplete RTT waiting list against plan	≤Plan	✗ 49,956	✗ 51,459	✗ 51,946	✗ 51,946	✗ 52,814	✗ 54,047	✗ 53,949	✗ 53,949	✗ 53,708	✗ 52,717	✗ 52,569	✗ 52,569	✗ 52,377	✗ 50,534	✗ 50,757	✗ 50,757	✗ 50,757
	Incomplete RTT pathways +52 weeks against plan	≤Plan	✗ 924	✗ 1,087	✗ 1,186	✗ 1,186	✗ 1,349	✗ 1,532	✗ 1,728	✗ 1,728	✗ 1,851	✗ 1,858	✗ 1,933	✗ 1,933	✗ 1,759	✗ 1,662	✗ 1,591	✗ 1,591	✗ 1,591
	Incomplete RTT pathways +65 weeks against plan	≤Plan	✓ 141	✗ 180	✗ 203	✗ 203	✗ 236	✗ 308	✗ 350	✗ 350	✗ 362	✗ 337	✗ 418	✗ 418	✗ 399	✗ 347	✗ 157	✗ 157	✗ 157
	Incomplete RTT pathways +78 weeks	0	✗ 8	✗ 8	✗ 6	✗ 6	✗ 6	✗ 3	✗ 3	✗ 3	✗ 7	✗ 5	✗ 14	✗ 14	✗ 17	✗ 12	✗ 5	✗ 5	✗ 5
	Incomplete RTT pathways +104 weeks	0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0	✓ 0
Diagnostics	Diagnostics activity against plan	≥Plan	✓ 111.2%	✓ 108.1%	✗ 98.6%	✓ 105.5%	✓ 106.7%	✓ 102.3%	✗ 96.7%	✓ 101.9%	✗ 91.5%	✗ 99.9%	✓ 112.4%	✓ 100.6%	✓ 102.6%	✓ 103.9%	✓ 106.8%	✓ 104.4%	✓ 103.0%
	Diagnostic DM01 Waiting List		10,952	11,476	11,462	11,462	11,121	10,155	10,377	10,377	10,238	10,563	9,377	10,563	9,836	10,471	11,607	11,607	11,607
	Diagnostic DM01 Backlog		3,737	3,538	3,508	3,508	3,704	4,101	3,928	3,928	3,761	3,726	4,055	3,726	3,659	3,344	3,430	3,430	3,430
	Diagnostic DM01 <6 weeks	≥99%	✗ 65.9%	✗ 69.2%	✗ 69.4%	✗ 69.4%	✗ 66.7%	✗ 59.6%	✗ 62.1%	✗ 62.1%	✗ 63.3%	✗ 64.7%	✗ 56.8%	✗ 64.7%	✗ 62.8%	✗ 68.1%	✗ 70.4%	✗ 70.4%	✗ 70.4%
Cancer	Faster Diagnosis Standard (FDS) Combined (%)	≥75%	✗ 73.4%	✓ 76.9%	✓ 79.2%	✓ 76.6%	✓ 82.8%	✓ 79.2%	✓ 75.4%	✓ 79.2%	✓ 81.3%	✓ 77.3%	✓ 80.6%	✓ 79.7%	✓ 76.0%	✓ 82.9%	-	-	-
	31 day combined performance (%)	≥96%	✗ 92.4%	✗ 91.6%	✗ 90.3%	✗ 90.3%	✗ 81.5%	✗ 75.9%	✗ 78.9%	✗ 78.6%	✗ 80.0%	✗ 75.2%	✗ 72.5%	✗ 75.7%	✗ 73.0%	✗ 80.0%	-	-	-
	62 day combined performance (%)	≥85%	✗ 76.0%	✗ 64.9%	✗ 76.5%	✗ 76.5%	✗ 70.8%	✗ 68.9%	✗ 63.6%	✗ 67.7%	✗ 52.9%	✗ 65.7%	✗ 57.7%	✗ 59.1%	✗ 58.6%	✗ 55.5%	-	-	-
	Number of local 2ww 62d backlog patients		58	58	55	55	54	88	94	94	89	86	89	89	76	50	52	52	52

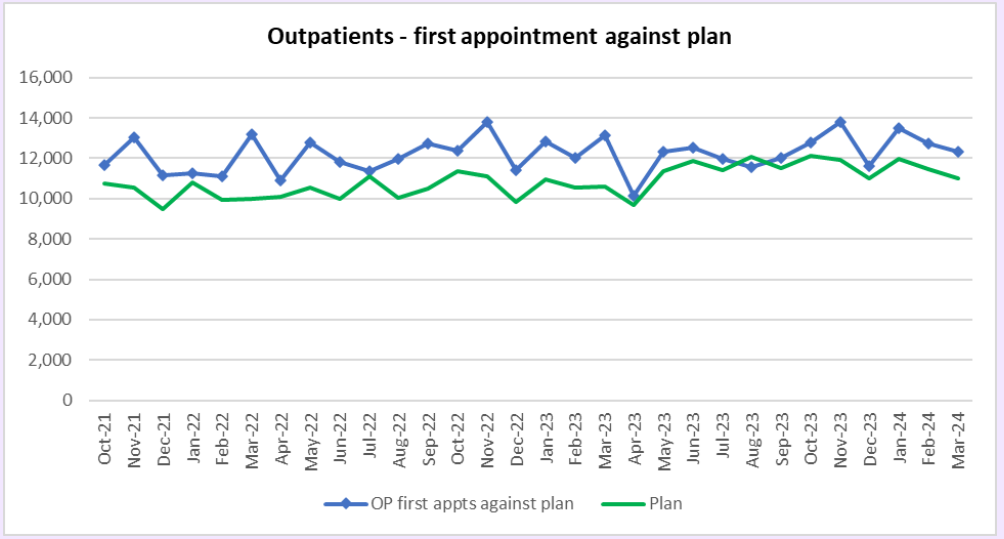
Revised national cancer waiting time standards launched in Oct-23 with the original 10 standards reduced to three. The 31-day and 62-day standards present validated month-end, published data against the new standards for Oct-23 and Nov-23. The historical data is based on a proxy as these metrics did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

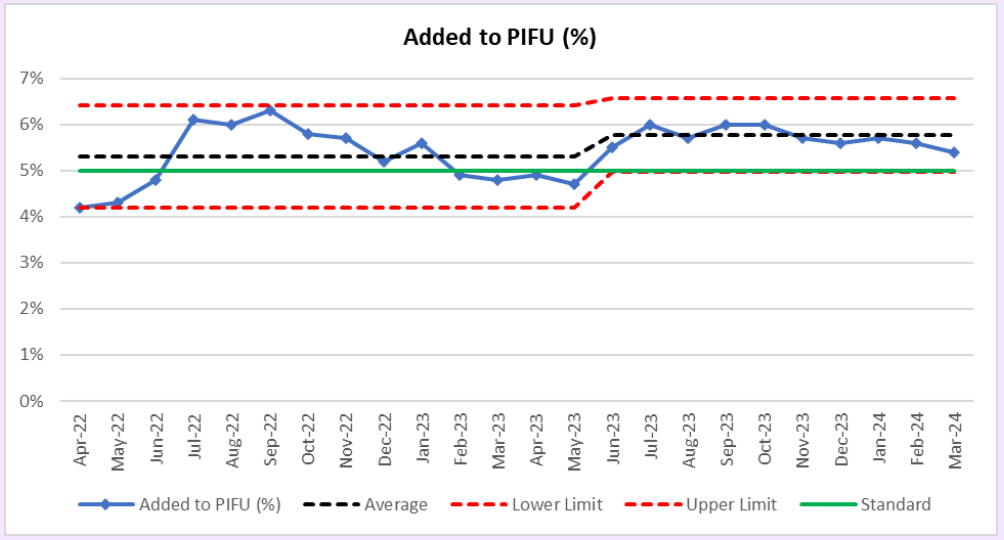
Indicators in Focus: Timely Care – Outpatient metrics (1/2)

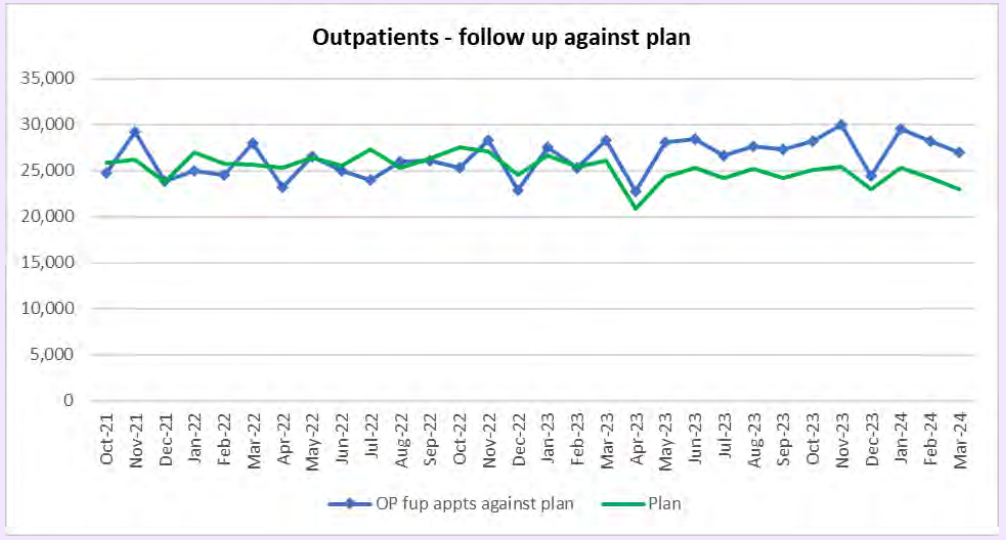
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

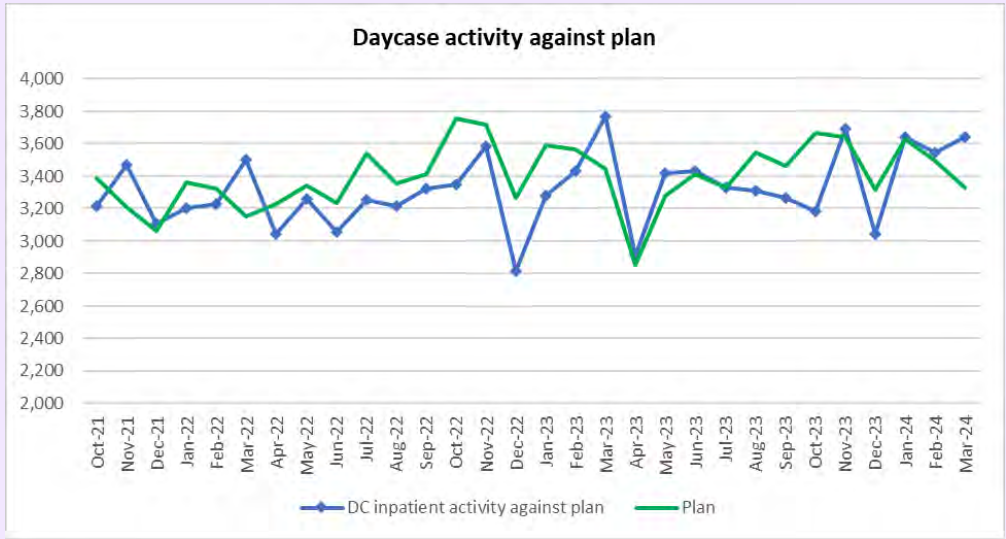
- We consistently deliver on Patient Initiated Follow Up (PIFU) and advice and guidance performance surpassing national targets. SFH have been in the top 10 Nationally for PIFU performance.
- Trust outpatient first attendance activity levels remain consistently above planned activity levels. Feb-24 was a strong month for activity levels across outpatient pathways despite Industrial Action (IA) in month.
- SFH (and the system) submitted a non-compliant plan against the outpatient follow-up reduction target of 25% in the 2022/23 and 2023/24 planning rounds. Our outpatient follow up activity levels have been above our non-compliant plan whilst we continue to experience challenges with patients waiting for overdue follow up reviews.
- The remote appointments agenda remains an area of underperformance across the Trust. The Operational Planning Guidance indicated that at least 25% of outpatient appointments should be delivered remotely via telephone or video consultation. We are currently delivering circa 15% this has been a stable position over the past year.

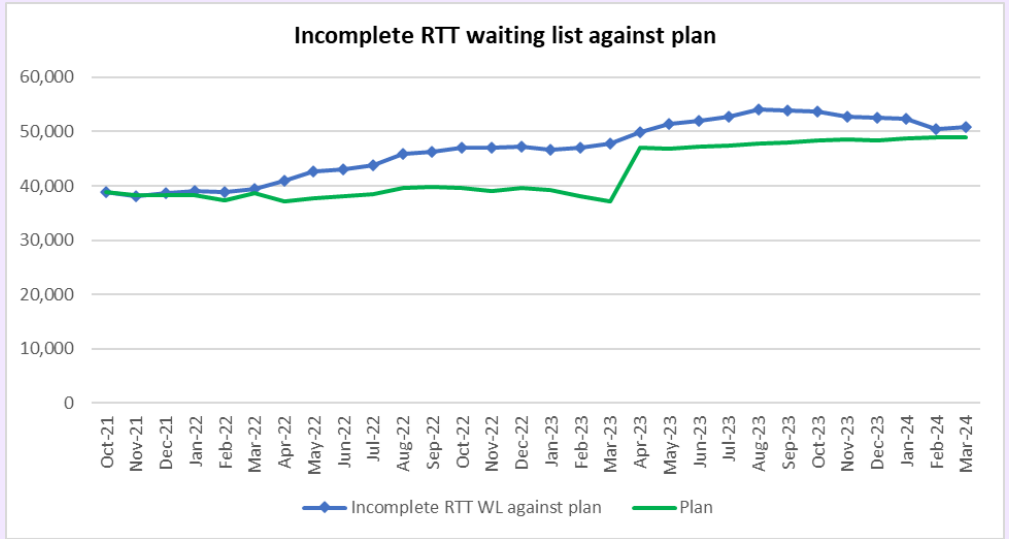
Root causes	Actions and timescale	Impact
Significant backlog of overdue reviews that developed during the Covid-19 pandemic due to lower outpatient activity levels as a result of social distancing and reduced clinician time allocated to seeing outpatients (focus on patients with higher clinical needs).	Rolling validation of the patients on the overdue review list to check if they still require their appointment.	Around 8% of patients contacted are removed from the waiting list. We typically contact 200 patients per week (approx. 16 patients removed from waiting list per week). Total Patient Tracking List (PTL) size continues to reduce.
	Insourcing in specialties with high overdue review lists. Specifically, Gastroenterology insourcing commenced in Oct-23. Insourcing to continue into 2024/25 to see any patients requiring follow up from the insourcing contract.	Insourcing to deliver circa 3,000 appointments split between new and follow up appointments by Mar-25. This will ensure any new appointments are followed up by the insourcing contract.
	GIRFT (Getting It Right First Time) Further Faster toolkits were launched in Q4 to all divisions to support improvement programme and identify productivity opportunities. Completion of toolkits and action plans developed by end of Q1.	Improvement across all outpatient metrics including DNA rates, reducing overdue reviews, and increasing 1st outpatient activity.
	Using the Further Faster toolkits to continue to embed PIFU to ensure patients only return to hospital when needed. Actions to be underway following Q1.	Reduced backlogs of patients awaiting follow up appointment and improvement in the ratio of new appointments to follow up. Exact impact will be realised once action plans have been developed.
Remote attendances below target due to clinician preference to see patients face-to-face.	Toolkit developed to assess at a specialty-level the current virtual attendance position, relevant benchmarking, potential trajectories, challenges and risks to inform clinical assessment of opportunity. Toolkit is in place and supports the actions identified in the Further Faster workbooks.	Incremental increase in the percentage of remote attendances with the aim to achieve 17% by the end of the financial year.
Lack of physical clinic space to increase activity levels.	Outpatient team review of all clinic space to ensure fit for generic use.	Flexibility of space across the organisation.
	Electronic system to be in place to support clinic booking across the trust. Online from May-24.	Improved utilisation of the clinic space and increased activity

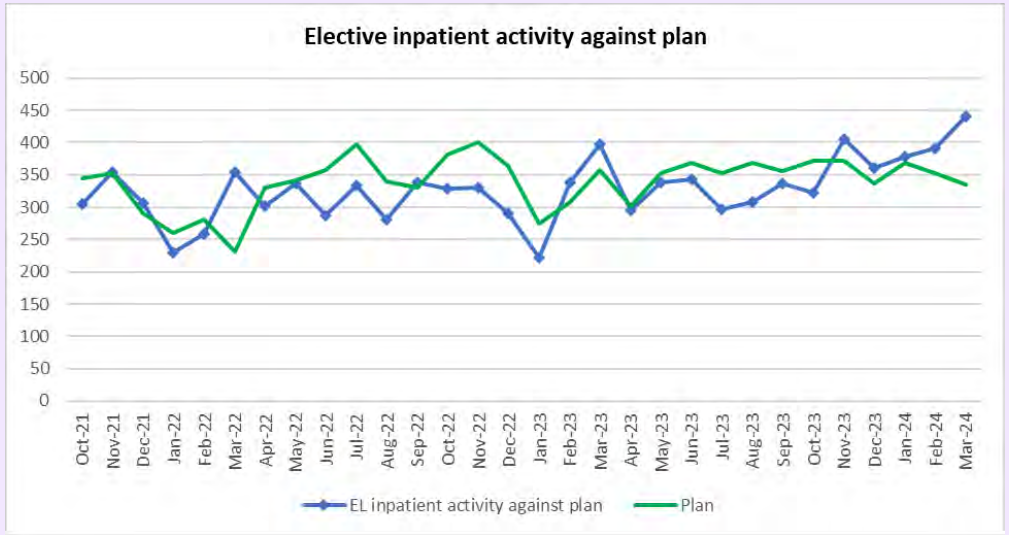
Indicators in Focus: Timely Care – Elective activity and waiting list metrics (1/2)

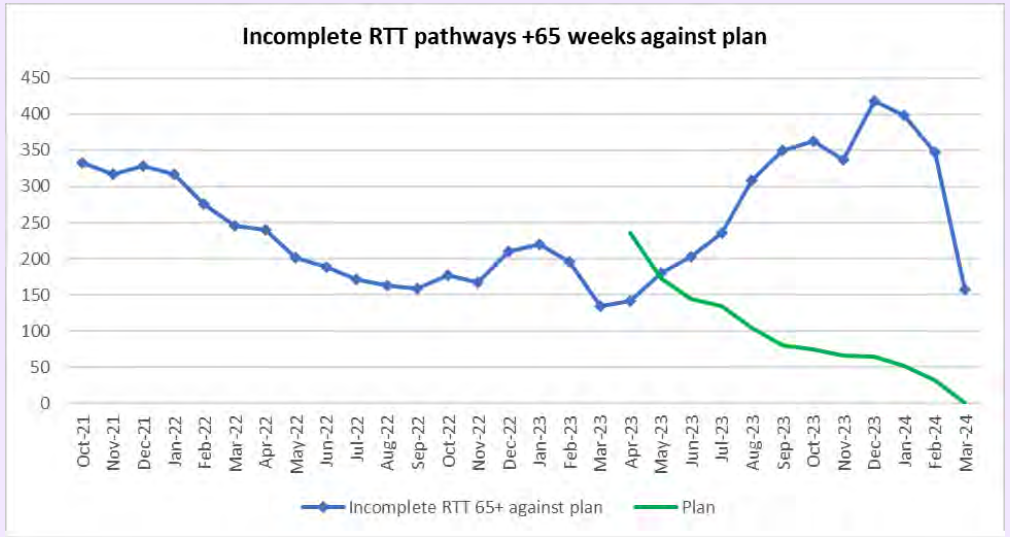
Sherwood Forest Hospitals NHS Foundation Trust

Data









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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Year to date we are below planned levels for elective inpatient and daycase activity, although we have had strong months when there has not been Industrial Action (IA). Activity levels in Feb-24 for daycase were strong despite IA, Elective Recovery Schemes coming online in Feb-24 have driven the increases in daycase activity levels.
- Referral to Treatment (RTT) waiting times across England continue to rise. Prior to the pandemic in Feb-20 there were nationally circa 4 million people on the waiting list, this is now 7.6 million by Jan-24. At SFH the RTT waits pre-pandemic was 26,000 patients and has continued to grow to a peak of just over 54,000 at the end of Aug-23. Since Aug-23 the PTL started to slowly reduce to just over 50,534 at the end of Feb-24.
- The national requirement was to have no patients on an RTT pathway waiting greater than 78-weeks by end of Mar-23. At SFH there were 5 patients waiting over 78 weeks at the end of Mar-24 (two patients awaiting cardiology diagnostics or appointments, one patient with complex diagnostic pathways and health needs, and two complex patients not well enough to be treated in month).
- Considering Jan-24 nationally reported data from 169 providers we have the 59th largest PTL. Only four providers with an equivalent or larger PTL have fewer longs waits (65ww and 78ww). 21 providers with smaller PTLs have more patients waiting greater than 65-weeks than SFH.

Root causes	Actions and timescale	Impact
IA impacting the delivery of planned care activity levels due to medical workforce being redeployed to support urgent and emergency care pathways.	Continue to operationally manage instances of IA with a focus on what we can deliver whilst ensuring clinical prioritisation.	Minimise the number of patients who have their planned care delayed during IA. Focus on treating patients in order of clinical priority.
Challenges with workforce availability due to hard to fill vacancies, particularly in Anaesthetics.	Backfill in-week theatre lists and use of additional clinics and theatre lists at weekends via Waiting List Initiatives. Recruitment to anaesthetic vacancies ongoing, recent agreement to implement recruitment incentives expected to have a positive impact.	Additional clinics and theatre lists. Theatre session utilisation has shown a steady trend between 80% and 85% since Feb-23. However, saw a dip in performance in Aug-23 and Dec-23.
	Outsourcing services throughout 2023/24 (e.g. Ophthalmology cataract referrals) and utilisation of local Independent Sector for Orthopaedics, General Surgery and Urology.	Ophthalmology outsourcing delivering 20 cases per month. Independent Sector delivering 40 cases per month. Independent Sector activity will support backlog reduction.
	Mutual aid between Sherwood Forest and Nottingham University hospitals continues to progress in pathways where waits are not equal across Nottinghamshire.	Equalise waits across the Nottinghamshire system.
Lack of physical space and infrastructure to enable increased activity required to reduce backlogs.	Newark Targeted Investment Fund (TIF) development to expand procedures in Gynaecology and ENT and support the transfer of Orthopaedic activity from King's Mill to Newark to release capacity for more complex, long waiting patients. New theatre opened in Nov-23.	Delivered circa 200 cases per month in 2024/25 Q4 in line with activity plan.
	As part of the Targeted Investment Fund (TIF) refurbish three existing procedure rooms due for completed delivering increased Dermatology capacity from Mar-24.	Increase of four procedures per week leading to a reduction in Cancer and RTT waiting times.
Opportunities for productivity gains.	Three of the Theatre Improvement Programme workstreams, scheduling, list timing and patient engagement underpinning actions will lead to improvements in elective activity and backlogs in 2024/25.	Elective Session Utilisation improvement from 75% to 77% in year 1 Capped in-session utilisation improvement from 77% to 80% for year 1 On-day cancellations at 8.9% reduced by 1% in year 1.

Indicators in Focus: Timely Care – Diagnostic metrics

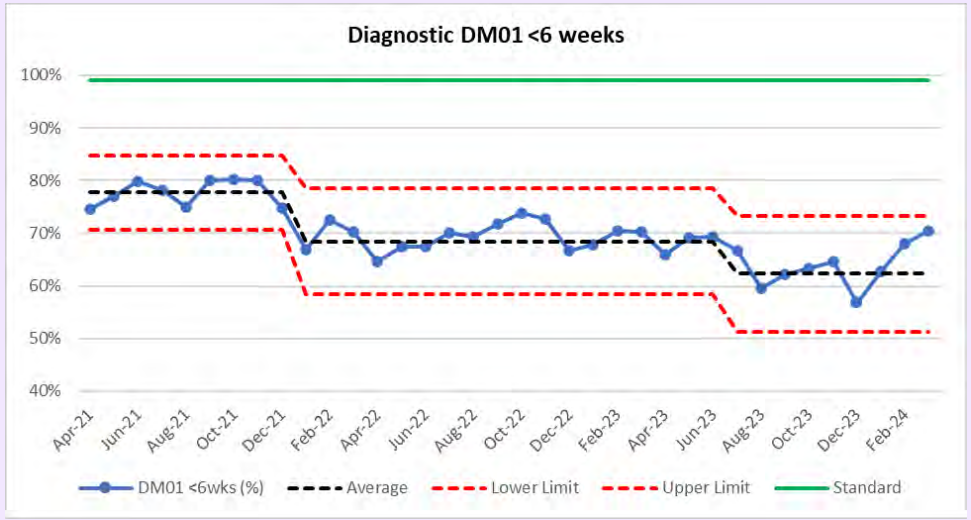
Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

- Nationally, the total number of patients waiting six weeks or more from referral for one of the 15 key diagnostic tests at the end of Jan-24 was just over 414,3500. This meant that 73.8% of patients nationally were seen within 6-weeks against the national standard of 99%. The local position at the end of Jan-24 was 68% of patients seen within 6-weeks; below the national position.
- Across SFH at the end of Jan-24 there were a total of 10,471 patients waiting for DM01 reportable diagnostic tests of which 3,344 patients were waiting greater than 6-weeks, this a reduction from Dec-23. Most are awaiting Echocardiography.
- Audiology, Dexa and Non-Obstetric Ultrasound achieved DM01 compliance >99% in Jan-24.
- In Mar-24, Quality Committee considered a paper outlining the current diagnostic position, risks and actions underway.

Root causes	Actions and timescale	Impact
Echo backlog and insufficient workforce to meet demand. Equipment and physical space are constraining backlog recovery alongside the workforce challenges.	Enhanced rates of pay to enable weekend working with existing teams from Jul-23.	7 additional cases per week.
	Community Diagnostic Centre (CDC) funding insourcing for Newark Hospital to increase from 3 to 5 days from early Q4.	50 additional cases per week.
	Insourced activity delivered at Mansfield Community Hospital in a newly equipped facility funded through CDC slippage.	60 additional cases per week.
	Mutual aid from NUH from Aug-23.	7 additional cases per week.
	The combined impact of the above mitigations will support gradual backlog reduction. Full recovery will require actions to continue into 2024/25. Jan-24 was our highest ever performing month for activity and total waiting list size reduced to <4,000, our lowest since Jul-23.	
CT Cardiac increase in demand (50% 2022-23) further driven by the targeted lung health check programme expansion.	Successful funding for new scanner to increase capacity for targeted lung health check expansion and CT cardiac capacity, working towards 2024/25 Q3 installation.	Up to 20 CT Cardiac cases per day.
Cystoscopy waiting list management and processes causing increase in overall diagnostic PTL size since Sep-23.	Validation of the waiting list took place by end of Mar-24.	Reduction in waiting list by 28% (50 patients) and reduction in backlog over 6-weeks by 50%.
	Any reporting actions to be identified and actioned by end of Apr-24.	Accurate patient tracking list.

Data



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

Sherwood Forest Hospitals NHS Foundation Trust

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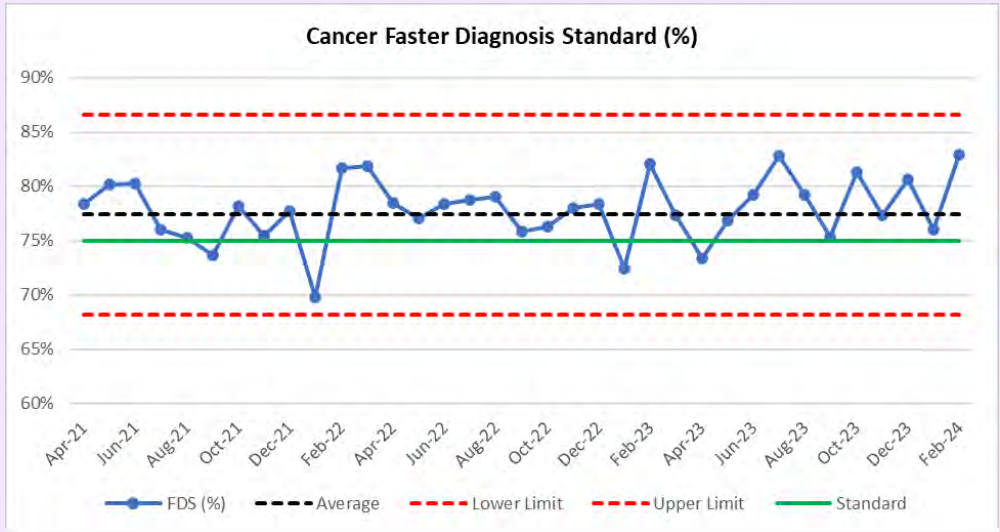
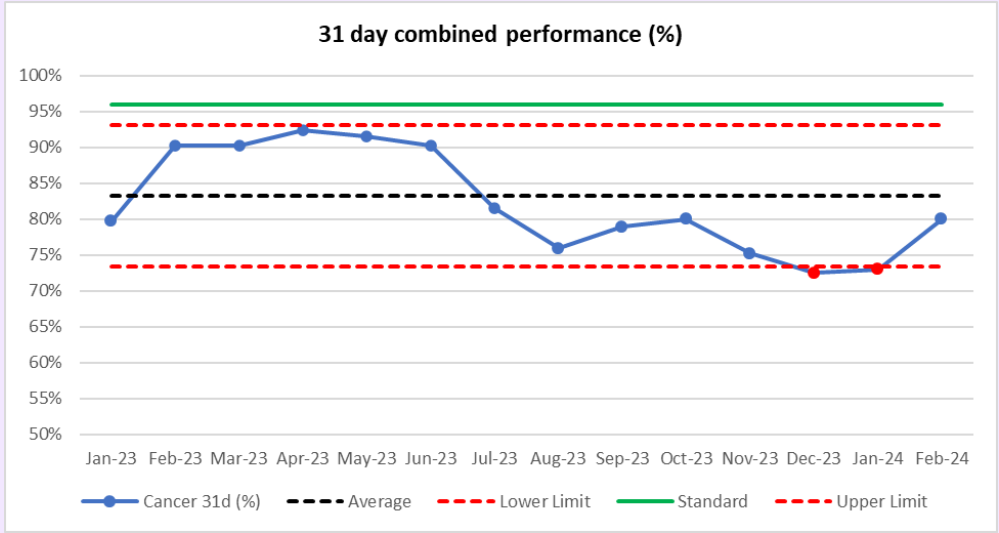
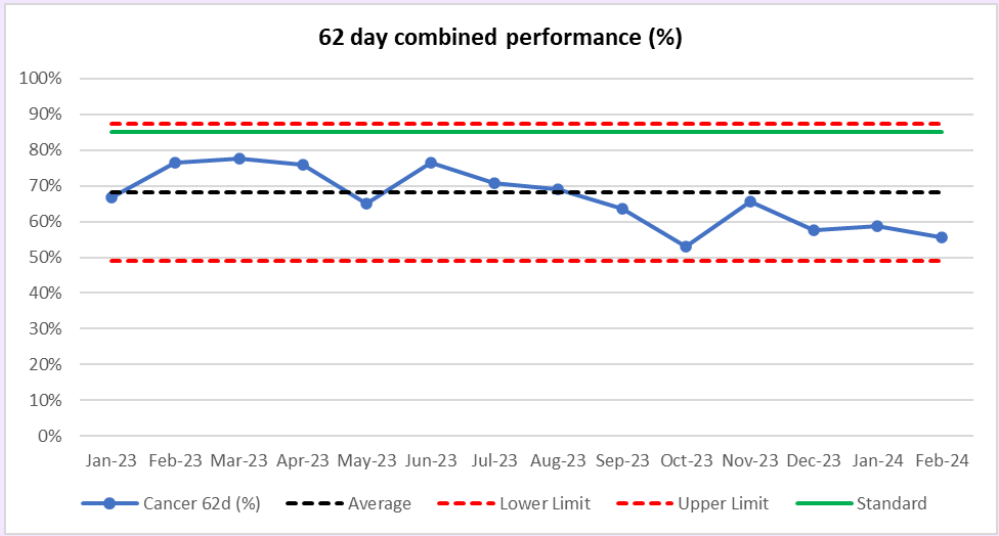




Revised national cancer waiting time standards launched in Oct-23 with the original 10 standards reduced to three. The 31-day and 62-day standards present validated month-end, published data against the new standards for Oct-23 and Nov-23. The historical data is based on a proxy as these metrics did 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.



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

Sherwood Forest Hospitals NHS Foundation Trust

National position & overview

Considering the latest national data (Nov-23):

- Nationally Faster Diagnosis Standard (FDS) is 70.9% against the 75% standard. Our position is performing better than the England position and above the national standard.
- Nationally 31-day treatment performance (first treatment) is 87.5% against the 96% standard. Our position is performing below the England position.
- Nationally 62-day performance is 62.3% against the 85% standard. Our position is performing below the England position.

Root causes	Actions and timescale	Impact
62-day standard - Lower GI has workforce challenges, high referral demand and difficulties with patient engagement.	Tumour site optimal timed pathway development and working group in place since Apr-23.	Reduction in pathway delays.
	Update patient information and launch a video for supporting patients with bowel preparation. Video development delayed due to capacity of communications team. Rescheduled for 2024/25 Q1.	Improve engagement and increase test compliance.
	Cancer Steering Group undertaking a review of clinical pathways and processes across all tumour sites, including how patients are reviewed, prioritised and the clinical time allocated to do so. For review May-24 steering group.	Equity of approach in clinical and operational management of patients across all tumour sites. E.g. the hot tray in Gynaecology, patients are reviewed by an assigned cancer clinician to ensure timely diagnosis or progression of patient pathway.
31-day standard - Skin tumour site referral demand.	Tele-dermatology pilot at Kings Mill site launched Feb-24 and saw a total of 74 patients in month, the service is now fully rolled out. Plans to develop the tele-dermatology service Newark are underway to commence Apr-24.	Feb-24 pilot observed the following outcomes: • 79% of patients removed from an urgent suspected cancer pathway • 109 clinic slots were reallocated • First seen average date reduced from 12 to 7 • Positive staff and patient feedback.
	Recruitment of locum and utilisation of available theatre capacity at where lists are not filled, and staffing is available. Full completion of Targeted Investment Fund programme at Newark to commence Apr-24	Increase operating capacity from Feb-24. Additional c.200 cancer procedures throughout Q4. Four procedures per week Newark activity increase leading to a reduction in waiting time and improvement in 31-day performance.
Industrial Action (IA) impacting the delivery of tumour site activity levels and pathway development.	Continue to operationally manage instances of IA with a focus on what we can deliver whilst ensuring clinical prioritisation.	Minimise the number of cancer patients who have their pathway delayed during IA.

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.

Domain Summary: Best Value Care

Sherwood Forest Hospitals NHS Foundation Trust

Overview	Lead
Income & Expenditure: • The reported financial position for Q4 shows an improving trajectory which largely relates to additional income received and a reduction in expenditure run rate. Although some of this relates to non-recurrent actions, it also demonstrates progress from the Financial Recovery Cabinet workstreams and the H2 forecast re-set. • The Trust reported an adverse position against the plan of £11.19m for the Q4 period, giving a 2023/24 deficit of £11.6m against a breakeven plan. The period saw the continuation of many of the challenges faced in previous quarters with further industrial action impact, the level of capacity open and high demand for beds and the cost of surge capacity when the Trust enacts the Full Capacity Protocol. The level of patients medically fit for discharge has remained at levels above those assumed in the 2023/24 annual plan. Q4 run rate hasn't changed, the plan assumed income and efficiencies in Q4 which would have seen a positive impact on run rate which didn't occur. • The costs of additional capacity remains the largest element of the adverse variance to plan, with £4.3m spent in Q4. This brings the annual total to £13.5m 2023/24 which includes the impact of beds remaining open despite an ICS planning assumption that they would close, the costs of surge capacity and winter pressures. • The Q4 position also sees the continuation of unplanned costs relating to the industrial action, with a direct financial impact that includes costs of covering gaps, an estimation of lost income relating to cancelled activity and accounts for missed efficiency opportunity of £3.4m in Q4. • FIP is adverse to plan due to the missed efficiency opportunity due to impact of industrial action. In addition, FIP achievement largely relates to non recurrent underspends and non divisional FIP. • Following the H2 re-set of likely forecast outturn the trust revised outturn was agreed at £8.5m deficit. This shifted to an actual 2023/24 outturn deficit of £11.6m due to non receipt of CDC income (£5.5m), reduced in part from the benefit of PDC non payment of £2.4m due to how we now account for the PFI lease in line with changes in accounting standards. **Capital Expenditure & Cash:** • Capital expenditure is adverse to plan of £15.42m for Q4, with 2023/24 outturn expenditure of £32m. This is £7.27m less than the annual financial plan due to changes in the CDC and EPR planned expenditure across financial years. • Closing cash on the 31st March was £4.74m, which is £1.87m higher than planned. However, this is masking an underlying pressure on available revenue cash resource, as it is being supported by capital PDC. **Agency Expenditure:** • The Trust reported agency expenditure of £3.96m during Q4, with 2023/24 outturn at £16.58m.	CFO

Scorecard: Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance	Indicator	Standard	Apr-23	May-23	Jun-23	2023/24 Qtr 1	Jul-23	Aug-23	Sep-23	2023/24 Qtr 2	Oct-23	Nov-23	Dec-23	2023/24 Qtr 3	Jan-24	Feb-24	Mar-24	2023/24 Qtr 4
Finance	Income & expenditure against plan (£m)	≥£0.00m	✓£0.00	✗-£0.98	✗-£0.06	✗-£1.04	✓£0.06	✗-£0.43	✗-£1.06	✗-£1.43	✗-£1.33	✓£0.82	✓£2.58	✓£2.07	✗-£0.76	✓£2.33	✗£12.76	✗£11.19
	Financial Improvement Programme (FIP) against plan (£m)	≥£0.00m	✓£0.01	✓£0.03	✓£0.00	✓£0.04	✗-£0.38	✗-£0.83	✗-£0.83	✗-£2.04	✗-£0.38	✗-£0.17	✗-£0.80	✗-£1.35	✓£1.27	✗-£0.43	✓£0.54	✓£1.38
	Capital expenditure against Plan (£m)	≤£0.00m	✗£0.23	✗£1.15	✗£4.91	✗£6.29	✗£3.87	✗£1.29	✗£3.52	✗£8.68	✗£3.19	✓-£0.70	✗£5.23	✗£7.72	✓-£2.01	✓-£0.88	✓£12.53	✓£15.42
	Cash balance against Plan (£m)	≥£0.00m	✗-£8.73	✓£4.35	✓£5.10	✓£0.72	✓£5.17	✗-£2.52	✗-£3.43	✗-£0.78	✗-£0.84	✓£0.10	✓£0.53	✗-£0.21	✓£0.53	✓£6.97	✗-£5.36	✓£2.14
	Agency expenditure against Plan (£m)	≥£0.00m	✓£0.02	✗-£0.32	✗-£0.16	✗-£0.46	✗-£0.20	✓£0.06	✗-£0.10	✗-£0.24	✗-£0.21	✓£0.62	✓£0.29	✓£0.70	✗-£1.36	✗-£1.17	✗-£1.09	✗-£3.62

Indicators in Focus: Best Value Care – Income and expenditure

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- The standard is the Trust financial plan which is a breakeven position for 2023/24
- The Trust has an adverse variance to plan of £11.19m in Q4. Giving a 2023/24 deficit of £11.60m against a breakeven plan.
- During the national H2 re-forecasting exercise the trust agreed a deficit outturn with NHSE of £8.5m. This changed in month 12 to £11.6m due to the non receipt of CDC funding (£5.5m), reduced in part from the benefit of PDC non payment of £2.4m due to how we now account for the PFI lease in line with changes in accounting standards.
- The plan for Q4 was a significant improvement on run rate due to the recognition of CDC income and FIP delivery. Both of which did not occur as planned. CDC was recognised throughout the year (ahead of plan) however given NHSE confirmation that it was not to be received resulted in the Q4position showing a reversal of previous months income recognition against a full year allocation of income. Therefore Q4 is a £9.6 adverse to the planned position (being £5.5m planned income in Q4 which didn't occur plus the reversal of the Q1-Q3 early recognition of this income).

Root causes

The adverse variance is due to

- The level of demand impacting on Full Capacity measures and additional capacity open this financial year including winter capacity pressures.
- Unfunded cost and income loss relating to the industrial action, including the costs of covering staffing gaps, an estimate of lost income relating to cancelled activity and missed efficiency opportunity.
- Q4 improved run rate position due to additional H2 re-set actions impacted in part by non receipt of CDC funding and non payment of PDC.

