MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: **Thursday 5th September 2024**
Time: **09:00 – 11:15**
Venue: **Boardroom, King's Mill Hospital**

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Patient Story: The Impacts of Pain and the Discharge Process** Laura Fuller, Registered Nurse	Assurance	Presentation
5.	09:20	**Minutes of the meeting held on 1st August 2024** To be agreed as an accurate record	Agree	Enclosure 5
6.	09:25	**Action Tracker**	Update	Enclosure 6
7.	09:30	**Acting Chair's Report** • **Council of Governors Highlight Report**	Assurance Assurance	Enclosure 7 Enclosure 7.1
8.	09:35	**Acting Chief Executive's Report**	Assurance	Enclosure 8
	Strategy			
9.	09:45	**Strategic Objective 1 – Provide outstanding care in the best place at the right time** • **Maternity Update** Report of the Director of Midwifery o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 9.1
10.	10:00	**Strategic Objective 2 – Empower and support our people to be the best they can be** • **Guardian of Safe Working** Report of the Acting Medical Director / Guardian of Safe Working	Assurance	Enclosure 10.1

	Time	Item	Status	Paper
11.	10:15	**Strategic Objective 5 – Sustainable use of resources and estate** • **NHS England (NHSE) Investigation and Intervention Process** Report of the Chief Financial Officer	Assurance	Enclosure 11.1
	BREAK (10 mins)			
	Governance			
12.	10.45	**Constitution Review** Report of the Chief Executive	Approval	Enclosure 12
13.	10:50	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (last meeting) • Partnerships and Communities Committee Report of the Committee Chair (last meeting)	Assurance Assurance	Enclosure 13.1 Enclosure 13.2
14.	11:00	**Outstanding Service – Organ Donation - Changing and Saving Lives**	Assurance	Presentation
15.	11:05	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
16.	11:10	**Any Other Business**		
17.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **3rd October 2024, Boardroom, King's Mill Hospital**		
18.		**Chair Declares the Meeting Closed**		
19.		**Questions from members of the public present** (Pertaining to items specific to the agenda)		
		Resolution to move to the closed session of the meeting In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: *"That representatives of the press and other members of the public, be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest."*		

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

Enc 09.1	• **Nursing and Midwifery Safer Staffing Reports**
Enc 12	• **Constitution final version**
Enc 13.1	• **Finance Committee – previous minutes**
Enc 13.2	• **Partnerships and Communities Committee – previous minutes**
Enc 13.2	• **ICS Stakeholder Briefing**
Enc 13.2	• **ICS Strategy**

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

UN-CONFIRMED MINUTES of the Board of Directors meeting held in Public at 09:00 on Thursday 1st August 2024, in the Boardroom, King's Mill Hospital

Present:	Graham Ward	Acting Chair	GW
	Steve Banks	Non-Executive Director	SB
	Barbara Brady	Non-Executive Director	BB
	Aly Rashid	Non-Executive Director	AR
	Andrew Rose-Britton	Non-Executive Director	ARB
	Andy Haynes	Specialist Advisor to the Board	AH
	David Selwyn	Acting Chief Executive	DS
	Claire Hinchley	Acting Director of Strategy and Partnerships	CH
	Sally Brook Shanahan	Director of Corporate Affairs	SBS
	Phil Bolton	Chief Nurse	PB
	Simon Roe	Acting Medical Director	SR
	Rob Simcox	Director of People	RS
	Rachel Eddie	Chief Operating Officer	RE
In Attendance:	Paula Shore	Director of Midwifery	PS
	Emma Mutimer-Hallgarth	Family Liaison Officer	EM
	Amelia Bradley	Patient's mother	AB
	Luke Sherwood	Patient's father	LS
	Sue Bradshaw	Minutes	
	Jess Baxter	Producer for MS Teams Public Broadcast	
	Caroline Kirk	Communications Specialist	
Observers:	Clare Jones	Corporate PA	
	Laura Keeling	Communications Officer	
	Debbie Kearsley	Deputy Director of People	
	Andrew Fooks	360 Assurance	
	Lauren Monaghan	Notts TV	
	0 members of the public		
Apologies:	Neil McDonald	Non-Executive Director	NM
	Manjeet Gill	Non-Executive Director	MG
	Richard Mills	Chief Financial Officer	RM

Item No.	Item	Action	Date
24/242	**WELCOME**		
1 min	The meeting being quorate, GW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders. The meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
24/243	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
24/244	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Neil McDonald, Non-Executive Director, Manjeet Gill, Non-Executive Director, and Richard Mills, Chief Financial Officer.		
24/245	**PATIENT STORY: THEO'S STORY**		
31 mins	PB and PS presented the Patient Story, which highlighted the failings in care provided, which resulted in the tragic death of Baby Theo. PB expressed apologies to AB and LS, acknowledging the difficult time for the family. The Trust has fully taken onboard the Coroner's findings and welcomes the feedback and input from AB and LS. GW expressed apologies to AB and LS on behalf of the Board of Directors and the Trust and thanked them for taking the time to share their story. The Trust does not always 'get it right' and it is important to recognise this and do as much as possible to ensure the same thing does not happen again. LS queried what measures will be put in place to ensure Theo's outcome does not happen to any more babies. PS advised there have been very open reflections with all midwives about this case, with clear expectations. The Prevention of Future Deaths Order, issued by the Coroner, has been shared with the Team and the Trust is very clear about the required actions highlighted in that report, which include actions in relation to education, expectations of staff and professional behaviours. Trust guidance has been updated. PB advised the Trust is keen to produce a video highlighting this case, which the family has agreed to support. This will be very powerful and will be shared with regional colleagues. The Trust will work with regional colleagues to ensure learning is shared. GW felt this story highlights there are lessons to be learned across the whole Trust and not just in the Maternity Service.		

	AB advised at the inquest into Theo's death, the Coroner noted there was a poor culture at the Trust. AB queried, what action the Trust is going to take to improve the culture and ensure complacency is removed. PS advised there is a need to identify if there are any wider issues and she will be seeking assurance from her team in relation to this. The Trust has engaged with the national programme and has reviewed other cases. Ward staff have had support to address the issues which have been identified in this case and there have been disciplinary consequences. The Trust has Maternity and Neonatal Safety Champions and there is a safety culture workstream. Listening events have been held and these have provided assurance. However, there are still some areas to work on. PB advised one of the key responsibilities of the Board of Directors is to set the culture of the organisation. There is a relentless drive to improve. GW advised the complacency aspect is the real lesson to learn across the whole organisation. The operational pressures within the NHS are recognised, but there is no excuse for complacency. It is important to continually highlight this. LS queried how training will be improved across maternity services and how the Trust will ensure staff are competent to be able to identify emergency equipment when it is required. PS advised the Trust has a standard resuscitation trolly. There are now two training trolleys on the unit and all staff are given the opportunity to look at the training trolleys. In addition, live simulation events are held to increase the opportunities for staff to open the trolleys and have a good look through the equipment they contain to ensure they are familiar with it. Simulation training also takes place out of hours and is part of the induction process for new starters. AB queried how the Trust is ensuring the duty of candour is maintained and families receive accurate information. PS advised there is a process in the Trust which is led by the Quality Governance Team. There is a need for open and honest conversations, which should be led by a senior clinician. Every patient and every family are different. Therefore, it is important to take a person-centred approach and be directed by the needs of the family. PB advised the Trust employs a family liaison officer, who provides a single point of contact for families. AB advised on the night Theo was born, she and LS received no information and they want to ensure families are kept informed. PB noted this was poor communication. A fundamental aspect of the Trust's work is how patients and families are communicated with and ensure they are kept updated. AB advised she was seen by the Clinical Matron and another member of staff the morning after Theo's birth and AB got the impression they were trying to establish what she knew, but they did not share any information. AB queried if this was standard practice.		

	PS advised this is the verbal duty of candour, which should be led by a senior clinician. PB advised investigations serve multiple purposes, but a key factor is to answer the questions the family has. LS advised he is aware there is public enquiry into maternity services nationally going to Parliament later in the year and queried if the Trust supports this. LS acknowledged in Theo's case SFHFT has accepted mistakes were made and changes will be made, but this is not the case in other organisations. DS advised the Trust is already supporting a public enquiry, which is led by Donna Ockenden, and is, therefore, involved in those processes. GW advised progress in maternity services is monitored by the Board of Directors each month. GW advised this is a story the Board of Directors needed to hear and to action. DS expressed thanks to AB and LS for their bravery in sharing their story and acknowledged the Trust failed them. DS shared some personal reflections from his clinical career and advised he wants Theo's story to be a defining story for the Trust. PS, EM, AB and LS left the meeting.		
24/246	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors meeting in Public held on 4th July 2024, the Board of Directors APPROVED the minutes as a true and accurate record.		
24/247	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 24/142.1, 24/175, 24/221.2, 24/224.1, 24/224.2 and 24/225 were complete and could be removed from the action tracker.		
24/248	**ACTING CHAIR'S REPORT**		
4 mins	GW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chair's perspective, highlighting meetings with chairs and other key stakeholders across the Integrated Care System (ICS) and the work of the volunteers across the Trust. The Board of Directors were ASSURED by the report.		
24/249	**ACTING CHIEF EXECUTIVE'S REPORT**		
14 mins	DS presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Acting Chief Executive's perspective, highlighting continued high levels of demand for emergency pathways, industrial action, Integrated Care Board (ICB) performance report, contact with newly elected Members of Parliament (MPs), a patient who received a new treatment for Parkinson's disease, the visit to the Trust by Professor Sir Jonathan Van-Tam, 'Veterans Aware' accreditation, Pride events, Project SEARCH initiative and installation of electric vehicle charging points.		

	DS advised the Trust's Annual report and Accounts for 2023/2024 was laid before Parliament on 26th July 2024. RS advised the planned industrial action by the GMB, in their dispute with Medirest, has been postponed. This is a positive sign, reflecting the conversations the Compass Group are having with the GMB in relation to the long-standing dispute. In terms of the pay offer for NHS staff, the recommendations from the NHS pay review body and the doctors and dentists pay review body have been accepted. The Trust is working through the details of when the 2024/2025 pay award will be processed. Colleagues on Agenda for Change terms and conditions will receive a 5.5% increase in their salary with effect from 1st April 2024 There will be a 6% increase for doctors. AR queried if the junior doctors at the Trust are supportive of the pay offer made for junior doctors. DS advised the soft intelligence indicates there has been a mixed response. Noting the significant disruption caused by the junior doctors taking industrial action, it is hoped this is a deal which has been negotiated with good faith on both sides and it has been recommend to the members that it is accepted. AR queried what the nurses' views are of the offer which has been made to the junior doctors, noting the 5.5% offer for Agenda for Change grades. PB advised the Royal College of Nursing (RCN) have been 'watching and waiting' prior to consulting with their members. There is likely to be a range of opinions and there may be a ballot of all Agenda for Change grades. The Board of Directors were ASSURED by the report.		
24/250	**STRATEGIC OBJECTIVE 1 – PROVIDE OUTSTANDING CARE IN THE BEST PLACE AT THE RIGHT TIME**		
6 mins	PS joined the meeting. **Maternity Update** ***Safety Champions update*** PB presented the report, highlighting the case of Arlo Lambert, service user voice, Maternity Safety Champion walkarounds, maternity forums, first progress update of NHS Resolution (NHSR) Year 6 and the UNICEF Baby Friendly Award. BB noted the free text report for the annual Care Quality Commission (CQC) survey has been made available and queried if this contains any new information or if it is reflective of what is known from other sources. PS advised this reaffirms the themes which are already known. The Trust is working closely with the Maternity Voices Partnership (MVP) chair. It was noted the report contains positive comments about staff. The Board of Directors were ASSURED by the report.		

	Maternity Perinatal Quality Surveillance PB presented the report, highlighting third and fourth degree tears, massive obstetric haemorrhage rate, prevention of future deaths orders and positive vacancy position. It was noted there was one suspension of service in June 2024. The Board of Directors were ASSURED by the report. PS left the meeting.		
24/251	**STRATEGIC OBJECTIVE 4 – CONTINUOUSLY LEARN AND IMPROVE**		
17 mins	**NHS Impact** CH presented the report, advising the Trust has completed the NHS Impact self-assessment tool, with the scores predominantly being starting or developing. This benchmarks similarly with other health providers in Nottinghamshire. The outcome of the self-assessment tool is included in the report and has been translated into a draft continuous improvement strategy. The initial step is to make visible and set expectations of the 200 colleagues across the Trust who have undertaken Quality, Service Improvement and Redesign (QSIR) training. The next steps will include identifying colleagues who have received other improvement training and put an improvement network in place. There are pockets of good practice and improvement across the organisation. GW felt this feels like a restart and there are some areas which have slipped. There is a need to understand any lessons learned from that. GW queried, in going through the process again, what assurance can be provided to evidence the Trust can embed processes. CH advised NHS Impact's scoring criteria is quite specific and the Trust took a harsh line in completing the self-assessment tool. There may be good pockets in some areas which would put the Trust further up the maturity scale, but this is not consistent. There is a need to celebrate those areas and learn from them but the scoring tool suggests there is more work to do to make it consistent across the organisation. BB queried if QSIR features in the appraisals for staff who have completed the training. CH advised the Trust is seeking to set expectations of people who have attended QSIR and other improvement training. For future QSIR training cohorts, the Trust wants to ensure they have an improvement project aligned to their service or division so they can work on that while undertaking the training. This will then feed into their appraisal. BB queried if progress on embedding QSIR training and the link to appraisals will be monitored via the People Committee. RS acknowledged there are occasions when individuals attend training courses and the learning is not taken back into their workplace. There is a balance of giving colleagues time to attend training, given the conflicting pressures. There is a need to make the expectations clear from the outset.		

	DS advised improvement needs to become everyone's business and this is a cultural change which will require a continuous focus. In terms of the training provided, there is a need to be very clear there are expectations of anyone attending the QSIR training. There is also a need to understand the resource of people who have already completed the training and harness that resource. In terms of monitoring progress, improvement sits with the Quality Committee. **Action** • **Report outlining progress in relation to Quality, Service Improvement and Redesign (QSIR) training, including lessons learned, etc. to be presented to the Quality Committee.** AH noted the desire for improvement to be part of the culture of the Trust and queried if enough visibility and recognition is given to improvement work. RS felt it forms part of the community of practice concept. There is further opportunity to review, for example, how appraisal practitioners are brought together to celebrate achievements. GW acknowledged the Trust does an element of celebrating success, but there is more to do. PB advised it is not just what people are doing with the QSIR training in terms of the project, but also how it changes people as a practitioner / individual. AH noted there is an award for the most improved team at the Annual Staff Excellence Awards and queried if anything is done directly in relation to service improvement. CH advised the Trust has introduced an improvement ambassador role as a way of celebrating success and there will be opportunities to build on that. In terms of what the QSIR training provides personally and professionally, CH advised she has received feedback from senior decision makers in another organisation who have advised the training supports decision making and the identification of the problem they are trying to solve. There is a need for SFHFT to think about the skillset across the senior leadership team, as well as the rest of the organisation. SB felt there is a need for members of the Board of Directors to be made aware of any actions they need to take to support and lead on the improvement agenda. CH advised it would be useful to have a workshop session on the improvement culture. **Action** • **Improvement Culture to be topic for a future Board of Directors Workshop.**	**CH** **CH**	**03/10/24** **TBC**

	DS advised currently CH is in an acting role. Therefore, there is currently a vacant substantive executive role which includes improvement in that portfolio. There have been discussions within the Executive Team in relation to the make up of that portfolio and the expectation is for improvement to be 'front and centre' of that role. The Board of Directors were ASSURED by the report.		
24/252	**QUARTERLY INTEGRATED PERFORMANCE REPORT (IPR)**		
51 mins	**QUALITY CARE** PB highlighted MRSA, reduction in the number of Clostridium difficile (C.diff) cases, Patient Safety Incident Response Framework (PSIRF), Patient Safety Incident Investigations (PSII), falls, never event, Klebsiella and Hospital Acquired Pressure Ulcers (HAPU). SR highlighted Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI). SB noted the last three never events were all within Dermatology and queried if there is a link between them. SB noted one of the actions being taken is for these procedures and biopsies to be undertaken by substantive staff only, which will cause a delay for some patients. SB queried what the next steps are in relation to this. PB advised the immediate suspension of locums undertaking procedures was the right action to take while the Trust worked to gain an understanding of what the issues were. This has been assessed and locums undertaking procedures has been reintroduced, with control measures in place. SR advised the similarity between the most recent Never Event and the previous one led to the decision to look at this case from a human factors perspective. This did lead to an increase in waiting times. There is now an enhanced induction and changes introduced to ensure locums are working with substantive staff. DS advised a walkthrough has been undertaken to test whether the new processes are having the desired impact. If the process had been followed, this latest Never Event would not have happened, hence looking at human factors. **PEOPLE AND CULTURE** RS highlighted mandatory training, vacancies and turnover, workforce loss, appraisals, sickness absence, employee relation cases and bank and agency usage. BB queried what preparations are underway for flu vaccinations for staff. RS advised the Trust has not yet been made aware of when vaccine supplies will be available. However, work has been ongoing for some time to recruit peer vaccinators. Plans for the flu vaccinations will be shared at the next meeting of the People Committee.		

	PB advised 110 peer vaccinators are in place, compared to 20 last year. The best way to get staff vaccinated is for people to vaccinate colleagues in their own teams and areas. There are leads in each area who will drive this forward. This will be in addition to the usual roving and 'pop-up' clinics. DS advised he has sought permission from the ICB for the Trust to offer a vaccination to any patients who have contact with the Trust. This has not yet been confirmed, but this would be a key aspect to the Trust's flu campaign. **Action** • **Plans for forthcoming flu vaccinations to be shared with the People Committee.** AH queried what is driving the increase in agency usage. RS advised industrial action, elective recovery and vacancies are contributing factors. Dependency on bank and agency has followed periods of industrial action. There has been an increased application rate for consultant vacances, with some high calibre applicants, including in some of the harder to fill roles. SR advised the increase in agency usage has been driven by the medical workforce. There has been some improvement, but significant challenges remain. GW felt it important to monitor sickness absence as this will impact on agency and bank usage. SB noted waiting times for treatment impacts on staff as well. There is a need to support staff wellbeing. **TIMELY CARE** In terms of the emergency pathway, RE highlighted A&E attendances, which are 11% higher than planned levels, non-elective admissions, planning for Winter, ambulance handover times, good Same Day Emergency Care (SDEC) performance, implementation of surgical SDEC, ED 4-hour wait performance and discharge lounge usage. In terms of elective care, RE highlighted the impact of industrial action, reduction in the number of long waiting patients, diagnostics, mutual aid with Nottingham University Hospitals (NUH), outpatient activity and Patient Initiated Follow Up (PIFU). In terms of the cancer pathway, RE highlighted the 28-day faster diagnostic standard and 62-day standard. ARB queried if there is any information available in relation to how many patients are attending ED who should be seen by primary care. RE advised it is known patients will attend ED as they are struggling to access either primary care or other services in the community. An audit has recently been completed and the aim is to gather this information on an ongoing basis. Previously the Trust had anecdotal information, but patients are now being asked if they tried to access an alternative service before attending ED.	**RS**	**03/10/24**

	AR queried the source of the pressure to not increase bed capacity and queried if this was for purely financial reasons. RE advised the national planning guidance required trusts to keep open all general and acute (G&A) bed capacity which was open last Winter. The current pressure to close beds is largely financially driven. The Trust supports the principle that if only appropriate patients come in, the 'outflow' is managed and demand is reduced, then beds would be closed to deliver the financial benefits. However, this is difficult to achieve given the current levels of demand. The Trust is working with partners in terms of SFHFT's asks of them. DS advised for a number of years the Trust has opened beds associated with Winter, but has not been able to close them. These beds have now been assumed into the base bed stock. Discussions are ongoing to determine if this is a re-set or is still additional capacity, noting both the financial angle and quality and timely care angle. The issue going into Winter is most of the additional capacity is open, which limits the Trust's ability to open extra wards. AR noted there is a tension between finance and quality and safety and felt there is a need to have open conversations about this as a system. RE advised the Trust is being asked to put forward 'brave' schemes. However, anything which is being considered will go through a Quality Impact Assessment (QIA) process. Beds will not be closed at the expense of keeping the hospital safe over Winter. Despite the increase in demand over the last 2-3 years, the Trust has not increased the bed baseline, which indicates the Trust is being more productive. AH noted the increased demand in terms of ED attends and admissions on the non-elective pathway and queried if the drivers of this demand are understood. RE advised there is good data available in terms of the demographic growth of the local population which has been produced by the System Analytics Intelligence Unit (SAIU) in the ICS. There is a disproportionate growth in the demographic, particularly in the elderly population, in mid-Nottinghamshire. The admission avoidance and community response work is critical. SR advised the SAIU has tried to get some information on acuity and co-morbidities. This is a complex picture and the data suggests there may be accesses issues in terms of same day access to primary care. RE advised there has been an increase in admissions from care homes. SR advised work is ongoing at a system level in relation to frailty. **BEST VALUE CARE** DS outlined the Trust's financial position at the end of Q1, highlighting risks, Financial Improvement Programme (FIP), capital allocation, agency spend and cash position. GW felt it would be useful to include agency spend, in terms of the financial cost, as a graph in the IPR.		

	Action • **Graph to be included in the IPR showing agency spend as a financial cost.** SB felt it would be useful to understand the amount of FIP which is recurrent in order to gain an understanding of the trajectory towards next year. DS advised these discussions feed into the conversations in relation to determining the core bed base. The Board of Directors CONSIDERED the report.	**RE**	**07/11/24**
24/253	**BOARD ASSURANCE FRAMEWORK (BAF)**		
4 mins	DS presented the report advising all the principal risks (PR) have been discussed by the relevant sub committees. In addition, the BAF in its entirety is subject to quarterly review by the Risk Committee. The changes, and amendments which have been made, are highlighted in the report. It was noted four risks, namely PR1 (Significant deterioration in standards of safety and care), PR2 (Demand that overwhelms capacity), PR3 (Critical shortage of workforce capacity and capability) and PR4 (Failure to achieve the Trust's financial strategy) remain as significant risks and they are also above their tolerable risk ratings. PR7 (Major disruptive incident) and PR8 (Failure to deliver sustainable reductions in the Trust's impact on climate change) are also above their tolerable risk ratings. The Board of Directors REVIEWED and APPROVED the Board Assurance Framework.		
24/254	**ASSURANCE FROM SUB-COMMITTEES**		
10 mins	**Audit and Assurance Committee** ARB presented the report, highlighting concern about the capacity to deliver the Trust strategy and the Moderate Assurance opinion following the internal audit for FIP. The Board of Directors were ASSURED by the report. **Finance Committee** GW presented the report, highlighting Month 3 financial performance and review of BAF PR4. The Board of Directors were ASSURED by the report. **Quality Committee** AR presented the report, highlighting 62-day cancer performance, fragile services and internal audit report into safeguarding.		

	People Committee SB presented the report, highlighting work being undertaken in the Urgent Care Team to improve working conditions and lack of system capacity for patients with mental health concerns. The Board of Directors were ASSURED by the report. **Charitable Funds Committee** AR presented the report, highlighting the project to re-scope End of Life rooms, Breast Services Appeal and approval of the purchase of a pair of Neptune 3 Rovers (a closed waste management system) for theatres at Newark Hospital. The Board of Directors were ASSURED by the report.		
24/255	**OUTSTANDING SERVICE – PATHOLOGY - THE TEAM BEHIND AN OUTSTANDING SERVICE**		
7 mins	A short video was played highlighting the work of the Pathology Team.		
24/256	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 mins	The Board of Directors AGREED the following items would be disseminated to the wider organisation: • Apology given to the parents of Baby Theo and the need to share his story. • Pathology Team outstanding service video. • Thanks to volunteers at the Trust. • Industrial action. • IPR. • Improvement offer. • Financial position.		
24/257	**ANY OTHER BUSINESS**		
	No other business was raised.		
24/258	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 5th September 2024 in the Boardroom at King's Mill Hospital. There being no further business the Chair declared the meeting closed at 12:00.		

