# MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

**NHS Sherwood Forest Hospitals NHS Foundation Trust**

# AGENDA

**Date:** **Thursday 5th May 2022**
**Time:** **09:00 – 13:00**
**Venue:** **Boardroom, King's Mill Hospital**

|  | Time | Item | Status | Paper |
|---|---|---|---|---|
| 1. | 09:00 | **Welcome** | | |
| 2. | | **Declarations of Interest**<br>To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-**<br>https://www.sfh-tr.nhs.uk/about-us/register-of-interests/<br>*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**<br>*Quoracy check: (s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)* | Agree | Verbal |
| 4. | 09:00 | **Minutes of the meeting held on 7th April 2022**<br>To be agreed as an accurate record | Agree | Enclosure 4 |
| 5. | 09:05 | **Matters Arising/Action Log** | Update | Enclosure 5 |
| 6. | 09:10 | **Chair's Report** | Assurance | Enclosure 6 |
| 7. | 09:15 | **Chief Executive's Report** | Assurance | Enclosure 7 |
|  |  | • **Integrated Care System Update**<br>Report of the Chief Executive | Assurance | Verbal |
|  |  | • **Covid Vaccinations Update**<br>Report of the Director of People | Assurance | Enclosure 7.2 |
|  | **Strategy** | | | |
| 8. | 09:25 | **Reflections on Ockenden**<br>Sarah Seddon, Maternity Parents' Voice Champion | Assurance | Presentation |
| 9. | 09:45 | **Strategic Priority 1 – To provide outstanding care** | | |
|  |  | • **Maternity Update**<br>Report of the Chief Nurse<br><br>    o **Ockenden Report**<br>    o **Safety Champions update**<br>    o **Maternity Perinatal Quality Surveillance Model** | Assurance | Enclosure 9.1 |
|  |  | • **Quality Strategy**<br>Report of the Medical Director / Chief Nurse | Approval | Enclosure 9.2 |

| | Time | Item | Status | Paper |
|---|---|---|---|---|
| 10. | 10:05 | **Strategic Priority 3 – To maximise the potential of our workforce** | | |
| | | • **Staff Survey and Action plan**<br>Report of the Director of Culture and Improvement | Assurance | Enclosure 10.1 |
| | | • **Nursing, Midwifery and Allied Health Professions (AHP) Staffing Annual Report**<br>Report of the Chief Nurse | Assurance | Enclosure 10.2 |
| 11. | 10:40 | **Strategic Priority 4 – To continuously learn and improve** | | |
| | | • **Research Strategy – Annual Report**<br>Report of Head of Research & Innovation | Assurance | Enclosure 11.1 |
| 12. | 10:55 | **DEFERRED**<br>**Strategic Priority 5 – To achieve better value** | | |
| | | • **PBP Full Year update**<br>Report of the Chief Executive Officer | Assurance | Enclosure 12.1 |
| 13. | 11:05 | **Strategic Priorities – Quarter 4**<br>Report of the Director of Culture and Improvement | Assurance | Enclosure 13 |
| | BREAK (10 mins) | | | |
| | **Operational** | | | |
| 14. | 11:30 | **Single Oversight Framework Performance – Quarterly Report**<br>Report of the Executive | Consider | Enclosure 14 |
| | **Governance** | | | |
| 15. | 12:15 | **Fit and Proper Person**<br>Report of the Director of Corporate Affairs | Assurance | Enclosure 15 |
| 16. | 12:20 | **NHSI Self Declaration**<br>Report of the Director of Corporate Affairs | Approval | Enclosure 16 |
| 17. | 12:25 | **Assurance from Sub Committees** | | |
| | | • Audit and Assurance Committee<br>Report of the Committee Chair (last meeting)<br>   o Audit and Assurance Committee Annual Report | Assurance | Enclosure 17.1 |
| | | • Finance Committee<br>Report of the Committee Chair (last meeting)<br>   o Finance Committee Annual Report | Assurance | Enclosure 17.2 |
| | | • Charitable Funds Committee<br>Report of the Committee Chair (last meeting) | Assurance | Enclosure 17.3 |
| | | • Quality Committee Annual Report | Assurance | Enclosure 17.4 |
| | | • People, Culture and Improvement Committee Annual Report | Assurance | Enclosure 17.5 |
| 18. | 12:40 | **Outstanding Service – EPMA - creating a smarter more digital hospital** | Assurance | Presentation |

| | Time | Item | Status | Paper |
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| 19. | 12:50 | **Communications to wider organisation**<br>(Agree Board decisions requiring communication to Trust) | Agree | Verbal |
| 20. | 12:55 | **Any Other Business** | | |
| 21. | 13:00 | **Date of next meeting**<br>The next scheduled meeting of the Board of Directors to be held in public will be<br>**9th June 2022, Boardroom, King's Mill Hospital** | | |
| 22. | | **Chair Declares the Meeting Closed** | | |
| 23. | | **Questions from members of the public present**<br>(Pertaining to items specific to the agenda) | | |
| | | **Resolution to move to the closed session of the meeting**<br>In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve:<br>*"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.

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|---|---|
| **Enc 17.1** | • **Audit and Assurance Committee – previous minutes** |
| **Enc 17.2** | • **Finance Committee – previous minutes** |
| **Enc 17.3** | • **Charitable Funds Committee – previous minutes** |
| **Enc 17.3** | • **Community Involvement Headline Report** |
| **Enc 17.3** | • **Charitable Funds Committee Terms of Reference** |
| **Enc 17.3** | • **Charitable Funds Committee Annual Workplan** |
| **Enc 17.3** | • **Charitable Funds Committee Health Check** |
| **Enc 17.3** | • **Charitable Funds Committee Risk Register** |

**UN-CONFIRMED MINUTES** of a Public meeting of the Board of Directors held at 09:00 on Thursday 7th April 2022 in the Boardroom, King's Mill Hospital and via video conference

| **Present:** | Claire Ward | Chair | CW |
|---|---|---|---|
| | Manjeet Gill | Non-Executive Director | MG |
| | Graham Ward | Non-Executive Director | GW |
| | Neal Gossage | Non-Executive Director | NG |
| | Barbara Brady | Non-Executive Director | BB |
| | Steve Banks | Non-Executive Director | StB |
| | Aly Rashid | Non-Executive Director | AR |
| | Andrew Rose-Britton | Non-Executive Director | ARB |
| | Paul Robinson | Chief Executive | PR |
| | Richard Mills | Chief Financial Officer | RM |
| | Shirley Higginbotham | Director of Corporate Affairs | SH |
| | Julie Hogg | Chief Nurse | JH |
| | David Selwyn | Medical Director | DS |
| | Emma Challans | Director of Culture and Improvement | EC |
| | Simon Barton | Chief Operating Officer | SiB |
| | Clare Teeney | Director of People | CT |
| | Marcus Duffield | Associate Director of Communications | MD |

| **In Attendance:** | Sue Bradshaw | Minutes | |
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| | Danny Hudson | Producer for MS Teams Public Broadcast | DH |
| | Rhian Cope | Matron | RC |

| **Observers:** | Andrew Marshall | Deputy Medical Director |
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| | Richard Brown | Head of Communications |
| | Sue Holmes | Public Governor |
| | Linda Dales | Appointed Governor |
| | Claire Page | 360 Assurance |
| | Andrew Topping | Notts TV |
| | Ian Frankcom | |
| | Raj Purewal | |

| **Apologies:** | Andy Haynes | Specialist Advisor to the Board | AH |
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**The meeting was held in the Boardroom, King's Mill Hospital and via video conference. All participants confirmed they were able to hear each other and were present throughout the meeting, except where indicated**

| Item No. | Item | Action | Date |
|---|---|---|---|
| **18/355** | **WELCOME** | | |
| 1 min | The meeting being quorate, CW declared the meeting open at 09:00 and confirmed that the meeting had been convened in accordance with the Trust's Constitution and Standing Orders.<br><br>Noting that due to the circumstances regarding Covid-19 and social distancing compliance, the meeting was held in person, via video conferencing 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. All participants confirmed they were able to hear each other. | | |
| **18/356** | **DECLARATIONS OF INTEREST** | | |
| 1 min | There were no declarations of interest pertaining to any items on the agenda. | | |
| **18/357** | **APOLOGIES FOR ABSENCE** | | |
| 1 min | Apologies for absence were received from Andy Haynes, Specialist Advisor to the Board. | | |
| **18/358** | **MINUTES OF THE PREVIOUS MEETING** | | |
| 1 min | Following a review of the minutes of the Board of Directors in Public held on 3rd March 2022, the Board of Directors APPROVED the minutes as a true and accurate record. | | |
| **18/359** | **MATTERS ARISING/ACTION LOG** | | |
| 1 min | The Board of Directors AGREED that action 18/331 was complete and could be removed from the action tracker. | | |
| **18/360** | **CHAIR'S REPORT** | | |
| 2 mins | CW presented the report, which provided an update regarding some of the most noteworthy events and items over the past month from the Chair's perspective, highlighting the governor elections. CW advised she continues to undertake walk arounds in order to engage with staff.<br><br>CW welcomed Andrew Rose-Britton, Non-Executive Director (NED), to his first Board of Directors meeting, advising he will replace Neal Gossage who leaves the Trust at the end of April 2022. Thanks were expressed to Neal for his work during his time with the Trust.<br><br>The Board of Directors were ASSURED by the report | | |
| **18/361** | **CHIEF EXECUTIVE'S REPORT** | | |
| 3 mins | PR presented the report, highlighting the Staff Survey results and the publication of the Ockenden Report. | | |

PR advised the Trust's urgent care services have been under sustained pressure for the last 2-3 weeks and expressed thanks to staff for their work. PR advised Clare Teeney, Director of People, will be leaving the Trust at the end of May 2022 to take up the post of Director of People for University Hospitals of Leicester. Phil Bolton will be joining the Trust at the end of May 2022 as Chief Nurse.

The Board of Directors were ASSURED by the report

**7 mins**

**Integrated Care System (ICS) Update**

PR presented the report, advising this provides an update on progress to establish the Provider Collaborative across Nottinghamshire, noting it is a statutory requirement to form a Provider Collaborative from 1st July 2022. It was noted Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust are included as Bassetlaw will move into the Nottinghamshire Integrated Care Partnership as of 1st July 2022. PR advised two NED engagement events have been held and highlighted the proposed governance arrangements.

StB queried if NED oversight will be through the Trust's Board of Directors or if NED input is required at other governance meetings. PR advised the NED events will continue over the summer. Initially the governance will be through the Trust's Board of Directors and through a partnership agreement which will provide the scope and extent of delegated responsibilities into the collaborative. However, this will be organic in terms of the extent to which this will be held in the Provider Collaborative. There will be full Board and NED input into those decisions. CW noted more thought will need to be given as to how the governors hold the NEDs of each organisation to account.

ARB queried if there is likely to be any slippage to the 1st July 2022 date. PR advised any slippage will not be in the establishment of the Provider Collaborative, as the governance will be in place, but there may be some slippage in the way the collaborative 'hits the ground running' and makes a meaningful impact.

BB noted Bassetlaw is not showing on the structure chart and queried if this is due to the fact they do not formally join until 1st July 2022. PR confirmed this was correct.

BB noted the Place Based Partnership (PBP) currently has an independent chair and sought clarification how this role will fit in with the Provider Collaborative. PR advised conversations are ongoing between the PBP and Lead Officer / Chief Executive Designate for the Integrated Care Board (ICB). PBP has delegated responsibility for the ICB as it will be established on 1st July 2022. This is distinct from the Provider Collaborative which is a collective partnership between providers which does not have the delegated responsibility.

The Board of Directors were ASSURED by the report

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| **12 mins** | **COVID-19 Vaccination Update**<br><br>CT presented the report, advising over 200k vaccines have been administered through the Hospital Hub.  Plans are being shaped up to deliver anticipated further boosters in Autumn 2022.  The Hospital Hub is in the process of being permanently relocated to take it out of the Education Centre.<br><br>BB noted the report does not contain a breakdown of staff uptake of the vaccination by division and staff group.  CT apologised for this oversight and provided assurance this would be included in future reports.<br><br>BB felt it would be useful for reports in the Autumn to also show uptake of the flu vaccination.<br><br>**Action**<br><br>• **Covid vaccination reports to show uptake of the flu vaccination when the flu vaccination campaign starts for 2022/2023**<br><br>DS advised there has been a cluster of flu Type A cases coming into the Trust and this is replicated across the system.  There is a need to maintain a forensic focus on flu vaccinations and there may be a slight skewing of the flu season.<br><br>StB noted uptake of the flu vaccine across all trusts was considerably less in 2021/2022 than previous years.  However, it is assuring to note SFHFT had the highest uptake.  CT advised formal planning for the 2022/2023 flu season will commence in June 2022.<br><br>AR noted just over 3,000 doses of vaccine have been wasted and queried if the amount of wastage is reducing.  CT advised wastage fluctuates and is dependent on the reason for wastage.  There was some early wastage due to a batch falling off a shelf in the storage area.  Sometimes wastage is as a consequence of how the vaccine is supplied as if it is already thawed, this will impact on the Trust's ability to use it in a timely way.  As much as possible is done to manage waste and contingencies are in place.  The Trust has supported reducing waste across the system by moving the vaccine around and deploying staff to different areas to administer the vaccine.<br><br>AR queried if 5-11 year olds are being vaccinated at the Hospital Hub.  CT advised vaccination for 5-11 year olds is via a variety of deliveries, i.e. vaccination centres, primary care centres and the Hospital Hub.  The Trust has put staff in place to support particular groups of citizens, for example, children with learning disabilities.<br><br>CW queried if any data is available as to why some individuals are only just coming forward for their first dose of the vaccine. | | |
| | | **CT** | **06/10/22** |

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| | CT advised the data is available but this has not been analysed in detail.  The Trust is having some difficulty in terms of the detail for staff as the organisation has not been given access to National Immunisation Management System (NIMS) records.  Early in the process SFHFT had access to immunisation records and were able to correlate the information to the staff record.  There are a small number of people who have been eligible for a while and are only just coming forward for the vaccine.  There was a good uptake of staff wanting the vaccine early in the programme.<br><br>SiB noted there is currently a very high prevalence of Covid within the population and queried if this will impact on vaccination uptake, either due to the waiting time between having Covid and receiving the vaccine or people thinking they do not need the vaccine as they have had Covid.<br><br>CT confirmed there has to be a delay between a person having Covid and receiving the vaccination and this will impact on the programme.  There is a need to remain agile in terms of preparations, responses, how to deal with the administration of the vaccine and the changing thoughts of the public about having the vaccine.  There is a need to continue to promote the Hospital Hub and vaccine availability and encourage people to have the vaccine as they are eligible.  The Trust works flexibly with people to ensure they can access the vaccine and have supportive and proactive conversations.  Information on uptake is tracked.<br><br>The Board of Directors were ASSURED by the report | | |
| **18/362** | **STRATEGIC PRIORITY 1 – TO PROVIDE OUTSTANDING CARE** | | |
| 23 mins | **Maternity Update**<br><br>***Safety Champions update***<br><br>JH presented the report, highlighting the appointment of a service user representative and a deputy head of midwifery, safety walk arounds, recruitment and retention lead midwife role and the quality improvement programme.  JH advised a concern was raised on a walk around in relation to women attending multiple appointments.  The text messaging service is unable to cope with sending the scan appointment and the antenatal clinic appointment via text message, leading to some confusion.  The team are currently investigating this.<br><br>MG noted the retention lead midwife role.  Given retention is a key element of the workforce, MG queried if there is any learning which can be applied from this role to other nursing professions.  JH advised if nursing and midwifery staff stay at SFHFT for two years, they are likely to remain for a long time.  Therefore, it is important to 'get it right' in the first two years, otherwise staff will leave.  The main things are to meet fundamental needs, for example, approving annual leave in a timely manner, competencies to be signed off in a timely manner and rosters to meet work / life balance to be received six weeks in advance.  Many of these areas are replicated across nursing, although there is no role looking at this in nursing as external funding was provided for the role in midwifery. | | |

Similar work is underway for Allied Health Professionals (AHPs) as external funding was sourced for that role.

The Board of Directors were ASSURED by the report

***Maternity Perinatal Quality Surveillance***

JH presented the report, highlighting the Apgar score, Friends and Family Test and core competency framework compliance.

StB noted the Apgar score is generally higher due to the way people are now recording and/or measuring Apgar. However, this is still above the national average. StB sought clarification in relation to this. JH advised Apgar is a very subjective view. It is a midwife's quick head to toe assessment of the baby. There was a case at the Trust where it is believed the Apgar score was overestimated. The Trust revisited the training for assessing Apgar and tried to make it less subjective by taking the approach of agreeing the score with a second midwife. This has led to an increase in the number of babies who have an Apgar score of less than 7. A deep dive looking into this in more detail will be presented to the Maternity Assurance Committee, who will report on to the Quality Committee.

StB noted the Trust is being more cautious and, therefore, it is likely more babies would potentially get extra attention due to a low Apgar score than might have been the case and felt this is a positive, even though it is showing as red. JH confirmed this is correct, advising when the onward outcome is taken into consideration, there is nothing of concern in terms of babies going to the neonatal unit.

NG noted there have been national reports in relation to the ratio of natural births to caesarean sections, with some women claiming their wishes were not taken into account and the decision to deliver by caesarean section was taken too late. NG queried what the ratio of natural births to caesarean sections is at SFHFT and how this compares to the national picture.

JH advised spontaneous vaginal delivery in February was 61%, which is slightly above the national average. Compared to many other organisations, more women are having second and third babies at SFHFT who have had a natural birth previously When considering complaints and themes from incidents, there is no recuring theme from women in relation to not being listened to during their labour. The Trust is strengthening its work in terms of listening to women and their families through the Service User Representative role.

The Board of Directors were ASSURED by the report

***Maternity Continuity of Carer (MCOC)***

JH presented the report, highlighting the safe staffing building blocks and workforce planning actions. JH advised this is a system-wide plan.

BB queried how many women fall into the target population group for this programme.

JH advised the ambition is for the programme to be provided to all women by 2024. If 40% is achieved, the Trust will reach the most vulnerable women.

The Board of Directors were ASSURED by the report

*Kirkup recommendations*

JH presented the report, advising the Trust is rated as Green for all the Kirkup recommendations. This has been through the Local Maternity and Neonatal System (LMNS) and Maternity Assurance Committee.

The Board of Directors were ASSURED by the report

*Ockenden Report update*

JH presented the report, advising there were seven immediate and essential actions in Ockenden 1. The Trust is fully compliant with six of those and is declaring 71% compliance in relation to informed consent. The LMNS and regional team support the Trust's view of compliance.

For Ockenden 2 there are 15 immediate and essential actions, centred around safe staffing, well trained workforce, learning from incidents and listening to families. The Trust is currently reviewing the self-assessment and compliance with these actions and the plan for the next steps will be reported to the Board of Directors in May 2022.

AR noted many of the immediate and essential actions relate to staffing, which is moving in an adverse direction. AR queried if this will impact on safety. JH advised when triangulated with other information there is nothing of concern identified. It was, however, acknowledged the workforce loss in maternity is significant but the Trust is mitigating the risks from a safety perspective. The maternity establishment has been uplifted to align with Birthrate Plus. While it appears to be a worsening position, there are new posts to respond to the forecast birth rate increase.

StB sought clarification in relation to independent and/or peer review of the assessments. JH advised there is external representation on the Trust's Maternity Assurance Committee in the form of the Head of Midwifery from University College London Hospitals, who partner with SFHFT for maternity, LMNS representative and the Service User Representative. The assessment goes on to LMNS for further scrutiny.

StB queried if this was also the process for review of incidents. JH confirmed this was the case, advising incidents which meet certain criteria are reviewed by the Perinatal Mortality Review Tool (PMRT) group which has external representation.

The Board of Directors were ASSURED by the report

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| 8 mins | **Learning from Deaths**<br><br>DS presented the report, highlighting Hospital Standardised Mortality Ratio (HSMR), trends in coding, development of a Structured Judgment Case Review (SJCR) faculty and learning disability related deaths.  DS advised 100% of deaths are scrutinised by the Trust's medical examiner service, who are also providing Learning from Deaths scrutiny of some community deaths.<br><br>The Board of Directors were ASSURED by the report | | |
| 18/363 | **PATIENT STORY – A JOURNEY THROUGH NICU** | | |
| 15 mins | RC joined the meeting<br><br>RC presented the patient story, which highlighted the work of the Neonatal Intensive Care Unit (NICU).<br><br>GW advised he went on a walk around when the twins featured in the story were on NICU.  GW advised he was impressed with how calm and well organised the unit is and was particularly impressed with the concept of the twin cot, which had been purchased through charitable fund donations<br><br>PR expressed thanks to RC and her team for the safe care provided and the person centred culture of the unit.<br><br>EC felt it was a wonderful story, noting the family centred approach shone through.  RC advised funding has been provided by the East Midlands Neonatal Network to purchase three iPads to help make the connection between the unit and home for families, thus helping with sibling relationships.<br><br>JH advised the unit is full of families having a difficult time.  However, all families are positive about the care received.  The unit has recently hosted a milk bank for donor breast milk to support some babies getting breast milk and the unit is aiming for Baby Friendly Initiative (BFI) accreditation.  RC confirmed planning is starting in terms of going for Infant and neonatal accreditation for BFI.<br><br>RC left the meeting | | |
| 18/364 | **SINGLE OVERSIGHT FRAMEWORK (SOF) MONTHLY PERFORMANCE REPORT** | | |
| 40 mins | **PEOPLE AND CULTURE**<br><br>EC highlighted the Staff Survey, mandatory and statutory training and ongoing work to build capacity and capability in the Trust and beyond.<br><br>CT highlighted appraisals and advised sickness absence has remained high, largely as a result of Covid absence in addition to non-Covid related absence.<br><br>ARB sought clarification regarding the target for mandatory training and appraisals. | | |

CT advised this is 95%. The soft metrics are being looked at through the People, Culture and Improvement Committee and some further work is being carried out in relation to this.

**QUALITY CARE**

JH highlighted nosocomial Covid infections and MRSA bacteraemia.

DS highlighted venous thromboembolism (VTE) and cardiac arrests.

CW queried if there is any information to suggest the MRSA cases were linked, for example in the same areas or wards. JH advised there is no commonality in the last two cases but the team is looking at the case from last year to provide further assurance.

AR queried if the electronic prescribing system linked to community pharmacies, which would allow patients to go home quicker and not wait for medication on discharge. DS advised this is not currently the case but it is the desire and aspiration for systems to be linked in the future. This will include acute trusts, primary care and pharmacists. In a perfect world the record would be updated by the hospital, which would update the GP record, the information would be sent to the pharmacy and the medication would be waiting at the patient's home for them when they were discharged. This is still some way off but some of this will happen.

CW queried if pharmacists based in GP surgeries would be able to view the record but this will not necessarily link to community pharmacies. DS advised the Trust can already view GP records and can do drug reconciliation through existing systems, but this needs to be more streamlined. This is a key component of the data strategy for Connected Notts.

**TIMELY CARE**

SiB advised the ED 4 hour was 85%, ranking SFHFT fifth in the NHS. The mean time in ED for an admitted patient was 30 minutes longer than it was in February 2020, but the non-admitted waiting times were the same. 41 patients waited over 12 hours for admission to a bed. It was noted the majority of waiting times are driven by exit block, the root cause of which is the continuing increase in the number of patients who are medically safe for discharge. Despite this, ambulance turnaround times remain good and are the lowest in the East Midland Ambulance Service (EMAS) area.

GW acknowledged the good performance but expressed concern in relation to the increasing number of patients who are medically safe for discharge. SiB advised there are additional beds open to attempt to meet the demand.

SiB advised in terms of cancer, the backlog trajectory continues to be higher than the original plan but is lower than the re-forecast trajectory. Positive results are starting to be seen from the redesign work which was undertaken on the gynae pathway and lower GI pathway. However, there is a demand and capacity imbalance on the cancer pathways, largely in the diagnostic phase. The ICS is leading a piece of work looking at this across the system.

AR noted the increase in 104 day cancer waits and queried which type of cancer are they for and how patients are monitored.

SiB advised every patient waiting over 104 days has a risk assessment completed and are brought forward if they are at risk of a deteriorating outcome. A lot of patients with the longest waits have cancers which are less aggressive and at lower risk tumour sites. The average waiting times are not significantly longer than they were pre-Covid.

BB advised cancer waits have been considered by the Quality Committee. There is a national tool to look at harm in relation to cancer. However, the harm which is difficult to assess is the phycological impact rather than the physical cancer journey.

SiB advised undiagnosed cancer is a greater risk of harm than patients on cancer pathways. GPs are encouraged to refer patients on a 2 week wait and there has been a 30% increase in referrals. This has led to an increased demand and capacity gap, but patients who are at risk from cancer are on the pathway and can be tracked and risk assessed.

AR queried if the increase in referrals is translating to more cancers. SiB advised slightly more cancers are being found.

SiB advised in terms of elective care, activity was 106% in February 2022 compared to February 2020. This is expected to fall during March, mainly due to patient cancellations due to Covid. At the end of March there were six patients waiting over 104 weeks.

AR queried how many patients are on virtual wards and what discussions are ongoing at the ICS in relation to virtual wards. SiB advised there are currently 10 patients on the Covid maternity virtual ward. There are no patients on wider virtual wards as this is not currently a commissioned service and workforce is required to run them. The ICS are developing a model of care around virtual wards which is clinically led. It is anticipated virtual wards will become operational in Q1 of 2022/2023, picking up areas in cardio-respiratory and other areas where patients can be easily monitored.

AR queried what the Trust's ambition is in terms of the number of patients who will be on virtual wards. SiB advised the Trust is not wishing to put a number on this. There is a need to build trust and work with clinicians to get the right people into virtual wards, as this needs to be patients coming out of bedded care. Case studies will be circulated, both good and where things could have worked better. Initially capacity will be 25-30 patients.

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| | CW queried if there is any indication of other trusts across the region using virtual wards more than SFHFT. SiB advised this is not the case for non-Covid patients. Virtual wards present lots of opportunities and over the next year they will become a substantial part of how the Trust works, but it does require workforce.<br><br>DS advised there is a regional and national push about the use of virtual wards. However, this is not currently commissioned or funded and there are workforce issues. Virtual wards need to be grown in a careful way and there is a need to be clear on governance and care of patients.<br><br>**BEST VALUE CARE**<br><br>RM outlined the Trust's financial position at the end of Month 11.<br><br>EC provided an update on the Trust's Financial Improvement Programme (FIP) at the end of Month 11.<br><br>The Board of Directors CONSIDERED the report | | |
| **18/365** | **APPLICATION OF THE TRUST SEAL** | | |
| 1 min | SH presented the report, advising in accordance with Standing Order 10 and the Scheme of Delegation, which delegates authority for application of the Trust Seal to the directors, the Trust Seal was applied to the following documents:<br><br>• Seal number 98 was affixed to a document on 25th February 2022 for Central Nottinghamshire Hospital PLC. The document was a Deed of Variation for waste market testing 2021.<br>• Seal number 99 was affixed to a document on 25th February 2022 for Cadent Gas Limited. The document was the lease of the gas governor site at King's Mill Hospital.<br><br>The Board of Directors APPROVED the Use of the Trust Seal numbers 98 and 99 | | |
| **18/366** | **STANDING FINANCIAL INSTRUCTIONS (SFIS) AND SCHEME OF DELEGATION** | | |
| 3 mins | RM presented the report advising the Standing Financial Instructions (SFIs) and Scheme of Delegation have been reviewed. There are three changes proposed to the Scheme of Delegation which have been reviewed and agreed by the Audit and Assurance Committee. There are no changes proposed to the SFIs.<br><br>DS noted some minor changes are required as the report references Divisional Clinical Directors, but this term is no longer used. In addition, complaints sit under the Chief Nurse, not the Medical Director. DS advised he would detail these amends and send them to RM.<br><br>**Action**<br><br>• **Details of minor amends identified to Scheme of Delegation to be sent to RM for updating** | **DS** | **05/05/22** |

| | The Board of Directors APPROVED the Standing Financial Instructions (SFIs) and Standing Orders and Scheme of Delegation subject to the minor amends to job titles being made | | |
|---|---|---|---|
| **18/367** | **ANNUAL SIGN OFF OF DECLARATIONS OF INTEREST** | | |
| 2 mins | SH presented the report, advising Declaration of Interests is an annual requirement and the report reflects the work done during 2021/2022. The conflicts of interest register will be published on the Trust website and will include details of people who have registered an interest, people who have made nil declarations and details of people who are non-compliant. <br><br>For 2021/2022 40 people are non-compliant, of 959 staff who are required to declare an interest. <br><br>GW advised more rigour will need to be applied to the wording of declarations, bearing in mind this is published on the Trust's website. <br><br>The Board of Directors APPROVED the annual Declarations of Interest report | | |
| **18/368** | **GENDER PAY GAP REPORT** | | |
| 5 mins | CT presented the report, advising the Trust is required to publish gender pay gap information annually.  The report has previously been presented to the People, Culture and Improvement Committee. <br><br>The gender pay gap has increased noting a higher proportion of men are employed in the higher pay bands.  The report details the actions being taken to explore this further.  In addition, the report provides information on bonus pay in the form of the Clinical Excellence Award (CEA) paid to medical staff. <br><br>JH advised a concern had been raised with her in relation to the CEA allocation, noting it is a national mechanism but it does adversely affect younger and female consultants.  JH queried if the mechanism would be different for this year.  CT advised this is a difficult issue and is tied up in national discussions.  Prior to the pandemic work was undertaken through NHS Employers to look at how CEAs could and should be awarded into the future.  The Trust is still working with national guidance, which is yet to be received for the coming year.  Last year was an interim mechanism. <br><br>DS advised it is likely the CEA process will significantly change and there will be more local latitude in ability to spread this more evenly.  CT advised the only caveat is these conversations have been happening for a number of years. <br><br>The Board of Directors APPROVED the Gender pay gap report | | |

| 18/369 | **WELL LED REVIEW ACTIONS** | | |
|---|---|---|---|
| 2 mins | SH presented the report, advising it details the actions from the recent external well-led review. There are eight key lines of enquiry. 15 recommendations were identified. There were no high-level recommendations, three medium level recommendations and 12 low level recommendations. The report details each of these, the actions being taken, the executive lead and the timeline for completion.<br><br>The Board of Directors were ASSURED by the report and APPROVED it for publication on the Trust's website. | | |
| 18/370 | **ASSURANCE FROM SUB COMMITTEES** | | |
| 10 mins | **Audit and Assurance Committee**<br><br>GW presented the report, highlighting counter fraud, internal audit implementation rate for recommendations and external audit plan.<br><br>**Finance Committee**<br><br>NG presented the report, highlighting Month 11 performance and forecast, 2022/2023 planning and the Transformation and Efficiency Programme.<br><br>**Quality Committee**<br><br>BB presented the report, highlighting HSMR, maternity, cardiac arrest rate deep dive, Mental Health Strategy, Board Assurance Framework (BAF) risk ratings and approval of CQC 'Should Do' recommendation.<br><br>**People, Culture and Improvement Committee**<br><br>MG presented the report, highlighting Staff Survey, cultural insights, workforce planning, People, Culture and Improvement Strategy and BAF risk ratings.<br><br>The Board of Directors were ASSURED by the reports | | |
| 18/371 | **OUTSTANDING SERVICE – IMPROVING PAEDIATRIC SURGICAL PATHWAYS** | | |
| 4 mins | A short video was played highlighting improvements to the Trust's paediatric surgical pathways and the work of Ward 25. | | |
| 18/372 | **COMMUNICATIONS TO WIDER ORGANISATION** | | |
| 2 min | The Board of Directors AGREED the following items would be distributed to the wider organisation:<br><br>• Acknowledge high level of pressure the organisation and colleagues have been under<br>• Staff Survey<br>• Ockenden report and safety of the Trust's maternity services<br>• Learning from Deaths<br>• Patient Story<br>• Outstanding Service | | |

| 18/373 | ANY OTHER BUSINESS | | |
|---|---|---|---|
| **6 min** | **Board reflections** CW sought the Board of Director's views on the morning's deliberations. The following points were raised: <br><br>• Pleased to have a mainly face to face meeting, which has helped the discussions <br>• Important discussions <br>• Right level of detail and assurance in the reports <br>• Discussions have been very patient and care focussed <br>• High level of quality and depth of assurance <br>• If a report has previously been presented to a Sub Committee, it would be useful for the Chair of the Committee to add to the assurance provided <br>• Need to improve the executive summary section of some reports <br>• Important not to repeat the same level of detail in the report to Board if it has previously been presented to a Sub Committee <br>• Very good discussions <br>• Executives and NEDs work well together <br>• Right level of challenge | | |
| 18/374 | DATE AND TIME OF NEXT MEETING | | |
| | It was CONFIRMED the next Board of Directors meeting in Public would be held on 5th May 2022 in Lecture Theatre 2 at King's Mill Hospital at 09:00. There being no further business the Chair declared the meeting closed at 11:40 | | |
| 18/375 | CHAIR DECLARED THE MEETING CLOSED | | |
| | Signed by the Chair as a true record of the meeting, subject to any amendments duly minuted. Claire Ward **Chair**            **Date** | | |

| 18/376 | **QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT** | | |
|---|---|---|---|
| | No questions were raised. | | |
| 18/377 | **BOARD OF DIRECTOR'S RESOLUTION** | | |
| 1 min | **EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting**<br><br>In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve:<br><br>"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."<br><br>Directors AGREED the Board of Director's Resolution. | | |

**PUBLIC BOARD ACTION TRACKER**

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

| Item No | Date | Action | Committee | Sub Committee | Deadline | Exec Lead | Action Lead | Progress | Rag Rating |
|---------|------|--------|-----------|---------------|----------|-----------|-------------|----------|------------|
| 18/195.1 | 04/11/2021 | Vacancy rate to be quoted as the number of people, rather than percentage point increases in future Nursing, Midwifery and Allied Health Professions (AHP) Staffing reports | Public Board of Directors | None | 05/05/2022 | J Hogg | | Included in report **Complete** | Green |
| 18/195.2 | 04/11/2021 | Consider including medical workforce in future Nursing, Midwifery and Allied Health Professions (AHP) Staffing 6 monthly reports | Public Board of Directors | None | 05/05/2022 | D Selwyn / J Hogg | | Included in report **Complete** | Green |
| 18/334 | 03/03/2022 | Consider how plans can be put in place, which can be stepped up when there is a surge, to assist with falls prevention | Public Board of Directors | Quality Committee | 09/06/2022 | J Hogg | | **Update 15th March 2022** To be reviewed by the Quality Committee in May | Grey |
| 18/361 | 07/04/2022 | Covid vaccination reports to show uptake of the flu vaccination when the flu vaccination campaign starts for 2022/2023 | Public Board of Directors | None | 06/10/2022 | C Teeney | | | Grey |
| 18/366 | 07/04/2022 | Details of minor amends identified to Scheme of Delegation to be sent to RM for updating | Public Board of Directors | None | 01/05/1985 | D Selwyn | | **Complete** | Green |

**Board of Directors Meeting in Public - Cover Sheet**

| Subject: | Chair's Report | 5 May 2022 | |
|---|---|---|---|
| **Prepared By:** | Marcus Duffield, Associate Director of Communications | | |
| **Approved By:** | Claire Ward, Chair, Marcus Duffield | | |
| **Presented By:** | Claire Ward, Chair | | |
| **Purpose** | | | |
| To update on key events and information from the last month. | **Approval** | | |
| | **Assurance** | **X** | |
| | **Update** | | |
| | **Consider** | | |

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

| **Overall Level of Assurance** | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | | X | |

| **Risks/Issues** | |
|---|---|
| **Financial** | |
| **Patient Impact** | |
| **Staff Impact** | |
| **Services** | |
| **Reputational** | |
| **Committees/groups where this item has been presented before** | |
| N/a | |

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

The past few weeks and months have been extremely challenging for our hospitals (and the NHS as a whole) and I would like to acknowledge the remarkable and continuing dedication, commitment and compassion demonstrated by colleagues across Sherwood Forest Hospitals.

Attendances for urgent and emergency care have been high and we have faced challenges discharging medically fit patients (those who no longer need the level of care delivered in an acute hospital).

Teams across the Trust have coped admirably to give the best treatment to patients and, on behalf of the Board of Directors, I would like to express our thanks to them.

**Welcome to our new Governors**

I am delighted to officially welcome our newly elected governors to Sherwood Forest Hospitals.

We have two new staff governors, to cover our King's Mill and Mansfield Community sites, four public governors for the Mansfield area and two for Ashfield.

Staff governors:

- Vikram Desai, Staff Governor for King's Mill and Mansfield Community Hospitals
- Justin Wyatt, Staff Governor for King's Mill and Mansfield Community Hospitals

Public governors:

- Janice Bramley, Public Governor for Mansfield
- Michael Longdon, Public Governor for Mansfield
- Ruth Scott, Public Governor for Mansfield
- John Howard Wood, Public Governor for Mansfield
- Liz Barret, Public Governor for Ashfield
- Jane Stubbings, Public Governor for Ashfield.

Our governors are here to represent the interests of staff and our membership, holding the Non-Executive Directors to account for the performance of the Trust Board. They bring valuable perspectives and play an important role holding the Trust accountable for the services it provides, as well as helping it deliver quality care to local communities.

More than 1,600 votes were cast during the election from our membership of 22,834.

**System-wide meetings and engagement**

We watch with interest as the legislation to enable the transfer of responsibilities to the Integrated Care System makes its journey through Parliament.

We continue to work within the Nottingham and Nottinghamshire system to develop our collaboration with system partners that can help to achieve the aims of improved patient health and reduce health inequalities.

Each month I take part in meetings with our partners across the system including leaders from Nottingham University Hospitals and Notts Healthcare.

**Trust welcomes international recruitment lead**

We welcomed the NHS's Deputy Chief Nursing Officer and national lead for international nurse recruitment, Duncan Burton, to celebrate our international recruitment efforts.

Duncan heard how we have successfully recruited more than 100 international colleagues, with more than 20 more waiting to be trained. During the visit, he met some of our international registered nurses and midwives before visiting our Same Day Emergency Care Unit (SDEC), RSU (Respiratory Assessment Unit) and Maternity.

He thanked colleagues for showcasing initiatives to improve patient care and our strong international recruitment programme.

He also awarded silver Chief Nurse Awards to Ardaine Ramos, a Trainee Advanced Clinical Practitioner in our Emergency Department; Clinical Governance Lead Nurse Kay Orgill; and Practice Development Matron Emma Bartle.

Well done to all three and thank you to everyone who helped make Duncan feel so welcome.

**Sherwood Forest announces new Director of Strategy and Partnerships**

Please join me in welcoming David Ainsworth to Sherwood Forest Hospitals as our new Director of Strategy and Partnerships.

Currently Locality Director for the Mid-Nottinghamshire Clinical Commissioning Group, David is joining #TeamSFH as we prepare for the new Nottingham and Mid-Nottinghamshire Integrated Care Partnership (ICP), which will support closer working between health and social care partners and our communities from July.

David will be a familiar face to many already as he is currently one of our appointed governors, and his work in primary care and with other partner organisations will be invaluable as the ICP develops new ways of working to improve patient care and the health of everyone we serve.

**New Chief Pharmacist**

I was delighted to take part in the selection process for our new Chief Pharmacist. We have been fortunate to harness some of our existing talent with the appointment of Mo Rahman to the role. Mo is currently our Assistant Chief Pharmacist and will be stepping up before the summer to lead the development of our pharmacy services with a vision to improve how we deliver care to patients.

**Easter donations throughout the Trust**

It was heart-warming to hear how pupils at Forest Glade Primary School in Sutton-in-Ashfield were donating Easter eggs to the maternity ward at King's Mill Hospital for staff to hand out to the siblings of new babies born over the Easter weekend.

The children decided to make the donations as part of a siblings project at the school.

We also received Easter eggs and toys from Mansfield Road Runners, who made their annual journey from the John Cockle Pub in Sutton-in-Ashfield to King's Mill Hospital. The club also donated £6,000 to the Trust, which is to be split between the neonatal and children's wards.

Members of Trent Vineyard Church showed their appreciation for the NHS with the donation of 139 eggs for staff.

Other Easter donations were received from: D Gyms, Nikita Wilson, Woods of Westgate, Mansfield Innovation Centre, the Old Ship Inn, Nottingham Building Society, Soul Takers Motorcycle Club, Widecombe Fair Pub, and the Food Warehouse

**Supporting national Administrative Professionals Day**

During April we celebrated and recognised the hard work and dedication of our administrative colleagues.

Coinciding with World Administrative Professionals Day on Wednesday April 27, colleagues were invited to take part in events through the week to support, develop and connect colleagues across the organisation, including nominating for the #TeamSFH Proud2bAdmin 2022 Awards.

Congratulations to:

- Georgie Schofield, Business Administration Apprentice of the Year

- Jayshree Wagstaff, Most Helpful Admin

- Paula Wilkinson, Admin Star of the Year

- The Corporate Secretariat, Admin Team of the Year

- Beth Hall, Best Newcomer to a Team

- Jill Murphy, Lifetime Achievement Award.

Well done to the winners and everyone who was nominated.

## Charity and volunteer activity

I was delighted to hear about the amazing work of Angela McCreadie and Wendy Broughton, who have been fund-raising since 2010 to support breast and urology services.

An amazing £102,000 has been donated, enabling us to enrich patient experience in these two specialties. Money is raised at an annual Breast and Balls event.

Thank you to Angela and Wendy and their supporters for their commitment to fund-raising for #TeamSFH.

## Consultant appointments

I'd like to formally welcome Khalid Khan, a locum Consultant in Trauma and Orthopaedics, who has been appointed substantively, and Aveek Mitra, who was a Post CCT Senior Trauma Fellow at Gloucester.

| Subject: | Chief Executive's Report | Date: 5th May 2022 | |
|---|---|---|---|
| Prepared By: | Marcus Duffield, Associate Director of Communications | | |
| Approved By: | Paul Robinson, Chief Executive; Marcus Duffield | | |
| Presented By: | Paul Robinson, Chief Executive | | |

| Purpose | | | |
|---|---|---|---|
| To update on key events and information from the last month | **Approval** | | |
| | **Assurance** | | X |
| | **Update** | | |
| | **Consider** | | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | | X | |

| Risks/Issues | |
|---|---|
| **Financial** | |
| **Patient Impact** | |
| **Staff Impact** | |
| **Services** | |
| **Reputational** | |

| Committees/groups where this item has been presented before |
|---|
| **N/A** |

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

**High demand for services**

Demand on our services remains high even though the winter period, when we would expect to be busier than usual, has now ended.

High attendances to Urgent and Emergency Care, the number of patients who were having to wait to be admitted to our wards and difficulties discharging medically-fit patients prompted us to declare a critical incident on April 12.

The response from teams across all our sites was remarkable and made a significant difference to our flow and available capacity and our position had improved enough to close the incident by April 14.

Urgent actions included:

- Pausing a small number of non-urgent operations where this frees up a bed for another patient
- Stepping down non-essential activity to free up colleagues to work in in-patient areas
- Working to set up a further facility, Sherwood Forest Community Unit, to create extra capacity for medically fit patients
- Providing a tracking service to allow additional opportunities offered by virtual ward or allowing diagnostic tests to happen rapidly, despite patient discharge
- Ensuring daily Executive oversight of medically fit patients for discharge.

I would like to thank every member of #TeamSFH for the way they rose to the challenges we faced throughout April and for their continuing hard work and dedication to delivering the best care and services to our patients and their families.

**Covid-19 update**

Covid-19 remains with us. Although continuing to decline (more details will be given elsewhere in this meeting), Covid-positive patients continue to be admitted and staff absence remains higher than we would expect due to high rates in the community.

We have, however, been able to further ease visiting restrictions across all our sites and full details are on the Sherwood Forest Hospitals website page For Patients and Visitors.

Face coverings must continue to be worn in all healthcare settings, unless patients are exempt. Patients and visitors are asked not to attend if they have Covid-19 symptoms.

Meanwhile our Vaccination Hub at King's Mill has moved to a more permanent home in the block known as TB3 after taking over the Conference Centre at the start of the roll-out programme.

This means our Occupational Health team has moved to Byron House and the Training, Education and Development team can finally return to their permanent home. Thanks to all for showing patience and understanding in these sometimes challenging circumstances.

**EPMA goes live**

Following a successful pilot scheme on Woodland Ward at King's Mill, I am delighted to report that our patients have started to get their medicines prescribed electronically in a major step towards full digitisation and more effective, efficient and safer care.

The full roll-out of our Electronic Prescribing and Medicines Administration (EPMA) system began at Newark Hospital's Sconce Ward and continued with the Medicine Division at King's Mill.

This is an exciting development and an important step in our journey to a smarter more electronic hospital and full digitisation. It will allow us to review medication remotely, communicate more easily between departments and allow us to analyse prescribing trends and increase sharing of data between different disciplines.

**Free staff parking extended until the autumn**

Financial support from the Government allowing us to provide free on-site parking for colleagues ended on April 1.

Free staff parking was one of the measures introduced early in the Covid-19 pandemic, recognising the contribution and sacrifices NHS workers were making in unprecedented and challenging circumstances.

It was, however, always a temporary measure and two years on, central funding has now ended.

Discussing this with my fellow directors, it did not feel right to re-introduce charges at such short notice and we decided that free parking will continue and will be reviewed in the autumn.

Eventually, however, we will need to bring back charges and I am committed to working with staff to make sure we offer the best service and value.

Government guidance suggests we prioritise those in greatest need – patients and visitors, as well as colleagues. This means free parking is likely to remain for the disabled, frequent visitors (such as patients with long-term and serious conditions) and staff working night shifts.

Over the next few months, we have the chance to informally seek views of our staff and collect ideas about how we might reintroduce charges as equitably as possible. I can't guarantee we will please everyone and ultimately many of us will need to resume paying if we are to continue driving to work but this gives us an opportunity to talk about the fairest ways it might be done.