Actions

- Non receipt of CDC funding notified in month 12 from NHSE
- Non payment of PDC due to changes in accounting standards for PFI leases
- Financial Recovery Cabinet in place reviewing opportunities
- Enhanced Financial Governance in place
- Revised outturn position following H2 re-set of £11.6m given changes in month 12 for CDC & PDC changes

Impact/Timescale

- Agreed outturn achieved
- Enhanced Financial Governance in place and continuing

Data

Indicators in Focus: Best Value Care – Financial Improvement Plan

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- The standard is the Trust financial Improvement Plan
- The Trust has a £10m Divisional Financial Improvement Programme which has reported full year savings of £8m which was £1.8m behind plan.
- The planned delivery is Q4 was impacted by industrial action and high capacity demands which meant this wasn't achievable adding £2m efficiency miss in Q4 alone.

Root causes

- The adverse variance is mainly due to delays in identifying schemes in time to deliver savings in line with plan. Current escalation capacity and Industrial Action will have taken time away from Divisions bandwidth to progress schemes and efficiency miss of £1.8m has been declared for 2023/24.

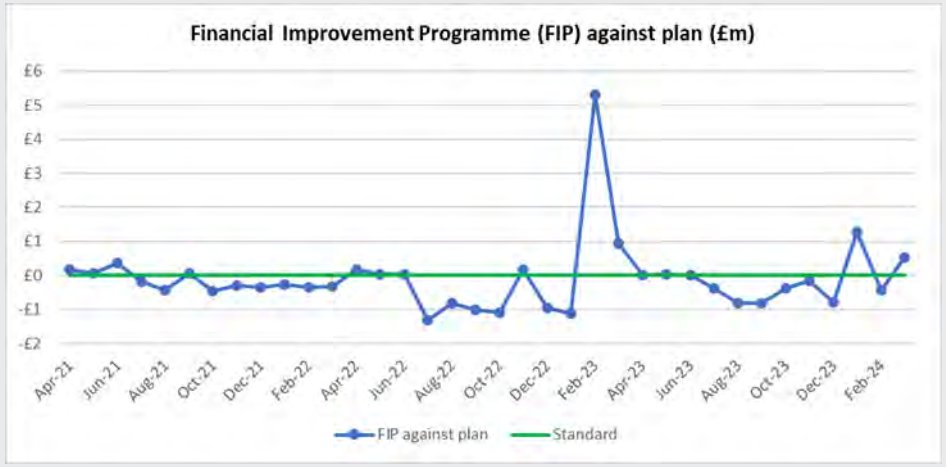
Actions

- Financial Recovery Cabinet in place with FIP being a key workstream in this process.
- Schemes do continuously move to 'In-Delivery'

Impact/Timescale

- Continuation of FIP scheme ideas and delivery.
- Pipeline schemes progress to in-delivery monthly.

Data



Indicators in Focus: Best Value Care – Cash Balance

Sherwood Forest Hospitals
NHS Foundation Trust

Standard & overview

- Standard is the plan and the minimum cash balance required by DHSC of £1.45m as part of our support.
- Variance year to date to plan with closing cash being £1.87m favourable to plan.
- Plan and actual required revenue borrowing PDC cash support from DHSC and 2024/25 forecast indicates a further requirement for revenue support.

Root causes	Actions	Impact/Timescale
Planned deficit and forecast deficit is driving the need for additional cash support above plan.	• Quarterly borrowing submission submitted to DHSC • All revenue PDC for 23/24 requested and approved and no additional deficit borrowing above plan was requested. • Revenue support application submitted for Q1 2024/245. Currently being reviewed by DHSC. • Capital PDC request to be prepared and submitted July 2024 in relation to the agreed 2024/25 capital plan.	Management of accounts payable supplier payment to match available cash.

Data

Indicators in Focus: Best Value Care – Capital expenditure

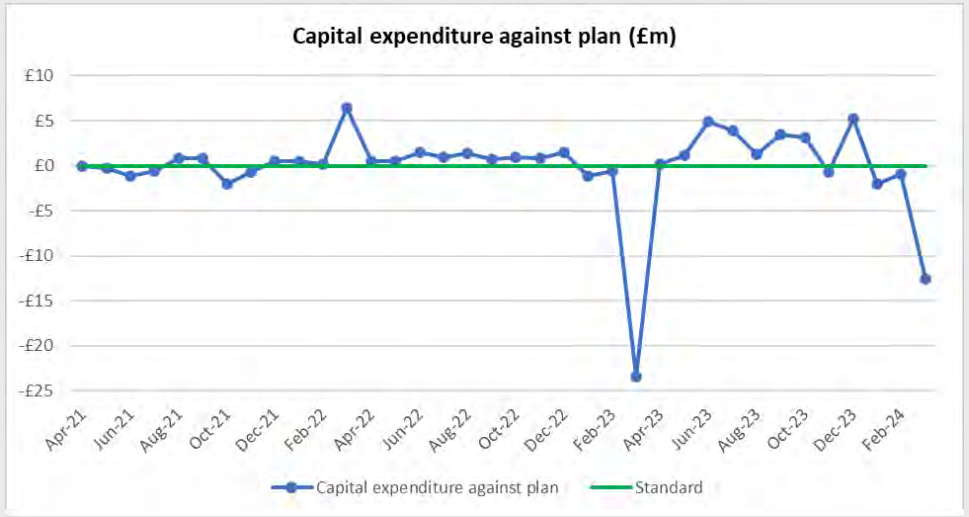
Sherwood Forest Hospitals
NHS Foundation Trust

Standard & overview

- Standard is the plan.
- Significant variance in outturn due to agreed changes to the phasing of EPR and Mansfield CDC across years., however, plan was delivered allowing for these know changes.
- Plan required capital borrowing support from DHSC, which presented a risk due to timing of spend compared to receipt of Capital PDC support, due to cash position of the Trust.
- Known overspends in relation to discharge lounge and Newark TIF capital schemes.

Root causes	Actions	Impact/Timescale
Outturn variance across schemes driven by the re-phasing of Mansfield CDC and EPR and reallocation of plan to cover known overspends on Newark TIF and discharge lounge.	• Agreed with NHSE reprofiling of the expenditure and associated borrowing relating to CDC, £2m and EPR £6.31m removed form 2023/24 and rephased into 2024/25. • Capital plan was reforecast in year to cover known overspends in relation to Discharge lounge and Newark TIF. • Monthly monitoring via Capital Resources Oversight Group. • Capital loan support received for 2023/24, and submission to be made in respect of 2024/25. • 5 year capital plan currently being refreshed as part of financial planning. Working group formed to consistently risk assess and prioritise forecast 2024/25 plan. • Allocation agreed with ICB partners for 2024/25.	Risk to capital plan delivery and cash until capital borrowing confirmed. Would present an increased risk to underlying cash balances in 2024/25.

Data



Indicators in Focus: Best Value Care – Agency expenditure

Sherwood Forest Hospitals NHS Foundation Trust

Standard & overview

- The standard is the planned agency spend
- The Trust has reported agency expenditure of £3.96m for Q4, this is £3.62m adverse to the planned level of spend. This is due to the phasing of the FIP plan on agency being loaded to the last quarter of the financial year. From a run rate perspective, the level of spending Q4 is in line with Q1-Q3.
- 2023/24 full year expenditure is £16.58m on agency which is £3.62m adverse to the plan of £12.96m
- Full year agency spend in relation to ERF equates to £1.3m which is offset by additional income.

Root causes

- Mainly due to the additional capacity that has remained open above planned levels which is covered by variable pay (including agency). As beds have become substantivised this level of expenditure has reduced.
- ERF scheme agency usage equates to £0.45m during Q4 for which there was minimal spend in Q1 & Q2. This expenditure is offset by additional ERF income.

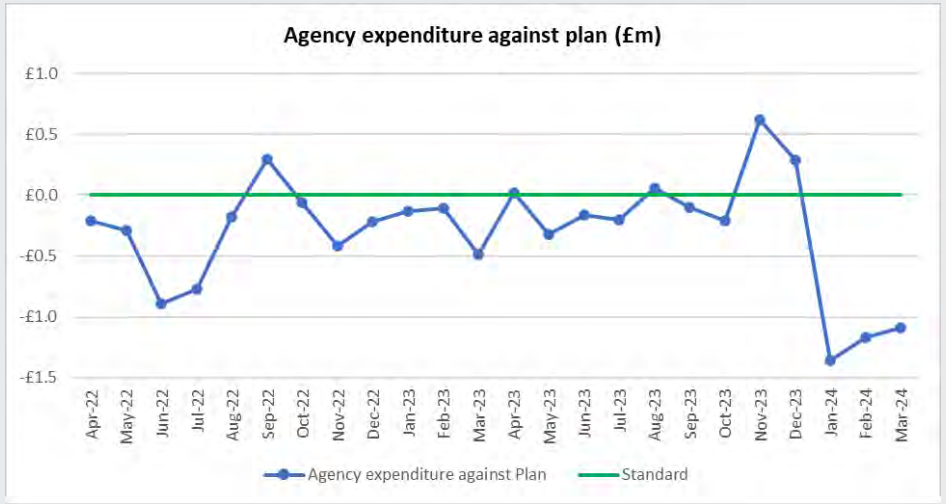
Actions

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

Impact/Timescale

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

Data



Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Quarterly Reflection Report - Documents Sealed and Signed (Quarter 4, 2023/24)	**Date:**	2nd May 2024
Prepared By:	Clare Jones, Corporate PA		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

This report serves to provide the Board with a comprehensive overview of the Trust's use of the Official Seal, ensuring transparency and accountability in its application.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

N/A

Acronyms

Q4 – Quarter 4

Executive Summary

This quarterly reflection report provides an overview of the documents sealed and signed by the Board during Q4 2023/24. In accordance with Standing Order 10 and the delegated authority in the Scheme of Delegation, the Sherwood Forest Hospitals (NHS) Foundation Trust Official Seal has been affixed to the following documents during Q4:

Seal number 108

Between:
Sherwood Forest Hospitals NHS FT and NHS Property Services Limited

Details of the contact:
Deed of surrender relating to: Out of Hours Emergency Facility (Byron House) at King's Mill Hospital

Signed/Sealed by the Chief Executive Officer and the Chief Financial Officer
Dated: 4th January 2024

Seal number 109

Between:
Sherwood Forest Hospitals NHS FT and Kier Construction Ltd

Details of the contract:
Demolition of the old Victorian Building and associated Service Divisions located at Mansfield Community Hospital

Signed/Sealed by the Chief Executive Officer and the Chief Financial Officer
Dated: 26th January 2024

Seal number 110

Between:
Sherwood Forest Hospitals NHS FT and Bizspace Ltd

Details of the contract:
Five-year lease for Byron Court

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 7th February 2024

Seal number 111

Between:
Sherwood Forest Hospitals NHS FT and Bevan Brittan

Details of the contract:
Appointment of WSP UK Ltd in relation to the Provision of Asset Surveying and Scheduling of Programmed Maintenance Works at KMH, MCH and Newark Hospital

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 23rd February 2024

Seal number 112

Between:
Sherwood Forest Hospitals NHS FT and Bevan Brittan

Details of the contract:
Survey Deed in relation to the Project Agreement for KHM, MCH and Newark Hospital

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 23rd February 2024

Seal number 113

Between:
Sherwood Forest Hospitals NHS FT and Bevan Brittan

Details of the contract:
Letter of Appointment of Fire Safety Engineer relating to Fire Safety Requirements at KMH, MCH and Newark Hospital

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 23rd February 2024

Seal number 114

Between:

Sherwood Forest Hospitals NHS FT, NHS Property Services Ltd, Nottinghamshire Healthcare NHS Foundation Trust and Bevan Brittan

Details of the contract:
Enabling Works Licence relating to land at Mansfield Community Hospital

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 28th February 2024

Seal number 115

Between:

Sherwood Forest Hospitals NHS FT, Newark & Sherwood District Council

Details of the contract:
Lease of car park, Bowbridge Road, Newark Hospital

Signed/Sealed by the Chief Executive and Chief Financial Officer
Dated 25th April 2024

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

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Fit and Proper Person Requirements – Implementation Update	**Date:**	2nd May 2024
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:			
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To provide assurance to the Executive Committee regarding compliance with the updated NHSE Fit and Proper Person Framework requirements in force from 30th September 2023 and seek approval to extend the requirements to current and new Deputies to Executive Directors.	**Approval**	**X**
	Assurance	**X**
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Executive Team Meeting – 24th April 2024

Acronyms

FPPT – Fit and Proper Person Test
FPP – Fit and Proper Person
ESR – Electronic Staff Record
SID – Senior Independent Director
NHSE – National Health Service England

Executive Summary

NHSE has developed a FPPT Framework (referred to in this paper as the "new Framework") for board members in response to recommendations from the Kark Review that reported in 2019 intended to strengthen and reinforce individual accountability and transparency for board members, thereby enhancing the quality of leadership within the NHS leading to positive impacts on patient safety.

This new Framework was published on 2nd August 2023 and went live on 30th September 2023. It applies to both executive and non-executive directors, both interim and permanent, irrespective of voting rights. The Framework does not apply to the Council of Governors.

In response to the requirements set out in the Framework the Trust has:

- Updated the FPP Requirements Policy (HR0012) to include the requirements of the new Framework and issued new associated FPP Recording and Reporting Guidance

- Issued a specific Board Member FPPT Privacy Notice (based on the template at Appendix 6 of the new Framework) to all those currently covered by the new Framework. All current Board Members, and the Director of Corporate Affairs as a regular board meeting attendee, have signed a copy of the Privacy Notice to confirm receipt, and this has been placed on each individual's file. The same process has and will continue to be applied to all new Board Members. The Privacy Notice provides details of the types of personal information the Trust collects and processes in relation to the FPPT and informs members that their FPPT information is kept on the ESR system for a career long period (to the member's 75th birthday).

- Implemented the new starter/annual FPPT self-attestation process. All the Trust's Board Members have now completed their annual self-declaration of on-going fitness in the format prescribed in Appendix 3 of the new Framework. The Trust's Recruitment Manager is currently in the process of entering the information from the self-declarations, and the results from the annual Insolvency, bankruptcy and social media checks, into ESR that is a specified requirement in the process. The new Framework mandates ESR as the recording repository for all FPPT checks and information. In addition, as noted above, the Director of Corporate Affairs maintains an individual file for each Board member and regular attendee (referred to as a local evidence folder) with the files kept in a designated, locked metal filing cabinet.

- Is preparing, once the updated annual checks have been entered on to ESR, for the Associate Director of People (Transformation) to run the Annual Reporting Template Report (in the format contained in Appendix 2 of the FPP Recording and Reporting Guidance). This report comprises a comprehensive record of all checks carried out plus Training & Development compliance, last appraisal date, any ongoing and discontinued disciplinary investigations and any disciplinary findings, as detailed in the FPPT checklist at Appendix 7 of the new Framework. The Director of Corporate Affairs will share this report with the Chair and, using the data from it, complete the Annual NHS FPPT submission to the NHSE Regional Director using the template at Appendix 5 of the new Framework that must be approved and signed by the Chair. This Annual submission includes in Part 1 the FPPT outcome for board members including starters and leavers in the period covered. Part 2 records any reviews or inspections of the FPP process, including by CQC, internal audit and Board effectiveness reviews. Its final section, Part 3, requires the SID or Deputy Chair to complete a Declaration regarding the Chair being Fit and proper and for the Chair to complete the same Declaration in respect of all other Board members. The process then requires the Chair to sign the overall declaration that the FPPT submission is complete.

The Director of Corporate Affairs will then send this first annual submission to the NHSE Regional Director by 30th June 2024. The Regional Director will review it and respond back as a record of receipt. The Regional Director will copy the submission to the NHSE Central FPPT Team where it will be collated with all the returns from other NHSE England regions.

It should also be noted that with the agreement of the Executive Committee the Trust has:

- Revised its arrangements for obtaining social media checks to ensure wide and consistent coverage via an external service provider, replacing the ad hoc checks

previously carried out in-house.
- Begun the process whereby all Board members will become subscribers to the DBS updating service rather than having a single DBS check on appointment only.

NHSE has published a leadership competency framework for board members based on six domains each with a range of competencies. The six domains are:

- Driving high-quality, and sustainable outcomes
- Setting strategy and delivering long-term transformation
- Promoting for equality and inclusion, and reducing health inequalities
- Providing robust governance
- Creating a compassionate, just and positive culture
- Building a trusted relationship with partners and communities

NHSE acknowledged that it is unlikely all NHS board members will be able to fulfil all of the competency examples all of the time and that first time directors may need time to develop proficiency. The Trust is required to incorporate the six competency domains into its board member role descriptions and recruitment processes from April 2024.

A revised Chair appraisal framework has been published and has been used in the 2023/24 Trust Chair appraisal. NHSE has announced that a new Board Member Appraisal Framework will be launched in Autumn 2024.

Assurance on the practical application of the new Framework since 30th September 2023 can be taken from the following:

- One externally recruited new Board member has been appointed since the new Framework went live. The FPP checks were completed in accordance with the new Framework and included obtaining references covering the mandated minimum six previous year period.
- To date the Trust has received three requests for references from staff covered by the new Framework, and these have been issued on the board member reference template (Appendix 2 in the new Framework) and stored on ESR and the People Directorate system.
- The Trust has complied with the requirement to prepare a reference on the prescribed Board Member Template Reference form following the resignation of an Executive Director. The reference was completed at the point the employment ended, as required by the Framework. The completed reference has been stored in ESR and the original placed on the former Executive Director's personal file ready for issue, if requested.
- The information provided to the Remuneration & Nomination Committee at its meeting on 4th April 2024, chaired and comprised exclusively of Board members, to assure the Committee that the Trust was compliant with the FPP requirements both at the time of the appointment of that Executive Director in 2022 (prior to introduction of the new Framework from 30th September 2023) and subsequently.
- The FPP process currently being run in respect of the Interim Board member appointee to ensure they meet the requirements of the new Framework, including the issue and signature of the board member Privacy Notice, further references being sought to cover the period of at least six years, and a new DBS check. In order to have the other designated Executive Director deputies ready to take up Board appointments, if required, it is proposed to extend the application of the FPP Requirements to the existing Deputy cohort and all new Deputy Executive Director appointments with immediate effect. The cost implications to do this are minimal.
- That arrangements have been made for the Internal Auditor to discuss with the Director of Corporate Affairs, the scope of the FPPT review included in the 2024/25 Internal Audit Plan. Outline terms of reference for this review have been prepared for use as the starting point for those discussions that will take place on 30th April 2024.

Recommendations:

That the Board

- takes assurance from the details in this paper describing the implementation of the new FPP Framework process,
- notes the arrangements, responsibilities, and timescale for the submission of the Trust's first annual submission to the NHSE Regional Director confirming compliance with the new Framework (by 30th June 2024), and
- agrees to extend the application of the FPP requirements of the new Framework to each Executive Director's designated deputy.

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Provider Licence Self Certification declarations	**Date:**	2nd May 2024
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose

The Executive team is asked to consider the annexed Self-certification declarations and recommend them to the Board of Directors for Approval.	**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**

Identify which Principal Risk this report relates to:

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

Committees/groups where this item has been presented before

Executive Team Meeting – 24th April 2024

Acronyms

CoS – Continuity of Service

Executive Summary

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence.

Compliance with the licence is routinely monitored through the NHS Oversight Framework however, on an annual basis, the licence requires providers to self-certify they have:

a) Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (Condition G6) and a reasonable expectation that required resources will be available to deliver the designated services for the 12 months from the date of the statement (Condition CoS7) by 31st May 2024, and
b) Complied with the required governance arrangements (condition FT4) by 30th June 2024.

The completed templates are attached.

The Trust is required to publish its self-certification on its website by the dates noted above and retain copies for record keeping purposes, noting there is no longer a requirement to submit them to NHSE.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Conditions G6 and CoS7

Sherwood Forest Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Financial Year to which self-certification relates 2023/24

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with licence conditions (FTs and NHS trusts)

1 Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.

Confirmed OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.

Confirmed

OR

3b After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.

OR

3c In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust's financial plan set out its resource requirements approved by the Board. Agile governance has seen a Financial Recovery Cabinet convened in the reporting year that will change focus to improvement in the year 2024/25. The Trust's accounts continue to be prepared on a going concern basis.

The Trust has robust systems and processes in place as part of its system of internal control to ensure it meets current compliance requirements through which risks to the Trust's strategic priorities and the compliance requirements of the CQC and the OF are considered. These include the Board/relevant Board Committees scrutinising the significant risks on the risk register and the board assurance framework as well as receiving robust operational performance reports. A robust governance structure is in place as part of the system of internal control.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Robinson	**Name**	Claire Ward
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

This template may be used by Foundation trusts and NHS trusts to record the self-certifications that must be made under their NHS Provider Licence.
You do not need to return your completed template to NHS Improvement unless it is requested for audit purposes.

Self-Certification Template - Condition FT4

Sherwood Forest Hospitals NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following self-certifications to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These self-certifications are set out in this template.

How to use this template

1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "FT4 declaration"

Financial Year to which self-certification relates 2023/2024

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

	Corporate Governance Statement	Response	Risks and Mitigating actions	
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	The Board continues to obtain assurance about systems and controls through the Audit and Assurance Committee. A detailed explanation about the Trust's system of corporate governance and internal controls is set out in the Annual Governance Statement included within the Trust's Annual Report.	Click here to access the Trust's Annual Report
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	As required, new and revised NHSE Guidance will be considered where appropriate in the governance structure and Board development activities	
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	The Board has an ongoing focus to ensure its structures continue to be effective to support its core functions around strategic planning, risk management and overseeing Trust performance.	
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	Please refer to the content of the Trust's Annual Report, including the Annual Governance Statement, for details.	Click here to access the Trust's Annual Report
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	Please refer to the content of the Trust's Annual Report, including the Annual Governance Statement, for details.	Click here to access the Trust's Annual Report
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	The Nominations related duties of the Board's Remuneration and Nominations Committee include that it reviews the composition of the Board and consider and advise the Board as to any changes which may be required to achieve a balanced and appropriately experienced and qualified Board. Further details are included in the Trust's Annual Report.	Click here to access the Trust's Annual Report

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature _____ **Signature** _____

Name Paul Robinson **Name** Claire Ward

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A N/A

OK

Worksheet "Training of governors"

Financial Year to which self-certification relates 2023/2024

Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Paul Robinson	**Name**	Claire Ward
Capacity	Chief Executive	**Capacity**	Chair
Date		**Date**	

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Committee Effectiveness Report	**Date:**	2nd May 2024
Prepared By:	Laura Webster, Corporate Secretariat Team Leader		
Approved By:	Sally Brook Shanahan, Director of Corporate Affairs		
Presented By:	Sally Brook Shanahan, Director of Corporate Affairs		

Purpose		
To provide the Board of Directors with assurance regarding the effectiveness of the Committees of the Board.	**Approval**	
	Assurance	**X**
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Audit and Assurance Committee, Finance Committee, Quality Committee, and Charitable Funds Committee have all completed the self-assessments.

Acronyms

None

Executive Summary

To ensure good governance and identify areas for improvement, the Board is supported by its committees, which have undergone a Committee Health Check self-assessment review.

All committees have reported that all assessment criteria have been fully met, with no actions identified.

The Terms of Reference and Work plans for all committees have been reviewed and agreed for 2024. These have been included in the reading room alongside each committee self-assessment review.

There is no annual report or self-assessment review for the Partnership and Communities Committee as it is only in its inaugural year.

Introduction

Effective Board Meetings and committees of the Board are a key part of an effective governance structure it is therefore important to ensure the Trust's organisational governance aligns with best practice and national guidance.

Scope of Review of Effectiveness

The Trust has undertaken a review of the effectiveness of the Committees of the Board, using a standardised, committee Health check self-assessment tool. The checklist is divided into five sections:

- Role and responsibilities
- Membership and independence
- Skills and experience
- Scope of work
- Communication

The aim of the Health Check is to help committees to review their governance arrangements, check they have appropriate systems in place and identify areas where they could improve.

Members of the committees completed each question and considered the evidence available to determine where the committee is on the following scale:

- Fully Met: The committee is confident that the requirement is in place and there is evidence to support it
- Part Met: The committee partly carries out the requirement and there is some evidence to support it, but current practice needs adapting or improving
- Not Met: The committee does not meet the requirements practice and current practice needs adapting or improving.

The current governance for the Trust is provided through a properly constituted Board established in accordance with the Trust's constitution. The Trust Board has the following committees:

- Quality
- Finance
- Audit and Assurance
- People
- Partnerships and Communities
- Charitable Funds Committee (established by the Board in its capacity as the Corporate Trustee)

The terms of reference and work plans for these committees were reviewed, in accordance with the annual requirement identified in the Terms of Reference.

Key Findings

The key findings for each of the committees are included in the reading room and are summarised below:

<u>Quality Committee</u>

- No actions identified. All assessment criteria fully met.

Finance Committee

- No actions identified. All assessment criteria fully met.

Charitable Funds Committee

- The current proposal for the self-assessment indicates that all criteria have been met, with no actions identified. This is consistent with the previous assessment outcome. The report is due to be presented at the next Charitable Funds Committee taking place 9th May 2024.

Audit and Assurance Committee

- No actions identified. All assessment criteria fully met.

People Committee

- No actions identified. All assessment criteria fully met.

Partnership and Communities Committee

- Self-assessment due 2025.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Standing Financial Instructions and Scheme of Delegation updates	**Date:**	2nd May 2024
Prepared By:	Michael Powell, Head of Financial Services		
Approved By:	Audit & Assurance Committee		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
Update of Standing Financial Instructions and Scheme of Delegation in response to changes in responsibility role and other changes of circumstances.	**Approval**	**X**
	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
X			**X**		

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	Failure to achieve the Trust's financial strategy	**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

Audit and Assurance Committee

Acronyms

DHSC – Department of Health and Social Care
SFI's- Standing Financial Instructions

Executive Summary

A high-level review of the SFIs and Scheme of Delegation has been undertaken as requested at Trust Management Team. A full review is due for presentation to the November 2024 Audit and Assurance Committee.

Two changes were made to the SFI's relating to the quotation process following a review at the Audit and Assurance committee meeting of March 2024, relating to the flow of the 'contracting and financial guidelines, section 9.3.5'. The Finance & Procurement team have updated this section to reflect current practice and as a consequence this has also meant a minor change to section 9.3.3.

In addition, two formal changes have been made to the scheme of delegation:

Table b Section 7.1)

- New line added to identify delegated limit of £100k for the Trust Management Team.
- Up to £5k amended from one to two delegated budget holders as requested by Divisional colleagues.

A large number of minor changes have also been made to the scheme of delegation in relation to responsible officers and their associated titles.

A tracked changes version of the Scheme of delegation and Standing Orders is attached, which highlights the proposed changes.

Members are requested to approve the proposed changes.

Outstanding Care,
Compassionate People,
Healthier Communities

Healthier Communities,
Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

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STANDING FINANCIAL INSTRUCTIONS

CONTENTS

1 INTRODUCTION

1.1 General

1.1.1 NHS Improvement (NHSI) sets the Terms of Authorisation for the Foundation Trust that require compliance with the principles of best practice applicable to corporate governance within the NHS / Health Sector with any relevant code of practice and guidance issued by NHSI.

1.1.2 The Code of Conduct and Accountability in the NHS issued by the Department of Health requires that each NHS organisation shall give, and may vary or revoke, Standing Financial Instructions for the regulation of the conduct of its members and officers in relation to all financial matters with which they are concerned. These Standing Financial Instructions (SFIs) are issued in accordance with the Code. They shall have effect as if incorporated in the Standing Orders (SOs) of the Foundation Trust.

These SFIs detail the financial responsibilities, policies and procedures to be adopted by the Foundation Trust. They are designed to ensure that its financial transactions are carried out in accordance with the law and Government policy in order to achieve probity, accuracy, economy, efficiency and effectiveness. They should be used in conjunction with the Schedule of Decisions Reserved to the Board of Directors within the Scheme of Delegation adopted by the Foundation Trust.

1.1.3 These SFIs identify the financial responsibilities, which apply to everyone working for the Foundation Trust and its constituent organisations including Trading Units. They do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes. The Chief Financial Officer must approve all financial procedures.

1.1.4 Should any difficulties arise regarding the interpretation or application of any of the SFIs then the advice of the Chief Financial Officer MUST BE SOUGHT BEFORE ACTING. The user of these SFIs should also be familiar with and comply with the provisions of the Foundation Trust's SOs.

FAILURE TO COMPLY WITH STANDING FINANCIAL INSTRUCTIONS AND STANDING ORDERS IS A DISCIPLINARY MATTER, WHICH COULD RESULT IN DISMISSAL.

Overriding Standing Financial Instructions – If for any reason these Standing Financial Instructions are not complied with, full details of the non-compliance and any justification for non-compliance and the circumstances around the non-compliance shall be reported to the next formal meeting of the Audit & Assurance Committee for referring action or ratification. All members of the Board of Directors and staff have a duty to disclose any non-compliance with these Standing Financial Instructions to the Chief Financial Officer as soon as possible.

1.2 Terminology

1.2.1 Any expression to which a meaning is given in Health Service Acts, or in the Financial Directions made under the Acts shall have the same meaning in these instructions.

Accounting Officer:
The Officer responsible and accountable for funds entrusted to the Foundation Trust in accordance with the NHS Foundation Trust Accounting Officer Memorandum. He shall be responsible for ensuring the proper stewardship of public funds and assets. The Health and Social Care Act designates the Chief Executive of the NHS Foundation Trust as the Accounting Officer.

Appointed Governors:

Those Members of the Council of Governors appointed by the appointing organisations.

Appointing Organisations:
Those organisations named in the constitution that are entitled to appoint members of the Council of Governors.

Areas of the Foundation Trust:
The four areas, which are (1) Ashfield (2) Derbyshire (3) Mansfield and (4) Newark & Sherwood.

Authorised Signatory:
An officer who has authority delegated by a Budget Holder to approve expenditure for a specific area of the organisation.

Budget Holder:
The director or employee with delegated authority to manage finances (Income and Expenditure) for a specific area of the organisation.

Board of Directors:
The Board of Directors as constituted in accordance with the Constitution.

Budget:
A resource, expressed in financial or manpower terms, proposed by the Board of Directors for the purpose of carrying out, for a specific period, any or all of the functions of the Foundation Trust.

CCG Governor:
A Member of the Council of Governors appointed by a Clinical Commissioning Group for which the Foundation Trust provides goods or services.

Charity:
The Charitable funds, gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust that are administered by the Board of Directors acting as trustees.

Chief Executive:
The Accounting Officer of the Foundation Trust.

Code of Conduct in the NHS:
Describes the three crucial public service values (Accountability, Probity and Openness), which must underpin the work of the health service.

Company Secretary:
The Company Secretary of the Foundation Trust or any other person appointed to perform the duties of the Company Secretary, including a joint, assistant or deputy secretary.

Constitution:
The constitution of the Foundation Trust that describes the type of organisation, its primary purpose, governance arrangements and membership.

Council of Governors:
The Council of Governors as constituted in the Constitution.

Director:
A member of the Board of Directors.

Elected Governor:

Those Members of the Council of Governors elected by the public constituencies and the classes of the staff constituency.

Executive Director:
A Director who is an officer and member of the Board of Directors.

Financial Auditor:
The person appointed to audit the accounts of the Foundation Trust.

Financial Year:
A period beginning with the date on which the Foundation Trust is authorised and ending with the next 31 March; and each successive period of twelve months beginning with 1 April.

Funds held on Trust:
Those funds which the Foundation Trust holds at its date of incorporation, receives on distribution by statutory instrument, or chooses subsequently to accept under powers derived under the National Health Service Act. Such funds may or may not be charitable.

Foundation Trust:
The Sherwood Forest Hospitals NHS Foundation Trust.

Legal Adviser:
The properly qualified person appointed by the Foundation Trust to provide legal advice.

Licence Conditions:
The licence document issued by NHS Improvement (formerly Monitor), confirming Foundation Trust status on the organisation.

Local Authority Governor:
A Member of the Council of Governors appointed by one or more local authorities whose area includes the whole or part of one of the areas of the Foundation Trust.

Member:
A member of the Foundation Trust.

NHS Improvement (NHSI):
The independent regulator.

NHS Standard Contract:
The legally binding contract established between the Foundation Trust and every CCG for which the Foundation Trust provides patient and other services.

Non-Executive Director:
A Director who is not an officer of the Foundation Trust and is not to be treated as an officer by virtue of the Constitution.

Officer:
An employee of the Foundation Trust.

Partner:
In relation to another person, a member of the same household living together as a family unit.

Partnership Governor:
A member of the Council of Governors appointed by a partnership organisation.

Property:
Land and buildings owned or leased by the Foundation Trust.

Public Governor:
A Member of the Council of Governors elected by the members of one of the public constituencies.

Relevant Asset:
The property/asset needed for the purposes of providing any of the mandatory goods and services and mandatory training and education.

Staff Governor:
Member of the Council of Governors elected by the members of one of the classes of the staff constituency.

Standing Financial Instructions (SFIs):
These regulate the conduct of the Foundation Trust's financial matters.

Standing Orders (SOs):
Incorporate the constitution and regulate the business conduct of the Foundation Trust.

Terms of Authorisation:
An authorisation given by NHS Improvement.

All references to the masculine gender will be deemed to apply equally to the feminine gender when used with these instructions.

1.2.2 Wherever the title Chief Executive, Chief Financial Officer, or other nominated officer is used in these instructions, it shall be deemed to include such other directors or employees who have been duly authorised to represent them.

Wherever the term "employee" is used and where the context permits it shall be deemed to include employees of third parties contracted to the Foundation Trust when acting on behalf of the Foundation Trust, including nursing and medical staff and consultants practising on the Foundation Trust premises.

1.3 **Responsibilities and Delegation**

1.3.1 The Foundation Trust shall at all times remain a going concern as defined by the relevant accounting standards in force. The Board of Directors exercises financial supervision and control by:

a) formulating the financial strategy;

b) requiring the submission and approval of budgets within overall income;

c) defining and approving essential features in respect of important procedures and financial systems (including the need to obtain value for money) and by ensuring appropriate audit provision;

d) defining specific responsibilities placed on directors and employees as indicated in the Scheme of Delegation document.

1.3.2 The constitution dictates that the Council of Governors may not delegate any of its powers to a committee or sub-committee. The Board of Directors has resolved that certain powers and decisions may only be exercised by the Board of Directors in formal session. These are set out in the "Reservation of Powers to the Board of Directors" document, published within the Scheme of Delegation. The Board of Directors will delegate responsibility for the performance of its functions in accordance with the Scheme of Delegation document adopted by the Foundation Trust.

1.3.3 Within the SFIs, it is acknowledged that the Chief Executive is ultimately accountable to the Board of Directors, and as the accounting officer for ensuring that the Board of Directors meets its obligation to perform its functions within the available financial resources. The Chief Executive has overall executive responsibility for the Foundation Trust's activities, is responsible to the Board of Directors for ensuring that its financial obligations and targets are met and has overall responsibility for the Foundation Trust's system of internal control.

1.3.4 The Chief Executive and Chief Financial Officer will, as far as possible, delegate their detailed responsibilities but they remain accountable for financial control.

1.3.5 It is a duty of the Chief Executive to ensure that existing directors and employees and all new appointees are notified of and understand their responsibilities within these instructions. All staff shall be responsible for ensuring conformity with the Standing Orders, Standing Financial Instructions and financial instructions and financial procedures of the Foundation Trust.

1.3.6 The Chief Financial Officer is responsible for:

a) implementing the Foundation Trust's financial policies and for co-ordinating any corrective action necessary to further these policies (The SFIs themselves do not provide detailed procedural advice. These statements should therefore be read in conjunction with the detailed departmental and financial procedure notes);

b) maintaining an effective system of internal financial control including ensuring that detailed financial procedures and systems incorporating the principles of separation of duties and internal checks are prepared, documented and maintained to supplement these instructions;

c) ensuring that sufficient records are maintained to show and explain the Foundation Trust's transactions, in order to disclose, with reasonable accuracy, the financial position of the Foundation Trust at any time and without prejudice to any other functions of directors and employees to the Foundation Trust. The duties of the Chief Financial Officer include;

i) the provision of financial advice to other members of the Board of Directors, Council of Governors and employees;

ii) the design, implementation and supervision of systems of internal financial control;

iii) the preparation and maintenance of such accounts, certificates, estimates, records and financial reports as the Foundation Trust may require for the purpose of carrying out its statutory duties.

1.3.7 All directors and employees, severally and collectively, are responsible for:

a) the security of the property of the Foundation Trust;

b) avoiding loss;

c) exercising economy and efficiency in the use of resources;

d) conforming with the requirements of Standing Orders, Standing Financial Instructions, financial procedures and the Scheme of Delegation.

1.3.8 Any contractor or employee of a contractor who is empowered by the Foundation Trust to commit the Foundation Trust to expenditure, or who is authorised to obtain income,

shall be covered by these instructions. It is the responsibility of the Chief Executive to ensure that such persons are made aware of this.

1.3.9 For any and all directors and employees who carry out a financial function, the form in which financial records are kept and the manner in which directors and employees discharge their duties must be to the satisfaction of the Chief Financial Officer.

2 AUDIT

2.1 Audit & Assurance Committee

2.1.1 In accordance with Standing Orders the Board of Directors shall formally establish a committee of three non-executive directors (Audit & Assurance Committee) to monitor the exercise of the financial auditor's function**,** with clearly defined terms of reference, which will provide an independent and objective view of internal control by:

a) overseeing Internal and External Audit services;

b) reviewing financial systems;

c) monitoring compliance with Standing Orders and Standing Financial Instructions;

d) reviewing schedules of losses and compensation and making recommendations to the Board of Directors;

e) reviewing the effective implementation of corporate governance measures to enable the Foundation Trust to implement best practice as set out in appropriate guidance. This will include the Assurance Framework and control related disclosure statements, for example the Annual Governance Statement and supporting assurance processes; together with any accompanying audit statement, prior to endorsement by the Board of Directors.

2.1.2 The Board of Directors shall satisfy itself that at least one member of the Audit & Assurance Committee has recent and relevant financial experience.

2.1.3 Where the Audit & Assurance Committee feel there is evidence of ultra vires transactions, evidence of improper acts, or if there are other important matters that the committee wish to raise, the chairman of the Audit & Assurance Committee should raise the matter at a full meeting of the Board of Directors. (To the Chief Financial Officer in the first instance.)

2.1.4 It is the responsibility of the Chief Financial Officer to ensure adequate internal and external audit services are provided and the Audit & Assurance Committee shall be involved in the selection process when an audit service provider is changed.

2.2 Fraud and Corruption

2.2.1 The Foundation Trust shall take all necessary steps to counter fraud affecting NHS funded services in accordance with:

a) The policy statement "Applying appropriate sanctions consistently" published by NHS Protect;

b) Any other reasonable guidance or advice issued by the NHS Counter Fraud Authority that affects efficiency, systemic and/or procedural matters.

2.2.2 The Chief Executive and Chief Financial Officer shall monitor and ensure compliance with the above.

2.2.3 The Foundation Trust shall nominate a suitable person to carry out the duties of the Local Counter Fraud Specialist as specified by the Standards for providers: Fraud, bribery and corruption.

2.2.4 The Local Counter Fraud Specialist shall report to the Foundation Trust Chief Financial Officer and shall work with the staff in the Counter Fraud and Security Management Service and the Counter Fraud Operational Service.

2.3. **Chief Financial Officer**

2.3.1 The Chief Financial Officer is responsible for:

a) ensuring there are arrangements to review, evaluate and report on the effectiveness of internal control including the establishment of an effective internal audit function and the coordination of other assurance arrangements;

b) ensuring that the internal audit is adequate and meets the NHS mandatory audit standards;

c) deciding at what stage to involve the police in cases of fraud, misappropriation, and other irregularities not involving fraud or corruption;

d) ensuring that an annual internal audit report is prepared for the consideration of the Audit & Assurance Committee and the Board of Directors. The report must cover:

i) a clear statement on the effectiveness of internal controls in accordance with current guidance issued by the Department of Health;

ii) major internal financial control weaknesses discovered;

iii) progress on the implementation of internal audit recommendations;

iv) progress against plan over the previous year;

v) strategic audit plan;

vi) a detailed plan for the coming year.

2.3.2 The Chief Financial Officer or designated auditors are entitled without necessarily giving prior notice to require and receive:

a) access to all records, documents and correspondence relating to any financial or other relevant transactions, including documents of a confidential nature;

b) access at all reasonable times to any land, premises, members of the Board of Directors and Council of Governors or employee of the Foundation Trust;

c) the production of any cash, stores or other property of the Foundation Trust under a member of the Board of Directors or employee's control; and

d) explanations concerning any matter under investigation.

2.4 **Role of Internal Audit**

2.4.1 Internal Audit will review, appraise and report upon:

a) the extent of compliance with, and the financial effect of, relevant established policies, plans and procedures;

b) the adequacy and application of financial and other related management controls;

c) the suitability of financial and other related management data;

d) the extent to which the Foundation Trust's assets and interests are accounted for and safeguarded from loss of any kind, arising from:

i) fraud and other offences;

ii) waste, extravagance, inefficient administration;

iii) poor value for money or other causes;

e) reporting on the Quality Account Indicators mandated by NHSI.