24/259	**CHAIR DECLARED THE MEETING CLOSED**		
	Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Graham Ward **Acting Chair** **Date**		

24/261	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
1 min	GW reminded people observing the meeting that the meeting is a Board of Directors meeting held in Public and is not a public meeting. Therefore, any questions must relate to the discussions which have taken place during the meeting. No questions were raised from members of the public.		
24/262	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting.** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Outstanding Care,
Compassionate People,
Healthier Communities

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
24/039	01/02/2024	Divisional breakdown within Freedom to Speak Up (FTSU) Guardian report to be shown as a percentage of workforce in future reports.	Public Board of Directors	None	~~01/08/2024~~ 03/10/2024	S Brook Shanahan	K Bosworth	**Update 15/07/2024** Report deferred to October Board meeting	Grey
24/108.2	04/04/2024	Report to be provided to the Quality Committee in relation to the work of the Lower Pelvic Floor Team, particularly the impact of their work on third and fourth degree tears.	Public Board of Directors	Quality Committee	~~04/07/2024~~ 03/10/2024	P Bolton	P Shore	**Update 17/04/2024** On agenda for June meeting of the Quality Committee **Update 20/06/2024** The Perinatal Pelvic Health Service paper will be presented at the August 2024 meeting of the Maternity Assurance Committee before presentation at the Quality Committee in September 2024	Grey
24/183.2	06/06/2024	Sub-committee annual reports to follow same format	Public Board of Directors	None	Apr-25	S Brook Shanahan			Grey
24/221.1	04/07/2024	Information in relation to the number of Equality Impact Assessments undertaken and their impact, etc. to be reported to the People Committee.	Public Board of Directors	People Committee	03/10/2024	R Simcox		**Update 15/08/2024** Item to be included on next People Committee agenda (24/09/2024)	Grey
24/223	04/07/2024	Information in relation to the cost of maintaining the current IT landscape, and what the costs are likely to be in five years' time, to be reported to the Finance Committee.	Public Board of Directors	Finance Committee	07/11/2024	D Selwyn	N Turner		Grey
24/251.1	01/08/2024	Report outlining progress in relation to Quality, Service Improvement and Redesign (QSIR) training, including lessons learned, etc. to be presented to the Quality Committee.	Public Board of Directors	Quality Committee	05/12/2024	C Hinchley		**Update 21/08/2024** Improvement will be the 'Hot Topic' at the November Quality Committee meeting.	Grey
24/251.2	01/08/2024	Improvement Culture to be topic for a future Board of Directors Workshop	Public Board of Directors	None	TBC	C Hinchley		Added to Board Workshop planner **Complete**	Green
24/252.1	01/08/2024	Plans for forthcoming flu vaccinations to be shared with the People Committee	Public Board of Directors	People Committee	03/10/2024	R Simcox		**Update 15/08/2024** Item to be included on next People Committee agenda (24/09/2024)	Grey
24/252.2	01/08/2024	Graph to be included in the IPR showing agency spend as a financial cost.	Public Board of Directors	None	07/11/2024	R Eddie	M Bolton		Grey

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chair's report	**Date:**	5th Sept 2024
Prepared By:	Rich Brown, Head of Communications		
Approved By:	Graham Ward, Acting Chair		
Presented By:	Graham Ward, Acting Chair		

Purpose

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

Strategic Objectives

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

Principal Risk

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

Committees/groups where this item has been presented before

None

Acronyms

ICB = Integrated Care Board
NHIS = Nottinghamshire Healthcare Informatics Service
NUH = Nottingham University Hospitals

Executive Summary

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

Sherwood Forest Hospitals prepares to celebrate Trust colleagues at annual *Excellence Awards*

Everyone at Sherwood Forest Hospitals is counting down to the Trust's staff *Excellence Awards* in September.

The awards are the Trust's single greatest opportunity to recognise colleagues who have gone over-and-above in their roles to make great patient care and 'improve lives' across our hospitals over the past year.

The Trust has received over 500 nominations for this year's awards, which just shows how appreciated our Trust colleagues' work is by their Trust colleagues, the organisations we work with, and the patients and communities we serve.

Crucially, the event is entirely funded by our sponsors who make generous donations to enable the Trust to make this celebration happen, while allowing the organisation to focus its resources on frontline patient care. This year's sponsors are Managed Healthcare Services, Kier and the Sherwood Forest Hospitals Charity and we are so grateful to them all for making this celebration possible.

I look forward to joining those celebrations with Trust colleagues at the event, which is due to take place on Thursday 12th September 2024.

Recruitment of new Non-Executive Directors to the Trust Board

The Trust is currently looking to recruit two new Non-Executive Directors to the Trust Board of Directors, following approval to appoint to these two important posts at the Trust's August meeting of its Council of Governors.

The first vacancy has arisen following my appointment to the role of Acting Chair, with this vacancy to have a financial focus.

The second will be to recruit an Associate Non-Executive Director with a specific focus on research and innovation – another key area for the Trust over the coming months.

Recruitment for both these roles is due to begin in September 2024, with both roles to be advertised externally. The recruitment for both roles is a governor-led process.

Community Involvement updates

Recognising the difference made by our Trust Charity and Trust volunteers

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

In August alone, 382 Trust volunteers generously gave over 4,650 hours of their time to help make great patient care happen across the 33 services they have supported during the month.

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

- The Trust was grateful to receive a donation of £7,250 from the Sherwood Forest Hospitals Charity. Pictured right.

  That donation has been used to purchase a bladder scanner at a cost to enable faster response times and improved patient experience on the unit.

- A generous donation of £1,505 was made to the Sherwood Forest Hospitals Charity during the month to the Trust's Gynaecology department at King's Mill Hospital from Shape Fitness. That money was raised by clients doing squats and a "plank" every day through March.

- We were delighted to wave-off fundraiser Jane and her family, who are embarking on a walk from King's Mill to Nottingham City Hospital via Hopewood House to raise funds for all three hospital charities. We are looking forward to hearing how much they have raised – and welcoming them back for an official presentation.

- The team were delighted to celebrate with our young volunteers who have secured great results in their GCSE's.

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

Trust approves schemes to benefit from volunteers' funding in latest Dragons' Den panels

The Community Involvement Department received a record number of applications for service improvement projects under £5,000, which are raised by funds from the wonderful King's Mill Hospital Volunteers from profits raised in the Daffodil Café and other fundraising stalls.

The process helps to utilise funds raised from charity efforts to ensure that precious Trust resources can remain focused on frontline patient care.

The panel were delighted with the number of responses and the passion and enthusiasm shown by those who came to present. Of the 28 applications received, funding has been approved for 13 projects with a total value of around £50,000.

A further eight bids will be supported by the Sherwood Forest Hospitals Charity, with support given to all successful applicants to navigate the finance and procurement process.

We remain so grateful to everyone who has given their time, money and support in other ways to support the Trust and our hard-working colleagues over the past month – and we look forward to sharing news of the difference these schemes will make across our hospitals.

Other notable engagements:

A number of meetings have been undertaken in the month as part of my role as Acting Chair. Those meetings include:

- Joining the Trust's Acting Chief Executive to meet with Sabrina Taylor, the Chief Executive of Nottingham and Nottinghamshire Healthwatch

- Meeting with Caroline Shaw as the Chief Executive of an organisation called Evergreen Life to explore how the Trust can make better use of the NHS app to further enhance the patient care it provides.

- Undertaking my latest '15 Steps' walkaround with the Trust's staff-side lead, Roz Norman, at the Trust's Nottinghamshire Healthcare Informatics Service (NHIS) and to visit the Corporate Planned Care Team.

- Conducting our latest 'Board to Board' meeting with members of the Nottingham and Nottinghamshire Integrated Care Board (ICB).

- A monthly update meeting with NHS England's regional director for the Midlands, Dale Bywater.

- Meeting with Mansfield District Council to further the Trust's place-based work with the Council.

- Quarterly meeting with other Trust Chairs from Nottingham University Hospitals (NUH) and Nottinghamshire Healthcare, where we were delighted to host them at King's Mill Hospital for our latest meeting.

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Acting Chief Executive's report	**Date:**	5th Sept 2024
Prepared By:	Rich Brown, Head of Communication		
Approved By:	David Selwyn, Acting Chief Executive		
Presented By:	David Selwyn, Acting Chief Executive		

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

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

Principal Risk		
PR1	Significant deterioration in standards of safety and care	
PR2	Demand that overwhelms capacity	
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PR7	Major disruptive incident	
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	

Committees/groups where this item has been presented before

None

Acronyms

BAF = Board Assurance Framework
CDC = Community Diagnostic Centre
CT = Computed tomography
GP = General Practitioner
HSJ = Health Service Journal
ICS = Integrated Care System

Executive Summary

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

Operational updates

Overview of operational performance

Demand across our urgent and emergency care pathway continued to be high and above plan in July 2024, with the sustained high demand places pressure on our urgent and emergency care pathway, with patients having to wait longer than we would wish for treatment and admission.

In August 2024, however, we have seen a seasonal ease in urgent and emergency care demand and a corresponding improvement in many of our operational performance metrics. This indicates that our underlying systems and processes are good and that it is our ability to cope with demand above planned levels that constrains our operational delivery.

Thankfully, we have not yet seen a significant impact on the Trust's services as a result of the collective action that has been taken by some local General Practice (GP) doctors in the Nottingham and Nottinghamshire Integrated Care System (ICS).

At the time of writing, our four-hour emergency access performance for the month-to-date for August is at the strongest position for over two-and-a-half years.

We also continue to benchmark among the best trusts in the country for ambulance handover times – a position we are proud of, as it recognises the emphasis we place on releasing ambulance crews to respond to the needs of our local community. That performance attracted media coverage in the Health Service Journal (HSJ) during August, where the Trust's ambulance handover times were named as the best anywhere in the Midlands. We look forward to sharing more about our ambulance handover performance at a future board meeting over the coming months.

The number of patients classified as 'medically safe for transfer' remaining in our hospitals once they have received the vital specialist hospital care they need and whose ongoing needs can be provided elsewhere. In August, the number of those patients we continued to care for in our hospitals remained below our operational planning levels. The challenge ahead of winter is maintaining low levels of discharge delays to support good hospital flow.

We are seeing a continued reduction in the number of planned care patients on our waiting list, including those patients waiting over 52- and 65-weeks for treatment. The number of long-wait patients remained below our planned levels at the end of July 2024.

From a diagnostics perspective, echocardiography, computed tomography (CT) cardiac and cystoscopy are our most challenged modalities, which we have recovery plans in place with weekly oversight.

Within our cancer services, we continue to meet the national 28-day faster diagnosis standard. We delivered against our planned performance level in June 2024 for our cancer 31-day and 62-day treatment metrics, although we recognised we have further work to continue to improve in the treatment phase of our cancer pathway.

A more comprehensive update on our operational performance will be presented at the November Trust Board meeting, where we are due to reflect on our quarter two 2024/25 performance in more detail.

NHS Oversight Framework 2023-24: Quarter 4 Segmentation

Amanda Sullivan, Chief Executive of the NHS Nottingham and Nottinghamshire Integrated Care Board (ICB), formally wrote to the Trust on 21st August 2024 to confirm the Trust's Quarter 4 2023-24 segmentation position and to set out the process and timescales for the 2024-25 Quarter 1 segmentation assessment. That letter is provided in full in appendix one of this report.

It was agreed that for Quarter 1 2024-25, Sherwood Forest NHS Foundation Trust should remain in Segment 2 of the NHS Oversight Framework. This rating is based on the quantitative and qualitative assessments of the five national themes and one local priority contained within the NHS Oversight Framework.

While the Sherwood Forest position will remain at Segment 2 for Quarter 1, there are rising concerns which will need to be addressed to prevent a movement into Segment 3 for future quarters, these are in relation to having:

1. a financial plan which is not balanced and/or there is a material actual or forecast deficit (this is a trigger for NOF 3 segment), recognising the financial challenges we face as a Trust.
2. deterioration in performance or sustained very poor (bottom decile) performance against one or more areas

The Trust's financial position will continue to be monitored through future updates to the Trust Board, where I will commit to continue to update the Board on our ongoing engagement with the Nottingham and Nottinghamshire Integrated Care Board and NHS England.

Despite many of the challenges the Trust faces are reflected in that assessment, the rating also recognises a number of areas that the Trust can be rightly proud of as the Trust continues to perform well against the Oversight Framework assessment metrics, with a significant amount of performance areas continuing to be in the upper quartile nationally.

The assessment also sets out the 'exit criteria' for the Trust as the next steps that will be required to progress from Segment 2 and not move to Segment 3. In order to realise this, the Trust will need to undertake the following actions:

1. Address the underlying and in-year deficit of the Trust, providing a plan to return to financial balance by March 2026, working across the system, to ensure a clear plan is in place with evidence of progress being made.
2. Continue to progress elective recovery through increasing productivity, ensuring sustained eradication of 78 weeks, achievement of the 65-week and 52-week reductions in 2024, maintain 62-day backlog reductions and deliver improvements for the diagnostic 6-week waits, especially with regard to the ECHO waits.
3. Address areas of rising risk across urgent care, including delivery of the 4-hour and 12-hour position
4. Continue to provide active contribution to the overall system financial sustainability, quality improvements and outcomes.
5. To be a key contributor to the wider system as an anchor institution.

As a new oversight framework is expected to be implemented in the autumn, NHS England is pausing the proactive segmentation review process for Quarter 2 and do not require a formal submission Nottingham and Nottinghamshire Integrated Care System from the ICB. The ICB will instead continue to undertake an internal review and assessment with providers for Quarter 2, as a way of monitoring progress against the segmentation drivers to support the ICB in fulfilling its current responsibility as set out in the NHS Oversight Framework. This will help the Integrated

Care Board (ICB) to maintain local oversight of local provider organisations, with NHS England maintaining statutory accountability for NHS provider organisations.

I will continue to keep the Board updated about this oversight review as it is undertaken each quarter.

Newark Urgent Treatment Centre (UTC) update

The Trust has been continuing its preparations to implement the new extended opening hours for Newark Urgent Treatment Centre (UTC), following the decision from the Nottingham and Nottinghamshire Integrated Care Board (ICB) to amend the opening hours of the facility.

Earlier this year, the Nottingham and Nottinghamshire Integrated Care Board (ICB) made its decision on the future opening hours of Newark Hospital's Urgent Treatment Centre (UTC) following feedback from residents, stakeholders and clinical input from healthcare experts.

The UTC, which is run by Sherwood Forest Hospitals NHS Foundation Trust, provides urgent care and non-life-threatening treatment for injuries or conditions, such as cuts, simple broken bones, wounds, minor burns and minor head, eye and back injuries.

Currently, the Urgent Treatment Centre operates between 9am and 10pm as a temporary measure, with the last patient being admitted at 9.30pm. As a result of the ICB decision on the Centre's permanent opening hours, the UTC will open between 8am and 10.30pm each day, seven days-a-week. Under the new opening hours, the last patient will be admitted at 9.30pm each day.

The new permanent opening hours will offer an extended window for patients to access essential healthcare services, opening earlier and longer to support people who need to access the service around working patterns and school times.

Once the new opening hours are introduced, the service will be open for 14.5 hours per day – exceeding the 12-hour minimum national standard for UTCs set by NHS England, as well as the current temporary operating hours at the UTC.

As part of the decision-making process, the Trust supported the ICB in engaging with residents and stakeholders to ensure that the preferred option for the UTC opening hours aligned with the community's needs. The feedback from residents of Newark clearly indicated the high value they place on the service received at the UTC. While there was clearly a strong preference for a return to 24 hours opening, this was balanced against other factors within a rounded, evidence-based decision.

The evidence-based decision follows a review by the East Midlands Clinical Senate and their subsequent recommendation to make permanent the overnight closure of the Urgent Treatment Centre.

Since that decision was made, the Trust has been working to implement those changes to the Centre's opening hours, including by undertaking formal consultation with the Trust staff who work there.

Once introduced, both the Trust and the ICB will also continue to assess the impact of the extended operating hours, monitoring usage and reviewing patient feedback to ensure we continue to provide a responsive service to local people.

Partnership updates

Meeting with Lee Anderson MP for Ashfield

During August, I met with the Member of Parliament (MP) for Ashfield, Lee Anderson MP, alongside the Trust's Chief Nurse, Phil Bolton, and its Director of Midwifery and its Divisional Director of Nursing for the Trust's Women and Childrens Division, Paula Shore.

The meeting was held ahead of Mr Anderson preparing to hold a parliamentary listening event and debate into preventable baby loss, which is due to take place in September.

The meeting proved very constructive meeting, both in providing an opportunity to provide a factual briefing before that parliamentary debate – as well as to discuss the Trust's wider maternity services, including our work to reduce smoking rates in pregnancy.

On Friday 23rd August 2024, we were delighted to welcome Mr Anderson back to the Trust for a walkaround of the Trust's maternity services to showcase the care we provide at Sherwood to help inform that debate.

Other Trust updates

Supporting Trust staff Southport murders and subsequent national unrest

As a Trust Board, we were saddened to hear the news of the tragic deaths of three young girls in Southport – Bebe King, six, Elsie Dot Stancombe, seven, and Alice Dasilva Aguiar, nine, were killed in the stabbing in Southport on Monday 29th July 2024.

The thoughts of everyone here at Sherwood Forest Hospitals remain with the friends and family of everyone affected by that tragedy.

Those events led to deplorable violent demonstrations across the country and while those demonstrations were thankfully not been seen in the communities of Mansfield, Ashfield, Newark and Sherwood that we primarily serve, we know that the national impact of those events were felt by colleagues at our Trust.

Here at Sherwood, we know how proud we all are of the diversity of our workforce and the part you all play in making great patient care happen across our hospitals. Celebrating the diversity of our people and the communities we all serve is at the heart of everything we do here as a Trust.

Following those events, we took the proactive step of reaching-out to all Trust colleagues with a message of support during what was a difficult time for many – a point that is especially true for colleagues from minority groups who felt particularly threatened during these national events.

The message also signposted colleagues to support provided by the Trust, as well as to encourage anyone who experienced physical, verbal, racial or any other kind of abuse while working in our hospitals to report it as soon as possible so we can take swift and decisive action.

During the month, members of our Executive Team also joined a number of vigils for peace that were held in faith spaces across all three Trust sites for colleagues to attend.

Trust prepares to host Annual General Meeting (AGM)

On Tuesday 24th September 2024, we are due to host our Annual General Meeting (AGM) at King's Mill Hospital to provide an in-depth look at the Trust's performance over the 2023/24 financial year – as well as highlighting how the Trust is planning to meet the challenges it will face for the remainder of 2024/25 and beyond.

The Trust's Annual Report and Accounts for the year ending 31st March 2024 will also be formally presented at the meeting, with our annual report already having been published on the Trust's website at www.sfh-tr.nhs.uk/about-us/publications-and-reports/ along with our Quality Report. A summary annual report will also be made available prior to the Annual General Meeting.

Members of the public are welcome to attend the AGM in-person, with the meeting also due to be streamed online. If you would prefer to observe the meeting online, you can email sfh-tr.communications@nhs.net and a link will be shared with you.

There will be an opportunity to put your questions to the Trust's Board of Directors at the meeting. All questions must be submitted in advance of the meeting by emailing sfh-tr.communications@nhs.net before midnight on Thursday 19th September 2024.

As with last year's Annual General Meeting, this year's event will also be hosted alongside the Trust's latest *Step into the NHS* careers showcase event in the hospital's main reception area.

The showcase will give anyone attending the event an opportunity to find out more about the work that is going on across our hospitals, as well as sharing the range of career opportunities within the Trust with potential job seekers.

Anyone attending the event is welcome to attend the showcase event which will begin after the meeting.

Anyone wishing to attend the Trust's *Step into the NHS* careers showcase event can secure their place online via the Eventbrite booking system.

Demolition of Victoria Hospital makes way for purpose-built Community Diagnostic Centre at Mansfield Community Hospital

During August, we were excited to reach a new milestone in the development of the new Community Diagnostic Centre (CDC) at Mansfield Community Hospital.

In February this year, work commenced on-site at the site in Stockwell Gate, Mansfield, and the Trust is excited to share that the derelict building formerly known as Victoria Hospital has now been completely demolished. That demolition has paved the way for building works to start on-site, with a grand opening of the new CDC site anticipated for spring 2025.

Hospital patients have already benefited from more than 38,000 extra diagnostic tests before the first brick has been laid for Nottinghamshire's first CDC. Once fully operational, Mansfield CDC will provide a one-stop shop for patients across Nottinghamshire to access the tests and investigations they need in a single visit to help them receive an 'all clear' or diagnosis sooner. As well as delivering thousands more tests each week, the CDC will also create hundreds of job opportunities.

In May 2024, the Trust submitted its updated planning application for the Mansfield CDC, with the new plans outlining the expansion of diagnostic services, ensuring faster and more convenient access to a variety of tests and investigations. The Trust is anticipating that planning application to be determined by Mansfield District Council in early September.

Throughout the demolition process, the Trust have prioritised sustainability and community benefits. As a result of these efforts, the demolition has achieved a 90% recycle rate on the waste generated on-site, with approximately 60% of the loose items within the building having been reclaimed to be re-used and recycled.

Additionally, the building's rubble will be crushed to form the levels for the rebuild works, saving 1,500 tons of imported material. By involving four local contractors in the demolitions works, the Trust ensured that the investment in this project benefits the local community.

For more information on the project, please visit our site at www.sfh-tr.nhs.uk/cdc

Caption: The artists' impression of how the Mansfield Community Diagnostic Centre is expected to look under the Trust's revised plans

Trust risk ratings reviewed

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

The full and updated Board Assurance Framework (BAF) is next due to be presented at the Public Meeting of the Trust's Board of Directors in November.

NHS
Nottingham and Nottinghamshire

Sir John Robinson House
Sir John Robinson Way
Arnold
Nottingham
NG5 6DA

21st August 2024

Letter sent via email

David Selwyn
Acting Chief Executive
Sherwood Forest Hospitals NHS Foundation Trust

Dear David

RE: NHS Oversight Framework 2024-25 – Quarter 1 Segmentation

Thank you very much to you and your teams for your continued leadership at Sherwood Forest Hospitals. I am writing to confirm the Quarter 4 2023-24 segmentation position for your organisation and to set out the process and timescales for the 2024-25 Quarter 1 segmentation assessment.

Quarter 4 Segmentation Review Outcome- Review Undertaken March 2024

Following the ICB peer review process undertaken June 2024, the proposed segmentation rating for NHS Provider organisations was reviewed and approved by Midlands Regional Support Group (RSG) at its meeting on the 25th July 2024, and notified to the ICB on the 5th August 2024. It was agreed that for Quarter 1 2024-25 Sherwood Forest NHS Foundation Trust should remain in segment 2 of the NHS Oversight Framework.

This rating is based on the quantitative and qualitative assessments of the 5 National Themes and one local priority contained within the NHS Oversight Framework. While the Sherwood Forest position will remain at Segment 2 for quarter 1, there are rising concerns which will need to be addressed to prevent a movement into Segment 3 for future quarters, these are in relation to having:

1. a financial plan which is not balanced and/or there is a material actual or forecast deficit (this is a trigger for NOF 3 segment)
2. deterioration in performance or sustained very poor (bottom decile) performance against one or more areas (this is also a trigger for NOF 3)

Quality of Care, access and outcomes – The Trust continues to perform well against the Oversight Framework assessment metrics, with a significant amount of performance continuing to be in the upper quartile nationally and the only area reporting in the lowest quartile relating to diagnostic performance, mainly in relation to ECHO, which has been an area of difficulty now for some time. There have been some improvements across a number of areas with the Trust reporting zero 104 and 78 week breaches in June. 65 week and 52 weeks remain on plan

against the improvement trajectory. Cancer backlogs delivered better than plan in May 2024 and the Trust continually delivers against the FDS.

There are increasing difficulties across the urgent care performance, in part to increased demand, MSFT and LLOS were remaining at high levels, and there were increasing difficulties with the UEC targets of 4 and 12 hour waits, with the 4-hour position reporting below the recovery plan levels expected. While ambulance handover delays continue to perform relatively well, these were also experiencing pressures at a higher than previously seen. The overcrowding within the Emergency Department remains a reported risk at Kings Mill Hospital.

Despite continuing internal pressures, the Trust maintains support for the wider system and frequently supports through mutual aid and agreed diverts.

The PSIRF policy and plan are in place and agreed, with a PSIRF oversight group having commenced to review themes, trends and duty of candour processes.

Responses to two paediatric Regulation 28 prevention of future death reports were due to be shared on the 28th May 2024. The improvement work required is being supported through the Emergency Department Improvement Plan.