**Risk ratings reviewed**

There have been no changes to the Risk Committee's ratings for Principal Risk 6 (Working more closely with local health and care partners does not fully deliver the required benefits), Principal Risk 7 (A major disruptive incident). and Principal Risk 8 (Failure to deliver sustainable reductions in the Trust's impact on climate change).

| Sherwood Forest Hospitals (SFH) 2019-2025 Strategic Objectives | Over the next five years we will..... | Ref | Second Half of the Year (H2) Priorities (October 21 - March 22) | Executive Lead | SFH Governance | Integrated Care System (ICS): H2 Priorities Plan: Recovery, Transformation, Financial, Workforce | ICS Governance | National Guidance | Measures of Success | Q4 Update |
|---|---|---|---|---|---|---|---|---|---|---|
| 1. To provide outstanding care | Give patients, carers and families a positive experience | 1.1 | To introduce a new Patient and Carer Engagement Strategy | Julie Hogg | Executive Team Meeting | • ICS 'Delivering Personalised Care' Priorities • ICS Quality Programme - Maternity | • ICS Personalised Care Board • Local Maternity and Neonatal System (LMNS) Executive Partnership | • Maternity Transformation Programme - https://www.england.nhs.uk/mat-transformation/ • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ | • The Patient and Carer Engagement Strategy is launched and year 1 objectives have been delivered | • The carers passport has been implemented and is now in use. |
| | Provide consistently safe and clinically effective care | 1.2 | Within agreed Infection, Prevention and Control (IPC) restrictions to increase patient treatment activity in line with the annual operating plan | Simon Barton | Executive Team Meeting | • ICS Accelerator Programme - Elective Recovery Fund • ICS Transformation Programme - Planned Care and Cancer • ICS Transformation Programme - Urgent and Emergency Care, Proactive Care and Self-Management | • Planned Care Transformation Board • Urgent Care Right Place First Time Board | • 2021/22 Priorities and Operational Planning Guidance - https://www.england.nhs.uk/operational-planning-and-contracting/ • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ | • Achievement of the national activity % levels for H2. | • Activity is now reported within the SOF to Trust Board. Overall elective activity has been above 100% of 2019/20 activity during Q4 overall with a quarterly output of 135% for outpatients, 110% for inpatients, and 114% for day cases. |
| | Improve coordination across health and social care | 1.3 | To ensure we have sufficient time to be a meaningful partner in the ICS | Paul Robinson | Executive Team Meeting | • ICS Integrated Care: Establishment of Provider Collaboratives • ICS Integrated Care: Local Partnerships, Strategic Commissioning, Population Health and Digital | • Nottingham and Nottinghamshire ICS Board • Mid-Nottinghamshire Integrated Care Partnership (ICP) Board | • 'Integrating care: Next steps to building strong and effective integrated care systems across England' - https://www.england.nhs.uk/wp-content/uploads/2021/01/integrating-care-next-steps-to-building-strong-and-effective-integrated-care-systems.pdf | • Maintain or improve SFH Single Oversight framework (SOF) indicators (including Accident and Emergency waiting times and numbers of long-waiters) • Evidence of strengthening relationships with ICS partners through demonstrable examples of genuine joint working that have collectively addressed health inequalities and inequity of access | • Urgent care demand has risen to unprecedented levels creating challenges for system working. • A&E waiting times have deteriorated and there has been an increase in the number of patients waiting 12 hours in department. • Bed capacity has been increased and some elective activity has been cancelled to cope with urgent care pressures and the number of patients waiting for elective procedures has increased. • System working across the NHS has been effective with mutual aid agreed in respect of ambulance diverts/deflects and the elective hub. • Social care and home care sectors continue to experience high-capacity loss due to workforce unavailability and closures due to covid outbreaks. This has led to further increases in the number of patients in SFH beds who are medically fit for discharge. • Improving this has been the focus of ICS workstreams and the pre-Easter period evidence improvements in the number of assisted discharges. It is recognised by the CEO Group that sustainable improvements and changes to the architecture are required and a business case for 22/23 is being developed. • Evidence of strengthening partnerships though the development of formal Provider Collaborative and Place Based Partnerships. |
| 2. To promote and support health and wellbeing | Support people to have healthier lifestyles | 2.1 | To develop and introduce a sustainable approach to Support the Mental and Physical Health and Wellbeing of Colleagues | Clare Teeney | People, Culture and Improvement Committee | • ICS 'People and Culture' Priorities | • People and Culture Programme Board | • NHS People Plan - https://www.england.nhs.uk/ournhspeople/ • 2021/22 Priorities and Operational Planning Guidance - https://www.england.nhs.uk/operational-planning-and-contracting/ | • Rationalise and Communicate the Offer during Quarters 1 and 2 (Q1 and Q2) • Embed the offers of psychological support during quarters 1 to 4 (Q1 to Q4) • Evaluate uptake of ICS Health and Wellbeing Interventions and benchmark against similar organisations/systems by the end of Q4 2021/2022 | • Dedicated People Wellbeing Lead and dedicated Physiological Support Lead commenced in post. • Successfully delivered a dedicated Health and Wellbeing campaign under the concept and brand of 'Boost' capturing 6 different themes. • Introduction of 20 new Wellbeing Champions with varied interest from physical activity, mental health to menopause were recruited throughout the campaign. • Our dedicated Wellbeing web page received more than 4,300 visits across the campaign, more than one third of the total website views. |
| | Help to improve mental wellbeing including reducing loneliness | 2.2 | Create and introduce a Mental Health Strategy for patients. | Julie Hogg | Executive Team Meeting | • ICS Transformation Programme - Mental Health | • Mental Health Transformation Board | • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ | • The Mental Health Strategy has been developed with Nottinghamshire Healthcare NHS Foundation Trust and year 1 objectives have been delivered | • The Strategy has been approved and has now been published. |
| 3. To maximise the potential of our workforce | Work with partners to reduce health inequalities for those in greatest need | 2.3 | To build clinical relationships in our response to the National 'Levelling Up' agenda to help reduce inequitable access and improve patient experience. | David Selwyn | Quality Committee | • ICS 'Population Health Management' Priorities • ICS 'Health Inequalities' Strategy • ICS Transformation Programme | • ICS Clinical Executive Group • ICS System Transformation Group | • 2021/22 Priorities and Operational Planning Guidance - https://www.england.nhs.uk/operational-planning-and-contracting/ • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ | • Review the enhancement of new and existing shared care pathways across ICS acute healthcare providers, and provide assurance that access and outcomes are consistent. • Utilise the Public Health England CHIME Health Inequalities Monitoring Tool to determine whether recovery and waiting list reduction initiatives are equitable in terms access; specifically looking at deprivation indicators, ethnicity, age and sex. | • A workstream has now been established which includes administrative and project support. • Work continues to ensure SFH and ICS HI strategies remain complimentary. • Clinical representation established on the ICS HI workstream. • Maternity, continuity of care and digital inequalities have been included in the programme. |
| | Attract and retain the right people | 3.1 | To achieve Pathway to Excellence accreditation as designated by American Nurses Credentialing Centre | Julie Hogg | Quality Committee | • ICS 'Delivering Personalised Care' Priorities • ICS Transformation Programme - Maternity • ICS 'People and Culture' Priorities | • ICS Personalised Care Board • LMNS Executive Partnership • People and Culture Programme Board | • Maternity Transformation Programme - https://www.england.nhs.uk/mat-transformation/ • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ • NHS People Plan - https://www.england.nhs.uk/ournhspeople/ | • SFH is designated as a Pathway to Excellence accredited organisation | • The collection of evidence continues to be on track; and is almost complete. The actual submission date is yet to be finalised, although we are projecting that this will be June 2022. |
| | Have an engaged, motivated and high performing workforce | 3.2 | To reduce colleague experience of Violence and Aggression and to increase reporting and learning of. | Julie Hogg | Quality Committee | • ICS 'People and Culture' Priorities | • People and Culture Programme Board | • NHS People Plan - https://www.england.nhs.uk/ournhspeople/ | • The Reducing Violence and Aggression standards have been implemented in full • Violence and aggression reporting is consistent with the levels reported in the staff survey • Harm associated with Violence and aggression is reduced | • Compliance with standards continues to progress. • The most recent staff survey shows that the top two two most improved questions relate to 'reporting violence' and 'aggression'. • DATIX concerns relating to violence and aggression against staff are however still high, this therefore remains a key focus for the Trust. |
| | Develop and nurture our teams of colleagues and volunteers | 3.3 | To develop and introduce a new SFH Talent Management Approach and Strategy. | Emma Challans | People, Culture and Improvement Committee | • ICS 'People and Culture' Priorities (Talent Management and Leadership Development Plan) | • People and Culture Programme Board | • NHS People Plan - https://www.england.nhs.uk/ournhspeople/ | • Introduction of new approach to Talent Management by end of March 2022 • Provision of Leadership Management offer that is inclusive and based on SFH workforce plan • Demonstrate increased diversity of colleagues accessing learning/leadership development offers • Improved Staff Survey Results relating to leadership development and talent management | • A new national Talent Management 'scope for growth' is due to be launched in late 2022. This is currently in test form. • New Head of Learning and OD role started on 7th Feb 2022 and is leading the design and implementation of a Talent strategy for SFH and System. • NSS21 results and a new approach to TNA will support the new strategy. • People Development operational sub-cabinet now established where the strategy will be developed. • Trust objective to develop a Talent strategy is embedded within the new People, Culture and Improvement Strategy 2022-2025. |
| 4. To continuously learn and improve | Continue to deliver evidence based best practice | 4.1 | To deliver Year 1 of the SFH vision for Continuous Improvement in SFH. | Emma Challans | People, Culture and Improvement Committee | • ICS Transformation Programme • ICS 'People and Culture' Priorities | • ICS System Transformation Group • People and Culture Programme Board | • 2021/22 Priorities and Operational Planning Guidance - https://www.england.nhs.uk/operational-planning-and-contracting/ • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ • NHS People Plan - https://www.england.nhs.uk/ournhspeople/ | • Complete Continuous Improvement Maturity Assessment (with recommendations to improve) by the end of Q4 2021/2022 • To ensure all those involved in Transformation Programmes are given time and are trained in Quality Improvement (QI) (in total 160 trained in Bronze QI and 40 trained in Silver QI by the end of quarter 4 2021/2022) • Delivery of 2021/2022 Transformation and Efficiency Programme by 31st March 2022 | • Maturity assessment completed and results to be presented at June SLT supported by the EMAHSN. • 2022/23 SOF metrics enhanced to reflect priority of capability and capacity. • Continuous Improvement vision embedded within the Trust PCI Strategy and the Quality Strategy. • Year 1 of the Vision for Continuous Improvement completed with recommendations to be agreed in June/July. |
| | Make the best use of information and digital technology | 4.2 | To deliver year 2 of the digital strategy | David Selwyn | Executive Team Meeting | • ICS 'Data, Analytics, Information and Technology (DAIT)' Strategy 2020-2024' | • Nottingham and Nottinghamshire ICS Board | • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ | • Implement year 2 objectives of the digital strategy (including compliance with digital aspects of the Ockenden Report): a. Objective 1: To deliver Electronic Patient Records (EPR) b. Objective 2: To connect digitally with patients and partners c. Objective 3: To support our colleagues d. Objective 4: To unleash information bringing insight to our decision making e. Objective 5: To improve our digital infrastructure Sherwood Forest Hospitals NHS Foundation Trust: Digital Strategy 2020-2025' - https://www.sfh-tr.nhs.uk/media/8804/digital-strategy-pdf.pdf | • EPMA roll out has now commenced. This will continue during Q1 2022/23. • External review of ePMA now completed. Lessons learnt will be fully adopted as part of all future system implementation programmes and projects. • EPR FBC now complete and will be submitted to Trust Board for approval in June 2022. Engagement has also commenced with regional colleagues regarding funding opportunities. • Digital exemplar bid on track for 2022/23. • N365 roll out approaching final stages. At end of Q4 85% completed. Outstanding issues relate to generic logins and 'unused' machines. Solutions in place to resolve both issues. • NHS has delivered a fully accredited response to keeping the organisation (and wider system) safe from possible cyber-attacks. This has been supplemented with the delivery of training for on-call managers plus targeted and coordinated communications. • Review of digital strategy and roadmap timelines continues. • CDIO will start in Q1 2022/23. |
| | Use research, innovation and improvement for the benefit of our communities | 4.3 | To introduce an Innovation Hub across the Mid Notts health and care partnership. | Emma Challans | Executive Team Meeting | • ICS Transformation Programme • Mid-Nottinghamshire ICP Priority | • Mid-Nottinghamshire ICP Board | • NHS People Plan - https://www.england.nhs.uk/ournhspeople/ • NHS Long Term Plan - https://www.longtermplan.nhs.uk/ | • Introduction of an Innovation Hub across Mid-Nottinghamshire ICP by Q4 2021/2022 • Key principles and year 1 aspirations defined and implemented by Q4 2021/2022 (including methodology for quantifying impact on patient care) | • Although the expectation is that our hub will be launched as a 'virtual offer' (i.e. on line) during Q1 (aimed primarily at adopting and implementing new ideas developed in other areas of the NHS); the remit has been extended slightly to encompass problem solving, organisational development and culture, by way of creating an environment where innovation is encouraged. The Hub will therefore now be based on the Culture and Improvement Directorate, with a single-point-of-contact for anyone to use should they require help and assistance to make an innovative idea a reality. Having something separate may simply convolute the purpose of the hub. • Although initially our plan was to launch this across the Mid-Nottinghamshire footprint, we will, as noted above, do this in the first instance at a Trust level. We are however, by way of securing funding, working closely with Nottinghamshire Healthcare. We have recently collaborated in a joint bid, which whilst allowing us to maintain our individual identity (and therefore fulfil our individual objectives) does |

| 5. To achieve better value | | | | | | | | | | maintain our individual identity (and therefore form our individual objectives) does provide an added level of opportunity by working cross-organisationally. There will be numerous opportunities to instigate and implement innovative ideas at a system level, which we hope to exploit. |
|---|---|---|---|---|---|---|---|---|---|---|
| | *Become financially sustainable* | 5.1 | To deliver Year 1 of a 3yr SFH Transformation and Efficiency Programme. | Emma Challans | Finance Committee | • ICS Transformation Programme | • ICS System Transformation Group<br>• ICS Strategy and Delivery Group meeting | • 2021/22 Priorities and Operational Planning Guidance - https://www.england.nhs.uk/operational-planning-and-contracting/<br>• Maternity Transformation Programme - https://www.england.nhs.uk/mat-transformation/ | • Deliver 2021/2022 financial efficiency plan (FIP) by 31st March 2022<br>• Ensure 2021/2022 FIP is deliverable on a recurrent basis by 31st March 2022<br>• Have in place a 3-year recurrent SFH Transformation Programme (2022-2025) by 31st March 2022<br>• Deliver Okenden Recommendations | • The level of FIP delivered in 2021/22 is £5.8m, which is £1.99m below the revised £7.79m target. This is due primarily to the removal of savings associated with the Same Day Emergency Care Programme (SDEC) (due to difficulties in agreeing the quantification of financial benefits) (£0.9m), the Estates and Facilities Programme (whereas the Medirest scheme has slipped into 2022/23) (£0.16m), the Procurement programme (due to a number of consumable schemes that have slipped into 2022/23) (£0.20m), the Variable Pay programme where all schemes have slipped into 2022-23 (£0.47m), under achievement of schemes such as the Cessation of Ophthalmology Outsourcing and additional ERF schemes within the W&C Division (£0.15m), schemes not identified (£0.15m) and Elective Recovery Funding under achievement (£0.23m). Corporate non-recurrent pay underspends, the Orthopaedic Prosthesis project and the D&O Divisional Financial Improvement Plan have delivered above their target (£0.29m).<br>• A 3-year programme in now place; this has been approved by the Finance Committee and has been socialised across the Trust (including, but not limited to DGMs, DFMs, Medical Managers, Corporate Leads, Clinical Chairs and Executive Directors). The programme is fully resourced, including requisite senior ownership, programme and project support and where necessary clinical input. It includes a plan to deliver £11.7m efficiency savings in 2022/23. |
| | *Work with our partners across Nottinghamshire to deliver efficiencies* | 5.2 | To build on existing partnership working agreements to deliver mutual opportunities that benefit the MN community. | Rich Mills | Executive Team Meeting | • ICS Integrated Care: Establishment of Provider Collaborative | • Nottingham and Nottinghamshire ICS Board<br>• Mid-Nottinghamshire ICP Board | • 'Working together at scale: guidance on provider collaboratives' - https://www.england.nhs.uk/wp-content/uploads/2021/06/B0754-working-together-at-scale-guidance-on-provider-collaboratives.pdf | • Develop formal work plans with partners (system wide) through provider collaboratives, place-based partnerships and other bilateral partnerships<br>• Ensure plans to deliver recurrent efficiencies are in place across the ICS by 1st April 2022 | • A collegiate workplan continues to evolve and develop. Progress has been slower than anticipated due mainly to operational pressures – which has resulted in the System Transformation Group (STG) meeting far less frequently than anticipated. As a consequence, the quantification of system financial efficiency opportunities will not be complete until Q1 2022/23.<br>• The Trust continues to proactively contribute to the Place Based Partnership (PBP), at both a strategic and transformational level. The role of the PBP in terms of delivering financial efficiencies will be determined during Q1 2022/23.<br>• Partners have agreed to the development of a Provider Collaborative Office, which will coordinate and drive forward projects and workstreams to identify and deliver opportunities. External support has been identified to help with this development. Early success includes the virtual ward programme, where the Trust has worked closely with partners across Nottinghamshire.<br>• Terms of Reference for a system costing group are being taken through respective governance routes for ratification at ICS DoFs. This will support clearer understanding of the cost to deliver 'Nottinghamshire services' and provide insight into better ways of working and improvements. |
| | *Maximise the use of all our resources* | 5.3 | To increase utilisation through delivery of the Estates and Flexible, Smarter Working strategies. | Rich Mills | Finance Committee | • ICS Transformation Programme - Estates<br>• ICS Transformation Programme - Back Office | • ICS System Transformation Group | • NHS Long Term Plan - https://www.longtermplan.nhs.uk/<br>• NHS People Plan - https://www.england.nhs.uk/ournhspeople/ | • 5% reduction in non-clinical space by end of 2021<br>• 10% reduction of under-utilised space by end of 2021<br>• 10% reduction on 2018 baseline of unwarranted variance on SFH model hospital Estates and Facilities Management benchmark position (Private Finance Initiative peer group) by end of 2021<br>• Ensure home/agile working embedded within organisational culture (where individual roles allow) ensuring that is consistently offered across the organisation by end of Q4 2021/2022<br>• Delivery of all schemes prioritised in capital expenditure plan by end of Q4 2021/2022 | • Agile Working Transformation Board in place and regular communications shared to support home/agile working models.<br>• Trust registered with P22 Procurement framework as alternate delivery for Estate's capital delivery schemes.<br>• Trust engagement with NHSEI regional team on acquisition of MCH site to realise improved system utilisation and designation of cold site.<br>• Capital Oversight Group established to monitor and support delivery of the capital expenditure plan. |

**Board of Directors Meeting in Public – Cover Sheet**

| Subject: | Sherwood Forest Hospitals NHS Foundation Trust (SFH) Second half of the Year (H2) Priorities – <u>Quarter 4 Update</u> | **Date:** 5<sup>th</sup> May 2022 | |
|---|---|---|---|
| **Prepared By:** | Jim Millns, Associate Director of Transformation | | |
| **Approved By:** | Executive Leads | | |
| **Presented By:** | Emma Challans, Director of Culture and Improvement | | |

| **Purpose** | | | |
|---|---|---|---|
| The purpose of this paper is to provide the Board of Directors with a quarterly update on delivery of the 2021/22 H2 Priorities. | **Approval** | | |
| | **Assurance** | X | |
| | **Update** | X | |
| | **Consider** | | |

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

| **Overall Level of Assurance** | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| Indicate the overall level of assurance provided by the report - | X | | | |

| **Risks/Issues** | |
|---|---|
| Indicate the risks or issues created or mitigated through the report | |
| **Financial** | Non delivery of financial strategic priorities would lead to cash issues, reputational issues and possible regulatory intervention. |
| **Patient Impact** | Our priorities include improvements that will have a positive patient impact. |
| **Staff Impact** | Our priorities include improvements that will have a positive impact on our colleagues. |
| **Services** | The quality and impact of our services will be enhanced by delivering our priorities. |
| **Reputational** | Delivering each of our priorities will have a positive reputational impact. |

| **Committees/groups where this item has been presented before** |
|---|
| Each Executive Director has provided (and has therefore approved) their own respective updates. |

## Executive Summary

Overview

As the Trust Board of Directors will recall, a paper was presented at the Board Meeting on 2nd September 2021, providing a summary of the SFH H2 priorities and their alignment to the 5 overarching Strategic Objectives as outlined in the 5-year strategy: *Healthier Communities, Outstanding Care*. The paper was endorsed by the Board, including a request that quarterly updates be provided.

The purpose of this paper therefore is to provide the quarter 4 update (which is the second and therefore the final update relating to 2021/22).

Recommendation

The Board of Directors are asked to:

1. Note the updates against each of the H2 priority areas as detailed in the accompanying paper.

# Single Oversight Framework

## Reporting Period: Q4 2021/22

# Single Oversight Framework – Q4 Overview (1)

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| Domain | Overview & risks | Lead |
|---|---|---|
| **Quality Care** | During quarter 4 we continued to experience the significant impact of Covid-19 variants, this presented significant workforce loss across the system and increased external delays for patients medically safe for discharge. This has resulted in continued crowding within the Emergency Department and opening of additional inpatient capacity above what was scheduled as part of the winter plan. Despite this the care delivered to our patients has remained as safe as possible and of high quality. We have had no serious incidents declared that were attributed to staffing levels. Hospital acquired pressure ulcers remain consistently low. Infection control remains a priority, both in terms of our continued Covid-19 response and executive focus on the reduction hospital associated Cdiff cases.<br><br>During quarter 4 there are 8 exception reports:<br>• **Rolling 12 month never events:** 2 never events declared during this period. Year to date we have had 5, with 4 being categorised wrong site surgery and compliance with WHO checklist, positive patient identification and marking of the surgical site. A thematic review of all has been commissioned.<br>• **STESIS reportable incidents:** 8 declared during quarter 4. 5 related to Nosocomial Covid-19 deaths. All incidents are currently being investigated in accordance with trust process.<br>• **Falls:** the falls rate for quarter 4 is 8.45, which remains above the national average of 6.63. Extensive work is being undertaken by the falls team to reduce falls with significant progress being made to reduce the number of repeat fallers.<br>• **COVID-19:** during March we have had 26 hospital acquired cases (YTD 111). Covid-19 outbreaks are being managed in accordance with UKHSA/NHS I/E guidance. All hospital associated cases undergo root cause analysis.<br>• **VTE risk assessments:** performance 92.5% (YTD 93.2%) target 95%. Manual data collection recommenced and data collection has significantly improved.<br>• **Dementia:** current performance 87.4% (YTD 70.6%) against a target of >90%. The compliance rate has remained greater than 80% for the last 6 months. Improvement plan continues to be delivered successfully.<br>• **HSMR:** YTD 113.1. The learning from deaths update in April demonstrated that Covid-19 continues to impact on HSMR data.<br>• **Cardiac arrests rate:** performance 1.20 (YTD 1.21) against a threshold of <1.0. A thematic review has been considered by the Quality Committee which demonstrates our rate is in line with the national average and below peer trusts. | MD, CN |

# Single Oversight Framework – Q4 Overview (2)

| Domain | Overview & risks | Lead |
|---|---|---|
| **People & Culture** | **People**<br><br>During Q4 we saw fluctuations in our sickness absence levels and overall workforce loss, sickness absence levels peaked in January 2022 to 6.8%, which sat higher than the Trust target, this is as a result of the regional/national trend and impact of COVID19, this was an expected increased. However since January 2022 absence levels have remained high and showed an additional peak in March 2022 (6.2%).<br><br>Although this second peak we influenced by COVID we are also seeing elevated non COVID absence level. The data shows this as an increases in stress and anxiety reasons, which we are planning how we can support.<br><br>Additional activity is evidenced through the services provided from the Trust **Occupational Health** Service, during Q4 there has been increased activity due to the Flu vaccine delivery and wider impact of the pandemic and additional omicron wave, We have seen a reduction to the overall levels since last quarter this still remains above target.<br><br>Overall resourcing indicators between January to March 2022 are positive with levels of vacancy's showing a reduction, additional to this to support winter pressure we have seen an increase to our overall staffing levels both in substantive and our bank workforce.<br><br>Across Q4 **appraisals** levels have been relatively stable and currently sit at 85%, this is below the Trust target however appraisals were paused at the end of December to increase possible workforce capacity to meet anticipated hospital surge.<br><br>Our Mandatory **Training and Development** compliance has seen a strong increase and currently sits at 90%. Mandatory Training workbook reviews are currently underway, with ToR for a Learning Governance Group being established that will provide a more uniform and considered approach to the discussion around MAST learning activity, along with exploring portability around learning from existing NHS Providers for new starts as part of there induction to the Trust.<br><br>There has been a focus on increasing access for colleagues to the **Covid-19 vaccine** across Q4 due the requirements at the time to meet Vaccination as a condition of deployment (VCOD) for all healthcare workers, that was subsequently revoked. The coordinated efforts resulted in 95.2% of substantive workforce receiving 2 vaccines and 80% of the substantive workforce receiving a Booster vaccine.<br><br>The annual flu campaign also concluded in Q4 with a final uptake figure of 76%, the update was lower that past years and consistent with other Trusts, but performance was significantly above the national update average of 60.5%, and Midlands region of 61.5% | DOP, DCI |

# Single Oversight Framework – Q4 Overview (2)
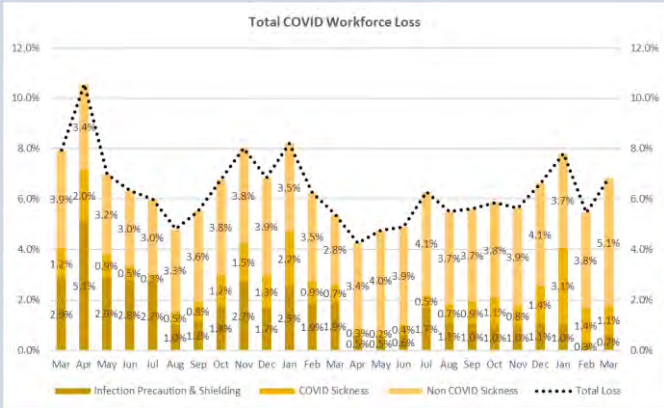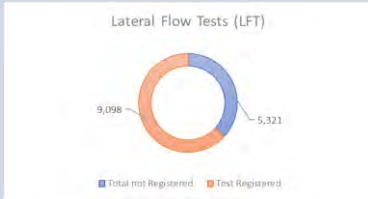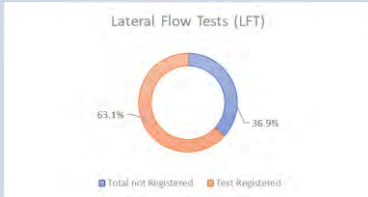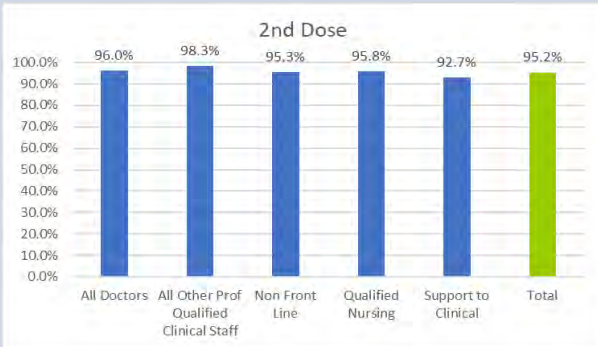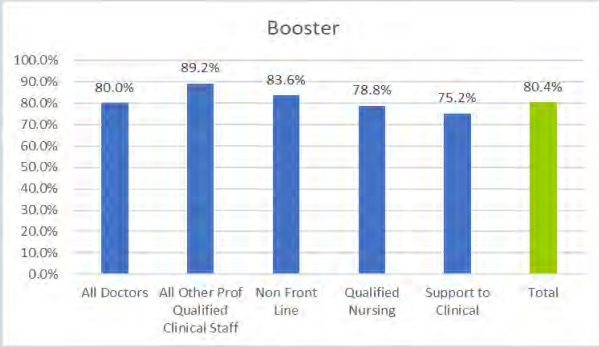
**NHS**
**Sherwood Forest Hospitals**

| Domain | Overview & risks | Lead |
|---|---|---|
| **People & Culture** | **Improvement**<br><br>As part of the vision for Continuous Improvement at SFH, a QI Maturity Matrix survey was deployed with the senior leadership team in December 21, with the results being collated by EMHSN for formal feedback in in June 22. Ensuing actions will feedback into the PCI Strategy. Face to face QSIR 'silver level' training resumed in March 22 and 39 colleagues have undergone QI training in Q1 as part of both bronze and silver level offers. There was a reduction in QI projects and Bright Spark ideas over Q4 due to organisational challenges and lack of colleague engagement activities – team leader and shared governance training opportunities; the delayed 'QI module' is due to be launched in April 22, which will mitigate this. Significant progress continues at system level to develop an integrated QI/OD approach.<br><br>**Cultural Engagement**<br><br>The National Staff Survey ran from 04.10.21 to 26.11.21. The survey closed with SFH's highest response rate to date of 66.4%. Key headlines from Picker reports were released from embargo at the end of March 22. Engagement of the results is well in train across the Trust and Divisional level to determine associated priorities for improvement. The Trust sits very favourably ranking 1st in the Midlands and overall 3rd nationally across the People Promise pillars.<br><br>A new SFH culture insights tool was shared at the People, Culture and Improvement Committee with implementation due in June 22.<br><br>Winter Wellbeing campaigns ran throughout Jan-March 22, providing support to keep colleagues well and at work. Offers in place including NHSI Leadership Circles and 'go to' partnership model. | DOP, DCI |

# Single Oversight Framework – Q4 Overview (3)

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| Domain | Overview & risks | Lead |
|---|---|---|
| **People & Culture** | **COVID Absence -** The Trust produces a daily Workforce SitRep for the organisation; this includes all COVID related absence elements which are wider than the sickness element reported above. When this is reviewed the total COVID related absence for March 2022 was 6.8%, (February 2022 5.5%). **Lateral Flow Tests** – Overall there were 14,419 test distributed, with 9,098 test registered (63.1%). Of the completed tests there has been 2,363 positive test (0.8% positive results). This increase is due to the Omicron variance.<br><br><br><br>**COVID Vaccination** – The charts below represent our vaccination levels, however these show a position as at February 2022. This gap in reporting is due to the national removal of NIMs, that we used for all vaccination reporting. The access to this is under consultation and as a result we are only able to under that vaccination levels at the beginning of February 2022. However we are looking at internal sources of reporting to mitigate this issue.<br><br> | DOP, DCI |

# Single Oversight Framework – M10 Overview

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| Domain | Overview & risks | Lead |
|---|---|---|
| **Timely care (exception reports pages)** | Emergency attendances in March increased by 8% with an average of 495 per day against 456 in the month of February. This was also 30% higher than March 2021 where there was 378 per day. This was further exacerbated with attendances peaking at or around 500 11 times over the 31 day period, with one day exceeding 600.  Overall occupancy within the trust remained high with peak days reaching to almost 98%.  The increase in the number of patients who are medically safe waiting for home care remains the key driver in high bed occupancy. The number of patients who are MFFD awaiting onward placement has increased further and is driven by severe workforce capacity issues in the homecare market, exacerbated by Covid+ absence and nursing home closures. Additional SFH beds remain open to try to supress occupancy and additional staffing is still in place for ED, notably in the evenings, although fill rates are variable. An implementation recovery plan has been developed across the ICS to mitigate the impact of this MFFD growth with a trajectory in place, but at this stage is not having the desired impact.<br><br>For cancer services, the number of patients waiting more than 62 days on a suspected cancer pathway at the end of February has reduced to 99 patients, adverse to the original trajectory set in H1 but better than the re-forecast position of 126 set in H2. An exception report detailing the root cause and actions being taken is included. The number of patients waiting 104 days at the end of February was 51 (54 in February 21). The Faster Diagnosis Standard (FDS) achieved the 75% standard in March at 81.7%.<br><br>For elective care in March the data baseline comparator month was affected by the start of the COVID 19 pandemic and the reduction in elective procedures and outpatient appointments in response to the national incident.  March 2020 activity is low therefore the % impact when comparing March 2022 shows a higher percentage against 2019/2020 activity than is expected. It will also affect March 2023 activity position for the same reason as we will still be using 2019/2020 as a comparator year. The number of patients waiting over 52 weeks are still well under trajectory and at the end of March there were 6 patients waiting 104+ weeks, a mix of complexity, COVID (patient and staff) and patient choice. This compares well to other Trusts in the midlands<br><br>Diagnostic performance against the DMO1 has improved from the previous month (reporting period Feb vs Jan) however it is not achieving the 99% target of patients receiving diagnostics under 6 weeks.  The main areas of delay are , Echocardiogram, Non Obstetric Ultrasound, Urodynamics and Cystoscopy.  This is monitored weekly and mutual aid discussions are taking place with NUH. | COO |

# Single Oversight Framework – Q4 Overview (5)

**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| Domain | Overview & risks | Lead |
|---|---|---|
| **Best Value care** | The Trust has reported a deficit of £13.3m for the financial year 2021/22 (on an ICS Achievement basis), compared to a planned break-even position. This is consistent with the deficit that has been forecast throughout Quarter 4.<br><br>The adverse financial variance to plan was caused by two key factors.<br><br>1) Additional Covid-19 costs compared to those expected in the plan, due to surges in demand and staffing unavailability in Summer 2021 and over the winter period.<br><br>2) An under-recovery of Elective Recovery Fund income compared to planned levels, which had three contributory factors. These were an in-year change to the threshold targets, the system-level calculation basis of performance, and the additional unplanned demand experienced in the latter half of the financial year.<br><br>The reported expenditure for the financial year includes £11.6m of costs relating to Covid-19 and a further £21.0m of costs relating to the Covid Vaccination Programme.<br><br>The Financial Improvement Programme (FIP ) delivered savings of £0.6m in March 2022, compared to a plan of £ 0.9m, and full-year savings of £5.8m for 2021/22.  This represents a shortfall against plan of £2.0m.<br><br>Capital expenditure for the financial year 2021/22 totalled £19.3m. This was £4.6m higher than the original plan, due to additional funding awarded during the year for specific projects (including Critical Care improvements and equipment to support elective recovery). The 'business as usual' capital plan funded by the ICS capital envelope was delivered in full.<br><br>The closing cash position for the year is £6.3m. This is £5.9m lower than planned due to the late receipt of capital funds. | CFO |

# Single Oversight Framework – Q4 Overview (1)

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| At a Glance | | Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|---|---|
| QUALITY CARE | Safe | Rolling 12 month count of Never Events | 0 | Mar-22 | 5 | - | | R | MD/CN | Q |
| | | Serious Incidents including Never Events (STEIS reportable) by reported date | <12 | Mar-22 | 26 | 8 | | R | MD/CN | Q |
| | | Patient safety incidents per rolling 12 month 1000 OBDs | >41 | Mar-22 | 45.86 | 44.65 | | G | MD/CN | M |
| | | All Falls per 1000 OBDs | 6.63 | Mar-22 | 7.14 | 8.45 | | A | CN | M |
| | | Number of Assisted Falls | TBC | Mar-22 | 114.00 | 7.00 | | | | |
| | | Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's | 22.6 | Mar-22 | 20.78 | 11.33 | | G | CN | M |
| | | Covid-19 Hospital onset | <37 | Mar-22 | 111 | 26 | | R | CN | M |
| | | Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's | 0 | Mar-22 | 0.94 | 0.00 | | G | CN | M |
| | | Rolling 12 month MSSA bacteraemia infection rate per 100,000 OBD's | 17 | Mar-22 | 9.44 | 0.00 | | G | CN | M |
| | | Eligible patients having Venous Thromboembolism (VTE) risk assessment | 95.0% | Mar-22 | 93.2% | 92.5% | | R | CN | M |
| | | Safe staffing care hours per patient day (CHPPD) | >8 | Mar-22 | 9.0 | 8.9 | | G | CN | M |
| | Caring | Complaints per rolling 12 months 1000 OBD's | <1.9 | Mar-22 | 1.54 | 1.98 | | G | MD/CN | M |
| | | Recommended Rate: Friends and Family Accident and Emergency | <90% | Mar-22 | 91.3% | 90.7% | | G | MD/CN | M |
| | | Recommended Rate: Friends and Family Inpatients | <96% | Mar-22 | 97.8% | 97.4% | | G | MD/CN | M |
| | | Eligible patients asked case finding question, or diagnosis of dementia or delirium | ≥90% | Mar-22 | 70.6% | 87.4% | | A | MD/CN | Q |
| | Effective | Rolling 12 months HSMR (basket of 56 diagnosis groups) | 100 | Dec-21 | 113.1 | - | | R | MD | Q |
| | | SHMI | 100 | Jul-21 | 97.25 | - | | G | MD | Q |
| | | Cardiac arrest rate per 1000 admissions | <1.0 | Mar-22 | 1.20 | 1.21 | | R | MD | M |
| | | Cumulative number of patients participating in research | 2500 | Mar-22 | 2763 | - | | on target | MD | Q |

# Single Oversight Framework – Q4 Overview (2)

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| At a Glance | | Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|---|---|
| PEOPLE & CULTURE | Staff health & well being | Sickness Absence | 3.5% | Mar-22 | 4.9% | 6.3% | | R | DoP | M |
| | | Take up of Occupational Health interventions | 800 - 1200 | Mar-22 | 27236 | 2295 | | R | DoP | M |
| | | Employee Relations Management | <10-12 | Mar-22 | 115 | 8 | | G | DoP | M |
| | Resourcing | Vacancy rate | ≤6.0% | Mar-22 | 5.1% | 3.0% | | G | DoP | M |
| | | Mandatory & Statutory Training | >90% | Mar-22 | 87.4% | 90.0% | | A | DoP | M |
| | | Appraisals | ≥95% | Mar-22 | 87.5% | 85.0% | | R | DoP | M |
| | Talent & Personal development | Recommendation of place to work and receive care | ≥80% | Qtr4 2021/22 | 82.0% | 83.1% | | | DoCI | Q |
| | Organisational Culture | Qi Training - Bronze | >40 | Qtr4 2021/22 | 203 | 26 | | A | DoCI | Q |
| | | Qi Training - Sliver | >10 | Qtr4 2021/22 | 60 | 13 | | G | DoCI | Q |
| | Quality Improvement | Registered Bright Sparks and Qi Projects | >45 | Qtr4 2021/22 | 140 | 14 | | R | DoCI | Q |
| | | Number of Registered Apprentices | >180 | Qtr4 2021/22 | 209 | - | | G | DoCI | Q |

# Single Oversight Framework – Q4 Overview (3)

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| At a Glance | | Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|---|---|
| Timely Care | Emergency Care | Number of patients waiting >4 hours for admission or discharge from ED | >90% | Mar-22 | 85.7% | 80.2% | | R | COO | M |
| | | Mean waiting time in ED (in minutes) | 220 | Mar-22 | 179 | 199 | | G | COO | M |
| | | Number of patients who have spent 12 hours or more in ED from arrival to departure | TBC | Mar-22 | 1208 | 263 | | | COO | M |
| | | Mean number of patients who are medically safe for transfer | 22 | Mar-22 | 71 | 94 | | R | COO | M |
| | | Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes | <10% | Mar-22 | 3.9% | 5.2% | | G | COO | M |
| | Cancer Care | Number of patients waiting over 62 days for Cancer treatment | 45 | Mar-22 | - | 99 | | R | COO | M |
| | | Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral | 75.0% | Feb-22 | 74.1% | 81.7% | | G | COO | M |
| | Elective Care | Elective Day Case activity against Yr2019/20 | 95.0% | Mar-22 | 100.0% | 135.5% | | G | COO | M |
| | | Elective Inpatient activity against Yr2019/20 | 95.0% | Mar-22 | 75.4% | 109.6% | | G | | |
| | | Elective Outpatient activity against Yr2019/20 | 95.0% | Mar-22 | 100.8% | 113.8% | | G | | |
| | | Number of patients on the elective PTL | 38729 | Mar-22 | - | 39383 | | | COO | M |
| | | Number of patients waiting over 1 year for treatment | 937 | Mar-22 | - | 613 | | | COO | M |
| | | Number of patients waiting over 2 years for treatment | 0 | Mar-22 | - | 6 | | | COO | M |
| | | Number of completed RTT Pathways against Yr2019/20 | ≥89% | Mar-22 | 101.1% | 94.8% | | | | |

# Single Oversight Framework – Q4 Overview (4)

| | At a Glance | Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|---|---|
| Best Value Care | Finance | Trust level performance against Plan | £0.00m | Mar-22 | -£13.29m | -£5.11m | | R | CFO | M |
| | | Underlying financial position against strategy | £0.00m | Mar-22 | tbc | tbc | | | CFO | M |
| | | Trust level performance against FIP plan | £0.00m | Mar-22 | -£1.99m | -£0.30m | | R | CFO | M |
| | | Capital expenditure against plan | £0.00m | Mar-22 | £4.56m | £6.42m | | R | CFO | M |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Rolling 12 month count of Never Events | 0 | Mar-22 | 5 | - | | R | MD/CN | Q |
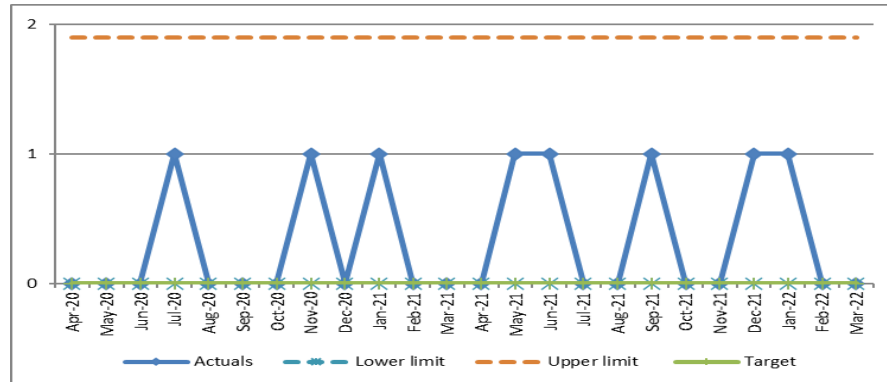


## National position & overview

- Never Events are serious incidents that are defined by NHS England/Improvement as entirely preventable events. Due to guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.

- During this reporting period 2 Never Events have been formally declared on STEIS.

- During the last 12 months the Trust has declared 5 Never Events 4 of which are categorised as 'Wrong Site Surgery'.

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| During this reporting period 2 Never Events have been formally declared on StEIS: | A number of actions are on-going as a result of the learning from previous Never Events: | • Ongoing |
| • January 2022: Retained guide wire. This is currently under investigation | • SIMPLE event themed around PPI Never Events – cases presented and discussed. | • Completed |
| • February 2022: Wrong lesion removed. This is currently under investigation. | • Formal WHO checklist audits for all procedures/departments where LocSSIPs/NatSSIPs are in place. | • Ongoing |
| • During the last 21 months the Trust has declared 7 Never Events all categorised as 'Wrong Site Surgery'. This includes the wrong lesion removal declared in February | • PPI learning events delivered in September 2021. Content to be developed into e-learning package for ease of access going forward. The development of this package has been recommenced now staff have returned from redeployment to ITU. | • Update end of quarter 1 |
| • **Recurring themes from concluded reports:**<br>• Inconsistent use of WHO Checklist/equivalent – or not in place.<br>• Surgical sites not being marked.<br>• Positive patient Identification (PPI) process not being followed. | • The medical director has commissioned a program of piece of work to further investigate and ensure and disseminate pull together learning from all 'Wrong Site Surgery' Never Events for dissemination and circulation across the Trust. This work has now recommenced following the return of staff to GSU from redeployment and is being led by the Director of Patient safety. | • June 22 |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Serious Incidents including Never Events (STEIS reportable) by reported date | <12 | Mar-22 | 26 | 8 | | R | MD/CN | Q |



NHS
**Sherwood Forest Hospitals**
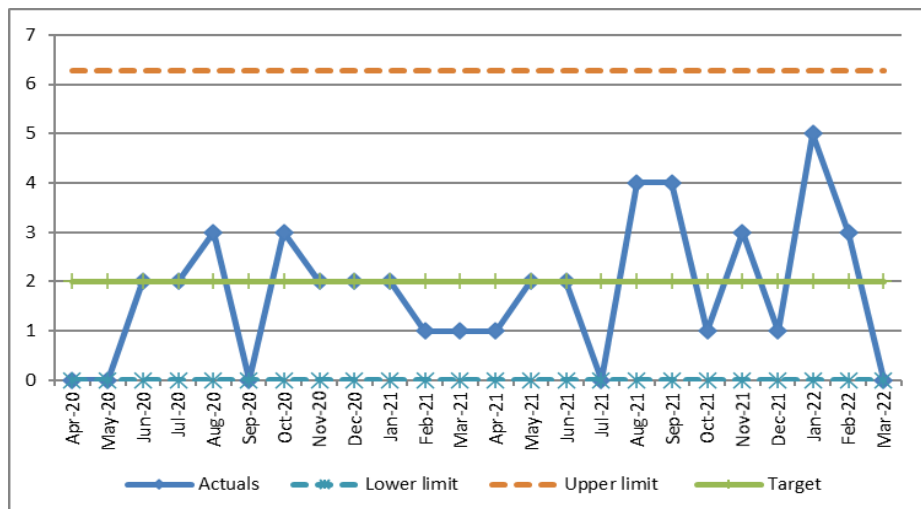
## National position & overview

- Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. They include acts or omissions in care that result in: unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm. Incidents meeting this criteria are reported on Strategic Executive Information System (STEIS) and monitored by the CCG, CQC and NHSE/I.

During Q4 there have been 8 incidents reported meeting the SI Framework criteria for escalation to StEIS:
- X5 Nosocomial Covid-19 deaths
- X2 Treatment and Care
- X1 Delay in Care

## Root causes

**January 22 x 5 incidents reported meeting SI criteria:**

- Retained guide wire.  Also declared as a Never Event. This is currently under investigation
- Unfortunately a delay in diagnosis of cancer.  This is currently under investigation.
- X 3 Nosocomial Covid-19 related deaths.

**February 22 x 3 incidents reported meeting SI criteria:**
- Vision loss due to medication toxicity.
- X 2 Nosocomial Covid-19 related deaths.

## Actions

- All incidents have been reported on STEIS awaiting completion of investigations.
- Nosocomial Covid-19 deaths are investigated by the Infection Control Team with support from GSU.
- Trial of MDT Rapid Review panels as an investigation methodology for completion of STEIS level investigations.
- The CCG maintain representation at all Scoping and Sign Off meetings and remain robustly assured by SFH incident investigation rigour.

## Impact/Timescale

- Ongoing.

- Ongoing

- Evaluation at the end of quarter 1

- Ongoing

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating |
|---|---|---|---|---|---|---|
| All Falls per 1000 OBDs | 6.63 | Mar-22 | 7.14 | 8.45 | | A |
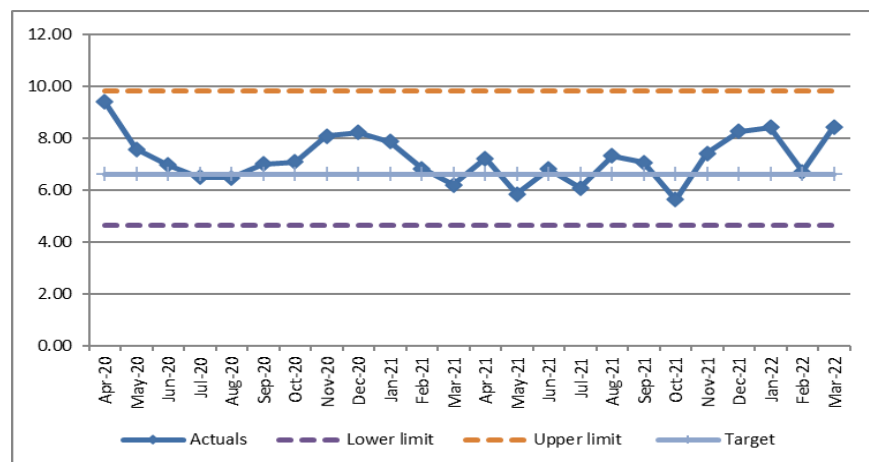


## National position & overview

- The falls rate for March is 8.45 above the national average of 6.63 per thousand bed days
- There has been one severe harm reported for March 22
- Reduction in repeat fallers In March 22
- Pandemic continues to reduce opportunity for older adults to be active, leading to decline in muscle mass, increased frailty, physical and cognitive deconditioning and associated increased risk of falls.
- Continue to have high numbers of MFFD patients due to insufficient capacity for community care, delaying D/C.
- Focus in month at SFH on improving systems for falls monitoring, investigation and learning.

## Root causes

- Covid-19 cases have increased again in month mostly incidental, this causes continued challenges for use of cubicles/bays, observation and visibility.
- In month high numbers of falls in cubicles reported.
- High volume of pathway 1 patients, MFFD residing, due to insufficient community capacity for placement/ package of care. These patients are at high risk of falls.
- We continue to have high numbers of patients with LOS > 21 days, as LOS increased in MFFD patients so does falls rates.
- All additional bed capacity remains open within across all 3 sites.
- Older adults struggling to work towards reconditioning
- Increased acuity of inpatients

## Actions

- Multifactorial falls risk assessment and falls care plan assurance audit completed, now being analysed.
- Falls and mobility care plan agreed for print, person centred, focus on primary prevention, simple to follow and quality content.
- Falls Investigation template to be combined and embedded within datix
- Partnership working with local NHS trusts, sharing good practice.
- Further Champion session completed March 2022 excellent feedback
- Review of Champion workstream and planning for 2022/3, analyse gaps in attendance and delivery into 2022/2023.
- Review of NAIF continues with recommended national actions and translation into our work in the Trust. QI opportunities for 2022/2023
- Revisit Falls group TOR , membership and the Falls strategy
- Nottingham/Nottinghamshire wide Falls Prevention Activity Promotion COP, spring event planned.
- Attended geriatrics governance, to promote work further attendance April confirmed.
- Agreed extension of secondment of therapy FPP to continue to support the trust.
- Connected care with EPO and dementia teams continues.

## Impact/Timescale

- June 2022

- Completed

- April 2022

- Ongoing

- Completed
- May 2022

- June 2022

- June 2022

- May 2022
- May 2022

- April 2022
- Ongoing

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Covid-19 Hospital onset | <37 | Mar-22 | 111 | 26 | | R | CN | M |
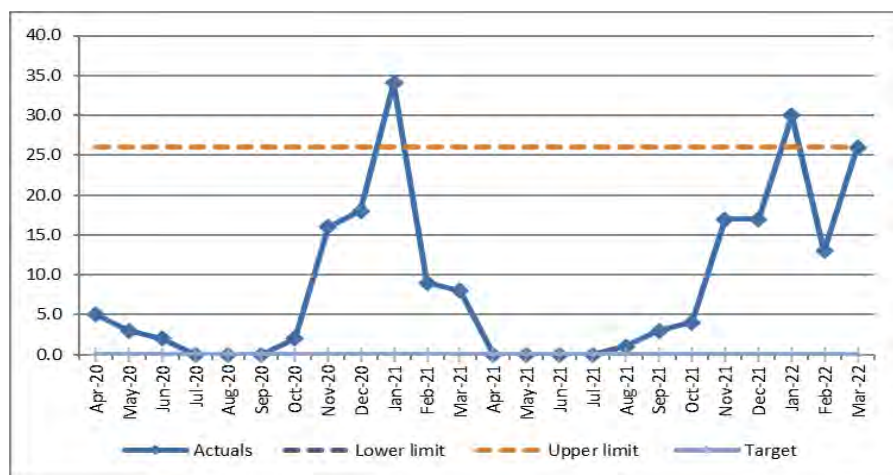


## National position & overview

- In accordance with national guidance all cases of Covid-19 deemed to be hospital associated, requires completion of an RCA.

- New cases identified 8 days post admission are deem probable hospital acquired and new cases identified 15 days or more after admission are definite hospital acquired cases.

- During March we had 18 cases post 8-14 days of admission and 26 cases post 15 days of admission.

## Root causes

- Unfortunately during March we encountered an increased number of active Covid-19 outbreaks compared with February. During March we had 7 active outbreaks involving 31 patient with a nosocomial covid-19.

- The other cases identified were sporadic and it was identified there was some community transmission from visitors who asymptomatic and aware they were positive at the time of visiting.

- The position at Sherwood is consistent with other organisations.

## Actions

- All outbreak areas and high risk areas continue to have enhanced cleaning by Medirest

- Daily hand hygiene, PPE and social distancing audits of any areas with an outbreak of cases of Covid are being conducted

- Regular outbreak meetings with NHSE/I and PHE to monitor progress of the outbreaks

- RCA are completed for all nosocomial outbreaks by the wards and these are fedback at the IPC RCA feedback meeting, to review for any lapse in care.

## Impact/Timescale

- Ongoing

- Ongoing

- Ongoing

- Ongoing

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Eligible patients having Venous Thromboembolism (VTE) risk assessment | 95.0% | Mar-22 | 93.2% | 92.5% | | R | CN | M |

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**NHS Foundation Trust**
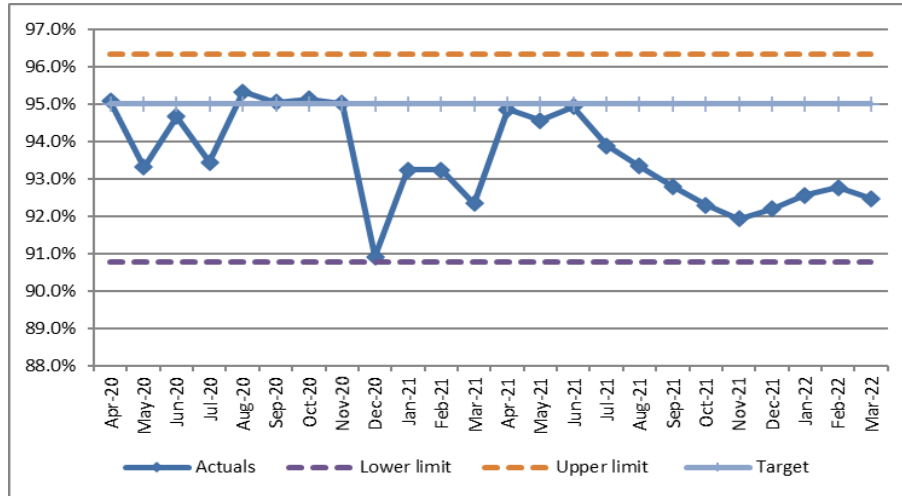


## National position & overview

- National reporting of VTE risk assessment screening was stopped in March 2020 in response to the developing Covid-19 pandemic. SFH continued with data collection for our own internal assurance process.

- The national target for VTE screening on admission to hospital is set at 95%.

- The resumption of the pre-Covid method of data collection has improved the compliance score; March's compliance standing at 92.47%

- Despite screening compliance not meeting the desired 95% target, the Trust incidence of hospital acquired VTE remains low. There has been one case, in Surgery during November 2021, in the past two years. The patient was successfully treated and made a good recovery.

## Root causes

- The data collection process for VTE risk assessment is currently a manual, paper based process, requiring a significant number of hours to complete.

- Currently awaiting roll out of mandatory electronic VTE screening tool via NerveCentre and linked to EPMA.

## Actions

- The GSU team resumed the pre Covid method of form collection from 1st April 21.

- GSU continue to work with the NerveCentre team to support development of the electronic screening tool and reporting functionality.

- Electronic screening tool now built based on NG89 standards.

- Plans for EPMA roll out presented at PSC in April 22. Agreed roll out with EPMA to go ahead.

- A VTE Screening Tool Hazard Workshop is planned for 9th May 2022.

## Impact/Timescale

- Completed

- Ongoing

- Completed

- May 2022

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating |
|---|---|---|---|---|---|---|
| Eligible patients asked case finding question, or diagnosis of dementia or delirium | ≥90% | Mar-22 | 70.6% | 87.4% | | A |

**Sherwood Forest Hospitals**
**NHS Foundation Trust**



Actuals — Lower limit — Upper limit — Target — National
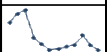
## National position & overview

- All patients 65yrs + admitted to the Trust for 72hrs or more require a dementia assessment
- The Trust continues to aim for a target of 90% of these screens despite the national reporting being cancelled
- March 2021 it was agreed for registered nurses following training could complete the assessment
- January 2022 Health Care worker appointed to assist process

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| Assessments not being completed on Nervecentre. | • Development of guidance on how to complete the assessment | • Completed |
| | • Amendments made to tool were limited and have had little effect on compliance. | • Completed |
| | • Embed the assessment process into ward routine. Support provided to areas as required to embed process | • Ongoing |
| | • Focus on assessment completion during May 2022 | • May 2022 |
| Nervecentre AMT assessment not implemented in ED. | • Nervecentre for observations only implemented in ED, UCC at Newark. Clinical lead for ICT indicates that AMT via nerve centre is not for implementation in the near future. | • On hold |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Rolling 12 months HSMR (basket of 56 diagnosis groups) | 100 | Dec-21 | 113.1 | - | | R | MD | Q |

**NHS**

## Sherwood Forest Hospitals

## National position & overview

- The HSMR for the 12 months to December 2021 is at 113.1 and statistically 'above expected'.
- HSMR for the 12 months to December 21 removing covid is 105.9 and is statistically 'as expected'. Work to understand how Covid might have had this disproportional impact on our HSMR is ongoing
- Palliative Care: The Trust continues to see a low rate with both the HSMR and across all activity. This will continue to impact on the Dr Foster model (HSMR) but will not impact the SHMI.

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| • COVID-19 deaths - Observed and expected deaths has a widening gap which has led to the increase (slight) in the HSMR | Monitor and review the HSMR / SHMI on a monthly basis | • On going |
| | Review and consider the implications of COVID-19 on the standardised mortality metrics. | • On going |
| | Review outcome of initial COPD analysis | • Completed |
| | Complete an initial review of the low volume diagnosis groups and continue to monitor both the relative risk and CUSUM. | • March 2022 |
| | Continue work internally on Liver disease, alcohol related. | • On going |
| | Review the findings of 360Assurance audit of our mortality data. Early indications are that the isolated elevation of HSMR is not truly representative of underlying problems with mortality. | • July 2022 |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Cardiac arrest rate per 1000 admissions | <1.0 | Mar-22 | 1.20 | 1.21 | | R | MD | M |

**NHS**

## Sherwood Forest Hospitals
### NHS Foundation Trust



### National position & overview

- Slightly above national average but below that for similar hospitals.



| Root causes | Actions | Impact/Timescale |
|---|---|---|
| • No single root cause. | | |
| • All events reviewed in depth as per Cardiac Arrest governance process, no trends around locations or times identified. | • Continue to fully review all cardiac arrest events. | • Ongoing |
| • Single avoidable CPR event (new terminology agreed with lead for ReSPECT development) - patient had DNACPR decision but validity questioned at point of cardiac arrest. | • Work with ReSPECT development group to agree which level of doctors can validate ReSPECT forms on completion. | • July 2022 |
| • When recalculated without avoidable CPR events the YTD activity figure becomes 0.95 per 1000 admissions. | • Continue work to reduce avoidable CPR events across all workstreams. | • Ongoing |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Sickness Absence | 3.5% | Mar-22 | 4.9% | 6.3% | | R | DoP | M |

**NHS**
## Sherwood Forest Hospitals
**NHS Foundation Trust**



### National position & overview

The Trust benchmarks favourably against a national and localised sickness figure, across NHS providers in Nottinghamshire SFH sits below the ICS average (6.6%)

Our NHSi peer group follows a similar trend to the sickness absence level at Sherwood Forest Hospitals, however the Trust level sits below the NHSi peer group.
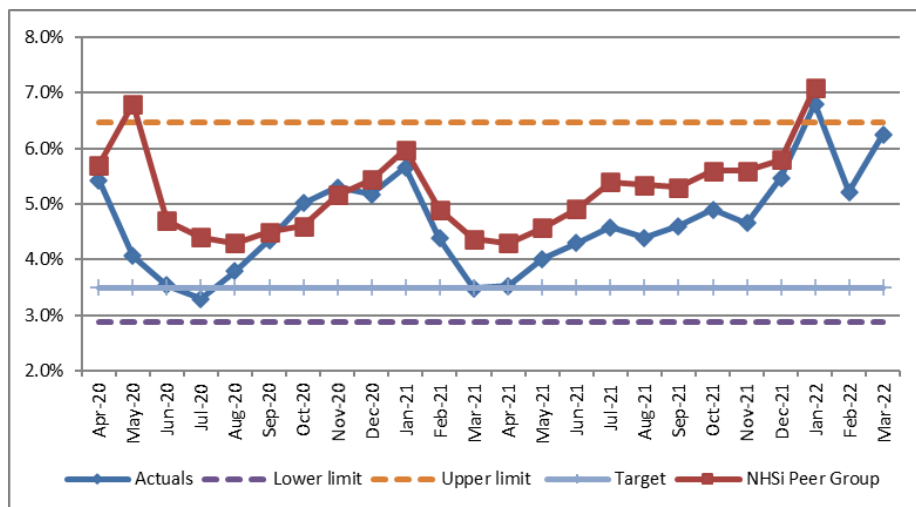
### Root causes

Sickness absence levels has shown an increase since from last month (5.2%). This now sits below the upper SPC and shows and sits above the Trust Target (3.5%). The sickness absence levels is above the sickness absence level in March 2021 (3.5%)

The short term sickness absence rate for March 22 is 4.6%. (February 2022 – 3.3%).