2.4.2 Whenever any matter arises which involves, or is thought to involve, irregularities concerning cash, stores, or other property or any suspected irregularity in the exercise of any function of a pecuniary nature, the Chief Financial Officer must be notified immediately.

2.4.3 The Head of Internal Audit will normally attend Audit & Assurance Committee meetings and has a right of access to all Audit & Assurance Committee members, the Chairman and Chief Executive of the Foundation Trust.

2.4.4 The Head of Internal Audit shall be accountable to the Chief Financial Officer. The reporting system for internal audit shall be agreed between the Chief Financial Officer, the Audit & Assurance Committee and the Head of Internal Audit. The agreement shall be in writing and shall comply with the guidance on reporting contained in the NHS Internal Audit Manual. The reporting system shall be reviewed at least every 3 years. Where, in exceptional circumstances, the use of normal reporting channels is thought to limit the objectivity of the audit, the Head of Internal Audit shall have access to report direct to the Chairman or a non-executive member of the Foundation Trust's Audit & Assurance Committee.

2.4.5 Managers in receipt of audit reports referred to them have a duty to take appropriate remedial actions within the agreed time-scales within the report. The Chief Financial Officer shall identify a formal review process to monitor the extent of compliance with audit recommendations. Where appropriate remedial action has failed to take place within a reasonable period, the matter shall be reported by the Chief Financial Officer to the Audit & Assurance Committee.

2.5 **External Audit**

2.5.1 The external auditor is appointed by the Council of Governors following recommendation from the Audit & Assurance Committee.

2.5.2 The Code of Audit Practice ("The Audit Code") contains the statutory responsibilities of NHS Foundation Trusts and auditors in relation to accounting and audit.

2.5.3 The Foundation Trust shall comply with the Audit Code.

2.5.4 The Auditor shall comply with the Audit Code.

2.5.5 References in 2.4.3 and 2.4.5 relate equally to internal and external audit.

2.5.6 In the event of the External Auditor issuing a Public Interest report the Foundation Trust shall forward a report to NHSI within 30 days (or such shorter period as NHSI may specify) of the report being issued. The report shall include details of the Foundation Trust's response to the issues raised within the Public Interest report.

2.6 **Financial Audit**

2.6.1 Duties

The Foundation Trust is to have a financial auditor and is to provide the financial auditor with every facility and all information, which he may reasonably require for the purposes of his functions.

The financial auditor is to carry out their duties in accordance with any directions given by NHSI on standards, procedures and techniques to be adopted.

2.6.2 Appointment of Financial Auditor

A person may only be appointed as the financial auditor if they (or in the case of a firm of each of its members) are a registered auditor.

The Council of Governors at a General Meeting shall appoint or remove the Foundation Trust's financial auditor.

The Board of Directors may resolve that external auditors be appointed to review and publish a report on any other aspect of the Foundation Trust's performance. Any such auditors are to be appointed by the Council of Governors.

3 BUSINESS AND FINANCIAL PLANNING, BUDGETS, BUDGETARY CONTROL AND MONITORING

3.1 **Preparation and approval of business plans and budgets**

3.1.1 The Chief Executive will compile and submit to the Board of Directors a strategic direction document that encompasses an annual business plan and takes into account financial targets and forecast limits of available resources. The annual business plan will contain:

a) statement of the significant assumptions on which the plan is based;

b) details of major changes in workload, delivery of services or resources required to achieve the plan.

3.1.2 Prior to the start of the financial year the Chief Financial Officer will, on behalf of the Chief Executive, prepare and submit budgets relating to income and expenditure for approval by the Board of Directors. Such budgets will:

a) be in accordance with the aims and objectives set out in the Foundation Trust's annual business plan, and the commissioners' local delivery plans;

b) accord with workload and manpower plans;

c) be produced following discussion with appropriate budget holders;

d) be prepared within the limits of available funds;

e) identify potential risks; and

f) be based on reasonable and realistic assumptions.

3.1.3 The Chief Financial Officer shall monitor financial performance against budgets, periodically review it and report to the Board of Directors. Any significant variances should be reported by the Chief Financial Officer to the Foundation Trust Board of Directors as soon as they come to light and the Board of Directors shall be advised of action to be taken in respect of such variances.

3.1.4 All budget holders must provide information as required by the Chief Financial Officer to enable budgets to be compiled.

3.1.5 The Chief Financial Officer has a responsibility to ensure that adequate training is delivered on an on-going basis to budget holders and authorised signatories to help them manage successfully.

3.2 **Budgetary delegation**

3.2.1 The Chief Executive may delegate the management of a budget to permit the performance of a defined range of activities, including pooled budget arrangements. This delegation must be in writing and be accompanied by a clear definition of:

a) the amount of the budget;

b) the purpose(s) of each budget heading;

c) individual and group responsibilities;

d) authority to exercise virement;

e) achievement of planned levels of service; and

f) the provision of regular reports.

3.2.2 The Chief Executive and delegated budget holders must not exceed the budgetary total or virement limits set by the Board of Directors.

3.2.3 Any budgeted funds not required for their designated purpose(s) revert to the immediate control of the Chief Executive, subject to any authorised use of virement.

3.2.4 Non-recurring budgets should not be used to finance recurring expenditure.

3.3 **Budgetary control and reporting**

3.3.1 The Chief Financial Officer will devise and maintain systems of budgetary control. These will include:

a) regular financial reports to the Board of Directors in a form approved by the board of Directors containing;

i) key financial performance indicators and forecasts;

ii) explanations of any material variances from plan/budget;

iii) details of any corrective action where necessary and the Chief Executive's and/or Chief Financial Officer's view of whether such actions are sufficient to correct the situation;

b) the issue of timely, accurate and comprehensible advice and financial reports to each budget holder, covering the areas for which they are responsible;

c) investigation and reporting or variances from financial and workload budgets;

d) monitoring of management action to correct variances;

e) arrangements for the authorisation of budget transfers;

f) advising the Chief Executive and Foundation Trust Board of Directors of the consequences of changes in policy, pay awards and other events and trends affecting budgets and shall advise on the economic and financial impact of future plans and projects; and

g) review of the bases and assumptions used to prepare the budgets.

3.3.2 In the performance of these duties the Chief Financial Officer will have access to all budget holders on budgetary matters and shall be provided with such financial and statistical information as is necessary.

3.3.3 Each Budget Holder is responsible for ensuring that:

a) any planned or known overspending or reduction of income which cannot be met by virement is not incurred without the prior consent of the Board of Directors;

b) officers shall not exceed the budget limit set;

c) the amount provided in the approved budget is not used in whole or in part for any purpose other than that specifically authorised subject to the rules of virement; and

d) no permanent employees are appointed without the approval of the Chief Executive or Chief Financial Officer other than those provided for in the budgeted establishment as approved by the Board of Directors.

3.3.4 The Chief Executive is responsible for identifying and implementing cost improvements and income generation initiatives in accordance with the requirements of the Annual Plan and a balanced budget.

3.4 **Capital expenditure**

3.4.1 The general rules applying to delegation and reporting shall also apply to capital expenditure. (The particular applications relating to capital are contained in Section 11.) A Project Sponsor will be identified who will assume responsibility for the budget relating to the scheme.

3.5 **Monitoring returns**

3.5.1 The Chief Executive is responsible for ensuring that the appropriate monitoring forms are submitted to NHSI within the specified time-scales.

4 ANNUAL ACCOUNTS AND REPORTS

4.1 **Accounts**

4.1.1 The Foundation Trust is to keep accounts in such form as NHSI may, with the approval of the Treasury, direct. The accounts are to be audited by the Foundation Trust's financial auditor. The following documents will be made available to the Comptroller and Auditor General for examination at his request:

a) the accounts;

b) any records relating to them; and

c) any report of the financial auditor on them.

4.1.2 The Foundation Trust is to prepare in respect of each financial year annual accounts in such form as NHSI may, with the approval of the Treasury, direct. In preparing its annual accounts, the Foundation Trust is to comply with any directions given by NHSI with the approval of the Treasury as to:

a) the methods and principles according to which the accounts are to be prepared;

b) the information to be given in the accounts.

4.1.3 The annual accounts, any report of the financial auditor on them, and the annual report are to be presented to the Council of Governors at a General Meeting.

4.1.4 The Foundation Trust shall:

a) lay a copy of the annual accounts, and any report of the financial auditor on them, before Parliament; and

b) once it has done so, send copies of those documents to NHSI.

Responsibility for complying with the requirements relating to the form, preparation and presentation of the accounts shall be delegated to the accounting officer.

4.2 Annual Reports

4.2.1 The Foundation Trust is to prepare annual reports and submit them to NHSI. The reports are to give:

a) information on any steps taken by the Foundation Trust to secure that (taken as a whole) the actual membership of its public constituencies and of the classes of the staff constituency is representative of those eligible for such membership; and

b) any other information NHSI requires.

4.2.2 The Foundation Trust is to comply with any decision NHSI makes as to:

a) the form of the reports;

b) when the reports are to be submitted;

c) the periods to which the reports are to relate.

4.3 Plans

The Foundation Trust is to give information as to its forward planning in respect of each financial year to NHSI. The document containing this information is to be prepared by the Directors, and in preparing the document, the Board of Directors must have regard to the views of the Council of Governors.

5 BANK ACCOUNTS

5.1 General

5.1.1 The Chief Financial Officer is responsible for managing the Foundation Trust banking arrangements and for advising the Foundation Trust on the provision of banking services and operation of accounts.

5.1.2 The Board of Directors shall approve the banking arrangements.

5.2 Bank accounts

5.2.1 The Chief Financial Officer is responsible for:

a) bank accounts and other forms of working capital financing that may be available from the Department of Health;

b) establishing separate bank accounts for the Foundation Trust's non-exchequer funds;

c) ensuring payments made from bank accounts do not exceed the amount credited to the account except where arrangements have been made;

d) reporting to the Board of Directors all arrangements made with the Foundation Trust's bankers for accounts to be overdrawn (together with the remedial action taken).

5.2.2 All accounts should be held in the name of the Foundation Trust. No officer other than the Chief Financial Officer shall open any account in the name of the Foundation Trust or for the purpose of furthering Foundation Trust activities.

5.3 Banking procedures

5.3.1 The Chief Financial Officer will prepare detailed instructions on the operation of bank accounts, which must include:

a) the conditions under which each bank account is to be operated;

b) the limit to be applied to any overdraft; and

c) those authorised to sign cheques or other orders drawn on the Foundation Trust's accounts.

5.3.2 The Chief Financial Officer must advise the Foundation Trust's bankers in writing of the conditions under which each account will be operated.

5.3.3 The Chief Financial Officer shall approve security procedures for any cheques issued without a hand-written signature e.g. lithographed. Manually produced cheques shall be signed by the authorised officer(s) in accordance with the bank mandate.

5.3.4 All cheques shall be treated as controlled stationery, in the charge of a duly designated officer controlling their issue.

5.4 Tendering and Review

5.4.1 The Chief Financial Officer will review the banking arrangements of the Foundation Trust at regular intervals to ensure they reflect best practice and represent best value for money by periodically seeking competitive tenders for the Foundation Trust's business banking.

5.4.2 Competitive tenders should be sought at least every 5 years. The results of the tendering exercise should be reported to the Board of Directors.

6 INCOME, FEES AND CHARGES AND SECURITY OF CASH, CHEQUES AND OTHER NEGOTIABLE INSTRUMENTS

6.1 Income systems

6.1.1 The Chief Financial Officer is responsible for designing, maintaining and ensuring compliance with systems for the proper recording, invoicing, collection and coding of all monies due.

6.1.2 All such systems shall incorporate, where practicable, in full the principles of internal check and separation of duties.

6.1.3 The Chief Financial Officer is also responsible for the prompt banking of all monies received.

6.2 Fees and charges

6.2.1 The Chief Financial Officer is responsible for approving and regularly reviewing the level of all fees and charges other than those determined by the Department of Health or by Statute. Independent professional advice on matters of valuation shall be taken as necessary. Where sponsorship income (including items in kind such as subsidised goods or loans of equipment) is considered the guidance in the NHS Commissioning Board's Standards of Business Conduct shall be followed.

6.2.2 All employees must inform the Chief Financial Officer promptly of money due arising from transactions which they initiate/deal with, including all contracts, leases, tenancy agreements, private patient undertakings and other transactions.

6.3 Debt recovery

6.3.1 The Chief Financial Officer is responsible for the appropriate recovery action on all outstanding debts, including a formal follow up procedure for all debtor accounts.

6.3.2 Income not received (bad debts) should be dealt with in accordance with losses procedures.

6.3.3 Overpayments should be detected (or preferably prevented) and recovery initiated.

6.4 Security of cash, cheques and other negotiable instruments

6.4.1 The Chief Financial Officer is responsible for:

a) approving the form of all receipt books, agreement forms or other means of officially acknowledging or recording monies received or receivable (no form of receipt which has not been specifically authorised by the Chief Financial Officer should be issued);

b) ordering and securely controlling any such stationery;

c) the provision of adequate facilities and systems for employees whose duties include collecting and holding cash, including the provision of safes or lockable cash boxes, the procedures for keys and for coin operated machines; and

d) prescribing systems and procedures for handling cash and negotiable securities on behalf of the Foundation Trust.

6.4.2 Official money shall not under any circumstances be used for the encashment of private cheques, nor IOUs.

6.4.3 Staff shall be informed in writing on appointment of their responsibilities and duties for the collection, handling or disbursement of cash, cheques, etc.

6.4.4 All cheques, postal orders, cash, etc. shall be banked promptly intact under arrangements approved by the Chief Financial Officer.

6.4.5 The holders of safe keys shall not accept unofficial funds for depositing in their safes unless such deposits are in special sealed envelopes or locked containers. It shall be made clear to the depositors that the Foundation Trust is not to be held liable for any loss, and written indemnities must be obtained from the organisation or individuals absolving the Foundation Trust from responsibility for any loss.

6.4.6 Any loss or shortfall of cash, cheques or other negotiable instruments, however occasioned, shall be monitored and recorded within the Finance Department. Any significant trends should be reported to the Chief Financial Officer and Internal Audit via the incident reporting system. Where there is prima facie evidence of fraud or corruption this should follow the form of the Foundation Trust's Counter Fraud, Bribery and Corruption Policy and the guidance provided by the Counter Fraud and Security Management Service. Where there is no evidence of fraud or corruption the loss should be dealt with in line with the Foundation Trust's Losses and Compensations Procedures.

7 CONTRACTS

7.1 NHS Standard Contracts

7.1.1 The Board of Directors of the Foundation Trust shall regularly review and at all times maintain and ensure the capacity and capability of the Foundation Trust to provide the commissioner requested services referred to in the NHS Provider Licence.

7.1.2 The Chief Executive, as the accounting officer, is responsible for ensuring the Foundation Trust enters into suitable NHS Standard Contracts with CCGs and other commissioners for the provision of NHS services. The Foundation Trust will follow the priorities contained within the schedules of the contract, and wherever possible, be based upon integrated care pathways to reflect expected patient experience. In discharging this responsibility, the Chief Executive should take into account:

a) the standards of service quality expected;

b) the relevant national service framework (if any);

c) the provision of reliable information on cost and volume of services;

d) that the contract builds where appropriate on existing partnership arrangements.

7.1.3 The Chief Executive is responsible for ensuring that the Foundation Trust works with all partner agencies involved in both the delivery and the commissioning of the service required.

7.1.4 The Chief Executive, as the accounting officer, will need to ensure that regular reports are provided to the Board of Directors detailing actual and forecast income from the contract. This will include appropriate payment by results performance information.

7.2 **Other contracts for services provided**

7.2.1 The Chief Executive, as the accounting officer, is responsible for ensuring the Foundation Trust enters into suitable contracts with CCGs and other commissioners for the provision of services outside of NHS Standard Contracts.

7.2.2 The Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation) that a business case is produced setting out:

a) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

b) appropriate project management and control arrangements; and

c) the involvement of appropriate Foundation Trust personnel and external agencies; and

d) that the Chief Financial Officer has certified professionally to the revenue and costs consequences detailed in the business case.

8 TERMS OF SERVICE, ALLOWANCES AND PAYMENT OF MEMBERS OF THE BOARD OF DIRECTORS AND EMPLOYEES

8.1 **Remuneration Committee**

8.1.1 In accordance with Standing Orders the Board of Directors shall establish a Remuneration Committee, with clearly defined terms of reference, specifying which posts fall within its area of responsibility, its composition, and the arrangements for reporting.

8.1.2 The Committee will:

a) advise the Board of Directors about appropriate remuneration and terms of service for the Chief Executive and other executive directors (and other senior employees), including;

i) all aspects of salary (including any performance-related elements/bonuses);

ii) provisions for other benefits, including pensions and cars;

iii) arrangements for termination of employment and other contractual terms;

b) make such recommendations to the Board of Directors on the remuneration and terms of service of executive directors (and other senior employees) to ensure they are fairly rewarded for their individual contribution to the Foundation Trust, having proper regard to the Foundation Trust's circumstances and performance and to the provisions of any national arrangements for such staff where appropriate;

c) monitor and evaluate the performance of individual executive directors (and other senior employees); and

d) advise on and oversee appropriate contractual arrangements for such staff including the proper calculation and scrutiny of termination payments taking account of such national guidance as is appropriate.

8.1.3 The Committee shall report in writing to the Board of Directors the basis for its recommendations. The Board of Directors shall use the report as the basis for their decisions, but remain accountable for taking decisions on the remuneration and terms of service of executive directors. Minutes of the Board of Directors meetings should record such decisions.

8.1.4 The Board of Directors will approve proposals presented by the Chief Executive for setting of remuneration and conditions of service for those employees not covered by the Committee.

8.1.5 The Council of Governors, at a General Meeting will decide the remuneration and allowances, and the other terms and conditions of office of the Non-Executive Directors.

8.2 **Funded establishment**

8.2.1 The manpower plans incorporated within the annual budget will form the funded establishment. The establishment of the Foundation Trust will be identified and monitored by the Director of People under delegation from the Chief Executive.

8.2.2 The funded establishment of any department may not be varied without the approval of the Chief Executive or individual nominated within the relevant section of the Scheme of Delegation.

8.3 **Staff appointments**

8.3.1 No Executive Director or employee may engage, re-engage, or re-grade employees, either on a permanent or temporary nature, or hire agency staff, or agree to changes in any aspect of remuneration unless within the limit of his approved budget and funded establishment as defined in the Scheme of Delegation.

8.3.2 The Board of Directors will approve procedures presented by the Chief Executive for the determination of commencing pay rates, condition of service, etc., for employees.

8.4 **Processing of the payroll**

8.4.1 The Director of People in conjunction with the Chief Financial Officer is responsible for:

a) specifying timetables for submission of properly authorised time records and other notifications;

b) the final determination of pay and allowances, including verification that the rate of pay and relevant conditions of service are in accordance with current agreements;

c) making payment on agreed dates; and

d) agreeing the method of payment.

8.4.2 The Chief Financial Officer will issue instructions regarding:

a) verification and documentation of data;

b) the timetable for receipt and preparation of payroll data and the payment of employees and allowances;

c) maintenance of subsidiary records for superannuation, income tax, social security and other authorised deductions from pay;

d) security and confidentiality of payroll information;

e) checks to be applied to completed payroll before and after payment;

f) authority to release payroll data under the provisions of the Data Protection Act / General Data Protection Regulation;

g) methods of payment available to various categories of employee;

h) procedures for payment by cheque, bank credit, or cash to employees;

i) procedures for the recall of cheques and bank credits;

j) pay advances and their recovery;

k) maintenance of regular and independent reconciliation of pay control accounts;

l) separation of duties of preparing records and handling cash; and

m) a system to ensure the recovery from leavers of sums of money and property due by them to the Foundation Trust.

8.4.3 Appropriately nominated managers have delegated responsibility for:

a) processing a signed copy of the contract/appointment form and such other documentation as may be required immediately upon an employee commencing duty;

b) submitting time records, and other notifications in accordance with agreed timetables;

c) completing time records and other notifications in accordance with the Director of People instructions and in the form prescribed by the Director of People ;

d) submitting termination forms in the prescribed form immediately upon knowing the effective date of an employee's resignation, termination or retirement. Where an employee fails to report for duty in circumstances that suggest they have left without notice, the Director of People must be informed immediately. In circumstances where fraud might be expected this must be reported to the Chief Financial Officer.

8.4.4 Regardless of the arrangements for providing the payroll service, the Director of People in conjunction with the Chief Financial Officer shall ensure that the chosen method is supported by appropriate (contracted) terms and conditions, adequate internal controls and audit review procedures and that suitable arrangements are made for the collection of payroll deductions and payment of these to appropriate bodies.

8.5 **Contracts of employment**

8.5.1 The Board of Directors shall delegate responsibility to a manager for:

a) ensuring that all employees are issued with a Contract of Employment in a form approved by the Board of Directors and which complies with employment, Health & Safety legislation; and

b) dealing with variations to, or termination of, contracts of employment.

9 NON-PAY EXPENDITURE

9.1 Delegation of authority

9.1.1 The Board of Directors will approve the level of non-pay expenditure on an annual basis and determine the level of delegation to budget holders.

9.1.2 The Chief Executive will set out:

a) the list of managers who are authorised to place requisitions for the supply of goods and services. This list should be updated and reviewed on an ongoing basis and annually by the Procurement Department or by officers in those departments that are responsible for their own procurement, for example Pathology, MEMD, Pharmacy;

b) the maximum level of each requisition and the system for authorisation above that level.

9.1.3 The Chief Executive shall set out procedures on the seeking of professional advice regarding the supply of goods and services.

9.2 Choice, requisitioning, ordering, receipt and payment for goods and services

9.2.1 The requisitioner, in choosing the item to be supplied (or the service to be performed) shall always obtain the best value for money for the Foundation Trust. In doing so, the advice of the Procurement Category Manager shall be sought. Where this advice is not acceptable to the requisitioner, the Chief Financial Officer (and/or the Chief Executive) shall be consulted.

9.2.2 The Chief Financial Officer shall be responsible for the prompt payment of properly authorised accounts and claims in accordance with the Better Payments Practice Code (BPPC). Payment of contract invoices shall be in accordance with contract terms, or otherwise, in accordance with national guidance.

9.2.3 The Chief Financial Officer will:

a) advise the Board of Directors regarding the setting of thresholds above which quotations (competitive or otherwise) or formal tenders must be obtained; and, once approved, the thresholds should be regularly reviewed;

b) prepare procedural instructions where not already provided in the Scheme of Delegation or procedure notes for budget holders on the obtaining of goods, works and services incorporating the thresholds;

c) be responsible for designing and maintaining a system of verification, recording and payment of all amounts payable. The system shall provide for:

i) a list of directors/employees (including specimens of their signatures) authorised to approve or incur expenditure. Where the authorisation system is computerised the list will be maintained within the computerised system and the 'signature' will be in the form of electronic authorisation in accordance with the access and authority controls maintained within the computerised system;

ii) Certification that:

- goods have been duly received, examined and are in accordance with specification and the prices are correct;

- work done or services rendered have been satisfactorily carried out in accordance with the order, and, where applicable, the materials used are of the requisite standard and the charges are correct;
- in the case of contracts based on the measurement of time, materials or expenses, the time charged is in accordance with the time sheets, the rates of labour are in accordance with the appropriate rates, the materials have been checked as regards quantity, quality, and price and the charges for the use of vehicles, plant and machinery have been examined;
- where appropriate, the expenditure is in accordance with regulations and all necessary authorisations have been obtained;
- the account is arithmetically correct;
- the account is in order for payment;

iii) a system is in place for the early payment of accounts subject to cash discounts or otherwise requiring early payment;

iv) instructions to employees regarding the handling and payment of accounts within the Finance Department;

d) be responsible for ensuring that payment for goods and services is only made once the goods and services are received (except as below).

9.2.4 Prepayments outside of normal commercial arrangements, for example fully comprehensive maintenance contracts, rental, insurance are only permitted where exceptional circumstances apply. In such instances:

a) prepayments are only permitted where the financial advantages outweigh the disadvantages (i.e. cash flow must be discounted to NPV using the National Loans Fund (NLF) rate;

b) the appropriate Officer in conjunction with the Procurement Department must provide, in the form of a written report, a case setting out all relevant circumstances of the purchase. The report must set out the effects on the Foundation Trust if the supplier is at some time during the course of the prepayment agreement unable to meet his commitments;

c) the Chief Financial Officer will need to be satisfied with the proposed arrangements before contractual arrangements proceed (taking into account the EU public procurement rules where the contract is above a stipulated financial threshold);

d) the Budget Holder is responsible for ensuring that all items due under a prepayment contract are received and he/she must immediately inform the appropriate Director or Chief Executive if problems are encountered.

9.2.5 Official Purchase Orders must:

a) be consecutively numbered;

b) be in a form approved by the Chief Financial Officer;

c) state the Foundation Trust terms and conditions of trade; and

d) only be issued to, and used by, those duly authorised by the Chief Executive.

9.2.6 Managers must ensure that they comply fully with the guidance and limits specified by the Chief Financial Officer and that:

a) where an officer certifying accounts relies upon other officers to do preliminary checking, he/she shall wherever possible ensure that those who check delivery or execution of work act independently of those who have placed orders and negotiated prices and terms;

b) no order shall be issued for any item or items to any firm which has made an offer of gifts, reward or benefit to directors or employees, other than isolated gifts of a trivial character or inexpensive seasonal gifts, such as:

i) calendars;

ii) conventional hospitality, such as lunches in the course of working visits;

c) no requisition/order is placed for any item or items for which there is no budget provision unless authorised by the Chief Financial Officer on behalf of the Chief Executive;

d) all goods, services or works are ordered on an official purchase order except for those specified on the Exceptions List, within the Procurement Manual. Payments must be authorised in accordance with the delegated limits set for non-pay;

e) verbal orders must only be issued very exceptionally - by an employee designated by the Chief Executive and only in cases of emergency or urgent necessity. These must be confirmed by an official order, and clearly marked "Confirmation Order";

f) orders are not split or otherwise placed in a manner devised so as to avoid the financial thresholds;

g) goods are not taken on trial or loan in circumstances that could commit the Foundation Trust to a future un-competitive purchase;

h) purchases from petty cash are restricted in value and by type of purchase in accordance with instructions issued by the Chief Financial Officer;

i) petty cash records are maintained in a form as determined by the Chief Financial Officer.

9.2.7 The Chief Executive and Chief Financial Officer shall ensure that the arrangements for financial control and financial audit of building and engineering contracts and property transactions comply with the guidance contained within the NHS Premises Assurance Model. The technical audit of these contracts shall be the responsibility of the relevant Director.

9.2.8 Under no circumstances should goods be ordered through the Foundation Trust for personal or private use.

9.3 Contracts Procedure Rules

9.3.1 Introduction

9.3.1.1 These Contract Procedure Rules provide a corporate framework for the procurement of all goods, services and works for the Trust. The Rules are designed to ensure that all procurement activity is conducted with openness, probity and accountability. Above all,

the Rules are designed to ensure that the Trust obtains value for money and the required level of quality and performance in all contracts that are let. Every contract for the supply of goods and services and for the execution of works made by or on behalf of the Trust shall comply with these Rules.

9.3.1.2 E-procurement procedures shall be used wherever possible. Where appropriate e-auctions may be used, so long as provision is made for this in the advert. Requests for quotations, pre-qualification questionnaires and Invitations to tender should wherever practical be issued to tenderers by electronic means. The e-tendering software that is to be used must be either the corporate e-tendering system or the Crown Commercial Services Rfx system.

9.3.1.3 The Trust is committed to dealing fairly with all relevant discrimination groups as defined in the Equalities Act 2010.

9.3.1.4 All financial values or thresholds in this Contracts Procedure Rules section include the cost of non-recoverable VAT.

9.3.2 **Compliance with contract procedure rules**

9.3.2.1 The provisions contained in these Rules are subject to the statutory requirements of both the European Union and the United Kingdom. The letting and content of Contracts shall conform to all statutory requirements and be subject to any over-riding directives of the European Union relating to contracts and procurement. This Rule cannot be waived, since a failure to comply with European legislation may result in a legal challenge to the Trust with consequent reputational and financial risk. If you are uncertain, advice can be sought from the Head of Procurement.

9.3.2.2 In estimating relevant contract values, officers shall have regard to the rules regarding aggregation, and also those regarding Value Added Tax, e.g. a three year contract at £40,000 (inclusive of VAT) per annum should be considered as a £120,000 value contract.

9.3.2.3 These Rules apply, in addition to other procurements, to any proposal for the Trust to become involved in a joint venture or partnership, including the monitoring of any such arrangement. All procurements must also comply with Freedom of Information and Data Protection requirements.

9.3.2.4 Where the Trust acts as lead body on a consortium or collaborative arrangement, the procedures for tendering contained within these Rules shall be followed.

9.3.3 **Normal procedure**

9.3.3.1 These Rules relate to ~~three~~four ~~four~~ categories of procurement based on the estimated value of the contract:

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~~a) £1 to £5,000;~~

~~b)~~a) £1~~5~~,~~000~~ to £25,000;

~~c)~~b) £25,000 to £EU Threshold;

~~d)~~c) Over the EU Threshold.

9.3.3.2 In all instances, goods, services or works should be obtained via the methods outlined below:

a) in-house services;

b) established corporate contracts or framework agreements;

c) call for competition framework contracts established by Purchasing Consortia, Procurement Hubs or other Trusts (to be agreed by the Strategic Head of Procurement). Access to frameworks can be by direct call off or further competition ("mini-competition"), dependent on specific framework terms.

All of the above options are subject to EU and/or UK Statutory requirements which must be complied with.

9.3.3.3 Orders and payments for goods, services and works shall be undertaken in accordance with the Standing Financial Instructions. In all cases, the following wording must be included in tender and request for quotation documents:

"Information in relation to this tender may be made available on demand in accordance with the requirements of the Freedom of Information Act. Tenderers should state if any of the information supplied by them is confidential or commercially sensitive or should not be disclosed in response to a request for information under the Act. Tenderers should state why they consider the information to be confidential or commercially sensitive. This will not guarantee that the information will not be disclosed but will be examined in the light of the exemptions provided in the Act."

9.3.3.4 Before entering into any procurement procedure, the Authorised Officer must liaise with the Procurement Department and/or Commercial Services for assistance and advice. The Authorised Officer must be satisfied that the following are in place:

a) a specification that will form the basis of the contract has been prepared. The specification should be retained on the appropriate contract file held within the service;

b) an estimate of the cost of the contract has been produced and documented. Where appropriate, any maintenance and on-going costs should be included in the estimate as a total cost of ownership;

c) for contracts over £25,000 where there is evident risk, a documented risk register for the procurement process and for the eventual contractual relationship should be produced and retained. As a minimum this should analyse all risks, identify how the risks will be managed, and the responsible officer(s);

d) for all contracts greater than £25,000 a draft contract should be produced to accompany the tender documents. This should utilise NHS Standard Terms and Conditions;

e) ensure that all evaluation criteria have been determined in advance, put into order of relative importance with weightings for each element and published in the tender pack.

9.3.3.5 Before entering into a contract the Authorised Officer must:

a) ensure that these Rules have been complied with, and that the proposed contract represents value for money; and

b) be satisfied about the technical capability of such proposed contractor and be satisfied that s/he has the power and authority to enter into the contract; and

c) for all contracts that exceed £25,000, the Authorised Officer shall undertake appropriate checks to ensure that the proposed contractor has the financial and resource capacity (taking account of contract value and risk) to perform the contract. Financial vetting shall initially be via the corporate credit check agency. This may be escalated to an officer designated by the Chief Financial Officer in the event of any queries. The Finance Officer shall advise on what, if any, security should be provided by the contractor in terms of a performance bond or parent company guarantee.

9.3.3.6 **Advertising**

Procurement procedures not undertaken via an existing framework valued over £25,000 shall be advertised and, in line with Government guidance, be available for download on the website www.gov.uk/contracts-finder. Contract award notices shall also be published on the website.

9.3.3.7 To invigorate local business spend, calls for competition may also be advertised locally. The Procurement Department should be consulted for further details.

9.3.3.8 All EU notices must be placed by the Procurement Department.

9.3.4 Exemptions

9.3.4.1 Subject to OJEU Regulations and statutory requirements, tenders need not be invited in accordance with these Rules in the following cases:

a) the goods or services are proprietary articles and, in the opinion of the appropriate Senior Officer (which should be put in writing and retained on the project file), no reasonably satisfactory alternative is available. Exemptions under this rule shall be notified to the Procurement Department who will report exemptions to the Audit and Assurance Committee;

b) the work to be executed or the goods or services to be supplied are controlled by a statutory body;

c) the work to be executed or the goods or services to be supplied constitute an extension to an existing contract and subject to the Senior Officer deciding that it would not be in the interests of the service or the Trust to tender the contract. The Senior Officer or his or her nominee should consult with the Strategic Head of Procurement who will advise whether this course of action is appropriate;

d) the contract is for the execution of work or the supply of goods or services certified by the appropriate Senior Officer to be required so urgently as to preclude the invitation of tenders. Exemptions under this rule shall be notified to the Procurement Department who will report exemptions to the Audit and Assurance Committee. Urgency may not be used as a routine exemption;

e) where any of the above exemptions apply, the Single Tender Waiver protocol must be followed.

9.3.4.2 Tenders need not be invited where the goods, services or works can be sourced via an appropriate, compliant framework agreement. Officers should contact the Procurement Department to ensure that any such frameworks under consideration have been let in accordance with UK and EU procurement directives and regulations. The Procurement Department should also advice on access arrangements, whether it be by direct call off or further competition.

9.3.5 Contracting and financial guidelines

9.3.5.1 Officers should order goods and services that are required through an arrangement illustrated in Rule 9.3.3.2. If however the Trust or the consortium providing them do not have the goods or services or resources available to meet the reasonable needs of the service then an alternative supply may be sourced. In all circumstances a written purchase order is required. If no purchase order has been issued, no payment will be made to a supplier.

9.3.5.2 It is good practice (for all but small value and routine purchases) to open the requirement up to competition.

9.3.5.3 Contracts £1 to £25,000
Procurement of goods and services estimated to be for amounts up to £25,000 shall be awarded based on ~~by a~~ single source direct award, or by competition where appropriate. There is ~~ano~~ mandatory requirement for the involvement of procurement ~~involvement, but officers should take account of the rules on aggregated spend. Between £5,000 and £25,000 officers must seek a minimum of 3 informal quotes.~~

~~9.3.5.4 Contracts £5,000 to £25,000 and Over~~
~~Procurement of goods and services estimated to be for amounts overup to £25,000 shall be by three informal quotes. Evidence of the quotes process must be included on the requisition document. There is no mandatory procurement involvement, but officers should take account of the rules on aggregated spend.~~

9.3.5.4 Contracts £25,000 to EU Threshold

i) Procurement of goods and services estimated to be for amounts in the range £25,000 to EU Threshold shall be by formal~~, advertised call for~~ competition, unless an arrangement under 9.3.3.2 has already been established. The Procurement Team should be involved in such projects, ideally from an early stage. They will offer advice on the appropriate procurement route and the necessary documentation required. The choice of procurement route and documentation will be based on the value, complexity, risk and urgency of the project;

ii) In cases where works are covered by Constructionline, this list may be used provided that at least three written quotations are obtained (and more where, in the opinion of the Authorised Officer, there is a reasonable level of competition or variety of solutions). The use of Constructionline must be structured in order to ensure open and fair competition with an appropriate rotation of suppliers from the list.

9.3.5.~~56~~ Contracts EU Threshold and above
Procurement of goods and services estimated to be for amounts in the range EU Threshold and above shall be by formal Invitation to Tender (ITT).

9.3.6 Probity

9.3.6.1 In every instance, the Procurement Department will maintain a record of the process. This shall be in accordance with the Procurement Toolkit and shall include the following, plus any information that may be required for submitting annual reports to the Government or other agencies:

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a) the officer(s) undertaking the procurement process and taking the decisions;

b) the rationale for the procurement route taken (including open or restricted procedure if above EU thresholds);

c) a copy of the specification, risk register and anything required by Financial Regulations;

d) copies of all tender submissions supplier questionnaire;

e) copy of the evaluation process and reasons for the decisions as to acceptance or rejection for every tender;

f) copy of the award letters.

9.3.6.2 Officers of the Foundation Trust shall only be eligible for inclusion on a tender evaluation panel if they have fully complied with the requirements of Conflict of Interest policies and procedures.

9.3.6.3 All contracts for goods, services and works must be registered on the Commercial Services Contracts Register and the original contract documents held centrally by Commercial Services. This will include a copy of the contract review and management process including the officer responsible for on-going contract management.

9.3.6.4 **Bribery Act**

The Act makes it an offence to pay or receive a bribe, either directly or indirectly. The Act provides for transactions that take place both in the public and private sectors. Where a commercial organisation is convicted of such an offence there is provision within the Regulations for the commercial organisation to be barred from participating in tenders for public contracts. The Government intends to change this in amended Regulations to give a discretion to the public body seeking the tender as to whether such a commercial organisation should be so barred. Where there is evidence to suggest a breach of the Act or a conviction under the Act, officers should inform the Strategic Head of Procurement, Director of People and the Solicitor to the Trust who will advise on a course of action.

9.3.7 **Receipt and Evaluation**

For all projects over £25,000, documentation shall be received via the corporate e-tendering system. Tender documentation will only be released for evaluation once the electronic vault opens at the pre-appointed time.

9.3.8 **Late Tenders**

Where a tender is submitted in competition and is received after the specified time then it shall be disqualified. This shall be subject to a test of reasonableness on the part of the Head of Procurement. The decision whether to accept or reject a late tender should be recorded in writing via the e-tender system.

9.3.9 **Acceptance**

9.3.9.1 Contracts shall be evaluated and awarded in accordance with the evaluation criteria issued with the tender documentation. Only those tenders that comply with the

evaluation criteria shall be considered for acceptance. Tenders must be accepted on the basis of "most economically advantageous" tender.

9.3.9.2 Unless variants have been expressly permitted, a tenderer who submits a qualified or conditional tender shall be given the opportunity to withdraw the qualification or condition without amendment to the tender. If the tenderer fails to do so the tender must be rejected.

9.3.9.3 Prior to final contract award, and as stipulated in the tender documentation instructions, the contractor must provide evidence of adequate insurance to cover:

a) public liability;

b) employers' liability; and,

c) where appropriate, professional indemnity;

d) where appropriate, product liability.

9.3.9.4 The decision on whether insurance is adequate shall be taken by the Chief Financial Officer. The contractor should be able to produce such evidence in their tender submissions where requested and during the life of the contract.

9.3.9.5 The notification of the award decision to unsuccessful bidders, based on the most economically advantageous tender, should contain:

a) the award criteria;

b) the score the tenderer obtained against those award criteria;

c) the score the winning tenderer obtained;

d) the name of the winning tenderer(s);

e) the relative advantage of the winning bid.

9.3.10 **Nominated or Named sub-Contractors and Suppliers**

Contracts must be awarded to a single entity or lead contractor, who in turn will take contractual responsibility for the performance (and risks) for all sub-contractors and supply-chains. This reduces the risk of the Trust becoming party to disputes between contractors.

9.3.11 **Performance Bonds and Guarantees**

In the case of all contracts valued above £25,000 where a risk is present, the Authorised Officer shall determine, based on advice from the Chief Financial Officer, the degree of security (if any) required to protect the Trust from a contractor default. This may be a performance bond or some other form of financial or performance guarantee, e.g. parent company guarantee. Where a performance bond and/or parent company guarantee is required, then the tender documents must provide for this.

9.3.12 **Liquidated Damages**

Any contract which is estimated to exceed £25,000 in value or amount, and is for the execution of works, or for the supply of goods or materials by a particular date or series of dates, shall provide for liquidated damages. The amount to be specified in each such contract shall be determined by the Strategic Head of Procurement.

9.3.13 **Contract Management**

Contract Management must take place on all final awarded contracts. This is outlined through the measurement of individual contractors' KPI's (Key Performance Indicators). It is recommended for contractors to be measured on a quarterly basis. However, depending on the specific contract area, the Trust has the discretion to decide for this to be more frequent.

9.4 Joint finance arrangements with local authorities and voluntary bodies

Payments to local authorities and voluntary organisations shall comply with procedures laid down by the Chief Financial Officer.

10 FUNDING AND INVESTMENTS

10.1 **Public Dividend Capital**

10.1.1 Additional Public Dividend Capital may be made available on such terms the Secretary of State (with the consent of the Treasury) decides.

10.1.2 Draw down of Public Dividend Capital should be authorised in accordance with the mandate held by the Department of Health Cash Funding Team.

10.1.3 The Foundation Trust shall be required to pay annually to the Department of Health a dividend on its Public Dividend Capital at a rate to be determined from time to time, by the Secretary of State.

10.2 **Working Capital Facility / Department of Health Loans**

10.2.1 The Foundation Trust may borrow money from Department of Health for the purposes of or in connection with its functions, subject to agreement by NHSI.

10.3 **Commercial Borrowing and Investment**

10.3.1 The Foundation Trust may borrow money from any commercial source for the purposes of or in connection with its functions, subject to agreement by NHSI.