Preventing ill-health and reducing inequalities – The Trust's Clinical Strategy has a clear focus on health inequalities, and it will be good to see this presented at the ICS Health Inequalities Oversight Group to highlight the opportunities identified. The Trust has continued to focus on elective restoration by targeting individuals of higher risk and supporting them to 'wait well'. There is ongoing commitment to smoking cessation with a positive evaluation of maternity services and direct impact on Smoking at the Time of Delivery. The Trust's regular attendance at the ICS Health Inequalities Oversight Group has provided welcome insight into the Group.

Finance and Use of Resources – The Trust underlying structural financial deficit position is the key driver for the level 2 NHS Oversight Framework segmentation rating and is the main area of concern for a potential trigger to level 3.

- The Trust closed 2023/24 with a £14m deficit, which was £14m adverse variance against the break-even plan. Efficiency targets were £1.8m adverse to plan and were mainly non-recurrent delivery, leading to £14.4m recurrent adverse position. Agency spend also reported over planned levels at £16.6m, which was a £3.6m adverse position against plan.
- 2024/25 financial plans were submitted with a £14m deficit. This position included a 5% efficiency requirement. Initial draft plans were submitted which presented a £14.7m deficit position for 2024-25. At the time of the June 2024 ICB review, there were no plans for financial sustainability in the medium term. We would ask that you continue to work both internally and with the system to deliver against the in-year plans submitted, and to plan for medium term financial sustainability, to support your improvement in your NHS OF Segmentation position and prevent deterioration to NOF 3 and to respond to the ICB Financial Undertakings in place for all system partners.

People – The Trust submitted a realistic workforce plan for 2024-25 and reported positively against the April plan position.

- Substantive –18.7WTE (0.36%) below plan
- Bank –45.6 WTE (9.75%) below plan
- Agency –10.9 WTE (10.22%) below plan
- Turnover is at 8.1% against a Target of 8.5%

- Sickness at 4.25% against a target of 4.1%

The Trust remained in the top quartile for February 2024 for staff leaver rates.

The Trust continued to perform well across the 2023 Staff Survey, with many areas reporting in the top quartile national. The only exception to this position being the proportion of staff in senior leadership roles who are from a BME background, however this is reporting year on year improvement, and a full programme of work is in place.

Leadership and capability – There has been active engagement in system transformation programmes, as well as increasing roles in collaborative working with participation in specialist groups such as fall and tissue viability. Engagement across health inequalities, people and place work programmes has reduced in recent months. There are no material concerns or support needs identified for the trust system or governance at Q1, as the trust has strengthened quality and governance roles.

The Trust has needed to make various interim arrangements at senior levels supported by a relatively new executive team, this will need clarity and focus to ensure pace and delivery against the competing in year challenges.

Local Strategic Priorities – The Trust has continued to support the wider system at times of urgent care pressures as well as providing support to progress with recovery of elective services through providing on-going system support to NUH and mutual aid and active management of its elective programme, despite significant continual pressures within the trust.

Segment 2 Exit Criteria

The ICB team will work closely with you to review the support needs for the Trust to address the triggers for current segmentation and rising areas of concern and continue to support progress against the exit criteria during 2023-24.

The ICB has also received enforcement undertakings in relation to the financial position which requires the ICB and system NHS Partner organisations to develop a single financial recovery plan, which delivers a return to breakeven by no later than 31st March 2026.

To progress from Segment 2 and not move to Segment 3 the Trust will need to undertake the following actions (exit criteria):

1. Address the underlying and in year deficit of the Trust, providing a plan to return to financial balance by March 2026, working across the system, to ensure a clear plan is in place with evidence of progress being made
2. Continue to progress elective recovery through increasing productivity, ensuring sustained eradication of 78 weeks, achievement of the 65-week and 52-week reductions in 2024, maintain 62-day backlog reductions and deliver improvements for the diagnostic 6ww, especially with regard to the ECHO waits.
3. Address areas of rising risk across urgent care, including delivery of the 4-hour and 12-hour position
4. Continue to provide active contribution to the overall system financial sustainability, quality improvements and outcomes.
5. To be a key contributor to the wider system as an anchor institution.

Quarter 2 2024-25 Segmentation Review Process

As a new oversight framework is expected to be implemented in the autumn, NHSE are pausing the proactive segmentation review process for quarter 2 and do not require a formal submission

from the ICB. However, the ICB will continue to undertake an internal ICB review and assessment with providers for quarter 2, as a way of monitoring progress against the segmentation drivers to support the ICB in fulfilling its current responsibility as set out in the NHS Oversight Framework, for Integrated Care Boards (ICB) to have local oversight of their NHS provider organisations with NHS England maintaining statutory accountability for NHS provider organisations.

The ICB will discuss any exceptional changes in circumstance with any provider, with NHS England lead.

We will continue to discuss the arrangements under the emerging NHS Oversight Framework with you, as we further develop our system operating framework. In the meantime, should you wish to discuss this further please contact myself or Sarah Bray, Associate Director of Performance and Assurance, (sarah.bray6@nhs.net) in the first instance.

May I take this opportunity to again thank you and your team for the on-going contribution you make to the local system, the segmentation rating is recognition of the significant focus which the trust continues to place on supporting staff, patients and the wider system.

With kind regards

Yours sincerely

Amanda Sullivan
Chief Executive
NHS Nottingham and Nottinghamshire ICB

cc. Julie Grant, Director of Strategic Transformation, NHSE Midlands

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors – Public – Cover Sheet

Subject:	Revised Constitution	**Date:**	5th September 2024
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	David Selwyn, Acting Chief Executive		
Presented By:	David Selwyn, Acting Chief Executive		

Purpose		
To seek approval from the Trust Board to changes to the Trust's Constitution on the recommendation of the Council of Governors.	**Approval**	**X**
	Assurance	
	Update	
	Consider	

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

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

Committees/groups where this item has been presented before

Constitution Working Group meetings held on 16th May and 5th July 2024

Acronyms

NHSE – National Health Service England
PBP – Place Based Partnership

Executive Summary

The Constitution was most recently approved in August 2022. As a result of feedback received regarding the need for changes to it, specifically in relation to the electoral constituencies and the modernisation of voting arrangements, a Governor working group was established in order to examine in detail and agree proposals to put before the full Council of Governors. The working group comprising Liz Barrett, the Lead Governor, Ian Holden, Peter Gregory, Sam Musson, and Vikram Desai met on 16th May and 5th July 2024 and was supported by the Director of Corporate Affairs and Head of Communications.

The amendments are incorporated in tracked changes on the attached version of the Constitution. They comprise:

- Proposed revisions in relation to the electoral constituencies reflect the working group's feedback about the need for the "Rest of the East Midlands" constituency to be more

specifically focussed on the local communities of Mansfield and Ashfield that it serves,

- the modernisation of the voting arrangements, specifically to incorporate the NHSE Model Election Rules that permit e.voting, thereby enabling future elections to be both more efficient and significantly less expensive as no postage charges will be incurred,

- updates to the paragraphs about terms of office to align them with NHSE requirements that they do not exceed a total of nine years,

- replacing the unused opportunity for the PBP to nominate a governor, with the opportunity for the new Combined Authority to make a nomination instead. The Mayor has welcomed this opportunity and has confirmed the Combined Authority will work with the Trust to ensure effective participation and representation, and

- taking the opportunity to revise out of date references e.g.to the role of Trust Secretary.

Paragraph 20 of the Constitution sets out the process for the approval of amendments. In accordance with it, the tracked changes version of the revised Constitution incorporating the proposed changed described above was presented to the Council of Governors on 13th August 2024 at which there was unanimous agreement for them to be recommended to the Trust Board for approval.

The amendments will take effect at the point they are approved by the Trust Board. It is for noting that as the proposed changes do not relate to the powers or duties of the Council of Governors there is no formal requirement for a Governor to present them to the Annual Public meeting on 24th September 2024. However, the Council of Governors recommended that a record of the amendments to the Constitution is formally placed in the public domain at the Annual Members' meeting to ensure full transparency. The final step that follows Trust Board approval is to notify NHSE of the changes to the Constitution.

A version of the Constitution document with tracked changes approved and numbering updated ('clean' version) is included in the Reading Room.

Recommendation: That the Trust Board approves the proposed changes to the Trust Constitution and to them being included on the agenda for the 2024 Annual Members' meeting for noting.

CONSTITUTION

OF

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

(A Public Benefit Corporation)

Approved from February 2007

Further revised version August 2022

Further revised version July 2024

Draft amended constitution - version control

Version 1 - Shirley Higginbotham 26 Jul 2022

Version 2 - Browne Jacobson 5 Aug 2022

Version 3 - Sally Brook Shanahan 5 July 2024

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Annex 2: Staff Constituencies

Annex 3: Model Election Rules

Annex 4: Board of Directors Standing Orders

Annex 5: Council of Governors Standing Orders

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST (A PUBLIC BENEFIT CORPORATION)

CONSTITUTION

This Constitution represents the constitution of Sherwood Forest Hospitals NHS Foundation Trust as adopted in accordance with the 2006 Act (as defined below) as amended by the 2012 Act (as defined below). This Constitution sets out the powers and functions of the Trust. In exercising its powers and carrying out its functions the Trust shall aim to provide the best possible patient care, based on evidence and in a culture that encourages continuous improvement

Unless a contrary intention is evident or the context requires otherwise, words or expressions contained in this Constitution shall bear the same meaning as in the 2006 Act as amended by the 2012 Act.

References in this Constitution to legislation include all amendments, replacements, or re-enactments made, and include all subordinate legislation made thereunder.

Headings are for ease of reference only and are not to affect interpretation. All annexes referred to in this Constitution form part of it.

Words importing the masculine gender only shall include the feminine gender; words importing the singular shall include the plural and vice-versa.

References to paragraphs are to paragraphs in this Constitution save that where there is a reference to a paragraph in an annex to this Constitution it shall be a reference to a paragraph in that annex unless the contrary is expressly stated, or the context otherwise so requires.

1 Definitions

In this Constitution:

2006 Act - means the National Health Service Act 2006.

2012 Act - means the Health and Social Care Act 2012.

2022 Act – means the Health and Care Act 2022.

Accounting Officer - means the Chief Executive who discharges the functions specified in paragraph 25(5) of Schedule 7 to the 2006 Act.

Annual Accounts - means those accounts prepared by the Trust (through the Accounting Officer) pursuant to paragraph 25 of Schedule 7 to the 2006 Act.

Annual Members' Meeting – means the annual meeting of the Members as provided for in paragraph 6.8.

Annual Report – means the annual report of the Trust prepared by the Trust as referred to at paragraph 15.1.

Appointed Governor - means ~~a PBP Governor~~, a Local Authority Governor, a Volunteer Governor or an Other Partnership Governor.

Audit Committee - means the committee of the Board of Directors as established pursuant to paragraph 8.4.

Auditor - means the auditor of the Trust appointed by the Council of Governors pursuant to paragraph 7.15.2.1.

Board of Directors - means the board of directors of the Trust as constituted in accordance with this Constitution;

~~PBP - means Mid Nottinghamshire Place Based Partnership~~

~~PBP Governor - means the Appointed Governor appointed by the PBP pursuant to paragraph 7.5.1.~~

Code of Conduct for Directors – means the Trust's code of conduct for Directors (as amended from time to time).

Code of Conduct for Governors - means the Trust's code of conduct for Governors (as amended from time to time).

CoG's Nominations Committee – means the committee appointed by the Council of Governors pursuant to paragraph 8.5.1.3.

Council of Governors - means the council of governors of the Trust as constituted in accordance with this Constitution.

Chair - means the Chair of the Trust appointed in accordance with paragraph 7.15.2.1.

Chief Executive - means the Chief Executive of the Trust appointed in accordance with paragraph 8.5.2.

Combined Authority – means the East Midlands Combined County Authority

Constituency – means either a Public Constituency or the Staff Constituency and "Constituencies" shall be construed accordingly.

Constitution - means this Constitution together with its annexes.

Designated Trust Sub-contractors – means Central Nottinghamshire Hospitals PLC (CNH) and such other sub-contractors of the Trust as may be designated as such from time to time by the Board of Directors.

Director - means an Executive or Non-Executive Director.

Director of Corporate Affairs – means the Executive lead for all aspects of the provision of advice, administration and services to the Governors.

Elected Governor - means a Staff Governor or a Public Governor.

Engagement Policy – means the engagement policy in relation to the interaction of the Board of Directors and Council of Governors as published by the Council of Governors from time to time.

Executive Director - means an Executive Director of the Trust being the Chief Executive, Chief Finance Officer or such other Executive Director as is appointed under paragraph 8.5.

Chief Finance Officer - means the Chief Finance Officer of the Trust appointed in accordance with paragraph 8.5.

Financial Year - each successive period of twelve months beginning with 1st April in any year.

Governor - means a member of the Council of Governors

Health Overview and Scrutiny Committee - means a local authority overview and scrutiny committee established pursuant to Section 21 of the Local Government Act 2000.

Health Service Body - shall have the meaning ascribed to it in section 65(1) of the 2006 Act.

Healthwatch - means a Healthwatch England committee as defined in section 181 of the Health and Social Care Act 2012 or a Local Healthwatch organisation as defined in section 222 of the Local Government and Public Involvement in Health Act 2007.

Hospital means: King's Mill Hospital; Newark Hospital; Mansfield Community Hospital and all associated hospitals, establishments and facilities at which the Trust provides and/or manages the provision of goods and/or services, including accommodation and "Hospitals" shall be construed accordingly.

Lead Governor - means the Governor appointed by the Council of Governors as the Trust's lead governor pursuant to paragraph 7.1.3.

Local Authority - means any of: Ashfield District Council; Mansfield District Council; Newark & Sherwood District Council; and Nottinghamshire County Council and "Local Authorities" shall be construed accordingly.

Local Authority Governor - means the Appointed Governor appointed pursuant to paragraph 7.7 by a Local Authority.

Member - means a member of the Trust and the term "Membership" shall be construed accordingly.

Model Election Rules - means the Model Election Rules 2014 ~~as~~ published ~~from time to time~~ by the Foundation Trust Network, or any subsequent version or successor arrangements.~~NHS Providers~~.

NHSE - means NHS England which was originally established as the NHS Commissioning Board under section 1H of the NHSA and renamed NHS England under section 1 of the 2022 Act.

Nolan Principles - means the seven principles of conduct of holders of public office enunciated by the Nolan Committee in its Report on Standards in Public Office.

Non-Executive Director - means the Chair or such other Non-Executive Director of the Trust appointed in accordance with paragraph 8.5.

Other Partnership Governor - means the Appointed Governor appointed by an Other Partnership Organisation pursuant to paragraph 7.8.

Other Partnership Organisation – means West Nottinghamshire College.

Policies – means the Trust's published policies on freedom to speak up, confidentiality, equal opportunities and such other reasonable Trust policies as are notified to the Directors and Governors in writing from time to time.

Public Constituency - means –one of the Public Constituencies as set out in Annex 1 and "Public Constituency" shall be construed accordingly.

Public Governor - means a member of the Council of Governors elected by the members of a Public Constituency.

Registered Dentist - means a registered dentist within the meaning of the Dentists Act 1984.

Registered Medical Practitioner - means a medical practitioner who is fully registered within the meaning of the Medical Act 1983 who holds a license to practice under that Act.

Registered Midwife – means a person who is registered to practice as a midwife by the Nursing and Midwifery Council.

Registered Nurse – means a person who is registered to practice as a nurse by the Nursing and Midwifery Council.

Senior Independent Director - means an independent Non-Executive Director appointed by the Board of Directors (in consultation with the Council of Governors) and having the role envisaged by the NHSE's NHS Foundation Trust Code of Governance.

Sherwood Forest Volunteers - means the volunteers who are engaged by the Trust to provide voluntary services.

Staff Constituency - means the constituency of the Trust as referred to Annex 2.

Staff Governor - means a member of the Council of Governors elected by the members of the Staff Constituency.

Sub-contractor Personnel – means the employees of any of the Trust's Designated Sub-contractors who, in the course of their employment, exercise functions on behalf of the Trust.

Trust - means the Sherwood Forest Hospitals NHS Foundation Trust.

~~Trust Secretary - means the secretary of the Trust or any other person or body corporate appointed to perform the duties of the secretary of the Trust, including a joint, assistant or deputy secretary.~~

Vice Chair - means the Non-Executive Director appointed as the vice chair of the Trust by the Council of Governors in general meeting.

Volunteer Governor – means the Appointed Governor appointed by the Sherwood Forest Volunteers.

2 Name

2.1 The name of the foundation trust is "Sherwood Forest Hospitals NHS Foundation Trust".

3 Principal Purpose

3.1 The Trust's principal purpose is the provision of goods and services for the purposes of the health service in England.

3.2 The Trust does not fulfil its principal purpose unless, in each Financial Year, its total income from the provision of goods and services for the purposes of the health service in England is greater than its total income from the provision of goods and services for any other purposes.

4 Other Purposes

4.1 In addition to the Trust's principal purpose as set out in paragraph 3, the Trust may:

4.1.1 provide goods and services for any purposes related to:

4.1.1.1 the provision of services provided to individuals for or in connection with the prevention, diagnosis or treatment of illness; and

4.1.1.2 the promotion and protection of public health.

4.1.2 carry out research in connection with the provision of health care and make facilities and staff available for the purposes of education, training or research carried on by others; and

4.1.3 carry on activities other than those mentioned above for the purpose of making additional income available in order to better carry on the Trust's principal purpose.

5 Powers

5.1 The Trust has all the powers of an NHS foundation trust as set out in the 2006 Act.

5.2 All the powers of the Trust shall be exercised by the Board of Directors on behalf of the Trust.

5.3 Any of the powers of the Trust may be delegated to a committee of Directors or to an Executive Director in accordance with this Constitution and the Standing Orders of the Board of Directors.

6 Members and constituencies

6.1 Constituencies

6.1.1 The Trust shall have members each of whom shall be a member of one of the following constituencies:

6.1.1.1 a Public Constituency; or~~and~~

6.1.1.2 the Staff Constituency.

6.2 Public Constituency

6.2.1 Subject to paragraph 6.5 an individual is eligible to become a member of a Public Constituency if they:

6.2.1.1 live in the area specified for that Public Constituency in the corresponding entry in column 2 of Annex 1.

6.2.1.2 are not a member of another Public Constituency .

6.2.1.3 are not eligible to become a member of the Staff Constituency; and

6.2.1.4 are at least 16 years old at the time of their application to be a Member.

6.2.2 Those individuals who are eligible to be members of a Public Constituency are referred to collectively as a "Public Constituency".

6.2.3 An eligible individual shall become a Member upon entry to the membership register pursuant to an application by them.

6.2.4 On receipt of an application for Membership and subject to being satisfied that the applicant is eligible the Director of Corporate Affairs ~~Trust Secretary~~ shall cause the applicant's name to be entered in the Trust's register of Members.

6.2.5 The minimum number of Members of each Public Constituency is set out in column 3 of Annex 1.

6.3 Staff Constituency

6.3.1 Subject to paragraphs 6.3.2 and 6.5 individuals are eligible to become members of the Staff Constituency if they are at least 16 years old and they are employed by the Trust under a contract of employment (other than as a Non-Executive Director);

6.3.2 For the avoidance doubt members of the Staff Constituency cannot be members of a Public Constituency.

6.3.3 An individual is only eligible to become a member of the Staff Constituency under paragraph 6.3.1 above if they satisfy the minimum duration requirements set out in 3(3) of Schedule 7 to the 2006 Act, that is to say:

6.3.2.1 In the case of individuals qualifying under paragraph 6.3.1.1 above, they:

(a) are employed by the Trust under a contract of employment which has no fixed term.

(b) are employed by the Trust under a contract of employment which has fixed term of at least 12 months; or

(c) have been continuously employed by the Trust under a contract of employment for at least 12 months.

6.3.2.2 Not used

6.3.2.3 For the purposes of paragraphs 6.3.2.1 Chapter 1 of Part 14 of the Employment Rights Act 1996 shall apply for the purposes of determining whether the individual has been continuously employed by the Trust or has continually exercised functions on behalf of the Trust.

6.3.4 An individual who is:

6.3.3.1 eligible to become a member of the Staff Constituency who qualifies under paragraph 6.3.1.1 and

6.3.3.2 is invited by the Trust to become a member of the Staff Constituency

shall become a Member of the Trust as a member of the Staff Constituency without an application for Membership being made unless they inform the Trust they do not wish to become a Member.

6.3.5 On receipt of an application for Membership for those qualifying for membership of the Trust and subject to being satisfied that the applicant is eligible, the ~~Trust Secretary~~ Director of Corporate Affairs shall cause the applicant's name to be entered in the Trust's register of Members.

6.3.6 Those individuals who are eligible for Membership by reason of the provisions set out in this paragraph 6.3 are referred to collectively as the "Staff Constituency".

6.3.7 The minimum number of Members for the Staff Constituency is set out in column 3 of Annex 2.

6.4 Not used

6.5 Disqualification for Membership

6.5.1 An individual may not be or continue as a Member of the Trust if, in respect of:

6.5.1.1 a Public Member they do not meet the relevant eligibility criteria under paragraph 6.2; or

6.5.1.2 a Staff Member they do not meet the relevant eligibility criteria under paragraph 6.3.

6.5.2 It is the responsibility of each Member to ensure their eligibility for membership. If the Trust is on notice that a Member may no longer be eligible to be a Member, the Trust shall carry out such reasonable enquiries as it considers necessary to establish if this is the case and shall invite the Member concerned to comment on its findings (within 14 days), and following receipt of any comments or expiry of that 14 day period (whichever occurs first) the Director of Corporate Affairs ~~Trust Secretary~~ shall decide whether such Member should be disqualified.

6.6 Termination of Membership

6.6.1 A Member shall cease to be a Member if they

6.6.1.1 resign by notice in writing to the ~~Director of Corporate Affairs~~ Director of Corporate Affairs ~~Trust Secretary~~; or

6.6.1.2 cease to fulfil the eligibility requirements of paragraphs 6.2 or 6.3 and/or is disqualified under paragraph 6.5.

6.7 Voting at Governor Elections

6.7.1 A Member may not vote in an election for an Elected Governor unless within the specified time period they have made a declaration in the specified form setting out the particulars of their qualification to vote as a member of the Constituency (and where relevant the appropriate class within that Constituency) for which the election is being held. The specified time period and form of declaration are specified in the Model Election Rules.

6.7.2 It is an offence for any Member to knowingly or recklessly make such a declaration as is referred to at paragraph 6.7.1 which is false in a material particular.

6.7.3 An individual who is a member of another foundation trust as well as the Trust may vote in elections for this Trust provided, they are able to comply with the provisions of this paragraph 6.7 (Voting at Governor Elections).

6.8 Annual Members' Meeting

6.8.1 The Trust shall every year hold an Annual Members' Meeting which shall be open to members of the public.

6.8.2 The following documents shall be presented at the Annual Members' Meeting by at least one of the Directors:

6.8.2.1 the Annual Accounts.

6.8.2.2 any report of the Auditor on the Annual Accounts; and

6.8.2.3 the Annual Report.

6.8.3 The Trust may combine a meeting of the Council of Governors convened for the purposes of being presented with the documents in sub-paragraph 6.8.2 with the Annual Members' Meeting.

6.8.4 In accordance with paragraph 20.3 where an amendment has been made to the Constitution in relation the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as a part of the Trust), Members shall be given an opportunity to vote at the Annual Members' Meeting on whether they approve the amendment which shall be presented to that meeting by at least one Governor.

6.8.5 Where an amendment has been presented to the Annual Member's Meeting in accordance with paragraph 6.8.4, and it is not approved by more than half of the Members voting such amendment shall cease to have effect and the Trust shall take such steps as are necessary as a result.

7 Council of Governors

7.1 Composition

7.1.1 The Trust shall have a Council of Governors which shall consist of Elected Governors and Appointed Governors (as set out in paragraph 7.1.2).

7.1.2 The composition of the Council of Governors shall be:

7.1.2.1 fourteen (14) Public Governors representing the Public Constituencies as set out in Annex 1;

7.1.2.2 Three (3) Staff Governors representing the Staff Constituency as set out in Annex 2;

~~7.1.2.3 one (1) PBP Governor;~~ one (1) Combined Authority Governor;

7.1.2.4 one (1) Volunteer Governor.

7.1.2.5 four (4) Local Authority Governors; and

~~7.1.2.6 one (1) Combined Authority Governor; and~~

7.1.2.6~~7~~ one (1) Other Partnership Governor.