The long term sickness absence rate for March 22 is 1.7%. (February 2022 – 1.9%).

COVID related absence make up 0.7% of the sickness absence level and has shown an increase from last month

Non COVID related absence has seen an gradual increase.

### Actions

The increase in absence levels coincidences with the increase nationally with the COVID surge and pressure noted across the Hospital, however there is an increase in staff reporting anxiety & stress sickness reasons. To ensure this isn't a trend we will review this and support staff where necessary

We have forecasted an decrease in sickness absence level over the next few months, to support our workforce during this period we have well being programmes and interventions, however we will ensure these are effective and support our workforce.

### Impact/Timescale

The sickness levels are recorded above the Trust target (3.5%), and this sits below the upper SPC level.

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Take up of Occupational Health interventions | 800 - 1200 | Mar-22 | 27236 | 2295 | | R | DoP | M |



## National position & overview

Local intelligence suggests the Trust is not a anomaly due to national increase in the requirements for Occupational Health services and support.

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| Over the last month there has been an increase in the overall workload, and this still remains above the target. The key cause of the increased levels and the above trajectory performance on the take up of Occupational Health interventions is mainly associated with the enhanced national increase around COVID. | The additional workload is being managed by:<br><br>• New ways of working (Telephone /virtual consultations)<br>• Paper screening for work health assessments instead of face to face<br>• Smart working<br>• All substantive OH staff working overtime<br>• Bank admin support<br><br>Our Occupational Health department has also moved location to a more appropriate location, purposeful location. | The expectations are that this workload will continue to show a decrease over 2022/23.<br><br>Pre COVID-19 pandemic, the Occupational Health service had already experienced a substantial increase in utilisation of the service with a 51% increase in overall activity seen over the last 5 years |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Appraisals | ≥95% | Mar-22 | 87.5% | 85.0% | | R | DoP | M |

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**
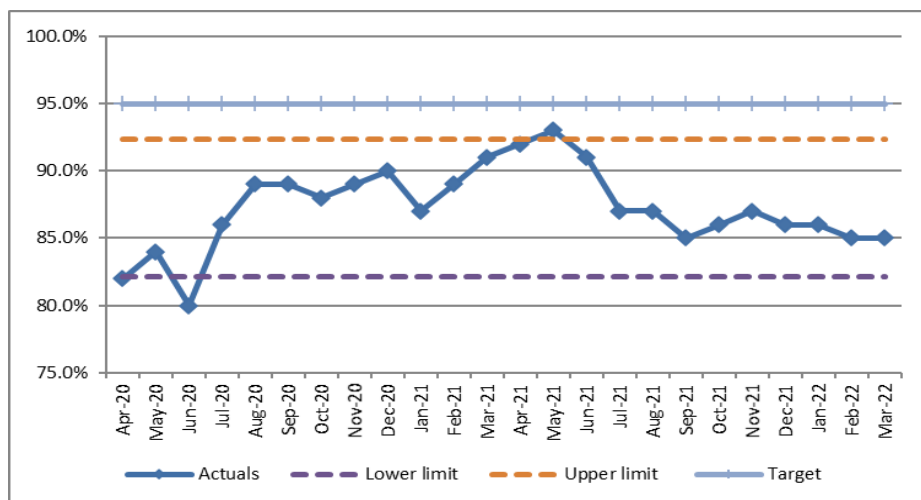


## National position & overview

The Trust benchmarks favourably nationally and local intelligence suggests the Trust's appraisal rates are amongst the highest in the region.

The Trust benchmarks favourably against a national and localised appraisal figure, across NHS providers in Nottinghamshire SFH sits above the ICS average (83.6%)

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| The Appraisal position is reported at 85.0%, and shows a position that is the similar to the previous month (February 2022 – 85.1%)<br><br>The key cause of below trajectory performance on the appraisal compliance is related to the delivery and capacity issues associated with the pandemic and hospital pressures. | The Human Resources Business Partners are supporting discussions with line managers at confirm and challenge sessions to identify appraisals which are outstanding and seeking assurance regarding timescales for completion. | Appraisal compliance to 90% by end of June 22 |

| Indicator | Plan / Standard | Period | YTD Actuals | Monthly / Quarterly Actuals | Trend | RAG Rating | Executive Director | Frequency |
|---|---|---|---|---|---|---|---|---|
| Registered Bright Sparks and Qi Projects | >45 | Qtr4 2021/22 | 140 | 14 | | R | DoCI | Q |

**NHS Sherwood Forest Hospitals**
**NHS Foundation Trust**
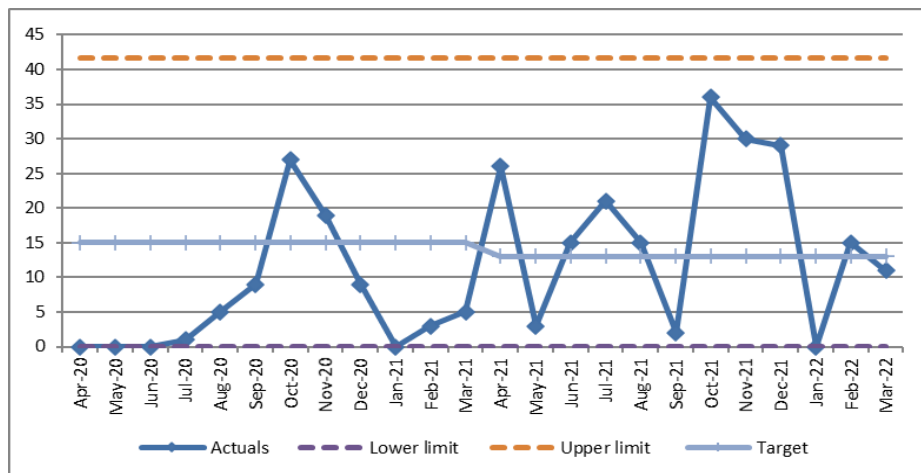


## National position & overview

Local target, with no national comparison

## Root causes

The majority of QI projects and Bright Spark ideas are captured during face to face interactions with colleagues, and these opportunities has been much reduced over the past 2 years, resulting the 'peaks' and 'troughs' visible in the data.

Colleagues are encouraged to capture QI projects on AMAT - the digital clinical audit system - that raises visibility and shares information across the organisation. Our SOF data is taken directly from entries in AMAT. This system was introduced in September 2020, and we have been waiting for the designers to launch the standalone QI module since June 2021 (delayed by Covid). This has resulted in a 'clunky' fit for colleagues to lodge their ideas within the system.

## Actions

Face to face training has now resumed, with more opportunities for colleagues to capture their QI projects and improvements; conversation are being held to advance these at pace and scale via team or role time out events.

The QI module in AMAT is due on 27th April 2022, and this will provide a tailored platform for colleagues to work through QI tools and capture outcomes and learning. It aligns with the ICS-wide QI approach and tools. A comprehensive Trust-wide communications launch will flag this platform to colleagues.

A bid for a single digital portal for ideas, requests for QI, OS, Research and Transformation input has been submitted to the 'Q Exchange' as part of a provider collaborative approach with NHCT and NUH, which will simplify the process for colleagues to have 'one route' to lodge ideas or requests for support, as opposed to the current many

## Impact/Timescale

Expected to recover to in Q1 22/23 with the return to face to face training/coaching opportunities.

Expected to recover in Q1 22/23 with the launch of the QI module and subsequent communication campaign.

Further information on bid expected in early May. This will simplify and give a single portal for colleagues to share ideas and also to request support.

| Number of patients waiting >4 hours for admission or discharge from ED | >90% | Mar-22 | 85.7% | 80.2% | | R | COO | M |
|---|---|---|---|---|---|---|---|---|

**NHS**

## Sherwood Forest Hospitals
### NHS Foundation Trust



Legend: Actuals, Lower limit, Upper limit, Target, National
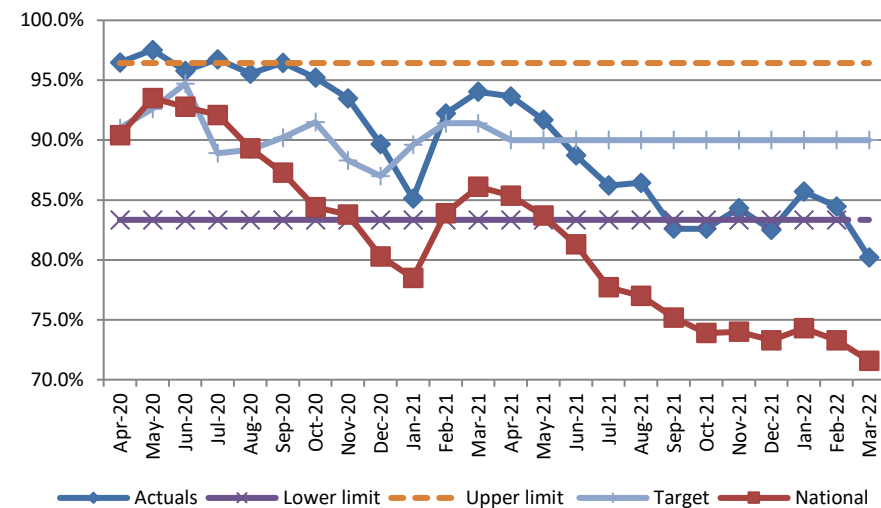
### National position & overview

- SFH 80.2% for March and 85.7% ytd. Performance continues to be driven mainly by exit block and high numbers of MSFT, although attendances were up for the month in comparison to March 2021
- National rank 7th out of 108 reporting Trusts
- Attends overall are higher than in March 2021. This is likely to be due to the surge in Covid-19
- Newark UTC was 96.9% which is lower than last month but still well above the 95% standard
- Bed pressure was a key driver of performance. The number of MSFT patients remained in excess of the ICS agreed threshold throughout the month and is showing a deteriorating position. MSFT is driving a total of 4 wards worth of demand against a threshold of one. This is shown in a further slide later in the SOF
- There were 49 patients who waited over 12 hours for admission to a bed, the majority of these were at the end of the month when attendances were high to ED.

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| **Bed capacity pressure** The Trust continues to experience delays in the discharge of patients who require social care support following discharge. There continues to be 4 wards worth of capacity that is currently being used solely for the care of patients who are medically fit but have no onward destination.<br><br>Attendances also increased throughout the month of March with high peaks of activity through the KMH and Newark sites. | In line with the winter plan agreed at Board in November, the Orthopaedic elective ward which became a medical ward as part of the plan was returned as planned in early March. There were further beds opened/moved to mitigate the loss across Medicine, Women's and Children's and Surgical Divisions and these will remain open until the end of April.<br><br>The maximisation of Same Day Emergency care continues to be successful and 40-50% more patients are seen in this service than in 2019, thereby avoiding admission to a bed<br><br>A mitigation plan has been developed across the system for the opening of capacity to reduce patients waiting times for their onward needs when they are MSFT, this has been presented and there is now a weekly improvement trajectory the system is monitoring. The benefits of this plan are yet to be evidenced within the Trust<br><br>Internal flow transformation plan in development | • Implemented<br><br>• Implemented<br><br>• Ongoing<br><br>• Development |

| Mean number of patients who are medically safe for transfer | 22 | Mar-22 | 71 | 94 |  | R | COO | M |
|---|---|---|---|---|---|---|---|---|
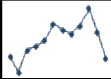
**NHS**
## Sherwood Forest Hospitals
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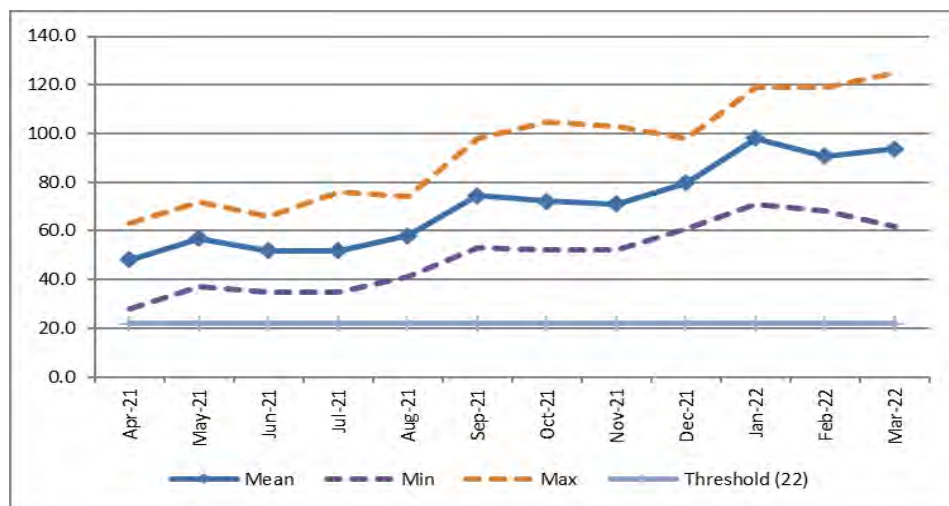


### National position & overview

- The local position continues to significantly worsen and remains above the agreed threshold of 22 patients ,in the acute trust, in delay.
- The worsening position is a direct link to workforce issues within adult social care, care agency hand back of care, closed care homes and further covid impact.
- MADEs continue to deliver some outputs with support from NHSEI
- Further national drive to support the roll out of Virtual Wards for early supported discharge is in progress with an ICS submission planned for the 6th June

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| • Pathway 1 demand and the available capacity to meet the variation in demand. This reflects the lack of available staff in care agencies (on the framework) to meet demand in particular for double up care QDS and TDS , as well as availability of social workers to manage the allocations. Recruitment into care and social worker roles is proving very difficult with posts unfilled and no agency cover.<br>• Care home closures for staffing and infection prevention issues have also contributed to delayed discharge allocation.<br>• Internal process issues contributing to referral delays due to minimum staffing numbers on the wards and IPC issues. | • HoS commences 25th April<br>• MADE events continue to deliver some outputs<br>• T2A process with ASC continues to develop<br>• Continuation of Tuvida winter capacity<br>• Extension of 25 beds at Ashmere care homes<br>• Planning to open 20 additional beds in a care home facility<br>• Virtual ward ICS business case 1st draft end April<br><br>**Escalation**<br>• Delays and workforce issues escalated through CEO group, D2A Board with daily system conversations.<br>• Potential patient harms as becoming unwell whilst waiting to be discharged<br>• Observe the capacity open in addition to support flow | • 25th April<br>• Ongoing<br>• Ongoing<br>• Complete<br>• Complete<br>• April 30th<br>• 27th April |

**NHS**

## Sherwood Forest Hospitals
### NHS Foundation Trust



| | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Original trajectory | 98 | 95 | 85 | 74 | 65 | 61 | 56 | 56 | 61 | 54 | 49 | 45 |
| Re-forecast | | | | | | | 140 | 132 | 129 | 129 | 127 | 126 |
| Actual | 101 | 87 | 110 | 110 | 116 | 130 | 125 | 121 | 128 | 144 | 122 | 99 |

## National position & overview

- In the 2021/22 operational planning guidance, NHS England (NHSE) set out a key objective to return the number of people waiting for longer than 62 days ("the backlog") to the level seen in February 20 (45 patients for SFH).

- A trajectory was developed in March 21 with 5 key risks to delivery highlighted: demand, diagnostic capacity, lower GI, dependency on the tertiary provider and the residual impact of covid. A re-forecast was shared with Board in October 21 (left

- March ended with a backlog of 99 which was above the trajectory of 45 but below the reforecast of 126. 6 out of 9 tumour sites are ahead of forecast.

- 104 day backlog is 51 (54 in February 2021)

## Root causes

- Year to date **referrals 20% above the 19/20** average (average is currently 1,500 per month compared to 1,270). LGI has seen a 30% increase.

- Referral increase **impact on diagnostic capacity** such as CT colon; compounded by a high volume of DNA/patient cancellations.

- **Other diagnostic and treatment delays due to tertiary provider capacity,** including PET scans, surgical and OP dates (most significantly in lower GI) and oncology.

## Actions

- Increasing CTC list capacity by 1 patient per list (14%) by utilising imaging assistants for cannulation and preparation.

- Increase outpatient/triage and testing capacity through Rapid Diagnostic Centre funding:
  - Gynae – increase consultant workforce, expand see and treat capacity, streamline straight to test (STT)

  - Urology and head and neck – expand STT capacity

- ICS assessment and review of sustained increased demand

- Gynaecology mutual aid meetings set up to support tertiary provider with capacity. Likely to extend SFH waits further but support an overall reduction across the system. Derby also supporting tertiary provider with complex cases.

## Impact/Timescale

- Appointments started in January 22. Training will be complete by March 22.

- Throughout Q4 21/22 into Q1 22/23:

  - Consultant interviews planned, sufficient capacity now in place with additional sessions planned in March to reduce waits further (waits reduced by 10+ days to date).
  - CSW in post (Jan 22), locum in place (Feb 22).

  - Underway – 1st D&C session to take place wc25/4

- Weekly meetings in place. Supporting protocols have been developed and the first patient has been transferred. Ongoing impact to be confirmed.

| Elective Inpatient activity against Yr2019/20 | | 95.0% | Mar-22 | 75.4% | 109.6% |  | G | COO | M | NHS |

## Sherwood Forest Hospitals

**Elective Day Case activity against Yr2019/20**
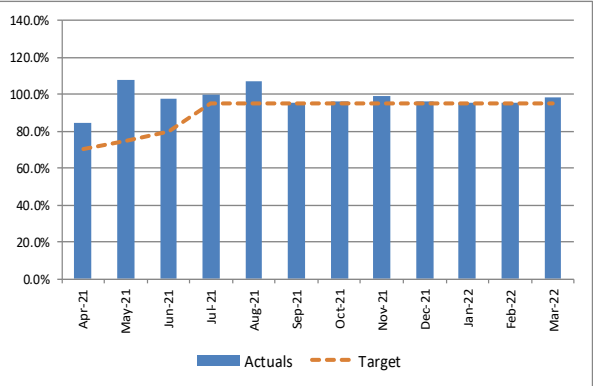


**Elective Inpatient activity against Yr2019/20**
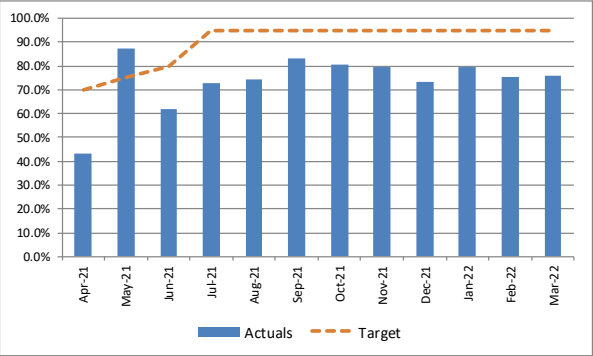


**Elective Outpatient activity against Yr2019/20**
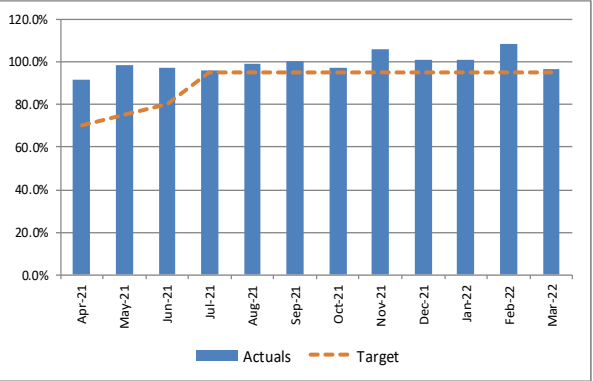


### National position & overview

- For March 2022 the activity volume is 109.6% against March 2020. This is due to the baseline data being low at the end of the month as the COVID pandemic started.

- When comparing the March projection to February activity for both years:
  - Day case - 2020 March – 2578, Feb – 3371 (-793) 2022 March – 3493, Feb – 3225 (268)
  - Outpatient: 2020 March – 35473, Feb – 32767 (2706) 2022 March – 40382, Feb – 35541 (4841)
  - Elective inpatient – 2020 March – 323, Feb 344 (-21) 2022 March – 354, Feb 259 (95)

- The on-going risk to elective activity due to the Omicron variant of Covid 19 continued throughout March. Staffing absence has continued to impact however where possible theatre lists were merged or re-ordered to ensure that negative patients were not cancelled. Patient cancellations have also been high during March due to the prevalence of Covid within the local community

| Root causes | Actions | Impact/Timescale |
|---|---|---|
| Some Surgical specialties are struggling for capacity due to a number of issues including covid absence, general absence and the inability to generate a pre op list that can be called off at short notice due to current covid regulations. Those specialties are specifically: <br>• Urology, <br>• T&O <br>• General Surgery <br>Mutual aid is being explored where appropriate at NUH and the IS and some of the short term absence will resolve in April to provide more capacity. | • Daily surgical prioritisation call established from 04/01 | • Staffing and patient position reviewed daily flexing capacity where required to ensure that cancer / urgent and long wait patient operating is maintained. |

| | Best Value Care |
|---|---|

**Sherwood Forest Hospitals**
NHS Foundation Trust

## 2021/22 Outturn

- The Trust has reported an outturn deficit of £13.29m for 2021/22, a marginal improvement on the previous forecast deficit of £13.34m. Further details on the drivers of this deficit are provided on the following page.

- Capital expenditure for the financial year 2021/22 totalled £19.25m. This was £4.56m higher than the original plan, due to additional in-year funding from NHSE/I for specific projects such as the Elective Accelerator Programme and the Targeted Investment Fund.

- Closing cash at 31st March was £6.32m. This is £5.85m lower than planned due to the late receipt of capital PDC.

| | March In-Month (H2 Plan) | | | Out-Turn | | |
|---|---|---|---|---|---|---|
| | **Plan** | **Actual** | **Variance** | **Plan** | **Actual** | **Variance** |
| | **£m** | **£m** | **£m** | **£m** | **£m** | **£m** |
| Income | 37.64 | 47.70 | 10.06 | 451.64 | 451.81 | 0.17 |
| Expenditure | (37.31) | (52.48) | (15.17) | (451.64) | (465.10) | (13.46) |
| **Surplus/(Deficit) - ICS Achievement Basis** | **0.33** | **(4.78)** | **(5.11)** | **(0.00)** | **(13.29)** | **(13.29)** |
| Capex (including donated) | (0.99) | (7.41) | (6.42) | (14.69) | (19.25) | (4.56) |
| Efficiencies (FIP) | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Closing Cash | 12.18 | 6.32 | (5.85) | 12.18 | 6.32 | (5.85) |

| Best Value Care |
|---|

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| 2021/22 Outturn |
|---|

The outturn deficit position of £13.29m is due to:

- Elective Recovery Fund Income below plan – impact £9.42m. This includes the impact of a change in ERF thresholds, which reduced the level of ERF income available to support the Trust's elective recovery programme, the ERF income being dependent on the performance of the ICS which has meant that SFH has not received all of the ERF income earned on an individual Trust basis, and the impact of emergency demand which has limited the Trust's ability to deliver the planned levels of elective recovery.

- Covid-19 costs of £11.58m are £2.39m higher than planned. This reflects the increased pressures driven by surges through the year, with an increase in positive patients, workforce unavailability and super surge mitigations including Cardiac Cath beds, Discharge Lounge beds, Lyndhurst Ward and enhanced cleaning costs.

- Other variances across services amounting to £1.48m

The variance is therefore predominantly driven from income (ERF shortfall) however this is not clear at an organisational level due to the impact of pass through costs and income. The table below removes the impact of these adjustments.

| | Income | | | Expenditure | | | Net organisational Variance | | |
|---|---|---|---|---|---|---|---|---|---|
| | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m | Plan £m | Actual £m | Variance £m |
| **Reported Surplus/(Deficit) - ICS Basis** | **451.64** | **451.81** | **0.17** | **(451.64)** | **(465.10)** | **(13.46)** | **0.00** | **(13.29)** | **(13.29)** |
| **Less effect of pass-through costs:** | | | | | | | | | |
| Central Fund (DH) Pension Contributions | 0.00 | (10.34) | (10.34) | 0.00 | 10.34 | 10.34 | 0.00 | 0.00 | 0.00 |
| Charitable Fund Donations | 0.00 | (0.34) | (0.34) | 0.00 | 0.34 | 0.34 | 0.00 | 0.00 | 0.00 |
| Donated Revenue Consumables (PPE) | 0.00 | (1.51) | (1.51) | 0.00 | 1.51 | 1.51 | 0.00 | 0.00 | 0.00 |
| Vaccination Programme | (24.42) | (21.05) | 3.37 | 24.42 | 21.05 | (3.37) | 0.00 | 0.00 | 0.00 |
| NHIS | (14.02) | (15.70) | (1.68) | 14.02 | 15.70 | 1.68 | 0.00 | 0.00 | 0.00 |
| **Reported Surplus/(Deficit) excl. Pass-Through** | **413.21** | **402.88** | **(10.33)** | **(413.21)** | **(416.17)** | **(2.96)** | **0.00** | **(13.29)** | **(13.29)** |
| | | | | | | | | | |
| **Explained by:** | | | | | | | | | |
| COVID | (9.19) | (9.19) | 0.00 | 9.19 | 11.58 | 2.39 | 0.00 | 2.39 | 2.39 |
| Elective Recovery Fund H1 (Threshold Change) | (7.07) | (4.16) | 2.91 | 0.00 | 0.00 | 0.00 | (7.07) | (4.16) | 2.91 |
| Elective Recovery Fund H1 (System Performance) | (0.53) | 0.00 | 0.53 | 0.00 | 0.00 | 0.00 | (0.53) | 0.00 | 0.53 |
| Elective Recovery Fund H2 (System Performance) | (2.73) | 0.00 | 2.73 | 0.00 | 0.00 | 0.00 | (2.73) | 0.00 | 2.73 |
| Elective Recovery Fund H2 (SFH Performance) | (3.77) | (0.52) | 3.25 | 0.00 | 0.00 | 0.00 | (3.77) | (0.52) | 3.25 |
| *All Other Budget Lines* | *(389.91)* | *(389.00)* | *0.91* | *404.02* | *404.59* | *0.57* | *14.11* | *15.59* | *1.48* |
| | | | **10.33** | | | **2.96** | | | **13.29** |

# Best Value Care

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

**ICS Achievement Basis, All values £'m**

| | In Month | | | | | Full Year 2021/22 | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | Plan | Non-Covid Actual | Covid Actual | Total Actual | Variance | Plan | Non-Covid Actual | Covid Actual | Total Actual | Variance |
| **Income:** | | | | | | | | | | |
| Block Contract | 23.82 | 23.96 | 0.00 | 23.96 | 0.14 | 286.04 | 285.93 | 0.00 | 285.93 | (0.11) |
| Top-Up System | 3.71 | 3.71 | 0.00 | 3.71 | 0.00 | 44.54 | 44.54 | 0.00 | 44.54 | 0.00 |
| ERF | 0.99 | 0.00 | 0.00 | 0.00 | (0.99) | 19.36 | 4.68 | 0.00 | 4.68 | (14.68) |
| COVID Income | 1.73 | 0.88 | 0.85 | 1.73 | (0.00) | 20.78 | 11.59 | 9.19 | 20.78 | (0.00) |
| Growth and SDF | 0.60 | 0.60 | 0.00 | 0.60 | 0.00 | 7.14 | 7.14 | 0.00 | 7.14 | 0.00 |
| Other Income | 7.63 | 17.76 | 0.00 | 17.76 | 10.13 | 82.39 | 88.19 | 0.00 | 88.19 | 5.80 |
| **Total Income** | **38.48** | **46.91** | **0.85** | **47.76** | **9.28** | **460.26** | **442.07** | **9.19** | **451.26** | **(8.99)** |
| **Expenditure:** | | | | | | | | | | |
| Pay - Substantive | (18.09) | (18.71) | (0.09) | (18.80) | (0.71) | (225.56) | (219.57) | (1.48) | (221.05) | 4.51 |
| Pay - Bank | (3.83) | (3.37) | (0.50) | (3.87) | (0.04) | (52.03) | (38.45) | (5.51) | (43.96) | 8.07 |
| Pay - Agency | (1.44) | (1.77) | (0.04) | (1.81) | (0.37) | (14.28) | (15.69) | (1.20) | (16.88) | (2.60) |
| Pay - Other (Apprentice Levy and Non Execs) | (0.13) | (10.42) | 0.00 | (10.42) | (10.29) | (1.34) | (11.96) | 0.00 | (11.96) | (10.62) |
| Total Pay | (23.49) | (34.26) | (0.64) | (34.90) | (11.41) | (293.21) | (285.66) | (8.19) | (293.85) | (0.63) |
| Non-Pay | (11.64) | (14.26) | (0.35) | (14.61) | (2.96) | (138.46) | (138.61) | (3.39) | (142.00) | (3.55) |
| Depreciation | (1.05) | (1.08) | 0.00 | (1.08) | (0.03) | (13.10) | (13.16) | 0.00 | (13.16) | (0.06) |
| Interest Expense | (1.26) | (1.26) | 0.00 | (1.26) | 0.00 | (14.85) | (14.87) | 0.00 | (14.87) | (0.02) |
| PDC Dividend Expense | (0.64) | (0.68) | 0.00 | (0.68) | (0.04) | (0.64) | (0.68) | 0.00 | (0.68) | (0.04) |
| Total Non-Pay | (14.60) | (17.28) | (0.35) | (17.63) | (3.03) | (167.04) | (167.31) | (3.39) | (170.71) | (3.66) |
| **Total Expenditure** | **(38.09)** | **(51.55)** | **(0.99)** | **(52.54)** | **(14.45)** | **(460.26)** | **(452.97)** | **(11.58)** | **(464.55)** | **(4.30)** |
| **Surplus/(Deficit)** | **0.39** | **(4.64)** | **(0.14)** | **(4.78)** | **(5.17)** | **0.00** | **(10.90)** | **(2.39)** | **(13.29)** | **(13.29)** |

The table includes Covid Vaccination Programme costs of £21.05m (£19.08m Pay and £1.97m Non pay), which are £3.37m lower than planned. This cost is a pass through and it has been assumed that this is fully offset in income.

**Sherwood Forest Hospitals**
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| FY22 Target | | FY22 Forecast | | FY22 Variance | | M12 Target | | M12 Actual | | M12 Variance | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| FIP £5.95m | ERF £1.84m | FIP £4.19m | ERF £1.61m | FIP (£1.75m) | ERF (£0.23m) | FIP £0.71m | ERF £0.16m | FIP £0.41m | ERF £0.16m | FIP (£0.30m) | ERF (£0.00m) |
| £7.79m | | £5.80m | | (£1.99m) | | £0.87m | | £0.57m | | (£0.30m) | |

**Overall Status**

**R** — Red rated due to full year actual delivery v Target.

## Target v Full-year Delivery

1. The full year delivery is £1.99m below target. This is due primarily to:

a. The removal of savings associated with the Same Day Emergency Care Programme (SDEC), due to difficulties in agreeing the quantification of financial benefits (£0.9m);
b. The Estates and Facilities Programme, whereas the Medirest scheme has slipped into 2022-23 (0.16m);
c. The Procurement programme, due to a number of consumable schemes that have slipped into 2022-23 (£0.20m);
d. The Variable Pay programme, whereas all schemes have slipped into 2022-23 (£0.47m);
e. Under achievement of schemes such as Cessation of Ophthalmology Outsourcing and additional ERF schemes within W&C (£0.15m);
f. Schemes not identified (£0.15m); and
g. Elective Recovery Funding under achievement (£0.23m).

2. Corporate non-recurrent pay underspends, Orthopaedic Prosthesis project and the D&O Divisional Financial Improvement Plan have delivered above their target (£0.29m).

### 2022/23 – 2024/25 Planning

1. Support continues to be targeted at Divisions to help review and evaluate the Benchmarking information provided to inform their Transformation and Efficiency plans.
2. Focused work continues with programmes and/or individual schemes that did not deliver in 2021-22 (such as the Variable Pay Programme, Procurement Programme and Estates and Facilities Programme). These have all been transferred to 2022-23.
3. Work continues with the Divisional Finance Managers to understand the bridge of opportunities from 2019-20 spend to 2022-23 budgets, to highlight 'cost increase-cost out' opportunities.

## Item 1: Cumulative Phased Forecast Savings Plan



## Item 2: Summary by Programme
*(Note: ERF actual figures are estimated)*

Key: > 95% | > 75% | < 75%

| Programme | Month 12 YTD Target | | | Month 12 YTD Actual | | | Delivery RAG |
|---|---|---|---|---|---|---|---|
| | FIP | ERF | Total | FIP | ERF | Total | |
| Outpatients innovation | £12,664 | £1,092,000 | £1,104,664 | £16,221 | £1,269,261 | £1,285,482 | Green |
| Theatres Productivity | £336,240 | £750,000 | £1,086,240 | £339,577 | £340,909 | £680,486 | Red |
| Variable Pay Programme | £475,800 | £0 | £475,800 | £0 | £0 | £0 | Red |
| Comparative and Benchmarking - SDEC | £900,000 | £0 | £900,000 | £0 | £0 | £0 | Red |
| Comparative and Benchmarking - Procurement | £171,300 | £0 | £171,300 | £0 | £0 | £0 | Red |
| Comparative and Benchmarking - Estates & Facilities | £160,000 | £0 | £160,000 | £0 | £0 | £0 | Red |
| Comparative and Benchmarking - Workforce | £33,000 | £0 | £33,000 | £0 | £0 | £0 | Red |
| Pathology Transformation | £0 | £0 | £0 | £20,400 | £0 | £20,400 | Green |
| Transactional - Trustwide | £2,278,000 | £0 | £2,278,000 | £2,278,000 | £0 | £2,278,000 | Green |
| Transactional - Corporate | £486,000 | £0 | £486,000 | £726,000 | £0 | £726,000 | Green |
| Transactional - D&O | £192,689 | £0 | £192,689 | £223,586 | £0 | £223,586 | Green |
| Transactional - Medicine | £30,000 | £0 | £30,000 | £0 | £0 | £0 | Red |
| Transactional - Surgery | £162,973 | £0 | £162,973 | £86,533 | £0 | £86,533 | Red |
| Transactional - UEC | £0 | £0 | £0 | £0 | £0 | £0 | |
| Transactional - W&C | £51,040 | £0 | £51,040 | £1,040 | £0 | £1,040 | Red |
| Covid spend Reduction | £500,000 | £0 | £500,000 | £499,999 | £0 | £499,999 | Green |
| Unidentified | £155,593 | £0 | £155,593 | | £0 | £0 | Red |
| Total | £5,945,300 | £1,842,000 | £7,787,300 | £4,191,357 | £1,610,170 | £5,801,527 | |

**Board of Directors Meeting in Public**

| Subject: | Fit and Proper Person Requirement Annual Report | Date: 5th May 2022 | |
|---|---|---|---|
| **Prepared By:** | Shirley A Higginbotham Director of Corporate Affairs | | |
| **Approved By:** | Shirley A Higginbotham Director of Corporate Affairs | | |
| **Presented By:** | Shirley A Higginbotham Director of Corporate Affairs | | |

| Purpose | | | |
|---|---|---|---|
| To provide assurance to the board regarding compliance with the Fit and Proper Person Requirement | **Approval** | | |
| | **Assurance** | **x** | |
| | **Update** | | |
| | **Consider** | | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| **Financial** | N/A | | | |
| **Patient Impact** | N/A | | | |
| **Staff Impact** | N/A | | | |
| **Services** | N/A | | | |
| **Reputational** | Failure to comply with the regulations could significantly impact on the reputation of the Trust | | | |

| Committees/groups where this item has been presented before | | | | |
|---|---|---|---|---|
| N/A | | | | |

| Executive Summary |
|---|
|  |

The Care Quality Commission Regulation 5: Fit and Proper Persons requirement came into force on 1st April 2015 and was revised in January 2018 to make explicit the requirement to undertake an enhanced DBS check for directors. The Trust was already doing this.

The Policy and Procedure for the Fit and Proper Person Requirements was updated to reflect minor amendments in with changes to national NHS structures and approved by the Joint Staff Side Partnership Forum in September 2021.

The regulation applies to all directors, executive and non-executive, permanent, interim and associate positions, irrespective of their voting rights. The regulation does not apply to the Council of Governors.

The personal files of all directors are held in the Director of Corporate Affairs office. An audit of the files is undertaken annually and keeps a record of the documentation required these include DBS checks, insolvency checks and the annual self-declaration.

A review of the personal files of all directors noted the evidence required to meet the requirements.

**Board of Directors - Public**

| Subject: | NHSI – Self –certification declaration – General condition 6, FT4 and Continuity of Service Condition 7 of the NHS provider License | Date: 5th May 2022 | |
|---|---|---|---|
| Prepared By: | Shirley A Higginbotham Director of Corporate Affairs | | |
| Approved By: | Shirley A Higginbotham Director of Corporate Affairs | | |
| Presented By: | Shirley A Higginbotham Director of Corporate Affairs | | |

| Purpose | | | |
|---|---|---|---|
| The Board of Directors are asked to:<br><br>Consider and approve the attached Self-certification declarations as recommend by the Executive Team. | Approval | | x |
| | Assurance | | |
| | Update | | |
| | Consider | | x |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | Significant | Sufficient | Limited | None |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| Financial | There are no risks or issues identified in this report | | | |
| Patient Impact | | | | |
| Staff Impact | | | | |
| Services | | | | |
| Reputational | | | | |

| Committees/groups where this item has been presented before |
|---|
| Executive Team meeting 20th April 2022 |

| Executive Summary |
|---|

The annual self-certification provides assurance that NHS providers are compliant with the conditions of their NHS provider licence.  Compliance with the licence is routinely monitored through the Single Oversight Framework, however on an annual basis, the licence requires providers to self-certify they have:

a) Effective systems to ensure compliance with the conditions of the NHS provider licence, NHS legislation and the duty to have regard to the NHS Constitution (condition G6);
b) Complied with governance arrangement (condition FT4) and
c) For NHS foundation trusts, the required resources available if providing commissioner requested services (CRS) (Condition CoS7)

Attached are draft templates, provided by NHSI which are to be completed and approved by board. The trust is no longer required to submit the approved templates to NHSI but is required to publish them and keep for record keeping purposes should NHSI audit the self-certification.

The Executive Team have reviewed and agreed the suggested statements.

The Board of Directors are asked to approve the recommendations of the Trust Executive Team once approved the forms will be published on the Trust Website.

# Self-Certification Template - Condition FT4

**Sherwood Forest Hospitals NHS Foundation Trust** | *Insert name of organisation*

**NHS Improvement**

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

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

These self-certifications are set out in this template.

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

Financial Year to which self-certification relates ............................................................................................ Please Respond

**Corporate Governance Statement (FTs and NHS trusts)**

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

| | **Corporate Governance Statement** | **Response** | **Risks and Mitigating actions** | |
|---|---|---|---|---|
| 1 | The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS. | Confirmed | Systems and processes require regular attention and continued vigilance, via management and the Board committee structure. System and controls assurances are obtained via the Audit and Aussrance Committee. More complete explanations about systems of corporate governance and internal control are set out in the Annual Governance Statement included in the Trust's annual report | #REF! |
| 2 | The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time | Confirmed | Revised guidance with regard to good corporate governance forms part of the board development programme as appropriate. Corporate governance processes and systems are revised to reflect the guidance where appropriate e.g Conflicts of Interest guidance from NHS England | #REF! |
| 3 | The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation. | Confirmed | Ongoing focus of the Board on its structures to ensure it can undertake its central role of strategic planning, risk management and performance oversight effectively. | #REF! |
| 4 | The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 5 | The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |
| 6 | The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence. | Confirmed | [including where the Board is able to respond 'Confirmed'] | #REF! |

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

**Signature**                    **Signature**

_____                _____

**Name** Claire Ward ............    **Name** Paul Robinson ............

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

A

Please Respond

**Worksheet "Training of governors"**          Financial Year to which self-certification relates          | 2021/2022 |          Please Respond

## Certification on training of governors (FTs only)

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

**Training of Governors**

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

| Confirmed | OK |

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

**Signature**                                  **Signature**

Name  Claire Ward                              Name  Paul Robinson

Capacity  Chair                                Capacity  Chief Executive

Date                                           Date

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

A   However the impact of the COVID 19 pandemic has signifiantly reduced the opportunities for governor training since the end of March 2022, although Governors have received regular communications regarding the impact of COVID 19 on the operational aspects of the Trust with regarding to patient services and staff welfare.

# Self-Certification Template - Conditions G6 and CoS7

**Sherwood Forest Hospitals NHS Foundation Trust**                    *Insert name of organisation*

**NHS Improvement**

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

*Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence*

*Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)*

These self-certifications are set out in this template.

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

Financial Year to which self-certification relates    2021/2022    Please complete the explanatory information in cell

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

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

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

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

**Confirmed**

OK

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

**EITHER:**

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

**Confirmed**

Please fill details in cell E22

**OR**

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

Please Respond

**OR**

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

Please Respond

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

[e.g. key risks to delivery of CRS, assets or subcontractors required to deliver CRS, etc.]

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

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

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

**Board of Directors Meeting in Public**

| Subject: | COVID-19 Vaccination Programme: UPDATE | Date: 5th May 2022 | |
|---|---|---|---|
| Prepared By: | Robert Simcox Deputy Director of People<br>Kim Kirk Operations Lead for Hospital Hub | | |
| Approved By: | Robert Simcox Deputy Director of People | | |
| Presented By: | Robert Simcox Deputy Director of People | | |

| Purpose | | | |
|---|---|---|---|
| The paper provides an overview to date of the contributions the Trust has made in supporting the COVID-19 Vaccination Programme role out across Nottingham and Nottinghamshire. | **Approval** | | |
| | **Assurance** | x | |
| | **Update** | | |
| | **Consider** | | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | Significant | Sufficient | Limited | None |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| Financial | Improving productivity and workforce utilisation and impact | | | |
| Patient Impact | Maintain safe staffing levels and a good patient experience | | | |
| Staff Impact | Improve working lives | | | |
| Services | Staffing levels impact service and bed availability | | | |
| Reputational | SFH recommended as a great place to work | | | |

| Committees/groups where this item has been presented before |
|---|
| None |

**Executive Summary**

The aim of the COVID-19 vaccination programme is to protect those who are at risk of serious illness or death should they develop COVID-19, and reduce transmission of the infection, thereby contributing to the protection of population health.

The paper provides an overview of the contributions the Trust has made to support the Nottingham and Nottinghamshire COVID-19 vaccination programme.

The details of the vaccinations issued to date are summarised in the attached slides.

The Summary highlights to date are:

- KMH Hub relocation
- KMH Hub currently delivered over 209,000 vaccines
- Assurance and operational approval for Moderna vaccine granted and daily clinics talking place
- Awaiting national update regarding cohorts to be offered 4th dose in Autumn 2022.

- KMH Hub currently offering vaccines to cohorts:

  - Adults aged 75 years and over,
  - Residents in a care home for older adults
  - 5-11 year olds
  - Immunosuppressed patients 12 years and older
  - Evergreen offer – 1st and 2nd doses to eligible cohorts

Recommendation

The Trust Board is asked to take assurance from the report and to note the significant contributions made by colleagues at Sherwood Forest to enable the successful delivery of vaccinations to the citizens of Nottinghamshire and colleagues working at Sherwood.

# Programme Assurance Report April 2022

## COVID 19 Vaccination Programme
## Sherwood Forest Hospital Hub
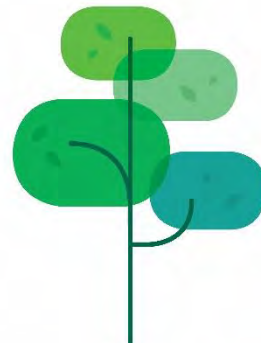
# Performance to date

(8th December 2020 – 22nd April 2022)



| Vaccines Administered | Total number of first doses administered | Total number of second doses administered | Total number of third/booster doses administered | Total 5-11 year old vaccines administered |
|---|---|---|---|---|
| 209,289 | 68,083 | 75,062 | 66,190 | 1,214 |

| Total waste recorded to date (all reasons) | Overall number of vaccines not administered | Overall number of DNAs recorded to date | Overall number of incidents recorded to date |
|---|---|---|---|
| 3,244 | 644 | 15K | 28 |



Administration of Vaccine by Cohort in 2022



Total Vaccines administered since December 2020
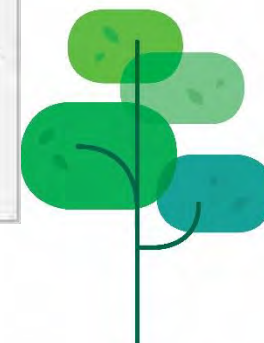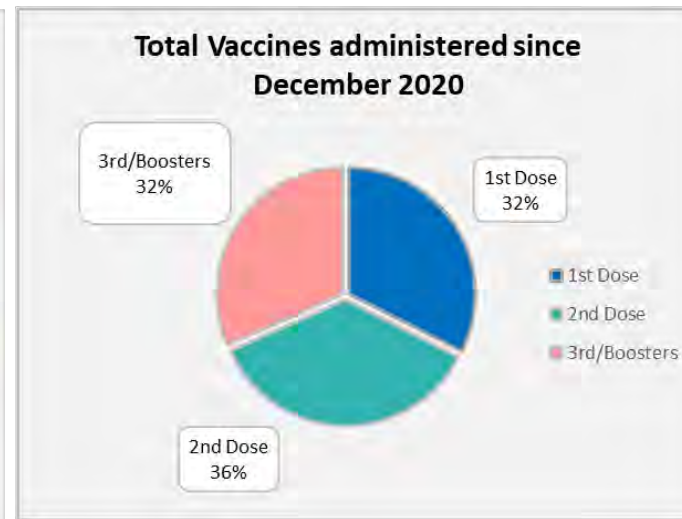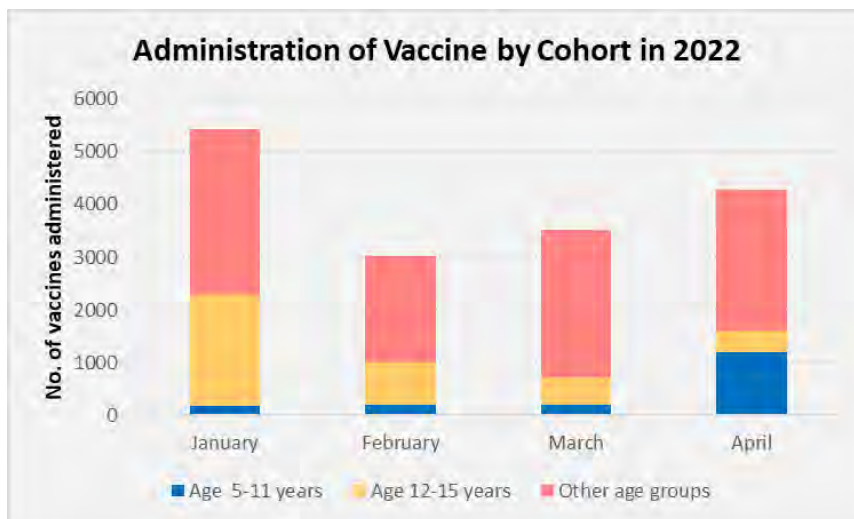
# Monthly performance (April 2022)

**Sherwood Forest Hospitals**
**NHS Foundation Trust**

| Total Vaccines Administered to date | Vaccines Administered this month | Overall number of vaccines not given this month | DNAs recorded during this month | Total waste recorded this month |
|---|---|---|---|---|
| 209,289 | 4,149 | 5 | 395 | 143 |



Daily Vaccinations by Dose - April 2022
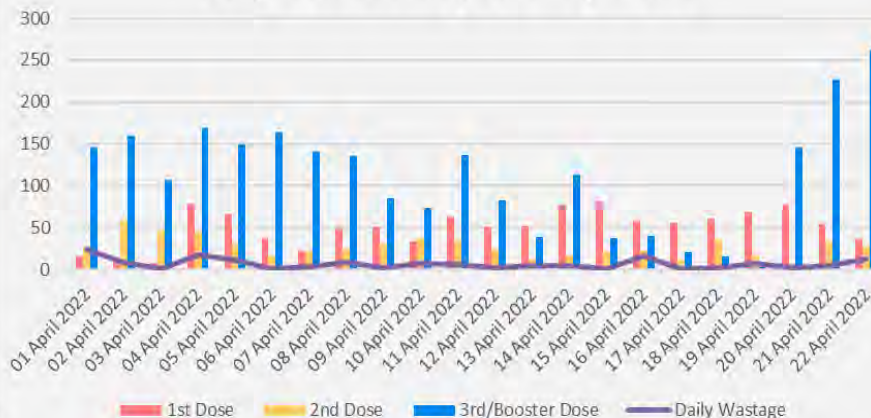


Daily Vaccinations - April 2022
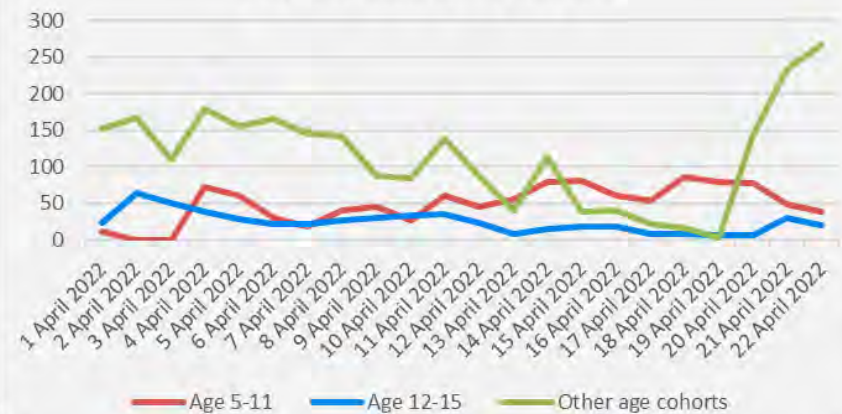
# KMH Hub Relocation Update

- KMH Hub relocated on 21st April 2022 from the Education Centre to TB3.
- A number of temporary fittings and fixtures are currently in place due to be completed in early May 2022.
- IPC visit completed and compliance confirmed
- Pharmacy Assurance visit completed and compliance met with assurance provided to regional programme
- All support services have been redirected to new location
- Internal and external communications to confirm relocation taken place, with adjustments to signs throughout KMH site. Social Media updates have been shared with map of KMH with previous hub location and new hub location
- Transfer of IT, telecommunications and signage has been completed to support relocation.

Assessment Area

Vaccination Area

Vaccination/Recovery Area

# Board of Directors Meeting - Cover Sheet

| Subject: | Ockenden Final Report Update | Date: 25/04/2022 | |
|---|---|---|---|
| Prepared By: | Paula Shore, Divisional Head of Nursing and Midwifery | | |
| Approved By: | Robin Binks, Deputy Chief Nurse | | |
| Presented By: | Julie Hogg, Executive Board Safety Champion & Clare Ward, Non-executive Board safety champion | | |

| Purpose | | | |
|---|---|---|---|
| To provide the board with an overview of the recently published report into Maternity Services at Shrewsbury and Telford Hospital NHS Trust (SaTH) and its associated impact and actions required at Sherwood Forest Hospitals NHS Foundation Trust (SFHFT). | **Approval** | | |
| | **Assurance** | | x |
| | **Update** | | x |
| | **Consider** | | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| **Financial** | | | | |
| **Patient Impact** | x | | | |
| **Staff Impact** | X | | | |
| **Services** | x | | | |
| **Reputational** | x | | | |

| Committees/groups where this item has been presented before |
|---|
| None |

| Executive Summary |
|---|

Following the publication of the interim report in December 2020, the final Ockenden report containing the findings, conclusions and essential actions from the independent review of maternity services at The Shrewsbury and Telford Hospital NHS Trust was published on 30th March 2022.

