Sherwood Forest Hospitals NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: Thursday 2nd February 2023
Time: 09:00 – 12:30
Venue: Boardroom, King's Mill Hospital

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 5th January 2023** To be agreed as an accurate record	Agree	Enclosure 4
5.	09:05	**Action Tracker**	Update	Enclosure 5
6.	09:10	**Chair's Report**	Assurance	Enclosure 6
7.	09:15	**Chief Executive's Report** • **Integrated Care System Update** Report of the Director of Strategy and Partnerships	Assurance Assurance	Enclosure 7 Enclosure 7.1
	Strategy			
8.	09:30	**2022/2023 Strategic Priorities Quarter 3 Update** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 8
9.	09:45	**Strategic Objective 1 – To provide outstanding care** • **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 Priority 2 - To promote and support health and wellbeing** • **Freedom to Speak Up** Report of the Freedom to Speak Up Guardian	Assurance	Enclosure 10.1
11.	10:10	**Strategic Priority 5 – To provide better value** • **2023/24 Planning Guidance update** Report of the Director of Strategy and Partnerships	Assurance	Enclosure 11.1

	Time	Item	Status	Paper
12.	10:20	**Staff Story – It's OK not to be OK** Amy Gouldstone, People Wellbeing Lead and Jacqueline Read, Head of People Partnering and People Operations teams	Assurance	Presentation
	BREAK (10 mins)			
	Operational			
13.	10:50	**Single Oversight Framework Performance – Quarterly Report** Report of the Executive	Consider	Enclosure 13
14.	11:40	**Board Assurance Framework (BAF)** Report of the Chief Executive	Approval	Enclosure 14
	Governance			
15.	11:50	**Use of the Trust Seal** Report of the Director of Corporate Affairs	Assurance	Enclosure 15
16.	11:50	**External Well-led Review Recommendations Progress Report** Report of the Director of Corporate Affairs	Assurance	Enclosure 16
17.	11:55	**Assurance from Sub Committees** • Audit and Assurance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting) • Charitable Funds Committee Report of the Committee Chair (last meeting) • Finance Committee Report of the Committee Chair (last meeting) • People, Culture and Improvement Committee Report of the Committee Chair (last meeting)	 Assurance Assurance Assurance Assurance Assurance	 Enclosure 17.1 Enclosure 17.2 Enclosure 17.3 Verbal Verbal
18.	12:10	**Outstanding Service – Working in Partnership to help people Step into the NHS**	Assurance	Presentation
19.	12:15	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
20.	12:20	**Any Other Business**		
21.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **2nd March 2023, Boardroom, King's Mill Hospital**		
22.		**Chair Declares the Meeting Closed**		
23.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		

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

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

Enc 13	• **Safe Staffing reports**
Enc 14	• **Significant Risks report**
Enc 17.1	• **Audit and Assurance Committee – previous minutes**
Enc 17.2	• **Quality Committee – previous minutes**
Enc 17.3	• **Charitable Funds Committee – previous minutes**

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 5th January 2023 in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Graham Ward	Non-Executive Director	GW
	Barbara Brady	Non-Executive Director	BB
	Steve Banks	Non-Executive Director	SB
	Manjeet Gill	Non-Executive Director	MG
	Andrew Rose-Britton	Non-Executive Director	ARB
	Aly Rashid	Non-Executive Director	AR
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	David Selwyn	Medical Director	DS
	Shirley Higginbotham	Director of Corporate Affairs	SH
	Rob Simcox	Director of People	RS
	Richard Mills	Chief Financial Officer	RM
	David Ainsworth	Director of Strategy and Partnerships	DA
	Rachel Eddie	Chief Operating Officer	RE
In Attendance:	Sue Bradshaw	Minutes	
	Jessica Baxter	Producer for MS Teams Public Broadcast	
	Carl Miller	Deputy to the Chief Nurse/Director of AHPs	CM
	Paula Shore	Director of Midwifery	PS
	Grace Radford	Patient Experience Manager	GR
Observers:	Sue Holmes	Public Governor	
	Rich Brown	Head of Communications	
	Rhishana Edwards	Senior HR Assistant	
	8 members of the public		
Apologies:	Phil Bolton	Chief Nurse	PB

Item No.	Item	Action	Date
23/001	**WELCOME**		
1 min	The meeting being quorate, CW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and any members of the public watching the live broadcast were able to submit questions via the live Q&A function.		
23/002	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
23/003	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Phil Bolton, Chief Nurse. It was noted Carl Miller, Deputy to the Chief Nurse/Director of AHPs, was attending the meeting in place of Phil Bolton.		
23/004	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 1st December 2022, the Board of Directors APPROVED the minutes as a true and accurate record.		
23/005	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors noted there were no actions due for review.		
23/006	**CHAIR'S REPORT**		
3 mins	CW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective, highlighting the support of the local community in the run-up to Christmas and the donations received by the Trust. CW paid tribute to the Trust's staff for their work and dedication during what has been an incredibly difficult and pressurised time over the Christmas and New Year period. In addition, CW expressed thanks to the public and patients for their patience and understanding during this particularly difficult time. It was acknowledged the Trust does not always get everything right and there are challenges which are difficult to manage. However, the staff are doing everything they possibly can to deliver the best possible care in the circumstances. The Board of Directors were ASSURED by the report		

23/007	**CHIEF EXECUTIVE'S REPORT**		
37 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 Trust's work with West Notts College and developments at Newark Hospital, including a £5.6m investment in theatre provision. PR advised the national planning guidance for 2023/2024 and 2024/2025 was issued on 23rd December 2022. This contains three key priorities, namely, recovering core services and productivity, delivering the NHS long term plan ambitions and transforming the NHS. In December 2022, the Trust received notification from the Integrated Care Board (ICB) of the Strategic Oversight Framework segmentation for Q2. The Trust remains in segment 2 of 4 due to the support required to address the underlying financial deficit. PR confirmed the questionnaire which was received by the Trust in relation to the Covid-19 Public Enquiry has been completed and was submitted by the due date. PR congratulated Phil Bolton, Chief Nurse, on his appointment as Honorary Associate Professor in the School of Health Sciences at the University of Derby. PR highlighted the pressures on the urgent care system, advising the Trust and the system remain in a critical incident which was called on 29th December 2022, noting at 8am on that date 49 patients were waiting in ED for a bed. The Trust has opened further capacity and all patients have received face to face senior reviews. Actions are being taken to expedite discharge. PR advised the Trust is unable to sustain the current level of pressure without taking decisions to stand down non-urgent activity. PR confirmed cancer procedures and urgent care are protected. The Trust continues to review the Infection Prevention and Control (IPC) approach in terms of flu and Covid. Vaccination uptake continues to be encouraged. PR expressed thanks to Trust staff for their work. BB noted Mansfield District Council work as part of the Transfer of Care Hub, which has been established at King's Mill Hospital, and queried if they are acting on behalf of the three district councils in the area to ensure patients from Newark and Ashfield areas are receiving the same level of provision. DA advised this is not the case. Mansfield District Council have a handyperson scheme, whereby they can respond to requests to make home adaptations to allow patients to get home quickly. This is solely Mansfield. However, the aim is to work with the other two councils to get the same level of response. The Trust has strong relationships with the local councils and voluntary sector and the aim is to formalise the agreement going forward. BB queried if an evaluation of the Transfer of Care Hub is ongoing to ensure learning.		

	PR advised the Transfer of Care Hub at SFHFT was established as part of the system-wide response to transfers of care and will form part of the longer term evaluation. A transfer of care hub was established at Nottingham University Hospitals (NUH) approximately one month prior to the one at SFHFT. Evaluation and learning from the hubs will be across both organisations. DS advised he has requested a timely review of the impact of the Transfer of Care Hub, both in terms of the internal impact and the difference it has made in the wider system. A best practice review process is taking place on 5th January 2023, which involves the Hub. Therefore, there will be some early learning from this. GW advised he was aware of a number of frameworks being established by district councils for handyperson services. GW acknowledged the update in relation to Newark Hospital, noting the delivery of additional parking spaces and the funding for theatres. This provides a timely opportunity to look at the Newark Strategy. PR advised the Trust is pleased with the relationships which have been built with Newark and Sherwood District Council. AR noted some elective activity has been stood down and queried if consultants who are not operating have been redeployed to ED. DS advised all medical staff are working flat out. On 4th January 2023 the Trust was running 6 of 7 theatres, all of which was emergency activity. There were three trauma theatres and, therefore, orthopaedic surgeons are doing additional work. The only activity which has been stepped down is that which would free-up beds. Therefore, day case work has continued as far as possible and the impact on elective activity is limited. To date, no cancer or urgent cases have been cancelled. MG queried if there is anything members of the Board of Directors can do to help support the executives and wider workforce through the current challenges. PR advised the Executive Team are currently taking stock of the past 2-3 weeks in terms of how the Trust plays its role in the system and how the system collectively responds to the challenges of sustained pressure. There is a need to build a strategic future to cope with future demands. The Board of Directors will be kept updated and involved in terms of playing a wider role in building a strategic future through the provider collaboratives and working with acute and community colleagues. AH felt the debrief after the incident will be critical. AH queried what measures the Trust has in place to keep patients safe at a time when ED is overcrowded. DS advised the pressure on ED is repeated across the country. ED is built for a set number of patients, which is being exceeded. This means patients are waiting in cramped conditions and causes some difficulties for patient reviews. However, all patients are reviewed. The Trust has uplifted and maximised all medical and nursing staffing ratios, noting the recently approved business case for enhanced ED staffing. Nursing staffing ratios are good, but patients are ‘scattered’ which makes it difficult to ensure patients are getting timely care, comfort rounds, observations, etc. If patients are waiting in ED for prolonged periods, they will be put on a bed, rather than a trolley.		

	In terms of patient safety, to date there are no huge concerns, but there has been an increase in pressure ulcers and it is likely some patients may not get medications in a timely way. It is important to note that to date there have been no catastrophic events. However, there is a concern about the safety of staff due to the pressure they are working under. AH noted there have been reports in the press about patients being nursed in less than ideal environments, for example, corridors, store cupboards, etc., and queried if this is an issue for the Trust. DS advised the Trust does not do 'corridor care'. The Trust takes the view the highest risk to patients is holding ambulances. Therefore, everything possible is done to release ambulances back into the community as quickly as possible. However, this leads to crowding in ED. Patients are waiting in different areas, but not in corridors. Patients are cohorted as far possible and are as close to ED as possible. CM advised the Trust is aware harm does increase at times of increased activity, but there is a focus on the quality and safety agenda. The heads of nursing and matrons have been stood down from their normal activity to be more present on wards and the emergency pathway to ensure the risk of harm is mitigated as far as possible. Staff wellbeing is very important. Staff expect to be able to deliver a certain level of care, which is difficult to achieve at times of intense pressure. This is affecting staff. RS advised the wellbeing of the workforce is imperative and the Trust is taking a variety of steps to support this. A dedicated helpline has been introduced to enable staff to speak to a member of the People Team to get support. The additional steps being taken will start to form part of the core offer in the future to ensure the workforce can access support. DS advised he, together with RE and PB, spend every working hour maximising the safety of patients. It was acknowledged the care currently being provided is not what the Trust aspires to provide and this has an impact on staff. The letter from the Board of Directors to all staff was well received and staff recognise the Board of Directors understand the pressures and supports colleagues, as there is concern about working in the current conditions. PR advised there is a good understanding of where patient risk is and there is a focus on decompressing ED. There is a need to work together and reinforce the messages in the letter from the Board of Directors. There will be difficult clinical decisions to be taken and things which will test people individually, but it is important to take decisions as a team and for colleagues to understand they have the support of the Board of Directors in those decisions which are taken to reduce patient risk. SB noted the activities which are ongoing to maximise patient safety and felt the Trust is also under pressure to deliver financial targets and efficiencies and queried if any additional funding was available to support the increased costs.		

	RM advised some additional funding was made available in the latter part of Q3 to support systems and social care with some of the extra pressures over the Winter period and how best to utilise this funding is being considered by the Trust and the system. There will be costs associated with the pressures being faced and it is important to understand the decisions made to evidence the right governance is in place to understand the costs so they can be factored into the forecast and ensure they are reflected in discussions with the regulators. MG queried what actions are being taken as a system in terms of managing patient and family's expectations in order to prevent stress escalating into abusive behaviour. DA advised in this area, particularly Ashfield, it is known there is a significant issue with domestic violence. Through December 2022, there was a local public campaign in relation to domestic violence, reporting incidents and how to get out of the house safely. The Trust has a place on the Community Safety Partnership Board. In terms of messaging to the public, a revised approach to communications, including social media, was discussed by the Executive Team on 4th January 2023. MG sought clarification what steps are being taken to manage the expectations of people waiting in ED. DA advised the volunteers are assisting in ED by providing drinks to staff and listening to concerns from patients. ARB queried if there are any ways the non-executive directors (NEDs) could be more visible and if this would help support staff. DS advised there is a need to get the balance right and a rolling programme of visits has been established. The NEDs could be involved with this. Staff appreciate the visits. RS reflected how powerful a simple 'thank-you' and some acknowledgment can be. AH noted it is known from the Staff Survey results the Trust has an issue in terms of abuse towards staff from members of the public and this is likely to be worse with the current pressures. While in some respects this is understandable, it is not acceptable. The Trust needs to take a strong line and be clear in the messaging. The Board of Directors were ASSURED by the report		
7 mins	**Integrated Care System (ICS) Update** DA presented the report, highlighting feedback on the draft ICS strategy, ICS Forward Plan and examples of SFHFT's role as an anchor organisation in the local area. AR queried what actions the ICS is taking to alleviate some of the current pressures on the system, particularly in relation to working with primary care. DA advised as an organisation, the Trust is concerned about the sustainability and resilience of general practice. It is well documented in the media that the public have concerns about the equity and accessibility of general practice, particularly the issue of contacting surgeries by phone. DA expressed the view there is a direct causal link to some of the acuity of patients requiring hospital admission, as a direct result of some of the proactive management which has not been undertaken in general practice.		

	In terms of what the system is doing to address these issues, this is a question which has been asked of the ICS Medical Director. RE joined the meeting DS advised there is a need to remember 'we' are the system and have a role to play in terms of changes and improvements. Once the critical incident is stood down and the Winter pressures are over, there is a need to review, as a system, what has gone well and what lessons need to be learnt to make improvements for future years. The Board of Directors were ASSURED by the report		
23/008	**STRATEGIC OBJECTIVE 1 – TO PROVIDE OUTSTANDING CARE**		
7 mins	**Maternity Update** PS joined the meeting ***Safety Champions update*** PS presented the report, highlighting the Maternity Parent Voice Champion flash report, Safety Champions walkaround, CQC Inspection, Ockenden compliance, NHS Resolution (NHSR) submission, Maternity and Neonatal Safety Improvement Programme and safety culture work. The Board of Directors were ASSURED by the report ***Maternity Perinatal Quality Surveillance*** PS presented the report, highlighting third and fourth degree tears, stillbirth rate, staffing red flags, home birth service and elective care. PS advised postpartum haemorrhage and the Apgar score are slightly raised this month, noting there is no harm associated with this. The Friends and Family test remains on track. The Board of Directors were ASSURED by the report PS left the meeting		
23/009	**STRATEGIC OBJECTIVE 2 - TO PROMOTE AND SUPPORT HEALTH AND WELLBEING**		
16 mins	**Covid Vaccination Update** RS presented the report, advising December 2022 saw the second anniversary of the Hospital Hub, with just under 250,000 vaccines administered in the Hub during this time. The current phase (Phase 5) of the vaccine programme has been challenging in terms of vaccine uptake nationally. However, the Trust continues to promote vaccine uptake through a flexible model and uptake is above the national average for the majority of cohorts. The vaccine programme beyond Phase 5 remains unclear, but there will be an ongoing requirement for people to receive vaccines and the Trust is likely to play a contributing role. Future reporting of vaccine uptake will form part of the Single Oversight Framework (SOF) report.		

	SB queried if it is known to what extent the lower uptake of Covid and flu vaccinations is contributing to the current pressures. DS advised this is unclear. However, for the first time in approximately 6 months, there are currently patients with Covid in the critical care unit. In addition, flu is having an impact on critical care. As of 4th January 2023, 50% of critical care capacity was taken up with patients with Covid or flu. Patients are primarily suffering with respiratory disease, rather than being admitted due to another condition and it being identified they have Covid or flu. It was noted there are some young, otherwise well, patients with flu requiring critical care. There is a need to continue to encourage all members of the public to take the opportunity to protect themselves from flu and Covid by having the vaccinations. SB noted there has been a lower than expected uptake of the Covid vaccination by people in the 'at risk' category and queried if there is any rationale for this and if there is anything further which can be done to target this group. RS advised the Trust has tried to maximise flexibility in terms of opening times for the Hub and vaccinations have been made available at locations where people in these categories may congregate in order to make the vaccine as accessible as possible. Individuals are not quite as aware as they were of the potential impact of not having the vaccine. The targeted approach will continue but there is some 'vaccine fatigue'. SB felt the Trust needs to be continually mindful of vaccine uptake in any communications, noting the media is not reporting the lack of vaccine uptake. BB noted 46% of healthcare workers have received the Covid vaccine and queried what percentage of Trust staff have received the Covid booster and flu vaccination. RS advised just over 60% of front line care workers at the Trust have received the flu vaccine and this is continually promoted as effectively as possible. It was noted SFHFT benchmarks well locally and regionally, but uptake of the flu vaccine is down on previous years. In relation to the Covid vaccine, it is still difficult to access reliable data. There is a need to continue to target key messages about protection. GW queried what level of sickness absence is due to flu and Covid. RS advised there have been no significant changes to the sickness absence figures. However, there are some seasonal increases which are comparable with previous years. GW noted it is getting late in flu vaccine season for any actions to make an impact for this year and queried if there is anything which can be done differently for next year. RS advised a debrief is undertaken at the end of every campaign to look at what went well and what could have gone better. CM advised any outbreaks of flu and Covid are tracked closely through the Trust's outbreak meetings. Currently there are no flu outbreaks on record with NHS England (NHSE) and there are two Covid outbreaks, which were originally community acquired Covid. There is no strong evidence of staff to patient or staff to staff transmission.		

	DA advised the picture in relation to staff uptake of the flu vaccination is similar for community uptake, noting there is a financial aspect to this as GPs have stock of flu vaccine which will shortly expire and will, therefore, be wasted. There is some onus on people coming forward for vaccine to avoid wasting public resources. CW queried if the Trust could operate a 'pop-up' clinic for patients to receive the flu vaccine. DA advised this is something the Trust may be able to provide, noting GPs are unable to offer this due to restraints related to workforce capacity. RS advised a variety of members of the public attend the hospital daily and any opportunity to offer vaccine needs to be given due consideration, noting the challenges in terms of consent, vaccine storage, etc. **Action** • **Consideration to be given to establishing 'pop-up' flu vaccination clinics for patients and members of the public** The Board of Directors were ASSURED by the report	**RS / DA**	**02/02/23**
23/010	**PATIENT STORY – BEYOND THE HOSPITAL WALLS**		
14 mins	GR joined the meeting GR presented the Patient Story, which highlighted a patient's journey through Covid and the discharge process, noting the issues with the discharge process which can be learnt from. CW advised it is always good to hear patients' stories and while the Trust is delivering good quality care, there are always areas for improvement. MG noted the bravery and courage in acknowledging areas which require improvement and the difficult decisions which have to be taken about what can be improved. GR advised overall the patient story was positive, but there is some learning from it which has been shared. SB felt the story highlighted the importance of Allied Health Professionals (AHPs) in the patient journey and sought an update regarding the number of AHPs in the organisation. CM advised the Trust employs approximately 300 AHPs and a programme is being developed to job plan with individuals to identify what can be done with that group of staff and how it can be strengthened. Assessment and discharge into the community is something which is not easy and there are always steps which need to be in place for discharge. DA felt the story was a reminder of the impact health and poor health can have on people's lives and serves as a reminder for people to have healthy lifestyles and reduce the risks they choose to take. AH advised the story reminded him of other stories from cancer survivors who have psychological issues when they are recovering at home, noting there are services in place to support those patients. AH noted the Trust used to have an outpatients service for people who were in intensive care and queried if this service is still available.		

	DS advised the Trust still has a critical care follow-up clinic. It was noted patients who have had a tracheostomy are unable to speak and, therefore, communication is difficult. The Team in critical care are trying to make improvements with signing, but this is one-way. There is an opportunity to invest in new technology which would help. It can take patients up to a year to recover from being in critical care for a month and it is important to support people through this process. GR left the meeting		
23/011	**STRATEGY DEVELOPMENT PROCESS**		
52 mins	DA presented the report, outlining the process which will be followed to develop the Trust's strategy for 2024-2029 and the proposed approach to increasing strategic focus by the Board of Directors. DA suggested the discussion point should be in relation to considering the pace and scale for encouraging a strategic approach, how this will be enabled and to agree the order of prioritisation for pieces of work. A further discussion point suggested by DA related to considering procuring external support. A general discussion followed, during which the following points were raised: • Responsibility of a Board of Directors falls into three areas, creating the future, delivering today and improving today. There is a need to put the right effort into improving today within the 0-12 month timescale. • Creating the future is 3-5 years, managing today is here and now and the 'middle ground' covers 1-3 years. This is where the work of the sub-committees is key. • If a relatively large change was to be made over the next 2-3 years, this would initially come via the sub-committees. • Quality Committee has a huge workload and needs space to deal with wider strategic issues. There is a need to consider how to balance strategic thinking with operational and assurance issues. • The care agenda should drive all other committees. • Whatever changes are made will have implications for workforce, finance, etc. There needs to be a way of synchronising across the committees. The patient journey begins with quality but consideration needs to be given to other areas. • Improvement of today is already discussed by sub-committees but is not necessarily recognised on the agenda. • Need a clear sense from discussions at sub-committees in relation to operational aspects, strategic aspects and lessons learned. • Sub-committee agendas should include pertinent questions for chairs to address. • Sub-committees to identify top priorities for discussion. • Need to be mindful the sub-committees are assurance committees and not operational committees. • If the Trust is serious about population health management and changing and improving health outcomes, there is a need to look at pathways through an assurance lens.		

	• For the Board of Directors to have the ability to think more strategically, assurance needs to be 'pushed back' into the sub-committees. • Need to keep the assurance element in the right place, which is the sub-committees. • Consider establishing a task and finish group, with the chairs of the sub-committees, to look at the strategic elements. This would provide focus without adding to the agendas of the sub-committees. • Board of Directors and sub-committees are interdependent. • Need to consider how sub-committees approach strategic work, for example via strategic workshops. • There is a need for a shared understanding / definition of strategic focus and thinking. • More information needs to be added to the headings of Strengths, Weaknesses, Opportunities and Threats (SWOT) in the report. • Culture sits as a strength in the report. While elements of the Trust's culture are strengths, there are others which are weaknesses and opportunities. • The People and Culture Strategy is owned by a sub-committee. • Need to think of a 5-year overarching Trust strategy, which individual strategies for People and Culture, Quality, etc. fit within. This makes the role of the sub-committees clearer. • Need to consider how the Trust will work with partners. • Need to consider what the Trust's assets are and how they can be best used. • The way the Trust works could tie in with the CQC domains as this provides a structure and assurance if the domains are being fulfilled. • Are we having an incremental strategy, continuing the direction of travel, or do we need to be more radical in approach? • There is an opportunity to build on current frameworks and learn from how sub-committees operate. • Part of the strategic discussions relate to defining the Trust as an organisation in terms of its function and services. • Need to consider how we look at the focus of the here and now, recognising in order to 'fix' some of those challenges there is a need to think further ahead and take longer term decisions to address issues for future years. • Need to be mindful of language; strategy is more than a single document. • Strategy is about 'painting the picture' of what we want the Trust to 'look like' in 5-years' time, taking into consideration what the data indicates demand will be and building a bold and radical framework to find a solution to the issues. • Being incremental will not deliver the significant change which is necessary to meet the increasing demands faced. Therefore, having bold ideas has to be the focus for strategic discussions. • Need to consider how healthcare is provided, recognising the demand. • Need to 'get ahead of the game' and address issues before they become risks. • Discussions and strategy development needs to happen in the context of a system conversation.		

	• Longer term strategic discussions have taken place at an ICS / ICB level and a piece of work will be taking place in the coming months to review the urgent care / adult social care architecture, with a view to envisaging a new structure and future. The Board of Directors CONSIDERED the report		
23/012	**ASSURANCE FROM SUB-COMMITTEES**		
4 mins	**Finance Committee** ARB presented the report, highlighting the significant discussion in relation to Principal Risk 4 of the Board Assurance Framework (BAF) and the business cases which were considered. ARB advised the Committee will review the Trust's financial forecast at the February meeting. The Board of Directors were ASSURED by the report **People, Culture and Improvement Committee** MG presented the report, highlighting the potential risks of industrial action and the impact of pensions, implementation of the workforce plan and positive assurance received, particularly in relation to the appraisals measure. The Board of Directors were ASSURED by the report		
23/013	**OUTSTANDING SERVICE – MACMILLAN CANCER INFORMATION AND SUPPORT**		
11 mins	A short video was played highlighting the work of the Macmillan Cancer Information and Support Service. BB acknowledged the services highlighted in the video, but noted patients have to have a cancer diagnostic 'label' in order to access services. There are patients who have a diagnosis of other conditions which are life changing in other ways. BB queried how the Trust can take the learning from the Macmillan Cancer Information and Support Service to ensure that level of support is wrapped around patients who are going through difficult times but do not have a cancer 'label'. GW felt support is not just about health support but can encompass meeting with patients who have faced a similar diagnosis. DS advised the need is recognised and advised the Trust has been able to grow certain services as they come with a 'badge' and, therefore, funding. It is difficult to transfer the same level of service for other patients, partly due to funding aspects. However, it is an aim which should be considered. CW felt there may be an opportunity to approach charitable funds. SB advised the Trust may also be able to link into other partnerships.		

	CM advised services have previously been provided in different areas, but these have reduced, possibly due to Covid. CM gave the example of the dementia café and support for stroke services. Therefore, there is historic learning which can be applied.		
23/014	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 min	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Thanks to all colleagues for their work over the past month • Reiterate Board of Directors support for staff in the difficult clinical decisions they have to take • Understand current pressures should not become the 'norm' and the Board of Directors is working hard to find solutions • Continue to encourage vaccine uptake • Communications and support to patients and families to manage expectations • Patient Story • Outstanding service video • Return of the home births service • Theatre developments at Newark Hospital • Strategic partnership with West Notts College • Thanks to Bunches UK for their kind donation of flowers before Christmas		
23/015	**ANY OTHER BUSINESS**		
	No other business was raised.		
23/016	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 2nd February 2023 in the Boardroom, King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:00.		
23/017	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Claire Ward **Chair** **Date**		

23/018	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
2 mins	CW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. CW advised a question had been received via the Q&A function on the live broadcast in relation to the public voice in the development of the Trust strategy and how the Trust might enable more engagement with the public, hopefully before they actually become patients. DA advised this will be built into the process for developing the Trust's 5-year strategy. There will be a set of activities which go out into the community and engage with people who have not touched the Trust. The mid-Nottinghamshire Place can be utilised to assist with this. The Trust has well established communication partnerships with the voluntary sector who are very close to the local population.		
23/019	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
18/435	09/06/2022	Future Equality and Diversity Annual Reports to capture the impact of activity and provide further information on the data in terms of actions to be taken	Public Board of Directors	None	01/06/2023	R Simcox			Grey
18/583.1	06/10/2022	Deep Dive into 3rd and 4th degree tears to be reported to the Quality Committee	Public Board of Directors	Quality Committee	~~01/12/2022~~ 02/02/2023	P Bolton		**Update 21/11/2022** To be presented to the January meeting of the Quality Committee **Update 04/01/2023** This will form part of the Nursing/Midwifery & AHP Report to January's QC meeting on 19/01/2023 **Complete**	Green
18/615	03/11/2022	Future strategic objective update report to include information where each priority sits and a narrative for any areas which are underperforming	Public Board of Directors	None	02/02/2023	D Ainsworth		**Update 25/01/2023** Information included in report for Board on 02/02/2023 **Complete**	Green
18/618.1	03/11/2022	Future Nursing, Midwifery and AHP Staffing reports to include information in relation to productivity and the position at a system level	Public Board of Directors	None	04/05/2023	P Bolton			Grey
18/652	01/12/2022	Progress on the evidence review for the NHSR submission to be included in the Maternity Assurance Committee report to the Quality Committee in January 2023	Public Board of Directors	Quality Committee	02/02/2023	P Bolton		**Update 04/01/2023** Assurance received this will be included in the regular MAC report scheduled on January's QC agenda **Complete**	Green
18/653	01/12/2022	Action plan detailing actions to be taken to improve the experience of junior doctors to be presented to the People, Culture and Improvement Committee	Public Board of Directors	People, Culture & Improvement Committee	02/02/2023	D Selwyn		**Update 04/01/2023** Notification sent to request this be included on January's PCI Committee (31/01/23) agenda **Update25/01/2023** On agenda for PCI Committee on 31st January 2023 **Complete**	Green
23/009	05/01/2023	Consideration to be given to establishing 'pop-up' flu vaccination clinics for patients and members of the public	Public Board of Directors	None	02/02/2023	R Simcox / D Ainsworth		**Update 16/01/2023** 'Pop-Up' flu vaccination clinics continue to be available and now allow patients, visitors and members of the public to have the opportunity to be vaccinated **Complete**	Green

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's report	**Date**: 2nd February 2023	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
An update regarding some of the most noteworthy events and items over the past month from the Chair's perspective.		**Approval**	
		Assurance	X
		Update	X
		Consider	

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

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

Committees/groups where this item has been presented before

Not applicable

Executive Summary

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

We are committed to working with our partners for the benefit of our local communities

One key development I am proud to share from over recent weeks has been the strengthening of our commitment to working with our local partners – namely in signing an agreement with Vision West Nottinghamshire College that commits us to working more closely together for the benefit of our local communities.

