Sherwood Forest Hospitals NHS Foundation Trust

MEETING OF THE BOARD OF DIRECTORS IN PUBLIC

AGENDA

Date: Thursday 9th June 2022
Time: 09:00 – 12:30
Venue: Boardroom, King's Mill Hospital

	Time	Item	Status	Paper
1.	09:00	**Welcome**		
2.		**Declarations of Interest** To declare any pecuniary or non-pecuniary interests not already declared on the Trust's Register of Interest **:-** https://www.sfh-tr.nhs.uk/about-us/register-of-interests/ *Check – Attendees to declare any potential conflict of items listed on the agenda to the Director of Corporate Affairs on receipt of agenda, prior to the meeting.*	Declaration	Verbal
3.		**Apologies for Absence** Quoracy check: *(s3.22.1 SOs: no business shall be transacted at a meeting of the Board unless at least 2/3rds of the whole number of Directors are present including at least one ED and one NED)*	Agree	Verbal
4.	09:00	**Minutes of the meeting held on 5th May 2022** 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** • **Council of Governors highlight report** Report of the Chair	Assurance Assurance	Enclosure 6 Enclosure 6.1
7.	09:15	**Chief Executive's Report** • **Integrated Care System Update** Report of the Chief Executive • **Covid Vaccinations Update** Report of the Director of People	Assurance Assurance Assurance	Enclosure 7 Enclosure 7.1 Enclosure 7.2
	Strategy			
8.	09:30	**Strategic Priority 1 – To provide outstanding care** • **Maternity Update** Report of the Chief Nurse o **Ockenden Report** o **Safety Champions update** o **Maternity Perinatal Quality Surveillance Model**	Assurance	Enclosure 8.1
9.	09:40	**Strategic Priority 2 – To promote and support health and wellbeing** • **Guardian of Safe Working** Report of the Guardian of Safe Working	Assurance	Enclosure 9.1

	Time	Item	Status	Paper
10.	09:55	**Strategic Priority 3 – To maximise the potential of our workforce** • **Equality and Diversity Annual Report** Report of the Director of People • **People, Culture and Improvement Strategy** Report of the Director of People and the Director of Culture and Improvement	Assurance Approve	Enclosure 10.1 Enclosure 10.2
11.	10:15	**Strategic Priority 5 – To achieve better value** • **PBP Full Year update** Report of the Chief Executive Officer • **ME2 Pathology Strategic Outline Case (SOC)** Elaine Torr, Divisional General Manager for Networks and Collaboration	Assurance Approve	Enclosure 11.1 Enclosure 11.2
12.	10:35	**Patient Story – Targeted Lung Health** June Morley, Lung Cancer Nurse Specialist	Assurance	Presentation
	BREAK (10 mins)			
	Operational			
13.	11:05	**Single Oversight Framework Performance – Monthly Report** Report of the Executive	Consider	Enclosure 13
14.	11:45	**Board Assurance Framework (BAF)** Report of the Chief Executive	Approval	Enclosure 14
	Governance			
15.	11:55	**Infection Prevention and Control BAF** Report of the Chief Nurse	Assurance	Enclosure 15
16.	12:05	**Assurance from Sub Committees** • Finance Committee Report of the Committee Chair (last meeting) • Quality Committee Report of the Committee Chair (last meeting)	Assurance Assurance	Enclosure 16.1 Enclosure 16.2
17.	12:15	**Committee ToR, workplans and effectiveness reviews** Report of the Director of Corporate Affairs	Assurance	Enclosure 17
18.	12:20	**Communications to wider organisation** (Agree Board decisions requiring communication to Trust)	Agree	Verbal
19.	12:25	**Any Other Business**		
20.		**Date of next meeting** The next scheduled meeting of the Board of Directors to be held in public will be **7th July 2022, Boardroom, King's Mill Hospital**		
21.		**Chair Declares the Meeting Closed**		

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

Board of Directors Information Library Documents

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

Enc 13	• **SOF Dashboard**
Enc 14	• **Significant Risks report**
Enc 16.1	• **Finance Committee – previous minutes**
Enc 16.2	• **Quality Committee – previous minutes**
Enc 17	• **Audit and Assurance Committee - TOR**
Enc 17	• **Audit and Assurance Committee – Workplan**
Enc 17	• **Finance Committee – TOR**
Enc 17	• **Finance Committee – Workplan**
Enc 17	• **Quality Committee – TOR**
Enc 17	• **Quality Committee - Workplan**
Enc 17	• **People, Culture and Improvement Committee – TOR**
Enc 17	• **People, Culture and Improvement Committee - Workplan**
Enc 17	• **Charitable Funds Committee – TOR**
Enc 17	• **Charitable Funds Committee - Workplan**

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

UN-CONFIRMED MINUTES of a Public meeting of the Board of Directors held at 09:00 on Thursday 5th May 2022 in the Boardroom, King's Mill Hospital

Present:	Claire Ward	Chair	CW
	Manjeet Gill	Non-Executive Director	MG
	Graham Ward	Non-Executive Director	GW
	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
	Andy Haynes	Specialist Advisor to the Board	AH
	Paul Robinson	Chief Executive	PR
	Richard Mills	Chief Financial Officer	RM
	Julie Hogg	Chief Nurse	JH
	David Selwyn	Medical Director	DS
	Emma Challans	Director of Culture and Improvement	EC
	Simon Barton	Chief Operating Officer	SiB
	Marcus Duffield	Associate Director of Communications	MD
In Attendance:	Rob Simcox	Deputy Director of People	RS
	Sue Bradshaw	Minutes	
	Danny Hudson	Producer for MS Teams Public Broadcast	DH
	Sarah Seddon	Maternity Parents' Voice Champion	SS
	Alison Steel	Head of Research and Innovation	AS
Observers:	Robin Binks	Deputy Chief Nurse	
	Sue Holmes	Public Governor	
	Isobel Carpenter		
Apologies:	Clare Teeney	Director of People	CT
	Shirley Higginbotham	Director of Corporate Affairs	SH

Item No.	Item	Action	Date
18/391	**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. Noting that due to the circumstances regarding Covid-19 and social distancing compliance, the meeting was held in person and was streamed live. This ensured the public were able to access the meeting. The agenda and reports were available on the Trust Website and the public were able to submit questions via the live Q&A function.		
18/392	**DECLARATIONS OF INTEREST**		
1 min	There were no declarations of interest pertaining to any items on the agenda.		
18/393	**APOLOGIES FOR ABSENCE**		
1 min	Apologies were received from Clare Teeney, Director of People and Shirley Higginbotham, Director of Corporate Affairs. It was noted Rob Simcox, Deputy Director of People, was attending the meeting in place of Clare Teeney.		
18/394	**MINUTES OF THE PREVIOUS MEETING**		
1 min	Following a review of the minutes of the Board of Directors in Public held on 7th April 2022, the Board of Directors APPROVED the minutes as a true and accurate record.		
18/395	**MATTERS ARISING/ACTION LOG**		
1 min	The Board of Directors AGREED that actions 18/195.1, 18/195.2 and 18/366 were complete and could be removed from the action tracker.		
18/396	**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, advising the newly elected governors have now completed their induction and have taken up their roles. The Board of Directors were ASSURED by the report		
18/397	**CHIEF EXECUTIVE'S REPORT**		
5 mins	PR presented the report, highlighting the continuing high demand for the Trust's services, which led to the declaration of a critical incident on 12th April 2022. It was acknowledged this is the last Board of Directors meeting for Julie Hogg, Chief Nurse, before she leaves SFHFT to take up her new role at University Hospitals, Leicester. Thanks were expressed to JH for her work during her time at SFHFT.		

	AR queried what actions could be taken forward into Winter from the learning from the critical incident in order for the Trust to be better prepared. SiB advised there were three elements to deal with the incident, namely the opening of additional capacity, pausing of elective surgery and increasing supportive discharges. The main area to take forward is the increase in supported discharges and to work with partners to make this more sustainable for the future. PR advised the Integrated Care Board (ICB) Chief Executive Designate held daily meetings throughout the incident and holds weekly meetings with all partners across the system. It has been agreed there will be a lessons learnt discussion in that forum. The Board of Directors were ASSURED by the report		
3 mins	**Integrated Care System (ICS) Update** PR advised the Health and Care Bill has now received Royal Assent. This confirms the establishment of the Integrated Care Board and Integrated Care System (ICS) on 1st July 2022. There were some amendments made during the final stages of the Bill, namely an additional NHS Provider partner member of the ICB to represent mental health. In Nottinghamshire, the designate appointments of the officers of the ICB is complete. In terms of Provider Collaboratives, KPMG have been commissioned to carry out a piece of work to identify the opportunities and key focus for the collaborative. This work will take place in May and into June 2022. The Board of Directors ACKNOWLEDGED the update		
8 mins	**COVID-19 Vaccination Update** RS presented the report, advising over 210k vaccines have been administered through the Hospital Hub. The Hospital Hub has now relocated from the Education Centre to the ground floor of TB3. The Board of Directors acknowledged the support provided by colleagues in the Education Centre in hosting the Hospital Hub. Plans continue to be shaped to deliver anticipated further boosters in Autumn 2022. BB noted the report does not contain a breakdown of staff uptake of the vaccination by division and staff group. BB felt it would be useful for reports in the Autumn to also show uptake of the flu vaccination. RS advised data in relation to staff uptake of the vaccination is included in the Single Oversight Framework (SOF) report. Consideration is being given to the co-administration of flu and Covid vaccinations in the Autumn. AH requested an update on uptake of the vaccination within the local population, particularly in terms of the harder to reach areas where people may not yet have had their first doses. In addition, AH requested an update in relation to the booster programme in care homes. RS advised he did not have the figures to hand but this information could be included in the report for June 2022.		

	Action • **Information in relation to uptake of the Covid vaccination across Nottinghamshire, including the booster programme, to be included in future Covid vaccination reports** AR noted the number of Did Not Attends (DNAs) and queried if any consideration had been given to an awareness campaign highlighting wasted resources, etc. RS advised DNAs are generally due to people being vaccinated elsewhere and not cancelling their appointment. The Trust is trying to raise the profile of the importance of notifying the Hub if an appointment needs to be cancelled. The vaccine offer has been made as easy as possible and people do not need to book an appointment. DS advised there was some communication about booking for a vaccine at the same time as the Hub opened up for walk-ins and felt these two messages were counterproductive as people did book but then did a walk-in elsewhere for their vaccination. SiB advised there has been an increase in DNAs for outpatients as deprivation deepens. DS advised the Trust tried to push the vaccine bus into areas of deprivation. The Board of Directors were ASSURED by the report	**CT**	**09/06/22**
18/398	**REFLECTIONS ON OCKENDEN**		
22 mins	SS joined the meeting SS gave a presentation detailing some reflections on the Ockenden Report and outlining her own experience as a bereaved mother. CW thanked SS for sharing her story. JH felt SS's story helped to bring Ockenden to life. SS's role as Maternity Parents' Voice Champion is a new role but she is already starting to amplify the voices of women and their families. PR expressed thanks to SS for sharing her story, acknowledging it was a difficult thing for her to do. It has helped the Board of Directors to understand what it feels like and what it means to families, rather than just reading reports. MG felt the story helped to highlight the human side of Ockenden. MG queried what further work can be done to listen to families where English may be a second language and where there may be cultural differences. SS advised work is in the planning stage but consideration is being given to the different groups in the community the Trust can reach out to. SS advised she is talking to people on the ward and offering advice in relation to the help available if women and their families are struggling to understand English. JH advised SS works closely with the Maternity Voices Partnership across Nottinghamshire.		

	StB felt it would be useful to encourage others to share their experiences with the Board of Directors and make requests of the Board as this adds impact and responsibility. GW felt this was a very moving presentation with SS putting the message across very well. There is a need to think about the human impact.		
18/399	**STRATEGIC PRIORITY 1 – TO PROVIDE OUTSTANDING CARE**		
11 mins	**Maternity Update** ***Ockenden Report update*** JH presented the report, advising the Trust is compliant with six of the seven immediate and essential actions arising from the initial Ockenden report. The national team will shortly be publishing all maternity units' compliance with the initial actions and SFHFT benchmarks well. There are a further 15 actions which the Maternity Assurance Committee is currently working through. The initial work evidences a lot of compliance but there is more work to do and some areas will require investment. The Board of Directors were ASSURED by the report ***Safety Champions update*** JH presented the report, highlighting the service user voice, Maternity Safety Champions walkaround, Maternity Forum, the lifting of visiting restrictions, smoking cessation service and the SCORE safety survey. SiB queried when the output of SCORE will be available and where this will be reported. JH advised the data will be reported through the Maternity Assurance Committee which will feed up to the Quality Committee. StB felt this work is very midwife focussed, noting mothers to be will be in contact with other professions. StB queried if there is anything further which needs to be done to pick up issues in a different way. JH advised the walkarounds and maternity forum are open to all professionals. There is an obstetric presence and increasingly there is an aesthetic and theatre team presence. The walkaround on 4th May 2022 was at 9am and there were more members of the multi-professional team available to speak to. Membership of the Maternity Assurance Committee has been widened following Ockenden. There is varying attendance on the walkarounds and there needs to be a focus on increasing attendance. The Board of Directors were ASSURED by the report ***Maternity Perinatal Quality Surveillance*** JH presented the report, highlighting the Apgar score and an incident of moderate harm relating to a delay in a category one caesarean section.		

	MG noted a new system was implemented in April for the Friends and Family test, which may cause some disruption. Further information was sought in relation to this. JH advised the reporting is not yet available. However, it is anticipated the response rate will have reduced due to the transition to the new service. Text messages were unable to be sent for the first three weeks of April. The messages will go out, but they have been delayed. The Board of Directors were ASSURED by the report		
8 mins	**Quality Strategy** JH presented the report, advising there are four campaigns. In developing the strategy there was been wide engagement with the multi-professional teams. The strategy is consistent with the ICS Quality Strategy and has been approved by the Quality Committee. DS advised there are two key elements to the strategy, namely the open and transparent culture within the Trust and patient safety aspects. EC felt it important to keep listening, engaging, understanding, learning and improving. SiB felt it is key the individual strategies integrate with each other as improved culture leads to improved quality. PR noted the word listening is not included in the strategy. While not necessarily changing the wording, there is a need to consider how listening to patients and staff experiences is built into quality improvement strategies. DS advised the strategy includes a lot of references to learning. This could be changed to listening and learning. AH referenced previous discussions by the Board of Directors in relation to the cultural heat map. There is a need to consider how that is incorporated going forward. MG felt it would be useful to see more information in relation to equitable services. JH felt it would be helpful to get feedback from SS to ensure the strategy responds to the asks she made of the Board of Directors. Ways of measuring equity and health inequalities will be explored. This originated from the ICS work and, therefore, the Trust will be reporting on these aspects. The Board of Directors APPROVED the Quality Strategy SS left the meeting		
18/400	**STRATEGIC PRIORITY 3 – TO MAXIMISE THE POTENTIAL OF OUR WORKFORCE**		
22 mins	**Staff Survey and Action Plan** EC presented the report, advising the results are positive and show SFHFT is a highly engaged organisation. However, the impact of Covid is evident. Colleagues are tired and there has been an impact on training and development over the last two years. Three core themes have been identified as priorities namely, valuing you, caring for you and developing you.		

	A number of areas for focus have already been identified through the development of the People, Culture and Improvement Strategy. A number of priorities and measures of success have been identified for the coming 12 months. The Trust has taken a collaborative approach to communicating and engaging with colleagues in sharing the results and empowering divisions to take the results forward. AH queried if the Trust was looking to learn from other organisations who were performing better than SFHFT in terms of appraisals. EC advised a review has been undertaken of better performing organisations and buddying arrangements are being considered to enable the sharing of best practice. There is a national rollout of Scope for Growth, which the system is aligned with, and this is being developed into the talent management approach. SiB highlighted two areas of concern, namely staff working additional paid hours and not enough staff to do the job properly, noting the Trust has deteriorated more than the national change in these two areas. SiB felt there is a need to focus on these areas. EC advised there is a need to have a workforce plan which is heavily linked to recruitment and retention. In terms of working additional paid hours, there is a need to understand if this relates to colleagues who are also on the Bank as this may underlie the figure for working additional paid hours. CW noted the deterioration in the number of people who are thinking of leaving the Trust. It is not clear if this relates to staff who are in jobs which are transferrable outside of the health sector or if they are healthcare professionals. A different approach is needed to these different staff groups and the challenges and opportunities which present to them in the local economy. RS acknowledged the last two years have been incredibly challenging for individuals and there is a need to consider how to empower staff and value their contributions and efforts. The Trust needs to have an understanding of what the workforce will look like over the next 3-5 years and put measures in place to enable conversations in relation to areas where there is fragility. In addition, there is a need to understand the workforce in its totality, recognising where bank and temporary opportunities have complimented some of the capacity challenges faced. If the system moves to the concept of provider collaboration, there is a need to consider how SFHFT can support partners as a future Bank is shaped and developed, which may be able to support some of the community services. AR queried if there was sufficient resource to deliver ‘caring for you’ and ‘developing you’ noting it would be useful to include an indicative monetary sum in future reports. ARB queried if the demographics of workforce and the risks associated with the various roles are considered, with advertising and work in relation to retention targeted accordingly. RS advised the workforce strategy will include a baseline of the current workforce demographic, including where they live, etc.		

	StB noted the changes to the membership of the Board of Directors and felt consideration and support should be provided to newer members of the Board of Directors so they feel well equipped to play their role in maintaining and/or improving performance. BB felt the Staff Survey is only part of the overall picture and queried how other intelligence is used during the year so there is nothing unexpected in the Staff Survey results. BB queried how this is built into monitoring systems. RM felt live monitoring and feedback is part of active listening and there is a need to ensure the right forums are in place to obtain feedback on a regular basis. Appraisals need to be personal, tailored conversations. EC advised the importance of having a good culture in the organisation is highlighted at the Trust's induction and there is a need to continually monitor this as a Board of Directors. The Trust is looking to strengthen the quarterly Pulse survey to gather additional feedback. The culture insights development work will triangulate information from complaints, incidents, Freedom to Speak Up, Pulse survey, etc. The Board of Directors were ASSURED by the report		
21 mins	**Nursing, Midwifery and Allied Health Professions (AHP) Staffing Annual Report** JH presented the report, highlighting the vacancy rate on the funded establishment, care hours per patient day, rollout of the Safer Nursing Care Tool, international recruitment, staffing challenges and risks within therapy services. There were 744 nursing and midwifery staffing related incidents over the year, all of which resulted in low or no harm. JH confirmed the workforce safeguards have been reviewed. GW sought further information in relation to the requested uplifts to ward establishments. JH advised the Safer Nursing Care Tool is run three times per year to assess the acuity and dependency of every patient on every ward for a month. Multipliers within the tool identify what the establishment should be. An average over the three months is taken and professional judgement applied in relation to issues such as what the ward layout looks like, how this triangulates with harm, patient experience and colleague experience, etc. This is a multi-professional review. JH advised approval is sought for an evidence based uplift which can be actioned within the existing 'envelope'. There is a further request for approval of uplifts which cannot be managed in the existing 'envelope' but there is assurance these are required as a result of the programme. The cost of this is £380k.		

	There are two wards currently operating outside of their usual speciality and bed base. These are Ward 43, as the Respiratory Support Unit (RSU), and the old Ward 21 which is funded for 16 beds but has not been within this bed base for over a year. The RSU has a higher nurse to patient ratio and is very reliant on temporary staffing. A strategic decision is required about the status of these wards. If they are to continue in their present form, an uplift of £1,063,994 is required to maintain this substantively. This is key to reducing agency spend. Finally there are some divisional requests where the division believe there is a need, but this does not form part of the evidence based ward establishment. These additional service improvement requests are being progressed via the service development business case route. GW advised he would expect to see business cases for second two asks (i.e. those relating to the RSU and Ward 21 and the divisional requests). JH confirmed approval is currently only being sought for the first two asks (the evidence based uplifts), with the second two as 'placeholders'. RM advised the first two requests are fully factored into the financial plans and divisional budgets for 2022/2023. The RSU and Ward 21 are included in current spending run rates. There is a need to go through a decision making process about the best use of the money which is already being spent and the best operational response to that capacity. This will go through the governance processes but has been factored in as operational costs within the financial plan. The final ask is subject to business cases and further review at a system level and is not factored into the financial plan. AH noted the risks in relation to AHP staffing and felt pharmacy is another risk area. AH advised he would like to see the same rigour applied to non-medical roles. BB felt consideration should be given to the use of new 'types' of roles, how they feature and how they address some of the gaps in competencies where traditionally solutions might have been sought from medicine, nursing or AHPs. RS felt there is a need for greater visibility of all staff groups and the Workforce Strategy will be split by staff group and have a greater focus on some of the smaller staff groups. There is a need to build on the workforce plan to understand what the workforce will look like in the next 3-5 years. This will inevitably identify some risks and there is a need to plan how to mitigate those risks and think about doing things differently. There is also a need to consider how strategic decisions are made in relation to investment. The Advancing Clinical Professionals (ACP) role will be an enabler to potentially mitigate some of the fragile services. EC felt it important the Trust does not lose sight of the administrative workforce as nationally there is equally a challenge recruiting to admin roles. The Board of Directors were ASSURED by the report and APPROVED the uplifts to ward establishments		

10 mins	**Medical Workforce Staffing** DS presented the report, highlighting medical appraisals, Clinical Fellows Programme, annual review of competencies, General Medical Council (GMC) revalidation, job planning, medical vacancies, Bank and agency expenditure, increase in medical trainees and medical staffing at Newark Hospital. AR sought clarification in relation to the 13 trainee vacancies quoted in the report. DS advised this figure has reduced compared to historical numbers. However, it is a concern as the Trust has to cover those vacancies with short term, expensive cover. Some of the vacancies are outwith the Trust's control and others are related to expansion. The Trust is working to close the gap. The Board of Directors were ASSURED by the report		
18/401	**STRATEGIC PRIORITY 4 – TO CONTINUOUSLY LEARN AND IMPROVE**		
16 mins	**Research Strategy – Annual Report** AS joined the meeting AS presented the report, highlighting recruitment, activity by speciality, finance, patient experience and highlights of 2021/2022. AH noted there are various pieces of work commencing in relation to health inequalities and felt the academic links may be interested in pursuing this. DS felt the study in relation to preparing patients may link into this. As the ICS going forwards includes Bassetlaw, this may provide an opportunity to link into Sheffield. AS advised this is something which can be explored. However, in terms of the Clinical Research Network (CRN), who are the overall funder and overseer for research, Bassetlaw still comes under Sheffield CRN, which may be a limiting factor. The Board of Directors were ASSURED by the report AS left the meeting		
18/402	**STRATEGIC PRIORITIES – QUARTER 4**		
4 mins	EC presented the report, highlighting the progress made in all priority areas and the alignment to strategies. MG queried what review process takes place at year end to look at what has and has not been achieved and why during the year and how this feeds into 2022/2023. MG noted the Innovation Hub is not currently taking place at a Mid-Nottinghamshire level and queried if some benefits are being lost if this is just within the Trust. EC advised in shaping the priorities for 2022/2023, the priorities for 2021/2022 have been taken into consideration to identify what areas remain a priority and for these to be built into 2022/2023. The Trust has identified what was delivered in 2021/2022 and what needs to continue.		

	In terms of the Innovation Hub, a bid has been submitted as part of a health foundation and it is hoped a new approach can be taken going forward. The plan is to build on a Provider Collaborative approach initially and then look to the wider system. It is hoped funding can be secured to mobilise this. The Board of Directors were ASSURED by the report		
18/403	**SINGLE OVERSIGHT FRAMEWORK (SOF) QUARTERLY PERFORMANCE REPORT**		
44 mins	**PEOPLE AND CULTURE** EC highlighted the increase in compliance with mandatory and statutory training, Staff Survey engagement work and the vision for continuous improvement. RS highlighted the staff wellbeing agenda, increase in non-Covid related absence, flu vaccination campaign, Covid vaccination uptake, portability of learning between organisations and recruitment microsite. **QUALITY CARE** JH highlighted falls and nosocomial Covid infections. DS highlighted Never Events and serious incidents, Hospital Standardised Mortality Ratio (HSMR), venous thromboembolism (VTE) and cardiac arrests. CW referenced the Never Events and queried what more can be done in terms of colleagues recognising the WHO checklists as a priority. DS advised the majority of Never Events reported are outwith the operating theatre environment, noting the WHO checklists were primarily developed for operating theatres. There are a series of modified WHO checklists for other areas and there is a need to ensure there is a consistent process and this is applied consistently. Sometimes distraction is a factor. For example, if an injection is being given in a shoulder, the consent and discussion about the procedure takes place facing the patient and the procedure is done behind the patient. It is useful for another member of staff to be present for them to double check before the procedure, but patients have been known to agree to procedures on the wrong site. CW queried if there is any work which can be done with patients to empower them to speak up. DS advised this can be considered but there is evidence to suggest patients agree to procedures on the incorrect site. AH queried if 'stop the line' incidents are measured. DS advised it is important to have a pause moment to confirm the right thing is being done to the right person at the right time. This is something the Trust encourages and is part of the education.		

	BB referenced the nosocomial Covid infections, noting a visitor came to the hospital knowing they were positive for Covid. The Trust can do everything possible to reduce and mitigate risk, but this was due to behaviour within the community. There is a need to communicate to the local population about the responsibility they have for their behaviour and how it puts patients and staff at risk. Due to lateral flow tests kits no longer being available for free, it is likely more people will come to the hospital who have Covid but do not know and this will impact on nosocomial infections. AH noted the number of medically fit patients is a contributory factor to the increased falls rate and queried how many of these patients have fallen. Noting the plans to discharge these patients to care home step down beds, is there a risk they will fall there and this risk is just passed on. JH advised the team has that data and will know how many patients who had a fall were deemed medically fit, but did not have the data to hand. However, they are generally patients waiting for interim care or to return to a care home. The number of Covid outbreaks in the community has led to in excess of 100 care homes being closed. The Trust does everything possible to get patients into the best physical condition possible before they go back to their care home or new home placement. The Trust will be passing the risk on, as the patients' risk of falling will be part of the reason they cannot live independently. SiB advised this cohort of patients are at a risk of falls wherever they are, but are at a lesser risk in their familiar home environment than they are in hospital. The important thing is for them to be in the right place. **TIMELY CARE** SiB advised the ED 4 hour wait was 80.2% in March, ranking SFHFT seventh in the NHS. The mean time in ED for an admitted patient was 24 minutes longer than it was in March 2020. 49 patients waited over 12 hours for admission to a bed, the majority of these were at the end of the month when ED attendances were high. A sample of these cases will be discussed at the Patient Safety Committee. 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, which reached a peak of 120 in March. There is a business case being worked through at system level in relation to investment in the social care workforce, which is key to the long term solution. The Trust continues to implement different ways of managing this group of patients. Despite the pressures, the Trust's ambulance turnaround times remain good and are the lowest in the East Midland Ambulance Service (EMAS) area. SiB advised the cancer backlog is now below 100 and the Trust is on track to achieve the target of 70 by March 2023. The current average wait for treatment is 6 days longer than it was before the pandemic. Demand has grown by 20%.		

	Demand and capacity work in relation to cancer is underway at a system level and this is due to report in the next couple of months. This will aid understanding of how cancer is diagnosed across Nottinghamshire. Cancer requires a system response as 70% of patients on a cancer pathway with SFHFT, will also receive treatment at Nottingham University Hospitals (NUH). Patients waiting over 100 days have regular contact with a nurse specialist who is able to bring them in if there are any concerns. AR felt people in deprived communities who have cancer are more likely to present late and have worse outcomes. AR noted the system work but felt this issue is more urgent and queried if there is anything the Trust can do to progress this. SiB advised internally the Trust could prioritise cancer. However, this will lead to an increase in routine waits. AR noted referrals have increased by 20% but what is not known is what percentage of those referrals will translate into cancer. SiB advised there is no greater yield. The proportional increase in cancers is in line with the referral increase. Every cancer referral has at least five interventions. Therefore, 1,000 more referrals equates to 5,000 more pieces of activity. Cancer patients are currently waiting only one week longer than before the pandemic. There is a sustained increase in demand. The key is to establish if the week extra wait makes a material difference to a patient's outcome. CW noted there are three specialities where cancer is particularly challenging in terms of waits. The other specialities will have a similar proportional increase in the number of cases. CW queried if there is any learning from those specialities. SiB advised the other specialties have lower numbers and, therefore, can consume a 20% increase as the number of interventions is still low. However, lower GI, for example, has a large number of referrals which translates to a large number of interventions. **BEST VALUE CARE** RM outlined the Trust's financial position at year end. The Board of Directors CONSIDERED the report		
18/404	**FIT AND PROPER PERSON**		
1 min	PR presented the report, advising the CQC Regulation 5, Fit and Proper Persons requirement, applies to all directors. A review of the personal files of all directors noted the evidence required to meet the requirements. The Board of Directors were ASSURED by the report		
18/405	**NHSI SELF CERTIFICATION**		
1 min	PR presented the report and advised this is an annual self-certification. This has previously been discussed by the Executive Team. There is no longer a requirement to submit the declaration to NHSI but it does need to be published on the Trust's website.		

	The Board of Directors APPROVED the declarations required by General Condition 6 and Continuity of Service Condition 7 of the NHS provider licence. The Board of Directors APPROVED the FT4 declaration		
18/406	**ASSURANCE FROM SUB COMMITTEES**		
8 mins	**Audit and Assurance Committee** GW presented the report, highlighting non-clinical policies and the interim Head of Internal Audit Opinion. The Audit and Assurance Committee Annual Report was noted **Finance Committee** ARB presented the report, highlighting Electronic Patient Record business case, review of Board Assurance Framework (BAF) and the system deficit position. The Finance Committee Annual Report was noted. **Charitable Funds Committee** StB presented the report, highlighting the Newark Breast One Stop Clinic. StB advised further discussion may be required by the Corporate Trustee in terms of the mechanism to review the circa £1m investment with Investec to ensure the money is invested in appropriate areas. GW advised Investec has been asked to provide further information in relation to the investments. **Quality Committee Annual Report** BB presented the report. The Quality Committee Annual Report was noted. **People, Culture and Improvement Committee Annual Report** MG presented the report. The People, Culture and Improvement Committee Annual Report was noted. The Board of Directors were ASSURED by the reports		
18/407	**OUTSTANDING SERVICE – EPMA - CREATING A SMARTER MORE DIGITAL HOSPITAL**		
7 mins	A short video was played highlighting the Electronic Prescribing and Medicines Administration (EPMA) system		

18/408	**COMMUNICATIONS TO WIDER ORGANISATION**		
2 min	The Board of Directors AGREED the following items would be distributed to the wider organisation: • Ockenden report reflections • Covid and Covid vaccinations • Research and innovation • Stop and think message for patients • Quality Strategy approval • Staff Survey action plan • Cancer waiting times		
18/409	**ANY OTHER BUSINESS**		
min	No other business was raised.		
18/410	**DATE AND TIME OF NEXT MEETING**		
	It was CONFIRMED the next Board of Directors meeting in Public would be held on 9th June 2022 in the Boardroom at King's Mill Hospital at 09:00. There being no further business the Chair declared the meeting closed at 12:40		
18/411	**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**		

18/412	**QUESTIONS FROM MEMBERS OF THE PUBLIC PRESENT**		
	No questions were raised.		
18/413	**BOARD OF DIRECTOR'S RESOLUTION**		
1 min	**EXCLUSION OF MEMBERS OF THE PUBLIC - Resolution to move to a closed session of the meeting** In accordance with Section 1 (2) Public Bodies (Admissions to Meetings) Act 1960, members of the Board are invited to resolve: "That representatives of the press and other members of the public be excluded from the remainder of this meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest." Directors AGREED the Board of Director's Resolution.		

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

PUBLIC BOARD ACTION TRACKER

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

Item No	Date	Action	Committee	Sub Committee	Deadline	Exec Lead	Action Lead	Progress	Rag Rating
18/334	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	P Bolton		**Update 15th March 2022** To be reviewed by the Quality Committee in May **Report presented to Quality Committee on 9th May 2022 - Complete**	Green
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
18/397	05/05/2022	Information in relation to uptake of the Covid vaccination across Nottinghamshire, including the booster programme, to be included in future Covid vaccination reports	Public Board of Directors	None	09/06/2022	C Teeney		**Update 26th May 2022** Addtional information to be inclulded in monthly vaccination report from 9th June onwards **Complete**	Green

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chair's Report	9th June 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.

#TeamSFH celebrates the Queen's Jubilee

Celebrations for the Queen's Platinum Jubilee were planned across all our sites over the extended bank holiday weekend and we have already had some fantastic feedback from the Lord Lieutenant of Nottinghamshire – the Queen's representative in the county – about #TeamSFH's appearance as part of a Health and Care Exhibition during May's Nottinghamshire County Show.

Thank you to everyone who represented us so brilliantly with displays of how our hospitals have developed over the past 70 years.

We are very much a part of the local communities we serve and our display at Newark Showground was particularly well-received.

We shared how we have evolved over the years from a number of hospitals on sites across Ashfield, Mansfield and Newark and Sherwood (many of them now closed but often fondly remembers) into the facilities we have today.

We have a fascinating video telling the story of the hospitals in our area and how they came together as today's Sherwood Forest Hospitals Trust.

New Governors welcomed

We formally welcomed our newly elected Governors to #TeamSFH during May.

Representing the public and staff, the Council of governors plays a key role in how we are run by holding the Trust to account for the services we provide, as well as helping us deliver quality care to our communities.

In addition to holding our Non-Executive Directors to account for the performance of the Board of Directors – that is, by making sure we are always working effectively and efficiently and in the best interests of all our colleagues and our patients – they are also a rich source of feedback so it is always helpful to listen to their views.

Key appointments for #TeamSFH

I am delighted to welcome Richard Walker to #TeamSFH as our new Clinical Digital Information Officer.

Richard moves into a new position, taking a leading role in the digitisation of our hospitals to make the care we provide smarter and safer. He joins #TeamSFH at an exciting time as we continue the rollout of our Electronic Prescribing and Medication Administration (EPMA) system – a huge step forward in our journey from being paper-based to fully electronic hospitals.

System-wide meetings and engagement

This will be our final board meeting before the new Integrated Care System takes on its statutory responsibilities from July 1.

Much work has been going on behind the scenes for many months now and will continue as the new ways of working for the Nottingham and Nottinghamshire health and care system develops and matures.

We will continue our collaborations with system partners to help to improve 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.

Proud2bAdmin Awards and International HR Day

During May we recognised the hard work and dedication of our administration and human resources teams. These are the people who are often unseen by our patients and the public but without them our hospitals simply wouldn't be able to function.

We received more than 200 nominations for our #TeamSFH Proud2bAdmin week. Congratulations to all of you, particularly the category winners.

Meanwhile, we thanked and praised our Human Resources team during International Human Resources Day (May 20), an opportunity for us all to recognise the invaluable contribution they play in attracting new people to #TeamSFH and retaining existing colleagues.

Charitable Trust and Volunteers

National Volunteers' Week took place recently and on behalf of the Trust Board I would like to express our thanks to the wonderful team of more than 400 dedicated volunteers who give their time to support our hospitals. I am proud of the resilience they have shown since the start of the pandemic. They have embraced the changes we have made to our ways of working and their dedication and kindness has made a big impact, not only on the patient care we deliver, but also in supporting #TeamSFH colleagues.

I was delighted to meet and thank many of our King's Mill volunteers last week and it was a great opportunity to present Margaret Langrick with her 25-year Long Service Award and Mary Heeley, a Newark volunteer, to be presented with her 35-year award.

It is my privilege to acknowledge our Sherwood Forest Hospitals Charity donors who have kindly donated in memory of loved ones to a range of specialities and departments across #TeamSFH, including:

- £16,600 of legacy funds have enabled the Charity to buy specialist photographic equipment, which identifies incision sites for dermatology procedures.
- Neo-natal Intensive Care Unit staff took part in fund-raising for World Prematurity Day last year and we have used £5,700 of the money raised to buy breast pumps for the department.

#TeamSFH Consultant appointments

I would like to welcome the following fixed-term consultant appointments to #TeamSFH:

- Mohamed Alshinnawy, a Specialty Doctor appointed to a Locum Consultant post in ED
- Divija Sannapareddy, a Specialty Doctor appointed to a Locum Consultant post in Critical Care.

Membership summary

We continue to work to improve membership from under-represented groups, particularly the under-50s, men and people from ethnic minorities. It is vitally important that we hear the voices from every part of our community and are doing some exciting work with local schools and colleges to raise our profile and increase representation from younger people. Our public membership total currently stands at 14,167.

Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Chief Executive's Report	**Date:** 9th June 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.

Responding to the Covid-19 pandemic

The Level 4 National Incident declared as part of our response to Covid-19 was stepped down to Level 3 in May and that is extremely good news for us all.

While it reflects the falling number of recorded cases of Covid-19 both in our hospitals and in the wider community we remain vigilant.

We will ease restrictions and the need to take precautions cautiously – the coronavirus remains with us and we need to continue to do everything we can to protect vulnerable people in our hospitals.

I would urge everyone visiting our sites: Please continue to wash your hands, wear a mask and maintain social distancing.

Our Executive Team Meeting and Quality Committee has reviewed all current guidance to ensure we remain compliant, and it is being applied consistently. We will keep the board updated.

We will continue to keep patients and visitors up –to date as things change. For the latest information, please visit our website's For Patients and Visitors page.

Leading the way on research to cut surgery recovery times

It was great to be able to celebrate all the fantastic work of our Research and Innovation Team as they celebrated with a week of events leading up to International Clinical Trials Day on May 20.

The celebrations culminated with the announcement we are launching the first multi-site randomised clinical trial to be led and sponsored by #TeamSFH.

Led by Dr Rebecca Barker, and following a successful evaluation, the research trial provides a digital clinic with one-to-one personal support to help patients make healthier lifestyle choices before and after operations.

This should help cut post-operative recovery times and support people to make longer lasting positive lifestyle choices, such as increasing exercise, reducing smoking and alcohol consumption and improving their diets.

This is a real credit to all involved and something that we should take pride in as we strive for healthier communities and outstanding care.

Another step along the road to fully digital care at #TeamSFH

It has been great to see the roll-out of our EPMA (Electronic Prescribing and Medicine Administration) system in May. Well done to all who have worked so hard to embrace new ways of working and thanks to the project team for their excellent work.

Once fully embedded, this will be a significant step in working differently and more safely for the benefit of our patients and as part of a more integrated health and care system.

#TeamSFH "an exemplar for acute medicine"

I was pleased to hear that #TeamSFH has been acknowledged as an exemplar for acute medicine by NHSEI's Getting It Right First Time (GIRFT) team.

GIRFT, the national, clinically-led programme designed to improve patient care within the NHS shares best practice and identifies changes that will improve patient outcomes, so it is no mean feat to be singled out in this way.

In fact, the GIRFT team has asked us to share our experiences at the launch of their National Report into Acute Medicine later this month. This reflects the excellent work across the Trust but particularly our Acute and Specialty teams in EAU (Emergency Assessment Unit), SDEC (Same Day Emergency Care) and SSU (Short Stay Unit).

We should all be proud that they will get the chance to showcase #TeamSFH on a national stage. Well done to all concerned.

Thank you for colleagues' response to TB3 incident

It was good to see such teamwork and co-operation between teams across the Trust following the incident when a car crashed into our TB3 building. The driver and a colleague in an office were treated in our Emergency Department and thanks go to all involved in the medical response.

But with initial fears that the building may have suffered structural damage and the crash might spark a fire, thanks should also go to our security team for working so swiftly to clear the building and make sure all colleagues in TB3 at the time were evacuated safely.

It was then good to see colleagues and partners, particularly our Estates Team, Skanska and Medirest, pulling together to ensure the building was safe and then get it back up and running so quickly.

Thank you for demonstrating how well we can react as a team in challenging circumstances.

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).

Mid-Nottinghamshire Integrated Care Partnership

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Single Oversight Framework

Reporting Period: Month 1

2022/23

Inspected and rated
Good
CareQuality Commission

Single Oversight Framework – Month 1 Overview (1)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Quality Care	During April 2022 we continue to experience crowding within the Emergency Department and additional inpatient capacity remaining open, alongside the opening of Sherwood Community Unit. Despite this, the experience of those accessing our services remains positive. 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 and response to C.diff. During April 2022 there are 5 exception reports: • **Falls:** The falls rate for April is 8.43, which remains above the national average of 6.63 with 2 individuals sustaining severe harm. Work is being undertaken by the falls team to reduce falls, with progress being made to reduce the number of repeat fallers. • **C.diff:** There have been 4 cases of hospital acquired C.diff in April. All patients received appropriate antibiotics. • **MRSA:** One patient has had a MRSA bacteraemia infection. This is the same patient as the case reported in February 2022. The source of this bacteraemia has been investigated and cannot be determined. • **VTE risk assessments:** Performance was 92.5% (YTD 93.2%). Target is 95%. GSU are working with the NerveCentre team to support the roll out of the electronic screening and supporting EAU with daily prompts. • **FFT:** April's Friends and Family inpatient test score was 94.7% against a standard of 96%. The existing providers contract ended in March 2022, with the new system requiring training to be provided to staff members, giving an understanding of the new system and its functions.	MD, CN

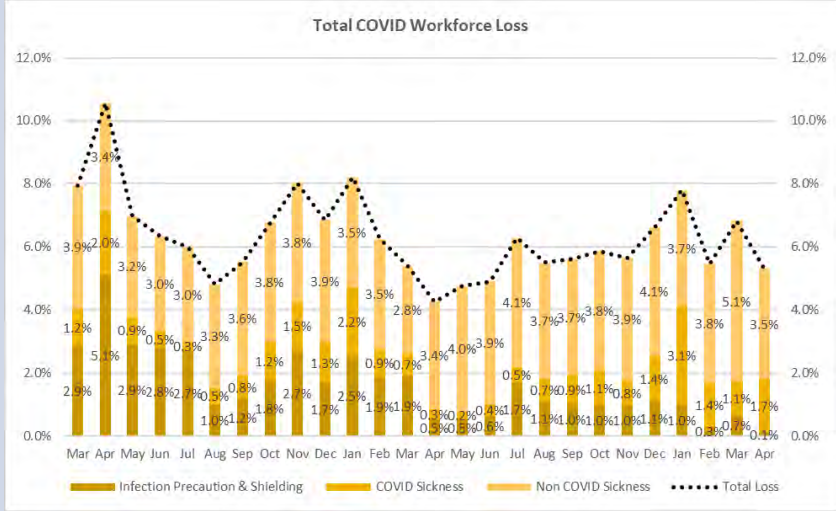
Single Oversight Framework – M1 Overview

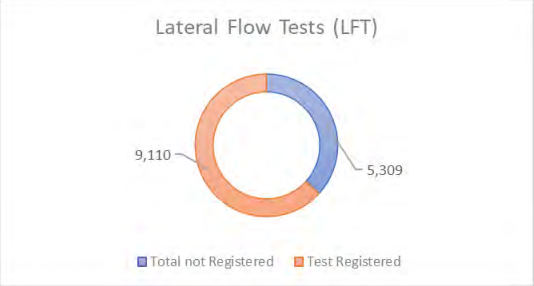
Domain	Overview & risks	Lead
People & Culture	**People** In M1 our sickness absence levels and overall workforce loss have shown a reduction from last month. The current sickness level is reported as 5.2% and had reduced from 6.2% in March 2022. This sits above the revised trust target (4%) and between the upper and lower SPC levels. The main reasons for sickness are reported as Chest and Respiratory problems and Stress and Anxiety. COVID is still a concern across the Trust with Chest and Respiratory the top reason for absence and the reason recorded. We have seen an increase in the number of Stage 2 meetings within the Trust which indicates an increased level of activity of sickness absence management. We are still seeing a high proportion of absences relating to stress and anxiety but our soft intelligence informs us this related to personal stressors outside of the workplace rather than work related reasons. Wellbeing support continues across the Trust and embedded within the divisions. Clinical Psychology support is now in place on a permanent basis for staff support. Divisional coaching and support for managers is in place with the People Partner team. Overall resourcing indicators for April 2022 are positive, our overall **vacancy's** show an increase, however this is an artificial increase due to the increase in establishment levels that have distorted the vacancy level Establishment increases are noted in Diagnostics and Outpatients and Women & Children's. **Improvement** The final report of the 360 review of Clinical Audit was formally received in April giving 'limited assurance' for Clinical Audit. It was recognised that the pandemic has had a significant impact on clinical audit activity and visibility, but that there were also internal governance issues to rectify. An action plan is in place and this is being reviewed on a monthly basis at senior level. Progress is being made to raise the visibility of the **SFH Continuous Improvement** approach within the PCI and the Quality strategy. A significant 'Transfer of Care' Improvement Programme is being scoped for launch in May, focussing on improving the patient pathway and experience from admission avoidance through to leaving the hospital to return home or to the community. This is sponsored by the Deputy Chief Operating Officer. **Cultural Engagement** 2021 Staff Survey results were released from embargo at the end of March 22. This identified 3 key themes for commitment to improve; **valuing you**, **caring about you** and **developing you**. Engagement was completed with all Divisional teams across April to determine priorities for improvement in each area, this information is currently being collated to help define actions. **Proud2bAdmin** Week was held during 25th-29th April to celebrate and recognise our colleagues in line with Admin Professionals Day (21st April) a variety of virtual events took place, including our first Proud2bAdmin Awards which had a great response (218 nominations). The quarterly pulse survey ran across April facilitated by our new provider Cisco – results and response rate are currently being analysed. **Learning and Development** Our **Mandatory Training and Development** compliance has marginally reduced and currently sits at 87%. This was expected as some training was cancelled due to site pressures and is part of an expected fluctuation that should settle quickly. Mandatory Training workbook reviews continued throughout April, 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, a new process was trialled in April to support this approach, introducing a 'Request for new workbooks' form which has been well received. We will also explore portability around learning from existing NHS Providers for new starts as part of their induction to the Trust. **Appraisals** levels have been relatively stable and currently sit at 85.8%, this is below the Trust target however appraisals were paused at the end of December to increase workforce capacity to meet anticipated hospital surge.	DOP, DCI

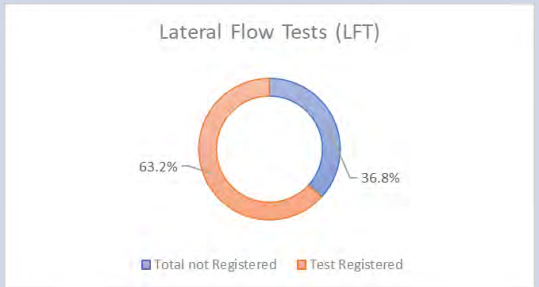
Single Oversight Framework – M1 Overview

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 April 2022 was 5.2%, (March 2022 6.2%). **Lateral Flow Tests** – Overall there were 14,419 test distributed, with 9,110 test registered (63.2%). Of the completed tests there has been 2,540 positive test (0.9% positive results).	DOP, DCI







Single Oversight Framework – M1 Overview

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Timely care	April was a challenging month for the emergency pathway, with the trust declaring an internal critical incident in the week before the Easter bank holiday. The trust had been on OPEL level 4 for 5 days leading up to the bank holiday, had experienced long delays in ED, resulting in overcrowding and high occupancy throughout the base wards with 10 consecutive days at over 92%. Average attendances were slightly lower than March 2022 (475 v 495) but considerably higher than April 2021 (407). The increase in the number of patients who are medically safe waiting for home care remains the key driver in high bed occupancy. The trauma and orthopaedic ward was returned to surgery mid March and further bed moves allowed the additional capacity beds to remain open throughout April. A recovery plan has been developed across the ICS to mitigate the impact of the increased MFFD patients in acute beds and a trajectory is in place however no tangible improvement has been seen. For cancer services, the number of patients waiting more than 62 days on a suspected cancer pathway in April was 121 patients which is below trajectory. The current target for the waiting list is to be lower than February 2021 (70) by the end of 2022/23. An exception report detailing the root cause and actions being taken is included, with a brief description of the new governance arrangements to ensure better sight of the cancer agenda and actions. 62 day performance for March was 67.6% which holds the Trust national ranking at 73/125 which is an improved position from February. The number of patients waiting 104 days at the end of March was 15.5. The Faster Diagnosis Standard (FDS) achieved the 75% standard in March at 81.9%. In the 2022/23 planning guidance, systems were asked to exceed 2019/20 activity to a target of 110% activity/104% value, it has not been possible to give the usual breakdown due to data issues for month 1 activity. In month 1, Overall RTT waiting list numbers were higher than planned which can be attributed in part to our response to increasing emergency flow pressure over Easter. The number of patients waiting over 52 weeks is as per the trajectory for April and 78 weeks is under trajectory. The 104 week position is still on track for 0 by the end of Q1 however this may be affected by sickness/COVID/patient choice nearer the time. All long wait (52+) patients are monitored on a weekly basis. Diagnostic performance against the DMO1 has deteriorated from last month (reporting period April vs March) and 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