The first report outlined the Local Actions for Learning (LAfL) and 15 Immediate and Essential Actions (IEAs) to be implemented at the Trust and wider maternity system in England. Within these 15 IEA's are 88 actions.

As a trust we have declared full compliance to six out of the seven IEAs with the remanding requiring further working with newly appointed interim Chair of the Maternity Voice Partnerships to achieve full compliance.

The new 15 IEAs are currently under review in preparation for the self-assessed return, progress as outlined within this paper.

**Overview**

At Sherwood Forest Hospitals we have started the process of starting to self-assess using our previous governance frameworks for reporting through the Maternity Assurance Committee (MAC) whilst awaiting further national instructions around the reporting requirements.

The immediate and essential areas for proposed national action from the report are as outlined below and the evidence for the self-assessment review has commenced, to date we have had 6 IEA's peer assessed.

| Ockenden Final Report 15 Immediate and Essential Actions | |
|---|---|
| 1. Workforce planning and sustainability- completed | 9. Preterm birth |
| 2. Safe staffing- completed | 10. Labour and birth |
| 3. Escalation and accountability- completed | 11. Obstetric anaesthesia |
| 4. Clinical governance (leadership) | 12. Postnatal care |
| 5. Clinical governance (investigation and complaints) | 13. Bereavement care |
| 6. Learning from maternal deaths | 14. Neonatal care |
| 7. Multidisciplinary training | 15. Supporting families |
| 8. Complex antenatal care | |

**Next steps**

The peer assessment will continue through the MAC with the aim to bring the final approved gap analysis and subsequent action plan to June's Board meeting.

**Recommendation**

That Board members note the contents of the report

**Board of Directors Meeting - Cover Sheet**

| Subject: | Maternity and Neonatal Safety Champions Update March 2022 | Date: 24th April 2022 | |
|---|---|---|---|
| Prepared By: | Paula Shore, Divisional Head of Nursing and Midwifery | | |
| Approved By: | Julie Hogg, Chief Nurse | | |
| Presented By: | Julie Hogg, Executive Board Safety Champion & Clare Ward, Non-executive Board safety champion | | |

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

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | Significant | Sufficient | Limited | None |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| Financial | | | | |
| Patient Impact | x | | | |
| Staff Impact | X | | | |
| Services | x | | | |
| Reputational | x | | | |

| Committees/groups where this item has been presented before |
|---|
| None |

| Executive Summary |
|---|

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

This report provides highlights of our work over the last month in relation to:
- The service user voice
- Staff engagement
- Governance
- Quality improvement
- Safety culture

Our monthly focus is on the professional midwifery advocate service. Board is asked to note the updates on these key pieces of work.

**Update on Mandated Maternity and Neonatal Safety Champion (MNSC) work for March 2022**

1. Service User Voice

   The Professional Midwifery Advocacy (PMA) service continues to provide services to both our women and their families, through the birth outside of guidance, birth after thoughts clinic and to staff through open clinics and planned clinical restorative supervision sessions.

   Sarah, our service user representative, is continuing to support and ensure that the maternal voices are heard within our services. We have completed our first 'walk of the patch', details as provided within the feature. Sarah will be sharing her own bereavement journey and her reflections on the Ockenden report during this board meeting.

2. Staff Engagement

   The MNSC Walk Round was completed on the 14th of March 2022. Positive feedback was received from the teams and colleagues were reassured that any necessary actions have been taken from previous walk rounds.

   The Maternity Forum occurred on the 21st of March, chaired by Robin Binks. Positive feedback was provided around several ideas to improve colleague experience such as the purchase of lanyards that identify individuals' roles. These have been progressed divisionally. A colleague raised concerns about birthing partners not being allowed into triage, discussion was had around the difficulties with this due to space and social distancing. It was reiterated by Paula Shore that anyone who requires an individualised support plan then we can accommodate these. Teams were reminded of the importance of personalised care and support plans. All discussion and subsequent actions are captured and shared out within the Maternity Matters newsletter which is distributed to all colleagues.

3. Governance

   The final Ockenden Report was released on the 31st of March, outlining 15 additional immediate and essential actions to be taken by all Trusts, a separate paper will be presented as to the current position and plans for SFH.

   NHSR have confirmed our full compliance with the 10 safety actions for year 3 as signed off by the board of directors in 2021. The Year 4 pause remains and the teams across the division continue to work on the minimum reporting requirements.

4. Quality Improvement Approach

   Work continues on the Maternity and Neonatal Safety Improvement Programme, and our smoking cessation team are due to present at the next regional meeting.

5. Safety Culture

   The executive team have approved procurement of the SCORE safety survey. The quality improvement team are planning the roll out across the maternity service and associated actions.

**2. Monthly Feature- Service User Representative and Professional Midwifery Advocates**

As outline above, Sarah completed her first walk of the patch this month, providing the below feedback to the MNSC meeting:

*I just wanted to let you know how overwhelmingly positive the feedback was today from the ladies who I listened to. I spoke with 11 women and one partner today and the key themes coming out were: 'amazing experience', 'partners involved', 'brilliant' 'staff going above & beyond', 'supportive', 'caring', 'helpful', 'positive', 'listened to' which was just lovely to hear and I will make sure I feed it back to people.*

- A couple of specific examples which jumped out at me from today that I wanted to make you aware of:

- One lady, who was a first-time mum:

  *"Before I came into hospital, I was really scared of midwives – some of the things which I have read in the news made me afraid of midwives and of what the birth would be like. But there was no need for me to feel frightened- it was the best experience ever".*

  I think it's really important to acknowledge how the Ockenden report and the NUH review and the way that they are reported in the media can affect families, their birth choices and how they feel about coming into hospital & accessing services...... I know that you already try to put things in place to support staff who may be affected by these reports but is there something specific for women/birthing people/families? Is there more we can do to put them at ease – even just acknowledging these reports on Trust social media & sharing a contact number for anyone who is booked here who has concerns which they would like to talk through?

- Another first-time mum:

  *"All the information given to us from Drs is at a time when our partners aren't on the ward so then I have to relay it to my partner, which I find really hard because I'm not a healthcare professional and he then has questions which I can't answer"*

  Is there anything which can be quickly implemented to resolve this kind of issue – e.g. if a woman would like her partner to listen in when a Dr is explaining things, could they join the conversation on speaker-phone or Facetime?

All the above comments and recommendations have been noted and actions taken through MNSC and relevant divisional meetings for action.

Our Professional Midwifery Advocacy (PMA) provided a further breakdown, see infographic below, as to their activities since the launch on the 6th of February. Again, the delivery issues have been noted and are being monitored. The main risk remains attendance at restorative clinical supervision.

# PMA Maternity Safety Champions Update: APRIL 2022

*Figures since PMA Launch

## Birth Afterthoughs(21)



(Themes)

Chart categories: Labour events, Poor experience, Poor communication, Future birth plans, Trauma, Consent, lack of compassion

### Key actions completed
- 21 Birth afterthoughts (2hr sessions) ^from 9

### Key actions Planned
- Receive feedback on all birth afterthoughts sessions
- Communications to approve letters/informing women how to self refer (signpost)
- Setting up birth afterthoughts clinics x2 per week

## Birth Options (6)



(Themes)

Chart categories: Choices regarding mode of delivery, In depth birth plan

### Key actions completed
- 6 women access birth options (on going) ^ from 2
- Poster/email sent to all consultants about this service & how to refer

### Key actions Planned
- Receive feedback on all birth options sessions
- Communications to approve letters/informing women how to self refer
- Setting up birth options clinics x1 per week
- Complete guideline 'personalised women centred care: shared decision making'

## RCS - Individual and group (29)



(Themes)

Chart categories: Civility & respect, QI, Career coaching, HSIB interviews, 1-2-1
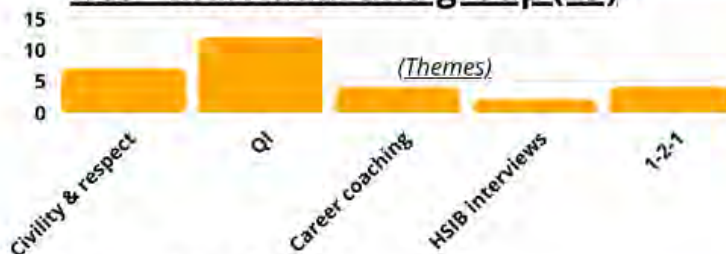
### Key actions completed
- List collated to invite midwives for individual RCS
- Working with governance to support midwives involved in incidences
- Monthly reflect and learn sessions with early career midwives

### Key actions Planned
- Invite midwives for individual RCS from April
- Offer TOIL to midwives attending RCS in their own time
- Invite midwives for individual RCS from April
- Offer TOIL to midwives attending RCS in their own time

## FFT



(Themes)

Homebirth service 6.9%
Delays 24.1%
Visiting 13.8%
Staffing 41.4%

### Key actions completed
- Indentifying themes

### Key actions Planned
- Improve quantity FFT feedback
- Share feedback with shared governance council- ideas for improvement

**Delivery risks:** Too early to comment

**Delivery issue:** Releasing staff for RCS sessions, uptake of RCS, implementing new guideline into practice

# Maternity Perinatal Quality Surveillance model for April 2022

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

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

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

## Exception report based on highlighted fields in monthly scorecard (Slide 2)

| Obstetric haemorrhage >1.5L (Mar 3%) | APGARS <7 at 5 minutes (2%, Mar 22) | Staffing red flags |
|---|---|---|
| • Improvement made on previous month, remains below revised national rate (>3.6%)<br>• Cases reportable via maternity triggers - no lapses in care / learning points identified<br>• Division have signed up to regional pilot- first planning meetings on hold for April 22 | • Rate, remains over national threshold, noted no adverse incident, cases or term admissions related to this rate.<br>• Board are reminded that over-reporting will result in enhanced observation of the baby<br>• Deep dive paper on agenda for MAC in May 2022 | • 4 staffing incidents reported in month<br>• Challenges due to short term/ short notice sickness related to COVID-19 persist but with an improving position.<br><br>**Home Birth Service**<br>• Due to vacancies and sickness homebirth services remains limited as per Board approval. This has been further escalated to the CCG and regionally for awareness.<br>• 1 Homebirth conducted in Mar 22, plan in place to re-start the full service in Quarter 2 22-23 |

### FFT (90% Mar 22)

| | Maternity Assurance Divisional Working Group | | Incidents reported Mar 22 (69 no/low harm, 1 as moderate) | |
|---|---|---|---|---|
| • FFT remains improved following revised actions<br>• New system being implemented in April which may cause disruption.<br>• CQC annual maternity feedback survey received, Trust results remain the same as other units, noting the COVID challenges, action plan made from findings.<br>• Service User Representative in post and providing additional pathways for maternal feedback | **NHSR** | **Ockenden** | **Most reported** | **Comments** |
| | • NHSR year 4 reporting has been paused – re-launch due Mid-April 22<br>• Confirmation received that SFH was successful in obtaining the Year 3 rebate | • One year on submission completed 15/04/22.<br>• Final Ockenden report released 31/03/22. 15 additional IEA's for all Trust nationally to work towards. Separate paper provided to board | Other (Labour & delivery) | No themes identified |
| | | | Triggers x 14 | Cases included, PPH, term admission, category 1 LSCS |
| | | | One incident reported as 'moderate' | |

## Other

- Staffing incidents remain static, review of 21-22 birthrate underway. Noted an increased and revised BR+ report to be completed on the 26/04/22
- LMNS quality insight visit planned for the 20/04/22 as part of the year one national Ockenden recommendations. Positive feedback received.
- Active recruitment continues, Matron for Maternity Governance post closed, strong applications.
- No further formal letters received and all women who have a planned homebirth, all women due April and Mau have been written to by the Head of Midwifery to outline current situation
- Midwifery Continuity of Carer formal data collection paused nationally, LMNS work ongoing for Year 1 plans for transformation, Year 1 focus on system alignment of digital workstream
- Moderate case taken to Trust scoping, for local investigation and learning. Delay in category One LSCS timeframes.

# Maternity Perinatal Quality Surveillance scorecard

| | OVERALL | | SAFE | | EFFECTIVE | | CARING | RESPONSIVE | | | WELL LED | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CQC Maternity Ratings - last assessed 2018 | GOOD | | GOOD | | GOOD | | OUTSTANDING | GOOD | | | GOOD | |
| | | | | | | | | | | | | |
| Maternity Safety Support Programme | No | | | | | | | | | | | |

| Maternity Quality Dashboard 2020-2021 | Alert [national standard /average where | Running Total/ average | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1:1 care in labour | >95% | 99.81% | 95% | 95% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| Women booked onto MCOC pathway | | | 18% | 20% | 20% | 20% | 20% | | | | |
| Women recoving MCOC intraprtum | | | 0% | 0% | 0% | 0% | 0% | | | | |
| Total BAME women booked | | | 21% | 21% | 20% | 20% | 20% | | | | |
| BAME women on CoC pathway | | | 5% | 15% | 15% | 15% | 15% | | | | |
| Spontaneous Vaginal Birth | | | 60% | 62% | 51% | 61% | 57% | 56% | 63% | 61% | 59% |
| 3rd/4th degree tear overall rate | >3.5% | 2.18% | 3.00% | 2.30% | 0.94% | 2.11% | 3.00% | 2.50% | 2.78% | 2.52% | 2.90% |
| Obstetric haemorrhage >1.5L | Actual | 116 | 7 | 8 | 8 | 9 | 10 | 9 | 6 | 8 | 7 |
| Obstetric haemorrhage >1.5L | >3.5% | 3.24% | 2.60% | 2.70% | 2.51% | 2.90% | 3.50% | 3% | 2.12% | 3.30% | 2.60% |
| Term admissions to NNU | <6% | 3.62% | 4.60% | 2.10% | 2.16% | 3.70% | 3.20% | 3.70% | 5.00% | 3.50% | 3.50% |
| Apgar <7 at 5 minutes | <1.2% | 1.56% | 1.30% | 0.68% | 1.20% | 1.52% | 2.03% | 2.10% | 1.90% | 1.80% | 2.00% |
| Stillbirth number | Actual | 11 | 1 | 0 | 1 | 0 | 0 | 3 | 1 | 1 | 1 |
| Stillbirth number/rate | >4.4/1000 | 4.63 | | | 2.176 | | | 3.400 | | | 3.727 |
| Rostered consultant cover on SBU – hours per | <60 hours | 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 |
| Midwife / band 3 to birth ratio (establishment) | >1:28 | | 1:30.4 | 1:30.4 | 1:30.4 | 1:29 | 1:29 | 1:29 | 1:29 | 1:22 | 1:22 |
| Midwife/ band 3 to birth ratio (in post) | >1:30 | | 1:31.4 | 1:31.4 | 1:31.4 | 1:29 | 1:29 | 1:28 | 1:28 | 1:24 | 1:24 |
| | | | | | | | | | | | |
| Number of compliments (PET) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| Number of concerns (PET) | | 9 | 2 | 1 | 2 | 4 | 0 | 0 | 0 | 0 | 2 |
| Complaints | | 11 | 1 | 2 | 1 | 3 | 2 | 1 | 1 | 1 | 2 |
| FFT recommendation rate | >93% | | 91% | 91% | 92% | 88% | 96% | 96% | 92% | 91% | 90% |
| | | | | | | | | | | | |
| PROMPT/Emergency skills all staff groups | | | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% | 100% |
| K2/CTG training all staff groups | | | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| CTG competency assessment all staff groups | | | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% | 98% |
| Core competency framework compliance | | | 26% | 38% | 50% | 62% | 70% | 70% | 81% | 81% | 88% |
| | | | | | | | | | | | |
| Progress against NHSR 10 Steps to Safety | 4 <7 7 & above | | | | | | | | | | |
| Maternity incidents no harm/low harm | Actual | 626 | 84 | 84 | 76 | 63 | 57 | 89 | 83 | 45 | 69 |
| Maternity incidents moderate harm & above | Actual | 5 | 0 | 0 | 0 | 1 | 1 | 0 | 1 | 1 | 1 |
| Coroner Reg 28 made directly to the Trust | | Y/N | N | N | N | N | N | 0 | 0 | 0 | 0 |
| HSIB/CQC etc with a concern or request for action | | Y/N | N | Y | N | N | N | | N | N | N |

Healthier Communities, Outstanding Care

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

# Sherwood Forest Hospitals Quality Strategy
## 2022-2025

**Best NHS Acute Trust in the Midlands**
(2018, 2019 and 2020 NHS Staff Survey)

# Contents

# Foreword

**Sherwood Forest Hospitals
Quality Strategy 2022-2025**

## Welcome to the Sherwood Forest Hospitals Quality Strategy 2022-2025.

**Cessit, que nisquia corecturit qui doluptur reribusci que possit escipsu scitationet voluptatis eiunt estiber eperia sequunt venim que vendus sit aut eium.**

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# Purpose of the Strategy

**Patient safety, clinical effectiveness and quality of care are at the heart of the Sherwood strategic vision. Every day colleagues demonstrate their commitment to providing outstanding patient-focussed care, as they strive to do their very best, in often difficult circumstances.**

Our commitment to continuously learn and improve is firmly embedded within this strategy, the purpose of which is to outline how we will deliver safe person-centred care to our citizens and support our colleagues by providing the best possible practice environment. This includes not only our Sherwood people, but everyone we collaborate with across health and social care in Nottinghamshire. This is underpinned by the Sherwood approach to quality improvement and our ambition to become a level 5 exemplar site for continued learning and improvement.

The following figure references the core components that have informed the development of this Strategy:
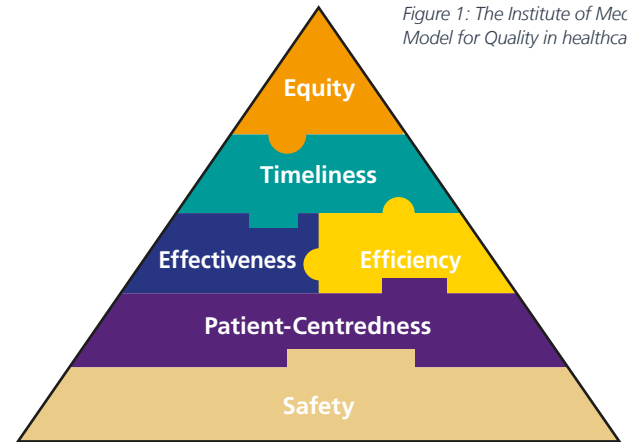


*Figure 1: The Institute of Medicine Model for Quality in healthcare*

**The following definitions of each component adapted for the OPTIC study**

**Equity** - no bias associated with access to continuum of care.

**Timeliness** - actions resulting in no unneccessary or unwanted delay.

**Effectiveness** - actions that align best available evidence with optimal outcome.

**Efficiency** - actions which cause no overuse or underuse of resources, e.g. investigations, treatments etc.

**Patient-Centredness** - actions informed by knowledge of and respect for diversity, values, choices and needs of residents. Emphasises care coordination, continuity, communication, education and shared decision-making.

**Safety** - actions that cause no unnecessary harm.

# Sherwood Forest Hospitals Quality Strategy 2022-2025
## Our Quality and Improvement Journey

**The 2018-2021 Quality Strategy saw the launch of a robust programme of innovative initiatives, underpinned by key priorities and measures.**

Key successes include the accreditation of Sherwood Forest Hospitals as a Schwartz Round site, the development of the PASCAL Safety Attitude Questionnaire that was launched in key services such as ED, Maternity, Theatres and across all wards. This involved over 2000 front line colleagues sharing their views on safety within their services. From this action plans were developed to target areas of both strength and areas for development. We focussed on awareness of quality at local levels, through clinical audit and activities such as quality rounds and '15 step' deep dives led by Governors and members of the Executive team. The strategy also led to a focus on external benchmarking and visits to peer organisations via Getting It Right First Time and peer reviews.

The above activities aligned to, and complimented the Quality Improvement Strategy, the focus of which was to develop an evidence-based QI approach, and to build improvement capabilities as part of an inclusive offer to all colleagues. This led to a system QI training offer, delivered in collaboration with partner organisations.

During the time, the Care Quality Commission inspected the organisation; in 2020, Sherwood was rated 'Good' overall and the main site, King's Mill Hospital was rated 'Outstanding'.

We believe that this revised strategy will further build on these successes. We will deliver the very highest quality of care and outcomes for our patients alongside ensuring our staff well-being. Our ambition is to be one of the leading healthcare organisations in the country, and to be at the forefront of services that will see us provide innovative, efficient, effective, and meaningful health and social care pathways.

| Ratings | |
| --- | --- |
| **Overall trust quality rating** | Good ● |
| Are services safe? | Good ● |
| Are services effective? | Good ● |
| Are services caring? | Outstanding ☆ |
| Are services responsive? | Good ● |
| Are services well-led? | Good ● |
| Are resources used productively? | Requires improvement ● |

# Overview

## Strategic Objectives

## Over the next five years we will...

## Values

**To provide outstanding care**
1. Give patients, carers and families a positive experience
2. Provide safer and clinically effective care
3. Improve coordination across health and social care

**1 Communicating and working together**

**To promote and support health and wellbeing**
1. Support people to have healthier lifestyles
2. Help to improve mental wellbeing including reducing loneliness
3. Work with partners to reduce health inequalities for those in greatest need

**2 Aspiring and improving**

**To maximise the potential of our workforce**
1. Attract and retain the right people
2. Have an engaged, motivated and high performing workforce
3. Develop and nurture our teams of colleagues and volunteers

**3 Respectful and caring**

**To continuously learn and improve**
1. Adopt evidence-based best practice
2. Make the best use of information and digital technology
3. Use research, innovation and improvement for the benefit of our communities

**4 Efficient and safe**

**To achieve better value**
1. Become financially sustainable
2. Work with our partners across Nottinghamshire to deliver efficiencies
3. Maximise the use of all our resources

## Vision:
Healthier communities and outstanding care for all

**Foundations:**

**Partnership:** Working with health and social care partners, including primary care, patients, carers, the voluntary sector, the public and of course SFH colleagues

**Culture:** Embedding our values and behaviours and promoting an open and inclusive culture that embraces diversity

# Reflections on our previous Quality Priorities

**Campaign One: A positive patient experience:**

**by 2021 we aim to: (i)** have moved beyond a paternalistic approach to a model of care that is genuinely patient-centred and making progress towards models of care developed in partnership with service users; **and (ii)** to consistently achieve and maintain service user recommendation ratings at or above 98%.

**Campaign Two: Care is safer:**

**by 2021 we aim to: (i)** have the lowest number of serious incidents of any East Midlands NHS acute care provider; **and (ii)** achieve 12 consecutive months or more without a Never Event.

**Campaign three: Care is clinically effective:**

**by 2021 we aim to: (i)** benchmark in the top quartile for lowest Length of Stay; **and (ii)** benchmark in the top quartile for lowest rate of readmissions within 28-days of discharge for the same HRG.

**Campaign Four: We stand out:**

**by 2021 we aim to: (i)** be rated outstanding by the Care Quality Commission; **and (ii)** at a system level, to keep patients with long term conditions well, as independent as possible and avoid foreseeable crisis points which often result in hospital admission.

The progress made on each campaign has been monitored and reviewed each month by the Medical Director and Chief Nurse. Progress was reported to the Quality Committee and routinely, as part of the cycle of business, to the Board of Directors. It is proposed that this governance route continues for this current strategy. As our improvement journey has matured, colleagues have gained confidence in implementing small changes and improvements within their local areas. These have positively contributed to the current position and we are recognised regionally and nationally for exemplar practice, benchmarking above the regional or national average in a significant number of indicators.

# Reflections on our previous Quality Priorities

This can be evidenced by the national recognition that we have gained, for example, as Finalist in the Health Service Journal Patient Safety Awards 2020 for our work on progressing the safety climate surveys. We continue to robustly monitor progress of our quality agenda through our safety and quality governance framework, and work in collaboration with other internal services as well as collaborating across the wider health and social care footprint.

Providing safe, effective, high quality care and protecting patients from avoidable harm is one of the five 'outcome' domains outlined in the NHS Outcomes Framework. This has led to increasing regulation and performance metrics which has shaped the way we structure, set, and monitor our quality outcomes. The following figure references the key reports and data sources that have supported the development of this strategy.

This strategy sets out the next steps on our 'Journey to Outstanding'. It builds on an increased expectation of individual organisations working together as systems to deliver safe and effective care against a backdrop of rising demand, constrained funding growth and increasing patient expectations.

Key priorities must include a focus on improving population health, making the very most of the funding we receive, and attracting, retaining and developing our staff. Our Quality Strategy underpins the 'Quadruple Aim' for delivering high quality of care

**In this document we have set out our strategy for quality in a way that is designed to hold value for our staff, patients, carers, commissioners and other stakeholders. We set out what 'outstanding' means to us and provide an overarching framework to:**

- Deliver outstanding safe care
- Ensure we meet the needs of our patients, carers and communities
- Work in partnerships to improve the health of the population and eliminate health inequalities
- Grow and strengthen our culture of continuous improvement and learning, and improve staff experience and well-being
- Deliver quality and value to achieve sustainability for the health service

# Developing our Quality Strategy:

## What does quality mean to our staff?

### We have listened and engaged with members of our staff, they told us:

*"Quality is correct treatment, correct time, and correct person"*
Sarah Chappell - Senior PPC

*"Quality for me means care that is safe and as personalised as possible. Not 'one size fits all"*
Diane Best - Lead Midwife

*"Aspiring to provide care, devices, and a service that meets or exceeds our definition of fitness for purpose"*
James Fuller - Orthotic Workshop Manager

*"The best treatment and care given at the correct time and involving patients and carers"*
Ian Pleasance - Specialist Audiologist

*"Providing good quality care to a standard that I would expect to receive myself"*
Natalie Ward - Senior Radiographer

*"Providing the safest, most efficient and personalised care without compromise"*
Leanne Milnes - Specialist Biomedical Scientist

*"From an outpatient area - to provide safe, timely and efficient care. Aspire to improve depending on patient feedback"*
Tracyjane Smith - Welcome Treatment Centre Department Leader

*"Transparent and accurate summary of medical management providing a platform to learn from deaths"*
Christopher Hewitt  Medical Examiner Officer

*"Means to support and develop our staff and students to deliver high quality personalised, patient care"*
Deborah Green - Professional Training and Education Nurse Trainer

*"Safe and efficient care to our patients and local community"*
Ming Cheung - Highly Specialist Pharmacist

# Developing our Quality Strategy:

## What does quality mean to our staff?

### We have listened and engaged with members of our staff, they told us:

*"Providing care that you would want for yourself or your family. Safe, effective and caring"*
Charlie Phillips - Registered Nurse

*"Quality is providing the correct care and treatment for each individual patient at the right time"*
Hannah Newman – Occupational Therapist

*"To provide the best quality is to treat people as you would like to be treated"*
Sharon Russo - Clerical Officer

*"To provide all patients with the opportunity to take part in research studies in a safe and ethical way which will contribute to the development of new and improved treatments and services for patients in the future"*
Sarah Shelton - Research Nurse

*"Quality is treating the whole patient not just their medical complaint; personalising our medical approach and giving patients the information, options, explanations and time to make the right decision for them based on their individual beliefs and circumstances"*
Dr Rebecca Barker - Consultant Anaestheist

# Our Quality Campaigns

The Care Quality Commission's Intelligent Monitoring System and new insight model focuses on key areas of quality and safety. Their assessment of services is based on the following five elements which, in turn, are based on the things that matter most to people. It is for this reason that they are key themes throughout this strategy.

## Safe
People are protected from abuse and avoidable harm.

## Effective
People's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

## Caring
Staff involve and treat people with compassion, kindness, dignity and respect.

## Responsive
Services are organised so that they meet people's needs.

## Well Led
The leadership, management and governance of the organisation assures the delivery of high quality person-centred care, supports learning and promotes an open and fair culture.

# Sherwood Forest Hospitals Quality Strategy 2022-2025
## Campaign One

## Create a positive practice environment to support the safest most effective care

**What does the safest and most effective care look like?**

Our patients will receive the safest and most effective interventions every time.

**What does success look like?**

Sherwood Forest Hospitals will be recognised by its patients, colleagues, community healthcare providers and regulators as providing outstanding safe and effective care.

**We are going to:**

Progress our focus on having a 'just culture'. We will do this by adopting a transparent and 'no blame' approach and by sharing learning when things go well and when things go wrong across the organisation and the system. Develop robust assurance processes that underpin safe systems in patient care and will engage proactively with our commissioners and regulators. We will ensure that we have systems in place to ensure clinical effectiveness, via Clinical Audit and our quality priorities. We will ensure that our colleagues have the appropriate training and development for their needs, to provide outstanding and evidence-based care.

| WE ARE GOING TO FOCUS ON | HOW WILL WE KNOW WE HAVE SUCCEEDED? | OUR MEASURE |
|---|---|---|
| Being accredited as a designated 'Pathway to Excellence' organisation | Awarded Pathway to Excellence designation by the American Nurses Credentialling Centre (ANCC) | **Well-Led** |
| Increase the external accreditation of Trust departments where available by progressing accreditation in Radiology, Cardiology and Ophthalmology and regaining Haematology Accreditation | Achieved accreditation by the United Kingdom Accreditation Services in each of these services | **Responsive** |
| Increasing our completion of the audit programme and visibility of outcomes | Audit 10% of all local audits to assess the quality of intervention and outcomes, and to pull through learning into the organisation. Sharing and learning events across the organisation, system and nationally | **Safe & Effective** |
| **Reducing avoidable harm by:**<br>a. Increasing the mobilisation of patients to reduce deconditioning and falls<br>b. Maintaining low rates of hospital acquired infections with no breaches in thresholds for monitored infections<br>c. Ensuring patients have appropriate VTE assessment and associated prophylaxis | Falls rate < 6.6 per 1000 bed day.<br><br>No breaches in thresholds for monitored infections.<br><br>95% of patients have a VTE assessment and appropriate prophylaxis | **Safe** |
| **Increasing medication safety by:**<br>d. Implementing the electronic prescribing and medicines administration system<br>e. No allergy breaches<br>f. Embedded learning from critical medication incidents<br>g. Embedded learning from medication associated errors | EPMA is live across the trust<br><br>No allergy breaches<br>Evidence of learning from critical medication incidents<br>Evidence of learning from medication associated errors | **Safe** |
| Understanding the safety attitude across the organisation with targeted intervention to enhance safety attitude | Implementation, roll out and use of SCORE Safety Attitude Questionnaire from 2022 | **Well-Led** |

# Campaign Two

## Excellent patient experience for users and the wider community

### What does an outstanding excellent patient experience look like?

We will ensure that patients, their families and carers receive person-centred care and an excellent experience, from referral to discharge.

### What does success look like?

There will be a year-on-year increase in positive feedback through mechanisms such as 'Friends and Family' surveys. There will be visible and transparent platforms in place for our citizens to engage with us, both within key organisational meetings and via our Quality Improvement projects. There will be evidence of community engagement in shaping our services.

### We are going to:

Listen and act on patient concerns, complaints and compliments.

Work with system health and social care providers to provide a person centred response.

Engage more directly with service users and our community, with more visibilities of opportunities to shape our quality of care

Work with our regulators and other external agencies to understand our current data, and to incorporate learning into actions via our continuous improvement approach.

| WE ARE GOING TO FOCUS ON | HOW WILL WE KNOW WE HAVE SUCCEEDED? | OUR MEASURE |
|---|---|---|
| Respond to complaints within Trust targets to efficiently identify and embed learning by delivering the patient experience strategy:<br>a. Reducing the number of complaints referred to the ombudsman.<br>b. Reducing the response time to complaints. | Reducing the number of complaints referred outside of the organisation 90% of complaints will be responded within agreed timescales | **Responsive Caring Effective** |
| Promoting the patient/service user facing Carers Passport by raising visibility of this across the community, and promoting its use within the organisation. | Number of Carer Passports issued.<br>Survey of carers passport users experience. | **Caring** |
| Increasing patient satisfaction survey results. | Maintained FFT at agreed thresholds.<br>Improvements to the annual inpatients, maternity and CYP surveys. | **Responsive Caring** |
| Increased service user/citizen engagement at key SFH meetings. | Assurance processes / Terms of Reference/Meeting Minutes. | **Responsive** |
| Number of service users/citizens engaged in QI. | Increased numbers of Citizen Improvement Partners. | **Effective** |

# Sherwood Forest Hospitals Quality Strategy 2022-2025
# Campaign Three

## Strengthen and sustain a learning culture of continuous quality improvement

### What does an outstanding culture of continuous quality improvement look like?

We will have an open and transparent culture where colleagues feel able to report incidents and speak up about concerns. We will listen and learn from these events collectively through shared governance and quality improvement.

### What does success look like?

The Trust will be recognised as a centre of excellence for learning and continuous quality improvement at local, regional and at national level. This will be reflected via delivery of this strategy and in awards and journal publications.

### We are going to:

- Use quality improvement to underpin the delivery of the quality strategy

- Ensure colleagues, from Board to ward have undertaken QI training as part of their roles

- Increase sharing of Clinical Audit and improvement outcomes across the organisation

- Have a clear road map towards QI exemplar status, as part of a structured evidence-based approach.

- Engage, develop and build on existing expertise, to ensure that we empower colleagues to lead improvement and to reach their maximum potential.

- Create a digital single portal for colleagues to put forward improvement ideas and feedback, as part of an Innovation Hub. It will encourage colleagues to share learning, for example, as part of Greatix and upgraded Datix platforms.

- Work with our regulators and other external organisations to share and embrace learning for safe patient care

| WE ARE GOING TO FOCUS ON | HOW WILL WE KNOW WE HAVE SUCCEEDED? | OUR MEASURE |
|---|---|---|
| Developing and embedding our approach to Patient Safety II by implementing and embedding Patient Safety Incident Response Framework. | Embedded patient safety framework to match the national patient safety incident framework. | **Safe**<br>**Responsive**<br>**Well Led** |
| Developing a digital Innovation Hub to offer a single portal for colleagues to share ideas/improvements. | Innovation Hub in place in 2022 | **Effective** |
| Increasing the number of colleagues who are QI interested and active | 400 colleagues trained in QI over 2022/23 | **Well Led** |

# Sherwood Forest Hospitals Quality Strategy 2022-2025
# Campaign Four

## Deliver high-quality care through kindness and 'joy at work'

### What does high-quality care delivered by well supported colleagues look like?

Care provided by the Trust will be of the highest quality nurtured through a culture pf psychological safety that supports civility, kindness and joy at work.

### What does success look like?

We will foster a sense of belonging in the NHS for our colleagues as part of the NHS People Plan. We will conduct Safety Attitude Questionnaire surveys with colleagues to understand and measure their feedback. We will record more feedback from patients and service users in terms of reduced complaints and improved Family and Friends survey results. Our NHS Staff Survey results will measure key indicators on staff wellbeing.

### We are going to:

- Promote zero tolerance campaigns to reduce experience of physical violence and discrimination to staff .
- Introduce an Anti-racism strategy to tackle racism across the Trust.
- Grow our networks of staff support groups, providing a safe space for our under-represented workforce.
- Refresh Schwartz rounds within the organisation.
- Strengthen Civility, Respect and Kindness programme of work, to include annual sharing and learning events.
- Refresh the Trust reward and recognition programme to ensure equity across the organisation.
- Work with our regulators and other external organisations to share and embrace learning for safe patient care.

| WE ARE GOING TO FOCUS ON | HOW WILL WE KNOW WE HAVE SUCCEEDED? | OUR MEASURE |
|---|---|---|
| Defined inclusive and equitable reward and recognition programme in place | New Trust Reward and Recognition strategy in place | **Well-Led** |
| Reduce colleagues working experience of violence and aggressive behaviour | Improved performance against the following key National Staff Survey indicators at a Trust level. We will report that staff have not experienced harassment, bullying discrimination or abuse from:<br><br>• Patients / service users, their relatives or members of the public; 21/22 = 72.9%, 22/23 target = 80%<br>• Other colleagues; 21/22 = 81.7%, 22/23 target = 85%<br>• Managers; 21/22 = 92.9%, 22/23 target = 95%<br>• Patients/service users, their relatives or other members of the public; 21/22 = 95%, 22/23 target = 97%<br>• Or not experienced physical violence from patients/service users, their relatives or other members of the public; 21/22 = 79.3%, 22/23 target = 85% | **Safe**<br>**Responsive** |
| Introduce a Trust-wide 'Cultural Humility' programme | Programme to be visible and rolled out to all colleagues across 2022 | **Wel-Led** |
| Develop a standardised approach to supporting colleagues psychological safety following human-centred incidents | Hot and cold debrief process is implemented and evaluated in 2022/23 | **Well led**<br>**Responsive**<br>**Safe** |
| Improved overall engagement in NHS Staff Survey | **Overall Engagement %l 21/22 = 66.4%, 22/23 target =** | **Well-Led** |

Sherwood Forest Hospitals Quality Strategy 2022-2025
# Strategy Directions

**Health inequalities are the preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental, and economic conditions within communities, which determine the risk of people getting ill or their ability to prevent sickness.**

This quality strategy is set to underpin the work the organisation is undertaking to reduce and ultimately eliminate health inequalities. As a member of the Nottinghamshire Integrated Care System, this strategy will align with the Nottingham and Nottinghamshire Integrated Care System Health Inequalities strategy 2020-2024 where the vision for health inequalities "is that everyone has the same opportunity to lead a healthy life no matter where they live or who they are and that our front-line professionals are valued and supported to deliver high quality care".

Specifically supporting the following strategy directions:

As a **citizen living** in Nottingham and Nottinghamshire, this means:

We will listen and engage with communities who need most support, deepening partnerships with community and voluntary sectors.

As a **person receiving support** from our health and care system:

Health and care services are accessible for all, particularly those at risk of exclusion because of personal, economic or social factors.

As a **person working** in our health and care system:

Health and care staff are valued and supported to maintain wellbeing and so deliver high-quality care in all settings.

# Strategy to Improvement

Sherwood strategy to improvement and redesign involves a number of workstreams to ensure delivery of the objectives which relate to quality improvement.
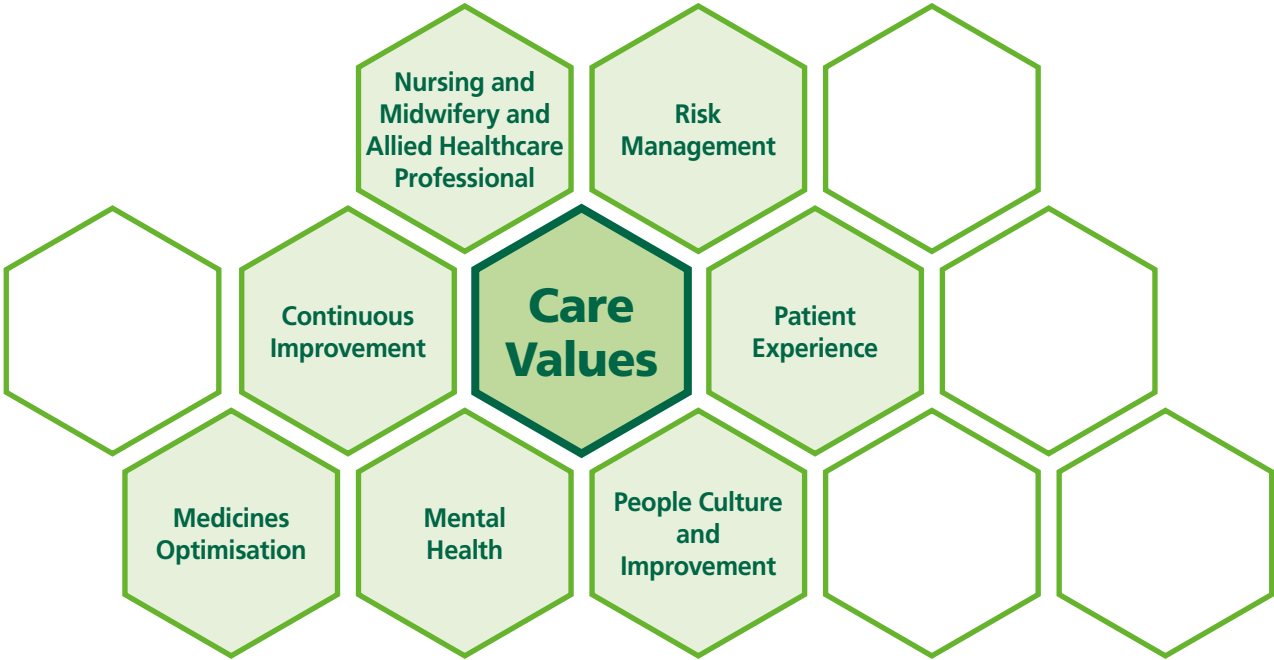
If you would like this information in an alternative format, for example large print or easy read, or if you need help with communicating with us, for example because you use British Sign Language, please let us know. You can call the Patient Experience Team on **01623 672222** or email **sfh-tr.PET@nhs.net**.

**Sherwood Forest Hospitals NHS Foundation Trust**
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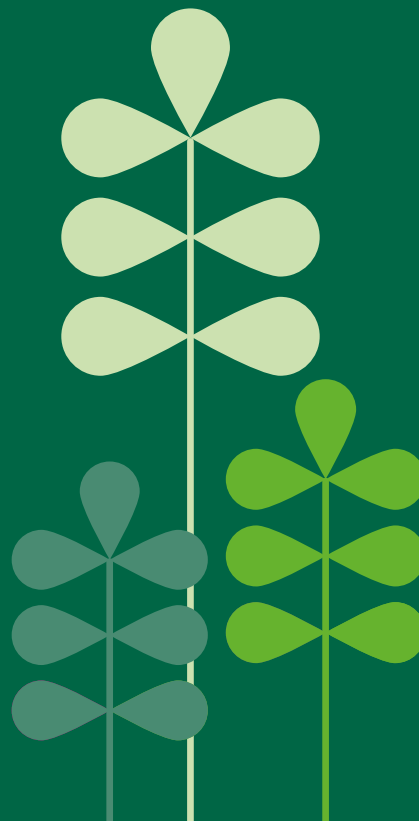
# Board of Directors Meeting in Public - Cover Sheet

## All reports MUST have a cover sheet

| | | |
|---|---|---|
| **Subject:** | Proposed Quality Strategy 2022-25 | **Date:** 20/04/2022 |
| **Prepared By:** | Carl Miller | |
| **Approved By:** | Julie Hogg | |
| **Presented By:** | Julie Hogg | |

### Purpose

| | | |
|---|---|---|
| The SFHFT Quality Strategy has been revised to reflect several local and national objectives. This builds on the success of prior strategies.<br>Board is asked to Approve the attached document. | **Approval** | **X** |
| | **Assurance** | |
| | **Update** | |
| | **Consider** | |

### Strategic Objectives

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

Indicate which strategic objective(s) the report support

### Overall Level of Assurance

| | Significant | Sufficient | Limited | None |
|---|---|---|---|---|
| | | Internal audit Quality Account and Annual Report 360 Assurance report | | |

### Risks/Issues

| | |
|---|---|
| **Financial** | |
| **Patient Impact** | |
| **Staff Impact** | |
| **Services** | |
| **Reputational** | |

### Committees/groups where this item has been presented before

Quality Committee
Executive Team
Heads of Nursing
Medical Managers

### Executive Summary

The Quality Strategy is published in line with the Sherwood Strategic Vision. There is a short review of our success against our previous strategy and reference to key objectives implemented during its lifetime (e.g. Swartz rounds). It goes on to describe how we will approach our commitment to provide outstanding care, learn and improve as we do this and do this whilst supporting our colleagues. This is presented under the headings of four quality improvement campaigns.

- Support safe and effective care
- Excellent patient experience
- Sustain a culture of continuous quality improvement
- Deliver high quality care with kindness

Quality priorities been identified from these campaigns and will be monitored through the Advancing Quality Programme and through this provide assurance to Quality Committee and Trust Board.

Board is asked to review the document and approve its content for publication.

**Healthier Communities, Outstanding Care**

**NHS Sherwood Forest Hospitals**
**NHS Foundation Trust**

## Board of Directors Meeting in Public - Cover Sheet

| Subject: | NHS Staff Survey 2021 – Results and Actions | Date: 05.05.2022 | |
|---|---|---|---|
| Prepared By: | Vicky Malia, Operational Lead NSS21 | | |
| Approved By: | Emma Challans, Executive Director of Culture and Improvement | | |
| Presented By: | Emma Challans, Executive Director of Culture and Improvement | | |

| Purpose | | | |
|---|---|---|---|
| This paper serves to update the Board on the National Staff Survey 2021 full results and provide assurance as to the process in place to share these results with the organisation and our focus areas for cultural improvement. | | **Approval** | |
| | | **Assurance** | x |
| | | **Update** | |
| | | **Consider** | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| Financial | | | | |
| Patient Impact | | | | |
| Staff Impact | Results identify areas of significant impact to staff experience | | | |
| Services | | | | |
| Reputational | Results have deteriorated, however against national average SFH still performs very well | | | |

| Committees/groups where this item has been presented before |
|---|
| Regular updates to Trust Management Team, Executive Team and People, Culture and Improvement Committee |

### Executive Summary

The National Staff Survey 2021 embargo lifted on 30th March 2022 with full results analysis and Trust focus areas now available.

The Trust closed the survey in November with 3442 colleagues taking the opportunity to share their voice, which was a 66.4% response rate (compared to 61% last year and 66% in 2019).  2021 saw our best response rate to date and therefore we can be confident that the results are a sound representation of the voice of the SFH workforce.

Headlines include:

- **1st** for response rate of all Acute Trusts in the Midlands (66.4%)
- **1st** for recommended as a place to work across the Midlands with 74.9% compared to highest result nationally of 77.6%
- **1st** for staff being happy with the standard of care provided by the organisation if a friend or relative needed treatment across the Midlands with 81.7% compared to highest result nationally of 89.5%

Information has been shared at every stage with all key leads as soon as available for the purpose of Divisional Management Team discussion and initial action planning.  Divisions are currently in

Divisional engagement exercises with their teams. Trust focus areas have been identified under 3 key themes:

- **Valuing You**
- **Caring for You**
- **Developing You**

A Trust staff survey explorer portal has also been developed for the first time this year to support Divisions, Departments and Teams to review and analyse their own data. The portal has been designed to help point colleagues to potential hot spot areas where scores are low in general, are low compared to the Trust average, or have decreased since last year, with the aim of stimulating conversation and commitment to action at a local level.

The Culture and Engagement team are working in partnership with Divisions and staff networks to identify and support specific areas that would benefit from additional support with either sharing their results with their teams or with their ongoing actions for improvement.

A full Staff Survey results update paper is attached.

**The Board is asked to note Trust performance and focus areas for cultural improvement during 2022/23 and beyond.**

**National Staff Survey 2021
Results Summary and Actions
Trust Board May 2022**

## 1. Context

The National Staff Survey for 2021 ran across October and November with 5182 colleagues invited to feedback around their experiences of working at Sherwood Forest Hospitals NHS Foundation Trust. A total of 3442 completed their survey giving a Trust response rate of 66.4% which was the highest % response rate ever for the Trust, and over 5% higher than 2020. This was also the top response rate for our comparator group (Acute and Acute Community Trusts) across the Midlands.

The median response rate for organisations in our group was 46%, demonstrating the exceptional engagement of colleagues at SFH. This engagement was heavily driven by leadership at a team and divisional level with Divisions taking real ownership of their own engagement with support from teams such as OD and Engagement. Of particular recognition was the response rate for the Surgery Division who ended the survey with a staggering 76.7% response rate.
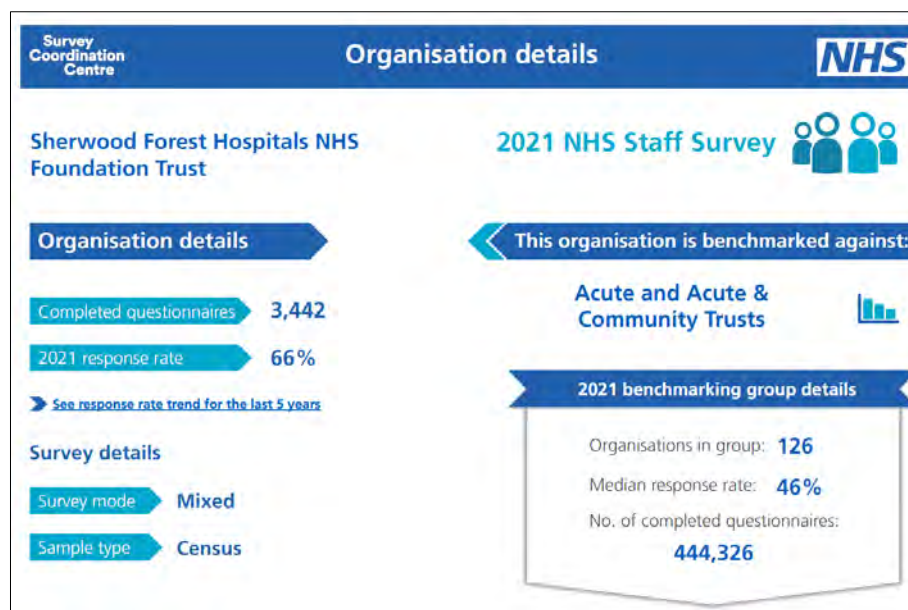


## 2. 2021 Question Bank

There were 92 questions in the 2021 National Staff Survey, 65 of which were also included in the 2020 survey. An additional group of questions were added to the 2021 survey largely relating to colleague wellbeing and behaviours within the organisation.

This means that comparison to last year in its entirety is not possible, with the 2021 survey structure setting a new model for the survey for subsequent years in line with the new NHS People Plan. However, wherever possible results have been compared to last year (with work ongoing to identify trends for the previous years

too), along with analysing low scores and scores outside of the national average, to enable the identification of key areas for improvement.

### 3. Benchmarking

For 2021, the survey results have been mapped against the national NHS People Promise domains, with Sherwood's favourable position against the national top, bottom and average scores outlined below:
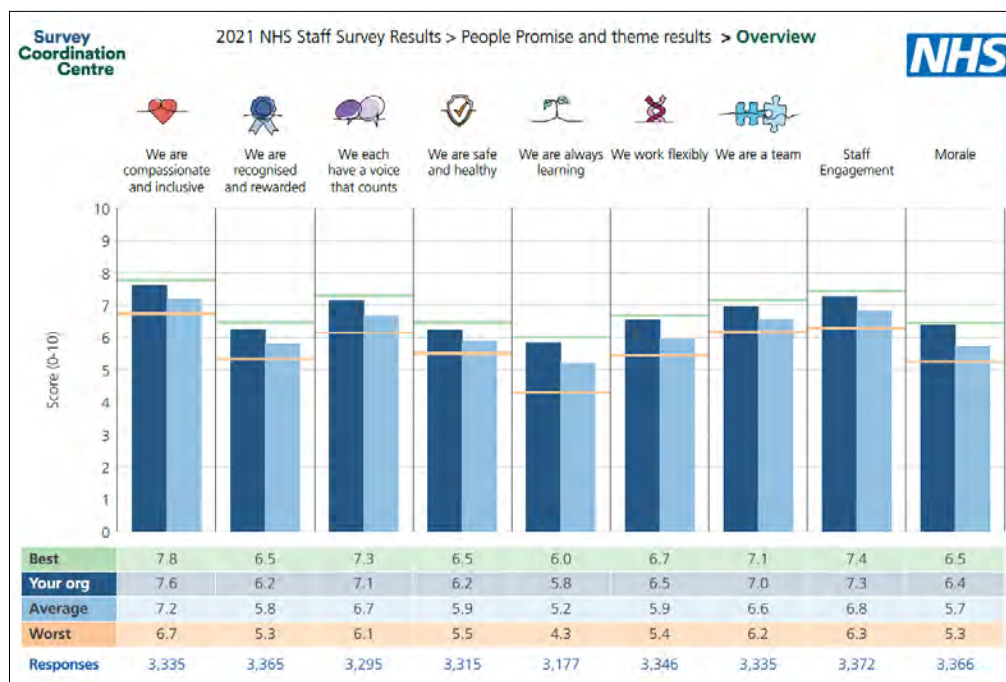


When benchmarked against our comparator group at a regional and national level, Sherwood ranks in the following positions:

| People Promise Theme | Score | Regional Position | National Position |
|---|---|---|---|
| Compassionate and Inclusive | 7.6 | 2nd | 4th |
| Recognised and Rewarded | 6.2 | 2nd | 4th |
| A Voice that Counts | 7.1 | Joint 1st | 3rd |
| Safe and Healthy | 6.2 | Joint 1st | 3rd |
| Always Learning | 5.8 | 2nd | 3rd |
| Working Flexibly | 6.5 | Joint 1st | 3rd |
| Working as a Team | 7.0 | Joint 1st | 4th |
| Staff Engagement | 7.3 | 1st | 4th |
| Morale | 6.4 | 1st | 2nd |

We are extremely proud of this and believe it demonstrates the ongoing focus and commitment we give to our culture and our people within the organisation.