10.3.2 The Foundation Trust may invest money (other than money held by it as charitable trustee) for the purposes of or in connection with its functions. Such investment may include forming, or participating in forming, or otherwise acquiring membership of bodies corporate.

10.3.3 The Foundation Trust may also give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its functions but is currently not registered to do so.

10.4 **Investment of Temporary Cash Surpluses**

10.4.1 Temporary cash surpluses must be held only in such public and private sector investments as authorised by the Board of Directors.

10.4.2 The Finance Committee is responsible for establishing and monitoring an appropriate investment strategy.

10.4.3 The Chief Financial Officer is responsible for advising the Board of Directors on investments and shall report periodically to the Board of Directors concerning the performance of investments held.

10.4.4 The Chief Financial Officer will prepare detailed procedural instructions on investment operations and on the records to be maintained. The Foundation Trust's Treasury Management policy will incorporate guidance from NHSI as appropriate.

11 CAPITAL INVESTMENT, PRIVATE FINANCING, FIXED ASSET REGISTERS AND SECURITY OF ASSETS

11.1 Capital investment

11.1.1 The Chief Executive:

a) shall ensure that there is an adequate appraisal and approval process in place for determining capital expenditure priorities and the effect of each proposal upon business plans;

b) is responsible for the management of all stages of capital schemes and for ensuring that schemes are delivered on time and to cost; and

c) shall ensure that the capital investment is not undertaken without the availability of resources to finance all revenue consequences, including capital charges.

11.1.2 For capital expenditure proposals the Chief Executive shall ensure (in accordance with the limits outlined in the Scheme of Delegation) that a business case is produced setting out:

e) an option appraisal of potential benefits compared with known costs to determine the option with the highest ratio of benefits to costs; and

f) appropriate project management and control arrangements; and

g) the involvement of appropriate Foundation Trust personnel and external agencies; and

h) that the Chief Financial Officer has certified professionally to the costs and revenue consequences detailed in the business case.

11.1.3 For capital schemes where the contracts stipulate stage payments, the Chief Executive will issue procedures for their management, incorporating the recommendations of the NHS Premises Assurance Model.

11.1.4 The Chief Financial Officer shall issue procedures for the regular reporting of expenditure and commitment against authorised expenditure.

11.1.5 The approval of a capital programme shall not constitute approval for expenditure on any scheme without the approval of an associated business case as set out in 11.1.2. Once approved, the manager responsible for any scheme is issued with:

a) specific authority to commit expenditure;

b) authority to proceed to tender;

c) approval to accept a successful tender.

11.1.6 The Chief Executive will issue a scheme of delegation for capital investment management in accordance with the NHS Premises Assurance Model and the Foundation Trust's Standing Orders.

11.1.7 The Chief Financial Officer shall issue procedures governing the financial management, including variations to contract, of capital investment projects and valuation for accounting purposes.

11.2 **Private finance**

The Foundation Trust should normally test for PFI when considering capital procurement. When the Board proposes, or is required, to use finance provided by the private sector the following should apply:

a) The Chief Executive shall demonstrate that the use of private finance represents value for money and genuinely transfers risk to the private sector;

b) A business case must be referred to NHSI/DHSC for approval or treated as per current guidelines;

c) The proposal must be specifically agreed by the Foundation Trust in the light of such professional advice as should reasonably be sought in particular with regard to vires;

d) The selection of a contractor / finance company must be on the basis of competitive tendering or quotations.

11.3 **Asset registers**

11.3.1 The Chief Executive is responsible for the maintenance of registers of assets, taking account of the advice of the Chief Financial Officer concerning the form of any register and the method of updating, and arranging for a physical check of assets against the Asset Register to be conducted once a year.

11.3.2 Additions to the Fixed Asset Register must be clearly identified to an appropriate budget holder and be validated by reference to:

a) properly authorised and approved agreements, architect's certificates, suppliers' invoices and other documentary evidence in respect of purchases from third parties;

b) stores, requisitions and wages records for own materials and labour including appropriate overheads; and

c) lease agreements in respect of assets held under a finance lease and capitalised.

11.3.3 Where capital assets are sold, scrapped, lost or otherwise disposed of, their value must be removed from the accounting records and each disposal must be validated by reference to authorisation documents and invoices (where appropriate).

11.3.4 The Chief Financial Officer shall approve procedures for reconciling balances on fixed assets accounts in ledgers against balances on Fixed Asset Registers.

11.3.5 The value of assets shall be periodically recalculated in line with the Department of Health Group Accounting Manual (GAM).

11.3.6 The value of each asset shall be depreciated using methods and rates as specified in the GAM.

11.3.7 The Chief Financial Officer shall calculate and pay capital charges as specified by NHSI.

11.4 **Relevant Assets**

11.4.1 A register of Relevant Assets is required to be maintained in accordance with requirements issued by NHSI.

11.4.2 No Relevant Assets may be disposed of without the approval of NHSI.

11.4.3 This will be achieved through the annual planning process. The annual plan will include proposed acquisitions, disposals and changes in the treatment of Relevant Assets.

11.4.4 Foundation Trusts are required to notify relevant bodies of the publication date of their plans to allow them to lodge any objections. Twenty-one days is allowed before the plans are then approved.

11.4.5 During the year when the proposed changes are made the Asset Register must be updated accordingly. The relevant bodies should then be notified that an updated Asset Register is available.

11.4.6 All other changes to the treatment of Relevant Assets must be in line with 'Section 5 – Continuity of Services, Condition CoS2 – Restriction on the disposal of assets' of NHSI's Licence Conditions.

11.5 **Security of assets**

11.5.1 The overall control of fixed assets is the responsibility of the Chief Executive advised by the Chief Financial Officer.

11.5.2 Asset control procedures (including fixed assets, cash, cheques and negotiable instruments, and also including donated assets) must be approved by the Chief Financial Officer. This procedure shall make provision for:

a) recording managerial responsibility for each asset;

b) identification of additions and disposals;

c) identification of all repairs and maintenance expenses;

d) physical security of assets;

i) periodic verification of the existence of, condition of, and title to, assets recorded;

ii) identification and reporting of all costs associated with the retention of an asset;

iii) reporting, recording and safekeeping of cash, cheques, and negotiable instruments.

11.5.3 All significant discrepancies revealed by verification of physical assets to Fixed Asset Register shall be notified to the Chief Financial Officer.

11.5.4 Whilst each employee has a responsibility for the security of property of the Foundation Trust, it is the responsibility of directors and senior employees in all disciplines to apply such appropriate routine security practices in relation to NHS property as may be determined by the Board of Directors. Any breach of agreed security practices must be reported in accordance with instructions.

11.5.5 Any damage to the Foundation Trust's premises, vehicles and equipment, or any loss of equipment, stores or supplies must be reported by directors and employees in accordance with the procedure for reporting losses.

11.5.6 Where practical, assets should be marked as Foundation Trust property.

12 STOCK STORES AND RECEIPT OF GOODS

12.1 Stocks are defined as those goods normally utilised in day to day activity, but which at a given point in time have not been used or consumed. There are three broad types of store:-

a) Controlled stores - specific areas designated for the holding and control of goods;

b) Wards and departments - goods required for immediate usage to support operational services;

c) Manufactured Items - where goods and consumables are being made or processes are being applied which add to the raw material cost of the goods.

12.2 Such stocks should be kept to a minimum and for;

a) controlled stores and other significant stores (as determined by the Chief Financial Officer) should be subjected to an annual stocktake or perpetual inventory procedures; and

b) valued at the lower of cost and net realisable value.

12.3 Subject to the responsibility of the Chief Financial Officer for the systems of control, overall responsibility for the control of stores shall be delegated to an employee by the Chief Executive. The day-to-day responsibility may be delegated by him to departmental employees and stores managers/keepers, subject to such delegation being entered in a record available to the Chief Financial Officer . The control of any Pharmaceutical stocks shall be the responsibility of a designated Pharmaceutical Officer.

12.4 The responsibility for security arrangements and the custody of keys for all stores and locations shall be clearly defined in writing by the designated manager.

12.5 Wherever practicable, stocks should be marked as Foundation Trust property.

12.6 The Chief Financial Officer shall set out procedures and systems to regulate the stores including records for receipt of goods, issues, and returns to stores, and losses.

12.7 Stocktaking arrangements shall be agreed with the Chief Financial Officer and there shall be a physical check covering all items in store at least once a year.

12.8 Where a complete system of stores control is not justified, alternative arrangements shall require the approval of the Chief Financial Officer.

12.9 The designated manager shall be responsible for a system approved by the Chief Financial Officer for a review of slow moving and obsolete items and for condemnation, disposal, and replacement of all unserviceable articles. The designated Officer shall report to the Chief Financial Officer any evidence of significant overstocking and of any negligence or malpractice (see also 13, Disposals and Condemnations, Insurance, Losses and Special Payments). Procedures for the disposal of obsolete stock shall follow the procedures set out for disposal of all surplus and obsolete goods.

Receipt of Goods

12.10 A delivery note shall be obtained from the supplier at the time of delivery and shall be signed by the person receiving the goods. All goods received shall be checked, by the appropriate department, as regards quantity and/or weight and inspected as to quality

and specification. Instructions shall be issued to staff covering the procedures to be adopted in those cases where a delivery note is not available.

12.11 All goods received shall be entered onto an appropriate goods received/stock record (whether a computer or manual system) on the day of receipt. If goods received are unsatisfactory, the records shall be marked accordingly. Further, where the goods received are found to be unsatisfactory, or short on delivery, they shall only be accepted on the authority of the designated officer and the supplier shall be notified immediately.

12.12 For goods supplied via the NHS Supply Chain central warehouses, the Chief Executive shall identify those authorised to requisition and accept goods from the store. The authorised person shall check receipt against the delivery note to satisfy themselves that the goods have been received. The Finance Department will make payment on receipt of an invoice.

Issue of Stocks

12.13 The issue of stocks shall be supplied by an authorised requisition note and a receipt for the stock issued shall be returned to the designated officer. Where a stock replenishment system is used, a record shall be maintained as approved by the Chief Financial Officer . Regular comparisons shall be made of the quantities issued to wards/departments etc. and explanations recorded of significant variations.

12.14 All transfers and returns shall be recorded on forms/systems provided for the purpose and approved by the Chief Financial Officer .

13 DISPOSALS AND CONDEMNATIONS, INSURANCE, LOSSES AND SPECIAL PAYMENTS

13.1 Disposals and condemnations

13.1.1 The Chief Financial Officer must prepare detailed procedures for the disposal of assets including condemnations, and ensure that these are notified to managers.

13.1.2 When it is decided to dispose of a Foundation Trust asset, the head of department or authorised deputy will determine and advise the Chief Financial Officer of the estimated market value of the item, taking account of professional advice where appropriate. For protected (relevant) assets see Section 11.4 of these SFIs.

13.1.3 All unserviceable articles shall be:

a) condemned or otherwise disposed of by an employee authorised for that purpose by the Chief Financial Officer;

b) recorded by the condemning officer in a form approved by the Chief Financial Officer, which will indicate whether the articles are to be converted, destroyed or otherwise disposed of. All entries shall be confirmed by the countersignature of a second employee authorised for the purpose by the Chief Financial Officer.

13.1.4 The condemning officer shall satisfy himself as to whether or not there is evidence of negligence in use and shall report any such evidence to the Chief Financial Officer who will take the appropriate action.

13.2 Losses and special payments

13.2.1 The Chief Financial Officer must prepare procedural instructions on the recording of and accounting for condemnations, losses, and special payments. The Chief Financial Officer must also prepare a fraud response plan that sets out the action to be taken both

by persons detecting a suspected fraud and those persons responsible for investigating it.

13.2.2 Any employee or officer discovering or suspecting a loss of any kind must either immediately inform their directorate manager or head of department, who must immediately inform the Chief Financial Officer who will liaise with the Chief Executive, or inform an officer charged with responsibility for responding to concerns involving loss confidentially. This officer will then appropriately inform the Chief Financial Officer who will liaise with the Chief Executive.

13.2.3 Where a criminal offence is suspected, the Chief Financial Officer must immediately inform the police if theft or arson is involved. In cases of fraud or corruption or of anomalies which may indicate fraud or corruption, the Chief Financial Officer must inform their Local Counter Fraud Specialist who will inform the relevant Counter Fraud regional team **before** any action is taken and reach agreement how the case is to be handled.

13.2.4 The Chief Financial Officer must notify Counter Fraud and Security Management Service of all frauds, and ensure that details are disclosed in the Annual Accounts.

13.2.5 For losses apparently caused by theft, arson, neglect of duty or gross carelessness, except if trivial the Chief Financial Officer must immediately notify the Board of Directors.

13.2.6 The Board of Directors shall approve the writing-off of all losses and special payments in accordance with the Scheme of Delegation.

13.2.7 The Chief Financial Officer shall be authorised to take any necessary steps to safeguard the Foundation Trust's interests in bankruptcies and company liquidations.

13.2.8 For any loss, the Chief Financial Officer should consider whether any insurance claim could be made.

13.2.9 The Chief Financial Officer shall maintain a Losses and Special Payments Register in which write-off action is recorded.

13.3 Insurance

The Chief Financial Officer shall ensure that insurance arrangements exist in accordance with the risk management programme.

13.4 Compensation claims

13.4.1 The Foundation Trust is committed to effective and timely investigation and response to any claim that includes allegations of clinical negligence, employee and other compensation claims. The Foundation Trust will follow the requirements and note the recommendations of NHSI / the Department of Health, and the NHS Litigation Authority (NHSLA) in the management of claims. Every member of staff is expected to co-operate fully, as required, in assessment and management of each claim.

13.4.2 The Foundation Trust will seek to reduce the incidence and adverse impact of clinical negligence, employee and other litigation by: -

a) Adopting prudent risk management strategies including continuous review;

b) Implementing in full the NHS Complaints Procedure, thus providing an alternative remedy for some potential litigants;

c) Adopting a systematic approach to claims handling in line with the best current and cost effective practice;

d) Following guidance issued by the NHSLA relating to clinical negligence;

e) Achieving the Care Quality Commission's 'Essential standards of quality and safety';

f) Implementing an effective system of Clinical Governance.

13.4.3 The Executive Medical Director and the Executive Director of Nursing and Quality are responsible for clinical governance. The Company Secretary is responsible for managing the claims process in collaboration with the Executive Medical Director and the Executive Director of Nursing and Quality, and for informing the Foundation Trust Board of Directors of any major developments on claims related issues.

14 INFORMATION TECHNOLOGY

14.1. The Chief Financial Officer, who is responsible for the accuracy and security of the computerised financial data of the Foundation Trust, shall:

a) devise and implement any necessary procedures to ensure adequate (reasonable) protection of the Foundation Trust's data, programs and computer hardware for which he/she is responsible from accidental or intentional disclosure to unauthorised persons, deletion or modification, theft or damage, having due regard for the Data Protection and Computer Misuse Acts;

b) ensure that adequate (reasonable) controls exist over data entry, processing, storage, transmission and output to ensure security, privacy, accuracy, completeness, and timeliness of the data, as well as the efficient and effective operation of the system;

c) ensure that adequate controls exist such that the computer operation is separated from development, maintenance and amendment;

d) ensure that adequate controls exist to maintain the security, privacy, accuracy and completeness of financial data sent via transmission networks;

e) ensure that an adequate management (audit) trail exists through the computerised system and that such computer audit reviews, as he/she may consider necessary are being carried out.

14.2 The Chief Financial Officer shall satisfy him/herself that new financial systems and amendments to current financial systems are developed in a controlled manner and thoroughly tested prior to implementation. Where this is undertaken by another organisation, assurances of adequacy will be obtained from them prior to implementation.

14.3 In the case of computer systems which are proposed general applications (i.e. normally those applications which the majority of NHS Organisations in the region wish to sponsor jointly e.g. PACS - Picture Archiving Communication System) all responsible directors and employees will send to the Senior Information Risk Owner:

a) details of the outline design of the system:

b) in the case of packages acquired either from a commercial organisation, from the NHS, or from another public sector organisation, the operational requirement.

14.4 The Senior Information Risk Owner shall ensure that contracts for computer services for financial applications with another health organisation or any other agency shall clearly define the responsibility of all parties for the security, privacy, accuracy,

completeness and timeliness of data during processing, transmission and storage. The contract should also ensure rights of access for audit purposes.

14.5 Where another health organisation or any other agency provides a computer service for financial applications, the Senior Information Risk Owner shall periodically seek assurances that adequate controls are in operation.

14.6 Where computer systems have an impact on corporate financial systems the Senior Information Risk Owner shall satisfy him/herself that:

a) systems acquisition, development and maintenance are in line with corporate policies such as an IM&T Strategic Plan;

b) data produced for use with financial systems is adequate, accurate, complete and timely, and that a management (audit) trail exists;

c) Senior Information Risk Owner staff have access to such data; and

d) such computer audit reviews as are considered necessary are being carried out.

14.7 The Foundation Trust shall disclose to NHSI and directly to any third parties, as may be specified by the Secretary of State, the information, if any, specified in the NHSI Licence. Other information, as requested, shall be provided to NHSI.

15 PATIENTS' PROPERTY

15.1 The Foundation Trust has a responsibility to provide safe custody for money and other personal property (hereafter referred to as "property") handed in by patients, in the possession of unconscious or confused patients, or found in the possession of patients dying in hospital or dead on arrival.

15.2 The Chief Executive is responsible for ensuring that patients or their guardians, as appropriate, are informed before or at admission that by the Foundation Trust will not accept responsibility or liability for patients' property brought into its premises, unless it is handed in for safe custody and a copy of an official patient's property record is obtained as a receipt. This information shall take the form of:

a) notices and information booklets;

b) hospital admission documentation and property records;

c) the oral advice of administrative and nursing staff responsible for admissions.

15.3 The Chief Financial Officer must provide detailed written instructions on the collection, custody, recording, safekeeping, and disposal of patients' property (including instructions on the disposal of the property of deceased patients and of patients transferred to other premises) for all staff whose duty is to administer, in any way, the property of patients. The said instructions shall cover the necessary arrangements for withdrawal of cash or disbursement of money held in accounts of patients who are incapable of handling their own financial affairs.

15.4 A patient's property record, in a form determined by the Chief Nurse shall be completed in respect of the following:

a) property handed in for safe custody by any patient (or guardian as appropriate); and

b) property taken into safe custody having been found in the possessions of:

i) mentally disordered patients

ii) confused and/or disorientated patients

iii) unconscious patients

iv) patients dying in hospital

v) patients found dead on arrival at hospital (property removed by police)

c) A record shall be completed in respect of all persons in category b, including a nil return if no property is taken into safe custody.

15.5 The record shall be completed by a member of the hospital staff in the presence of a second member of staff and the patient (or representative) where practicable. It shall then be signed by both members of staff and by the patient, except where the latter is restricted by physical or mental incapacity. Any alterations shall be validated by signature as required in the original entry on the record.

15.6 Refunds of cash handed in for safe custody will be dealt with in accordance with the Trust's Policy and Procedure for the Safeguarding and Custody of Patients' Property. Property other than cash, which has been handed in for safe custody, shall be returned to the patient as required, by the officer who has been responsible for its security. The return shall be receipted by the patient or guardian as appropriate and witnessed.

15.7 The disposal of property of deceased patients shall be effected by the officer who has been responsible for its security. Such disposal shall be in accordance with written instructions issued by the Chief Financial Officer, in particular, where cash or valuables have been deposited for safe custody, they shall only be released after written authority has been given by the Chief Financial Officer. Such authority shall include details of the lawful kin or other person entitled to the cash and valuables in question.

15.8 In all cases where property of a deceased patient is of a total value in excess of the amount prescribed in the Administration of Estates Act, the production of Probate or Letters of Administration shall be required before any of the property is released. Where the total value of property is less than the amount prescribed in the Act, forms of indemnity shall be obtained.

15.9 Property handed over for safe custody shall be placed into the care of the appropriate administrative staff. Where there are no administrative staff present, the property shall be placed in the secure care of the most senior member of nursing staff on duty.

15.10 In respect of deceased patients, if there is no will and no lawful next of kin the property vests in the Crown and particulars shall, therefore, be notified to the Treasury Solicitor.

15.11 Any funeral expenses necessarily borne by the Foundation Trust are a first charge on a deceased person's estate. Where arrangements for burial or cremation are not made privately, any element of the estate held by the Foundation Trust may be appropriated towards funeral expenses, upon the authorisation of the Chief Financial Officer.

15.12 Staff should be informed, on appointment, by the appropriate departmental or senior manager of their responsibilities and duties for the administration of the property of patients.

15.13 Where patients' property or income is received for specific purposes and held for safekeeping the property or income shall be used only for that purpose, unless any variation is approved by the donor or patient in writing.

16 FUNDS HELD ON TRUST

16.1 General

16.1.1 The Foundation Trust has a responsibility as a corporate trustee for the management of funds it holds on trust. The management processes may overlap with those of the organisation of the Foundation Trust, however, the trustee responsibilities must be discharged separately and full recognition given to its dual accountabilities to the Charity Commission.

16.1.2 The reserved powers of the Board of Directors and the Scheme of Delegation make clear where decisions are to be taken and by whom.

16.1.3 As management processes overlap most of the sections of these Standing Financial Instructions will apply to the management of funds held on trust.

16.1.4 The over-riding principle is that the integrity of each trust must be maintained and statutory and trust obligations met. Materiality must be assessed separately from Exchequer activities and funds.

16.1.5 Charitable Funds are those gifts, donations and endowments made under the relevant charities legislation and held on trust for purposes relating to the Trust and the objectives of which are for the benefit of the NHS in England. They are administered by the Foundation Trust Board of Directors acting as trustees.

16.1.6 The Chief Financial Officer shall maintain such accounts and records as may be necessary to record and protect all transactions and funds of the Foundation Trust as trustees of Charitable Funds, including an Investment Register.

16.2 Existing Charitable Funds

16.2.1 The Chief Financial Officer shall arrange for the administration of all existing funds. Terms of Registration must exist for every fund and detailed codes of procedure shall be produced covering every aspect of the financial management of charitable funds, for the guidance of fund managers. The Terms of Registration shall identify the restricted nature of certain funds, and it is the responsibility of fund managers, within their delegated authority, and the Charitable Funds Committee, to ensure that funds are utilised in accordance with the terms of the Deed.

16.2.2 The Chief Financial Officer shall periodically review the funds in existence and shall make recommendations to the Charitable Funds Committee regarding the potential for rationalisation of such funds within statutory guidelines.

16.2.3 The Chief Financial Officer shall ensure that all funds are currently registered with the Charity Commission in accordance with the Charities Act.

16.3 New Charitable Funds

16.3.1 The Chief Financial Officer shall recommend the creation of a new fund where funds and/or other assets, received for charitable purposes, cannot adequately be managed as part of an existing fund.

16.3.2 The Deed of Establishment for any new fund shall clearly identify, inter alia, the objects of the new fund, the nominated fund manager, the estimated annual income and, where applicable, the Charitable Funds Committee's power to assign the residue of the fund to another fund contingent upon certain conditions, e.g. discharge of original objects.

16.4 Sources of New Funds

16.4.1 All gifts accepted shall be received and held in the name of the Charity and administered in accordance with the Charity's policy, subject to the terms of specific funds. As the Charity can accept gifts only for all or any purposes relating to the Terms of Registration, officers shall, in cases of doubt, consult the Chief Financial Officer before accepting any gift. Advice to the Board of Directors on the financial implications of fund raising activities by outside bodies or organisations shall be given by the Chief Financial Officer.

16.4.2 All gifts, donations and proceeds of fund-raising activities, which are intended for the Charity's use, must be handed immediately to the Chief Financial Officer via the Cash Office to be banked directly to the Charitable Funds Bank Account.

16.4.3 In respect of donations, the Chief Financial Officer shall:-

a) provide guidelines to Officers of the Foundation Trust as to how to proceed when offered funds. These will include:

i) the identification of the donor's intentions;

ii) where possible, the avoidance of creating excessive numbers of funds;

iii) the avoidance of impossible, undesirable or administratively difficult objects;

iv) sources of immediate further advice; and

v) treatment of offers for personal gifts;

b) provide secure and appropriate receipting arrangements, which will indicate that donations have been accepted directly into the appropriate fund and that the donor's intentions have been noted and accepted.

16.4.4 In respect of Legacies and Bequests, the Chief Financial Officer shall be kept informed of and record all enquiries regarding legacies and bequests. Where required, the Chief Financial Officer shall:

a) provide advice covering any approach regarding the receipt of funds/other assets from executors;

b) after the death of a testator the Chief Financial Officer shall be responsible for ensuring that all correspondence and executor discharge concerning a legacy shall be dealt with on behalf of the Charity;

c) where necessary, obtain grant of probate or make application for grant of letters of administration;

d) be empowered to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty; and

e) be directly responsible, in conjunction with the Charitable Funds Committee, for the appropriate treatment of all legacies and bequests.

16.4.5 In respect of fund-raising, the final approval for major appeals will be given by the Board of Directors (as Trustee). Final approval for smaller appeals will be given by the Charitable Funds Committee. The Chief Financial Officer shall:

a) advise on the financial implications of any proposal for fund-raising activities;

b) deal with all arrangements for fund-raising by and/or on behalf of the Charity and ensure compliance with all statutes and regulations;

c) be empowered to liaise with other organisations/persons raising funds for the Charity and provide them with an adequate discharge;

d) be responsible for alerting the Charitable Funds Committee and the Board of Directors (as Trustee) to any irregularities regarding the use of the Charity's name or its registration numbers; and

e) be responsible for the appropriate treatment of all funds received from this source.

16.4.6 In respect of Trading Income (in line with Charity Commission Guidance), the Chief Financial Officer shall:

a) be primarily responsible, along with designated fund managers, for any trading undertaken by the Charity; and

b) be primarily responsible for the appropriate treatment of all funds received from this source.

16.4.7 In respect of Investment Income, the Chief Financial Officer shall be responsible for the appropriate treatment of all dividends, interest and other receipts from this source (see below).

16.5 Investment Management

16.5.1 The Charitable Funds Committee shall be responsible for all aspects of the management of the investment of charitable funds as delegated under the terms of the approved investment policy. The issues on which the Chief Financial Officer shall be required to provide advice to the Charitable Funds Committee shall include:-

a) the formulation of investment policy which meets statutory requirements (Trustee Investment Act) with regard to income generation and the enhancement of capital value;

b) the appointment of advisers, brokers and, where appropriate, investment fund managers and:

i) The Chief Financial Officer shall recommend the terms of such appointments; and for which;

ii) written agreements shall be signed by the Chief Executive;

c) pooling of investment resources and the preparation of a submission to the Charity Commission for them to make a scheme;

d) the participation by the Charity in common investment funds and the agreement of terms of entry and withdrawal from such funds;

e) that the use of assets shall be appropriately authorised in writing and charges raised within policy guidelines;

f) the review of the performance of brokers and fund managers;

g) the reporting of investment performance.

16.5.2 The Chief Financial Officer shall prepare detailed procedural instructions concerning the receiving, recording, investment and accounting for Charitable Funds.

16.6 Expenditure from Charitable Funds

16.6.1 Expenditure from Charitable Funds shall be managed by the Charitable Funds Committee on behalf of the Board of Directors (as Trustee). In so doing the committee shall be aware of the following:

a) the objects of various funds and the designated objectives;

b) the availability of liquid funds within each trust;

c) the powers of delegation available to commit resources;

d) the avoidance of the use of exchequer funds to discharge endowment fund liabilities (except where administratively unavoidable), and to ensure that any indebtedness to the Exchequer shall be discharged by trust funds at the earliest possible time;

e) that funds are to be spent rather than preserved, subject to the wishes of the donor and the needs of the Foundation Trust; and the definitions of "charitable purposes".

16.6.2 Delegated authority to incur expenditure which meets the purpose of the funds is set out in the Scheme of Delegation; exceptions are as follows:

a) Any staff salaries/wages costs require Charitable Funds Committee approval;

b) No funds are to be "overdrawn" except in the exceptional circumstance that Charitable Funds Committee approval is granted.

16.7 Banking Services

16.7.1 The Chief Financial Officer shall advise the Charitable Funds Committee and, with its approval, shall ensure that appropriate banking services are available in respect of administering the Charitable Funds. These bank accounts should permit the separate identification of liquid funds to each trust where this is deemed necessary by the Charity Commission.

16.8 Asset Management

16.8.1 Assets in the ownership of or used by the Foundation Trust shall be maintained along with the general estate and inventory of assets of the Foundation Trust. The Chief Financial Officer shall ensure:-

a) that appropriate records of all donated assets owned by the Foundation Trust are maintained, and that all assets, at agreed valuations are brought to account;

b) that appropriate measures are taken to protect and/or to replace assets. These to include decisions regarding insurance, inventory control, and the reporting of losses;

c) that donated assets received on trust shall be accounted for appropriately;

d) that all assets acquired from Charitable Funds which are intended to be retained within the funds are appropriately accounted for.

16.9 Reporting

16.9.1 The Chief Financial Officer shall ensure that regular reports are made to the Charitable Funds Committee and Board of Directors with regard to, inter alia, the receipt of funds, investments and expenditure.

16.9.2 The Chief Financial Officer shall prepare annual accounts in the required manner, which shall be submitted to the Board of Directors within agreed timescales.

16.9.3 The Chief Financial Officer shall prepare an annual trustees' report and the required returns to the Charity Commission for adoption by the Charitable Funds Committee.

16.10 Accounting and Audit

16.10.1 The Chief Financial Officer shall maintain all financial records to enable the production of reports as above and to the satisfaction of internal and external audit.

16.10.2 Distribution of investment income to the charitable funds and the recovery of administration costs shall be performed on a basis determined by the Chief Financial Officer.

16.10.3 The Chief Financial Officer shall ensure that the records, accounts and returns receive adequate scrutiny by internal audit during the year. He/she will liaise with external audit and provide them with all necessary information.

16.10.4 The Charitable Funds Committee shall be advised by the Chief Financial Officer on the outcome of the annual audit.

16.11 Taxation and Excise Duty

16.11.1 The Chief Financial Officer shall ensure that the Charity's liability to taxation and excise duty is managed appropriately, in line with HMRC regulations, through the maintenance of appropriate records, the preparation and submission of the required returns and the recovery of deductions at source.

17 ACCEPTANCE OF GIFTS AND HOSPITALITY BY STAFF

17.1 The Company Secretary shall ensure that all staff are made aware of the Foundation Trust policy on acceptance of gifts and other benefits in kind by staff.

18 RETENTION OF DOCUMENTS

18.1 The Chief Executive shall be responsible for maintaining archives for all documents required to be retained under the direction contained in the Retention and Destruction of Records Policy and the Freedom of Information Act.

18.2 The documents held in archives shall be capable of retrieval by authorised persons.

18.3 Records shall be maintained of documents destroyed, as defined in the Retention and Destruction of Records Policy.

19 RISK MANAGEMENT

19.1 The Chief Executive shall ensure that the Foundation Trust has a programme of risk management, in accordance with current NHSI / Department of Health and Social Care requirements, which must be approved and monitored by the Board of Directors.

19.2 The programme of risk management shall include:

a) a process for identifying and quantifying risks and potential liabilities;

b) engendering among all levels of staff a positive attitude towards the control of risk;

c) management processes to ensure all significant risks and potential liabilities are addressed including effective systems of internal control, cost effective insurance cover, and decisions on the acceptable level of retained risk;

d) contingency plans to offset the impact of adverse events;

e) audit arrangements including; internal audit, clinical audit, health and safety review;

f) decisions on which risks shall be insured;

g) arrangements to review the risk management programme;

19.3 The existence, integration and evaluation of the above elements will assist in providing a basis to make a statement on the effectiveness of Internal Control (Annual Governance Statement) within the Annual Report and Accounts as required by current guidance.

Sherwood Forest Hospitals
NHS Foundation Trust

SCHEME OF DELEGATION

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2 INTRODUCTION

2.1. Reservation of Powers

Section 4 of the Trust's Standing Orders for the Board of Directors states that "The Board of Directors may make arrangements for the exercise, on behalf of the Trust of any of its functions by a committee, or sub-committee, appointed by virtue of Standing Order 5.1 or 5.2, or by a Director or an Officer of the Trust in each case subject to such restrictions and conditions as the Board of Directors thinks fit". The Code of Conduct of Accountability in the NHS also requires that there should be a formal schedule of matters specifically reserved to the Board of Directors of the Foundation Trust.

The purpose of this document is to detail how the powers are reserved to the Board of Directors, while at the same time delegating to the appropriate level the detailed application of Foundation Trust policies and procedures. However, the Board of Directors remains accountable for all of its functions, even those delegated to committees, sub committees, individual directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it to maintain a monitoring role.

2.2. Role of the Chief Executive

All powers of the Foundation Trust, which have not been retained as reserved by the Board of Directors or delegated to an executive committee or sub-committee, shall be exercised on behalf of the Board of Directors by the Chief Executive. The Chief Executive shall prepare a Scheme of Delegation identifying which functions he/she shall perform personally and which functions have been delegated to other directors and officers for operational responsibility.

All powers delegated by the Chief Executive can be re-assumed by him/her should the need arise.

2.3 Caution over the Use of Delegated Powers

Powers are delegated to directors and officers on the understanding that they would not exercise delegated powers in a manner which in their judgement was likely to be a cause for public concern.

2.4 Absence of Directors or Officers to Whom Powers have been Delegated

In the absence of a director or officer to whom powers have been delegated, those powers shall be exercised by that director or officer's superior unless alternative arrangements have been approved by the Board of Directors. If the Chief Executive is absent, powers delegated to him/her may be exercised by the nominated officer acting in his/her absence after taking appropriate advice from the Chief Financial Officer. In the absence of the Chief Financial Officer, appropriate advice should be sought from the Deputy Chief Financial Officer.

3. RESERVATION OF POWERS TO THE BOARD OF DIRECTORS

3.1 Accountability

The Code of Conduct of Accountability in the NHS, which has been adopted by the Foundation Trust, requires the Board of Directors to determine those matters on which decisions are reserved unto itself. These reserved matters are set out in paragraphs 3.2 to 3.9 below:

3.2 General Enabling Provision

The Board of Directors may determine any matter, for which it has authority, it wishes in full session within its statutory powers.

3.3 Regulations and Control

The Board of Directors remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it is maintain a monitoring role. These following are decisions reserved to the board:

- Approval of Standing Orders (SOs), a schedule of matters reserved to the Board of Directors and Standing Financial Instructions for the regulation of its proceedings and business.
- Suspend Standing Orders.
- Vary or amend the Standing Orders.
- Ratification of any urgent decisions taken by the Chairman and Chief Executive in accordance with SO 4.2.
- Approval of a scheme of delegation of powers from the Board of Directors to committees.
- Requiring and receiving the declaration of Directors' interests which may conflict with those of the Foundation Trust and determining the extent to which that director may remain involved with the matter under consideration.
- Requiring and receiving the declaration of officers' interests which may conflict with those of the Foundation Trust.
- Adoption of the organisational structures, processes and procedures to facilitate the discharge of business by the Foundation Trust and to agree modifications thereto.
- To receive reports from committees including those which the Foundation Trust is required by the Constitution and the Health and Social Care Act 2012 or other regulation to establish and to take appropriate action thereon.
- To confirm the recommendations of the Foundation Trust's committees where the committees do not have executive powers.
- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a corporate trustee for funds held on trust.
- To establish terms of reference and reporting arrangements of all committees and sub-committees that are established by the Board of Directors.

- Approval of arrangements relating to the discharge of the Foundation Trust's responsibilities as a bailer for patients' property.
- Authorise use of the seal.
- Ratify or otherwise instances of failure to comply with Standing Orders brought to the Chief Executive's attention.
- Disciplining Board members or employees that report to the Chief Executive, who are in breach of Statutory Requirements or Standing Orders.

3.4 Appointments / Dismissal

- Appointment of the Vice Chairman / Senior Independent Director of the Board of Directors.
- The appointment and dismissal of committees (and individual members) that are directly accountable to the Board of Directors.
- Confirm the appointment of members of any committee of the Foundation Trust as representatives on outside bodies.

3.5 Policy Determination

The approval of Foundation Trust management policies including Human Resources policies incorporating the arrangements for the appointment, dismissal and remuneration of staff.

3.6 Strategy and Business Plans and Budgets

- Definition of the strategic aims and objectives of the Foundation Trust.
- Approval and monitoring of the Foundation Trust's policies and procedures for the management of risk.
- Approve Business Cases for Capital Investment with significant capital expenditure commitments according to the limits set out in Table B.
- Approve budgets.
- Approve annually the Foundation Trust's proposed business plan including operational budgets and capital expenditure programme.
- Ratify proposals for acquisition, disposal or change of use of land and/or buildings.
- Approve proposals on individual contracts, including purchase orders (other than NHS contracts) of a capital or revenue nature amounting to, or likely to amount to the limits specified in Table B (Financial Limits) of the Scheme of Delegation.
- Approve proposals in individual cases for the write off of losses or making of special payments above the limits of delegation (Table B) to the Chief Executive and Chief Financial Officer.

- Approve proposals for action on litigation against or on behalf of the Foundation Trust where the likely financial impact is expected to exceed the limits specified in Table B, or contentious or novel or likely to lead to extreme adverse publicity, excluding claims covered by the NHS risk pooling schemes.
- Review use of NHS risk pooling schemes.

3.7 Audit Arrangements

To receive recommendations regarding the appointment (and where necessary dismissal) of the internal and external auditors. The appointment or removal of the external auditors must be ratified by the Council of Governors.

3.8 Annual Reports and Accounts

- Receipt and approval of the Foundation Trust's Annual Report and Annual Accounts and Quality Accounts prior to submission to NHS England ~~and NHS Improvement~~ and subsequent presentation to the Council of Governors at a Members Meeting.
- Receipt and approval of the Annual Report and Accounts for funds held on trust.

3.9 Monitoring

- Receipt of such reports as the Board of Directors sees fit from committees in respect of their exercise of powers delegated.
- Continuous appraisal of the affairs of the Foundation Trust by means of the provision to the Board of Directors as the Board of Directors may require from directors, committees, and officers of the Foundation Trust as set out in management policy statements.
- Receive reports from the Chief Financial Officer on financial performance against budget and business plan and receive the minutes of the Finance Committee.

4 DELEGATION OF POWERS TO COMMITTEES

4.1 Delegation to Committees

The Board of Directors may determine that certain of its powers shall be exercised by Standing Committees. The composition and terms of reference of such committees shall be that approved by the Board of Directors. The Board of Directors shall determine the reporting requirements in respect of these committees. In accordance with SO 5.5, committees may not delegate executive powers to sub-committees unless expressly authorised by the Board of Directors. Terms of Reference for these Standing Committees shall be approved by the Board of Directors.

5 SCHEME OF DELEGATION TO OFFICERS

5.1 Delegation

Standing Orders and Standing Financial Instructions set out in some detail the financial responsibilities of the Chief Executive, the Chief Financial Officer and other directors. ~~These responsibilities are summarised below.~~

Delegated matters in respect of decisions that may have a far-reaching effect must be reported to the Chief Executive. **The delegation shown below is the lowest level to which authority is delegated.**

Table A - Delegated Authority

Table B - Delegated Financial Limits

Delegation to lower levels is only permitted with written approval of the Chief Executive who will, before authorising such delegation, consult with other Senior Managers as appropriate.