That agreement strengthens the relationship we are already enjoying, including by supporting local learners into employment within the local NHS, creating opportunities for work experience and committing our Executive Team to take part in regular Q&As with learners to have their say on the running of their local hospitals.

I was delighted to attend the recent *Step into the NHS* recruitment event we hosted alongside the College that was attended by over 650 people. That was a vital first public demonstration of that commitment, with the event resulting in the Trust making a number of vital connections with local people who are considering pursuing a career in the NHS.

This is just one of the partnerships that demonstrates our role as an anchor institution within our local community and I look forward to that fruitful partnership continuing.

We are continuing to engage with our local communities, thanks to our governors

During the week commencing Monday 23rd January, our governors gave their time to host eight 'Meet Your Governor' events to give our local communities the opportunity to feedback about their experience of coming into contact with our services.

I am grateful to our governors for hosting the five sessions at King's Mill Hospital and three sessions at Newark Hospital during the week, which are an essential part of how we engage with our local communities.

Our local governors also hosted a dedicated stall at the *Step into the NHS* recruitment event at Vision West Nottinghamshire College, where I understand a number of new Trust members were registered. Governors also explained their role in the Trust and encouraged others to take interest in our governor elections later this year. Engagement with all of the communities we serve is vital

to ensuring that our membership represents all of the communities we serve to ensure as many voices can help shape the services we provide.

Other engagements and visits over the past month include

- Regular meetings with our governors and Lead Governor
- 15 Steps visit around maternity
- Visit to Newark to meet with staff
- Walkaround with Chief Executive of Nottinghamshire County Council
- Discussions with Non Executive Directors to consider the work taking place in committees
- Meeting with Mayor and Chief Executive of Mansfield District Council

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's report	**Date**: 2nd February 2023	
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
To update on key events and information from the last month.		**Approval**	
		Assurance	X
		Update	X
		Consider	

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

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

Committees/groups where this item has been presented before

Not applicable

Executive Summary

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

Pressures update from your local hospitals

Sherwood Forest Hospitals – like the whole of our NHS – remains under pressure right now.

Locally, those pressures resulted in the whole Nottingham and Nottinghamshire health and care system starting 2023 in a critical incident.

Those pressures have been caused by the demand we continue to see at the 'front door' of our Emergency Department and our Urgent Treatment Centre at Newark Hospital, as well as the challenges we also face in discharging patients in a timely way.

On an average day in December, 111 patients occupied inpatient beds in our hospitals despite them being medically fit to leave – that's around one-in-seven of all our beds that were open at the time (773) during a period when we had more beds open than at any other time in our Trust's history.

It is often said that the most difficult of times bring out the best in us and that has certainly been true of recent weeks, where we have seen so many brilliant examples of how our whole Trust stepping-up to help manage those pressures. Whether it be through examples like our SDEC extending its opening hours to become a 24/7 operation for a short time or our brilliant volunteers putting in extra hours over weekends to bolster our efforts, our 'whole Trust' response has been a source of real pride for me.

Thankfully, we are now in a slightly better position and, as a result, we have been able to stand-down the critical incident. Despite this, we remain challenged and some of the escalation capacity we opened during the critical incident remains open.

I want to pay tribute and thank each and every one of our staff for their hard work, skill and dedication which have ensured we have been able to deliver safe patient care throughout such a challenging period.

We know that working through such intense pressures has been difficult, tiring and challenging for them all. We also recognise how our staff have been asked to go to lengths to make extraordinary decisions and changes that we would usually not have to make.

Throughout the month, members of the Executive and Senior Leadership Teams have been out and about talking with colleagues, giving our thanks to them for going above-and-beyond. We also took time to listen to their experiences and ideas on how we can support and improve things. I appreciate everyone's honesty and openness throughout those conversations. We will consider the actions necessary to improve these and all issues raised. I personally commit to keep the Board updated on this work.

From the conversations we have had with colleagues over recent weeks, I want our colleagues to know that we hear them and that they have the full support of the Board of Directors in taking the decisions to ensure patients are safe and can continue to access the care they need and deserve this winter.

Despite the huge challenges that we continue to face, I firmly believe that we can all look forward to 2023 with real positivity.

We're working with our local education providers to encourage local people to *Step into the NHS*

In January, we were delighted to have worked alongside our partners from West Nottinghamshire College and Nottingham Trent University to host a special *Step into the NHS* careers event to showcase the wide range of opportunities available in the NHS.

The event took place on Tuesday 17 January at the College's Derby Road campus and was attended by more than 650 people who turned out in numbers to learn about the various career paths, apprenticeship opportunities and how to enrol at the university's Mansfield-based campus.

I would like to place on record my thanks to our partners and #TeamSFH staff who came together to help make this fantastic event possible.

The event was the first what looks like to be a series of successful events of its kind – so please watch this space for details of future events. We look forward to sharing more details of the event as part of this month's Outstanding Service video that will be displayed at our Public Board meeting.

We've shared our multimillion pound plans to bring faster, more convenient diagnoses to Mansfield

We have recently announced the multimillion pound plans we have submitted to Mansfield District Council for a purpose-built 'Community Diagnostics Centre' that will run alongside our existing Mansfield Community Hospital in Stockwell Gate.

If approved, the Centre – Nottinghamshire's first of its kind – will become a 'one-stop shop' for patients to access the tests and investigations they need in a single visit, helping them to give them an answer to their concerns.

Getting a rapid diagnosis for conditions such as cancer will help patients access the treatments they need more quickly – something that could be genuinely life-saving, as earlier diagnosis is key to improving survival rates and quality of life for those suffering chronic diseases.

Checks available at the new Centre will include a host of X-rays, scans and tests for a range of other conditions, including cancer and other long-term conditions – like heart and lung disease.

If approved, the plans could see the purpose-built facility open its doors to its first patients as soon as autumn 2024 to complement the services already provided at the Trust's King's Mill, Newark and Mansfield Community Hospital sites.

The plans are currently subject to a national funding bid. If the funding is secured and the plans are approved, it is hoped the Centre will welcome thousands of patients each year – as well as creating hundreds of new jobs.

The Centre will be built where a derelict building that is awaiting demolition currently stands on the Mansfield Community Hospital site.

As part of the unveiling of our plans, we hosted a public information event at Mansfield Community Hospital on Thursday 26 January for local people to learn more about these exciting new plans.

Thank you to everyone who has supported this initiative so far to help make this great work happen.

We're working to expand our operating theatres at Newark Hospital

Patients needing certain operations will get treatment faster thanks to a £5.6million project that will create new and improved theatres at Newark Hospital.

An extra 2,600 operations and procedures are expected to take place each year as a result of a new state-of-the-art theatre and recovery area and the development of two minor operations suites.

The Newark Elective Hub will significantly reduce waiting times, improve patient experience, as well as create new jobs for nursing and healthcare staff.

Expansion of the Newark Hospital site will help to address health inequalities by providing services locally for patients who would previously have had to travel further afield for treatment.

The development has been announced, thanks to a successful bid we have made to NHS England's Targeted Investment Fund (TIF).

NHS Nottingham and Nottinghamshire Integrated Care Board (ICB) sought support from Nottinghamshire County Council's Health Scrutiny Committee at their meeting on 10 January 2023, where the committee approved the plans for us to continue the planned expansion.

The project will create extra capacity in elective (non-urgent) care for urology and ear, nose and throat (ENT) surgery, which have the greatest backlogs. In addition, it will also enable clinically-appropriate procedures to be moved out of the theatres into minor operations suites to free up space for bigger procedures, in line with the national initiatives.

Preparation work is expected to start early in 2023, with the theatre expected to be on site in spring and in use from the summer.

The project is in-line with the Trust's strategy to maximise the potential of Newark Hospital for local residents and ensure it's a valued and vibrant community asset. We know how much residents value Newark Hospital and we are committed to making best use of the site and further improving the services we provide and the speed in which people can access them.

This project will enable us to carry out more procedures in Newark, making it much more convenient for patients to get the care they need and help them get back to living fuller lives, faster – without having to travel to King's Mill or further afield.

Risk ratings reviewed

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

- Principal Risk 6: Working more closely with local health and care partners does not fully deliver the required benefits
- Principal Risk 7: A major disruptive incident
- Principal Risk 8: Failure to deliver sustainable reductions in the Trust's impact on climate change.

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals NHS Foundation Trust (SFH) 2022-23 Strategic Priorities

Quarter 3 Update

Contents		Page
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Healthier Communities, Outstanding Care

NHS
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1. Summary – 'Q3 Position on a Page'

Ref	2022/23 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Overall RAG Qtr. 3	Change to Previous Qtr.
1.1	Develop an action plan to re-launch Family and Friends feedback, plus develop a framework for assurance (on actions taken).	Chief Nurse				⟺
1.2	Improve the Quality and Safety of the services we provide to children with complex needs.	Medical Director	Update will be provided in Q2			⟺
1.3	Achieve the levels of waiting times as identified in the 2022/23 plan and trajectories.	Chief Operating Officer				⟺
1.4	Work with all partners to reduce the number of patients who are delayed moving to their onward destination outside of SFH.	Chief Operating Officer				⟺
2.1	Delivery of the SFH Green Plan and provide support to deliver the ICS Green Plan.	Chief Financial Officer				⟺
2.2	To embed and enhance the current offer of support regarding the Mental and Physical Wellbeing of our Colleagues.	Director of People				⟺
2.3	Design and deliver a recruitment and retention programme for maternity; to right size the service and enable the delivery of the Continuity of Carer Health Inequalities service delivery model (Maternity Transformation).	Chief Nurse				⟺
3.1	Develop and Implement a Strategic workforce Plan for SFH in collaboration with the ICS.	Director of People				⟺

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	2022/23 Trust Priority	Executive Lead	Overall RAG Qtr. 1	Overall RAG Qtr. 2	Overall RAG Qtr. 3	Change to Previous Qtr.
3.2	Respond to the 2021 NHS Staff Survey. Identify Key Focus Areas.	Director of People				⇔
4.1	Successfully implement and optimise the use of EPMA.	Medical Director				⇩
4.2	Develop a refreshed Digital Strategy.	Medical Director				⇩
4.3	To introduce an Innovation Hub across the Mid Notts Place Based Partnership.	Director of Strategy & Partnerships				⇧
5.1	Delivery of the SFH Transformation & Efficiency Programme that supports the delivery at PCB/ICP level.	Chief Financial Officer				⇔
5.2	Be a key partner in the development of the Provider Collaborative.	~~Chief Executive~~ Director of Strategy and Partnership				⇔
5.3	Shape and define a new SFH Trust 5-year strategy (~~2023-2028~~) working with ICS partners.	Director of Strategy and Partnership				⇔
5.4	Continue to progress Pathology Network initiatives alongside NUH (and across the region where required).	Director of Strategy and Partnership				⇔

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 3 Update

<table>
<tr><th>Ref</th><th>2022-23 Trust Priorities</th><th>Executive Lead</th><th>SFH Governance</th><th>Measures of Success</th><th>Quarter 3 Update</th></tr>
<tr><td>1.1</td><td><u>To Provide Outstanding Care</u> - Develop an action plan to re-launch Family and Friends feedback, plus develop a framework for assurance (on actions taken).</td><td>Chief Nurse</td><td>Quality Committee</td><td>• Action plan developed to re-launch Family and Friends feedback
• Establish assurance framework by the end of Qtr 3</td><td>• The key highlight in this update is the introduction of the under 16s survey on ward 25, CAU, community paediatrics and paediatrics at both Newark and Kings Mill. It currently is not possible to interrogate the data to identify under16s in isolation.
• Volunteers continue to assist and engage with FFT collection, data input and escalating concerns to the Patient Experience Team. We are working to improve engagement in lower scoring areas.
• Work continues in collaboration with clinical illustrations to roll out the QR codes across the organisation.
• We now have 164 staff users on the system and training continues.
• Our systems have recently been updated to incorporate questions on virtual appointments, seeing automatic reports being generated for monitoring weekly feedback.
• Reports are generated monthly and sent to divisions. We have engaged with:
<table><tr><td>Area</td><td>October</td><td>November</td></tr><tr><td>ED</td><td>online 1264</td><td>SMS 1
online 1257</td></tr><tr><td>Inpatient</td><td>smartphone 199</td><td></td></tr><tr><td></td><td>paper 43</td><td>paper 159</td></tr><tr><td></td><td>online 1732</td><td>online 1933</td></tr><tr><td>Maternity-birth</td><td>online 44</td><td>online 40</td></tr><tr><td>Care on post-natal</td><td>8 online</td><td>10 online</td></tr><tr><td>Postnatal community provision</td><td>5 online</td><td>8 online</td></tr><tr><td>Outpatients</td><td>62 paper</td><td>Paper 26</td></tr><tr><td></td><td>2203 online</td><td>online2720</td></tr><tr><td></td><td></td><td>SMS 1</td></tr></table></td></tr>
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1.2	**<u>To Provide Outstanding Care</u>** - Improve the Quality and Safety of the services we provide to children with complex needs.	Medical Director	Quality Committee	• Appoint SFH lead to lead transition of complex paediatric patients into adult service via MDT forum by the end of Q2 2022/23 • Support ICB to link SFH, NHCT and NUH transition MDTs by the end of Q3 2022/23 • Develop business case for ICB wide transition nurse specialist team to support parents, patients and service development by the end of Q4 2022/23	• ICB business case progression delayed as a result of critical incident with meetings cancelled • In house bereavement service considerations on-going but no funding stream yet identified
1.3	**<u>To Provide Outstanding Care</u>** - Achieve the levels of waiting times as identified in the 2022/23 plan and trajectories.	Chief Operating Officer	Quality Committee	• 'Timely care' SOF metrics to be presented to Trust Board of Directors, which will illustrate performance (reported monthly) (*Note: this will also include system performance metrics*)	• Key SOF metrics relating to the delivery of timely care on the emergency pathway are rated Red. During Q3 there has been a deterioration in some of the key emergency pathway metrics. We have seen high demand on our services with growing numbers of Covid-19 and Flu patients during the quarter. G&A bed occupancy has remained high together with the number of patients in hospital whilst medically safe for transfer. The end of Q3 (post-Christmas period) was exceptionally challenging with surge actions and capacity enacted. • Key waiting time standards tracked through the relevant Steering Groups with Trust Board oversight within the SOF performance report. The Steering Groups meet at least monthly and track key pieces of improvement work including the Optimising the Patient Journey Programme. • Achievement of key SOF metrics relating to the delivery of timely elective care have been variable. There are positives (Green-rated items), for example, PIFU performance and maintaining zero 104ww; but also Red-rated items such as growth in the overall incomplete RTT waiting list size and higher than planned levels of 78ww patients. • Weekly Patient Tracking List (PTL) processes remain in place across planned care (elective and cancer) to monitor and act upon any issues in delivering timely patient care in line with local and national standards.

					• Key SOF metrics relating to the delivery of timely cancer care have been strong (green-rated) with continued strong performance against the 28-day faster diagnostic standard and the 62-day backlog reducing during Q3 to close in Dec-22 just below trajectory. There remain challenges within specific tumour sites adversely impacting on metrics such as cancer 2ww standard (e.g. challenges due to high demand in our skin service).
1.4	**<u>To Provide Outstanding Care</u>** - Work with all partners to reduce the number of patients who are delayed moving to their onward destination outside of SFH.	Chief Operating Officer	Quality Committee	• 'Timely care' SOF metrics to be presented to Trust Board of Directors, which will illustrate performance (reported monthly) (*Note: this will also include system performance metrics*)	• Medically safe for transfer data routinely presented to Trust Board in the SOF. • The local position continues to remain significantly above the agreed threshold of 22 delayed patients. The position significantly worsened during Q2 (peaking in Sep-22) which was directly linked to capacity issues within adult social care and care agencies. The position during Q3 remains relatively stable. • Additional winter capacity remains open with additional surge capacity used during times of exceptional pressure. At the most pressured times however this has not been sufficient to enable timely flow out of ED and through the acute bed base. • The roll out of Virtual Wards for early supported discharge commenced in Q3; but was paused in Dec-22 to ensure appropriate clinical systems were in place to effectively monitor patients. The Respiratory Virtual Ward relaunch is planned for Jan-23. • The system D2A business case and trajectory were signed off in Q2; however, in Q3 there

					has been no clear and material sign of improvement. The SFH Transfer of Care Hub opened in Q3 which has significantly improved communication between system partners to expedite discharge to the most suitable care environment.
2.1	**<u>To Promote and Support Health and Wellbeing</u>** - Delivery of the SFH Green Plan and provide support to deliver the ICS Green Plan.	Chief Financial Officer	Executive Team Meeting	• Embed Environmental Impact Assessment into all planning and investment case process by end of Q2 2022/23 • Evidence that the SFH Green Plan has been promoted internally and externally, including public commitments by the Trust Board of Directors.	• Environmental Impact Assessment incorporated in the standard business case template and considered as part of the decision making process. • Green Plan update from December 2022 indicates that: o 2022 should demonstrate a 48% reduction in carbon emissions against our baseline year of 2014. o Predicted carbon emissions for 2022 indicate a 6.2% decrease in total emissions since 2021. o SFH is proud to report Zero use of Desflurane Anaesthetic gas to date in 2022/23. The national NHS target is less than 5% use'. o A core working group has been formed to address medical gas waste & leakage (Nitrous Oxide & Entonox).

					o The Hope Orchard project has resulted in over 270 trees being planted since its inception in March 2021. o The Trust's Green Plan Action Plan has been populated with all actions that have been carried out, underway and yet to be undertaken on a traffic light system. o Sustainable Development Steering Group (SDSG) Terms of Reference, Agenda and Action plan tracker have been created to allow this group to gather in Q4 to map out an Operational Management Group which will oversee the allocation of Green Plan Action Plan tasks for the 11 key chapters within our Green Plan. o Heathier Futures Grant applications x 4 (Bus Stop on site @ KMH, Cycle to Work Bike lockers 1 x KMH & 1 x Newark , Equipment to facilitate Walking Aid Reuse Scheme. All applications unsuccessful October 2022. However NHS England Procurement Team viewed the walking aid reuse programme as a model for other trusts and offered financial and administrative support in setting this up in November 2022. • Awaiting a decision regarding the SFH bid submission to Phase 3b of the Public Sector Decarbonisation Scheme (PSDS) to support heat decarbonisation and energy efficiency schemes (Decision likely in Q4 2022/23). • PID submitted for 2 Bus Shelters to be sited within the grounds of KMH, agreement in principle from COG, but awaiting sufficient funds to be available.

					• Further activities planned: o Review of published ERIC (Estates Return Information Collection) data to assess performance compared to peers (Q4) o Plans underway to deliver in January 2023 'Fresh Start for January' Initiative (Veganuary) featuring Health, Wellbeing and Awareness for staff and patients. o SFH Thermal Survey scheduled for Q4 to assess areas of heat loss from our buildings, this project was funded via ICS grant secured in 2022. o Securing quotations for expansion of the Electric Vehicle charging facilities at KMH. • Discussions held with ICS representative to standardise sustainability training for staff, management and Board of Directors. Plans to construct training and possibly deliver by the end of Q4 or perhaps into Q1 2023/24.
2.2	**<u>To Promote and Support Health and Wellbeing</u>** - To embed and enhance the current offer of support regarding the Mental and Physical Wellbeing of our Colleagues.	Director of People	People, Culture and Improvement Committee	• Staff health and well-being SoF metrics to board each month (On-going) • Introduction of a dedicated Health and Wellbeing Approach by the end of Q2 2022/23 • Embedded Health and Wellbeing Approach by the end of Q4 2022/23	Wellbeing framework engagement from key stakeholders has identified areas of focus including supporting Managers and Leaders to model Wellbeing and support their colleagues. This will inform areas of focus for Wellbeing Strategy. Wellness Campaign programme commenced with focus on 3 key areas *Financial Wellbeing* • Citizen Advice Bureau have attended site to support staff with advice and guidance with positive engagement and uptake. Open appointments are available for staff to access Citizen advice off site. Financial Wellbeing leaflet developed, Talk Money week focus, Team Brief focus on Financial Wellbeing. Medirest offer of 50% off hot food at level 6

					"Spice of Life" till 31st March 2023. *Mental Wellbeing* • Stress Awareness week focus, Resilience and mindfulness training implemented, National Grief week recognition, Domestic abuse training offered *Physical Wellbeing* • Movember campaign supporting Mens Health messaging • Wellbeing Champion led Physical Activity Advent Calendar *Critical Incident* • People Directorate and Wellbeing team supported walkarounds at peak times to provide wellbeing support with focused message on rehydrate and refuel • Chaplains provided pastoral care to all staff during this time • Pilot of Enhanced Rest Rehydrate and Refuel messages at time of critical incident. This included distribution of a food and drink provision to key identified areas • Financial Wellbeing group established to support with proposals and initiatives to support staff financial wellbeing through winter. Initiatives include consideration of food banks, exploration of hardship funds, buy a meal/drink scheme. Work with VISION West Nottinghamshire College has led to a Make Your Money go Further with Maths Course. Delivery planned for Quarter 4. • Menopause conference delivered in person and streamed online with topics including HRT, male menopause, Physiotherapy and Psychological support along with some real stories from our colleagues' experiencing symptoms of the Menopause. 90 attendees from Sherwood Forest and additional colleagues from the ICS. Colleagues rated the conference an average of 9.7 out of 10. • Monthly peers support sessions called "Take a

					Pause to talk about Menopause" have been attended by up to 47 different colleagues. • Schwartz rounds continue with focused session on Disability Awareness to coincide Disability History month. This supported staff psychological wellbeing across the whole organisation. • Festive Thank You for all staff – free hot drink and mince pie with support from Voluntary Services. • Additional Clinical Psychology support in place within Clinical Psychology team.
2.3	**To Promote and Support Health and Wellbeing** - Design and deliver a recruitment and retention programme for maternity; to right size the service and enable the delivery of the Continuity of Carer Health Inequalities service delivery model (Maternity Transformation).	Chief Nurse	Quality Committee	• Delivery of Ockenden recommendations for Continuity of Carer (by end of Q4 2022/23)	• We remain in a state of pause in relation to MCoC delivery. During this time we are focussed ensuring the building blocks continue to be established both locally in Sherwood and regionally as partners in the LMNS. • The steps continue to be around suitable recruitment, retention and developing relationships to delivery hub working • We have a joint plan agreed with NUH through the LMNS that reflects this.
3.1	**To Maximise the Potential of our Workforce** - Develop and Implement a Strategic workforce Plan for SFH in collaboration with the ICS.	Director of People	People, Culture and Improvement Committee	• Resourcing SoF metrics to board each month (On-going) • Introduction of a dedicated Strategic Workforce Plan by the end of Q2 2022/3 • Annual refresh of dedicated Strategic Workforce Plan by the end of Q4 2022/23	• The People Directorate have developed Tactical People Profiles that will be delivered by the end of January 23, we have also supported the development of various staffing models to support workforce growth (Newark TIF and CDC) • The People Directorate are developing and will present a revised quarterly report for People Cabinet to support improved governance and intelligence (Jan 23)

3.2	**To Maximise the Potential of our Workforce** - Respond to the 2021 NHS Staff Survey. Identify Key Focus Areas.	Director of People	People, Culture and Improvement Committee	A number of detailed metrics will be monitored via the People, Culture and Improvement Committee. These will be focused on: • **Valuing YOU**; enough staff to do my job, recognition and reward programme • **Caring about YOU**; reducing colleague experience of V&A/BH from patients/users/colleagues • **Developing YOU**; improve quality of appraisals, fair career development Improvement trajectories have been set and a summary of performance will be reported to the Trust Board of Directors via quarterly updates throughout 2022/23.	• All commitment pillars have an allocated lead and working group in place that report into People Cabinet and Committee with clear plans and actions. • ¼ly assurance updates provided by all Divisions at Divisional Performance reviews on staff survey including actions, areas of focus and escalations. This is in line with Trust commitment areas • NSS22 Launch on 3/10/22. Final figures show approx. 61% engagement with the survey from across the Trust. This is a 5% decrease from the previous year. We are awaiting final details from Picker. • Cultural insights work being mapped in line with workforce transformation piece of work and this will include NSS22 data and will highlight areas of focus for 22/23.
4.1	**To Continuously Learn and Improve** - Successfully implement and optimise the use of EPMA.	Medical Director	Executive Team Meeting	• Roll out EPMA into surgery, incorporate VTE screening tool, develop and embed fluids module, scope requirements for ED EPMA module. Complete by end of Q2/beginning of Q3 2022/23 • Develop and embed analysis and system reporting opportunities by the end of Q4 2022/23	• ED rollout paused pending reduction in activity • Relaunch date agreed with Divisional Team • Peripheral sites go live dates agreed

4.2	**To Continuously Learn and Improve** - Develop a refreshed Digital Strategy.	Medical Director	Executive Team Meeting	• EPR Business case approved by NHSE by the end of Q4 2022/23 • Production of three-year digital investment plan in line with the Multi Year planning process (Dates to be published by NHSE)	• EPR re-procurement process underway with guidance and support from NHSE Frontline Digitalisation • EPR Capital Infrastructure bid for £5.966k confirmed and orders placed • Digital Team structure business case at TMT Jan 23
4.3	**To Continuously Learn and Improve** - To introduce an Innovation Hub across the Mid Notts Place Based Partnership.	Director of Strategy & Partnerships	People, Culture and Improvement Committee	• Introduction of an Innovation Hub, working in partnership with key ICS Partners, implemented by Q1 2022/23 • Key principles and year 1 aspirations defined and implemented by Q1 2022/23 (including methodology for quantifying impact on patient care)	• Whilst the proactive promotion of innovation remains a key priority, the development of a specific Innovation Hub has been superseded by the planned establishment of a Trust Improvement Faculty. • The role of the faculty will be to bring together teams and individuals for whom Improvement is part of their core role; to create an entity within the Trust where ideas, concepts and examples of good practice are scoped, tested and (where appropriate) implemented; working in partnership with colleagues across the organisation. • It will become a centre of excellence for innovative practice, transformational change, quality improvement, efficiency, productivity, and patient safety. • Discussions are however continuing with system partners around developing an online portal to ensure that anyone can easily access help, assistance and sources of online information and support. Whilst this will in essence act as an Innovation Hub, the remit will be expanded slightly to encompass all aspects of Improvement. The online portal will therefore be retitled (and branded) to reflect this.

5.1	**<u>To Achieve Better Value</u>** - Delivery of the SFH Transformation & Efficiency Programme that supports the delivery at PCB/ICP level.	Chief Financial Officer	Finance Committee	• Deliver Year 1 of the 2022-25 Transformation and Efficiency Programme ('the Programme') by 31st March 2023 • Deliver Financial Improvement element of the Programme by 31st March 2023, ensuring it is delivered on a recurrent basis • Have in place a plan for the delivery of Year 2 of the Programme (plan developed Q3 2022/23, implementation begins Q4 2022/23) • Continuously review delivery milestones ensuring that changes are enacted where there is a risk of under delivery (ongoing and overseen by the Transformation and Efficiency Cabinet) • Proactively contribute to the ICS/PBP Transformational Programmes of work, ensuring all collaborative opportunities are exploited ((ongoing and overseen by the Transformation and Efficiency Cabinet)	• Although a three-year Transformation and Efficiency Programme has been developed and is being implemented, which includes a £11.7m financial improvement component; the current forecast (at month 8) is that £3.7m will be delivered. • Urgent mitigation work, involving the Trusts Senior Leadership Team, is therefore underway focusing on discretionary spend, non-pay budgets, procurement, and productivity opportunities. • Associate Director of Transformation continues to remain an active member of various System Transformation Groups. In addition, they are also coordinating the Trusts participation in a robust and coordinated system-wide financial review; the anticipated outcomes of which will be a series of identified transactional saving opportunities.
5.2	**<u>To Achieve Better Value</u>** - Be a key partner in the development of the Provider Collaborative.	~~Chief Executive~~ Director of Strategy and Partnership	Executive Team Meeting	• Provider Collaborative Formally Established by 1st July 2022 • PC priorities established by 30th September 2022 • Formal review of PC achievements reported to SFH and System Boards March 2023	• SFH remains a key partner in the provider collaborative through various forums. This quarter we have been working with partners to influence the ICS strategy and gave formal and collective feedback. • A key planning workshop is now being planned to test the appetite of organisations to work together on previously identified priorities.

5.3	**To Achieve Better Value** - Shape and define a new SFH Trust 5-year strategy ~~(2023-2028)~~ working with ICS and wider partners.	Director of Strategy and Partnership	Executive Team Meeting	• Strategy agreed at SFH Board November 2022 • Launch of new strategy completed by 31st January 2023	• Paper presented to Trust Board 5th January 2023 establishing the process for the final year of the current strategy and the development of a strategy covering 2024-29.
5.4	**To Achieve Better Value** - Continue to progress Pathology Network initiatives alongside NUH (and across the region where required).	Director of Strategy and Partnership	Executive Team Meeting	• Programme Delivery in line with existing programme plan and national planning expectations (**to be refined once Director of Strategy and Partnership commences**)	• Clinical lead from SFH continues to attend and there is nothing to escalate at this stage. • Discussions about the future footprint are underway.