7.1.3 The Council of Governors shall nominate a Governor to be the Trust's Lead Governor.

7.2 Governor Elections

7.2.1 Elected Governors shall be chosen by election by their Constituency or, where there are classes within a Constituency, by their class within that Constituency. The number of Governors to be elected by each Constituency or, where appropriate, by each class of each Constituency, is as set out in Annexes 1 and 2.

7.2.2 Elections for Elected Governors shall be conducted in accordance with the Model Election Rules First Past the Post system which include provisions for the use of e-voting systems.

7.2.3 The Model Election Rules, including the specified forms of and periods for declarations to be made by candidates standing for office and Members as a condition of voting and the process if the election is uncontested, are set out in Annex 3.

7.2.4 A subsequent variation to the Model Election Rules to reflect a change by NHS Providers shall not constitute a variation of the terms of this Constitution for the purposes of paragraph 20.1.

7.2.5 The Model Election Rules provide for arrangements to be made to assist those persons requiring assistance to vote.

7.2.6 Members:

7.2.4.1 standing for; and/or

7.2.4.2 voting in.

Governor elections must comply with the terms of the Model Election Rules.

7.2.7 Where an election is contested, the election shall be by secret ballot.

7.3 Public Governors

7.3.1 Each Public Constituency shall elect the number of Governors set against it in column 4 of Annex 1.

7.3.2 Members of each Public Constituency may elect any of their number who is eligible to be a Public Governor.

7.3.3 An individual may not stand for election to the Council of Governors as a Public Governor unless:

7.3.3.1 within the period specified in paragraph 12 of the Model Election Rules (Annex 3), they have made a declaration in the form specified in that part of that annex of their qualification to vote as a Member of the Public Constituency Class for which the election is being held; and

7.3.3.2 they are not prevented from being a member of the Council of Governors by paragraph 7.12 (Suspension and disqualification).

7.3.4 It is an offence for any Member to knowingly or recklessly make such a declaration as is referred to in paragraph 7.3.3.1 which is false in a material particular.

7.4 Staff Governors

7.4.1 Members of the Staff Constituency may elect the number of Governors for that Staff Class as set out in Annex 2.

7.4.2 Members of the Staff Constituency may elect any individual who is eligible to be a Staff Governor in respect of the relevant Staff Constituency.

7.5 ~~PBP Governors~~Not used

~~7.5.1 The PBP may appoint 1 PBP Governor (such person must be eligible to be, and not disqualified from being, a Governor under this Constitution) pursuant to a process agreed between the PBP and the Trust.~~

7.6 Volunteer Governor

7.6.1 The Sherwood Forest Volunteers will appoint 1 Governor (such person must be eligible to be, and not disqualified from being, a Governor under this Constitution) pursuant to a process agreed between the Sherwood Forest Volunteers and the Trust.

7.7 Local Authority and Combined Authority Governors

7.7.1 Each of the Local Authorities and the Combined Authority may appoint one Local/Combined (as applicable) Authority Governor (such person must be eligible to be, and not disqualified from being, a Governor under this Constitution) by notice in writing signed by:

7.7.1.1 the leader of the relevant council.

7.7.1.2 or a member of the relevant council's/authority's executive and delivered to the Director of Corporate Affairs ~~Trust Secretary~~.

7.8 Other Partnership Governors

7.8.1 The Other Partnership Organisation may appoint one Other Partnership Governor (such person being eligible to be, and not disqualified from being, a Governor under this Constitution) as set out. West Nottinghamshire College may appoint its Other Partnership Governor by notice in writing signed by the principal of West Nottinghamshire College and delivered to the Director of Corporate Affairs ~~Trust Secretary.~~

7.9 Transition arrangements

7.9.1 Where an Elected Governor ceases to be eligible to hold the office to which they were elected by virtue of paragraphs 6.2 or 6.3 that Elected Governor shall immediately notify the Director of Corporate Affairs ~~Trust Secretary~~ of the circumstances giving rise to their ineligibility.

7.9.2 Where the Director of Corporate Affairs ~~Trust Secretary~~ receives notice from an Elected Governor, pursuant to paragraph 7.8.1, that they believe they are no longer eligible to hold office (or the Director of Corporate Affairs ~~Trust Secretary~~ otherwise becomes aware that the

Elected Governor is no longer eligible to hold office) the Director of Corporate Affairs ~~Trust Secretary~~ shall notify the Elected Governor that their position is suspended with immediate effect and shall ask the Governor if they:

7.9.2.1 wish to stand down as a Governor: and

7.9.3 Where the Elected Governor confirms in writing they:

7.9.3.1 will stand down as a Governor, such resignation shall take effect immediately.

7.10 Terms of Office

7.10.1 Elected Governors:

7.10.1.1 shall be elected for a period of 3 years.

7.10.1.2 are, subject to paragraphs 7.10.1.3 and 7.10.1.4 eligible for re-election at the end of the period referred to in paragraph 7.10.1.1.

7.10.1.3 may hold office for a maximum of 9 years ~~but in exceptional circumstances (as determined by the Council of Governors) may serve longer than 9 years, but any extension beyond 9 years will be subject to annual re-election and, in any event, they shall not serve for a total term longer than 12 years.~~; and

7.10.2 Appointed Governors:

7.10.2.1 shall be appointed for a period of 3 years.

7.10.2.2 are, subject to paragraphs 7.10.2.3 and 7.10.2.4 eligible for reappointment at the end of the period referred to in paragraph 7.10.2.1.

7.10.2.3 may hold office for a maximum of 9 years ~~but in exceptional circumstances (as determined by the Council of Governors) may serve longer than 9 years, but any extension beyond 9 years will be subject to annual re-appointment and, in any event, they shall not serve for a total term longer than 12 years~~; and

7.10.2.4 shall cease to hold office if their appointing organisation withdraws its appointment of them or in any other situation specified in this Constitution.

7.10.2.5 Governors must comply with the Trust's:

7.10.2.5.1 Constitution.

7.10.2.5.2 Standing Orders for the Council of Governors.

7.10.2.5.3 Code of Conduct for Governors; and

7.10.2.5.4 Policies.

7.11 Termination of Tenure

7.11.1 A Governor may resign from office at any time during the term of office by giving notice in writing to the Director of Corporate Affairs ~~Trust Secretary~~ or the Chair.

7.11.2 A Governor's tenure:

7.11.2.1 shall be terminated immediately if a Governor fails to attend two consecutive meetings of the Council of Governors, unless a majority of the other Governors are satisfied that:

(a) the absence was due to a reasonable cause; and

(b) they will be able to start attending meetings of the Council of Governors again within such a period as they consider reasonable.

7.11.2.2 shall be terminated immediately if the Council of Governors decide (by a majority of the other Governors) that a Governor has:

(a) failed to comply with paragraph 7.12.3; (except where the Council of Governors decide that termination of tenure would not be appropriate in the circumstances);

(b) conducted themselves in an inappropriate manner which would adversely affect public confidence in the Trust or the Council of Governors; or

(c) conducted themselves in such a manner as is likely to bring the Trust into disrepute including, but without prejudice to the generality of the foregoing, a failure to declare a material or pecuniary interest which would or would be likely to result in a conflict of interest.

The Council of Governors may request that the CoG's Nominations Committee investigates any matter which would give rise to them exercising their powers in paragraph 7.11.2 and to receive the representations of the relevant Governor and any representative appointed by them for that purpose except to the extent that the Code of Conduct for Governors provides a procedure for the same in which case such procedure must be followed.

Any engagement of the Council of Governor''s Remuneration and Nominations Committee pursuant to paragraph 7.11.2 shall make such report and recommendations to the Council of Governors as it deems fit and shall, as far as practicable, submit any report and recommendations to the Council of Governors within 4 months of commencing their investigation.

7.12 Suspension and disqualification from office

7.12.1 Where a Staff Governor has been:

7.12.1.1 made the subject of a written warning or a period of suspension in excess of 28 days: or

7.12.1.2 absent from their post as an employee of the Trust for a continuous period of not less than four months and no reasonable cause (in the opinion of the Council of Governors acting by simple majority) has been given for absence.

their term of office as Governor may be suspended by the Council of Governors for such period of time as the Council of Governors deems fit and so as to enable, if necessary, an investigation to be carried out to determine whether or not the tenure of that Staff Governor should then be terminated. The Staff Governor in question may submit reasons to the Council of Governors as to why they should still be eligible to continue as a Staff Governor and the Council of Governors shall decide whether to terminate the Governor's term of office and such determination of the Council of Governors shall be final.

7.12.2 An individual is immediately disqualified from becoming or continuing to hold office as a Governor if they:

7.12.2.1 have been adjudged bankrupt or their estate has been sequestrated and in either case he has not been discharged.

7.12.2.2 are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

7.12.2.3 have made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it;

7.12.2.4 have within the preceding five years been convicted in the British Islands of any offence and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

7.12.2.5 have within the preceding three years been dismissed (including, but not limited to, by reason of redundancy) by the Trust.

7.12.2.6 are under 16 years of age.

7.12.2.7 are an individual whose tenure of office as the Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interest of the health service, for non-attendance at meetings or for non-disclosure of a pecuniary interest;

7.12.2.8 are an Executive or Non-Executive Director, Governor, , Chair, Chief Executive Officer of another NHS foundation trust.

7.12.2.9 has had their name removed from any list prepared pursuant to paragraph 14 of the National Health Service (Performers List) Regulations 2013 or section 151 of the 2006 Act (or similar provision elsewhere) and has not subsequently had their name included in such a list.

7.12.2.10 are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs.

7.12.2.11 are registered as a sex offender pursuant to Part 1 of the Sex Offenders Act 1997.

7.12.2.12 has been identified and given notice in writing by the Chief Executive to the effect that they are a vexatious complainant in respect of the Trust;

7.12.2.13 is a member of Healthwatch; or

7.12.2.14 has contravened any other provision of this Constitution.

7.12.3 An individual is disqualified from becoming or continuing to hold office as a Public Governor if:

7.12.3.1 they cease to be a Member of a Public Constituency; or

7.12.3.2 they are eligible to be a Member of the Staff Constituency.

7.12.4 An individual is disqualified from becoming or continuing to hold office as a Staff Governor if:

7.12.4.1 they cease to be a Member of the Staff Constituency; or

7.12.4.2 they are employed by the Trust on a temporary contract which contract is or was identified on the face of it as a temporary contract.

7.12.5 An individual is disqualified from becoming or continuing to hold office as an Appointed Governor if the relevant appointing organisation withdraws its appointment of him.

7.12.6 If an Elected or Appointed Governor ceases to be eligible to hold such office because grounds for disqualification exist pursuant to paragraph 7.12 (other than under paragraph 7.12.1 and paragraph 7.11.2), they shall immediately notify the Director of Corporate Affairs ~~Trust Secretary~~ in writing of the circumstances.

7.12.7 If the Trust is on notice that a Governor may no longer be eligible to be a Governor, the Trust shall carry out such reasonable enquiries as it considers necessary to establish if this is the case and shall invite the Governor concerned to comment on its findings (within 14 days) and following receipt of any comments or expiry of that 14 day period

(whichever occurs first) the Council of Governors shall decide whether such Governor's term of office should be terminated.

7.13 Consequences of termination of tenure

7.13.1 Where a Governor:

7.13.1.1 has given notice of resignation in accordance with paragraph 7.11.1.

7.13.1.2 has had their term of office terminated pursuant to the terms of this Constitution in any manner whatsoever; or

7.13.1.3 is otherwise disqualified from holding office pursuant to the Constitution or the 2006 Act,

that Governor shall thereupon cease to be a Governor and their name shall be forthwith removed from the Register of Governors.

7.13.2 A Governor who resigns or whose tenure of office is terminated shall not be eligible to stand for re-election for a period of three years from the date of their resignation or termination of office.

7.14 Vacancies

7.14.1 Where a Governor's tenure of office ceases for one or more of the reasons set out in paragraph 7.11 or 7.12, in the case of:

7.14.1.1 Public Governors and Staff Governors, such vacancy shall, subject to provisions of paragraphs 7.14.2, be filled by elections held in accordance with the Model Election Rules set out in Annex 3: and

7.14.1.2 ~~the PBP Governor~~, the Local Authority Governors, the Combined Authority Governor~~,~~ the Partnership Governor and the Volunteer Governor shall be replaced in accordance with the processes set out in paragraphs 7.5 - 7.8.

7.14.2 Where a vacancy arises amongst the Elected Governors for any reason (including, for the avoidance of doubt, an increase in the number of Elected Governors effected by an amendment to the Constitution in accordance with paragraph 20.1 below) other than the expiry of the term of office, the Council of Governors shall decide either:

7.14.2.1 to call an election within three months to fill the vacancy, unless an election is due within nine months in which case the seat shall stand vacant until the following scheduled election.

7.14.2.2 to invite the next highest polling candidate in the relevant constituency at the most recent election who is willing to take office, to fill the vacancy, provided that the candidate achieved at least 5% of the vote in the last held election for the relevant constituency and, where appropriate, class (the "Reserved Governor"). If the vacancy is filled in this way,

the Reserved Governor shall be eligible for re-election for a further two full three-year terms; or

7.14.2.3 to leave the seat vacant until the next scheduled elections are held.

except that if the aggregate number of Public Governors does not exceed half the total membership of the Council of Governors an election will be held in accordance with the Model Election Rules as soon as reasonably practicable.

7.15 Roles and Responsibilities of Governors

7.15.1 The general duties of the Council of Governors are:

7.15.1.1 to hold the Non-Executive Directors individually and collectively to account for the performance of the Board of Directors; and

7.15.1.2 to represent the interests of the Members of the Trust as a whole and the interests of the public.

The Trust must take steps to secure that its Governors are equipped with the skills and knowledge they require to carry out their role as a Governor.

7.15.2 The roles and responsibilities of the Governors (in addition to any roles and responsibilities set out elsewhere in this Constitution) are:

7.15.2.1 at a General Meeting:

(a) to appoint or remove the Chair and the other Non-Executive Directors as further set out in the Standing Orders for the Council of Governors. The removal of the Chair or a Non-Executive Director requires the approval of three-quarters of the members of the Council of Governors.

(b) to approve the appointment (by the Non-Executive Directors) of the Chief Executive as further set out in the Standing Orders for the Council of Governors.

(c) to decide the remuneration and allowances, and other terms and conditions of office of the Non-Executive Directors.

(d) to appoint or remove the Trust's Auditor; and

(e) to be presented with the Annual Accounts, any report of the Auditor on them and the Annual Report.

7.15.2.2 to give the views of the Council of Governors to the Board of Directors for the purposes of the preparation by the Board of Directors of the document containing the information to be given to the NHSE as to the Trust's forward planning in respect of each Financial Year.

7.15.2.3 to consider the Annual Accounts, any report of the Auditor on them and the Annual Report.

7.15.2.4 to respond as appropriate when consulted by the Directors in accordance with this Constitution; and

7.15.2.5 to represent the interests of Members and the Other Partnership Organisations in the governance of the Trust, regularly feeding back information about the Trust, its vision and its performance to the Constituency or Other Partnership Organisation they represent. and

7.15.2.6 to hold the Non-executives accountable for the monitoring of the activities of Executive Directors who have wider roles across the local health system, to ensure focus on the strategic objectives of the Trust and alignment with the strategic objectives of the local health system.

7.16 Council of Governors - Further Provisions

7.16.1 Expenses

7.16.1.1 Governors are entitled to receive re-imbursement for travelling and other expenses incurred and evidenced by receipts in accordance with the Trust's expenses policy at such rates as the Trust decides from time to time.

7.16.1.2 The Trust shall publish the rates referred to in paragraph 7.16.1.1 in the Annual Report.

7.16.2 Remuneration

Governors are not entitled to receive remuneration for their role.

7.16.3 Meetings

Meetings of the Council of Governors shall be conducted in accordance with the provisions of the Standing Orders for the Council of Governors as set out in Annex 5.

Meetings of the Council of Governors shall be chaired by the Chair or in their absence the Vice Chair. If the Vice Chair is also unavailable the meeting shall be chaired by such person as is chosen in accordance with the Standing Orders for the Council of Governors.

The Council of Governors is to meet at least four times per year, including an annual meeting no later than 30 September in each year where the Council of Governors shall receive and consider the annual accounts, any report of the auditor on them and the annual report.

The Council of Governors may require one or more of the Directors to attend a meeting for the purposes of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and deciding whether to propose a vote on the Trust's or

Directors' performance). Unless otherwise agreed, at least five working days' notice of the meeting must be provided.

Meetings of the Council of Governors shall be open to members of the public, but members of the public may be excluded from a meeting for special reasons.

No defect in the election or appointment of a Governor nor any deficiency in the composition of the Council of Governors shall affect the validity of any act or decision of the Council of Governors.

7.16.4 Committees and Sub-Committees

The Council of Governors may appoint committees and sub-committees in accordance with the provisions of the Standing Orders for the Council of Governors.

The Council of Governors cannot delegate its powers to any committee or sub-committee.

7.16.5 Conflicts of Interests of Governors

If a Governor has a pecuniary, personal or family interest, whether that interest is actual or potential and whether that interest is direct or indirect, in any proposed contract or other matter which is under consideration or is to be considered by the Council of Governors, the Governor shall disclose that interest to the members of the Council of Governors as soon as they become aware of it.

The Standing Orders of the Council of Governors shall make provision for the disclosure of interests and arrangements for the exclusion of a Governor declaring any interest from any discussion or consideration of the matter in respect of which an interest has been disclosed and Governors shall comply with the provisions of the Standing Orders for the Council of Governors.

7.16.6 Referral to the Panel

A Governor may refer a question as to whether the Trust has failed or is failing.

7.16.6.1 to act in accordance with the Constitution; or

7.16.6.2 to act in accordance with provision made by or under Chapter 5 of the 2006 Act.

to the Panel only if more than half of the members of the Council of Governors voting approve the referral.

In this paragraph, the Panel means a panel of persons appointed by NHSE to which a Governor of the Trust may refer a question

7.16.7 Engagement Policy

The Governors and Directors shall observe the terms of the Engagement Policy in relation to their engagement with each other on matters concerning the Trust.

8 Board of Directors

8.1 The Trust shall have a Board of Directors which shall consist of Executive and Non-Executive Directors.

8.2 The Board of Directors shall comprise the following:

8.2.1 the Chair (a Non-Executive Director);

8.2.2 at least 5 other Non-Executive Directors;

8.2.3 the Chief Executive (an Executive Director);

8.2.4 the Chief Finance Officer (an Executive Director); and

8.2.5 at least 2 other Executive Directors but subject to the provisions of paragraph 8.4

8.3 One of the Executive Directors is to be:

8.3.1 a Registered Medical Practitioner or Registered Dentist; and

8.3.2 a Registered Nurse or Registered Midwife.

8.4 At all times the composition of the Board of Directors shall be such that the number of Voting Executive Directors is less than the number of Non-Executive Directors.

8.5 Appointment and removal of Non-Executive Directors and Executive Directors.

8.5.1 Appointment and removal of Non-Executive Directors.

8.5.1.1 The Council of Governors, at a general meeting of the Council of Governors, shall appoint and remove the Chair and other Non-Executive Directors;

8.5.1.2 The Council of Governors, at a general meeting of the Council of Governors shall appoint one of the Non-Executive Directors as Vice Chair;

8.5.1.3 The Council of Governors shall establish the CoG's Remuneration and Nominations Committee (comprising the Chair, four Public Governors, one Staff Governor and one Appointed Governor) to consider candidates for appointment as Non-Executive Directors against an agreed job specification.

8.5.1.4 The CoG's Remuneration and Nominations Committee shall shortlist from those candidates meeting the specified criteria, those candidates whom it wishes to interview and shall conduct interviews with the said candidates and thereafter make its recommendation to the Council of

Governors as to who should be appointed as a Non-Executive Director.

8.5.1.5 The Council of Governors shall consider the recommendation of the CoG's Remuneration and Nominations Committee and make a decision as to the appointment of the Non-Executive Directors in general meeting.

8.5.1.6 An individual shall not be appointed as a Non-Executive Director unless they are a member of the Public Constituency.

8.5.1.7 The removal of a Non-Executive Director shall require the approval of three-quarters of the members of the Council of Governors.

8.5.2 Appointment and removal of Executive Directors

8.5.2.1 It is for the Chair and the other Non-Executive Directors to appoint (subject to the approval of the Council of Governors) or remove the Chief Executive.

8.5.2.2 It is for a committee consisting of the Chair, the Chief Executive and the other Non-Executive Directors to appoint or remove the Executive Directors (other than the Chief Executive).

8.6 Terms of Office

8.6.1 Subject to paragraph 8.6.3, the Chair and the other Non-Executive Directors are to be appointed for a period of office in accordance with the terms and conditions of office (including as to remunerations and allowances, which shall be published in the Annual Report) decided by the Council of Governors in general meeting.

8.6.2 The Executive Directors shall hold offices for a period in accordance with the terms and conditions of office (including as to remunerations and allowances) decided by the relevant committee of Non-Executive Directors.

8.6.3 Non-Executive Directors:

8.6.3.1 shall be appointed for a period of up to 3 years;

8.6.3.2 are, subject to paragraphs 8.6.3.3 and 8.6.3.4 eligible for re-election at the end of the period referred to in paragraph 8.6.3.1.

8.6.3.3 shall not, except in exceptional circumstances, hold office for a period in excess of 6 years; and

8.6.3.4 where appointed for more than 6 years shall, at the discretion of the Council of Governors, be so appointed either on the basis of:

a) annual re-appointment; or

b) a competitive process up to a maximum 9 years.

8.6.4 The Directors shall comply with the Trust's:

8.6.4.1 Constitution.

8.6.4.2 Standing Orders for the Board of Directors;

8.6.4.3 Code of Conduct for Directors; and

8.6.4.4 Policies.

8.7 Disqualification

8.7.1 An individual may not become or continue as a Director of the Trust if:

8.7.1.1 they have been adjudged bankrupt or their estate has been sequestrated and in either case they have not been discharged.

8.7.1.2 they are a person in relation to whom a moratorium period under a debt relief order applies (under Part 7A of the Insolvency Act 1986);

8.7.1.3 they have made a composition or arrangement with, or granted a trust deed for, their creditors and has not been discharged in respect of it.

8.7.1.4 they have within the preceding five years been convicted in the British Islands of any offence, and a sentence of imprisonment (whether suspended or not) for a period of three months or more (without the option of a fine) was imposed on them.

8.7.1.5 they are a person whose tenure of office as a Chair or as a member or director of a Health Service Body has been terminated on the grounds that their appointment is not in the interests of public service, for non-attendance at meetings, or for non-disclosure of a pecuniary interest.

8.7.1.6 has had their name removed from any list prepared pursuant to paragraph 14 of the National Health Service (Performers List) Regulations 2013 or section 151 of the 2006 Act (or similar provision elsewhere) and has not subsequently had their name included in such a list.

8.7.1.7 they have within the preceding three years been dismissed, otherwise than by reason of redundancy or ill

health, from any paid employment with a Health Service Body.

8.7.1.8 NHSE has exercised its powers under the 2006 Act to:

(a) remove that individual as a director of the Trust or any other NHS foundation trust within its jurisdiction.

(b) suspend them from office; or

(c) disqualify them from holding office as a director of the Trust or of any other NHS foundation trust

for a specified period.

8.7.1.9 they are incapable by reason of mental disorder, illness or injury of managing and administering their property and affairs.

8.7.1.10 they are registered as a sex offender pursuant to Part I of the Sex Offenders Act 1997.

8.7.1.11 they have been identified as a vexatious complainant in respect of the Trust and has been notified to that effect by notice in writing given by the Chief Executive; or

8.7.1.12 they have been unable to dedicate adequate time to the role and responsibilities of a Director of the Trust.

8.7.1.13 An individual may not be a Non-Executive Director if they cease to be a member of the Public Constituency.

8.7.1.14 The Board of Directors may in their discretion appoint a Committee of the Board of Directors to enquire into any such matter as may be raised in connection with paragraph 8.7.1 above in accordance with terms of reference as determined by the Board of Directors and to make recommendations to the Board of Directors in respect thereof.

8.8 Duties, Roles and Responsibilities

8.8.1 The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the Members of Trust as a whole and for the public.

8.8.2 The Directors, having regard to the views of the Council of Governors, are to prepare the information as to the Trust's forward planning in respect of each Financial Year to be given to the NHSE.

8.8.3 The Directors are to present to the Council of Governors at a general meeting the Annual Accounts, any report of the Auditor on them and the Annual Report.