TABLE A.1

Delegated Authority

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
1.	**Standing Orders / Standing Financial Instructions**		
a)	Final authority in interpretation of Standing Orders	Chair~~man~~	Chair~~man~~
b)	Notifying Directors and employees of their responsibilities within the Standing Orders and Standing Financial Instructions, and ensuring that they understand the responsibilities	Chief Executive	All Line Managers
c)	Responsibility for security of the Foundation Trust's property, avoiding loss, exercising economy and efficiency in using resources and conforming with Standing Orders, Standing Financial Instructions (SFIs) and financial procedures	Chief Executive	All Directors and Employees
d)	Suspension of Standing Orders	Board of Directors	Board of Directors
e)	Review suspension of Standing Orders	Audit and Assurance Committee	Audit and Assurance Committee
f)	Variation or amendment to Standing Orders	Board of Directors	Board of Directors
g)	Emergency powers relating to the authorities retained by the Board of Directors	Chair and Chief Executive with two non-executives	Chair and Chief Executive with two non-executives
h)	Disclosure of non-compliance with Standing Orders to the Chief Executive (report to the Board of Directors)	All	All
i)	Disclosure of non-compliance with SFIs to the Chief Financial Officer (report to the Audit and Assurance Committee)	All	All
j)	Advice on interpretation or application of SFIs and this Scheme of Delegation	Chief Financial Officer	Chief Financial Officer / Internal Audit

Table A

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
1.	**Audit Arrangements**		
a)	Ensure adequate internal and external audit services, for which they are accountable, are provided (and prepare recommendations to the board for the replacement of either internal or external audit. NB. Whilst the board can unilaterally replace the internal auditor, the Council of Governors has to ratify the replacement or removal of the external auditor. See Section 3)	Audit and Assurance Committee	Chief Financial Officer
b)	Review, appraise and report in accordance with Public Sector Internal Audit Standards and best practice	Audit and Assurance Committee	Head of Internal Audit
c)	Provide an independent and objective view on internal control and probity	Audit and Assurance Committee	Internal Audit / External Audit
d)	Ensure cost-effective audit service	Audit and Assurance Committee	Chief Financial Officer
e)	Implement recommendations	Chief Executive	Assigned~~Relevant~~ Officers
f)	Track progress of recommendation implementation	Chief Financial Officer	Risk and Assurance Manager
2.	**Authorisation of Clinical Trials and Research Projects**	Chief Executive **or** Chief Financial Officer **and** Executive Medical Director	Research Governance Committee / Head of Research and Innovation

TABLE A.2

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
3.	**Authorisation of New Drugs**	Chief Executive	Medicines Management Committee
4.	**Bank Accounts / Cash** (Excluding Charitable Fund (Funds Held on Trust) Accounts)		
a)	Operation: • Managing banking arrangements and operation of bank accounts (Board of Directors approves arrangements)	Chief Financial Officer	Head of Financial Services
	• Opening bank accounts	Chief Financial Officer	Head of Financial Services
	• Authorisation of transfers between Foundation Trust bank accounts	Chief Financial Officer	To be completed in accordance with bank mandate / internal procedures
	• Approve and apply arrangements for the electronic transfer of funds	Chief Financial Officer	Head of Financial Services
	• Authorisation of: - CHAPS schedules - BACS schedules - Automated cheque schedules - Manual cheques	Chief Financial Officer	To be completed in accordance with bank mandate / internal procedures
b)	Investment of surplus funds in accordance with the Foundation Trust's investment policy	Chief Financial Officer	Head of Financial Services
c)	Petty Cash	Chief Financial Officer	**Refer To Table B Delegated Limits**
5.	**Business Cases – including Tenders for Services Provided**		
a)	Preparation of business cases / tenders	Chief Executive	Executive Directors / Corporate Directors~~Divisional General Managers~~
b)	Approval of business cases / tenders which generate a positive financial contribution	Chief Executive	**Refer To Table B Delegated Limits**
c)	Approval of business cases / tenders which generate a negative financial contribution	Board of Directors	**Refer To Table B Delegated Limits**
6.	**Capital Investment**		
a)	Programme: • Ensure that there is adequate appraisal and approval process for determining capital expenditure priorities and the effect that each has on business plans	Chief Executive	Chief Financial Officer
	• Preparation of Capital Investment Programme	Chief Executive	Chief Financial Officer
	• Financial monitoring and reporting on all capital scheme expenditure including variations to contract	Chief Financial Officer	Deputy Chief Financial Officer~~/ Head of Financial Services~~
	• Responsible for the management of capital schemes and for ensuring that they are delivered on time and within cost	Chief Executive	Chief Financial Officer~~t~~
	• Ensure that capital investment is not undertaken without availability of resources to finance all revenue consequences	Chief Financial Officer	Deputy Chief Financial Officer ~~Chief Financial Officer~~
	• Issue procedures to support: o Capital investment o Staged payments	Chief Executive	**Refer to Table B Delegated Limits**
	• Issuing the capital scheme project manager with specific authority to commit capital, proceed / accept tenders in accordance with the SOs and SFIs	Chief Financial Officer	
7.	**Clinical Audit**		
	Design, implement and monitor the Foundation Trust's Clinical Audit Programme	Chief Executive	Lead Clinician for Clinical Audit / Service Directors / Clinical Managers / Department Heads / Clinical Audit Department

TABLE A.3

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
8.	**Commercial Sponsorship**		
	Agreement to proposal	Chief Executive	**Refer to Table B Delegated Limits**
9.	**Complaints (Patients and Relatives)**		
a)	Overall responsibility for ensuring that all complaints are dealt with effectively	Executive Medical Director	Divisional Clinical Chairs ~~Directors~~ / Divisional Nurse Directors ~~Matrons~~ / Patient Experience Manager
b)	Responsibility for ensuring complaints relating to a division / department are investigated thoroughly	Executive Medical Director	Divisional Clinical Chairs~~Directors~~ / Divisional Nurse Directors~~Matrons~~
c)	Medico - Legal Complaints Coordination of their management	Executive Medical Director	~~Legal Services Manager~~Trust Solicitor
10.	**Confidential Information**		
	Review of the Foundation Trust's compliance with the Caldicott report on protecting patients' confidentiality in the NHS	Chief Executive ~~Caldicott Guardian~~	Chief Nurse / ~~Executive Medical Director~~Caldicott Guardian
	Freedom of Information Act compliance code	Chief Executive	Senior Information Risk Owner
11.	**Data Protection Act**		
	Review of Foundation Trust's compliance	Chief Executive	Senior Information Risk Owner
12.	**Declaration of Interest**		
	• Maintaining a register	Chief Executive	Director of Corporate Affairs
	• Declaring relevant and material interests	All Directors	All staff
13.	**Disposal and Condemnations**		
	• Items obsolete, redundant, irreparable or cannot be repaired cost effectively	Chief Financial Officer	**Refer to Table B Delegated Limits**
	• Develop arrangements for the sale of assets	~~Chief Financial Officer~~	
14.	**Environmental Regulations**		
	Review of compliance with environmental regulations, for example those relating to clean air and waste disposal	Chief Executive	Associate Director of Estates and Facilities
15.	**External Financing**		
a)	Advise Board of Directors of the requirements to repay / draw down Public Dividend Capital	Chief Financial Officer	Head of Financial Services
b)	Application for draw down of Public Dividend Capital and other forms of foundation trust funding	Chief Financial Officer	Head of Financial Services
c)	Application for draw down of overdrafts and other forms of external borrowing	Chief Financial Officer	In accordance with the Treasury Management Policy
d)	Preparation of procedural instructions	Chief Financial Officer	Head of Financial Services
e)	Private Finance:		
	• Demonstrate that the use of private finance represents best value for money and transfers risk to the private sector. Proposal to use PFI must be specifically agreed by the Board of Directors	Chief Executive	Chief Financial Officer – subject to agreement by NHSE~~I~~
f)	Leases (including property, equipment and operating leases)		
	• Granting and termination of leases with Annual rent < £100k	Chief Executive	Chief Financial O~~e~~fficer
	• Granting and termination of leases of > £100k should be reported to the Board of Directors	Board of Directors	~~Chief Executive /~~ Chief Financial Officer
g)	Finance leases (any value)	Board of Directors	Chief Financial Officer – subject to agreement by NHSE~~I~~

TABLE A.4

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
16.	**Financial Planning / Budgetary Responsibility**		
a)	Setting:		
	• Submit agreed business plan to the Board of Directors	Chief Executive	Chief Financial Officer
	• Submit capital and revenue budgets to the Board of Directors	Chief Executive	Chief Financial Officer
	• Submit financial estimates and forecasts to the Board of Directors	Chief Executive	Chief Financial Officer
b)	Monitoring:		
	• Delegate budgets to budget holders	Chief Executive	Chief Financial Officer / Prime Budget Holders
	• Monitor performance against budget	Chief Financial Officer	Executive Directors / Prime Budget Holders
	• Ensuring adequate training is delivered to budget holders to facilitate their management of the allocated budget	Chief Financial Officer	Divisional Finance Managers
	• Submit in accordance with NHSI's requirements financial monitoring returns	Chief Executive	Chief Financial Officer
	• Meet reporting requirements of banking terms and conditions	Chief Executive	Chief Financial Officer
	• Identify and implement cost improvements and income generation activities in line with the Business Plan	Chief Executive	All budget holders
	• Monitor performance against the cost improvement programme	Chief Executive	Associate Director of Transformation
	Preparation of:		
	• Annual Accounts	Chief Financial Officer	Deputy Chief Financial Officer
	• Annual Report	Chief Executive	Director of Corporate Affairs~~Company Secretary~~
c)	Authorisation of Virement: It is not possible for any officer to vire from non-recurring headings to recurring budgets, from capital to revenue / revenue to capital, or between NHSI Plan expenditure categories Virement between different budget holders requires the agreement of both parties	Chief Financial Officer	**Refer To Table B Delegated Limits**
17.	**Financial Procedures and Systems**		
a)	Maintenance and update of Foundation Trust Financial Procedures	Chief Financial Officer	Deputy Chief Financial Officer
b)	Responsibilities:		
	• Implement Foundation Trust's financial policies and co-ordinate corrective action	Chief Financial Officer	Deputy Chief Financial Officer
	• Ensure that adequate records are maintained to explain Foundation Trust's transactions and financial position		Head of Financial Services
	• Provide financial advice to members of the Board of Directors and staff		Deputy Chief Financial Officer ~~/ Head of Financial Services~~
	• Ensure that appropriate statutory records are maintained		Head of Financial Services
	• Design and maintain compliance with all financial systems		Deputy Chief Financial Officer

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TABLE A.5

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
18.	**Fire Precautions** • Ensure that the Fire Precautions and prevention policies and procedures are adequate and that fire safety and integrity of the estate is intact	Chief Executive	Director of People / Head of Fire~~Fire Prevention & Security Management Specialist~~
19.	**Fixed Assets**		
a)	Maintenance of Trust asset register including asset identification and monitoring	Chief Financial Officer	Head of Financial Services
b)	Maintenance of IT asset register for items associated with other NHIS clients, including asset identification and monitoring	Chief Financial Officer	Director of NHIS
c)	Ensuring arrangements for financial control and financial audit of building and engineering contracts and property transactions are in line with the NHS Premises Assurance Model and latest guidance	Chief Executive	Associate Director of Estates and Facilities
d)	Calculate and pay capital charges in accordance with the requirements of the Independent Regulator	Chief Financial Officer	Head of Financial Services
e)	Responsibility for security of Foundation Trust's assets including notifying discrepancies to the Chief Financial Officer and reporting losses in accordance with Foundation Trust's procedures	Chief Executive	All staff
20.	**Funds Held on Trust (Charitable and Non Charitable Funds)**		
a)	Management: • Funds held on trust are managed appropriately	Chief Financial Officer (supported by the Charitable Trustees)	~~Deputy Chief Financial Officer /~~ Head of Financial Services
b)	Maintenance of authorised signatory list of nominated fund holders	Chief Financial Officer	Head of Financial Services
c)	Expenditure limits	Chief Financial Officer	**Refer To Table B Delegated Limits**
d)	Developing systems for receiving donations	Chief Financial Officer	Head of Financial Services
e)	Dealing with legacies	Chief Financial Officer	Head of Financial Services
f)	Fundraising Appeals	Charitable Funds Committee	Community Involvement Manager
	▪ Preparation and monitoring of budget	Chief Financial Officer	Community Involvement Manager with advice from Head of Financial Services
	▪ Reporting progress and performance against budget	Chief Financial Officer	Community Involvement Manager with advice from Head of Financial Services
g)	Operation of Bank Accounts: • Managing banking arrangements and operation of bank accounts	Chief Financial Officer	Head of Financial Services
	• Opening bank accounts	Chief Financial Officer	Head of Financial Services
h)	Investments: • Nominating deposit taker	Charitable Funds Committee	Chief Financial Officer
	• Placing transactions in accordance with the Charitable Funds Investment Policy	Chief Financial Officer	Head of Financial Services
21.	**Health and Safety**		
	Review of all statutory compliance with legislation and Health and Safety requirements including Control of Substances Hazardous to	Chief Executive	Director of People / Health and Safety Manager

TABLE A.6

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
	Health Regulations		
22.	**Hospitality/Gifts**		
a)	Keeping of hospitality register	Chief Executive	Director of Corporate Affairs
b)	Applies to both individual and collective hospitality receipt items.		All staff declaration required in Foundation Trust's Hospitality Register **Refer To Table B Delegated Limits**
23.	**Infectious Diseases and Notifiable Outbreaks**	Chief Executive	Executive Medical Director
24.	**Information Management and Technology**		
a)	Developing systems in accordance with the Foundation Trust's IM&T Strategy	Executive Directors / Director of Health Informatics Service	Chief Digital Information Officer / Heads of Service in conjunction with IT advisors
b)	Implementing new systems ensuring that they are developed in a controlled manner and thoroughly tested		
c)	Seeking third party assurances regarding systems operated externally		
d)	Ensuring that contracts for computer services for financial applications define responsibility regarding security, privacy, accuracy, completeness and timeliness of data during processing and storage		
25.	**Legal Proceedings**		
a)	Engagement of Foundation Trust's Solicitors	Chief Executive ~~/ Director of People~~	Director of Corporate Affairs / Director of People
b)	Approve and sign all documents which will be necessary in legal proceedings	Chief Executive	Any Executive Director
c)	Sign on behalf of the Foundation Trust any agreement or document not requested to be executed as a deed (i.e. any legal contract)	Chief Executive	Any Executive Director
26.	**Losses and Special Payments**		
a)	Prepare procedures for recording and accounting for losses and special payments including preparation of a Fraud Response Plan and informing Counter Fraud Management Services of frauds	Chief Executive	Chief Financial Officer
b)	Losses Losses of cash and cash equivalents due to theft, fraud, overpayment & others Fruitless payments (including abandoned Capital Schemes) Bad debts and claims abandoned (e.g. private patients, overseas visitors, road traffic act claims) Damage to buildings, fittings, furniture and equipment in use due to culpable causes (e.g. fraud, theft, arson, neglect) General losses (e.g. linen and bedding, equipment, stores items) Un-vouched payments Overpayment of salaries, fees and allowances		**Refer To Table B Delegated Limits**
	Special Payments i) Clinical negligence after legal advice • Medical negligence ii) Non-clinical negligence • Personal injury iii) Other (Ex-gratia payments) • Compensation payments by Court Order • To patients/staff for loss of personal effects • Extra contractual payments to contractors		**Refer To Table B Delegated Limits**

TABLE A.7

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
c)	A register of all of the payments should be maintained by the Finance Department and made available for inspection	Chief Financial Officer	Head of Financial Services
d)	A report of all of the above payments should be presented to the Audit and Assurance Committee at least annually	Chief Financial Officer	Head of Financial Services
27.	**Meetings**		
a)	Calling meetings of the Foundation Trust Board	Chairman	Director of Corporate Affairs
b)	Chair all Foundation Board of Directors meetings and associated responsibilities	Chairman	Chairman
28.	**Medical**		
	• Clinical Governance arrangements	Chief Nurse	Head of Governance / Lead Clinician for Clinical Audit / Divisional Clinical Chairs ~~Directors~~ / Service Directors / Divisional Nurse Directors~~Matrons~~
	• Medical Leadership	Executive Medical Director	Divisional Clinical Chairs ~~Directors~~ / Service Directors
	• Programmes of medical education	Executive Medical Director	Director of Medical Education
	• Clinical staffing plans	Chief Executive	Heads of Service ~~Directors~~
	• Matters involving individual professional competence of medical staff	Executive Medical Director	Divisional Clinical Chais~~Directors~~
	• Medical Research	Executive Medical Director	Research Governance Committee Chairman / Head of Research and Innovation
29.	**Non Pay Expenditure**		
a)	Maintenance of a list of managers authorised to place requisitions/orders and accept goods in accordance with Table B	Chief Executive	Deputy Chief Financial Officer / Head of Financial Services
b)	Obtain the best value for money when requisitioning goods/services	Chief Executive	Strategic Head of Procurement Development / Divisional General Managers / Heads of ~~Department~~Service
c)	Non-Pay Expenditure for which no specific budget has been set up and which is not subject to funding under delegated powers of virement. (Subject to the limits specified above in (a))	Chief Executive	Chief Financial Officer
d)	Develop systems for the payment of accounts	Chief Financial Officer	Head of Financial Services
e)	Prompt payment of accounts	Chief Financial Officer	Head of Financial Services
f)	Financial limits for ordering / requisitioning goods and services	Chief Financial Officer	**Refer To Table B Delegated Limits**
30.	**Nursing**		
a)	Compliance with statutory and regulatory arrangements relating to professional nursing and midwifery practice	Chief Nurse	Deputy Director of Nursing / Divisional Nurse Directors ~~Matrons~~
b)	Matters involving individual professional competence of nursing staff	Chief Nurse	Deputy Director of Nursing / ~~Divisional~~ Divisional Nurse Directors ~~Matrons~~
c)	Compliance with professional training and development of nursing staff	Chief Nurse	Deputy Director of Nursing / Divisional Nurse Directors ~~Divisional Matrons~~
d)	Quality assurance of nursing processes	Chief Nurse	Deputy Director of Nursing / Divisional Nurse Directors ~~Divisional Matrons~~
31.	**Patient Services Agreements**		
a)	Negotiation of Foundation Trust Contract and	Chief Executive	Chief Financial Officer / Strategic Head of

TABLE A.8

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
	Non Commercial Contracts		Procurement ~~Deputy Director - Income and Performance~~
b)	Quantifying and monitoring out of area treatments	Chief Financial Officer	Head of Finance Business Intelligence ~~Deputy Director - Income and Performance~~
c)	Reporting actual and forecast income	Chief Financial Officer	Head of Finance Business Intelligence~~Deputy Director - Income and Performance~~
d)	Costing Foundation Trust Contract and Non Commercial Contracts	Chief Financial Officer	Head of Finance Business Intelligence ~~Deputy Director - Income and Performance~~
e)	Reference Costing / Payment by Results	Chief Financial Officer	Deputy Chief Financial Officer
f)	Ad hoc costing relating to changes in activity, developments, business cases and bids for funding	Chief Financial Officer	Head of Finance Business Intelligence ~~Deputy Director - Income and Performance~~ / Divisional Finance Managers
32.	**Patients' Property** (in conjunction with financial advice from the Head of Financial Services)		
a)	Ensuring patients and guardians are informed about patients' monies and property procedures on admission	Chief Executive	Chief Nurse / Divisional General Managers / Heads of Service~~Department~~ / Divisional Nurse Directrs~~Matrons~~
b)	Prepare detailed written instructions for the administration of patients' property	Chief Nurse / Chief Financial Officer	Deputy Director of Nursing / Head of Financial Services
c)	Informing staff of their duties in respect of patients' property	Chief Nurse	Divisional General Managers / Heads of ~~Department~~ Service / Divisional Matrons
d)	Issuing property of deceased patients (See SFI 15.9, 15.10)		**Refer To Table B Delegated Limits**
e)	Repayment of cash held for safe keeping	Chief Financial Officer	Divisional General Managers / Head of Financial Services
33.	**Personnel & Pay** (excluding Non-executive Directors whose remuneration, terms and conditions are dealt with by the Board of Governors Nominations Committee)		
a)	Develop Human Resource policies and strategies for approval by the board including employee relations	Director of People ~~/ Director of Culture and Improvement~~	Deputy Director of Human Resources ~~/ Head of Learning and OD~~
b)	Authority to fill funded post on the establishment with permanent staff	Director of People	Budget Holders
c)	The granting of additional increments to staff within budget	Director of People	Director of People
d)	Develop training policies	Director of People~~Director of Culture and Improvement~~	Deputy Director of Human Resources~~Head of Learning and OD~~
e)	All requests for re-grading shall be dealt with in accordance with Foundation Trust Procedure	Director of People	Budget Holders
f)	Establishments		
	• Recurrent changes to establishment outside existing recurrent funding without identified recurrent sources of funding	Chief Executive	Chief Financial Officer
	• Recurrent changes to establishment outside existing recurrent funding but with identified recurrent sources of funding	Chief Financial Officer	Prime Budget Holders
	• Recurrent changes to establishment within existing recurrent funding	Chief Financial Officer	Budget Holders
	• Terminations	Director of People	Line Managers
g)	Pay		
	• Presentation of proposals to the Board of Directors for the setting of remuneration and conditions of service for those staff not covered by the Remuneration and Nominations Committee or national terms and conditions	Chief Executive	Director of People

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TABLE A.9

DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
• Authority to commit pay expenditure	Director of People ~~Human Resources and Organisational Development~~ / Chief Financial Officer	Budget Holders
• Approval of completed variable pay claims forms	Chief Financial Officer	Budget Holders
• Approval of travel and subsistence expenses	Chief Financial Officer	Authorised Signatories
h) Leave		
Annual Leave		
• Approval of annual leave		Line/Departmental Manager
• Approval of carry forward up to a maximum 5 days (to occur in exceptional circumstances only)	Chief Executive	Chief Executive / Executive Directors / Chief Operating Officer
• Approval to pay outstanding annual leave (except for leavers)	Chief Executive	Chief Executive / Executive Directors / Chief Operating Officer
Special Leave	Director of People	
• Compassionate leave		Divisional General Managers / Heads of Service~~Department~~
• Special leave arrangements for domestic/personal/family reasons • Paternity leave • Carers leave • Adoption leave		Divisional General Managers / Heads of ~~Department~~ Service
(to be applied in accordance with Foundation Trust Policy)		
• Special Leave – this includes Jury Service, Armed Services, School Governor (to be applied in accordance with Foundation Trust Policy)		Divisional General Managers / Heads of Service ~~Department~~
• Leave without pay		
• Medical Staff Leave of Absence – paid and unpaid		Divisional General Managers / Heads of Service ~~Department~~
• Time off in lieu	Director of People	
• Maternity Leave - paid and unpaid		Executive Medical Director
Sick Leave		
• Extension of sick leave on pay		Line/Departmental Manager
• Return to work part-time on full pay to assist recovery		Automatic approval with guidance Executive Director / Chief Operating Officer Divisional General Managers / relevant Director / Deputy Chief Financial Officer
Study Leave		
• Non-medical leave	Director of People	Relevant Executive Director / Divisional General Managers

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TABLE A.10

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
	• Medical staff study leave	Executive Medical Director	
	- Consultant / Career Grade		Service Directors
	- Doctors in training		Post Graduate Tutor
i)	Removal Expenses, Excess Rent and House Purchases in accordance with Trust policy Authorisation of payment of removal expenses incurred by officers taking up new appointments (providing consideration was promised at interview)	Director of People	Director of People~~Human Resources and Organisational Development~~ / Divisional General Managers
j)	Grievance Procedure All grievances cases must be dealt with strictly in accordance with the Grievance Procedure and the advice of the Director of Human Resources and Organisational Development must be sought when the grievance reaches the level of Chief Operating Officer / Heads of Department	Director of People	Executive Directors / Chief Operating Officer / Heads of Service~~Department~~
k)	Authorised - Car Users		
	▪ Leased car	Chief Financial Officer	Payroll & Pensions Manager
	▪ Regular/standard car user arrangements	Chief Financial Officer	Line/Department Manager
l)	Mobile Phone Users	Chief Financial Officer	Line/Department Manager
m)	Renewal of Fixed Term Contract	See 33 (f)	See 33 (f)
n)	Operation of Staff Retirement Policy	Chief Executive	Director of People / Divisional General Managers
o)	Redundancy	Board of Directors	
	▪ Executive Directors		Remuneration and Nominations Committee
	▪ All staff excluding Board Members		Executive Team
p)	Ill Health Retirement Decision to pursue retirement on the grounds of ill-health following advice from the Occupational Health Department	Director of People	Divisional General Managers
q)	Disciplinary Procedure		To be applied in accordance with the Foundation Trust's Disciplinary Procedure
	▪ Chief Executive	Chairm~~an~~	
	▪ Others	Chief Executive	
r)	Waiting List Payments ▪ Approval of Rates of Pay	Chief Executive	Chief Financial Officer / Director of People ~~Human Resources and Organisational Development~~
s)	Ensure that all employees are issued with a Contract of employment in a form approved by the Board of Directors and which complies with employment legislation.	Director of People	Deputy Director of Human Resources
t)	Engagement of staff not on the establishment		
	▪ Management Consultants	Chief Executive / Chief Financial Officer	Budget Holders
	▪ Management of use and booking of bank staff		
	a. Nursing	Chief Operating Officer	Budget Holders
	b. Other	Divisional General Managers	Budget Holders
	▪ Management of use and booking of agency staff		
	a. Nursing	Chief Operating Officer	Budget Holders
	b. Other	Divisional General Managers	Budget Holders
34.	**Quotation, Tendering & Contract Procedures - Purchases**		
a)	Services:		
	▪ Best value for money is demonstrated for all services provided under contract or in-house	Chief Financial Officer	Strategic Head of Procurement
	▪ Nominate officers to oversee and manage	Chief Financial Officer	Divisional General Managers / Heads of

TABLE A.11

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
	contracts on behalf of the Foundation Trust		~~Department~~Service
b)	Competitive Tenders:		
	▪ Authorisation Limits	Chief Executive	**Refer To Table B Delegated Limits**
	▪ Receipt and custody of tenders received ~~by post prior to opening~~	Chief Executive	Director of Corporate Affairs ~~Company Secretary~~
	▪ Opening tenders	Chief Executive	Director of Corporate Affairs ~~Company Secretary~~ and an Executive Director
	▪ Decide if late tenders should be considered	Chief Executive	Chief Financial Officer
c)	Quotations	Chief Executive	**Refer To Table B Delegated Limits**
d)	Waiving the requirement to request		
	▪ Tenders - subject to SOs	Chief Executive	Chief Financial Officer
	▪ Quotes - subject to SOs	Chief Financial Officer	Budget Holders
e)	Maintain contract register	Chief Financial Officer	Business Support Manager
35.	**Records**		
a)	Review Foundation Trust's compliance with the Records Management Code of Practice for Health and Social Care	Chief Executive~~Senior Information Risk Owner~~	Executive Directors ~~Executive Directors~~ / Divisional General Managers / Heads of Department Senior Information Risk Owner
b)	Ensuring the form and adequacy of the financial records of all departments	Chief Financial Officer	Deputy Chief Financial Officer
36.	**Reporting of Incidents to the Police**		
a)	Where a criminal offence is suspected * Criminal offence of a violent nature * Arson or theft * Other	Chief Executive	Executive/Senior Manager On-call / Divisional General Managers / Heads of Service~~Department~~ / Caldicott Guardian
b)	Where a fraud is involved (reporting to the NHS Directorate of Counter Fraud Services)	Chief Financial Officer	Head of Internal Audit / Local Counter Fraud Specialist
37.	**Risk Management**		
	• Ensuring the Foundation Trust has a Risk Management Strategy and a programme of risk management	Chief Executive	Director of Corporate Affairs
	• Developing systems for the management of risk	Director of Corporate Affairs	Risk and Assurance Manager
	• Developing incident and accident reporting systems	Chief Nurse / Executive Medical Director / Director of Corporate Affairs	Divisional Clinical Chairs~~Directors~~ / Risk and Assurance Manager / Deputy Head of Nursing for Quality Governance / Health & Safety Manager / Patient Safety Manager
	• Compliance with the reporting of incidents and accidents	Chief Nurse / Executive Medical Director / Director of Corporate Affairs	All staff
	• Compliance with statutory safeguarding children and young people requirements	Chief Nurse	Named Nurse / Named Doctor for Safeguarding Children
38.	**Seal**		
a)	The keeping of a register of seal and safekeeping of the seal	Chief Executive	Director of Corporate Affairs
b)	Approval of documents for sealing	Chief Executive / Chief Financial Officer	Director of Corporate Affairs / Strategic Head of Procurement/
c)	Use of seal in accordance with Standing Orders	Chairman / Chief Executive	Chairman / Director of Corporate Affairs
d)	Report to the Board of Directors at least quarterly	Chief Executive	Director of Corporate Affairs
e)	Property transactions and any other legal requirement for the use of the seal	Chairman / Chief Executive	Director of Corporate Affairs

TABLE A.12

	DELEGATED MATTER	DELEGATED TO	OPERATIONAL RESPONSIBILITY / AUTHORITY
39.	**Setting of Fees and Charges (Income)**		
a)	Private Patient, Overseas Visitors, Income Generation and other patient related services	Chief Financial Officer	Associate Director Business Planning and Partnership
b)	Non patient care income	Chief Financial Officer	Associate Director Business Planning and Partnership
c)	Informing the Chief Financial Officer of monies due to the Foundation Trust	Chief Financial Officer	All Staff
d)	Recovery of debt	Chief Financial Officer	Head of Financial Services
40.	**Stores and Receipt of Goods**		
a)	Responsibility for systems of control over stores and receipt of goods, issues and returns	Chief Financial Officer	Associate Director of Estates & Facilities / Strategic Head of Procurement / Head of Pharmacy / Head of IT
b)	Stocktaking arrangements	Chief Financial Officer	Head of Financial Services
c)	Recovery of debt	Chief Financial Officer	Head of Financial Services

Table B – Delegated Financial Limits

All thresholds include the cost of non-recoverable VAT.

	Financial Limits (Subject to funding available in budget)		**Includes:**
1	**CHARITABLE FUNDS**		
1.1	**Expenditure**		
	Board of Directors (as Trustee)	Over £100,000	
	Charitable Funds Committee	Up to £100,000	
	Chief Executive / Chief Financial Officer	Up to £25,000	
	Fund Monitor and Manager	Up to £15,000	Specific purpose funds only
	Heads of Service	Upto £4,000	
2	**LOSSES AND SPECIAL PAYMENTS**		
2.1	**Losses**		
	Board of Directors	Over £100,000	
	Audit and Assurance Committee	Up to £100,000	
	Chief Executive / Chief Financial Officer - reported to the Audit and Assurance Committee	Up to £25,000	
2.2	**Special Payments – Non-Clinical Negligence (Clinical Negligence litigation payments managed by the NHSLA)**		
	Chief Executive / Chief Financial Officer	Over £10,000	Non-clinical Negligence payments by the NHSLA, through the RPST, subject to scheme excesses
	Company Secretary - reported to the Audit and Assurance Committee	Up to £10,000	
2.3	**Special Payments – Others (Ex-gratia payments)**		
	Board of Directors	Over £100,000	All subject to HM Treasury approval
	Audit and Assurance Committee	Up to £100,000	
	Chief Executive / Chief Financial Officer - reported to the Audit and Assurance Committee	Up to £25,000	
2.4	**Special Payments - made under legal obligation – not related to negligence claims**		
	Chief Executive	Over £30,000	
	Director of Corporate Affairs / Director of People	Up to £30,000	
3	**HOSPITALITY/GIFTS**		
	Director of Corporate Affairs	Over £50	Personal gifts or hospitality
4	**PETTY CASH DISBURSEMENTS (authority to pay)**		
4.1	**Sundry Exchequer Items**		**Conditions:**
	Chief Financial Officer or Nominated Deputy	Over £100	
	Petty Cash Imprest Holder	Up to £100	On receipt of signed claim form from an authorised Budget Holder
4.2	**Petty Cash Float Reimbursement**		
	Petty Cash Imprest Holder	Up to £3,100	King's Mill total imprest balance
	Petty Cash Imprest Holder	Up to £2,000	Newark total imprest balance
	Petty Cash Imprest Holder	Up to £800	Mansfield total imprest balance
5	**PATIENTS' PROPERTY (INCLUDING CASH)**		**Conditions:**
5.1	**Inpatients and Discharged Patients**		
	Head of Financial Services	Over £250	On receipt of the appropriate Reclaim Form
	Petty Cash Imprest Holder	Up to £250	On receipt of a signed claim form from an authorised Budget Holder and the patient
5.2	**Deceased Patients**		
	Testate		
	Chief Operating Officer / Head of Financial Services	Over £5,000	Copy of Probate required
	Chief Operating Officer / Head of Financial Services	Up to £5,000	To the executor to the will on receipt of indemnity
	Intestate		
	Chief Operating Officer / Head of Financial Services	Any amount	Letter of Administration required

	Financial Limits (Subject to funding available in budget)		Includes:
6	**QUOTATIONS AND TENDERS (SOs Section 9)**		
6.1	**Quotations**		
	Chief Financial Officer / Strategic Head of Procurement	Over £25,000	To be advertised on the website www.gov.uk/contracts-finder
	~~Chief Financial Officer / Strategic Head of Procurement~~	~~£5,000 to £25,000~~	Obtain minimum of 3 informal quotations for goods/services/disposals
6.2	**Tenders**		
	Official Journal of the European Union (OJEU)	Crown Commercial Service Threshold Levels	Works / Supplies & Services levels stated within the Crown Commercial Service's Procurement Policy Note : New Threshold Levels
	Chief Financial Officer / Strategic Head of Procurement	Over £25,000 (in compliance with EC Directives as appropriate)	Competitive Tenders: Obtaining a minimum of 3 written competitive tenders for goods, services, materials, manufactured articles, rendering of services (including Management Consultancy) construction and disposals
7	**REQUISITIONING GOODS AND SERVICES, AND APPROVING PAYMENTS WITHOUT AN APPROVED REQUISITION**		
7.1	**Revenue Expenditure**		
	Board of Directors	Over £1,000,000	Over £250,000 subject to NHSE/I approval where necessary
	Finance Committee	Up to £1,000,000	Over £250,000 subject to NHSE/I approval where necessary
	Executive Team	Up to £250,000	Consultancy expenses over £50,000 subject to NHSI approval where necessary
	Trust Management Team	Up to £100,000	Voting and non-voting members
	Executive Board Members	Up to £100,000	Divisional General Managers / Deputy Divisional General Managers / Clinical Directors / Chief Pharmacist / Divisional Nurse Matrons / Deputy Directors reporting directly to Executive Board Members
	Prime Budget Holders	Up to £50,000	Divisional General Managers
	Discretionary Spend, Consultancy, and Professional fees and training.	Up to £50,000	
	Delegated Budget Holders	Up to £25,000	One per cost centre Ward Matrons / Heads of Service / Assistant Divisional General Managers / Deputy Directors
	Ward/Department Budget Holders	Up to £5,000	~~One~~ Two per cost centre Ward Leaders / Heads of ~~Department~~Service
	Other Authorised Signatories	Up to £1,000	
7.2	**Capital Expenditure**		
	Delegated Budget Holders	Up to the value of the individual capital scheme	One per cost centre All schemes to be approved by the Board of Directors
7.3	**Private Financing Initiative Charges**		
	Chief Financial Officer	Up to value of monthly charge in agreed contract	
7.4	**Mandatory Payments – regulatory charges**		
	Chief Executive or Chief Financial Officer	Up to value of assessed charge	Rates CNST
7.5	**Partnership Arrangements**		
	Lead Executive Director	Within the Board of Directors approved agreement	Sustainability & Transformation Partnerships Mid Nottinghamshire Alliance NUH Partnership~~ip~~

	Financial Limits (Subject to funding available in budget**)**		**Includes:**
8	**CAPITAL EXPENDITURE AND BUSINESS CASES – including external tenders for services provided, investments and disinvestments**		
8.1	**Total Project Value / Cost Implications**		
	Board of Directors	Over £1,000,000	Advised by Finance Committee - over £250,000 subject to NHSI approval where necessary
	Finance Committee	Up to £1,000,000	Subject to Executive Team approval and part of approved Capital plan Over £250,000 subject to NHSI approval where necessary
	Executive Team	Up to £250,000	
	Capital Oversight Group	Up to £100,000	
9	**ASSET DISPOSALS**		
9.1	**Asset Register items (Net Book Value) – including accelerated depreciation**		
	Board of Directors	Any value	Land and Buildings
	Chief Financial Officer - reported to the Audit and Assurance Committee	Over £25,000	All other assets
	Head of Financial Services	Up to £25,000	All other assets
9.2	**Non-Asset Register items (Replacement Cost)**		
	Chief Financial Officer - reported to the Audit and Assurance Committee	Over £25,000	
	Head of Financial Services	Up to £25,000	
	Divisional General Managers	Up to £1,000	
10	**COMMERCIAL SPONSORSHIP**		
	Chief Financial Officer Executive Directors	Over £5,000	
		Up to £5,000	
11	**VIREMENTS**		**Conditions:**
	Executive Directors / Chief Operating Officer / Deputy Chief Financial Officer	Over £5,000	Total Division/Department budget remains in balance
	Budget Holders	Up to £5,000	Total Division/Department budget remains in balance

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	22nd April 2024
Prepared By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery, Divisional Director of Nursing for Women and Childrens		

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

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

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

Committees/groups where this item has been presented before

- Nursing and Midwifery AHP Committee
- Maternity Assurance Committee

Acronyms

- Maternity and Neonatal Safety Champion (MNSC)
- Maternity and Neonatal Voice Champion (MNVP)
- Care Quality Commission (CQC)
- Local Maternity and Neonatal System (LMNS)
- PROMPT - PRactical Obstetric Multi-Professional Training

Executive Summary

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

- build the maternity safety movement in your service locally, working with your maternity clinical network safety champion and continuing to build the momentum generated by the maternity transformation programme and the national ambition.

- provide visible organisational leadership and act as a change agent among health professionals and the wider maternity team working to deliver safe, personalised maternity care.
- act as a conduit to share learning and best practice from national and international research and local investigations or initiatives within your organisation.

This report provides highlights of our work over the last month

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

1.Service User Voice

A focus this month presented to the MNSC focused on the provision of pain relief during and after birth at SFH. The recent CQC Maternity Survey highlighted the need to address our service-user experiences of pain control. The Parent Voice champion carried out a listening event on the maternity ward and via the MVP volunteer networks to try to gain a wide range of viewpoints across diverse members of our local population.

An antenatal class was also observed as these were paused during Covid and were re-instated after the CQC survey was carried out (full report of this observation available separately as it covers the entire class and not just the section on pain relief). 25 women and birthing people gave their opinions about their pain relief during and after birth and the full themes log is attached, which contains greater detail of individual conversations. People were not pushed to discuss any aspect of their pain relief but instead were asked to share their experiences relating to pain relief.

Description of conversation	Number of people (percentage of all people)
People who said they were offered pain relief in a timely manner	**11 (44%)**
People who said they were not offered pain relief in a timely manner	**10 (40%)**
People who felt they understood all the options for pain relief and could make an informed choice	**14 (56%)**
People who felt they did not understand all the options for pain relief and could not make an informed choice	**5 (20%)**
People who described feeling 'judged' about their choices or felt their choice was taken away from them	**6 (24%)**

Suggested recommendations and updates from the report author following the review.

The following recommendations are suggested for discussion and consideration, depending on resources available and current priorities within the service:

1. Carry out an advertising campaign for the SFH antenatal classes to increase awareness, especially in our more deprived communities:

    •include physically going out to community groups, religious groups, charities, baby groups
    • include digital information and paper leaflets
    • include information in multiple languages

2. Secure funding and staffing to increase choice of day / time and location of antenatal classes to ensure they are accessible for all.

3. (NB: Action already ongoing): Continue the new PROMPT training which includes a session on compassionate communication / being person centred / informed consent and continue to prioritise this as having equal value to clinical expertise.

4. Review in more detail the barriers that exist on the post-natal ward regarding timely access to pain relief, inconsistencies in regularly checking how someone's pain is and staff ability to give more (personalised) information about pain relief options.

5. (NB: This has already been actioned at the time of writing): ensure that information about pain relief options is easily accessible on the SFH maternity public-facing website.

The ongoing monitoring will be cited at maternity governance with any escalation to the MNSC meeting.

2.Staff Engagement

The planned MNSC walk round took place on the 9th of April 2024, following the visit from the Labour leader Keir Starmer and Shadow Health Secretary Wes Streeting. Whilst the activity remained high on the MNSC walk round, staff reflected the positive changes around the staffing which was supporting these higher periods of activity. The teams reflected on the walk round and though the forum regarding the increase in women who chose to have services at SFH that are out of the traditional areas in which sit within the hospital's areas. This has been raised at the MNSC meeting and whilst the work has focused on the retrospective view of postcode analysis the establishment of an "out of area clinic" based at SFH will allow for a more proactive way to manage and plan care given the tangible changes in numbers.

As mentioned on the 8th of April 2024, the MNSC led the visit with the Labour Leader and Shadow Health Secretary spending time speaking to women, birthing people, and families on the maternity ward. The visit was positively received by the staff, women, birthing people, and their families and allowed for discussion around the complexities within maternity and neonatal services.

On the 11th of April 2024 the Maternity Forum was held. Chaired by the Chief Nurse and led this month by the new Head of Midwifery, the teams discussed the changes, following the feedback from the staff and culture survey that are place. The teams also discussed the priority plans for the year, update from the triage working group and workforce planning.

3.Governance Summary

Three Year Maternity and Neonatal Plan:
The Maternity Safety Team continued to work with the LMNS at looking at the planned workbook activities and how this can embed into the current work the division is undertaking. Key deliverables have been identified, and the Trust are working through individual plans. The planned focus on the MNVP restructure has been supported and now progressing the focus will now be upon equity within the system.

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

NHSR:
The Year 5 submission for full compliance has been submitted to NHSR for the deadline of the 2nd of February 2024. We have now received the confirmation that our submission has been successful, and the rebate granted. The Year 6 compliance has now been released and the task and finish group has reinstated to support the submission.

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

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

4. Quality Improvement
The Perinatal Pelvic Health Service (PPHS) for Nottinghamshire official launched at the beginning of April 2024.

The establishment of Perinatal Pelvic Health Service (PPHS) nationwide is a huge step forward to providing women with the knowledge and support that they require through the antenatal and postnatal period, and an open door beyond the immediate postnatal period to receive the specialist physiotherapy that they need when they develop symptoms that impact on their quality of life.