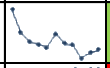
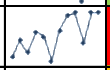
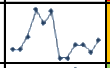
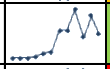
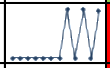
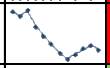
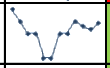
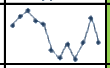
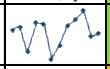
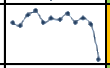
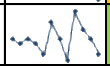
Single Oversight Framework – Month 1 Overview (5)

Sherwood Forest Hospitals
NHS Foundation Trust

Domain	Overview & risks	Lead
Best Value care	**Income & Expenditure:** • The Trust and Nottinghamshire ICS partners submitted a financial plan for 2022/23 on 28 April 2022, in line with the timescales set out by NHS England & NHS Improvement (NHSE/I). The financial plan for SHF shows a deficit of £13.7m, while the overall planned deficit for the ICS is £64.7m. • The deficit values include 'excess inflation' costs of £8.5m for SFH and £45.8m for the ICS, which are the costs relating to energy and RPI inflation on excess of the inflationary uplift applied to allocations. NHSE/I has signalled that additional uplifts will be applied to the original allocations, and this should offset some or all of the excess costs included within the plan. • The Trust has reported a deficit of £1.1m for the month of April 2022 (on an ICS Achievement basis). This is a marginal adverse variance to the planned deficit. • The Trust continues to incur costs relating to Covid-19, which includes the costs of covering for increased staff absence as well as infection prevention measures. For April these costs totalled £1.0m. Costs relating to the Covid Vaccination Programme continue to be reimbursed on a pass-through basis. These totalled £1.0m in Month 1. • Elective Recovery Fund (ERF) income of £0.8m has been included in the Month 1. • The forecast outturn reported at Month 1 is aligned to the financial plan, as a deficit of £13.7m. There are a number of risks inherent in the 2022/23 financial plan and sensitivity analysis is being worked up in relation to these. **Financial Improvement Programme (FIP):** • The Financial Improvement Programme (FIP) delivered savings of £0.4m in April 2022, compared to a plan of £ 0.2m. The expected full-year savings for 2022/23 total £13.9m, including the expected benefit of Elective Recovery Funding (ERF). **Capital Expenditure & Cash:** • The Trust has an indicative capital expenditure plan of £19.5m for the financial year 2022/23. This is still to be confirmed and agreed at an ICS level. Capital expenditure of £0.3m has been reported for Month 1. • The closing cash position at 30 April was £6.2m, which is £2.3m higher than planned. The Trust has complied with the 95% Better Payment Practice Code (BPPC) target in month.	CFO

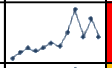
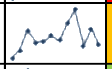
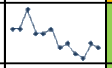
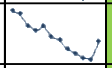
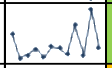
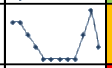
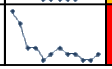
Single Oversight Framework – Month 1 Overview (1)

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	Patient safety incidents per rolling 12 month 1000 OBDs	>44	Apr-22	45.60	45.60		G	MD/CN	M
		All Falls per 1000 OBDs	6.63	Apr-22	8.43	8.43		R	CN	M
		Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	20.6	Apr-22	22.35	22.35		A	CN	M
		Covid-19 Hospital onset	<37	Apr-22	15	15		G	CN	M
		Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0	Apr-22	5.59	5.59		R	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	Apr-22	9.0	9.0		G	CN	M
	Caring	Complaints per rolling 12 months 1000 OBD's	<1.9	Apr-22	1.40	1.40		G	MD/CN	M
		Recommended Rate: Friends and Family Accident and Emergency	<90%	Apr-22	91.1%	91.1%		G	MD/CN	M
		Recommended Rate: Friends and Family Inpatients	<96%	Apr-22	94.7%	94.7%		A	MD/CN	M
	Effective	Cardiac arrest rate per 1000 admissions	<1.0	Apr-22	0.65	0.65		G	MD	M

Single Oversight Framework – Month 1 Overview (2)

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 and Culture	Staff health & well being	Sickness Absence	<4.0%	Apr-22	5.2%	5.2%		R	DoP	M
		Total Workforce Loss (inc Sickness, Maternity, Infection Precaution)	<6.5%	Apr-22	7.3%	7.3%		A	DoP	M
		Employee Relations Management	<10-12	Apr-22	7	7		G	DoP	M
	Resourcing	Vacancy rate	≤6.0%	Apr-22	4.5%	4.5%		G	DoP	M
		Turnover in month (excluding rotational Drs.)	<0.9%	Apr-22	0.6%	0.6%		G	DoP	M
		Mandatory & Statutory Training	>90%	Apr-22	87.0%	87.0%		A	DoCI	M
		Appraisals	≥95%	Apr-22	86.0%	86.0%		R	DoCI	M

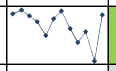
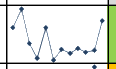
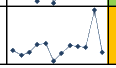
Single Oversight Framework – Month 1 Overview (3)

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	90.0%	Apr-22	80.9%	80.9%		R	COO	M
		Mean waiting time in ED (in minutes)	220	Apr-22	199	199		G	COO	M
		Percentage of Ambulance Arrivals who have a handover delayed > 30 minutes	<5%	Apr-22	4.7%	4.7%		G	COO	M
		Number of patients who have spent 12 hours or more in ED from arrival to departure as a % of all ED Attendances	shadow monitoring	Apr-22	2.2%	2.2%			COO	M
		Mean number of patients who are medically safe for transfer	<22	Apr-22	98	98		R	COO	M
		Adult G&A Bed Occupancy (8:00am position as per U&EC Sitrep)	<92%	Apr-22	93.8%	93.8%		A	COO	M
	Elective Care	Remote Attendances as a percentage of Total Outpatient Attendances	on trajectory	Apr-22	17.9%	17.9%		R	COO	M
		Outpatient Episodes moved / discharged to a Patient Initiated Follow-up Pathway	on trajectory	Apr-22	4.2%	4.2%		A	COO	M
		Follow Up Outpatient Attendances reduce against Yr2019/20	on trajectory	Apr-22	12.4%	12.4%		R	COO	M
		Elective Day Case activity against Plan	on trajectory	Apr-22	94.2%	94.2%		A	COO	M
		Elective Inpatient activity against Plan	on trajectory	Apr-22	90.9%	90.9%		A	COO	M
		Elective Outpatient activity against Plan	on trajectory	Apr-22	95.3%	95.3%		A	COO	M
	Diagnostics	Diagnostics activity increase against Yr2019/20	on trajectory	Apr-22	107.8%	107.8%		G	COO	M
	RTT	Number of patients on the incomplete RTT waiting list	on trajectory	Apr-22	-	40996		A	COO	M
		Number of patients waiting 78+ weeks for treatment	on trajectory	Apr-22	-	103		G	COO	M
		Number of patients waiting 104+ weeks for treatment	on trajectory	Apr-22	-	6		G	COO	M
		Number of completed RTT Pathways against Yr2019/20	on trajectory	Apr-22	91.2%	91.2%		A	COO	M
	Cancer Care	Number of patients waiting over 62 days for Cancer treatment	100	Apr-22	-	121		R	COO	M
		Percentage of patients receiving a definitive diagnosis or ruling out of cancer within 28 days of a referral	75.0%	Mar-22	77.4%	81.9%		G	COO	M

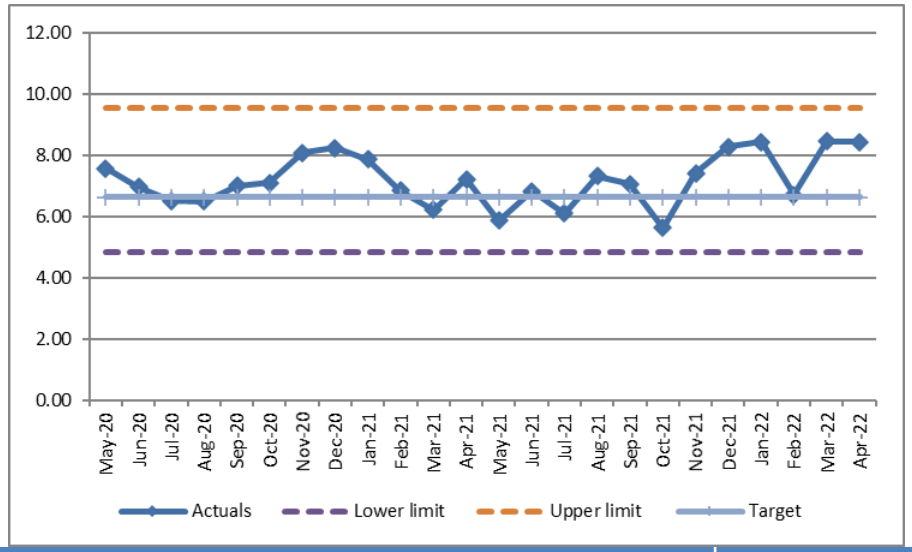
Single Oversight Framework – Month 1 Overview (4)

Sherwood Forest Hospitals
NHS Foundation Trust

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	Apr-22	-£0.02m	-£0.02m		G	CFO	M
		Underlying financial position against strategy	£0.00m	Apr-22	tbc	tbc			CFO	M
		Trust level performance against FIP plan	£0.00m	Apr-22	£0.18m	£0.18m		G	CFO	M
		Capital expenditure against plan	£0.00m	Apr-22	£0.52m	£0.52m		A	CFO	M

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
All Falls per 1000 OBDs	6.63	Apr-22	8.43	8.43		R	CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

- The falls rate for April 2022 is 8.43 which is above the national ambition of 6.63 per thousand bed days.
- Nationally, deconditioning continues to affect both people at home and in hospital.
- A number of medically safe patients remain in acute beds due to reduced capacity for community care and limiting ability to safely discharge.
- Length of stay remains increased.
- 2 severe harm, 131 recorded as no harm.
- Increased number of mobility falls against falls from bed/chair.

Root causes

- High volume of pathway 1 patients, MFFD residing, due to insufficient community capacity for placement/POC's. These patients are at high risk of falls.
- We continue to have high numbers of patients with LOS > 21 days, as the LOS increases in MFFD patients so does falls rates.
- All additional bed capacity remains open across 3 sites.
- The impact of the pandemic continues to reduce opportunity for older adults to be active, contributing to deconditioning and associated increased risk of falls.
- Older adults struggling to work towards reconditioning
- Increased acuity of inpatients

Actions

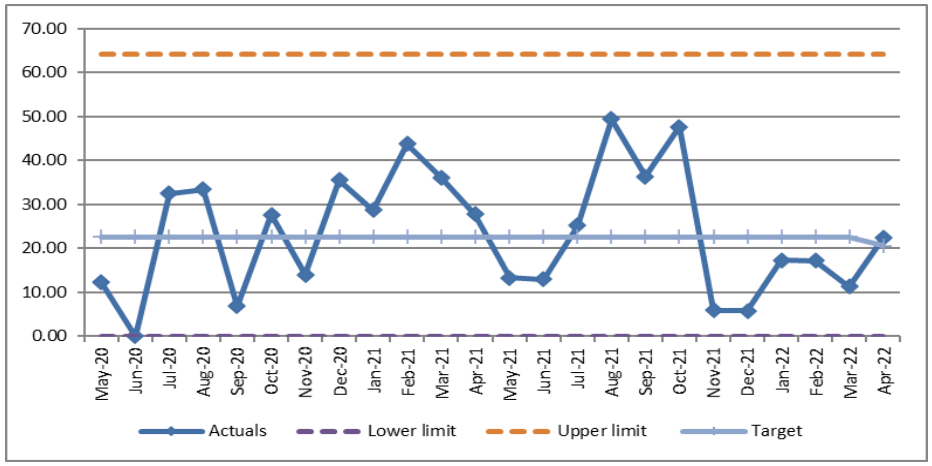
- Multifactorial falls risk assessment and falls care plan assurance audit
- Falls and mobility care plan now in place
- Planning visits to local Trusts – networking and sharing good practise
- Review of Champion session for 2022/3
- NAIF recommended actions and translated into our work in the Trust
- Review , reflect and re –engage on the work in 2021/22-annual plan
- Falls group TOR , membership and the Falls Strategy discussed
- #Walk this May - Mobility and deconditioning focus
- Falls awareness week planning for September 2022 with East Midlands Falls group. Also in-house seminar planned for November 2022.
- Meet with clinical audit dept to look at falls data and analysis going forward
- System Community of Practice event planned for next quarter
- Connected Care within the organisation linking dementia and EPO with falls team will continue
- Discuss falls at Quality Committee and Council of Governors

Impact/Timescale

- May 2022
- Complete
- Ongoing 2022
- May 2022
- June 2022
- June 2022
- June 2022
- May 2022
- On going
- May 2022
- June 2022
- On going
- Completed

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 month Clostridium Difficile infection rate per 100,000 OBD's	20.6	Apr-22	22.35	22.35		A	CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



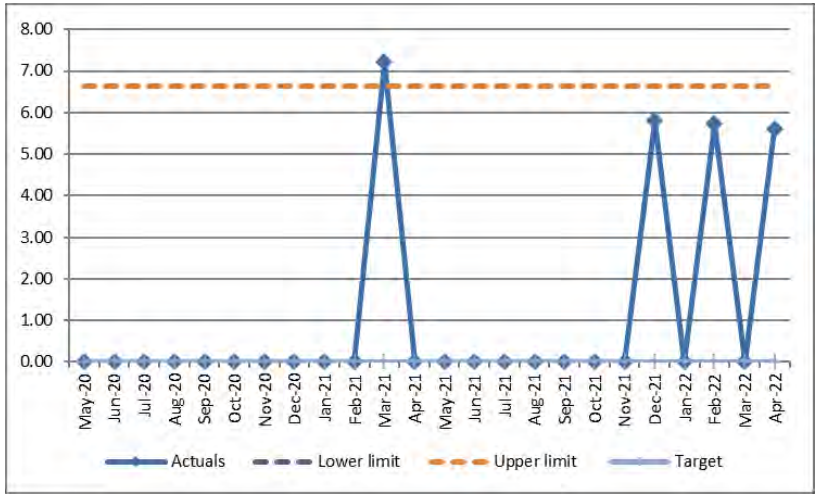
National position & overview

- This year the organisation has been given a threshold for C.diff of 92 cases.
- The Trust have seen a reduction in the number of hospital associated cases of C.diff when compared with the same time last year.
- The total Trust Attributed C.diff cases to date for this year is 4, compared to 9 in 2021/22

Root causes	Actions	Impact/Timescale
• There have been 4 cases of hospital acquired Cdiff in April 2022.	• All possible samples are still being sent to Leeds for ribotyping.	• On going
• All cases had received antibiotics which were appropriate for their condition.	• Bed cleaning programme has been extended and is working well.	• On going
	• Second Peer review to be conducted by NHSE/I , UKHSA and CCG	• July 2022
	• RCA's are being carried out on all 4 cases.	• May 2022
	• IPC team are following up all patients who have been re-admitted and had C.diff previously to identify earlier if any indication of continuing infection.	• On going
	• Chief Nurse Clinical Fellow for C.diff is now in post for a year.	• Completed
	• In response to the national "C.diff what is the problem" commence a Chief Executive lead C.diff group	• Completed

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Rolling 12 month MRSA bacteraemia infection rate per 100,000 OBD's	0	Apr-22	5.59	5.59		R	CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



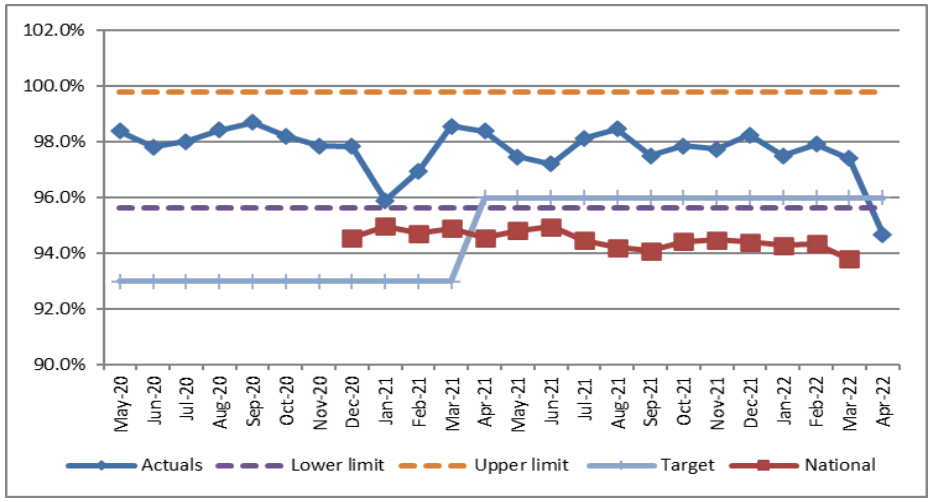
National position & overview

- The Trusts national threshold for MRSA bacteraemia is zero for 2022-23.
- All organisations nationally now have a zero target for MRSA.
- This MRSA case is the same patient as the case in February 2022. They are colonised with MRSA, which has been found on routine swabs that have been taken.

Root causes	Actions	Impact/Timescale
The direct source of this bacteraemia has been investigated and cannot be determined.	All patients with an infection tag on Careflow are now followed up by the IPC team on readmission to ensure correct isolation and treatment are commenced where required.	• Ongoing
Learning points identified are that the patient was not screened within the first 24 hours of admission and they were not commenced on the decolonisation therapy required for patients who have had MRSA previously.	Snap shot decolonisation audit to be undertaken.	• June 2022

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Recommended Rate: Friends and Family Inpatients	<96%	Apr-22	94.7%	94.7%		A	MD/CN	M

Sherwood Forest Hospitals
NHS Foundation Trust



National position & overview

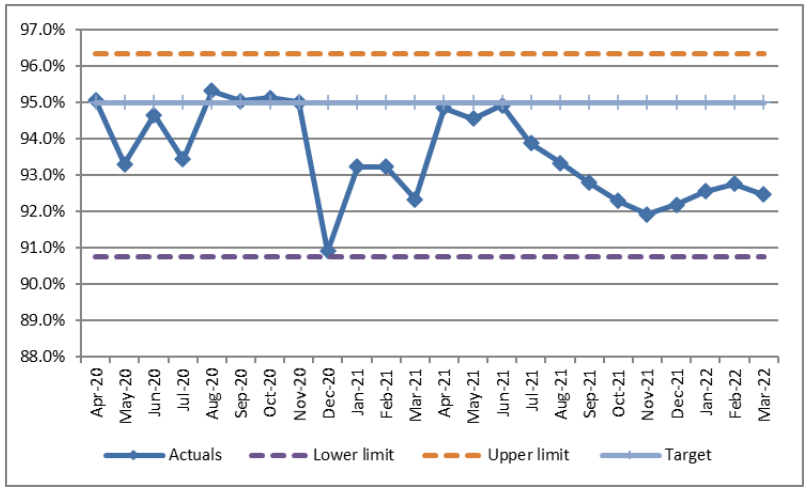
The Friends and Family Test (FFT) gives patients the opportunity to share feedback on our services, collating results on a scale of extremely unlikely to extremely likely. Results are then benchmarked against a positive or negative approach. The data provides a total response rate, overall responses, and the percentages of a positive or negative experience.

April inpatient area score:
91.86% Positive
4.81% Negative
With a response rate of 26%.

Root causes	Actions	Impact/Timescale
The Trust's previous provider's contract came to an end in March 2022. As a result, we explored other options and companies that were able to provide the survey requirements for the FFT to add extra support concerning training, reports, feedback and local surveys to help locate the key issues within our services.	• Implement the new system. Including SMS, QR codes, and online surveys, with the development of a landing pad on all Nerve Centre devices, giving people easy access to the FFT on their handheld devices.	• May 2022
	• Provide training to staff members, on the new system and its reporting functions.	• July 2022
During April 2022, access to paper surveys was the only option with no SMS, online, or QR codes available.	• Use our feedback to focus on key areas for service improvement.	• On going

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

Sherwood Forest Hospitals
NHS Foundation Trust



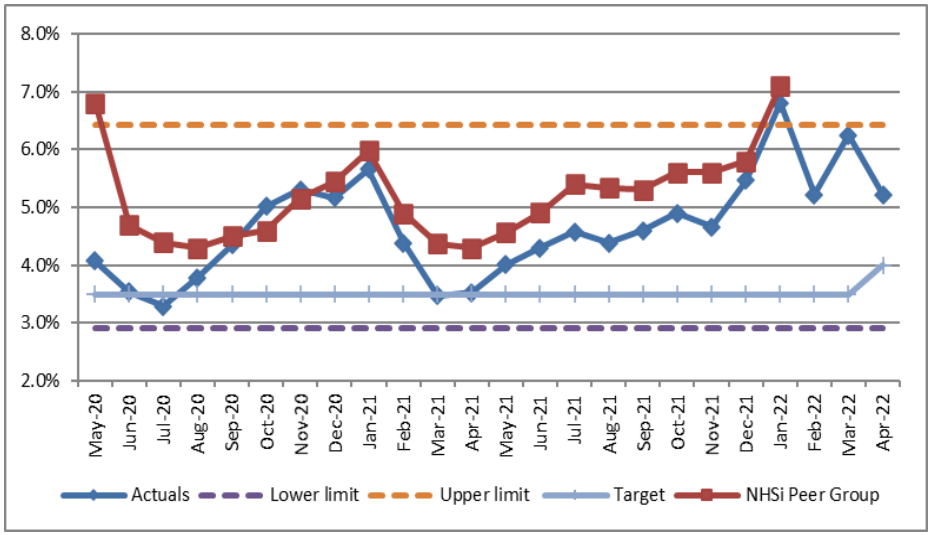
National position & overview

- National reporting of VTE risk assessment screening was stopped in March 2020 in response to the Covid pandemic. SFH continued with data collection for our own internal monitoring 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 initially significantly improved the compliance score; the data has since demonstrated a steady downward trajectory with April 2022 compliance standing at 92.5%

Root causes	Actions	Impact/Timescale
• The data collection process for VTE risk assessment is currently a manual, paper based process, requiring a significant number of hours to complete.	• The GSU team resumed the pre Covid method of form collection from April 2022.	• Completed
	• GSU continue to work with the NerveCentre team to support the roll out of the electronic screening tool and reporting functionality.	• On going
• Roll out of electronic VTE screening tool via NerveCentre commenced May 2022.	• Electronic screening tool now rolled out across Medicine and based on NG89 standards.	• On going
	• Paper based pink form collection continues across Surgery (due to EPMA in place across the organisation).	• August 2022
	• GSU continue with daily prompts across admissions areas to aid completion of the VTE assessment.	• On going

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Sickness Absence	<4.0%	Apr-22	5.2%	5.0%		R	DoP	M

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.

We have reviewed our overall trust sickness target based on the last 24 months data and we have set a differential divisional sickness targets, the Trust targets has moved from 3.5% to 4.0%.

Root causes

Sickness absence levels has shown an decrease since from last month (5.2%). This sits above the Trust Target (4.0%). The sickness absence levels is above the sickness absence level in April 2021 (3.5%)

The short term sickness absence rate for April 22 is 3.6%. (March 2022 – 4.6%).

The long term sickness absence rate for April 22 is 1.6%. (March 2022 – 1.7%).

COVID related absence make up 1.2% of the sickness absence level and has shown an increase from last month

Non COVID related absence has seen an decrease.

Actions

The decrease in absence levels coincidences with the decrease 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 (4.0%)

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Appraisals	≥95%	Apr-22	86.0%	87.0%		R	DoP	M

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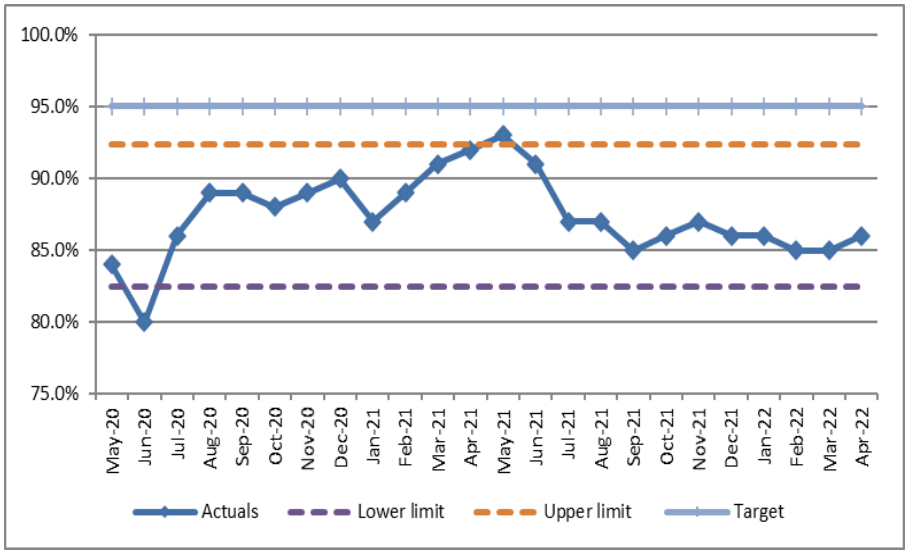
NHS Foundation Trust



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 85.8%, and shows a position that is the similar to the previous month (March 2022 – 85.0%)	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
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.	**Ongoing actions:** Consider including appraisals within Protected Learning Time Policy (PLT) to ensure appraisals are prioritised. Consider removing Talent Management from appraisals and dedicate separate time to this to avoid consumption of conversations.	To be assessed – by end 22/23

Number of patients waiting >4 hours for admission or discharge from ED	>95%	Apr-22	80.9%	80.9%		R	COO	M

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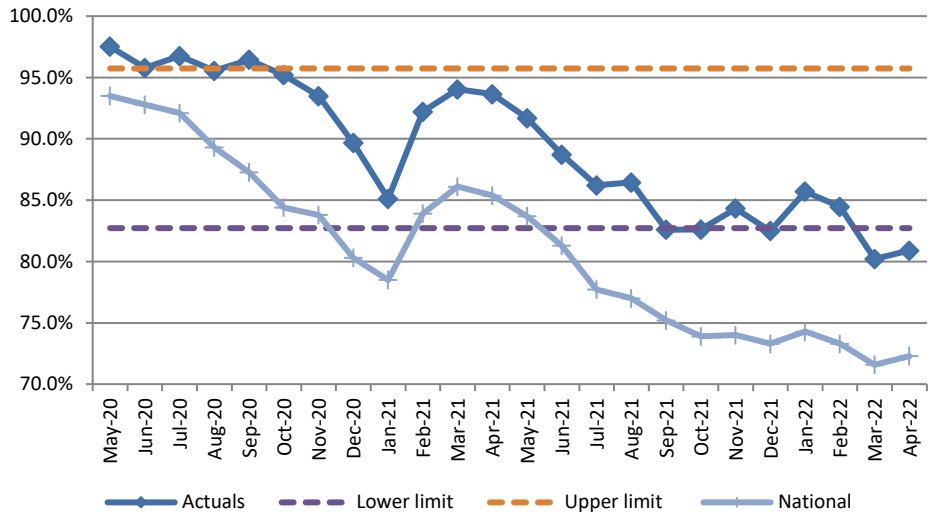
NHS Foundation Trust



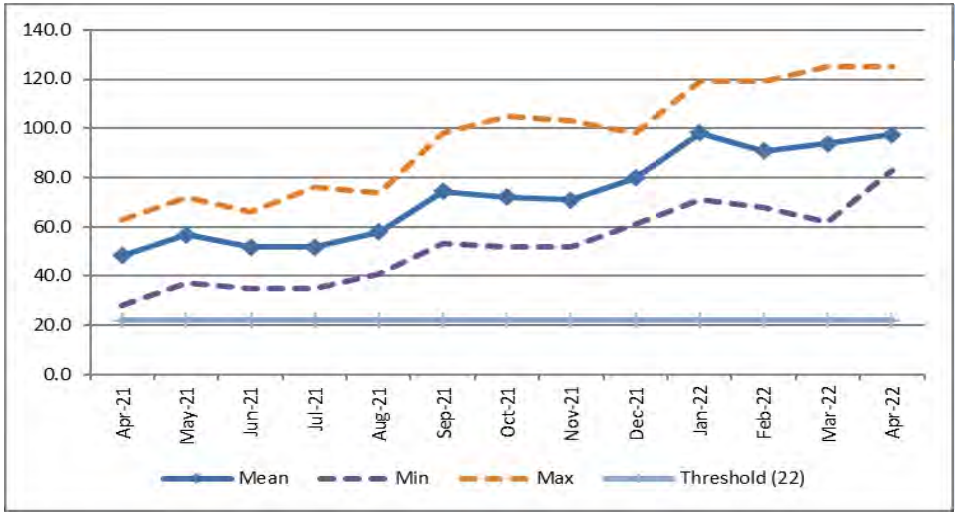
National position & overview

- A critical incident was called in April as the trust had been on OPEL L4 for 5 consecutive days, had reduced discharges, high MSFT numbers, high occupancy and an overcrowded ED with long waiting patients
- SFH performance was 80.9% for April. Performance continues to be driven mainly by exit block and high numbers of MSFT, although average attendances were up for the month in comparison to April 2021
- National rank 4th out of all comparison Trusts
- Newark UTC performed well with an average 99.54% of patients seen and treated under 4 hrs, 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

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. An internal critical incident was called to take extraordinary action due to 5 consecutive days of high pressure, low discharges and high occupancy	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 which have remained open 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 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 The trust opened Sherwood Community Care Home to mitigate a number of MSFT patients in response to the internal critical incident. These beds will remain open for 13 weeks. These beds did not mitigate the MSFT risk fully. Internal flow development transformation plan in development	• Implemented • Implemented • Ongoing • Implemented • Development

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Mean number of patients who are medically safe for transfer	<22	Apr-22	98	98		R	COO	M

Sherwood Forest Hospitals
NHS Foundation Trust



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 continuing link to workforce issues within adult social care and care agency hand back of care
- Additional surge capacity being remains open with" winter "capacity also remaining open.
- 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

- Pathway 1 and 2 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.
- Care home closures for staffing and infection prevention issues have also contributed to delayed discharge allocation although this has significantly improved
- Internal process issues contributing to referral delays due to EPMA and TTO, and ability to prepare for early discharge
- No visible workforce plan/ timelines to improve the position in the system

Actions

- T2A process with system partners continues to develop
- Continuation of winter capacity
- D2A business case circa £8m allocated (£2.5 as new with £5.5m already in system run rate)
- VW system business case submission 6th June with SFH looking to "go at risk" to start service in June for IV home therapy, respiratory and frailty
- System wide agreement continues to progress for FNC assessments, interim placements and wider bedded capacity access
- Opening of Sherwood Community Care Home to mitigate a proportion of the number of MSFT patients in acute beds

Escalation

- Delays and workforce issues escalated through CEO group, D2A Board with daily system conversations.
- Potential patient harms as deconditioning whilst waiting

Impact/Timescale

Workshop 24th May 22 to progress plan
Linked to the above

6th June 22

June 22

April 2022 for 13 weeks

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Remote Attendances as a percentage of Total Outpatient Attendances	>25%	Apr-22	17.6%	17.9%		R	COO	M

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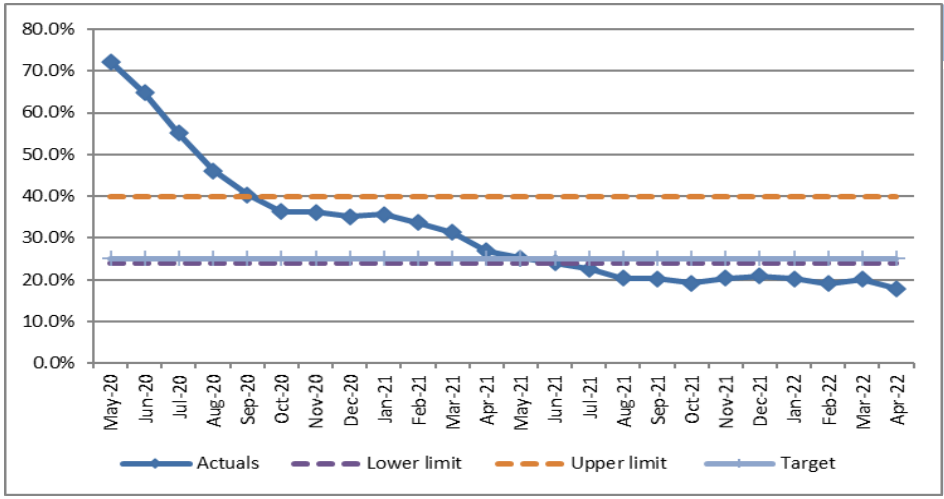

National position & overview

- The 2022/23 plan details a desire to increase the numbers of patients who are able to access a virtual appointment to 25% of total OP attendances.
- Remote attendances include both Telephone and Video consultations
- There was an increase in the number of patients choosing virtual appointments during the COVID pandemic
- The % of patients being seen virtually is declining, this may be due to clinical staff preferring face to face appointments
- A strategy for this programme is under development within the OP Transformation Group

Root causes	Actions	Impact/Timescale
1. There is an emerging preference for face to face consultations amongst clinicians	Targeting roll out in core specialties ENT suggested as initial specialty, Benefits mapping exercise to be undertaken and clinical drop in session set up	• Underway as part of OP transformation group
2. There are a number of barriers including: equipment, signal issues, support for staff and patients to conduct 'virtual' sessions, fixed clinic sessions for video consultation.	Exploration around the role of a virtual receptionist Good practice shared by Derby and knowledge of a pilot at NUH. Scoping exercise underway to understand if we have the 'right' video consultation technology to take the agenda forward.	• Bid for funding planned to enable this to be piloted at SFH.
3. Some specialties not reporting their telephone and advice line activity	Process for recording and reporting this activity agreed. SOP has been drafted Promoting wider awareness amongst clinicians.	• Inclusion of missing specialties will positively impact the position from June.
4. 22/23 plans for 'virtual' appointments need to be signed off.	Meeting planned 24/05 to agree plan.	• June

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Follow Up Outpatient Attendances reduce against Yr2019/20	>25%	Apr-22	12.4%	12.4%		R	COO	M

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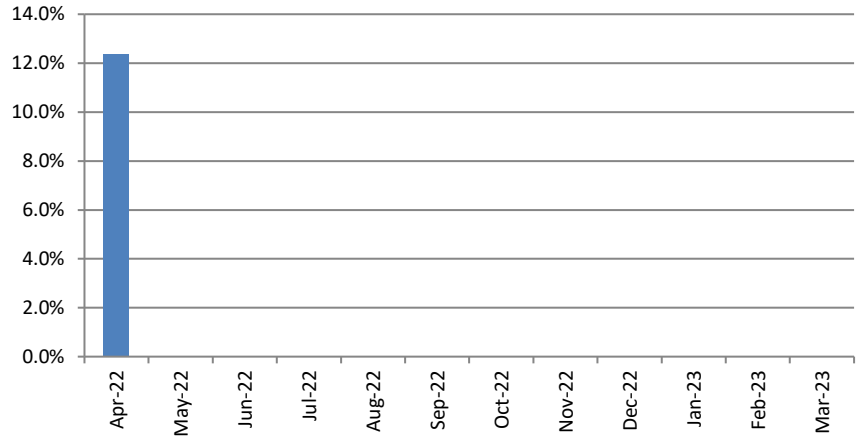
NHS Foundation Trust



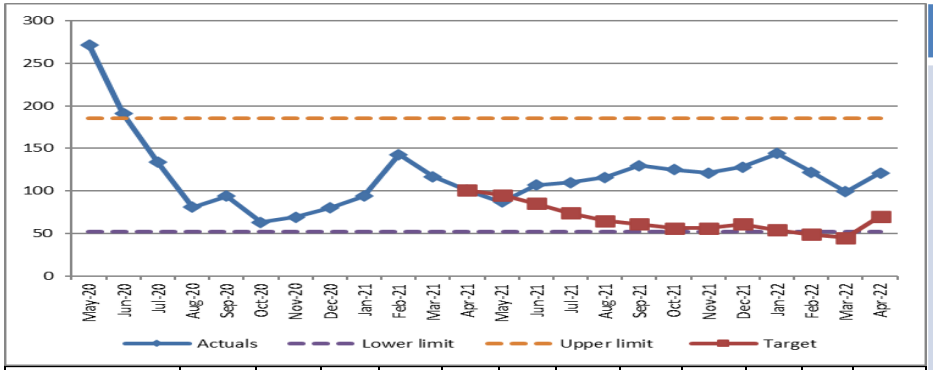
National position & overview

- National Planning 2022/23 target to reduce follow up appointments by 25% of 2019/20 actuals
- SFH submitted a plan declaring that would not be compliant with the target in 2022/23 due to the size of the current overdue review backlog and activity plan aim to achieve 110% of 2019/20 activity
- The target will still be monitored and reported against at a trust level
- Most acute trusts in the midlands declaring a non compliant position
- Alternatives to Follow Up are being progressed through Patient Initiated Follow Up (PIFU)

Root causes	Actions	Impact/Timescale
1. PIFU pathways are not set up in all specialities.	• PIFU working group established • Project plan developed – sign off 24/05 • Two cohorts. Cohort 1: Review of specialties using open appts and PIFU. Cohort 2: specialities only using open appts.	Plan to move all open appts over to PIFU pathways by Nov.
2. Standard PIFU pathways not suitable for patients with long term conditions.	Development of a PIFU pathway for patients with long term conditions (PIFU SOS) will need to be established to enable all open appts to be transferred to PIFU pathways, as these patients will not be discharged.	PIFU SOS will be included in the PIFU plan.
3. Patient Knows Best (PKB) tool is in use within the clinical specialties but not being rolled out at the pace required. This tool allows patients to monitor and manage their own conditions and reduce the need to attend hospital unnecessarily (Non PIFU but an enabler)	Deputy DGMs from Medicine and Surgery to progress PKB and report back to the Board with support offered via the Transformation team.	Supports the SOS agenda, by reducing the number of patients attending for routine monitoring.

Indicator	Plan / Standard	Period	YTD Actuals	Monthly / Quarterly Actuals	Trend	RAG Rating	Executive Director	Frequency
Number of patients waiting over 62 days for Cancer treatment	70	Apr-22	-	121		R	COO	M

Sherwood Forest Hospitals



	April	May	Jun	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
19/20 Backlog	70	85	93	92	108	112	93	83	80	77	62	64
22/23 Trajectory	123	110	105	97	102	104	90	85	88	99	91	85
22/23 Actual	121											

National position & overview

- In the 2022/23 priorities and operational planning guidance, NHS England (NHSE) set out a key objective: As a priority, complete any outstanding work on the post-pandemic cancer recovery objectives - return the number of people waiting for longer than 62 days to the level in February 2020 (based on the national average in February 2020) For SFH this was 45 at month end in February 2020, the average in February 2020 was 70.
- SFH were ranked 73rd out of 125 providers for 62 wait for first treatment
- SFH were ranked 16th out of 129 providers for Faster Diagnosis Standard
- A trajectory was developed in March 22 with 5 key risks to delivery highlighted: demand, diagnostic capacity, lower GI, dependency on the tertiary provider and the residual impact of covid. April ended at 121, above the February 2020 average of 70 but below the reforecast of 123.

Root causes	Actions	Impact/Timescale
• Delays to STT in Gynae due to Hysteroscopy capacity	• Gynae – Expand see and treat capacity, streamline straight to test (STT) Additional lists provided throughout May to support STT.	• Impact of additional lists, should be seen in June, with a reduction in days to first seen. For Gynae STT.
• Urology, Head and Neck clinic waits both locally and at the tertiary centre due to consultant leave.	• Head and neck working with NUH colleagues to understand gap and address clinic capacity.	• Head and Neck looking to increase additional theatres for June
• Lower GI impacted by consultant leave due to both annual leave and covid sickness	• Urology working to increase template capacity with the start of MRI fusion in outpatients. • Lower GI to add additional clinics and theatres where possible.	• Throughout Q1 and Q2 22/23.
• Other diagnostic and treatment delays provided by the tertiary centre including PET scans, surgical dates and oncology.	• ICS assessment and review of sustained increased demand	• Underway – discussions ongoing between COO and Director of Commissioning
	• New cancer Steering Group in place to give greater focus to the cancer agenda and reducing patient waits	• Throughout Q1 and Q2 22/23:

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

M1 Summary

- The Trust has reported a deficit of £1.09m for the month of April 2022 (on an ICS Achievement basis). This is a marginal adverse variance to the planned deficit of £1.06m.
- The forecast outturn reported at Month 1 is aligned to the financial plan, as a deficit of £13.66m.
- Capital expenditure was £0.33m. This was £0.52m lower than plan primarily relating to MRI where funding has yet to be formally approved.
- Closing cash at 30th April was £6.15m, which is £2.31m higher than planned. The Trust has complied with the 95% BPPC target in month.

	April In-Month			Annual Plan	Forecast	Forecast Variance
	Plan £m	Actual £m	Variance £m			
Income	37.26	37.06	(0.19)	441.10	440.91	(0.19)
Expenditure	(38.32)	(38.15)	0.17	(454.76)	(454.57)	0.19
Surplus/(Deficit) - ICS Achievement Basis	**(1.06)**	**(1.09)**	**(0.02)**	(13.66)	(13.66)	**(0.00)**
Capex (including donated)	(0.85)	(0.33)	0.52	(19.46)	(19.46)	0.00
Closing Cash	3.84	6.15	2.31	1.55	1.55	0.00

Best Value Care

Sherwood Forest Hospitals
NHS Foundation Trust

ICS Achievement Basis, All values £'m

	In Month					Forecast				
	Plan	Non-Covid Actual	Covid Actual	Total Actual	Variance	Plan	Non-Covid Forecast	Covid Forecast	Total Forecast	Variance
Income:										
Contract Income	29.07	28.94	0.00	28.94	(0.13)	348.81	348.69	0.00	348.69	(0.13)
ERF	0.83	0.83	0.00	0.83	(0.00)	9.92	9.92	0.00	9.92	(0.00)
Other Income	6.66	6.59	0.00	6.59	(0.06)	73.93	73.87	0.00	73.87	(0.06)
Total Income	**37.23**	**37.05**	**(0.01)**	**37.04**	**(0.19)**	**440.80**	**440.62**	**(0.01)**	**440.61**	**(0.19)**
Expenditure:										
Pay - Substantive	(20.34)	(20.08)	(0.02)	(20.10)	0.25	(238.57)	(237.49)	(0.81)	(238.30)	0.27
Pay - Bank	(2.30)	(2.25)	(0.65)	(2.90)	(0.60)	(23.22)	(22.27)	(1.55)	(23.82)	(0.60)
Pay - Agency	(0.82)	(0.75)	(0.08)	(0.83)	(0.01)	(15.04)	(14.97)	(0.08)	(15.05)	(0.01)
Pay - Other (Apprentice Levy and Non Execs)	(0.11)	(0.10)	0.00	(0.10)	0.01	(1.35)	(1.34)	0.00	(1.34)	0.01
Total Pay	(23.58)	(23.19)	(0.74)	(23.93)	(0.35)	(278.18)	(276.06)	(2.44)	(278.51)	(0.33)
Non-Pay	(12.11)	(11.39)	(0.25)	(11.64)	0.47	(143.54)	(141.99)	(1.09)	(143.08)	0.46
Depreciation	(1.24)	(1.19)	0.00	(1.19)	0.05	(14.80)	(14.74)	0.00	(14.74)	0.05
Interest Expense	(1.37)	(1.37)	0.00	(1.37)	(0.00)	(16.64)	(16.64)	0.00	(16.64)	(0.00)
PDC Dividend Expense	0.00	0.00	0.00	0.00	0.00	(1.31)	(1.31)	0.00	(1.31)	0.00
Total Non-Pay	(14.71)	(13.94)	(0.25)	(14.19)	0.52	(176.29)	(174.68)	(1.09)	(175.77)	0.52
Total Expenditure	**(38.29)**	**(37.13)**	**(0.99)**	**(38.13)**	**0.17**	**(454.46)**	**(450.74)**	**(3.53)**	**(454.28)**	**0.19**
Surplus/(Deficit)	**(1.06)**	**(0.08)**	**(1.00)**	**(1.09)**	**(0.02)**	**(13.66)**	**(10.12)**	**(3.54)**	**(13.66)**	**(0.00)**

The table above shows the deficit position of £1.09m for Month 1 (April 2022).

Income is adverse to plan mainly due to the adjustment required around NHS England commissioned high cost drugs, which vary based on usage. This adjustment is offset within non-pay. The Trust has reported full receipt of planned ERF income. Although the Trust performance for April was below the plan, the plan has been achieved at an ICS level.

Pay expenditure exceeded plan in Month 1 due to additional bedded capacity above planned levels and staffing unavailability due to covid again higher than planned levels.

The Month 1 forecast outturn is aligned to plan. There are various risks inherent within the 2022/23 financial plan a sensitivity analysis is being worked up, which takes into account the current bed pressures, ERF & FIP achievement, Covid costs, some of the assumed income streams and excess inflation.

FY23 Target		FY23 Forecast		FY23 Variance		M1 Target		M1 Actual		M1 Variance		YTD Target		YTD Actual		YTD Variance	
FIP £11.73m	ERF £2.21m	FIP £11.73m	ERF £2.21m	FIP £0.00m	ERF £0.00m	FIP £0.04m	ERF £0.18m	FIP £0.00m	ERF £0.40m	FIP (£0.03m)	ERF £0.21m	FIP £0.04m	ERF £0.18m	FIP £0.00m	ERF £0.40m	FIP (£0.03m)	ERF £0.21m
£13.94m		£13.94m		£0.00m		£0.22m		£0.40m		£0.18m		£0.22m		£0.40m		£0.18m	

Overall Status
G

Green rated due to full year achievement assumption

Financial Improvement Plan Delivery

a. In-month delivery was slightly behind plan due to a delay in procurement savings; though these are expected to catch-up. Digital letters continued to achieve above plan.

Elective Recovery Funding (ERF)

a. The Transformation & Efficiency Programme continues to contribute to the delivery of ERF. This will however be reported separately. Should activity exceed plan however, and this results in the delivery of additional ERF, this additional funding will be allocated to the FIP.

b. In-month delivery is above the planned trajectory overall, however the Theatres Transformation activity is below plan. The overall impact on the achievement of ERF in month 1 is not yet known. The figures shown are therefore indicative at this stage.

c. The planned trajectory for 2022-23 is being reviewed, in line with revised (stretch) targets.

Full Year Forecast

a. It has been assumed, at this stage, that the 2022-23 FIP will be delivered in full by the end of the year. The 'overall status' therefore has been rated green.

b. The Medical, NMAHP and Procurement Programmes are expected to be included in month 2 reporting.

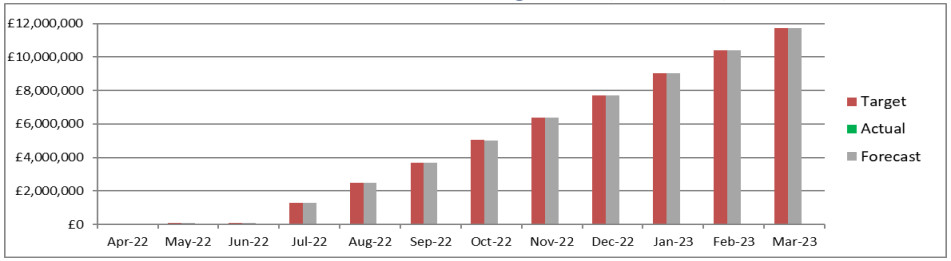
c. There is currently £3.8m unallocated FIP, which has notionally been assigned to individual divisions. There are 50+ programme specific ideas currently being worked up, with an additional 40+ schemes on the idea's log. These ideas will help address the unallocated amount.