8.8.4 The Board of Directors shall appoint an audit committee of Non-Executive Directors to monitor, review and carry out such other functions in relation to audit as are appropriate.

8.8.5 The functions of the Trust under paragraph 14 are delegated to the Chief Executive as accounting officer.

9 Meetings of Directors

9.1 Meetings of the Board of Directors shall be conducted in accordance with the provisions of the Standing Orders for the Board of Directors which are set out in Annex 4.

9.2 Meetings of the Board of Directors shall be open to members of the public. Members of the public may be excluded from a meeting for special reasons.

9.3 Before holding a meeting, the Board of Directors must send a copy of the agenda of the meeting to the Council of Governors.

9.4 As soon as practicable after holding a meeting, the Board of Directors must send a copy of the minutes of the Board of Directors meeting to the Council of Governors.

10 Conflicts of Interest of Directors

10.1 The duties that a Director has by virtue of being a Director include in particular:

10.1.1 a duty to avoid a situation in which the Director has (or can have) a direct or indirect interest that conflicts (or possibly may conflict) with the interests of the Trust; and

10.1.2 a duty not to accept a benefit from a third party by reason of being a Director or doing (or not doing) anything in that capacity.

10.2 The duty referred to in sub-paragraph 10.1.1 is not infringed if:

10.2.1 the situation cannot reasonably be regarded as likely to give rise to a conflict of interest; or

10.2.2 the matter has been authorised in accordance with the Constitution.

10.3 The duty referred to in sub-paragraph 10.1.2 is not infringed if acceptance of the benefit cannot reasonably be regarded as likely to give rise to a conflict of interest.

10.4 In sub-paragraph 10.1.2, "third party" means a person other than:

10.4.1 the Trust; or

10.4.2 a person acting on its behalf.

10.5 If a Director has in any way a direct or indirect interest in a proposed transaction or arrangement with the Trust, the Director must declare the nature and extent of that interest to the other Directors. If a declaration under this paragraph proves to be, or becomes, inaccurate, incomplete, a further declaration must be made.

10.6 Any declaration required by this paragraph must be made before the Trust enters into the transaction or arrangement.

10.7 This paragraph does not require a declaration of an interest of which the Director is not aware or where the Director is not aware of the transaction or arrangement in question.

10.8 A Director need not declare an interest:

10.8.1 if it cannot reasonably be regarded as likely to give rise to a conflict of interest.

10.8.2 if, or to the extent that, the Directors are already aware of it.

10.8.3 if, or to the extent that, it concerns terms of the Director's appointment that have been or are to be considered:

10.8.3.1 by a meeting of the Board of Directors, or

10.8.3.2 by a committee of the Directors appointed for the purpose under the Constitution.

10.9 Directors shall comply with the provisions of the Standing Orders for the Board of Directors in relation to the declaration and management of conflicts of interests.

11 Registers

11.1 The Trust is to have:

11.1.1 a register of Members showing, in respect of each Member, the Constituency and where there are classes within it, the class to which they belong.

11.1.2 a register of members of the Council of Governors.

11.1.3 a register of interests of the members of the Council of Governors.

11.1.4 a register of Directors; and

11.1.5 a register of interests of the Directors.

11.2 The Director of Corporate Affairs ~~Trust Secretary~~ shall admit to the:

11.2.1 Register of Members the name, Constituency and class of Constituency of a Member upon receipt of a signed declaration from the Member confirming their eligibility as a Member.

11.2.2 Register of Governors the name and Constituency (and where relevant class within the Constituency) of those Members who have been elected or appointed as a Governor of the Trust.

11.3 The Director of Corporate Affairs ~~Trust Secretary~~ shall remove from the:

11.3.1 Register of Members any Member:

11.3.1.1 who is not, or who is no longer, eligible to be a Member.

11.3.1.2 indicates in writing that they no longer wish to be a Member; or

11.3.1.3 has died, upon receipt of a notice to that effect from the Member's next of kin or personal representative.

11.3.2 Register of Governors those Governors:

11.3.2.1 who have not been re-elected.

11.3.2.2 who have had their appointment withdrawn.

11.3.2.3 whose tenure of office as Governors has been terminated; or

11.3.2.4 who are otherwise disqualified from office.

11.4 The Director of Corporate Affairs ~~Trust Secretary~~ shall maintain the respective Registers of Interests of the Directors and Governors and undertake a review of the same at least once in every year by notice to that effect to all Directors and Governors.

12 Public Documents

12.1 The following documents of the Trust are to be available for inspection by members of the public free of charge at all reasonable times:

12.1.1 a copy of the current Constitution.

12.1.2 a copy of the latest Annual Accounts and of any report of the Auditor on them.

12.1.3 a copy of the latest Annual Report.

12.2 The Trust shall also make the following documents relating to a special administration of the Trust available for inspection by members of the public free of charge at all reasonable times:

12.2.1 a copy of any order made under section 65D (appointment of trust special administrator), 65J (power to extend time), 65KC (action following Secretary of State's rejection of final report), 65L (trusts coming out of administration) or 65LA (trust to be dissolved) of the 2006 Act.

12.2.2 a copy of any report laid under section 65D (appointment of trust special administrator) of the 2006 Act.

12.2.3 a copy of any information published under section 65D (appointment of trust special administrator) of the 2006 Act.

12.2.4 a copy of any draft report published under section 65F (administrator's draft report) of the 2006 Act.

12.2.5 a copy of any statement provided under Section 65F (administrators draft report) of 2006 Act.

12.2.6 a copy of any notice published under section 65F (administrator's draft report), 65G (consultation plan), 65H (consultation requirements), 65J (power to extend time), 65KA (Regulator's decision), 65KB (Secretary of State's response to Regulator's decision), 65KC (action following Secretary of State's rejection of final report) or 65KD (Secretary of State's response to re-submitted final report) of the 2006 Act.

12.2.7 a copy of any statement published or provided under section 65G (consultation plan) of the 2006.

12.2.8 a copy of any statement published or provided under section 65G (consultation plan) of the 2006 Act.

12.2.9 a copy of any final report published under section 65I (administrators final report) of the 2006 Act.

12.2.10 a copy of any statement published under section 65J (power to extend time) or 65KC (action following Secretary of State's rejection of final report) of the 2006 Act.

12.2.11 a copy of any information published under section 65M (replacement of trust special administrator) of the 2006 Act.

12.3 Any person who requests it shall be provided with a copy or extract from any of the above documents.

12.4 The registers mentioned in paragraph 11.1 above are also to be made available for inspection by members of the public, except in circumstances prescribed by regulations made under the 2006 Act, and so far as those registers are required to be available:

12.4.1 they are to be available free of charge at all reasonable times; and

12.4.2 a person who requests shall be provided with a copy of or extract from them.

12.5 The Trust shall not make any part of its register available for inspection by members of the public which show details of any Member of the Trust if the Member so requests.

12.6 If the person requesting a copy or extract of a register or a document referred to in this paragraph 12 above is not a Member of the Trust, the Trust may impose a reasonable charge for providing the copy or extract.

13 Auditor

13.1 The Trust is to have an Auditor and is to provide the Auditor with every facility and all information which they may reasonably require for the purposes of their functions under Chapter 5 of Part 2 to the 2006 Act.

13.2 An individual may only be appointed Auditor if they (or in the case of a firm each of its members) is a member of one or more of the bodies referred to in paragraph 23 (4) of Schedule 7 to the 2006 Act.

13.3 Appointment of the Auditor by the Council of Governors is covered in paragraph 7.15.

13.4 The Auditor is to carry out their duties in accordance with Schedule 10 to the 2006 Act and in accordance with any directions given by the NHSE on standards, procedures and techniques to be adopted.

14 Accounts

14.1 The Trust must keep proper accounts and proper records in relation to the accounts.

14.2 The NHSE may with the approval of the Secretary of State give directions to the Trust as to the content and form of its accounts.

14.3 The accounts are to be audited by the Trust's Auditor.

14.4 The following documents will be made available to the Comptroller and Auditor General for examination at their request:

14.4.1 the accounts.

14.4.2 the records relating to them; and

14.4.3 any report of the Auditor on them.

14.5 If trustees are appointed under section 51 of the 2006 Act, the Comptroller and the Auditor General may also examine:

14.5.1 the accounts kept by the Trustees.

14.5.2 any records relating to them; and

14.5.3 any report of an auditor on them.

14.6 The Trust shall prepare in respect of each Financial Year, Annual Accounts in such form as the NHSE may with the approval of the Secretary of State direct.

14.7 The function of the Trust with respect to the preparation of the Annual Accounts shall be delegated to the Accounting Officer.

14.8 In preparing its Annual Accounts, the Trust is to comply with any directions given by the NHSE with the approval of the Secretary of State as to:

14.8.1 the period or periods in respect of which the Trust shall prepare accounts; and

14.8.2 the audit requirements of any such accounts.

14.9 the Trust must:

14.9.1 lay a copy of the Annual Accounts, and any report of the Auditor on them, before Parliament; and

14.9.2 once it has done so, send copies of those documents to the NHSE within such a period as the NHSE may direct.

14.10 The Trust must send to the NHSE within such period as the NHSE may direct:

14.10.1 a copy of any accounts prepared by the Trust by virtue of paragraph 25(1A)(a) of the 2006 Act; and

14.10.2 a copy of any report of an auditor on them prepared by virtue of 25(1A) (b).

15 Annual Reports, Forward Plans and Non-NHS Work

15.1 The Trust shall prepare an Annual Report and send it to the NHSE.

15.2 The Annual Report shall contain:

15.2.1 information on any steps taken by the Trust to secure that (taken as a whole) the actual membership of any public constituency is representative of those eligible for such membership.

15.2.2 information on any occasions in the period to which the report relates on which the Council of Governors exercised its power under paragraph 7.15.

15.2.3 information on the Trust's policy on pay and on the work of the Remunerations and Nominations committee and such other procedures as the Trust has on pay.

15.2.4 the remuneration of the Directors and the expenses of the Governors and the Directors; and

15.2.5 any other information the NHSE requires.

15.3 The Trust is to comply with any decision the NHSE makes as to:

15.3.1 the form of the Annual Reports.

15.3.2 when the Annual Reports are to be sent to it.

15.3.3 the periods to which the Annual Reports are to relate

15.4 The Trust shall give information as to its forward planning in respect of each Financial Year to the NHSE. This information is to be prepared by the Directors, who must have regard to the views of the Council of Governors.

15.5 Each forward plan must include information about -

15.5.1 the activities other than the provision of goods and services for the purposes of the health service in England that the Trust proposes to carry on, and

15.5.2 the income it expects to receive from doing so.

15.6 Where a forward plan contains a proposal that the Trust carry on an activity of a kind mentioned in sub-paragraph 15.5.1 the Council of Governors must:

15.6.1 determine whether it is satisfied that the carrying on of the activity will not to any significant extent interfere with the fulfilment by the

Trust of its principal purpose or the performance of its other functions, and

15.6.2 notify the Directors of the Trust of its determination.

15.7 If the Trust proposes to increase by 5% or more the proportion of its total income in any Financial Year attributable to activities other than the Principal Purpose referred to in paragraph 3 it may implement the proposal only if more than half of the members of the Council of Governors voting approve its implementation.

16 Mergers, Significant Transactions and other transaction requirements

16.1 The Trust may only apply for a merger, acquisition, separation or dissolution with the approval of more than half of the members of the Council of Governors.

16.2 The Trust may enter into a Significant Transaction only if more than half of the members of the Council of Governors voting approve entering into the transaction.

16.3 "Significant Transaction" means:

16.3.1 the acquisition of, or an agreement to acquire, whether contingent or not, assets the value of which is more than 20% of the value of the Trust's gross assets before the acquisition.

16.3.2 the disposition of, or an agreement to dispose of, whether contingent or not, assets of the Trust the value of which is more than 20% of the value of the Trust's gross assets before the disposition; or

16.3.3 a transaction that has or is likely to have the effect of the Trust acquiring rights or interests or incurring obligations or liabilities, including contingent liabilities, the value of which is more than 20% of the value of the Trust's gross assets before the transaction.

16.4 For the purpose of this paragraph 16:

16.4.1 "Gross assets" means the total of fixed assets and current assets;

16.4.2 in assessing the value of any contingent liability for the purposes of sub paragraph 16.3.3 the Directors:

16.4.2.1 must have regard to all circumstances that the Directors know, or ought to know, affect, or may affect, the value of the contingent liability; and

16.4.2.2 may rely on estimates of the contingent liability that are reasonable in the circumstances; and

16.4.2.3 may take account of the likelihood of the contingency occurring.

16.5 Where the Trust has a single requirement for goods, services or works, and a number of transactions are to be entered into to fulfil that requirement, the

value of the transaction for the purpose of paragraph 16.3 is the aggregate value of each of those transactions.

16.6 The Trust shall inform, as soon as is reasonably practicable, the Council of Governors of any transaction which it has approved which in its opinion is likely to have a negative effect on the Trust's reputation.

17 Indemnity

17.1 Members of the Council of Governors and Board of Directors who act honestly and in good faith will not have to meet out of their personal resources any personal civil liability which is incurred in the execution or purported execution of their board functions, save where they have acted recklessly. Any costs arising in this way will be met by the Trust.

17.2 The Trust may make such arrangements as it considers appropriate for the provision of indemnity insurance or similar arrangement for the benefit of the Trust, Governors or Directors to meet all or any liabilities which are properly the liability of the Trust under paragraph 17.1.

18 Instruments and acts of the Trust etc.

18.1 A document purporting to be duly executed under the Trust's seal or to be signed on its behalf is to be received in evidence and, unless the contrary is proved, taken to be so executed or signed.

18.2 The Trust is to have a seal, but this is not to be affixed except in accordance with the provisions of the Standing Orders for the Board of Directors.

18.3 The validity of any act of the Trust is not affected by any vacancy among the Directors or by any defect in the appointment of any Director.

19 Engagement

19.1 The Trust has adopted an Engagement Policy for matters relating to interaction between the Council of Governors and the Board of Directors.

20 Amendment of the Constitution

20.1 This Constitution may only be amended with the approval of:

20.1.1 more than half of the members of the Board of Directors voting; and

20.1.2 more than half of the members of the Council of Governors voting.

20.2 Amendments made under paragraph 20.1 take effect as soon as the conditions in that paragraph are satisfied, but the amendment has no effect in so far as the constitution would, as a result of amendment, not accord with Schedule 7 of the 2006 Act.

20.3 Where an amendment is made to the Constitution in relation to the powers or duties of the Council of Governors (or otherwise with respect to the role that the Council of Governors has as part of the Trust):

20.3.1 at least one member of the Council of Governors must attend the next Annual Members' Meeting and present the amendment; and

20.3.2 the Trust must give the Members an opportunity to vote on whether they approve the amendment.

20.4 If more than half of the Members voting approve the amendment, the amendment continues to have effect; otherwise, it ceases to have effect and the Trust must take such steps as are necessary as a result.

20.5 The Trust shall inform the NHSE of any amendments to the Constitution.

Annex 1: PUBLIC CONSTITUENCIES OF THE TRUST

NAME OF CONSTITUENCY	AREA	MINIMUM NUMBER OF MEMBERS	NUMBER OF GOVERNORS
Mansfield, Ashfield and surrounding wards ~~the Rest of the East Midlands~~	All Wards of Ashfield District Council, plus the Wards of: Newstead Abbey Ward from Gedling District Council All wards of Mansfield District Council, plus the Ward of Welbeck, from Bassetlaw District Council. ~~Any area within an electoral constituency of the East Midlands region not covered above. In geographical terms ,this covers the local authority districts across the rest of Nottinghamshire, Derbyshire Rutland, Lincolnshire, Leicestershire, Northamptonshire~~	50	~~910~~ 9

~~Greater~~ **Newark** **& Sherwood and surrounding wards** ~~Hospital~~ **Constituency**	All Wards of Newark & Sherwood District Council, plus the Wards of:~~:~~ Tuxford and Trent, from Bassetlaw District Council; ~~and~~ the Wards of: Loveden Heath from South Kesteven District Council; and the Wards of Bingham North and Bingham South from Rushcliffe Borough Council.	50	45~~4~~

Rest of England	Any area within an electoral constituency in the rest of England, not covered by the constituencies above.	12	1

Totals	**~~Population~~**		
	Minimum Membership	**680**	
	Public Governors		**14**

~~*Source: National Statistics (Nomis: www.nomisweb.co.uk)~~

Annex 2: Staff Constituency

1. The minimum number of Members required for the Staff Constituency shall be: 950.
2. The Staff Constituency shall be entitled to elect three Governors:

Annex 3 – Model Election Rules

Add link here

Annex 4 – Board of Directors Standing Orders

Add link here

Annex 5 – Council of Governors Standing Orders

Add link here

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Council of Governors' Chair's Highlight Report to Board of Directors

Subject:	Council of Governors (CoG)	**Date:**	5th September 2024
Prepared By:	Sally Brook Shanahan, Director of Corporate Affairs		
Approved By:	Graham Ward, Acting Chair		
Presented By:	Graham Ward, Acting Chair		
Purpose:			
To provide assurance to the Board of Directors from the CoG meeting held on 13th August 2024		**Assurance**	Significant

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
	The roll out of the new Meet Your Governor arrangements has begun. Consideration to be given to how feedback from it can be given to the System.
Positive Assurances to Provide	**Decisions Made** (include BAF review outcomes)
Confirmation of the appointment of a Medical Lead for Sepsis. Confirmation of the timely implementation and sign off by both Chairs & SID and NHSE to fulfil the requirements of the new Fit and Proper Person Framework. 15 Steps visit feedback. Update on the Nursing Workforce Demographic in response to governor questions about whether nursing staff having the appropriate level of skills. Quadrant Reports received from the Audit and Assurance, Quality, Finance, People and Charitable Funds Committees. The Annual Accounts for the year ending 31st March 2024 alongside key audit findings were received.	To approve the updated Code of Conduct for Governors with immediate effect. NED appraisal outcomes agreed. To recommend the proposals for amendments to the Constitution to the September Board for approval. To approve the re-appointment as NEDs of Manjeet Gill from 31/10/24 and Barbara Brady from 30/09/24 the for a period of one year each. To appoint Barbara Brady as Vice Chair of the Trust Board with immediate effect. To recruit a new Associate NED with a background in Research and Innovation.
Comments on effectiveness of the meeting	
Another very well attended meeting with good engagement from governors.	
Items recommended for consideration by other Committees	
To consider how the visibility of the monitoring of the sub-strategies can be improved.	

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Report	**Date:**	5 September 2024
Prepared By:	Sarah Ayre Head of Midwifery, Women and Childrens		
Approved By:	Philip Bolton, Executive Chief Nurse		
Presented By:	Paula Shore, Director of Midwifery/Divisional Director of Nursing, Women and Childrens, Philip Bolton, Executive Chief Nurse		

Purpose		
To update the board on our progress as maternity and neonatal safety champions	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

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

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

Committees/groups where items have been presented before

- Divisional Governance Meeting
- Maternity and Gynaecology Clinical Governance
- Paediatric Clinical Governance
- Service Line
- DPR
- Maternity Forum
- Divisional People Committee
- Senior Management Team weekly meeting

Acronyms

- APH - Antepartum Haemorrhage Intrapartum Haemorrhage (IPH),
- BSOTS - Birmingham Symptom Specific Obstetric Triage System
- CQC - Care Quality Commission
- IPH - Intrapartum Haemorrhage (IPH),
- KLOE – Key lines of enquiry
- LMNS - Local Maternity and Neonatal System
- MIS – Maternity Incentive Scheme
- MNSC - Maternity and Neonatal Safety Champion

- MNSI - Maternity and Newborn Safety Investigations
- MNVP - Maternity and Neonatal Voice Champion
- RSV - Respiratory syncytial virus
- SBLCB – Saving Babies Lives Care Bundle

Executive Summary

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

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

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

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

1.Service User Voice

A key deliverable in July 2024, as reported, was the MNVP identifying that nationally the free text report for the annual CQC survey from February 2023 had been made available. Through joint working this report was made available to the team and they are now leading on the survey feedback, building the comments into an action plan. 300 women were invited to participate and 116 completed the survey, which is a 39% return rate. Some of the free text received from our service users:

"I repeatedly asked for an epidural and was ignored multiple times."

"I was made aware by every member of staff how short staffed the department was which made me feel unsafe"

"I found the most difficult aspect after birth was trying to breastfeed my baby and think that if I had received more information before the birth, I would have been better prepared at how hard breastfeeding can be"

"I was asked to come in for growth scan I was told it was most likely I'd be induced I never got told any information about the induction until the week before I wasn't very happy with that service."

Most Sherwood Forest Hospitals NHS Foundation Trust's scores are in the intermediate-60% range of all Trusts surveyed by IQVIA. There are 9 scores in the top-20% range, which appear mainly in the antenatal and postnatal care at home sections. There are 9 scores in the lower-20% range, which are mainly in the labour and birth section.

Nearly all responses showed very little statistical change from the previous year (2022). It is important to remember that our women and birthing people were surveyed in February 2023 and many of the actions from the previous year's responses had not been fully implemented due to the publication of the previous year's report only being released in November 2022. Many of the recommendations made in that report were addressed in last year's action plan and this work continues with improvements likely to be reflected in the survey results for 2024, anticipated mid-2025.

The current action plan will be presented by Consultant Midwife Gemma Boyd in collaboration with our MNVP Leads at September's MNSC meeting and is overseen by Sarah Ayre, Head of Midwifery through Maternity and Gynaecology Clinical Governance (monthly), Maternity and Neonatal Safety Champions (every other month) and the LMNS Patient Safety and Quality Group (quarterly). The report has also been shared openly with our multi-disciplinary staff for awareness.

2. Staff Engagement

The planned MNSC walk round was undertaken on Tuesday the 6th of August 2024 introducing and welcoming the new Non-Executive Director (NED) for Women and Childrens Neil McDonald.

Neil has lived in Nottinghamshire since 1999 and joined the Trust Board as a Non-Executive Director in December 2023. He has 38 years' experience in the rail industry, having started out as an engineering apprentice. After 27 years in engineering, he moved into general management as Managing Director of the Industrial Business Unit of EWS Railways/DeutscheBahn, followed by a period as Head of Sales. In 2015, he became the Chief Operating Officer of the first heavy haul Railway in the UAE, a joint venture between DB and Etihad Rail. For five years, he was a Non-Executive Director of the Railway Safety and Standards Board, representing freight members. Since 2018, he has been a member of the Board of Governors for West Nottinghamshire College where has been a member of the Senior Postholder and Governance Committee and Chair of the Audit Committee. He has an MBA from Nottingham Trent University and brings 20 years' executive management experience to the Trust Board.

As part of the planned walkaround, Neil has asked that we spend time over the coming months introducing him to the pregnancy journey, with this month's focus being Antenatal and Outpatients Clinic. Claire Allison, the Matron for Antenatal and Outpatients, spent time talking Neil through the journey in outpatients and highlighted the service and current changes including the national RSV programme which is due to go live at SFH at the beginning of September 2024. Claire highlighted the estates issues that the teams are currently facing in the department and the MNSC were able to support with some immediate resolutions, and support with the ongoing review into the planned outpatient transformation.

The MNSC were able to speak with some staff members, whilst it was clearly a busy session the staff reflected that they loved working at SFH, with one member of staff moving into a significant period of long service. This positive feedback was further echoed across the teams and families using the service that morning.

The next walkaround is planned for 2.00pm on Thursday 12th September 2024 and we will be looking at how Neil can meet and engage with our community and specialist midwifery and nursing teams and families that receive care from these teams.

The monthly Maternity Forum took place, on 15th August 2024. The Forum was well attended by the multi-disciplinary workforce despite increased acuity and operational challenges. Paula Shore, DoM/DDN has provided the following overview:

On the 15th of August we held the monthly Maternity Forum. Chaired by the Chief Nurse and attend by the Chief Executive Officer, open conversation was had around the actions taken following the recent Coroners cases. Staff felt that through open conversations that they understood why the actions were needed. Staff also reflected that the activity felt higher than normal, for an August. Upon reflection, whilst forward looking the activity planned is average it feels that there is a sustained increase in the acuity. This has been identified by the Head of Midwifery who is looking at how as an MDT we could prioritise the workload differently and how we can build this change into this year's establishment review. We also reflected the positive news around this month's Daisy award that was presented to Jess Rawson and the number of nominations and short listing for Staff Excellence Awards that we have received within Maternity Services.