Appendix A

Timetable for 22-23 Updates

Period	Trust Board of Directors Meeting
Quarter 3 (October 2022 – December 2022)	2nd February 2023
Quarter 4 (January 2023 – March 2023)	4th May 2023

Trust Board - Cover Sheet

Subject:	Qtr 3 Board Assurance 22-23 Strategic Priorities	**Date: 2nd February 2023**	
Prepared By:	Kevin Gallacher, Associate Director – Planning & Partnerships		
Approved By:	David Ainsworth, Director of Strategy & Partnerships		
Presented By:	Kevin Gallacher, Associate Director – Planning & Partnerships		
Purpose			
To update the Board on progress against the 22-23 Strategic Priorities.		**Approval**	
		Assurance	**X**
		Update	**X**
		Consider	

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

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

Committees/groups where this item has been presented before

Discussed at Executive Team meeting

Executive Summary

The attached update sets out progress on the 2022-23 strategic priorities at the end of Quarter 3.

The Board is asked to:

- **Note the changes to Executive responsibilities shown in red text in the detailed Qtr 3 report.**
- **Note the update.**

Mid-Nottinghamshire Integrated Care Partnership

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Single Oversight Framework

Reporting Period: Q3

2022/23

Inspected and rated
Good
Care Quality Commission

Single Oversight Framework – Q3 Overview

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Quality Care	In Q3 our prolonged period of exceptional pressure across all services and pathways within the Trust has continued. Throughout Q3 additional bed capacity has been flexed to meet the demands (Full Capacity Protocol), and the Trust remains above the Winter Plan and this has required the Trust to utilise super-surge. The pressure has been felt across the organisation, and particularly with Emergency Department with ongoing episodes of overcrowding and exceptionally long waits, which impacts on the nursing and medical staff to give care and treatment in a safe, consistent manner and does not allow our patients to have a good experience. The pressures were particularly heightened during the Christmas and New Year holidays where exceptional capacity was opened to support capacity and flow. The staff have also had an impact on their experience and morale during these difficult times, and despite these challenges and difficulties our teams have continued to focus on delivering care in the safe manner possible. **There are five exception reports to note for Q3:** **1. Serious Incidents including Never Events (reportable STEIS) by reported date** **2. All falls per 1000 OBDs** **3. Covid-19 Hospital onset** **4. Rolling 12 months MRSA bacteraemia infection rate per 100,000 OBDs** **5. Eligible patients asked the case finding questions or diagnosis of dementia or delirium**	MD, CN

Single Oversight Framework – Q3 Overview

Domain	Overview & risks	Lead
	People Over Q3 (October 2022 – December 2022) our sickness absence level over the last few months has shown a gradual increase to a level of 5.9% in December 2022. Sickness does sit above the Trust target (4.0%) and between the upper and lower SPC levels. Benchmarked levels show that the Sherwood Forest absence rate is below our ICB provider partners (December 6.2%). Total workforce loss (Inc. sickness, maternity and infection precaution) sits at 7.9%, this sits above the target 6.5%. A key pillar of support to our people has been the focused Wellbeing programme that continues to provide support for teams and focuses on 3 key areas of support; • Financial Wellbeing- Citizen Advice Bureau have attended site to support staff with advice and guidance with positive engagement and uptake. Open appointments are available for staff to access Citizen advice off site. Financial Wellbeing leaflet developed, Talk Money week focus, Team Brief focus on Financial Wellbeing. Medirest offer of 50% off hot food at level 6 "Spice of Life" till 31st March 2023. • Mental Wellbeing -Stress Awareness week focus, Resilience and mindfulness training implemented, National Grief week recognition, Domestic abuse training offered • Physical Wellbeing. - Movember campaign supporting Men's Health messaging and Wellbeing Champion led Physical Activity Advent Calendar Schwartz rounds continue to support all themes above. Critical incident support has been provided by the People Directorate and Chaplaincy to support during critical times and these have included wellbeing checks ins, delivery of critical incident food parcels and re-enforcement of the Rest Rehydrate and Refuel messages. The People Directorate facilitated a '*festive thank you*' for all staff to access a hot drink and mince pie in December 2022. Menopause conference delivered in person and streamed online with topics including HRT, male menopause, Physiotherapy and Psychological support along with some real stories from our colleagues' experiencing symptoms of the Menopause. 90 attendees from Sherwood Forest and additional colleagues from the ICS. We have noticed an upward trajectory within our employee relation cases and this sits towards our upper SPC limit. Since October 2022 our figures do include formal stage 2 cases, and we have seen an increase in the number of grievances raised. To support the increases, we are directly working with service lines undertaking focused work, while understanding any root cause for the increase. Over the last two months we have seen a gradual increase in the Trust vacancy level, currently this is recorded at 5.6%, with our Q3 level recorded at 5.0% (this is higher than our Q2 figures – 4.7%). Local benchmarking shows that the ICB provider vacancy level is reported at 11.5%. Part of this increase is due to investments that show an uplift in establishment levels and are sat within the recruitment process. Supporting the winter plan and a planned reduction of our vacancy levels we recent held successful recruitment fairs and continue to have a really active and engaged programme that has scheduled events over the next few months. We have recent held 2 very successful events, one a Newark Hospital and one at West Nottinghamshire College.	DOP, DCI

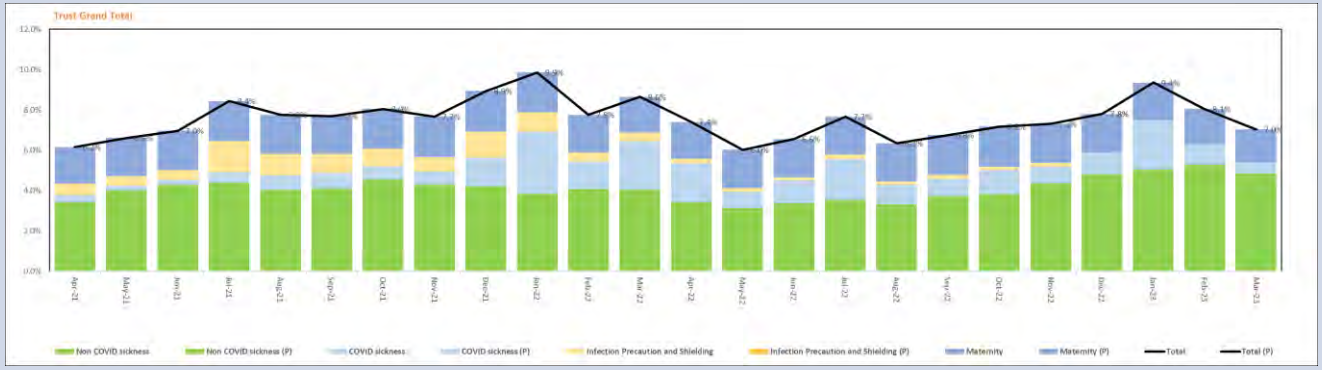
Single Oversight Framework – Q3 Overview

Domain	Overview & risks	Lead
People & Culture	A number of Trade Unions have conducted ballots of their members at Sherwood Forest Hospitals NHS Foundation Trust for action short of strike action and strike action, this includes the Royal College of Nursing (RCN), UNISON and Chartered Society of Physiotherapists (CSP). These ballots have not met the legal threshold for action to take placed at the Trust. Nevertheless, our system partners have met the threshold and industrial action, including strike action has impacted on their services. With this in mind, the Trust has had representation at system incident meetings to ensure the services at the Trust are prepared for any impact to our services while also offering support to our system partners. It is also important to note the British Medical Association (BMA) are currently balloting junior doctors at the Trust for strike action. This ballot opened on 9 January 2023 and closes on 20 February 2023. The Trust has a well-established Industrial Action Group which is meeting on a fortnightly basis to plan for any industrial action. This group is also considering the impact of other industry on our people and services. **Culture and Engagement** The National Staff Survey for 2022 launched on Monday 3rd October and closed Friday 25th November. Supporting teams with engagement in the survey has been a focus for Q3. Results are expected Q4. The OD Partner team continued to develop the core OD offer into the organisation with a view to relaunching and formally introducing the team to the organisation in January. The core offers will focus on: • Embedding a coaching culture • Moving Civility, Respect and Kindness into action through our new ACTIVATE team programme offer • Team development day to include personality profiling and team charter • 360 degree facilitation • Mediation in particular support of FTSU Reward and Recognition continues to be a key focus for the team with key deliverables in Q3; • SFH George Cross pin badges distribution to over 5000 colleagues across SFH, Medirest and Skanska. • Festive Thank you – Free hot drink and mince pie to all staff to say Thank you with Exec leads supporting at the Voluntary Café. Engagement and feedback were positive Further to this the department are provided dedicated support for key transformation programmes; Theatres, Maternity, Case Notes and Opthalmology	DOP

Single Oversight Framework – Q3 Overview

Domain	Overview & risks	Lead
People & Culture	**Learning & Development** **Mandatory and Statutory Training (MaST)** performance levels are reported at 87.3%, with our Q3 level recorded at 87.3% (this is higher than our Q2 figures – 87.0%). We have also had IPC requirements lifted and as such our Education Centre is up to full capacity. During Quarter 3 we commenced a small group looking at Mandatory Training with the focus predominantly being the revised matrix for 23/24 and new training requests. The next steps are to re-instated the Full Mandatory Training Group to start to agree action to improve compliance levels (group to be live early February). In the interim there is some focused work underway with Maternity services to agree tangible actions to address low compliance areas and both Line Managers and People Partners are pushing the need for compliance at a service level. From 1st April 2023 it is possible that the pause on Mandatory training compliance linked to pay increments will be removed which will encourage some staff to improve their completion rate, a paper to approve this has not yet been agreed. Training rates for our ICS are reported at 83.4% and show reductions over the last few months, within SFH we have seen a constant level showing our strong performance across mandatory training. We expect to see an upturn in compliance during the coming months. **Appraisals** performance levels are reported at 85.0%, with our Q3 level recorded at 85.2% (this is marginally higher than our Q2 figures – 84.7%). Our ambition was to achieve a 90% target at the end of quarter 3, this was not acheived. Across Service Lines we have been actively encouraging the completion of appraisals. Service lines with low appraisal rates have been supported to develop action plans to work on improving appraisal compliance. In addition, Service Lines are sighted on non-compliance rates and assurance is sought via Performance meetings on improving compliance. Our focus has been on those employees who haven't had appraisal for over 18 months, as part of this we are ensuring managers are appropriate trained and staff are engaged in this process. By quarter 4 we envisage we will be ready to launch our revised paperwork for appraisals, we are also planning to have our appraisal compliance level at 90%. **Improvement** Following a re-organisation of portfolios, the intention to develop an Improvement Faculty aligning Improvement, Transformation, Planning and Patient Safety has been shared and approved at Trust-wide fora. The Faculty will be launched in Q1 2023/24. This will ensure that resources and learning are optimised to focus on quality, safety, efficiency and value, as part of our continuous improvement approach. Over Q3, the number of QI projects registered on AMAT, our knowledge management platform, dropped significantly and is reported as red. We are aware that there are a number of QI projects underway, having led several internal QI training courses over this period, but due to organisational challenges and vacancies in the Improvement team, colleagues have had less capacity to input and register them. The Improvement team will be up to full complement in Q4, and will ensure that this is a focus going forward.	DOP DOSP

Single Oversight Framework – Q3 Overview

	Overview & risks	Lead
People & Culture	COVID Absence – The Trust produces a daily Workforce SitRep for the organisation; this includes all COVID related absence elements which are wider than the sickness element reported above. When this is reviewed the total COVID related absence for December 2022 was 7.8%, (November 2022 67.3%). This is expressed in figure 1. Figure 1 – Total COVID Workforce Loss  **Vaccinations** Our Frontline Staff **Flu take** up is reported at 62.9%, it is acknowledged that this is lower than in previous years, however nationally the NHS are reporting lower figures, 50.2% of eligible healthcare workers nationally having had a flu vaccine and regional (Nottinghamshire) figures reporting 54.2% of eligible healthcare workers vaccinated. The **COVID booster** vaccination level for Nottinghamshire sits at 47.16%, this sits at a higher level compared to midlands figures (45.97%), and the national level (reported at 46.43%). Across the Trust we are actively promoting COVID and Flu vaccinations and are linking this into our Health & Wellbeing campaigns, aligning to the keeping well during winter programmes. Additionally, to support the take up across SFH we are adopting different measures and where possible are taking the vaccines to staff as we accept the acuity of the hospital has had an impact on vaccination levels. Actions we have undertaken include: • pop up vaccination clinics at different locations, including a return to the KTC • Supporting the implementation of access to staff flu vaccination at the vaccine hub in TB3 • offering COVID and Flu vaccinations together at the vaccine hub and during pop up clinics • Implementing a plan for roaming clinics around the hospitals as well as a “call out” service for staff to request a visit to their area. All COVID and Flu plans supported with clear communications.	DOP

Single Oversight Framework – Q3 Overview

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Timely care	In 2022/23 Q3 (Oct-Dec) our services have operated under sustained and increasing pressure much like many acute Trusts across the country. Towards the end of the quarter we saw attendance and admission levels due to influenza, Covid-19 and other respiratory illnesses surge across our adult services following pressure in paediatric services. In Dec-22 we saw our highest ever recorded daily ED attendances across our King's Mill and Newark sites of 703 patients (on 19/12/22) compared to a Dec-22 average of 547. As attendance levels surged, we saw increased levels of admissions via ED. The combination of the increased demand and continued high levels of medically safe patients waiting to leave our hospitals meant that, particularly towards the end of the quarter, patient demand exceeded the capacity of our hospitals. This mismatch in demand and capacity resulted in Critical Incidents being declared from 14 to 16-Dec and from 29-Dec to 9-Jan. The post-Christmas Critical Incident was ICS-wide with the system remaining in incident until 12-Jan. As a result of the attendance demand pressures and the challenge in transferring patients out of our ED in a timely manner, unfortunately in Dec-22 we saw a decline in a number of our emergency care metrics. Performance against the 4-hour standard dropped sharply to 66% (previous low of circa 75%); mean time in ED rose to almost 270 minutes (previous high of circa 220 minutes); ambulance handovers over 30 minutes increased to almost 11% (previous high in 2022 of circa 6%); and the proportion of ED 12-hour length of stay patients rose to over 6.5% (previous high of 4%). Despite the sharp downturn in performance, our relative performance nationally and regionally remains good, for example, we are the third best in the region against the 4-hour standard (32nd in the country) and our ambulance handover performance remains one of the best in the region. In response to the pressures described above, we enacted escalation actions and our full capacity protocol and at the peak opened an additional 74 beds beyond our winter plan (and many in areas not intended for inpatient clinical use) and converted two elective wards to care for medical patients. These actions meant that whilst our bed occupancy remained relatively stable, we saw an increase in the total number of beds in use across our hospitals. The interplay between emergency and elective pathways meant that as our emergency pathway surged, elective activity levels reduced. During the Critical Incidents non-cancer and non-urgent elective activity was paused which adversely impacted on our elective and RTT performance. Activity is now resumed although challenges for elective inpatients continue given ongoing flow and reduced elective bed capacity. The national requirements to meet zero 78-week waiters by Mar-23 is currently off trajectory; however, plans are underway to date all patients before 31-Jan. The provision of mutual aid is a risk to achieving the 78-week wait trajectory. The Trust submitted a non-compliant plan against the outpatient follow-up reduction target of 25% in the 2022/23 planning round. To date, the reduction made has been small (3.1%) and due to the size of the overdue review list it is unlikely that this will improve significantly. Good progress has been made against the 5% Patient Initiated Follow Up (PIFU) target with performance continuing to exceed the target. Remote attendance levels are stable with improvement required to meet trajectory. We are relaunching to Outpatient Improvement Programme. The Cancer 28-day Faster Diagnosis Standard (FDS) performance continues to be above target. The number of patients waiting more than 62-days on a suspected cancer pathway in Dec-22 was 73 which is ahead of trajectory and showing an improving position. 62-day performance for Nov-22 was 61% which improved on the previous month 50.6%, against a standard of 85%.	COO

Single Oversight Framework – Q3 Overview

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Best Value care	**Income & Expenditure:** • The Trust reported a deficit of £2.1m for the Q3 period, resulting in a YTD deficit to the end of Q3 totalling £11.7m. This represents an adverse variance to plan of £7.0m. The period saw the continuation of many of the challenges faced in earlier periods. • The costs of additional capacity remains the largest element of the adverse variance to plan, with £3.8m spent in Q3 against an original plan of £1.1m. YTD costs of additional capacity total £8.4m, which is £4.4m higher than the allocated budget. • Covid expenditure over Q3 totalled £1.2m. In-line with guidance, no budget was allocated for Covid costs after August 2022 and therefore this represents an overspend against the financial plan. The YTD costs of Covid total £5.6m, which is £2.1m higher than planned. • Other financial challenges include a shortfall on Out of Area Elective Services Recovery Funding (ESRF), additional financing costs (Public Dividend Capital and Depreciation) and a shortfall in Financial Improvement Programme savings, although this is offset in part by other divisional underspends. • The impact of these challenges will impact the forecast outturn and the Trust continues to review opportunities to minimise the impact. NHS England has published a protocol for changes to forecast and we are working with ICB partners to agree a stretching but realistic outturn. **Capital Expenditure & Cash:** • Capital expenditure of £2.7m has been reported for the Q3 period, with YTD expenditure totalling £6.3m. A significant increase in capital expenditure is forecast in Q4 to ensure that the Trust's share of the ICB capital allocation is £11.1m is spent in full. In addition the Trust is progressing schemes that have been funded by specific allocations, including the Newark elective developments and digital infrastructure. • The cash balance at the end of Q3 stands at £2.0m, which is slightly higher than planned. The financial deficit and the timing of cash receipts and fixed payment points continues to present challenges to cash flow; this is being actively managed by the Trust. **Agency Expenditure:** • The Trust reported agency expenditure of £4.6m during Q3, with YTD expenditure totalling £13.5m. Despite the operational pressures experienced over the period, the Q3 position demonstrates a reduction in overall agency expenditure as well as a reduction in the total value of price cap and framework override breaches.	CFO

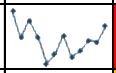
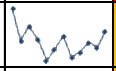
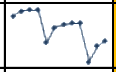
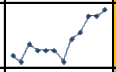
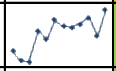
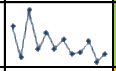
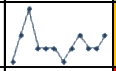
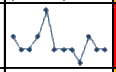
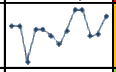
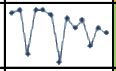
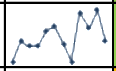
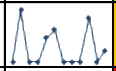
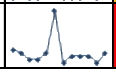
Single Oversight Framework – Q3 Overview (1)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director
QUALITY CARE	Safe	Rolling 12 month count of Never Events	0	Dec-22	1	-		A	MD/CN
		Serious Incidents including Never Events (STEIS reportable) by reported date	<21	Dec-22	28	6		R	MD/CN
		Patient safety incidents per rolling 12 month 1000 OBDs	>44	Dec-22	45.61	45.66		G	MD/CN
		All Falls per 1000 OBDs	6.63	Dec-22	7.63	8.40		R	CN
		Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	20.6	Dec-22	17.59	20.43		G	CN
		Covid-19 Hospital onset	<37 PA	Dec-22	145	10		R	CN
		Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0 PA	Dec-22	1.70	0.00		R	CN
		Eligible patients having Venous Thromboembolism (VTE) risk assessment	95.0%	Nov-22	97.1%	99.5%		G	CN
		Safe staffing care hours per patient day (CHPPD)	>8	Dec-22	8.8	8.5		G	CN
	Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Dec-22	1.17	1.12		G	MD/CN
		Recommended Rate: Friends and Family Accident and Emergency	<90%	Dec-22	88.5%	84.0%		R	MD/CN
		Recommended Rate: Friends and Family Inpatients	<96%	Dec-22	95.0%	94.1%		A	MD/CN
		Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	Dec-22	87.0%	84.9%		R	MD/CN
	Effective	Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Sep-22	124.6	-		R	MD
		SHMI	100	Jul-22	101.91	-		A	MD
		Cardiac arrest rate per 1000 admissions	<1.0	Nov-22	0.83	0.42		G	MD
		Cumulative number of patients participating in research	2200	Dec-22	2048	-		G	MD

Single Oversight Framework – Q3 Overview (2)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director
PEOPLE & CULTURE	Staff health & well being	Sickness Absence	<4.0%	Dec-22	4.8%	5.9%		R	DoP
		Total Workforce Loss (inc Sickness, Maternity, Infection Precaution)	<6.5%	Dec-22	6.9%	7.9%		A	DoP
		Flu vaccinations uptake - Front Line Staff	>90%	Dec-22	62.6%	-		A	DoP
		Employee Relations Management	<10-12	Dec-22	85	14		A	DoP
	Resourcing	Vacancy rate	<6.0%	Dec-22	4.8%	5.6%		G	DoP
		Turnover in month (excluding rotational Drs.)	<0.9%	Dec-22	0.6%	0.5%		G	DoP
		Mandatory & Statutory Training	>90%	Dec-22	87.0%	88.0%		A	DoSP
		Appraisals	>95%	Dec-22	85.0%	85.0%		R	DoSP
	Culture & Improvement	Recommendation of place to work	≥80%	Qtr2 2022/23	78.7%	78.7%		A	DoSP
		Recommendation of place to receive care	≥80%	Qtr2 2022/23	84.1%	84.1%		G	DoSP
		Qi Training - Bronze	>60	Qtr3 2022/23	183	76		G	DoSP
		Qi Training - Silver	>15	Qtr3 2022/23	28	14		A	DoSP
		Number of QI Projects	>40	Qtr3 2022/23	47	11		R	DoSP

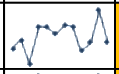
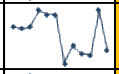
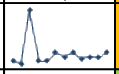
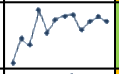
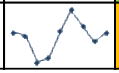
Single Oversight Framework – Q3 Overview (3)

Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director
TIMELY CARE	Emergency Care	Percentage of patients waiting >4 hours for admission or discharge from ED	95.0%	Dec-22	76.2%	65.8%		R	COO
		Mean waiting time in ED (in minutes)	220	Dec-22	217	269		R	COO
		Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<5%	Dec-22	5.4%	10.8%		R	COO
		Number of patients who have spent 12 hours or more in ED from arrival to departure as a % of all ED Attendances	shadow monitoring	Dec-22	3.1%	6.7%			COO
		Mean number of patients who are medically safe for transfer	<22	Dec-22	105	111		R	COO
		Adult G&A Bed Occupancy (8:00am position as per U&EC Sitrep)	<92%	Dec-22	95.3%	95.7%		R	COO
	Elective Care	Remote Attendances as a percentage of Total Outpatient Attendances	25.0%	Dec-22	16.3%	15.3%		A	COO
		Outpatient Episodes moved / discharged to a Patient Initiated Follow-up Pathway	5.0%	Dec-22	5.2%	5.2%		G	COO
		Follow Up Outpatient Attendances reduce against Yr2019/20	-25.0%	Dec-22	-3.1%	-1.6%		R	COO
		Elective Day Case activity against Plan	on trajectory	Dec-22	93.6%	86.0%		R	COO
		Elective Inpatient activity against Plan	on trajectory	Dec-22	87.4%	79.9%		R	COO
		Elective Outpatient activity against Plan	on trajectory	Dec-22	101.9%	98.8%		A	COO
	Diagnostics	Diagnostics activity increase against Plan	on trajectory	Dec-22	110.8%	105.4%		G	COO
	RTT	Number of patients on the incomplete RTT waiting list	42853	Dec-22	-	47225		R	COO
		Number of patients waiting 78+ weeks for treatment	10	Dec-22	-	37		R	COO
		Number of patients waiting 104+ weeks for treatment	0	Dec-22	-	0		G	COO
		Number of completed RTT Pathways against Plan	on trajectory	Dec-22	98.0%	98.3%		A	COO
	Cancer Care	Number of local 2ww patients waiting over 62 days for cancer treatment	74	Dec-22	-	73		G	COO
		Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Nov-22	77.5%	78.0%		G	COO

Single Oversight Framework – Q3 Overview (4)

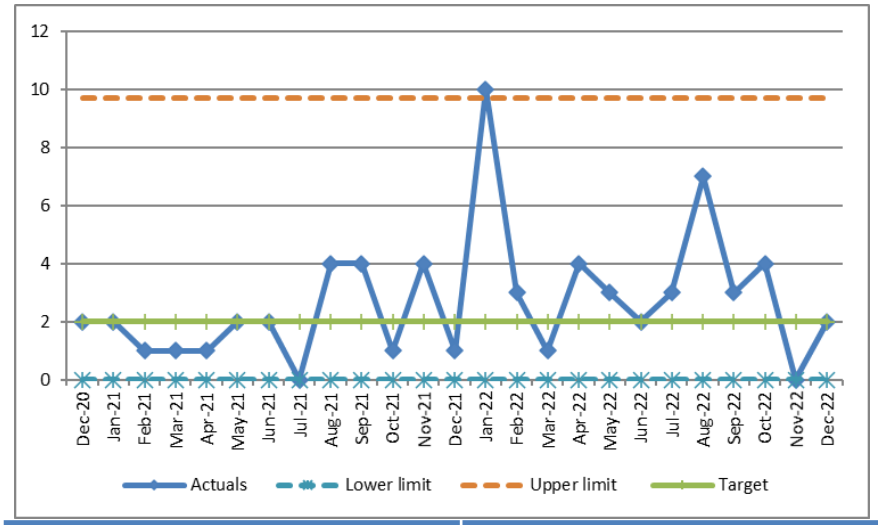
Sherwood Forest Hospitals
NHS Foundation Trust

At a Glance		Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director
BEST VALUE CARE	Finance	Income & Expenditure - Trust level performance against Plan	£0.00m	Dec-22	-£6.99m	-£2.09m		A	CFO
		Financial Improvement Programme - Trust level performance against Plan	£0.00m	Dec-22	-£4.77m	-£0.96m		A	CFO
		Capital expenditure against Plan	£0.00m	Dec-22	£8.94m	£1.50m		A	CFO
		Cash balance against Plan	£0.00m	Dec-22	£0.41m	-£0.41m		G	CFO
		Agency expenditure against Plan	£0.00m	Dec-22	-£2.74m	-£0.22m		A	CFO

Key to Executive Director Roles:
MD = Medical Director
CN = Chief Nurse
DoP – Director of People
DoSP – Director of Strategy and Partnerships
COO – Chief Operating Officer
CFO – Chief Finance Officer

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Serious Incidents including Never Events (STEIS reportable) by reported date	<21	Dec-22	28	6		R	MD/CN	Q

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- There has been one Never Event in 2022/23;
- In December there were 3 serious incidents reported on STEIS, one Urgent & Emergency Care and two in Maternity (relating to neonatal deaths – currently being investigated by HSIB);
- No STEIS in November 2022.

Root causes	Actions	Impact/Timescale
• Two maternity incidents relating to neonatal deaths;	• Awaiting the results of the HSIB investigations	• Ongoing
• Child death in Emergency Department;	• Awaiting STEIS investigation and report	• Ongoing

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
All Falls per 1000 OBDs	6.63	Dec-22	7.63	8.40		R	CN	M

Sherwood Forest Hospitals
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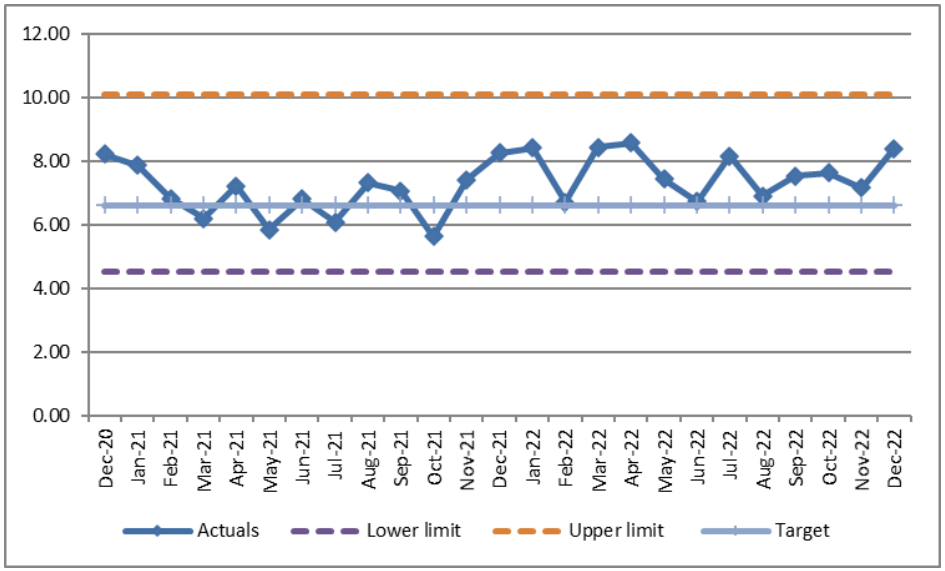


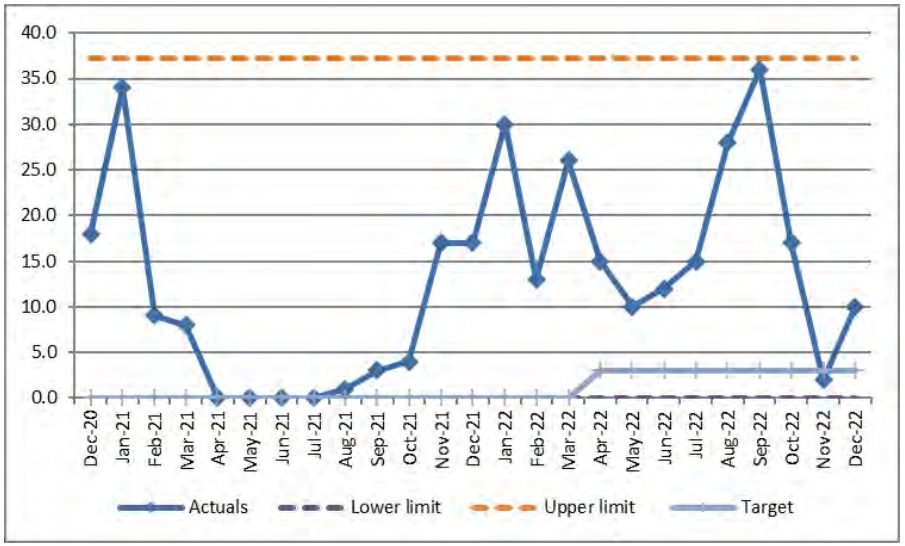
National position & overview

- The falls rate for December was 8.40, above the national average of 6.63 per thousand occupied bed days (OBDs)
- 5 severe harms for the month
- High volume of patients accessing emergency care
- High number of patients medically fit, with length of stay over 21 days
- Additional bed capacity opened
- Critical incident declared three times throughout December
- Increased number of frail, older people in hospital, increases risk of falls
- Insufficient strength and balance provision across the community.
- Increased incidence of adults, especially over 75, less physically activity at home and deconditioned, pre hospital admission (impact of C19)

Root causes	Actions	Impact/Timescale
• Increased number of patients with a length of stay over 21 days. Evidence suggests this increases the risk of falls	• Disseminate learning from incidents using ICare regarding equipment (commodes), escalated to the Harms Free Care Group and Mobility and Falls Group	• Completed
• Additional bed capacity	• Project to be initiated in the Emergency Department, visual cueing in falls management, using yellow socks and blankets for high-risk patients	• Ongoing
	• Project to initiate visual acuity checks electronically	• Ongoing
	• Recruitment to the Mobility and Falls Team	• Ongoing/ Advert closes 31/01/23
	• Target wards with high falls	• Ongoing
	• Target repeat fallers	• Ongoing
	• Raise awareness amongst health care professionals and share trends	• Ongoing
	• Focussed review of recent falls completed and discussion planned for NMAHP committee	• Review complete

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Covid-19 Hospital onset	<37 PA	Dec-22	145	10		R	CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- During Quarter 3 we observed a steady increase in the number of Covid-19 case and this was reflected nationally.
- There was almost double the number of cases identified in the region during December
- The number of nosocomial cases identified each month where:
- October - 25,
- November - 2 and
- December - 17

Root causes

- We have had 3 outbreaks during Quarter 3, which involved 19 patients and the key theme from each was contact with a community positive case.
- Also during Quarter 3 we reduced our level of asymptomatic testing in line with national guidance.
- We also identified a high number of asymptomatic positive cases when carry out the routine testing required for discharge to a care home in line with national guidance. These patients would not have been screened prior to this since admission.