Issues and Risks

a. Although a large-scale Transformation and Efficiency programme has been worked up, there is (as noted above) £3.8m currently unallocated. As well as continuing to work up new ideas, a Transformation and Efficiency working group is being established. This will be an opportunity for Divisional and clinical colleagues to explore, identify and scope new financial saving opportunities.

b. Delays in the re-establishment of 'pre-Covid bank rates' will potentially delay savings identified as part of the NMAHP Transformation Programme.

Item 1: Cumulative Phased Forecast Savings Plan (excl. ERF)



Item 2: Summary by Programme

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

Programme	Month 1 In-Month Target			Month 1 In-Month Actual			Delivery RAG
	FIP	ERF	Total	FIP	ERF	Total	
Outpatients Innovation	£1,667	£121,979	£123,646	£2,197	£397,592	£399,789	
Theatres Transformation	£0	£62,500	£62,500	£0	£0	£0	
NMAHP Transformation	£0	£0	£0	£0	£0	£0	
Medical Transformation	£0	£0	£0	£0	£0	£0	
Pathology Transformation	£0	£0	£0	£0	£0	£0	
Diagnostics Transformation Programme	£0	£0	£0	£0	£0	£0	
Ophthalmology Transformation	£0	£0	£0	£0	£0	£0	
Corporate Services	£33,333	£0	£33,333	£0	£0	£0	
Divisional Schemes	£0	£0	£0	£0	£0	£0	
Total	£35,000	£184,479	£219,479	£2,197	£397,592	£399,789	

Board Assurance Framework (BAF): May 2022

The key elements of the BAF are:

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

Key to lead committee assurance ratings:

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

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

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

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

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

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

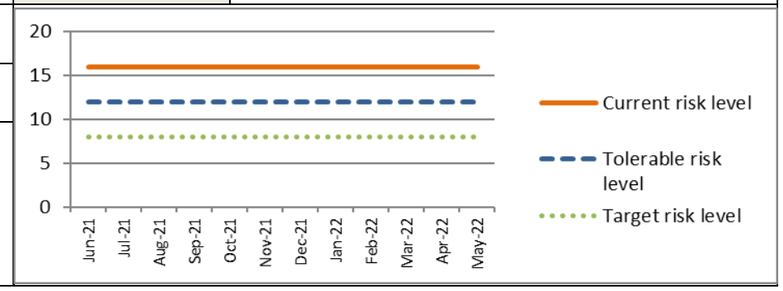
Board committees should review the BAF with particular reference to comparing the tolerable risk level to the current exposure risk rating

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

Reference	Principal risk	Lead committee	Initial date of assessment	Last reviewed	Target risk score C x L	Previous risk score (at previous review/update) C x L	Current risk score C x L
PR1	Significant deterioration in standards of safety and care	Medical Director	01/04/2018	09/05/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR2	Demand that overwhelms capacity	Chief Operating Officer	01/04/2018	09/05/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR3	Critical shortage of workforce capacity and capability	Director of People	01/04/2018	31/05/2022	4 x 2 = 8	4 x 4 = 16	4 x 4 = 16
PR4	Failure to achieve the Trust's financial strategy	Chief Financial Officer	01/04/2018	26/04/2022	4 x 2 = 8	4 x 3 = 16	4 x 3 = 16
PR5	Inability to initiate and implement evidence-based improvement and innovation	Director of Culture & Improvement	17/03/2020	27/05/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9
PR6	Working more closely with local health and care partners does not fully deliver the required benefits	Chief Executive Officer	01/04/2020	25/05/2022	2 x 2 = 4	2 x 3 = 6	2 x 3 = 6
PR7	Major disruptive incident	Director of Corporate Affairs	01/04/2018	30/05/2022	4 x 1 = 4	4 x 2 = 8	~~4 x 2 = 8~~4 x 3 = 12
PR8	Failure to deliver sustainable reductions in the Trust's impact on climate change	Chief Executive Officer	22/11/2021	25/05/2022	3 x 2 = 6	3 x 3 = 9	3 x 3 = 9

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 1: Significant deterioration in standards of safety and care** Significant deterioration in standards of safety and quality of patient care across the Trust resulting in substantial incidents of avoidable harm and poor clinical outcomes							**Strategic objective**	1. To provide outstanding care
Lead Committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Executive lead	Medical Director	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	09/05/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	09/05/2022								



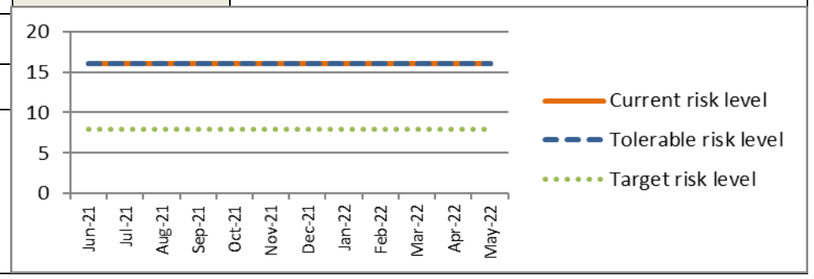
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction	▪ Clinical service structures, accountability & quality governance arrangements at Trust, division & service levels including: ▪ Monthly meeting of Patient Safety Committee (PSC) with work programme aligned to CQC registration regulations ▪ Nursing and Midwifery and AHP Business meeting ▪ Clinical policies, procedures, guidelines, pathways, supporting documentation & IT systems ▪ Clinical audit programme & monitoring arrangements ▪ Clinical staff recruitment, induction, mandatory training, registration & re-validation ▪ Defined safe medical & nurse staffing levels for all wards & departments (Nursing safeguards monitored by Chief Nurse) ▪ Ward assurance/ metrics and accreditation programme ▪ Nursing & Midwifery Strategy ▪ AHP Strategy ▪ Scoping and sign-off process for incidents and Sis ▪ Internal Reviews against External National Reports ▪ Getting it Right First Time (GIRFT) localised deep dives, reports and action plans ▪ CQC Bi-monthly Engagement Meetings ▪ Operational grip on workforce gaps reporting into the Incident Control Team	~~Intranet currently contains some out of date clinical information that may still be accessible~~ Lack of real time data collection Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care	~~Intranet documents review~~ ~~**SLT Lead:** Head of Communications~~ **Timescale:** ~~March 2022~~ Information, EPMA, EPR and IT Developments in development or progress **SLT Lead:** Medical Director **Progress:** EPMA rollout commenced; EPR business case to Board in June 2022 **Timescale:** ~~March 2022~~June 2022 ~~More specific~~ Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~September 2022	**Management:** Learning from deaths Report to QC and Board; Quarterly Strategic Priority Report to Board; Divisional risk reports to Risk Committee bi-annually; Guardian of Safe Working report to Board qrtly Quality and Governance Reporting Pathway; Patient Safety Committee →Quality Committee reports include: - DPR Report to PSC monthly and QC bi-monthly - PSC assurance report to QC bi-monthly - Patient Safety Culture (PSC) programme - EoLC Annual Report to QC - Safeguarding Annual Report to QC - CYPP report to QC quarterly - Medical Education update report to QC - Medicines Optimisation Annual Report to QC Outputs from internal reviews against External National Reports including; - HSIB and HQIP ~~Thromboembolic Maternity Report (Oct 2020)~~National and local Reports - ~~National Audit for Care of end of Life (Sep 2020)~~ ~~- Ockenden Report (Dec 2020)~~ **Risk and compliance:** Quality Dashboard and SOF to PSC Monthly; Quality Account Report Qtrly to PSC and QC; SI & Duty of Candour report to PSC monthly; CQC report to QC bi-monthly; Significant Risk Report to RC monthly **Independent assurance**: CQC ~~Inspection Report 2020~~Engagement meeting reports to Quality Committee bi-monthly Screening Quality Assurance Services assessments and reports of: - Antenatal and New-born screening - Breast Cancer Screening Services - Bowel Cancer Screening Services - Cervical Screening Services External Accreditation/Regulation annual assessments and reports of; - Pathology (UKAS) - Endoscopy Services (JAG) - Medical Equipment and Medical Devices (BSI) - Blood Transfusion Annual Compliance Report (MHRA)	None	Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
An outbreak of infectious disease (such as pandemic influenza; Coronavirus; norovirus; infections resistant to antibiotics) that forces closure of one or more areas of the hospital	▪ Infection prevention & control (IPC) programme Policies/ Procedures; Staff training; Environmental cleaning audits ▪ PFI arrangements for cleaning services ▪ Root Cause Analysis and Root Cause Analysis Group ▪ Reports from Public Health England received and acted upon ▪ Infection control annual plan developed in line with the Hygiene Code ▪ Influenza and Covid vaccination programmes ▪ Public communications re: norovirus and infectious diseases ▪ Coronavirus identification and management process ▪ Infection Prevention and Control Board Assurance Framework ▪ Outbreak meeting including external representation, CCG, PHE, Regional IPC ▪ CQC IPC Key lines of enquiry engagement sessions	None	N/A	**Management:** Divisional reports to IPC Committee (every 6 weeks); IPC Annual Report to QC and Board; Water Safety Group; IPC BAF report to PSC and QC **Risk and compliance:** IPC Committee report to PSC qtrly; SOF Performance Report to Board monthly; IPC Clinical audits in IPCC report to PSC qtrly **Independent assurance:** Internal audit plan; CQC Rating Good with Outstanding for Care May '20; PLACE Assessment and Scores Estates Governance bi-monthly; Public Health England attendance at IPC Committee; Influenza vaccination cumulative number of staff vaccinated; ICS vaccination governance report monthly; HSE visit (COVID-19 arrangements) Dec ~~'20~~'21 – no concerns highlighted; IPC BAF Peer Review by Medway Trust; HSE External assessment and report; HSIB IPC assessment and report	~~Learning from the impact on activity, patient safety and staffing due to COVID-19 wave 1~~ ~~Constraints of critical care capacity and PPE availability dependent on the size of future waves and restoration activity – Business Case approved in principle – no commencement date yet identified~~ Business case to enhance oxygen capacity/flow has been delivered – BOC commencement date ~~Jan 2022~~April 2022 ~~Unable to provide assurance that infection risk is monitored at the front door and documented in the patient notes~~ Information capture to be moved onto the electronic patient record **SLT Lead:** Chief Nurse **Timescale:** ~~March 2022~~Complete	Inconclusive Last changed April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 2: Demand that overwhelms capacity** Demand for services that overwhelms capacity resulting in a deterioration in the quality, safety and effectiveness of patient care							**Strategic objective**	1. To provide outstanding care
Lead Committee	Quality	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Patient harm		
Executive lead	Chief Operating Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Minimal		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	4. Somewhat likely	2. Unlikely				
Last reviewed	09/05/2022	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**				
Last changed	09/05/2022								



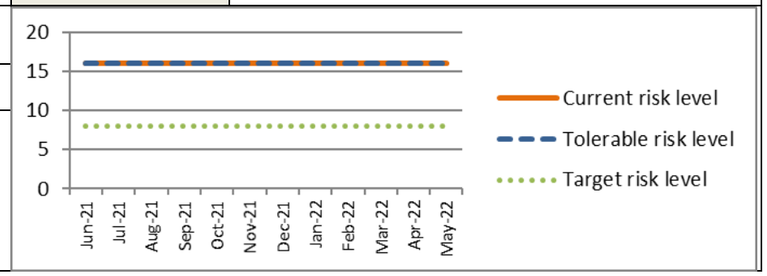
Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gap and issues relating to COVID-19** (Insufficient evidence as to effectiveness of the controls or negative assurance)	**Assurance rating**
Growth in demand for care caused by: • An ageing population • A further Covid 19 wave of admissions driven by Omicron variant • Increased acuity leading to more admissions and longer length of stay	▪ Emergency admission avoidance schemes across the system ▪ Single streaming process for ED & Primary Care – regular meetings with NEMs ▪ Trust and System escalation process ▪ Cancer Improvement plan ▪ Trust leadership of and attendance at A&E Board ▪ Patient pathway, some of which are joint with NUH ▪ Inter-professional standards across the Trust to ensure turnaround times such as diagnostics are completed within 1 day ▪ Proactive system leadership engagement from SFH into Better Together Alliance Delivery Board ▪ Patient Flow Programme ▪ SFH internal Winter capacity plan & Mid Notts system capacity plan ▪ Referral management systems shared between primary and secondary care ▪ MSK pathways ▪ COVID-19 Incident planning and governance process ▪ Some cancer services maintained during COVID-19 ▪ Risk assessments to prioritise individual patients ▪ Elective Steering Group now meeting monthly to steer the recovery of elective waiting times ▪ Accelerator Programme – SFH has been successful in being part of the national Elective Accelerator programme attracting £2.5m of funding to help speed up the recovery of services ▪ Super Surge Plan	~~Robust delivery of the demand management schemes across the system~~	~~'Super surge' plan developed to cope with growth in Covid-19 admissions caused by Omicron variant against a backdrop of hospitals with already high occupancy, with no national lockdowns~~	**Management:** Performance management reporting arrangements between Divisions, Service Lines and Executive Team; Winter Plan to Board Nov '21; ~~Exec to Exec meetings;~~ Cancer 62 day improvement plan to Board; Planning documents for ~~19/20~~ 22/23 to identify clear demand and capacity gaps/bridges; Identifying and capturing Potential Harm Resultant from COVID-19 Pandemic report to Board Jun '20; COVID-19 Recovery Plan to Board Sep '20; ~~Elective Services Report to Recovery Committee monthly;~~ Elective Steering Group report to Executive Team weekly; Waiting list update to Board quarterly; Super Surge Plan to Board Feb '22 **Risk and compliance:** Divisional risk reports to Risk Committee bi-annually; Significant Risk Report to RC monthly; Single Oversight Framework Integrated Monthly Performance Report including national rankings to Board; Incident Control Team governance structure to TMT Mar '20; Cancer services report to Board Jun '21 **Independent assurance:** NHSI Intensive Support Team review of cancer processes May '20		Positive Last changed December 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gap and issues relating to COVID-19 (Insufficient evidence as to effectiveness of the controls or negative assurance)	Assurance rating
Reductions in availability hospital bed capacity caused by increasing numbers of MFFD (medically fit for discharge) patients remaining in hospital	▪ Daily and weekly themed reporting of the number of MFFD patients in hospital beds ▪ The provision of a 'Discharge Cell' meeting with system partners to take forward this work ▪ Mitigation Plan to reduce number of MSFT patients in hospital beds	Lack of consistent achievement of the Mid-Notts threshold for MSFT patients of 22 – this is mainly associated with social care packages (Pathway 1) and is related to home care workforce shortages	~~Mitigation plan has been developed and is being implemented across the system to reduce number of MSFT patients in hospital beds (Dec 21).~~ ~~There is national guidance stating that the numbers of MSFT patients in acute beds need to be reduced by 50%~~ Business case for social care expansion **SLT Lead:** TBC **Timescale:** TBC Virtual ward model of care funding plan to beconsidered by Executive Team 27th April **SLT Lead:** Chief Operating Officer **Timescale:** April 2022	**Management:** Reporting into the group reports into the system CEOs group; Trust winter plan presented to Board Nov '21; Mitigation Plan to reduce number of MSFT patients in hospital beds to Board Dec '21 **Risk and compliance:** Exception reporting on the number of MFFD into the Trust Board via the SOF		Inconclusive New threat added January 2022
Operational failure of General Practice to cope with demand resulting in even higher demand for secondary care as the 'provider of last resort'	▪ Visibility on the CCG risk register/BAF entry relating to operational failure of General Practice ▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development ▪ Weekly Executive meeting with the CCGs ▪ Weekly Mid Notts Network Calls			**Management:** Routine mechanism for sharing of CCG and SFH risk registers – particularly with regard to risks for primary care staffing and demand **Independent assurance:** ~~'Drivers of demand' discussed at Board Aug '19~~		Inconclusive No change since April 2020
Drop in operational performance of neighbouring providers that creates a shift in the flow of patients and referrals to SFH	▪ Engagement in Integrated Care System (ICS), and assuming a leading role in Integrated Care Provider development ▪ Horizon scanning with neighbour organisations via meetings between relevant Executive Directors ▪ Weekly management meeting with the Service Director from Notts HC ▪ Bilateral work – Strategic Partnership forum			**Risk and compliance:** Divisional NUH/SFH strategic partnership forum minutes and action log; NUH service support to SFH paper to Executive Team	Lack of control over the flow of patients from the surrounding area	Inconclusive No change since April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 3: Critical shortage of workforce capacity and capability** A shortage of workforce capacity and capability resulting in a deterioration of staff experience, morale and well-being which can have an adverse impact on patient care							**Strategic objective** 3: To maximise the potential of our workforce
Lead Committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services	
Executive lead	Director of People	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious	
Initial date of assessment	01/04/2018	**Likelihood**	4. Somewhat likely	4. Somewhat likely	2. Unlikely			
Last reviewed	31/05/2022	**Risk rating**	**16. Significant**	**16. Significant**	**8. Medium**			
Last changed	31/05/2022							

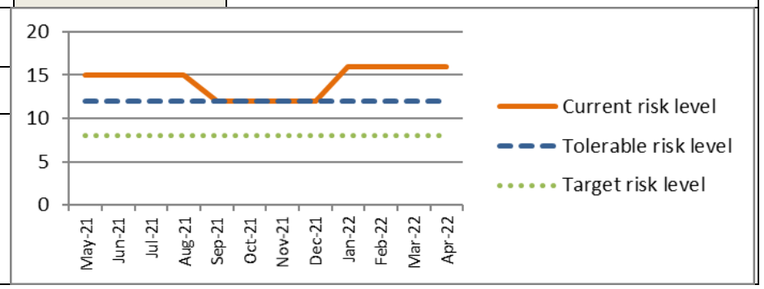


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Inability to attract and retain staff due to demographic changes (including a significant impact of external factors and/or unforeseen circumstances) and shifting cultural attitudes to careers, combined with employment market factors (such as reduced availability and increased competition), or mental health issues relating to the working environment, resulting in critical workforce gaps in some clinical services	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Medical and Nursing task force ▪ Activity, Workforce and Financial plan ▪ 2 year workforce plan supported by Workforce Planning Group and review processes (consultant job planning; workforce modelling; winter capacity plans) ▪ Vacancy management and recruitment systems and processes ▪ TRAC system for recruitment; e-Rostering systems and procedures used to plan staff utilisation ▪ Defined safe medical & nurse staffing levels for all wards and departments / Safe Staffing Standard Operating Procedure ▪ Temporary staffing approval and recruitment processes with defined authorisation levels ▪ Education partnerships ▪ Director of People attendance at People and Culture Board ▪ Workforce planning for system work stream ▪ Communications issued regarding HMRC taxation rules on pensions and provision of pensions advice ▪ Pensions restructuring payment introduced ▪ Risk assessments for at-risk staff groups ▪ Refined and expanded Health and Wellbeing support system ▪ Operational grip on workforce gaps reporting into the Incident Control Team ▪ Nursing and Midwifery Workforce Transformation Cabinet ▪ Medical Workforce Transformation Cabinet	~~Lack of Divisional ownership and understanding of their workforce issues~~ Medical, nursing, AHP and maternity staff gaps in key areas across the Trust, which may impact on the quality and standard of care ~~Likely impact of workforce capacity loss due to the pending COVID vaccination legislation across areas of CQC regulated activity~~	Deliver the People, Culture and Improvement Strategy (People and Inclusion) **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Executive Director of People **Timescale:** March 2023 Continued focus on recruitment and retention in significantly impacted areas, including system wide oversight **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Dedicated focus on improving vaccination uptake through exploring reasons of vaccination hesitancy **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete	**Management:** Quarterly Strategic Priority Report to Board; Nursing and Midwifery and AHP six monthly staffing report to PCI Committee; Workforce and OD ICS/ICP update quarterly; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Recruitment & Retention report monthly; Strategic Workforce Plan to Board Oct '21; Employee Relations Quarterly Assurance Report to People, Culture and Improvement Committee; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** Risk Committee significant risk report Monthly; HR & Workforce planning report Risk Committee; SOF – Workforce Indicators (Monthly); Bank and agency report (monthly); Guardian of safe working report to Board quarterly **Independent assurance**: Well-led report CQC; NHSI use of resources report; Pre-employment Checks internal audit report Feb '21 – significant assurance; HSJ Award for Acute Trust of the Year 2021; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr'21	~~Staff becoming infected, leading to increased sickness absence~~ ~~Staff working in unfamiliar roles~~ Staff mental health issues as a result of psychological trauma Potential impact of pending changes to the pensions arrangements and NI rules	Inconclusive Last changed April 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	Primary risk controls (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	Gaps in control (Specific areas / issues where further work is required to manage the risk to accepted appetite/ tolerance level)	Plans to improve control (are further controls possible in order to reduce risk exposure within tolerable range?)	Sources of assurance (and date) (**Evidence** that the controls/ systems which we are placing reliance on are effective)	Gaps in assurance / actions to address gaps and issues relating to COVID-19	Assurance rating
			Develop and implement mitigations for workforce capacity loss **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete			
A significant loss of workforce productivity arising from a short-term reduction in staff availability or a reduction in effort above and beyond contractual requirements amongst a substantial proportion of the workforce and/or loss of experienced colleagues from the service, or caused by other factors such as poor job satisfaction, lack of opportunities for personal development, on-going pay restraint, workforce fatigue or wellbeing issues, or failure to achieve consistent values and behaviours in line with desired culture This could also lead to lack of engagement with patients, resulting in failure to address patient empowerment and self-help and failure to work across the system to empower patients and carers to enable personalised patient centred care	▪ People Culture and Improvement Strategy ▪ People and Inclusion Cabinet ▪ Culture and Improvement Cabinet ▪ Chief Executive's blog / Staff Communication bulletin ▪ Engagement events with Staff Networks (BAME, LGBT, WAND, Time to Change) ▪ Schwartz rounds ▪ Learning from COVID ▪ Staff morale identified as 'profile risk' in Divisional risk registers ▪ Star of the month/ milestone events ▪ Divisional action plans from staff survey ▪ Policies (inc. staff development; appraisal process; sickness and relationships at work policy) ▪ Just and restorative culture ▪ Influenza vaccination programme ▪ COVID-19 vaccination programme ▪ Staff wellbeing drop-in sessions ▪ Staff counselling / Occ Health support ▪ Enhanced equality, diversity and inclusion focus on workforce demographics ▪ Freedom to Speak Up Guardian and champion networks ▪ Emergency Planning, Resilience & Response (EPRR) arrangements for temporary loss of essential staffing (including industrial action and extreme weather event) ▪ Combined violence and aggression campaign across system partners ▪ Anti-racism Strategy	Inequalities in staff inclusivity and wellbeing across protected characteristics groups	Deliver the Equality, Diversity and Inclusivity Strategy **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Deliver the People, Culture and Improvement Strategy (Culture and Improvement) **SLT Lead:** Executive Director of People **Timescale:** ~~March 2022~~Complete Deliver the People, Culture and Improvement Strategy – Year 1 **SLT Lead:** Executive Director of People **Timescale:** March 2023	**Management:** Staff Survey Action Plan to Board May '21; Staff Survey Annual Report to Board Jun '21; Diversity & Inclusion Annual report Jun '21;WRES and WDES report to Board Jun '21; Quarterly Assurance reports on People & Inclusion and Culture & Improvement to People Culture and Improvement Committee; Winter Wellness Campaign report to Board Oct '21; People Plan updates to People, Culture and Improvement Committee quarterly **Risk and compliance:** EPRR Report (bi-annually); Freedom to speak up self-review Board Aug '21; Freedom to Speak Up Guardian report quarterly; Guardian of Safe Working report to Board quarterly; Significant Risk Report to RC monthly; Gender Pay Gap report to Board Apr '21; Assurance Report to People, Culture and Improvement Committee quarterly; People Plan to People, Culture and Improvement Committee Apr'21; Anti-Racism Strategy to Board Mar '22 **Independent assurance:** National Staff Survey Mar '21; SFFT/Pulse surveys (Quarterly); Well-led report CQC; Well-led Review report to Board Apr '22	~~Reduction in available staff due to COVID-19, e.g. staff isolating, shielding of vulnerable staff groups and social distancing; redeployment to the vaccination programme~~ ~~Reduction in effort above and beyond contractual requirements due to COVID-19 service restrictions~~ ~~Reluctance of some staff members to return to work due to COVID-19-associated health concerns~~ ~~Restrictions to deployment of key staff due to reduced availability of Mandatory and Statutory Training, and the consequential expiry of certification~~ ~~Increase in violence and aggression towards staff~~ Potential impact of cost of living issues on staff morale and wellbeing Implement the recommendations from the SWE Expert Group report 'Violence & Aggression and Associated Risks' **SLT Lead:** Chief Nurse **Timescale:** ~~March 2022~~Complete	Inconclusive Last changed May 2020

Board Assurance Framework (BAF): May 2022

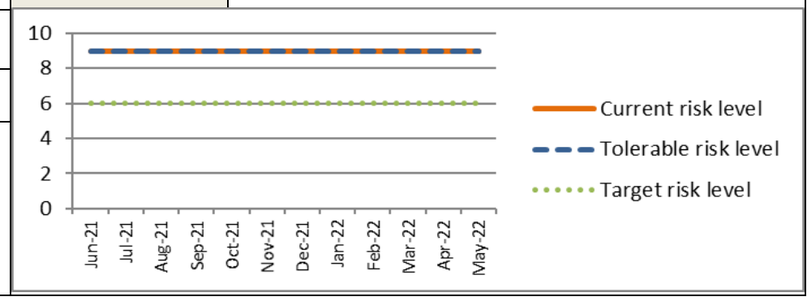
Principal risk (what could prevent us achieving this strategic objective)	**PR 4: Failure to achieve the Trust's financial strategy** Failure to achieve agreed trajectories resulting in regulatory action							**Strategic objective**	5: To achieve better value
Lead Committee	Finance	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Regulatory action		
Executive lead	Chief Financial Officer	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious		
Initial date of assessment	01/04/2018	**Likelihood**	**4. Somewhat likely**	3. Possible	2. Unlikely				
Last reviewed	26/04/2022	**Risk rating**	**16. Significant**	**12. High**	**8. Medium**				
Last changed	26/04/2022								

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control**	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps**	**Assurance rating**
A reduction in funding or change in financial trajectory or unexpected event resulting in an increased Financial Improvement Plan (FIP) requirement to reduce the scale of the financial deficit, without having an adverse impact on quality and safety	▪ 5 year long term financial model ▪ Working capital support through agreed loan arrangements ▪ Annual ~~plan, including control total consideration; reduction of underlying financial deficit and unwinding of the PFI benefit by £0.5m annually~~ financial plan and budgets, based on available resources and stretching financial improvement targets. ▪ ~~Engagement with the Better Together alliance programme~~ ▪ Transformation and Efficiency Cabinet, FIP planning processes and PMO coordination of delivery ▪ Delivery of budget holder training workshops and enhancements to financial reporting ▪ ~~A full 'wash up' of portfolio planning, delivery and engagement conducted; recovery plan in place, Board approved & governance in place~~ ▪ ~~Medical Pay Task Force action plan in place~~ ▪ Close working with ICS partners to identify system-wide planning, transformation and cost reductions ▪ Executive oversight of commitments ▪ COVID-19 related funding application process in place at Trust level ▪ Development of a three-year Transformation and Efficiency Programme covering 2022-25 ▪ ~~2021/22 Planning guidance confirms continuation of 2020/21 funding regime for H1 and H2~~	No long term commitment received for liquidity / cash support ~~Lack of identification of opportunities for recurrent delivery of FIP~~ Financial allocations for 2022/23 not yet confirmed	Full receipt of required cash following delivery of NHSI required future trajectories **SLT Lead:** Chief Financial Officer **Timescale:** ~~end February 2022~~Complete **Progress:** Revenue funding received – awaiting confirmation of allocation of capital cash funding Submission of cash plan for 2022/23 **SLT Lead:** Chief Financial Officer Timescale: April 2022 Full review of ability to improve recurrent delivery of FIP within financial planning for 2022/23 SLT Lead: Director of Culture and Improvement Timescale: ~~March 2022~~Complete Budget setting process for 2022/23 to include enhanced review of recurrent cost base SLT Lead: Chief Financial Officer Timescale: ~~March 2022~~Complete Final 2022/23 Financial Plan submission in April 2022. **SLT Lead:** Chief Financial Officer **Timescale:** April 2022	**Management:** CFO's Financial Reports and ~~FIP~~ Transformation & Efficiency Summary (Monthly); Quarterly Strategic Priority Report to Board; ~~Alliance Progress Report & STP FIP (at each Finance Committee meeting);~~ ICS finance report to Finance Committee (monthly); Capital Oversight Group; Divisonal Perfroamcne Reviews (monthly) ~~Investment governance work programme~~; Divisional risk reports to Risk Committee bi-annually; Transformation & Efficiency Cabinet updates to Executive Team **Risk and compliance:** Risk Committee significant risk report Monthly **Independent assurance**: Inte`rnal Audit of FIP/ QIPP processes Sep '21; EY Financial Recovery Plan; Deloitte audit of COVID-19 expenditure; Internal Audit reports: - Key Financial Systems - Asset Register Jan '22 - Integrity of the General Ledger and Financial Reporting Dec '21 - Financial Reporting Arrangements Nov 21	~~Awaiting 2022/23 NHSI/E planning guidance~~ NHSE/I feedback to be sought on final plan submission	Inconclusive Last changed July 2020
ICS system deficit results in a negative financial impact to the Trust	▪ Full participation in ICS planning ▪ SFH plan consistency with ICS and partner plans ~~plan~~ ▪ ICS DoFs Group ▪ ICS Operational Finance Directors Group ▪ ICS Financial Framework	ICS underlying financial deficit	Full participation in the development of the ICS Financial Strategy and aligned payment mechanisms for 2022/23 **SLT Lead:** Chief Financial Officer **Timescale:** ~~March 2022~~Complete Final aligned SFH and ICS financial plan submission for 2022/23 SLT Lead: Chief Financial Officer Timescale: April 2022	**Risk and compliance:** ICS financial reports to Finance Committee; ICS Board updates to SFH Trust Board	~~Awaiting 2022/23 NHSI/E planning guidance~~ NHSE/I feedback to be sought on final plan submission	Inconclusive Last changed July 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 5: Inability to initiate and implement evidence-based improvement and innovation** Lack of support, capability and agility to optimise strategic and operational opportunities to improve patient care						
Lead Committee	People, Culture & Improvement	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation
Executive lead	Director of Culture & Improvement	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious
Initial date of assessment	17/03/2020	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely		
Last reviewed	27/05/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**		
Last changed	27/05/2022						

Strategic objective	4: To continuously learn and improve

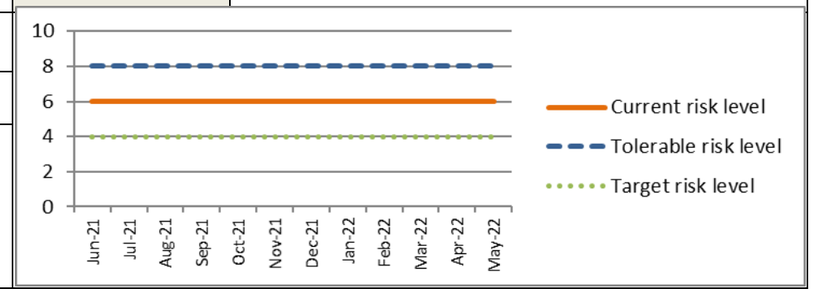


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Lack of understanding and agility resulting in reduced efficiency and effectiveness around how we provide care for patients	▪ Digital Strategy ▪ People, Culture & Improvement Strategy ▪ Quality Strategy ▪ People, Culture & Improvement Committee ▪ Leadership development programmes ▪ Talent management map ▪ Programme Management Office ▪ Culture & Improvement Cabinet ▪ Transformation Cabinet ▪ Ideas generator platform	The full scope of potential issues is not currently known – therefore further investigation is under way	Establishment of an Innovation Hub **SLT Lead:** Director of Culture and Improvement **Timescale:** ~~March 2022~~May 2022 **Progress:** Pursuing a joint venture with Notts Healthcare and NUH Recruit a Chief Digital Information Officer **SLT Lead:** Medical Director **Timescale:** ~~January 2022~~Complete Recommendations implemented following the review of the EPMA programme of work **SLT Lead:** Medical Director **Timescale:** ~~January 2022~~Complete	**Management:** Monthly Transformation and Efficiency report to FC; Clinical Audit & Improvement report to ~~PSC~~ Advancing Quality Group quarterly; Culture & Improvement Assurance Report to PC&IC bi-monthly **Risk and compliance:** SOF Culture and Improvement indicators; SFH Trust Priorities ~~breakthrough objectives~~ to Board quarterly **Independent assurance:** ~~none currently in place~~ Internal Audit of FIP/ QIPP processes Sep '21; 360 assessment in relation to Clinical Effectiveness. Report May 2022	Delays in training, planned improvement and innovation programmes due to COVID-19 Lack of independent assurance, evidence and insight Progress: Independent review and recommendations by EMAHSN relating to the SFH Vision for Continuous Improvement. Complete.	Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 6: Working more closely with local health and care partners does not fully deliver the required benefits** Influencing the wider determinants of health and improving our collective financial position requires close partnership working. This may be difficult because of differences in governance, objectives and appetite for and ability to change						
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Executive lead	Chief Executive Officer	**Consequence**	**2. Low**	2. Low	2. Low	**Risk appetite**	Cautious
Initial date of assessment	01/04/2020	**Likelihood**	**3. Possible**	4. Somewhat likely	2. Unlikely		
Last reviewed	25/05/2022	**Risk rating**	**6. Low**	**8. Medium**	**4. Low**		
Last changed	10/05/2022						

Strategic objective	2: To promote and support health and wellbeing

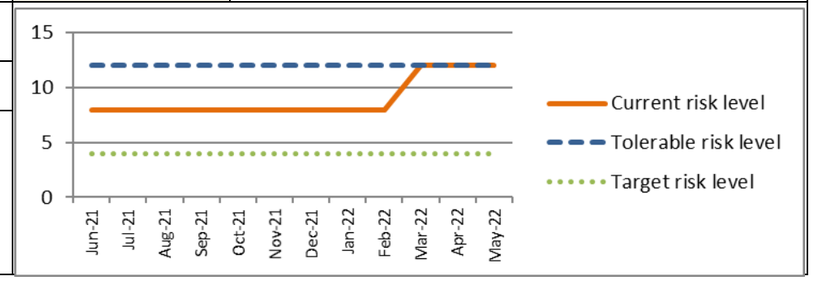


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Conflicting priorities, financial pressures (system financial plan misalignment) and/or ineffective governance resulting in a breakdown of relationships amongst ICS and ICP partners and an inability to influence further integration of services across acute, mental, primary and social care	• Mid-Nottinghamshire Integrated Care Partnership Board • Mid-Nottinghamshire ICP Executive formed May 2020 • Mid-Nottinghamshire ICP breakthrough objectives signed off July 2020 • Nottingham and Nottinghamshire Integrated Care System Board • Continued engagement with ICP and ICS planning and governance arrangements • Quarterly ICS performance review with NHSI • Joint development of plans at ICS level • Finance Directors Group • ICS Planning Group • Alignment of Trust, ICS and ICP plans • Statutory submission of Trust plans as a component of the ICS plan for the system • Independent chair for ICP • ICS Transition and Risk Committee • Approved implementation plan for establishing system risk arrangements • ICS Provider Collaborative development • ICS System Oversight Group • Engagement with the establishment of the formal ICB and place-based partnership	Continued misalignment in organisational priorities Suboptimal system oversight and arrangements for discharge of complex patients	Delivery of the agreed system priorities and plans **SLT Lead:** Chief Executive Officer **Timescale:** March 2022 Consideration by ICS Chief Executives Group of sustainable architecture for to enable effective and timely discharge of MFFD patients. Provider collaborative considering taking ownership **SLT Lead:** Chief Executive Officer **Timescale:** TBC	**Management:** ~~Alliance Development Summary to Board;~~ Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Nottingham and Nottinghamshire ICS Leadership Board Summary Briefing to Board; Planning Update to Board **Risk and compliance:** Significant Risk Report to RC monthly **Independent assurance**: 360 Assurance review of SFH readiness to play a full part in the ICS – Significant Assurance	~~Delay in delivering the benefits of system working due to the impact of COVID-19~~	Positive Last changed May 2022
Clinical service strategies and/or commissioning intentions that do not sufficiently anticipate evolving healthcare needs of the local population and/or reduce health inequalities	▪ Continued engagement with commissioners and ICS developments in clinical service strategies focused on prevention ▪ Partnership working at a more local level, including active participation in the mid-Nottinghamshire ICP ▪ ICS Clinical Services Strategy now complete ▪ ICS Health and Equality Strategy	The needs of the population and the statutory obligations of each individual organisation will not be met until the ICS Clinical Services Strategy is implemented	Implement the ICS Clinical Services Strategy **SLT Lead:** Medical Director **Timescale:** TBC	**Management:** Mid-Notts ICP Objectives Update to Board**;** Strategic Partnerships Update to Board; mid-Nottinghamshire ICP delivery report to FC (as meeting schedule); Finance Committee report to Board; Planning Update to Board **Independent assurance**: none currently in place	~~Delay in delivering the benefits of system working due to the impact of COVID-19~~	~~Positive~~ Inconclusive Last changed ~~May 2021~~ May 2022

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 7: Major disruptive incident** A major incident resulting in temporary hospital closure or a prolonged disruption to the continuity of core services across the Trust, which also impacts significantly on the local health service community						
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Services
Executive lead	Director of Corporate Affairs	**Consequence**	**4. High**	4. High	4. High	**Risk appetite**	Cautious
Initial date of assessment	01/04/2018	**Likelihood**	~~2. Unlikely~~3. Possible	3. Possible	1. Very unlikely		
Last reviewed	30/05/2022	**Risk rating**	~~8. Medium~~ 12. High	**12. High**	**4. Low**		
Last changed	10/05/2022						

Strategic objective	1: To provide outstanding care

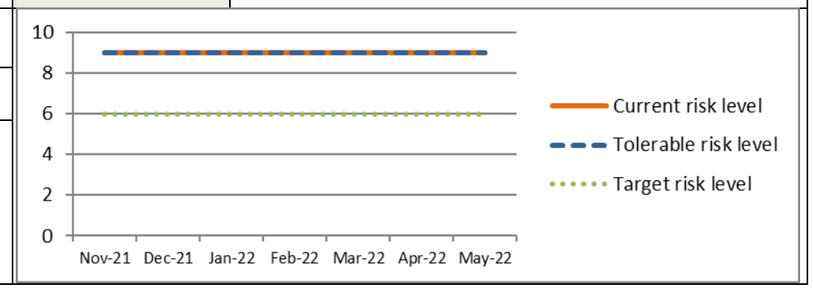


Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Shut down of the IT network due to a large-scale cyber-attack or system failure that severely limits the availability of essential information for a prolonged period	▪ Information Governance Assurance Framework (IGAF) & NHIS Cyber Security Strategy ▪ Cyber Security Programme Board & Cyber Security Project Group and work plan ▪ Cyber news – circulated to all NHIS partners ▪ High Severity Alerts issued by NHS Digital ▪ Network accounts checked after 50 days of inactivity – disabled after 80 days if not used ▪ Major incident plan in place ▪ Periodic phishing exercises carried out by 360 Assurance ▪ Spam and malware email notifications circulated ▪ Periodic cyber-attack exercises carried out by NHIS and the Trust's EPRR lead	~~Misalignment with NCSC Cyber Security Metrics:~~ ~~- High Severity Alerts completion and reporting not within required timeframe~~ ~~- Unsupported systems~~ ~~- Low degree of alignment with NCSC backup guidance~~ ~~Password criteria do not meet IT Healthcheck standards~~		**Management:** Data Protection and Security Toolkit submission to Board Apr '21- 100% compliance; Hygiene Report to Cyber Security Board monthly; NHIS report to Risk Committee quarterly; IG Bi-annual report to Risk Committee; ~~Cyber Security and COVID-19 Report to Board May '20~~; Cyber Security report to Risk Committee – increased levels of attack due to Ukraine **Risk and compliance:** **Independent assurance**: ~~360 Assurance Cyber Security Governance Report Jan '19 – Significant Assurance;~~ ISO 27001 Information Security Management Certification; TIAN / 360 Assurance Cyber Security Survey - The impact of Covid-19 on the NHS Dec '20; CCG Cyber Security Report Mar '21- Significant Assurance; 360 Assurance NHIS Governance and Interface audit – limited assurance; 360 Assurance Data Security and Protection Toolkit audit May '21 – substantial assurance; ~~Cyber Essentials achieved Sep '21~~; IT Healthcheck – 2 of 9 elements failed (negative assurance); Cyber Essentials Plus accreditation Jan '22	Implement the actions from the NHIS Governance and Interface internal audit report **SLT Lead:** Medical Director **Timescale:** ~~March 2022~~Complete	Positive No change since April 2020
A critical infrastructure failure caused by an interruption to the supply of one or more utilities (electricity, gas, water), an uncontrolled fire, flood or other climate change impact, security incident or failure of the built environment that renders a significant proportion of the estate inaccessible or unserviceable, disrupting services for a prolonged period	▪ Premises Assurance Model Action Plan ▪ Estates Strategy 2015-2025 ▪ PFI Contract and Estates Governance arrangements with PFI Partners ▪ Fire Safety Strategy ▪ NHS Supply Chain resilience planning ▪ Emergency Preparedness, Resilience & Response (EPRR) arrangements at regional, Trust, division and service levels ▪ Operational strategies & plans for specific types of major incident (e.g. industrial action; fuel shortage; pandemic disease; power failure; severe winter weather; evacuation; CBRNe) ▪ Gold, Silver, Bronze command structure for major incidents ▪ Business Continuity, Emergency Planning & security policies ▪ Resilience Assurance Committee (RAC) oversight of EPRR ▪ Independent Authorising Engineer (Water) ▪ Major incident plan in place			**Management:** Central Nottinghamshire Hospitals plc monthly performance report; Fire Safety Annual Report; Water Safety Update Report to Risk Committee Jul '20; Patient Safety Concerns report to QC March '21; Hard and soft FM assurance reports **Risk and compliance:** Monthly Significant Risk Report to Risk Committee **Independent assurance:** Premises Assurance Model to RC Dec '18; ~~EPRR Report;~~ EPRR Core standards compliance rating (Oct ~~'19~~'21) – Substantial Assurance; Water Safety report (WSP) to Joint Liaison Committee Oct '19; WSP report – hard FM independent audit; MEMD ISO 9001:2015 Recertification Mar '21; British Standards Institute MEMD Assessment Report Feb '22	360 Assurance internal audit of contract management **SLT Lead:** Associate Director of Estates & Facilities **Timescale:** ~~January 2022~~April 2022 **Progress:** Terms of Reference agreed	Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
A critical supply chain failure that severely restricts the availability of essential goods, medicines or services for a prolonged period	▪ NHS Supply Chain resilience planning Business Continuity Management System & Core standards ▪ CAS alert system – Disruption in supply alerts ▪ Major incident plan in place ▪ PPE Strategy ~~▪ PPE Winter Forecast 2020/21~~ ~~▪ EU Exit Preparation Meetings~~ ▪ COVID-19 Pandemic Surge Plan ▪ Procurement Influenza Pandemic Business Continuity Plan ▪ Interim provision for transmission of personal data to the United Kingdom clause within the EU Exit agreement	None		**Management:** Procurement Annual Report to Audit & Assurance Committee; Oxygen Supply Assurance report to Incident Control Team Apr '20; COVID-19 Governance Assurance Report to Board May '20 **Risk and compliance:** **Independent assurance**: ~~Internal Audit Business Continuity and Emergency Planning Sep '18 – Significant Assurance; 2019/20~~2020/21 Counter Fraud, Bribery and Corruption Annual Report; ~~EU Exit Risk System Overview – Nottingham and Nottinghamshire System Dec '20;~~ 360 Assurance Procurement Review Apr '21 – Significant Assurance		Positive No change since April 2020

Board Assurance Framework (BAF): May 2022

Principal risk (what could prevent us achieving this strategic objective)	**PR 8: Failure to deliver sustainable reductions in the Trust's impact on climate change** The vision to further embed sustainability into the organisation's strategies, policies and reporting processes by engaging stakeholders and assigning responsibility for delivering the actions within our Green Plan may not be achieved or achievable						**Strategic objective**	2: To promote and support health and wellbeing
Lead Committee	Risk	**Risk rating**	**Current exposure**	**Tolerable**	**Target**	**Risk type**	Reputation / regulatory action	
Executive lead	Chief Executive Officer	**Consequence**	**3. Moderate**	3. Moderate	3. Moderate	**Risk appetite**	Cautious	
Initial date of assessment	22/11/2021	**Likelihood**	**3. Possible**	3. Possible	2. Unlikely			
Last reviewed	25/05/2022	**Risk rating**	**9. Medium**	**9. Medium**	**6. Low**			
Last changed	08/03/2022							

Strategic threat (what might cause this to happen)	**Primary risk controls** (what controls/ systems & processes do we **already** have in place to assist us in managing the risk and reducing the likelihood/ impact of the threat)	**Gaps in control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Plans to improve control** (are further controls possible in order to reduce risk exposure within tolerable range?)	**Sources of assurance (and date)** (**Evidence** that the controls/ systems which we are placing reliance on are effective)	**Gaps in assurance / actions to address gaps and issues relating to COVID-19**	**Assurance rating**
Failure to take all the actions required to embed sustainability and reduce the impact of climate change on our community	▪ Estates & Facilities Department oversee the plan and education on climate change impacts ▪ Green Plan 2021-2026 ▪ Climate Action Project Group ▪ Engagement and awareness campaigns (internal/external stakeholders) ▪ Estates Strategy ▪ Digital Strategy ▪ Capital Planning sustainability impact assessments ▪ Environmental Sustainability Impact Assessments built into the Project Implementation Documentation process ▪ Engagement with the wider NHS sustainability sector for best practice, guidance and support	Lack of data to accurately measure and monitor improvements Education of Board and staff at all levels Lack of Environmental Impact Assessments	Develop and embed processes for gathering and reporting statistical data **Lead:** Associate Director of Estates and Facilities **Timescale:** June 2022 Training of the Board, decision makers and all staff at an appropriate level to increase awareness and understanding of sustainable healthcare **Lead:** Associate Director of Estates and Facilities **Timescale:** June 2022 Capital Oversight Group to develop a mechanism to ensure that environmental impact assessments are embedded in decision making processes and key documents (e.g. business cases, investment cases, board papers, capital bids, new and existing policies) **Lead:** Chief Financial Officer **Timescale:** ~~January 2022~~March 2022 **Progress:** Environmental Impact tool approved by TMT	**Management:** **Risk and compliance:** Green Plan to Board Apr '21 Sustainability Report included in the Trust Annual Report **Independent assurance:** ERIC returns and benchmarking feedback	Reporting to Transformation and Efficiency Cabinet not yet defined Agree reporting structure **Lead:** Associate Director of Estates and Facilities **Timescale:** ~~March 2022~~July 2025	Inconclusive New risk added November 2021

Healthier Communities, Outstanding Care

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public

Subject:	Board Assurance Framework and Significant Risks Report	**Date:** 9th June 2022	
Prepared By:	Neil Wilkinson, Risk and Assurance Manager		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
Presented By:	Paul Robinson, Chief Executive Officer		
Purpose			
To enable the Board to review the effectiveness of risk management within the Board Assurance Framework (BAF) and approve the proposed changes agreed by the respective Board sub-committees, and for oversight of significant operational risks.		**Approval**	✓
		Assurance	
		Update	
		Consider	

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

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**
		✓		

Risks/Issues	
Financial	Principal Risk 4 concerns achievement of the Trust's financial strategy
Patient Impact	Principal Risk 1 concerns the delivery of safe and effective patient care
Staff Impact	Principal Risk 3 concerns staff capability and capacity
Services	Principal Risk 2 concerns the management of capacity and demand Principal Risk 6 concerns the delivery of benefits from working more closely with local health and care partners Principal Risk 7 concerns the management of major disruptive incidents
Reputational	Principal Risk 5 concerns the implementation of evidence-based improvement and innovation Principal Risk 8 concerns the Trust's impact on climate change

Committees/groups where this item has been presented before

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

Executive Summary

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

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

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

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

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

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

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

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

- Quality Committee: PR1 and PR2 – 14th March and 9th May
- People, Culture and Improvement Committee: PR3 and PR5 – 4th April and 7th June
- Finance Committee: PR4 – 29th March and 26th April
- Risk Committee: PR6 and PR7 – 8th February, 8th March, 5th April, 10th May and 7th June

PR1, PR2, PR3 and PR4 are significant risks.