3. Governance Summary

Three Year Maternity and Neonatal Plan:
The Maternity Team continue to collaborate with the LMNS. The first joint meeting with Nottinghamshire University Hospitals, hosted and chaired by the LMNS, was held at the end of June 2024 from which a template has been developed to track agreed actions against the plan and ensure system oversight. It was

acknowledged by the Chair that neonatal collaboration going forward across the system would be strengthened to ensure a perinatal approach to all work streams.

Our senior team are working together to appraise the template in detail and this work is led by Consultant Midwife Gemma Boyd. The initial review of the template has provided assurance to the divisional senior triumvirate of compliance with the main areas however escalation will be made via MNSC meeting in September regarding any areas that may be a potential risk, with a robust plan and trajectory for addressing compliance, overseen by Head of Midwifery, Sarah Ayre.

Ockenden:
The report received following our annual Ockenden visit in October 2023 forms the basis of the robust action plan currently overseen by Head of Midwifery Sarah Ayre. The visit findings supported the self-assessment completed by the Trusts. Areas have been identified from the visit to strengthen the embedding of the immediate and essential actions however important to note the continuing progress as a system around bereavement care provision, specifically with the counselling support available for families as a system which is a feature of the Three-Year plan. This is being progressed now through the systems Transformation Committee attended by Head of Midwifery, Sarah Ayre.

NHSR:
The task and finish group for the Maternity Incentive Scheme (MIS) Year 6 is now established, meeting fortnightly to work through the evidence upload needed to meet each of the 10 Safety Actions. Each action has been allocated a nominated individual who is required to present evidence and escalate any concerns around challenges faced in achieving within the agreed monitoring period. The group is chaired by Speciality General Manager Sam Cole. Several national changes have been communicated since year 5 and the team have updated their work plan accordingly.

In brief the safety actions are:

SA1 Perinatal Mortality Review Tool
SA2 Maternity Services Data Set
SA3 Transitional Care
SA4 Workforce – medical
SA5 Workforce – midwifery
SA6 SBLCBV3
SA7 Service User
SA8 Training
SA9 Board assurance
SA10 Maternity and Newborn Safety Investigations (MNSI) programme and to
NHS Resolution's Early Notification (EN) Scheme

Midwifery Workforce (Safety Action 5):
Head of Midwifery Sarah Ayre is currently working closely with the Health Roster Team, Matrons and team leads to review availability of staff in post, secondments, flexible working patterns, study leave and management days to ensure safe staffing initiatives. The team are revisiting use of software functions such as auto roster and roster analyser to ensure robust planning. Alongside this is a review and relaunch of the Division’s escalation policy, OPEL status management and Bronze on Call support, led by Deputy Head of Midwifery Lisa Butler.

Saving Babies Lives (Safety Action 6):
SFH has continued to monitor its compliance with all elements of the Saving Babies’ Lives Care Bundle (SBLCB) in version 2 and following the uploaded evidence submitted to the regional teams, we have received confirmation that we have achieved the agreed over 70% of compliance for version 3 (SFH currently at 87%). Work continues to ensure that we aim for full compliance within the agreed time thresholds. Key area of focus is to support the newest element within the version 3 of the bundle which focuses upon the diabetes service. We have recently recruited a further specialist Midwife and are reviewing current caseloads against national trend of an increase in women and birthing individuals in pregnancy managing diabetes.

CQC:
Following the “Good” rating from the planned 3-day visit from the Care Quality Commission (CQC) in early 2020, the evidence submitted has been rated as “green” through the Quality Committee. It is noted however that further work is needed for these actions to become embedded, and a clear action plan is being reviewed and overseen by Head of Midwifery Sarah Ayre. The “Must-Do” progress will be tracked through the MNSC. These include Trust Mandatory training, which continues to remain above the 90% threshold, and a standardised triage system: Birmingham Symptom Specific Obstetric Triage System (BSOTS).

The Triage task and finish group, chaired by Divisional Manager Matthew Warrilow, continues to escalate through the MNSC meeting and this work is split into 5 main work streams and is benchmarked against the Royal College of Obstetricians and Gynaecologists (RCOG) Good Practice Paper on Maternity Triage. (Appendix 1)

A revised peer review programme has commenced, initially across our acute areas within maternity to review the CQC programme; a current focus on infection prevention and control across the Maternity Ward is being overseen by Matron Melanie Johnson with escalation to MNSC. This includes weekly walkarounds by Head of Midwifery Sarah Ayre and visits by the senior leadership team over night and at weekends to support staff engagement. An action log has been drafted to capture all small works, equipment and signage issues that need addressing and a review of the risk register is planned for September 2024.

4. Quality Improvement

Divisional Strategy
Next steps: Review of our key objectives and ambitions, benchmarking progress is underway and being overseen via the senior triumvirate at our weekly Senior Management Team (SMT) meeting.

Maternity
In terms of Antepartum Haemorrhage (APH) and Intrapartum Haemorrhage (IPH), we have participated in a system wide meeting, supported by the regional Midwifery, Obstetric and QI team alongside MNSI and the Health Innovation Network. This group is reviewing the evidence around APH and IPH to plan an evidence-based approach to the assessment and management of APH/IPH noting the concerns that have been raised on both sites and seen as a theme through our recent coronial cases. We have met twice and asked the academic team supporting us to investigate the literature with the search terms, IPH and APH. We are re-grouping at the beginning of September 2024 to look at the next steps following the literature review.

Neonatal
Transitional Care (safety action 3). A Task and Finish group to be launched to support embedding of the service, relaunch of SOP and staff roles and responsibilities. Collaboration across Maternity and Neonatal leadership team to undertake the work streams identified. Update on plan and progress to be shared at MNSC meeting in October 2024.

Urgent review underway to evaluate the MIS Year 6 technical advice for this safety action to ascertain evidence available to ensure compliance, overseen by Rachael Giles, Deputy Divisional Director Nursing.

5.Safety Culture

As part of the perinatal cultural workplan, drawing on the three themes identified, a focused action plan drawing all current work streams together is being devised by Consultant Midwife Gemma Boyd. This action plan will sit within the CQC’s 5 key lines of enquiry (KLOE) and will ensure a focus on communication, leadership and health and wellbeing.

Additionally, following staff feedback, a further element which will be incorporated into the culture plan work is the issues raised following the recent Coroners inquests; this will include how we organise and provide support both for professional learning and personal wellbeing

Royal College of Obstetricians & Gynaecologists

Maternity Triage

Good Practice Paper No. 17
December 2023

Maternity Triage

This is the first edition of this guidance. This guidance is for healthcare professionals who care for women, non-binary and trans people who are pregnant.

Within this document we use the terms woman and women's health. However, it is important to acknowledge that it is not only women for whom it is necessary to access women's health and reproductive services in order to maintain their maternal health and reproductive wellbeing. Obstetric services and delivery of care must therefore be appropriate, inclusive and sensitive to the needs of those individuals whose gender identity does not align with the sex they were assigned at birth.

1. Purpose

This document highlights the challenges in maternity triage departments* and defines their role as emergency portals into maternity units. It has been produced in response to a UK Government and Parliament petition in 2021, which requested a national review of triage procedures used by NHS maternity wards,[1] and proposed to mandate the implementation of a standardised risk assessment-based system for maternity triage; assessing every woman within 15 minutes and prioritising care based on urgency.

The paper is aimed at stakeholders responsible for developing and improving maternity services. It presents the recommendations for the operational structure and pathways within maternity triage to improve safety and experience for both women and staff, by recommending implementation of the Birmingham Symptom-specific Obstetric Triage System (BSOTS), while recognising opportunities for future research and evaluation.

2. Introduction and background

Beyond scheduled antenatal clinic and ultrasound appointments, most attendances to maternity services are unscheduled (emergency). Unscheduled attendances can occur because of conditions ranging from physiological labour or concerns related to pregnancy (such as pain, vaginal bleeding or reduced fetal movements) to acute obstetric or medical emergencies.

Prior to earlier published confidential enquiries,[2,3] all emergency attendances to maternity units were assessed by the duty team on labour ward. This resulted in high numbers of women attending with pregnancy-related problems that did not necessarily require urgent action, and diverted midwifery and obstetric staff from caring for those in active labour. In response, national recommendations directed pregnant women attending with unscheduled visits to be seen in areas separate from the labour ward. These recommendations have now been accepted throughout the UK, and new standalone maternity triage departments have developed in other physical spaces, such as day assessment units and labour induction bays.

Maternity triage departments function as emergency portals to access maternity services for pregnant or newly postnatal women and people who have unexpected complications or concerns. Unlike general emergency departments, they have developed without appropriate organisational and clinical systems in place to prioritise the clinical urgency of the women presenting. On average, the number of triage attendances are double or treble the number of births in an individual maternity unit, although accurate reporting and routine data collection are not common.

* In different Trusts/organisations, maternity triage departments are variously described as Maternity Triage Service, Maternity Assessment Suite, Maternity Assessment Unit, or Maternity Triage Unit.

Maternity triage departments have local guidelines, as national standardised pathways have not previously existed. Women are often seen in the order in which they arrive, rather than following a standardised assessment and clinical prioritisation, as happens in general emergency departments. Space limitation can further hinder the process, leading to women with relatively non-urgent issues being reviewed ahead of emergencies that require urgent action, thus contributing to increased maternal and perinatal morbidity.

The need for national standardised maternity triage systems has been highlighted in UK confidential enquiries,[2–4] as well as in many local Care Quality Commission and Healthcare Safety Investigation Branch[5] reviews. A 2021 UK Government and Parliament petition[1] also recognised that, unlike mainstream emergency medicine, there was no nationally standardised triage system within maternity for women who attend for unscheduled appointments.

The need to develop guidelines for the triage of pregnant women and people has also been recommended by the American College of Obstetricians and Gynecologists,[6] which advocates the use of standardised tools to improve quality and efficiency.

3. Existing standards

In emergency medicine, the Australian Triage System (ATS) was developed more than 20 years ago and formed the basis for the Manchester Triage System (MTS),[7] which was initiated in the UK in 1997 by the Manchester Triage Group. It was jointly developed by the then Royal College of Nursing, Accident and Emergency Association and the British Association for Accident and Emergency Medicine, and differs from the other systems in that it is an algorithm-based approach to decision making. The system aimed to standardise assessment and increase reproducibility and validity, and has been mandated for use in UK emergency departments.

No national standards currently exist for staffing numbers in maternity triage departments, other than within the overall standards for midwifery staffing levels, summarised in the National Institute for Health and Care Excellence (NICE) guideline [NG4] *Safe Midwifery Staffing for Maternity Settings*.[8] This guideline used evidence from numerous national reports to provide regulated targets for midwifery staffing, including the core standard of one-to-one care for pregnant women in labour.

4. Principles of triage

Triage is a process of standardised clinical assessment, prioritisation, and delivery of emergency care when workload exceeds capacity. It is particularly useful in areas of high-flow patient care with diverse clinical needs. Triage systems are designed to ensure the patient receives the level and quality of care appropriate to their clinical needs and the resources available are used most effectively. It involves a systemic prioritisation of the order in which patients receive medical attention on arrival, guiding treatment according to clinical need.

The clinical triage process results in a clinical priority being assigned and involves:

a) identification of the presenting problem; and,
b) undertaking a standardised assessment including vital signs.

5. Triage in maternity

The generic parameters of standard triage tools cannot be extrapolated to pregnancy as the physiological changes of pregnancy are associated with a higher resting heart rate, lower blood pressure and increased respiratory rate. This together with the underlying good health of the maternity population may mask the severity of maternal illness, unless a specific assessment is undertaken by appropriately trained healthcare professionals. Triage of pregnant women has been identified as being less reliable when using mainstream triage systems,[9,10] and therefore this area has

been highlighted as requiring development of specific guidelines and education packages.[11] There is also no means of assessing the condition of the unborn baby using existing emergency medicine triage tools.

In Australia, triage algorithms for pre-eclampsia and antepartum haemorrhage for use by midwives were re-evaluated and showed marked improvements in consistency of assessment and documentation.[12]

Within the UK setting, BSOTS has been co-developed by clinicians from Birmingham Women's Hospital and researchers from the University of Birmingham. It was developed in response to the need for a standardised process to identify those women who required more urgent attention in a busy clinical setting. Initial evaluation showed an increase in the numbers of women assessed within 15 minutes of attendance (from 39% to 54%) (RR 1.4, 95% CI 1.2–1.7; $P < 0.0001$), and that women identified as having greater urgency were seen more quickly by a doctor. The system had excellent inter-operator reliability (intraclass correlation 0.961, 95% CI 0.91–0.99). Healthcare professionals felt the system improved the management of the department and increased patient safety. BSOTS has been widely adopted throughout the UK and is the recommended triage system in England.[13]

5.1 Pathways in maternity triage

In maternity services, the pre-hospital contact for women may be through:

a) their primary care team (GP or community midwife),
b) verbal, telephone or online advice from friends or family, calling 999 or NHS 111, charity websites (see the Tommy's symptom checker in Appendix I, with further information available from Tommy's and the Mama Academy), or
c) direct contact with their maternity triage department.

Advice on when to contact maternity services is often included in scheduled antenatal consultations or can be accessed from handheld or electronic patient records (EPRs). Details of how to contact maternity services or where to attend with concerns related to their pregnancy should also be made available from the same sources. However, it is vital to recognise the confusion and additional challenges for people from ethnic minorities, those without English as their primary language or from areas of social deprivation.[14,15] Minimum standards for telephone triage are included in section 6.2.1.

BSOTS[14] includes a standardised initial assessment of all women and their babies within 15 minutes of arrival and the use of symptom-specific algorithms to determine the clinical urgency of further investigations and seniority of review.

6. Recommendations for maternity services

6.1 Learning from emergency medicine

Evidence from the Royal College of Emergency Medicine[16] has shown that patient harm is associated with crowding in emergency departments, and that this harm increases with increasing length of stay.

The model of core emergency care should form the foundations for maternity triage departments. Maternity services need to define their core emergency 24/7 triage service (both telephone-based and in-person), with appropriately senior midwifery and medical decision makers, and adequate physical and equipment facilities. The service should have 24/7 access to prompt clinical investigations and additional administrative space and support in those departments.

This model of multidisciplinary care with senior decision makers available for high quality, time-critical clinical plans and treatment enables the management of short-term issues, and visible clinical leadership with training for all staff, which will improve experience and safety for women and their babies.

6.2 Recommendations and key principles for maternity triage

Maternity triage should be recognised as the emergency portal of maternity units, for pregnant or newly postnatal women (up to 6 weeks) with unscheduled related concerns or problems. Women and people should be provided with clear information on how and when to contact maternity services and where to attend with concerns related to their pregnancy, in a format and language that they can readily access and understand.

Maternity triage should include appropriately trained midwifery staff whose primary responsibility is to assess women both by telephone and in-person. This role should be seen as an essential part of operating a safe maternity service, therefore these midwives should only be moved out of triage in exceptional circumstances. Accurate and contemporaneous recording of both phone calls to triage and triage attendances will ensure identification of women who call or attend on multiple occasions.

It is the responsibility of NHS service providers to ensure interpreting and translation services are made available to their patients, and are free at the point of delivery.[17] Advice and guidance on language interpreting and translation can be found in the migrant health guide.

6.2.1 Recommendations for maternity telephone triage

1. Ensure there are well-defined pathways and clearly signposted telephone numbers to call depending on the woman's concerns.
2. Ensure there is a dedicated telephone line for women and people with unscheduled pregnancy or postnatal concerns and that calls are answered promptly.
3. Ensure calls are taken outside the clinical area in a dedicated and protected quiet space – to ensure confidentiality – by a midwife who is clinically active and familiar with maternity triage, but whose duties at that time are solely for telephone triage. Calls should ideally be audio recorded with consent.
4. Ensure all such consultations are documented using a standardised telephone triage template (see Appendix II) so that there is a reliable and accurate record of the conversation and the paperwork is integrated into EPRs if used.
5. Ensure there is a contemporaneous documentation of the call and advice given. If handwritten, ensure robust systems are in place to add the documentation to the maternity records.
6. Midwives should have access to the EPRs if in place.
7. Ensure requests to attend hospital are documented and the woman is clearly informed of the urgency and timeframe for attendance.
8. Do not assign a clinical priority or use an appointment system based on telephone triage. Where a time-critical emergency is identified, the woman/caller is directed to dial 999 for an ambulance and a system is in place within each integrated care system, to ensure that any time-critical emergencies are clearly managed to safeguard the woman, and ensure they are taken to the most appropriate maternity services, dependent upon the location and condition of the woman at the point of arrival of the emergency services.
9. Continuity of telephone triage assessment process is important. For example, if the telephone triage midwife is absent, local escalation policies should be in place so this absence can be covered.

6.2.2 Recommendations for in-person maternity triage

1. Ensure a prompt and brief assessment (triage) of the woman is undertaken by a midwife within 15 minutes of attendance, and the clinical urgency in which they need to be seen is determined in a standardised way, using a system that has been evaluated (e.g. BSOTS[14]). This system should have minimal variation in the assessment of urgency between midwives, and include physiological assessment with use of a modified early obstetric/maternal early warning score (e.g. MEOWS or MEWS).
2. Ensure triage assessment and clinical prioritisation is performed by clinical staff who have been trained in the specific method of triage and demonstrate their competency to do this. The initial triage assessment is in-person and should normally take 5–10 minutes.

3. Ensure there is a seated waiting area where women can wait as they may require further assessment, investigations, and ongoing management (see the triage pathway in Appendix III).
4. Ensure the seated area is in an adequately sized space, ideally visible to the clinical staff.
5. Ensure further assessment, investigations and ongoing management are standardised in line with local guidance and are led by a midwife with obstetric input when required. It may include continuous risk assessment and safeguarding.
6. Ensure triage attendances/episodes are clearly recorded, either in maternity notes using a standard template (see Appendix II for an example triage assessment card) or in EPRs.
7. Ensure there is a centralised overview of the department showing workload and location of women in the department and their progress (e.g. waiting for initial triage assessment, triaged and clinical priority). This should include the ability to record time of arrival, initial time of assessment, clinical priority assigned and time of further tests and investigations.
8. The most senior obstetrician on call for the labour ward (consultant/specialist) and midwifery coordinator on labour ward must have an overview of triage activity and any escalation. To ensure this occurs, review of triage activity should be included in the consultant-led labour ward rounds twice daily (over 24 hours), 7 days a week.[18]
9. Ensure that if the department becomes very busy, with either many women attending at the same time (and triage within 15 minutes is not possible) or a number of women and people requiring ongoing care, there are local escalation policies in place to call for additional staff.

7. Recommendations for facilities and space

7.1 Access to maternity triage

Pre-hospital information should be clear for women and people who are pregnant about where the maternity triage unit is, the reasons for contacting the unit, and when to call and when to attend. Systems need to be in place to ensure women are directed to the correct department if maternity triage is not appropriate (i.e. Early Pregnancy Assessment Unit), and that those with administrative queries (such as appointment changes) are redirected.

7.2 Maternity triage

There should be:

- A dedicated telephone line for women with queries or concerns, with calls ideally taken outside the clinical area by appropriately trained midwives.
- 24/7 access to maternity triage for women, and they need to be informed what the local arrangements are. Dedicated triage areas should be clearly signposted throughout the hospital. They should be situated onsite, ideally alongside the labour ward to facilitate easy transfer.
- A reception area (ideally with receptionists who can inform midwifery staff of the woman's attendance) and a waiting area for those waiting to be triaged or awaiting further investigation/review. There should be easy access to clinical staff should the women require more urgent attention than anticipated.
- Constant access to a space where the initial triage can be undertaken by a midwife is key. Within this space there needs to be a trolley to facilitate transfer as required and the equipment to carry out a physical assessment. There are two options:
  - The first is to have a single room where all women are triaged. In this instance all women would be transferred out of that room following the triage, either directly to labour ward (if it is an emergency), to a bay for further assessment (requiring urgent care), or – for those deemed to be less urgent – to a seated waiting area to await further assessment in a timely manner.
  - The second option is to rotate the initial triage room. This means several single rooms need to be available and once the initial triage assessment has been undertaken, the woman either remains in that room if she is deemed to require more urgent care, or sits back outside to await further assessment. If the room is occupied following the initial triage, further triages take place in another single room.

- Sufficient space to enable timely, ongoing assessment of the women in attendance. Any available space should adequately accommodate healthcare staff, women and their families and provide safety, privacy and confidentiality.
- An office space within the clinical area to facilitate clear handover between the triage midwife and midwife undertaking ongoing assessments. This space should include a centralised overview of the department showing the present workload. This facilitates efficient management of the department by enabling staff to:
  - Establish how many women have not yet had their initial triage assessment to determine level of clinical urgency.
  - Know the level of clinical urgency assigned to each woman who has received initial assessment.
  - Know when further assessments are due for each woman.
  - Provide easy handover between shifts.
- Access to electronic fetal monitoring with computerised cardiotocography (cCTG), and to diagnostic tests such as blood tests, urine samples and ultrasound scanning when required.

7.3 Recommendations likely to require additional planning, resources and finance

Additional resources may be required:

- For extra medical, midwifery and maternity support worker (MSW) staffing to ensure the safe functioning of both telephone triage and the department; to allow midwifery staff to have primary responsibility to assess and care for those women in triage.
- To identify a protected quiet space away from the clinical area for telephone triage to be carried out by a midwife.
- For changes to be made to the physical space to provide an available room/bay for the initial triage to be undertaken in a timely way. This space may be flexible and rotate its function, but there must always be dedicated space to assess and triage new arrivals.
- To provide additional trolley space for women, where ongoing tests, fetal monitoring and maternal investigations can be undertaken in a timely way.

Midwifery-led units (either standalone or alongside) cannot meet the standards required outlined above to provide maternity triage and should not be undertaking this work.

8. Recommendations for staffing and workforce

Women who attend maternity triage with unscheduled pregnancy-related concerns should be seen in a single place, whatever the reason, without any appointment system, but should be asked to attend promptly. Women who require ad-hoc medical review or are booked/scheduled for tests/investigations/scan reviews/treatments should be seen by different staff to avoid potential delay in triage and assessment of those women presenting with unscheduled pregnancy-related concerns.

Local midwifery and medical staffing numbers and skill mix will depend on how busy the triage department is, and may vary with different shift times. The priority must be to undertake the initial triage assessment (5–10 minutes) within 15 minutes of arrival, and numbers of staff will therefore depend on the numbers of women who attend. It is advisable to undertake an audit within each individual maternity unit to assess the numbers of women attending, times of attendance and the waiting time for initial triage. This can be used to inform staffing models/business cases for additional staff, e.g. extra midwives may be required at certain times of the day/night.

It is recommended that one midwife is responsible for the initial triage assessment and at least one other midwife carries out the subsequent care and investigations. In smaller units, such as those with fewer than 3000 births, one midwife may assume both roles (along with a MSW), but will need to remain responsive to new attendees and interrupt the ongoing care of women to triage each arrival.

An MSW can be an integral part of the multidisciplinary team and can undertake tasks in their sphere of practice, but initial triage assessment, including maternal observations, should be carried out by a midwife.

This separation of roles so that one midwife undertakes the initial triage assessment and another carries out subsequent care and investigations is a different way of working and staff may require support to make this change. It should be emphasised that this change ensures that women and people are prioritised based on clinical need and improves safety. Training in this way of working should be mandatory, both before implementation and for new staff.

Defined thresholds for escalation (for both midwifery and medical staffing) for when a department exceeds capacity, and the need for additional staffing, should be based on numbers of women attending the department and their clinical categories of urgency. For example, there needs to be an escalation policy for when Tier 2 medical staff review of women categorised as orange cannot take place within 15 minutes because of workload. Careful consideration should be given to the workload within triage before reducing staffing in response to acuity elsewhere, but this needs to be done considering the acuity of other areas of the maternity unit to maintain minimal safe staffing levels across the whole service.

Within these operational policies, both midwifery and medical staffing escalation are required to maintain safe and timely initial triage assessment, and ongoing review and medical assessment. This may also include locally agreed thresholds for consultant/senior attendance beyond the twice daily ward rounds.

Further distractions in the clinical area, such as answering the telephone to external queries or reviewing ad-hoc queries from other departments, should be removed from the maternity triage area.

8.1 Models of care

Table 1 details the minimum staffing recommendations for maternity triage departments. However, flexibility in staffing is required in response to increased workload and to maintain the standard for initial assessment within 15 minutes of arrival. Following initial triage assessment, women should be seen in the order of their clinical need and should be informed when they are likely to be seen, or if there are any anticipated delays. The key to successful triage is to be able to assess patients rapidly and to accurately prioritise their clinical need.