Actions

- Continue to conduct Covid-19 testing on all patients at time of admission.
- Enhanced cleaning was implemented in all outbreak/cluster areas
- Regular outbreak meetings with NHSE/I and PHE to monitor progress of the outbreaks
- To screen all patients from or going to a care home every 48 hours to identify any asymptomatic cases earlier.

Impact/Timescale

- To establish a point in time baseline for that patient
- To further reduce environmental contamination
- To monitor cases and capture learning early

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0 PA	Dec-22	1.70	0.00		R	CN	M

Sherwood Forest Hospitals
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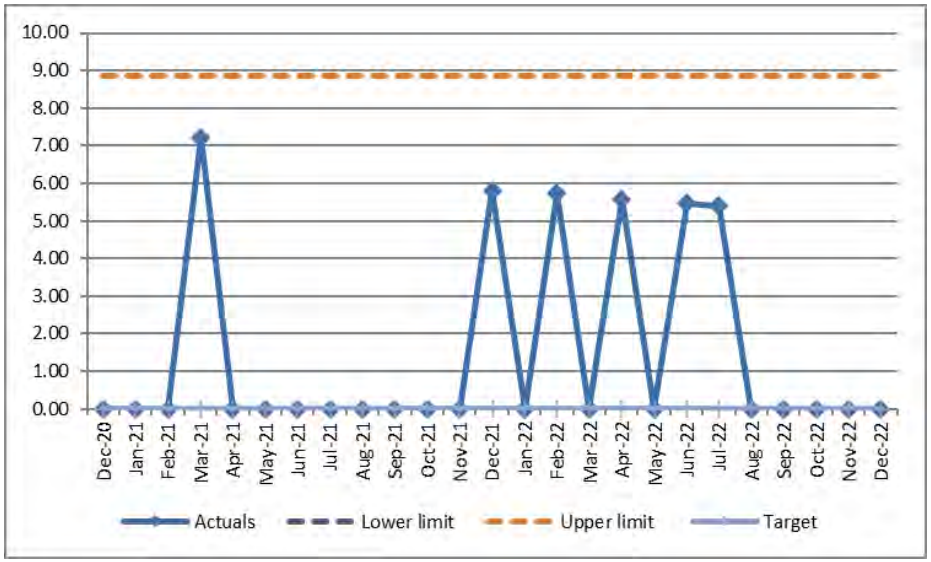


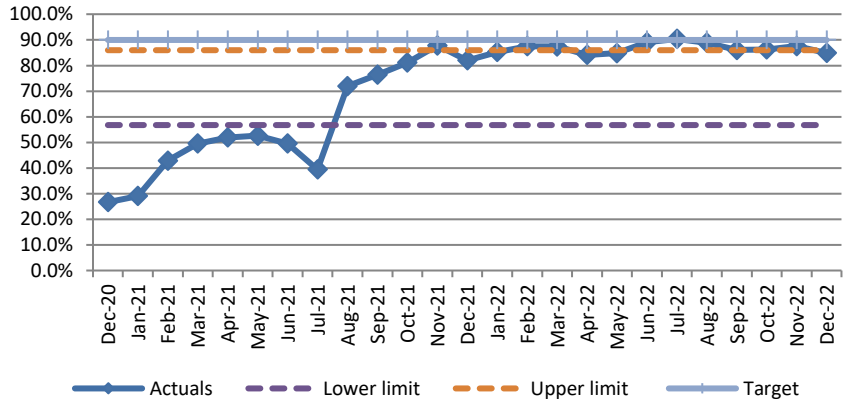
National position & overview

- For this year we have had 3 cases of MRSA bacteraemia, with the last one being in July 2022, breaching our target of 0.
- When monitoring our position against other Trusts in the region, we have all breached out target with between 1 and 5 bacteraemia this year to date.
- With regards to our peer Trusts 7 of the 10 Trusts have also breached their target with between 1 and 4 cases to date this year.

Root causes	Actions	Impact/Timescale
There have been no cases of MRSA bacteraemia since July 2022	We are maintaining our emergency and elective screening of patients for MRSA. We continue to use decolonisation for all high risk patients who are admitted.	To monitor for carriage To reduce the risk if patients are carrying it on their skin.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Eligible patients asked case finding question, or diagnosis of dementia or delirium	≥90%	Dec-22	87.0%	84.9%		R	MD/CN	Q

Sherwood Forest Hospitals



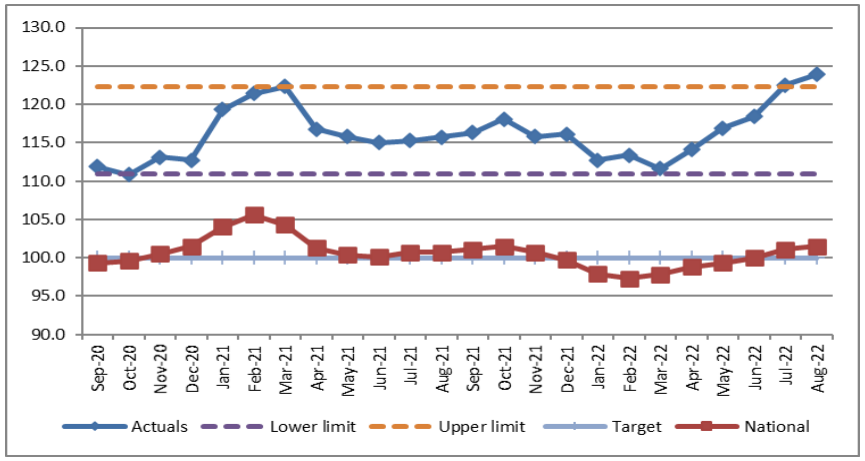
National position & overview

- All patients 65yrs + admitted to the Trust for 72hrs and above to have a dementia screen completed which incorporates the SQuib screening for delirium
- The Trust continues to aim for a target of 90% completion rate of these screens despite the national reporting no longer required
- Reporting changed to quarterly 2021 and the decision made in 2022 that action plans required only when rag rating red

Root causes	Actions	Impact/Timescale
Data completion rate for October 86.3%, November 87.6% and December 84.9% with the average for the quarter 86.2%	The monthly actual for December 84.9% has been identified as the figure receiving a red rag rating and requiring an action plan	As the figure has been consistently achieving the required 85% and above, the team will continue to encourage completion
Data has not been reviewed since July 2022 despite attempts made to obtain	Data to be requested each month until a live dashboard can be created to enable closer monitoring	This will ensure the achievement is maintained
Discussion with other organisations during the National Dementia Audit process has identified that dementia screening only occurs if long term confusion identified when completing the Squib for delirium	Meeting undertaken with RRLP, plan to discuss with Nervecentre team the option of changing the screening tool	The changes will reduce the inappropriate referrals to RRLP, and the time frame will depend upon the Nervecentre team

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 months HSMR (basket of 56 diagnosis groups)	100	Sep-22	124.6	-		R	MD	Q

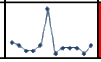
NHS
Sherwood Forest Hospitals
NHS Foundation Trust



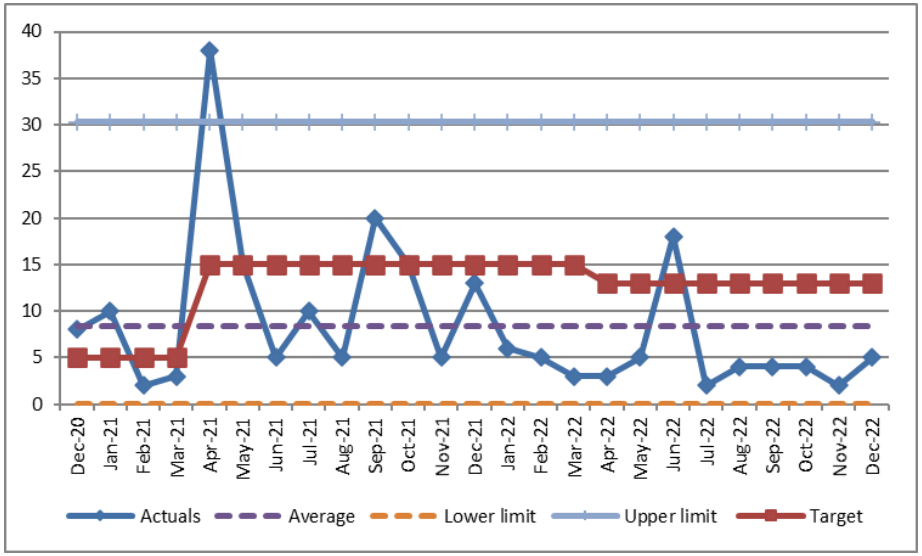
National position & overview

- National figures show upward trend (last 6 data points increasing)
- Local data does indicate additional special cause variation
- SHMI is also rising, although, remains "as expected".
- Learning from Deaths have instigated a process whereby diagnoses triggering in HSMR, CuSUM and SHMI, or other identified escalation, undergo focussed clinical case-note review in attempt to understand causation or separate signal from noise. Current ongoing areas:
    - Fractured Neck of Femur (#NOF)
    - Liver disease (alcohol / other)
    - Pleurisy, pneumothorax, pulmonary collapse
    - The local HSMR trend is thought, in part, to be driven by a reduction in expected rate combined with a stable or increasing crude rate.

Root causes	Actions	Impact/Timescale
HSMR - As previously reported and scrutinised at Quality committee, there are a number of data, coding and SFH specific variances to account for the rise in HSMR As discussed and explained previously the 12 month rolling HSMR will show this increase until remedial actions to data quality, coding and other actions impact and full 12-month impact realised. Specifically specialist palliative care (SPC) coding, co-morbidity coding and consultant fixed spells are all contributing to this rise. SHMI - A recent rise in SHMI is thought, in part, to be due to a decreasing "expected" against a relatively stable (or lesser rise in) observed. No clear clinical evidence for "less poorly" patients but depth of coding tailing off, especially in non-elective care	Deep-dive analysis and review undertaken via learning from deaths and HSMR sub-group. Coding review and "look backs" in progress, alongside engagement discussions with clinical teams around coding diagnosis, co-morbidities and admission documentation completion Clinically-led task and finish group to review admission documentation under DMD. Focussed clinical reviews requested Report into "missed coding" due to non-documentation of chronic disease Discussions between external palliative care service around service delivery whilst ensuring contacts with specialist palliative care and End of Life (EOL) services are recorded and subsequently coded Continued triangulation with other quality markers to ensure earlier identification of potential or actual patient harm	Rolling 12-month HSMR negates any immediate impact and project work is anticipated to take 12 months Targeted reviews are agreed to report into Learning from Deaths the following month (Ongoing) T&F group is due to meet imminently with good initial engagement from clinical areas. Report awaited Ongoing- any service changes are intended to see immediate "on the ground" impact but will, unlikely, reflect in HSMR trends for up to 12 months. Forms part of wider Learning from Deaths but also feeds into Quality Committee.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of QI Projects	>40	Qtr3 2022/23	47	11		R	DoCI	Q

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- Data demonstrates that QI projects are not being registered on AMAT, the Trust's knowledge management platform, to the extent that we know that QI projects are being undertaken. The 'QI project' module went live in June 2022, as projects were previously captured and reported from the 'Clinical Audit' module.
- The QI module of AMAT is better equipped to lead colleagues through using tools and the methodology, and is simple and intuitive. Most clinical colleagues are familiar with AMAT from the ward/clinical audit process, so are familiar with how it works.
- There needs to be a communication campaign to raise the visibility of AMAT within corporate teams, and the launch of the Improvement Faculty will support this.

Root causes

- The Improvement and Clinical Audit team has carried 2 x wte vacancies since July 2022 (out of a team of 6) and this has impeded our capacity to support and remind colleagues to register QI projects on AMAT
- Whilst clinical colleagues are aware of AMAT, there is a lack of visibility with corporate colleagues on what and how they should register, although there are clear guides available on the intranet
- Organisational challenges have impeded capacity for colleagues to register QI projects

Actions

A full re-launch of AMAT as part of the Improvement Faculty offer in Q1 2023/34, with corporate colleagues being encouraged to register Improvement projects in the platform

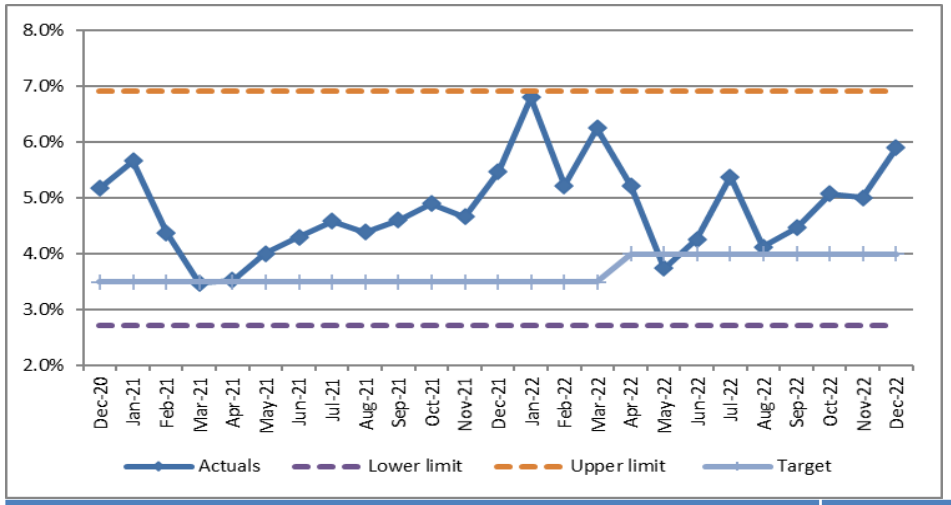
Improvement and Clinical Audit team will be at full complement from February 2023, and will focus on supporting a communication campaign

Impact/Timescale

QI projects registered on AMAT to increase to the higher level of performance over Q1 2023/24.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Sickness Absence	<4.0%	Dec-22	4.80%	5.30%		R	DoP	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

The Trust benchmarks positively against a national and localised sickness figure, across NHS providers in Nottinghamshire SFH sits below the ICS average (6.2%)

Our NHSi peer group follows a similar trend to the sickness absence level at Sherwood Forest Hospitals, however the Trust level has sat below the NHSi peer group. We are currently waiting for updates to Model system so we can updated our benchmarks

Root causes

Sickness absence levels has shown a increase since November 2022 to a quarterly position of 5.3% (Q3) and 5.9% in December 2022. This sits below the upper SPC but above the Trust Target (4.0%). The sickness absence levels is above the sickness absence level in December 2021 (5.5%)

Our main areas for sickness absence are recorded as stress & anxiety, chest & respiratory and cold, cough & flu.

COVID related absence make up 1.1% of the sickness absence level and has shown a gradual increase from last month

Non COVID related absence has seen a gradual increase, however this is an expected annual movement.

Actions

The increase in absence levels coincidences with the increase nationally with the COVID surges and sicknesses associated with the winter period (Cold, Coughs and Flu)

We have forecasted a decrease in sickness absence level over the next few months, to support our workforce during this period we have developed a Winter Wellbeing programme and are continuing to promote the COVID Booster and Influenza vaccine.

Impact/Timescale

The sickness levels are recorded above the Trust target (4.0%) and sits below the upper SPC level.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Appraisals	>95%	Dec-22	85.40%	85.20%		R	DoCI	M

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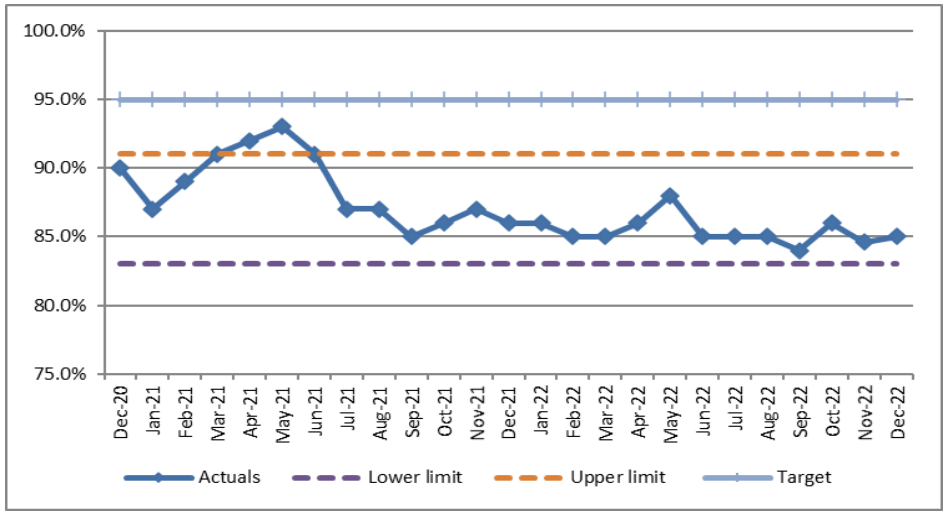

National position & overview

The Trust benchmarks favourably against a national and localised appraisal figure, across NHS providers. Across the ICB the appraisal level for Q3 2022 is recorded at 80.9%.

The NHS Corporate Benchmarking exercise indicates the Trust compliance level on appraisal is in the upper quartile , with the national NHS median at 76.3%, and the upper quartile at 82.2%. These figures are for 2021/22.

Root causes

The Appraisal position is reported at 85.2%, and is at a higher level than last month.

The key cause of below trajectory performance on the appraisal compliance is related to workforce loss linked to the hospital acuity, along with Annual Leave impact.

Our People Partners will continue to support discussions with Line Managers at confirm and challenge sessions seeking assurance and offering guidance.

Actions

Ongoing actions:

Draft paperwork developed but requires the inclusions of a revised Talent Management Framework – then to be piloted.

The move to a digital platform will offer a more streamlined and collaborative approach to undertaking appraisals, moving away from the clunky paper-based approaches. This is being explored further due to the additional benefits it will bring the People Development function.

We will continue to strive for improvements in compliance between now and March 2023 but recognise there will be a higher level of annual leave , so will continue to monitor.

Impact/Timescale

By end 22/23

Agree talent management content within appraisal paperwork

Pilot paperwork.

Paper to TMT to agree to progress digital solution, integrate piloted paperwork into the digital solution.

Launch

Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director	Frequency
Percentage of patients waiting >4 hours for admission or discharge from ED	95.0%	Dec-22	76.2%	65.8%		R	COO	M
Mean waiting time in ED (in minutes)	220	Dec-22	217	269		R	COO	M
Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<5%	Dec-22	5.4%	10.8%		R	COO	M

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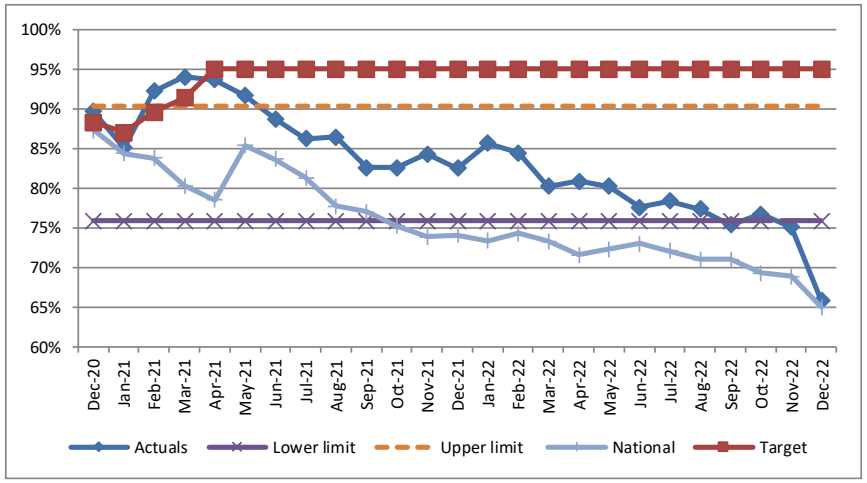
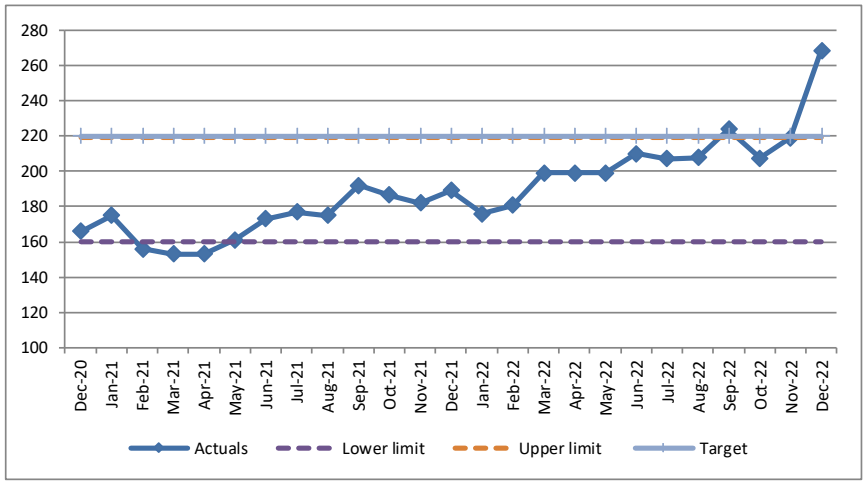
Percentage of patients waiting >4 hours for admission or discharge from ED



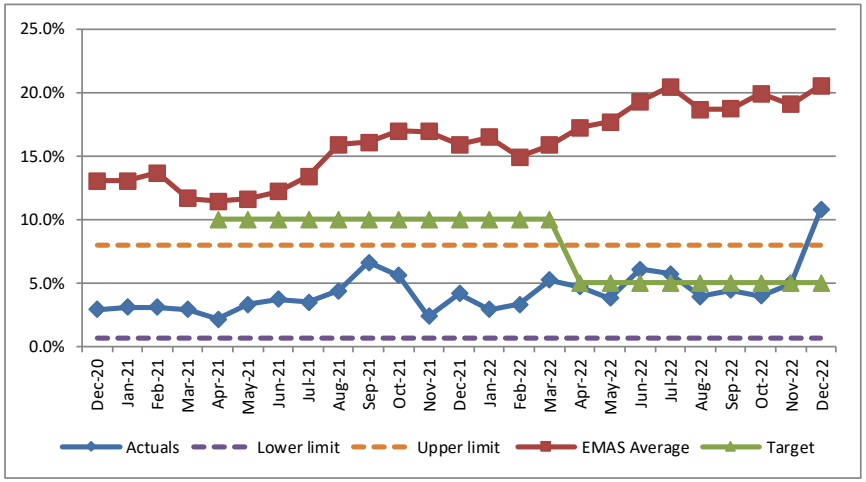
National position & overview

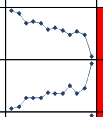
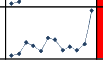
- SFH Critical Incidents from 14 to 16-Dec and 29-Dec to 9-Jan.
- ICS system-wide Critical Incident from 29-Dec to 12-Jan.
- SFH 4-hour performance 65.8% in Dec-22 with a ED mean wait of 269 minutes.
- 4-hour rank 3rd (regional) and 32nd (national).
- Number of patients spending greater than 12 hours from decision to admit to admission - 502, national rank 64th.
- Performance, particularly in Dec-22 was driven by attendance demand pressures and the challenge in transferring patients out of our ED in a timely manner due to our bed constraints. We continue to see high levels of medically safe patients in our acute and sub-acute bed base.
- In Dec-22 we saw our highest ever daily ED attendances across our King's Mill and Newark sites of 703 patients compared to a in-month average of 547.
- 4-hour performance strong at Newark UTC at 92.8%.
- Ambulance handover delays reached the highest ever levels in Dec-22.
- 20.5% of regional EMAS ambulance handovers were over 30 minutes (SFH 10.8%).
- 24.4% of regional EMAS ambulance handovers were over 60 minutes (SFH 1.4%).
- Average regional handover time for EMAS 64 mins (King's Mill: 20mins, Newark: 6mins).

Mean waiting time in ED (in minutes)



Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes



Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director	Frequency
Percentage of patients waiting >4 hours for admission or discharge from ED	95.0%	Dec-22	76.2%	65.8%		R	COO	M
Mean waiting time in ED (in minutes)	220	Dec-22	217	269		R	COO	M
Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<5%	Dec-22	5.4%	10.8%		R	COO	M

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Root causes	Actions	Impact/Timescale
Attendance demand & ED overcrowding		
• Attendance growth throughout the quarter. In Dec-22 there were an average of 547 attends per day which continues to be above planned capacity. High attends were coupled with increased acuity. Paediatric attendances 30% increase in Dec-22 due to STREP A concerns.	• OPEL 4 declared 29 out of 31 days in Dec-22 with associated actions in place with oversight via flow and capacity meetings that take place five times each day.	• Ongoing.
	• Utilisation of X-Ray as additional majors capacity.	• As required during escalation.
	• Proposal to expand ED footprint discussed at Trust Management Team on 18 January, agreement to work up full business case.	• To be confirmed.
• Average occupancy between 14:00 and 20:00 in majors and resus departments at 161% due to high attendance demand and admissions pressures (detailed below) resulting in patients waiting in ED for a bed.	• Extended opening hours of Children's Assessment Unit (CAU).	• Ongoing.
	• Utilisation of Paediatric waiting area for adult bed waits.	• As required during escalation.
	• Recruitment of additional medical resource in line with ED business case agreed at Trust Board to reduce time to be seen for our patients.	• ED recruitment underway – all doctor and ACP posts filled and awaiting start dates. Nurse recruitment ongoing.
	• Continued focus on Same Day Emergency Care (SDEC) to avoid admission – up to 25% of attendances were streamed to SDEC in Dec-22.	
	• Conversion rate to inpatient admission reduced in Dec-22 (22%).	
Admission demand and bed capacity pressure		
• Continued high bed occupancy despite increasing bed capacity due to admission demand increasing during the quarter and length of stay remaining high (partly driven by the medically safe position).	• We enacted escalation actions and our full capacity protocol and at the peak opened an additional 74 beds beyond our winter plan and converted two elective wards to care for medical patients (much of this capacity has returned to elective care).	• Dec-22 to Jan-23 for the first four listed actions.
	• Utilised theatre recovery overnight for elective cancer patients (now closed).	
	• Paused non-cancer and non-urgent elective operating (now restarted).	
	• Converted Ward 43 (Orthopaedics) and Ward 14 to medical wards (transferring back to surgical capacity).	
	• Optimising the Patient Journey improvement programme commenced.	• Ongoing during Q4 and into 2023/24.
• The Trust continues to experience delays in the discharge of medically safe patients.	• Please see the next page.	

Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director	Frequency
Mean number of patients who are medically safe for transfer	<22	Dec-22	105	111		R	COO	M
Adult G&A Bed Occupancy (8:00am position as per U&EC Sitrep)	<92%	Dec-22	95.3%	95.7%		R	COO	M

Sherwood Forest Hospitals
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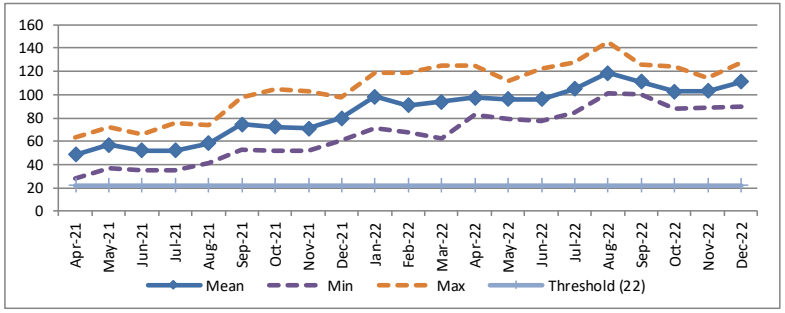
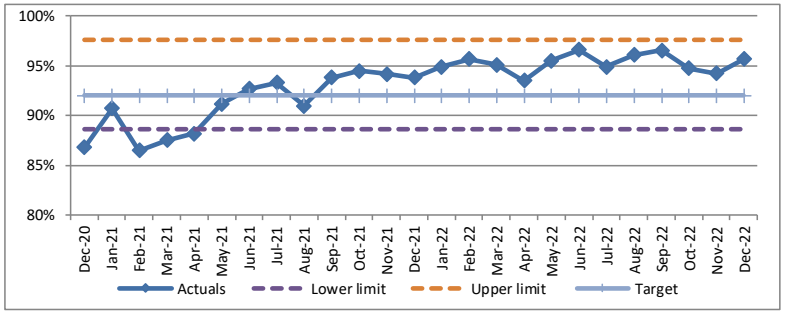
Mean number of patients who are medically safe for transfer



Adult G&A Bed Occupancy @ 8:00am (U&EC Sitrep)



National position & overview

- The number of patients medically safe for transfer (MSFT) reduced at the start of 2022/23 Q3 (Oct-22); however, once again increased in Dec-22.
- The local position remains significantly above the agreed threshold.
- Additional winter capacity as described in the winter plan was opened.
- To mitigate extraordinary UEC pressures and ED overcrowding, a peak of 75 escalation and surge beds were open by the end of Q3. Medical patients were also outlied into surgical capacity limiting the amount of elective activity undertaken.
- System D2A programme commenced; however, further progress is required to meet medically safe trajectories.
- System discharge lead supporting us to improve internal discharge processes.
- Our hospitals continue to operate at occupancy levels significantly higher than the planned 92% (94.2% during Q3 on average; 95.2% in Dec-22).
- Delays to the onward care of MSFT patients continue to have a detrimental effect on acute capacity and flow.

Root causes

- The Trust continues to experience delays in the discharge of patients who are MSFT. In Dec-22 there were over 110 patients (over the equivalent of four wards) MSFT for greater than 24 hours waiting for discharge.
- Continued high bed occupancy despite increasing bed capacity due to admission demand increasing during the quarter and length of stay remaining high (partly driven by the medically safe position).

Actions

- Transfer of Care hub MDT pathway 1-3 referral reviews three-times daily.
- Daily attendance at system calls to ensure appropriate challenge to partners.
- Continue to utilise SDEC and streaming pathways to avoid admission where possible.
- System discharge lead supporting us to improve internal discharge processes.
- Optimising the Patient Journey improvement programme commenced.
- Additional bed capacity opened as previously described.
- Virtual ward due to reopen at the end of Jan-23 after being paused in Dec-22 whilst system and process improvements were implemented.

Impact/Timescale

- The first six actions are all ongoing.
- Jan-23.

Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director	Frequency
Follow Up Outpatient Attendances reduce against Yr2019/20	-25.0%	Dec-22	-3.1%	-1.6%		R	COO	M

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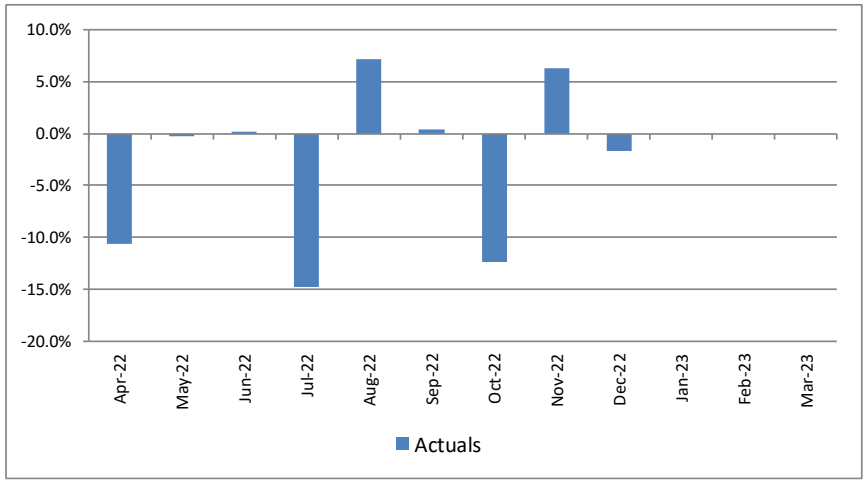
Follow Up Outpatient Attendances reduce against Yr2019/20



National position & overview

- The Trust (and system) submitted a non-compliant plan against the outpatient follow-up reduction target of 25% in the 2022/23 planning round.
- Within our Trust there remains a significant volume of overdue reviews which is impacting on the ability to reduce overall follow-up attendances.
- The Trust have currently discharged 5.2% of patients to a Patient Initiated Follow-Up (PIFU) pathway, against a national target of 5% by March 2023.

Root causes	Actions	Impact/Timescale
• At mid-Jan-23, the Trust continues to have a significant overdue review list.	• The Trust is utilising PIFU to support a reduction in follow-up attendances. A PIFU project group meets on a weekly basis to explore how use of PIFU can be improved.	• Ongoing.
• Ophthalmology, ENT and Gastroenterology represent the specialties with the highest volume of overdue reviews. Together, these specialties represent 43% of the Trust's total overdue review backlog.	• A PIFU SOP is in development with General Surgery, to launch in the coming weeks.	• Mar-23.
	• Specialty meetings, to understand any challenges/barriers in discharging a higher percentage of patients to PIFU, are planned with ENT and Gynaecology where PIFU utilisation is below 5%.	• Feb-23.
• PIFU pathways are not in place for all specialities.	• Meetings planned with specialties that do not currently have PIFU in place, including Diabetes & Endocrine, Geriatrics, Rheumatology, Breast, and Paediatrics to understand whether it would be clinically appropriate to introduce. These were due to go ahead in early Jan-23; however, were stood down as a result of the Critical Incident.	• Feb-23.
	• Benchmarking PIFU performance at a specialty-level against neighbouring Trusts is being conducted to support a gap analysis and identify areas for potential improvement.	• Feb-23.
	• Patient leaflets for both standard and long-term condition PIFU have been developed to support patient uptake.	• Feb-23.

Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director	Frequency
Elective Day Case activity against Plan	on trajectory	Dec-22	93.6%	86.0%		R	COO	M
Elective Inpatient activity against Plan	on trajectory	Dec-22	87.4%	79.9%		R	COO	M

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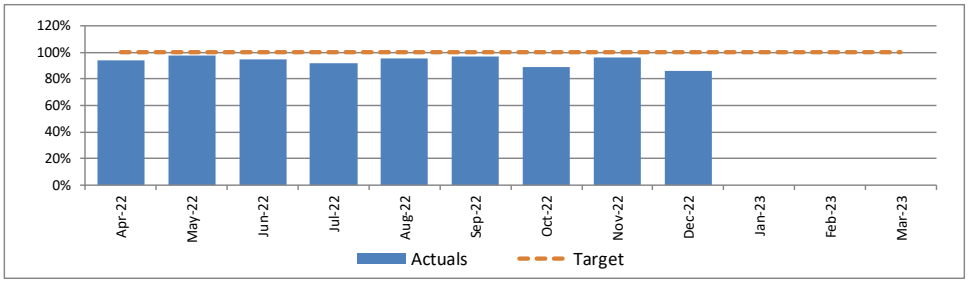
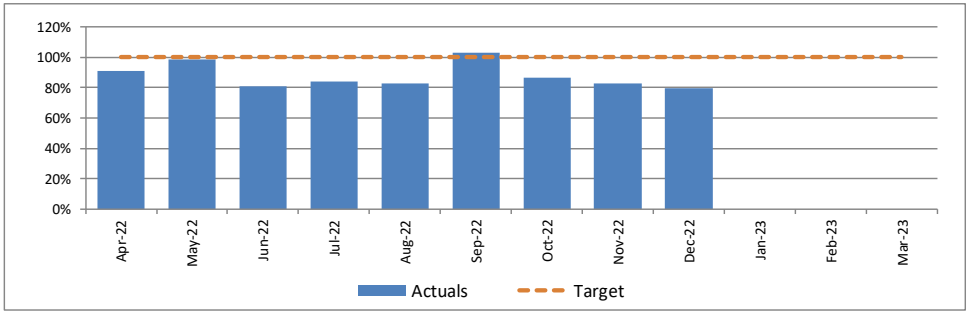
Elective Day Case activity against Plan



Elective Inpatient activity against Plan



National position & overview

- Elective daycase and inpatient activity throughout Dec-22 was adversely affected due to the emergency pathway pressures previously described. These pressure will continue to impact the start of 2022/23 Q4.

Daycase

- Dec-22 daycase activity volume is 86% against the 2022/23 plan and 90.9% against 2019/20 activity levels.
- When comparing Dec-22 (2,812) to Dec-19 (3,095) there is a shortfall of 283 daycase procedures.

Inpatient

- Dec-22 inpatient activity volume is 79.9% against the 2022/23 plan and 72.2% against 2019/20 activity levels.
- When comparing Dec-22 (291) to Dec-19 (403) there is a shortfall of 112 inpatient procedures.

Root causes	Actions	Impact/Timescale
• Anaesthetic and theatre staff shortages. • Bed pressures, actions in response to the Critical Incidents and more recently lack of daycase capacity to support electives. • Peak holiday period in Dec-22 together with reduced working days due to the bank holidays. • Increased focus on reducing cancer backlog meaning case numbers may be less on certain elective lists (i.e. general surgery 1 case on a cancer list compared to 2-3 on a standard list).	• Bed base to be handed back to surgery to allow electives to run. • Poor performing specialities theatre utilisation to be addressed through service line meetings. • Cancellations to be backfilled wherever possible, appreciating this can be difficult at short notice. • Effective theatre scheduling to ensure maximum efficiencies on lists.	• Jan-23. • Ongoing during Q4 and into 2023/24. • Ongoing. • Ongoing.

Indicator	Plan / Standard	Period	YTD Actuals	Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of patients on the incomplete RTT waiting list	42853	Dec-22	-	47225		R	COO	M
Number of patients waiting 78+ weeks for treatment	10	Dec-22	-	37		R	COO	M

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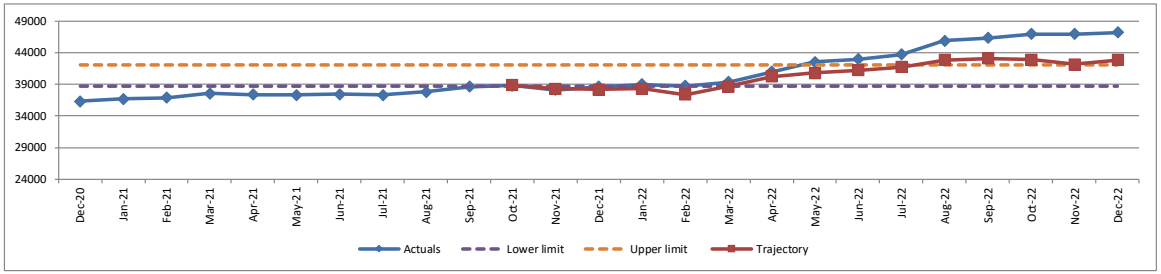
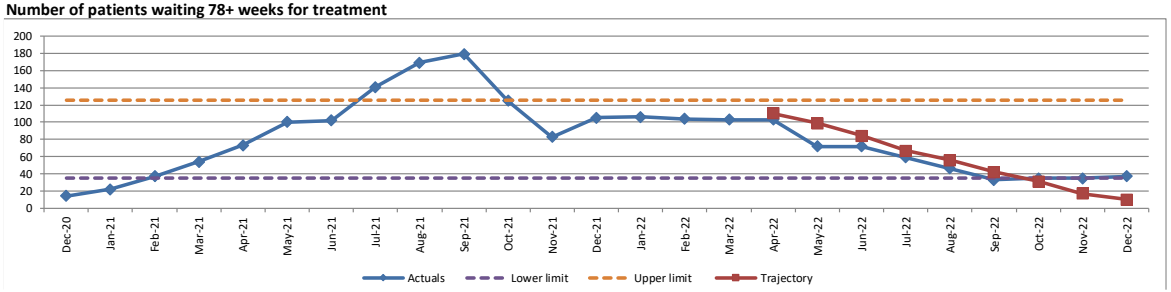
Number of patients on the incomplete RTT waiting list



Number of patients waiting 78+ weeks for treatment



National position & overview

- Referral to treatment (RTT) waiting times across England continues to rise.
- Prior to the pandemic in Feb-20 there were nationally circa 4 million people on the waiting list, this has grown to circa 7 million in 2022/23 Q3.
- At SFH we have seen a significant rise from 26,000 RTT waiters pre-pandemic to 47,000 in Dec-22.
- National requirement to have no patients on an RTT pathway waiting greater than 78 weeks by Mar-23.

Root causes

- Cancellation of procedures during and since the pandemic due to emergency pressure and recent Critical Incidents.
- Availability of cardiology diagnostic tests and delays in reporting.
- Demand for new outpatient services resulting in a significant rise in the number of Appointment Slot Issues (ASIs) and overdue routine follow-up appointment numbers increasing.
- Workforce capacity issues (e.g. anaesthetic cover for elective lists).
- Physical space and infrastructure to enable increased activity required to recover the position.
- National focus on long waiting patients (78+ weeks), including provision of mutual aid, increasing backlogs below 78 weeks.

Actions

- Increase the number of services offering Referral Assessment Services to direct patients to the most appropriate next steps at point of referral e.g. straight to test.
- Validation of the ASI list to ensure all waiters are appropriately managed and clinically prioritised, including clinical review of all 78-week cohort patients.
- Use of additional clinics and theatre lists, outsourcing services (e.g. ophthalmology cataract referrals) and insourcing services to increase capacity.
- Continue use of private sector for routine elective procedures.
- Use and expansion of PIFU (Patient Initiated Follow-Up) pathways.
- Daily tracking of all patients to prevent 78-week breaches post Mar-23.

Impact/Timescale

- The first four actions are ongoing during Q4 and into 2023/24.
- Please see earlier page for PIFU.

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

Income & Expenditure *Trust Level Performance against Plan*	In-Month	**(£2.09m)**	The Trust has reported a deficit of £2.44m for Month 9 (December 2022), on an ICS Achievement basis. This is a £2.09m adverse variance to the planned deficit.
	Year-to-Date	**(£6.99m)**	The Trust has reported a deficit of £11.67m for the Year-to-Date, on an ICS Achievement basis. This is a £6.99m adverse variance to the planned deficit.
	Forecast Outturn	**£0.00m**	The forecast outturn reported at Month 9 is aligned to the 2022/23 financial plan, as a deficit of £4.65m.
Financial Improvement Programme *Trust Level Performance against Plan*	In-Month	**(£0.96m)**	The Trust has reported FIP savings of £0.56m for Month 9 (December 2022), which is £0.96m lower than planned.
	Year-to-Date	**(£4.77m)**	The Trust has reported FIP savings of £4.61m for the Year-to-Date, which is £4.77m lower than planned.
	Forecast Outturn	**£0.00m**	The Trust has forecast FIP savings of £13.95m for the Financial Year 2022/23, which is aligned to the plan (includes notional Elective Recovery Fund (ERF) of £2.21m).
Capital Expenditure Programme *Trust Level Performance against Plan*	In-Month	**£1.50m**	Capital expenditure in Month 9 (December 2022) totalled £1.23m, which is £1.50m less than planned.
	Year-to-Date	**£8.94m**	Capital expenditure totals £6.26m for the Year-to-Date, which is £8.94m less than planned.
	Forecast Outturn	**£11.95m**	The Trust has forecast capital expenditure totalling £31.41m for the Financial Year 2022/23, allowing for additional national approved capital submissions in year.
Cash Balance *Trust Level Performance against Plan*	In-Month	**(£0.41m)**	The Trust's cash balance decreased by £0.63m in Month 9 (December 2022), which is an adverse variance of £0.41m compared to the plan.
	Year-to-Date	**£0.41m**	The Trust reported a closing cash balance of £1.95m as of 31st December 2022, which is £0.41m higher than planned.
	Forecast Outturn	**£0.00m**	The Trust has forecast a year end cash balance of £1.45m for 2022/23, which is aligned to the plan, but which requires working capital borrowing support.

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

Agency Expenditure Against Plan *Trust Level Performance against Plan*	In-Month	**(£0.22m)**	The Trust has spent £1.44m in month 9 (December 2022). This is a £0.22m adverse variance to the planned level of spend.
	Year-to-Date	**(£2.74m)**	The Trust has spent £13.51m for the Year-to-Date on agency, This is a £2.74m adverse variance to the planned level of spend.
	Forecast Outturn	**(£3.94m)**	The forecast outturn reported at Month 9 is to spend £18.62m on agency. This will be £3.94m adverse to the planned level of spend.

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

M9 Summary

- The Trust has reported a year to date deficit of £11.67m for the period up to the end of Quarter 3 (December 2022) on an ICS Achievement basis. This is an adverse variance of £6.99m to the planned deficit of £4.69m.
- The ICS forecast outturn reported at Month 9 is a £4.65m deficit in line with the 22/23 financial plan.
- Capital expenditure for month 9 (December 2022) was £1.23m. This was £1.50m lower than plan primarily relating to MRI where funding is now being utilised to deliver CDC in quarter 4, throughout 2023/24 and quarter 1 of 2024/25. The base capital plan requires PDC capital support, and the associated request has been submitted to NHSE/I for review and approval. Significant additional expenditure has been approved by the DHSC in year which is reflected in the year end outturn. This is a significant challenge to deliver, however Operational Estates and Finance colleagues are all actively engaged in managing delivery of the revised forecast outturn.
- Closing cash on the 31st December was £1.95m, which is £0.41m higher than planned. The cashflow forecast demonstrates that working capital PDC support is required to support the forecast cash outflow. A submission has been made to DHSC for support in December. This is a consequence of current slippage to plan including delivery of cash releasing efficiency savings and utilisation of balance sheet items which are not cash backed in year. Cash support of £1.60m has been approved for January 2023.
- The Trust has year to date expenditure of £13.51m of agency costs. This is £2.74m adverse to the planned spend of £10.77m due to additional capacity opened and agency covering vacancies within Divisions.

	December In-Month			Year to Date			Forecast		
	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m	Plan £m	Actual £m	Variance £m
Income	37.90	39.21	1.31	345.23	349.66	4.43	459.53	464.67	5.14
Expenditure	(38.25)	(41.80)	(3.55)	(349.99)	(361.43)	(11.44)	(464.28)	(469.49)	(5.21)
Donated Assets & Disposals	0.01	0.15	0.15	0.07	0.10	0.02	0.09	0.17	0.07
Surplus/(Deficit) - ICS Achievement Basis	**(0.34)**	**(2.44)**	**(2.09)**	**(4.69)**	**(11.67)**	**(6.99)**	**(4.65)**	**(4.65)**	**(0.00)**
Capex (including donated)	(2.73)	(1.23)	1.50	(15.20)	(6.26)	8.94	(19.46)	(31.41)	(11.95)
Closing Cash	(0.21)	(0.63)	(0.41)	1.53	1.95	0.41	1.45	1.45	-
Agency Spend	(1.21)	(1.44)	(0.22)	(10.77)	(13.51)	(2.74)	(14.68)	(18.62)	(3.94)

FY23 Target		FY23 Forecast		FY23 Variance		M9 Target		M9 Actual		M9 Variance		YTD Target		YTD Actual		YTD Variance		Overall Status
FIP £11.73m	ERF £2.21m	FIP £11.73m	ERF £2.21m	FIP £0.00m	ERF £0.00m	FIP £1.34m	ERF £0.18m	FIP £0.35m	ERF £0.21m	FIP (£0.99m)	ERF £0.03m	FIP £7.71m	ERF £1.66m	FIP £2.69m	ERF £1.92m	FIP (£5.02m)	ERF £0.26m	R
£13.94m		£13.94m		£0.00m		£1.52m		£0.56m		(£0.96m)		£9.37m		£4.61m		(£4.77m)		Red rated due to YTD shortfall to plan and potential impact on full year forecast

Section 2 - Financial Improvement Plan Actual Delivery (Month 9)

Year To Date Delivery

a. In-month FIP delivery is behind plan. **We have delivered £2,690k against a plan of £7,712k**.
b. There are currently 25 schemes in delivery (an increase of 3 from last month).
c. Procurement and Medical Transformation have see an increase in their anticipated YTD delivery due to receipt of rebates and improved vacancy management (£117k and £15k respectively)
d. The Medical and Nursing, Midwifery & AHP Transformation programmes projects such as 'Reduction of Bank Rates' where costs were previously aligned to the 'Covid' budget, may now be classed as Cost Avoidance.
e. The savings planned for Diagnostics Transformation were due to start in July. Delay to the appointment of the Diagnostics Improvement Programme Manager has had an impact on delivery. No savings have yet been identified for 2022-23.
f. Other Corporate Services projects have been delayed such as a decision to delay the re-introduction of parking charges for staff and awaiting for the outcomes of the National Consultation on uniforms. Further work is required to identify other opportunities, plus mitigate against corporate overspends which are impacting on transactional FIP delivery.
g. Operational capacity has undoubtedly been impacted by the recent critical incident (and ongoing pressure); divisional FIP engagement has therefore been understandably challenging.
h. Work is on-going to align underspends against FIP delivery.

Programme	Overall Trust Target v Delivery			FIP Delivery - Year to Date																
				Corporate Services Division			Clinical Support, Therapies and Outpatients Division			Medicine Division			Surgery, Anaesthetics & Critical Care Division			Urgent and Emergency Care Division			Women's & Children's Division		
	Target £'000	Actual Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG	Target £'000	Delivery £'000	Delivery RAG
Medical Transformation	£1,973	£1,232		£0	£0		£56	£0		£905	£1,077		£484	£142		£374	£13		£155	£0	
Nursing Midwifery and AHP Transformation	£1,340	£358		£0	£3		£44	£0		£572	£157		£267	£117		£243	£82		£214	-£1	
Ophthalmology Transformation	£33	£105		£0	£0		£0	£0		£0	£0		£33	£105		£0	£0		£0	£0	
Outpatients Innovation	£15	£28		£15	£28		£0	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Pathology Transformation	£27	£6		£0	£0		£27	£6		£0	£0		£0	£0		£0	£0		£0	£0	
Procurement	£300	£162		£68	£117		£15	£0		£113	£45		£75	£0		£15	£0		£15	£0	
Estates & Facilities	£430	£652		£430	£652		£0	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Other Corporate Services	£604	£0		£604	£0		£0	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Diagnostics Transformation	£133	£0		£0	£0		£133	£0		£0	£0		£0	£0		£0	£0		£0	£0	
Divisional Schemes	£2,553	£147		£587	£29		£407	£23		£613	£7		£513	£54		£227	£0		£207	£35	
Total	**£7,409**	**£2,690**		**£1,704**	**£830**		**£682**	**£29**		**£2,203**	**£1,286**		**£1,372**	**£418**		**£859**	**£95**		**£590**	**£34**	

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Public

Subject:	SOF – Integrated Performance Report – Quarter 3 2022/2023	**Date**: 2nd February 2022	
Prepared By:	Shirley A Higginbotham – Director of Corporate Affairs		
Approved By:	The Executive Team		
Presented By:	Paul Robinson - CEO		
Purpose			
To provide assurance to the Board regarding the Performance of the Trust as measured in the SOF Integrated Performance Report		**Approval**	
		Assurance	x
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
x	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	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 25th January 2023

Executive Summary

The SOF – Integrated Performance report provides the Board with assurance regarding the performance of the Trust in respect of the standards identified on the dashboard. The Board agreed to in November 2022, the reports should be provided on a quarterly basis.

This report is for quarter 3 2022/23, all standards, identified on the report are RAG rated and the threshold for each standard is noted on the dashboard. An SPC chart which identifies trends is provided for each standard these are illustrated in the individual slides.

There were two internal and system critical incidents in the period, and these will have impacted on the performance against some of the standards in the report.

There are a total of 54 standards reported on the Q3 SOF report, of those 20 are rated as red, 16 are rated as amber, 17 are rated as green and one is currently only in shadow monitoring form, so no RAG rating is provided.

<u>Quality Care</u>

Seven standards are rated as red for quarter 3 compared to five for quarter 2. Cardiac arrest rate per 1,000 admissions has moved from a red to a green rating in the quarter with actuals falling to 0.83 a reduction from 0.89 year to date at quarter 2.

A brief overview of the actions in relation to the seven standards rated as red is given below

Serious incident including Never Events (STEIS reportable) by reported date

There have been 28 incidents year to date, including one Never Event. This is an increase from Q2 of 18 incidents year to date

All Falls per 1000 OBD's

This indicator was rated as amber in Q2 with a year-to-date total of 7.56 this has increased in Q3 to 7.63. The key reasons for this were the increased number of medically fit patients with a length of stay over 21 days, evidence suggests this increases the risk of falls. The increase in the number of medically fit patients resulted in the Trust opening extra bed capacity which can also lead to an increase in the risk of falls due to the number of frail, older people in an acute hospital setting.

Covid-19 Hospital onset

During quarter 3 there was a steady increase in the number of Covid-19 cases, and this was reflected nationally.

Rolling 12-month MRSA bacteraemia infection rate per 100,000 OBD's

There have been three cases of MRSA bacteraemia since April 2022 the last one being July 2022.

Eligible patients asked case finding questions, or diagnosis of dementia or delirium

This indicator was rated as amber at Q2 with a rate of 87.5%, however this has reduced to 84.9% in the quarter breaching the threshold of <85%. The Trust continues to aim for a target of 90% completion rate screens, despite the national reporting no longer being required.

Rolling 12 months HSMR (basket of 56 diagnosis groups)

The HSMR rate as reported in Q2 was 121.4, this being June data. In Q3 the figure has risen to 124.6, September data. The trusts learning from deaths group have instigated a process whereby diagnoses triggering in HSMR undergo focussed clinical case-note review in an attempt to understand causation, this is currently happening in the following areas – fractured neck of femur, liver disease and pleurisy, pneumothorax, pulmonary collapse.

<u>People and Culture</u>

Three standards are rated as red quarter 3. One standard, QI training – Bronze has improved from amber at Q2 to Green at Q3 and one standard QI training – Silver has improved from a rating of red at Q2 to amber at Q3. A brief overview of the actions in relation to the three standards rated as red is given below

Sickness Absence

Sickness absence has increased in the period from 4.5% to 4.8%, however the Trust continues to benchmark well nationally and also across the Nottinghamshire ICS where the average is 6.2%

Appraisals

Performance against this standard has deteriorated slightly in the quarter from 85.5% to 85%, the

main causes of the below trajectory performance is related to workforce loss linked to the pressure on services withing the hospitals and the impact of annual leave taken in the period.

Timely Care

Nine standards are rated as red for Q3 compared to six for Q2 reflecting the impact on performance standards due to the operational pressures in the hospitals.

Two standards have moved from red in Q2,

- Remote attendances as a percentage of total outpatient attendances, where performance against the trajectory has improved from red to amber
- Number of local 2ww patients waiting over 62 days for cancer treatment has reduced from 102 in Q2 to 73 in Q3 against a trajectory of 74.

Number of patients waiting >4 hours for admission or discharge from ED, Percentage of ambulance arrivals who have a handover delayed >30 minutes

Performance of 76.2% in Q3 a reduction from 78.3% in Q2 for 4-hour performance. The Trust ranked 3rd in the region and 32nd nationally. Performance was driven by increased attendances, and in December the Trust saw its highest level of attendances in one day of 703 patients compared to an average of 547. This together with challenges in transferring patients out of ED in a timely manner due to bed constraints impacted on performance including the ability to undertake ambulances handovers where performance in the period deteriorated from 4.8% waiting more than 30 minutes to 10.8% in December 2022.

Mean number of patients who are medically safe for transfer
During the period the number of patients who are medically safe for transfer remained at 111 against a standard of <22 patients. The system D2A programme has commenced however further progress is required to meet the trajectories.

Adult G & A Bed Occupancy (8.00am position as per U & EC Sitrep)
Performance has remained fairly static in the period at 95.7% but remains l significantly higher than the planned standard of 92%. Delays in the onward care of medically safe for transfer patients continues to have a detrimental impact on acute capacity and flow.

Follow up Outpatient Attendances reduce against 2019/20
Performance against this standard has decreased slightly in the period and is significantly below the national target of a 25% reduction. The Trust submitted a non-compliant plan against this standard due to the volume of overdue reviews.

Elective Day Case activity against Yr 2019/20
This standard was rated as amber in Q2 with performance of 95.1% this has deteriorated to 93.6% in Q3.. Several actions have been identified to address this deterioration and these are noted in the attached slides.

Elective Inpatient activity against Yr 2019/20
Performance against this standard has deteriorated from 90.1% in Q2 to 87.4% in Q3. A number of actions are in place to address performance.