Further, it will change the dialogue for women from confusion about when and where to get help and what to tolerate as 'normal' to an expectation of specialist care to optimise their perinatal experience and minimise their future pelvic floor problems.

As a system the Nottinghamshire LMNS have supported the PPHS and now has in place a team including Maternity Commissioning, Clinical Lead Physiotherapist, Obstetrics and Gynaecology leads and key stakeholders from both organisations to support the work outlined within the long-term plan.

To allow time for embedding and actions, the PPHS plan to present their findings, plans and any QI work to the MNSC in July 2024.

5.Safety Culture

With the completion of the debriefing for the cultural survey completed and the findings of the national staff survey released, as below, the newly formed perinatal culture team are leading on the action plan for the year. The perinatal quad verbally updated their progress against the national programme and plans to present a report to the MNSC monthly.

Maternity Perinatal Quality Surveillance model for April 2024

Sherwood Forest Hospitals
NHS Foundation Trust

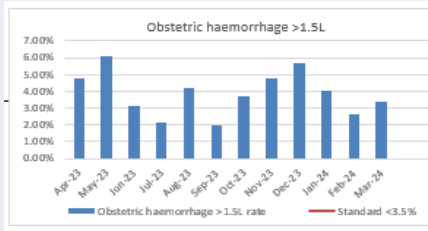
CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme				No		

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

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

Massive Obstetric Haemorrhage (Mar 3.4%)

- Consecutive reduction in cases this month
- LMNS PQSG meeting to align the PSIRP plans



Elective Care

Elective Caesarean (EL LSCS)

- Case numbers remain high, additional lit added to extend for a four-week period support

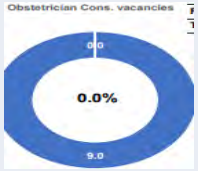
Induction of Labour

- Outpatient trial now started, supportive measure for experience, system alignment and capacity.
- IOL for end of year average 28% which is positive. Supported role remains in place to support the QI work.

Midwifery & Obstetric Workforce

Current vacancy rate (PWR data)

- Midwifery workforce 2%, recent vacancy due to staff leaving NHS, advert out.
- MSSW recruitment successful and post appointed.
- No obstetric vacancy



Staffing red flags (Feb 2024)

- 10 staffing incident reported in the month, same numbers reported on previous month
- No harm related staffing incident, increase noted in short term sickness/ Datix needed for agency approval.

Suspension of Maternity Services

- One suspension of services within March, duration <6 hours and three women diverted to neighbouring units for clinical assessment.

Home Birth Service

- 57 Homebirth conducted since re-launch, current rate of 1.6% of all births, back to pre-COVID-19 rate.

Saving Babies Lives

Saving Babies Lives Care Bundle Version 3

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

Stillbirth rate (3.1 /1000 births)

- One stillbirth reported in March and reported through the PMRT
- For 2023/2024 the rate per 1000 births is 3.1. This is below the national threshold of 4.4/1000

Maternity Assurance

NHSR

- Confirmation SFH have been successful in the Year 5 submission
- Year 6 MIS now live

Ockenden

- Initial 7 IEA- 100% compliant
- System plan in place for 3-year

Incidents reported Jan 2024 (133 no/low harm, 1 moderate or above*)

MDT reviews	Comments
Triggers x 20	Category 1 LSCS

0 Incidents reported as 'moderate or above'

Other

- End of year data now being analysed. Birth rate remains static for the year, noticeable monthly variation noted. This data will be fed into the out of area work focus.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Maternal Perinatal Quality Surveillance Scorecard

Quality Metric	Standard	Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			55%	54%	43%	56%	56%	55%	55%	51%	53%	47%	56%	49%	
3rd/4th degree tear overall rate	<3.5%	3.50%	3.40%	3.50%	3.60%	4.60%	4.50%	3.50%	3.90%	5.20%	2.40%	3.00%	5.00%	2.10%	
3rd/4th degree tear overall number		71	6	7	6	8	6	6	7	9	4	5	8	3	
Obstetric haemorrhage >1.5L number		118	13	19	9	6	11	6	11	15	17	13	6	9	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	4.80%	6.10%	3.10%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	
Term admissions to NICU	<6%	3.10%	1.30%	2.00%	3.20%	5.40%	3.40%	3.40%	3.70%	3.00%	3.10%	3.00%	2.80%	3.80%	
Stillbirth number		9	1	0	1	0	1	0	0	0	2	1	2	1	
Stillbirth rate	<4.4/1000				2.200			1.700			2.300			3.100	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	
Number of compliments (PET)		35	2	2	3	2	3	3	4	4	3	2	3	4	
Number of concerns (PET)		13	2	1	1	1	1	1	2	0	1	1	1	1	
Complaints		4	0	0	0	0	1	1	1	0	0	1	0	0	
FFT recommendation rate	>93%		89%	90%	90%	89%	91%	91%	90%	91%	90%	90%	90%	90%	

External Reporting	Standard	Total/ average	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Trend
Maternity incidents no harm/low harm		1233	58	78	85	86	85	107	130	158	94	148	102	102	
Maternity incidents moderate harm & above		12	0	1	1	0	1	3	2	2	1	1	0	0	
Findings of review of all perinatal deaths using the real time monitoring tool	Mar-24	PMRT case are within reporting timeframes inline with MIS, deadline met. Annual report downloded and presented at MAC for QC in May.													
Findings of review all cases eligible for referral to MNSI	Mar-24	Two current live cases with MNSI, one report now final, meeting conducted with the family, for LMNS and Trust sign off. One report ongoing investigation.													
Service user voice feedback	Mar-24	Findings from Pain relief review presented to MNSC-action plan to be completed.													
Staff feedback from frontline champions and walk-abouts	Mar-24	Staffing reporting higher activity supported by additonal staff. Work ongoing with an out of area focus.													
HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	N	N	N	Y	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	0	0	
Progress in Achievement of CNST 10	<4 <7 7 & above														

Trust Board

Subject:	**Nursing, Midwifery, and Allied Health Professional Annual Staffing Report.**	**Date:** May 2024
Prepared By:	Rebecca Herring (Associate Director of Nursing - Workforce) Paula Shore (Director of Midwifery and Divisional Director of Nursing) Kate Wright (Associate Chief Allied Health Professional)	
Approved By:	Phil Bolton, Chief Nurse	
Presented By:	Phil Bolton, Chief Nurse	

Purpose

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

Strategic Objectives

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

Principal Risk

PR1	Significant deterioration in standards of safety and care	**X**
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	**X**
PR4	Failure to achieve the Trust's financial strategy	

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

Committees/groups where this item has been presented before

Nursing, Midwifery, and Allied Health Professional Committee March 2024

People, Culture and Improvement Committee, March 2024

Acronyms

Allied Health Professional (AHP)

Sherwood Forest Hospitals Foundation NHS Trust (SFH).

National Institute for Health and Care Excellence (NICE),

National Quality Board (NQB)

Care Hours per Patient Day (CHPPD)

Adult Safer Nursing Care Tool (SNCT)

Care Quality Commission (CQC)

NHS Improvement (NHSI)

Objective Structured Clinical Examinations (OSCEs).

Healthcare Support Workers (HCSWs)

NHS England (NHSE)

Local Maternity and Neonatal Systems (LMNS)

Whole-time Equivalent (WTE)

Health and Care Professions Council (HCPC).

Clinical Services, Therapies, and Outpatient (CSTO)

Speech and Language Therapy (SLT)

Integrated Care System (ICS)

Integrated Care Board (ICB)

Nursing and Midwifery Council (NMC)

Occupational Therapy (OT)

Operating Department Practitioner (ODP)

Registered Nurse (RN)

Nursing Associate (NA)

Trainee nursing associate (TNA)

Executive Summary

Background

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

1.1 This is supported by an overview of staffing availability over the year, the quality impact upon nurse-sensitive indicators, progress with assessing the acuity and dependency of patients in ward areas, and the outcomes of the 2024-2025 NMAHP inpatient establishment reviews. Furthermore, planning progress will be discussed across the outlined disciplines.

Nursing and Midwifery Staffing Overview

1.2 Quarter one of 2023/2024 saw the Trust's collective vacancy rate for nursing, midwifery, and AHPs across all divisions remain at 8%. However, from quarter 2 onwards, there has been a consistent positive reduction of 4% overall.

1.3 Collective nursing and midwifery vacancies at SFH have remained favourable compared to the national position average. The Trust remains committed to the national policy drivers in ensuring there are safe and sustainable workforce provisions and has pledged additional investment in local and international recruitment campaigns. With that said, our band 5 nursing workforce is one of our largest safety-critical resources; therefore, maintaining momentum in reducing the vacancy deficit in this cohort of staff remains our absolute priority, albeit an ongoing challenge due to the national workforce pressures.

1.4 Since our last report, we have remained under significant operational pressure, with multiple areas working above their baseline capacity. A phased approach over 2023 has been taken to substantivize staffing in several of the longstanding escalation areas; nonetheless, continued reliance on agency staffing across all clinical areas remains, but the overall trend has demonstrated that this is positively reducing.

1.5 Aligned to the overall decreasing agency usage, usage at escalated rates has also seen a reducing downward trend. Whilst it is acknowledged there is still work to be done on reducing standard cascade agency usage overall, the targeted focus of higher cost rates has been favourable. Priority focus has been placed on a timely escalation of staffing shortfalls and de-escalation when service needs allow, bespoke roster training for areas, and mandatory refresh training for all band 7s.

1.6 Care Hours per Patient Day (CHPPD) at the Trust level has remained stable despite national fragility. Benchmarking data from Model Hospital (October 2023) demonstrates that the Trust value sits within the third of four quartiles at 8.3 and is aligned with an overall peer median of 8.4. This metric should not be used in isolation, but it does indicate that our staffing levels are reflective of similar-sized peer organisations across the NHS.

1.7 In addition to Datix reporting, red flags for midwifery services are recorded within the BirthRate Plus® system. The theme of red flags reported aligns with the incidents reported within the Datix system and is themed with delays in inductions of labour or delays in the artificial rupture of membranes. As per our previous report, the themes remain consistent with actions undertaken to meet patient acuity by utilising staff redeployment, matron on-call working clinically, and escalation to managers enacted to mitigate risk.

Establishment Planning Reviews 2024/2025

1.8 Since the last establishment review, the Trust has continued with an evidence-based approach to re-setting the nursing and midwifery establishments ensuring we are compliant with the NQB standards. Safer Nursing Care Tool (SNCT) is an objective evidence-based workforce planning tool that provides patient acuity and dependency intelligence, aligned with nurse-sensitive indicators and professional judgement to inform the Trust establishment setting process.

1.9 A multidisciplinary review of the nursing and midwifery establishments commenced in late November and concluded in January 2024. The reviews were led by the Director of Nursing/ Deputy Chief Nurse, and the Lead Nurse for Safer Staffing, with representation from the Deputy Chief Financial Officer, Divisional Directors of Nursing/ Midwifery, Divisional Matrons, and Divisional Finance Managers.

1.10 The collective establishment recommendation which was agreed by the Trust Management Team was for an increase of 18.83 WTE and subsequent recruitment within the nursing and midwifery workforce; with a total cost impact of £70,609.

Figure 1:

Division	WTE Requested	Financial Investment Requested
Medicine	8.64	£0
Urgent and Emergency care	0	£0
Surgery	8.12	£0- Funded through TIF and EFR
Clinical Therapies, Services, and Outpatients	0	£0
Women and Children	2.07	£70,609
Total	**18.83**	**£70,609**

1.11 The full breakdown of the establishment review and recommendations can be found in Appendix Two.

Nursing Forward Planning

1.12 An executive decision was made to suspend the international recruitment program in November due to feedback from the clinical teams regarding reducing vacancies and difficulties in providing additional clinical support and supervision for staff during their transition into a registrant role. The relevant communications have taken place with our national colleagues, external partners, and the remaining international nurses who were pending start dates. Pastoral support to our new colleagues remains ongoing alongside OSCE preparation training ahead of the upcoming examinations.

1.13 SNCT for adult inpatient areas and adult assessment areas was updated in 2023 to reflect the changing complexities of patients' needs. It has been recognised that enhanced patient observations and areas with a high percentage of cubicles need increased workforce requirements. Therefore, additional levels of care have been included within the new tool to support this. The data cycles have also increased from 20 to 30 days to ensure a greater insight into the themes and trends during that time frame. SFH was one of the pilot sites for the refresh beta testing phase and has been acknowledged in the tool's user manual.

1.14 A Golden Ticket Recruitment Offer Scheme is now available for ward and department leaders who support student nurses within their clinical areas. The scheme is aimed at third-year nurses who have undergone placements at SFH, displayed clinical excellence, and role-modelled the Trust CARE values. Whilst the scheme is currently only available in nursing, significant interest has been generated within maternity and AHP roles; therefore, collaborative working is underway to expand the scope of the scheme.

1.15 The Registered Nurse Degree Apprenticeship students are progressing well, and the Trust is engaging with them to confirm their intentions of employment after they qualify in August 2024.

Midwifery Forward Planning

1.16 The alignment of the maternity support worker workforce with the national framework continues, and plans are in place to support our current staff in meeting educational requirements within this framework. This also aligns with the Three-Year Delivery Plan and the Royal College of Midwifery Position Statement (2022), which outlined that registered nurses should not be used within maternity services and that organisations should look at the development of the maternity support worker workforce.

1.17 The Trust continues to support the MSc midwifery shortened programmes. Our Birmingham City University students completed their studies in January 2024, and our Derby University students will complete their studies in January 2025. A new cohort of student midwives will commence their programme in January 2024 and are expected to complete it in January 2026.

1.18 The maternity team has welcomed the recently appointed Head of Midwifery into their new role, completing the midwifery leadership team structure.

1.19 Planning is underway for a midwifery careers event for students who are in their third year of training, and a reserve list has been commenced for students who have expressed an interest in SFH. All third-year students will be invited to attend.

AHP Overview

1.20 AHPs are a wide-ranging group of clinicians who work in diagnosis, treatment, rehabilitation, health promotion, discharge, and improving the quality of life of patients. AHP professional titles are recognised by NHS England (NHSE), protected by law,

and registered and regulated by the Health and Care Professions Council (HCPC). Collectively they are the third largest workforce in the NHS and are essential in the delivery of the NHS People Plan, to support future demands, transform sustainable healthcare, and assist deliverables of the NHS Long Term Plan.

1.21 The SLT head and neck Band 8a specialist post continues to be provided by agency staffing as the service was previously provided via a service line agreement by Nottingham University Hospitals. A business case has now gained recent approval, and two fixed-term posts (band 7 and band 8a) are currently out to advert. Additional SLT posts in recruitment include 0.8 WTE Band 6 ICSS, with the post remaining vacant since January. This has previously been advertised twice with no interest. It has now been added to the band 6 rotation and we have five applicants to shortlist. The High Dependency Unit paediatric band 7 post has been appointed as a job share and is waiting for staff members to start.

1.22 Ongoing concerns nationally remain with a vacancy rate of 25-28% within the SLT profession. SFH continues to be in a good position against the national trend due to the huge amount of effort placed on retention. However, this continues to be an ongoing challenge as band 6 SLT posts are particularly difficult to recruit to. The ICS rotational scheme continues to be successful and fully recruited, and SFH continues to hold membership within this scheme with a band 5 post on the ICS rotation.

1.23 Occupational Therapy (OT) is a workforce risk and is on the Clinical Services, Therapies, and Outpatient (CTSO) division risk register. NHSE has deemed OTs an at-risk' professional group. Nationally, there are significant challenges in recruitment across acute settings partnered with limited bank and agency workforce available. Acute placements are not mandated as part of an OT's undergraduate training.

1.24 Operating Department Practitioners (ODPs) continue to be a workforce risk due to having seven open vacancies. Recent updates to support the ongoing recruitment plan include the appointment of an additional international ODP on a one-year fixed-term contract, the recent appointment of a bank ODP, three ODP apprentices are expected to qualify in June 2024, and three existing theatre health care support workers in and one band 3 ANP will commence their ODP apprenticeship programme in May 2024. The team continue to fill staffing gaps with long-term agency staff in the interim.

1.25 Against the national trend, radiology continues to see positive recruitment with current vacancies out to advert. These include a senior mammographer, advanced clinical practitioner, band 8a, band 6 rotational radiographer and an imaging assistant. Our recent successful appointments include a band 7, lead radiographer in CT and a band 7 radiography clinical educator.

Clinical Placement Expansion Programme

1.26 SFH remains the leading provider in the Nottingham and Nottinghamshire ICS regarding the 'fair share' student model. The student numbers and capacity are being evaluated and reviewed to support additional AHP placements. In September 2024, Trent University will commence an undergraduate OT course, and we are working closely with the programme coordinators to support future OT placements here at SFH.

ICS AHP Faculty and AHP Cabinet

1.27 SFH and the Associate Chief AHP continue to host NHSE/ICB AHP funds including:

- ICS AHP support workforce, Higher development awards
- ICS AHP improved practice education – 'quality' (AHP educator development)
- Improving practice education- 'capacity and utilisation' (AHP placement innovation)
- AHP preceptorship

The AHP faculty also supports undergraduate students with AHP leadership placements, which has continued successfully since the pandemic.

National Compliance

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

1.29 The Chief Nurse and Director of Nursing recommend that there is good compliance with the Developing Workforce Safeguards.

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

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

Recommendations

1.32 The Board is asked to:

- Receive this report and note the ongoing plan to provide safe staffing provisions within nursing, midwifery, and AHP disciplines across the Trust.
- Receive this report and note the outcome of the establishment setting review for 2024/2025
- The Board is asked to note the AHP staffing and risk position within the report whilst noting the ongoing recruitment plans to support services.
- The Board is asked to note the compliance standards used with SNCT, and the ongoing quality of data it provides to underpin the Trust establishment process.

Nursing, Midwifery, and Allied Health Professional Annual Staffing Report 2024

Purpose

2.1 The purpose of this report is to provide an overview of NMAHP staffing capacity and Trust compliance with the NICE (2014) safe staffing guidance, NQB (2016) Standards, and the NHSI (2018) Developing Workforce Safeguards recommendations.

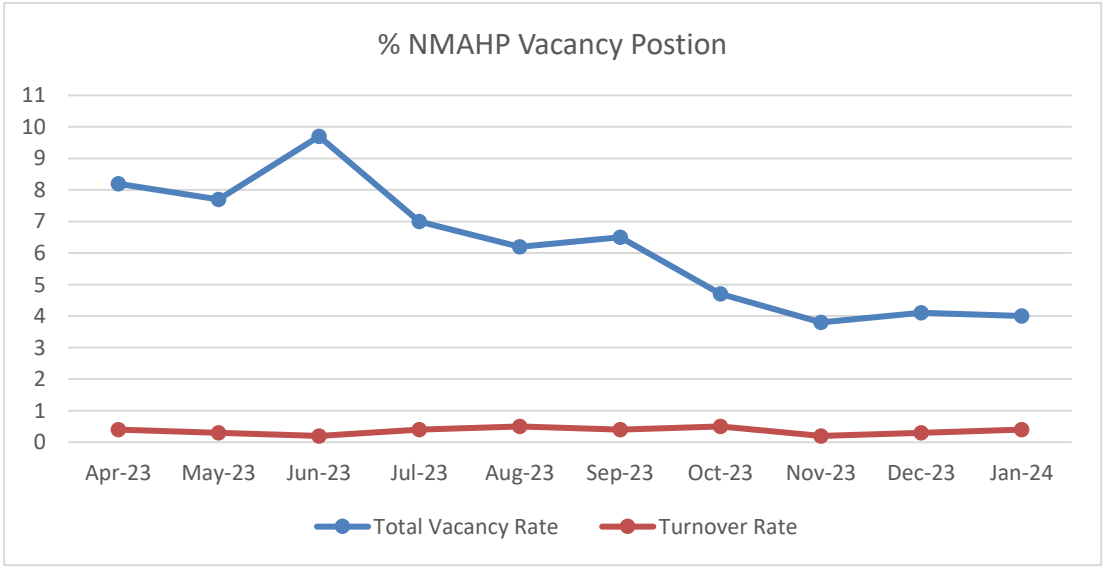
2.2 This is supported by an overview of staffing availability, oversight of nurse-sensitive indicators, progress with assessing the acuity and dependency of patients across ward areas, ongoing recruitment, service development across our services, and recommendations from the establishment reviews.

Nursing and Midwifery Overview

Local Nursing and Midwifery Context

3.0 Quarter 1 of 2023/2024 saw the Trust's collective vacancy rate for nursing, midwifery, and AHPs across all divisions remain in the 8% margin. However, from quarter 2 onwards, there has been a consistent positive reduction of 4% overall. SFH has consistently demonstrated a low turnover rate, which is a strong indicator that the Trust's strategic priorities are well aligned with the organisation's micro and macro culture.

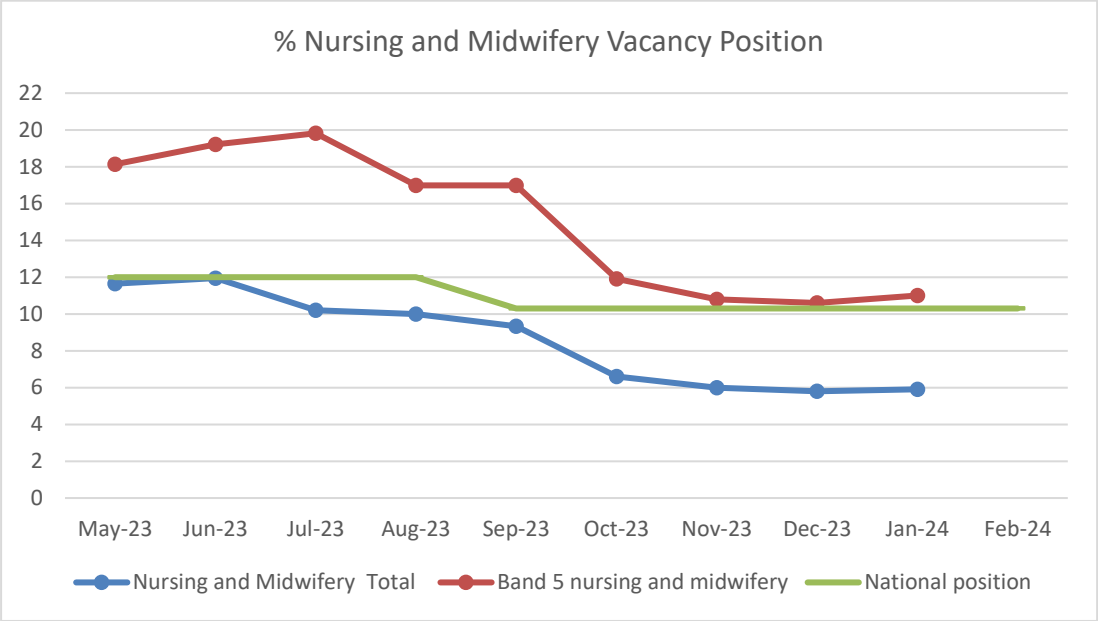
Figure 2:



Data Source Workforce Informatics.

3.1 Collective nursing and midwifery vacancies at SFH have remained in a favourable position when compared to the national position average. The Trust remains committed to the national policy drivers in ensuring there are safe and sustainable workforce provisions and has pledged additional investment in local and international recruitment campaigns. With that said, our band 5 nursing workforce is one of our largest safety-critical resources, therefore maintaining momentum in reducing the vacancy deficit in this cohort of staff remains our absolute priority, albeit an ongoing challenge due to the national workforce pressures.

Figure 3:



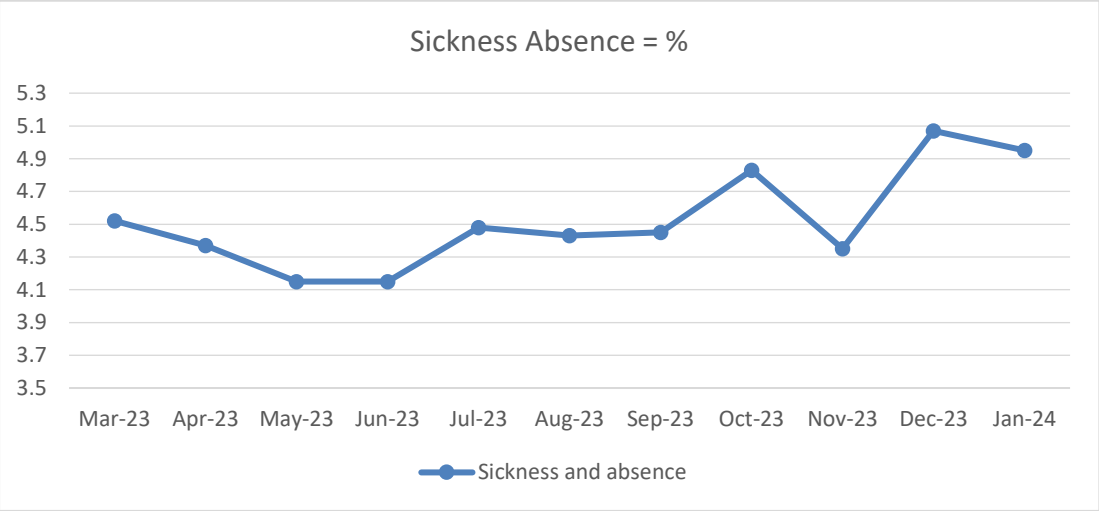
Data Source: Workforce Information.

3.2 The national picture for nursing vacancies remains turbulent, and a concerted emphasis on the NHS Long Term Workforce Plan (NHSE, 2023) has determined growing domestic education and training, and increased training provisions should be the fundamental building blocks of our recruitment and retention strategies. SFH is working in partnership with the ICS Recruitment and Retention Delivery Programme with a focus on three of the five high-impact national actions for retaining nursing and midwifery colleagues (NHSE, 2022).

3.3 Band 5 nursing vacancies are now being tracked through the NMAHP Transformation Group to ensure a more granular oversight of our real-time position. It is anticipated this approach will enable collaborative support for teams where required and strengthen our ability to be innovative with recruitment.

3.4 Since our last report, we have continued to maintain a sickness absence position of approximately 4.5% overall for all staff groups. Whilst this is lower than the baseline during the pandemic, it remains consistently higher than pre-pandemic levels of absence. Many resources and priority focus regarding health and wellbeing services have been embedded across the organisation to support staff and echo the countrywide trend.

Figure 4:

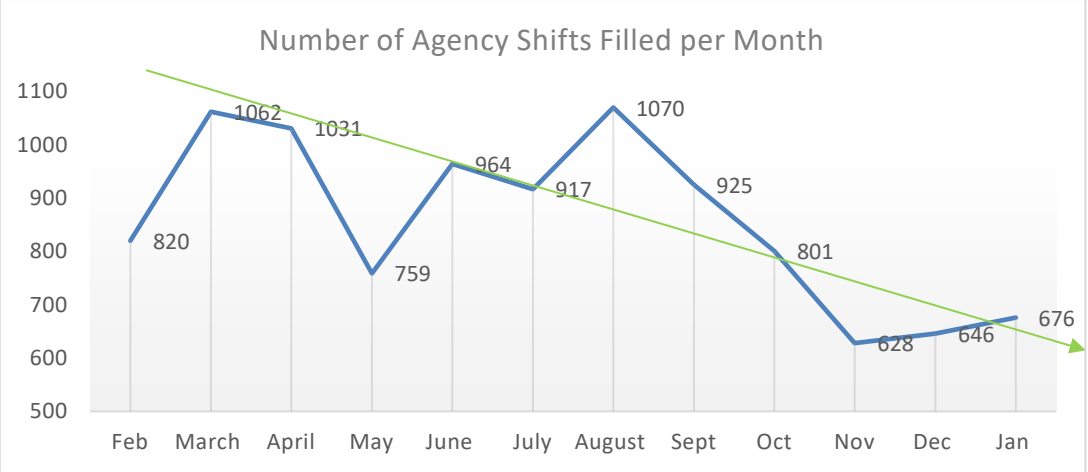


Data Source: Workforce Informatics

3.5 The Trust has remained under significant operational pressure, with multiple areas working above their baseline capacity. There has been a phased approach over 2023 to substantivize staffing in several of the longstanding escalation areas; nonetheless, continued reliance on agency staffing across all clinical areas remains. The acuity and dependency needs of our patients attending the hospital remain high, with many needing complex care coupled with sustained flow and capacity throughout the year.

3.6 These unprecedented pressures are being experienced nationwide, with January 2024 being noted as the busiest month in the history of the NHS. Despite this, the overall trajectory for 2023 continues to reduce positively and indicates the ongoing improvement work and strategic focus work being undertaken regarding agency expenditure.

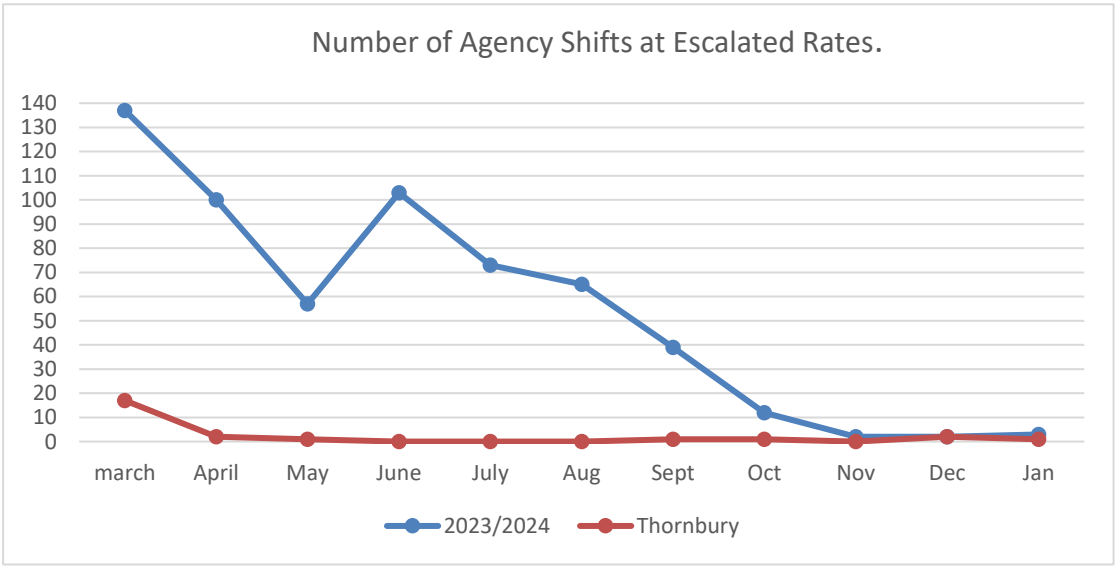
Figure 5:



Data Source: Temporary Staffing Office Data

3.7 In line with the continued overall decreasing agency usage, agency usage at escalated rates has seen a reducing downward trend. Whilst it is acknowledged there is still work to be done on reducing standard cascade agency usage overall, the targeted focus of higher cost rates has been favourable. Priority focus has been placed on timely escalation of staffing shortfalls and de-escalation when service needs allow, bespoke roster training for areas, and mandatory refresh training for all band 7s. This progress is monitored through the NMAHP transformation Group to ensure regular opportunities to review and evaluate whilst ensuring safety and quality care remain the overarching driving priority.

Figure 6:

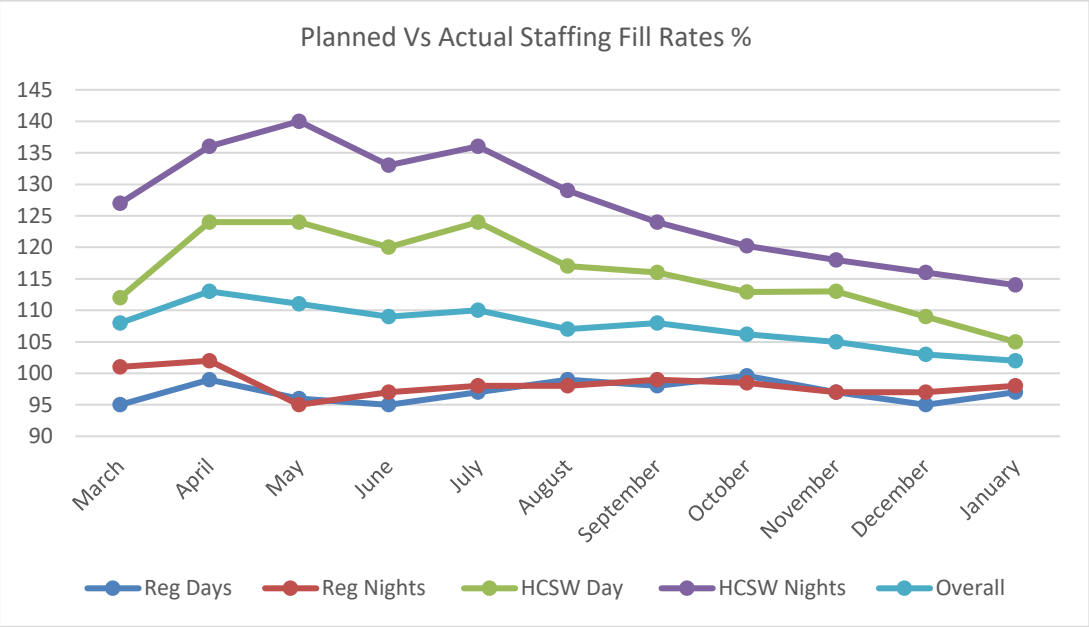


Data Source: Temporary Staffing Office Data

Planned Versus Actual Staffing

4.0 This data highlights the planned staffing hours aligned to actual staffing hours worked (actual hours worked by substantive and temporary staff).

Figure 7:



Data Source: Unify Data

4.1 As previously discussed, ensuring safe staffing has remained challenging due to sickness absence, extra capacity, and patients requiring enhanced care. That said, clinical leaders have worked hard to ensure our staffing levels have remained safe and aligned with national guidance. Through flexible workforce deployment, The Trust has consistently remained above 95% of the planned staffing fill rates for registered staff.

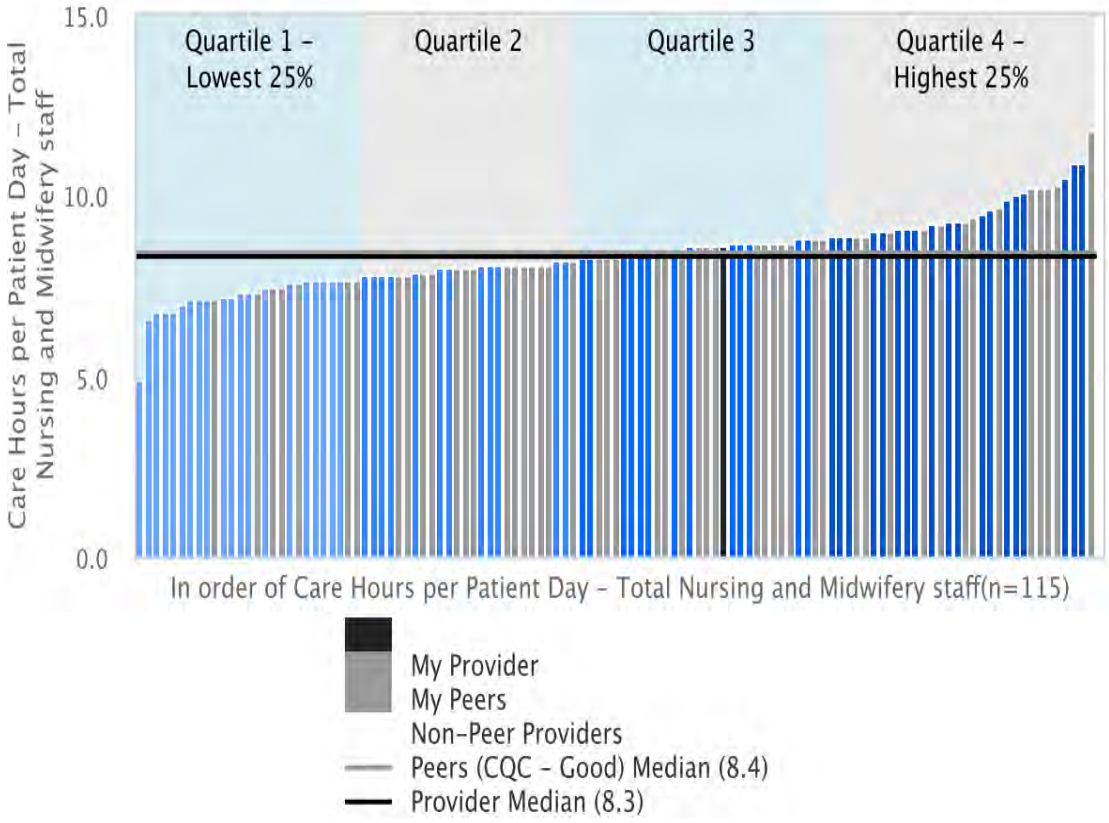
4.2 The Rostering Matron has been working closely with the midwifery matron team in terms of strengthening the roster templates to ensure we are accurately capturing actual work done. Due to the on-call system- shift times are amended to when a midwife has been called in for duty, however, the outstanding shift template that is not required is not being removed. Which, in turn, appears to negatively influence the fill rate position and is not reflective of the true position.

4.3 The fill rate for HCSW consistently remains higher than planned and is driven by the delivery of enhanced observations to reduce the risk of harm to our patients. It is acknowledged that this element of care is dynamic and is difficult to forward plan due to the need for constant reassessment. Ongoing work continues around therapeutic interventions and the promotion of the Carers Passport to strengthen our resource provisions.

4.4 CHPPD provides a value that demonstrates the average number of actual care hours spent with each patient per day, and data at the Trust and ward level for all acute providers is published on NHS Model Hospital to assist in reducing unwarranted variation by providing a transparent comparable data set.

4.5 CHPPD at the Trust level has remained stable despite national fragility. Benchmarking data from Model Hospital (October 2023) demonstrates that the Trust value sits within the third of four quartiles at 8.3 and is aligned with an overall peer median of 8.4. This metric should not be used in isolation, but it does indicate that our staffing levels are reflective of similar-sized peer organisations across the NHS.

Figure 8:



Data Source: Model Hospital 2024.

4.6 Clinical Narrative from the matron team indicates safe staffing across all services remains an ongoing priority, particularly with the seasonal variables and the exceptional circumstances of industrial action amongst the healthcare profession. However, staffing resources have been efficiently flexed and deployed to meet patient

demand, activity, and acuity. It is recognised, that this has meant clinical areas on occasions have been working with staffing levels below optimum but agreed minimum staffing levels have been maintained. Nurse-sensitive indicators continue to be monitored and reviewed in line with staffing shortfalls.

Measurement and Improvement of Quality Care

5.0 Patient care that is of the highest quality is the absolute priority in our assurance that our staffing is safe and responsive, therefore the senior nursing and midwifery team reviews workforce metrics, indicators of quality, and measures of productivity monthly within the monthly Safe Staffing Reports.

5.1 Since April 2023, 762 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system. All incidents were recorded as no or low harm, and the appropriate actions were taken at the time (when investigations had been successfully closed).

Figure 9:

Datix Staffing Incidents										
2023/2024	**April**	**May**	**June**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**
Nursing Staffing Incidents	57	58	49	52	54	93	76	72	93	78
Red Flags	2	2	1	3	4	6	6	3	8	6
Midwifery Staffing Incidents	1	0	6	6	2	2	23	17	14	9
Red Flags	0	0	2	3	2	2	6	6	2	2

Data Source: Datix Reporting System

5.2 Providing enhanced patient observations has continued to be a dominant nursing theme since our last report alongside delays in delivering fundamental care and having to divert services due to high capacity. With the recent iteration of the SNCT, enhanced care is identified as a separate recommendation and it is anticipated that this will

provide ward-level intelligence to support ward-level staffing requirements at the establishment setting reviews going forward.

5.3 Work is underway to review the current reporting categories for staffing incidents and align these with the NICE red flag categories. This will enable a more concise process for staff reporting incidents and for those reviewing investigations.

5.4 In addition to Datix reporting, red flags for midwifery services are also recorded within the BirthRate Plus® system. The theme of red flags reported aligns with the incidents reported within the Datix system. It has been recognised that there have been some issues with the interpretation of some of the red flag reporting, and staff have been supported in their understanding of this data capture. As per our previous report, the themes remain consistent with actions undertaken to meet patient acuity by utilising redeployment of staff, matron on-call working clinically, and escalation to managers enacted to mitigate risk.

5.5 In May of 2023, the BirthRate Plus Team launched a review of the Ward Acuity platform, which was first developed by a profession-led Expert Group in 2015. They recognised there had been significant changes in service delivery, clinical practice, and policy in recent years, most notably from the findings of The Ockenden Review and therefore placed a temporary pause on the use of the ward application. The review concluded at the end of 2023, and refresh sessions were offered by the National team for trust-led updates. The Deputy Divisional Director of Midwifery has commenced a programme to refresh staff with a plan for the ward tool to be fully used by February.