Safety is improved by excellent inter-rater reliability of the triage system, which means the accuracy of the initial triage assessment should vary minimally between midwives. This will be further enhanced by standardisation of subsequent care and investigations and a shared language between professionals.

Maternity units have a number of midwifery models for staffing, with some having a team who work permanently in triage, other staff triage from labour ward staffing, and others use a mixture of the two with a smaller core team and midwives co-opted from the labour ward rota. All models are feasible, but all staff who work in triage need training and regular experience. For any system to work effectively there needs to be some continuity to ensure familiarity and consistency, as well as consideration given to size in terms of provision of staff who are adequately trained. Escalation policies should be in place with plans to manage peak activity.

8.2 Midwifery staffing

Midwifery staff should be available 24/7 to respond to telephone calls regarding unscheduled pregnancy or newly postnatal concerns or problems. These calls should not be dedicated/diverted to clerical staff.

There may be benefit in pooling midwifery staffing resources across maternity systems and basing the midwives within the ambulance service – as is already in place in some local maternity and neonatal systems.

Table 1. Recommendations for minimum staffing levels for maternity triage departments.

Maternity unit (births/year)	Midwifery staffing (Bands 6 and 7)	Medical staffing (seniority equivalents)
< 3000	• One midwife 24/7 • One MSW 24/7	• FY2/GP VTS/ST1–2/LED (usually on-call LW team) • ST3–7 or specialty doctor or LED available (usually on-call LW team) • Obstetric consultant/specialist* available
3000–4500	• One midwife 24/7 • One additional midwife for peak time of workload (usually 1–9pm)	• FY2/GP VTS/ST1–2/LED in maternity triage department 'in hours' • FY2/GP VTS/ST1–2/LED available (usually on-call LW team) ST3–7 or specialty doctor/LED available (usually on-call LW team) • Obstetric consultant/specialist available
4500–6000	• Two midwives 24/7 • Consider one additional midwife for peak time of workload (usually 1–9pm)	• FY2/GP VTS/ST1–2/LED in maternity triage department 'in hours' • Additional FY2/GP VTS/ST1–2/LED available (usually on-call LW team) • ST3–7, specialty doctor or LED available (usually on-call LW team) • Obstetric consultant/specialist available
6000–8000	• Two midwives 24/7 • One additional midwife for peak time of workload (usually 1–9pm)	• FY2/GP VTS/ST1–2/LED in maternity triage department 'in hours' • Additional FY2/GP VTS/ST1–2/LED or ST3–7/specialty doctor available for peak workload period (usually 1–9pm) • ST3–7, specialty doctor or LED available (usually on-call LW team) • Obstetric consultant/specialist available
> 8000	• Two midwives 24/7 • One additional midwife for peak time of workload (usually 1–9pm) • One MSW 24/7	• FY2/GP VTS/ST1–2/LED in maternity triage department 24/7 • ST3–7, specialty doctor or LED in maternity triage department for peak workload period (usually 1–9pm) • Additional FY2/GP VTS/ST1–2/LED and ST3–7/specialty doctor available (usually on-call LW team) • Obstetric consultant/specialist available

FY2, foundation year two; GP VTS, General Practice Vocational Training Scheme; LED, locally employed doctor; MSW, maternity support worker; LW, labour ward; ST, specialty trainee.

*Specialist doctors are senior SAS doctors who are able to practice autonomously in a defined area of obstetrics and gynaecology.

8.3 Medical staffing

Those women who require more urgent clinical assessment (red/orange) should be seen by a ST3–7, specialty doctor or equivalent level of Locally Employed Doctors (LED) obstetrician from labour ward with more senior expertise, to ensure prompt assessment and planned care. Women allocated the red category of urgency should be transferred to the labour ward for assessment. For those women allocated the orange category of urgency, review within 15 minutes is required if there is abnormal MEOWS or MEWS, abnormal cCTG, or urgent maternal/fetal concern (guided by individual algorithms). This is likely to represent 15–20% of women attending triage. Those women prioritised as less urgent (yellow/green) can be seen by a FY2/GP VTS/ST1–2/LED in a timely way. One of the principles in BSOTS is that those assigned red/orange priority are seen and assessed by ST3–7, specialty doctor or equivalent level of LED because they represent the most unwell requiring urgent clinical attention. However, if the ST3–7, specialty doctor or

LED is not available within the timeframe, that initial assessment can be made by the FY2/GP VTS/ST1–2/LED, with escalation to ST3–7, specialty doctor, equivalent level LED or consultant/specialist to ensure timely review by medical staff.

9. Assessment of performance

The ability to assess the performance of an individual maternity triage department requires appropriate metrics and high-quality data. Measurement of arrival and waiting times in maternity triage is rarely collected routinely and, without the assistance of EPRs, often inaccurate and incomplete. In emergency medicine, the introduction of the 4-hour standard effectively drove change, but performance of a single area needs to consider the whole maternity unit and avoid undermining quality of care in other areas.

Maternity units should regularly review their own data. This should include the baseline characteristics of the women who attend (including ethnicity). Data should be collected for a 24-hour period to enable identification of the times breaches may occur, and might include:

- Time of arrival
- Time of triage
- Time triage completed
- Reason for attendance
- Category of urgency
- Time ongoing care commenced
- Time ongoing care completed
- Time medical review requested
- Time of medical review
- Time of transfer/admission or discharge.

However, audit data may not always capture the length of time the triage took, whether the women categorised as less urgent (yellow/green) were seated back outside, or whether the triage and ongoing care was undertaken by different midwives (in units with more than 3000 births) – and these features are key to successful implementation.

Auditable standards of wait for initial assessment and triage after arrival can provide evidence of workload, times of peak activity, delays and staffing levels. These data, together with accuracy of the triage undertaken, how long women waited for further assessment and potentially medical review, will enable maternity units to plan their midwifery and medical staffing models more effectively. If problems are identified, further work will be required to explore the reasons, such as was the midwife responding to telephone calls that took them away from the women in front of them, or were women attending for ad-hoc reviews or scheduled attendances causing similar issues. This information should then be used to improve services. These data should be triangulated with clinical incidents, episodes of escalation for staffing, as well as feedback from women and staff from the maternity triage department and the whole service.

10. Conclusion

Maternity triage should be recognised as the emergency portal of maternity units, for pregnant or newly postnatal women and people who are pregnant with unscheduled related concerns or problems. A dedicated telephone advice line should be made available to women, which should be answered by a midwife using a standardised telephone triage template. Clear pre-hospital information should be provided to women with the location of the maternity triage unit, the reasons for contacting the unit, and when to call and when to attend.

Maternity units should make sure a standardised system is in place to provide prompt assessment of all women and people who attend with unscheduled pregnancy-related issues or concerns within a designated area, which should be accessible 24/7.

The recommended standardised maternity triage system is BSOTS, which has been evaluated and shown to have minimal variation in the assessment of urgency between midwives. A prompt and brief (5–10 minutes) initial triage assessment of the women is carried out by a midwife within 15 minutes of attendance, with clinical urgency determined in a standardised way, including physiological assessment with use of a modified early obstetric/maternal early warning score. Standardisation of immediate tests and investigations using evidence-based clinical guidance and pathways further supports timely and appropriate review.

Implementation of BSOTS can help address some of the safety issues identified from inspections of maternity units:

- Lack of dedicated triage department (triage staff also covering Day Assessment Unit).
- Poor telephone triage (lack of dedicated phone line, poor record of phone calls, triage phone answered by clinical staff within the clinical area).
- Lack of robust, consistent systems to triage women and prioritise care in a timely manner.
- Poor record keeping and inconsistent documentation.
- Insufficient or inconsistent staffing by midwives and doctors.
- No clear guidance for escalation.

Successful implementation can require significant system level change and investment and is dependent on:

- Recognition that maternity triage is the emergency portal for maternity services.
- A multidisciplinary desire to improve the pathway to enable timely identification of women (and their babies) who require more urgent care.
- A designated area dedicated to triage of women with suitable space to undertake ongoing care. This should include both a waiting area and space for ongoing management.
- Sufficient numbers of adequately trained midwifery and medical staff.
- A centralised overview of the department showing workload and location of women within the department.
- Development of escalation plans for both midwifery and medical staff to ensure timely response to capacity.

Following implementation:

- Continuous audit should be undertaken to maintain compliance, as well as identify and respond to issues arising.
- Local leadership and ongoing training of midwifery and medical staff is required.

11. Tools for implementation

More information about BSOTS is available on the BSOTS Public Page. Once permissions have been obtained, successful implementation is supported by online training and support materials available within the resources area of this website.

12. Future considerations

An agreed national standard and reporting tool for maternity triage, similar to that used in emergency medicine, is essential. This should include staffing requirements, agreed audit standards reported nationally and frameworks for improvement.

The role of advanced midwifery practitioners has potential within maternity triage and could be considered when exploring staffing models.

Telephone triage is inherently complex as it does not include clinical assessment, but relies on individual account and is impacted by the expertise of the person answering the telephone. It is therefore important to adopt a standardised approach to what questions are asked depending on the reason for the call, and to who is asked to attend (and who is

not asked). Additional training for healthcare professionals and further evaluation of a more standardised approach to telephone triage is required.

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Appendix I: Example of who to contact and when for women.

Appendix II: Example of telephone triage assessment card.

TELEPHONE TRIAGE ASSESSMENT CARD	1st Call

Telephone call taken by	Print Name			PIN	
	Signature				
	Date	Time		Location	
Woman's name				Woman's Telephone number	
Registration no. or DOB			Lead Professional		
Gravida	Parity	EDD or Date of delivery	D D - M M - Y Y	Gestation	Days PN

Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Fetal movements -Reduced / absent (circle as required)			
Relevant medical & obstetric history						
Current pregnancy						

All women to be asked following questions as appropriate (tick box)	Antenatal		Postnatal	
	Reduced fetal movements		Mode of birth	
	Ruptured membranes		Complications	
	Abdominal pain		Feeling unwell/ feverish	
	PV bleeding			
Additional information	*(including social & lifestyle history)*			
Advice given including time-frame if you ask woman to attend triage	If asked to attend, COVID-19 questions completed (tick)			

Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received	

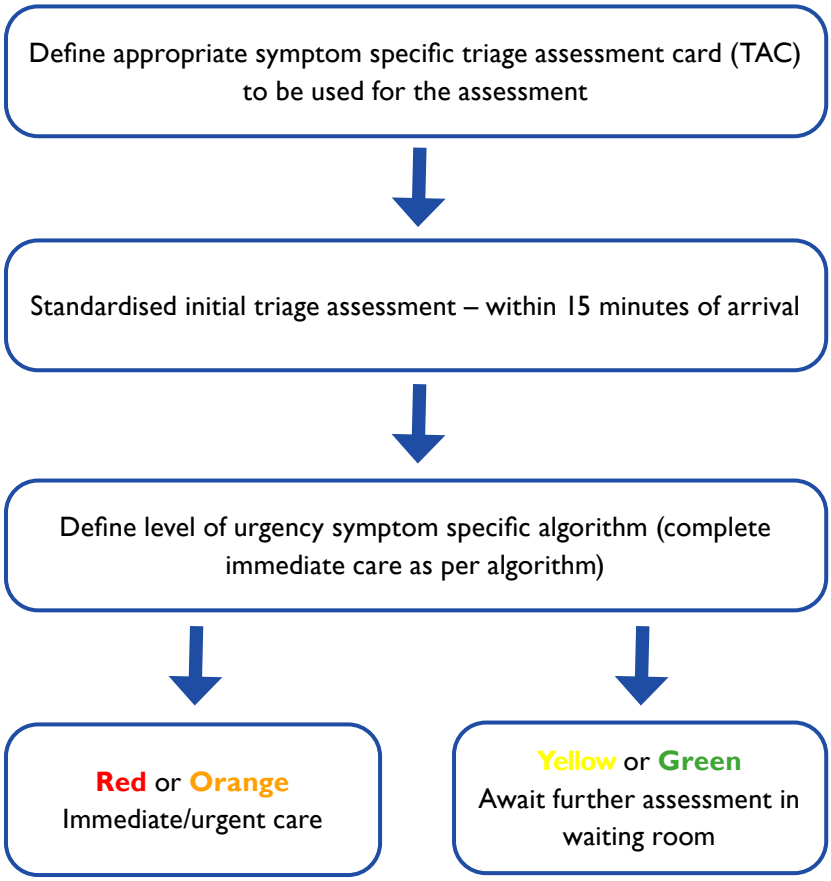
					To call back if:			
Specific early labour advice	Mobilise		Paracetamol					
	Rest		Regular fluids		Any changes		PV Bleed	
					Change in FMs		SROM	
	Regular snacks		Warm bath		Increase in strength and/or frequency of contractions		Worried about anything	

PLEASE ATTACH TO HOSPITAL NOTES AND FILE ON ADMISSION

TELEPHONE TRIAGE ASSESSMENT CARD			2nd Call		Consider Triage attendance	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given including time-frame if asked to attend triage						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature		Date & time call completed		

TELEPHONE TRIAGE ASSESSMENT			3rd Call		[redacted]	
Primary reason for calling Triage	Abdominal pain		Antenatal bleeding		Hypertension	
	Postnatal concern		Ruptured membranes		Suspected labour	
	Unwell/other		Reduced fetal movements			
Relevant medical & obstetric history						
Current pregnancy						
Changes since last call						
Advice given including time-frame if asked to attend triage						
Plan (please circle)	Phone ambulance; attend triage immediately	Attend triage (use own transport)	Referred to CMW	Referred to GP	Advised with no further action	
Actions if woman advised to attend	Timeframe for woman to attend	Inform LW and medics if urgent attendance	Request hospital notes (ward clerk)	Inform ward clerk of urgency & to alert you when notes are received		
Print Name & PIN		Signature		Date & time call completed		

Appendix III: The triage pathway.



This guideline was produced on behalf of the Royal College of Obstetricians and Gynaecologists by:
Professor S Kenyon FRCOG, Birmingham; and Dr N Johns MRCOG, Wolverhampton.

Acknowledgement

B Wilson-Crellin, Clinical Lead, Culture and Leadership, Maternity and Neonatal Programme (MNP), NHS England, who contributed to the development of the section on telephone triage.

The following organisations and individuals submitted comments at peer review:
Association for Improvement in Maternity Services (AIMS); H Allmond, Consultant Midwife, United Lincolnshire Hospitals NHS Trust; A Anderson, Midwife and Head of Early Notification Clinical Team, NHS Resolution; Birthrights; K Brintworth, Regional Chief Midwife NHS England, London; British Association of Perinatal Medicine; British Maternal & Fetal Medicine Society; Dr KA Edey MRCOG, Exeter; C Foulds, Maternity Triage Ward Manager and Registered Midwife, Manchester Foundation Trust Saint Mary's Hospital; Dr A Gorry MRCOG, London; Dr ED Johnstone MRCOG, Manchester; Dr SJ Mountfield FRCOG, Southampton; Royal College of Midwives; Dr F Siddiqui FRCOG, Leicester; and M Upton, Head of Maternity and Neonatal Safety, NHS England.

The Committee lead reviewers were: Mr W Yoong FRCOG, London; and Dr E Khan MRCOG, Milton Keynes.

The chair of the RCOG Patient Safety Committee was: Dr SL Cunningham MRCOG, Stoke-on-Trent.

The final version is the responsibility of the Patient Safety Committee of the RCOG.

The review process will commence in 2026, unless otherwise indicated.

Maternity Perinatal Quality Surveillance model for August 2024

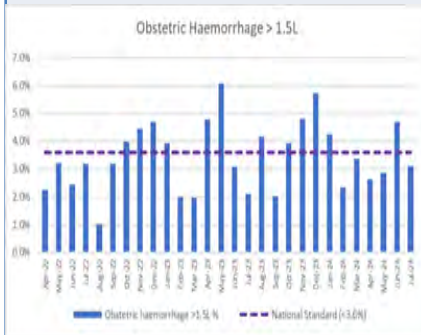
CQC Maternity Ratings- assessed 2023	Overall	Safe	Effective	Caring	Responsive	Well led
	Good	Requires Improvement	Good	Outstanding	Good	Good
Unit on the Maternity Improvement Programme			No			

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

Exception report including highlighted fields in monthly scorecard using July data (Slide 2)

Massive Obstetric Haemorrhage (July 3.1%)

- MOH surveillance continues, reviewed through MDT meeting- no themes, trends or immediate action needed.
- RCOG quality indicator is 3.6%



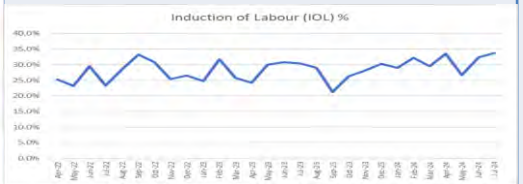
Elective Care

Elective Caesarean (EL LSCS)

- First month of electronic diary complete – review of impact anticipated but initial feedback is positive

Induction of labour (IOL)

- Outpatient training complete – IOL champions on every shift
- Delays in commencing and proceeding with IOL increasing – review planned for September to identify themes and solutions



Midwifery & Obstetric Workforce

Current vacancy rate (PWR data)

- Midwifery workforce 2%, vacancy fully recruited- all expected in post by Jan 25
- MSW recruitment planned for September – 4 wte vacancies
- Band 4 MSW and HoM overseeing HEE Strategy for B2/B3 roles and responsibilities. Review and launch planned for MSW Day in October
- No obstetric vacancy

Staffing red flags (July 2024)

- 6 staffing incidents reported
- No harm reported related to staffing red flags
- Full review of acute rosters and staffing metrics underway

Suspension of Maternity Services

- No suspensions of services in July

Home Birth Service

- 4 Homebirths in July
- Emerging risk to HB service due to expected maternity leave- divisional review and planning underway

Complaints, Compliments and FTT

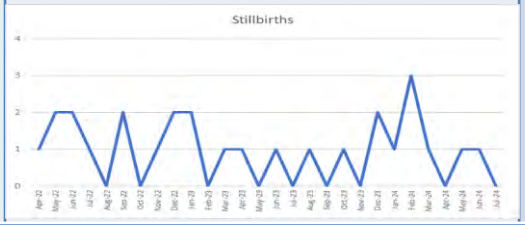
- Deep dive of the data demonstrated 100% of the responses for Postnatal Community would recommend the service

MDT Training Compliance (Target 93%)

- 92.1% for July, additional spaces for September created to accommodate staff escalated during high acuity

Stillbirth rate (YTD 1.7%)

- No stillbirths reported in July.



Maternity Assurance

NHSR	Ockenden
• Year 6 MIS now live • Fortnightly task and finish group progressing • No immediate challenges anticipated	• Initial 7 IEA- 100% compliant • System reporting for Three-Year plan in development

Incidents reported July 2024 (125 no/low harm, 1 moderate or above*)

MDT reviews	Comments
Triggers x 12	

*1 Incident reported as 'moderate or above'

- 20+/40 Neonatal Death (signs of life at birth). Missed opportunity for preterm surveillance as pathway not followed.
- Reviewed at Triggers and further MDT Rapid Review planned as per process

Other:

- 2 PFDS received following cases at Coroner's Court in May and in July. 1 response with legal team, ready for submission, 1 response with HoM being drafted, to legal team by end of August

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

Quality Metric	Standard	Running Total/ average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Trend
1:1 care in labour	>95%	100.00%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Spontaneous Vaginal Birth			56%	56%	55%	55%	51%	53%	47%	56%	49%	49%	48%	48%	46%	
3rd/4th degree tear overall rate	<3.5%	3.50%	4.60%	4.50%	3.50%	3.90%	5.20%	2.40%	3.00%	5.00%	2.10%	6.00%	4.50%	3.00%	2.80%	
3rd/4th degree tear overall number		79	8	6	6	7	9	4	5	8	3	11	8	4	4	
Obstetric haemorrhage >1.5L number		127	6	11	6	11	15	17	13	6	9	9	9	11	9	
Obstetric haemorrhage >1.5L rate	<3.5%	3.90%	2.10%	4.20%	2.00%	3.70%	4.80%	5.70%	4.00%	2.60%	3.40%	2.60%	2.90%	4.70%	3.10%	
Term admissions to NICU	<6%	3.10%	5.40%	3.40%	3.40%	3.70%	3.00%	3.10%	3.00%	2.80%	3.80%	2.60%	4.00%	2.90%	4.70%	
Stillbirth number		10	0	1	0	0	0	2	1	2	1	0	1	1	0	
Stillbirth rate	<4.4/1000				1.700			2.300			3.100			2.300	2.300	
Rostered consultant cover on SBU - hours per week	60 hours	60	60	60	60	60	60	60	60	60	60	60	60	60	60	
Dedicated anaesthetic cover on SBU - pw	10	10	10	10	10	10	10	10	10	10	10	10	10	10	10	
Midwife / band 3 to birth ratio (establishment)	<1:28		1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:27	1:22	
Midwife/ band 3 to birth ratio (in post)	<1:30		1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:29	1:23	
Number of compliments (PET)		38	2	3	3	4	4	3	2	3	4	5	4	1	2	
Number of concerns (PET)		9	1	1	1	2	0	1	1	1	1	0	0	4	1	
Complaints		6	0	1	1	1	0	0	1	0	0	1	1	0	1	
FFT recommendation rate - SBU	>93%		89%	91%	91%	90%	91%	90%	90%	90%	90%	90%	91%	91%	88%	

External Reporting	Standard	Running Total/ average	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Trend
Maternity incidents no harm/low harm		1339	86	85	107	130	158	94	148	102	102	95	130	102	125	
Maternity incidents moderate harm & above		10	0	1	3	2	2	1	1	0	0	0	0	0	1	

HSIB/CQC/NHSR with a concern or request for action		Y/N	N	N	N	Y	N	N	N	N	N	N	N	N	N	
Coroner Reg 28 made directly to the Trust		Y/N	0	0	0	0	0	0	0	0	0	0	0	0	1	1
Progress in Achievement of MIS YEAR 6	<4 <7 7 & above															

Outstanding Care, Compassionate People, Healthier Communities

NHS Sherwood Forest Hospitals NHS Foundation Trust

Guardian of Safe Working Report - Cover Sheet

Subject:	Guardian of Safe Working Report	**Date:**	5/9/2024
Prepared By:	Rebecca Freeman – Head of Medical Workforce		
Approved By:	Dr Simon Roe – Acting Medical Director		
Presented By:	Dr Simon Roe – Acting Medical Director		

Purpose		
The paper provides the Board of Directors with an update on the exception reports received from resident doctors and between 1st May 2024 and 31st July 2024.	**Approval**	
	Assurance	**X**
	Update	**X**
	Consider	

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

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

Committees/groups where this item has been presented before

Verbal update provided at the Joint Local Negotiating Committee the paper was also presented to the People Cabinet.

Acronyms

NHSE – National Health Service – England
LTFT – Less than Full Time
PA – Programmed Activity
WTE – Whole Time Equivalent
TOIL – Time Off in Lieu
FY1 – Foundation Year 1 Doctor
St – Specialty Trainee

Executive Summary

The Board of Directors is asked to take assurance from this paper and to note the following: -

- That the largest number of exception reports have been received from the Division of Medicine, closely followed by the Division of Surgery, Anaesthetics and Critical Care.
- Most Exception reports are being received from St1 doctors.
- The number of exception reports being received from St3+ doctors has increased considerably from the last report.
- Progress relating to the new doctor's mess has been delayed due to recent changes to building regulations.

- A survey has been sent to the resident doctors on Exception Reporting and although the response rate was poor, it has identified several areas of focus for August onwards.
- The Guardian of Safe Working is continuing to walk around clinical areas to meet resident doctors.

Guardian of Safe Working Report covering the period from 1st May 2024 to 31st July 2024

Introduction

This report provides an update on exception reporting data, from 1st May 2024 to 31st July 2024. It outlines the exception reports that have been received during the last three months, the actions and developments that have taken place during this time and work that is ongoing to provide assurance that there is safe working as per TCS of the 2016 junior doctors' contract.

As can be seen from the data below, 231 (219.3 wte) resident doctors have been allocated to the Trust by NHSE. The Trust has an establishment of 251 trainee posts, so this rotation, the final rotation of the year, there are 26 vacant trainee posts. This is due to NHSE not being able to fill these posts for a variety of reasons, including doctors being on maternity leave (8 doctors), unanticipated lack of training progress (not passing their exams), doctors leaving the training programme early, or there not being enough trainees following a particular training pathway to fill the posts across the country. The Trust isn't always informed of the reasons for the vacant posts and as can be seen from previous reports, these vacancy numbers fluctuate for each rotation. It is generally the last rotation of the year where there are the most vacancies. Further information is included in the vacancies section.