Number of patients on the incomplete RTT waiting list
There has been an increase in patients from 46,346 in Q2 to 47,225 in Q3. The main causes of this are cancellation of procedures during and since the pandemic due to emergency pressures and recent critical incidents.

Number of patients waiting 78+ weeks for treatment.
The number of patients waiting over 78 weeks has increased from 33 in Q2 to 37 in Q3, there is daily tracking in place to prevent 78-week breaches post March 2023 in line with the national requirement.

Best Value Care

There have been no changes in the RAG ratings of the five standards.

Board Assurance Framework (BAF): January 2023

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

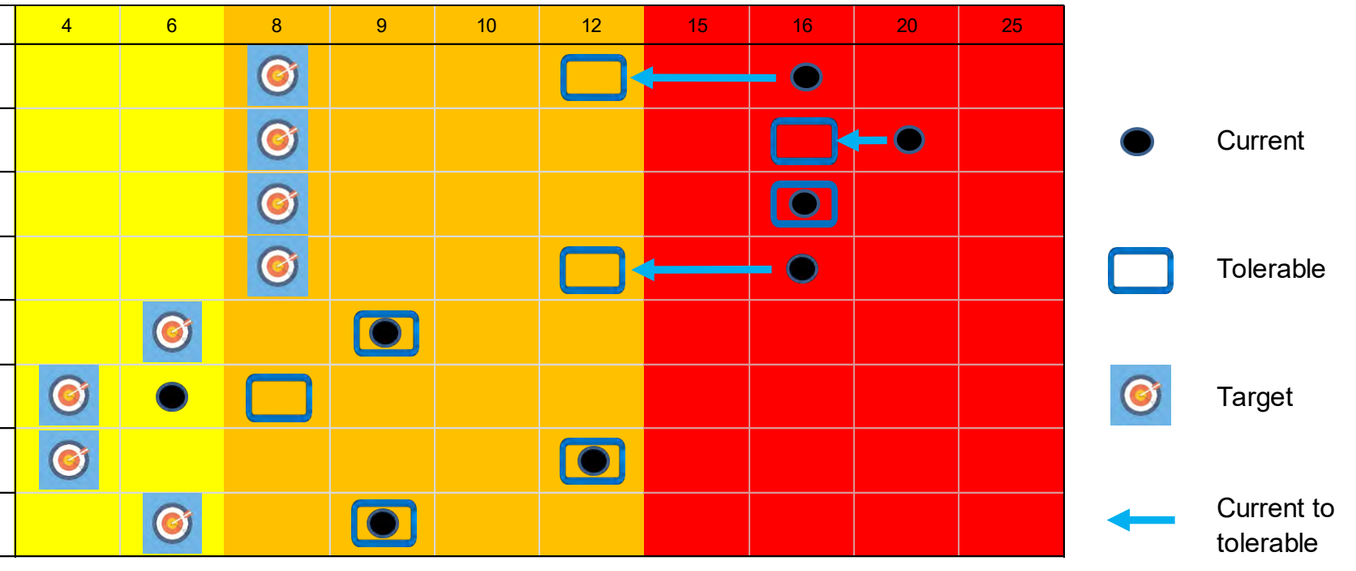
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity

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

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

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

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



Board Assurance Framework (BAF): January 2023

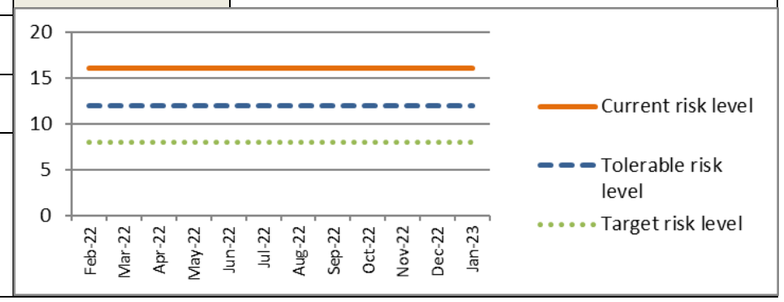
Previous table being replaced

Reference	Principal risk	Lead director	Initial date of assessment	Last reviewed	Target risk score C x L	Previous risk score (at previous review/update) C x L	Current risk score C x L
PR1	Significant deterioration in standards of safety and care	Medical Director	01/04/2018	19/01/2023	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR2	Demand that overwhelms capacity	Chief Operating Officer	01/04/2018	19/01/2023	4 x 2 = 8	4 x 4 = 16	4 x 5 = 20
PR3	Critical shortage of workforce capacity and capability	Director of People	01/04/2018	19/01/2023	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR4	Failure to achieve the Trust's financial strategy	Chief Financial Officer	01/04/2018	19/01/2023	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR5	Inability to initiate and implement evidence-based improvement and innovation	Chief Executive	17/03/2020	19/01/2023	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	Director of Strategy and Partnerships	01/04/2020	10/01/2023	2 x 2 = 4	2 x 3 = 6	2 x 3 = 6
PR7	Major disruptive incident	Director of Corporate Affairs	01/04/2018	10/01/2023	4 x 1 = 4	4 x 3 = 12	4 x 3 = 12
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	Chief Financial Officer	22/11/2021	10/01/2023	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes						
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm
Lead director	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely		
Last reviewed	19/01/2023	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**		
Last changed	19/01/2023						

Strategic objective	1. To provide outstanding care



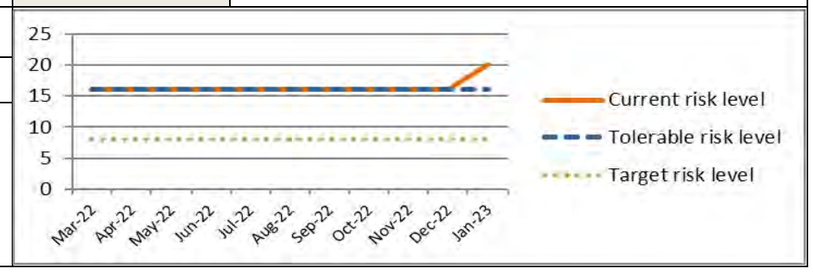
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Scoping and sign-off process for incidents and Sis ▪ Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC Bi-monthly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ People, Culture and Improvement Strategy	Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care ePMA project issues identified as part of the maturing rollout Lack of oversight of established clinical governance when meetings are sttod down due to operational pressures	Review of informatics function and development of informatics strategy **Progress:** Strategic paper developed, awaiting TMT review **SLT Lead:** Chief Digital Information Officer **Timescale:** ~~January~~ February 2023 Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People **Progress:** People, Culture and Improvement Strategy launched, and a number of task and finish groups established **Timescale:** March 2023 Oversee the ePMA project board to resolve identified issues with eTTOs, critical medicines and allergy documentation **SLT Lead:** Medical Director **Timescale:** September 2023 Review and describe which committees are essential to maintain quality and patient care and safety when the Trust in a state of sustained heightened clinical activity **SLT Lead:** Director of Patient Safety **Timescale:** May 2023	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board qrtly Quality and Governance Reporting Pathway; Patient Safety Committee → Quality Committee reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including HSIB and HQIP National and local Reports **Risk and compliance:** Quality Dashboard and SOF to PSC Monthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC bi-monthly; Significant Risk Report to RC monthly **Independent assurance**: CQC Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)		Positive No change since April 2020

Board Assurance Framework (BAF): January 2023

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease (such as pandemic influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Public communications re: norovirus and infectious diseases ▪ Coronavirus identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, CCG, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions ▪ Maintaining mask wearing and screening of patients on admission, and ensuring maintenance of pre-existing IPC requirements			**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly; Regular IPC updates to ICT; PLACE Assessment and Scores Estates Governance bi-monthly **Independent assurance:** Internal audit plan; CQC Rating Good with Outstanding for Care May 20; UKHSA attendance at IPC Committee; Independent Microbiologist scrutiny via IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; HSE visit (COVID-19 arrangements) Dec 21 – no concerns highlighted; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; HSIB IPC assessment and report Nov 20		~~Inconclusive~~ Positive Last changed ~~April 2020~~ November 2022

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care							**Strategic objective**	1. To provide outstanding care
Lead committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Lead director	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	~~4. Somewhat likely~~ 5. Very likely	4. Somewhat likely	2. Unlikely				
Last reviewed	19/01/2023	**Risk rating**	~~16.~~ 20. **Significant**	**16. Significant**	**8. Medium**				
Last changed	19/01/2023								

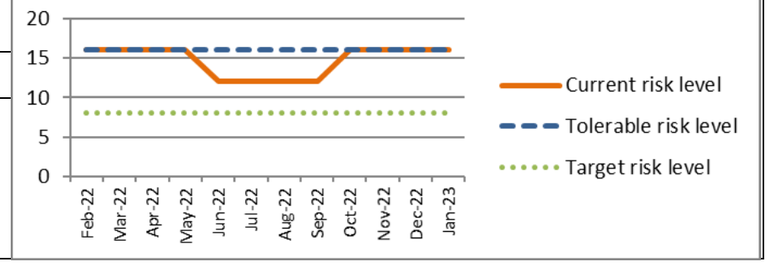


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • F~~A f~~urther ~~Covid-19~~ wave~~s~~ of admissions driven by ~~Omicron variant~~Covid-19, Flu or other infectious diseases. • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ SFH Same Day Emergency Care service in place to avoid admissions into inpatient facilities ▪ Single streaming process for ED & Primary Care – regular meetings with NEMS.~~s~~ ▪ Trust and System escalation policies and proces~~s~~es, including Full Capacity Protocol and Pandemic Surge Plan ▪ COVID-19 Incident planning and governance process ~~▪ Cancer Improvement plan~~ ▪ Trust leadership of and attendance at ~~A&E~~ICS UEC Delivery Board ~~▪ Patient pathway, some of which are joint with NUH~~ ▪ Inter-professional standards across the Trust to ensure we complete today's work today e.g. turnaround times such as diagnostics are completed within 1 day ~~▪ Proactive system leadership engagement from SFH into Better Together Alliance Delivery Board~~ ~~▪ Improving Patient Journey Programme~~ ▪ SFH ~~internal~~ annual ~~Winter~~ capacity plan with specific focus on the Winter period. ~~& Mid Notts~~ICS ~~system capacity plan~~ ▪ Patient pathways, some of which are joint with NUH ▪ Referral management systems shared between primary and secondary care ~~▪ MSK pathways~~ ~~▪ COVID-19 Incident planning and governance process~~ ~~▪ Risk assessments to prioritise individual patients~~ ▪ Optimising Patient Journey Programme focussing on internal flow ▪ Theatres, Outpatients and Diagnostics Transformation Programmes ▪ Elective Steering Group ~~now meeting monthly~~relaunched to steer the recovery of elective waiting times ▪ Emergency Steering Group relaunched to steer improvement across the emergency pathway.~~improvement~~ ▪ ~~Super Surge Plan~~	Physical staffed capacity/estate is insufficient to cope with surges in demand without undertaking exceptional actions e.g. reducing elective operating, bedding patients in alternative areas i.e. daycase	Bed modelling and review of funded/escalation capacity **SLT Lead:** Chief Operating Officer **Timescale:** January to April 2023	**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; Winter Plan considered by ~~to~~ Board in~~Nov 21~~Oct 22; ~~Cancer 62-day improvement plan to Board;~~ Planning documents for 2~~3~~2/2~~4~~3 to identify clear demand and capacity gaps/bridges~~;~~ ~~COVID-19 Recovery Plan to Board Sep 20~~; ~~Elective Steering Group report to Executive Team weekly;~~ Waiting list update to ~~Board quarterly~~TMT monthly; Super Surge Plan considered by ~~to~~ Board in Feb 22. **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Single Oversight Framework Integrated Monthly Performance Report including national rankings to Board; Incident Control Team governance structure considered by ~~to~~ TMT in Mar 20; Cancer services report considered by ~~to~~ Board in Jun 21 **Independent assurance:** NHSI Intensive Support Team reviewed ~~of~~ cancer processes in May 20; Performance Management Framework internal audit report Jun 22 with actions under way.		Positive Last changed December 2020

Board Assurance Framework (BAF): January 2023

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Reductions in availability of hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	~~Daily and weekly themed reporting of the number of MFFD patients in hospital beds~~ ▪ ~~The provision of a 'Discharge Cell' meeting with system partners to take forward this work~~Engagement in ICB Discharge Operational Steering Group ▪ ICS Discharge to Assess business case being implemented~~Mitigation Plan to reduce number of MSFT patients in hospital beds – Discharge to Assess Business Case signed off by ICB August 2022~~ ▪ Multidisciplinary Transfer of Care Hub opened at SFH in October 22. ▪ Opening of additional beds (Sherwood Care Home May 22, Mansfield Community Hospital Nov 22 – Mar 23)	Lack of consistent achievement of the m~~M~~id-Notts threshold for MSFT patients of 22 ~~– this is mainly associated with social care packages (Pathway 1) and is related to home care workforce shortages~~	~~Business case for social care expansion~~Delivery of ICS Discharge to Assess Business Case **SLT Lead:** Chief Operating Officer **Timescale:** phased to ~~March~~ April 2023 Virtual ward ~~model of care funding plan to be considered by Executive Team 27th April~~programme implementation **SLT Lead:** Chief Operating Officer **Timescale:** ~~April 2022~~1st phase to April 2023	**Management:** ~~Reporting into the group reports~~Daily and weekly themed reporting of the number of MFFD patient in hospital beds. Reports into the system CEOs group; ~~Trust winter plan presented to Board Nov 21~~~~Oct 22; Mitigation Plan to reduce number of MSFT patients in hospital beds to Board Dec 21~~ICS UEC Delivery Board and ICS Demand and Capacity Group **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the SOF	Further refinements to MFFD reporting to ensure a single and shared version of the truth within the Trust and between system partners **SLT Lead:** Chief Operating Officer **Timescale:** continual review and improvement to June 2023	Inconclusive No change since ~~New~~ threat added in January 2022
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the ~~CCG~~ ICS risk register/BAF entry relating to operational failure of General Practice ~~Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development~~ ▪ Weekly ~~Executive meeting with the CCGs~~Chief Officer calls across ICS, including Primary Care ▪ ~~Weekly Mid-Notts Network Calls~~Mid Notts ICP represented at weekly Incident Control Team meeting			**Management:** Routine mechanism for sharing of ~~CCG~~ ICS and SFH risk registers – particularly with regard to risks for primary care staffing and demand	Lack of visibility in primary care demand and capacity **Action:** Continue to push via ICS UEC Delivery Board and ICS Demand and Capacity Group the importance of system-wide oversight of demand and capacity **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development. ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ ~~Weekly management meeting with the Service Director from Notts HC~~ ▪ ~~Bilateral work – Strategic Partnership forum~~			**Risk and compliance:** ~~Divisional NUH/SFH strategic partnership forum minutes and action log;~~ NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area **Action:** Continue to work with system partners within ICS forums e.g. ICS UEC Delivery Board and System Flow Meetings **SLT Lead:** Chief Operating Officer **Timescale:** Ongoing during 2023	~~Inconclusive~~ Positive ~~No change since April 2020~~Last changed November 2022
Growth in demand for care in our maternity services (population growth and increase in out of area referrals)	▪ Over-established midwifery by 10% from 2021/22 ▪ Fully restarted home birth services following closure during the pandemic (and partial re-opening in early post-pandemic phase) ▪ Additional antenatal clinics based on overtime/bank ▪ Recruited additional consultants (12 in 2020 to 14 at time of writing) ▪ Maternity assurance group (monthly) ▪ Director of Midwifery providing Board-level oversight	Midwifery staffing vacancies (gap of 5.6% WTE against establishment) No increase in junior medical staffing Nursing gaps in neonatal unit Not standalone junior out of hours on call for neonatal (as per critical care review) Physical capacity/estate will be insufficient should growth trends continue in the coming years	Maternity and Neonatal service review document in development **SLT Lead:** Chief Operating Officer **Timescale:** end of March 2023 ANP recruitment under way **SLT Lead:** Chief Operating Officer **Timescale:** Current recruitment round to complete in 22/23 Q4	**Management:** Maternity dashboard that includes all relevant KPIs and quality standards (live and reviewed monthly at performance meetings) **Risk and compliance:** Maternity and gynaecology and divisional performance meetings (monthly)		Positive New threat added January 2023

Board Assurance Framework (BAF): January 2023

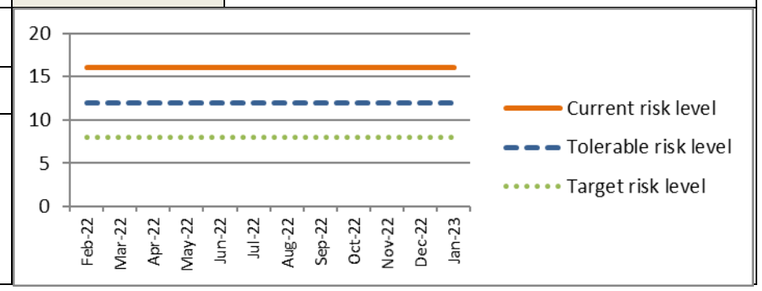
Principal risk (what could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care							**Strategic objective**	3: To maximise the potential of our workforce
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	4. Somewhat likely	2. Unlikely				
Last reviewed	19/01/2023	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**				
Last changed	19/01/2023								

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Inability to attract and retain staff due to demographic changes (including a significant impact of external factors and/or unforeseen circumstances) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition), or mental health issues relating to the working environment, resulting in critical workforce gaps in some clinical services	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Medical and Nursing task force ▪ Activity, Workforce and Financial plan ▪ 2-year workforce plan supported by Workforce Planning Group and review processes (consultant job planning; workforce modelling; winter capacity plans) ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels ▪ Education partnerships ▪ Director of People attendance at People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ Nursing and Midwifery Workforce Transformation Cabinet ▪ Medical Workforce Transformation Cabinet ▪ Strategic People Plan	Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care Lack of consistency across the system with regard to recruitment and retention, creating competition and not maximising opportunities	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** March 2023 Involvement in the recruitment process for the system Chief People Officer **SLT Lead:** Director of People **Timescale**: ~~November 2022~~Complete Work with the Chief People Officer to form a provider collaborative forum for recruitment and retention **SLT Lead:** Director of People **Timescale**: June 2023	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to PCI Committee Jun 22; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to PCI Committee bi-monthly; Leadership Development Strategy Assurance Report to PCI Committee Jun 22 **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators (Monthly); Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Pre-employment Checks internal audit report Feb 21 – significant assurance; HSJ Award for Acute Trust of the Year 2021; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr 21	Staff mental health issues as a result of psychological trauma Potential impact of pending changes to the pensions arrangements and NI rules Explore the implementation of payment via multiple assignments to reduce pension tax liabilities **SLT Lead**: Director of People **Timescale**: ~~November 2022~~Complete	Positive Last changed June 2022

Board Assurance Framework (BAF): January 2023

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A significant loss of workforce productivity arising from a short-term reduction in staff availability or a reduction in effort above and beyond contractual requirements amongst a substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint, workforce fatigue or wellbeing issues, or failure to achieve consistent values and behaviours in line with desired culture This could also lead to lack of engagement with patients, resulting in failure to address patient empowerment and self-help and failure to work across the system to empower patients and carers to enable personalised patient centred care	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Chief Executive's blog / Staff Communication bulletin ▪ Engagement events with Staff Networks (BAME, LGBT, WAND, Time to Change) ▪ Schwartz rounds ▪ Learning from COVID ▪ Staff morale identified as 'profile risk' in Divisional risk registers ▪ Star of the month/ milestone events ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Winter wellbeing approach for 2022/23 ▪ Staff counselling / Occ Health support ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy ▪ Industrial action group further developing preparedness for the Trust, ~~and~~ system and the wider community	Inequalities in staff inclusivity and wellbeing across protected characteristics groups	Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Director of People **Timescale:** March 2023	**Management:** Staff Survey Action Plan to Board May 21; Staff Survey Annual Report to Board Jun 21; Equality and Diversity Annual Report Jun 22; WRES and WDES report to Board Jun 21; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Winter Wellness Campaign report to Board Oct 21; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug 21; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr 21; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr 21; Anti-Racism Strategy to Board Mar 22; Mental Health Strategy to PCI Committee Jun 22 **Independent assurance:** National Staff Survey Mar 21; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr 22; NHS People Plan – Focus on Equality, Diversity and Inclusion internal audit report Jun 22	Potential impact of cost of living issues on staff morale and wellbeing Expected increase in staff sickness and isolation levels due to COVID-19 and influenza Potential industrial action up to and including strike action from all NHS unions, affecting all system partners Finalise and implement the industrial action plan **SLT Lead:** Director of People **Timescale**: ~~November 2022~~Complete Develop operational plans for any junior doctor strikes **SLT Lead:** Director of People Timescale: February 2023	Inconclusive Last changed October 2022

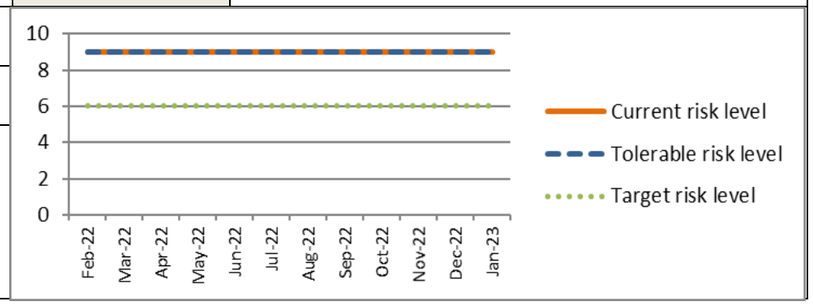
Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**	5: To achieve better value
Lead committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
Lead director	Chief Financial Officer	**Consequence**	4. High	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	3. Possible	2. Unlikely				
Last reviewed	19/01/2023	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	19/01/2023								

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ Transformation and Efficiency Cabinet, FIP planning processes and PMO coordination of delivery ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ Close working with ICB partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ COVID-19 related funding application process in place at Trust level ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ Forecast sensitivity analysis and underlying financial position reported to Finance Committee ▪ Capital Oversight Group	Medium/Long Term Financial Strategy was developed pre-pandemic and does not reflect the current financial framework Revenue business case process may not adequately represent the longer-term priorities and potential consequences of future years	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level. SLT Lead: Chief Financial Officer Timescale: January 2023 Review and implement enhanced business case process for 2023/24 planning and in-year prioritisation **SLT Lead:** Chief Financial Officer **Timescale:** January 2023	**Management:** CFO's Financial Reports and Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ICS finance report to Finance Committee (monthly); Capital Oversight Group; Divisional Performance Reviews (monthly); Divisional risk reports to Risk Committee bi-annually; Transformation & Efficiency Cabinet updates to Executive Team **Risk and compliance:** Risk Committee significant risk report Monthly **Independent assurance**: Deloitte audit of COVID-19 expenditure; External Audit Year-end Report 2021/22 Internal Audit reports: - Key Financial Systems - Asset Register Jan 22 - Integrity of the General Ledger and Financial Reporting Dec 21 - Financial Reporting Arrangements Nov 21 - Improving NHS financial sustainability Dec 22	Off trajectory to achieve year-end financial plan, including FIP target Reprioritisation to achieve FIP recovery plan **SLT Lead:** Chief Financial Officer **Timescale:** ~~November 2022~~Complete Complete the steps of the forecast change protocol and agree a revised forecast with ICB partners and NHS England **SLT Lead:** Chief Financial Officer **Progress:** We have been instructed by NHSE not to change the forecast for month 9 **Timescale:**-February 2023	Positive Last changed July 2022
ICB system deficit results in a negative financial impact to the Trust	▪ Full participation in ICB planning ▪ SFH plan consistency with ICB and partner plans ▪ ICB DoFs Group ▪ ICB Operational Finance Directors Group ▪ ICB Financial Framework	ICB Medium/Long Term Financial Strategy to be developed	Financial strategy for 3-5 years to be developed at a Trust and Integrated Care Board level **SLT Lead**: Chief Financial Officer **Timescale:** TBC (dependant on NHSE/I and ICB Guidance)	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board		Positive Last changed July 2022

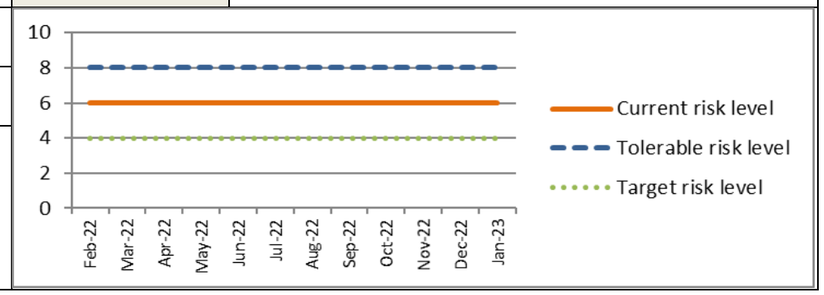
Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care						**Strategic objective**	4: To continuously learn and improve
Lead committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation	
Lead director	~~Chief Executive~~ Director of Strategy and Partnerships	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious	
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely			
Last reviewed	19/01/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	19/01/2023							



Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform	The improvement function needs to be defined and organistionally embedded following the restructure	Establishment of an Innovation Hub **Progress:** Successful bid for £20k from the Health Foundation to support development of an organisational level Innovation Hub, and a Provider Collaborative Hub between SFH, NUH and NHCT **SLT Lead:** Director of Culture and Improvement **Timescale:** ~~December 2022~~Superseded Development of an ideas platform within the remit of the Improvement Faculty **SLT Lead:** Director of Strategy and Partnerships **Timescale:** June 2023	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** SOF Culture and Improvement indicators; SFH Trust Priorities to Board quarterly **Independent assurance:** Internal Audit of FIP/ QIPP processes Sep 21; 360 assessment in relation to Clinical Effectiveness - report May 2022	~~Delays in training, planned improvement and innovation programmes due to COVID-19~~ Lack of capacity for colleagues to engage with improvement Consider ways to provide the capacity to progress improvement activity **SLT Lead:** ~~Chief Executive~~ Director of Strategy and Partnerships **Timescale:** ~~December 2022~~ June 2023	Inconclusive Last changed October 2022

Board Assurance Framework (BAF): January 2023

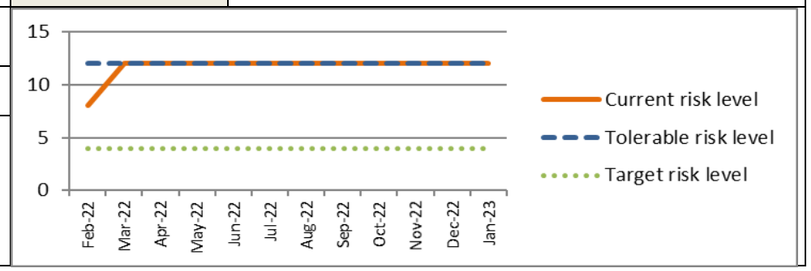
Principal risk (what could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working. This may be difficult because of differences in governance, objectives and appetite for and ability to change							**Strategic objective**	2: To promote and support health and wellbeing
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services		
Lead director	Director of Strategy and Partnerships	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely				
Last reviewed	10/01/2023	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**				
Last changed	26/10/2022								

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP breakthrough objectives signed off July 2020 • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSE • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans • Full alignment of organisational priorities with system planning for 2022/23 • Independent chair for ICP • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative development • ICS System Oversight Group • Engagement with the establishment of the formal ICB and place-based partnership • SFH Chief Executive is a member of the ICB as a partner member representing hospital and urgent & emergency care services (both formally established on 1st July 2022) • Mid Notts Place Executive			**Management:** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board **Risk and compliance:** Significant Risk Report to RC monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance		Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy ▪ ICS Clinical Services workstreams are well established across elective and urgent care and SFH is represented and involved appropriately ▪ Clinical Directors and PCN Directors clinical partnership working	The needs of the population and the statutory obligations of each individual organisation will not be met until the ICS Clinical Services Strategy is implemented	Refreshed ICS Clinical Services Strategy led by the ICB Medical Director **SLT Lead:** Medical Director **Timescale:** September 2023	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place		Positive Last changed October 2022

Board Assurance Framework (BAF): January 2023

Principal risk (what could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						
Lead committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Lead director	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	**3. Possible**	3. Possible	1. Very unlikely		
Last reviewed	19/12/2022	**Risk rating**	**12. High**	**12. High**	**4. Low**		
Last changed	31/10/2022						

Strategic objective	1: To provide outstanding care

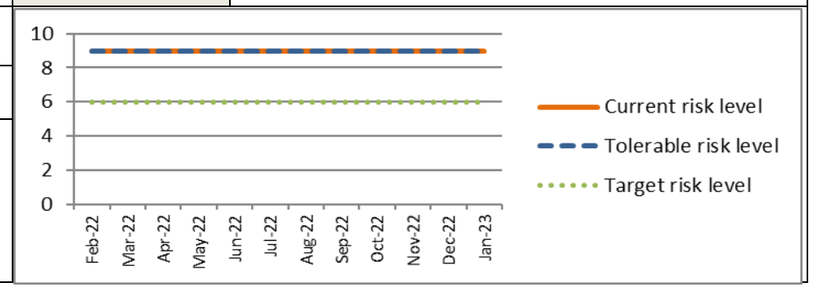


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ Cyber news – circulated to all NHIS partners ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead			**Management:** Data Security and Protection Toolkit submission to Board Jul 22- compliant on 108/109 elements; Hygiene Report to Cyber Security Board monthly; Cyber Security Assurance Highlight Report to Cyber Security Board monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; Cyber Security report to Risk Committee – increased levels of attack due to the war in Ukraine **Risk and compliance:** **Independent assurance**: ISO 27001 Information Security Management Certification; TIAN / 360 Assurance Cyber Security Survey - The impact of Covid-19 on the NHS Dec 20; CCG Cyber Security Report Mar 21- Significant Assurance; 360 Assurance NHIS Governance and Interface audit – limited assurance; 360 Assurance Data Security and Protection Toolkit audit Jul 22 –moderate assurance; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan 22		Positive No change since April 2020
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Water Safety Update Report to Risk Committee Jul 20; Patient Safety Concerns report to QC March 21; Hard and soft FM assurance reports **Risk and compliance:** Monthly Significant Risk Report to Risk Committee **Independent assurance:** Premises Assurance Model to ~~RC Dec 18~~Executive Team Oct 22; EPRR Core standards compliance rating (Oct 21) – Substantial Assurance; Water Safety report (WSP) to Joint Liaison Committee Oct 19; WSP report – hard FM independent audit; MEMD ISO 9001:2015 Recertification Mar 21; British Standards Institute MEMD Assessment Report Feb 22		Positive No change since April 2020

Board Assurance Framework (BAF): January 2023

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period	▪ NHS Supply Chain resilience planning Business Continuity Management System & Core standards ▪ CAS alert system – Disruption in supply alerts ▪ Major incident plan in place ▪ PPE Strategy ▪ COVID-19 Pandemic Surge Plan ▪ Procurement Influenza Pandemic Business Continuity Plan ▪ Interim provision for transmission of personal data to the United Kingdom clause within the EU Exit agreement			**Management:** Procurement Annual Report to Audit & Assurance Committee; Oxygen Supply Assurance report to Incident Control Team Apr 20; COVID-19 Governance Assurance Report to Board May 20 **Risk and compliance:** **Independent assurance**: 2021/22 Counter Fraud Annual Report; 360 Assurance Procurement Review Apr 21 – Significant Assurance; 360 Assurance internal audit of contract management – limited assurance		Positive No change since April 2020

Principal risk (what could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable							**Strategic objective**	2: To promote and support health and wellbeing
Lead committee	~~Risk~~Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action		
Lead director	Chief Financial Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious		
Initial date of assessment	22/11/2021	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely				
Last reviewed	19/01/2023	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**				
Last changed	23/12/2022								



Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (are further controls possible in order to reduce risk exposure within tolerable range?)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support ▪ Process in place for gathering and reporting statistical data	Education of Board and staff at all levels Dedicated capacity to implement ideas for change	Training of the Board, decision makers and all staff at an appropriate level to increase awareness and understanding of sustainable healthcare **Lead:** Associate Director of Estates and Facilities **Timescale:** December 2022 Review of existing approaches and capacity to act on ideas to improve the Trust's impact on climate change. **Lead:** Chief Financial Officer **Timescale:** ~~October 2022~~Complete Proposal to ICB partners for collaborative approach and resource. **Lead:** Chief Financial Officer **Timescale:** ~~October~~ December 2022	**Management:** Sustainability update report to TMT Oct 22; Green updates provided routinely to Finance Committee **Risk and compliance:** Green Plan to Board Apr 21; Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Governance structure for reporting on progress to be confirmed **Lead:** Chief Financial Officer **Timescale:** ~~October 2022~~Complete	~~Inconclusive~~ Positive ~~New risk added November 2021~~ Last changed November 2022

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Board Assurance Framework and Significant Risks Report	**Date**: 2nd February 2023	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
Presented By:	Paul Robinson, Chief Executive		

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

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

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

Committees/groups where this item has been presented before

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

Executive Summary

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

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

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

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

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

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

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

Schedule of BAF reviews since last received by the Board of Directors on 3rd November:

- Quality Committee: PR1 and PR2 – November and January
- People, Culture and Improvement Committee: December and January [1]
- Finance Committee: PR4 and PR8 – December and January [1, 2]
- Risk Committee: PR6, PR7 and PR8 – November, December and January [2]

1. The Finance and People, Culture and Improvement Committee meetings are scheduled for 31st January so some of the proposed changes had not been reviewed by those committees at the time of submitting this report
2. The Finance Committee reviewed PR8 as part of the proposed change of lead committee from Risk Committee

PR1, PR2, PR3 and PR4 remain significant risks, and it is proposed that the current risk score for PR2 increases to 20 to reflect the current operational pressures.