In addition to our performance against these themes, we were reported by our colleagues as being the best place to work across all Acute Trusts in the Midlands (2nd nationally) and came top for staff being happy with the standard of care provided by the organisation if a friend or relative needed treatment.

Overall, as an average across all of the People Promise domains, **Sherwood results placed us as the 3rd best Acute or Acute Community Trust in the country.**

### 4. Summary of Results

We do however recognise there has been a decline in employee experience across the majority of questions in 2021, combined with other questions having very low scores, which gives us a clear indication of colleague experience deteriorating overall in the past 12 months; a picture sadly seen nationally.

- **13** (out of 65) questions showed improvement from 2020
- **14** (out of 92) questions scored above 80%
- **84** (out of 92) questions scored above national average
- **42** (out of 65) questions showed deterioration from 2020
- **14** (out of 92) questions scored below 50%
- **8** (out of 92) questions scored below national average (however 6 of the 8 were within 2% of national average)

### i. Areas indicating positive results:

The majority of our results were above national average, with 44 more than 5% above national average. This indicates a more positive experience at SFH in comparison to other Trusts.

Improvements from 2020:

| Rank | Description | 2020 | 2021 | Change |
|---|---|---|---|---|
| 1 | Last experience of harassment/bullying/abuse reported | 45.2% | 51.2% | +6.0% |
| 2 | Last experience of physical violence reported | 62.1% | 65.2% | +3.1% |
| 3 | Would feel secure raising concerns about unsafe clinical practice | 75.5% | 78.5% | +3.0% |
| 4 | Immediate manager asks for my opinion before making decisions that affect my work | 59.2% | 62.0% | +2.8% |
| 5 | Not experienced harassment, bullying or abuse from managers | 90.9% | 92.9% | +2.0% |
| 6 | Immediate manager gives clear feedback on my work | 67.1% | 68.7% | +1.6% |
| 7 | Always know what work responsibilities are | 88.9% | 90.1% | +1.2% |
| 8 | Feel trusted to do my job | 91.6% | 92.6% | +1.0% |
| 9 | Opportunities to show initiative frequently in my role | 74.4% | 75.4% | +1.0% |
| 10 | Would feel confident that organisation would address concerns about unsafe clinical practice | 67.8% | 68.8% | +1.0% |
| 11 | Not felt pressure from manager to come to work when not feeling well enough | 71.8% | 72.7% | +0.9% |
| 12 | Immediate manager encourages me at work | 74.0% | 74.9% | +0.9% |
| 13 | Involved in deciding changes that affect work | 53.8% | 54.2% | +0.4% |

Scores <u>above</u> 80%:

| Rank | Description | Percent |
|---|---|---|
| 1 | Not experienced physical violence from managers | 99.6% |
| 2 | Not experienced physical violence from other colleagues | 98.5% |
| 3 | Not experienced discrimination from patients/service users, their relatives or other members of the public | 95.0% |
| 4 | Not experienced discrimination from manager/team leader or other colleagues | 93.6% |
| 5 | Not experienced harassment, bullying or abuse from managers | 92.9% |
| 6 | Feel trusted to do my job | 92.6% |
| 7 | Feel my role makes a difference to patients/service users | 90.4% |
| 8 | Always know what work responsibilities are | 90.1% |
| 9 | Received appraisal in the past 12 months | 89.5% |
| 10 | Care of patients/service users is organisation's top priority | 83.8% |
| 11 | Enjoy working with colleagues in team | 82.7% |
| 12 | Not experienced harassment, bullying or abuse from other colleagues | 81.7% |
| 13 | If friend/relative needed treatment would be happy with standard of care provided by organisation | 81.6% |
| 14 | Organisation acts on concerns raised by patients/service users | 80.4% |

Scores more than 10% <u>above</u> national average:

| Rank | Description | SFH | Average | Difference |
|---|---|---|---|---|
| 1 | Would recommend organisation as place to work | 74.8% | 59.4% | +15.4% |
| 2 | If friend/relative needed treatment would be happy with standard of care provided by organisation | 81.6% | 66.3% | +15.3% |
| 3 | Have adequate materials, supplies and equipment to do my work | 68.8% | 55.8% | +13.0% |
| 4 | Able to access the right learning and development opportunities when I need to | 68.1% | 55.2% | +12.9% |
| 5 | Feel organisation would address any concerns I raised | 61.3% | 49.6% | +11.7% |
| 6 | Enough staff at organisation to do my job properly | 38.0% | 26.7% | +11.4% |
| 7 | I don't often think about leaving this organisation | 53.9% | 42.7% | +11.2% |
| 8 | I am not planning on leaving this organisation | 68.0% | 57.1% | +10.9% |
| 9 | Organisation takes positive action on health and well-being | 67.8% | 56.9% | +10.9% |
| 10 | I am unlikely to look for a job at a new organisation in the next 12 months | 61.4% | 50.9% | +10.5% |
| 11 | Would feel confident that organisation would address concerns about unsafe clinical practice | 68.8% | 58.7% | +10.1% |

## ii.    Areas indicating room for improvement:

10 most deteriorated results since 2020:

| Question | 2020 | 2021 | SFH Change | National Change |
|---|---|---|---|---|
| Often/always enthusiastic about my job | 78.1% | 73.9% | **-4.2%** | -5.5% |
| I don't often think about leaving this organisation | 58.2% | 53.9% | **-4.3%** | -4.6% |
| Often/always look forward to going to work | 62.2% | 57.1% | **-5.1%** | -6.6% |
| Would recommend organisation as place to work | 80.2% | 74.8% | **-5.4%** | -8.6% |
| I am unlikely to look for a job at a new organisation in the next 12 months | 66.8% | 61.4% | **-5.4%** | -3.4% |
| Satisfied with level of pay | 42.2% | 36.6% | **-5.6%** | -4.2% |
| In last 3 months, have not come to work when not feeling well enough to perform duties | 50.5% | 43.6% | **-6.9%** | -8.4% |
| Satisfied with extent organisation values my work | 57.4% | 50.4% | **-7.0%** | -6.3% |
| Don't work any additional paid hours per week for this organisation, over and above contracted hours | 61.2% | 51.9% | **-9.3%** | -3.2% |
| Enough staff at organisation to do my job properly | 52.6% | 38.0% | **-14.6%** | -10.9% |

Scores <u>below</u> 50%:

| Question | Trust Avg |
|---|---|
| Never/rarely worn out at the end of work | 17.4% |
| Never/rarely frustrated by work | 21.3% |
| Never/rarely find work emotionally exhausting | 22.0% |
| Appraisal helped me improve how I do my job | 23.6% |
| Have realistic time pressures | 26.0% |
| Never/rarely feel burnt out because of work | 29.5% |
| Appraisal helped me agree clear objectives for my work | 33.6% |
| Appraisal left me feeling organisation values my work | 36.2% |
| Satisfied with level of pay | 36.6% |
| Never/rarely exhausted by the thought of another day/shift at work | 37.0% |
| Never/rarely lack energy for family and friends | 37.6% |
| Enough staff at organisation to do my job properly | 38.0% |
| In last 3 months, have not come to work when not feeling well enough to perform duties | 43.6% |
| Relationships at work are unstrained | 45.5% |

Scores <u>below</u> national average:

| Rank | Description | SFH | Average | Difference |
|---|---|---|---|---|
| 85 | Colleagues are understanding and kind to one another | 69.1% | 69.4% | -0.3% |
| 86 | Colleagues are polite and treat each other with respect | 70.2% | 70.8% | -0.6% |
| 87 | In last 3 months, have not come to work when not feeling well enough to perform duties | 43.6% | 44.7% | -1.0% |
| 88 | Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public | 72.9% | 74.0% | -1.1% |
| 89 | Not felt pressure from manager to come to work when not feeling well enough | 72.7% | 74.0% | -1.3% |
| 90 | Last experience of physical violence reported | 65.2% | 67.3% | -2.0% |
| 91 | Not experienced physical violence from patients/service users, their relatives or other members of the public | 79.3% | 85.7% | -6.4% |
| 92 | Don't work any additional paid hours per week for this organisation, over and above contracted hours | 51.9% | 60.8% | -8.9% |

## 5. Cascade of Results:

National Staff Survey Open for Colleagues:
October and November 2021

Results shared with organisation by Picker (Survey Provider): **Jan/Feb 2022 <u>under embargo</u> –** only able to shared with SLT and key programme leads

<u>Embargo lifted 30.03.22</u>: Full Trust/Divisional Engagement Begins
➤ Headlines included in Staff Brief
➤ All staff email from CEO
➤ MS Teams drop in sessions for leaders to find out more
➤ Attendance at all key Trust forums over April/Early May to present key headlines and offer of 'deep dive' support
➤ SFH Survey Explorer Portal developed and live for all staff
➤ Trust priority areas for next 12 months agreed
➤ Partnership working with HRBPs re: cascade of Divisional Results
➤ Key topic for Divisional Performance Reviews 29.04.22 – to present initial areas of focus and actions (corporate divisions also undertaking same exercise virtually)

We are here

**May 2022:**
➤ Clinical and Corporate Division actions confirmed by leads
➤ Monthly communication of Trust focus areas and progress updates to staff commences

## 6. Online Survey Explorer

New for 2022, we have developed an innovative Trust survey explorer portal to support Divisions, Departments and Teams to review and analyse their own data. The portal has been designed to help 'remove the noise' from the big reports made available from our survey provider and allow any individual in the organisation access to the information in a more manageable way. The portal contains all the information for each team but also helpfully points colleagues to potential hot spot areas where scores are low in general, are low compared to the Trust average, or have decreased since last year, in order to stimulate conversation and commitment to action at a local level.

## 7. Working with System Partners

The Integrated Care System (ICS) Organisational Development (OD) and Improvement Delivery Group commissioned a piece of culture insight work to recognise common themes from the NHS Staff Survey from all, of the system partners involved. The review has identified some common themes across organisations, and these will be taken forward by Sherwood and partnering peers. For example, development of a Leadership Strategy and a programme of initiatives to support Civility, Respect and Kindness across our health and care partners. These will be overseen by the system OD & Improvement Delivery Group, chaired by the Trust Director of Culture and Improvement with progress reported in to the ICS People and Culture Board.

## 8. Key focus areas for 2022/23:

The Trust results give us insight into areas for improvement. However, reassuringly most of these areas were already identified as part of our ongoing programmes around culture improvement and therefore, a, number of actions will be focussed on continuing to build on our existing plans and offers.

There are however 3 core commitments that we will specifically focus on at a Trust level during 2022/23 in addition to our business as usual. These commitments align to our newly developed People, Culture and Improvement Strategy for 2022-2025 and our in-year People, Culture and Improvement priorities. We believe these focus areas are drivers to improve overall colleague experience which in turn will support improvements in their wellbeing (alongside our focussed wellbeing programme).

1.  **Valuing <u>You</u>:**

    Actions to include:

    - ➤ Robust and communicated workforce plan including focussed recruitment campaigns for areas demonstrating workforce risk and service fragility

    - ➤ Reward and recognition review

    - ➤ Person centred absence management

| Measure | Driver for inclusion | 2021 survey result | 2022 survey target | 2023 survey target |
|---|---|---|---|---|
| Enough staff at the organisation to do my job properly | Biggest deterioration from 2020 (-14.6%) | 38% | 45% | 53% |
| Satisfied with the extent to which the organisation values my work | Deterioration from 2020 (-7%) | 50.4% | 55% | 60% |
| I am unlikely to look for a job at new organisation in the next 12 months | Deterioration from 2020 (-5.4%) | 61.4% | 65% | 68% |

2. **Caring about <u>You</u>:**

Actions to include:

➢ Embedding wellbeing strategy

➢ Focussed violence and aggression reduction programme of work

➢ EDI specific focus work to reduce experience of discrimination towards colleagues from some protected characteristic groups

| Measure | Driver for inclusion | 2021 survey result | 2022 survey target | 2023 survey target |
|---|---|---|---|---|
| Not experienced physical violence from patients, service users or other members of the public | Deterioration and outlier from national average (-6.4%) | 79.3% | 85% | 87% |
| Not experienced discrimination from patients/service users, their relatives, or other members of the public | Variation in experience (poorer) of colleagues from some protected characteristic groups | Org: 95% White: 96.7% BAME: 83.7% <br><br> Straight: 95.3% LGBTQ: 88.3% | BAME: 88% <br><br><br><br><br> LGBTQ: 92% | BAME: 95% <br><br><br><br><br> LGBTQ: 95% |
| Relationships at work are unstrained | Low Score | 45.5% | 50% | 55% |

3. **Developing <u>You</u>:**

Actions to include:

➢ Inclusive, equitable and diverse development offers and career opportunities

➢ Specific expectations, leadership, and management development

➢ Added value appraisal conversations

| Measure | Driver for inclusion | 2021 survey result | 2022 survey target | 2023 survey target |
|---|---|---|---|---|
| Appraisal helped me agree clear objectives for my work | Low Score | 33.6% | 38% | 45% |
| Appraisal helped me improve how I do my job | Low Score | 23.6% | 28% | 35% |
| Organisation acts fairly: career progression | Free text comment key theme | 64.6% | 70% | 75% |

## 9. Monitoring and Assurance

We recognise these are not 'quick fixes' and an ongoing commitment to culture improvement is in place, with specific focus on these areas for the next 12 months. Focus areas will be reviewed on a regular basis with any areas that have improved sufficiently moving to business as usual, and any new areas for focussed improvement agreed.

Updates on the above priority areas will be provided for assurance to the Culture and Improvement Cabinet and the People and Inclusion Cabinet, with a progress report to the People Culture and Improvement Committee (PCIC) on a quarterly basis.
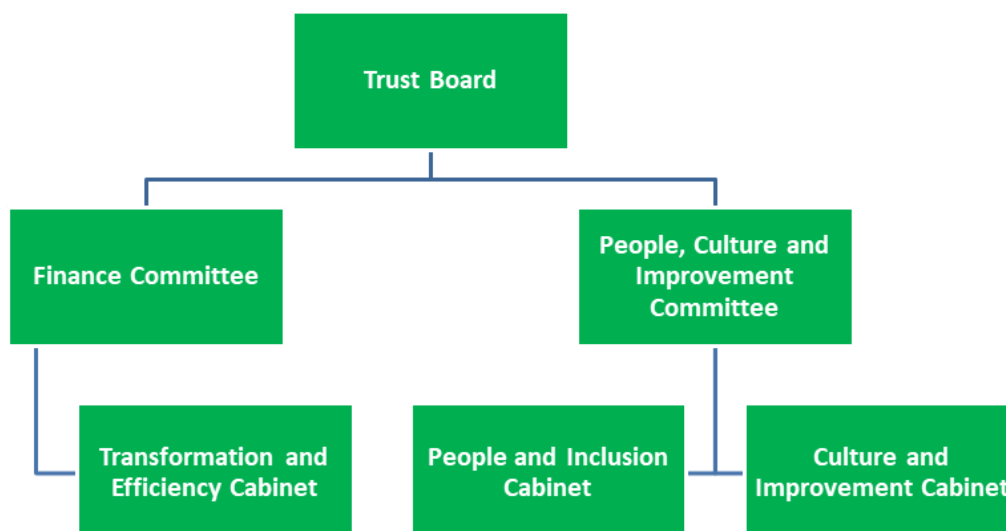


The key measures outlined will also be included in our quarterly pulse survey question bank so that in addition to an annual result from the national staff survey, we also have a quarterly indication of improvement.

Divisions will report progress against their Divisional improvement areas routinely as part of the Divisional Performance Review (DPR) process. Learning will be shared through our 'You Said, Together We Did' communications across the organisation.

**10. Communication Plan:**

It is important to us that our results are transparent and therefore all colleagues are, able to access results directly through the survey explorer tool hosted online. This link has been shared in Trust and Divisional communications and will continue to be signposted to at all opportunities.

Leaders in Divisions are being supported by HRBPs to review and share their results with teams and identify 2-3 areas for improvement at a team level. Assurance has been given that this is happening across the organisation.

Divisions will communicate and receive updates on progress through their monthly service level meetings. They will then feed into the Trust level communications to share examples of 'You Said, Together We Did' on a regular basis.

From May 2022 there will be a monthly update in the Trust bulletin and Staff Brief from a key lead in the Trust focusing on actions happening in one priority area at a time. Each priority area will therefore provide progress updates three times before the next results are expected, and importantly updates will continue in the run up to, and during, the next survey window to connect colleagues to the impact their voice had in 2021 shaping 2022 priorities.

The schedule for this is as follows:

| Theme | 1st Update | 2nd Update | 3rd Update |
|---|---|---|---|
| Valuing You | June | September | December |
| Caring about You | May | August | November |
| Developing You | July | October | January |

Trusted voices from within the organisation will also be asked to share their stories relating to these areas of work, examples may include colleagues who have:

- Received breakaway training in areas experiencing high incidents of violence
- Undertaken career coaching/positive appraisal experience
- Been recognised as part of our new approach to reward and recognition

**11. Summary**

The Trust has taken appropriate steps following the results of the NHS Staff Survey 2021, and with this has undertaken significant engagement across the organisation. The Trust has identified key areas for focussed improvement and agreed supportive approaches to change, oversight, and communication.

The Trust is proud to see the results of the 2021 survey, of which many areas should be celebrated, whilst also recognising key areas for cultural improvement. Sherwood remains committed to improving the culture of the organisation and ensuring Sherwood is a great place to work and receive care.

| Subject: | **Nursing, Midwifery, and Allied Health Professional Annual Staffing Report.** | **Date:** 21st April 2022 |
|---|---|---|
| **Prepared By:** | Rebecca Herring (Corporate Matron) <br> Paula Shore (Head of Midwifery and Nursing) <br> Kate Wright (Associate Chief Allied Health Professional) | |
| **Approved By:** | Julie Hogg, Chief Nurse | |
| **Presented By:** | Julie Hogg, Chief Nurse | |

| Purpose | | |
|---|---|---|
| The purpose of this report is to provide the Board of Directors with an overview of nursing, midwifery, and allied health professional (AHP) staffing capacity and compliance within Sherwood Forest Hospitals Foundation NHS Trust (SFHFT). <br><br> It is also to provide assurance on our compliance with the National Institute for Health and Care Excellence (NICE) Safe Staffing Guidance, National Quality Board (NQB) Standards, and the NHS Improvement (NHSI) Developing Workforce Safeguards. <br><br> It is a national requirement for the Board of Directors to receive this report bi-annually. | **Approval** | **X** |
| | **Assurance** | **X** |
| | **Update** | |
| | **Consider** | |

**Strategic Objectives**

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

**Overall Level of Assurance**

| | Significant | Sufficient | Limited | None |
|---|---|---|---|---|
| | | Triangulated internal / external reports | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| | | | | |
| **Financial** | X | | | |
| **Patient Impact** | X | | | |
| **Staff Impact** | X | | | |
| **Services** | X | | | |
| **Reputational** | | | | |

**Committees/groups where this item has been presented before**

Nursing, Midwifery, and Allied Health Professional Committee April 2022

**Executive Summary**

**1.0  Background**

**1.1** The purpose of this report is to provide an overview of nursing, midwifery, and AHP (NMAHP) staffing capacity and compliance within SFHFT which is aligned to NICE Safe Staffing Guidance, NQB Standards, and the NHSI Developing Workforce Safeguards Guidance.

**1.2** This is supported by an overview of staffing availability over the previous year and progress with assessing the acuity and dependency of patients on ward areas. This data has informed the review of the nursing and midwifery establishment reviews for 2022/2023 and are discussed within this paper.

**Nursing and Midwifery Staffing Overview**

**1.3** Since the start of 2021/2022 the Trust vacancy rate has seen a continual positive reduction from 8.7% down to 3.9%. This captures nursing, midwifery, and AHP staff from band 2 upwards and represents collective ongoing recruitment efforts being undertaken within our teams.

**1.4** The midwifery workforce challenges, in particular the vacancies in the community midwifery team, have begun to stabilise since the revised approach to midwifery continuity of carer (MCoC). This is due to both changes in the delivery of MCoC and the approach to recruitment and retention. The overall vacancy rate was 21.89% at the end of March 2022 across the whole of maternity services, 18% of this was within community midwifery.

**1.5** In line with the increasing agency usage, there has been a rising trend in the use of escalated rates from May onwards. This has been significantly influenced by the increased capacity open across our services, alongside the increased acuity and dependency of patients requiring admission. The previous twelve months have been extremely challenging for staff across all services due to the ongoing significant workforce loss that has persisted due to sickness and the national isolation measures that have been in place.

**1.6** Despite the unprecedented challenges over the last 12 months, the Trust (overall) has consistently remained above 95% of the planned staffing fill rates. The data demonstrates a more variable position for nursing associates; however, it is acknowledged this particular team is very small in numbers (less than ten who are qualified across the Trust), and the team has been affected by Covid-19 absence, annual leave, and long-term absence for compassionate reasons.

**1.7** The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs. Benchmarking

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data from Model Hospital (December 2021) demonstrates that at Trust value sits within the third quartile at 8.9 and is slightly above the national and peer median of 8.2.

**1.8** Midwifery staffing has been safely matched to birth activity over the last six months, but to help achieve this, acute staffing shortages have been supported with bank and agency use and with the deployment of a registered nurse to support acute maternity. Midwives have continued to receive an enhanced payment rate for bank shifts including a review of all non-clinical roles. The Birth Rate Plus® workforce review that was completed in September 2020 provides richer detail to the complex variables affecting staffing requirements in a maternity service and showing predicts a forecast of the establishment requirement. Since this review, multiple factors have changed leading to a revised Birth Rate Plus® review which is expected to be undertaken at the end of April 2022. This is due to the subsequent increased birth rate at SFHFT for 2020-21 and 2021-22 and, local and national changes to the delivery of MCoC.

**1.9** Since March 2021, 744 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system. All incidents were recorded as no, or low harm, and the appropriate actions were taken at the time. 27 of these incidents have been identified as red flag incidents (as defined by NICE) due to a delay in fundamental care or delays in time-critical activity. It is recognised that despite no adverse clinical outcome, the delays in care will have negatively impacted the overall experience of patients and colleagues.

**1.10** In addition to Datix reporting, red flags for midwifery services are recorded within Birth Rate Plus®. A review of the data inputted into the tool indicated that training and implementation had not been consistent and there was no process for external validation of the scoring. A review and refresh of training have been undertaken, with the full support of the Birth Rate Plus® national team. The tool is now in full use and the red flag data will be included with Safe Staffing Reports going forward.

**Recruitment and Retention**

**1.11** In the last 12 months, the Trust has recruited 107 international registered nurses (IRN) and two international registered midwives (IRMW). There are currently 25 IRNs and one IRMW awaiting their Objective Structured Clinical Examinations (OSCEs), with three awaiting re-sits scheduled at the end of March. The number of IRNs currently working with a Nursing and Midwifery Council (NMC) registration is 82, and currently, this is waiting to be reflected on the ESR system. The Trust had two IRNs leave the Trust, one to move closer to her partner in Burton, Derbyshire, and the second had taken a post at King's College Hospitals London.

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**1.12** The Trust was successful in funding opportunities to support IRN recruitment and this has supported the Trust to create additional opportunities for international recruitment. In 2022/23 the Trust has secured further funding to support the further recruitment of 50 IRNs,

**1.13** Since our last report there has been capacity issues within the NMC Test of Competency Centres, which has caused delays in our IRNs being able to take their OSCEs. This was escalated to regional and national teams, and the national response was very supportive, and we were able to facilitate 32 IRNs to undertake their tests. This was escalated as a risk at the Nursing, Midwifery & AHP Transformation Group.

**1.14** The Trust currently has 31 trainee nursing associates (TNAs) in post, with two TNAs taking a break from studying; one is on maternity leave and the second is taking a career break. Cohort 2 will qualify in October 2022 (currently 16) and will move into band 4 posts on the ward as part of the registered establishment. The heads of nursing are reviewing their establishments to ensure that the nursing associates can remain within the base wards. Cohort 3 is six months into their training, and there are 15 TNAs with two undertaking career breaks. The Trust will be looking for further opportunities for funding to support another cohort of TNAs in October 2022.

**1.15** NHS England has shared with Trusts their plans to roll out the National Preceptorship Framework, which will support student nurses' transition to registered nurses. The framework will align all preceptorship programmes within the trust, which will include midwifery and AHPs. The lead for preceptorship is reviewing the framework and undertaking a gap analysis, before presenting to the Nursing, Midwifery & AHP Committee their recommendations.

**1.16** NHSE/I provided additional funding for a Recruitment and Retention (R&R) Lead post for midwifery in late 2021, and the Trust was successful in its bid for this funding, with the post commencing in February 2022. The focus for this role is to provide individualised situated support in a clinical environment for students, return to practice learners and early career midwives and will develop mechanisms for identifying and addressing individual needs, provide or signpost to resources that will promote job satisfaction and retention across multiple domains. This will include those related to pastoral care, learning support, and career development.

**Nursing and Midwifery Forward Planning**

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**1.17** The ED tool for Safer Nursing Care Tool (SNCT) has recently been published and nationwide training is being delivered by NHS England/ NHS Improvement (NHSE/I). The trust has acquired the license for use and has registered the corporate matron for safe staffing, matron for ED, and head of nursing for UEC for training in the use of the tool. When this has been undertaken the corporate matron for safe staffing will lead a programme of work for acuity and dependency scoring cycles to help further inform the establishment review process going forward.

**1.18** Progress within the Workforce Transformation Group is proceeding well, with workstreams focused upon exemplar rostering, enhanced care, virtual ward development, international recruitment, apprenticeships, expanding the nursing associate workforce, mandatory training, and bank rates.

**1.19** The unavailability of community midwifery service has led to a limited home birth service with a hope to re-instate a full service from Q2 2022-23, given the planned regional review of the service and pipeline of recruitment into these teams. This reduction of the homebirth service has been taken in line with supportive guidance from the Royal College of Gynaecologists (RCOG) and the Royal College of Midwifery (RCM) and executive sign-the off from Trust Board. This limited service is reported internally to Trust Board and externally to NHSE and all women are informed from booking onto this pathway in regard to its limitations. The detailed workforce review which was undertaken to inform the business planning for 22/23 remains under review, reflecting the changes in the national ask for the delivery of MCoC.

**Nursing and Midwifery Establishment Review 2022/2023**

**1.20** Since the last establishment review, the Trust has refreshed its approach to setting the nursing and midwifery establishments to ensure we are compliant with the NQB standards. This has included the implementation of the SNCT, an evidence-based workforce planning tool that provides patient acuity and dependency intelligence, which has informed the Trust establishment setting process. SNCT is an objective tool that utilises levels of care to support workforce planning and has been recognised for supporting safe staffing across in-patient wards, receiving the endorsement from NICE in 2014.

**1.21** Staffing establishments consider the need to allow nursing, midwifery, and healthcare support workers (HCSW) time to undertake professional development and fulfil mentorship and supervision roles. Core principles in determining the nursing and midwifery establishment are maintained as per previous years.

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**1.22** The full establishment review can be located in appendix two.

**1.23** There are five wards/ departments that require small evidence-based uplifts to the establishment which can be managed within the existing envelope. These are as follows:

| Division | Area | Current WTE | Agreed WTE | Comments |
|---|---|---|---|---|
| Surgery | Ward 11/AU | 42.53 | 42.74 | The SNCT principles and professional judgement have been applied and a 0.21 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 12 | 37.5 | 37.9 | The SNCT principles and professional judgment have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 31 | 34.83 | 35.23 | The SNCT principles and professional judgment have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 32 | 32.31 | 32.71 | The SNCT principles and professional judgment have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | ITU | 98.01 | 98.39 | The GPICS principles and professional judgment have been applied and a 0.38 WTE increase to the establishment has been recommended. The additional resource will support the addition of the Rehab Family Support Nurse. This is supported by the Matron and Head of Nursing. |

**1.24** There are a further five wards/ departments that require evidence-based uplifts to the establishment These require an investment of £379,328 in totality, this investment has been supported by the executive team. These are as follows:

| Division | Area | Current WTE | Agreed WTE | Extra Funding Required | Comments |
|---|---|---|---|---|---|
| Medicine | Lindhurst/ WD 41 - | 29.24 | 35.16 | £ 121,108 | The SNCT principles and professional judgement have been applied and a 2.74 WTE uplift has been recommended to the establishment. This increase will provide additional registered nurses on each day duty 7 days per week. It has been recognised that the speciality of the ward is providing a sub-acute and a rehabilitation patient pathway; therefore, the additional staffing will |

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| Division | Ward / Department | | | | Comments: |
|---|---|---|---|---|---|
| | | | | | support the increase in dependency of patients' needs. The uplift has been supported whilst the team are situated at the Kings Mill site and once re-located back to MCH the rehabilitation modelling can be re-instated. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Surgery | DCU - King's Mill | 33.64 | 34.34 | £ 18,880 | Professional judgement has been applied and a 0.70 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| Surgery | Minister - NWK | 22 | 23.24 | £ 42,765 | Professional judgement has been applied and 1.24 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| UEC | UCC - Newark | 18.76 | 21.87 | £ 114,575 | The SNCT principles and professional judgement have been applied and a 2.11 WTE increase to the establishment has been recommended. The additional resource will support the ENP service provision. This is supported by the Matron and Head of Nursing. |
| W&C | Midwifery | 167.52 | 169.67 | £ 82,000 | The BirthRate Plus principles and professional judgment have been applied and an additional 2.15 WTE increase to the establishment has been recommended for the midwifery specialty requirement. There is sufficient resource available to staff Sherwood birthing Unit, Maternity ward, Community caseloads, Triage, and Outpatients. This is supported by the Matron and Head of Nursing. |

1.25    There are two wards currently operating outside of their usual speciality and bed base. The is ward 43 as the Respiratory Support Unit (RSU) and old ward 21 which is funded for 16 beds but has not been within this bed based for over a year. A strategic decision is required about the status of these. If they are to continue in their present forms an uplift of £1,063.994 is required to maintain this substantively. The board are asked to consider this request.

| Division | Ward / Department | Current WTE | Agreed WTE | Additional funding required | Comments: |
|---|---|---|---|---|---|
| Medicine | RSU | 40.85 | 53.38 | £ 813,039 | The SNCT principles and professional judgement have been applied and a 12.53 WTE increase the establishment recommended. This supports the level 1 and level 2 beds for acute respiratory patients. This is supported by the Matron and Head of Nursing. |

| Division | Ward / Department | Current WTE | Agreed WTE | Additional funding required | Comments: |
|---|---|---|---|---|---|
| **Surgery** | Ward 21 | 21.2 | 32.71 | £ 250,955 | The SNCT principles and professional judgement have been applied and an 11.51 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership and will support the unit to a full capacity of 24 beds. This is supported by the Matron and Head of Nursing. |

**1.26** There are a further 8 areas requesting uplift in establishments to support service developments. These equate to £1,289,670 in totality and it is therefore recommended that these are reviewed as part of the service development business case process.

| Division | Ward / Department | Current WTE | Agreed WTE | Additional funding required | Comments: |
|---|---|---|---|---|---|
| Medicine | WTC | 7.6 | 9.6 | £ 136,030 | Professional judgement has been applied and a 2.0 WTE uplift to the establishment has been recommended. The increase will support the development of the band 6 pathway and strengthen the chemotherapy service   This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. |
| Medicine | OPAT/ MDCU | 7.44 | 17.56 | £ 408,250 | Where applicable SNCT principles have been applied including professional judgement. A 10.12 WTE uplift has been recommended as the additional resource will enable an increase in the overall service provision. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. |
| UEC | Discharge Lounge | 7.8 | 9.01 | £ 44,059 | Professional judgement has been applied and 1.22 WTE increase to the establishment has been recommended. This will provide additional leadership support within the team whilst optimising progression opportunities within the team. This is supported by the Matron and Head of Nursing. |
| **UEC** | ED | 154.88 | 168.05 | £ 405,138 | The SNCT principles and professional judgement have been applied and 13.17 WTE uplift has been recommended to the establishment. This increase will provide additional registered nurses on twilight duty 7 days per week.  This will facilitate the children's and young people's area to remain open later in the evening providing a more therapeutic patient experience. It has been acknowledged when the area closes– children and young people are managed in adult areas and this is not a suitable quality pathway. Additional registered nurse presence on the day and night shifts will support prompt care delivery across all areas of the department. It has been acknowledged that whilst SNCT has recommended 123.3 WTE, the tool does not recognise leadership positions, specialist roles, and the additional care delivery roles that sit alongside the core workforce. These are roles that are unique to SFHFT and are included in the current establishment.   The data set used for SNCT has included several weeks where a national lockdown was in place and the attendance rate was reduced. The layout of the different areas within the department and the staffing requirements in each area has also been taken into consideration.  This recommendation is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |

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| | | | | |
|---|---|---|---|---|
| UEC | HOOH | 8.76 | 9.26 | £ 27,311 | Professional judgement has been applied and 0.a 5 WTE increase to the establishment has been recommended. This will provide a clear leadership role within the service. This is supported by the Matron and Head of Nursing. |
| D&O | KMH - Outpatients | 95.8 | 101.8 | £ 180,360 | Professional judgement has been applied and a 6.0 WTE increase to the establishment has been recommended. This will support the increase in clinic capacity and activity in urology and the AVH diagnostic hub. This is supported by the Matron and Head of Nursing. |
| D&O | Phlebotomy | 14.78 | 16.78 | £ 48,622 | Professional judgement has been applied and a 2.0 WTE increase to the establishment has been recommended. Activity has increased by 9 % since 2019 and the additional resource will continue to support activity and demand. This is supported by the Matron and Head of Nursing. |
| W&C | Paed SN | 9.08 | 10.98 | £ 39,900 | Professional judgement has been applied and a 1.9 WTE increase in the establishment has been recommended. This is to increase the hours of the team and uplift a band 6 to band 7. This is supported by the Matron and Head of Nursing |

**1.27** There is also a need to align theatre establishments to the evidence base. This has been included within the wider theatre transformation case. It is recommended that the investment in NMAHP staffing of £397,847 is supported when that case is reviewed.

## AHP Overview

**1.28** There is no single guidance or standard approach to inform safe staffing levels required within services provided by AHPs. Each AHP has profession-specific information and guidance only, available to support staffing levels of a particular type of service.

## Constraints

**1.29** Since our last report, the staffing challenges and risks within therapy services have begun to improve, this has been influenced by successful recruitment into several vacancies over recent weeks. Speech and language therapy (SLT) and dietetics have small specialist staffing establishments but remain below the benchmark of other organizations of a similar size as per Model Hospital.

**1.30** Therapy services have been unable to recruit occupational therapist (OT) into posts for the first time and have been experienced system wide. Three-band 5 OT's have been recruited but this is not sufficient to support upcoming maternity leave cover. There remain two band 5 vacancies in addition to eleven maternity leaves pending, resulting in the band 5 vacancies being put out to advert again. The AHP Faculty work includes increasing OT placements at SFHFT to aid recruitment, and the 'system' is considering an Integrated Care System (ICS) OT rotation. A band 7 post in ICCU has been approved as part of the ICCU business case

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and it will be advertised imminently. Expectations are recruitment into the specialist post will be more successful than the band 5/6 posts.

1.31 Speech and language therapy services have now been TUPE'd over from Nottinghamshire Healthcare and commenced at SFHFT in January 2022. The vacancies have been recruited into and staff are expected to start imminently. A band 5 position remains vacant, but the recruitment process has begun. From June 2022, an ICS rotation is proposed and SFHFT is currently exploring the benefits of this in supporting SLT service delivery, with support from human resource and finance teams via the ICS resourcing meetings. A team leader/ICCU post (band 8a) has been successfully recruited into and is also the dedicated ICCU SLT at SFHT (which is funded via the ICCU business case).

1.32 The lack of a sonographer workforce is causing a risk. There are 3.4 WTE vacancies within the team with the addition of another two maternity leaves pending. One application has been received in response to an advert and the candidate is being interviewed. MSK specialist screening is a hard to recruit speciality with limited agency resources, furthermore, it is also worth noting that the agency hourly rate has also increased above the capped rate. Therefore, an open day in April is planned to target school leavers and raise the profile of a career in sonography. An ACP business case is being developed, and radiology has requested two sonographer ACP posts and will continue to support in-house training of ACPs to mitigate future risks.

1.33 Pathology services remain under significant pressure with serology testing. Additional services have commenced for neutralising monoclonal antibodies (nMAB) infusions and serum testing will be performed by the SFHFT Microbiology team.

**AHP Faculty/ AHP Cabinet**

1.34 SFHFT Associate Chief AHPs continue to be key members of the AHP Faculty and ICS AHP Cabinet. The Nottingham and Nottinghamshire AHP Faculty and ICS Cabinet have a number of workstreams underway to support AHP workforce across the region. The Clinical Placement Expansion Programme (CPEP) has been extended and continues to be funded by Health Education England (HEE). The CPEP team is now working with Nottinghamshire Alliance Training Hub (NATH) team to establish and review AHP provision and placements within acute providers, general practice and PCN's.

1.35 The funding for the AHP project to support the recruitment of BME workforce has been completed and the findings of the report have been shared across the ICS. The AHP cabinet has been successful in gaining a further £1000k towards continued AHP Faculty projects and

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Faculty sustainability. As part of this funding, a key performance indicator for equality, diversity, and inclusivity will pick up this workstream and continue the progress and recommendations already made by the BME project. SFHFT is the host organisation for all the above projects with the Associate Chief AHPs as the named leads.

**Long Covid**

1.36    The Nottinghamshire ICS has successfully been awarded £1.6 million from HEE for long covid treatment. This involves significant support and utilisation of the ICS AHP workforce. The collaborative system approach is essential in allocating and providing a long covid treatment service. Diagnostic tests required and provided by SFHT are reportedly low. A review of respiratory out-patient provision by providers is currently being scoped for demand.

1.37    Long Covid assessment clinics for Nottinghamshire ICS continue to be provided on behalf of the system by Nottinghamshire Healthcare. A provider meeting is planned to review funding and additional treatment requirements which are continuing to gain pace with demand increasing.

**National Compliance**

1.38    The Developing Workforce Safeguards published by NHS Improvement in October 2018 were designed to help Trusts manage workforce planning and staff deployment.  Trusts are now assessed for compliance with the triangulated approach to deciding staff requirements detailed within the NQB guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

1.39    The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

1.40    The Chief Nurse and Medical Director have confirmed they are satisfied that staffing is safe, effective, and sustainable.

1.41    Appendix three details the Trust's compliance with the nursing and midwifery element of the Developing Workforce Safeguards recommendations.

**Recommendations**

1.42    The Board is asked to:

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- Approve the evidence-based cost-neutral uplifts to the 5 wards and departments identified.

- Approve the evidence-based uplifts to the 5 wards and departments identified at a cost of £379,328.

- Confirm the strategic direction for Ward 43 and 21 and approve the associated investment required.

- Recommend that the additional service improvement requests are progressed via the service development business case route.

**1.43**    The Board is asked to receive this report and note the on-going plans to provide safe staffing levels within nursing, midwifery and AHP disciplines across the Trust.

**1.44**    The Board is asked to note the maternity staffing position and the local position which is common with the national profile.

**1.45**    The Board is asked to note the AHP staffing and risk position within the report whilst noting the ongoing recruitment plans to support each service.

**1.46**    The Board is asked to note the compliance standards used in relation to SNCT, and the ongoing quality of data it provides to underpin the Trust establishment process.

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**Appendix One - Nursing, Midwifery, and Allied Health Professional Annual Staffing Report 2022**

**2.0    Purpose**

**2.1**    The purpose of this report is to provide an overview of NMAHP staffing capacity and compliance with the NICE Safe Staffing, NQB Standards, and the NHSI Developing Workforce Safeguards guidance.

**2.2**    It will provide a cumulative oversight of CHPPD and the available data for the cost per care hours (CPCH) each month.

**2.3**    This is supported by an overview of staffing availability since the last report and progress with assessing the acuity and dependency of patients on ward areas. This data has informed the nursing and midwifery establishment reviews for 2022/2023.

**Nursing and Midwifery Overview**

**3.0    Local Nursing and Midwifery Context**

**3.1**    Since the start of 2021/2022 the Trust vacancy rate has seen a continual positive reduction from 8.7% down to 3.9%.  This captures NMAHP staff from band 2 upwards and represents collective ongoing recruitment efforts being undertaken within our teams.

**3.2**    Great efforts have been made within nursing and midwifery in reducing the vacancy deficit, especially since Covid-19 has remained an immediate challenge. Focused workstreams supporting international recruitment have been successful and plans are in place to continue to support the programme.  The Trust remains on track with the NHS Long Term Plan to reduce nursing vacancies to 5% by 2028. However, it is recognised that due to the overall fragility felt within the national nursing vacancy position of 10.5%, recruitment and retention will remain a key priority within national policy and within the strategic steer for the Trust.

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*Figure 1:*



Nursing and Midwifery Vacancy Rate = %
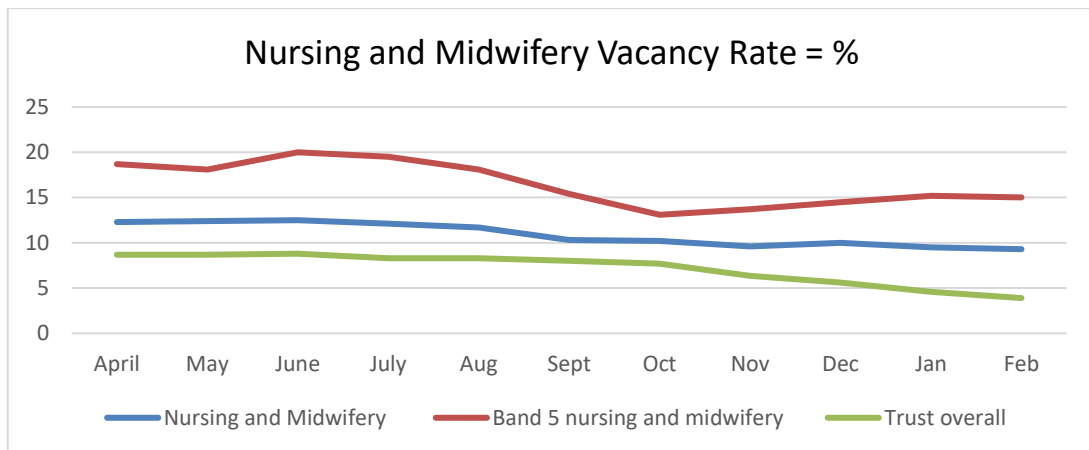
*Data Source: Workforce Informatics*

**3.3** The midwifery workforce challenges, reported in the previous paper, in particular the vacancies in the community midwifery team, have begun to stabilise since the revised approach to MCoC. This is due to both changes in the delivery of MCoC and the approach to recruitment and retention. The overall vacancy rate was 21.89% at the end of March 2022 across the whole of maternity services, 18% of this was within community midwifery.

**3.4** Overall sickness absence for all staff groups continues to be been an ongoing challenge due to the sustained impact presented by the pandemic, with the peak of absences being noted in January. Significant difficulties were experienced due to the fourth surge of Covid-19 and the sustained operational pressures at this time.

*Figure 2:*



Sickness Absence = %

*Data Source: Workforce Informatics.*

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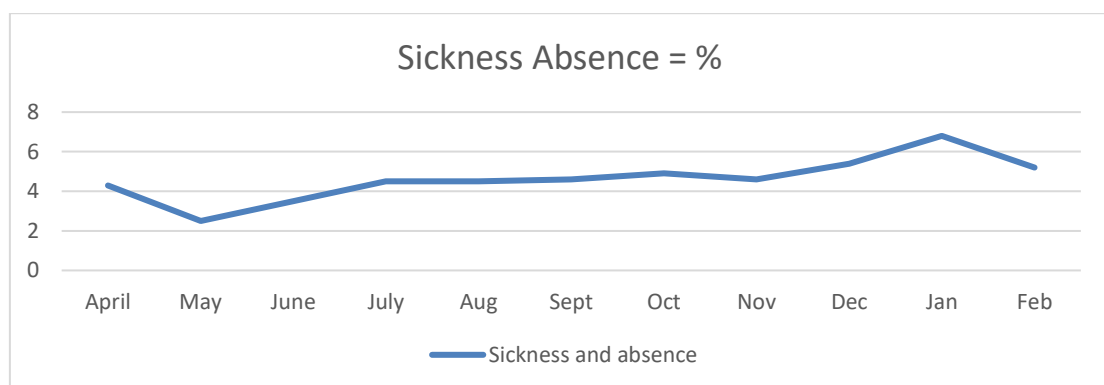
**3.5**   Agency usage within the clinical areas continues to see a sustained demand with the number of shifts increasing month on month since April 2021, with peak usage in September 2021 and January 2022. The peak months illustrate the height of the previous surges of patient admissions, which were predominantly driven by the Covid-19 pandemic. Acuity and dependency of patients attending the hospital over the previous year have continued to remain high and this has been combined with very high levels of flow and capacity during the winter months. Therefore, additional winter and surge capacity has been open across the organisation.

*Figure 3:*



**Shifts Filled by Agency**

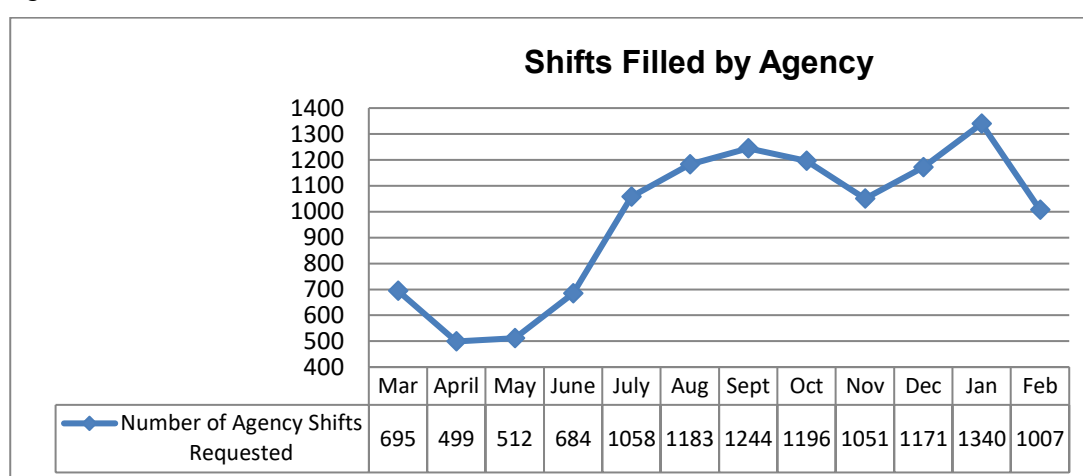|  | Mar | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Agency Shifts Requested | 695 | 499 | 512 | 684 | 1058 | 1183 | 1244 | 1196 | 1051 | 1171 | 1340 | 1007 |

*Data Source: Temporary Staffing Office.*

**3.6**   In line with the increasing agency usage, there has been a rising trend in the use of escalated rates from May onwards. This has been significantly influenced by the increased capacity open across our services, alongside the increased acuity and dependency of patients requiring admission. The previous twelve months have also been extremely challenging for staff across all services due to the ongoing significant workforce challenges that have persisted due to sickness and national isolation measures that have been in place. Information provided by the Temporary Staffing Office outlines the reason for each request and this triangulates with the above. The leading request reasons were additional capacity, short term sickness, Covid-19 sickness, and vacancies.

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*Figure 4:*



**Shifts Filled at Escalated Rates**

Legend:
- Escalated Rate Level 1
- Escalated Rate Level 2
- Escalated Rate Level 3
- Total
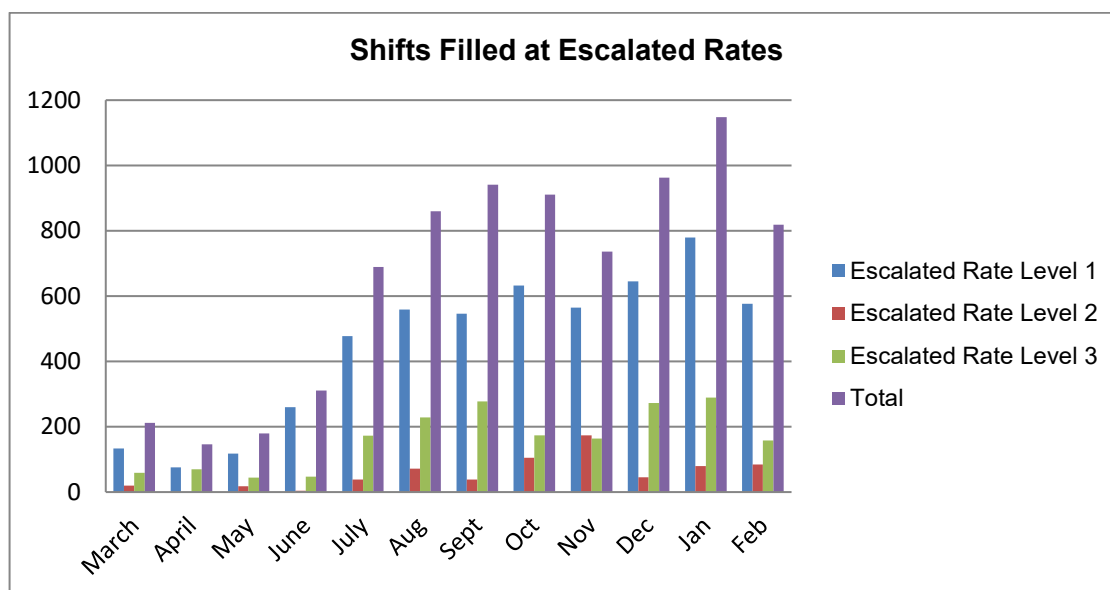
*Data Source: Temporary Staffing Office.*

## 4.0    Planned versus Actual Staffing & Care Hours per Patient Day (CHPPD)

4.1    All NHS providers are required to publish inpatient nursing and midwifery staffing data on a monthly basis and a national report is submitted each month. This data highlights the planned staffing hours (hours planned into a working roster template) aligned to actual staffing hours worked (actual hours worked by substantive and temporary staff). In addition to CHPPD, cost per care hours (CPCH) are also monitored.

4.2    Despite the unprecedented challenges over the last 12 months the Trust has consistently remained above 95% of the planned staffing fill rates. The data for March demonstrated a more variable position for nursing associates; however, it is acknowledged this particular team is very small in numbers (less than ten across the Trust), and the team has been affected by Covid-19 absence, annual leave, and long-term absence for compassionate reasons.

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*Figure 5:*

**Planned vs Actual Staffing Fill Rates 2021/2022**

| | Marc | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Trust | 96% | 102% | 100% | 100% | 100% | 102% | 104% | 104% | 106% | 104% | 106% | 106% |
| RN/M Day | 98% | 97% | 95% | 93% | 96% | 95% | 98% | 98% | 99% | 97% | 98% | 96% |
| RN/M Night | 102% | 108% | 96% | 103% | 103% | 101% | 106% | 103% | 102% | 109% | 112% | 101% |
| HCSW Day | 105% | 99% | 105% | 94% | 98% | 105% | 103% | 107% | 111% | 102% | 103% | 111% |
| HCSW Night | 111% | 113% | 110% | 112% | 111% | 117% | 118% | 119% | 123% | 119% | 120% | 118% |
| NA Days Only | 63% | 86% | 89% | 83% | 95% | 92% | 86% | 105% | 68% | 74% | 70% | 76% |
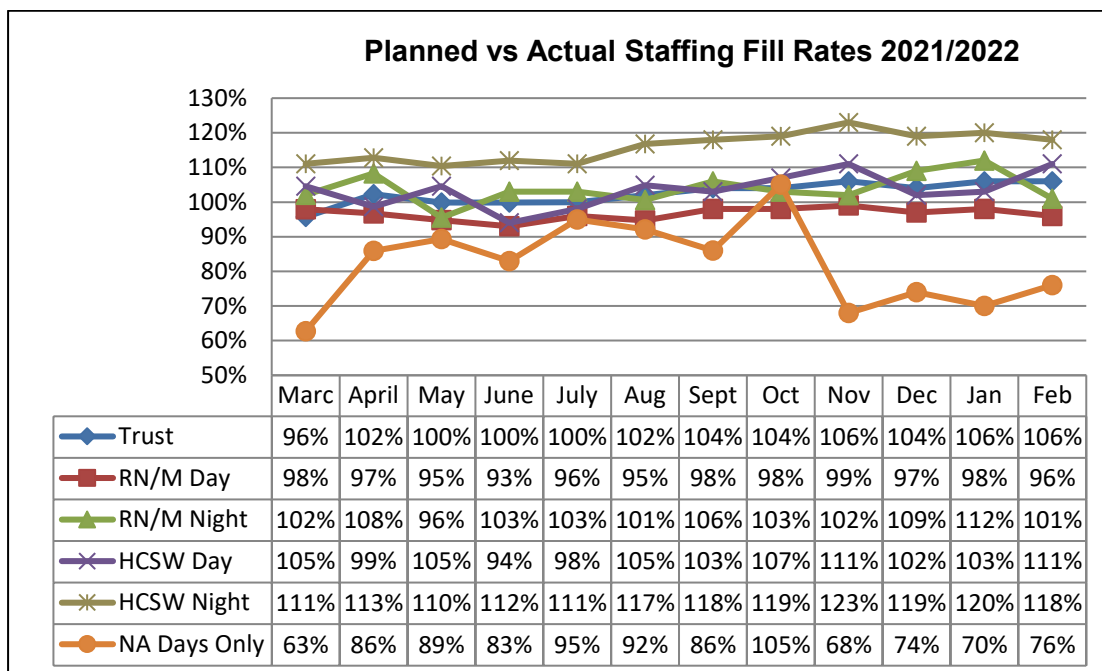
*Data Source: Unify Staffing Data.*

**4.3** CHPPD is calculated by adding together the hours of registered nurses/ midwives and health care support staff (HCSW) and dividing the total by every 24 hours of inpatient admissions. This provides a value that demonstrates the average number of actual registered nursing care hours spent with each patient per day. Data from Trust and ward level for all acute Trusts are published on NHS Model Hospital to enable a central and transparent comparable data set.