The current risk ratings for PR1 and PR4 remain above their tolerable risk ratings. This was discussed at the recent Board workshop, where it was agreed that Quality Committee and Finance Committee respectively would scrutinise the risk ratings at their next meetings.

This report is prepared on the assumption that the People, Culture and Improvement Committee agree to the proposed changes submitted to their 7th June meeting. Further changes may be agreed at this meeting, and at the Risk Committee meeting on the same day.

Board members are requested to:

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

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Infection Prevention and Control Board Assurance Framework	**Date: 01/06/2022**	
Prepared By:	Sally Palmer, Nurse Consultant IPC		
Approved By:	Philip Bolton, Chief Nurse		
Presented By:	Philip Bolton, Chief Nurse		
Purpose			
To update the Board on our compliance with NHS England/Improvements Infection Prevention and Control Board Assurance Framework		**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**	

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
Patient Safety Committee

Executive Summary

The Infection Prevention and Control (IPC) Board Assurance Framework was first received in May 2020 in response to the significant infection control measures required to meet the demands of Covid-19. It was update in December 2021 and is currently under review again.

The United Kingdom Health Security Agency (UKHSA) and other related agency guidance on the required infection prevention and control measures has been published, updated and refined to reflect the opportunities to identify good practice and learning. This continuous process will ensure organisations can respond in an evidence-based way to maintain the safety of patients, service users and staff.

The IPC BAF work has been developed to help providers assess themselves against the guidance as a source of internal assurance that quality standards are being maintained. It will also help them identify any areas of risk and show the corrective actions taken in response. The work to provide the assurance within this document is continuing and all aspects will be continually monitored.

Following the update there are now 122 key lines of enquiry (KLoE); 80 of these are new and 42 remain from the previous document. The Trust can evidence its compliance with 120 KLoE. The two outstanding KLoE relate to ventilation and require more evidence. We are working closely with our Estates team to obtain this evidence.

Sherwood Forest Hospitals
NHS Foundation Trust

Infection Prevention and Control Board Assurance Framework – Compliance

May 2022

Inspected and rated
Good
Care Quality Commission

1. Systems to manage and monitor the prevention and control of infection.

Sherwood Forest Hospitals
NHS Foundation Trust

- This section has 15 key lines of enquiry.
- These include implementing all IPC guidelines in accordance with national guidelines for respiratory viruses
- On going monitoring of compliance with guidance and completing risk assessments is deviation is required.

2. Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections

Sherwood Forest Hospitals
NHS Foundation Trust

- 17 key lines of enquiry
- These include ensuring that the new national cleaning standards are implemented along with any increased frequency of cleaning required.
- On going monitoring of compliance is maintained again by weekly and monthly audits and joint audits with the estates team
- Ventilation meets the required standard in HTM 04-01 and systematic reviews and risk assessments take place.
- Where clinical areas have low air changes and no natural ventilation consider alternative technologies.

- The trust are currently working with Skanska to provide the evidence for some of the ventilation section as we are currently working to a different HTM and assessing the differences.

3. Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance

Sherwood Forest Hospitals
NHS Foundation Trust

- 5 key lines of enquiry
- These include maintain process's for antimicrobial stewardship and maintain mandatory reporting requirements.
- Microbiology ward rounds involving the Consultant Microbiologist and Antimicrobial Pharmacist have continued sometimes virtually to monitor patients on antibiotics
- The Antimicrobial Pharmacists have continued to monitor the usage levels of antibiotics in the Trust and the Infection Control Team have continued to monitor all infection rates and report to PHE where required.

4. Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/ medical care in a timely fashion

Sherwood Forest Hospitals
NHS Foundation Trust

- 8 key lines of enquiry
- This includes information being available for patients and visitors about maintain wellbeing and safety
- National visiting guidance is implemented
- Clearly displayed information to prompt patients, visitors and staff to wear facemasks, socially distance and wash hands

5. Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people

Sherwood Forest Hospitals
NHS Foundation Trust

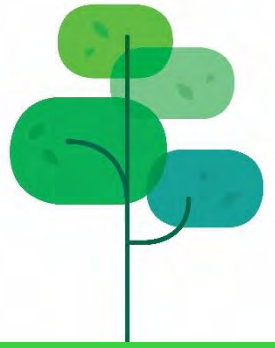
- 17 key lines of enquiry
- This includes testing all patients on admission,
- triaging patients and limiting movement of positive and symptomatic patients,
- all patients wearing face masks and adhering to 2 meters social distancing
- compliance with routine Covid testing

- Compliance is monitored monthly via audits

6. Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection

Sherwood Forest Hospitals
NHS Foundation Trust

- 12 key lines of enquiry
- IPC training and education is available for staff, patients and visitors
- Adherence to national guidance on use of PPE
- Staff maintaining social distancing of 1 metre or greater
- Nosocomial cases of Covid are investigated using the RCA process
- Monthly reviews of these areas are carried out.



7. Provide or secure adequate isolation facilities

Sherwood Forest Hospitals
NHS Foundation Trust

- 7 key lines of enquiry
- This includes, isolating patients in side rooms and if cohorting is required the facilities are appropriate.
- We are fortunate to have 50% on suite side rooms on the wards at KMH which has enabled isolation of most positive patients
- The bays have their own bathroom facilities allowing for appropriate cohorting.
- Ongoing assessment of social distancing is maintained
- Standard IPC precautions are used

8. Secure adequate access to laboratory support as appropriate

Sherwood Forest Hospitals
NHS Foundation Trust

- 13 key lines of enquiry
- This includes screens being taken and report within 24 hours, monitoring of turn around times, guidelines are followed on timing of tests,
- continue to test for other infections
- Monitoring of these elements is on going. Turnaround times have to be reported nationally everyday and we remain within the 24 hour turn around time. Process in place for elective patients to come in for testing.
- Audits undertaken of admission testing compliance.

9. Have and adhere to policies designed for the individual's care and provider organisations that will help to prevent and control infections

Sherwood Forest Hospitals
NHS Foundation Trust

- 6 key lines of enquiry
- All IPC policies available and in date
- Reviewing waste and linen compliance
- Having robust outbreak management plans in place
- On going monitoring is undertaken through audits , additional training and regular updates

10. Have a system in place to manage the occupational health needs and obligations of staff in relation to infection

Sherwood Forest Hospitals
NHS Foundation Trust

- 22 key lines of enquiry
- This includes completing individual staff risk assessments,
- fit testing,
- reducing movement of staff,
- staff wearing face masks,
- monitoring staff absence relating to Covid
- staff having access to correct information if they test positive.

Governance

Sherwood Forest Hospitals
NHS Foundation Trust

- All audits results are reported to the Nurse in Charge at the time of the audit and also sent out to the Ward Leaders and Matrons.
- The incident control team receive a weekly IPC report
- The BAF is reviewed and updated every month – it is reviewed by the Infection Prevention and Control Committee and Patient Safety Committee and

Sherwood Forest Hospitals
NHS Foundation Trust

Public - Board of Directors

Committee Effectiveness Report 9th June 2022

Author – Shirley A Higginbotham, Director of Corporate Affairs

Introduction

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

Scope of Review of Effectiveness

The Trust has undertaken a review of the effectiveness of the Committees of the Board, for the Audit and Assurance Committee the checklist has been taken from the HFMA's NHS Audit Committee Handbook, the People, Culture and Improvement Committee have undertaken a maturity assessment during the year, other committees used a standardised, committee Health check self-assessment tool. The checklist is divided into five sections:

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

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

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

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

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

- Audit and Assurance
- Finance
- Quality
- Remuneration and Nominations
- People, Culture and Improvement

The Charitable Funds Committee, although not a committee of the Board reports regularly to the Board, as the Corporate Trustee, to appraise of the outcomes of the committee meetings and provide assurance the committee is aligned with delivering the strategic objectives of the Trust.

.

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

Key Findings

The detailed key findings for each of the committee is included in the reading room, where questions were assessed as part met or not met and action plan has been developed which details the action required, the lead officer and the timelines. These action plans will be monitored within each of the committees.

A brief analysis of the actions identified for each of the committees is detailed below

Quality Committee

No actions identified

Finance Committee

- No actions identified

Charitable Funds Committee

- No actions identified
-

Audit and Assurance Committee

- Is the timing of Committee meetings discussed with all the parties involved?
  - to be agreed in committee
- Does the Committee review assurance and regulatory compliance reporting processes?
  - To formalise the process
- Does the Committee hold periodic private discussions with the Head of Internal Audit?
  - Currently the Chair only meets with the Head of Internal Audit, this will be expanded to include other members of the committee
  -

People, Culture and Improvement

- Have undertaken a Maturity Assessment – the actions identified are being addressed by the committee

Remuneration and Nominations

The Remuneration and Nominations committee is scheduled to review its Terms of Reference at its next meeting and will complete a review of effectiveness at that meeting too.

Sherwood Forest Hospitals
NHS Foundation Trust

Public - Board of Directors

Subject:	Committee Effectiveness Report	**Date:** 9th June 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 the Board of Directors with assurance regarding the effectiveness of the Committees of the Board.		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	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

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

Executive Summary

The Board is supported by its committees, to ensure the committees are demonstrating good governance and identifying areas of improvement a Committee Health Check self-assessment review has been undertaken.

This year the Audit and Assurance Committee effectiveness report was undertaken using the HFMA's NHS Audit Committee Handbook.

A maturity matrix has been developed by 360 internal audit and the Good Governance Institute, this was utilised for the Audit and Assurance Committee in 2019 and an action plan developed progress against this has been completed.

As a result of the success of the maturity matrix process in the Audit and Assurance Committee, work has progressed with 360 internal audit to develop the same process for all committees of the Board.

It has previously been agreed for those committees who undertake a maturity matrix assessment a committee effectiveness report is not required. The People, Culture and Improvement Committee are currently in the process of responding to the actions identified in their maturity matrix assessment and therefore have not completed a committee effectiveness report. The outcome of the exercise will be reported to Board via the regular People, Culture, and Improvement committee report.

Three actions have been identified as a result of the committee effectiveness review – these are for the Audit and Assurance Committee:

- Is the timing of Committee meetings discussed with all the parties involved?
  - to be agreed in committee
- Does the Committee review assurance and regulatory compliance reporting processes?
  - To formalise the process
- Does the Committee hold periodic private discussions with the Head of Internal Audit?
  - Currently the Chair only meets with the Head of Internal Audit, this will be expanded to include other members of the committee

The Terms of Reference and Work plans for all committees have been reviewed and agreed.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Chair's Highlight Report to Trust Board

Subject:	Council of Governors	**Date:** 9th June 2022	
Prepared By:	Shirley A Higginbotham, Director of Corporate Affairs		
Approved By:	Claire Ward, Chair		
Presented By:	Claire Ward, Chair		
Purpose			
To provide assurance to the Trust Board, regarding the activities of the Council of Governors		**Assurance**	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ Governors role in the ICS/provider collaborative – agreed for a development session to review the opportunities.	▪ As a result of the remaining vacancies on the Council of Governors. The Council agreed to establish a working group to review the public and staff constituencies as identified in the constitution. With a view to merging the constituencies and establishing a youth constituency.
Positive Assurances to Provide	**Decisions Made**
▪ The Council were assured by the following reports: o Board Assurance Framework o Staff Survey o Chairs Appraisal	• Agreed the quality priority of "Increased service user/citizen engagement at key SFHFT meetings" for the 2022/23 Quality Account • Agreed to approach the Mansfield governor who was next on the election report to ask if still wished to take up the role as the governor elected had resigned.
Comments on Effectiveness of the Meeting	
▪ The Council acknowledged this was the first face to face meeting for over two years and agreed it was preferable and good to meet in person, particularly governors new to the Council.	

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors

Subject:	Provider Collaborative	**Date: 9th June 2022**	
Prepared By:	Provider Collaborative Working Group		
Approved By:	Paul Robinson, Chief Executive		
Presented By:	Paul Robinson, Chief Executive		
Purpose			
To update on the work to establish the Provider Collaborative and to obtain the necessary approvals to progress this.		**Approval**	X
		Assurance	
		Update	X
		Consider	

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

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

Risks/Issues	
Financial	Risk of lost opportunities for delivering financial benefit from collaborative working at scale.
Patient Impact	Risk of lost opportunities for collaborative working at scale that otherwise would have had a positive benefit to patient outcomes.
Staff Impact	Risk of lost opportunities for collaborative working at scale that otherwise would have had a positive benefit to staff.
Services	Risk of lost opportunities for collaborative working at scale that otherwise would have had a positive benefit to services.
Reputational	Failure to establish a Provider Collaborative would have adverse reputational consequences

Committees/groups where this item has been presented before

Provider Collaborative Leadership Board

Executive Summary

This paper provides an update on the work progressing to establish an ICS Provider Collaborative at scale between Sherwood Forest Hospitals NHS Foundation Trust (SFH), Nottinghamshire Healthcare NHS Foundation Trust (Notts HC), Nottingham University Hospitals NHS Trust (NUH), Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust (DBH) and East Midlands Ambulance Service NHS Trust (EMAS).

The paper focusses on:

- Establishment of the Provider Leadership Board (PLB)
- Nominations for the Partner Member Representatives for NHS Trusts and Foundation Trusts on the Nottingham and Nottinghamshire Integrated Care Board (ICB)
- Leadership of the Provider Collaborative at Scale
- Ongoing Development of the Provider Collaborative at Scale.

Board Committee is asked to:

1. **Approve the establishment of the Provider Leadership Board for the Nottingham and Nottinghamshire ICS Provider Collaborative at Scale**

2. **Approve the proposed nominations for the two Partner Member Representatives for NHS Trusts and Foundation Trusts on the Nottingham and Nottinghamshire Integrated Care Board (ICB), and**

3. **Confirm the proposed leadership of the Nottingham and Nottinghamshire ICS Provider Collaborative at Scale.**

Establishing an ICS Provider Collaborative at Scale

May/June 2022

1. Background

1.1. Trust Boards will be aware of the previous work that has been undertaken to develop a Provider Collaborative at Scale across our Integrated Care System, as referenced in the joint Board paper that was shared with SFH, Notts HC and NUH's Public Board meetings in March or April 2022. The paper was also shared with EMAS at a Trust Board development session in May and with the Deputy Chair of DBH for sharing with DBH Board colleagues.

1.2. In that paper, it was referenced that although the date of establishment of any Provider Collaborative at Scale has been slipped to 1 July 2022 along with the establishment of the Integrated Care Board, this date will remain as a step in our journey of our collaboration, not an end-point.

1.3. This paper sets out the recent actions that are being taken to develop the Provider Collaborative at Scale and asks Board to agree the recommendations in relation to establishment and nomination of Integrated Care Board partner member representatives.

2. Establishment of the Provider Leadership Board

2.1. In the last update to Board, it was confirmed that as a starting point, a shadow Provider Leadership Board (PLB) would be established and reviewed every 6 months. We have been operating a shadow Provider Leadership Board since then.

2.2. At this moment in time, the shadow PLB is chaired by Dr. John Brewin, Chief Executive of Notts HC. It was agreed that the Provider Leadership Board would be chaired by a nominated lead from one of the Provider Collaborative Member organisations.

2.3. Since we already have a shadow model in place, for the 1 July establishment date, we are asking Trust Boards to agree to formalise this arrangement. Board members will be aware that over time, we would look to delegate authority to the Provider Leadership Board in order to simplify the delivery of some of the key work areas.

2.4. As colleagues will also be aware, we are currently undertaking a piece of work supported by external partners, in order to confirm and prioritise our initial areas of focus. Board members from across the providers are being encouraged to participate in this work.

2.5. In terms of delegated authority, we have always approached the development of the Provider Collaborative to ensure that form follows function. On that basis, we are not proposing that any authority is delegated to the Provider Leadership Board at this stage. Once we determine and prioritise our key areas of focus, in areas that we can add unique value within our system, the next step will be to consider what authority may need to be delegated in order to be able to do that most effectively.

2.6. At the point when we consider delegating any authority we will need to return to Boards and consider that with appropriate information and details. This will also mean that we will consider the make-up of the PLB and consider our governance arrangements, for example, by considering whether there may need to be roles for Non-Executives on the PLB. These considerations will take place when the functions determine them.

2.7. The Trust Board is asked to approve the establishment of the Provider Leadership Board for the Nottingham and Nottinghamshire Provider Collaborative at Scale.

3. Partner Member Representatives for the Integrated Care Board

3.1. In the previous update to Boards, we highlighted that provider organisations would likely support the Partner Member representative seat around the Integrated Care Board for NHS Trusts and Foundation Trusts being filled by the Chair of the PLB. However, as the legislation has passed through Parliament, there has been an amendment, which has introduced a second Partner Member representative seat around the ICB.

3.2. These two ICB Partner Member roles are different; one must be able to bring an informed view of hospital, urgent and emergency care services and the other member must be able to bring an informed view of mental health, intellectual disability and community services. As the ICB is a unitary Board, Partner Members will also hold collective accountability, along with all other Board members, for the broader responsibilities of the ICS, alongside their specific areas of focus.

3.3. Each Trust or NHS Trust eligible to nominate for the partner member representative seats has been asked by the Chair and Chief Executive of the ICB to do so. The organisations eligible to nominate in Nottingham and Nottinghamshire are Notts HC, SFH, NUH, DBH and EMAS. Each organisation will be asked to nominate for both posts and nominations can be a Chief Executive or an Executive Director with a relevant portfolio. The Chair of the ICB will then consider all nominations and determine who is most appropriate to fill the posts.

3.4. Clearly the initial thinking around how we approached the nomination process is no longer relevant. Chairs and Chief Executives of provider collaborative member organisations discussed the nomination process at their meeting on 16 May 2022.

3.5. For the Partner Member representative role covering mental health, intellectual disability and community services, it was agreed that Notts HC are most appropriately placed to provide a representative. Given the importance of this role this post will be provided from the Office of the Chief Executive at Notts HC. Members of the Nottingham and Nottinghamshire Provider Collaborative at Scale are proposing to nominate the Chief Executive of Notts HC for this role.

3.6. As the remaining four key partner organisations could demonstrate some evidence in meeting the brief for the other partner member role, this is the seat that the Chairs and Chief Executives have discussed in detail.

3.7. Conversations with EMAS and DBH have confirmed that it is unlikely that they will want to field a representative for the Nottingham and Nottinghamshire ICB, given their geographical reach into other ICB areas.

3.8. As NUH is currently in the process of awaiting for a new Chief Executive to start in post, the environment for nominations is a little complex. In order to consider the second partner member post, it is important we do so by considering it alongside the role of Lead for the Provider Collaborative at Scale.

4. Leadership of the Provider Collaborative at Scale

4.1. As referenced in section two of the paper, the current Chair of the Provider Leadership Board is Dr. John Brewin. Colleagues will likely have seen that Dr. Brewin has recently announced his retirement and will leave Notts HC in August 2022. On this basis, further consideration is also needed to determine who will lead the Provider Collaborative at Scale.

4.2. If we consider the fact that DBH and EMAS are both involved in other ICS areas, the fact that Notts HC will have a representative on the ICB and are also currently due to lose their current Chief Executive to retirement, it leaves SFH and NUH as key members of the Provider Collaborative at Scale with no currently agreed role.

4.3. To ensure that the three key organisations all play a system leadership role within the provider landscape and there is a fair and balanced distribution of leadership capacity and involvement in representing and developing the provider landscape across Nottingham and Nottinghamshire, it is recommended that NUH and SFH each undertake one of the 2 lead roles, (a) for the Provider Collaborative and (b) the ICB Partner Member for NHS Trusts and Foundation Trusts covering hospital services and urgent and emergency care across NUH and SFH.

4.4. Given the necessity to ensure, where possible, the continuity of any ICB appointments and drawing on the expertise available to fulfil that role, it is proposed that Paul Robinson, as Chief Executive of SFH, is nominated as the Partner Member Representative for NHS Trusts and Foundation Trusts focusing on hospital services and urgent and emergency care.

4.5. On that basis, it is proposed that NUH will lead the Provider Collaborative at Scale and Chair of the Provider Leadership Board going forwards. This will mean that Rupert Eggington will fill that role until there becomes an appropriate time to hand over to Anthony May, the incoming NUH Chief Executive.

4.6. Trust Boards are reminded that these appointments are for 2 years in the first instance.

4.7. Given that the timescales for nomination by the ICB will have passed by the time that the Board receives this paper, these nominations have already been submitted to the ICB with the caveat that Boards will have to ratify them at their next meetings.

4.8. The Trust Board is asked to approve the nomination of Notts HC Chief Executive and Paul Robinson, Chief Executive of SFH, as the Partner Member Representatives on the ICB for NHS Trusts and Foundation Trusts, covering mental health intellectual disability and community services and hospital services and urgent and emergency care respectively.

4.9. The Trust Board is asked to approve the proposal that Rupert Egginton and then Anthony May, in their role as Chief Executive of NUH will lead the Provider Collaborative at Scale and Chair the Provider Leadership Board.

5. Ongoing Development of the ICS Provider Collaborative at Scale

5.1. Oversight of the development of the Provider Collaborative has been taking place through the ICS Transition & Risk committee up until May 2022, to ensure alignment with other developing system plans / architecture but this committee will cease to exist after the May meeting. At this point, the Provider Leadership Board will assume responsibility for the ongoing development of the ICS Provider Collaborative at Scale, along with oversight and leadership of the work programmes that are owned by the Provider Collaborative.

6. Conclusion

6.1. This paper provides an update on the work progressing to establish an ICS Provider Collaborative at scale across the Nottingham and Nottinghamshire ICS and makes recommendations to establish the Provider Leadership Board, nominate suitable representatives for the Nottingham and Nottinghamshire ICS Partner Member roles and agree the future leadership of the Provider Leadership Board.

Board of Directors Meeting in Public

Subject:	COVID-19 Vaccination Programme: UPDATE	**Date: 9th June 2022**	
Prepared By:	Robert Simcox Deputy Director of People Kim Kirk Operations Lead for Hospital Hub		
Approved By:	Robert Simcox Deputy Director of People		
Presented By:	Clare Teeney, 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:

- Participated in two case studies nationally recognising positive impact to supporting uptake of Paediatric Vaccinations highlighting closely working with Paediatric colleagues.
- KMH Hub currently delivered over 216,000 vaccines since December 2020
- 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.
- Summer Plan will continue to focus on uptake from eligible cohorts, Over 75's and Immunosuppressed cohorts.
- 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

- Following discussion at the May Trust board further details associated with Information in relation to uptake of the Covid vaccination across Nottinghamshire, have been included providing visibility of system wide update
- Due to access to the National Immunisation Management System (NIMS) still not being available any updated position on Trust staff vaccine uptake is only as of February 2022. However, the Trust are activity reviewing the possibilities of access returning especially if the co-administration of COVID and Flu vaccine takes places this autumn.

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.

Sherwood Forest Hospitals
NHS Foundation Trust

Programme Assurance Report
May 2022

COVID 19 Vaccination Programme
Sherwood Forest Hospital Hub

Inspected and rated
Good
CareQuality Commission

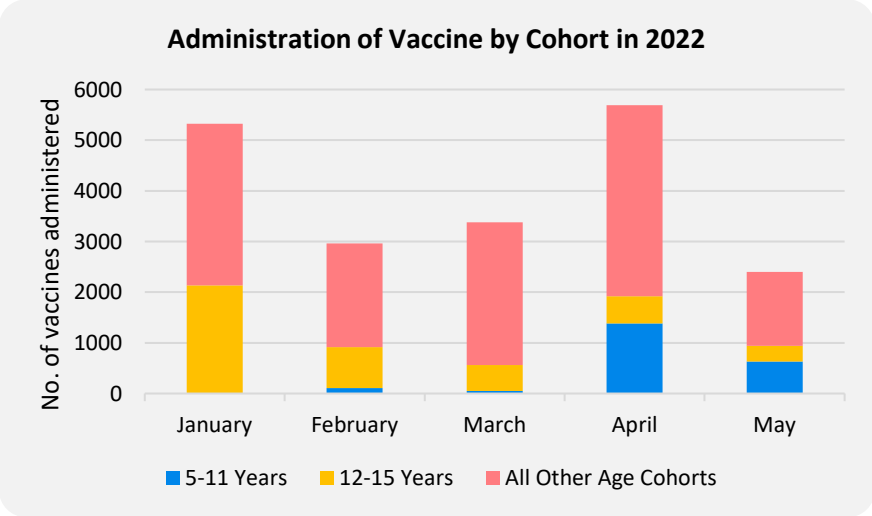
Performance to date

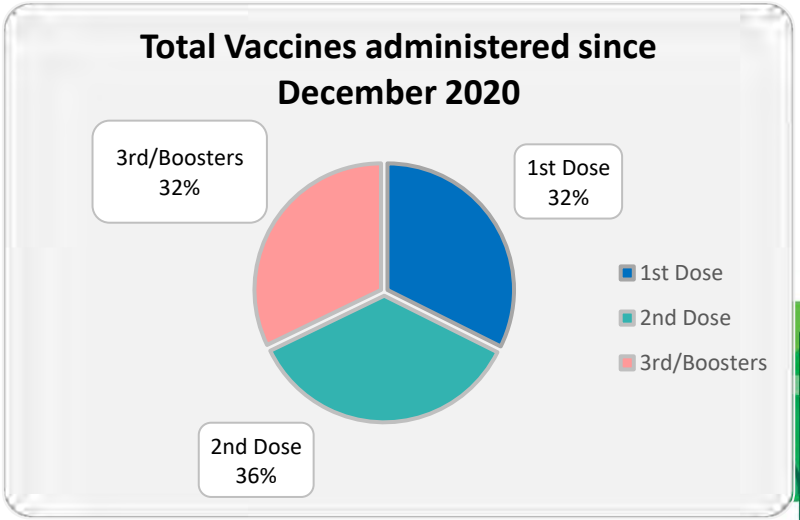
(8th December 2020 – 22nd May 2022)

Sherwood Forest Hospitals
NHS Foundation Trust

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
213,178	69,001	75,649	68,531	2,960

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
3,550	654	15K	28

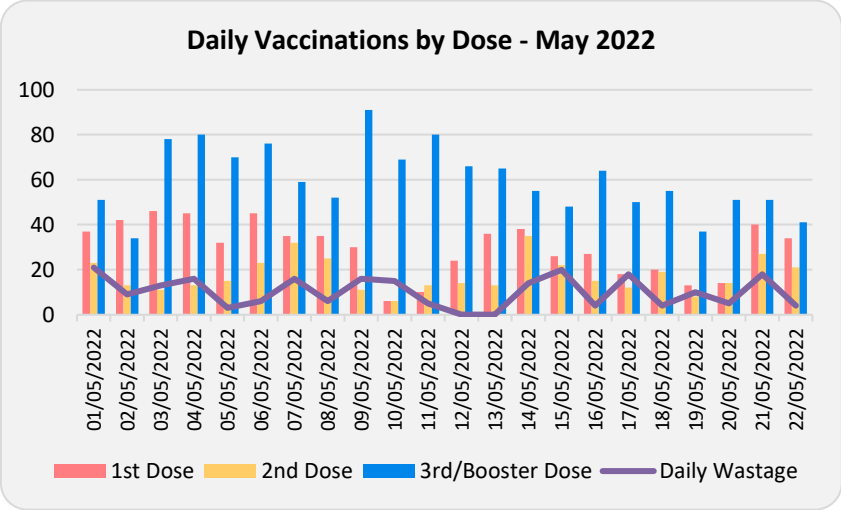


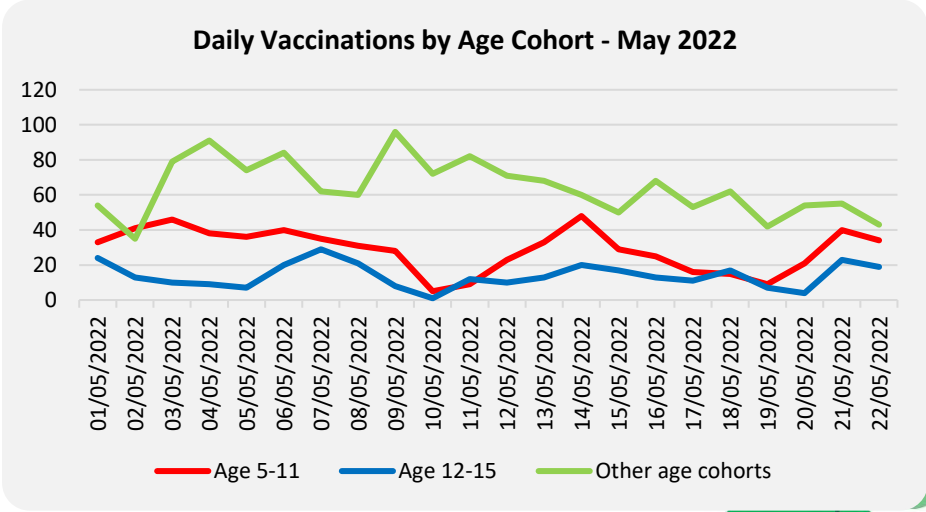


Monthly performance (May 2022)

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
213,256	2,361	10	318	223





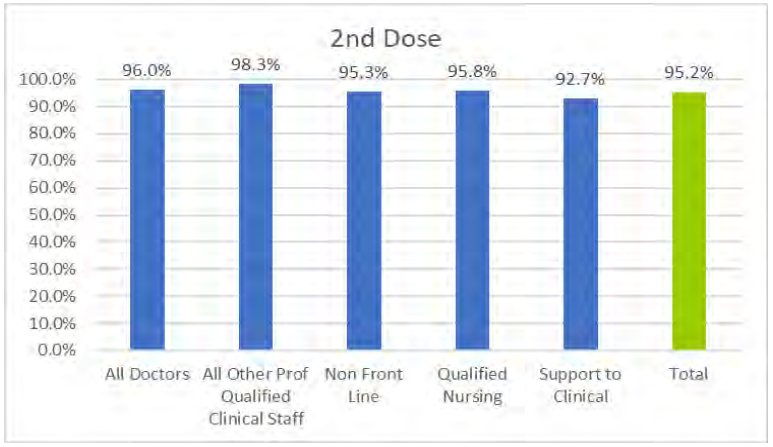
Staff Vaccination Programme

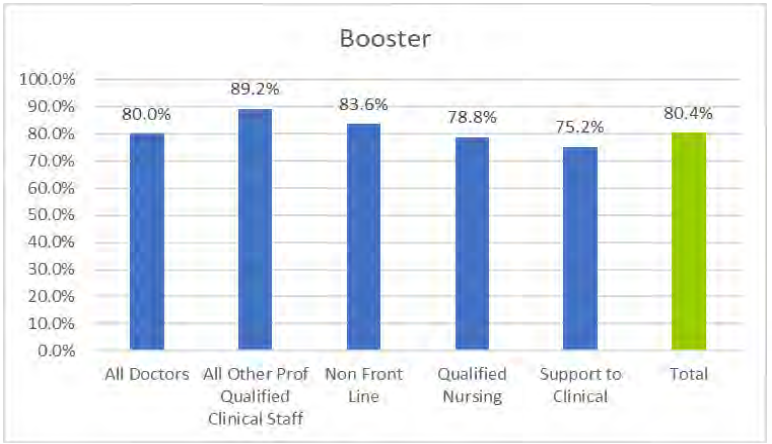
Sherwood Forest Hospitals
NHS Foundation Trust

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 the National Immunisation Reporting service (NIMs), that we used for all vaccination reporting. All Trusts were encouraged to record on and report on this system.

The removal was due to concerns around information governance and was a national decision. We have subsequently appealed and attempted to gain access, however this is still under review with no national decision taken as yet.

To mitigate against this we will be recording and reporting using the newly implemented OPAS Occupational Health system, we are now using within the Trust and are discussing how we upload our data into OPAS and then the mechanisms to keep thiss updated. We will be working on this during Q2 with an ambition to get recording during Q2.

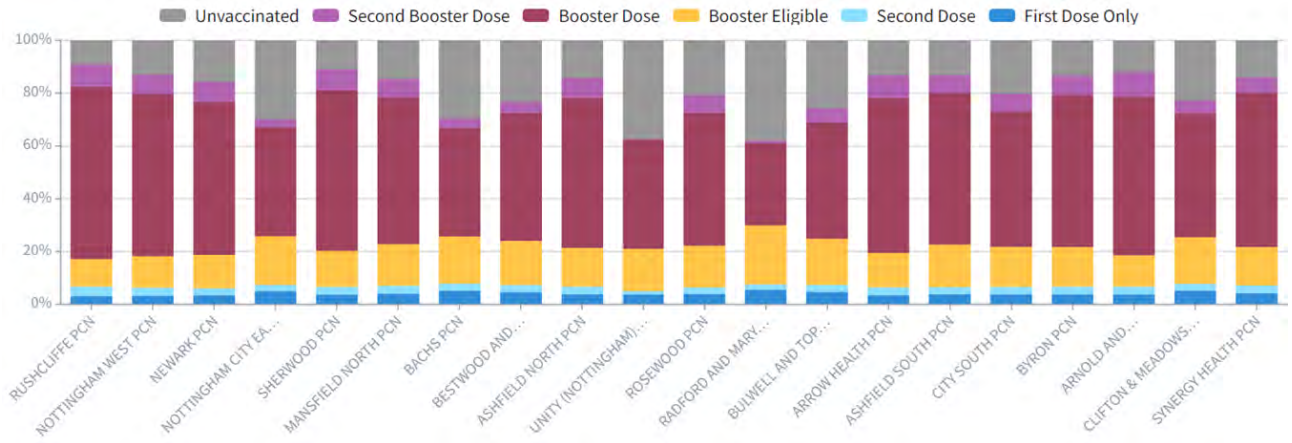




Programme Update - Evergreen Offer to over 12 years old

Sherwood Forest Hospitals
NHS Foundation Trust

Eligible population 977,082
First dose 794,364 (81.3%)
Second dose 754,669 (753,766)
Booster dose 583,649 (582,001)



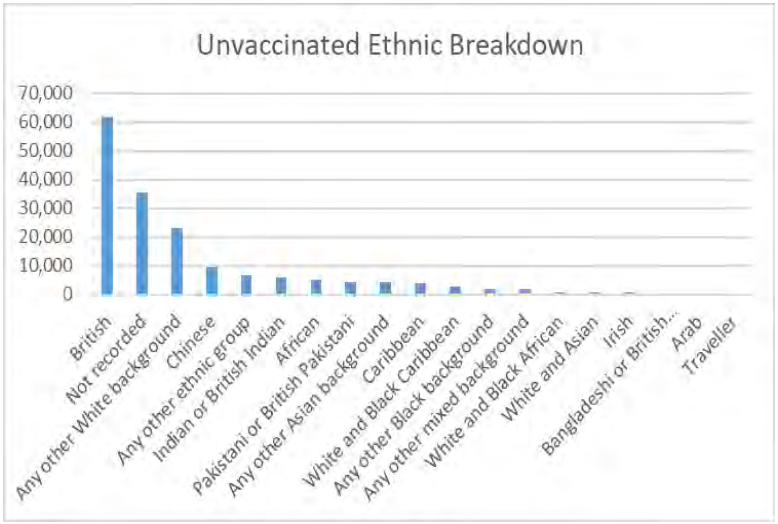
	National	Regional	ICS	
First Dose (C1-9)	90.80%	91.40%	91.40%	
Second dose (C1-9)	88.80%	89.50%	89.40%	
Booster dose (C1-9)	88.20%	88.15%	87.90%	
Booster dose (All cohorts)	81.40%	80.60%	80.10%	
12-15 First dose	54.90%	54.70%	55.00%	
12-15 Second dose	34.60%	34.20%	35.40%	
16-17 First dose	66.20%	66.10%	65.50%	
16-17 Second dose	49.50%	48.60%	48.20%	

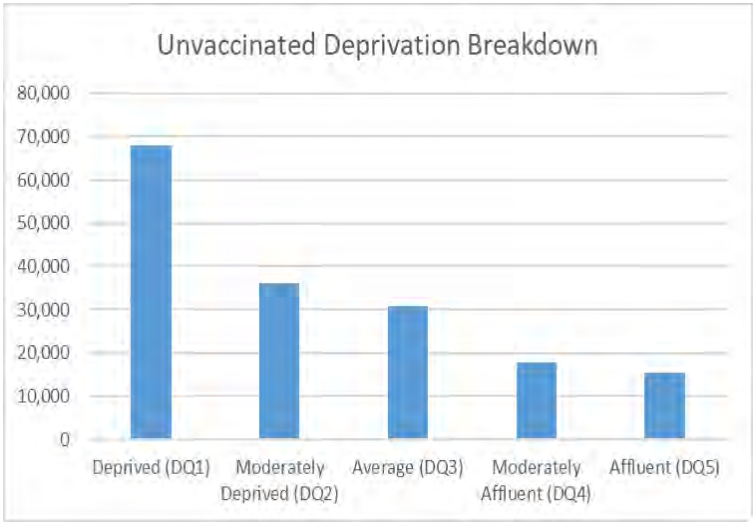
Performance reasonably in line with national and regional performance, except for booster doses and second doses for 16-17 year olds

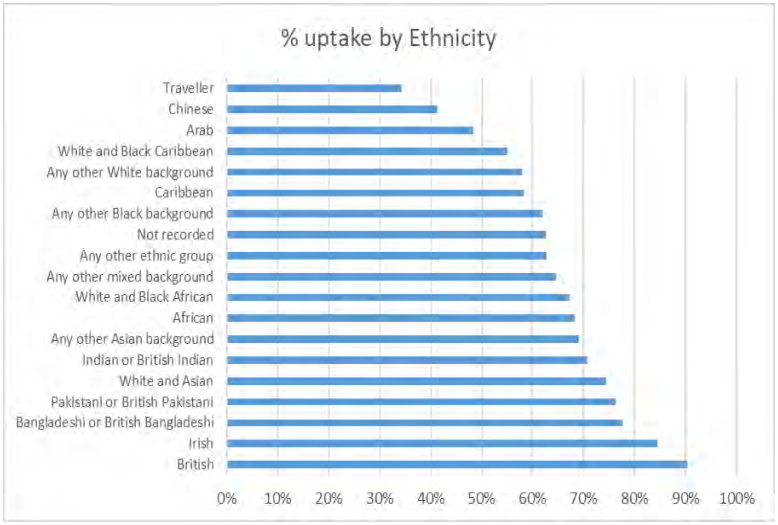
Red – More than 1% below National average.
Amber – Up to 1% below National average.
Green – Equal or above National average.

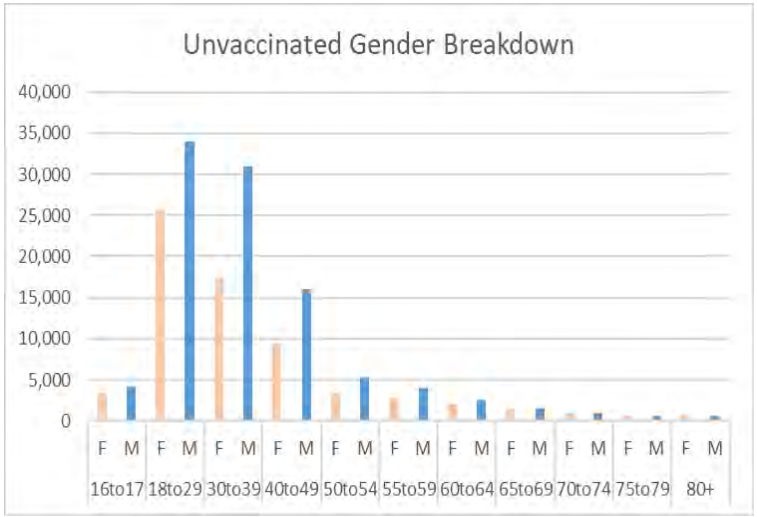
COVID Vaccination – May 2022 Overall Demographics Over 16

Sherwood Forest Hospitals
NHS Foundation Trust









Most unvaccinated population

- White British
- Other White Background

Lower percentage uptake:

- Chinese
- Other White Background
- Black ethnic groups

Uptake lower in more deprived population

More men than women unvaccinated

Gender gap greatest in working age population

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“Lets Talk Vaccination – Health on the move” – supporting accessibility for local citizens

The Covid-19 vaccination programme in Nottingham and Nottinghamshire are using different approaches to help make it as easy as possible for people to receive the Covid-19 vaccine to address inequalities; “Lets Talk Vaccination – health on the move”. A number of these initiatives include:

Vaccination Medivans – vaccination vans are being used in well-known locations around the city and county allowing the pubic to get vaccinated outside of our vaccination centres. Including businesses e.g Amazon. Schedules are published on the www.nhs.uk, www.nottsccg.nhs.uk and social media platforms.

Vaccination Sanctuaries – a mobile clinic based setting led by clinicians to provide an opportunity to ask questions to an expert and find out more about the Covid-19 vaccine. No vaccinations taking place on site, the trained staff will be focused specifically on answering questions, providing information, and giving advice. There have been 57 Sanctuaries held between January and May 2022, 31 of these in the City and 26 in the County

5-11 Year olds Pop Up Clinics – Vaccination clinics taking place in sites across the County and City currently covering Clifton and Arnold, extending to Broxtowe, St Ann’s and Burrows Court.

Making Every Contact Count (MECC) – Vaccination programme working closely with City Council exploring twice weekly Health & Wellbeing Workers Clinics supporting local industry and businesses.

Board of Directors Meeting - Cover Sheet

Subject:	Ockenden Final Report Update	**Date: 09/05/2022**	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery		
Approved By:	Robin Binks, Deputy Chief Nurse		
Presented By:	Philip Bolton, 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 the process of self-assessment, using our previous governance frameworks for reporting through the Maternity Assurance Committee (MAC), has started. However, the review has been paused whilst the Trust awaits further national instructions around the reporting requirements and the Senior Nursing team are focused on the implementation of the new MIS.

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 10 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

At June's LMNs meeting, we will be exploring the implementation of continuity of care to ensure our plan is aligned with neighbouring organisations.

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

Recommendation

Board members note the contents of the report

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting - Cover Sheet

Subject:	Maternity and Neonatal Safety Champions Update May 2022	**Date: 09/06/2022**	
Prepared By:	Paula Shore, Divisional Head of Nursing and Midwifery		
Approved By:	Robin Binks, Deputy Chief Nurse		
Presented By:	Phil Bolton, 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. At provider level, local champions should:

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

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

Update on Mandated Maternity and Neonatal Safety Champion (MNSC) work for April 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 is further planned to present at this month's board regarding her journey.

2. Staff Engagement

   The MNSC Walk Round was completed on 5th April 2022. Positive feedback was received, and thanks was given to Julie Hogg on her last walk round from the Maternity team. The Maternity Forum occurred on 21st April, chaired by Robin Binks. Updates were provided on the raised bright sparks idea regarding the lanyards and how this idea might be replicated Trust wide. 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 31st 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 was lifted on 6th May 2022, the divisional working group has been relaunched to help the delivery of the scheme.

4. Quality Improvement Approach

   Work continues within Maternity and Neonatal Safety Improvement Programme, looking at the 2022-23 improvement plan with a focus on pre-term birth. A team from SFH will be attending the planned QI Mat/Neo Safety Network event on 8th June 2022.

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. The aim is to survey in August 2022.

2. Monthly Feature- Maternity and Neonatal Safety Collaborative

The Maternity, Neonatal Safety Improvement Programme (MatNeoSIP), was renamed following the launch of the NHS Patient Safety Strategy in July 2019. It was previously known as the Maternal and Neonatal Health Safety Collaborative.

MatNeoSIP is led by the National Patient Safety team and covers all maternity and neonatal services across England. It continues to be supported by 15 regionally-based Patient Safety Collaboratives.

The programme aims to:

- Improve the safety and outcomes of maternal and neonatal care by reducing unwarranted variation and provide a high-quality healthcare experience for all women, babies and families across maternity and neonatal care settings in England.
- Contribute to the national ambition, set out in Better Births of reducing the rates of maternal and neonatal deaths, stillbirths, and brain injuries that occur during or soon after birth by 50% by 2025.

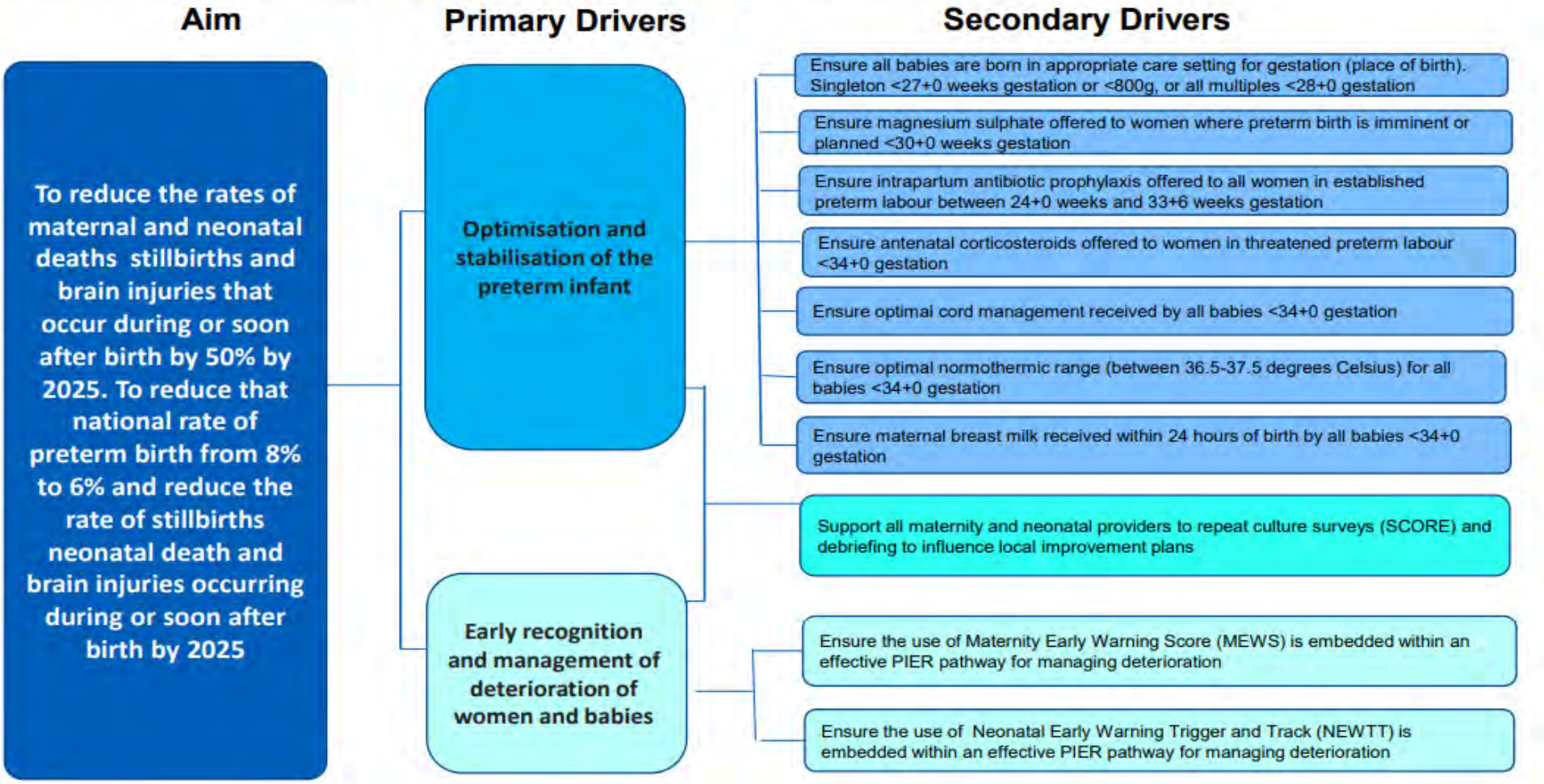
To aid the delivery of the programme, the East Midlands Academic Health Science Network Patient Safety Collaborative (EMASHN PSC) are commissioned to support. This offer includes the below:

- Build on the MatNeo Safety Network
- System leadership for safety improvement
- Support and scale up improvement activities
- Support measurement: baseline data and outcomes
- Share lessons and best practice
- Embed and support MatNeoSIP priorities
- Support clinical improvement advisor role in the safety network

The SFH improvement plan will focus upon the primary driver of optimisation and stabilisation of the preterm infant (appendix 1). The national ask is to focus on this driver noting the national launch of MEWS and NEWTT in Q3 2022-23. SFH are assessing the baseline data in or der to inform the plan. This will be presented and monitored through MAC.