The current risk ratings for PR1 and PR4 remain above their tolerable risk ratings, and the proposed increase in score moves PR2 above its tolerable rating.

The Lead Director for PR5 has been changed to reflect the current structure.

A new chart has been added to the front sheet of the BAF, that shows the current, tolerable and target risk scores for each of the principal risks, and highlights where current risk ratings are above tolerable levels.

It is proposed that this table replaces the table used in previous reports (shown on page 2 of the attached BAF).

Board members are requested to:

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

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors - Public - Cover Sheet

Subject:	Application of Trust Seal	**Date**: 2nd February 2023	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Shirley A Higginbotham, Director of Corporate Affairs		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
To provide the Board with notification of the use of the Trusts Official Seal		**Approval**	x
		Assurance	
		Update	
		Consider	

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

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

Committees/groups where this item has been presented before

N/A

Executive Summary

In accordance with Standing Order 10, the Sherwood Forest Hospitals (NHS) Trust Official Seal has been affixed:

(18th January 2023), to the following documents by the Chief Executive and the Director of Corporate Affairs / Company Secretary.

- Seal number 100:
  Sherwood Forest Hospitals NHS FT and Keir Construction Ltd – The repair and upgrade of firestopping installation (Keir project number 036356)

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	External Well-led Review – Recommendations, Progress Report	**Date**: 2nd February 2023	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Shirley A Higginbotham, Director of Corporate Affairs		
Presented By:	Shirley A Higginbotham, Director of Corporate Affairs		
Purpose			
The purpose of this paper is for the Board to receive assurance regarding progress against the achievement of the recommendations identified in the final report from the Grant Thornton Well Led Review March 2022		**Approval**	
		Assurance	x
		Update	
		Consider	

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

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

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

Executive Summary

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

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

The initial report detailing the 15 recommendations was presented to Board in April 2022 and a further update in August 2022.

This report provides progress against those recommendations, noting 11 are complete and four remain outstanding, progress reports are provided for those which remain outstanding.

Recommendation 8 – Requires further discussion and agreement by Board

Board of Directors Meeting in Public

Subject: External Well-led Review – Recommendations, Progress Report
Date: 2nd February 2023
Author: Shirley A Higginbotham, Director of Corporate Affairs

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

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

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

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

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

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

This report provides progress against those recommendations, noting 11 are complete and four remain outstanding, progress reports are provided for those which remain outstanding.

Recommendation 8:

The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.

This has been included in the FTSU reports to Board, however the system used to collate the Guardian of Safe Working Hours report does not have the facility to record ethnicity and gender data, which would mean a manual investigation via ESR for each exception report, which would be very time consuming. This data is included in the Medical Workforce Report. Board are asked to discuss and agree if this recommendation can be closed.

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

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

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

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

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

		raised concerns three to six months following closure of the case to discuss how they are and if they have suffered detriment as a result of speaking up				
8.	**Low**	**Reporting data to capture gender and ethnicity characteristics** The FTSU Guardian submits data as required to the National Guardian's Office and the FTSU Guardian and the Guardian of Safe Working Hours report to the Board twice a year. Neither Guardians report data by ethnic group or gender and this may offer additional information for the Board to analyse in terms of themes and trends. **Recommendation:** The FTSU Guardian and Guardian of Safe Working Hours should capture data by gender and ethnicity where possible to allow for additional analysis, themes and trends.	**Progress update February 2023**: Included in the FTSU report to Board in August 2022. Complex to include in Guardian of Safe Working Hours report, is included in Medical Workforce Report	Director of Corporate Affairs and Executive Medical Director	**Board to Agree if accept recommendation completed**	September 2022
KLOE 4 – Are there clear responsibilities, roles and systems of accountability to support good governance and management?						
9.	**Low**	**Highlight report to the Board of Directors** There is variance in the quality of reporting the work of the Committees to the Board. A more common approach using a quadrant style	A quadrant template has been developed and has been implemented from April Committees. **Complete**	Director of Corporate Affairs	**Complete**	June 2022

		reporting could more effectively identify key issues and action taken. **Recommendation:** Committee Chairs should consider the use of a quadrant style report to present at the Board meeting. Headings of the 4 quadrants are commonly: • Matters of concern or key risks to escalate • Major actions commissioned / work underway • Positive assurances to provide • Decisions made				
10.	**Low**	**Committee Assurance** Committee Chairs have not routinely observed the key meetings that feed into their Committee for assurance, and this should be considered on an annual basis to confirm confidence in the governance and reporting framework. **Recommendation:** On an annual basis NEDs who Chair Committees should observe the sub-meetings/groups that feed into their Committee to gain a view on how business is undertaken.	Committee Chairs have observed all key meetings which feed into their committee	Director of Corporate Affairs	**Complete**	September 2022
11.	**Low**	**People, Culture and Improvement**				

		Committee The Chair of the Committee does not routinely meet with the Lead Executive for this Committee, more ad-hoc arrangements occur. Setting up a scheduled arrangement would be beneficial to allow for regular discussion of progress, current issues and the identification of areas where further work my b indicated **Recommendation:** The Chair of the People, Culture and Improvement Committee should set up regular meetings with the lead Executive Directors	A schedule of regular meetings prior to committee meeting will be developed and implemented **Complete**	Director of People	**Complete**	June 2022
	KLOE 5. – Are there clear and effective processes for managing risks, issues and performance?					
12.	**Low**	**Divisional Performance Reviews** We attended the November 2021 round of Performance Reviews for all five clinical Divisions. The Performance Review meetings are well organised and mutually supportive. We note that Urgent and Emergency Care Division presented an informative HR performance report and whilst other Divisions talk about their HR issues, they did not include a presentation of metrics. HR	All future Divisional Performance Reviews will include the presentation of their HR Performance report. All divisions now have an HR report which they present monthly within their DPRs **Complete**	Chief Operating Officer	**Complete**	June 2022

		performance reports are routinely created and supplied to Divisions via the HR Business Partner, and these should be presented at each Division Performance Review. **Recommendation:** All Divisions should ensure their HR performance report is presented for discussion at Divisional Performance Reviews.				
	KLOE 6 – Is appropriate and accurate information being effectively processed, challenged and acted on					
13.	**Medium**	**Data Quality Strategy** The Trust's Data Quality Strategy 2018-2020 is due for review. It sets out governance arrangements involving the Data Quality Oversight Group (DQOG). However, the DQOG was disbanded in November 2020 as the workstreams actions had been completed. Therefore, the Trust does not currently have a stand-alone formal forum through which data quality issues are monitored and addressed. The Trust is currently in the process of moving to a more integrated approach, where data quality is		Executive Medical Director		December 2022

		owned and monitored across the wider governance structure. It is intended that updates on data quality for areas within their remit will be provided regularly through the Divisional governance structures and the Trust's Risk Management framework, but this process is not yet fully documented, and roles and responsibilities need to be clarified. It is however a reasonable expectation that the new postholder will formalise the governance arrangements at the time the Data Quality Strategy is refreshed. **Recommendation :** Once in post the new Chief Digital Information Officer should contribute to the refresh of the Data Quality Strategy to ensure it adequately documents roles/responsibilities and the governance structure where data quality issues will receive oversight and management.	The Trust has established a Patient Information and Data Assurance Group (PIDAG). This has been chaired by the Chief Digital Information Officer. The group has: • Begun to develop a workplan relating to data quality issues • Capture and track NHS Data Set Change Notices • Reviewed the initial work relating to 'kitemarking' of key data sets • Begun to consider the importance of the data quality lifecycle in relation to all the above			
14.	**Low**	**Data Quality Assurance Indicators** The Trust does not at present utilise a Data Quality Assurance Indicator. A data quality traffic light or kite mark		Director of Corporate Affairs	**On-Going**	On-Going

		could be used to appear next to key performance indicators in the SOF report to provide visual assurance on the quality of data underpinning a performance indicator. A visual indicator acknowledges the variability of data and makes an explicit assessment of the quality of evidence on which the performance measurement is based **Recommendation:** The Trust should consider the use of Data Quality Assurance Indicators to inform users of any data quality risks attached to the data that might impact decision making.	The initial work of the group will address the Information management sign off and governance in relation to data and its quality.			
	KLOE 7. – Are people who use services, the public, staff and external partner engaged and involved to support high quality sustainable services?					
	We have not made any recommendations in this area as the Trust is already working on issues identified.					
	KLOE 8. – Are there robust systems and processes for learning, continuous improvement and innovation?					
15.	**Medium**	**Continuous Improvement** The Trust has a vision for 'Continuous Improvement at SFH'. Whilst it is clear that there is considerable improvement activity at the Trust it is not clear how the improvement activities e.g. Continuous Improvement; Pathways to Excellence; Advancing Quality programme and Clinical Audit are linked. Although staff refer to a	**Progress update February 2023** There are currently 32 improvement projects recorded on AMAT since the module went live in July 2022, and this is available to colleagues across the organisation as a knowledge	Director of Strategy and Partnerships	**On-Going**	September 2022

		Continuous Improvement Strategy this is not described in a document and this is required to demonstrate the breadth and depth of work, how it aligns to other strategies and to enable a better understanding for staff. During our interviews, including some Board level interviews, this area was not well articulated, with staff talking very generally about improvement activity and some staff not being familiar with what improvement methodology was in place. It is important that staff can articulate how the Trust describes and navigates its improvement activities, and this will be a key area CQC will look for assurances of an embedded and well understood approach when they talk to staff, and further work is required as a priority to achieve this. **Recommendation:** Further work is required to document and communicate the vision for 'Continuous Improvement at SFH' This will assist staff in their understanding of the breadth and depth of work and the methodologies in use. Outcomes of quality improvement projects should be celebrated through the Trust's services.	management resource. Learning from projects has been shared at various forums over 2022 – the Improvement and Learning sub cabinet, the Senior Leadership team meeting, the People, Culture and Improvement Committee and the Improvement and Clinical Audit Group (all minuted/recorded). Over 2023, the aim is to focus all Improvement resources under a single Improvement Faculty, which should further amplify the visibility, focus and learning from Improvement at SFH. This will also clarify the 'Improvement Production System' on how we undertake Improvement at SFH, in line with national learning from the Virginia Mason NHS experience and the proposed NHSE national Improvement Framework.			

Sherwood Forest Hospitals
NHS Foundation Trust

Public Board of Directors meeting
Coversheet and Report

Subject:	Integrated Care System Update	**Date**: 2nd February 2023	
Prepared By:	David Ainsworth, Executive Director of Strategy & Partnerships		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	David Ainsworth, Executive Director of Strategy & Partnerships		
Purpose			
To update on key events and information from the past month.		**Approval**	
		Assurance	x
		Update	
		Consider	

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

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

Committees/groups where this item has been presented before

None

Executive Summary

Provider Collaborative at Scale

A visioning event is being held on 30th January. An opportunity to test appetite for change. Using a number of carefully thought through transformation opportunities. Topics including discharge, workforce and general practice. The event will be attended by executives, chairs and CEOs. Board can expect an update next time on the agreed outputs.

Mid Nottinghamshire Place Based Board

A workshop to agree the priorities for 2023/24 is also being held in January. With key partners across the wider determinants. An opportunity to reset the focus for the coming year. It is expected real challenge on being specific about the added value of working together brings. The workshop will include the public voice.

Mid Nottinghamshire Place – Care Home Deterioration

The place based team, employed by SFH, were successful in a bid to deliver a contract on behalf of the ICS. Delivering training into care homes around early deterioration. Supported by the corporate nursing and education teams at SFH, a programme of training and support will be delivered over the next 12 months into local care homes. The expectation of training is that proactive management may reduce the number of crises through earlier clinical intervention.

Mansfield Place Board

Met in January and reviewed the membership for 2023. SFH were asked to remain the sole NHS partner on the board. Over the last 2 years we have supported in the background on the development of plans for The Beales shopping centre into a much broader health and wellbeing hub. The bid successfully attracted levelling up funds which is fantastic news for Mansfield. Further conversations will be held to understand the interdependency with developments at Mansfield Community Hospital.

Health Scrutiny Committee Gives Approval

The HSC reviewed the Newark TIF plans and approved the trust to continue with the planned expansion. This is great news for Newark and will create additional jobs as well as bring a real vibrancy to Newark Hospital site. Demonstrating our strategic intent to develop Newark Hospital for the future.

Notts County Council Visit to Kings Mill Hospital

Adrian Smith, CEO, Nottinghamshire County Council, visited Kings Mill site in January. Meeting colleagues from divisions along the urgent and emergency pathway through to the integrated discharge hub. This opens further positive opportunities for SFH to work with the County Council on strategic priorities. A care agency has been approached to develop some early testing around monitoring people in their own home setting; especially around discharge support from hospital.

Our Role as Anchor in the Education Sector

Board will have seen and heard of the positive ‘Step in to the NHS’ Careers event heled at Vision Wets Notts College with partners from Nottingham Trent University. Indicating our success in working with partners and our ability to create local job opportunities for local people. This, over time, supports the local economy.

Arts, Culture and Heritage – Mansfield and Ashfield Compact

SFH provides the chair role through the director of strategy and partnerships. The compact is a partnership of sector representatives including libraries, theatres, business and councils. Attracting Arts Council funding with an ambition to drive local people’s aspiration in the sector – for future workforce pipeline as well as contributing to the local visitor and tourism economy. This month the compact submitted an expression for continued funding to continue the compact during 2023. The decision is outstanding at time of writing.

The Board are asked to **NOTE** the update.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

All reports MUST have a cover sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:** 2 February 2023	
Prepared By:	Paula Shore, Director of Midwifery/ Head of Nursing		
Approved By:	Phil Bolton, Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/ Head of Nursing, Phil Bolton, Chief Nurse		
Purpose			
To update the board on our progress as Maternity and Neonatal safety champions		**Approval**	
		Assurance	**X**
		Update	**X**
		Consider	

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

Identify which principal risk this report relates to:		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
PR3	Critical shortage of workforce capacity and capability	
PR4	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

- Maternity and Neonatal Safety Champions Meeting

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 (MTP) 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 December 2022

1.Service User Voice

Due to operational pressures the meeting was conducted by a virtually review of the agenda. As part of the agenda the below wordal was shared by our Parent Voice Champion Sarah who is pulling together an annual report. This wordal has been performed from her first 9 months in post after 186 contacts with women and their families. Once the annual report is available this will be presented to through the safety champion forums and meetings, alongside being shared with the teams.

2.Staff Engagement

The MNSC Walk Round was completed on the 19th of December 2002. Staff spoke about and was visible the change in activity however they noted the position of the Trust in regard to the critical incident and how this has impacts on the services. Similar themes to previous walk round have been report around the increased activity and the issues around the estates as to how this is impacting on the daily activity.

The maternity forum was cancelled due to ongoing Trust wide pressures this month and is rescheduled for January.

3.Governance
Ockenden:

The National team are currently out for consultation for a single delivery plan which is understood that the findings from the Ockenden and Kirkup Report being combined under a singular assurance framework due Easter 2023.

Through the LMNS Ockenden Assurance Meeting, we are working on the three elements of the East Kent Report to focus on as a system until the single oversight framework is available, once

the details have been finalised these will be reviewed through both the MNSC meeting and MAC. Attendance from SFH continues at both the monthly and quarterly Ockenden Assurance Panel. The outstanding action required for full compliance sits with the development of the website at SFH, now the digital system has been implemented this has now been prioritised.

NHSR:

The divisional working group continues to work on the delivery of the scheme, meeting fortnightly with the last meeting planned in January for this year's submission. No risks have been identified since the reporting deadline for the 5th of December has closed and the safety actions are being prepared for the review through MAC. The final presentation to Trust Board has been prepared and listed for review through the MAC, QC and LMNS Executive Partnership Meeting.

Saving Babies Lives:

The Saving Babies Lives Care Bundle provides detailed information for providers and commissioners of maternity care on how to reduce perinatal mortality across England. The second version of the care bundle brings together five elements of care that are widely recognised as evidence-based and/or best practice:

Reducing smoking in pregnancy
Risk assessment, prevention and surveillance of pregnancies at risk of fetal growth restriction (FGR)
Raising awareness of reduced fetal movement (RFM)
Effective fetal monitoring during labour
Reducing preterm birth

Version 3 of the care bundle will be launched this year adding an additional element focusing on diabetes. Due to the reporting and training requirements divisional we are looking at a role which will support the delivery of this as part of the maternity safety team.

SFH has continued to monitor its compliance with all elements of the Saving Babies' Lives Care Bundle v2. On-going progress is reported externally quarterly to NHSE via the Midlands Maternity Clinical Network. Within Safety Action 6 of the Maternity Incentive Scheme, process and outcome measures regarding compliance have been validated. SFH are continuing to work towards compliance and are being supported through action plan, drafted by the service director and supported by the MCN, LMNS and ICB. The quarterly paper will be delayed until the next agenda due to the data release dates.

CQC:

On the 22nd of November 2022 we had a 3-day visit from the Care Quality Commission (CQC). This was part of the national planned review of all Maternity Services across England following the recommendation from the Ockenden Report. We have received the draft report and are responding to this within the allocated timeframes, once the report is final this will be shared with the teams.

4. Quality Improvement

On the 11th of January 2023 the CQC released the result of the 2022 national Maternity Survey. Women and other pregnant people who gave birth between 1 and 28 February 2022 (and January if a trust did not have a minimum of 300 eligible births in February) were invited to take part in the survey. Fieldwork took place between April and August 2022. Responses were received from 20,927 women and people who had recently given birth. This was a response rate of 46.5%.

At a national level the 2022 maternity survey shows that people's experiences of care have deteriorated in the last 5 years. Trend analysis was carried out on 26 evaluative questions on data from between 2017 and 2022. Of these questions, 1 showed a statistically significant upward trend, 4 showed no change and 21 showed a statistically significant downward trend. Furthermore, of the 21 questions with downwards trends, results for 2022 were at the lowest point for the 5-year period in 10 cases.

Results for 18 of these questions declined during the height of the pandemic (2021). Out of the 18 questions that saw a large decline in experience in 2021, 5 have seen a further decline in 2022 and 6 have stayed level with 2021 results. This indicates that some experiences of maternity services haven’t yet recovered to pre-pandemic levels including care during labour and birth and postnatal care at home and in hospital.

At SFH we have reviewed our data and a detailed response and action plan will be brought through the MNSC to Board.

5.Safety Culture

The planned delivery for the SCORE survey has commenced for Q4 2022/23 with a slight delay due to the critical incident. This will be used to provide a local quality improvement plan, triangulating the PTE and staff survey findings.

Maternity Perinatal Quality Surveillance model for January 2023

	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE	WELL LED
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD	GOOD

Sherwood Forest Hospitals
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2019	
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	72%
Proportion of speciality trainees in O&G responding with 'excellent or good' on how they would rate the quality of clinical supervision out of hours (reported annually)	89.29%

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

3rd and 4th Degree Tears (1.83% N=3 Dec 2022)

- Rate back below national threshold.
- Deep dive review into cases and comparison to be completed. No identifiable themes are trends found.

Stillbirth rate Q3 (3.2/1000 births)

- SFH stillbirth rate, for year to date now returned and remains below the national ambition of 4.1/1000 birth
- Two reportable cases for December, reportable to PMRT surveillance tool only at present.

Staffing red flags (Dec 2022)

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

Home Birth Service

- Homebirth services resumed on the 19th of September.
- 10 Homebirth conducted since the writing of the paper

Delays in Elective Care

- No delays in EL LSCS
- Elective List to commence on the 10th of January 2023
- Induction of Labour- no delays reported

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• NHSR year 4 guidance revised, Interim post in to support Reporting timeline approved through MAC • No escalations from the task and finish group	• Initial 7 IEA- final IEA is 91% compliant following evidence review at LMNS panel. • Final 15 IEA, 14 have been peer assessed pause as single oversight framework delayed until Easter 23

Incidents reported Dec 2022 (76 no/low harm, 1 moderate or above)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 15	Themes includes Category 1 LSCS, 3rd and 4th degree tears and PPH

Other

- PPH remains above the national threshold, SFH continue to engage with the regional offer from NHSE for the Obs Cymru care bundle, to monitor as part of the bundle includes accurate measuring of the blood loss which may have increased the rate.
- One Moderate case reported PPH, reviewed through MDT meeting and harm downgraded with no further action required.
- Apgar's reduced below national reporting levels.
- FFT rate remains improved with QI work, to remain on scorecard.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Sherwood Forest Hospitals														
	OVERALL	SAFE	EFFECTIVE	CARING	RESPONSIVE							WELL LED		
CQC Maternity Ratings - last assessed 2018	GOOD	GOOD	GOOD	OUTSTANDING	GOOD							GOOD		

Maternity Quality Dashboard 2020-2021	Alert [national standard/average	Running Total/ average	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC pathway														
Women reccving MCOC intraprtum														
Total BAME women booked														
BAME women on CoC pathway														
Spontaneous Vaginal Birth			63%	61%	59%	55%	60%	60%	60%	58%	55%	55%	54%	43%
3rd/4th degree tear overall rate	>3.5%	2.18%	2.78%	2.52%	2.90%	3.00%	6.20%	3.72%	2.84%	6.30%	2.40%	4.30%	2.80%	1.80%
Obstetric haemorrhage >1.5L	Actual	116	6	8	7	6	9	7	7	3	9	9	14	14
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.12%	3.30%	2.60%	2.20%	3.20%	2.45%	2.45%	1.10%	3.20%	3.90%	4.60%	4.80%
Term admissions to NNU	<6%	3.62%	5.00%	3.50%	3.50%	1.60%	4.00%	2.60%	2.60%	3.70%	3.1%	1.30%	2.00%	3.20%
Apgar <7 at 5 minutes	<1.2%	1.56%	1.90%	1.80%	2.00%	0.84%	0.40%	1.20%	1.20%	1.20%	0.79%	2.10%	2.70%	1.10%
Stillbirth number	Actual	11	1	1	0	1	2	2	1	0	2	0	2	2
Stillbirth number/rate	0	4.63			3.727			5.952			3.300			3.240
Rostered consultant cover on SBU - hours per week	<60	60	60	60	60	60	60	60	60	60	60	60	60	60
Dedicated anaesthetic cover on SBU - pw	<10	10	10	10	10	10	10	10	10	10	10	10	10	10
Midwife / band 3 to birth ratio (establishment)	>1:28		1:29	1:22	1:22	1:22	1:22	1:24.5	1:27	1:27	1:27	1:27	1:27	1:27
Midwife/ band 3 to birth ratio (in post)	>1:30		1:28	1:24	1:24	1:24	1:24	1:26.5	1:29	1:29	1:29	1:29	1:29	1:29
Number of compliments (PET)		0	0	0	1	1	1	1	1	1	2	2	2	3
Number of concerns (PET)		9	0	0	2	2	1	0	0	0	1	2	1	1
Complaints		11	1	1	2	1	0	2	1	0	0	0	0	0
FFT recommendation rate	>93%		92%	91%	90%	89%	88%	88%	94%	91%	91%	89%	90%	90%
PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	94%	95%	95%	95%	96%	92%	94%	
K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	98%	
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%	98%	92%	92%	
Core competency framework compliance			81%	81%	88%	95%	95%	95%	95%	95%	95%	95%	95%	
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above													
Maternity incidents no harm/low harm	Actual	928	83	45	69	58	70	99	105	72	96	72	80	79
Maternity incidents moderate harm & above	Actual	7	1	1	1	1	1	1	1	0	0	0	0	0
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	0	0
HSIB/CQC etc with a concern or request for action		Y/N	N	N	N	N	N	N	Y	N	N	N	N	N

Sherwood Forest Hospitals NHS Foundation Trust

Public Board Meeting

Subject:	Freedom To Speak Up	**Date**: 2nd Feb 2023	
Prepared By:	Kerry Bosworth		
Approved By:	Shirley Higginbotham		
Presented By:	Kerry Bosworth – Freedom To Speak Up Guardian		
Purpose			
The purpose of this paper is to provide an update to the Board on the Freedom to Speak Up Agenda within the Trust and provide assurance of the Speaking Up service.		**Approval**	
		Assurance	x
		Update	x
		Consider	

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

The FTSUG submitted a report to the PCI Committee in Jan 2023 using data contained within the report

Executive Summary

This report provides a review of speaking up cases for Q2/ Q3 22/23 and assurance of the FTSU provision at SFH. Included is the learning and improvement actions taken from concerns, highlighted with a case study .

During Q2&Q3 2022 there were 70 concerns raised with the FTSU Guardian. People profiles are included.

Nursing and Admin/Clerical colleagues have raised the most concerns. FTSU is represented across all the Divisions. New concerns have been raised by students.

The key categories remain, Bullying & Harassment, Inappropriate behaviours and Attitudes – Trust values not upheld. EDI concerns surrounding colleagues with disabilities has increased.

Actions from these concerns have included triangulation with OD practitioners and senior leadership to develop interventions to target specific teams with concerns around team culture.

The Freedom To Speak Up Guardian is working with the EDI lead and staff networks to ensure learning is embedded in training and development programmes. Individual coaching and mentoring have been offered to those who aren't able to engage with a formal escalation process and who wish to remain confidential.

Leadership training and awareness education remains a challenge and it is recommended all line managers have speak up/listen up training as indicated in the guidance from NHSEI/NGO, this is being explored with the Director of People regarding how this training could be delivered in 2023. Senior leaders are recommended to complete Follow Up training.

Case study demonstrates follow up and improvement from FTSU concerns, working collaboratively with Improvement & Divisional Teams.

FTSU Assurance is also highlighted via an update on the FTSU Champion Network and recognition awards locally and nationally.