*Figure                                                                                    6:*



Safe staffing care hours per patient day (CHPPD)
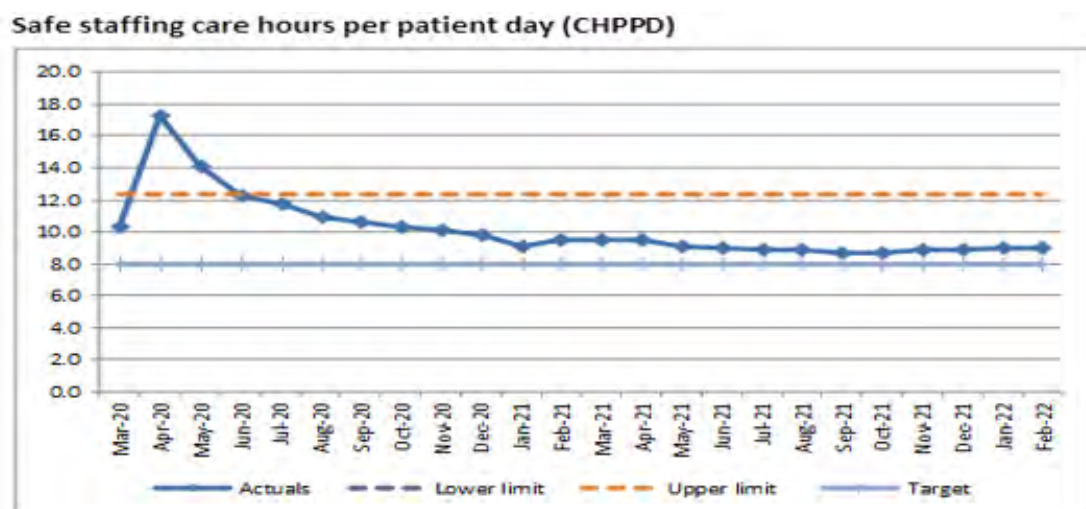
*Data Source: Information Services*

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**4.4**   The CHPPD at Trust level has remained stable demonstrating where safely possible the workforce is being flexed in line to meet patient activity and patient needs. Benchmarking data from Model Hospital (December 2021) demonstrates that the Trust value sits within the third quartile at 8.9 and is slightly above the national and peer median of 8.2
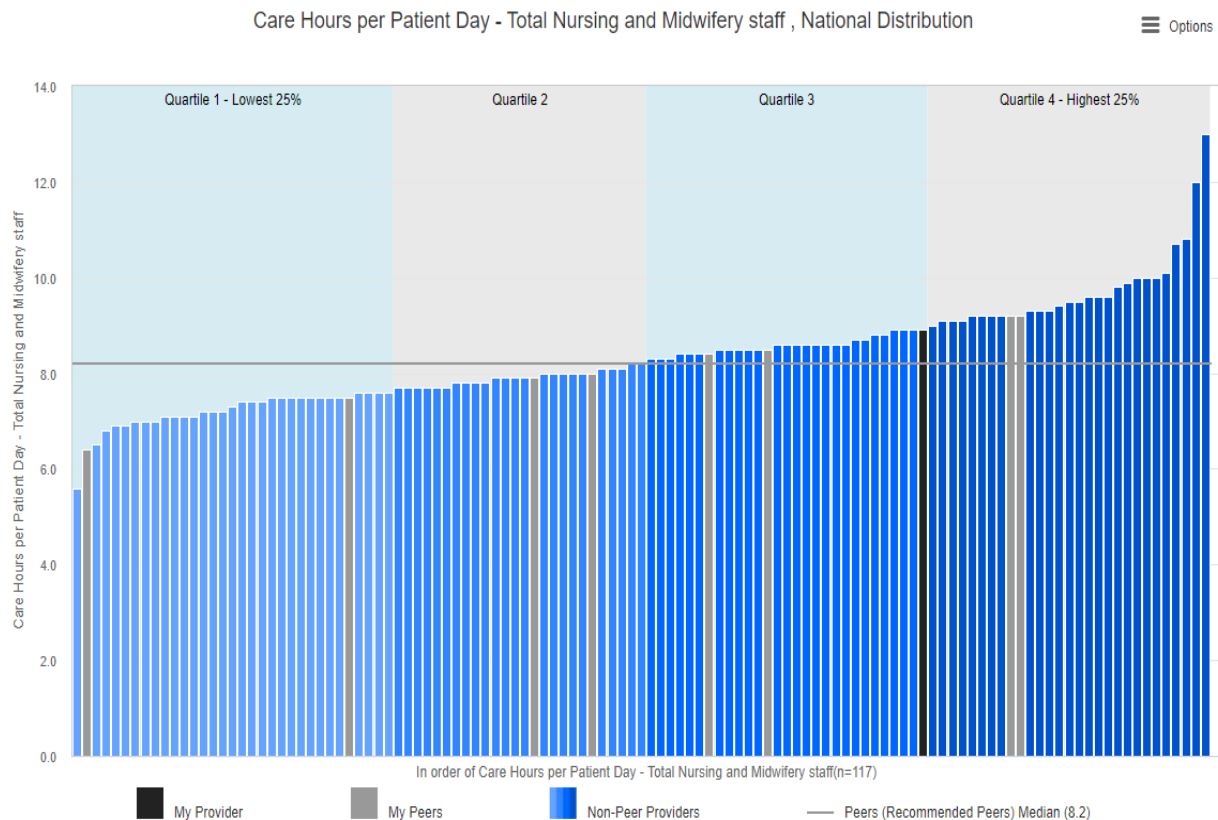
Figure 7:



Care Hours per Patient Day - Total Nursing and Midwifery staff , National Distribution

*Data Source: Model Hospital*

**4.5**   Divisional narrative from the matron team highlights ensuring safe staffing across all services has been a constant process that has been significantly challenging for all involved. Nonetheless, staffing resource has been safely flexed to meet patient demand, activity, and acuity. Since our last report, the workforce loss generated from the pandemic has been unprecedented and widespread, and the continued effort given by our teams to ensure service provision has been outstanding.

**4.6**   Midwifery staffing has been safely matched to birth activity over the last six months, but to help achieve this, acute staffing shortages have been supported with bank and agency use and with the deployment of a registered nurse to support acute maternity. Midwives have continued to receive an enhanced payment rate for bank shifts and a

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review of all non-clinical roles. The Birth Rate Plus® workforce review that was completed in September 2020 provides richer detail to the complex variables affecting staffing requirements in a maternity service and showing predicts a forecast of the establishment requirement. Since this review, multiple factors have changed leading to a revised Birth Rate Plus® review which is expected to be undertaken at the end of April 2022. This is due to the subsequent increased birth rate at SFHFT for 2020-21 and 2021-22 and, local and national changes to the delivery of MCoC.

4.7 CPCH is measured as the average cost spent per hour of care, and benchmarking variance at ward level with peers may help to identify potential savings opportunities in the cost of providing care. Safe staffing and financial returns include substantive, bank, and agency staff; therefore, a higher cost may indicate greater reliance on agency staff as a proportion to substantive. Since our last report, the variance in CHPPD for March to July illustrates a more stable picture, however, the CPCH is rising and could be indicative of increased reliance on agency and temporary staff as seen below in figure 5.

*Figure 8:*

**Carter Metrics For Nursing and Midwifery**

| | Marc | April | May | June | July | Aug | Sept | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|
| CHPPD | 9.5 | 9.5 | 9.1 | 9 | 8.9 | 8.9 | 8.7 | 8.9 | 8.9 | 9 | 9 |
| CPCH | 28.33 | 29.68 | 28.21 | 29.5 | 29.75 | 30.54 | 32.85 | 29.26 | 31.31 | 29.85 | 33.13 |
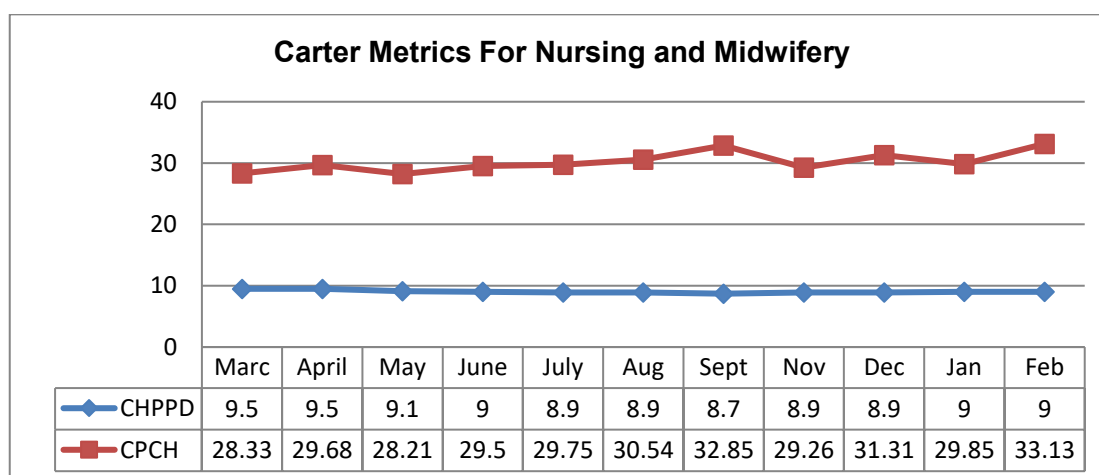
*Data Source: Finance Services*

**5.0 Measure and Improvement**

5.1 To ensure there is a triangulated approach in our oversight of safe staffing, the senior nursing and midwifery team review workforce metrics, indicators of quality, and measures of productivity monthly within the monthly Safe Staffing Report. It is important to acknowledge these should not be reviewed in isolation when understanding quality.

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*Figure 9:*

|  | March | April | May | June | July | Aug | Sept | Oct | Nov | Dec | Jan | Feb |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Staffing Incidents** | 55 | 56 | 86 | 87 | 52 | 68 | 74 | 61 | 53 | 58 | 45 | 49 |
| **Red Flags** | 3 | 0 | 2 | 2 | 1 | 4 | 4 | 3 | 2 | 3 | 2 | 1 |

*Data Source: Datix Reporting System*

**5.2** Since March 2021, 744 nursing and midwifery staffing-related incidents have been reported through the Datix reporting system. All incidents were recorded as no or low harm, and the appropriate actions were taken at the time. 27 of these incidents have been identified as *red flag* incidents (as defined by NICE) due to a delay in fundamental care or delays in time-critical activity. It is recognised that despite no adverse clinical outcome, the delays in care will have negatively impacted the overall experience of patients and colleagues.

**5.3** In addition to Datix reporting, red flags for midwifery services are recorded within Birth Rate Plus®. A review of the data inputted into the tool indicated that training and implementation had not been consistent and there was no process for external validation of the scoring. A review and refresh of training have been undertaken, with the full support of the Birthrate Plus national team. The tool is now in full use and the red flag data will be included with Safe Staffing Reports going forward.

**6.0 Nursing and Midwifery Recruitment and Retention.**

**6.1** In the last 12 months, the Trust has recruited 107 international registered nurses (IRN) and two international registered midwives (IRMW). There are currently 25 IRNs and one IRMW awaiting their Objective Structured Clinical Examinations (OSCEs), with three awaiting re-sits scheduled at the end of March. The number of IRNs currently working with Nursing and Midwifery Council (NMC) registration is 82, and currently, this is waiting to be reflected on the ESR system. The Trust had two IRNs leave the Trust, one to move closer to her partner in Burton, Derbyshire, and the second had taken a post at King's College Hospitals London.

**6.2** The Trust was successful in funding opportunities to support IRN recruitment and this has supported the Trust to create more opportunities for international recruitment. In

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2022/23 the Trust has secured further funding to support the continued recruitment of 50 IRNs.

6.3    Since our last report there has been capacity issues within the NMC Test of Competency Centres, which has caused delays in our IRNs being able to take their OSCEs.  This was escalated to regional and national teams, and the national response was very supportive, and we were able to facilitate 32 IRNs to undertake their tests.  This was escalated as a risk at the Nursing, Midwifery & AHP Transformation Group.

6.4    In 2022/23 the Trust will move towards the Pastoral Care Quality Awards and revise our system of onboarding and pastoral care to excel in the care and support we offer our IRN colleagues.

6.5    In September 2021, the Trust embarked on the first cohort of registered nurse degree apprenticeships at Nottingham Trent University.  The initial cohort comprised of 41 successful students, with a large number of students leaving within the first three months, leaving the cohort with 21 students.  On reflection, the recruitment process could have been stronger, and we could have been more prepared. We have discussed with Nottingham Trent University the promotion of the course locally may have supported improved retention.  Nottingham Trent University is also going to review their accommodation at the Mansfield location, as this was identified as another cause of the attrition.

6.6    The Trust currently has 31 trainee nursing associates (TNAs) in post, with two TNAs taking a break from studying; one is on maternity Leave and the second is taking a career break.  Cohort 2 will qualify in October 2022 (currently 16) and will move into band 4 posts on the ward as part of the band 5 establishments. The heads of nursing are reviewing their establishments to ensure that the nursing associates can remain within the base wards.  Cohort 3 is six months into their training, and there are 15 TNAs with two undertaking career breaks.

6.7    The Trust will be looking for further opportunities for funding to support another cohort of TNAs in October 2022.

6.8    The Trust continues to advertise for newly qualified registered nurses, and we are recruiting all those that have applied through this route.  The heads of nursing are

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receiving the application forms monthly, and the senior nursing team has identified a process to expedite these nurses into posts upon qualifying.

**6.9** NHSE has shared with Trusts nationally their plans to roll out the National Preceptorship Framework, which will support student nurses' transition to registered nurses. The framework will align all preceptorship programmes within the trust, which will include midwifery and AHPs. The lead for preceptorship is reviewing the framework and undertaking a gap analysis, before presenting to the Nursing, Midwifery & AHP Committee their recommendations.

**6.10** The Trust is actively engaged in the recruitment and retention of HCSWs and will be embarking on the recruitment of a practice development matron to develop the pastoral care and supporting engagement for this group of staff.

**6.11** During February five registered nurses from SFHFT commenced their training to become registered midwives, this is a shortened MSc program of two years and is being delivered by Birmingham City University.

**6.12** The deputy head of midwifery position has been successfully recruited following a competitive recruitment process, and ongoing recruitment within the acute and community team remains active due to staff within these teams gaining successful internal promotions.

**6.13** NHSE/I provided additional funding for a Recruitment and Retention (R&R) Lead post for midwifery in late 2021, and the Trust was successful in its bid for this funding, with the post commencing in February 2022. The focus for this role is to provide individualised support in a clinical environment for students, return to practice learners, and early career midwives and will develop mechanisms for identifying and addressing individual needs, provide, or signpost to resources that will promote job satisfaction and retention across multiple domains. This will include those related to pastoral care, learning support, and career development. Whilst this role is new the initial evaluations have been positive.

**6.14** Whilst this is a high rate of recruitment of early career midwives, national data continues to reveal an alarmingly high rate of early career midwives leaving the profession, which supported the bid for the R&R Lead Midwife post (RCM, 2021).

**7.0** **Nursing Forward Planning**

**7.1** SNCT acuity and dependency cycles will continue into 2022/2023 with planning underway for June, October, and January 2023. The senior corporate nursing team will continue to support validation and assurance with data collection, with refresh education being rolled out to all areas.

**7.2** The ED tool for SNCT has recently been published and nationwide training is being delivered by NHSE/I. The trust has acquired the license for use and has registered the corporate matron for safe staffing, matron for ED, and head of nursing for UEC for training in the use of the tool. When this has been undertaken the corporate matron for safe staffing will lead a programme of work for acuity and dependency scoring cycles to help further inform the establishment review process going forward.

**7.3** Progress within the Workforce Transformation Group is proceeding well, with workstreams focused upon exemplar rostering, enhanced care, virtual ward development, international recruitment, apprenticeships, expanding the nursing associate workforce, mandatory training, and bank rates.

**8.0** **Midwifery Forward Planning**

**8.1** The unavailability of the community midwifery service has led to a limited home birth service with a hope to re-instate a full service from Q2 2022-23, given the planned regional review of the service and pipeline of recruitment into these teams. This reduction of the homebirth service has been taken in line with supportive guidance from the RCOG and RCM and sign-off from Trust Board. This limited service is reported internally to Trust Board and externally to NHSE and all women are informed from booking onto this pathway in regard to its limitations. The detailed workforce review which was undertaken to inform the business planning for 22/23 remains under review, reflecting the changes in the national ask for the delivery of MCoC

**8.2** The age profile within midwifery supports a need for a recruitment and retention role, with a significant number of these midwives being early careers across the service. The role objectives of the R&R lead midwife, as outlined by NHSI, ask that the role considers legacy mentoring, and supporting the wealth of experience of senior midwives and how they could further support with. This will be a focus of work for phase two of the role.

**8.3** Whilst the R&R lead midwife role will help to support the early career midwives, we also acknowledge the associated impact of the experience midwives who are at/

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beyond retirement age. Additional measures have been taken to limit these impacts, these include shift flexibility, bank contracts, and personal letters from the chief nurse to encourage temporary returns. It is expected with the substantive recruitment of the Head of Midwifery and the deputy head of midwifery, will provide stability amongst the senior leadership team and support the progressing plans for talent management and succession planning.

## 9.0    Nursing and Midwifery Establishment Review 2022/2023

9.1    Since the last establishment review, the Trust has refreshed its approach to setting the nursing and midwifery establishments to ensure we are compliant with the NQB standards. This has included the implementation of the SNCT, an evidence-based workforce planning tool that provides patient acuity and dependency intelligence, which has informed the Trust establishment setting process. SNCT is an objective tool that utilises levels of care to support workforce planning and has been recognised for supporting safe staffing across in-patient wards, receiving the endorsement from NICE in 2014.

9.2    The first SNCT data collection cycle of 2021 took place in April; however, this was initially planned for February but was delayed due to the second wave of the pandemic. Subsequent cycles were rescheduled and completed in June and again in October, with data collection across adult and paediatric in-patient areas.

9.3    A multidisciplinary review of the nursing and midwifery establishments commenced in early February and was led by the Chief Nurse with representation from the deputy chief nurse, divisional heads of nursing/ midwifery, divisional finance managers, and the corporate matron for safe staffing.

9.4    Each review was aligned to the components below:

- Each review panel ensured professional judgement was applied to staffing and was representative of activity requirements.
- The appropriate skill mix of staff was aligned to the speciality.
- Three cycles of SNCT acuity and dependency data were used to inform each confirm and challenge discussion.
- The financial impact on the setting of budgets was considered.
- Benchmarking ward level care hours per patient day (CHPPD) data was aligned with the national mean.

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- A 12-month overview of nurse/midwifery-sensitive indicators for each area was reviewed.

**9.5**  Trust compliance against SNCT guidelines can be found in appendix four.

**10.0**  **Recommended Nursing and Midwifery Establishments for 2022-2023**

**10.1**  Staffing establishments consider the need to allow nursing, midwifery and healthcare support workers (HCSW) time to undertake professional development and fulfil mentorship and supervision roles. Core principles in determining the nursing and midwifery establishment are maintained as per previous years, namely:

- The ward/department leader role is supervisory, enabling them to apply their time to provide direct care, undertake front-line clinical leadership, and support unfilled shifts.
- The skill mix on the ward should aim to have a recommended ratio of 65:35% split for registered nurses to HCSW in acute wards and 60:40 for sub-acute/rehab wards.
- 22% 'headroom' is allocated to establishments to allow for annual leave, sickness, maternity leave, training, and development. The Carter report recommends 25%; however, 22% is the minimum 'headroom' supported within the SNCT and represents a built-in efficiency. ED, Newark Urgent Treatment Centre, NICCU, and ICU were allocated 25% headroom acknowledging the specialty guidance for additional training requirements for these specific areas.

**10.2**  The full establishment review can be located in appendix two.

**10.3**  There are five wards/ departments that require small evidence-based uplifts to the establishment which can be managed within the existing envelope. These are as follows:

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| Division | Area | Current WTE | Agreed WTE | Comments |
|----------|------|-------------|------------|----------|
| Surgery | Ward 11/AU | 42.53 | 42.74 | The SNCT principles and professional judgement have been applied and a 0.21 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 12 | 37.5 | 37.9 | The SNCT principles and professional judgment have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 31 | 34.83 | 35.23 | The SNCT principles and professional judgment have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 32 | 32.31 | 32.71 | The SNCT principles and professional judgment have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | ITU | 98.01 | 98.39 | The GPICS principles and professional judgment have been applied and a 0.38 WTE increase to the establishment has been recommended. The additional resource will support the addition of the Rehab Family Support Nurse. This is supported by the Matron and Head of Nursing. |

**10.4** There are a further five wards/ departments that require evidence-based uplifts to the establishment These require an investment of £379,328 in totality. These are as follows:

Figure 11:

| Division | Area | Current WTE | Agreed WTE | Extra Funding Required | Comments |
|----------|------|-------------|------------|-----------------------|----------|
| Medicine | Lindhurst/ WD 41 - | 29.24 | 35.16 | £ 121,108 | The SNCT principles and professional judgement have been applied and a 2.74 WTE uplift has been recommended to the establishment. This increase will provide additional registered nurses on each day duty 7 days per week. It has been recognised that the speciality of the ward is providing a sub-acute and a rehabilitation patient pathway; therefore, the additional staffing will support the increase in dependency of |

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| Division | Ward / Department | | | | |
|---|---|---|---|---|---|
| | | | | | patients' needs. The uplift has been supported whilst the team are situated at the Kings Mill site and once re-located back to MCH the rehabilitation modelling can be re-instated. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Surgery | DCU - King's Mill | 33.64 | 34.34 | £ 18,880 | Professional judgement has been applied and a 0.70 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| Surgery | Minister - NWK | 22 | 23.24 | £ 42,765 | Professional judgement has been applied and 1.24 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| UEC | UCC - Newark | 18.76 | 21.87 | £ 114,575 | The SNCT principles and professional judgement have been applied and a 2.11 WTE increase to the establishment has been recommended. The additional resource will support the ENP service provision. This is supported by the Matron and Head of Nursing. |
| W&C | Midwifery | 167.52 | 169.67 | £ 82,000 | The BirthRate Plus principles and professional judgment have been applied and an additional 2.15 WTE increase to the establishment has been recommended for the midwifery specialty requirement. There is sufficient resource available to staff Sherwood birthing Unit, Maternity ward, Community caseloads, Triage, and Outpatients. This is supported by the Matron and Head of Nursing. |

**10.5** There are two wards currently operating outside of their usual speciality and bed base. The is ward 43 as the Respiratory Support Unit and old ward 21 which is funded for 16 beds but has not been within this bed based for over a year. A strategic decision is required about the status of these. If they are to continue in their present forms an uplift of £1,063.994 is required to maintain this substantively.

*Figure 12:*

| Division | Ward / Department | Current WTE | Agreed WTE | Additional funding required | Comments: |
|---|---|---|---|---|---|
| Medicine | RSU | 40.85 | 53.38 | £ 813,039 | The SNCT principles and professional judgement have been applied and a 12.53 WTE increase the establishment recommended. This supports the level 1 and level 2 beds for acute respiratory patients. This is supported by the Matron and Head of Nursing. |

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| Surgery | Ward 21 | 21.2 | 32.71 | £ 250,955 | The SNCT principles and professional judgement have been applied and an 11.51 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership and will support the unit to a full capacity of 24 beds. This is supported by the Matron and Head of Nursing. |
|---|---|---|---|---|---|

**10.6** There are a further 8 areas requesting uplift in establishments to support service developments. These equate to £1,289,670 in totality and it is therefore recommended that these are reviewed as part of the service development business case process.

*Figure 13:*

| Division | Ward / Department | Current WTE | Agreed WTE | Additional funding required | Comments: |
|---|---|---|---|---|---|
| Medicine | WTC | 7.6 | 9.6 | £ 136,030 | Professional judgement has been applied and a 2.0 WTE uplift to the establishment has been recommended. The increase will support the development of the band 6 pathway and strengthen the chemotherapy service   This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. |
| Medicine | OPAT/ MDCU | 7.44 | 17.56 | £ 408,250 | Where applicable SNCT principles have been applied including professional judgement.  A 10.12 WTE uplift has been recommended as the additional resource will enable an increase in the overall service provision. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. |
| UEC | Discharge Lounge | 7.8 | 9.01 | £ 44,059 | Professional judgement has been applied and 1.22 WTE increase to the establishment has been recommended. This will provide additional leadership support within the team whilst optimising progression opportunities within the team. This is supported by the Matron and Head of Nursing. |
| UEC | ED | 154.88 | 168.05 | £ 405,138 | The SNCT principles and professional judgement have been applied and 13.17 WTE uplift has been recommended to the establishment. This increase will provide additional registered nurses on twilight duty 7 days per week.   This will facilitate the children's and young people's area to remain open later in the evening providing a more therapeutic patient experience. It has been acknowledged when the area closes– children and young people are managed in adult areas and this is not a suitable quality pathway.  Additional registered nurse presence on the day and night shifts will support prompt care delivery across all areas of the department. It has been acknowledged that whilst SNCT has recommended 123.3 WTE, the tool does not recognise leadership positions, specialist roles, and the additional care delivery roles that sit alongside the core workforce. These are roles that are unique to SFHFT and are included in the current establishment.   The data set used for SNCT has included several weeks where a national lockdown was in place and the attendance rate was reduced. The layout of the different areas within the department and the staffing requirements in each area has also been taken into consideration.  This |

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| | | | | |
|---|---|---|---|---|
| | | | | recommendation is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| UEC | HOOH | 8.76 | 9.26 | £ 27,311 | Professional judgement has been applied and 0.a 5 WTE increase to the establishment has been recommended. This will provide a clear leadership role within the service. This is supported by the Matron and Head of Nursing. |
| D&O | KMH - Outpatients | 95.8 | 101.8 | £ 180,360 | Professional judgement has been applied and a 6.0 WTE increase to the establishment has been recommended. This will support the increase in clinic capacity and activity in urology and the AVH diagnostic hub. This is supported by the Matron and Head of Nursing. |
| D&O | Phlebotomy | 14.78 | 16.78 | £ 48,622 | Professional judgement has been applied and a 2.0 WTE increase to the establishment has been recommended. Activity has increased by 9 % since 2019 and the additional resource will continue to support activity and demand. This is supported by the Matron and Head of Nursing. |
| W&C | Paed SN | 9.08 | 10.98 | £ 39,900 | Professional judgement has been applied and a 1.9 WTE increase in the establishment has been recommended. This is to increase the hours of the team and uplift a band 6 to band 7. This is supported by the Matron and Head of Nursing |

**10.7** There is also a need to align theatre establishments to the evidence base. This has been included within the wider theatre transformation case. It is recommended that the investment in NMAHP staffing of £397,847 is supported when that case is reviewed.

**10.8** The collective recommended establishment change is as follows

- Evidence-based cost-neutral uplifts to the 5 wards and departments increase of 1.79WTE at a cost of £0

- Evidence-based uplifts to the 5 wards and departments increase of 8.94WTE at a cost of £379,328

- Maintenance of Ward 43 and 21 in their current specialty and bed base is an increase of 24.04wte at a cost of £1,063,994

- Additional service improvement requests are an increase of 36.91 WTE at a cost of £1,289,670

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**11.0** There is no single guidance or standard approach to inform safe staffing levels required within services provided by AHPs. Each AHP has profession-specific information and guidance only, available to support staffing levels of a particular type of service.

**11.1 Risks and Constraints**

**11.2** Since our last report, the staffing challenges and risks within therapy services have begun to improve, this has been influenced by successful recruitment into several vacancies over recent weeks. Speech and language therapy (SLT) and dietetics have small specialist staffing establishments but remain below the benchmark of other organisations of a similar size (Model Hospital).

**11.3** Therapy services have been unable to recruit occupational therapist (OT) posts for the first time and have been experienced system-wide. Three-band 5 OT's have been recruited but this is not sufficient to support upcoming maternity leave cover. There remain two band 5 vacancies in addition to eleven maternity leaves pending, resulting in the band 5 vacancies out to advert again. The AHP Faculty work includes an increase in OT placements at SFHFT to aid recruitment, and the 'system' is considering an Integrated Care System (ICS) OT rotation. A band 7 post in ICCU has been approved as part of the ICCU business case and it will be advertised imminently. Expectations are recruitment into the specialist post will be more successful than the band 5/6 posts.

**11.4** Speech and language therapy services have now been TUPE'd over from Nottinghamshire Healthcare and commenced at SFHFT in January 2022. The vacancies have been recruited into and staff are expected to start imminently. A band 5 position remains vacant, but the recruitment process has begun. From June 2022, an ICS rotation is proposed and SFHFT is currently exploring the benefits of this in supporting SLT service delivery, with support from human resource and finance teams via the ICS resourcing meetings. A team leader/ICCU post (band 8a) has been successfully recruited into and is also the dedicated ICCU SLT at SFHT (which is funded via the ICCU business case).

**11.5** Paediatric dietetics have successfully used AHP job planning to support a business case for additional capacity. An additional band 6 is due to commence in April 2022 to support the paediatric service. The band 6 (diabetic and endocrinology) vacancy was

unsuccessful in recruiting the right candidate and therefore has gone back out to advert. Funding has been obtained via the ICCU business case for a specialist dietitian (band 8a) and will support the adult dietitians who are deployed to support ICCU at the detriment of the ward service provision. The team is currently exploring the potential of this being an advanced clinical practitioner (ACP) role and expects to recruit into this specialist role with ease.

11.6 There are no significant issues with recruitment within Physiotherapy at SFHFT. A band 7 Musculoskeletal (MSK) team leader post is in the recruitment process and it is expected an appointment will be made from the calibre of candidates who have applied. We have also successfully recruited a physiotherapy ACP post for ICCU, which has been supported by the ACP lead. Furthermore, physiotherapy continues to support two therapy assistants on the Physiotherapy Apprenticeship Scheme at Sheffield Hallam University.

11.7 The lack of a sonographer workforce is causing a risk. There are 3.4 WTE vacancies within the team with the addition of another two maternity leaves pending. One application has been received in response to an advert and the candidate is being interviewed. MSK specialist screening is hard to recruit speciality with limited agency resources is also worth noting that the agency hourly rate has also increased above the capped rate. An open day in April is planned to target school leavers and raise the profile of a career in sonography. An ACP business case is being developed, and radiology has requested two sonographer ACP posts and will continue to support in-house training of ACPs to mitigate future risks.

11.8 There are two band 5 radiographer vacancies, and the level of calibre and interest of applicants that have applied is very encouraging, with the recruitment process ongoing. It is anticipated that without the ability to over recruit, further vacancies will be more difficult to recruit into due to undergraduates qualifying in the spring. However, a successful programme of recruitment has seen the appointment of a radiology nurse, a qualified reporting radiographer, two band 7 team leaders and a band 6 position.

11.9 There is a current workforce plan underway for the new MRI department which includes two additional scanners planned and will operate seven days a week. It is acknowledged that this will be a challenge to fill the posts required considering that Nottingham University Hospitals currently have 11 band 6 vacancies in MRI. We are developing a robust plan to mitigate this risk.

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**11.10** There has been successful recruitment of a band 6 orthotist which has resulted in the service being at its full establishment.

**11.11** Pathology services remain under significant pressure with serology testing. Additional services have commenced for neutralising monoclonal antibodies (nMAB) infusions and serum testing will be performed by the SFHFT Microbiology team.

**12.0** **AHP Faculty/ AHP Cabinet**

**12.1** SFHFT Associate Chief AHPs continue to be key members of the AHP Faculty and ICS AHP Cabinet. The Nottingham and Nottinghamshire AHP Faculty and ICS Cabinet have a number of workstreams underway to support AHP workforce across the region.

**12.2** The Clinical Placement Expansion Programme (CPEP) has been extended and continues to be funded by HEE. The CPEP team is now working with Nottinghamshire Alliance Training Hub (NATH) team in order to establish and review AHP provision and placements within acute providers, and PCN's.

**12.3** The current workstreams include CPEP for physiotherapy, occupational, therapy, SLT and dietetics, retention and support for students and the newly qualified workforce, early careers, apprenticeships, profession-specific growth, and AHP support workforce.

**12.4** At SFHFT we are supporting the following AHPs on secondment to deliver CPEP and the AHP faculty workstreams and including:

- one physiotherapist
- one radiographer
- one occupational therapist
- one operating department practitioner
- one SLT and one dietitian from Nottingham City Healthcare are also supporting delivery against the workstreams.

**12.5** As providers, HEE has allocated £62k to AHP leadership and support workers. Within the Trust, we have a physiotherapist and a radiographer on secondment who will review the AHP support workforce and support the delivery of the key performance indicators.

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**12.6** The funding for the AHP project to support the recruitment of BME workforce has been completed and the findings of the report have been shared across the ICS. The AHP cabinet has been successful in gaining a further £1000k towards continued AHP Faculty projects and Faculty sustainability. As part of this funding, a key performance indicator for equality, diversity, and inclusivity will pick up this workstream and continue the progress and recommendations already made by the BME project. SFHFT is the host organisation for all the above projects with the Associate Chief AHPs as the named leads.

**13.0 Discharge to Assess (D2A)**

**13.1** Therapy services are continuing to work closely with IDAT and system colleagues to deliver the D2A model. An SFHFT occupational therapist, working with IDAT screens pathway 1 patients for adult social care packages and START, supporting the social care pressures. There are now 15 'trusted screeners' identified (awaiting a final sign off by adult social care) within therapy services who are able to recommend care packages. Progress so far demonstrates it is proving beneficial, improving the efficiency of transfer of care between acute and social care and reducing the length of stay for this cohort of patients. Work remains ongoing to secure substantive funding for this model.

**14.0 Long Covid**

**14.1** The Nottinghamshire ICS has successfully been awarded £1.6 million from HEE for long covid treatment. This involves significant support and utilisation of the ICS AHP workforce. The collaborative system approach is essential in allocating and providing a long covid treatment service. Diagnostic tests required and provided by SFHT are reportedly low. A review of respiratory out-patient provision by providers is currently being scoped for demand.

**14.2** Long Covid assessment clinics for Nottinghamshire ICS continue to be provided on behalf of the system by Nottinghamshire Healthcare. A provider meeting is planned to review funding and additional treatment requirements which are continuing to gain pace with demand increasing.

**15.0 AHP Leadership**

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**15.1** Carl Miller (Reporting Radiographer) has been successful in obtaining the Deputy Chief Nurse and Associate Director of AHPs post and Kate Wright (Physiotherapist) has undertaken the role of Associate Chief AHP full time.

## 16.0   National Compliance

**16.1** The Developing Workforce Safeguards published by NHS Improvement in October 2018 were designed to help Trusts manage workforce planning and staff deployment. Trusts are now assessed for compliance with the triangulated approach to deciding staff requirements described within the NQB guidance. This combines evidence-based tools with professional judgement and outcomes to ensure the right staff, with the right skills are in the right place at the right time.

**16.2** The recommendation from the Chief Nurse is there is good compliance with the Developing Workforce Safeguards.

**16.3** The Chief Nurse and Medical Director have confirmed they are satisfied that staffing is safe, effective, and sustainable.

**16.4** Appendix three details the Trust's compliance with the nursing and midwifery element of the Developing Workforce Safeguards recommendations.

## 17.0   Recommendations

**17.1** The Board of Directors are asked to receive this report and note the ongoing plans to provide safe staffing levels within nursing, midwifery, and AHP disciplines across the Trust.

**17.2** The Board of Directors are to note the maternity staffing position and the local position which includes a recruitment and retention risk, which is common with the national profile.

**17.3** The Board of Directors is asked to note the AHP staffing and risk position within the report whilst noting the ongoing recruitment plans to support each service.

**17.4** The Board of Directors is asked to approve the evidence-based cost-neutral uplifts to the five wards and departments identified.

**17.5**   The Board of Directors is asked to approve the evidence-based uplifts to the five wards and departments identified at a cost of £379,328

**17.6**   The Board of Directors is asked to confirm the strategic direction for Ward 43 and 21 and approve the associated investment required.

**17.7**   The Board of Directors is asked to recommend that the additional service improvement requests are progressed via the service development business case route.

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**18.0 APPENDIX TWO: Nursing and Midwifery Establishments Review 2022/2023**

| Division | Ward/ Department: | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
|---|---|---|---|---|---|---|---|---|---|---|
| Medicine | 22 | 35.82 | 37.89 | 30.22 | 2.07 | 0 | 7.11 | 7.09 | 57/35 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | 23 | 35.07 | 35.16 | 33.08 | 0.09 | 0 | 7.31 | 7.68 | 77/33 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | Ward 24 | 36.93 | 37.89 | 32.43 | 0.96 | 0 | 7.14 | 7.68 | 57/47 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. It is acknowledged that the specialty on the ward is haematology and general medicine; however, the attendance rate for acute haematology is low and therefore difficult to capture in SNCT. This is supported by the Matron and Head of Nursing and existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | Ward 33 | 37.40 | 37.67 | 33.87 | 0.96 | 0 | 7.80 | 6.32 | 54/46 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. Existing shift numbers have been re-aligned to the current budget/ WTE. The skill mix reflects the rehabilitation staffing model and is supported by the Matron and Head of Nursing. |

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|---|---|---|---|---|---|---|---|---|---|
| Medicine | Ward 34 | 34.91 | 35.16 | 37.39 | 0.25 | 0 | 6.52 | 6.32 | 54/46 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. Existing shift numbers have been re-aligned to the current budget/ WTE. The skill mix reflects the higher dependency needs of patients and is supported by the Matron and Head of Nursing. |
| Medicine | Ward 42 | 35.09 | 35.16 | 33.49 | 0.07 | 0 | 7.17 | 7.34 | 54/46 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. Existing shift numbers have been re-aligned to the current budget/ WTE. The skill mix reflects the increased dependency needs of patients and the ward layout and is supported by the Matron and Head of Nursing. |
| Medicine | Ward 43 (resp) | 40.85 | 40.40 | 41.09 | 0.45 | 0 | 8.35 | 7.34 | | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | RSU | 40.85 | 53.38 | NA | 12.53 | 813,039 | NA | NA | NA | The SNCT principles and professional judgement have been applied and a 12.53 WTE increase the establishment recommended. This supports the level 2 and level 3 beds for acute respiratory patients. This is supported by the Matron and Head of Nursing. |
| Medicine | Ward 44 | 34.93 | 35.16 | 33.77 | 0.29 | 0 | 7.31 | 7.68 | 66/34 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | Ward 51 | 39.59 | 40.79 | 35.29 | 1.20 | 0 | 6.89 | 7.09 | 46/54 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. The skill mix reflects additional non-registered staff to assist with enhanced patient observations. Currently 1:1, care is not yet captured within the SNCT modelling. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |

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|---|---|---|---|---|---|---|---|---|---|
| Medicine | Ward 52 | 41.31 | 40.79 | 39.05 | 0.52 | 0 | 7.74 | 7.09 | 46/54 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. The skill mix reflects additional non-registered staff to assist with enhanced patient observations. Currently, 1:1 care is not yet captured within the SNCT modelling. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | Stroke Unit | 62.32 | 62.85 | 61.87 RCP | 0.53 | 0 | 9.49 | 7.16 | 60/40 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. The ward includes 4 HASU beds 25 rehabilitation beds. |
| Medicine | Sconce - NWK | 35.04 | 35.16 | 32.26 | 0.12 | 0 | 8.32 | 6.27 | | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to current budget/ WTE |
| Medicine | Oakham – (Chatsworth) MCH | 30.80 | 27.19 | NA | (3.61) | 0 | NA | NA | NA | Professional judgement has been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. Funding is being sought from the 22/23 planning process. |
| Medicine | Lindhurst/ WD 41 - | 29.24 | 35.16 | 37.05 | 5.92. investment required for only 2.74 | 121,108 | NA | 6.71 | NA | The SNCT principles and professional judgement have been applied and a 2.74 WTE uplift has been recommended to the establishment. This increase will provide additional registered nurses on each day duty 7 days per week. It has been recognised that the speciality of the ward is providing a sub-acute and a rehabilitation patient pathway; therefore, the additional staffing will support the increase in dependency of patients' needs. The uplift has been supported whilst the team are situated at the Kings Mill site and once re-located back to MCH the rehabilitation modelling can be re-instated. This is supported by the Matron and Head of Nursing. |

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| Division | Ward/ Department: | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | Existing shift numbers have been re-aligned to the current budget/ WTE. |
| Medicine | WTC | 7.60 | 9.60 | NA | 2.0 | 136,030 | NA | NA | NA | Professional judgement has been applied and a 2.0 WTE uplift to the establishment has been recommended. The increase will support the development of the band 6 pathway and strengthen the chemotherapy service   This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. |
| Medicine | OPAT/MDCU | 7.44 | 17.56 | NA | 10.12 | 408,250.10 | NA | NA | NA | Where applicable SNCT principles have been applied including professional judgement.  A 10.12 WTE uplift has been recommended as the additional resource will enable an increase in the overall service provision. This is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to budget/ WTE. |
| Division | Ward/ Department: | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
| Surgery | Ward 11/AU | 42.53 | 42.74 | 42.74 | 0.21 | £7,103 | 9.85 | 6.95 | 57/43 | The SNCT principles and professional judgement have been applied and a 0.21 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |

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|---|---|---|---|---|---|---|---|---|---|---|
| Surgery | Ward 12 | 37.50 | 37.90 | 37.50 | 0.40 | 16,873 | 7.56 | 7.46 | 50/50 | The SNCT principles and professional judgement have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 21 (24 beds) | 21.20 | 32.71 | - | 11.51 | £400,955 | 7.82 | 7.46 | 67/43 | The SNCT principles and professional judgement have been applied and an 11.51 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership and will support the unit to a full capacity of 24 beds. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 21 (16 beds) | 21.20 | 23.51 | 23.51 | 2.31 | 55,443 | 7.82 | 7.46 | 67/43 | The SNCT principles and professional judgement have been applied and an 11.51 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 31 | 34.83 | 35.23 | 34.83 | 0.40 | 15,375 | 5.88 | 7.54 | 62/38 | The SNCT principles and professional judgement have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | Ward 32 | 32.31 | 32.71 | 32.71 | 0.40 | £4,685 | 7.18 | 6.95 | 62/38 | The SNCT principles and professional judgement have been applied and a 0.40 WTE increase to the establishment has been recommended. The additional resource will enable the ward leader to work in a supervisory role providing support and leadership. This is supported by the Matron and Head of Nursing. |
| Surgery | ITU | 98.01 | 98.39 | GPICS | 0.38 | £56 585 | | | | The GPICS principles and professional judgement have been applied and a 0.38 WTE increase to the establishment has been recommended. The additional resource will support the addition of the Rehab Family Support Nurse. This is supported by the Matron and Head of Nursing. |

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| Division | Ward/ Department: | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
|---|---|---|---|---|---|---|---|---|---|---|
| Surgery | DCU - King's Mill | 33.64 | 34.34 | NA | 0.70 | £18,800 | 23.01 | 8.25 | NA | Professional judgement has been applied and a 0.70 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing |
| Surgery | Minister - NWK | 22.00 | 23.24 | NA | 1.24 | 42,765 | NA | NA | NA | Professional judgement has been applied and a 1.24 WTE increase to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| UEC | UCC - Newark | 18.76 | 21.87 | NA | 2.11 | 114,575.11 | NA | NA | NA | The SNCT principles and professional judgement have been applied and a 2.11 WTE increase to the establishment has been recommended. The additional resource will support the ENP service provision. This is supported by the Matron and Head of Nursing. |
| UEC | SSU | 58.61 | 58.61 | 53.31 | 0 | 0 | 6.51 | 7.45 | 68/32 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. |
| UEC | EAU | 86.41 | 86.41 | 82.06 | 0 | 0 | 11.30 | 7.99 | 55/45 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. |
| UEC | Discharge Lounge | 7.80 | 9.01 | NA | 1.22 | 44,058.86 | NA | NA | NA | Professional judgement has been applied and a 1.22 WTE increase to the establishment has been recommended. This will provide additional leadership support within the team whilst optimising progression opportunities within the team. This is supported by the Matron and Head of Nursing. |
| UEC | SDEC | 21.77 | 21.77 | NA | 0 | 0 | NA | NA | NA | Professional judgement has been applied and no change to the establishment has been recommended. This is supported by the Matron and Head of Nursing. |
| UEC | ED | 154.88 | 168.05 | 123.3 | 13.17 | 405,137.29 | NA | NA | NA | The SNCT principles and professional judgement have been applied and 13.17 WTE uplift has been recommended to the establishment. This increase will provide additional registered nurses on twilight duty 7 days per week. This will facilitate the children's and young people's area to remain open later in the |

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| Division | Ward/ Department | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | evening providing a more therapeutic patient experience. It has been acknowledged when the area closes– children and young people are managed in adult areas and this is not a suitable quality pathway. Additional registered nurse presence on the day and night shifts will support prompt care delivery across all areas of the department. It has been acknowledged that whilst SNCT has recommended 123.3 WTE, the tool does not recognise leadership positions, specialist roles, and the additional care delivery roles that sit alongside the core workforce. These are roles that are unique to SFHFT and are included in the current establishment.   The data set used for SNCT has included several weeks where national lockdown was in place and the attendance rate was reduced. The layout of the different areas within the department and the staffing requirements in each area has also been taken into consideration.  This recommendation is supported by the Matron and Head of Nursing. Existing shift numbers have been re-aligned to the current budget/ WTE. |
| UEC | HOOH | 8.76 | 9.26 | NA | 0.5 | 27,310.92 | NA | NA | NA | Professional judgement has been applied and a 0.5 WTE increase to the establishment has been recommended. This will provide a clear leadership role within the service. This is supported by the Matron and Head of Nursing. |
| Division | Ward/ Department | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
| D&O | Newark Outpatients | 15.8 | 15.8 | NA | 0 | 0 | NA | NA | NA | Professional judgement has been applied and no changes to the establishment have been recommended. This is supported by the Matron and Head of Nursing. |
| D&O | KMH Outpatients | 95.8 | 101.8 | NA | 6.0 | 180,863 | NA | NA | NA | Professional judgement has been applied and a 6.0 WTE increase to the establishment has been recommended. This will support the increase in clinic capacity and activity in urology and the AVH diagnostic hub. This is supported by the Matron and Head of Nursing. |

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| | Ward/Department | Current WTE | Suggested WTE: | SNCT | Variance | Cost Impact | CHPPD Actual | CHPPD Peer Median | Skill mix % | Comments: |
|---|---|---|---|---|---|---|---|---|---|---|
| D&O | Phlebotomy | 14.78 | 16.78 | NA | 2.0 | 48,622 | NA | NA | NA | Professional judgement has been applied and a 2.0 WTE increase to the establishment has been recommended. Activity has increased by 9 % since 2019 and the additional resource will continue to support activity and demand. This is supported by the Matron and Head of Nursing. |
| W&C | Ward 25 | 45.97 | 45.97 | 46.7 | 0 | 0 | 10.86 | 11.79 | 68/38 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. |
| W&C | Ward 14 | 24.73 | 24.73 | 23.57 | 0 | 0 | 9.06 | 7.85 | 63/37 | The SNCT principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. |
| W&C | NICU | 39.67 | 39.67 | BPAM 38.1 | 0 | 0 | 13.99 | 11.45 | NA | The BPAM principles and professional judgement have been applied with no changes to the establishment recommended. This is supported by the Matron and Head of Nursing. |
| W&C | Clinic 11 | 10.42 | 10.42 | NA | 0 | 0 | NA | NA | NA | Professional judgement has been applied and no changes to the establishment have been recommended. This is supported by the Matron and Head of Nursing |
| W&C | Gynae SN | 1.28 | 1.28 | NA | 0 | 0 | NA | NA | NA | Professional judgement has been applied and no changes to the establishment have been recommended. This is supported by the Matron and Head of Nursing. |
| W&C | Paed SN | 9.08 | 10.98 | NA | 1.90 | 39,900 | NA | NA | NA | Professional judgement has been applied and a 1.9 WTE increase in the establishment have been recommended. This is to increase the hours of the team and uplift a band 6 to a band 7. This is supported by the Matron and Head of Nursing |
| W&C | Colposcopy | 4.80 | 4.80 | NA | 0 | 0 | NA | NA | NA | Professional judgement has been applied and no changes to the establishment have been recommended. This is supported by the Matron and Head of Nursing. |
| W&C | Midwifery | 167.52 | 169.67 | Birthrate Plus | 2.15 | £117,000 | NA | NA | NA | The BirthRate Plus principles and professional judgement have been applied and an additional 2.15 WTE increase to the establishment has been |

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| | | | | | | | | | | recommended the midwifery speciality requires there is sufficient resources available to staff Sherwood birthing Unit, Maternity ward, Community caseloads, Triage, and Outpatients. This is supported by the Matron and Head of Nursing. |
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**19.0** **APPENDIX THREE: Compliance with Developing Workforce Safeguards, Nursing and Midwifery**

**19.1** The Workforce Safeguards published by NHSI in October 2018 are used to assess compliance with the Triangulated approach to staff planning in accordance with the NQB guidance.

**19.2** Although the guidance applies to all staff, this paper will outline nursing and midwifery's current compliance with the 14 safeguards recommendations and identify any areas of improvement.

| Recommendation: | Compliance: |
|---|---|
| **Recommendation 1:**<br>Trusts must formally ensure NQB's 2016 guidance is embedded in their safe staffing governance. | **Compliant**<br>SNCT has been embedded within both adult and Paediatric in-patient areas.<br>BirthRate Plus is embedded with Maternity services and a refresh of training has been undertaken. |
| **Recommendation 2:**<br>Trust must ensure the three components are used in their safe staffing process. | **Fully Compliant**<br>SNCT and BirthRate in use at the Trust to provide an evidence base for our establishment setting process. Nurse sensitive indicators information is aligned to each establishment review and professional judgement is always considered. |
| **Recommendation 3 & 4:**<br>Assessment will be based on a review of the annual governance statement in which Trusts will be required to confirm their staffing governance processes are safe and sustainable. | **Fully Compliant**<br>Confirmation is included in the annual governance statement that our staffing governance processes are safe and sustainable. |
| **Recommendation 5:**<br>As part of the yearly assessment, assurance will be sought through the Single Oversight Framework (SOF) in which performance is monitored against five themes. | **Fully Compliant**<br>We collate and review data every month for a range of workforce metrics, quality indicators and productivity measures – as a whole and not in isolation from each other. |
| **Recommendation 6:**<br>As part of the safe staffing review, the Chief Nurse and Medical Director must confirm in a statement to their Board that they are satisfied with the outcome of any assessment that staffing is safe, effective and sustainable. | **Fully Compliant**<br>Biannual and Annual Nursing, Midwifery and Allied Health Professional Staffing Report sign off. |
| **Recommendation 7:** | **Fully Compliant** |

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| Trusts must have an effective workforce plan that is updated annually and signed off by the Chief Executive and Executive Leaders.  The Board should discuss the workforce plan in a public meeting. | Annual submission to NHS Improvement |
| **Recommendation 8:** They must ensure their organisation has an agreed local quality dashboard that cross-checks comparative data on staffing and skill mix with other efficiency and quality metrics such as the Model Hospital dashboard. Trusts should report on this to their Board monthly. | **Fully Compliant** Monthly Safe Staffing Reports for Nursing and Midwifery and staffing dashboard triangulates this information. |
| **Recommendation 9:** An assessment or resetting of the nursing establishment and skill mix (based on acuity and dependency data and using an evidence-based toolkit where available) must be reported to the Board by ward or service area twice a year, in accordance with NQB guidance and NHS Improvement resources.  This must also be linked to professional judgement and outcomes. | **Partially Compliant.** Bi-annual review for nursing is not completed across all services; We have implemented the first full cycle data collection of SNCT for 2022 will conclude in late October. An annual and bi-annual staffing report is presented to the Nursing, Midwifery and Allied Health Professional Committee, People, Culture and Inclusivity Committee and the Board of Directors |
| **Recommendation 10:** There must be no local manipulation of the identified nursing resource from the evidence-based figures embedded in the evidence-based tool used, except in the context of a rigorous independent research study, as this may adversely affect the recommended establishment figures derived from the use of the tool. | **Fully Compliant** SNCT and Birthrate Plus in use as per license agreements. |
| **Recommendation 11 & 12:** As stated in CQC's well-led framework guidance (2018) and NQB's guidance any service changes, including skill-mix changes and new roles, must have a full quality impact assessment (QIA) review. | **Fully Compliant** Completed as part of the establishment setting process and monitored by the Nursing, Midwifery, and Allied Health Committee. |
| **Recommendation 13 & 14:** Given day-to-day operational challenges, we expect trusts to carry out business-as-usual dynamic staffing risk assessments including formal escalation processes.  Any risk to safety, quality, finance, performance and staff experience must be clearly described in these risk assessments. Should risks associated with staffing continue or increase and mitigations prove insufficient, trusts must escalate the issue (and where appropriate, implement business continuity plans) to the Board to maintain safety and care quality. | **Fully Compliant** Daily staffing meetings. Staffing also discussed at the flow and capacity meetings throughout the day. Staffing escalation process. Safe Staffing Standard Operating Procedure. Maternity Assurance Committee.Monthly Safe Staffing Report for Nursing and the Monthly Safe Staffing Report for Midwifery. |

Nursing, Midwifery and Allied Health Professional Annual Staffing Report. April 2022. V1.