Establishment Planning Reviews 2024/2025

6.0 Since the last establishment review, the Trust has continued with an evidence-based approach to resetting the nursing and midwifery establishments, ensuring compliance with the NQB standards. SNCT is an objective, evidence-based workforce planning tool that provides patient acuity and dependency intelligence, aligned with nurse-sensitive indicators and professional judgement, to inform the Trust establishment-setting process.

6.1 As per the licensing agreement, two 20-day cycles of SNCT data collection took place in March and September 2023, which ensured representation of seasonal variation.

During these cycles, it was highlighted that several areas were operating escalation capacity during at least one of the data sets.

6.2 A multidisciplinary review of the nursing and midwifery establishments commenced in late November and concluded in January 2024. The reviews were led by the Director of Nursing/ Deputy Chief Nurse and the Lead Nurse for Safe Staffing, with representation from the Deputy Chief Financial Officer, Divisional Directors of Nursing/ Midwifery, Divisional Matrons, and Divisional Finance Managers.

6.3 Each review was aligned to the components below:

- ✓ Professional judgement is applied to workforce planning and is representative of speciality and activity requirements.
- ✓ The appropriate skill mix of staff reflective of speciality.
- ✓ Funded bed base modelling whilst acknowledging escalation capacity and winter bed capacity needs.
- ✓ SNCT acuity and dependency data to inform each confirm and challenge discussion.
- ✓ Benchmarking ward-level CHPPD data aligned with the national mean and peer providers.
- ✓ A 12-month overview of nurse/midwifery-sensitive indicators for each area.
- ✓ Consideration of the financial impact of budgets.

6.4 Staffing establishments should consider the need to enable nursing, midwifery, and healthcare support workers (HCSW) time to undertake professional development and fulfil mentorship and supervision roles. Core principles in determining these establishments have remained aligned with previous reviews, namely:

- ✓ The ward/department leader role is supervisory, enabling them to apply their time to provide direct care, undertake front-line clinical leadership, and support unfilled shifts.
- ✓ The skill mix on the ward should aim to have a recommended ratio of 65:35% split for registered nurses to HCSW in acute wards, 60:40 for sub-acute wards, and 50:50% for rehabilitation wards. However, professional judgement is always considered, noting individual environmental factors, multidisciplinary input, and care pathways.
- ✓ 22% of ‘headroom’ is allocated to establishments. The Carter Report (2016) notes a significant variation amongst Trusts, ranging from 18% to 27%. However, 22% is

the minimum 'headroom' supported within the SNCT and represents a built-in efficiency. ED, Newark Urgent Treatment Centre, NICCU, and ICU were allocated 25% headroom, acknowledging the specialty guidance for additional training requirements for these specific areas.

6.5 Birthrate Plus is a framework for maternity workforce planning and strategic decision-making and has been in variable use in UK maternity units since 1988, with periodic revisions as national maternity policies and guidance are published. It is based upon an understanding of the total midwifery time required to care for women and on a minimum standard of providing one-to-one midwifery care throughout established labour. The principles underpinning the Birthrate Plus methodology are consistent with the recommendations in the NICE safe staffing guideline for midwives in maternity settings and have been endorsed by the Royal College of Midwives and the Royal College of Obstetricians and Gynaecologists.

6.6 The Medical Division requires an additional 8.64 WTE distributed across Ward 33, Ward 34, Ward 41, and Ward 52. However, a reduction of 2.45 WTE has been proposed for Ward 51, Ward 53, and Sconce, resulting in the overall ask of 6.19 WTE being requested. The increase in WTE is to enable the alignment of clinical demand with current roster templates and current run rate expenditure. The Medical Division is not seeking any additional financial investment for the 2024/2025 establishment resetting.

6.7 The Urgent and Emergency Care Division is not seeking any additional investment during the re-setting of the 2024/2025 establishments. During the professional confirm and challenge discussion the current establishment was deemed to be safe, sustainable, and in line with speciality guidance. The SNCT information triangulated with nurse-sensitive information also informed the discussion and was supported by the Divisional Director of Nursing.

6.8 A high level of national focus remains on maternity services as safer staffing provisions continue to headline the national agenda. In line with previous reviews, the content of the maternity establishment review has been predicated upon Birthrate Plus® recommendations. The Trust received the updated workforce proposal earlier in 2023, and through the application of local professional judgement, maternity staffing remains aligned with best practice guidance and an evidence-based workforce modelling tool.

6.9 The Women's and Children Division has requested investment to support 1.65 WTE on Ward 25. The reconfiguration of the current staffing will enable a static bed base of 26 beds for 24 hours 7 days per week, thus enhancing the patient pathway experience and optimising operational efficiency. Ward 14 has requested investment to support a 0.42 WTE increase in the Early Pregnancy workforce to provide services for women 7 days per week instead of the current 6-day modelling. The Women's and Children's Division is seeking a financial investment of £70,609 to support an additional 2.07 WTE.

6.10 The Surgical Division is requesting an increase of 3.9 WTE on Minster which will align the additional resources provided by the TIF funding stream. 4.22 WTE investment I is also being requested for the Day Case Unit located at KMH, due to two additional ophthalmology lists and additional flexible cystoscopy activity being accommodated. The identified uplift is for HSCWs, and the proposed increase is to be funded via the Elective Recovery Fund 24/25 planning workstream. ITU has recommended a reduction of 0.17 WTE and remains in line with clinical activity and GPICS guidance.

6.11 Recognising the complexities of the surgical reconfiguration that has recently been enacted, an additional review was held with Executive representation. The meeting sought a detailed review of the financial reconciliation and workforce position specifically related to the reconfiguration, and assurance was provided by the Divisional General Manager and Divisional Director of Nursing that no additional investment was required from the establishment review process. The Surgical Division does not require any additional financial investment for the 2024/2025 establishments.

6.12 CSTO Division has undertaken an in-depth review of their current care delivery provision alongside the affiliated therapy services since the last review, which successfully increased the workforce for SLT, Dietitians, Physiotherapy and Occupational Therapy. Three of these services are identified as 'small and vital professions' by NHS England due to the risk of a fragile workforce with constraints relating to recruitment. However, with that said, all hard-to-recruit posts have been filled and the services have minimal vacancies at SFH. This has been achievable through robust recruitment strategies and flexing roles where possible. It is anticipated the ongoing direction of travel will continue with the advancement of AHP job planning.

6.13 Alongside therapy services, outpatient provisions have also been reviewed. During the professional confirmation and challenge discussion the current establishment was deemed to be safe, and sustainable however a wider service review remains in progress and will inform future business cases. Consequently, the CSTO division does not require any additional establishment to current services. This is supported by the Divisional Director of Nursing and the Chief AHP.

6.14 The collective establishment recommendation is for an increase of 18.83 WTE and subsequent recruitment within the nursing and midwifery workforce; with a total cost impact of £70,609.

Figure 10:

Establishment Reconciliation 2024/2025		
Division	**WTE Requested**	**Financial Investment Requested**
Medicine	8.64	£0
Urgent and Emergency care	0	£0
Surgery	8.12	£0- Funded through TIF and EFR
Clinical Therapies, Services, and Outpatients	0	£0
Women and Children	2.07	£70,609
Total	**18.83**	**£70,609**

6.15 The full breakdown of the establishment review and recommendations can be found in Appendix Two.

Nursing Workforce Future Planning

7.0 An executive decision was made to suspend the international recruitment program in November due to feedback from the clinical teams regarding reducing vacancies and difficulties in providing additional clinical support and supervision for staff during their transition into a registrant role. The relevant communications have occurred with our national colleagues, external partners, and the remaining international nurses who were pending start dates. Pastoral support to our new colleagues remains ongoing alongside OSCE preparation training ahead of the upcoming examinations.

7.1 With the support of NHSE, alternative employment has been arranged at several other NHS Trusts for the remaining candidates who had not been allocated clinical areas, and this completes our pipeline agreement with NHSE.

7.2 SNCT for adult inpatient areas and adult assessment areas was updated in 2023 to reflect the changing complexities of patients' needs. It has been recognised that enhanced patient observations and areas with a high percentage of cubicles need increased workforce requirements, therefore additional levels of care have been included within the new tool to support this. The data cycles have also increased from 20 days to 30 days to ensure a greater insight into the themes and trends during that time frame. SFH was one of the pilot sites for the refresh beta testing phase and has been acknowledged in the tool's user manual.

7.3 A refresh programme has been led by the Associate Director of Nursing Workforce and the next cycle will commence in March 2024.

7.4 A Golden Ticket Recruitment Offer Scheme is now available for ward and department leaders who support student nurses within their clinical areas. The scheme is aimed at third-year nurses who have undergone placements at SFH, displayed clinical excellence, and role-modelled the Trust CARE values. Whilst the scheme is currently only available in nursing, significant interest has been generated within maternity and AHP roles; therefore, collaborative working is underway to expand the scope of the scheme.

7.5 Years 1 and 2 of our trainee nursing associate's students are progressing well in their Programme, with no concerns raised.

7.6 The Trust currently has four nursing associates who are topping up their qualifications by undertaking registered nurse training with the University of Derby and will qualify in February 2024. Three have posts within our wards and departments, and the fourth has not given her intention of employment following her qualification. There are six top-up students at Nottingham Trent University and two at the University of Derby who will qualify in September 2024, and these are progressing well.

7.7 The RDNA students are progressing well, and the Trust is engaging with them to confirm their employment intentions following their qualifying in August 2024.

Midwifery Workforce Future Planning

8.0 SFH recommissioned a new BirthRate Plus report which was completed in January 2023 to ensure that staffing reflected the increase in activity and acuity and was in line with changes in the national maternity agenda. This report is still reflective of the activity and acuity needs of women accessing our services throughout 23/24.

8.1 Specialist midwife's roles are continually reviewed in line with changes in the National Agenda, mainly the Three-Year Delivery Plan for Maternity and Neonatal Services (March 2023). A review of the specialist services is planned to identify fragile services and increase establishment to reduce potential risks.

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

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

8.4 Our Recruitment and Retention Lead Midwife role continues to be evaluated successfully. Targeted work supporting preceptorship and ongoing pastoral support remains aligned with the Long-Term Workforce Plan (NHSE, 2023), and has highlighted that this role has ensured all midwives that have been recruited have remained in post here at SFH.

8.5 The Trust continues to support the MSc midwifery shortened programmes. Our Birmingham City University students completed their studies in January 2024, and our Derby University students will complete their studies in January 2025. A new cohort of student midwives will commence their programme in January 2024 and are expected to complete it in January 2026.

8.6 Planning is underway for a midwifery careers event for students who are in their third year of training and a reserve list has commenced for students who have expressed an interest at SFH. All third-year students will be and will be invited to attend.

AHP Overview

9.0 AHPs are a wide-ranging group of clinicians who work in the diagnosis, treatment, rehabilitation, health promotion, discharge and improving the quality of life of patients. AHP professional titles are recognised by NHSE, protected by law, and registered and regulated by the HCPC. There is no single guidance or standard approach to inform safe staffing levels required in services provided by AHP. Each AHP has profession-specific information and guidance only, to support staffing levels of a particular type of service. At SFH, we directly employ 9 of the 14 AHP professions as defined by NHSE.

AHP Job Planning

10.0 All band 5 AHPs will have an electronic job plan by 31 March 2023, equating to 28% of the AHP workforce. The CNCF secondment in AHP job planning is due to finish on 31 March 2024. There remains significant potential to realise the use of our resources if the remainder of the AHP workforce is also job planned (NHSE requirements set out pre-COVID-19).

10.1 Job planning and the use of AHP variable pay have been added to the NMAHP transformation programme, and reporting against this will occur from April 2024. A business case is in development to support the continuation of the job planning project beyond 31st March 2024. CSTO division is in the process of transitioning AHP teams onto the electronic rostering system, which, along with job planning, will support understanding future potential efficiencies.

AHP Staffing Updates

11.0 A diabetes dietitian post is out to recruit, which has been a challenge to recruit. Therefore, it has been advertised as a band 5/6 development role. A successful paediatric dietitian (0.6 WTE) appointment will commence in the post from April; 0.4 WTE remains vacant and is due to return to advert. Unfortunately, a band 7 MacMillan dietitian has recently left the team, so this post is back out to advert soon.

11.1 The SLT head and neck band 8a specialist post continues to be provided by agency staffing as the service was previously provided via a service line agreement by Nottingham University Hospitals. A business case has now gained recent approval, and two fixed-term posts (band 7 and band 8a) are currently out to advert. Additional SLT posts in recruitment include 0.8 WTE band 6 ICSS, with the post remaining vacant since January. This has previously been advertised twice with no interest. It has now been added to the band 6 rotation and we have five applicants to shortlist. The HDU paediatric band 7 post has been appointed as a job share and is waiting for staff members to start.

11.2 Ongoing concerns nationally remain with a vacancy rate of 25-28% within the SLT profession. SFH continues in a good position against the national trend, due to a huge amount of effort placed on retention. However, this continues to be an ongoing challenge as band 6 SLT posts are particularly difficult to recruit to. The ICS rotational scheme continues to be successful and fully recruited and SFH continue to hold membership within this scheme with a band 5 post on the ICS rotation.

11.3 ODPs continue to be a workforce risk due to having seven open vacancies. Recent updates to support the ongoing recruitment plan include the appointment of an additional international ODP on a one-year fixed-term contract, the recent appointment of a bank ODP, three ODP apprentices are expected to qualify in June 2024, and three existing theatre Health care support workers in and one band 3 ANP will commence their ODP apprenticeship programme in May 2024. The team continue to fill staffing gaps with long-term agency staff in the interim.

11.4 Orthotist posts are fully established with no vacancies. There has been a recent vacancy in the Orthotic technician team (25% of the in-house manufacturing team), and this is currently out for recruitment.

11.5 Orthoptist posts are currently fully established, but areas of service development and concerns remain due to SFH not meeting national standards in its provision for learning-disabled patients. There are no screening lead Orthoptists in the community or schools, and this has been highlighted at the Surgery division service line.

11.6 OT is a workforce risk and remains on the CSTO risk register. OTs are defined by NHSE as ‘at risk’ professionals and are on the Home Office occupation risk register.

Nationally, there are significant challenges in recruitment across acute settings, particularly noting the limited bank and agency workforce available. Acute placements are not mandated as part of the undergraduate training of an OT.

11.7 There is focused work at SFH to support recruitment and retention. The appointment of a Professional Practice OT (six-month fixed term) will support the workstream, and the Associate Chief AHP will work closely with the local workforce regarding retention strategies. From May, we will be fully established for band 5 OT posts and have recently had approval for a band 7 team leader OT in neurology/stroke, ensuring equity with the other therapies and raising the profile of the profession. The band 6 OT stroke post is currently covered by agency staffing following repeated difficulty in attracting candidates. This remains under review.

11.8 The ICS OT rotational scheme has been launched to aid recruitment and retention within the Nottingham and Nottinghamshire ICS. SFH is a member of this scheme and has a band 5 post on the rotation.

11.9 We currently employ four paramedics working in advanced clinical practitioner (ACPs) roles at KMH. Two are based in the ED, one is based in the ICU, and the fourth is working at Newark Urgent Treatment Centre.

11.10 There are no current concerns over physiotherapy recruitment, and this continues to attract a healthy number of applicants into this workforce. A new ACP post has been established in the neurology rehabilitation therapy team, and an ACP physiotherapist has recently commenced in post.

11.11 Against the national trend, radiology continues to see positive recruitment with current vacancies out to advert. These include a senior mammographer ACP band 8a, a band 6 rotational radiographer and an imaging assistant. Our recent successful appointments include a band 7 lead radiographer in CT and a band 7 radiography clinical educator.

11.12 The Associate Chief AHP continues to undertake all the AHP exit interviews and is on the MDT Exit Interview Working Group to analyse and identify themes for retention.

AHP Apprenticeships

12.0 To support apprenticeships, AHP services need to utilise existing support workforce posts and do not have any supernumerary apprenticeship posts established. There are no support staff in dietetics, SLT, orthotics or orthoptics; therefore, apprenticeships are not able to be considered in these professions at this point. It is acknowledged that this will have implications for implementing recommendations from the NHS Long-term Workforce Plan.

12.1 The Trust's first radiography apprentice is due to commence in March 2024; two physiotherapy apprenticeships are currently in training, and a further two are expected to commence training in March 2024. One OT apprenticeship is currently underway, with an additional one due to commence in March 2024. The assistant posts are being utilised to support the apprenticeships in radiology and therapy, but it should be recognised that this does impact teams supporting AHP apprenticeships.

12.2 The wider ODP team continue to support an apprentice through the ODP apprenticeship scheme. However, as a point of note, supernumerary apprenticeship posts exist in theatres and are utilised as part of the existing nursing establishment.

AHP Preceptorship

13.0 NHSE has recently published new standards for AHP preceptorship, therefore, to ensure we are aligned at SFH A chief nurse clinical fellow will lead this programme of work.

AHP Clinical Placement Expansion Programme

14.0 SFH remain the leading provider in the Nottingham and Nottinghamshire ICS regarding the ‘fair share’ student model. There is an ongoing evaluation of the student numbers and a review of capacity to support additional AHP placements. In September 2024, Trent University will commence an undergraduate OT course and we are working closely with the programme coordinators to support future OT placements here at SFH.

ICS AHP Faculty and AHP Cabinet

15.0 SFHT and the Associate Chief AHP continue to host NHSE/ICB AHP funds including:

- ICS AHP support workforce, Higher development awards
- ICS AHP improved practice education – 'quality' (AHP educator development)
- Improving practice education- 'capacity and utilisation' (AHP placement innovation)
- AHP preceptorship

The AHP faculty also supports undergraduate students with AHP leadership placements which has continued successfully since the pandemic.

National Compliance

16.0 The Developing Workforce Safeguards published by NHS Improvement in 2018 were designed to support effective workforce planning and staff deployment. Trusts are assessed for compliance with the triangulated approach to deciding staff requirements described within the National Quality Board guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

16.1 The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

16.2 The Chief Nurse has confirmed they are satisfied that staffing is safe, effective, and sustainable.

16.3 Appendix One details the Trust's compliance with the nursing and midwifery elements of the Developing Workforce Safeguards recommendations.

Recommendations

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

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

17.2 The Board of Directors is asked to receive this report and note the outcome of the establishment setting review for 2024/2025.

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

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

18.0 Appendix One: Developing Workforce Safeguards Compliance Standards

Recommendation:	Compliance:
Recommendation 1: Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance.	**Compliant** ✓ SNCT has been embedded within adult in-patient areas, paediatric in-patient areas, and the Emergency Department. ✓ BirthRate Plus is embedded with Maternity services and a refresh of training has been undertaken.
Recommendation 2: Trust must ensure the three components are used in their safe staffing process.	**Fully Compliant** ✓ SNCT and BirthRate are in use at the Trust and provide an evidence-based benchmark for our establishment setting process. Nurse-sensitive indicators information is aligned to each establishment review and professional judgement is always considered.
Recommendation 3 & 4: Assessment will be based on a review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and sustainable.	**Fully Compliant** ✓ Confirmation is included in the annual governance statement that our staffing governance processes are safe and sustainable.
Recommendation 5: As part of the yearly assessment, assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes.	**Fully Compliant** ✓ Data is reviewed and collated every month for a range of workforce metrics, quality indicators, and productivity measures – as a whole and not in isolation from each other.
Recommendation 6: As part of the safe staffing review, the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective, and sustainable.	**Fully Compliant** ✓ Biannual and Annual Nursing, Midwifery, and Allied Health Professional Staffing Report.
Recommendation 7: Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders. The Board should discuss the workforce plan in a public meeting.	**Fully Compliant** ✓ Annual submission to NHS Improvement

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

Developing Workforce Safeguards (NHS Improvement, 2018)

19.0 Appendix Two: Establishments Outcome Breakdown 2024/2025

Division	Ward/ Depart	WTE	Proposed WTE	WTE Variance	SNCT	Cost Impact	CHPPD Actual	CHPPD Peer Median	Skill Mix	Comments:
Medicine	Ward 22 (24 beds)	37.9	37.90	0	30.5	0	6.67	7.05	50/50	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	Ward 23 (23 beds)	35.16	35.16	0	33.8	0	7.22	7.93	70/30	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Divisional Director of Nursing.
	Ward 24 (24 beds)	37.9	37.9	0	31.56	0	7.21	7.8	50/50	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. It is acknowledged that the speciality on the ward is haematology and cardiology medicine; however, the attendance rate for acute haematology is low and therefore difficult to capture in SNCT. This is supported by the Matron and Divisional Director of Nursing
	Ward 33 (24 beds)	35.16	37.89	2.73	37.5	0	7.1	7.72	50/50	The SNCT principles and professional judgement have been applied and a 2.73 WTE increase to the establishment is recommended. No financial investment is required due to the WTE being included within the run rate. This is supported by the Divisional Director of Nursing.
	Ward 34 (24 beds)	35.16	37.89	2.73	36.7	0	6.75	6.25	50/50	The SNCT principles and professional judgement have been applied and a 2.73 WTE increase to the establishment is recommended. No financial investment is required due to the WTE being included within the run rate. This is supported by the Divisional Director of Nursing.
	Ward 41 (24 beds)	35.16	37.89	2.73	36.7	0	7.39	7.05	50/50	The SNCT principles and professional judgement have been applied and a 2.73 WTE increase to the establishment is recommended. No financial investment is required due to the WTE being included within the run rate. This is supported by the Divisional Director of Nursing.
	Ward 42 (24 beds)	37.0	37.90	0	35.4	0	8.33	7.0	50/50	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	21/ RSU (24 beds)	40.40	40.40	0	43.2	0	7.8	7.06	62/38	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.

	Ward 44 (24 beds)	37.90	37.90	0	34.9	0	7.26	7.0	50/50	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	Ward 51 (24 beds)	40.82	40.71	-0.22	36.4	0	7.44	7.05	50/50	The SNCT principles and professional judgement have been applied with a 0.22 WTE reduction to the establishment recommended. Staffing provision is not being reduced across the service on a day-to-day level, but the roster template has been reviewed to reflect actual staffing. This is supported by the Divisional Director of Nursing.
	Ward 52 (24 beds)	40.82	41.72	0.45	39.9	0	8.13	7.05	50/50	The SNCT principles and professional judgement have been applied and a 0.45 WTE increase to the establishment is recommended. No financial investment is required due to the WTE being included within the run rate and being aligned to roster templates. This is supported by the Divisional Director of Nursing.
	Stroke Unit (35 beds, 4 HASU and 31 acute stroke beds)	75.78	74.95	0.83	72	0	9.65	7.39	60/40	The SNCT principles of professional judgement and RCP stroke guidance have been applied and a 0.83 WTE reduction to the establishment is recommended. No financial investment is required due to the WTE being included within the run rate and being aligned to roster templates. This is supported by the Divisional Director of Nursing.
	Sconce (24 beds & 6 escalation beds)	45.63	44.12	-1.51	42.4	0	6.8	8.02	50/50	The SNCT principles and professional judgement have been applied with a 1.51 WTE reduction to the establishment recommended. Staffing provision is not being reduced across the service on a day-to-day level, but the roster template has been reviewed to reflect actual staffing. The increase for HCSWs is absorbed by the run rate. The reduction in band 5 WTE is based on a vacant 8 shift not utilised, cost was not being incurred thus no savings. This has enabled an alignment of WTE (per substantivizing paper). This is supported by the Divisional Director of Nursing.
	Castle (18 beds- escalation)	27.19	27.19	0	26.4	0	8.88	7.54	50/40	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	Chatsworth MCH (16 beds- escalation)	24.69	24.69	0	NA	0	7.53	7.52	40/50	Professional judgement has been applied with no changes to the overall establishment recommended. 1 WTE Band 5 to be uplifted to Band 6 to provide continued leadership in the absence of the Department Leader. This will be funded through variable pay. This is supported by the Divisional Director of Nursing.
	Lindhurst (19 beds- escalation)	27.19	27.19	0	32.1	0	7.06	6.78	40/50	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. The pathway 2 pilot if continued will remain as cost pressure to the division. This is supported by the Divisional Director of Nursing.

	Oakham MCH (24 beds)	32.42	32.42	0	34.4	0	6.15	7.05	50/50	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
Surgery	**New Ward 11 T&O (24 beds)**	0	37.90	37.90	NA	0	NA	NA	50/50	Professional judgement has been applied and no increase to the establishment has been recommended. This ward has formed part of the divisional reconfiguration and funding has been agreed from a separate business case, this included amalgamating financial resources from Ward 43 and additional capacity expenditure. This is supported by the Divisional Director of Nursing.
	Ward 12 (24 beds)	37.9	37.9	0	39.2	0	7.21	8.5	50/50	The SNCT principles and professional judgement have been applied and no changes to the establishment have been recommended. This is supported by the Divisional Director of Nursing.
	Ward 14B-Elective (11 beds)	24.57	24.57	0	NA	0	NA	NA	60/40	Professional judgement has been applied and no increase to the establishment has been recommended. This ward has formed part of the divisional reconfiguration and funding has been agreed from a separate business case, this included amalgamating financial resources from Ward 43 and additional capacity expenditure. This is supported by the Divisional Director of Nursing.
	Ward 31 (24 beds)	35.19	35.19	0	35.5	0	6.94	7.91	57/43	The SNCT principles and professional judgement have been applied and no changes to the establishment have been recommended. This is supported by the Divisional Director of Nursing.
	Ward 32 (24 beds)	37.95	37.95	5.24	35.59	0	7.11	7.91	50/50	The SNCT principles and professional judgement have been applied and a 5.24 WTE increase to the establishment alignment is recommended. No financial investment is required due to the WTE being included with the run rate and had an agreement in May 2023 from the Executive Directors as part of the Substantivizing the Workforce Report. This is supported by the Divisional Director of Nursing.
	Ward 33 SAU/SDEC (17 beds, 5 recliners and 4 trolleys)	42.74	36.82	(6.91)	43.7	(270,400) repurposed for reconfiguration	9.5	8.22	66/34	The SNCT principles and professional judgement have been applied and due to the reconfiguration of services, a 6.91 WTE reduction has been recommended. This resource will be utilised in the workforce for new Ward 11 T&O. This is supported by the Divisional Director of Nursing.
	ITU	99.26	99.09	0.17	GPICS	(£3,682) repurposed for reconfiguration	49.77	27.48	GPICS	The GPICS principles and professional judgement have been applied and a 0.17 WTE reduction to the establishment has been recommended. This is aligning the WTE. This is supported by the Divisional Director of Nursing.
	DCU - King's Mill	34.34	38.56	4.22	NA	0	NA	NA	54/36	Professional judgement has been applied and a 4.22 WTE increase to the establishment has been recommended. This will align the workforce to the EFR funding stream being provided. This is supported by the Divisional Director of Nursing.

	Minister - NWK	23.23	27.19	3.96	NA	0	NA	NA	NA	Professional judgement has been applied and a 3.9 WTE increase to the establishment has been recommended. This will align the workforce to the TIF funding stream being provided. This is supported by the Divisional Director of Nursing.
UEC	**UCC - Newark**	21.76	21.76	0	NA	0	NA	NA	NA	Professional judgement has been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	SSU (40 beds)	57.84	57.84	0	54.3	0	7.09	8.02	58/42	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Divisional Director of Nursing.
	EAU (40 beds)	85.41	85.41	0	79.1	0	11.74	8.13	57/43	The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	Discharge Lounge	7.16	7.16	0	NA	0	NA	NA	50/50	Professional judgement has been applied and professional judgement has been applied with no changes to the establishment recommended. This is supported by the Divisional Director of Nursing.
	SDEC	21.77	21.77	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. This is supported by the Divisional Director of Nursing.
	ED	208.86	208.86	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the financed establishment has been recommended. This is supported by the Divisional Director of Nursing.
	HOOH	9.28	9.28	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. This is supported by the Matron and Divisional Director of Nursing.
CSTO	**Inpatient Dietetics**	15.8	15.8	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. A service review has been recommended to fully explore the wider extent of the service provision and service need. This is supported by the Divisional Director of Nursing.
	Inpatient SLT	14	14	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. A service review has been recommended to fully explore the wider extent of the service provision balanced with service needs and system-level support. This is supported by the Divisional Director of Nursing.

	Inpatient Orthotics	8	8	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. This is supported by the Divisional Director of Nursing
	Inpatient PT and OT	99.52	99.52	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. A service review has been undertaken and funding is being explored from various funding streams. This is supported by the Divisional Director of Nursing and the Chief AHP.
	Outpatients	96.86	96.86	0	NA	0	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. A service provision and productivity review are underway. This is supported by the Divisional Director of Nursing.
W&C	Ward 25	50.06	51.74	1.65	48.0	£54,113	11.7	12.42	75/25	The SNCT principles and professional judgement have been applied and a 1.65 WTE increase to the establishment is recommended. This will enable a static bed base for the ward areas 7 days per week, enhancing the patient experience pathway and optimising operational efficiency. This is supported by the Deputy Divisional Director of Nursing and Divisional Director of Nursing
	Ward 25 (HDU)	7.82	7.82	0	NA	0	NA	NA	PICS	Professional judgement and Guidance from PICS guidance have been applied with no changes to the establishment recommended. This is supported by the Deputy Divisional Director of Nursing and Divisional Director of Nursing
	Ward 14 (13 beds)	26.21	26.63	0.42	24.2	£16,496	8.48	8.28	57/43	The SNCT principles and professional judgement have been applied and a 0.42 increase to the establishment recommended. This will enable the expansion of the EPU service from 6 days to 7 days per week. This is supported by the Matron and Divisional Director of Nursing
	NICU	39.47	39.47	0	BPAM	0	13.36	12.27	BAPM	The BPAM principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Deputy Divisional Director of Divisional Nursing and Divisional Director of Nursing.
	Midwifery	189.07	189.07	0	Birthrate Plus	0	NA	NA	Birthrate Plus	The BirthRate Plus principles and professional judgement have been applied and no changes to the establishment are recommended. This is supported by the Director of Midwifery
	CYP clinic 11	18.84	18.84	0	NA	NA	NA	NA	NA	Professional judgement has been applied and no change to the establishment has been recommended. A service provision and productivity review are underway. This is supported by the Divisional Director of Nursing.

Board of Directors Meeting in Public

Subject:	Medical Workforce Update	**Date:**	2nd May 2024
Prepared By:	Rebecca Freeman – Head of Medical Workforce		
Approved By:	David Selwyn – Medical Director		
Presented By:	David Selwyn – Medical Director		

Purpose		
The purpose of this report is to provide the Board of Directors with an update on progress of Medical Workforce Initiatives	**Approval**	
	Assurance	**X**
	Update	
	Consider	

Strategic Objectives					
Provide outstanding care in the best place at the right time	Empower and support our people to be the best they can be	Improve health and wellbeing within our communities	Continuously learn and improve	Sustainable use of resources and estates	Work collaboratively with partners in the community
X	**X**		**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	Failure to achieve the Trust's financial strategy	**X**
PR5	Inability to initiate and implement evidence-based Improvement and innovation	
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

The People Committee

Acronyms

ARCP – Annual Review of Competency Progression
BMA – British Medical Association
SAS – Specialty Doctor and Associate Specialist/Specialist
CESR – Certificate of Eligibility of Specialist Registration
NETS – National Education and Training Survey
ED – Emergency Department
EAU – Emergency Assessment Unit

Executive Summary

The Board of Directors is asked to note the updates provided in this paper, specifically around;

- the progress with job planning, statutory appraisal and revalidation
- the progress being made to recruit to the vacancies and the support that is being provided by Remedium Partners
- the challenges that have been experienced as a resultant of BMA Industrial Action

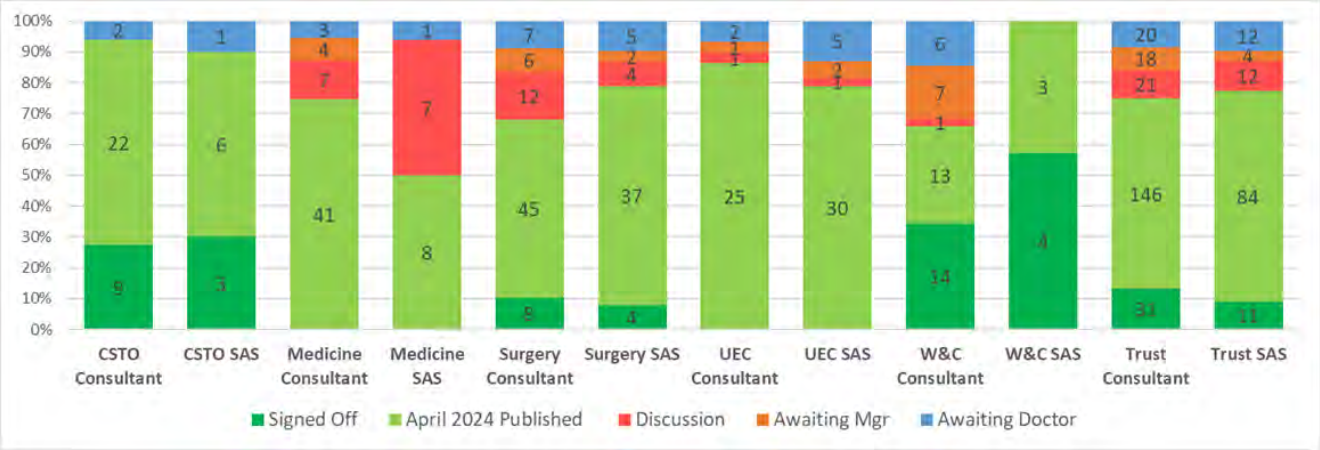
- the increase in the medical workforce numbers and the composition of our medical workforce
- The summary of the educational feedback NETS and GMC Surveys
- the implementation of revised bank rates for Specialty Doctors, Trainees, Senior Clinical Fellows and Clinical Fellows
- The delay in the doctor's mess re-location project

Looking after our People

Job Planning

As the job planning round for 2023/24 ends, with 55 job plans awaiting full sign off from April 2023, the job planning round for 2024/25 is now underway. There are a small number of services that continue to require further support to obtain full sign-off for the job plans. In particular, those that have had a large number of in year changes, with 37 still going through the sign off process.

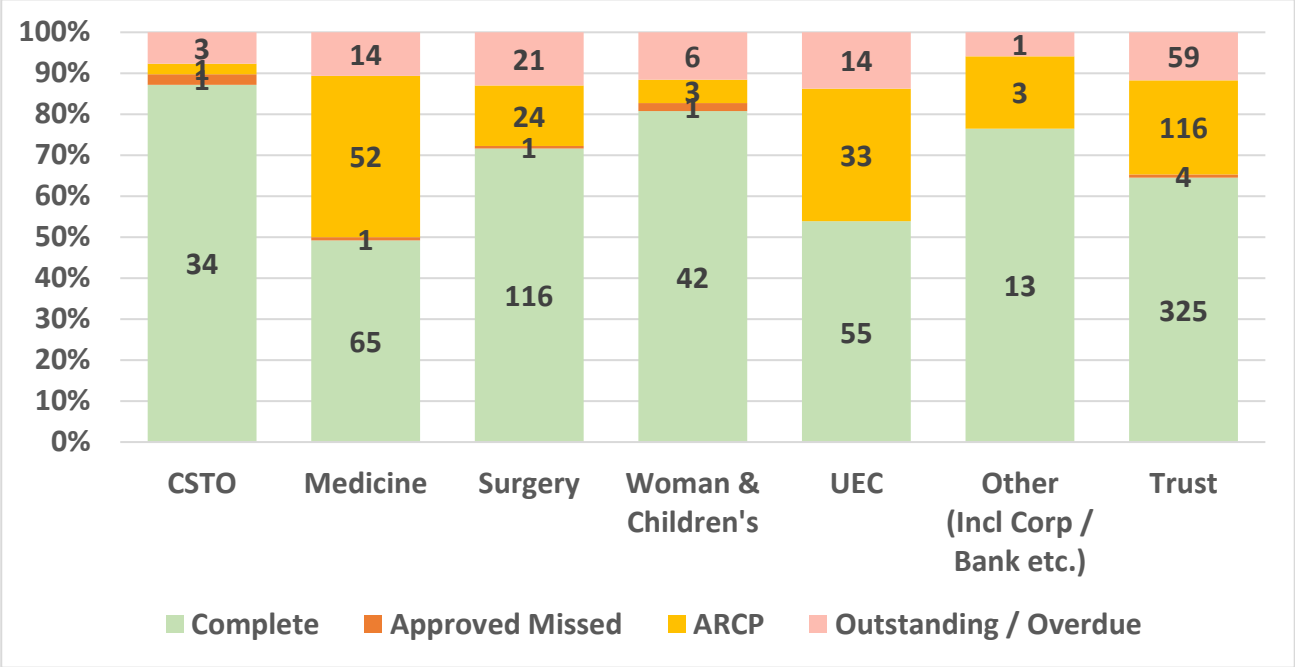
Some Divisional Job Planning Panels for 2024/25 round have already been held, and agreed sign off for some areas, with more Panels to take place in the coming weeks. The current position for April 2024 can be seen below.



Appraisal

As we move into Spring, the required numbers of appraisals due to be completed each month increases, in March in particular. So, the compliance rate for appraisal completion has held steady at 87% for a few months, this increased requirement may result in a slight decline in April. Industrial action has impacted on the completion rates throughout Winter, as we would have normally seen an upturn in February, which did not occur.

The Trust currently has 25 appraisers undertaking appraisals; however, this number will increase as 8 individuals attended an Appraiser training session and they will start to appraise colleagues from 1st April 2024, which will increase the capacity and is also likely to improve the compliance rate.

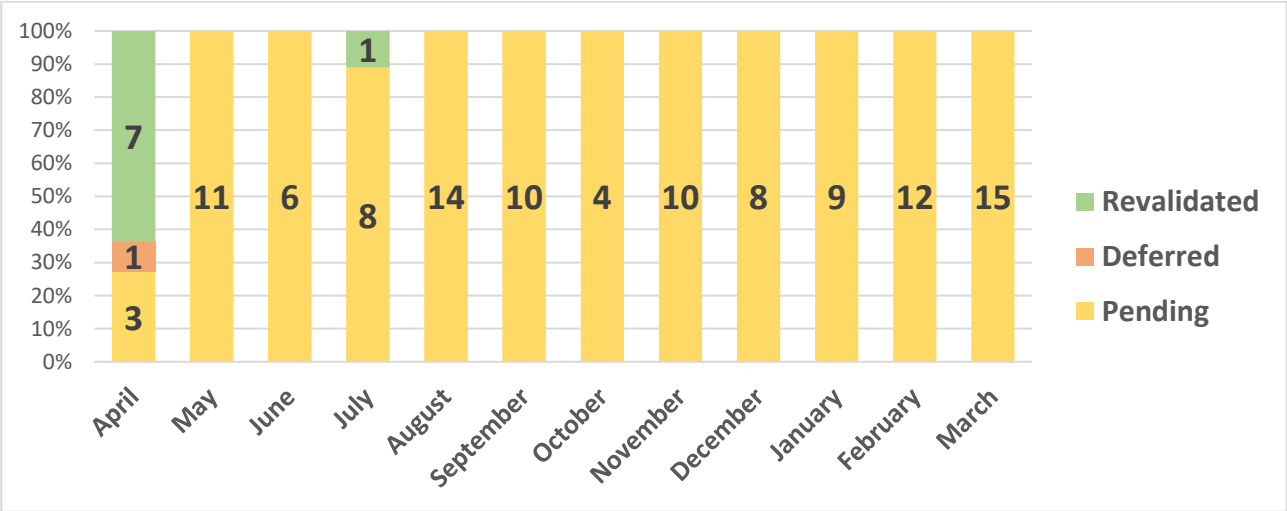


GMC Revalidation

63 doctors were due to revalidate between April 2023 and March 2024. Of those, 12 doctors have been deferred. This is due to several reasons, including not having patient feedback outputs and extended periods of leave such as maternity leave and/or sickness. All others have been revalidated.

Between April 2024 and March 2025 there are 120 doctors that are due to revalidate. 8 of which have been revalidated.

2024/25 Revalidation Tracker



BMA Industrial Action

There have been over 12 months of BMA Industrial Action. This included 10 junior doctor strikes, unprecedented joint consultant and junior doctor strikes and a 6 day strike recognised as the longest strike in NHS history.

The most recent were periods of industrial action taken by the Junior Doctors with two periods of industrial action over the Christmas period, those being from 7am on 20th December 2023 until 7am

on 23rd December 2023 and from 7am on 3rd January 2024 until 7am on Tuesday 9th January 2024. A further period of industrial action took place from 7am on 24th February 2024 until 11.59pm on Wednesday 28th February 2024.

There were no picket lines at the Trust during these periods of industrial action.
The Trust has continued to support with a well-being offer including tea, coffee, cold drinks and snacks in the Deli Marche at the Kings Mill Site and refreshments have also been made available at both Newark and Mansfield Community Hospitals.

The mandate for strike action has now expired and the junior doctors held another ballot from 7th February until 20th March 2024. 98% of those that voted were in favour of extending their mandate for industrial action over pay for another six months. We have no further updates currently on planned Junior Doctor Industrial Action.