Appendix 1

Maternity and Neonatal Safety Improvement 2022.23



Maternity Perinatal Quality Surveillance model for May 2022

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

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

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

Obstetric haemorrhage >1.5L (Apr 2.51%)

- Improvement made on previous month, remains below revised national rate (>3.6%)
- Cases reportable via maternity triggers - no lapses in care / learning points identified
- First regional meeting attend and actions taken

APGARS <7 at 5 minutes (0.84%, Apr 22)

- Rate improved and below national threshold for reporting, noted no adverse incident, cases or term admissions within this number.
- Deep dive paper presented to MAC in May- action plan commenced from findings

Staffing red flags

- 2 staffing incidents reported in month
- Challenges due to recent sickness related to COVID-19 significantly improved.

Home Birth Service

- Due to vacancies homebirth services remains limited as per Board approval. This has been further escalated to the CCG and regionally for awareness.
- 1 Homebirth conducted in Ape 22, plan in place to re-start the full service in Quarter 2 22-23

FFT (89% Apr 22)

- FFT remains improved following revised actions
- New system being implemented in May which may cause disruption.
- Service User Representative in post and providing additional pathways for maternal feedback through Maternity and Neonatal Safety Champions Meeting

Maternity Assurance Divisional Working Group

NHSR	Ockenden
• NHSR year 4 MIS re launched, working group re-established and 360 assurance commissioned. • Evidence to be taken through MAC prior to Board.	• Final Ockenden report released 31/03/22. 15 additional IEA's for all Trust nationally to work towards. • Separate paper provided to board

Incidents reported Apr 22 (58 no/low harm, 1 as moderate)

Most reported	Comments
Other (Labour & delivery)	No themes identified
Triggers x 13	Cases included, PPH, term admission,
One Moderate case reported	

Other

- Staffing incidents remain static, review of 21-22 birth rate underway. BR+ revised establishment review started anticipated completion end o f June 22.
- LMNS quality insight visit final report provided, overall positive report. For the recommendations made action plans are underway within division, to note none of these are immediate safety concerns or recommendations.
- Active recruitment continues, Matron for Maternity Governance appointed and Matron for Intrapartum Care and Community are live.
- No further formal letters received and all women who have a planned homebirth, all women due June and July have been written to by the Head of Midwifery to outline current situation
- Midwifery Continuity of Carer formal data collection paused nationally, LMNS regional submission on track for 15th June 2022 with a Year 1 focus on system alignment of digital workstream
- Moderate case taken to Trust scoping, category 1 LSCS delay in transfer to theatre for Divisional investigation.

Maternity Perinatal Quality Surveillance scorecard

Sherwood Forest Hospitals
NHS Foundation Trust

CQC Maternity Ratings - last assessed 2018	GOOD		GOOD		GOOD		OUTSTANDING	GOOD		
Maternity Safety Support Programme	No									
Maternity Quality Dashboard 2020-2021	**Alert [national standard/average**	**Running Total/ average**	**Sep-21**	**Oct-21**	**Nov-21**	**Dec-21**	**Jan-22**	**Feb-22**	**Mar-22**	**Apr-22**
1:1 care in labour	>95%	99.81%	100%	100%	100%	100%	100%	100%	100%	100%
Women booked onto MCOC pathway			20%	20%	20%					
Women reccving MCOC intraprtum			0%	0%	0%					
Total BAME women booked			20%	20%	20%					
BAME women on CoC pathway			15%	15%	15%					
Spontaneous Vaginal Birth			51%	61%	57%	56%	63%	61%	59%	55%
3rd/4th degree tear overall rate	>3.5%	2.18%	0.94%	2.11%	3.00%	2.50%	2.78%	2.52%	2.90%	3.00%
Obstetric haemorrhage >1.5L	Actual	116	8	9	10	9	6	8	7	6
Obstetric haemorrhage >1.5L	>3.5%	3.24%	2.51%	2.90%	3.50%	3%	2.12%	3.30%	2.60%	2.20%
Term admissions to NNU	<6%	3.62%	2.16%	3.70%	3.20%	3.70%	5.00%	3.50%	3.50%	1.60%
Apgar <7 at 5 minutes	<1.2%	1.56%	1.20%	1.52%	2.03%	2.10%	1.90%	1.80%	2.00%	0.84%
Stillbirth number	Actual	11	1	0	0	3	1	1	1	0
Stillbirth number/rate	0	4.63	2,176			3,400			3,727	
Rostered consultant cover on SBU - hours per week	<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
Midwife / band 3 to birth ratio (establishment)	>1:28		1:30.4	1:29	1:29	1:29	1:29	1:22	1:22	1:22
Midwife/ band 3 to birth ratio (in post)	>1:30		1:31.4	1:29	1:29	1:28	1:28	1:24	1:24	1:24
Number of compliments (PET)		0	0	0	0	0	0	0	1	1
Number of concerns (PET)		9	2	4	0	0	0	0	2	2
Complaints		11	1	3	2	1	1	1	2	1
FFT recommendation rate	>93%		92%	88%	96%	96%	92%	91%	90%	89%
PROMPT/Emergency skills all staff groups			100%	100%	100%	100%	100%	100%	100%	100%
K2/CTG training all staff groups			98%	98%	98%	98%	98%	98%	98%	98%
CTG competency assessment all staff groups			98%	98%	98%	98%	98%	98%	98%	98%
Core competency framework compliance			50%	62%	70%	70%	81%	81%	88%	95%
Progress against NHSR 10 Steps to Safety	<4 <7 7 & above									
Maternity incidents no harm/low harm	Actual	540	76	63	57	89	83	45	69	58
Maternity incidents moderate harm & above	Actual	6	0	1	1	0	1	1	1	1
Coroner Reg 28 made directly to the Trust		Y/N	N	N	N	0	0	0	0	0
HSIB/CQC etc with a concern or request for action		Y/N	N	N	N		N	N	N	N

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Board of Directors Meeting in Public

Subject:	Guardian of Safe Working Hours Report	**Date: 9th June 2022**	
Prepared By:	Rebecca Freeman – Head of Medical Workforce Jayne Cresswell – Medical Workforce Advisor		
Approved By:	Dr M Cooper – Guardian of Safe Working Hours Dr D Selwyn – Medical Director		
Presented By:			
Purpose			
This report is a Mandatory requirement for assurance of safe working as per the Terms and Conditions of Service (TCS) of the 2016 Junior Doctors Contract.		**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	Through fines for breaches of safe working hours, additional payment and cost of locums for rota gaps.
Patient Impact	Adequate medical staffing is required to deliver a safe, sustainable and efficient service for our patients.
Staff Impact	Engagement with exception reporting and the Terms and Conditions of Service of the 2016 contract is required to retain trainee posts and will impact on recruitment and retention.
Services	Having adequate numbers of medical staff to ensure the delivery of the service.
Reputational	Facilitating an environment where there is trust wide engagement with the 2016 contract and exception reporting is positively and constructively responded to so trainees feel this is a Trust where they are supported to achieve their training outcomes.

Committees/groups where this item has been presented before

This report will be presented at the Joint Local Negotiating Committee after presentation at the Trust Board of Directors.

Executive Summary

The Guardian of Safe Working Hours report provides information relating to the exception reports received between 1st February 2022 to 30th April 2022.

The report gives an overview of the exception reports that have been received by Division and grade of doctor and the reasons for the exceptions, making comparisons against previous years.

There have been no fines or work schedule review requests during this period.

The report also describes actions that have been undertaken since the last report by Dr Martin Cooper the Guardian of Safe Working and actions that are planned for the next quarter in accordance with the action plan in Appendix 1.

Introduction

This report provides an update on exception reporting data, from 1st February 2022 until 30th April 2022. It outlines the exception reports that have been received during the last three months, the actions and developments that have taken place during this period of time and work that is ongoing to provide assurance that there is safe working as per TCS of the 2016 junior doctors' contract.

As can be seen from the below, there are 203 doctors in training, a decrease of 10 from the previous rotation.

High level data

Number of doctors in training (total):	203
Number of doctors in training on 2016 TCS (total):	203
Number of training posts unfilled by a doctor in training:	26
Number of unfilled training posts filled by a clinical fellow/locum:	5
Total number of non-training doctors including teaching fellows:	83
Amount of time available in the job plan for the guardian:	1 PA
Administrative support provided to the guardian:	0.1 WTE
Amount of job planned time for Educational Supervisors:	0.25 PAs per trainee

Exception reports From February 2022 (with regard to working hours)

The data from 1st February 2022 until 30th April 2022 shows there have been 68 exception reports in total, 58 related specifically to safe working hours while 8 related to the rota pattern and 2 were related to educational issues.

None of the exception reports were categorised by the Trainees as Immediate Safety Concerns.

By month there were 19 in February 2022, 30 in March 2022 and 19 in April 2022.

Of the 58 exception reports related to safe working hours, 51 were due to working additional hours, 5 related to rest and 2 were due to not being able to take a natural break.

Of the total 68 exception reports 30 (44%) have been closed with 38 (56%) still open and all 38 of these are overdue. Of the 38 overdue exception reports, 32 are still waiting for the initial meeting to take place, the other 6 are unresolved or waiting for the junior doctor's agreement.

For the exception reports where there has been an initial meeting with the supervisor the median time to first meeting is 26.7 days. Recommendations are that the initial meeting with the supervisor should be within 7 days of the exception report. In total 75% (51) of all exception reports either had an initial meeting beyond 7 days or have not had an initial meeting.

Where an outcome has been suggested there are 17 with time off in lieu (TOIL), 11 with additional payment, 1 with no further action and 1 unresolved.

The Allocate software used to raise exception reports and document the outcome does not currently have the facility to be able to link to the eRota system to confirm TOIL has been taken or additional payment received.

Table 1 also refers to an immediate safety concern details of which were referred to in the last guardian report, although this has been addressed by the department, the exception report had not been closed by the trainee as at the end of April 2022.

Reasons for ER over last quarter by specialty & grade						
ER relating to:	Specialty	Grade	No. ERs carried over from last report	No. ERs raised	No. ERs closed	No. ERs outstanding
Immediate patient safety issues	Acute Medicine	ST2	1	0	0	0
Total			**1**	**0**	**0**	**0**
No. relating to hours/pattern	Accident and emergency	ST5	0	4	0	4
	Acute Medicine	CT2	0	2	0	2
	Acute Medicine	CT3	1	6	0	7
	Acute Medicine	FY2	4	0	4	0
	Acute Medicine	ST2	1	0	0	0
	Anaesthetics	ST4	0	2	1	0
	Cardiology	CT2	0	1	0	1
	Gastroenterology	FY1	1	0	0	1
	General medicine	CT1	0	3	2	1
	General medicine	CT2	0	6	6	0
	General medicine	FY1	3	12	4	14
	General medicine	FY2	1	8	6	3
	General medicine	ST6	1	0	0	1
	General practice	FY2	0	0	0	2
	General surgery	FY1	0	1	0	1
	Genito-urinary medicine	FY2	0	1	0	1
	Obstetrics and gynaecology	FY1	0	3	0	3
	Obstetrics and gynaecology	FY2	0	1	0	1
	Obstetrics and gynaecology	ST1	1	0	0	1
	Obstetrics and gynaecology	ST4	0	1	0	1
	Ophthalmology	ST1	1	0	1	0
	Paediatrics	FY1	0	1	0	1
	Paediatrics	FY2	1	0	0	1
	Paediatrics	ST2	3	3	0	6
	Paediatrics	ST4	3	0	0	3
	Paediatrics	ST6	0	1	0	1
	Respiratory Medicine	FY1	1	0	0	1
	Surgical specialties	CT2	0	1	1	0
	Surgical specialties	FY1	4	1	2	3
	Trauma & Orthopaedic Surgery	FY2	4	0	0	9
	Trauma & Orthopaedic Surgery	ST7	0	8	0	8
Total			**30**	**66**	**27**	**77**
No. relating to educational opportunities	Anaesthetics	CT1	1	0	0	1
	Ophthalmology	ST2	0	1	0	1
	Paediatrics	ST4	1	0	0	1
	Respiratory Medicine	FY1	1	0	1	0
	Trauma & Orthopaedic Surgery	FY2	0	1	0	1
Total			**3**	**2**	**1**	**4**
No. relating to service support available						
Total			**0**	**0**	**0**	**0**

Table 1 Exception Reports for Working Hours by Grade and Division

**Acute Medicine shifts involve doctors from the Medical Division*

The majority of the exception reports received during this period - 42 (44%) in total - are from junior doctors working in the **Medical Division**. Although the doctors are within the Medical Division their Acute Medicine shifts are within the Urgent and Emergency Care Division. Therefore, of the 42 exception reports, 12 were whilst doing acute medicine shifts and 30 whilst doing specialty specific or ward-based work within Medicine. (Table 1) (Figure 1).

Within the Medical Division 12 of the exception reports have come from the Foundation Year 1 Doctors, 18 from the Foundation Year 2 Doctors and IMT Trainees and none from the ST4+ Trainees.

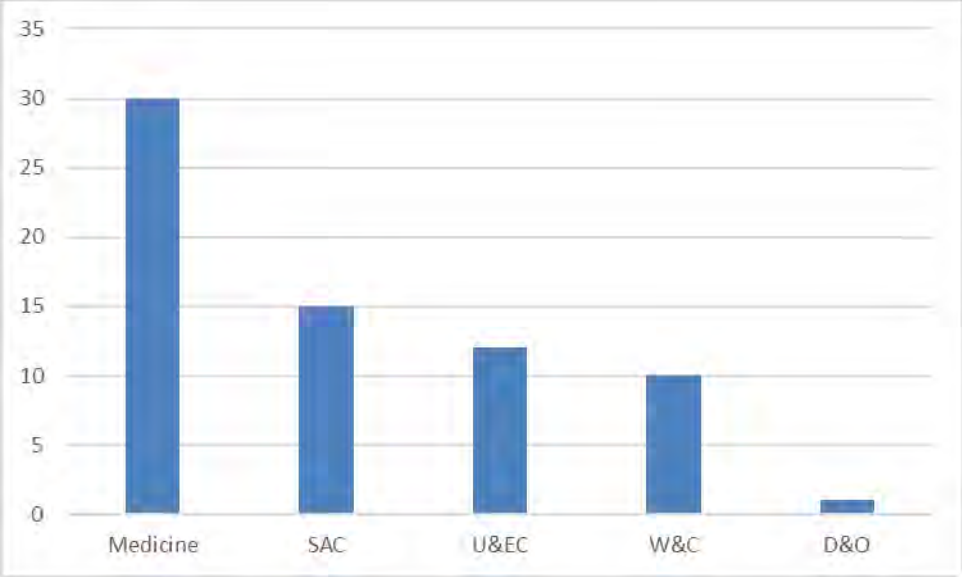


Figure 1 Exception reports by Division for Trainees

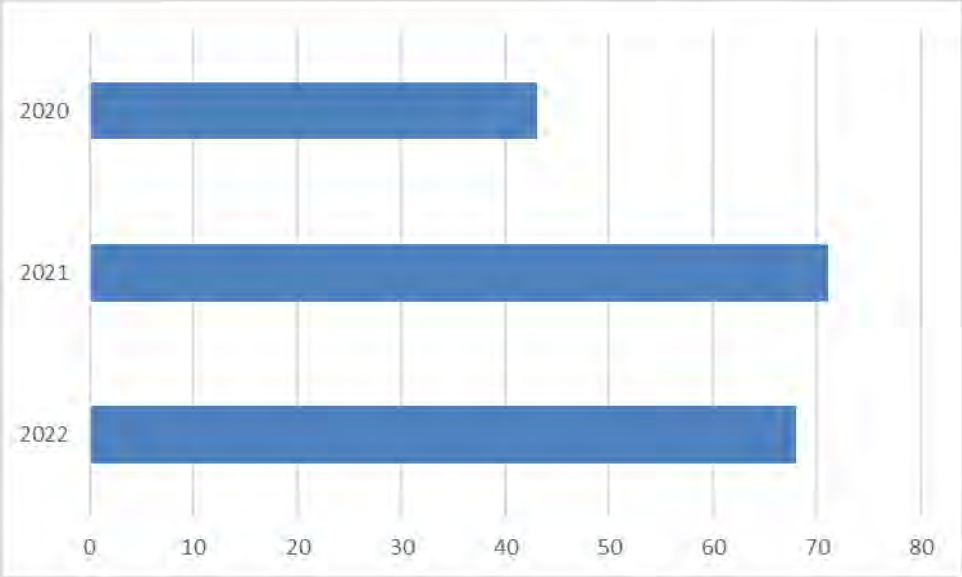


Figure 2. Comparison of number of exception reports for the same period between 2020, 2021 and 2022

Currently the proportion of junior doctors in training in each of the three tiers of F1, F2/CT/IMT1-2/ST1-2/GPST and ST3+ are 17%, 57% and 26%. However, the proportion of total exception reports from each tier is 25%, 51% and 24% respectively.

Figure 3 shows that this year there have been fewer exception reports from the F1 and the F2/CT/IMT1-2/ST1-2/GPST doctors than in the previous two years but there is an increase in the number of ST3+ doctors submitting exception reports.

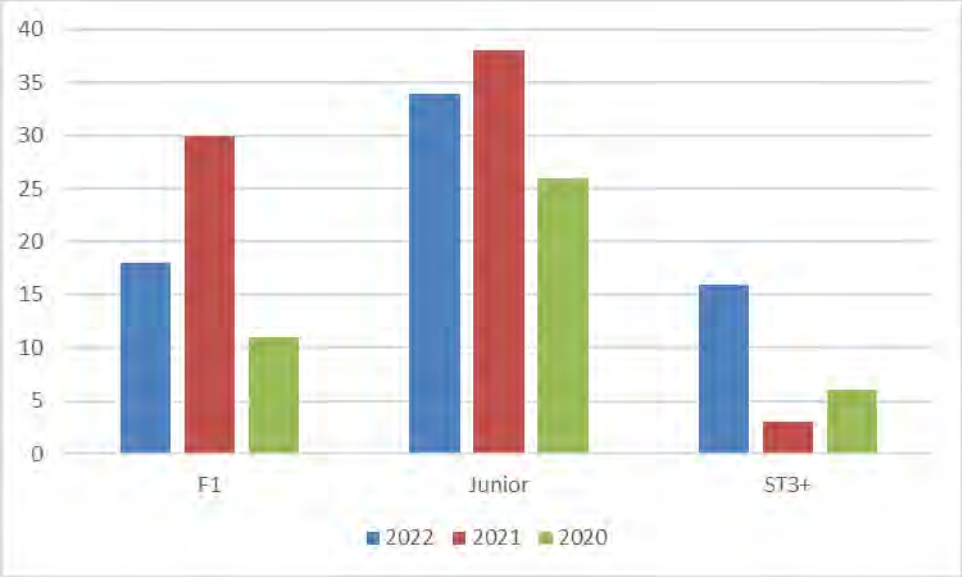


Figure 3. Number of Exception reports by doctors by grade for the same quarter between 2019, 2020 and 2021.

Exception Reports from Clinical Fellows

There have been 15 exception reports received from Clinical Fellows during this period. 11 Exception reports were from Medicine and 4 exception reports were from Urgent & Emergency Care. The Clinical Fellows worked an average of an additional 1 hour and 30 minutes each at the end of a normal working day, the exception reports have been reviewed by the clinical supervisors, all were supported and time in lieu given to the doctors.

The Clinical Fellows are regularly reminded about completing exception reports and receiving this number of exception reports shows that they are keen to report any exceptions. The numbers of reports received will be monitored on an ongoing basis

Work Schedule Reviews

There have been no work schedule reviews. Exception reports continue to be dealt with as a one-off with few progressing to a work schedule review for issues that are recurrent.

Within Trauma & Orthopaedics an issue was raised by one of the St3+ doctors regarding the rostering of the rota for the Senior Trainees. On investigation, it appeared that the rota had not been rostered correctly and as such a number of additional days had been worked by four trainees. These trainees left the Trust at the beginning of April and have been compensated financially for the additional hours that have been worked over and above the roster.

This has been discussed with the Service Director of the Specialty and the rota coordinator to ensure that in future the roster that is worked mirrors the template rota.

Fines

There were no fines issued this quarter.

Vacancies

26 of the 203 training posts are unfilled by a doctor in training, however, 5 of the 26 vacancies are filled by a Clinical Fellow. The remaining gaps are offered to doctors on the Trust bank, where it is not possible to fill the posts using doctors on the Trust bank, locum agencies will be used. A number of these posts have become vacant in April during the last rotation, this is particularly the case of 3 GP trainee posts. In addition there are a number of less than full time trainees in post, particularly in Paediatrics and Anaesthetics.

Qualitative information

The number of exception reports made by those at IMT/St3+ level still remains low with none being reported during this period. It is understood that having an IMT3 doctor supporting the Medical Registrar out of hours has had a positive impact in Medicine, the hospital has remained very busy with a major incident being declared over the Easter period, therefore it is felt that this group of doctors are still under reporting.

The Chief Registrar is currently undertaking a quality improvement project, raising the awareness of exception reporting. Posters have been developed and put in ward areas and in doctors offices encouraging the completion of exception reports. The impact of this project on the rate of exception reporting by both doctors in training and clinical fellows is currently being evaluated and results should be available for the next reporting period.

A meeting took place with Allocate on Friday 25th February 2022 to discuss the planned developments for the exception reporting system and unfortunately there are no immediate developments planned for the exception reporting element of the system.

The response to the exception reports by Educational and Clinical Supervisors within the required 7 days still remains a concern. Table 2 below indicates the number and percentage of exception reports that were not responded to within the required time frame of 7 days over the last year. This

has increased following this report despite sending reminders to some Educational/Clinical Supervisors with exception reports outstanding.

On investigation, it appears that logging onto the system seems to be the barrier as often discussions have taken place however they are not reflected on the allocate system.

Date of the Guardian Report	**Number and Percentage of reports not responded to within 7 days**
February 2022 – April 2022	56% of all reports received 38 reports
November 2021 – January 2022	50% of all reports received 15 reports
August 2021 – October 2021	52% of all reports received 15 reports
May 2021 – July 2021	33% of all reports received 13 reports
November 2020 – April 2021 (6 month combined report)	44% of all reports received 21 reports

Table 2 Exception Reports not responded to within 7 days

For those exception reports yet to be identified as resolved and closed, Dr Cooper has contacted the trainee doctors and their Educational and Clinical Supervisors to ask for updates on outstanding reports. Responses to date suggest that a number have been addressed and resolved to the satisfaction of the trainee but have yet to be closed on the Allocate system. Dr Cooper plans to write to the Educational and Clinical Supervisors advising them of the importance of responding to exception reports using the system in a timely manner. In addition he will stress the importance of Supervisors

promoting the raising of exception reports by trainees and clinical fellows. Understanding that this not only ensures good working conditions for staff but can identify clinical areas and services which may benefit from enhanced medical staffing levels will be key in fully engaging with the system.

Work has been undertaken within Medicine to review the rotas at foundation level, IMT1&2 levels and the Clinical Fellow rota. This has been done in conjunction with the junior doctors. The rota has remained fundamentally the same and as doctor numbers have increased, the lines on the rota have increased to the point where there were 33 lines on the Medicine rota. This has been divided up into 17 line rotas. A number of meetings have been held with junior doctor representatives to discuss the rota in detail and alterations have been made to improve the rota as discussions have progressed.

The final rotas have been supported by the current trainee representatives and are now being sent to the Trainees due to commence in post in August 2022 as part of the work schedule.

Progress against the Actions to be undertaken by the Guardian of Safe Working

The number of exceptions being reported by Clinical Fellows is increasing, this will continue to be monitored on a quarterly basis in this report.

Conclusion

Trust Board is asked to:

- Note that a letter is being sent to the Educational and Clinical Supervisors by the Guardian of Safe regarding the timely completion of exception reports and the Guardian of Safe Working will also regularly attend the Educational Supervisors forum to remind the clinicians of the importance of responding to exception reports through the system to enable accurate reporting.
- Note that details of the exception reports from clinical Fellows will be included in the Quarterly Guardian of Safe Working reports going forwards.
- The Chief Registrar has undertaken a quality improvement project which has involved putting posters on the wards and in doctors offices to remind trainees to exception report.

Appendix 1

Issues/Actions arising from the Guardian of Safe Working Report

Action/Issue	**Action Taken (to be taken)**	**Date of completion**
Educational/Clinical Supervisors to be encouraged to complete exception reports in a timely manner.	Guardian of Safe Working to write to Educational and Clinical Supervisors to encourage them to review exception reports in a timely manner using the allocate system.	10th June 2022
Include Clinical Fellows and other non training grade exception reporting data in Quarterly reports.	2 Clinical Fellow exception reports received in the report in November 2021, and 15 reports have been received in the report in February 2022. The numbers will be reported on an ongoing basis.	Complete
Continually encourage the trainees to complete exception reports	Quality Improvement Project undertaken by the Chief Registrar in March 2022 and posters put in ward areas and doctors offices reminding trainees and Clinical Fellows to exception report.	Ongoing

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

Equality, Diversity and Inclusion Activity Report 2021 – 2022

diverse inclusive together

disability confident EMPLOYER

We're supporting AGE POSITIVE

Carer-friendly Employer

MINDFUL EMPLOYER

1 Contents

SHERWOOD FOREST HOSPITALS NHS FOUNDATION TRUST

EQUALITY, DIVERSITY AND INCLUSION ACTIVITY REPORT 2021 - 2022

1. Introduction

This report provides the Board of Directors with an update on the achievements, progress and developments in relation to the Equality, Diversity and Inclusion agenda at Sherwood Forest Hospitals NHS Foundation Trust.

2021/2022 has been another very challenging year for the Trust. Continued Covid-19 infections and significant Winter pressures in addition to our Covid Recovery Plans have seen our colleagues and hospitals continuing to respond at pace in order to manage the demands on our services whilst maintaining the high standards of care that our community rely upon us to provide.

We have remained committed to providing an environment where all staff, service users and carers enjoy equality of opportunity. We oppose all forms of unlawful or unfair discrimination on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation.

Despite the challenges, we have ensured that the Equality, Diversity and Inclusion agenda has continued to be supported at all levels within the Trust.

As reported last year, in February 2021, the Trust demonstrated its commitment to EDI with the appointment of a workforce Equality, Diversity & Inclusion Lead for a six-month secondment initially. This full-time dedicated resource was welcomed and the success of the role was recognised; as a result the role was made substantive and was appointed to following a competitive recruitment process in May 2022.

2 Organisational

2.1 People, Equality, Diversity and Inclusion Sub-Cabinet

The sub-cabinet meets on a monthly basis and the focus of their work is ensuring an inclusive workplace for all colleagues and supporting the delivery of the strategies, policies and statutory duties associated with the EDI agenda.

The following are a summary of the main actions achieved by the sub-cabinet in the last 12-months;

- appointed a new Vice-Chair
- agreement of the new EDI strategy and the new Anti-Racism Strategy
- agreement of reviewed EDI policy and new guidance prior to JSPF ratification
- development of a new EDI statement for all new job descriptions
- development of assessment questions now included in all interview packs for recruiting panels
- agreed content for the EDI page on new Recruitment microsite
- inclusion question agreed and added to leavers questionnaire

The sub-cabinet reviewed and agreed updated terms of reference at their meeting in May 2022. During this meeting the priorities for the upcoming 12-months were also agreed; these have been aligned to the EDI priorities contained within the new People, Culture and Improvement Strategy whilst still maintaining a focus on the EDI Strategy/6 High Impact Action Plan and Anti-Racism Strategy. The priorities identified are;

- Continuing to embed EDI across the Trust with a particular focus on front-line colleagues and middle managers
- Growth and development of our staff networks
- Raise awareness of and embed the anti-racism approach throughout the Trust

The sub-cabinet provides monthly reports to the People and Inclusion Cabinet and the People and the Culture and Improvement Committee. Updates are also provided to the Joint Staff Partnership Forum (JSPF). There is also an inclusion in the Trust's annual report to the Board of Directors which notes our workforce EDI priorities and actions to be delivered.

2.2 Staff Networks

During the last 12 months, we have increased our number of staff networks from three to four and we have just (staff networks day, May 2022) invited colleagues to join a brand-new Women's staff network which will bring our network total to five. In the last 12 months, we have appointed Chairs and Vice Chairs to our three established staff networks and aim to ensure that each network has a Chair and Vice Chair to lead, develop and grow the networks and an Executive Sponsor to support their work.

Staff Network	Chair/Co-Chair	No. of members	Executive Sponsor
Ethnic Minority	Suman Dove Geraldine Edwards	55	Emma Challans
LGBT+	Mitchel Speed	49	Dave Selwyn

	Phil Eardley		
WAND (Disability)	Robin Binks Ali Pearson	22	To be appointed
Carers (NEW)	To be appointed	18	Emma Challans
Women's (Just Launched!)	To be appointed	2	To be appointed

All staff networks have an agreed Terms of Reference outlining the purpose and aims of the network. Whilst each network has its own terms, the purpose and aims are broadly the same;

- Purpose: To promote an inclusive workplace where all colleagues are welcomed, valued and have a true sense of belonging; for Sherwood Forest Hospitals to be 'a great place to be' for everyone
- Aims:
    - To work to eliminate any workplace stigma, discrimination, racism, bullying or harassment and promote equality
    - To influence and monitor policies
    - To support the Trust in its mandatory reporting and duties under the Public Sector Equality Duty and the Equality Act 2010
    - To provide support to colleagues through events and signposting to support
    - Provide education to aid understanding of the experience of colleagues from minority groups

Our staff network leads are invited to attend the People, Equality Diversity and Inclusion sub-cabinet where the work of the networks can be promoted and matters for escalation can be discussed and agreed.

3 Compliance with mandatory reporting and the Equality Act 2010

3.1 The Public Sector Equality Duty

The Equality Act 2010 (s.149) places an Equality Duty on public bodies which encourages the Trust to engage with the diverse communities affected by our activities to ensure that policies and services are appropriate and accessible to all and meet the different needs of the communities and people we serve.

The Equality Duty consists of a General Duty with three main aims. It requires the Trust to have due regard for the need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by or under the Equality Act 2010
- Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it.

- Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.

Having ‘due regard’ means the Trust must consciously think about the three aims as part of our decision making processes and considerations of equality issues must influence our decisions, such as, how we act as an employer; how we develop, evaluate and review policy; how we design, deliver and evaluate services and how we commission and buy services from others. The general duty is also underpinned by a number of specific duties which include the need for us to:

- Set specific, measurable equality objectives;
- Analyse the effect of our policies and practices on equality and consider how they further the equality aims;
- Publish sufficient information to demonstrate we have complied with the general equality duty on an annual basis.

3.2 Specific Duties

The Equality Duty is supported by specific duties, set out in the regulations which came into force on 10th September 2011. The specific duties require public bodies to publish relevant, proportionate information demonstrating their compliance with the Equality Duty, and to set themselves specific measurable equality objectives. All information must be published in a way which makes it easy for people to access.

The information published must include;

- Information relating to employees who share protected characteristics (for public bodies with 150 or more employees); and
- Information relating to people who are affected by the public body’s policies and practices who share protected characteristics (for example, service users).
- However it is up to each public body to decide itself what information it publishes to show its compliance with the Equality Duty.

3.3 Publication Duties

The information must be published on an annual basis. The Trust has published;

3.3.1 Workforce Figures

The information published on workforce figures identifies information in relation to the Trust’s workforce and protected characteristics as defined by the Equality Act 2010.

- Equality, Diversity and Inclusion Annual Activity report
- NHS Staff Survey Summary
- Workforce Race Equality Standards (WRES)
- Workforce Disability Equality Standard (WDES)
- Gender Pay Gap Report

3.3.2 Patient Figures

As part of the Equality Act 2010 information in relation to patients and protected characteristics must be collated and published. The patient figures published reports which are related to patients and particular protected characteristics are detailed below, however will be delayed in publishing due to COVID-19.

- Patient activity data on protected characteristics 2020/2021
- Membership report within the Annual Report and Accounts 2020/2021

3.3.3 Organisational Information

The Trust published its updated Equality, Diversity and Inclusion Strategy in May 2021 outlining its objectives along with our 6 High Impact Action Plan which outlines how the Trust is meeting the needs of the Equality Act 2010. In addition, the Trust launched its new Anti-Racism Strategy in February 2022 which further strengthens our commitment to equality and inclusion within our hospitals.

4 Gender Pay Gap Reporting

In accordance with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017, employers with 250 or more employees are required to publish statutory calculations no later than 30th March each year. The information aims to establish the pay gap between male and female employees as at 31 March the previous year.

The Equality and Human Rights Commission defines the difference between equal pay and the gender pay gap as follows:

- Equal pay means that men and women in the same employment performing equal work must receive equal pay, as set out in the Equality Act 2010.
- The gender pay gap is a measure of the difference between men's and women's average earnings across an organisation or the labour market. It is expressed as a percentage of men's earnings.

Salaries at the Trust are determined through a national NHS job evaluation scheme called Agenda for Change (AfC). Job evaluation evaluates the job and not the post holder. It makes no reference to gender or any other personal characteristics of existing or potential job holders. Therefore, the Trust is confident it is paying the same salary to roles of equal value.

The legislation requires an employer to publish six calculations:

- Average gender pay gap as a mean average
- Average gender pay gap as a median average
- Average bonus gender pay gap as a mean average
- Average bonus gender pay gap as a median average
- Proportion of males receiving a bonus payment and proportion of females receiving a bonus payment
- Proportion of males and females when divided into four groups ordered from lowest to highest pay.

A summary breakdown of our workforce by gender and pay banding as at March 2021, which was published in March 2022, can be found on the Trust's website.

The Trust will undertake a number of actions which relate to these findings as follows:

- Identify and address the gaps in our female medical workforce
- Address gender pay gaps in divisions where they are evident

5 Equality Delivery System (EDS)

EDS is a mandatory framework to assist us with ensuring we treat our patients and staff fairly and equally. The Equality and Diversity Council (EDC) is currently leading on a review of the EDS and early in 2022 requested NHS organisations review new paperwork ahead of piloting the new EDS. The pilot was expected in 2020 but due to the Covid-19 pandemic it has been delayed.

The Nottingham and Nottinghamshire ICS requested to take part in the pilot of the new EDS as a system and a meeting with a representative from NHSE/I with Nottinghamshire Equality leads took place in late 2019. As we will be one of the pilot organisations, we did not undertake our EDS grading exercise in December 2021.

6 Workforce Race Equality Standard (WRES)

The Workforce Race Equality Standard (WRES) is a mandatory framework that we have to complete on an annual basis. The WRES standards are included in the NHS Standard Contract and all NHS organisations are required to demonstrate progress against nine indicators; four workforce data metrics, four staff survey findings regarding White and BME experiences, and one Board metric to address low levels of BME representation. The CQC inspect on the WRES implementation under the well-led domain. The Trust's WRES data for 2020/2021 was published in October 2021 and a WRES action plan developed. The national WRES report, published in Spring 2022, names Sherwood as one of only three Trusts in the country (and the only Trust in the Midlands) for sustaining improvement in providing non-mandatory training and CPD for BAME colleagues.

7 Workforce Disability Equality Standard (WDES)

The Workforce Disability Equality Standard (WDES) is a mandatory standard introduced in April 2019 that is completed on an annual basis. All NHS organisations are required to demonstrate progress against ten indicators; three workforce data metrics, six staff survey metrics and one Board metric. The Metrics have been developed to capture information relating to the experience of Disabled staff in the NHS. The Trust's WDES report for 2020/2021 data was published in October 2021 and a WDES action plan developed.

8 Equality Impact Assessments

We have agreed that no policy, procedure or process can be approved until an Equality Impact Assessment (EqIA) has been carried out. An EqIA is the detailed and systematic analysis of the potential or actual effects of a policy, procedure or process, which is undertaken in order to establish whether the policy, procedure or process has a differential impact on different groups of people. The aim of the EqIA is to eliminate discrimination and produce positive outcomes for equality. EqIA audits are undertaken on a quarterly basis and reported back to the Equality, Diverity and Inclusion sub-cabinet.

9 Workforce Information

The Trust is committed to treating all its service users and staff with dignity and respect. Embracing diversity supports the delivery of our strategic vision and helps to ensure that we are providing effective services that meet the needs of our community.

We have a workforce EDI Strategy which is a public declaration of how we will demonstrably take forward our commitment to ensuring equality is embedded within all aspects of the organisation. Further details can be found on the Diversity and Inclusivity page on the Trust's website.

9.1 Ethnicity

In 2021/2022 the ethnicity composition has risen when compared with the previous year. The ethnicity profile of our workforce is positive compared with the profile of the local community which is 95% White.

Ethnic Origin	2020/21		2021/22	
	%	Heads	%	Heads
Asian	8.2%	426	9.3%	543
Black	2.1%	109	2.2%	130
Chinese	0.3%	14	0.4%	26
Mixed	1.6%	86	1.8%	106
Other	0.0%	0	1.5%	90
Not Started	2.4%	124	1.7%	98
White	85.5%	4463	83.0%	4833
Total		**5222**		**5826**

9.2 Disability

The Trust collects data from all new employees regarding disability status and employees are encouraged to keep their own staff record updated throughout their employment. The current data identified 16.5% of staff have not declared their disability status, a decrease compared to last year. We have seen an increase in those declaring their disability which is pleasing to see.

Disability	2020/21		2021/22	
	%	Heads	%	Heads
No	74.1%	3867	75.7%	4412
Not Declared	19.9%	1040	16.5%	961
Undefined	1.5%	76	1.5%	86
Yes	4.6%	239	6.3%	367
Total		**5222**		**5826**

9.3 Staff Age Profile

The overall age profile for the Trust's workforce is dominated by the 31-40 and 51-60 age groups. We continue planning for potential retirements within coming years giving particular consideration to the Registered Nurse staff group where Nurses who have special class status can retire from 55 years of age. The facility for flexi-retirement continues to retain colleague's

valuable knowledge, skills and experience within the Trust; allowing staff to retire and return to work. On the whole the age demographics continue to remain static, with a typical distribution across the age ranges. The Medical age profile is representative of the numbers of Doctors in training.

Age	2020/21		2021/22	
	%	Heads	%	Heads
Under 20	0.7%	39	0.5%	29
21-30	19.4%	1013	19.1%	1113
31-40	25.2%	1318	27.1%	1577
41-50	22.7%	1188	22.5%	1312
51-60	24.7%	1291	24.1%	1405
61-65	6.0%	313	5.6%	325
66 +	1.1%	60	1.1%	65
Total		**5222**		**5826**

9.4 Medical Staff Age profile

Medical Age	2020/21		2021/22	
	%	Heads	%	Heads
Under 20	0.0%	0	0.0%	0
21-30	24.2%	136	24.9%	151
31-40	31.6%	177	30.4%	184
41-50	21.6%	121	23.8%	144
51-60	17.1%	96	15.2%	92
61-65	4.1%	23	4.3%	26
66 +	1.4%	8	1.5%	9
Total		**561**		**606**

9.5 Nursing Staff Age profile

Nursing Age	2020/21		2021/22	
	%	Heads	%	Heads
Under 20	0.0%	0	0.0%	0
21-30	19.5%	290	18.9%	333
31-40	26.1%	388	29.0%	510
41-50	23.5%	349	23.9%	421
51-60	24.3%	361	22.2%	391
61-65	6.0%	89	5.3%	93
66 +	0.7%	10	0.6%	10
Total		**1487**		**1758**

9.6 Gender

In 2021/2022 the female workforce continues to dominate the overall headcount with 82% of employees being female. This is a small increase when compared to the previous year's figures. Male headcount increased slightly compared to the previous year although the % of males in the workforce has decreased; this is due to the overall increase in headcount. Whilst

the male demographic of the workforce is considerably lower than the local demographic, this is comparable with NHS national demographic.

Gender	2020/21		2021/22	
	%	Heads	%	Heads
Male	19.5%	1019	18.0%	1046
Female	80.5%	4203	82.0%	4780
Total		**5222**		**5826**

9.7 Sexual Orientation

In 2021/2022, we have seen a decrease in the number of colleagues not declaring their sexual orientation; whilst this is positive, our numbers of those identifying as LGBT+ in our workforce remains lower than the estimated local population of 5-10%. We are hopeful that the continued focus on growth of our LGBT+ staff network, LGBT+ allies scheme and awareness raising events will provide colleagues, who have declined to declare their sexual orientation, with the reassurance to update their personal details in order to provide us with more accurate data. We also eagerly await the results of the 2021 Census to compare our LGBT+ community within our workplaces to those in our local community.

Sexual Orientation	2020/21		2021/22	
	%	Heads	%	Heads
Bi Sexual	0.7%	37	0.9%	50
Gay or Lesbian	1.2%	65	1.4%	83
Heterosexual or Straight	80.4%	4201	82.5%	4804
Not stated	17.6%	918	15.2%	885
Other Not Listed	0.0%	1	0.1%	4
Total		**5222**		**5826**

10 Membership and Public Involvement

10.1 Membership

As a Foundation Trust we are proud of our membership totalling in excess of 21,000, which is around 5% of the local population. Excluding staff membership this number is closer to 16,000. The breakdown for this can be seen below:

	Number of members	**Membership profile**	**Population profile**
Age (years)			
0-16	6	0.04%	19.6%
17-21	31	0.2%	5.9%
22+	13, 745	92.4%	7.3%

Not stated	1,106	7.4%	0%
Ethnicity			
White	13,269	89.2%	89.1%
Mixed	29	0.19%	1.6%
Asian	83	0.5%	6.2%
Black	30	0.2%	1.7%
Other	8	0.05%	0.3%
Not stated	1,469	9.8%	0%
Gender			
Male	5,352	35.9%	49.4%
Female	9,334	62.7%	50.5%
Not stated	202	1.3%	0%

10.2 Membership activity, events and communication

As with the previous years, the Governor's Membership and Engagement Committee has continued to focus on how best to engage with members. We have continued to issue a monthly e-newsletter, Trust Matters, which includes a digital event.

10.3 Annual General Meeting/Annual Members' Meeting

Owing to the Covid 19 pandemic this year's AGM was held virtually via Microsoft Teams on Monday 28 September 2020. The link to the event was shared with all public and staff members, stakeholder and members of the general public to allow them to view the event. As we move into living with Covid 19 the ambition will be to hold this years (2022) AGM face to face but also offering the opportunity for people to attend virtually.

We will continue to work closely with our members to help us to be truly accountable for the quality of the services we provide and deliver our ambition to deliver outstanding care to our local communities.

10.4 Forum for Public Involvement

The Forum for Public Involvement continues to take place monthly and virtually this year. We are hopeful that as restrictions ease in our hospitals we will be able to engage the group in a blended approach of face to face and virtual meetings. The group has wider ranging discussions and input into Trust services and policies and regularly hears from colleagues across the Trust including around the Equality, Diversity and Inclusivity agenda.

11 Our CARE Values

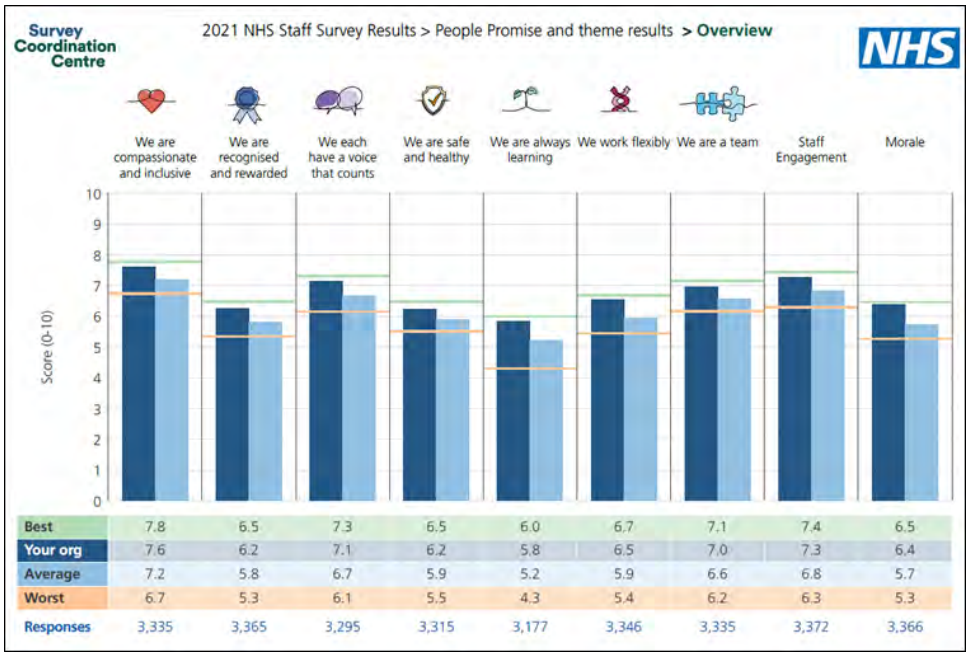
The values an organisation holds are central to how it plans, organises and delivers service. Our CARE values describe the ethos of the Trust and our approach to working with patients, the public, staff, and partner organisations. Our CARE values underpin the work of the Equality, Diversity and Inclusion strategy and associated work plans, and are an effective framework to promote dignity, respect, embrace diversity and promote culture change.

12 Staff Survey 2021

The Trust participates in the national NHS Staff Survey on an annual basis. The 2021 survey was undertaken from the early October and the last day for survey submissions was 26 November 2021.

In 2021 the response rate was 66.4% with over 3440 colleagues sharing their voice, an increase of over 5% on the previous year, and our highest engagement rate to date. The median response rate for organisations in our group was 46%, demonstrating the exceptional engagement of colleagues at SFH.

This year the staff survey findings are reported in line with the 7 People Promise themes, plus staff engagement and staff morale. The People Promise covers themes including 'we are compassionate and inclusive' and 'we are safe and healthy'.



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Best	7.8	6.5	7.3	6.5	6.0	6.7	7.1	7.4	6.5
Your org	7.6	6.2	7.1	6.2	5.8	6.5	7.0	7.3	6.4
Average	7.2	5.8	6.7	5.9	5.2	5.9	6.6	6.8	5.7
Worst	6.7	5.3	6.1	5.5	4.3	5.4	6.2	6.3	5.3
Responses	3,335	3,365	3,295	3,315	3,177	3,346	3,335	3,372	3,366

The Trust remains the highest scoring Acute/Acute Community Trust as a recommended place to work at in the Midlands region for the fourth year running and overall 3rd highest scoring Acute/Acute Community Trust in the country across the People Promise themes.