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## 20.0 APPENDIX FOUR: SNCT Assessment Criteria

| Criteria | Compliance | Evidence |
|---|---|---|
| Have you got a licence to use SNCT from Imperial Innovations? | **Yes** | Licence renewed which has been confirmed by the Chief Nurse. |
| Do you collect a minimum of 20 days data twice a year for this? | **Yes** | Held on central database |
| Are a maximum of 3 senior staff trained and the levels of care recorded? | **Yes** | Held on the central database: - due to staffing challenges during the pandemic there are some areas that have requested 4 staff (all senior levels) to enable guaranteed continuity. |
| Is an established external validation of assessments in place? | **Yes** | Held on the central database – A Member of the senior nursing team are allocated to ward areas and undertake validation each week during the cycle. A core group of staff is maintained to ensure consistency. |
| Has an inter-rater reliability assessment been carried out with these staff? | **Yes** | Held on central database. |
| Is A&D data collected daily, reflecting the total care provided for the previous 24 hours as part of a bed-to-bed ward round review? | **Yes** | Held on central database. |
| Are enhanced observations (specials) patients reported separately? | **Yes** | Requests for additional staffing for enhanced patient observations are reported through Datix Reporting System. |
| Has the executive board agreed on the process for reviewing and responding to safe staffing recommendations? | **Yes** | Escalation process and SOP in place. |

Nursing, Midwifery and Allied Health Professional Annual Staffing Report. April 2022. V1.

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Nursing, Midwifery and Allied Health Professional Annual Staffing Report. April 2022. V1.

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**Board of Directors Meeting in Public**

| Subject: | Medical Workforce Report | Date: 5th May 2022 |
|---|---|---|
| Prepared By: | Rebecca Freeman | |
| Approved By: | Dr David Selwyn - Medical Director | |
| Presented By: | Dr David Selwyn - Medical Director | |

| Purpose | | | |
|---|---|---|---|
| The purpose of this report is to provide the Board of Directors with an overview of the Medical Workforce. The report will focus on staffing capacity, recent developments, initiatives, and compliance with regulatory requirements. | Approval | | |
| | Assurance | X | |
| | Update | | |
| | Consider | | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | Significant | Sufficient | Limited | None |
| | | X | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| Financial | X | | | |
| Patient Impact | X | | | |
| Staff Impact | X | | | |
| Services | X | | | |
| Reputational | X | | | |

| Committees/groups where this item has been presented before |
|---|
| None.<br>This report will be presented to the Joint Local Negotiating Committee (LNC) following approval at this Trust Board of Directors meeting. |

**Executive Summary**

**This is the first Medical Workforce report being presented to the Board of Directors and it is anticipated that this will become a bi-annual report in line with and sitting alongside, the Nursing and AHP Trust Board reports.**

**The report gives an overview of the progress against the regulatory aspects; medical appraisal and revalidation and also describes the progress in medical job planning for 2022-23 and the adherence to the requirements of the 360 Assurance Audit finalised in 2021.**

**The report includes details of both medical vacancies, newly established medical posts and the progress in the recruitment to these posts over the last four years.**

**A summary of the bank and agency expenditure over the last six months is also provided together with the clearly focused aim on reduction in the agency expenditure, going forwards.**

**The report describes the increase in known training posts for August 2022 and the anticipated increase in Specialists, Senior Clinical Fellow and Clinical Fellow posts at Newark Hospital.**

**The work that has taken place in both Anaesthetics and Critical Care (one of our identified**

**challenged services) is also included together with the plans to continue to provide further support going forwards.**

**Board is asked to;**

- **Note the contents of the report, the strategic direction described for the medical workforce**
- **Comment on the information provided, recognising future reports could be adapted**
- **Recognise that this work cuts across and feeds into a number of other areas of focus including the Guardian of Safe Working report, Strategic Direction of Medical Training and Education at SFH, the established Medical Workforce Taskforce, the newly created Medical Workforce Transformation Programme along with the development of a wider SFH workforce strategy**

**Appraisal and Revalidation**



## Appraisal Figures

- NHSi March 2022 Figure 90%
- 44 are outstanding (20/04/2022)
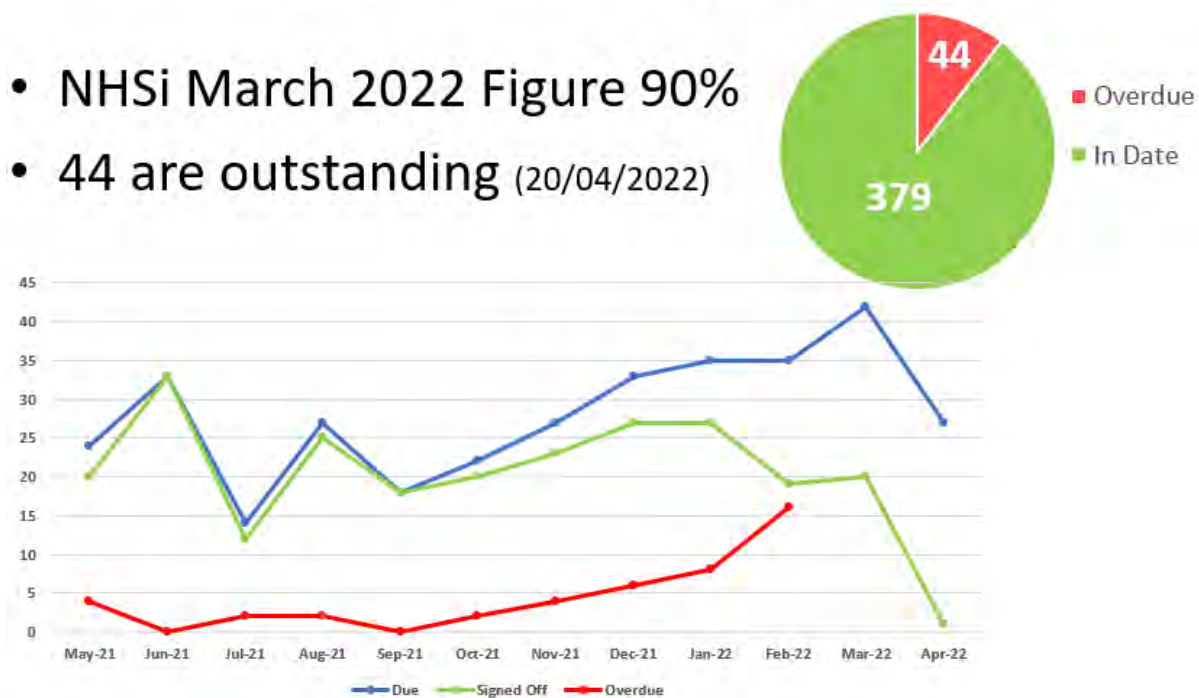
As can be seen from the figure above, the appraisal compliance for Consultants, Specialists and Specialty Doctors has improved and is now 90%.
This compares very favourably with surrounding local Trusts.
The GMC stipulated 'light touch' approach to medical appraisals that was introduced during the Covid-19 pandemic remains in place and the 44 overdue appraisals are being encouraged and supported to complete their appraisal now that a more traditional appraisal requirement has been re-introduced.
Additionally, due to the increase in the numbers of Medical staff in these grades and some recent retirements, a recruitment campaign for more appraisers will commence within the next few weeks.

Senior Clinical Fellows and Clinical Fellows employed by the Trust undertake an annual review of their progress against specified competencies (ARCP) which is where each doctor presents their e-portfolio to a panel of consultant representatives who make an assessment of progress to date. This approach mirrors that undertaken by Health Education East Midlands for the Trainees across the Trust.

Currently there are 80 Senior Clinical Fellows and Clinical Fellows going through this process with assessments currently scheduled for 64 doctors. This novel, supportive and innovative approach to non-training grade doctors, has met with significant regional interest.

**Revalidation**

From April 2021 until March 2022, 80 doctors were due to be revalidated. 57 doctors were successfully revalidated and 23 were deferred.

The reasons for the deferrals were primarily due to mandatory training being non-compliant and the lack of patient feedback.

Feedback from patients has historically been obtained following their interaction with the doctor, however, due to the number of face to face clinics reducing, it has been difficult in some circumstances to obtain the feedback required from patients to support the revalidation decision. From April 2022 until March 2023 there are 70 doctors due to revalidate, three have been revalidated to date and there have been no deferrals.

**Job Planning**
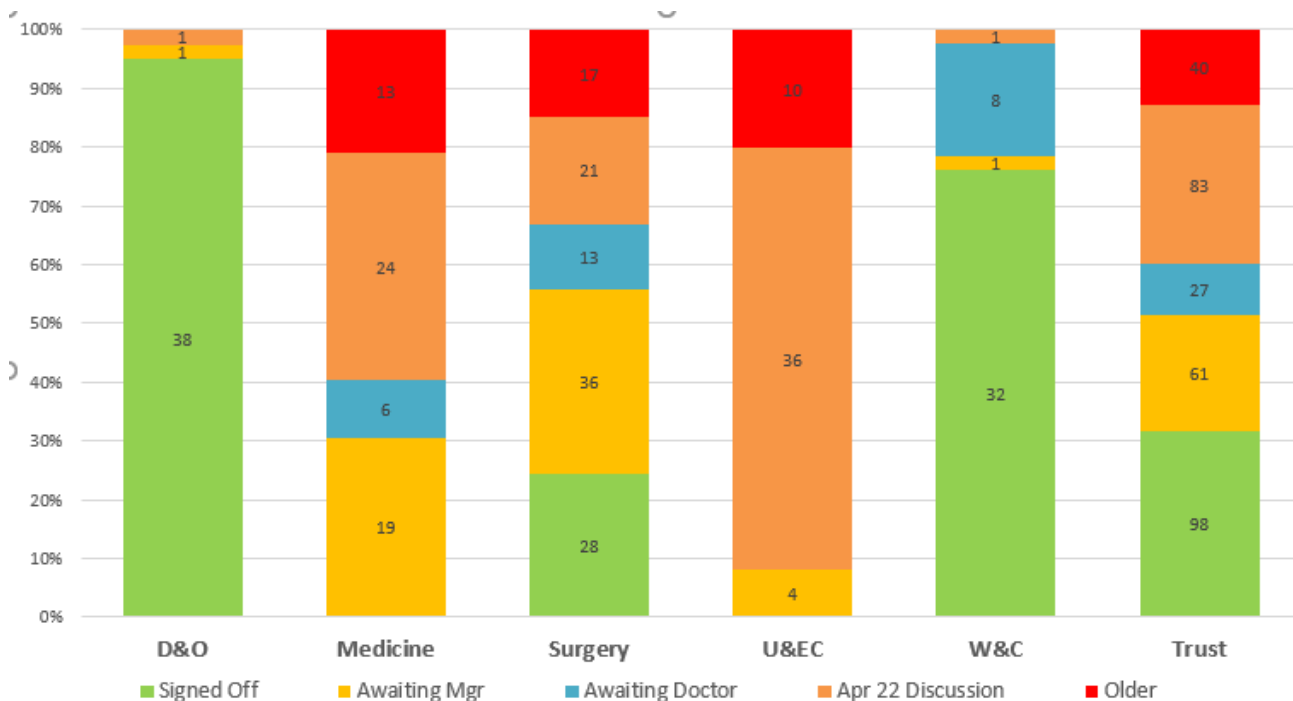


In 2021 a decision was taken by the MD in conjunction with the LNC and Medical HR, that a light touch approach was taken in relation to job planning due to the pandemic. The direction was that the majority of job plans were rolled over from 2020 to 2021. A small number where substantial change had occurred, were reviewed on an ad hoc basis.

For the 2022/23 job planning year it was agreed that a full review of all job plans would be undertaken, particularly in light of substantial changes to workload and ways of working resultant from the global pandemic.   Prior to this being carried out, training sessions on the job planning process were held for Heads of Service/Service Directors and Business Managers.

As can be seen from the above both Diagnostics & Outpatients and Women & Children's have almost completed the job planning process for the year which has enabled any changes to salaries to be transacted.  The other Divisions are progressing well, however, due to the recent increase in clinical activity the sign off process has been slightly delayed.  Reports detailing progress are being sent to the Heads of Service/Service Directors, HRBP's and Divisional teams weekly for each area.

Job planning was the subject of a 360 Assurance audit (limited assurance) in 2021 and there were two key recommendations of the report, as follows:-

- Any change in programmed activities due to a job plan change must transacted from  a payroll perspective from the date of the commencement of the job plan.   Where job plan sign off  is delayed and there is a change in the programmed activities worked, this  results in a delay which can result in doctors being under/over paid.  Any delay in job plan sign off is to be monitored.  As detailed above, reports are produced and sent to the Divisions weekly detailing the current position.

- A reconciliation takes place between the programmed activities that are paid/job planned on a quarterly basis to ensure that any anomalies are regularly identified and addressed. The last reconciliation was undertaken in February and a further one is planned in May 2022.

**Medical Vacancies**

**Vacant Posts**

|  | Apr-22 | Mar-21 | Apr-20 | Apr-19 | Apr-18 |
|---|---|---|---|---|---|
| Consultant | 16 | 14 | 16 | 17 | 16 |
| Specialist | 0 | 0 | 0 | 0 | 0 |
| Middle Grade | 23 | 12 | 10 | 9 | 15 |
| Junior Grade | 5 | 3 | 4 | 4 | 14 |
| **TOTAL** | **44** | **29** | **30** | **30** | **45** |

|  | 13 HEEM | 10 HEEM | 7 HEEM | 5 HEEM |
|---|---|---|---|---|



Vacant Posts
April 2018 - April 2022
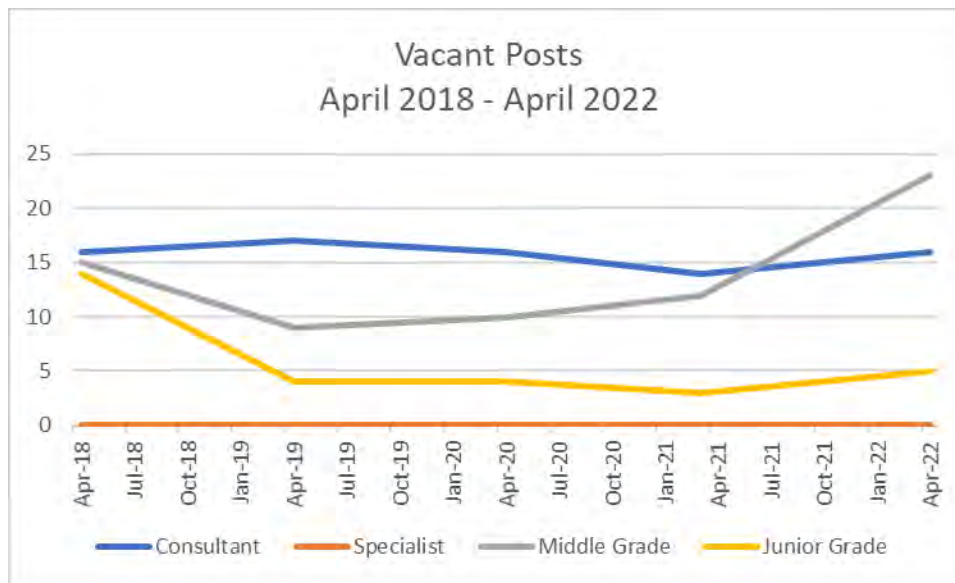
The Graph and table show the current medical vacancies at each grade. The Specialist is a new grade which was introduced in April 2021 as part of the SAS doctor contract reform.

As you can see the number of vacancies have reduced considerably between April 2018 and April 2021, there has however, been an increase in the vacancies this month in middle grades which is primarily due to having 13 trainee vacancies during this rotation at middle grade level across the Trust. Most of these vacancies are in the Medical Division.

**New Posts**

New

|  | Apr-22 | Mar-21 | Apr-20 | Apr-19 |
|---|---|---|---|---|
| Consultant | 15 | 10 | 19 | 5 |
| Specialist | 2 | 0 | 0 | 0 |
| Middle Grade | 11 | 9 | 9 | 12 |
| Junior Grade | 0 | 1 | 4 | 0 |
| **TOTAL** | **28** | **20** | **32** | **17** |

New posts
April 2019 - April 2022
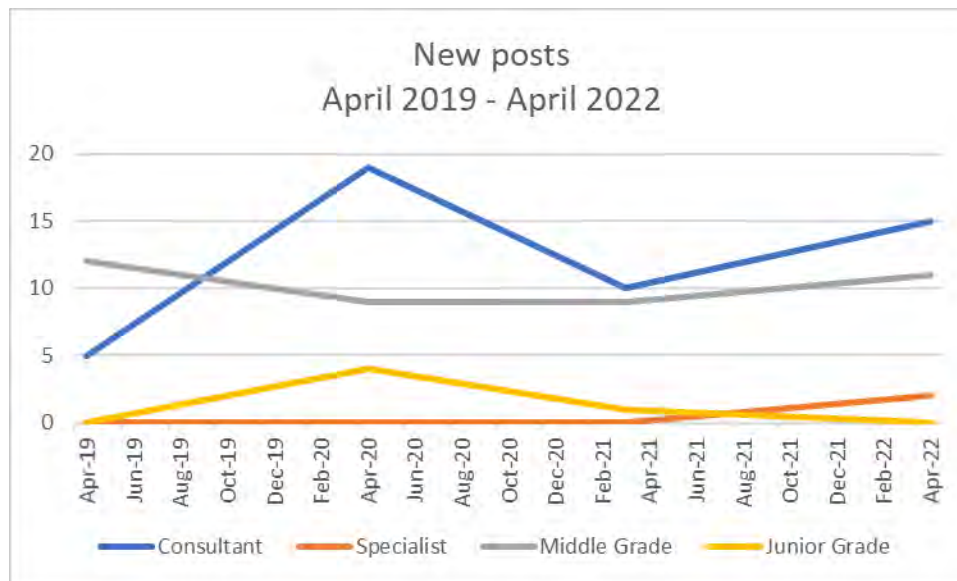
The graph and table show the newly established Medical posts from April 2019 until April 2022.
It is anticipated that going forward, the new Specialist post which is a Senior level where the clinician can practice independently is likely to feature in the Medical Workforce plan for a number of specialties.  The Specialist post is a post that will be of interest to doctors with a considerable number of years of clinical experience that do not want to become consultants but do want to be recognised for their clinical expertise and work at a senior level.  It is therefore anticipated that some vacancies at Consultant level detailed above could be converted into specialist post where it is considered appropriate for the service.

**Bank and Agency Expenditure**

The Trust has encouraged doctors to have a bank post in addition to a substantive post, any additional duty worked is then paid through the bank post this enables payment for any additional duty to be made the following week after the work is carried out which is particularly attractive to trainees.  With effect from this month all waiting list work undertaken will be paid through the bank. In the last 6 months bank work has been primarily undertaken by medical staff in Medicine, Surgery and Urgent & Emergency Care, within surgery this is primarily waiting list initiative work. The total expenditure being £3.9m.

The expenditure through agency has again been primarily in Medicine, Surgery and Urgent & Emergency Care and that has equated to £5.3m in the last 6 months.  In Medicine, this is primarily due to some long term vacancies at Consultant level and a number of specialties are looking at the possibility of converting some of these vacancies where appropriate to Specialist posts as mentioned above.

A Medical Workforce Review Task & Finish Group has been established and one of the primary objectives of this Trust wide group will be to aim to review and reduce the agency expenditure. This group is chaired by the Associate Medical Director for Workforce.

**Trainees**

The numbers of medical trainees in the Trust has increased over the last few years and August 2022 will be no exception, to date the Trust will have three additional doctors at Foundation Year 1 level and Specialist Registrar in Paediatrics. There are discussions currently taking place with HEEM relating to additional doctors at Foundation level. The final numbers will be known within the next few weeks and will be included in the next Medical Workforce report.

Work has also taken place reviewing the rotas for both trainees and clinical fellows in Medicine. Following the increase in numbers of Clinical Fellows in Medicine it was felt that that rather than have one rota with 34 doctors on the rota, that should be split into two rotas to ensure that the shifts and the cover on the wards was more even than had been the case historically. The rotas have been developed and consultation is currently taking place with the Trainees and the Clinical Fellows and this move has been received positively.

In the last three years, the Trust has recruited a Chief Registrar, this programme is supported by the Royal College of Physicians and the purpose is to give a registrar at a senior level the opportunity to have a role that has both clinical and management responsibility. The Chief Registrar is mentored by the Medical Director and has a number of management related projects to complete during the year. The previous postholders have found this period of time most beneficial and the Trust is currently advertising for a Chief Registrar to commence in post in August 2022.

**Areas of Concern and action being taken**

**Critical Care**

An Executive led Task and Finish Group was established in January 2022 to support Critical Care, where there were a number of vacancies for Medical Staff at all levels. This has provided an opportunity to discuss the difficulties being faced and for key stakeholders to focus on recruitment. All the vacancies at a Junior and middle grade level have been recruited to and all new incumbents apart from one have now commenced in post.

A fixed term consultant has also commenced in post and interviews are taking place Week commencing 2nd May 2022 for a substantive consultant for a joint post between Critical Care and ED. There are still a number of vacancies at consultant level and this is a specialty that has considered the specialist post as part of their long term medical workforce plan. An advert has recently been placed for this post and 10 applications have been received. These are currently being shortlisted and interviews being arranged. The Task and Finish group will continue to meet on a fortnightly basis to support Critical Care.

**Anaesthetics**

A Task and Finish Group has recently been established in Anaesthetics, again there have been medical vacancies at most grades. An exercise has been undertaken to rebase the Medical Establishment in Anaesthetics and also as far as possible split the Anaesthetics and Critical Care establishments which historically there has been one establishment for both areas.

A meeting has also taken place with HEEM to discuss the impact of having vacant trainee slots at short notice has on the service. A recruitment programme is also underway, one substantive consultant has been appointed, interviews are taking place for a fixed term consultant post and this is another specialty that has advertised for a Specialist post and there have been 34 applicants for the post and interviews are being arranged.

It is recognised that there is national concern around historical workforce plans for both these specialities and this group of colleagues has been particularly impacted and stretched during the Covid-19 pandemic.

**<u>Medical Staffing at Newark Hospital</u>**

A paper is currently being finalised to enhance the Medical Staffing across Newark. This will involve recruiting Specialists to support the Urgent Treatment Centre, Senior Clinical Fellows for the Medical Ward and Clinical Fellows/Foundation Year 3 doctors for the Surgical/T & O Ward.

Currently Newark is staffed by locums particularly for the Medical and Surgical Wards and this paper will aim to provide an opportunity particularly for the Senior/Clinical Fellows to rotate to Newark and enable them to have the time in a sub-acute setting to facilitate non-clinical activity such as clinical audit and quality improvement alongside their clinical work. Feedback from our fellows is that these aspects are often difficult to progress to allow career development. At the same time having a more permanent dedicated staff group across the Newark Hospital campus, should allow us to start to grow clinical activity in line with the Trust's strategic aspirations.

**Conclusion**

Whilst the Trust has robust controls in place to manage day to day operational medical staffing demands and gaps, there are a number of more strategic areas described in this paper, that will facilitate our recruitment and retention plans for the future medical workforce at SFH.

Trust Board is asked to;

- Note the contents of the report, the strategic direction described for the medical workforce
- Comment on the information provided, recognising future reports could be adapted
- Recognise that this work cuts across and feeds into a number of other areas of focus including the Guardian of Safe Working report, Strategic Direction of Medical Training and Education at SFH, the established Medical Workforce Taskforce, the newly created Medical Transformation Programme along with the development of a wider SFH workforce strategy

# COVID-19 Research Overview

## PANORAMIC - Platform Adaptive trial of NOvel antiviRals for eArly treatMent of covid-19 In the Community

### Status – Open to Recruitment

Now, new 'antiviral' drugs have been developed which act directly against the virus that causes COVID, which could help people with COVID in the community avoid severe disease and hospitalisation. The PANORAMIC study plans to enrol people either aged 50 or over or aged 18 or over with a medical condition which makes them at higher risk of severe COVID, who have recently developed COVID symptoms, and have had a positive PCR test. They will be randomly assigned by a computer program to receive either standard NHS care for COVID, or one of the new antiviral drugs in addition to the usual care provided by the NHS.

The main question will be whether these new antiviral treatments safely help people with COVID-19 avoid the need for hospital admission, but will also test whether these drugs:
- Shorten the length of time that people have symptoms of COVID.
- Reduce the chance that people living with someone who has COVID also catches it.
- Lessen the amount of the virus we shed when we are infected.
- Are affected by new variants or changes in the virus once we start using them.
- Offer value for money to the NHS.

**Total Recruited - 19**

## RECOVERY – Randomised Evolution of COVID-19 Therapy

### Status – Open to Recruitment

The RECOVERY Trial is testing suggested treatments on COVID19+ patients

Data from the trial will be regularly reviewed so that any effective treatment can be identified quickly and made available to all patients.
The RECOVERY Trial team will constantly review information on new drugs and include promising ones in the trial.

**Total Recruited – 408**

## PHOSP-COVID

### Status – Open to Recruitment

A national consortium to understand and improve long-term health outcomes
All patients who are admitted to UK recruiting hospital sites will be invited to join the study following discharge from hospital with clinician suspected COVID-19

**Total Recruited – 150**

## GENOMICC - Genetics of susceptibility and mortality in critical care

**Status – Open to Recruitment**

Susceptibility to COVID-19 is almost certainly, in part, genetic.

GenOMICC can find the genes that cause susceptibility, which may help to prioritise treatments to respond to the global crisis. GenOMICC was designed for this crisis.

All patients with confirmed COVID-19 in Critical Care are eligible for GenOMICC.

**Total Recruited – 68**

## REMAP-CAP – Randomised, Embedded, Multifactorial Adaptive Platform trial for Community-Acquired Pneumonia

**Status – Open to Recruitment**

A trial designed by clinicians who cared for patients and conducted research during the 2009 H1N1 pandemic.

The goal is to generate evidence that can be applied during the pandemic to reduce mortality or reduce the length of ICU admission in critically ill patients with COVID-19 infection.

**Total Recruited – 3**

## Psychological Impact of COVID-19 - The psychological impact of surviving an intensive care admission due to COVID-19

**Status – Open to Recruitment**

To identify the proportion of patients surviving an admission to intensive care due to COVID-19 who experience anxiety, depression and/or trauma symptoms in the 6 months post-discharge, assessed using the Hospital Anxiety and Depression Scale (HADS) and the Impact of Event Scale-6 (IES-6). We will attempt to identify demographic, clinical and/or psychosocial predictors of depression, anxiety and/or trauma symptoms at 3-, 6- and 12-months post discharge from ICU.

**Total Recruited – 71**

## CLARITY: Impact of Biologic Therapy on SARS-COV-2 Infection & immunity

**Status – In Follow Up**

This study will provide an evidence base for safer prescribing of immunomodulator and biologic drugs in the COVID-19 era and inform public health policy regarding physical distancing measures, and future vaccination strategies.

Although this study will define risk in IBD patients, there are potentially important lessons to be learned for millions of patients across the UK with other immune mediated diseases treated with similar therapies.

**Total Recruited – 100**

## PSYCHOLOGICAL IMPACT OF COVID-19 - pandemic and experience: An international survey
**Status – Closed**

This study will explore the psychological impact of the COVID-19 outbreak and the resultant restrictions in terms of behavioural, emotional and social factors.

Questions will be asked of the data collected to see what factors may be supportive or more detrimental to wellbeing.

The general public including health professionals and those with pre-existing mental health conditions will be invited to complete the survey.

This study is in its second wave of recruitment and has adapted its survey based on results from the first wave.

**Total Recruited – 839**

## ISARIC - Clinical Characterisation Protocol for Severe Emerging Infection

**Status – Closed**

This study will gain important information about COVID-19 in order to try to find better ways to manage and treat the infection in the future.

Information is collected from routine clinical records such as signs and symptoms, medications being taken, and the results of any blood test and laboratory results that doctors have ordered in hospital.

Samples may be collected which are in addition to what would normally be collected for your medical care, if recruited to Tier 2

We have recently been notified that the data from this study informs vaccines.

**Total Recruited – 876**

## SIREN - SARS-COV2 Immunity and Reinfection Evaluation

**Status – Closed**

This study aims to find out whether healthcare workers who have evidence of prior COVID-19, detected by antibody assays (positive antibody tests), compared to those who do not have evidence of infection (negative antibody tests) are protected from future episodes of infection.

Healthcare workers will be followed for a set amount of time to study their immune response to the virus causing COVID-19.

All NHS staff who delivers care to patients will be asked to have a nose and throat swab every other week in order to detect mild cases or cases that do not have symptoms.

**Total Recruited – 745**

## PAN-COVID - Pregnancy and Neonatal Outcomes in COVID-19

**Status – Closed**

PAN-COVID will develop a global database detailing a number of outcomes (death of the baby or mother, stillbirth, miscarriage, pregnancy complications, gestational age at delivery, delivery method and testing the baby for SARS-CoV-2).

The aim of this database is to understand the natural history of SARS-CoV-2 and COVID-19 and the impact on mothers and their babies to guide both treatment and prevention.

**Total Recruited – 31**

## COVIDTrach; a UK national cohort study of mechanically ventilated COVID-19 patients undergoing tracheostomy

**Status – Closed**

COVIDTrach is collaborative project by surgeons and intensive care doctors that looks at the outcomes of ventilated COVID-19 patients undergoing tracheostomy and evaluates the use of personal protective equipment and rate of COVID-19 infection amongst operators.

**Total Recruited – 19**

## COVID Dogs - Using medical-detection dogs to identify people with SARS-CoV-2. Phase I. Proof-of-concept studies.

**Status – Closed**

The purpose of this study is to determine whether trained medical detection dogs are able to detect the presence of Coronavirus (also known as SARS-CoV-2 or COVID-19) in breath, body and foot odour samples from adults, aged 16 years or older, who are not currently showing any symptoms or mild symptoms.

**Total Recruited – 200**

## The PRIEST Study: Pandemic Respiratory Infection Emergency System Triage

**Status – Closed**

To optimise the triage of people using the emergency care system (111 and 999 calls, ambulance conveyance, or hospital emergency department) with suspected respiratory infections during a pandemic and identify the most accurate triage method for predicting severe illness among patients attending the emergency department with suspected respiratory infection.

**Total Recruited – 224**

**Total – 3753 participants recruited to COVID-19 Research**

**Data cut from 1st participant recruited onto COVID-19 Research at SFH 17/03/2020 to 31/03/2022**

# Research & Innovation
# 21-22 Performance Report

We are pleased to present the year end 2021/22 performance review of research activity at Sherwood Forest Hospitals NHS Foundation Trust.
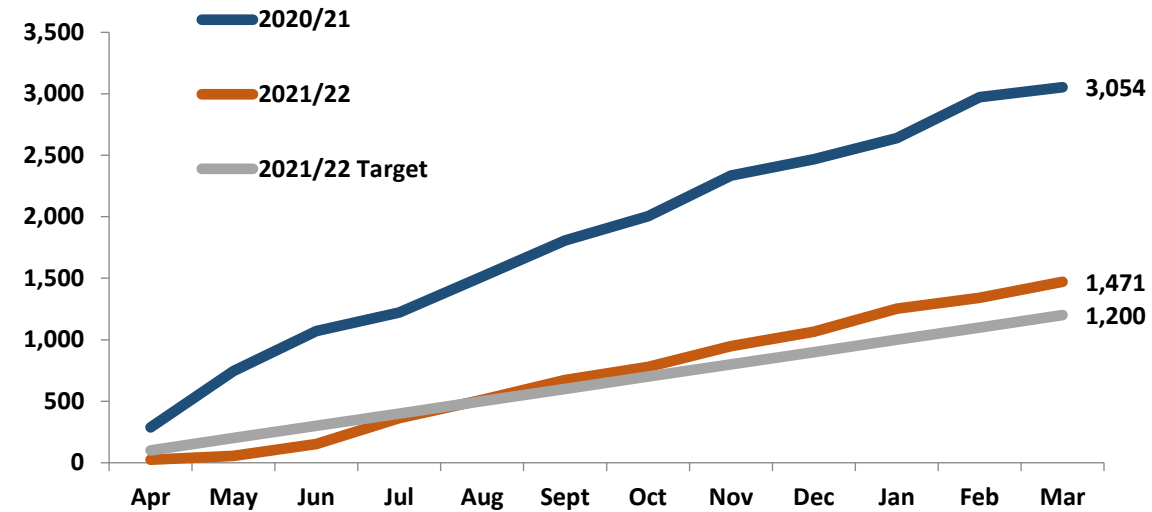
The COVID-19 pandemic has brought into focus the strength and importance of Health and Social Care research in the UK. Research has made a leading contribution to the knowledge base during this time. However, the UK has learnt important lessons about where we can improve. This includes empowering healthcare and research workers to ensure they are supported and resilient to future challenges, alongside being more innovative in trial design and delivery. National policy is strengthening the importance of putting research at the heart of everything the NHS does, making it an essential and rewarding part of effective patient care

SFH research activity during the pandemic has been fundamental to improving the lives of our patients as a way to improve the detection, diagnosis, treatment and prevention of disease. The research portfolio is developing as we focus on growth in our specialities and COVID-19 research becomes business as usual. We are confident embedding clinical research as part of clinical care is achievable and delivers for patients. A key part of the journey to realising this is to build a culture across SFH and the wider system that is positive about research, where staff feel empowered and supported to take part in clinical research delivery as part of their job



TODAY'S RESEARCH IS TOMORROW'S TREATMENT



NHS
Sherwood Forest Hospitals
NHS Foundation Trust

# Performance

## Cumulative Monthly Recruitment 2020-21 and 2021-22



- 2020/21 — 3,054
- 2021/22 — 1,471
- 2021/22 Target — 1,200

## Total Recruited



| Year | Total Recruited |
| --- | --- |
| 2016/17 | 958 |
| 2017/18 | 1649 |
| 2018/19 | 2130 |
| 2019/20 | 3297 |
| 2020/21 | 3054 |
| 2021/22 To Date | 1471 |
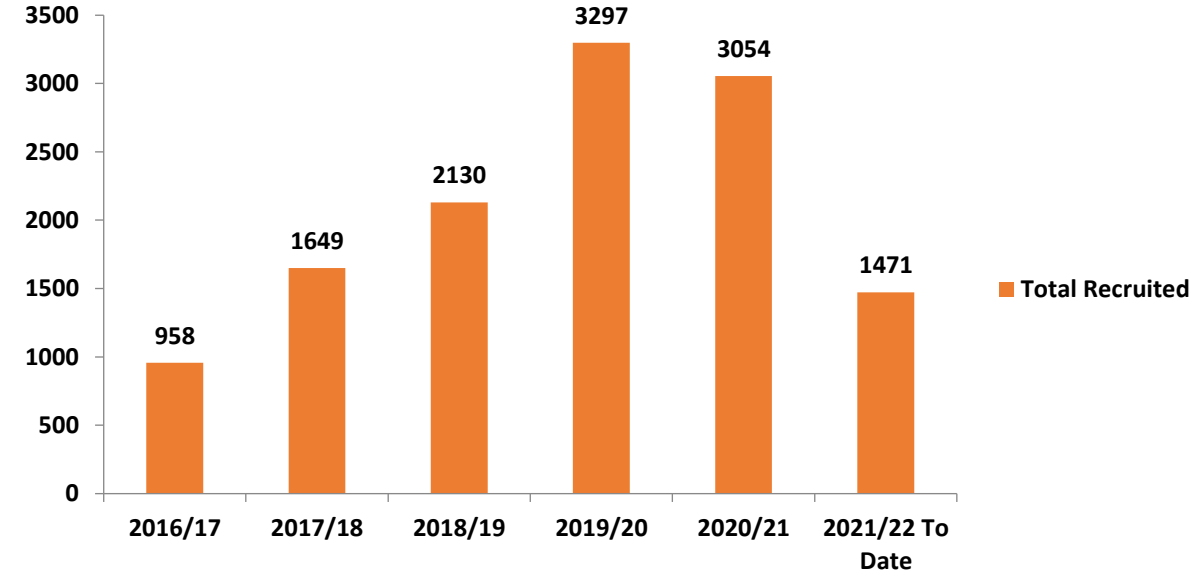
## Non-Commercial and Commercial Recruitment by Year



| | TOTAL Recruited 20-21 | TOTAL Recruited 21-22 |
| --- | --- | --- |
| Non-Commercial | 3047 | 1454 |
| Commercial | 7 | 17 |
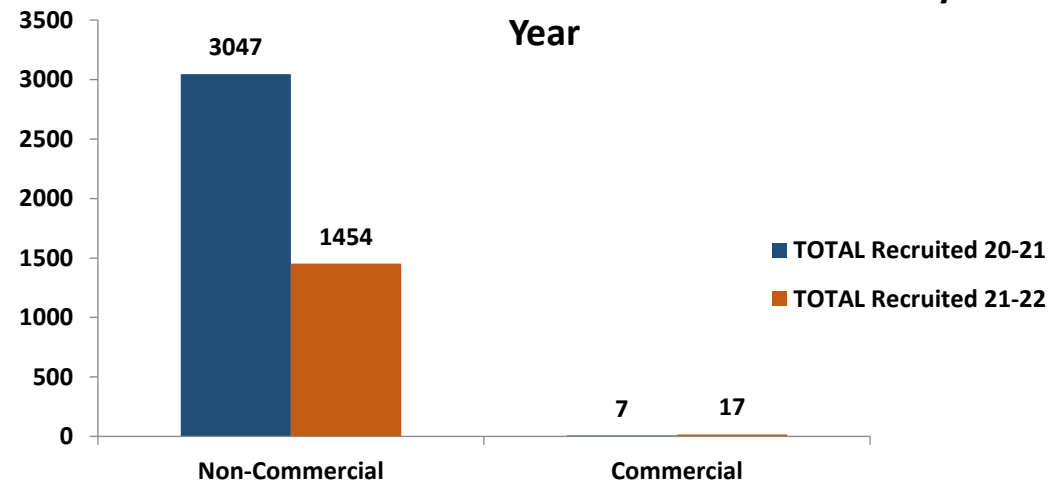
# Performance

## Total Studies, Open, In Follow Up and Total Recruitment by Speciality
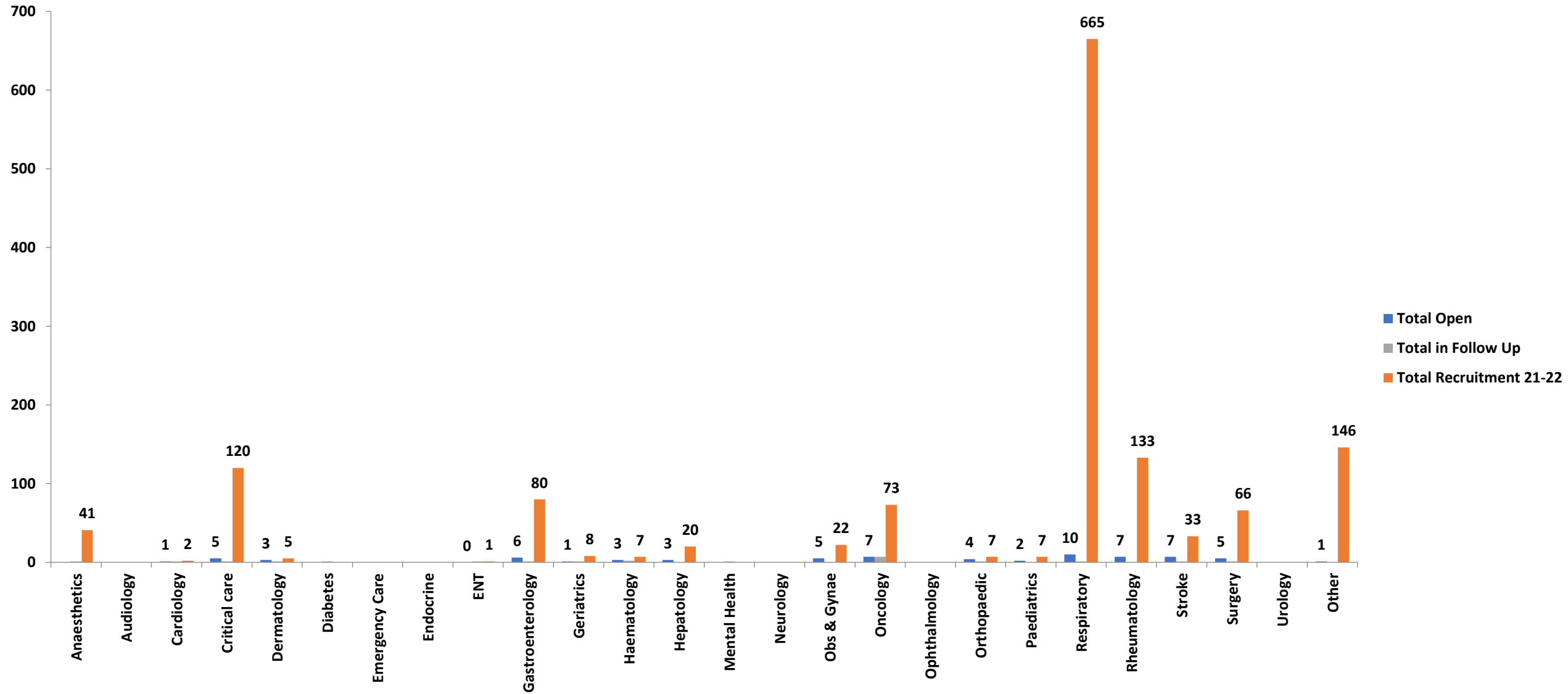
# Finance

**2021/22**

**CRN East Midlands Income**

**£752,652.04**

**2022/2023**

**Indicative Budget**

**£755,435,10**

**Department of Health Funding**

**£20,000.00**

**To maintain research capability and capacity**

2021/22

Commercial Income

£164,088.11

For re-investment into future research capability and capacity

# 2021/22 Highlights

Post pandemic renewed government commitment to support health and care research:
- Spending Review - > £300 million increase in funding, largest ever annual uplift
- Health and Care Bill – requirements for the promotion and facilitation of research within organisations such as NHSE and ICB's will be strengthened as part of legislation

Leading Research – Chief Investigator and Sponsor for a grant funded multi-site study for the first time

Influencing and informing through the Nottinghamshire ICS Research Partners Group

Development of formal partnership with NTU to increase research opportunities and clinical academic careers for Nurses, Midwives and AHP's

**Build Back Better**

**Infrastructure**

**Sponsorship**

**Integration**

**Collaboration**

Reset and Recovery – fully implemented, portfolio growth and Covid 19 research is business as usual  - 30 new trials opened in year

CRF space secured -  in use for existing trials with further transformation planned 22/23 to enable earlier phase research

Working across boundaries - Joint Senior Research Nurse post across primary care and SFH post active

Inclusion in NUH successful CRF re-bidding and mobile research unit

NHS
**Sherwood Forest Hospitals**
NHS Foundation Trust

**Board of Directors Meeting in Public - Cover Sheet**

| Subject: | Research and Development Performance Report – 2021/22 | Date: 5th May 2022 | |
|---|---|---|---|
| **Prepared By:** | Alison Steel, Head of Research and Innovation | | |
| **Approved By:** | Elizabeth Gemmill, Research and Innovation Director | | |
| **Presented By:** | Alison Steel, Head of Research and Innovation | | |

| Purpose | | | |
|---|---|---|---|
| To present the Research and Innovation Annual Performance Report<br><br>Update and assurance on performance KPI's and financial position<br><br>Update on recovery and growth of the SFH research portfolio | **Approval** | | |
| | **Assurance** | X | |
| | **Update** | | |
| | **Consider** | | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | X | | |

| Risks/Issues | | |
|---|---|---|
| **Financial** | • Confirmed £755,435.10 EMCRN 2022/23 budget – rollover, no enhancements<br>• Commercial income in 21/22 for re-investment - £164,088.11 | |
| **Patient Impact** | • 1471 participants recruited into research studies, 853 in to UPH studies | |
| **Staff Impact** | • Collaboration with Nottingham Trent University to support development of clinical academic careers and research exposure for clinical staff | |
| **Services** | • Support Clinical Divisions with research engagement<br>• CRF estate secured | |
| **Reputational** | • Retain a strong reputation for research delivery, re set and recovery<br>• Leading the way with collaboration with GP practises, HEI's and other NHS organisations to increase Research opportunities<br>• Leading on multi-site clinical trial | |

| Committees/groups where this item has been presented before |
|---|
| **None** |

| Executive Summary |
|---|
| **Performance Metrics**<br><br>• 1471 participants recruited into research studies compared to 3054 in 20/21, 64 studies on the SFH portfolio<br>• Confirmed £755,435.10 EMCRN 2022/23 budget.<br>• Commercial income at £164,088.11<br><br>**Patient Experience**<br><br>• 91% of participants Agree/Strongly Agree their participation in Research has been valued<br>• 93% of participants would consider taking part in Research again<br>• All Participants Agree/Strongly Agree that they have been treated with courtesy and respect |

**Research highlights 21-22**

1. Post pandemic renewed government commitment to support health and care research
2. CRF space secured
3. Leading Research – Chief Investigator and Sponsor for a grant funded multi-site study
4. Influencing and informing through the Nottinghamshire ICS Research Partners Group
5. Working across boundaries - Joint Senior Research Nurse post across primary care and SFH post active
6. Development of formal partnership with NTU
7. Inclusion in NUH successful CRF re bidding and plans for mobile research unit

# Audit and Assurance Committee Annual Report 2021/22

## Introduction

The Audit and Assurance Committee is established under Board delegation with approved terms of reference aligned with the *Audit and Risk Assurance Committee Handbook*, published by the Department of Health.

The Audit and Assurance Committee was chaired by Graham Ward, a Fellow of the Institute of Chartered Accountants (England & Wales) with extensive financial expertise. The Committee membership comprises wholly non-executive directors with executives and others in attendance.  Attendance at meetings is detailed below:

| | |
|---|---|
| Graham Ward | 7/7 |
| Barbara Brady | 6/7 |
| Manjeet Gill | 3/5 |
| Steve Banks | 2/2 |

According to the Terms of Reference, the Chief Executive and other executive directors are invited to attend the Audit and Assurance Committee meeting as and when required, but particularly when the Audit and Assurance Committee is discussing areas of risk or operation that are the responsibility of that director.

## Objectives from 2021/22

The Committee's agreed objectives for 2021/22 were:

- Maintain the review and control processes currently in place, including ensuring that actions and process changes in response to internal and external audit recommendations have been implemented on a timely basis
  - ➢ This has been achieved by the Committee fulfilling its work plan and maintaining oversight of processes

- Complete the implementation of the actions identified in the Committee's maturity assessment action plan, and continue with an emphasis on working closely with the other sub-committees of board
  - ➢ The actions on the maturity assessment action plan are all complete

- Extra focus on the system/ICS to ensure the alignment of internal control processes with the Integrated Care System, Integrated Care Partnership and Primary Care Networks

  ➢ The work on this has been delayed as the ICS legislation is not yet in place

- Maintain focus and review of the Register of Interests, and pursue further improvement in the compliance rate

  ➢ The Register of Interests report is a standing item on the Committee agenda for each meeting – there is evidence of improving compliance across the Trust and details of progress are noted in the 'Conduct and behaviour policies' section below

**Principal review areas**

This annual report is divided into five sections reflecting the five key duties of the Committee as set out in the terms of reference.

1. <u>Governance and internal control</u>

   The Committee reviewed relevant disclosure statements for 2020/21, in particular the Annual Governance Statement (AGS) together with the Head of Internal Audit Opinion, External Audit opinions (Financial and Quality Accounts) and other appropriate independent assurances and consider that the AGS is consistent with the Committee's view on the Trust's system of internal control. Accordingly, the Committee supported Board approval of the AGS.

   The Committee has received update reports on Information Governance and members were pleased to note that the Data Security Protection Toolkit compliance had been maintained in 2021.

2. <u>Internal audit</u>

   Throughout the year the Committee has worked effectively with internal audit to strengthen the Trust's internal control processes. The Committee has also in year:

   - Reviewed and approved the internal audit operational plan for 2022/23 and more detailed programme of work initially and then on an on-going basis to take into account the impact of the COVID-19 pandemic, while ensuring the provision of the internal audit service continued to be sufficient in supporting the Committee in fulfilling its role

- Considered the major findings of internal audit and are assured that the Head of Internal Audit Opinion and AGS for 2020/21 reflect any significant internal control issues

- Invited lead directors of any internal audit reports issued with Limited Assurance to attend Committee meetings, present the report and provide assurance that actions will be implemented within agreed timescales

- Worked with colleagues internally and externally to address deteriorating performance regarding the provision of evidence and the achievement of internal audit actions, and the impact of the pandemic on timely completion of actions

- Regular review of outstanding audit actions, and are assured that a robust progress monitoring process is in place

3. Counter Fraud Service

The Committee received regular progress reports on activity conducted as part of the agreed Counter Fraud Work Plan, including:

- Annual Report for 2020/21
- Updates on investigations
- Conflicts of Interest Policy and Declarations of Interest Register review
- Risk assessment in line with Counter Fraud Functional Standards

4. External audit

The Committee reviewed and agreed external audit's annual plan for 2021/22, noting that the Trust's main risk remains to be the valuation of land and buildings and that KPMG's audit focus this year is the implementation of IFRS 16 (leases) transition.

The Committee reviews and comments on reports prepared by external audit and welcomes their advice on areas of specific expertise.

5. Management

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources both internally and externally throughout the year. This process has also included calling managers to account when considered necessary to obtain relevant assurance.

6. Annual Report and Accounts

The Committee received schedules and assurance of processes in place to satisfactorily produce the Annual Report, Quality Account and Financial Accounts.

As part of the year-end process and approval of the 2020/21 accounts for the Board for ratification, the Committee reviewed and took into account:

- Head of Internal Audit Opinion on both financial and non-financial matters
- External audit opinion on the accounts and value for money opinion
- Letter of Representation to external audit
- Going Concern assessment, to assure themselves of the effective financial and non-financial propriety of the Trust

The following key risks highlighted within the financial statements were noted:

- Valuation of Land and Buildings
- Fraud risk from expenditure recognition
- Fraud risk from revenue recognition
- Management Override of Controls
- Valuation of land and buildings

All of these were found by the auditors to be 'satisfactory'.

**Other areas of focus**

Conduct and behaviour policies

Regular reports of the Register of Interests compliance were received during the year, and it was noted that the number of non-compliant staff had decreased during the year (from 88 in March 2021 to 40 in March 2022). Committee members were assured by the focus in this area and the process in place.

Cost Control and Financial Governance reviews

Throughout the year the Committee received reports on Single Tender Waivers, Losses and Special Payments, gaining assurance on value for money and probity within controls.

Governance documents

A report of non-clinical policies reviews was received, and the process to address those past their review dates was agreed.

<u>Other areas of assurance</u>

The Committee received update reports on the Due Diligence Process for Future Suppliers, and Freedom to Speak Up arrangements, noting the consistent improvement against the FTSU index.

Also received was an assessment on the NAO Cyber and Information Security Good Practice Guide, and progress made in meeting the recommendations required to achieve full compliance.

In addition, the Committee received the Risk Committee and Procurement Annual Reports, and the Board Assurance Framework periodically to provide assurance on the review process.

## Review of the effectiveness and impact of the Audit and Assurance Committee

The Committee has been active during the year in carrying out its duty in providing the Board with assurance that effective internal control arrangements are in place.

The Committee continued to meet throughout the pandemic with positive attendance from Committee members.

An annual Committee self-assessment, using the HFMA's NHS Audit Committee Handbook checklist, was completed by the non-executive director members of the Audit and Assurance Committee, from which no significant issues were identified.