The SFH Speak Up policy has been reviewed and the NGO / NHSEI Speak Up Policy 2022 has been incorporated into the SFH policy including a new pathway for reporting detriment and follow up. The SFH policy is awaiting ratification in January's JSPF – due to take place Jan 31st

Abbreviations used-
SFH – Sherwood Forest Hospitals
EDI – Equality, Diversity & Inclusion
FTSUG Freedom To Speak Up Guardian
FTSU Freedom To Speak Up
NGO National Guardians Office
OD Organisational Development
NHSEI NHS England and Improvement
JSPF – Joint Staff Partnership Forum
EM – Ethnic Minority

Freedom To Speak Up

SFH Board Report – Feb 2023

Kerry Bosworth FTSU Guardian

Sherwood Forest Hospitals NHS Foundation Trust

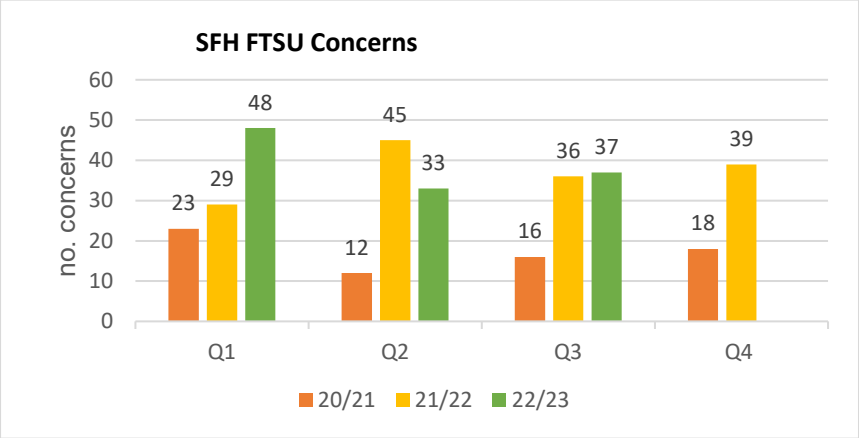
Purpose

This report provides a review of speaking up cases for Q2/ Q3 22/23 and assurance of the FTSU provision at SFH. Included is the learning and improvement actions taken from concerns, highlighted with a case study.

Overview

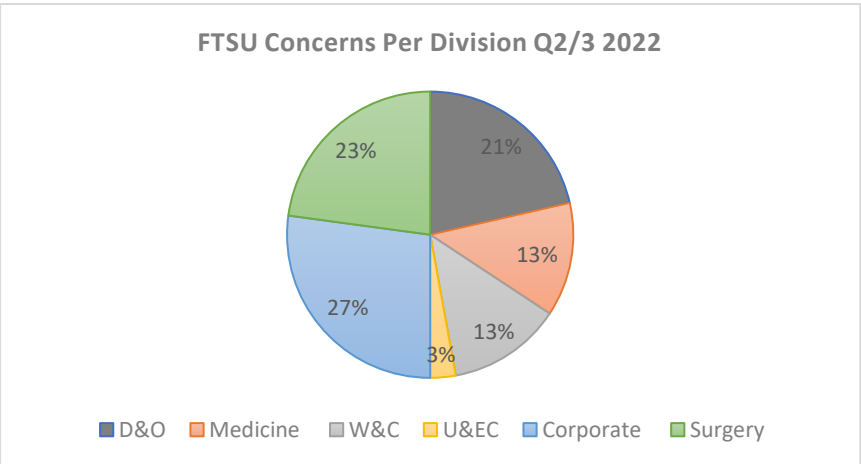
During Q2&Q3 2022 there were 70 concerns raised with the FTSU Guardian.

Quarterly comparisons demonstrate consistent engagement with FTSU as a route for raising concerns.



Out of the 22/23 Q2 & Q3 concerns raised, 41 were raised openly, 29 were raised confidentially (known to FTSUG only) and there were no anonymous concerns. This continues to show increasing trust in escalating concerns openly to those in a position to support and follow up the concerns.

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



People Profile of Q2/3

Admin/Clerical colleagues have raised the most concerns in both quarters, also represented are nursing , midwifery, medical, estates and AHP colleagues. There have also been concerns raised from students and this reflects the spread of FTSU awareness into the training cohorts. The FTSUG has proactively engaged with some of the nursing student cohorts to highlight speaking up is for all.

EDI Information

The majority of concerns raised are from females. Ethnicity is predominantly white British however Indian, African, other Asian origin and dual ethnicity origin are also represented in both quarters.

There have been colleagues with disabilities raising concerns during this period, which is an increase.

EDI information is via an electronic survey or in person information.

Themes from Q2/3

The NGO have realigned the categories for reporting cases; therefore the below theme headings are in alignment with national reporting for clarity and consistency

Patient Safety & Quality

- Unsafe care
- Unable to provide expected level of care
- Workload – unable to take breaks
- Work environment not conducive to quality care for patients

Bullying & Harassment

- Bullying from a peer
- Bullying from a line manager
- Bullying culture within a team

Attitudes and Behaviours within B&H

- Racism – microaggressions in work environment
- Ableism – microagressions and lack of leadership awareness of disability and equality policies and support
- Perception of lack of career development - race, age and social relationships barriers
- Hierarchy in department – workplace silenced, power imbalance

Worker Safety or Wellbeing

- Environment unsafe or poor maintenance of resources to do the job – lack of basic needs to do job
- Impact of work experience on wellbeing
- Impact of poor relationship working and wellbeing impacts
- Emotional impact on workers – fatigue, low resilience, constant “firefighting” approach
- Impact of people processes on individuals – policy not followed and impact
- Lack of breaks
- Damage / theft of personal property on site

Elements Of Other Inappropriate Attitudes or Behaviours

- Incivility
- Gaslighting behaviours
- Leadership poor response to raising concerns
- Leadership styles
- Favouritism
- Behaviours within people processes and concerns not acted on or resolved

FTSU Learning & Triangulation

The majority of concerns fall into the Inappropriate Attitudes or Behaviours category. Concerns involving leadership remain significant in this category but also feature in the Worker Safety and Wellbeing category – citing people process impacts and processes/ policies not followed or applied. A theme within this involves colleagues with disabilities who feel their line management is not inclusive, or empathetic. Knowledge of support regarding policies supporting disability are not known and used . Actions from these concerns involve the FTSUG directly referring to the senior People Lead Teams and support to line managers on the process and care of colleagues with disabilities. There has been regular triangulation with the EDI Lead to ensure experiences are shared for training and education purposes and fed to the relevant staff network.

Concerns involving team culture and individual poor behaviours impacting teams, have been shared with the OD & Learning team. Having appointed OD Practitioners to SFH has enabled the concerns regarding this type of behaviour amongst teams with consistent issues in this area to be supported. Close working with the FTSUG and OD practitioners has resulted in targeted support and information to the teams and leadership. This is especially beneficial when the concern raiser is fearful of open escalation of their concerns. They have been able to remain confidential if they choose to do so but actions can still be taken.

Leadership support from the People Team has helped navigate difficult conversations with colleagues and upskill managers in these difficult team conversations

Concerns regarding patient safety and quality have been shared with the Chief Nurse for review. Medical FTSU concerns are shared with the Medical Director for review

Concerns involving colleagues who feel disadvantaged in career development, citing ethnicity as a reason have been supported by the EM Staff Network. The FTSUG has been able to share individual cases with the senior nursing team. Actions include support with CV preparation, interview skills and personal coaching allocation from senior nurse team. This is a very new proactive way to support colleagues who feel they suffer detriment due to their ethnicity and consequently lost confidence to apply for roles and develop.

The FTSUG now meets regularly with the Director Of People to showcase concerns and experiences with people processes to help organisational learning and oversight of themes in this category. Following the recommendation from NHSEI for all workers to undertake Speak Up & Listen Up training, the Director of People is exploring this within the mandatory training framework with the FTSUG. With the restructure of the Training & Development / OD & Learning Teams it is hoped this will be an action for 2023 and will address how to deliver this training to the existing workforce.

Case Review

Multiple concerns raised from within a department to FTSUG via email. Several team members collated concerns and wished to remain confidential after escalating to the FTSUG

Themes were –

- Poor work environment – safety of workers, lack of basic supplies, deterioration in staff facilities.
- Leadership – lack of response to concerns raised, favouritism, lack of process.
- Workload – unrelenting workload, vacancies and impact, quality of work highlighted in repeated incidents and complaints.
- Felt department not valued and forgotten about.
- Wellbeing impacts from the above and relationships strained as consequence.

FTSU Actions and Follow Up

- FTSUG raised with Senior Divisional Team outside of the department.
- Senior People Lead met with FTSUG to understand how to support the teams and leadership support.
- Action plan shared with FTSUG to review and address the concerns.
- FTSUG, Staff Side Representative and OD Practitioner triangulated concerns and provided direct support to colleagues through visits to team, follow up support and visibility.
- OD interventions and support to leadership within the team.
- H&S review of department to follow up on worker safety elements and report presented to Divisional Team.
- 15 Steps visits to department from senior SFH leadership teams.
- Restructure and recruitment priorities enacted by leadership team.
- FTSUG escalated to Wellbeing Team for support and awareness for targeted support.
- Basic equipment and supply chains reviewed.

Feedback was communicated from the project manager to the FTSUG on progress and individuals were able to receive feedback via the FTSUG to maintain confidentiality. The concern raisers cited they felt some improvement and engagement was better. Also felt processes and clear sight of line management had improved dialogue to teams

FTSU Assurance at SFH

Speak Up Month – October was Speak Up month and the FTSUG toured the organisation, visiting teams and promoting the speak up culture. This generated concerns but also teams were able to ask and explore the FTSU process. Champions supported their wards and teams in local events and success was reported via the Champions undertaking this.

One ward used their Champion to initiate a confidential forum where the Champion acted as the intermediary to the leadership team to hear all staff voices and concerns, which were then taken forward for discussion and feedback – it was a resounding success and enabled the ward to initiate improvements and acknowledge the worries and support wellbeing.

Champion Update

The FTSU Champions were shortlisted to the final 3 in the CARE category award at the most recent Staff Excellence Awards recognising their contribution to FTSU.

New Champions have been recruited this quarter increasing the Champion numbers to 22. There is now a FTSU Champion on the Sherwood Board of Directors – this is valuable as often leaders in the organisation raising concerns have further barriers to overcome due to their senior position. This allows a safe space for those in leadership roles to have a voice and access support.

The FTSU Team were finalists at the recent HSJ Awards showcasing "Growing Our FTSU Culture at SFH" . From this the NGO wish to spotlight a media article on the entry and publish to their website for sharing and learning nationally.

FTSU Feedback

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

Recent feedback –

I would recommend anyone who needs to speak up please get in touch with the team. Kerry was so lovely and helpful I don't think I could have done it without her.

I have been listened to and treat with understanding through the process.

FTSU have for me, have been exceptional. Very understanding, kind and made me feel that I was being taken seriously by not brushing me off or making excuses for those I spoke against

National Updates

NHSEI / NGO released the new Freedom To Speak Up Policy 2022 in Summer 22 and require all providers to adopt the policy by Jan 2024 . The FTSUG has reviewed the current Speak Up policy for SFH and aligned to the national policy. The SFH Speak Up Policy is awaiting ratification in January's JSPF forum. Included in the SFH policy is a new section on how

colleagues who feel they have suffered detriment for speaking up can report and how this will be followed up.

NGO Speak Up Data

On a quarterly basis the FTSUG is required to share anonymised speak up data on concerns raised to the NGO. This enables valuable information to inform the national picture and provide valuable insight into implementation of FTSU in organisations.

The national data collated so far for 2022/23 shows SFH position is comparable to the national picture in terms of most concerns are raised within the Inappropriate Attitude & Behaviours category and engagement with FTSU is comparable with other providers in the region.

Training for workers in Speak Up , Listen Up & Follow Up

NHSEI and NGO continue to recommend all workers are trained in Speak Up & Listen Up, with senior leaders undertaking the Follow Up module. Currently there is no mandate to do so at SFH. However, the FTSUG and Director of People plan to explore and review how this could be delivered across the organisation.

The FTSUG delivered a Board Development session in August 2022 to provide overview of the Follow Up training.

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

Freedom To Speak Up

SFH Board Report – Feb 2023

Kerry Bosworth FTSU Guardian

Sherwood Forest Hospitals
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Sherwood Forest Hospitals NHS Foundation Trust

Trust Board - Cover Sheet

Subject:	Planning Guidance Update	**Date**: 2nd February 2023	
Prepared By:	Kevin Gallacher, Associate Director – Business Planning & Partnerships		
Approved By:	David Ainsworth, Director of Strategy and Partnerships		
Presented By:	David Ainsworth, Director of Strategy and Partnerships		
Purpose			
To communicate the 2023-24 NHSE Operational Planning Guidance		**Approval**	
		Assurance	
		Update	X
		Consider	

Strategic Objectives				
To provide outstanding care	**To promote and support health and wellbeing**	**To maximise the potential of our workforce**	**To continuously learn and improve**	**To achieve better value**
X	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	X
PR3	Critical shortage of workforce capacity and capability	X
PR4	Failure to achieve the Trust's financial strategy	X
PR5	Inability to initiate and implement evidence-based Improvement and innovation	X
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	X
PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	X

Committees/groups where this item has been presented before

None

Executive Summary

The enclosed presentation summarises the current NHSE planning guidance for 2023-24.

Some key technical guidance relating to recovery planning for urgent and emergency care, elective recovery and the maternity delivery plan is outstanding and will be published shortly.

The Nottingham and Nottinghamshire Integrated Care System (ICS) is required to submit draft plans by Thursday 23rd February and final plans by Thursday 30th March and SFH has a process in place to feed the SFH activity & performance, workforce and financial information into the ICS plan submission.

The Board are asked to:

Note the update

Sherwood Forest Hospitals
NHS Foundation Trust

2023-24 Operational Planning Guidance Update

SFH Board 2nd February 2023

Inspected and rated
Good
Care Quality Commission

2023-24 Operational Planning

Sherwood Forest Hospitals
NHS Foundation Trust

- On 23rd December 2022, NHS England (NHSE) released its 2023-24 priorities and operational planning guidance with associated technical guidance published early January 2023.
- The guidance is shorter than 2022-23 with fewer targets, a greater emphasis on outcomes and less prescription on how to achieve them. It signals a new relationship between the service and the centre in the future, which empowers local leaders.
- NHSE simultaneously published guidance on developing the Joint Forward Plan (JFP).
- ICBs are asked to work with system partners to develop plans to meet the objectives set out in the operational planning guidance before the end of March 2023 (and JFP by the end of June 2023).
- Further guidance, which is fundamental for detailed operational planning, is still to be published
    - NHSE recovery plans for Urgent and Emergency Care (UEC) and General Practice Access.
    - NHSE single Maternity Delivery Plan.
    - NHSE elective recovery technical guidance and commissioner/Trust level targets supported by a 'pay per unit' model.

Technical guidance published 12th January 2023 set out the requirement for a **Draft ICS plan submission Thursday 23rd February with final ICS plan submission 30th March** (SFH No longer submits its plan separately with Nottingham & Nottinghamshire NHS providers and the Integrated Care Board submitting a single consolidated ICS Plan)

2023-24 Operational Planning

Sherwood Forest Hospitals
NHS Foundation Trust

The 2023/24 priorities and operational planning guidance sets out three core priorities informed by three underlying principles:

1. Recovering our core services and improving productivity	2. Make progress in delivering the key NHS Long Term Plan ambitions	3. Continue transforming the NHS for the future
Smaller number of national objectives which matter most to the public and patients		
More empowered and accountable local systems		
NHSE guidance focused on the “why” and “what”, not the “how”		

The guidance covers 12 areas and 32 national objectives against the first two priorities (see appendix).

2023-24 Operational Planning

Sherwood Forest Hospitals
NHS Foundation Trust

Headline ambitions

- **Recovering our core services and improving productivity including:**
    - Improve **ambulance** response and **A&E** waiting times.
    - Reduce **elective** long waits and **cancer** backlogs, and improve performance against the core **diagnostic** standard.
    - Make it easier for people to access primary care services, particularly **general practice**.
- Recovering **productivity** and improving **whole system flow** are critical to achieving these objectives
- We must collectively address the challenge of **staff retention and attendance**.
- Throughout all the above will be a focus on narrowing **health inequalities** in access, outcomes and experiences, and maintaining **quality and safety** in our services, particularly in **maternity** services.

2023-24 Operational Planning

Sherwood Forest Hospitals
NHS Foundation Trust

Headline ambitions

- **Delivering the key Long Term Plan ambitions and transforming the NHS including:**
  - Improve **mental health** services and services for people with a learning disability and autistic people.
  - Continue to support delivery of the **primary and secondary prevention** priorities and the effective management of long-term conditions.
  - Ensure that the **workforce** is put on a sustainable footing for the long term, including publication of a NHS Long Term Workforce Plan.
  - Level up **digital infrastructure** and drive greater connectivity, including development of the NHS App to help patients to identify their needs and get the right care in the right setting.
- **Local empowerment and accountability**
  - ICSs are best placed to understand population needs and are expected to agree **specific local objectives** that complement the national NHS objectives.
  - As set out in **Operating Framework**, NHS England will continue to support the local NHS [integrated care boards (ICBs) and providers] to deliver their objectives and publish information on progress against the key objectives set out in the NHS Long Term Plan.

2023-24 Operational Planning

Sherwood Forest Hospitals
NHS Foundation Trust

Appendix:

- Table setting out the 12 areas and 32 national objectives set out in the 2023-24 priorities and operational planning guidance
- Useful links

2023-24 Operational Planning

Sherwood Forest Hospitals NHS Foundation Trust

Table summarising the 12 areas and 32 national objectives set out within the NHSE 2023/24 priorities and operational planning guidance			
	Ref	**Area**	**Objective**
Recovering our core services and improving productivity	**1a**	**Urgent and emergency care***	Improve A&E waiting times so that no less than 76% of patients are seen within 4 hours by March 2024 with further improvement in 2024/25
			Improve category 2 ambulance response times to an average of 30 minutes across 2023/24, with further improvement towards pre-pandemic levels in 2024/25
			Reduce adult general and acute (G&A) bed occupancy to 92% or below
	1b	**Community health services**	Consistently meet or exceed the 70% 2-hour urgent community response (UCR) standard
			Reduce unnecessary GP appointments and improve patient experience by streamlining direct access and setting up local pathways for direct referrals
	1c	**Primary care***	Make it easier for people to contact a GP practice, including by supporting general practice to ensure that everyone who needs an appointment with their GP practice gets one within two weeks and those who contact their practice urgently are assessed the same or next day according to clinical need
			Continue on the trajectory to deliver 50 million more appointments in general practice by the end of March 2024
			Continue to recruit 26,000 Additional Roles Reimbursement Scheme (ARRS) roles by the end of March 2024
			Recover dental activity, improving units of dental activity (UDAs) towards pre-pandemic levels
	1d	**Elective care**	Eliminate waits of over 65 weeks for elective care by March 2024 (except where patients choose to wait longer or in specific specialties)
			Deliver the system- specific activity target (agreed through the operational planning process)
	1e	**Cancer**	Continue to reduce the number of patients waiting over 62 days
			Meet the cancer faster diagnosis standard by March 2024 so that 75% of patients who have been urgently referred by their GP for suspected cancer are diagnosed or have cancer ruled out within 28 days
			Increase the percentage of cancers diagnosed at stages 1 and 2 in line with the 75% early diagnosis ambition by 2028
	1f	**Diagnostics**	Increase the percentage of patients that receive a diagnostic test within six weeks in line with the March 2025 ambition of 95%
			Deliver diagnostic activity levels that support plans to address elective and cancer backlogs and the diagnostic waiting time ambition
	1g	**Maternity***	Make progress towards the national safety ambition to reduce stillbirth, neonatal mortality, maternal mortality and serious intrapartum brain injury
			Increase fill rates against funded establishment for maternity staff
	1h	**Use of resources**	Deliver a balanced net system financial position for 2023/24
	2d	**Workforce**	Improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise
	2a	**Mental health**	Improve access to mental health support for children and young people in line with the national ambition for 345,000 additional individuals aged 0-25 accessing NHS funded services (compared to 2019)
			Increase the number of adults and older adults accessing IAPT treatment
			Achieve a 5% year on year increase in the number of adults and older adults supported by community mental health services
			Work towards eliminating inappropriate adult acute out of area placements
			Recover the dementia diagnosis rate to 66.7%
			Improve access to perinatal mental health services
	2b	**People with a learning disability and autistic people**	Ensure 75% of people aged over 14 on GP learning disability registers receive an annual health check and health action plan by March 2024
			Reduce reliance on inpatient care, while improving the quality of inpatient care, so that by March 2024 no more than 30 adults with a learning disability and/or who are autistic per million adults and no more than 12–15 under 18s with a learning disability and/or who are autistic per million under 18s are cared for in an inpatient unit
	2c	**Prevention and health inequalities**	Increase percentage of patients with hypertension treated to NICE guidance to 77% by March 2024
			Increase the percentage of patients aged between 25 and 84 years with a CVD risk score greater than 20 percent on lipid lowering therapies to 60%
			Continue to address health inequalities and deliver on the Core20PLUS5 approach

**ICBs and providers should review the UEC and general practice access recovery plans, and the single maternity delivery plan for further detail when published*

2023-24 Operational Planning

Sherwood Forest Hospitals
NHS Foundation Trust

Useful Links

- NHSE Operational and Joint Forward Planning guidance is available at the following link: NHS England » NHS operational planning and contracting guidance
- **The NHS Confederation has produced a very helpful summary of the 2023/24 planning guidance at the following link:** 2023/24 NHS priorities and operational planning guidance | NHS Confederation

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

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

Subject:	Audit & Assurance Committee (AAC) Report	**Date:** 19th January 2023	
Prepared By:	Graham Ward – AAC Chair		
Approved By:			
Presented By:	Graham Ward – AAC Chair		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ Internal Audit – Implementation of internal audit recommendations is improving – currently at 66% (up from 55% at last report) implemented by due date (needs to be >75% for Head of Internal Audit Opinion to be significant assurance). ▪ Internal Audit Report with Limited Assurance – the recommendations (4 medium and 2 low risks) and actions were presented. The Committee gained good assurance that the recommendation implementations were progressing well. ▪ Governance Survey – as this survey is confined to directors only (executive and non-executive) in future years it will not be done anonymously. ▪ Register of Interests – this is now down to an all time low of 32 who haven't declared (out of 942 Grade 7+ staff). ▪ Non-Clinical Policies – The number of well overdue policies has now reduced to 10, for which plans are in place to update and approve. This is a significant improvement.	▪ Internal Audit Programme – This is currently under discussion for 2023/24 between SLT and 360 Assurance. The draft programme will be discussed at the next Audit Committee meeting, which will include detailed explanations of why the areas have been selected. ▪ Maturity Matrix – 360 Assurance presented a number of areas for discussion for areas of further improvement. Two actions were agreed: o A policy note be prepared to cover any potential conflicts of interest for the Chair of the Audit Committee; and o An additional standing item be added to the agenda for System related updates. ▪ Procurement – Requested that the single tender waiver report includes details on the percentage of payments where there is no purchase order as the next area of focus for improvement (this currently stands at 18%).

▪ HfMA Financial Sustainability Audit – this has now been completed and assurance gained from the internal auditors that SFH's responses, if anything, understated SFH's position. The full set of responses will be reviewed by Finance Committee and implementation of improvements for those scored 3 or below (out of 5) will be monitored. ▪ Single Tender Waivers – This process is now well embedded and is helping deliver improved VFM and better planning for future procurements.	
Positive Assurances to Provide	**Decisions Made**
▪ Internal Audit – The Head of Internal Audit Opinion Stage 2 paper was presented, which with the exception of the recommendation implementation rate (66%, which represents moderate assurance) was very positive. ▪ External Audit – KPMG gave an update on the preliminary risk assessment for SFH. This included the proposed materiality for 2022/23 which has been increased from £9M to £11.5M, primarily due to a reduced risk assessment which changed the percentage of forecast revenue from 2% to 2.5%.	▪ Internal Audit Programme –Approval of proposed changes were agreed.
Comments on Effectiveness of the Meeting	
▪ All papers were of a high quality and clear which helped the meeting run smoothly.	

Healthier Communities, Outstanding Care

Sherwood Forest Hospitals NHS Foundation Trust

(Insert meeting title here) Chair's Highlight Report to Trust Board

Subject:	Quality Committee Report	**Date:** 19th January 2023	
Prepared By:	Barbara Brady, Non – Executive Director, Chair of QC		
Approved By:	Barbara Brady		
Presented By:	Barbara Brady, Chair of Quality Committee		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ GIRFT – Insufficient capacity available to implement recommendations (these would in turn support financial sustainability) ▪ Accommodation for Cancer Services ▪ HSMR, data presented on quarterly basis is 12 month rolling period, so time lag in seeing changes feed through	▪ Committee annual report
Positive Assurances to Provide	**Decisions Made**
• Submission to meet requirements of Maternity Incentive scheme • Deep Dive of 3rd and 4th degree tears • Water Quality • Annual report of cancer services	▪ BAF reviewed o PR1 rating unchanged o PR2 current exposure increased to 20 as a result of increasing likelihood score to 5
Comments on Effectiveness of the Meeting	
▪ Good discussion and challenge aided by the quality of papers and contributions from members. Added benefit of having ICB colleague contributing to the meeting	

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Charitable Funds Committee Chair's Highlight Report to Trust Board

Subject:	Charitable Funds Committee feedback report	**Date:** 24th January 2023	
Prepared By:	Steve Banks – Non-Executive Director and Committee Chair		
Approved By:			
Presented By:	Steve Banks – Non-Executive Director		
Purpose			
To provide assurance to the Trust Board		**Assurance**	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
Delays with Estates projects, although improving Supporting Colleagues Psychological Safety project. The implementation of TRiM model risk management tool for colleagues is delayed due to Winter pressures Fluctuating nature of the Investment Market	Finance to finalise transfer of funds to ICCU from surgery fund and pathology to cancer fund by end Q4 Fund Manager training to be incorporated into scheduled budget manager training Fundraising strategy and objectives being updated for April CFC meeting Creation of a staff wellbeing fund to be investigated
Positive Assurances to Provide	**Decisions Made**
The effectiveness of the Operational Group The Community Involvement Q3 report, highlighting great work and making a difference The project and fundraising update Supporting Colleagues Psychological Safety project evaluation Investment Update	Staff survey to be undertaken to gauge opinion regarding the charity and accessing funds To recommend approval for a dementia appeal in the interim until the Trust Strategy guides future appeals To support requests for patient treatment chairs in the oncology Welcome treatment Centre To propose ground rules for use of funds on renewables To increase Comms focus on CFC to promote understanding and access to funds
Comments on Effectiveness of the Meeting	
The meeting was reviewed, and it was commented that the papers were relevant, concise and gave the information needed. There was a satisfactory level of discussion and challenge, and the work of the Operational Group supported the receipt of assurance and good debate where needed.	

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Chair's Highlight Report to Trust Board

Subject:	Finance Committee meeting	**Date:** 31st January 2023	
Prepared By:	Richard Mills		
Approved By:	Andrew Rose-Britton		
Presented By:	Andrew Rose-Britton		
Purpose			
The paper summaries the key highlights from the Finance Committee meeting held on 31st January 2023		**Assurance**	**Sufficient**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ PR4 Failure to achieve Trust's financial strategy ▪ PR8 Failure to deliver Trust's impact of climate change	External overview of Committees effectiveness
Positive Assurances to Provide	**Decisions Made**
▪ Monthly Finance report ▪ NHIS Performance ▪ ICS/ICP Update ▪ Financial planning and budgeting ▪ Procurement review ▪ Trust Strategic Priorities 2023 ▪ PFI Governance	▪ Committee Annual report ▪ Committee Effectiveness Self-Assessment ▪ Workplan update
Comments on Effectiveness of the Meeting	
▪ Excellent papers submitted to the Committee. ▪ In depth discussion on the financial challenges facing the Trust and ICB	

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

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

Subject:	People, Culture & Improvement Committee Highlight Report	**Date:** 31/01/2023	
Prepared By:	Manjeet Gill, Non-Executive Director		
Approved By:	Manjeet Gill, Non-Executive Director		
Presented By:	Manjeet Gill, Non-Executive Director		
Purpose			
		Assurance	**X**

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Assurance by way of update reports were provided on industrial action and the mitigations in place to address. • Employee relations assurance showed an increase in disciplinaries / grievances, and it was agreed that a deeper dive was needed to understand and assure risks being mitigated.	• An update on the workforce plans gave assurance on a long-term plan, the work underway and how it linked to system working and other trust plans.
Positive Assurances to Provide	**Decisions Made**
• Progress report on the People Culture and Improvement Strategy at the end of Q3 • Freedom to Speak Up Q3 report • Equality Diversity and Inclusion Q3 report • Improvement Faculty development and how based on national best practice and frameworks. • Junior Doctors experience feedback and the actions being taken to address key areas. • Positive assurance reports on wellbeing work to support our people • A reflective account regarding the Step into NHS Careers event, leading to positive local interest, recruitment, and more reach into the local community, to develop more tailored careers pathways.	• Committee Terms of Reference reviewed and agreed • Committee Annual Report reviewed and agreed • Committee effectiveness reviewed and agreed • Agreement and review of BAF PR3 and PR5 where risk rating remanded unchanged

Comments on Effectiveness of the Meeting
• The Committee was observed by the Chief Executive Officer and Lead Governor where the effectiveness of the committee was discussed and explored offering positive reflections regarding the level of positive assurance and content of the papers provided.