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

The key findings from the SFH 2021 National Staff Survey are as follows;

Top 5 scores (furthest above comparison group national average)	**SFH**	**Average**	**Difference**
Would recommend organisation as place to work	74.8%	59.4%	+15.4%
If friend/relative needed treatment would be happy with standard of care provided by organisation	81.6%	66.3%	+15.3%
Have adequate materials, supplies and equipment to do my work	68.8%	55.8%	+13.0%
Able to access the right learning and development opportunities when I need to	68.1%	55.2%	+12.9%
Feel organisation would address any concerns I raised	61.3%	49.6%	+11.7%
Bottom 5 scores (furthest below comparison group national average)	**SFH**	**Average**	**Difference**
Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public	72.9%	74.0%	-1.1%
Not felt pressure from manager to come to work when not feeling well enough	72.7%	74.0%	-1.3%
Last experience of physical violence reported	65.2%	67.3%	-2.0%
Not experienced physical violence from patients/service users, their relatives or other members of the public	79.3%	85.7%	-6.4%

Don't work any additional paid hours per week for this organisation, over and above contracted hours	51.9%	60.8%	-8.9%

From an Equality, Diversity and Inclusivity perspective the 2021 Staff Survey also identified:

- Ethnic Minority data is promising and has closed the gap in a number reported scores compared to non-ethnic minority colleagues, with 36 scores more than 3% higher than the Trust average and 15 scores more than 3% lower than the Trust average. The remaining scores were all around the Trust average. The scores more than 3% below Trust average related largely to experience of bullying, harassment, discrimination and/or physical violence.
- No significant variation exists in Gender difference between male and female colleagues – however for those colleagues who chose 'prefer not to say' regarding gender – only 10 scores were around or above the Trust average, with the remaining 80+ scores more than 3% below the Trust average.
- Disability remains a significant variation in experience with only 3 scores the same or above Trust average and around 85% of scores more than 3% below the Trust average
- Those under 21 and over 66 continue to report a poorer experience at work

The 2021 Staff Survey results have been communicated to Divisions/Departments across the Trust. The data will also be shared with staff network members at upcoming meetings where they will be supported to decide upon actions that support the Trusts overall commitments to 'Caring about you';

- Reducing colleagues' experience of violence and aggression from patients and/or members of the public
- Reducing discrimination towards colleagues with protected characteristics from patients and/or members of the public
- Improving colleague to colleague relationships at work

13 Human Resource Activities

13.1 Training and Development

The Training, Education and Development Department at Sherwood Forest Hospitals NHS Foundation Trust have a strong regional reputation for the quality of its education and training provision. The department is extremely proud of the role it plays in developing our current and future workforces to provide high quality and safe patient care.

Sherwood Forest Hospitals NHS Foundation Trust
Training Activities 2021/2022 Gender/Ethnicity Profile

Course Title	Male		Female		Total Gender
	Number	%	Number	%	Number
Customer Relations	210	25	637	75	847
Health & Safety	989	24	3150	76	4139
Induction	572	21	2132	79	2704
Informatics	2	12	15	88	17
Medical Equipment	1850	14	11133	86	12983
Occupational Knowledge & Skills	2523	14	15090	86	17613
Personal Development	293	15	1710	85	2003
Resuscitation	607	32	1262	68	1869
Risk Management	3141	20	12745	80	15886

Course Title	White		Other Ethnic Background		Not Stated		Total Ethnicity
	Number	%	Number	%	Number	%	Number
Customer Relations	707	83	113	13	27	4	847
Health & Safety	3549	86	527	13	63	1	4139
Induction	1762	65	802	30	140	5	2704
Informatics	16	94	0	-	1	6	17
Medical Equipment	10423	80	2291	18	269	2	12983
Occupational Knowledge & Skills	13916	79	3213	18	484	3	17613
Personal Development	1699	85	271	14	33	1	2003
Resuscitation	1222	65	606	32	41	3	1869
Risk Management	13031	82	2551	16	304	2	15886

13.1.1 Equality, Diversity and Inclusion (EDI) Training

EDI training is mandatory for all staff at the Trust. During 2021/2022, a total of 4,723 staff undertook diversity and equality training across the Trust compared to 4,381 in 2010/2021.

13.1.2 Mental Health Awareness e-learning

During 2021/2022, 139 colleagues completed this e-learning course. 100% of colleagues said the learning was needed and that they would use it in their role.

13.1.3 LGBT Awareness and Hate Crime Training e-learning

During 2021/2022 28 colleagues completed this e-learning course. 100% of colleagues said the learning was needed and that they will use it in their role.

13.1.4 Orientation

Equality, Diversity and Inclusion continues to be included within the Human Resources section of the Trust's orientation day for all new staff members and in the volunteer induction programme.

13.1.5 Manager's Induction

Our EDI Lead continues to deliver an EDI Awareness session for manager's induction and is now delivering a session on the Team Leader Development day and the Clinical Leadership Development Day.

13.2 Human Resource Policies, Procedures and Practice

During 2021/2022, seven Human Resource policies were developed/reviewed and implemented within the Trust following approval and ratification by the appropriate forum.

13.3 Workforce Recruitment

The Trust operates fair recruitment practices to ensure equal access to employment opportunities for all. 3.6% of our current workforce that have declared a disability. We have been awarded the 'Disability Confident Employer' and use this marque on our recruitment material to show we encourage applications from disabled people.
The scheme helps employers:

- draw from the widest possible pool of talent
- secure high quality staff who are skilled, loyal and hard working
- improve employee morale and commitment by demonstrating that we treat all employees fairly

Our anonymous applicant tracking system specifically highlights to appointing managers when an applicant has declared a disability to ensure we do not miss the opportunity to offer preferential interviews if the applicant meets the minimum selection criteria. We also make reasonable adjustments throughout the recruitment and selection process to support disabled job applicants and employees.

The Trust supports employees with a disability in a number of ways and takes steps to meet needs and achieve equal outcomes, even if this requires 'positive action'. For example, designating disabled parking bays close to entrances, adjusting application processes, purchasing any required additional equipment, plus providing support or advocacy and all employees can join our WAND staff network which supports those colleagues with a disability or long term condition. Any employee who acquires a disability or long term condition during the course of their employment is supported by occupational health assessments, reasonable adjustments to their duties and if necessary supporting their search for suitable alternative employment, with the aim of valuing and redeploying employees to retain their knowledge, skills and experience in the Trust.

13.3.1 International Recruitment

We positively embrace diversity and believe that a diverse workforce, which shares its knowledge and experience, facilitates the provision of high quality patient care. We actively attempt to recruit employees from outside the local area to strengthen diversity.

Between 1st April 2021 and 31st March 2022, the Trust recruited 68 international Nurses. We anticipate at least a further 12 will join the organisation over the next six months.

In the last 12 months we have issued 54 certificates of sponsorship to doctors who are overseas nationals.
We also continue to provide certificates of sponsorship for professional employees wishing to stay in the UK but move to the local area.

14 Charters

14.1 Mindful Employer

The Trust continues to be a signatory to the Charter for Employers who are positive about Mental Health reflecting the general philosophy of Mindful Employer. 2020/21 will be the tenth year we have been a signatory to the Charter. The Charter helps the Trust to support staff that experience mental ill health, assisting us in achieving the following aims:

- Show a positive and enabling attitude to employees and job applicants with mental health issues, including positive statements in local recruitment literature.
- Ensure all staff involved in recruitment and selection are briefed on mental health issues and the Equality Act 2010, and given appropriate interview skills.

- Make it clear in any recruitment or occupational health check that people who have experienced mental health issues will not be discriminated against and that disclosure will enable both employee and employer to assess and provide the right level of support or adjustments.
- Not make assumptions that a person with a mental health issue will be more vulnerable to workplace stress or take more time off than any other employee or job applicant.
- Provide non-judgemental and proactive support to individual staff that experience mental health issues.
- Ensure all line managers have information and training about managing mental health in the workplace.

14.2 Disability Confident Employer Accreditation

The Trust maintains its "Disability Confident Employer – level 2" accreditation.
The Disability Confident scheme aims to help organisations successfully employ and retain disabled people and shows applicants and employees who inform us they have a disability that we are committed to being an inclusive employer. We are committed to working towards the level 3 accreditation and are working together with the Nottingham and Nottinghamshire ICS in achieving this as individual organisations but through sharing good practice from organisations where this has already been achieved.

14.3 Age Positive

DWP's Age Positive initiative brings together research and information from employers on effectively managing an ageing workforce of all generations. As we support and practice the points covered by the DWP's 'Employing older workers' guide, we can now freely display the Age Positive logo on recruitment materials.

We support the Age Positive initiative by:

- Offering flexible working, flexible retirement and apprenticeships
- Providing training on being age positive on the Trust's recruitment and selection training
- Not stating number of years' experience on our job adverts or person specifications
- Not specifying qualifications as selection criteria where they are not essential for the job so as not to exclude older candidates who might have the right skills and experience but didn't have the opportunity to take the qualifications specified
- Not asking for date of birth in our main application, only in an equality monitoring section

15 Safeguarding; Learning Disabilities, Mental Health, Children & Young People

15.1 Safeguarding Team

Safeguarding Adults, Domestic Violence, Learning Disability, Children and Young People, Mental Health, work closely together under the wider remit of the Safeguarding Team. The reporting structure for safeguarding is via the Safeguarding Steering Group and then to Patient Safety Committee. The Trust Safeguarding steering group meets every quarter and includes Divisional membership and on invitation external stakeholders such as the CCGs. For assurance the safeguarding teams produce quarterly reports and annual reports outlining all activity and exception reports where required to ensure risks are highlighted to the Board.

The safeguarding team are available in core hours enabling all queries are responded to within the working day. Out of hours support is available via the information recorded on the safeguarding intranet site. Work is also underway to develop support processes for senior members of staff out of hours.

15.2 Training

The safeguarding team facilitates:

- Safeguarding for both children and adults under a combined Think Family remit
- There is a national PREVENT mandatory e-learning module for all staff to undertake we are able to evidence full compliance with this training and staff are required to update annually via e-learning
- All the training has been reviewed in line with National developments and also includes themes from safeguarding referrals
- The safeguarding team facilitate a session on the annual mandatory update; this is updated each year and focuses upon the lessons learnt within the Trust from a safeguarding perspective each year. We link this also to learning from local and national incidents
- Hospital staff continue to receive training on Learning Disabilities via the Induction day (New nurses and Healthcare assistants) and via the Mandatory training programme. This programme has been reinvented with the use of video of the experiences of local patients followed by questions based on observations

15.3 Learning Disabilities

The referral processes for patients attending the Trust with a Learning Disability continues to be in place. The LD specialist nurse is notified of patients with an LD Diagnosis via GP, carers of patient, care Homes, SFH staff and external professionals (i.e. social services, community LD teams) they will then apply an LD alert to Medway, SystmOne and Nerve Centre. We are reliant upon them to identify the patients so we can flag their records and develop plans for care to support their transition into the hospital settings.

The training package titled Learning Disability Awareness is delivered at induction to all new starters to the Trust. This introduces the LD service and the roles and responsibilities of staff when caring for patients with a LD. The LD service continues to develop internal partnerships to support and provide advice to Trust staff, patients and carers where there are needs and/or vulnerabilities.

LD nurse specialist also provides training to ED and EAU health care staff from a LD perspective which evaluates well and provides an opportunity for staff working in these areas to discuss cases with LD nurse for advice and feedback.

The Learning Disability Care Plan continues to be in place to ensure that any patient admitted receives all the correct and most up to date paperwork. This plan is inclusive of risk assessments, pain tools, traffic light assessments and discharge planning.

The LD specialist nurse is notified of LD patients who are coming through the outpatient departments that may require additional support through reasonable adjustments or best interest processes. These notifications can come from SFH staff, GP, carers of patient, care Homes, and external professionals (i.e. social services, community LD teams).

15.4 Dementia

The Dementia Nurse Specialist supports training to staff on the induction, clinical skills and mandatory update sessions.

15.5 Mental Health

We have continued to enhance liaison between Trust services and those provided by the Liaison Psychiatry service provided by the local Mental Health Trust. A guide was developed to support patients with mental health issues affected by Covid 19. Support as appropriate is offered to staff to signpost to relevant services if this is requested

16 Chaplaincy

16.1 Patient Visits (including out of hours)

During 2021/2022, restrictions remained in place and families and community faith leaders could not visit our patients. Our Chaplains have continued to support compassionate visiting where there is a referral or urgent call, for example at the end of life, or because a patient is distressed and in need of comfort. The Chaplains supported iPad calls for Patients and their loved ones.

We provide multi-faith, inclusive materials and resources for prayer, worship and reflection in our resource boxes which are available in the ward areas.

We have worked alongside our Muslim colleagues to create an on-call system for end of life Muslim's. In normal times, the support of an Iman would be requested for end-of-life rites and rituals, but the local Iman has been shielding so our Muslim colleagues have volunteered to attend the patient and liaise between staff and distressed families. Quran cubes (small audio devices that play Quranic verses and prayers at the bedside) are also available on request.

We continued to provide support for those patients of catholic faith through our local community Priest including last rites for those who are receiving end of life care.

16.2 Staff support

The Chaplains regularly visit staff just to check how they are doing, drop off some sweet treats or give a listening ear. The Faith Centre remained open, but services were suspended as required by national guidelines. Staff have found great comfort in using the space for quiet reflection or a socially distanced informal visit.

A Rota was set up to enable our Muslim colleagues to continue with socially distanced prayers and we now welcome 20 people per session to Friday prayers which are facilitated in the Faith Centre.

The addition of Wellbeing chaplain during the period of the Covid pandemic has been a real boost to chaplaincy and has given us the opportunity to build confidential relationships with many members of staff; we hope these relationships will continue as we recover from the pandemic.

A contact who works for the Nottingham Panthers provided us with approx. 1,000 complimentary tickets for staff to attend some of their home games. It has been extremely

appreciated by the staff who have attended the games with their families. We are hoping to secure more tickets next season.

16.3 Events

Despite the on-going restrictions, our chaplains have led a number of events in the last 12-months:

- Memorial Services for members of staff
- Covid Memorial Day
- Remembrance Day
- International Workers Day
- Monthly Baby Loss Group meetings
- Wave of Light – Baby loss walk around the Res
- Diwali Celebration in the Faith Centre
- Baby Bereavement Memorial service – Held at St. Phillips in Mansfield as the Faith Centre was not suitable for social distancing for large numbers
- Carols – Xmas Eve
- Pancake day – Handed out 300 individual Pancakes and sweet treats to staff
- Maundy Thursday – Handed out 300 individually wrapped Hot cross buns
- Ramadan and Eid – We supported our Muslim Colleague's by providing Sweets and Treats before and after Ramadan
- Prayers for Ukraine – Daily in the Faith Centre
- Daily Prayer

17 Diversity and Inclusion Programme

17.1 Events

As with last year, ongoing difficulties with the pandemic and winter pressures have impacted on the number of events we have managed to complete in the last 12-months. However, there was still plenty to smile about;

17.1.1 Carers Week – June 2021

Following the success of the Carers Passport launch for patients during carers week in 2020, we launched the scheme for colleagues in 2021. During the week, we shared a video of colleagues who are also carers, provided sessions about the carers passport to raise awareness, developed guidance and also celebrated that Sherwood Forest had become a Carer Friendly Employer through Nottinghamshire Carers Association. We launched our Carers Staff Network which, to date, has 18 members. We also appealed for colleagues to come forward to become Carers Champions and have since recruited and trained six carers champions in the Trust.

17.2.2 PRIDE – July 2021

- First ever celebration at Newark hospital
    - Information stand
    - PRIDE march around the hospital grounds
- Biggest ever PRIDE march at Kings Mill Hospital (on the hottest day of the year)!
    - a video clip from the march was featured during the NHS England PRIDE day in August 2022

In addition to our Trust activities, we once again partnered with the Nottingham & Nottinghamshire ICS for a live virtual PRIDE conference which took place on 10 August.

17.1.3 Black History Month – October 2021

Once again, this year we partnered with the Nottingham and Nottinghamshire ICS for a live virtual event which took place via MS Teams on 28 October.

17.1.4 International Day of Persons with Disabilities – December 2021

This year, the Nottingham and Nottinghamshire ICS led the celebrations on International Day of Persons with Disabilities on 3 December with a virtual event held on MS Teams. During the event, our EDI Lead Ali Pearson's poem, written for Disability Day in 2020, was proudly shared with ICS colleagues;

17.1.5 UK RACE Equality Week, theme: #ActionNotJustWords – February 2022

The Trust is very proud of its diverse workforce but year on year, we are saddened by our staff survey results which are evidence that our colleagues from ethnic minority backgrounds are being abused by patients and/or members of the public and colleagues more than those from a White background.

The Trust has implemented campaigns to reduce instances of abuse against our staff, most recently, our 'No Excuse for Abuse' campaign which ran in the Spring/Summer of 2021. However, we have not dedicated a campaign to address the racism towards colleagues that occurs from patients, family members and/or other visitors but also from other colleagues and managers.

Whilst the Trust acknowledges that abuse of any kind is not acceptable towards any of our colleagues, we felt we needed to take action to tackle the issue of racism in our hospitals and our community.

So, on 7 February 2022, the Trust took action and launched our Anti-Racism strategy with the predominant aim of protecting our colleagues from harm. We also seek to ensure our diversity is visible to all, communicate our anti-racism message clearly, provide education to improve understanding and to encourage colleagues to speak up and call it out when they witness instances of racism, bully or discriminatory behaviour.

The launch was a great success with local coverage on news websites/social media and Trust colleagues were interviewed and featured on ITV Central News. [Pictured is the poster design used for the strategy launch and on-going campaign].

17.1.6 International Day for the Elimination of Racial Discrimination – March 2022

We marked this day on March 21, with the unveiling of new artwork created especially for Sherwood Forest Hospitals. The artwork was designed to celebrate the Diversity within Sherwood and does so through pictures of the 88 flags of the countries of birth of our colleagues (as at December 2021).

18 Services

Throughout 2021/2022 thebigword have continued to provide our interpreting and translation services. The Nottinghamshire Deaf Society also provides a service for sign language. Divisional management secretaries are responsible for liaising with the supplier on a day to day basis and placing our bookings for face to face interpreting services.

We have also recruited additional volunteer interpreters during the year, and we have on a couple of occasions called on their services and they have been a great help at short notice.

We continue to maintain links with the Interpreting team at Nottingham University Hospitals (NUH) to discuss improvements which can be made to our services. They have also assisted us on a few occasions where we have been unable to obtain an interpreter in certain languages. The Interpreting Manager at NUH is also available as a support mechanism to our volunteer interpreters should this ever be required.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public – Cover Sheet

Subject:	Equality and Diversity Annual Report	**Date:** 9th June 2022	
Prepared By:	Ali Pearson, People Equality, Diversity and Inclusion Lead		
Approved By:	Rob Simcox, Deputy Director of People		
Presented By:	Clare Teeney, Director of People		
Purpose			
This report is being presented to provide a summary of the Equality, Diversity and Inclusion activity that has taken place during 2021/2022.		**Approval**	
		Assurance	
		Update	**X**
		Consider	

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

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

Risks/Issues	
Financial	Improving productivity, workforce utilisation and impact
Patient Impact	Ensuring a good patient experience
Staff Impact	Improve the working experience for colleagues in Sherwood
Services	Services available when needed to ensure quality and timely care
Reputational	SFH recommended as a great place to work

Committees/groups where this item has been presented before

n/a

Executive Summary

Summary

The Trust is required to report to the Board annually it's activity in regards to equality, diversity and inclusion for colleagues and patients. This report which is published on the Trust website also enables us to demonstrate that we are meeting our requirements under the Public Sector Equality Duty.

The report

The report describes how we govern Equality, Diversity and Inclusion within the Trust and describes the mandatory reporting that has been completed in the 2021/2022 year as required by the Government and/or NHS England and Improvement and signpost to where this information has been published.

The report provides an overview of our workforce based on Ethnicity, Gender, Disability, Age and Sexual Orientation and we describe what various departments have worked on during 2021/2022 to support the EDI agenda in the Trust.

The report highlights the services we offer to patients who have additional needs to ensure their care is not compromised in any way as a result of their needs, including but not limited to, translation services, accessibility and chaplaincy.

The report also provides a summary of the events that have taken place during 2021/2022 to raise the profile of EDI and to raise awareness of particular topics on the agenda, for example, Race Equality.

Conclusion
Whilst 2021/2022 has been another challenging year for the Trust, there has been success with the EDI agenda and the highlights include;

- Trust achieves 'Carer Friendly Employer' status in June 2021
- Biggest ever PRIDE celebrations in July 2021 including our inaugural event at Newark hospital
- Launch of our Anti-Racism strategy – February 2022
- Unveiling of Diversity artwork – March 2022

We are very proud of the work that has been achieved and detailed within the report and look forward to reporting to you next year. In the meantime, the ongoing work associated with Equality, Diversity and Inclusion will continue to be reported to the People and Inclusion Cabinet and People, Culture and Improvement Committee who oversee this work.

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Trust Board - Cover Sheet

Subject:	People, Culture and Improvement Strategy 2022-2025	**Date:** 09/06/22	
Prepared By:	Beth Hall – Business Support Officer		
Approved By:	Emma Challans – Executive Director Culture and Improvement Rob Simcox – Deputy Director of People		
Presented By:	Emma Challans – Executive Director Culture and Improvement Rob Simcox – Deputy Director of People		
Purpose			
To share the People, Culture and Improvement strategic priorities for 2022-2025 for approval and provide assurance to Trust Board following approval at the Executive Team Meeting.		**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**
		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

- People, Culture and Improvement Committee
- Culture and Improvement Cabinet
- People and Inclusion Cabinet
- Culture and Engagement Sub-Cabinet
- People Development Sub-Cabinet
- Improvement and Learning Sub-Cabinet
- Culture and Improvement Directorate 'Keeping Connected'
- JSPF
- LNC
- Senior Nursing Forum
- Clinical Chairs
- Staff Networks
- SFH Proud2bAdmin
- Divisions
- Executive Team Meeting

Executive Summary

The attached document details the People, Culture and Improvement strategic priorities for financial years 2022-2025.

We are delighted to introduce our ambitions which see us build on the firm foundations that have been established at Sherwood over a number of years. We believe this is a positive step forwards for Sherwood and provides us with a strong platform to keep improving experiences for our patients and colleagues.

Our strategy has been co-created in collaboration with leads from the People and Culture and Improvement Directorates. The document has been shaped over the last 4 months, with a robust engagement schedule within and outside our Directorates at key forums (as outlined above) providing opportunity for colleagues to understand and contribute to our vision.

Engagement has helped us refine content, creating what we feel is a cohesive story which highlights our priority actions for the next 3 years, along with our vision of what this will mean for patients, colleagues, partners, and citizens.

Our delivery pillars tie into key national directives, including the People Plan, Quality and Improvement priorities. As part of our engagement and development of the strategy we have cross-referenced other key SFH strategies, such as Nursing and Quality to ensure they complement each other.

Key success measures have been identified so that we can monitor our progress. We have detailed action plans which will be delivered through our operational sub-cabinets which will provide progress updates in a bottom-up approach starting with updates to our Cabinets (People and Inclusion Cabinet, Culture and Improvement Cabinet and Transformation and Efficiency Cabinet). Cabinet's report into our committees (People, Culture and Improvement, Quality Committee) which then provide assurance to Trust Board.

Our strategy will drive the vision for Continuous Improvement at SFH and is closely linked to the Quality Strategy. We have also articulated how we work as a system, with our partnership work across Nottingham and Nottinghamshire Integrated Care System (ICS).

Our strategy was presented and agreed at the Executive team on 25th May. A formal launch will take place starting mid-June and will run over a 4-week period, supported by an internal comms schedule. 13th June – 8th July, with an official launch at Staff Brief on 29th June.

Recommendation
Trust Board members are asked to take assurance and approve the Strategy.

NHS
Sherwood Forest Hospitals
NHS Foundation Trust

People, Culture and Improvement Strategy

2022-2025

Helping our people to be the best they can be

Best NHS Acute Trust in the Midlands
(2018, 2019, 2020 and 2021 NHS Staff Survey)

Contents

Welcome

to Sherwood Forest Hospitals, People, Culture and Improvement strategy for 2022-2025.

Our commitment: *Helping our people to be the best they can be*

We are delighted to introduce our plans for 2022 and beyond, which sees us build on the firm foundations that have been established at Sherwood over a number of years.

The past two years have seen unprecedented challenges in healthcare and a significant increase of demand on our services. We recognise the impact this has had on our patients and colleagues both physically and mentally, in both our roles and daily lives.

We are confident that our teams will continue to support divisions to provide high quality, safe care for patients and ensure that Sherwood is a great place to work and belong.

We will achieve this by continuing to develop a culture of compassion, kindness and appetite of learning for improvement. All of which underpin the successful delivery of our objectives.

Our key focus areas for 2022-2025 will be:

- **Looking after our people**
- **Belonging in the NHS**
- **New ways of working and delivering care**
- **Growing for the future**

We have co-created these objectives in close partnership with colleagues from the People Directorate and the Directorate of Culture and Improvement at Sherwood.

We will continue to work collaboratively across our portfolios and outwardly with our ICS partners to achieve our vision of promoting healthier communities and providing outstanding care for all.

Thank you to everyone across our Directorates for shaping our People, Culture and Improvement vision and objectives for SFH.

Rob

Rob Simcox

Director of People

Emma

Emma Challans

Executive Director of Culture and Improvement

CARE values

Sherwood Forest Hospitals Strategy – Healthier Communities Outstanding Care

The Trust's CARE values underpin this strategy and run throughout its content. All Trust colleagues are expected to live these values whilst caring for our patients and each other. Our values are embedded in our ethos and in the culture of Sherwood.

Our Trust strategic objectives are built from our understanding of national guidance and local intelligence. Our People, Culture and Improvement strategy is equally informed by national guidance and local priorities.

Directives considered include:

- NHS People Plan
- NHS Long Term Plan
- NHS Operating & Improvement Plan
- NHS People Promise
- Sherwood Quality Strategy

"We aim to enable our collective voices to be heard in every patient experience at Sherwood Forest Hospitals."

Overview

Vision:

Healthier communities and outstanding care for all

Strategic Objectives	Over the next five years we will...
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
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
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
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
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

Values

1. Communicating and working together
2. Aspiring and improving
3. Respectful and caring
4. Efficient and safe

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

Our vision

For patients..

My husband was recently admitted to Kings Mill Hospital after falling and fracturing his knee. He has dementia so he gets very confused and distressed when he's in unfamiliar surroundings. The people at Kings Mill were so friendly and explained things so simply it helped keep him calm. I was told I could apply for a carer's passport and I'm so glad I did – it meant I could see my husband most of the day (outside of normal visiting hours), help him have a wash and make sure he had something to eat. He would have hated anyone else doing these things for him, I'm so glad I could help. I'm sure it will have helped so many others...

For partners..

I work as part of the Organisational Development and Improvement Delivery Workstream at ICS level, and it has been great to hear from Sherwood Forest Hospitals on their Continuous Improvement journey, and how we have been jointly delivering Improvement training across partner organisations for several years; really great foundations to build on. We have started to underpin our Delivery workstreams using the Improvement approach, which has provided a structure for discussions, and has helped to build Improvement capability and has helped to create mutual trust. I feel like we're building a better future for citizens together...

For colleagues..

In 2022 I was a Staff Nurse at Newark Hospital. I remember we had a new Manager join from another Trust; I was a little nervous for my first appraisal with her. We ended up having a lengthy conversation about my previous experience and how I could develop. She really listened to me and even suggested some training courses. I've since completed my courses and recently been promoted to Ward Sister - it's great to feel recognised for my hard work and it wouldn't have happened without the support from my Manager. The training has helped me feel confident in my new role. We see some very sick patients, so it can be quite overwhelming at times. If it ever becomes too much, I know I can talk to one of my colleagues or our Wellbeing Champions – they've been a great help to me and show such compassion. I feel the team at Sherwood really care about me...

For citizens..

I'm in my final year at West Notts College, I've been studying Public Services, but I've been struggling to decide what to do when I finish in June. I want to get experience on the job but wasn't sure where to start. We had a talk with a lady from Kings Mill Hospital recently, she was so passionate about her job and it sounded really interesting! She had a chat with me on my own afterwards and suggested I look into the Level 4 Health and Social Care Apprenticeship programme. Since then, I've decided to apply for the course starting in September – a few of my course mates have done the same – she was so inspiring; I really hope we get accepted...

These stories are examples of what we would like to hear following successful implementation of our 2022-2025 action plans...

Our delivery pillars

Looking after our people

We will make the NHS a better place to work by ensuring our colleagues are safe and healthy, plus physically and mentally supported. We will continue to build a culture where colleagues find 'joy at work' within a psychologically safe and meaningful environment, leading to better colleague and patient experience.

Belonging in the NHS

We must continue our efforts to make our culture at SFH universally understanding, kind and inclusive. Feedback and evidence suggest colleague experience at Sherwood can be variable based on role, location of work or protected characteristic. We know the positive experience of working at SFH that we wish for all of our colleagues can too often fall short of expectations. To achieve excellence in colleague and patient experience we need to address this and ensure all colleagues feel a sense of belonging and value in our organisation.

At SFH we will therefore take deliberate action to ensure the organisation is inclusive and compassionate, a place where there is a zero-tolerance approach to discrimination, violence and bullying to, and between our people.

Our delivery pillars

Growing for the future

We are committed to attracting, developing and retaining colleagues; our focus is on learning, and continuous improvement. We will ensure colleagues feel confident and capable in their roles through personalised development offers. We will ensure talent is recognised and support is provided to develop the future generation of SFH colleagues and leaders. We will work innovatively to be the employer of choice in the local area, with higher numbers of applications to education and training. Our plans will shape a better future for colleagues at SFH, ensuring the best patient care is provided.

New ways of working and delivering care

We will do this by developing improvement and change management capabilities and making effective use of the full range of our people's skills and experience. We will support colleagues to work flexibly and in different ways. We will embrace transformation, innovation and partnership working as a way of addressing increases in demand, improving clinical outcomes, and reducing unwarranted variation. The People Culture and Improvement strategy will drive the vision for Continuous Improvement at SFH via the following Improvement Foundations:

- Building Improvement Capability and Leadership
- Nurturing a Learning and Sharing Mindset
- Supporting Cultural Improvements
- Clinical Audit and Effectiveness
- Improvement Programmes and Projects

People, Culture and Improvement priorities 2022-2025

Looking after our people

Our 2022/2023 Action Plan:

- Improve the wellbeing of colleagues
    - An enhanced wellbeing strategy in place
    - Review and rebrand wellbeing champions
    - Embed wellbeing conversations, including training for managers and a mechanism for reporting uptake
    - Bi-yearly risk assessments for staff in vulnerable groups
    - Timely and evidence based psychological de-briefing for all colleagues trialled and embedded
    - Refresh and re-launch Schwartz rounds

- Become an organisation that continuously learns and improves
    - Commission and deploy SCORE Safety Attitude Questionnaire survey

Our 2023/2024 Action Plan:

- Embedded Wellbeing passport
- Formal review of psychological debriefing approach
- Implementation of the carer's passport and carer's champions
- Become an accredited carer friendly organisation.

Our 2024/2025 Action Plan:

- Daily communications huddle for all teams (where appropriate) and develop a tool to measure impact
- Expand and develop our benefits package
- Hold strategy refresh session to inform our next 3 years
- Formal review of SCORE Safety Attitude Questionnaire evaluation

People, Culture and Improvement priorities 2022-2025

Belonging in the NHS

Our 2022/2023 Action Plan:

- Build and improve our culture
    - Embed the Culture Collaborative
    - Grow our Staff Networks, providing a safe space to share experience and be part of action for improvement
    - Define Civility, Respect and Kindness programme of work
    - Introduce culture insights tool
    - Embed the anti-racism strategy and the approach to tackling racism across the Trust
    - Launch of the Project Search programme

- Improve the working experience of our colleagues
    - Refresh and launch new Trust Reward and Recognition programme to ensure equity across the organisation
    - Scope 6 months after starting 'lived experience' conversation spaces

- Recruit and retain the best staff
    - Introduce a Person-Centred welcome to all new joiners
    - Delivery of 6 High Impact actions to close the gap in recruitment and promotion outcomes

Our 2023/2024 Action Plan:

- Embed a Just and Learning Culture across the Trust
- Full review of the Trust Staff Reward and Recognition programme
- Deliver the 'Closing the Gap' action plan to reduce gender pay gap

Our 2024/2025 Action Plan:

- Delivery against model employer goals. Increasing black and minority ethnic representation at senior levels across SFH/ICS
- Increase disabled applicants being appointed to roles in the Trust

People, Culture and Improvement priorities 2022-2025

Growing for the future

Our 2022/2023 Action Plan:

- Develop our workforce
  - Growth of Apprenticeship offer in relation to workforce challenges alongside providing equitable access to development opportunities
  - Quality appraisal review
  - Development of a Protected Learning Time policy (PLT) to support the continued development of a progressive learning culture
  - Develop initial Talent Management approach aligned to a system approach
  - Leadership development strategy implemented.
  - Development and growth of Sherwood E-Academy
  - Ensure fair and equitable access to educational funding & development opportunities

- Become an organisation that continuously learns and improves
  - Increased Improvement capability from Board to ward
  - Increase Improvement Coaching opportunities
  - Action Plan to reach exemplar QI status, as per National Improvement Framework

- Be a leading partner in the ICS
  - Improvement training extended to include ICS partners

- Build and improve our culture
  - Proud2bOps@SFH piloted

Our 2023/2024 Action Plan:

- Introduction of a Careers strategy aligned to CARE4NOTTS
- Review and refine Talent Management approach
- Review and refine leadership development strategy
- Introduction of a People Hub concept across Nottinghamshire
- Divisional level structure of diffused Improvement leaders progressed
- Extension of Learning Hub content externally

Our 2024/2025 Action Plan:

- Introduction of a divisional lead integrated talent map
- Introduction Career trials programme for younger people
- Development of “ICS wide placement offers” for those identified in the talent management approach
- SFH at ‘Level 5’ exemplar level in terms of Improvement Maturity

People, Culture and Improvement priorities 2022-2025

New ways of working and delivering care

Our 2022/2023 Action Plan:

- Develop our workforce
  - Development of a 3-year Strategic Workforce Plan to inform future and sustaining longer term capacity
  - Begin workforce reviews to develop an equitable and efficient approach to Admin and Clerical roles across the Trust

- Become an organisation that continuously learns and improves
  - Year 2 of the Continuous Improvement at SFH strategy achieved
  - Aligned and enabling Improvement actions to support delivery of the SFH Quality Strategy
  - 3 Year Transformation & Efficiency Programme developed, and Year 1 delivered (inc. digital aspirations)
  - SFH Improvement Maturity Matrix deployed and explored for system deployment
  - Increase citizen engagement in Improvement from current baseline
  - Establish link with CDIO role to ensure digitalisation is a key enabler across all priority areas
  - Trust Innovation Hub launched

- Improve the working experience of our colleagues
  - Agile working approach defined and embedded across the Trust

Our 2023/2024 Action Plan:

- Introduction of a divisional integrated 3 year workforce plan
- Development opportunities for new / aspiring clinical leaders
- Year 3 of the Continuous Improvement at SFH strategy achieved
- Year 2 of Transformation & Efficiency Programme delivered including Financial Improvement elements
  - Review of Mandatory and Statutory Training offer with a view for more digitalisation
  - Establish common career routes focusing on how we can attract new people into Health

Our 2024/2025 Action Plan:

- Using digital solutions and new ways of working to make best use of skills, experience, and capacity
- Citizen engagement strategy in QI evaluated
- Active listening training in place for all leaders
- Year 4 of the Continuous Improvement at SFH strategy achieved
- Year 3 of Transformation & Efficiency Programme delivered including Financial Improvement elements

Our Key Success Measures

Looking after our people

- Average yearly sickness level of 4.0%
- Turnover below 8% by end of 2023
- Improvement in specific Staff Survey areas relating to Health & Wellbeing
- 100% of colleagues in vulnerable groups have a bi-yearly Individual Staff Risk Assessment where relevant (measurement tool to be developed)
- Quarterly evaluation of psychological support offer
- Minimum of 4 Schwartz rounds completed annually
- SCORE Safety Attitude Questionnaire survey results and actions reported annually in April 2023,2024

Belonging in the NHS

- WRES improved results through an increase in BAME colleagues at band 6 (Clinical)
- WDES improved results through increased disability declarations to 5%
- Decrease in overall gender pay gap in 2023
- Increased engagement in National Staff Survey/Quarterly Pulse Surveys and improved performance against a set of key NSS indicators
- Reduction in variation of experience for colleagues with protected characteristics
- Increased year on year engagement with FTSU Guardians
- Increased engagement with Trust awards programme (staff excellence and care values)

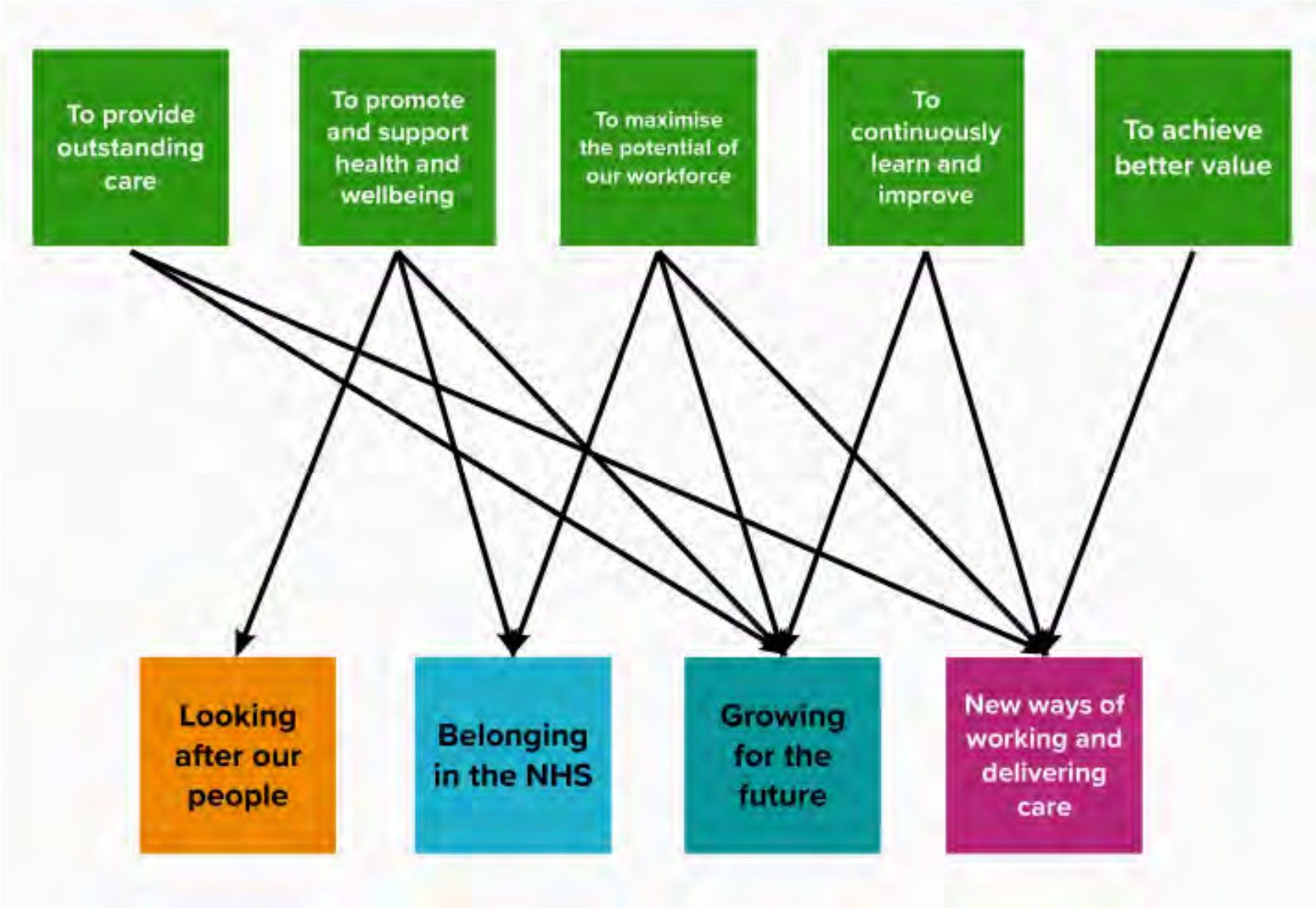
Growing for the future

- Staff Survey – year on year improvement in Quality Appraisals overall score from Admin staff
- 240 colleagues received Bronze level Improvement training/60 at Silver level in 22/23
- Apprenticeship access developed aiming for >180 registered
- All Leadership apprenticeship colleagues offered Improvement training
- Increase in educational HEE funding access for all eligible colleagues year on year
- Increase in MAST compliance to >90% via MAST review and PLT policy implementation
- SFH reach exemplar status in Improvement against National Improvement framework

New ways of working and delivering care

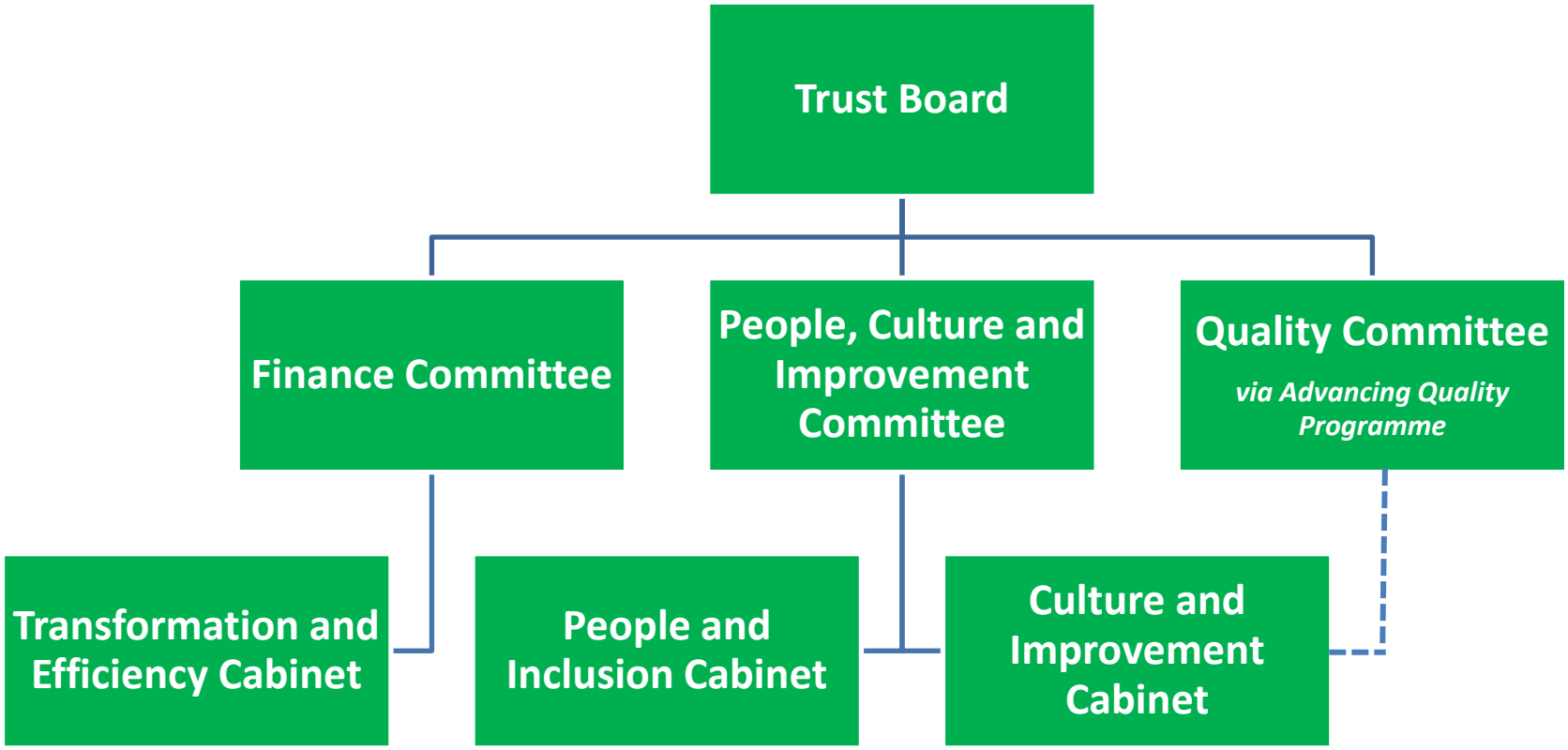
- Financial improvement requirements delivered in line with forecast plan
- 3 Year Transformation and Efficiency Programme in place with robust governance structure established
- Increase citizens engaged in Improvement and at key SFH meetings
- Improvement of 'Agile working' experience - Year on Year increase / 20% of our Admin and Clerical colleagues are based at home (at least day per week)
- Colleagues sharing learning from Improvement projects – minimum of 45 Bright Sparks / QI projects registered on AMAT quarterly
- Evidence of national profile in Improvement – national awards & publications
- Increased visibility of improvement outcomes in Clinical Audit

Links to Sherwood priorities



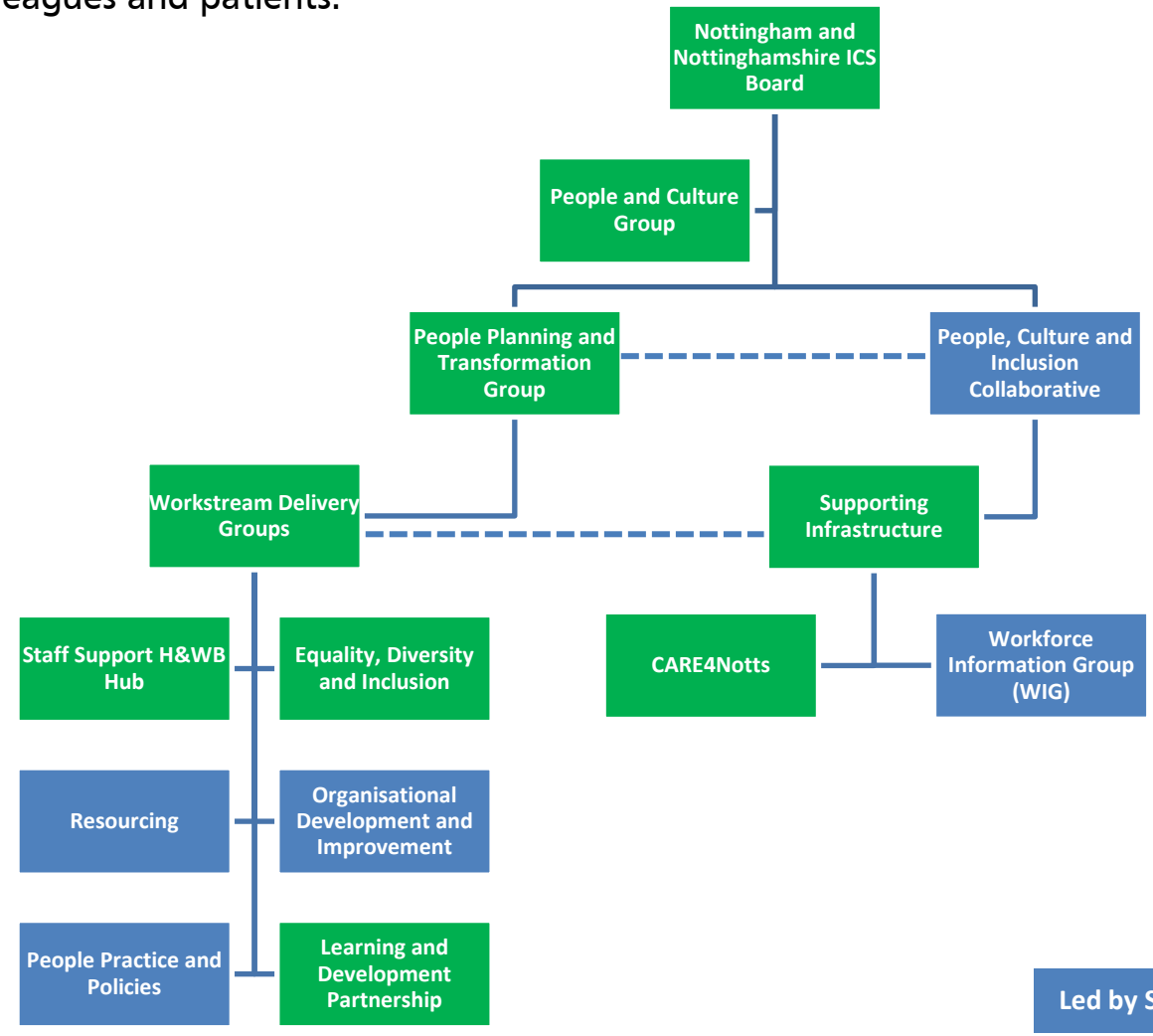
Our Governance in Sherwood

Our action plans will be delivered through our operational sub-cabinets which will provide progress updates in a bottom-up approach starting with updates to our Cabinets. Cabinets will report into Committees which then provide assurance to Trust Board. Our governance structure is shown below.