A pay deal has been offered to both the SAS doctors and the Consultants, however, after initially rejecting the deal, Consultants have now accepted a revised deal. However, talks are continuing with SAS doctors.

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

There are also concerns about the impact that strike action is having on junior doctor training. Following direction of the Board, I have asked our local NHSE (Education) Postgraduate Dean for any assurance around training outcomes but this is not currently captured nor available. Subsequently, I have asked NHSE Director of Education and Training, Professor Sheona MacLeod if this data is being collated or captured by NHSE.

Clinical Fellows

It has been agreed to over recruit Clinical Fellows in Medicine again for August 2024. This recruitment has commenced, interviews have taken place and offers made to the doctors for August. As in previous years, this will enable the training posts that have not been filled by trainees to be filled by Clinical Fellows. In addition, there will be Clinical Fellows available to provide additional cover over the winter period.

This process is also being considered in some areas in Surgery, Anaesthetics and Critical Care where there is a pattern of posts not being filled by trainees.

Foundation Training Programme Expansion

The Trust has been invited to bid for additional Foundation Training Programme posts, the posts will have almost 50% of the basic salary funded by NHSE. A paper has been produced for the Trust Management Team to consider a bid of 12 Foundation Year 1 doctors in August 2024. Although having these doctors will be a cost pressure in 2024/25, in 2025, the 12 Foundation Level 2 doctors would potentially reduce the number of Clinical Fellows, therefore recovering the majority of the cost incurred in 2024/25. Further discussions around this proposal are currently occurring.

Medical Workforce Data

The figures below show the increase in the Medical Workforce since September 2017 when the Medical Workforce team was established. Since 2017 this Workforce has increased by 37%.

September 2017

448 Total

- 174 Consultant (including Locum)
- 11 Associate Specialists
- 49 Specialty Doctors
- 35 Clinical Fellows
- 174 Doctors in Training

April 2024

723 Total

- 237 Consultants (including Locum)
- 19 Associate Specialists / Specialists
- 104 Specialty Doctors
- 120 Clinical Fellows
- 243 Doctors in Training

Belonging in the NHS

Doctors Mess

Work to relocate the Doctors mess from its current location to the Deli Marche has unfortunately been delayed the most recent quotation for the works was a much higher cost than expected and as a result this has been scrutinised. The project is going ahead, and we are currently awaiting confirmation of a start date.

Medical Workforce Data

The Chart below shows the doctors that are employed by the Trust by contract type and gender split by full time/part time. There are currently 723 doctors employed by the Trust, this figure excludes doctors on the Trust bank. The majority 581 (80%) work full-time and 142 (20%) work part-time.

Medical Workforce

	Fixed Term Temp	Locum	Permanent	Grand Total
Female	**202**	**2**	**112**	**316**
Full Time	158	2	73	233
Part Time	44		39	83
Male	**199**	**17**	**191**	**407**
Full Time	178	13	157	348
Part Time	21	4	34	59
Grand Total	**401**	**19**	**303**	**723**

Consultants

The chart below concentrates on the Consultant workforce. It shows the age profile of the consultant body and as can be seen below 63 (27%) of consultants are 56 years of age and above. This group of doctors represents over a quarter of our consultant workforce therefore our very experienced doctors are likely to be considering retirement within the next few years and work is being undertaken to develop workforce plans in the specific areas that this is likely to affect.

	Fixed Term Temp	Locum	Permanent	Grand Total
31-35			1	1

36-40	6	3	24	33
41-45	5	4	40	49
46-50	6	5	39	50
51-55	4	2	32	38
56-60	3	2	32	37
61-65	4	2	12	18
66-70	2		6	8
>=71 Years			3	3

The chart below shows that we currently have 237 consultants employed by the Trust, 74 are female and 163 male, the chart also shows the full-time and part time split by gender and contract type. This also shows us that 73% of our consultant body work on a full-time basis.

	Fixed Term Temp	Locum	Permanent	Grand Total
Female	**6**	**2**	**66**	**74**
Full Time	5	2	40	47
Part Time	1		26	27
Male	**24**	**16**	**123**	**163**
Full Time	19	13	94	126
Part Time	5	3	29	37
Grand Total	**30**	**18**	**189**	**237**

SAS Workforce

The charts below concentrate on the SAS workforce. It shows the age profile of the SAS doctors and as can be seen below 21 (17%) of consultants are 56 years of age and above.

	Fixed Term Temp	Locum	Permanent	Grand Total
26-30	1			1
31-35			14	14
36-40	5		31	36
41-45	2		23	25
46-50	1		16	17
51-55			9	9
56-60			12	12
61-65	1	1	4	6
66-70			2	2
>=71 Years			1	1

The chart below shows that we currently have 124 SAS doctors employed by the Trust, 49 are female and 75 male, the chart also shows the full-time and part time split by gender and contract type. This also shows us that 84% of our SAS workforce work on a full-time basis.

	Fixed Term Temp	Locum	Permanent	Grand Total
Female	**3**		**45**	**48**
Full Time	3		33	36
Part Time			12	12
Male	**7**	**1**	**67**	**75**
Full Time	6		62	68
Part Time	1	1	5	7
Grand Total	**10**	**1**	**112**	**123**

Doctors in Training

The chart below shows that we currently have 243 Doctors in Training employed by the Trust, 146 are female and 97 male, the chart also shows the full-time and part time split by gender and contract type. This also shows us that 79% of our Doctors in Training work on a full-time basis.

	Total
Female	**146**
Full Time	109
Part Time	37
Male	**97**
Full Time	84
Part Time	13
Grand Total	**243**

Meetings with SAS Doctors

Individual meetings are currently taking place with Specialty Doctors, Associate Specialists and Specialists. These groups of doctors make up a key part of the medical workforce at Sherwood Forest Hospitals and following SAS week in October, a commitment was made to have quarterly meetings with them, in addition to meet with the doctors on an individual basis. The purpose of the individual meetings is to discuss their roles, the support available for them and to understand their career aims and understand their plans in place to realise these aims. This in turn enables the Trust to understand the numbers of SAS doctors that are currently working on the portfolio pathway/CESR with the aim of becoming a substantive consultant in the future, the likely completion of that programme and whether any support is needed to help the doctors achieve their aims.

These meetings are still ongoing and on initial verbal feedback, the doctors are finding the meetings extremely useful. A survey will be undertaken when the meetings have been concluded and the results included in the next medical workforce update. Those planning on, or already in the process of working on the portfolio pathway/CESR will be our core members of the Senior Medical Workforce of the future, and this rich data will inform our workforce planning model.

Doctors in Training Surveys

Both the GMC and the NETS (National Education and Training Survey) surveys have recently been undertaken by the Trainees. Following the GMC survey, 4 outlier areas were flagged: Anaesthetics, Surgery, EAU and ED. NHSE asked for responses from these four and were satisfied with the

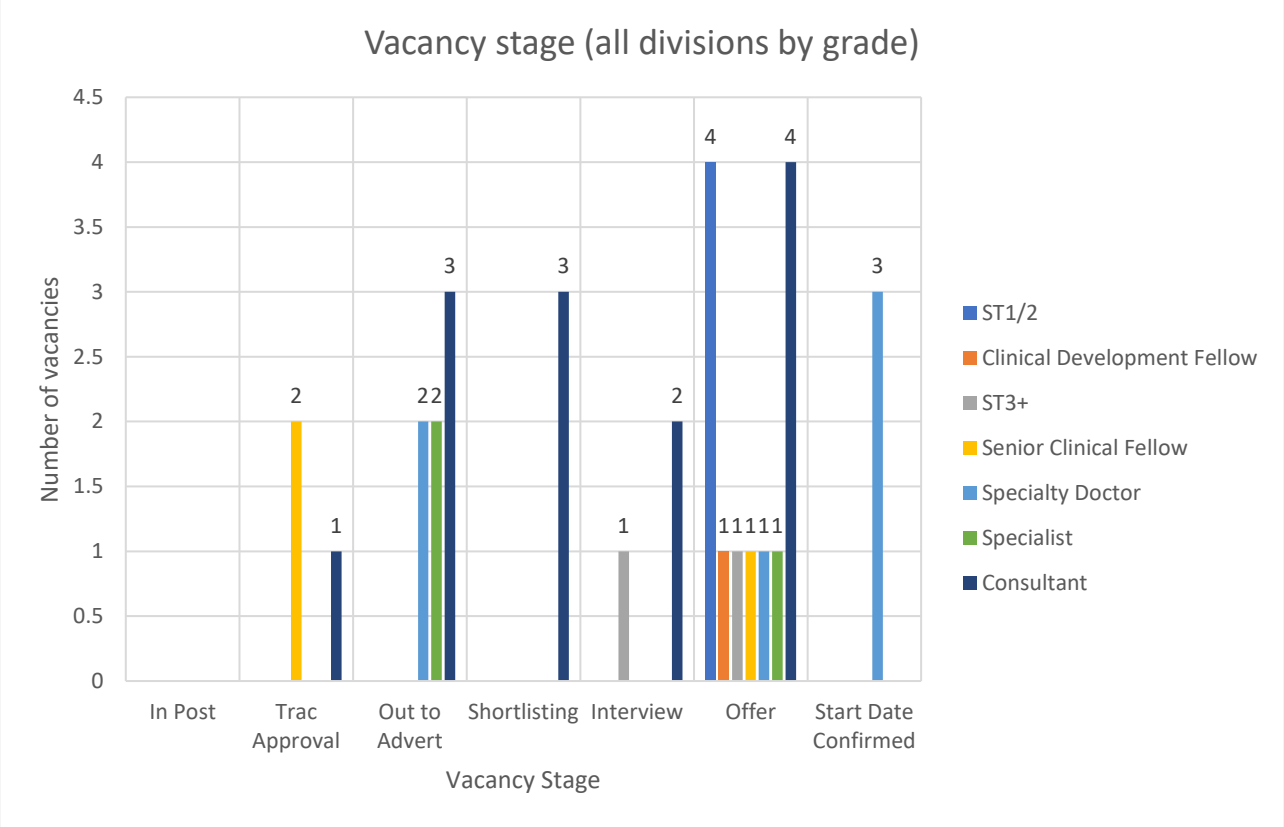
responses from ED, EAU and Surgery. They have requested to visit Anaesthetics and that visit will take place on 20th May 2024. There is a plan to review the results of the NETS survey to decide if further visits are required in the other 3 specialities.
On the recent NETS survey, concerns were flagged in General Surgery (for bullying and undermining) and Anaesthetics (for facilities available within the specialty). It is therefore suspected they will also want to visit Surgery, but they have yet to process the results and ask for requests for responses.
For the areas of concern, action plans are being developed in conjunction with the Medical Education Team to review. The area that is of most concern to the Medical Education team is EAU as that is a consistent concern from trainees regarding training, and patient safety. This specialty has also been featured in the Guardian of Safe Working Report. The issues that have been raised have come from a variety of sources (exception reports, conversations, surveys and Datix reports) providing some triangulation.

Some trials of different ways of working have taken place in this area including operating the Hospital Out of Hours processes in EAU, a business case has been submitted requesting additional support and some working practises have been changed which have included making the handover more formal, discussions are planned to understand the impact the changes in working practises have had on the Trainees.

In the surveys, there were some very high scoring Specialties, and they included Paediatrics which consistently is a high scoring Specialty, Radiology has also scored well. Obstetrics & Gynaecology have had a positive outlier flag in supervision which, considering last year's challenges within the Specialty locally is a good result. The Anaesthetic Foundation trainees have also provided excellent feedback for the department. A summary action plan and progress against the action plan will be provided in the next Medical Workforce Update.

New Ways of Working

Vacancies



The graph above shows the current recruitment position for 32 medical vacancies that we are actively recruiting across the Trust. As can be seen six offers of appointment have been made and start dates have been confirmed for four successful candidates. We currently have 12 interviews arranged across all grades.

The graph also shows that there are 13 consultant posts that are being actively recruited to.

Remedium Partners

Remedium Partners have been working closely with the Trust to support the recruitment of Medical posts. The Trust has also engaged with Remedium Partners in undertaking an executive search for Consultants in a number of areas that we are finding particularly difficult to fill at Consultant level, those areas being Stroke Medicine, Haematology and Anaesthetics. The executive search model targets doctors currently working as Consultants within these specialties to establish if they would be interested in coming to work at Sherwood Forest Hospitals. All three searches have commenced within the last few weeks, therefore Remedium are currently undertaking a mapping exercise prior to contacting individual doctors.

Task and Finish Group progress

The Task and Finish Groups are progressing across the challenged services. In Anaesthetics, one Fixed term Consultant has been appointed, a Specialty Doctor who has submitted their CESR application has been appointed as an Acting Consultant pending them obtaining the outcome of their CESR, a substantive appointment has also been made and this is a joint post between Sherwood Forest Hospitals and Sheffield Teaching Hospitals. One appointment has also been made to a Specialist post, which was an internal appointment. A number of vacancies still remain at both Consultant level and Specialty Doctor level in this specialty. Therefore, work is ongoing in this area to support the recruitment to posts.

Stroke Medicine remains a very difficult to fill area to fill nationally, there are 17 vacancies at Consultant level across the East Midlands. We have recently recruited to a Specialist in Stroke; however, we have not had any success in recruiting to Consultant posts to date.

An appointment has been made to a Consultant post in Gastroenterology, this was an internal applicant who obtained their CESR, another colleague has also submitted their CESR application and they will be supported to become an Acting Consultant within the next few months.

Trust Bank Rates

The Trust implemented new bank rates for Specialty Doctors, Trainees, Senior Clinical Fellows and Clinical Fellows on 1st February 2024. These rates were bench marked against bank rates across the East Midlands. The bank rate card that was in place prior to the implementation of the new rates was implemented in 2020 and these rates were not being adhered to, as market forces dictated the amount paid in each area. The revised rate card is fair and equitable across all specialties.

Conclusion & Recommendations

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

- the progress with job planning, appraisal, and revalidation
- the progress being made to recruit to the vacancies and the support that is being provided by Remedium Partners
- the challenges that have been experienced by Industrial Action
- the increase in the medical workforce numbers and the composition of the medical workforce
- The summary of the NETS and GMC Surveys
- the implementation of revised bank rates for Specialty Doctors, trainees, Senior Clinical Fellows and Clinical Fellows.
- The delay in the doctor's mess re-location project.

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Audit & Assurance Committee Chair's Highlight Report to Board

Subject:	Audit and Assurance Committee	**Date**	18th April 2024
Prepared By:	Manjeet Gill		
Approved By:	Manjeet Gill		
Presented By:	Manjeet Gill		
Purpose:			
Assurance report to Board		**Assurance**	Substantial Assurance

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
First follow up implementation rate of IA actions is 72% against the target of 75% with resulting impact on the HOIA Opinion. Positive Assurance on lessons learned and planned actions to strengthen the internal processes to track progress.	A Review of the Committee effectiveness process will look at how this could be developed alongside the Committee Maturity Review planned this year.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Interim Head of Internal Audit Opinion for 2023/24 received and will inform the Annual Governance Statement when finalised. Progress update on the draft Annual Report and Annual Governance Statement (AGS) preparation. Register of Conflicts of Interest. Assurance received on the process and that no breaches had been identified. Positive progress reported on timely renewal of non-clinical Trust policies. Medicines Stocktake and process for control. Progress with draft Annual Accounts and the Going Concern statement, Valuation Process, Accounting Policies and Standards and IFRS16 and how that impacts on our PFI accounting, with no impact compared to the previous IFRS15 standard. Losses and Special payments, with assurance on how to improve debt collection and prevent debt.	The updates to the Standing Financial Instructions and Scheme of Delegations were approved and a recommendation agreed for them to be ratified by the Board of Directors at its meeting in May 2024.

Employment Tribunal Settlement. The process, decisions and lessons learnt. Data Security Protection Toolkit. Assurance on progress with indicators showing 83/108 complete as at 17.04.24 with training compliance on track to achieve 92%. Assurance received on the timeline and progress of the current 2023/2024 Quality Account	

Comments on effectiveness of the meeting

Well-presented reports and assurance, helping understanding of some complex accounting and governance standards, in order to effectively carry out assurance role.

Items recommended for consideration by other Committees

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

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Board of Directors - Public

Subject:	Audit and Assurance Committee Annual Report	**Date:**	2nd May 2024
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Manjeet Gill, Audit & Assurance Committee Chair		
Presented By:	Manjeet Gill, Audit & Assurance Committee Chair		

Purpose		
Consider and receive assurance from the presentation of the Audit and Assurance Committee Annual Report.	**Approval**	
	Assurance	✓
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Audit and Assurance Committee – 21st March 2024

Acronyms

Executive Summary

The attached Audit and Assurance Committee Annual Report outlines the principal review areas and activities carried out by the Committee throughout 2023/24.

The Committee is of the opinion that this annual report is consistent with the draft AGS, Head of Internal Audit Opinion and the external audit review and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

The report concludes that the Committee has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

Committee members are requested to note the report.

Audit and Assurance Committee Annual Report 2023/24

Introduction

The Audit and Assurance Committee is established under Board delegation with approved terms of reference aligned with the *Audit and Risk Assurance Committee Handbook*, published by the Department of Health.

The Audit and Assurance Committee membership comprises wholly non-executive directors with executives and others in attendance.

The Committee was chaired by Graham Ward, a Fellow of the Institute of Chartered Accountants (England & Wales) with extensive financial expertise, until July 2023, after which he remained as a Committee member with Manjeet Gill becoming Committee Chair.

Other changes to membership were made, commencing from the September meeting.

Attendance at meetings is detailed below:

Graham Ward	7/7
Manjeet Gill	3/4 (from September 2023)
Barbara Brady	2/3 (until July 2023)
Steve Banks	6/7
Andrew Rose-Britton	4/4 (from September 2023)

According to the Terms of Reference, the Chief Executive and other executive directors are invited to attend the Audit and Assurance Committee meeting as and when required, but particularly when the Audit and Assurance Committee is discussing areas of risk or operation that are the responsibility of that director.

Objectives for 2023/24

The Committee's agreed objectives for 2023/24 were:

- Maintain the review and control processes currently in place, including a strengthened focus on internal audit actions implementation tracking and improving the implementation compliance rate

- This has been achieved by the Committee fulfilling its work plan and maintaining oversight of processes

- Maintain focus and review of the compliance rate of the Register of Interests
  - The Register of Interests report is a standing item on the Committee agenda for each meeting – there is evidence of significant improvement in compliance across the Trust and strengthened processes and procedures to address non-compliance; details of progress are noted in the 'Conduct and behaviour policies' section below

- Maintain oversight of Integrated Care System updates pertinent to the Trust and gain assurances from the ICB sub-committees
  - 'Integrated Care System update' is a standing agenda item for each Committee meeting, and the Committee received a report on ICS System Risk Management Arrangements at the January 2024 meeting

- Ensure the alignment of trust internal control processes with the outcomes of the Hewitt report on governance within Integrated Care Systems
  - Relevant controls are in place with the approval of the new Trust Strategy, and the establishment of the new Partnerships & Communities Committee with the role including "*assess key updates from strategic forums in the System*", "*analyse gaps in partnerships arrangements and propose options for solutions*" and "*assess the impact of the Provider Collaborative at Scale and monitor the effectiveness of the Trust's response*"

- Ensure Trust alignment of governance processes relating to provider collaboratives and other strategic partnerships
  - The Trust established a Partnerships & Communities Committee in November 2023, with the principal purpose of providing assurance that the Trust is progressing and developing partnerships to contribute to delivery of the Trust strategic objectives and to assess the priorities and benefits from strategic partnerships

Principal review areas

This annual report is divided into five sections reflecting the five key duties of the Committee as set out in the terms of reference.

1. <u>Governance and internal control</u>

   The Committee reviewed relevant disclosure statements for 2022/23, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit opinions (Financial and Quality Accounts) and other appropriate independent assurances and consider that the AGS is consistent with the Committee's view on the Trust's system of internal control. Accordingly, the Committee supported Board approval of the AGS.

2. Internal audit

Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Committee has also in year:

- Reviewed and approved the internal audit operational plan for 2024/25 and more detailed programme of work initially and then on an on-going basis to take into account the impact of operational pressures, while ensuring the provision of the internal audit service continued to be sufficient in supporting the Committee in fulfilling its role

- Considered the major findings of internal audit and are assured that the Head of Internal Audit Opinion and AGS for 2022/23 reflect that no significant internal control issues were identified

- Invited lead directors of any internal audit reports issued with Limited or Moderate Assurance to attend Committee meetings, present the report and provide assurance that actions will be implemented within agreed timescales

- Worked with colleagues internally and externally to address under-performance regarding the provision of evidence and the achievement of internal audit actions, and the impact of operational pressures on timely completion of actions

- Regularly reviewed outstanding audit actions, and are assured that a robust progress monitoring process is in place - Committee members noted an improvement in compliance towards a 'Significant' Head of Internal Audit Opinion for this element

3. Counter Fraud Service

The Committee received regular progress reports on activity conducted as part of the agreed Counter Fraud Work Plan, including:

- Counter Fraud Annual Report for 2022/23 – presented in June 2023
- Updates on investigations (at each meeting)
- Conflicts of Interest reports and Declarations of Interest Register reviews at each meeting
- Periodic risk assessments in line with Counter Fraud Functional Standards

Committee members noted full compliance with the 2023 Counter Fraud Functional Standard Return.

4. External audit

The Committee reviewed and agreed the external audit annual plan for the 2023/24 accounts. An area of KPMG's audit focus this year is on arrangements for the PFI

transition to of IFRS 16 (leases), which will be fully adopted for the first time within the 2023/24 accounts.

The Committee reviews and comments on reports prepared by external audit and receives their advice on areas of specific expertise.

5. Management

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year.

6. Annual Report and Accounts

The Committee received schedules and assurance of processes in place to satisfactorily produce the Annual Report, Quality Account and Financial Accounts.

As part of the year-end process and approval of the 2022/23 accounts for the Board for ratification, the Committee reviewed and took into account:

- The Head of Internal Audit Opinion on both financial and non-financial matters
- External audit opinion on the accounts and value for money opinion
- Representation letter from the Chief Executive Officer to external audit
- Going Concern Statement, to assure themselves of the effective financial and non-financial propriety of the Trust

The following significant risks highlighted within the financial statements were noted:

- Fraud risk from expenditure recognition – completeness and accuracy
- Management override of controls
- Valuation of Land and Buildings

The auditors have rebutted the significant risk relating to revenue recognition due to the nature of the revenue within the Trust.

Other areas of focus

Conduct and behaviour policies

Regular reports of the Register of Interests compliance were received during the year.

It was noted that the number of non-compliant staff had decreased during the year (to 51 in March 2024 from 96 in March 2023), reflecting the continued focus in this area and the process in place.

Cost Control and Financial Governance reviews

Throughout the year the Committee received reports on Single Tender Waivers, Losses and Special Payments, gaining assurance on value for money and probity within controls.

Information Governance

The Committee has received update reports on Information Governance and members noted that from the Data Security Protection Toolkit (DSPT) Final Submission (June 2023), all standards were achieved, and the overall score was 'Standards Met'. The auditors undertook an audit of the 10 National Data Guardian Standards in the DSPT and provided an assessment of 'Substantial' for 7 standards and 'Moderate' for 3, giving an overall risk assurance of 'Moderate'.

Governance documents

Reports of non-clinical policies reviews were received, and focus has been maintained to address those past their review dates. The number of overdue policies has significantly reduced during the year to 2 (from 7 in March 2023).

Other areas of assurance

The Committee received updates on Risk Committee items for escalation, a Speaking Up Activity update, the Procurement Annual Report, and a Clinical Audit Planning Process report.

In addition, the Committee received a report on ICS System Risk Management Arrangements in January 2024, and the Board Assurance Framework bi-annually, to provide assurance on the review process.

HFMA Financial Sustainability Audit updates, detailing the progress against the action plan from the Trust's self-assessment, were received in April June and September 2023 and provided assurance on the process followed to ensure SFHFT was adequately addressing the areas for improvement.

Review of the effectiveness and impact of the Audit and Assurance Committee

The Committee has been active during the year in carrying out its duty in providing the Board with assurance that effective internal control arrangements are in place.

An annual Committee self-assessment was completed by the non-executive director members of the Audit and Assurance Committee, from which no significant issues were identified.

Cost/benefit analysis

It is not possible to accurately quantify the benefits of the work of the Committee during the year as it is impossible to determine the financial impact of risks mitigated and costs avoided, and the proportion of these that could be apportioned to the Committee work. However, the current and future costs associated with loss of reputation have been mitigated as a result of the work performed by the Committee.

Conclusion

The Committee is of the opinion that this annual report is consistent with the draft AGS, Head of Internal Audit Opinion and the external audit review and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

The Committee has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

Objectives

The Committee's objectives for 2024/25 are:

- Maintain the review and control processes currently in place, including a strengthened focus on internal audit actions implementation tracking and improving the implementation compliance rate
- Maintain focus and review of the compliance rate of the Register of Interests and timely reviews of non-clinical policies
- Maintain oversight of Integrated Care System updates pertinent to the Trust and gain assurances from the ICB sub-committees
- Ensure the alignment of trust internal control processes with the outcomes of the Hewitt report on governance within Integrated Care Systems
- Ensure Trust alignment of governance processes relating to provider collaboratives and other strategic partnerships

Manjeet Gill

Audit and Assurance Committee Chair

March 2024

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Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:** 2 May 2024	
Prepared By:	Graham Ward – FC Chair		
Approved By:			
Presented By:	Graham Ward – FC Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee meeting of 23 April 2024.		**Assurance**	Significant

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• FIP – concern that £6.5M of the 2023/24 FIP delivered was non-recurrent, put together with the current FIP target for 2024/25 of £27.1M equates to a full requirement this year of £33.6M (over 6%). For NOTING. • CDC – the temporary facilities must be maintained for 2024/25 until the new CDC is completed (otherwise Trust performance will be materially impacted), yet it remains unfunded due to a technicality. ACTION: recommend that a letter from the Board go to the ICB and Region. • Month 12 Finance Report – The draft deficit for the full year is £11.6M, £3.1M adverse to the H2 Re-submission, due to the non-payment of £5.5M re CDC, offset by a gain of £2.4M on PDC. Key issue for NOTING: o Concerns continue with respect to cash, exacerbated by the non-payment of the expected CDC income (cash pressure in 2024/25 of £39M). • 2024/25 Planning – Good progress but NOTE CDC risk above, FIP requirement of £33.6M and starting underlying deficit of £22M.	• FIP, Agency/Bank Expenditure, Productivity and Cash – All to be subject to deep dives as part of the May Informal Committee Meeting. • Sustainability – Not assured on progress and lack of a strong communication strategy. • Month 12 Finance Report – waterfalls to be prepared to show underlying deficit and extent of cask risk for sharing with Committee and Board. • 2024/25 Planning Update – Table of compliance and comments to include a risk of delivery column, together with further comments.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• FIP – Process to identify, manage and deliver well worked through including quality impact assessments and linkages to People and Quality Committees. • Agency and Implied Productivity – reviewed background information ahead of deep dive in May. • NHSE and ICB Updates – positions noted. • Month 12 Finance Report – Finance team and Trust, as a whole, were	• Treasury Management Policy – Approved • Workplan – Approved subject to addition at the end on informal meetings. • Terms of Reference – Approved subject to addition of sustainability. • BAF – agreed to hold PR4 (financial Strategy) at 16 and to recommend an increase in PR8 (Sustainability) to 12.

congratulated on being on track to deliver the revised 2023/24 financial outturn, before the impact of the CDC funding withdrawal. • Procurement – noted the forward programme and move towards greater collaboration with NUH and NHT. • PFI Settlement – continuing to progress, though on fire safety the impact of the new Building Safety Act is still being determined. • Internal Audit Reports – reports on Procurement, and Budget Setting, Reporting & Monitoring were presented. Both reports were issued with significant assurance and assured that recommendations were on track to be implemented by agreed dates. • Strategic Priorities – Q4 position and progress noted.	
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	
• Audit Committee to be appraised that the 2 internal audit reports were reviewed and actions to implement discussed. • Quality and People Committees to note their inclusion in the 'governance' around the FIP programme. Committee chairs to discuss whether any 'joint' meetings may be required.	

Annual Report from the Finance Committee 2023

1. Summary

This report provides an overview of risk management activities undertaken throughout the Trust and a summary of the work undertaken within the Finance Committee activities from January to December 2023, for assurance that the Committee has carried out its obligations in accordance with its Terms of Reference and work programme for 2023.

The time period is aligned to the annual governance timetable to enable consideration by the Audit & Assurance Committee and the Board of Directors, and to support the Annual Governance Statement.

2. Background

The Finance Committee meets not less than 6 times a year and reports to the Board of Directors. Its Terms of Reference establish that its role is to conduct independent and objective reviews of financial and investment policy and performance issues.

The Committee's membership is set out below:

- Three Non-Executive Directors one of whom nominated as Chair and one as Vice Chair. The Chair of the Committee is appointed by the Board of Directors
- Chief Executive
- Chief Financial Officer
- Chief Operating Officer
- Associate Director of Estates & Facilities

Also in routine attendance:

- Deputy Chief Financial Officer
- Associate Director of Transformation (Deputy Director of Strategy and Partnerships from November 2023)*
- Governor observers

**A Strategy and Partnerships Leadership Team was established during 2023, the Committee therefore agreed that from November 2023, attendance from that Team would be the Deputy Director for Strategy and Partnerships (replacing the Associate Director of Transformation).*

Other Directors and Managers have attended meetings in accordance with the Committee work programme and/or in response to specific issues being identified.

3. Meetings

The Committee has held 12 meetings during the period covered by this report.

Attendance of core members (or a nominated deputy) at meetings during the period covered by this report is detailed below:

Non-Executive Director ** (Chair Jan-Aug, Vice Chair Nov-Dec)	12/12
Non-Executive Director ** (Vice Chair, Jan-Aug, Chair Sep-Dec)	12/12
Non-Executive Director ** (Jan-Aug)	5/8
Non-Executive Director ** (Dec)	1/1

Chief Executive	12/12
Chief Financial Officer	12/12
Chief Operating Officer	8/12
Associate Director of Estates & Facilities	9/12

*** A review of roles and responsibilities of Non-Executive Directors was undertaken by the Board of Directors in September 2023, this led to a new Chair and Non-Executive Director Member being identified for each Sub Committee. A new Vice-Chair was approved by the Finance Committee at its November 2023 meeting along with the appointment of a new Non-Executive Director in December 2023. The above reflects the changes in roles and responsibilities.*

In 2022 the Committee agreed that the 2023 meetings would be scheduled on a monthly basis over the calendar year with a limited agenda in place for 6 of those meetings in order to consider specific items warranting focused discussion.

In September 2023 the Committee agreed that in between the formal reporting of the BAF (as per the work programme) an informal review would take place at each meeting to ensure updates were captured in line with discussions/actions agreed.

4. Work Programme

The Committee has received regular reports throughout the year in accordance with its agreed Annual Work Programme. A series of regular reports are received from Committee members in respect of:

- Monthly Financial Performance Report (including Financial Improvement Programme and Agency Performance)
- PFI Governance
- Nottingham & Nottinghamshire ICB/ICS and NHS England Updates
- Procurement Forward View
- Board Assurance Framework (BAF) – Principal Risk 4 and Principal Risk 8

The Committee has also received reports on the following specific matters:

- Financial Recovery Cabinet Update
- Financial Planning and Budgeting
- Financial Strategy
- Nottinghamshire Health Informatics Service (NHIS) quarterly performance
- Capital Planning
- Trust Strategic Priorities Updates
- Terms of reference review (March 2023 and June 2023)
- National Cost Collection submission
- Internal Audit Reports
- Capital Resources Oversight Group Quadrant Report
- Sustainability Development Strategy Group Quadrant Report

5. Approvals

The Trust Scheme of Delegation describes the Committee has delegated authority from the Board of Directors to approve revenue and capital expenditure up to the value of £1.0m.

The Governance process requires Finance Committee approval of all expenditure in excess of £250,000. Expenditure above the £1.0m threshold requires the final approval of the Board.

In accordance with this the Committee has considered and approved the following:

- GP IT Refresh
- Discharge Lounge Capital Fund Draw Down
- Appointment of Trust Energy Suppliers
- NHIS ICB Spend (Notes Scanning)
- Health and Social Care HSCN Contract for recommendation to the Board of Directors
- P2G Purchase Order
- EPR Outline Business Care for recommendation to the Board of Directors
- Public Sector Decarbonisation Scheme Funding Investment
- Extension to Patient Knows Best (PKB) Contract
- Mobile Endoscopy/CT Unit Lease Extension
- Extension to Managed Service for Urology Theatres for recommendation to the Board of Directors
- Extension to the Microbiology Managed Service Contract for recommendation to the Board of Directors
- Imaging Transformational Additional Asset Bid
- Renewal of Byron Court Lease
- Nottingham CitiCare Partnership IT Refresh
- Implementation of Endoscopy Service Capital and Revenue Bids
- Lease of Relocatable MRI Scanner for recommendation to the Board of Directors
- Level 2 Paediatrics Business Case
- PAS Contract
- Clinical Research Facility Capital
- Phoenix Team Recruitment

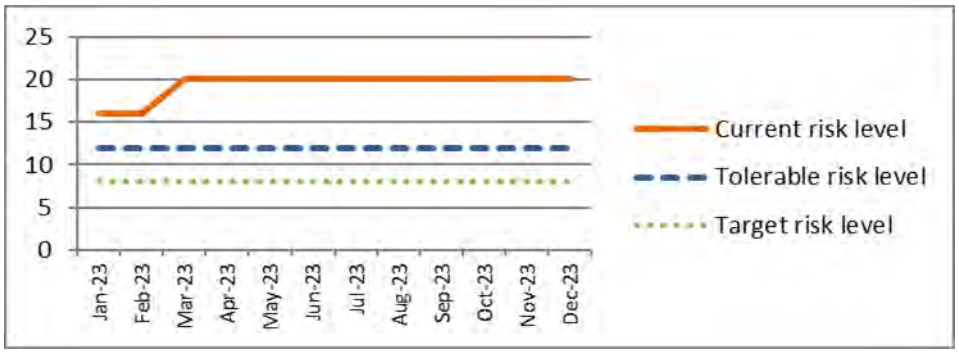
The Committee has also reviewed and approved the following business items:

- Capital Programme 2023/24 (and reprioritisation) for recommendation to the Board of Directors and 5-Year Capital Plan
- Revenue Borrowing and Cash Submissions (under delegated authority by Board of Directors)
- EPR Procurement Strategy and Approvals Process
- NHIS Strategy
- Budgetary Control Process
- PFI Settlement Deed for recommendation to the Board of Directors

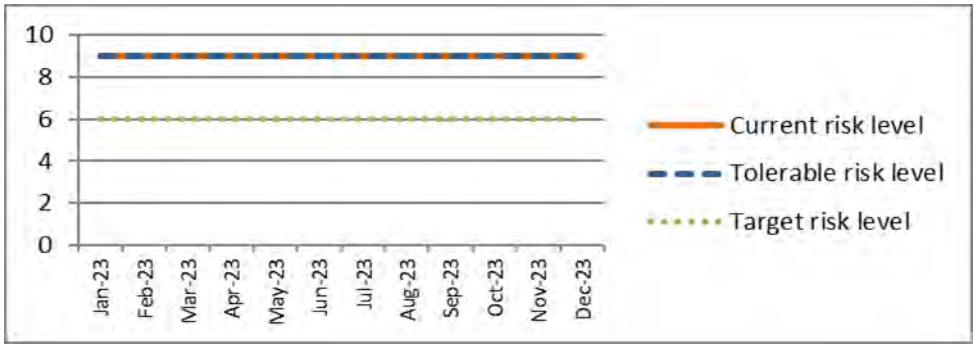
6. Board Assurance Framework

The Committee reviews BAF Principal Risk 4 (Failure to maintain financial sustainability) and Principal Risk 8 (Failure to deliver sustainable reductions in the Trust's impact on climate change) at each meeting.

The risk rating of PR4 was increased to 20 (Significant) at the March 2023 meeting of the Committee, reflecting the increased likelihood of regulatory action in relation to the financial performance of the Nottingham & Nottinghamshire ICS. This included a Consequence score of 4 (High) and a Likelihood score of 5 (Very Likely). This has remained throughout the year.



The risk rating of PR8 has remained at a 9 (Medium) throughout the financial year. This includes a Consequence score of 3 (Moderate) and a Likelihood score of 3 (Possible).



7. Committee Effectiveness Review

The Committee carried out an Effectiveness Review which was reported in February 2023. The review was based upon the National Audit Office Committee Healthcheck and is to help review governance arrangements, check appropriate systems are in place and to identify areas for improvement.

The self-assessment tool considered 16 criteria and the Committee reported that each was fully met. Evidence to support this assessment was reported, one action was required 'outline updates on the longer-term financial strategy to be incorporated into the Committee Workplan'. This has been incorporated into the Workplan for future meetings.

8. Matters for Escalation

At the end of each Committee meeting items for escalation to the Board of Directors are identified. Throughout the year, at various points in time, these have included:

- Approval of business cases, or support for cases requiring ratification by the Board, as detailed in Section 5 of this report.
- Financial performance, financial position and forecast outturn updates for financial years 2022/2023 and 2023/2024, including agency expenditure and cash position updates and financial performance of the Nottingham & Nottinghamshire ICS.
- Financial planning and budgeting updates, including risks and NHS England context.
- The approach to financial recovery, and updates from the Financial Recovery Cabinet.
- NHS England correspondence.
- Procurement activities, including future contract requirements.

- Transformation & Efficiency updates, including Financial Improvement Programme (FIP) plans and performance updates (as part of the Monthly Finance Report).
- Board Assurance Framework (BAF) assurance updates, relating to Principal Risks 4 and 8.

A quadrant report highlighting these escalations is prepared for the Board of Directors Meeting in Public, following each meeting of the Finance Committee. In addition to the matters for escalation, this details areas of positive assurance, work commissioned and decisions made.

In addition to escalations to the Board of Directors, in October 2023 the Finance Committee also introduced matters be identified as escalations to the ICB. These included:

- The agreement to extend Byron Court lease and request to explore with partners alternative options for consideration over the next 3 years.
- Noting of the Financial Recovery work underway within the identified Workstreams.
- Inpatient MRI capacity business case.
- Update on ED business case for assurance.
- The Trust cashflow position.
- The approach being taken to support the Phoenix Team work.
- Opportunities and improvements identified through the 360-assurance work on wider transformation across the ICB.

9. Conclusion

The Committee self-assessments of compliance with Terms of Reference, the review of effectiveness, the robust work programme and escalations to Board of Directors provide assurance that the Committee continues to be effective in discharging its responsibilities.

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

Subject:	Quality Committee Meeting	**Date:**	22nd April 2024
Prepared By:	Aly Rashid, Non-Executive Director		
Approved By:	Aly Rashid, Non-Executive Director		
Presented By:	Aly Rashid, Non-Executive Director		
Purpose:			
To provide an update to the Trust BOD following the Quality Committee Meeting on 22nd April 2024.		**Assurance**	**x**

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
- **No Medical Lead for Sepsis.** - **HSMR- Recognising the importance and complexity of the work being undertake, the committee raised questions regarding whether adequate resources were available to the team.** - **Timely Care paper to be provided to the QC in specific relation to trends in cancers diagnosed at stages 1-4.**	- HSMR- An approach has been made with regional peer Trust Dudley Group NHS Foundation Trust, who appear to have been on a similar journey in relation to elevated HSMR. The Trust will benefit from shared learning and support.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
- Verbal update in relation to breast services with a formal paper to be presented in the coming months. - Positive assurance gained in relation to HSMR, IPR, PSC, NMAHP and MAC papers. - Positive assurance provided following BAF Risk Score comparisons to other Trusts.	- APPROVED- Quality Committee Terms of Reference pending agreed amendments. - APPROVED- Quality Committee Annual Work Plan 2024/25, pending agreed amendments. - Invitation to be extended to the CQC for Quality Committee for transparency.

Comments on effectiveness of the meeting

High quality of papers provided, prompting a positive level of discussion and challenge.

Items recommended for consideration by other Committees

No

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Partnerships & Communities Chair's Highlight Report to Board of Directors

Subject:	Partnerships & Communities Quadrant Report	**Date:**	2nd May 2024
Prepared By:	Barbara Brady, Chair of Partnerships & Communities Committee		
Approved By:	Barbara Brady, Chair of Partnerships & Communities Committee		
Presented By:	Barbara Brady, Chair of Partnerships & Communities Committee		
Purpose:			
To provide an overview of the key discussion items from the April meeting of the Partnerships and Communities Committee		**Assurance**	

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
Ongoing challenge of resources required to support partnership work and the needed to constantly prioritise work	A single integrated delivery plan covering all the responsibilities of this committee
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
Latest version of the Delivery Plan Review of gaps in Partnership arrangements and next steps Population health overview with next steps	BAF, PR6 score raised to 8
Comments on effectiveness of the meeting	
Good meeting, high quality of papers enabled good discussion	
Items recommended for consideration by other Committees	
None on this occasion	

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