High level data as of 31st July 2024

Established resident doctor posts:	251		
Established trust grade doctor posts:	122		
	Posts	**Heads**	**WTE**
Number of resident doctors in post:	225	231	219.3
Number of vacant resident doctor posts:	26	-	31.7
Number of unfilled resident doctor posts filled by a trust grade doctor:	7	-	6.6
Number of non-resident doctors in post:	106	107	105.8
Number of vacant trust grade doctor posts:	16	-	16.2

Please note *the above table shows that there are 231 doctors in training (219.3 wte) covering 225 training posts, this is due to more than 1 LTFT doctor occupying a post.*

High level data from previous quarter (as of 30th April 2024)

Established resident doctor posts:	251		
Established trust grade doctor posts:	120		
	Posts	**Heads**	**WTE**
Number of resident doctors in post:	223	232	219.5
Number of vacant resident doctor posts:	28	-	31.5
Number of unfilled resident doctor posts filled by a trust grade doctor:	8	-	7.6
Number of trust grade doctors in post:	102	108	105.8
Number of vacant trust grade doctor posts:	18	-	14.2

Amount of time available in the job plan for the guardian:	1 PA
Administrative support provided to the guardian:	0.1 WTE
Amount of job planned time for Educational Supervisors:	0.25 PA per trainee

Exception reports from 1st May 2024 (with regard to working hours)

The data from 1st May 2024 to 31st July 2024 shows there have been 51 exception reports in total.

Of the 51 exception reports from the resident doctors, four were categorised as an immediate safety concern. Further details of the immediate safety concerns can be found in Table 1.

By month there were 11 exception reports in May 2024, 16 in June 2024 and 24 in July 2024.

Of the 51 exception reports 40 were due to working additional hours, 9 were due to the service support available and 2 were due to educational reasons.

Of the total 51 exception reports, all have been closed.

For the exception reports where there has been an initial meeting with the supervisor the median time to first meeting is 8 days. The time to the first meeting is better than the previous report by 5.5 days. Recommendations are that the initial meeting with the supervisor should be within 7 days of the exception report. In total 26 (51%) of all exception reports either had an initial meeting beyond 7 days or have not had an initial meeting, this is an improvement on 67% from the last quarter. Reminders are sent automatically to the Educational Supervisors listed by the resident doctor to respond to the exception report. These reminders are sent regularly until the reports are responded to. For the more straight forward exception reports, the Medical Workforce Team will respond, however, often further information is needed from the Educational Supervisor to complete the response. Where a doctor is on nights, it can be difficult to ensure that the initial meeting takes place within 7 days. However, all of the exception reports have had the initial meeting which is an improvement on previous reports.

Where an outcome has been suggested there are 16 (31%) with time off in lieu (TOIL) totalling 21 hours and 40 minutes, 19 (38%) with additional payment totalling 21 hours and 30 minutes at normal hourly rate and 1 hour at premium rate and 16 (31%) with no further action.

The Allocate software used to raise exception reports and document the outcome does not currently have the facility to be able to link to the eRota system to confirm TOIL has been taken or additional payment received, therefore this is actioned manually by the Medical Workforce Team, a report is

completed for the rota coordinators and the payroll team to ensure that time off in lieu is added to the doctor's record or any payment is made. This is completed on a monthly basis in line with payroll cut off periods.

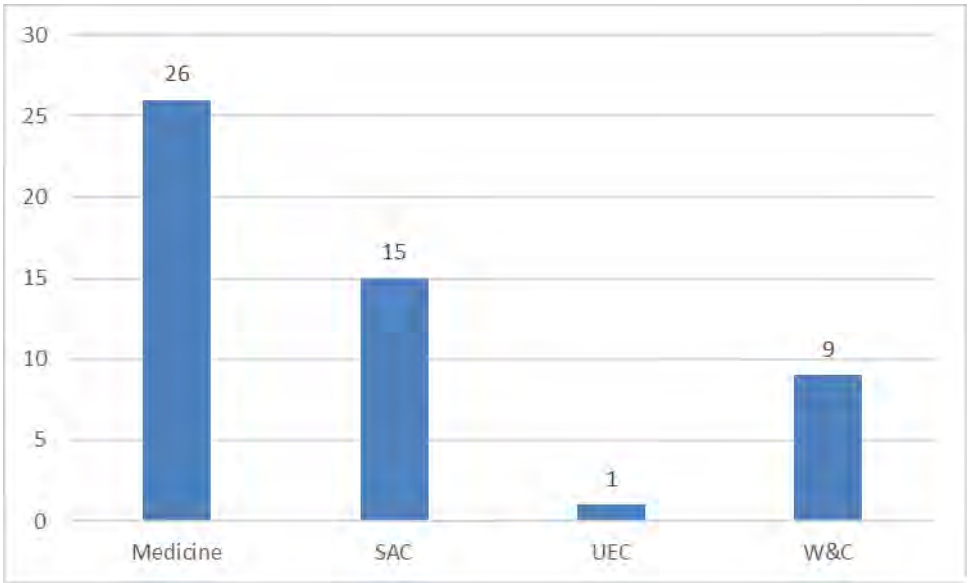


Figure 1. Exception reports submitted by Division.

Figure 1 shows that the majority of the exception reports received during this period - 26 (51%) in total - are from resident doctors working in the **Medicine Division**. This has increased from 12 exception reports (44%) in the previous report.

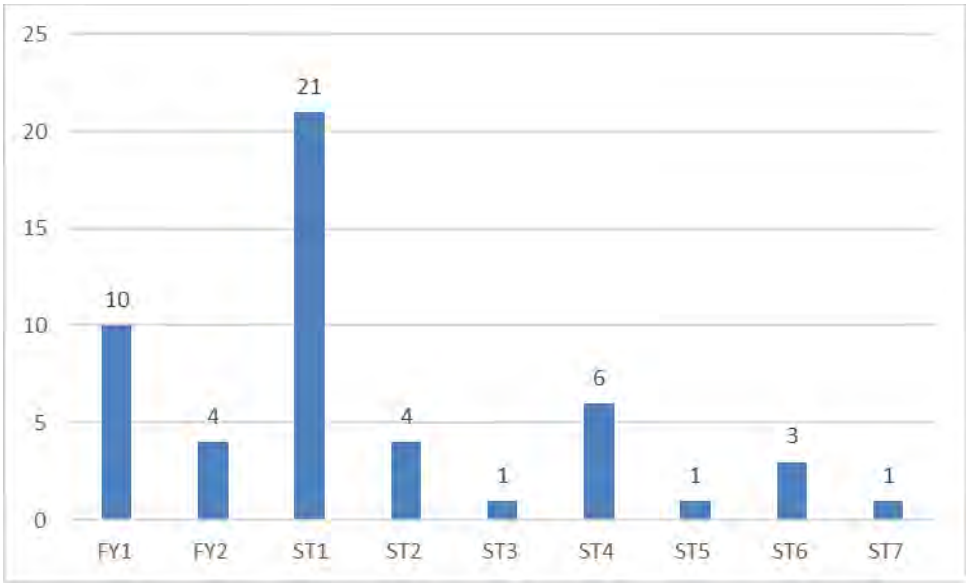


Figure 2. Exception reports submitted by Grade.

Figure 2 shows a high number of exception reports were submitted by the ST1/2 doctors. In total 10 (20%) of the exception reports have come from the Foundation Year 1 doctors, 4 (8%) from the Foundation Year 2 doctors, 25 (49%) from the ST1/2 doctors and 12 (23%) from ST3+ doctors. This is a considerable increase in exception reports from St3+ doctors which was 1 exception report (4%) in the previous report.

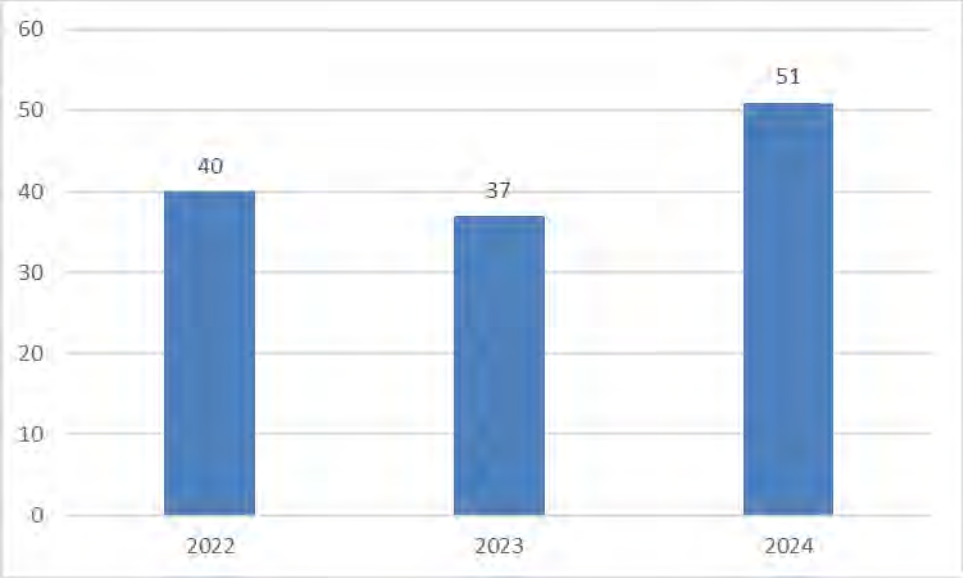


Figure 3. Comparison of number of exception reports for the same quarter between 2022, 2023 and 2024.

Figure 3 shows that for this period this year there have been more exception reports in total than in the previous years.

Date	Grade and Specialty of Doctor	Details of Immediate Safety Concern reported by the Trainee	Action Taken	Status of the Concern
17 May 2024	ST1 in Medicine	Complex patient needing theatre coordination for central access. Stabilising for theatre transfer.	There was a need for the doctor to stay to support. The doctor was compensated for working the additional time. Consideration to be given re additional support in future.	Exception Report closed
27 May 2024	ST6 in Obstetrics & Gynaecology	Covered both the Obs & Gynae bleep from 8am until 1pm on a normal working day post bank holiday.	It was agreed that in future, discussions would need to take place regarding standing elective activity down.	Exception Report closed
28 May 2024	ST6 in Obstetrics & Gynaecology	Covered both the Obs & Gynae bleep from 8am until 1pm on a normal working day post bank holiday.	It was agreed that in future, discussions would need to take place regarding standing elective activity down.	Exception Report closed
10 Jun 2024	ST6 in Anaesthetics	No Tier 2 ICU shift covered (one less member of staff for on call team).	Workload shared amongst the team, support provided by the on call consultant.	Exception Report closed

Table 1. Immediate Safety Concern Concerns Raised.

Figure 4. Comparison of number of exception reports submitted by grade for the same quarter between 2022, 2023 and 2024.

Figure 4 shows that for this period this year there have been less exception reports from the Foundation Doctors but more from the ST1/ST2 and ST3+ doctors than in the previous years. The Guardian of Safe Working is keen to encourage doctors at St3+ to exception report.

Work Schedule Reviews

There have been no work schedule reviews during this period.

Fines

There have been no fines.

Vacancies

The Trust currently has 252 resident doctors allocated by NHSE. As mentioned in the introduction, there are 26 vacancies where the Trust has not been allocated resident doctors by NHSE, the reasons for these posts not being filled were also mentioned in the introduction, 6 of the vacancies are currently filled by trust grade doctors. Clinical Fellow recruitment is ongoing with the aim of filling as many training vacancies as possible particularly in Medicine, Urgent & Emergency Care and some specialties within Surgery, Anaesthetics and Critical Care.

The remaining gaps will be filled by doctors on the bank where needed to support the rotas, which represents a cost pressure to the Trust.

The process of recruiting Clinical Fellows for August is complete with the doctors now working through their supernumerary periods.

Qualitative information

Table 3 below indicates the number and percentage of exception reports that were not responded to within the required time frame of 7 days over the last year. This number is high and is an ongoing theme, however, with the intervention of the Guardian of Safe Working and the Medical Workforce team there has been an improvement.

Date of the Guardian Report	Number and Percentage of reports <u>not</u> responded to within 7 days
May 2024 – July 2024	51% of all reports received. 26 reports
February 2024 – April 2024	67% of all reports received. 18 reports
November 2023 - January 2024	68% of all reports received. 38 reports
August 2023 – October 2023	53% of all reports received. 29 reports

Table 3 Exception reports <u>not</u> responded to within 7 days.

<u>Junior Doctors Mess</u>

Due to a change in building regulations, there has been a delay in the progress of the Doctors Mess. A plan is being produced with the aim of minimising the delay, however, the changes to install the kitchen in the mess will involve some work being required to be undertaken relating to fire compartments and this will need to be reviewed by the building Safety Regulator.

<u>Industrial Action</u>

A period of Industrial Action took place from 7 am on Thursday 27th June until 7am on Tuesday 2nd July 2024, just prior to the election. Talks have since taken place with the current government and an offer made which is an average of 22.3% increase over two years. This offer is currently being put to BMA members; the referendum closes on 15th September 2024.

<u>Visiting Clinical Areas</u>

The Guardian of Safe Working and the Head of Medical Workforce has walked around the wards and other clinical areas within the Trust on a number of occasions over the last three months to talk to doctors about the importance of exception reporting and how the role of Guardian of Safe Working supports the resident doctors.

<u>Survey on Exception Reporting</u>

Prior to the resident doctors leaving the Trust a survey was sent to them asking some questions about exception reporting. Unfortunately, only 26 resident doctors responded to the Survey.

The summary of responses is as follows: -

- 69% did not know who the Guardian of Safe Working is.
- 77% did know the process for Exception Reporting
- 73% have not exception reported during their time with the Trust
- 19% didn't find the process easy to follow when Exception Reporting

- 93% of those that exception reported felt supported to exception report and were satisfied with the outcome of their exception report.

For those doctors that have not exception reported, the main reasons for not doing so were that they didn't know how to exception report, they didn't have time to exception report and they were not aware of the exception reporting process.

Immediate Safety Concerns

Two immediate safety concerns have been received from Obstetrics & Gynaecology, one from Anaesthetics and one from Medicine. These have been acted on and the exception reports closed. No concerns have been raised by doctors in Acute Medicine during this quarter.

Improving Working Lives for Resident Doctors

Work is being undertaken to comply with the request from HSE and further information will be provided in the Medical Update Report for the Trust board in October and the next Guardian of Safe Working quarterly report.

Conclusion

- Note that the largest number of exception reports have been received from the Division of Medicine, closely followed by the Division of Surgery, Anaesthetics and Critical Care.
- Most Exception reports are being received from St1 doctors.
- The number of exception reports being received from St3+ doctors has increased considerably from the last report.
- Progress relating to the new doctor's mess has been delayed due to recent changes to building regulations.
- A survey has been sent to the resident doctors on Exception Reporting and although the response rate was poor, it has identified several areas of focus for August onwards.
- The Guardian of Safe Working is continuing to walk around clinical areas to meet resident doctors.

Appendix 1

Issues/Actions arising from the Guardian of Safe Working Report to be taken forward.

Action/Issue	**Action Taken (to be taken)**	**Date of completion**
Doctors Mess has been delayed due to building regulation changes.	Task and Finish Group in place involving key stakeholders to support this project.	On going
Raise the profile of the Guardian of Safe Working and the process of exception reporting with the new cohort of resident doctors.	Visits to clinical areas to continue and information to be sent to the resident doctors about how to report exceptions on a regular basis in different formats. Action taken following review of exception reports also to be communicated to the resident doctors. The reporting structure for Resident Doctors Forums is also to be reviewed.	On going

Outstanding Care, Compassionate People, Healthier Communities

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors - Cover Sheet

Subject:	NHS England Investigation & Intervention Process	**Date:**	5th September 2024
Prepared By:	Richard Mills, Chief Financial Officer		
Approved By:	Dave Selwyn, Acting Chief Executive		
Presented By:	Richard Mills, Chief Financial Officer		

Purpose		
To update the Board of Directors on the NHS England initiated Investigation and Intervention (I&I) process.	**Approval**	
	Assurance	
	Update	**X**
	Consider	

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

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

Executive Team
Finance Committee

Acronyms

- NHSE – NHS England
- I&I – Investigation & Intervention
- ICB – Integrated Care Board
- ICS – Integrated Care System
- SFH – Sherwood Forest Hospitals NHSFT
- FY24/25 – Financial Year 2024/25
- KPIs – Key Performance Indicators
- EQIA – Equality & Quality Impact Assessment
- CIP – Cost Improvement Programme
- RAG – Red/Amber/Green (Risk Ratings)

Executive Summary

In July 2024 NHS England introduced the Investigation and Intervention (I&I) process, with the intent to undertake rapid reviews for those systems where there are concerns regarding the delivery of financial plans. The Nottingham & Nottinghamshire ICS was identified as one of nine systems that were selected for the first wave of this process.

The process is made up of two stages, described below.

Phase 1 – Investigation:

- A four-week rapid assessment of key areas of opportunity to rapidly improve the in-year (FY24/25) run rate of the system, undertaken by a chosen supplier.

- Includes an assessment of governance frameworks that sit across cost improvement and efficiency programmes as well as grip & control processes.

- Builds upon existing reviews or diagnostic intelligence (available to the trusts or ICB, or to NHSE), placing reliance on existing/previous work where this is time relevant and credible.

- The Supplier will be report to an NHSE nominated leader who will oversee and challenge both the work delivered, and the system itself in the delivery of their financial plan.

- The outcome is expected to be a short report containing 4-6 key interventions to be implemented across the system, and a proposed resource profile to design, develop and implement the interventions.

Phase 2 – Intervention:

- A twelve-week process to support the system in designing, developing and implementing the interventions identified in Phase 1, following agreement with the ICB.

- The interventions from Phase 1 will be focused on the areas specific to the system and will be designed and developed in a consistent manner that will include KPIs, EQIAs and a handover plan.

- The supplier will support the system to implement each of the interventions, and support handover so that upon departure of the supplier after 12 weeks of intervention support, each intervention will continue to deliver the benefits required.

The Investigation phase has now been completed, with a Phase 1 report shared with the ICS and NHS England. The findings of this report have been discussed at the Trust's Finance Committee, and those most relevant to SFH are briefly summarised below. At the time of writing the approach to the Intervention phase is being finalised and is due to be presented to Chief Executives of ICS partners by 4th September 2024.

Phase 1 Findings (SFH):

1. The adverse risk rating of the current plans is the key reason for the significant gap against the CIP target. Certain material schemes should be de-risked.

2. 28% of the Trust's planned CIP schemes are recurrent and 72% are non-recurrent, as such we are an outlier within our system.

3. It is recognised that under standard circumstances existing CIP resource would have been appropriate, however it is insufficient for a programme of £38.5m.

4. Based on the review of the CIP programme and supporting documentation, some key weaknesses have been identified:

    - In relation to the highest-value schemes, it is recommended that we produce bottom-up plans for high-value, cross-cutting schemes.

    - Whilst the Trust tracker does allow the tracing of cross-cutting schemes back to divisions, it is not always possible to directly track those savings by division back from the tracker to the constituent highlight report.

    - It is recommended that for cross-cutting schemes, reporting is developed to capture savings per division.

- The Trust's internal CIP tracker does not report consistently in terms of the target, unweighted plan, RAG adjusted view and forecast. It is recommended that the tracker be modified to demonstrate all four of these metrics.

5. There is limited bottom-up plan development and overreliance on non-recurrent schemes. In addition, there are proportionally very few transformational and service reconfiguration projects, as well as significant agency reduction schemes. Similar to other organisations within the ICS, there is insufficient cross-system working with regard to system-wide opportunities for benefits realisation, e.g. procurement, harmonisation of bank/agency, digital projects.

The Trust acknowledges the findings of the report and has enacted some immediate changes to address some of the weaknesses identified, particularly in relation to governance processes and supporting documentation.

The Board of Directors are asked to note the update on the NHS England Investigation and Intervention process.

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Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee (FC) Report	**Date:** 5th September 2024	
Prepared By:	Graham Ward – FC Chair		
Approved By:			
Presented By:	Graham Ward – FC Chair		
Purpose:			
To provide an overview of the key discussion items from the Finance Committee meeting of 27th August 2024.		**Assurance**	Significant

Matters of Concern or Key Risks Escalated for Noting / Action	Major Actions Commissioned / Work Underway
• Month 4 Financial Performance and FIP Deep Dive (to NOTE): o £0.94M adverse to plan o Grant Thornton and PA reports reviewed. Highlights areas for improvement on FIP governance and support. o Workforce presentation reviewed and discussed. o Delivered planned FIP, BUT still a huge challenge for full year as requirement ramps up o ERF forecast being prepared to year end (on target year to date, but needs to further improve) • Cash (to NOTE) – Availability of cash continues to be a key issue, with Monthly requests having to be made. Increasing concern on impact and to be further reported to the Committee and Board. • Internal Audit Report on Capital (to NOTE) – Significant Assurance with 3 low risk recommendations. All agreed and in process of being implemented.	• FIP – Continued close focus on the plans and progress tracking on delivery, with particular emphasis on increasing levels of recurrent savings. Workplan to include individual Divisions presenting their progress on delivery of FIP.
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• Electronic Patient Record – Progress noted. • Internal Audit Report on System Financial Controls – follow up report to be reviewed and noted on status of the 37 (of 80) self-assessed controls classed as 'Not complete and in place'. A further 22 controls now implemented.	• Patient Engagement Portal Business Case – recommended for approval by Board. • Theatre Productivity Investment – approved by Finance Committee, subject to NHSE approval. Agreed that regular updates to be tabled at future Committees to monitor improvements and preparedness for hand-over of processes to in-house resources.

	• Nottinghamshire Health Informatics Service Business Case – Approved the renewal of contracts providing access to technical expertise in digital and data analytics. • BAF – PR4 (Financial Sustainability), agreed to maintain risk score at 16, but to monitor closely as FIP plan further developed. PR8 (Sustainable Reductions in Trust's Impact on Climate Change), agreed to maintain risk score at 12 and to review as plans to improve control implemented through to September.
Comments on Effectiveness of the Meeting	
• All papers were of a high quality and clear which helped the meeting run smoothly and promoted good constructive challenge and discussion.	
Items recommended for consideration by other Committees	
• To Audit Committee that the two Internal Audit Reports were thoroughly discussed and implemented of recommendations will be monitored.	

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Partnerships & Communities Committee **Chair's Highlight Report to Board**

Subject:	Partnerships & Communities Committee	**Date:**	5th September 2024
Prepared By:	Barbara Brady, Non- Executive Director, Chair of Committee		
Approved By:	Barbara Brady, Non- Executive Director, Chair of Committee		
Presented By:	Barbara Brady, Non- Executive Director, Chair of Committee		
Purpose:			
Summary of the August Committee meeting		**Assurance**	**Limited**

Matters of Concern or Key Risks Escalated for Noting / Action	**Major Actions Commissioned / Work Underway**
• Insufficient capacity to engage with external partnerships effectively is challenging and requires continual review and re prioritisation. In particular this is the case of the Health inequalities agenda and fragile services. • Ongoing focus on financial situation within SFHT has meant work on partnerships is not prioritised, no change to this in anticipated in the foreseeable future. • Concerns regarding the terms of reference for various partnership forums across our system and place-based arrangements are overlapping causing inefficiencies and confusion e.g. fragile services as part of EMAP, Nottinghamshire Provider Collaborative and ICB	Board Workshop to focus on partnerships Review of controls and gaps for BAF PR6 Risk
Positive Assurances to Provide	**Decisions Made** *(include BAF review outcomes)*
• Work in support of Anchor organisation • Plan for implantation of Making Every Contact Count is progressing • Good alignment continues between ICS and SFHT strategy following recent slight revisions to ICS strategy (this is in the reading room for reference)	Rephrasing of overall risks and individual threats for BAF- PR6. Current risk is now 12. (Consequence 3 and Likelihood 4) Tolerable risk is now 9 (Consequence 3 and Likelihood 3) Target risk is now 6 (Consequence 3 and Likelihood 2)

Comments on effectiveness of the meeting
Good discussion and challenge Limited attendance noted but also that this was an August meeting
Items recommended for consideration by other Committees
Request that Quality Committee provides an update on programme of work around Digital inequalities

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