Our partnership across Nottinghamshire

We lead and work in collaboration with the Nottingham and Nottinghamshire Integrated Care System (ICS). Executive Leaders in Sherwood both Chair and participate in relevant Collaboratives and Groups. Where relevant and effective, our aim across People, Culture, and Improvement, is to co-create and implement key strategic objectives to improve the experiences of colleagues and patients.



Integrated Care System
Nottingham & Nottinghamshire

Led by Sherwood People, Culture and Improvement Lead

System design and delivery

Our commitment is to be a key partner in the delivery of healthcare and a system of choice as a place to work. Integrated Care Systems consist of multiple organisations and bodies that provide health and care services for the communities they serve.

Sherwood people and improvement teams will work closely with peers across the Mid-Nottinghamshire and wider Nottingham and Nottinghamshire health and care footprint: *community* and *mental health, primary care, voluntary, independent,* and *charitable organisations.*

We will continually review and agree our strategic objectives and actions to improve in line with both our organisational and system priorities. Equally we expect and will work closely with our National Regional Team to ensure delivery as a system and to be held to account and respond as a system.

Design and delivery aspirations as a system:

- Leadership & Management Development
- Talent Management
- Improvement capability and capacity
- Civility, Respect and Kindness
- Cultural Insights
- Communities of Practice

Our Leadership team

Rob Simcox
Director of People

Vacancy
Deputy Director of People

Emma Challans
Executive Director of Culture and Improvement

Jim Millns
Associate Director of Transformation

Donna Mariner
Associate Director of People (Resourcing)

Richard Cotterill
Head of Workforce Information

Ceri Feltbower
Associate Director of Improvement

Deborah Kearsley
Associate Director of People (Operations)

Kim Kirk
Operations Lead: Hospital COVID Vaccination Hub

Vicky Malia
Head of Culture and Engagement

Jacqueline Read
Head of People Partnering

Jill Murphy
HR Secretary – People function

Michael Du Rose
Head of Learning and Development

Contact us

Sherwood Forest Hospitals
NHS Foundation Trust

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.

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Mid-Nottinghamshire PBP Forum – Coversheet

TITLE:	Quarter 4 update of the PBP objectives

DATE OF MEETING:	19/05/2022	**PAPER REF:**	Item 7

AUTHOR:	Diane Carter	**PRESENTER:**	Diane Carter
		SPONSOR / COLLABORATOR:	Paper reviewed at the MN PBP Executive Team 28th April 2022

WHICH ICP OBJECTIVES DOES THIS RELATE TO (SELECT ALL THAT ARE RELEVANT)
☒ To give every child the best start in life.
☒ To promote and encourage healthy choices.
☒ To support our population to age well.
☒ To maximise opportunities to develop our built environment into healthy places.
☒ To tackle physical inactivity.

EXECUTIVE SUMMARY (OVERVIEW):

The 5 PBP objectives and 10 breakthrough objectives identified for 20/21 provide the Partnership Forum with several actions that would be undertaken in support of delivery of our strategic objectives which provide the framework and themes in support of our overarching long term PBP vision.

The Q3 progress report against our strategic objectives continues to demonstrate that the breakthrough objectives remain long term and continue to need to be embedded in our partner organisations strategies and planning with the aim of delivering our aim of healthier and happier communities.

In 20/21 we agreed that our breakthrough objectives were identified following a test based on our core principles and PBP purpose.

1. Does a collective PBP approach add value over and above a single organisational approach?
2. is it inclusive, overtly reflecting ways in which inequalities within our population will be addressed?
3. How does it connect to our identified neighbourhoods in greatest need?
4. Is the objective now specific, measurable, achievable, realistic and time limited/ time stated?
5. Is it clear who is the lead, for the smart objective delivery and who will support?
6. Does it reflect either an area of expected delivery, and / or an area of our agreed 5 priorities?
7. Is it in line with wider ICS/ CCG objectives?
8. Does it recognise the new world with COVID in our communities?

The objective leads continue to work with the PBP support team to deliver the breakthrough objectives to ensure they reflect the learning and can be measured, and progress evidenced during 21/22. The attached report aims to identify the progress of each of the objectives and to provide the Partnership Forum with assurance where the objective is on track and the opportunity to explore actions required where the objective is not on track.

The Partnership Forum are asked to recognise the work that the PBP partner organisations are continuing to play in embedding the PBP strategic objectives and vision through identified leads

and the work being undertaken in connecting the objectives and ensuring appropriate membership and inclusion of all partners across our PBP.

Some highlights include:

4.2 Rough sleepers reduced from 27 in 2020 to as low as 2 in 2021. The Mansfield Housing First scheme has been instrumental in delivering this change and is the first of its kind in Notts.
The council are bidding for funding to continue the project till 2025."

5.2 The engagement and empowerment of the community in Bellamy to start to influence what happens in the estate.

2.1 MSK Piloting some work with Everyone Active in Ashfield and with Active 4 Today in Newark. Have met with Serco in Mansfield to start conversations. From April 22 we will have an ESCAPE pain group and a community back pain class running in Newark Leisure centre and The Lammas.

Considerations for the Forum:

2.2 Despite the high prevalence of smokers in most localities, the systematic referral from professionals via an opt-out process for smokers is not apparent. This includes referrals from secondary care. Referrals from dentists are minimal.

Forum Action: Do members of the Forum have any insight of work that may be happening that could impact this?

1.2 Giving every child the best start in life continues to gain traction at a national level. However, capacity to support the agenda is limited which may become a challenge as the work progresses.

Forum Action: Do Forum members have any insight into anything at a local level that could support this work?

Members of the Partnership Forum are asked to endorse the Q4 update and to provide any insight into the questions posed in support of the work being carried out.

RECOMMENDATION:

☒ To endorse.
☒ To approve.
☐ To receive the recommendation *(see details below)*
☐ To discuss.

Mid Notts Priorities 2022/23

Mid-Nottinghamshire Integrated Care Partnership
Creating happier, healthier communities together

		Priority 1 End of Life Together / Priority 2 An integrated model for Care Homes / Priority 3 MSK a model for the future		Priority 4 Focus on our place		Priority 4 Focus on our place	Priority 4 Focus on our place	Priority 4 Focus on our place	Priority 4 Focus on our place	
	PBP Objectives update									
	Objective 1.1 Increase readiness for school and the number of children with skills needed to start school.	**Objective 1.2** Mothers and Babies have positive pregnancy outcomes. Children and parents have good health outcomes.	**Objective 2.1** Improve the connections and integration of the voluntary sector and current health and social services available, to build effective services that support Alcohol, Diabetes, Cancer, EOL and joint and bone health MSK	**Objective 2.2** Help people to stop smoking	**Objective 3.1** Build on the integration across the PCNs building on community based assets that include the voluntary sector, care homes and care in community settings.	**Objective 3.2** Make sure people known to be frail are looked after in the best possible way.	**Objective 4.1** Continue or ensure the physical environment within our communities is better used to ensure it has a positive impact on their health and wellbeing.	**Objective 4.2** Continue to ensure everyone lives in safe and suitable housing and there is increased availability of social housing.	**Objective 5.1** Increased awareness within targeted communities of the existing and new programmes and initiatives	**Objective 5.2** Building on our understanding of Physical activity, work together to enable communities to move more.
ON TRACK										
NEEDS ASSISTANCE	**ON TRACK**	**ON TRACK**	**ON TRACK**	**ON TRACK**	**ON TRACK**	**NEEDS ASSISTANCE**	**ON TRACK**	**ON TRACK**	**ON TRACK**	**ON TRACK**
OFF TRACK										
Questions	**Lead: Irene Kakoullis**	**Lead: Kerrie Adams**	**Lead: Lorraine Palmer**	**Lead: Lucy Jones and Stephanie Morrisey**	**Lead: Lorraine Palmer**	**Lead:**	**Lead: Mariam Amos**	**Lead: Mariam Amos**	**Lead: Theresa Hodgkinson**	**Lead: Theresa Hodgkinson**
What is working well?	We have delivered the first year of the five year Best Start Strategy which includes 'school readiness' as one of the 10 ambitions of the strategy. Take up rates for funded childcare entitlement are even higher than pre-pandemic levels and this continues to increase. 82.18% of eligible children were taking up a place.	System partners continue to be well engaged in Best Start Partnership meetings, and have responded positively to the 'ask 'to be active contributors to discussions within the quarterly meetings. The Healthy Families Programme, delivered by Nottinghamshire Healthcare continues to perform well despite the additional pressures of the pandemic.	**EOL** Capacity and demand review underway for EOL to demonstrate the effectiveness of the service but also to reflect and understand the impact of the pandemic on palliative care services for end of life care together. This is due to be presented to the programme in April 2022 with the aim to discuss and agree outcomes and actions in May 2022. **MSK** Piloting some work with Everyone Active in Ashfield and with Active 4 Today in Newark. Have met with Senco in Mansfield to start conversations. From April 22 we will have an ESCAPE pain group and a community back pain class running in Newark Leisure centre and The Lammas.	A survey with clients has identified the remote service delivery has been accepted well through covid and will become embedded as a part of the ongoing service offer. It will also be a part of a blended approach to service delivery.	All 3 VCS lead organisations in MN (AVA, MCVS, N&S CVS) have access to Community Champions funding allowing them to work effectively with partners and to deliver the agreed KPIs. • Individuals facing multiple barriers are supported to access a range of health care services in their community. • System partners such as LAs and PCN Link Workers can call on the Network for support to deliver key health messages and outreach services. Ringfenced funding will enable the VCS organisations to continue offering support into the coming year giving them the ability to respond to the needs of partners and the community as and when needs arise.	The work with the ICS falls in Care Homes team is still ongoing and the next community of practice meeting is planned for April.	Bellamy - Since NCC vacated Trowell Court, the Centre is now being used more frequently by the community. Following a tender exercise the contract for Bellamy play park and Learn to Ride Track as part of the redevelopment of the estate has been awarded with work commencing on site on 21 March 22. Bull Farm & Please - a new MUGA has been developed by MDC at Bull Farm Park and is now nearing completion. Warsop - Warsop Health Hub - £3 million has been allocated from the Towns Fund and a further £1.5 million from council funds towards the capital cost of this scheme.	Decarbonisation of private homes - Phase 1b and Phase 2 Green Homes Grant projects nearing completion. Decarbonisation of social homes - MDC successfully bid for funding to retrofit 3 blocks of flats on Bellamy estate, works beginning imminently. New social affordable homes - due to complete 4 Passivhaus homes on Saundby Avenue shortly. Play area and cycle track on Bellamy to begin in March with housing to start afterwards. Planning granted for phase 3 of Centenary Rd development. Homelessness/rough sleeping - Mansfield's Housing First project 'First Steps' is going very well with plans to increase from 12-15 units this year.	Mansfield - The walk and talk initiative and One Step At A Time programme in Mansfield is progressing well Ashfield - Programming for the new leisure centre in Kirkby has commenced. The centre will open Summer 2022. Newark and Sherwood -The Ollerton Thursday night project tasters @ Walesby Scout camp have gone really well with 55 young people engaged to date, -Tag Tap launches in Ollerton on 1st April, the app will launch with a small competition over Easter.	Newark and Sherwood - New Local Improvement Group due to start from the end of April involving NSDC, community sector partners and local residents. Ashfield - New Health and Wellbeing Officer has been recruited with a focus on aging well (across the District) and Leamington (priority area). Mansfield - In Bellamy residents are starting to engage in programmes and activities. -Oak Tree is continuing to be an area of focus for the Mansfield Health Partnership, Work has already begun to support the primary school as a beacon in the community.
Do you have any areas of concern?	There is currently no Early Years Foundation Stage Data which measures progress of children in relation to school readiness. We know that more work needs to be done with vulnerable children aged 2-4, the majority of which have Special Educational Needs or Disabilities (SEND).	Giving every Child the best start in life continues to gain traction at a National level. However capacity to support the agenda is limited which may become a challenge as the work progresses.	**EOL** Capacity and demand review for EOL has highlighted changes in practice from the original assumptions. These are not clinical concerns but need additional testing through clinical audit to establish new assumptions. **MSK** Currently funding of the gyms is found in additional resources but this is finite and won't be able to expand much further	Despite the high prevalence of smokers in most localities, the systematic referral from professionals via an opt-out process for smokers is not apparent. This includes referrals from secondary care. Referals from dentists are minimal.	Ensuring the delivery of the KPIs set in the original proposal to NHSEI are met, ensuring the voice of the community is heard whilst gathering the KPIs agreed with NHSEI. Communication, Our CVS colleagues have been made aware via social media that health and wellbeing pop ups are happening but the CVS were not aware and now there is a risk of duplication but also reduction in engagement from our communities as they will be overwhelmed with these.	No lead in place for this Objective. Falls in Care Homes TAFG pilot is paused due to challenges in on boarding care homes.	Bellamy - Investment in the MUGA facility is delayed as the Community Centre has 7 years left on the lease with Nottinghamshire County Council (NCC)and the Football Foundation want 20 years on the lease to invest. Warsop - Warsop Health Hub - further funding is still required to support this scheme and reduce the level of borrowing required by MDC	The demand for social housing far outstrips supply - with 7000 applicants and only 400 house let so far this year. The government has announced a review of supported housing requirements so it is hoped that improved standards will be a requirement in future.	None	The NHS prevention programme aligns well with this objective for targeted work in Bellamy and Coxmoor however it is taking time to get going. Marrying up the desire to work differently (residents being supported to make the changes they wish to see in their communities) against the outputs and outcomes for the funding.
Do you have or forsee any risks to delivering the objective?	The Early Years Foundation Stage assessment has now been changed by DfE and Ofsted. This means that when the data is published (autumn 2022), we will not be comparing 'like for like' so analysis of trends will need to be considered with some caution.	Competing priorities within clinical services continue to impact on the availability of key stakeholders to lead and drive some of the ambitions within the Best Start Strategy.	**MSK** without financial mechanisms in place to move resources from areas of low to high value based on the decisions of the population stewardship forum the investment into some of the placed based rehab delivery may be limited.	Increasing staff levels will enable staff to provide a blended approach of service delivery and therefore there should be no risks to delivering the objective.	Delivery of the care Home Business case will need support from all partners and engagement. Support from the ICS to deliver a model across all homes within Mid Notts.	Having a lead for the Objective to collate and coordinate Frailty	Bellamy - Not being able to resolve the lease agreement presents a risk in not being able to capitalise on the investment opportunity in the MUGA facility.	Rough sleeping and homelessness - the remaining rough sleepers known to MDC have very complex issues including mental health and substance misuse and as a result, the current accommodation offer in Mansfield can't meet their needs.	None	The only foreseeable Risk would be if capacity in the Districts to continue to work in this way is redirected into other work streams
What would you like to celebrate?	• A new Speech, Language and Communication Needs (SLCN) resource has been created on Notts Help Yourself. • The Children's' Centre Service has recently updated their menu of interventions	1. Giving every child the best start in life will be one of the overarching ambitions within the Joint Health and Wellbeing Strategy 2022-2026. 2. The new parent/infant interaction team is now operational within the Nottinghamshire Healthy Families Programme.	**MSK** starting up community based rehab sessions, both formal groups and supervised rehab in a gym environment. **EOL** would like to celebrate from Oct 2018 there were 1753 patients identified in Mid-Notts with palliative care needs to there now being 2843 patients identified which is 0.84% of the total population of Mid-Notts		Work on Bellamy Road Estate inc NHSE/I Prevention Project • Bellamy Health & Wellbeing Day 24/1/22. • Bellamy Stakeholder meetings/collaboration workshops • Bellamy NHSE/1 project meetings. • Additional funds secured to enhance the delivery of the NHSE/I programme. • Bellamy Communities Officer recruitment. • Accommodation for the Lead Officer and Communities Officer secured at Trowell Court Community Centre.	Within Frailty they are working with active partners to consider a pilot connecting people who have been readmitted to Sherwood Forest Hospital because of recurrent falls to any community resource or identifying what community resources may be required.		Rough sleeping - Rough sleepers reduced from 27 in 2020 to as low as 2 in 2021. The Mansfield Housing First scheme has been instrumental in delivering this change and is the first of its kind in Notts. The council are bidding for funding to continue the project till 2025.	The Thursday night project (as described above)	The engagement and empowerment of the community in Bellamy to start to influence what happens in the estate
Any further comments you would like the group to know?	The Best Start Annual Report will be presented at the County Council's Children and Young People's committee and the Health and Wellbeing Board in April. Both meetings will be streamed live on the NCC YouTube channel.		**MSK** would like to evolve the population stewardship forum to include partners at place who can bring the local knowledge of the citizens to strengthen the prevention and health offer of MSK Together **EOL** service is looking how it can support Fast Track services in the future to offer an integrated approach for palliative care and continuing care services that promotes the personalisation agenda at the same time delivering a consistency of service from personal care through to specialist palliative care.	Work is underway to review Tobacco Control work across Nottinghamshire and looking at doing this jointly with Nottingham city. We are asking for partners to support this	Delivery of the NHSEI programme across the ICS continues and a report is being written to be presented in July, this will include the programme to date and data / finances for NHSEI to consider further investment in the project.			The Private Sector Housing team and the Housing Needs team are working together to launch a Mansfield 'Healthy Housing Hub' to launch from April 2022. The Private Sector Housing Minimum Energy Efficiency Standards (MEES) project has completed resulting in the EPC's for over 50 privately rented properties being improved.		
Who are your key partners to delivering your objective?	Early Years providers (schools and private, voluntary and independent sectors), Children's Centre Service, Healthy Family Teams, Speech and Language Therapy Teams, Virtual School (for children looked after by the LA), voluntary sector eg HomeStart; maternity services, ICPs, CCGs and Public Health.	Nottinghamshire County Council Public Health and Early Childhood Services; NHS services including Maternity Services and maternity voices partnership (MVP), Perinatal Mental Health, Healthy Families Teams, SLCN teams, and NHS commissioners; District and Borough council representatives; Comms and engagement leads across NHS and LA; Health and Wellbeing Board members.		Key partners to delivering the objectives are health professionals from all disciplines.	Mansfield CVS, Newark and Sherwood CVS, Ashfield Voluntary Action. Mid Notts Locality Team. NHSEI Bellamy Steering Group		Notts County Council, Residents and Community Leaders, Voluntary Organisations such as CVS and food clubs, Active Notts, CCGs, PCNs, Local Schools, Funding Partners, Bellamy- Football Association, Wrasop - Sports England, West Notts College and Nottingham Trent University	Notts County Council, Residents and Community Leaders, Voluntary Organisations such as CVS and food clubs, Active Notts, CCGs, PCNs, Local Schools, Funding Partners, Bellamy- Football Association, Wrasop - Sports England, West Notts College and Nottingham Trent University	Key partners are Mansfield, Ashfield and Newark & Sherwood District Council	Key partners are Mansfield, Ashfield and Newark & Sherwood District Council
Executive update					The Executives discussed the Communication and have a agreed plan to contact NCC to discuss.	Agreed at Executives that SFHT would take this back and review the lead for this breakthrough objective.				

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	PBP Strategic Objectives Update	**Date: 9th June 2022**	
Prepared By:	Diane Carter (PBP)		
Approved By:	Paul Robinson - Chief Executive		
Presented By:	Paul Robinson - Chief Executive		
Purpose			
To provide the SFHFT Board with an update on the position against the Mid Nottinghamshire Place Based Partnership (PBP) Strategic Objectives for the final quarter of 2021/2022		**Approval**	
		Assurance	**X**
		Update	
		Consider	

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

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

Mid-Nottinghamshire PBP Forum meeting – 19th May 2022

Executive Summary

The Place Based Partnership Forum (formerly known as Integrated Care Partnership Board) identified 5 PBP Objectives and 10 breakthrough objectives for 2020/2021. These provide the PBP Forum with a number of actions that would be undertaken during 2021/22 in support of delivery of the strategic objectives which provide the framework and themes in support of the overarching long term PBP vision.

The Q4 progress report against the PBP strategic objectives and actions for 2021/2022 continues to demonstrate that the breakthrough objectives remain long term and continue to need to be embedded in partner organisations' strategies and planning with the aim of delivering the aim of Healthier and Happier Communities.

The attached report was presented to the PBP Forum at its latest meeting on 19th May 2022.

A revision of Place Based Objectives is taking place and future updates will be provided when this is developed.

The Board is requested to NOTE the report.

Sherwood Forest Hospitals NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	**ME2 Pathology Network Strategic Outline Case**	**Date:** 9th June 2022	
Prepared By:	Elaine Torr DGM Networks and Collaboration,		
Approved By:	Dr David Selwyn, Executive Medical Director		
Presented By:	Elaine Torr		
Purpose			
To present the ME2 Pathology Network's Strategic Outline Case, (SOC) for approval.		**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**

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

Risks/Issues	
Financial	Investment required to support Pathology Network to achieve efficiency at scale.
Patient Impact	Networks should deliver improved services to patients and reduce unwarranted variation.
Staff Impact	Support to training and development of workforce
Services	Supports sustainable services
Reputational	The SOC will support the development of the Network to the maturity expected by NHSEI

Committees/groups where this item has been presented before

ME2 Implementation Board and the SFHT Executive Meeting 25th May 2022

Executive Summary

The purpose of this Strategic Outline Case (SOC) is to secure organisational Board support for the next steps in considering the optimisation of pathology services across the Midlands and East 2 (ME2) Pathology Network. It has been developed with the full support and input of the member organisations (and their stakeholders).

Midlands and East 2 (ME2) pathology network partners have been working collaboratively under a Memorandum of Understanding since 2019.

The approval of the SOC by member Trust Boards is seen as a key enabler to allow the Network to progress its maturity to the level required by NHSEI.

Network discussions resulted in the generation of five options, it is now proposed that three of those options are taken forward for further development and appraisal culminating in the production of an Outline Business Case (OBC).

Those three options are;

- Joint Venture
- A Hosted Organisation
- Provider Collaborative

Tight timelines prescribed in the NHSEI Network Maturity Matrix mean the network leadership team seeks a level of delegated authority to develop the network on Trust member organisations behalf through their nominated representatives via the ME2 Executive Steering Group. In co-ordinating the programme of work, the network leadership team are conscious of striking a balance between updating member organisation boards and a level of devolved autonomy to allow the network to progress its implementation plan.

The network seeks support in allowing this level of autonomy. Examples of delegated authority in practice may include;

- Co-ordination of network level Cost Improvement Programmes (e.g. Procurement)
- Optimisation of referred test work stream

The detailed proposal for network delegated authority will be provided as part of the Outline Business Case (OBC) when the Target Operating Model (TOM) and final preferred network development option will be provided.

A £1,000,000 investment in the Midlands and East 2 Pathology Network represents a 0.5% cost improvement target for the network in order for partner organisations to realise a return on their investment.

The financial request to support substantive recruitment to Network posts for SFHT, as a 7% split of costs is:

Year 1 £42, 910 Total cost of £7636k
On-going £114,100 Total cost £1.853million

Decisions Required

The Executive and Board are asked to consider the Strategic Outline Case, and approve the recommendations to;

- Produce a detailed Outline Business Case (OBC) developing the three shortlisted options of; Joint Venture, Hosted Organisation and Provider Collaborative that will be completed in time for consideration at Trust Board meetings in Q3 2022.
- Begin the process of recruiting ME2 leadership and Clinical roles that will drive this work forward.
- Commit to enabling expenditure for next period of activity as defined in the paper.

MIDLANDS AND EAST 2 PATHOLOGY NETWORK

STRATEGIC OUTLINE CASE

Senior Responsible Office: Tony Campbell, Deputy Chief Executive Officer, DHU Healthcare

Date: 20th May 2022

Executive Summary

The purpose of this Strategic Outline Case (SOC) is to secure organisational Board support for the next steps in considering the optimisation of pathology services across the Midlands and East 2 (ME2) Pathology Network. It has been developed with the full support and input of the member organisations (and their stakeholders) and is the Network's response to NHS Improvement's expectation that further consolidation of pathology services, as heralded in the Carter Review of 2006, and later in the NHS Long Term Plan would take place across the NHS. NHSEI's expectations were communicated to NHS providers of pathology services in September 2017 and most recently reiterated in a letter to ICS and Trust Executive Teams in April 2022 which outlines target milestones for network development in line with NHSEI's Pathology Network Maturity Matrix. Midlands and East 2 (ME2) pathology network partners have been working collaboratively under a Memorandum of Understanding since 2019

Optimisation of pathology services across the Midlands and East 2 (ME2) pathology network may deliver financial benefits, however it offers other more significant and advantageous gains such as improving robustness and sustainability of clinical services, harmonising equity across the network, raising quality standards and providing opportunities for continuous improvement and learning.

Network discussions have resulted in the generation of five options, it is now proposed that three of those options are taken forward for further development and appraisal culminating in the production of an Outline Business Case (OBC).

Organisational Boards are asked to approve the Strategic Outline Case and confirm their support for development of the shortlisted options, including the modest investment set out in section 9 of this Strategic Outline Case, and to approve development of the Outline Business Case.

1. Introduction

The purpose of this strategic outline case is to describe the background, current context and proposals in respect of pathology services across the member Organisations of the Midlands and East 2 (ME2) Pathology Network, set out the drivers for change, including a summary of the challenges and opportunities that face the services in scope and, importantly, to seek member Trust Boards' approval for the development of an Outline Business Case.

The Network must now gain approval from member Trust Boards to develop an Outline Business Case for the rationalisation of pathology services across the Midlands and East 2 (ME2) Pathology Network. The reasons for delays in achieving this to date are multifactorial and considered as part of this Strategic Outline Case but can be summarised as the challenges presented by the Network's geography and size, the lack of resource to develop a strategic case and impacts attributable to the COVID-19 pandemic response. The commitment required from Boards to develop the Outline Business Case will include resourcing such a step and this is addressed through this proposal.

Oversight of the Strategic Outline Case development has been undertaken by the ME2 Pathology Network Implementation Board, Chaired by Tony Campbell, Deputy Chief Executive Officer of DHU Healthcare who is the Senior Responsible Officer (SRO) for the Strategic Outline Case. The Strategic Outline Case was considered by the Network Implementation Board at its 17th May 2022 meeting and the Network Executive Steering Group at its 28th March 2022 meeting and supported by all members.

2. Project rational and context

Nationally we do not have sufficient diagnostic provision to deliver the level of service desired by all service users. There are insufficient resources to invest in all Trusts to maintain world class pathology capability. The formal creation of the Midlands and East 2 Pathology Network will enable a more strategic and system level approach to delivering pathology services in an efficient and coordinated manner. The creation of a Pathology network spanning the East Midlands provides an exciting opportunity to not only future proof valuable services but save multiple

millions in procuring at scale together and developing new collaborative ways of working. The development of the network will aim to ensure we have well trained staff, appropriate resources, resilience and efficiency. The Midlands and East 2 Pathology Network has the potential to be the exemplar network to work for. It provides a depth and breadth of opportunity at both individual and organisational level to align clinical services from each partner Trust and to draw upon best practice for the benefit of all stakeholders within the network.

The Midlands and East 2 (ME2) Pathology Network is 1 of 29 within England, where the size and scope has already been agreed and for organisational purposes includes all Trusts summarised. NHSEI's expectations were communicated to NHS providers of pathology services in September 2017 including the view that for the Midlands and East 2 Pathology Network, financial modelling indicated that the Network could potentially release £11.4m in efficiency savings. The efficiency savings potential identified by NHSEI is based on data outputs from the Model Hospital. The collective pathology network workforce and non-pay costs for Midlands and East 2 (ME2) Pathology Network are circa £200m per year (**Table 1**).

Trust	**Total cost (million) Pay and non-pay**	**Non pay cost (million)**	**Pay cost (million)**
National Median	*17.75*	*8.57*	*9.18*
Chesterfield*	9.61	5.15	4.46
UHDB*	31.23	14.43	16.8
Kettering	12.93	7.32	5.61
Leicester	38.75	17.19	21.56
Northampton	17.01	9.73	7.28
Nottingham	43.27	21.64	21.63
Sherwood	14.13	8.2	5.93
Path Links:** ULHT NLAG	34.78	19.27	15.51
TOTALs	**£201.71**	**£102.93**	**£98.78**

Table 1: Current pay and non-pay costs (Model hospital whole service 2019):
**Derbyshire Pathology – Joint venture hosted by University Hospitals of Derby and Burton*
***Path Links – Pathology service in Lincolnshire hosted by Northern Lincolnshire and Goole.*

Pathology in the East Midlands delivers over 110 million tests a year from 15 laboratories in 9 Trusts and employs ~2400 staff (**Table 2**).

Trust	Number tests 19/20 (million)	No Requests (million)
National Median	*9.26*	*1.56*
Chesterfield*	6.84	1.33
UHDB*	25.07	3.59
Kettering	8.44	1.56
Leicester	21.71	3.32
Northampton	7.29	1.55
Nottingham	20.26	3.67
Sherwood	7.02	2.95
Path Links:**	23.86	4.08
ULHT	6.97	2.06
NLAG	16.89	2.02
TOTALs	**113.65**	**20.72**

Table 2: Number of tests and requests per year (Model hospital whole service 2019)
**Derbyshire Pathology – Joint venture hosted by University Hospitals of Derby and Burton*
***Path Links – Pathology service in Lincolnshire hosted by Northern Lincolnshire and Goole.*

The Pathology service provision across the East Midlands is complex. Past attempts to unify comparative services across the whole region have struggled to apply models which work elsewhere nationally. Significant variation across the network exists in terms of costs per test (**Table 3**) and opportunities exist to improve this situation.

Trust	Total cost (million) Pay and non-pay	Number tests 19/20 (million)	Cost per test 19/20- whole service (£)
National Median	*17.75*	*9.26*	*1.97*
Chesterfield*	9.61	6.84	1.40
UHDB*	31.23	25.07	1.25
Kettering	12.93	8.44	1.53
Leicester	38.75	21.71	1.79
Northampton	17.01	7.29	2.33
Nottingham	43.27	20.26	2.14
Sherwood	14.13	7.02	2.01
Path Links:**	34.78	23.86	1.46
ULHT		6.97	
NLAG		16.89	
TOTALs	**£201.71**	**113.65**	**£1.77**

Table 3: Cost per test – Whole service (Model hospital whole service 2019)

The Pathology service response to COVID-19 within the Midlands and East 2 region has provided a unique opportunity to work together, providing a blueprint to inform an operational model which best fits the complexities of the Midlands and East 2 region and the attendant stakeholder requirements.

The network has established four “clusters” who work under different governance models;

- **Derbyshire Pathology** (University Hospitals of Derby and Burton NHS FT & Chesterfield Royal Hospital NHS FT) has formed as a contractual joint venture between CRH & UHDB, hosted by UHDB.
- **Path Links** (Northern Lincolnshire & Goole NHS FT and United Lincolnshire Hospitals NHS Trust) is a single managed network hosted by Northern Lincolnshire & Goole NHS FT. It has been in place for over 20 years and is renowned nationally for its success in doing so.
- **Nottinghamshire** (Nottingham University Hospitals NHS Trust and Sherwood Forest Hospitals NHS FT) have a joint Pathology Board and Memorandum of Understanding.
- **LNR** (University Hospitals of Leicester, Northampton General Hospital NHS Trust and Kettering General Hospital NHS FT) has a joint Pathology Board and Memorandum of Understanding.

The aim of the network is to build upon these “clusters” as the emergent operating model so all sites can benefit from the rewards working as a combined network can provide. The response to the COVID-19 pandemic most clearly demonstrated how providers can work together effectively at scale and pace to achieve common objectives.

The four cluster arrangement aligns with ICS geographical footprints therefore making strategic sense and facilitates the network developing incrementally over time in order to overcome the complexities of forming a network of this size with a significant number of member organisations involved. The pandemic response from Pathology services has provided a unique opportunity for us to work through and develop plans based on evidence and experience, effectively testing the effectiveness and sustainability of the four cluster model we propose taking forward.

Collaborative working and shared objectives have been the driving forces behind our coordinated approach.

3. NHSEI Pathology Network Maturity Matrix – 'When is a network a network'

The NHS Long Term Plan committed the NHS to establishing Pathology networks across England by December 2021. Realising the benefits of a Pathology Network will take time and, as networks adapt to the new way of working to deliver the expected transformation of Pathology services, they will need to progress along the maturity curve. To assist Networks, regions and the national team with this progression, the Pathology Network Maturity Matrix Tool was introduced as a means of objectively assessing maturity aligned to five progression stages; Pre-emerging, Emerging, Developing, Maturing and Thriving.

The tool identifies seven domains that characterise a Pathology Network formation and as networks develop through implementation, a description of indicative deliverables is offered in each matrix for the domain.

As such each matrix will;

- Provide networks with content to self-assess their current position
- Highlight key areas and topics for consideration at each stage of network development
- Support decision making within the network

The seven domains are;

- Governance
- Leadership
- Operational
- Quality
- IT and Digital
- Workforce
- Shared Supply Chain

Midlands and East 2 (ME2) pathology network completed the self-assessment and submitted its response to NHSEI in December 2021. All pathology networks were

expected to fall within the later 3 stages in their overall scoring by the end of 2021. The ME2 network scored 11 placing it within the ‘Emerging’ stage with an initial NHSEI challenge to achieve ‘Developing’ by the end of March 2022 and ‘Maturing’ by March 2023. Trusts were notified by NHSEI in April 2022 that these timescales have now been revised. The revised challenge is to achieve ‘Developing’ status no later than December 2022. In order to meet the ‘Developing’ status challenge the network needs to score a minimum of 15, of which development of this strategic outline case plays a fundamental part in order to secure points across multiple domains.

4. Strategic case for change

Pathology is an essential clinical service for all acute and primary care healthcare providers with 70-80% of clinical decisions requiring input from pathology and 95% of chronic disease pathways reliant upon pathology. As such it is critical to delivering a high quality clinical service which assists in patient flow in acute settings, reduces inappropriate bed occupancy, and helps to avoids unnecessary admissions and fewer secondary complications that meet the needs of patients and clinicians.
One of the key purposes of the national pathology consolidation programme is to ‘deliver the test, with the right advice at the right time, utilising the right approach and technology’

Operational Strategy

Reducing variation in operational practice facilitates;

- Consistency of method and standardisation of operating procedures
- Supports network based accreditation
- Reduces cost base

This work can be guided using information and data from GIRFT and model hospital.

One of the key aims of this strategy will be to ensure effective utilisation of resources and that each site has the benefits of accessing the wider network for support in service delivery. Optimising testing through rationalisation will be required, as not all laboratories will have the resources or the requirement to provide a full range of tests into the future. The scope of tests required will only widen, therefore laboratories will

have to consider what to optimise in order to have full access to the tests required to support the increasing diagnostic demands and complexities.

The development of Midlands and East 2 (ME2) Pathology Network requires a substantial development programme with the network achieving ‘Developing’ on the NHSEI Network Maturity Matrix no later than 31st December 2022 (an NHSEI challenge). A gap analysis detailing how the network will reach ‘Maturing’ by the end of 2024/2025 needs to be submitted to NHSEI by 30th June 2022. Progress reports and proposals for approval will be required to go to member Trust Boards on a regular basis.

Implementation of the Midlands and East 2 Pathology Network should be carried out incrementally to minimise operational risk. There is sufficient evidence of failure in other pathology consolidations so there will need to be clear and methodical transition planning. It should also be recognised that consolidation of pathology is a resource intensive project that requires a dedicated team working alongside management, clinical and operational teams to deliver a successful outcome. NHSEI has identified the following project resources as key enablers in developing a network. These roles, with the exception of the SRO and Clinical Director, should be full time roles:

- Senior responsible officer for the network
- Clinical Director/Lead
- Network Operations/ integration director
- Procurement Lead
- Programme Manager
- Quality Lead
- Workforce Lead
- Digital programme Manager
- Programme support officer
- Network Admin support
- Finance & analytical lead
- Communications lead

Currently many of these roles are covered on a voluntary basis, where existing senior leaders within the pathology network are undertaking multiple roles that are not sustainable. The total recurrent cost will be approximately £1,630,000 spilt proportionally across each member Trust.

Clinical Strategy

'Getting it right first time' (GIRFT)(NHSEI, 2021) is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking and presenting a data-driven evidence base to support change. The national Pathology GIRFT report was published in 2021 and makes 21 recommendations. The Midlands and East 2 (ME2) Pathology network Clinical Strategy is underpinned by those national programme recommendations with 8 listed below selected as our top clinical priorities;

- Urgently investigate acute kidney injury (AKI) flags to understand variation.
- Develop an integrated venous thromboembolism (VTE) pathway for network use.
- Interrogate all tests to ensure all are based on a valid clinical question, necessary, appropriate and sufficient to answer that question. Starting with urine sample requesting.
- Interrogate usage and wastage data for blood products, and address identified problems.
- Review and develop a robust Immunology service in the Network.
- Establish electronic requesting and messaging as standard in all labs and with all requestors.
- Embrace and support innovation in pathology, including digital pathology and improved decision support.
- Establish a proactive, integrated approach to ensure new technology can be adopted at speed, procuring as a network to deliver a standardised, high quality and cost effective service.

The Midlands and East 2 (ME2) pathology network clinical strategy focuses on ensuring the right test is available for the right patient at the right time with the right result. In order to attain this, the network first needs to ensure its clinical workforce is robust, removes duplication and works toward sustainability of its services. Particular

areas of focus are Cellular Pathology and Immunology where national staffing shortages exist and network optimisation provides opportunities for mutual aid and innovative ways of working to support each other. The network will define additional clinical priority areas as a means to work together and develop the network incrementally.

Procurement Strategy

The key aim of the Midlands and East 2 (ME2) procurement work stream is to identify opportunities for network procurements to deliver a standardised, high quality and cost effective service.

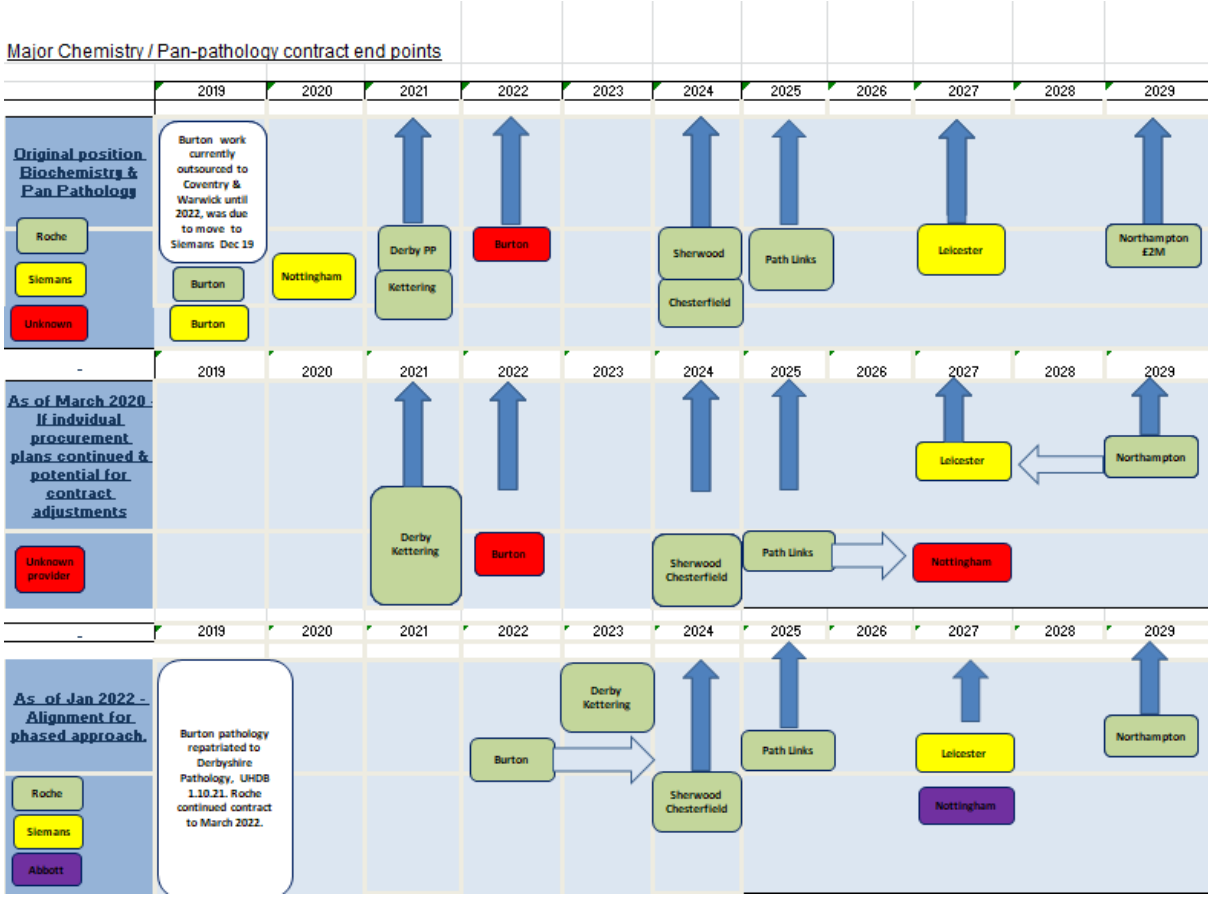
Whilst currently operating within an existing network or single site pathology service provider, the group aims to jointly procure as one network incorporating all Midlands and East 2 partner organisations.

The procurement work stream group aims to procure equipment and services on behalf of its ME2 network partners to support;

- Short, medium and long term alignment of major contracts.
- Standardisation of equipment platforms for resilience.
- Higher specification of equipment to improve the quality service across the network.
- Delivery of financial efficiencies associated with economies of scale and service reconfiguration.
- Value added contracts to improve service resilience (e.g. network engineer support)
- Reduction in variation of services to improve consistency of patient pathways across the network.
- Widening the scope of expertise through training/shared learning of standardised platforms.

Recognising the need to maintain service delivery during the early stages of the formation of the Midlands and East 2 network, some key major procurements have continued but the overarching vision is still in place.

Significant progress has been made in understanding the overall position of the major pathology contracts of the partner organisations. During the COVID pandemic a number of large scale procurements were paused and this presented opportunities for the group to work collaboratively to further align contracts as indicated below.



Taking learning points from the COVID pandemic and the associated challenges to the supply chain, a phased procurement approach is being proposed.

Phase 1 includes Derbyshire Pathology (Derby, Burton and Chesterfield), Kettering, Path Links and Sherwood but will not preclude other partners from joining the contract at a later date.

In the absence of delegated authority for financial decisions, the Trust boards of each Midlands and East 2 network partner will need to fully support the joint procurement approach in advance of the commencement of the procurement process.

All of the four main framework providers reviewed, have confirmed that it is possible to jointly procure equipment to achieve the aims of the procurement work stream whilst retaining separate contracts for individual Trusts or subnetworks within Midlands and East 2.

Digital Strategy

The ME2 digital strategy is focused on three levels:

1 Network development and opportunities for quality, efficiency, and affordability improvement

2 Making the best use of an extensive range of services and expertise within the network, providing patients and service users with access to enhanced, responsive, standardised and seamless pathology diagnostic services

3 Utilising digital resources to transform service delivery, collaborative working and resilience

Whilst recognising varying degrees of digital maturity across the network, all pathology network partners share a common vision and purpose to developing the described digital road map.

Close collaborative working established throughout the COVID pandemic not only highlighted the absolute need for wider integration and interoperability but also demonstrated gaps in service provision particularly in wider health community and social care settings

<u>INTEROPERABILITY</u>

The development of an ME2 Pathology Integration Engine (PIE) is fundamental to addressing both inter-provider operability and standardisation.

Capturing all network digital test request inputs, the PIE has the capacity and capability of translating all non-standardised inputs into a common standardised output. PIE routing algorithms will seamlessly distribute test requests to any network provider, irrespective of source location, creating a ‘request anywhere & test anywhere’ concept.

This will create an opportunity to maximise efficiency, improve standard practice and will support the development of an operating model for the network that is right for the East Midlands' patients and service users.

The construct of the PIE programme is shaped to deliver:

- Open access to the extended test repertoire of the network to all service users
- Wider access to (limited) electronic test requesting in community and social care settings, e.g. for the requesting of SARS-Cov-2 tests and their subsequent electronic result availability
- Full deployment of electronic test requesting in all settings
- A standardised approach to data management accelerating and facilitating network strategic design and data driven operational, workforce and quality improvements
- Infinite scalability with extended interoperability capability between pathology networks and other regional or national services e.g. genomics

There are four key elements and deliverables of the programme:

1. PIE Development

    1.1. Single test pilot

        - Proof of concept and testing/validation of PIE transformation and messaging flows (test order entry – LIMS result capture)

    1.2. Low Capacity and Specialist Tests

        - Extension of interoperability for specific test repertoire to underpin network clinical strategy, consolidation, and rationalisation, including repatriation of outsourced test activity
        - Full system scalability to provide individual laboratory business continuity measures and further underpin network clinical strategy and consolidation of more common higher volume tests

2. ‘Mini’ Order Comms

   – Maximal utilisation of electronic test requesting to realise full potential of PIE and PIE database functionality

   – Simple and intuitive ‘limited test repertoire’ system for extended use in community health and social care settings, opening service access and secure, timeliness of results reporting

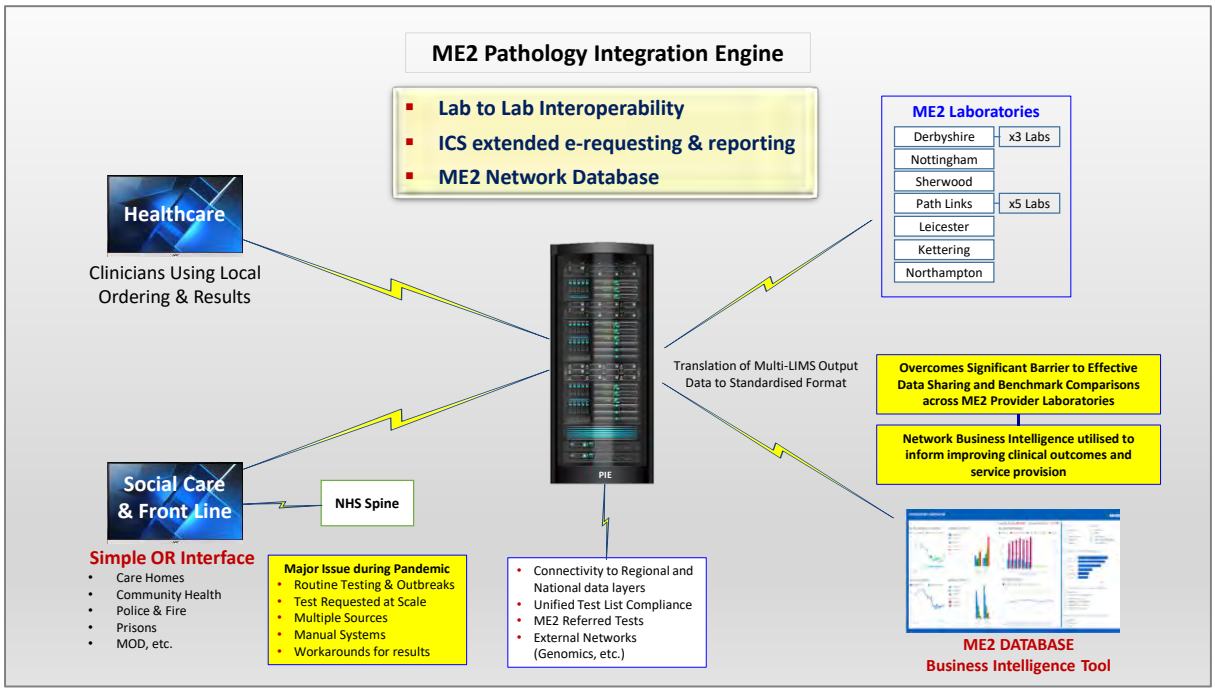
   – Extended test repertoire for acute healthcare setting with limited or no access to electronic requesting

3. PIE Database and Business Intelligence functions

   – Multi-Trust database linkage to Business Intelligence tools to provide a standardised approach to network data management, feeding through to national data collection schemes, and driving forward network benchmarking and collaborative improvement opportunities

4. Clinical & Patient Portal

   – Providing database accessibility to patients and service users at a local and regional level through the development of a user portal



The ME2 Pathology Network has been successful in receiving £1.1m national funding for the scheme. Timescale for delivery is Q3/Q4 2022-2023

DIGITAL HISTOPATHOLOGY

The ME2 Network vision is one of full digitisation of standard glass slide reporting across all providers. The plan is not only to secure the wider deployment of digital slide scanners but also to capitalise on novel digital infrastructure opportunities and artificial intelligence [AI] to transform histopathology service provision to an integrated regional model, by:

1. Full deployment of digital scanning equipment and reporting systems to all network histopathology services
2. Standardisation of digital systems and architecture to facilitate interoperability across the ME2 network, enabling and facilitating the development of WSI exchange and remote reporting
3. Developing and deploying a network digital solution allowing operational and working practice re-design, facilitating reporting anywhere (in the workplace, in any Trust, at home, etc.) and making best use of specialist and scarce clinical resource

The ME2 Network ambition is to, not only address interoperability issues between providers, but also to transform seven provider services into a single network offering

Supported by a national investment of over £8 million, all network histopathology laboratories will be digitally enabled from Q1/Q2 2022-2023

Progressing through an implementation and transformation phase, the ambition is to achieve a ‘Leading’ level of digital maturity by Q4 2022-2023 and progressing further thereafter.