The Committee participated in the well led review carried out by Grant Thornton, inviting the lead to observe the November Committee meeting, which resulted in very positive outcomes and feedback.

## Cost/benefit analysis

It is not possible to accurately quantify the benefits of the work of the Committee during the year as it is impossible to determine the financial impact of risks mitigated and costs avoided, and the proportion of these that could be apportioned to the Committee work. However, the current and future costs associated with loss of reputation have been mitigated as a result of the work performed by the Committee.

## Conclusion

The Committee is of the opinion that this annual report is consistent with the draft AGS, Head of Internal Audit Opinion and the external audit review and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

The Committee has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business.

**Objectives**

The Committee's objectives for 2022/23 are:

- Maintain the review and control processes currently in place, including a strengthened focus on internal and external audit actions implementation tracking and improving the implementation compliance rate

- Ensure the alignment of internal control processes with the Integrated Care System, provider collaboratives and other strategic partnerships

- Maintain focus and review of the Register of Interests, and pursue further improvement in the compliance rate

**Graham Ward**

Audit and Assurance Committee Chair

March 2022

**Board of Directors - Public**

| Subject: | Audit and Assurance Committee Annual Report | **Date:** 5th May 2022 |
|---|---|---|
| **Prepared By:** | Neil Wilkinson, Risk & Assurance Manager | |
| **Approved By:** | Graham Ward, Audit & Assurance Committee Chair | |
| **Presented By:** | Graham Ward, Audit & Assurance Committee Chair | |

| Purpose | | |
|---|---|---|
| Consider and receive assurance from the presentation of the Audit and Assurance Committee Annual Report | **Approval** | |
| | **Assurance** | ✓ |
| | **Update** | |
| | **Consider** | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | ✓ | | |

| Risks/Issues | |
|---|---|
| **Financial** | |
| **Patient Impact** | |
| **Staff Impact** | |
| **Services** | |
| **Reputational** | |

| Committees/groups where this item has been presented before |
|---|
| Audit and Assurance Committee – 15th March 2022 |

| Executive Summary |
|---|
| The attached Audit and Assurance Committee Annual Report outlines the principal review areas and activities carried out by the Committee throughout 2021/22.<br><br>The Committee is of the opinion that this annual report is consistent with the draft AGS, Head of Internal Audit Opinion and the external audit review and there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.<br><br>The report concludes that the Committee has discharged its responsibilities for scrutinising the risks and controls which affect all aspects of the organisation's business. |

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

| | |
|---|---|
| **Subject:** | Audit & Assurance Committee (AAC) Report    **Date:** 21st April 2022 |
| **Prepared By:** | Graham Ward – AAC Chair |
| **Approved By:** | |
| **Presented By:** | Graham Ward – AAC Chair |
| **Purpose** | |

| | Assurance | |
|---|---|---|
| | | |

| Matters of Concern or Key Risks to Escalate | Major Actions Commissioned / Work Underway |
|---|---|
| ▪ **Non-Clinical Policies** – there are a large number of these that are out of date across all executive directors and as a priority these need reviewing, updating as appropriate and approving. | ▪ **Clinical Policies** – Quality Committee has been asked to provide assurance that Clinical Policies are up to date and approved. |

| Positive Assurances to Provide | Decisions Made |
|---|---|
| ▪ **Head of Internal Audit Opinion** – an interim opinion of Significant Assurance was given by 360 Assurance.<br>▪ **Draft Annual Accounts** – received and discussed, all to time and draft results as expected.<br>▪ **Draft Annual Report and Quality** Account – both progressing well.<br>▪ **Register of Conflict of Interest Breaches Report** – no breaches identified during 2021/22 | ▪ **Internal Audit Plan 2022/23** – Proposed change to plan to include a further Maternity Standards review to be undertaken in 2022/23 at request of Chief Nurse with Medical Research review being pushed back a quarter to QI 2023/24 was agreed subject to receiving details for the request from the Chief Nurse (to be circulated outside of meeting) |

**Comments on Effectiveness of the Meeting**

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

**Board of Directors Meeting in Public**

| Subject: | Finance Committee Annual Report | Date: 5 May 2022 | |
|---|---|---|---|
| Prepared By: | Richard Mills, Chief Financial Officer | | |
| Approved By: | Neal Gossage, Non Executive Director and Chair of Finance Committee | | |
| Presented By: | Richard Mills, Chief Financial Officer | | |
| **Purpose** | | | |
| To provide assurances the Finance Committee is performing its responsibilities as set out within its Terms of Reference. | **Approval** | | ✓ |
| | **Assurance** | | |
| | **Update** | | |
| | **Consider** | | |

**Strategic Objectives**

| To provide outstanding care to our patients | To support each other to do a great job | To inspire excellence | To get the most from our resources | To play a leading role in transforming health and care services |
|---|---|---|---|---|
| ✓ | ✓ | ✓ | ✓ | ✓ |

**Overall Level of Assurance**

| | Significant | Sufficient | Limited | None |
|---|---|---|---|---|
| | ✓ | | | |

| **Risks/Issues** | | | | |
|---|---|---|---|---|
| **Financial** | | | | |
| **Patient Impact** | | | | |
| **Staff Impact** | | | | |
| **Services** | | | | |
| **Reputational** | The Annual Report is an element of overall Trust governance arrangements. Failure to apply agreed governance arrangements could result in significant reputational consequences. | | | |

**Committees/groups where this item has been presented before**

Finance Committee – January 2022

**Executive Summary**

This report provides a description of the activities and assurance that the Finance Committee has carried out its obligations in accordance with its terms of reference and work programme for the 2021 calendar year. It provides assurances and synopsis on activity undertaken throughout the year and identifies areas for development.

The time period is aligned to the annual governance timetable to enable consideration by the Audit & Assurance Committee and the Board of Directors, and to support the Annual Governance Statement.

# Annual Report from the Finance Committee 2021

## 1. Summary

This report provides an overview of risk management activities undertaken throughout the Trust and a summary of the work undertaken within the Finance Committee activities from January to December 2021, for assurance that the Committee has carried out its obligations in accordance with its Terms of Reference and work programme for 2021.

The time period is aligned to the annual governance timetable to enable consideration by the Audit & Assurance Committee and the Board of Directors, and to support the Annual Governance Statement.

## 2. Background

The Finance Committee meets not less than 6 times a year and reports to the Board of Directors. Its Terms of Reference establish that its role is to conduct independent and objective reviews of financial and investment policy and performance issues.

The Committee's membership is set out below:

- Four Non-Executive Directors one of whom nominated as Chair and one as Vice Chair. The Chair of the Committee is appointed by the Board of Directors.
- Chief Executive.
- Chief Financial Officer.
- Chief Operating Officer.
- Director of Culture & Improvement
- Associate Director of Estates & Facilities

Also in routine attendance:

- Deputy Chief Financial Officer
- Associate Director of Transformation
- Associate Director – Business Planning & Partnership
- Governor observer

Other Directors and Managers have attended meetings in accordance with the Committee work programme and/or in response to specific issues being identified.

## 3. Meetings

The Committee has held 10 meetings during the period covered by this report, 2 meetings being held as Extra-ordinary meetings as agreed by the Committee.

Attendance of core members (or a nominated deputy) at meetings during the period covered by this report is detailed below:

| | |
|---|---|
| Non-Executive Director Chair | 10/10 |
| Non-Executive Director Vice Chair | 10/10 |
| Non-Executive Director (left SFH in Nov-21) | 8/8 |
| Non-Executive Director (joined FC Mar-21) | 5/8 |
| Chief Executive | 1/10 |
| Chief Financial Officer | 10/10 |
| Chief Operating Officer | 7/10 |
| Director of Culture & Improvement | 7/10 |
| Associate Director of Estates & Facilities | 8/10 |

## 4. Work Programme

The Committee has received regular reports throughout the year in accordance with its agreed Annual Work Programme. A series of monthly reports are received from Committee members in respect of:

- Financial Performance
- Financial Improvement Plan
- PFI Governance
- ICS and NHSI Updates
- Procurement Forward View
- Board Assurance Framework (BAF) – Principal Risk 4

The Committee has also received reports on the following specific matters:

- Annual Planning and Budgeting process and delivery
- NHIS quarterly performance
- Capital Plan
- Strategic Objective 5 update
- Terms of reference review (March 2021)
- National Cost Collection submission
- Internal Audit Reports

## 5. Approvals

The Trust Scheme of Delegation describes the Committee has delegated authority from the Board of Directors to approve revenue and capital expenditure up to the value of £1m. The Governance process requires Finance Committee approval of all expenditure in excess of £250,000. Expenditure above the £1m threshold requires the final approval of the Board.

In accordance with this the Committee has considered and approved the following:

- Pathology Laboratory Information Management System (LIMS) replacement
- NHIS Network Infrastructure replacement
- GP Network Switch replacement
- Covid-19 Vaccination Centre Security provision
- P2G support for PFI settlement
- Soft FM Procurement
- CCG and GP IT Refresh (virtual approval)
- Mobile CT and Mobile Endoscopy units
- Mobile MRI Van contract renewal

- Medical Interoperability Gateway (MIG) contract renewal
- Microsoft Enterprise Subscription Agreement contract renewal
- Allocate contract extension
- Critical Care capacity investment
- Medical Staffing business case

## 6. Board Assurance Framework

The Committee reviews BAF principle risk 4 (Failure to maintain financial sustainability) at each ordinary meeting. At the start of the period covered by this report the risk score was recorded at 15 (Significant). The score was revised to 12 (High) at the September 2021 meeting. This was due to a change in the consequence score changing from 5 (Very High) to 4 (High), given there was no suggestion of regulatory action being taken at that point. The score remained unchanged for the rest of the period.
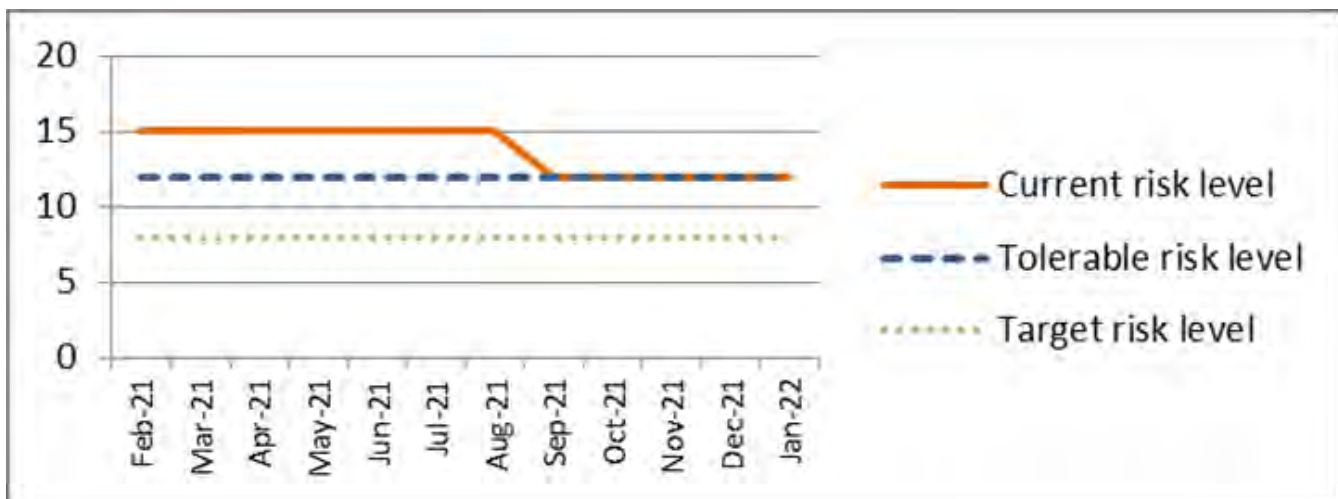


## 7. Committee Effectiveness Review

The Committee carried out and Effectiveness Review which was reported in March 2021. The review was based upon the National Audit Office Committee Healthcheck and is to help review governance arrangements, check appropriate systems are in place and to identify areas for improvement

The self-assessment tool considered 16 criteria and the Committee reported that each was fully met. Evidence to support this assessment was reported and no required actions were identified.

## 8. Matters for escalation

At the end of each Committee meeting items for escalation to the Board of Directors are identified. Throughout the year, at various points in time, these have included:

- Financial performance and forecast outturn updates, including financial year 2020/21, the 2021/22 H1 financial period (1st March 2021 to 30th September 2021) and the 2021/22 H2 financial period (1st October 2021 to 31st March 2022)

- Approval of expenditure exceeding the Finance Committee £1.0m limit, requiring final approval from the Board of Directors (Pathology LIMS, Mobile CT and Endoscopy Units, Mobile MRI and Microsoft ESA contract renewals, Critical Care and Medical Staffing business cases)

- Transformation & Efficiency updates, including Financial Improvement Programme (FIP) plans and performance updates

- Covid vaccination programme financial arrangements

- Financial planning and budgeting updates, including revisions to NHS financial framework

- Increase in service calls to NHIS

- PFI contract updates, including PFI settlement agreement standstill period recommendations and approval

- Soft FM Procurement

- Capital programme updates

- Significant assurance provided in the Integrity of the General Ledger and Financial Reporting audit report

- Plans and performance in respect of Elective Recovery and changes to Elective Recovery Fund rules

- ICS developments

- Procurement Spend Comparison Service (SCS) league table data

- MCH asset transfer proposal and potential for financial risk

- BAF current exposure score amendment to 4

- National Cost Collection (NCC) final submission

- Approval of NHIS Digital Strategy

## 9. Conclusion

The Committee self-assessments of compliance with Terms of Reference, the review of effectiveness, the robust work programme and escalations to Board of Directors provide assurance that the Committee continues to be effective in discharging its responsibilities.

**Finance Committee Chair's Highlight Report to Trust Board**

| Subject: | Finance Committee - Report of the Committee Chair (last meeting) | Date: 26 April 2022 | |
|---|---|---|---|
| Prepared By: | Richard Mills, Chief Finance Officer | | |
| Approved By: | Andrew Rose-Britton, Non-Executive Director | | |
| Presented By: | Andrew Rose-Britton, Non-Executive Director | | |
| Purpose | | | |
| This paper summarises the assurance provided by the Finance Committee around financial management in the Trust and records matters the Committee considers need to be brought to the attention of the Board of Directors. | Assurance | Sufficient | |

| Matters of Concern or Key Risks to Escalate | Major Actions Commissioned / Work Underway |
|---|---|
| ▪ 2021/22 financial outturn was confirmed as a £13.3m deficit, which is consistent with the previous forecast outturn.<br><br>▪ The 2022/23 financial plan is due for submission on 28 April 2022. The Nottinghamshire ICS will submit a deficit financial plan, although this will be improved compared to the previous draft submission. The final organisational level split was to be confirmed. | ▪ NHIS Performance: report to committee on bringing in Bassetlaw.<br><br>▪ Capacity in Nursing homes: may need virtual approval if costs exceed £250K.<br><br>▪ Further review of agency expenditure and workforce growth to be considered for a future meeting.<br><br>▪ Work to finalise the Electronic Patient Record business case is expected to be completed in May 2022. |
| **Positive Assurances to Provide** | **Decisions Made** |
| ▪ Maturity Action Plan (May 2021) actions considered and agreed as completed. | ▪ Extraordinary Finance Committee to be held in May 2022 to review the Electronic Patient Record business case and the 2022/23 financial plan and budgets in further detail.<br><br>▪ BAF Principal Risk 4 reviewed and narrative changes agreed. The overall score remains at 16, reflecting the deficit financial plan for 2022/23. |
| **Comments on Effectiveness of the Meeting** | |
| ▪ Committee members agreed that the meeting provided a good level of review of pertinent issues, with constructive and positive contributions and outcomes. | |

**Healthier Communities, Outstanding Care**

**NHS**
**Sherwood Forest Hospitals**
**NHS Foundation Trust**

## Charitable Funds Committee Chair's Highlight Report to

## Trust Board

| Subject: | Charitable Funds Committee Feedback Report | Date: 21st April 2022 | |
|---|---|---|---|
| Prepared By: | Steve Banks – Non-Executive Director | | |
| Approved By: | | | |
| Presented By: | Steve Banks – Non-Executive Director | | |
| **Purpose** | | | |
| To provide assurance to the Trust Board | | Assurance | |

| Matters of Concern or Key Risks to Escalate | Major Actions Commissioned / Work Underway |
|---|---|
| ▪ The Newark Breast One Stop Clinic is planned to commence in May and has taken too long to come to fruition. Future SFH Charity projects are now reviewed at the Capital Oversight Group which will provide more scrutiny, including on implementation and progress. | ▪ The End-of-Life appeal has reached target with work commencing to upgrade identified rooms<br>▪ Request made to review whether the way funds are invested is in line with Trust values |
| **Positive Assurances to Provide** | **Decisions Made** |
| ▪ The Committee Terms of Reference and Annual work plan were reviewed and updated<br>▪ The Review of Committee Effectiveness was reported and proposals for Committee members and new Governors to receive relevant training during the coming year were agreed<br>▪ The Committee Risk Register was reviewed<br>▪ Evaluation forms were received for the outcome of the use of funds in supporting the Gamma Scanner and care after death – memory making trolley were received | ▪ N/A |
| **Comments on Effectiveness of the Meeting** | |

- The meeting was reviewed, and it was commented that the papers were relevant, concise and gave the information needed. There was also a satisfactory level of discussion and challenge.

## Quality Committee Annual Report 2021

Report Covers Period January 2021 to December 2021 – 6 Scheduled Meetings

### Introduction

The Quality Committee is established under Board delegation with approved Terms of Reference.

The Quality Committee was chaired by Barbara Brady, a non-Executive Director, who is a retired registered General Nurse and Director of Public Health. In addition to the Chair, the Committee membership is comprised of two Non-Executive Directors, the Executive Medical Director, Chief Nurse and Chief Operating Officer. Others are in attendance at the Committee with additional attendees invited as required. Two Governors observe the committee and report to the Council of Governors. Membership attendance at core meetings is detailed below:
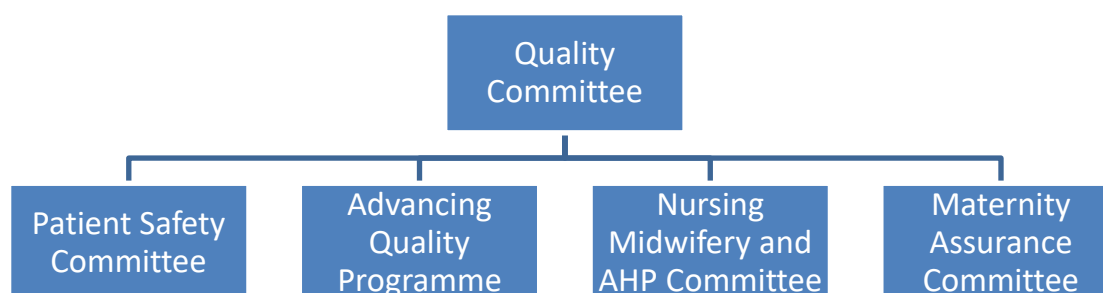
Non-Executive Director Barbara Brady (Chair) 6/6
Non-Executive Director Tim Reddish 4/5
Non-Executive Director Claire Ward 2/2 (Trust Chair from April 2021)
Medical Director David Selwyn 6/6
Chief Nurse Julie Hogg 5/6
Chief Operating Officer Simon Barton 6/6

Dr Andrew Haynes attended 2/2 meetings as appointed Specialist Advisor to the Board
Manjeet Gill attended 2/3 meetings as Non-Executive Director in place for either Claire Ward or Tim Reddish as required

According to the Terms of reference, the Head of Regulation and Patient Safety [ Post title now Head of Regulation and Deputy Head of Clinical Governance], the Deputy Chief Nurse, the Head of Clinical Governance and a representative from the CCG will be in attendance at the Committee.

The Committee has oversight of several subgroups and Committees who have a responsibility to provide assurance to the Quality Committee. The reporting structure is as below, where the 4 key direct reports have a responsibility to provide assurance from their associated subgroups to the Quality Committee.

```
                          ┌──────────────────┐
                          │     Quality      │
                          │    Committee     │
                          └──────────────────┘
        ┌────────────────┬─────────┴─────────┬────────────────┐
┌───────────────┐ ┌───────────────┐ ┌───────────────┐ ┌───────────────┐
│ Patient Safety│ │   Advancing   │ │    Nursing    │ │   Maternity   │
│   Committee   │ │    Quality    │ │ Midwifery and │ │   Assurance   │
│               │ │   Programme   │ │ AHP Committee │ │   Committee   │
└───────────────┘ └───────────────┘ └───────────────┘ └───────────────┘
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## Principal Review Areas

The report is divided into sections which represent the key duties of the Quality Committee through the definition of quality in *"High Quality Care for All" (2008)*. This definition has since been embraced by staff throughout the NHS.
This definition sets out three dimensions to quality, *all three of which* must be present in order to provide a high quality service:
**Clinical effectiveness**– quality care is care which is delivered according to the best evidence as to what is clinically effective in improving an individual's health outcomes;
**Safety**– quality care is care which is delivered so as to avoid all avoidable harm and risks to the individual's safety;
**Patient experience**– quality care looks to give the individual a positive experience when being in receipt of and recovering from care, including being treated according to what that individual wants or needs, and with compassion, dignity and respect

The Committee has an approved work plan which is used to review the establishment and maintenance of an effective system of quality governance, risk management and internal control across organisations activities using the three-quality dimension above. The Committee have adjusted the Work Plan in 2021 to outline where key reports match more than one of the three quality dimensions.

The updates from the Patient Safety Committee and the Nursing Midwifery and Allied Health Professions Board meet the requirements of all three quality dimensions.

## Clinical Effectiveness and Patient Safety

The Committee was updated at regular intervals over the CQC registration status and how the Trust was meeting the action plans. These updates form part of the Advancing Quality Programme reports. The Committee received its first annual report of Trust wide Accreditation and Regulation Activities, they provided an oversight on registration activities as and when they occurred, including Joint Advisory Group (JAG), United Kingdom Accreditation Services (UKAS) and screening services such as Antenatal Screening.

The Committee received an annual update from Cancer Services, End of Life Care, while receiving more regular updates, biannually around the medicine's optimisation strategy and quarterly around fragile services in difficulty and the Hospital Standardised Mortality Ratio.

The Committee heard the annual clinical effectiveness report which included updates on Clinical Audit, the associated forward plan and current progress of this, the annual audit forward plan was also approved by the Committee. The Nursing Midwifery and AHP strategy was reviewed by the committee in September and was approved.

## Patient Safety

At each of the meetings held, reports were presented, and the Committee heard, discussed and reviewed items on the Patient Safety Committee, Advancing Quality Programme, Nursing Midwifery and AHP Board and Maternity Assurance Committee agendas.

The Committee continued to receive regular updates on potential harms to Non-Covid patients in response to the COVID-19 pandemic through the Patient Safety Committee updates.

The Committee received annual reports staggered throughout the year to provide assurance on the patient safety requirements of the Committee, these included

**Report Author**
Patrick McCormack – Head of Regulation and Deputy Head of Clinical Governance

- Safeguarding
- Infection Prevention and Control
- Children and Young People's Board

In March the Committee heard the outcomes of a deep dive into maternity incidents after a spike in December 2020. As a result of the deep dive all subsequent Committee's received and discussed a two monthly maternity incidents update.

## Patient Experience

The Committee received reports at each meeting in relation to the Nursing, Midwifery and AHP Board; this included the 15 steps programme. The Committee approved the terms of reference for the Nursing, Midwifery and AHP Board

The Committee continued to examine patient experience through annual staggered reports, these included:
- Patient Experience, including patient experience surveys, inpatient and outpatient surveys

## Additional Assurance

In addition to the assigned work plan the Committee received updates and assurance as requested throughout the year.
**March** – Updates on Deprivation of Liberty Recommendations, Falsified Medicines Directive and Thromboembolic Prevention and Complications
**May** – Update on Safe and Timely Discharges
**June** – Update following the 2020 Discharge Accuracy audit and information around patients being sent home without their To Take Out (TTO's)
**July** – Report on a Falls Deep Dive presented with and improvement trajectory, updates on Community Onset Healthcare Associated *Clostridium Difficile* and Ophthalmology post 2018 quality summit

## Governance

Board Assurance Framework principle risks were considered and approved as part of each Committee. Where appropriate the Committee recommended and approved the alteration of risk scoring based on the evidence and agreement of those in attendance. The two principle risks the Committee primarily discuss are:

- PR1 Significant deteriorations in standards of safety and care
- PR2 Demand that overwhelms capacity

The Committee also receives internal audit reports if they relate to clinical quality. During the reporting period the Committee received audit reports on
- Trust's Safeguarding Progress
- Maternity Services and assessment tool
- Data Quality Framework
- Patient Consent

In 2021 the Committee was reviewed as part of a maturity matrix, the work as a result of this is ongoing and contributes to the development of the Committee in ensuring its responsibility to the Board. This met the annual quality objectives outlined in the 2020 Quality Committee Report to Board.

**Report Author**
Patrick McCormack – Head of Regulation and Deputy Head of Clinical Governance

## Management

The Committee has continually challenged the assurance process when appropriate and has requested and received assurance reports from Trust management and various other sources, both internally and externally throughout the year. This process has also included requesting managers to present and discuss when necessary to obtain relevant assurance.

In 2021 the Trust Quality Strategy is due for review, in December 2021 the Committee received a draft strategy for review and consultation. The Committee reflected positively on the new strategy and aims to approve this in early 2022 for distribution.

## Review of the effectiveness and impact of the Quality Committee

The Committee has been active during the year in carrying out its duty in providing the Board with assurance that effective internal control arrangements are in place. The Committee summarises escalations to the board at the end of every meeting.

Committee effectiveness self-assessment review is conducted as part of the Committee process. These were completed throughout the year with no show stopping issues identified.

The Committee continue to review and update the associated work plan as the reporting sub-Committees governance matures. Changes and agreements are documented as part of the Committee documentation process.

## Cost/benefit analysis

It is not possible to accurately quantify the benefits of the work of the Committee during the year as it is impossible to determine the financial impact internal control and governance mitigation the Committee has ensured leading to costs avoided. However, the current and future costs associated with the loss of reputation have been mitigated as a result of the work performed by the Committee. This includes annual updates on the risks associated with the private finance initiative contract and review and approval of quality impact assessments for the financial improvement programme.

## Objectives

The Committee has reviewed and supported an audit of compliance against CQC key lines of enquiry (KLOE) and will continue to support work to seek oversight of the reporting, this includes

- Supporting the Trusts ongoing work of the KLOE currently not embedded within governance structures and designated work streams
- Seek assurance for the outstanding governance of KLOE which are work streams but not within the reporting structure of the Committee
- Work with other sub board committees where KLOE are not within the oversight of the quality committee but are within others and ensure clear reporting for board assurance

**Report Author**
Patrick McCormack – Head of Regulation and Deputy Head of Clinical Governance

# Board of Directors Meeting in Public - Cover Sheet

| Subject: | Quality Committee Annual Report | Date: May 2022 | |
|---|---|---|---|
| **Prepared By:** | Patrick McCormack – Head of Regulation and Deputy Head of Clinical Governance | | |
| **Approved By:** | Barbara Brady, Non- Executive Director and Committee Chair | | |
| **Presented By:** | Barbara Brady, Non- Executive Director and Committee Chair | | |

| **Purpose** | | | |
|---|---|---|---|
| To provide assurances the Quality Committee is performing its responsibilities as set out within its Terms of Reference. | **Approval** | | |
| | **Assurance** | X | |
| | **Update** | | |
| | **Consider** | | |

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

| **Overall Level of Assurance** | | | | |
|---|---|---|---|---|
| | **Significant** | **Sufficient** | **Limited** | **None** |
| | | X | | |

| **Risks/Issues** | | | | |
|---|---|---|---|---|
| **Financial** | | | | |
| **Patient Impact** | | | | |
| **Staff Impact** | | | | |
| **Services** | | | | |
| **Reputational** | The Annual Report is an element of overall Trust governance arrangements. Failure to apply agreed governance arrangements could result in significant reputational consequences. | | | |

| **Committees/groups where this item has been presented before** |
|---|
| **This report has been approved in its current form by the Quality Committee prior to board** |

| **Executive Summary** |
|---|
| This report provides a description of the activities and assurance that the Quality Committee has carried out its obligations in accordance with its terms of reference and work programme for the 2021 calendar year. |
| It provides assurances and synopsis on activity undertaken throughout the year objectives for the 2022 year. The time period is aligned to the annual governance timetable to enable consideration by the Board of Directors, and to support the Annual Governance Statement. |

**Annual Report from the People, Culture & Improvement Committee**

Summary

This report provides a summary of People, Culture and Improvement Committee activities and assurance that the Committee has carried out its obligations in accordance with its Terms of Reference and work programme for 2021.

The time period is aligned to the annual governance timetable to enable consideration by the Board of Directors.

This report provides an overview of activities undertaken throughout the Trust and a summary of the work undertaken within the People, Culture and Improvement Committee activities from January to December 2021.

Background

The People, Culture and Improvement Committee meets 6 times per year and reports to the Board of Directors.  Its Terms of Reference establish the following purposes:

- Review the BAF risks associated with workforce, culture and improvement and provide assurance to the Board that those risks are being effectively mitigated or managed in a controlled way.

- Provide the Board with assurance concerning all aspects of the Trusts workforce strategy and annual implementation plan, both in relation to delivery and impact.

- Where necessary, seek assurance into any areas of work related to workforce and culture on behalf of the Board.

- Assure the Board that the structures, systems and processes are in place and functioning to support the workforce in the provision and delivery of high quality patient care.

- Contribute to, oversight of and assurance from an SFH perspective, the People, Culture and Improvement Plan and plans of the ICS/ICP.

- In fulfilling its obligations, the Committee will be mindful of the need to improve the diversity of the workforce so that it better reflects the population which the Trust serves.

- The Committee shall review the Freedom to Speak Up agenda via quarterly assurance reports.

The Committee's membership is set out below:

- Non-Executive Director (Chair)
- Non-Executive Director
- Non-Executive Director
- Director of People
- Director of Culture & Improvement
- Medical Director
- Chief Nurse

In routine attendance:

- Head of Learning & OD
- Deputy Director of People
- Acting Head of Communications
- Head of Medical Workforce
- Head of Corporate Nursing
- Community Involvement Manager
- Head of Resourcing
- Associate Director of Service Improvement
- Head of Workforce Information
- Associate Director of Transformation
- Head of Operational Human Resources
- Equality, Diversity & Inclusion Lead
- Risk and Assurance Manager
- Workforce Analytics Manager
- Operational Development and Network Manager

2 Staff governors are also invited to attend as observers.

Other Directors and Managers have attended meetings in accordance with the People, Culture and Improvement Committee work programme and/or in response particular work being identified.

Meetings

Meetings shall be held not less than four times a year and where appropriate should coincide with key dates in the quarterly reporting cycle. A development session shall also be held not less than annually.

Attendance of core members (or a nominated deputy) at meetings during the period covered by this report is detailed below:

| | |
|---|---|
| Non- Executive Director (Chair) | 6/6 |
| Non-Executive Director | 6/6 |
| Non-Executive Director | 5/6 |
| Director of People | 5/6 |
| Director of Culture and Improvement | 6/6 |
| Medical Director | 4/6 |

Chief Nurse                                                4/6

Attendance of officers in routine attendance

   Deputy Director of Training, Education, Development 3/4
   Deputy Director of Human Resources    4/6
   Acting Head of Communications     3/6
   Head of Medical Workforce      6/6
   Head of Corporate Nursing      1/6
   Community Involvement Manager    5/6
   Head of Resourcing        5/6
   Associate Director of Service Improvement  3/6
   Head of Operational Human Resources   6/6
   Risk and Assurance Manager     6/6

One staff governor attended 4 out of the 5 meetings and further staff governor attended 2 out of 5 of the People, Culture and Improvement Committee during the year as an observer.

Work Programme

The Committee has received regular reports throughout the year in accordance with its agreed Annual Work Programme. Reports are received at each meeting from the Director of People, Director of Culture and Improvement, Medical Director and Chief Nurse in relation to workforce risks and the Workforce Board Assurance Framework. In addition, assurance and highlight reports are provided on an ad hoc basis.

The Committee has also received reports on other specific risk-related matters, including:

- Nursing Safe Staffing Report
- Staff Safe Staffing – Medical Staffing Report
- Communications Report
- Volunteer Report
- Employee Relations Assurance Report
- Leadership and Culture Update
- Training, Education and Development Update
- Raising Concerns Update
- Medical Education Update
- Flu Campaign
- Equality and Diversity Assurance Report

Horizon Scanning

The People, Culture and Improvement Committee identify and review any risks and work plans which are on the horizon. The following are the main areas identified:

- NHS People Plan
- WRES and WDES data and national reporting

- Written statement of employment particulars
- COVID-19 Vaccinations
- NHS Pension Scheme changes and implications of the Annual and Lifetime allowance.

All of the above have been added to the appropriate action plans and any risks, mitigation plans are in place.

Positive Stories

At the beginning of each People, Culture and Improvement Committee meeting positive stories and achievements are shared and identified. Throughout the year these have included:

- The Trust recruited to a dedicated Equality, Diversity & Inclusivity (EDI) Lead.
- The national network Proud2bOps won the HSJ Partnership 'Workforce Innovation' Award.
- SFH Colleague Welfare and Wellbeing offer was shortlisted in the 2021 HSJ Patient Safety Awards in the category 'Mental Health Initiative' of the year.
- Nottingham and Nottinghamshire ICS: Mass Vaccination Team was shortlisted for a Healthcare People Management Association (HPMA) Award in the category for 'Cross-sector Working'.
- SFH was shortlisted for the Culture Pioneers award following the Trust's collaborative approach around wellbeing and welfare over the past 12 months and the Trust's approach to continuous improvement.
- SFH's Rostering Team were finalists in the Allocate awards.
- SFH was a finalist and came second place in the Healthcare People Management Association (HPMA) awards which took place in September 2021 for the collaborative work regarding vaccinations.
- SFH had two entries in the 2021 Health Service Journal (HSJ) National awards. These entries relate to work undertaken by Proud2bOps and the work undertaken by the Climate Action Team which aligns to SFH's culture.
- SFH was shortlisted for three Nursing Times awards, these awards relate to the real time management of oxygen during Covid-19, high volume service-user services, and the development of an End of Life (EOL) ward during the pandemic.

A summary report developed and presented to the Board of Directors

Board Assurance Framework Risks

The People, Culture and Improvement Committee monitors the Board Assurance Framework (BAF) workforce and improvement risks.

The principal risks on the BAF reviewed by the People, Culture and Improvement Committee are;

Workforce capacity and capability

- Inability to attract and retain staff

- A significant loss of workforce productivity arising from short-term reduction in staff availability or a reduction in effort above and beyond contractual requirements
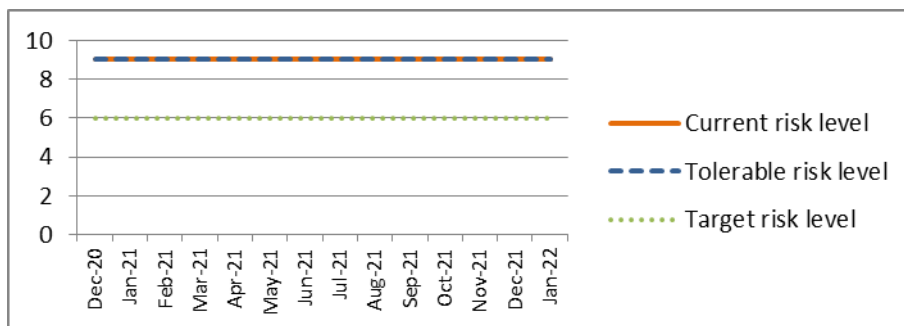
Improvement and innovation

- Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients

The below graphs identify the current risk level, tolerable risk level and target risk level for each of the BAF risks.
Workforce capacity and capability
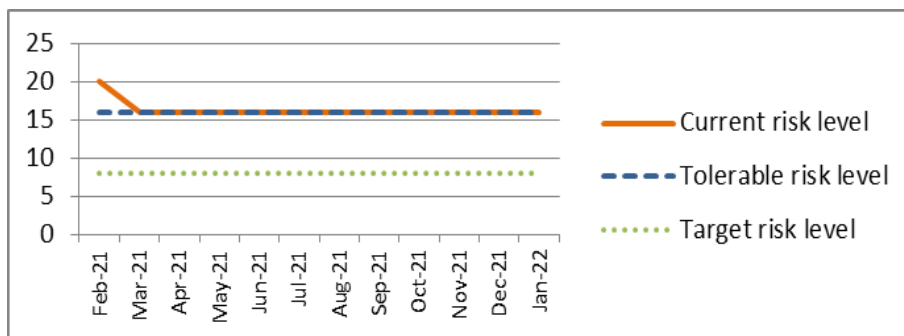


Improvement and innovation



People Culture and Improvement Plan

The Trust had introduced a 1-year People, Culture and Improvement Plan capturing 2021/22 and was implemented with effect from April 2021.

The plan was developed to enable to support the recovery from the global COVID-19 pandemic and an opportunity for any further strategy to be aligned to the NHS People Plan that's publication was delayed.

The focus of the Plan was to develop and introduce aspects of high impact under the themes and topics that are aligned

- People Health Wellbeing and Welfare

- People Practices
- People Development
- People Equality Inclusion and Diversity
- People Resourcing and Retention
- Culture and Engagement
- Improvement and Learning

Over the last quarter of 2021/22 the Committee has focused on developing a 3 year People, Culture and Improvement Plan, that will be underpinned by the NHS People Plan, and the NHS People Promise.

Safe Staffing Nursing and Medical

*Nursing*

The Chief Nurse has presented bi-monthly staffing report to provide an overview for Nursing, Midwifery and Allied Health Professional staffing and compliance within the Trust with the National Institute for Clinical Excellence (NICE) Safe Staffing, National Quality Board (NQB) Standards and the NHS Improvement Workforce Safeguards guidance.

The reports presented provided assurance of the staffing availability over the previous six months and process with assessing acuity and dependency for patients on ward areas. The information and data presented will support the review of the Nursing and Midwifery establishment reviews for 2021/2022.

The Chief Nurse will present the Nursing and Midwifery establishment review to the Committee and will continue to present reports to provide an overview and assurance regarding the staffing and safety compliance of the Nursing, Midwifery and Allied Health Professional workforce.

*Medical*

The Medical Director's provides bi-monthly Medical Staffing Report which highlights the main challenges and difficulties experienced during the ongoing challenges associated with COVID-19 surge.

In order to respond to the challenges new rotas have been designed for all grades of doctors to ensure that there is sufficient support in the Trust to manage the situation. Assurance has been provided to the Committee in terms of number of doctors, the escalation process in place where there are concerns and the support that is in place for junior doctors in respect of the guardian of Safe Working and the Leadership Registrars.

The reports have presented external factors relating to COVID-19, including restrictions on international travel etc. have impacted on the availability of doctors, particularly related to the Trust's successful Clinical Fellow programme.  This has resulted in increased usage of Bank and Agency locum Doctors.

The Committee has also received quarterly reports providing assurance on the Doctor's appraisal and revalidation process and compliance.

Overall, the reports from the Medical Director have provided assurance the work being undertaken in relation to the Medical Workforce provides safe and effective care to patients while supporting and maintaining the well-being of the Trust's medical staff.

Across 2021 the Medical Director also presented reports to the Committee with the aim of providing assurance regarding the work undertaken to support the Medical Workforce and confirm compliance with GMC, Health Education England and NHS England/Improvement guidance and standards.

Equality and Diversity

The People, Culture and Improvement Committee has received regular reports with an update on the achievements, progress and developments in relation to the Equality, Diversity and Inclusivity agenda at Sherwood Forest Hospitals NHS Foundation Trust.

The Committee has had assurance the Trust has met its statutory duties as outlined in the Equality Act 2010. The Committee has also been presented with the following information prior to being published in line with statutory requirements

- Diversity and Inclusivity Report
- Workforce Race Equality Standards (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender Pay Gap Report

Over the past year the Trust has celebrated some key Equality and Diversity events including the Trust's PRIDE march in July 2021 Black History Month in October 2021 and Disability History Month in November.

The Trust has really focused on our inclusion agenda as part of ensuring Sherwood is a Great Place to Work for everyone.

While assurance was obtained from the reports and evidence presented to the Committee in 2021, it is recognised there is still significant work to be taken forward in relation to this agenda.

Key actions include increasing diversity reporting amongst staff, continuing to ensure compliance with reporting duties, and increasing knowledge of the Diversity agenda across the Trust.

Volunteer Services

Across the reporting period the Committee were provided with regular updates regarding the invaluable support to a variety of clinical and non-clinical services across all of our three sites.  Each of the reports demonstrated how our volunteering

service play an important role and part in the variety of services that are delivered across the Trust.

Strategic Workforce Plan

The Committee received the overarching Strategic Workforce Plan identifying a workforce baseline as at 2021 and how through workforce assumptions the workforce profile across the Trust will change across the next 3-5 years. The baseline has informed future strategy and how through collaboration known workforce challenges can be mitigated.

Freedom to Speaking Up

Effective speaking up arrangements protect patients and improve the experience of NHS Workers. All staff, but specifically all executive directors have a responsibility for creating a safe culture and an environment which workers are able to highlight problems and make suggestions for improvement.

The Trust's Freedom to Speak Up Guardian has provided assurance reports to the Committee which highlighted additional uptake in 2021 compared to 2020, there has been an increase in the number of concerns raised. The increasing number of concerns is positive and provides assurance about the effectiveness of the Freedom to Speak Up Guardian role and the Freedom to Speak Up Champions.

The most prevalent findings from the reports presented is that 'bullying and harassment' and  bullying type behaviours from line managers or senior managers within departments was the most common concern raised by staff. As a result of this the Committee has received reports and evidence from the Director of Culture and Improvement about focused work which has been facilitated to support the reduction of bullying and harassment within the Trust.

A Freedom to Speak Up strategy has been developed; this has been developed in line with the Trust Objective and Strategies and in line with the NHS People Plan. The objectives of the Freedom to Speak Up strategy are;

- Create the right conditions for all our staff to speak up
- Enabling our leaders to connect with staff and be responsive
- Take learning and improve the quality of services for staff and patients.

The People, Culture and Improvement Committee has received assurance throughout the year in relation to the Freedom to Speak Up agenda and also supported the development and implementation of the strategy.

People and Inclusion

At each meeting the Director of People has presented an assurance paper on the people and inclusion agenda.

The papers presented have provided assurance that all Human Resources Policies are compliant with best practice and employment law.

In addition, the Committee has been kept up-to-date regarding the COVID-19 pandemic and measures the government has announced to support the reduction in the spread of the virus and also protect those who are extremely clinically vulnerable. This has included the implementation of self-isolation and self-shielding.

It has been recognised as a result of these national measures the Trust has experienced an increase in workforce loss related to sickness and COVID-19 related absences. The Committee have been assured the Trust has implemented all national measures which have been implemented in response to the pandemic and associated workforce loss and have also implemented support mechanism for staff who have absence.

The below graph highlights the sickness absence analysis which show the increased in sickness corresponds to the COVID-19 pandemic surge.
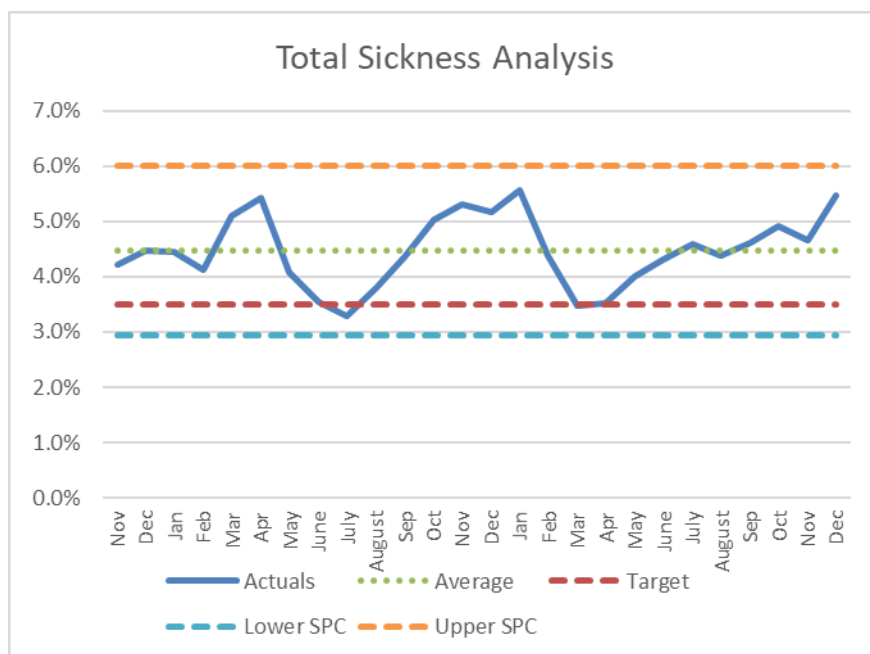


The Trust's annual flu campaign continues to be a tangible success for the Trust. In 2020/21 86.7% of front-line workers had the vaccine. In 2021/22 figure was 75.6%. The Committee had significant assurance in relation to the annual flu campaign.

The =Committee also received updates regarding the implementation of the Trust's Employee Assistant Provision (EAP), the completion of COVID-19 risk assessments and resourcing and were assured by the work facilitated to support the people and inclusion agenda.

Culture and Improvement

The Committee has received regular reports and evidence from the Director of Culture and Improvement and Director of People regarding culture, improvement and organisational development. These reports have given assurance to the Committee

on key culture and improvement metrics and provided narrative on the actions which have been undertaken.

During the COVID-19 pandemic, some of the performance matrix have slipped, including appraisals and mandatory and statutory training, this is as a result of pausing elements of these matrix within the Trust to ensure core services and care to patients remains safe.

The below graph outlines mandatory training compliance from November 2019 to December 2021
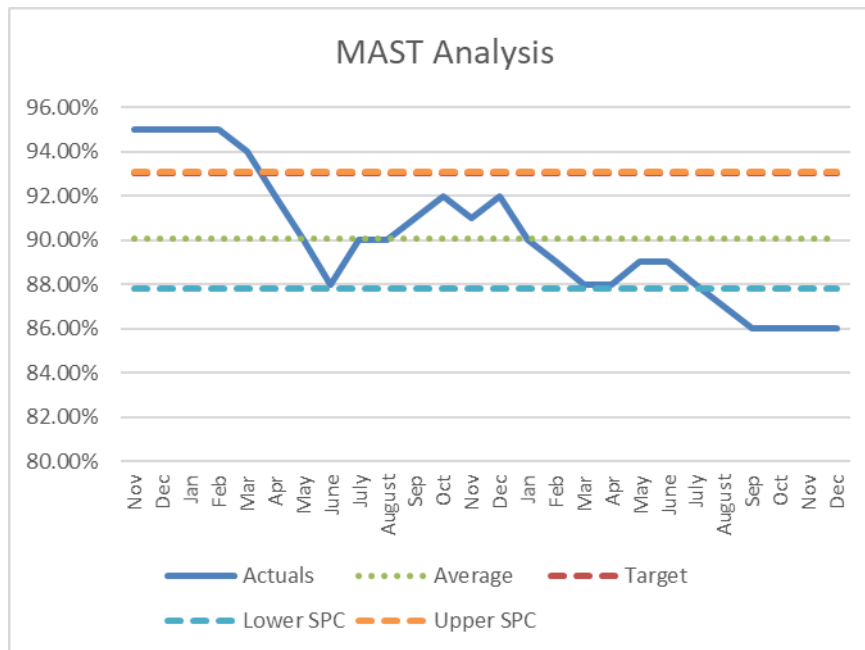


The below graph outlines appraisal compliance from November 2019 to December 2021
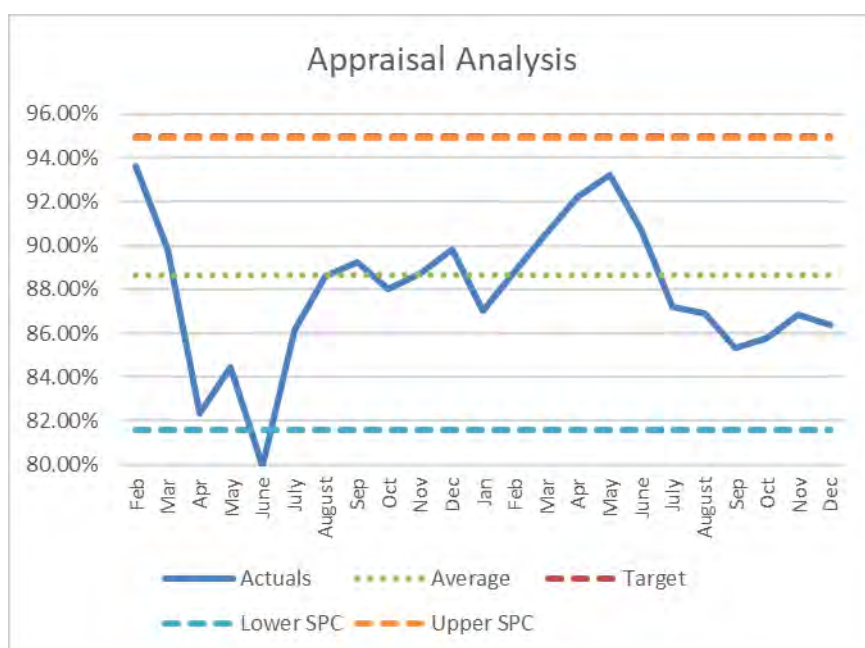
The Committee have been provided evidence of the welfare and well-being initiatives and programmes which have been implemented to support staff during the pandemic. This has included food provisions, a well-being den, the appointment of a Welfare and Wellbeing Specialist, Psychological Support via Nottinghamshire Healthcare NHS Foundation Trust etc. The effectiveness of these initiatives has been measured via pulse surveys and the results have shown a positive response to the support offered by the trust as outlined below.



1. How well has SFH supported you since the start of Covid-19?

Overall Meridian score for this question: 75.29% (based on 1193 responses)
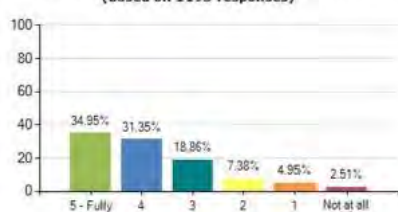
75.29% of colleagues registering a positive response to the question 'How well has SFH supported you since the start of Covid-19'?

It is important to note the effects of the COVID-19 pandemic will be significant and therefore the focus on the welfare and well-being agenda will have an emphasis on physical health, healthy behaviours and mental and psychological well-being and support.

During 2021 the Committee has gained assurance in relation to the culture and improvement agenda and noted the work which has been undertaken and achieved.

In 2022 the People, Culture and Improvement Committee will continue to be provided with updates on the following areas related to culture and improvement;

- Training, Education and Development including Mandatory and Statutory Training and Appraisals
- Welfare and Well-being
- Improvement and transformation
- Engagement, leadership and recognition
- Colleague recognition
- National NHS Staff Survey

Conclusions

The Committee has a challenging and substantial work plan and agenda seeking assurance regarding the development, delivery and impact of the Trust's workforce strategy and plan. In addition, the Committee also seeks assurance concerning organisational development activity undertaken to promote and embed effective organisation culture.

Although 2021 has been demanding and tough, the Committee has gained assurance in relation to the work undertaken in relation to the workforce agenda.

**Board of Directors Meeting in Public**

| Subject: | People, Culture, and Improvement Committee Annual Report | Date: 5th May 2022 | |
|---|---|---|---|
| Prepared By: | Rob Simcox, Deputy Director of HR | | |
| Approved By: | Manjeet Gill, Non-Executive Director (Chair of People Culture and Improvement Committee) | | |
| Presented By: | Manjeet Gill, Non-Executive Director (Chair of People Culture and Improvement Committee) | | |

| Purpose | | | |
|---|---|---|---|
| To provide assurance the People, Culture & Improvement Committee is performing its responsibilities as set out within its Terms of Reference and a summary of activities performed across 2021 | | Approval | |
| | | Assurance | |
| | | Update | |
| | | Consider | |

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

| Overall Level of Assurance | | | | |
|---|---|---|---|---|
| | Significant | Sufficient | Limited | None |
| | | x | | |

| Risks/Issues | | | | |
|---|---|---|---|---|
| Financial | Improving productivity and workforce utilisation and impact | | | |
| Patient Impact | Maintain safe staffing levels and a good patient experience | | | |
| Staff Impact | Improve working lives | | | |
| Services | Staffing levels impact service and bed availability | | | |
| Reputational | SFH recommended as a great place to work | | | |

| Committees/groups where this item has been presented before |
|---|
| Item present and approved at the January People, Culture & Improvement Committee |

| Executive Summary |
|---|
| This report provides a summary of People, Culture & Improvement Committee activities and assurance that the Committee has carried out its obligations in accordance with its terms of reference and work programme for the 2021 calendar year. |