Workforce Strategy

Staffing is a major constraint in service provision and extension of opening hours. A network workforce vision is required to meet the national aim of 'right role, right person'. There is significant variation in approach at Trust level to the modernisation of the pathology workforce and we are looking to develop a much more consistent and coherent approach together. There has always been significant staff movement around the region. Nationally we have excess equipment capacity yet increasing workforce shortages. Networking across wider geographies provides a solution to localised recruitment challenges and development of advance scientific roles.
As a collective we can address some disparities by standardising the workforce. We want to be in a position where a band 6 has the same capability and responsibilities no matter which laboratory they are in. There is hidden talent and skills amongst our staff that could be harnessed and will ultimately improve morale and career progression. Consideration will also be given to a network wide strategy to support out of hours working.

The pathology workforce is said to be one of the most complex and heterogeneous in the NHS. This complicates service planning, particularly in relation to workforce. Advanced roles need to be part of the future operating model in order to fill the staffing gaps held by all Trusts

Training and education must complement both delivery of healthcare and sustainability of the future workforce. As a network, we hold a huge number of highly skilled, specialist and dedicated staff who could work across the network to deliver training and support in a coordinated and targeted approach.

The workforce strategy will encompass:

- Training and education
- Standardisation of roles
- Development of advanced roles

All of these areas will improve our workforce position but only if we do this as a large network approach. This work will not have longevity if done in silos.

Quality Strategy

The Midlands and East 2 (ME2) pathology network quality strategy aims to harmonise quality functions across the network to ensure user needs and requirements are met. Each partner Trust currently works to ISO15189 standards and are at varying places within their accreditation schedule. As a network we acknowledge that the road to a single quality management system encompassing all Trusts in the network is something that under several of the options under consideration is unachievable however in the longer term as the network progresses may be possible with comprehensive planning and implementation. Currently each Trust holds individual accreditation under a series of accreditation numbers (**Appendix C**).

The key aim of the Midlands and East 2 (ME2) quality work stream is to ensure network quality inputs and outputs are standardised, resulting in high quality and cost effective services which meet user need and expectation.

Midlands and East 2 (ME2) pathology network currently operates multiple network and single organisation quality management systems with multiple software packages in use. The Quality Leads group aims to cohesively bring together QMS outputs from these systems to provide a network quality overview, identifying areas which can be harmonised immediately alongside developing a plan for aligning key functions and reporting mechanisms which align with the networks Quality Policy and overarching strategy.

Recognising the need to maintain accreditation status during the early stages of the formation of the Midlands and East 2 (ME2) pathology network, no changes to organisational legal entity have been made and individual organisations are continuing on their planned accreditation inspection schedules.

This status will remain until such a time that the network overarching quality vision is in place and sufficient elements have been harmonised to facilitate accreditation at cluster level.

A summary of the initial phased development of the strategy is outlined below;

Phase 1 – Delivered by March 2022

- Develop a network wide Quality Policy
- Develop a Quality Team structure led by a designated network quality lead
- Ensure PQAD is in use at all network sites with a review of inputs to provide standardisation and network benchmarking accuracy.
- Develop a network Quality Team meeting with formalised attendees, Terms of Reference and Agenda.

Phase 2 – Target March 2023

- Development of Network Mission, Vision and Values
- Development of network wide quality objectives and reporting mechanisms
- Review network quality management activities to reduce duplication

Phases 1 and 2 of the quality strategy are directly aligned to Domain 4 of NHSEIs Pathology Network Maturity Matrix in order to achieve ‘Maturing’ by March 2023.

Point of Care Strategy

The Midlands and East 2 (ME2) pathology network POCT Strategy is still in its infancy but will be developed further as part of the network outline business case.

To date the network has formed a POCT Committee which reports directly to the ME2 Clinical Reference Group and ultimately the ME2 Implementation Board. Representatives from each member Trust who hold POCT expertise attend the committee with the aim of defining ME2s POCT strategy and requirements.

Communications Strategy

The Midlands and East 2 (ME2) pathology network communications strategy has yet to be developed. Early discussions have focused on the networks identity and branding. This work stream will be developed further as part of the network outline business case. It is envisaged that staff within the network will be given the opportunity to participate in ‘naming’ the network to create a sense of involvement

and ownership as the network is formed. Consideration will need to be given to developing the networks vision, mission and values statements going forward.

Finance Strategy

The Midlands and East 2 (ME2) pathology network finance strategy has yet to be formally outlined. It is recognised that appointment to a network Finance Lead will be crucial in developing and implementing this work stream. Currently any funding received by the network is allocated to respective ICS' and drawn down by individual member Trusts. The finance work stream will feed into the ME2 Implementation Board and be overseen by the ME2 Executive Steering Group. As per the current working model, member Trust's retain individual autonomy and responsibility for capital to support their own service pending development of the outline business case.

5. Pathology Benchmarking

Pathology features within the 'Model Hospital', as an area of opportunity for removal of unwarranted variation. The model hospital is the key output of Lord Carter's earlier review of hospital efficiency and productivity, which identifies a potential for pathology to save £200m nationally. The NHS Long Term Plan confirms and builds on this approach. The delivery of the recommendations from the NHS Long Term Plan alongside realisation of the opportunities within the 'Model Hospital' is being led by NHSEI and there is growing expectation that the Midlands and East 2 Pathology Network makes progress on this agenda. Equally the COVID-19 pandemic has highlighted the weakness in the nation's diagnostic capability which has to be addressed.

The table below compares the cost per test per discipline for each site:

	Microbiology	Cellular Pathology	Blood Sciences
KGH	4.70	30.16	0.95
NGH	7.88	24.95	1.26
NUH	6.33	36.50	1.35
Path Links	2.19	19.19	0.61
SFH	2.37	21.59	0.88
UHDB	5.01	24.73	0.91
CRH	6.43	-	0.59
UHL	4.11	25.10	1.30
Group Median	4.70	24.92	1.30
National Median	4.57	26.46	1.14

Table 4: Cost per test by discipline for each Trust (Model Hospital; Latest published period 2019)

6. Current Position

The key milestone to moving the Midlands and East 2 region towards becoming a network is to define and agree its operating model. The emergent operating model within our network is that of a 4 “cluster” arrangement, aligned across relevant ICSs and underpinned by existing relationships, as follows;

- Derbyshire Pathology (Joint venture between Chesterfield Royal NHS FT and UHDB NHS FT)
- LNR - University Hospitals of Leicester, Kettering NHS FT and Northampton General Hospital.
- Nottinghamshire – Sherwood Forest Hospitals NHS FT and Nottingham University Hospitals
- Path Links – Northern Lincolnshire & Goole FT and United Lincolnshire Hospitals Trust – Legal entity hosted by NL&G)

Cluster	**Number tests 19/20 (million)**
Derbyshire	31.91
LNR	37.44
Nottinghamshire	27.28
Path Links	23.86
TOTALs	**113.65**

Table 5: Number of tests per Cluster

The Midlands and East 2 (ME2) pathology network is one of, if not the largest NHSEI proposed pathology network which presents a number of unique complexities.

Geographically the network encompasses nine individual acute hospital trusts over an extremely large geographical area spanning multiple ICS. The 4 cluster model we currently operate utilises existing working relationships to the networks advantage and works cohesively with the ICS footprint and patient flow.

The current network governance structure and its integration with the Midlands Pathology Board is depicted in **Appendices A** and **B**.

7. Consideration of Options

Midlands and East 2 (ME2) pathology network is the largest of the 29 consolidated pathology networks proposed by NHSEI in terms of geography, distance and proportion of tests undertaken which presents many unique challenges.

Reflecting the nature and location of pathology services in the Network area, members agreed that wholesale adoption of the NHSEI Hub and Essential Service Laboratories (ESL) or 'Spoke' recommended model was unlikely to meet the needs and aspirations of local providers and as such work was undertaken to scope and evaluate the options open to the Network which had the potential to realise the quality and financial benefits described in the Model Hospital. We recognise that while physical consolidation is important for some parts of the service, an integrated LIMS, digital histopathology, common equipment and shared procurement can deliver many of the Carter benefits through a virtual consolidation. Whichever model is chosen needs to be flexible and able to respond to new challenges. Hub and Spoke application may be considered on a bespoke basis within individual clusters or test type but not at wholesale network level.

When developing these proposals, particularly with a view to considering the long term sustainability of the arrangement, significant consideration needs to be given to the commercial model. There are 5 commercial models the network could choose to follow.

Option 1 - No change from current model

Main features: No change in overall service ownership. Individual trusts could continue to co-operate for mutual benefit on procurement etc. but would be under no obligation to do so.

Capital: Each Trust is responsible for raising the capital required or contracting with a private organisation to supply capital.

Profit and Liability: Each Trust holds their own accounts.

Autonomy: Each Trust retains individual autonomy.

Feasibility: Not feasible – Fails to develop a networked pathology service across ME2.

There is no option to not form a network; however, it is important to understand the risks of not formalising the Midlands and East 2 Pathology Network and capitalising on the excellent work already undertaken by the current member organisations;

- NHSEI has established a level of governance that would result in an inability to bid for national pathology funding streams as a result of failing to develop or under developing network strategies. In order to be in a strong position to ensure we are able to draw down from any investment coming into pathology services, we must operate in a coordinated approach.
- Continuing to operate under the existing Memorandum of Understanding (MOU) does not allow the network to mature and evolve sufficiently to realise the benefit of delegated authority from member Trusts.
- Eroding any of the cross network support that has emerged will decrease resilience and the resulting fragility of service could place individual Trusts in a precarious position with regards to their future pathology service provision.
- Business continuity and service sustainability risks sit with individual Trusts for resolution.
- Inability to benefit from economies of scale offered by potential service transformation initiatives.

Option 2 - Joint Venture / Community Interest Company

Main features: Full/Partial consolidation of pathology services. Configuration will be dependent on specialism. The incorporated organisation will have a memorandum (describing the members setting up the organisation) and articles of association (describing how the company is to be run and any benefits shared).

Capital: Through partners as per partnership agreement

Profit and Liability: Distributed to partners as per partnership agreement

Autonomy: Full autonomy

Feasibility: Potentially feasible – NHS Trusts and Foundation Trusts are free to enter into a joint venture, providing that the proposal meets competition requirements.

Joint ventures, or shared service agreements form a new structure with shared equity and governance to provide services. Risk and gain share is dependent on the partnership agreement put in place. Joint ventures between NHS organisations are comparatively rare when compared to the prevalence of the involvement of the private sector. Reasons for this are multiple, but the overarching one being that the independent sector can provide start-up capital, expertise and enterprise to accelerate the venture.

The option to form a joint venture is potentially feasible and will therefore be taken forward for detailed evaluation as part of the outline business case.

Option 3 - Outsourcing

Main features: Partnership with private provider to deliver pathology services for all providers on the same terms following a procurement process.

Capital: Each Trust is responsible for raising the capital required or contracting with a private organisation to supply capital

Profit and Liability: Each Trust holds their own accounts

Autonomy: Autonomy over outsourcing contract arrangements and KPIs only.

Feasibility: Feasible – Outsourced pathology services exist within England.

Potential pitfalls of an outsourced pathology network include;

- Clinical teams having a lack of control over the service
- Governance would be through a private company or neighbouring pathology network.
- Limited control of sample turnaround times which may impact patient flow
- Cost
- Inability to transform or improve services

Whilst feasible, the ME2 Executive Steering Group and thus network member Trusts have rejected this option as it presents unwarranted risks to services, destabilisation of patient pathways and limits development of clinical services, therefore outsourcing will not be taken forward for detailed evaluation as part of the outline business case (OBC).

Option 4 - A Hosted Organisation

Main features: Full consolidation into a single managed network hosted by a member organisation. Configuration will be dependent on specialism. This may involve the transfer of some staff from the non-host trusts to the host trust under Transfer of Undertakings (TUPE). All contracts, finance systems, liabilities and responsibilities transfer to the host trust. This structure allows for a responsive service that is well-defined commercially and where the operational management team has full control of operations at all sites. This means it has greater leverage to optimise the efficiency of the service and implement change.

Capital: Host trust is responsible for raising capital or contracting with a private organisation to supply capital.

Profit and Liability: To be shared in accordance with joint venture agreement.

Autonomy: Full autonomy as pathology operates as a division of the host trust under a delegated authority scheme.

Feasibility: Potentially Feasible – Any of the individual member Trusts could host the network. Clear operational and clinical governance structures would need to be defined.

The most common of commercial models found within networks. Midlands and East 2 is the biggest network in the country in terms of geography, patient population and staffing. Although this would be the option most likely supported by NHSEI, there are substantial barriers due to its scale that make this an unlikely achievable model. The TUPE transfer of 2333 staff, the financial obligations and HR risks associated for the host organisations are potentially too great and too distracting to reap the short terms benefits and there are no clear patient pathway flows between all locations.

Despite the risks above the option remains feasible and will therefore be taken forward for detailed evaluation as part of the outline business case.

Option 5 – Provider Collaborative

Main Features: Provider collaboratives are partnership arrangements involving at least two trusts (in this instance 9 acute Trusts) working at scale across multiple places, with a shared purpose and effective decision-making arrangements. By working effectively at scale; reduction in unwarranted variation, improved resilience and consolidation to provide better outcomes are key objectives of provider collaboratives.

Capital: Each trust is responsible for raising the capital required or contracting with a private organisation to supply capital

Profit and Liability: Each trust to hold their own accounts.

Autonomy: Decisions are subject to approval by all trusts, including clinical governance. Contracting can be utilised to support this.

Feasibility: Feasible – Requires common agreement between the Trusts.

There are 3 provider collaborative models. The models are not mutually exclusive; they can be combined or work in parallel, and one may evolve into another.

- **Provider Leadership Board Model** - Chief executives or other directors from participating trusts come together, with common delegated responsibilities from their respective boards (in line with their schemes of delegation), such that they can tackle areas of common concern and deliver a shared agenda on behalf of the collaborative and its system partners. To ensure effective oversight of the provider leadership board, trusts should consider how to involve their non-executive directors in providing scrutiny and challenge.
- **Lead Provider Model** - A single NHS trust or foundation trust takes contractual responsibility for an agreed set of services, on behalf of the provider collaborative, and then subcontracts to other providers as required.

- **Shared Leadership Model** - Members share a defined leadership structure in which the same person or people lead each of the providers involved, with at least a joint chief executive.

The provider collaborative model would formalise the current cluster arrangement, allowing those relationships to build and for teams to focus on current operational challenges.

All trusts providing acute and mental health services are expected to be part of one or more provider collaboratives by April 2022. Choosing to form a network provider collaborative realises this objective for all partner organisations involved.

Governance arrangements supporting provider collaboratives are under development as such if this option is selected the network will need to learn and evolve as information becomes available.

Option Appraisal overview:

Based on an initial feasibility appraisal it is recommended that Options; 2 (Joint Venture), 4 (A Hosted Organisation) and 5 (Provider Collaborative) be taken forward for detailed evaluation through an Outline Business Case (OBC).

8. Future Network Management Model

The purpose of any reconfiguration of activity will be to sustain quality over the long term whilst ensuring the best use of resources. The Network recognises that changes to delivery model may result in differential impact between organisational members. This is likely to require the network to describe partnership and governance arrangements that ensure an appropriate distribution of the resulting risks and benefits. The options for such arrangements will be explored at OBC phase for final conclusion in the Full Business Case (FBC).

Autonomy

Tight timelines prescribed in the NHSEI Network Maturity Matrix mean the network leadership team will seek a level of delegated authority to develop the network managed on Trust member organisations behalf through their nominated representatives via the ME2 Executive Steering Group. Examples of delegated authority in practice may include;

- Co-ordination of network level Cost Improvement Programmes (e.g. Procurement)
- Optimisation of referred test work stream

The network would also seek autonomy to allocate realised cost efficiencies toward recruitment of its network roles.

9. Project Structure and Resourcing

The resources outlined below are required in order to support development of the options appraisal in the form of the outline business case and to progress development of the network in order to adhere to the timescales set by NHSEI in terms of progress against the network maturity curve. Following completion of the OBC and FBC the recurrent resources will be required for the on-going co-ordination of the network.

Maturity Matrix Domain	Roles	Estimated Cost (£)	20% add on costs (£)
Leadership Team	Senior Responsible Officer (0.2 WTE)	25 - 30	5 - 6
	Programme Manager 8C (1 WTE)	66	13.2
	Programme Officer 6 (1 WTE)	35	7
	Admin Support 4 (1 WTE)	23	4.6
	Network Operational Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Clinical/Medical Director	2 – 6 PAs	4 - 12
	Network Procurement Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Network Digital/IT Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Workforce Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Communications Lead 8B (1 WTE)	64	12.8
	Finance Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
Quality	Quality Lead 8C (1.0 WTE)	66	13.2
Digital	Programme Manager 8C (1 WTE)	66	13.2
Supply chain	Procurement Manager 8B (1 WTE)	64	12.8
	Category Manager 7 (1 WTE)	41	8.2
	Admin Support 4 (1 WTE)	23	4.6
Workforce	Project Manager 7 (1 WTE)	41	8.2
Clinical	Project Manager 7 (1 WTE)	41	8.2
	Data Analyst 7 (1 WTE)	41	8.2
	Admin Support 4 (1 WTE)	23	4.6
Total		**£1.63m**	**£223k**

Table 6: Proposed recurrent resource requirement

Year 1 resource requirement

Maturity Matrix Domain	Roles	Estimated Cost (£)	20% add on costs (£)
Leadership Team	Senior Responsible Officer (0.2 WTE)	25 - 30	5 - 6
	Programme Manager 8C (1 WTE)	66	13.2
	Programme Officer 6 (1 WTE)	35	7
	Network Operational Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Clinical/Medical Director	2 – 6 PAs	4 – 12
	Communications Lead 8B (0.5 WTE)	32	6.4
	Finance Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Information Analyst 7 (1 WTE)	41	8.2
Supply chain	Procurement Manager 8B (1 WTE)	64	12.8
	Category Manager 7 (1 WTE)	41	8.2
	Admin Support 4 (1 WTE)	23	4.6
Workforce	Project Manager 7 (1 WTE)	41	8.2
Total		**£613k**	**£123k**

Table 7: Proposed Year 1 resource requirement needed to progress OBC

Risk and Reward share

Midlands and East 2 (ME2) pathology network development has the capability to generate efficiency savings potential as a means to provide a return on investment of recurrent resources. It is proposed that rewards generated from efficiency savings produced by network activities are split as per Trust contribution for recurrent resource investment based on Pay/Non Pay costings (**Table 8**). It is not envisaged that all recurrent resources will be required in year 1, as such a revised split is offered (**Table 9**). A £1,000,000 investment in the Midlands and East 2 Pathology Network represents a 0.5% cost improvement target for the network in order for partner organisations to realise a return on their investment.

Trust	Split (%)	Cost (£)
Leicester	19%	309,700
UHDB	15.5%	252,650
Kettering	6.5%	105,950
Northampton	8.5%	138,550
Chesterfield	4.8%	78,200
Nottingham	21.5%	350,450
Sherwood	7%	114,100
Path Links: ULHT NLAG	17.2%	280,360

Table 8: Illustrative example of Trust contribution to total recurrent resource requirement based on Pay and Non Pay costings.

Trust	Split (%)	Cost (£)
Leicester	19%	116,470
UHDB	15.5%	95,015
Kettering	6.5%	39,845
Northampton	8.5%	52,105
Chesterfield	4.8%	29,424
Nottingham	21.5%	131,795
Sherwood	7%	42,910
Path Links: ULHT NLAG	17.2%	105,436

Table 9: Illustrative example of Trust contribution to Year 1 resource requirement based on Pay and Non Pay costings.

10. Network Successes to Date

Development of the network gives member organisations the opportunity to access various funding streams and business opportunities to enhance income. Some of the networks current successes are below;

Path Lake

Digital pathology is one of the Midlands and East 2 (ME2) network work streams and a regional business case was submitted at the end of November 2019 for the Innovate UK funding as part of the “Scaling up our Digital Pathology, Imaging and AI Centres of Excellence in England” initiative. Finance and service leads worked to tight timelines as part of an ME2 network bid. At the beginning of February 2020, the Regional Diagnostic Lead was informed that two Trusts within the ME2 network, UHDB and NUH had been approved to receive grant funding from Innovate UK. Working collaboratively, both UHDB and NUH have now successfully procured Digital Pathology equipment and are in the process of implementing this in line with the expectations of the PathLAKE+ project timelines.

Funding in support of digital strategy

In April 2022, the Digital Diagnostics Capability Programme issued its 2022-2025 roadmap and investment proposal for the midlands. The Midlands and East 2 (ME2) pathology network was successful in securing £8.83m for Digital Pathology, £880,000 for LIMS and £175,000 towards LIMS home reporting during 2021/2022, investments which would not have been attainable had the bid not been submitted as a network. Central funding proposals for 2022/2023 equate to further £1.76m investment and benefit the entire Midlands and East 2 network allowing development of individual Trust pathology digital service offerings.

Central funding requirements for the remainder of the roadmap can be seen below:

Area of Work	Description	Amount of Central Funding Required **Capital 2022/23**	Amount of Central Funding Required **Capital 2023/24**	Amount of Central Funding Required **Capital 2024/25**
LIMS Interoperability	Digital Interoperability		£10,250,000	£8,400,000
Digital Histopathology	Digital Histopathology – extend scope, capacity, and interoperability of existing multi-site digital systems	£744,000	£1,140,000	£2,400,000
Interoperability (Other)	Network shared resource management system	£142,000		
	Network Quality Management System (QMS)	£114,000		
	Training & Education	£114,000		
	Asset Management	£114,000		
	Development and commissioning of a Network User Digital Portal		£250,000	
Interoperability (POCT)	Network integrated POCT	£336,000		
ALL	Project management to support implementation and business change	£200,000	£210,000	£220,000

Table 10: Digital funding proposals for 2022-2025.

Analyser interfacing associated with COVID

The network was able to received funding to connect analysers to associated Middleware, enabling them to be connected to downstream systems such as ICE, and aid reporting of results to Point of Care generated Tests, CACTUS and the UKHSA SGSS system.

We have also received Digital Integration funding which we used to procure the PCR A.I software at Sherwood Forest Hospitals NHS Foundation Trust, which automates the interpretation and reporting of PCR test results.

The network attracted interface funding in excess of £37,000**.**

Equipment associated with COVID

The network was able to successfully secure several pieces of additional equipment to support the COVID-19 pandemic workload and subsequent replacements to replace equipment whose original lifespan had been shortened.

The network attracted funding in excess of £650,000.

Cancer Alliance Funding

The network has been successful in securing funding from the alliance over the last couple of years and a further £150,000 non-recurrent investment to support network development throughout 2022/23 from East Midlands Cancer Alliance has also been secured. The funding was awarded on the understanding that Network roles would need to be funded by network member Trusts from 2023/24 onwards as outlined in this strategic outline case in order for the network to be self-sustaining.

Learning Lessons Workshop

The Midlands and East 2 Pathology network has the opportunity to benefit enormously from the experience of its partner organisations, some of which are networks in their own right. In March 2021 the network held a learning lessons workshop to explore those experiences using them to inform initial decision making regarding network development. It was clear from that presentation that everyone could identify successes born of those experiences but also identify what didn't work as well as envisaged. Those views are summarised below;

Common key factors to support network development success;

- Trust board commitment and support
- Strong clinical and managerial leadership
- Understanding clinical need
- Access to financial resource
- Partner equity (risk and reward)

Common key enablers;

- IT connectivity
- Transport
- Sufficient resource
- Ensuring staff understand the need for change

Common difficulties;

- Communication with all staff regarding process
- Managing change

The networks response to the COVID-19 pandemic gave us further opportunity to identify what worked well. Similar principles were evident;

- Clear leadership with ability to make managerial decisions at local level
- Honest and open working
- Timely, responsive and adaptive working
- Business contingency through use of varying platforms
- I.T and logistics key to sharing work efficiently and effectively

11. Timetable and Next Steps

Subject to support of member Boards, it is proposed that the shortlisted options are developed further and evaluated through the production of an Outline Business Case (OBC), through which a preferred option will be identified for Final Business Case (FBC) development.

Through the presentation of the SOC, member organisations are asked to confirm that none of the short-listed options are unacceptable, in principle, remain committed to the current Memorandum of Understanding as the governance framework for the next phase of this programme and commit to the investment proposed in section 9 with regards to project structure and resourcing.

Key Milestones	Timing
SOC Approval – ME2	April – May 2022
SOC Approval – Member Trust Boards	May – June 2022
OBC Draft	June – September 2022
OBC Approval	September 2022 – March 2023

12. Key Risks

The primary risks to the OBC development and proposed mitigation measures are described below;

Risk	Mitigation Measures
Failure to secure support of member organisation boards	Senior representation from member organisations on Network Board and Executive representation from member organisations on Network Executive Steering Group to enable identification of concerns and barriers to approval.
Failure to secure investment to resource network roles	Secure commitment to resource through SOC approval
Failure to obtain NHSEI approval of OBC approach	SOC approval and early agreement of NHSEI for OBC approach and content. Involvement of key NHSEI personnel on Network Board and related activities
Failure to sustain clinical services	ME2 Clinical Reference Group in place chaired by network Clinical Director Clinical priorities developed as part of SOC
Insufficient capacity and expertise to develop OBC to required standard	Secure commitment to resource through OBC. Identify additional capacity and capability from member organisations and/or external sources.
Failure to align member organisation CIP activities compromising Network development	Senior representation from member organisations on Network Board and Executive representation from member organisations on Network Executive Steering Group to enable effective CIP discussion.
Recruitment to permanent network roles may create hard to fill vacancies at individual trust level	Expertise from those Trusts potentially retained within the network providing opportunity for recruitment and transitionary phase Mutual aid from network partners
Failure to meet proposed timeline	Establish robust programme management and oversight arrangements including sufficient capacity and capability.

13. Recommendation

Trust Boards are asked to approve this Strategic Outline Case (SOC) and in doing so agree to:

1. The detailed development of the three shortlisted options to OBC level:
    - Joint Venture
    - Hosted Organisation
    - Provider Collaborative
2. Commitment to the proposed share of recurrent programme costs

14. Frequently Asked Questions

Question 1: Given that the formation of the 29 proposed Pathology Networks in England is a national directive, why is it not centrally funded?

Answer: NHSEI 'pump primed' development of the network by providing a non-recurrent investment of £310k to support recruitment of recommended network roles. Onus then falls on respective member Trusts to support development of the network and realise the potential efficiency savings that can be utilised to sustain the network.

Question 2: What happens if a member organisation declines approval of the Strategic Outline Case and development of the Outline Business Case?

Answer: The development of the Midlands and East 2 (ME2) pathology network is a national directive. Failure to support its development will leave member Trusts accountable to NHSEI

15. References

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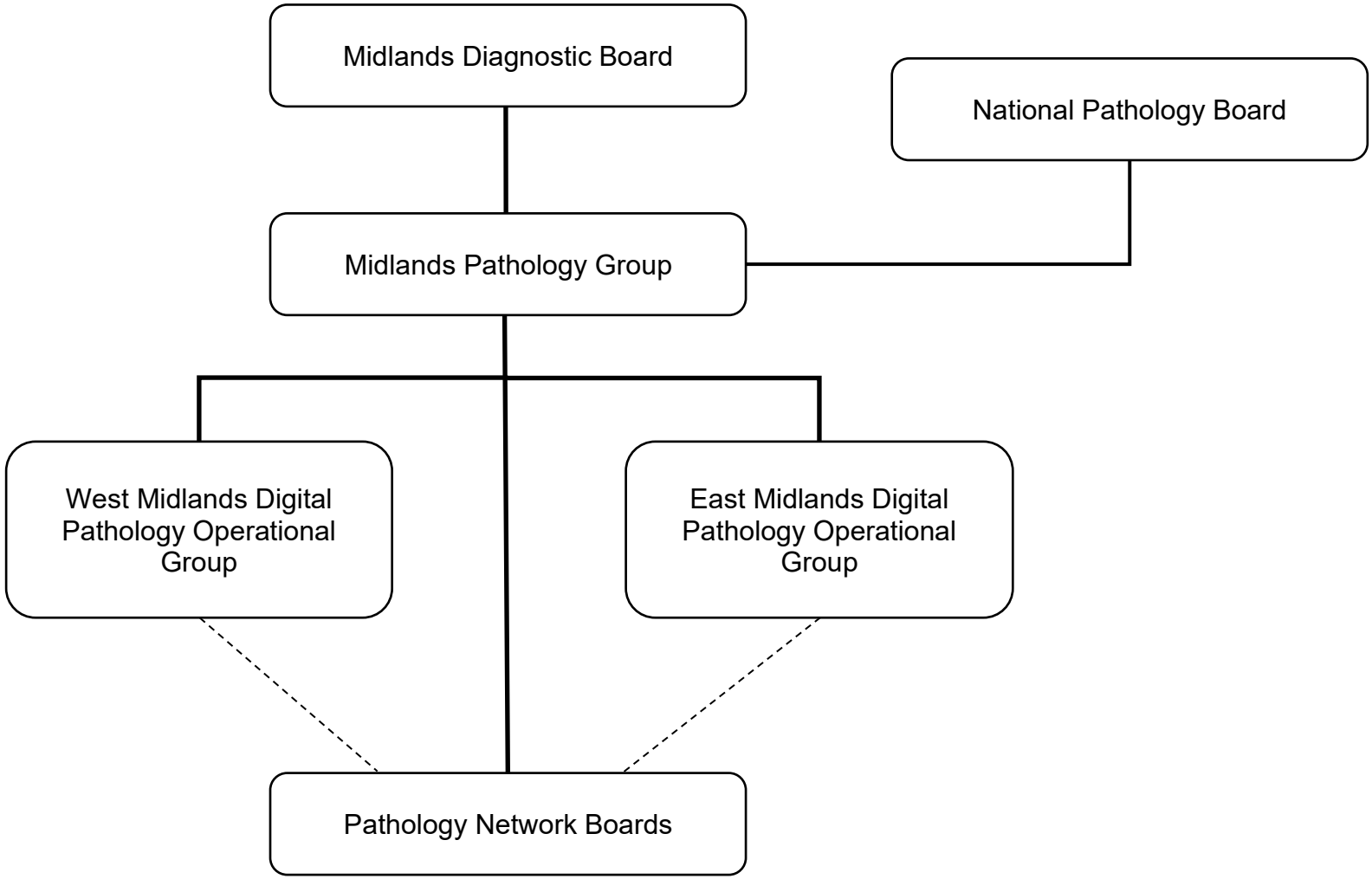
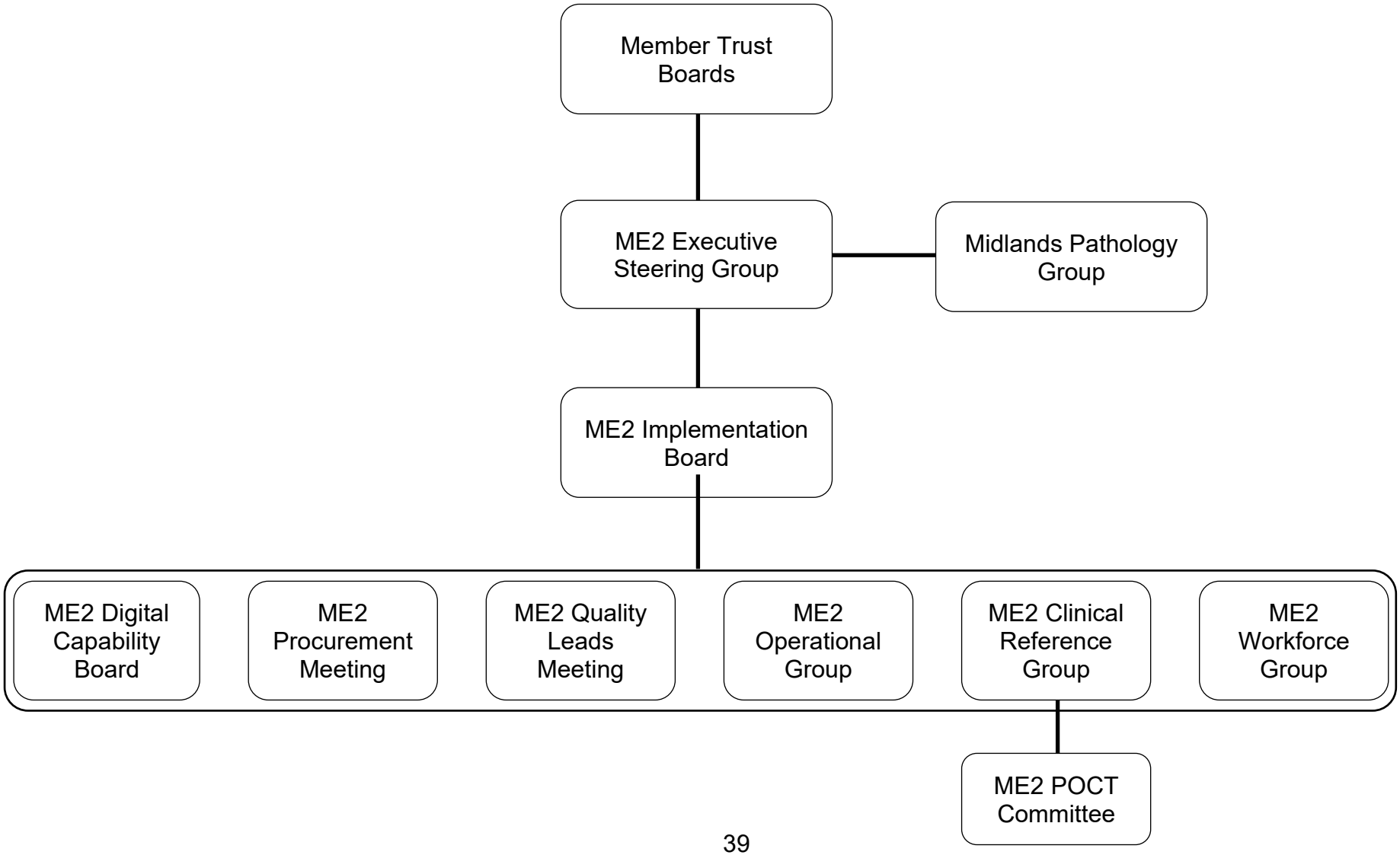
Appendix A.

Midlands Pathology Group Reporting Structure



Appendix B

Midlands and East 2 Pathology Network Reporting Structure



Appendix C.

Current configuration of Pathology Services within the Midlands and East 2 Pathology Network

Organisation	Pathology Service Provided	Accreditation Number
Path Links; • Northern Lincolnshire & Goole NHS Foundation Trust • United Lincolnshire Hospitals NHS Trust	Blood Sciences Microbiology Cellular Pathology Andrology	8833
UHDB; • University Hospitals of Derby & Burton NHS Foundation Trust, • Chesterfield Royal Hospital NHS Trust	Blood Sciences Microbiology Cellular Pathology	9308
	Blood Sciences	9807
	Microbiology	9096
Kettering General Hospital NHS Foundation Trust	Blood Sciences Microbiology Cellular Pathology	8118
University Hospitals of Leicester NHS Trust	Blood Sciences	8376
	Cellular Pathology	8608
	Microbiology	8605
	Cytogenetics	8069
Northampton General Hospital NHS Trust	Blood Sciences Microbiology Cellular Pathology	Unaccredited - ETS Unaccredited - ETS 8115
Nottingham University Hospitals NHS Foundation Trust	Cytogenetics	8031
	Molecular Genetics	8044
	Cellular Pathology	8162
	Clinical Pathology	8848
	Microbiology	8755
Sherwood Forest Hospitals NHS Foundation Trust	Microbiology	9356
	Haematology & Blood Transfusion	Unaccredited
	Biochemistry	8676
	Cellular Pathology	8705

TRUST BOARD REPORT

Meeting Date:	
Title:	Strategic Outline Case for the development of the Midlands and East 2 (ME2) Pathology Network
Action Requested:	
Author(s): **Contact Details:**	Tony Campbell, Senior Responsible Officer (tony.campbell@DHUHealthCare.nhs.uk) Gemma Sankey, ME2 Programme Manager (gemma.sankey@ulh.nhs.uk)
Public or Private:	Public

Introduction:

The Midlands and East 2 (ME2) Pathology Network's Strategic Outline Case (SOC) is the Network's response to NHS Improvement's expectation that further consolidation of pathology services, as heralded in the Carter Review of 2006, and later in the NHS Long Term Plan would take place across the NHS. NHSEI's expectations were communicated to NHS providers of pathology services in September 2017. The NHS Long Term Plan committed the NHS to establishing Pathology networks across England by December 2021 and most recently reiterated in a letter to ICS and Trust Executive Teams in April 2022 which outlines target milestones for network development in line with NHSEI's Pathology Network Maturity Matrix. The Midlands and East 2 (ME2) Pathology Network is 1 of 29 within England, where the size and scope has already been agreed.

Realising the benefits of a Pathology Network will take time and, as networks adapt to the new way of working to deliver the expected transformation of Pathology services, they will need to progress along the maturity curve. To assist Networks, regions and the national team with this progression, the Pathology Network Maturity Matrix Tool was introduced as a means of objectively assessing maturity aligned to five progression stages; Pre-emerging, Emerging, Developing, Maturing and Thriving. The Midlands and East 2 (ME2) Pathology Network was placed within the 'Emerging' stage with an initial NHSEI challenge to achieve 'Developing' by the end of March 2022 and 'Maturing' by March 2023. Trusts were notified by NHSEI in April 2022 that these timescales have now been revised. The revised challenge is to achieve 'Developing' status no later than December 2022 and 'Maturing' by the end of 2024.

The Midlands and East 2 (ME2) Pathology Network Implementation Board, has been meeting regularly since January 2019 to discuss the opportunities that could be realised by creating a pathology network from the nine Trust services that are currently operating. Whilst all members understand and acknowledge the concern caused by large scale change, there has been a consistent and firm view that the creation of a collaborative service offers a real opportunity to address some of the critical challenges that are being faced by pathology services across the NHS. Foremost amongst these are recruitment and retention of key staff, and the ability to maintain and develop quality of service in the face of financial constraints.

While the Strategic Outline Case (SOC) concentrates, quite rightly, on the available options and governance structure in place, it is important to view this process as one aimed at creating a service that is strong and sustainable, focused on quality, and fit for the future. It must be a service that is attractive to high quality staff, fully integrated with all other clinical services across the locality, and set fair to move quickly to implement new scientific developments as they become available.

The success of any pathology service is dependent on the expertise and commitment of the staff, who provide far more than a simple technical 'results' function. Pathology is an integral part of all patient-facing clinical services and this close relationship must be maintained if the proposed network optimisation is to be successful. Accordingly, we are proposing that:

- The next stage (production of Outline Business Case (OBC) and Target Operating Model (TOM)) includes considerable staff and stakeholder involvement as the detail of network is developed and agreed.
- A medically led clinical reference group remains in place to oversee service quality
- The governance arrangements facilitate equitable input from all Trusts.

Strategic Outline Case (SOC)

The purpose of this Strategic Outline Case (SOC) is to secure organisational Board support for the next steps in considering the optimisation of pathology services across the Midlands and East 2 (ME2) Pathology Network. It has been developed with the full support and input of the member organisations (and their stakeholders).

Midlands and East 2 (ME2) pathology network partners have been working collaboratively under a Memorandum of Understanding since 2019.

Network discussions resulted in the generation of five options, it is now proposed that three of those options are taken forward for further development and appraisal culminating in the production of an Outline Business Case (OBC). Those three options are;

- Joint Venture
- A Hosted Organisation
- Provider Collaborative

Tight timelines prescribed in the NHSEI Network Maturity Matrix mean the network leadership team seeks a level of delegated authority to develop the network on Trust member organisations behalf through their nominated representatives via the ME2 Executive Steering Group. In co-ordinating the programme of work, the network leadership team are conscious of striking a balance between updating member organisation boards and a level of devolved autonomy to allow the network to progress its implementation plan. The network seeks support in allowing this level of autonomy. Examples of delegated authority in practice may include;

- Co-ordination of network level Cost Improvement Programmes (e.g. Procurement)
- Optimisation of referred test work stream

The detailed proposal for network delegated authority will be provided as part of the Outline Business Case (OBC) when the Target Operating Model (TOM) and final preferred network development option will be provided.

Currently many of the network leadership roles are covered on a voluntary basis, where existing senior leaders within the pathology network are undertaking multiple roles that is not sustainable long term. The resources outlined below represent the Year 1 resources that are required in order to support development of the options appraisal in the form of the outline business case and to progress development of the network in order to adhere to the timescales set by NHSEI in terms of progress against the network maturity curve.

Maturity Matrix Domain	Roles	Estimated Cost (£)	20% add on costs (£)
Leadership Team	Senior Responsible Officer (0.2 WTE)	25 - 30	5 - 6
	Programme Manager 8C (1 WTE)	66	13.2
	Programme Officer 6 (1 WTE)	35	7
	Network Operational Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Clinical/Medical Director	2 – 6 PAs	4 – 12
	Communications Lead 8B (0.5 WTE)	32	6.4
	Finance Lead 8C/D (1 WTE)	66 – 90	13.2 – 18
	Information Analyst 7 (1 WTE)	41	8.2
Supply chain	Procurement Manager 8B (1 WTE)	64	12.8
	Category Manager 7 (1 WTE)	41	8.2
	Admin Support 4 (1 WTE)	23	4.6
Workforce	Project Manager 7 (1 WTE)	41	8.2
Total		**£613k**	**£123k**

It is proposed that rewards generated from efficiency savings produced by network activities are split as per Trust contribution for recurrent resource investment based on Pay/Non Pay costings.

It is not envisaged that all recurrent resources outline in section 9 will be required in year 1, as such the Year 1 contribution split is offered below;

Trust	Split (%)	Cost (£)
Leicester	19%	116,470
UHDB	15.5%	95,015
Kettering	6.5%	39,845
Northampton	8.5%	52,105
Chesterfield	4.8%	29,424
Nottingham	21.5%	131,795
Sherwood	7%	42,910
Path Links: ULHT NLAG	17.2%	105,436

A £1,000,000 investment in the Midlands and East 2 Pathology Network represents a 0.5% cost improvement target for the network in order for partner organisations to realise a return on their investment.

Risks

The risks associated with not supporting this proposal are;

- An inability to achieve the benefits and network development in a timeframe that is congruent with the requirements of NHSEIs Maturity Matrix
- The risk of not securing network resources resulting in failure to realise the benefits and savings potential that network development will bring.

Decisions Required

The Boards are asked to consider the Strategic Outline Case, and approve the recommendations to;

- Produce a detailed Outline Business Case (OBC) developing the three shortlisted options of; Joint Venture, Hosted Organisation and Provider Collaborative that will be completed in time for consideration at Trust Board meetings in Q3 2022.
- Begin process of recruiting ME2 leadership and Clinical roles that will drive this work forward.
- Commit to enabling expenditure for next period of activity as defined in attached summary.

Tony Campbell, Senior Responsible Officer
Gemma Sankey, ME2 Programme Manager
ME2 Leadership Team
May 2022

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

Finance Committee Chair's Highlight Report to Trust Board

Subject:	Finance Committee Highlight Report	**Date:** 24/05/22	
Prepared By:	Andrew Rose-Britton, Finance Committee Chair / NED		
Approved By:	Shirley Higginbotham, Director of Corporate Affairs		
Presented By:	Andrew Rose-Britton, Finance Committee Chair / NED		
Purpose			
This paper summaries the assurance provided by the Finance Committee around financial management in the Trust and records matters the committee need to be brought to the attention of the Board.		**Assurance**	Sufficient

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The risks inherent in the 2022/23 financial plan were discussed at length. These will be monitored through the in-year financial reports to the Finance Committee.	• It was agreed to hold informal meetings to update on financial matters, if and when necessary between Finance Committee meetings. • Continued engagement with NHSE/I and ICS partners regarding the Electronic Patient Record (EPR) business case. • Engagement with ICS partners on the SFH virtual ward proposals.
Positive Assurances to Provide	**Decisions Made**
• Positive assurance on NHSE/I support for the Trust to implement an Electronic Patient Record (EPR) system was received.	• The Electronic Patient Record (EPR) was discussed in detail, with unanimous support for the potential benefits and approval to present to the Trust Board. • Approval was granted for NHIS to provide support services for Bassetlaw CCG as they integrate into the ICB, subject to approval of the costs by the ICB. • Approval for the appointment of P2G to support settlement discussions regarding the PFI contract. • Approval to begin the recruitment process for virtual ward nursing posts.
Comments on Effectiveness of the Meeting	
The committee felt the extraordinary meeting was effective in covering important approvals in a timely manner, whilst also enabling a helpful and productive discussion on the 2022/23 financial plan.	

Healthier Communities, Outstanding Care

NHS Sherwood Forest Hospitals NHS Foundation Trust

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

Subject:	Quality Committee Report	**Date: 9th June 2022**	
Prepared By:	Barbara Brady, Non – Executive Director, Chair of QC		
Approved By:	Barbara Brady		
Presented By:	Barbara Brady, Chair of Quality Committee		
Purpose			
		Assurance	

Matters of Concern or Key Risks to Escalate	Major Actions Commissioned / Work Underway
▪ Clinical Policies - Circa 13% past review date 120/947) with a further 15% due within the next 3 months. Work underway to address these.	▪ A review of CQUINs from the last 3 years to determine next steps in terms of embedding. ▪ Self-Assessment against CQC KLOE completed and improvement plan to be developed
Positive Assurances to Provide	**Decisions Made**
▪ JAG accreditation for endoscopy at both KMH and Newark ▪ Falls Prevention Plan ▪ QC Maturity action plan (2021) actions considered and agreed as complete ▪ Progress on maternity services in response to national guidance	▪ BAF PR1 & PR2 reviewed, overall risk scorers remain the same
Comments on Effectiveness of the Meeting	
▪ Good discussion and challenge aided by the quality of papers and contributions from members	