Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Board of Directors
To be held on Tuesday 30 July 2019 at 9:15am
in the Boardroom, Doncaster Royal Infirmary

AGENDA

		LEAD	ACTION	TIME / ENC
A	**COMMITTEE BUSINESS**			**9:15**
A1	Apologies for absence	SBE	Note	Verbal
A2	Declarations of Interest Members of the Board and others present are reminded that they are required to declare any pecuniary or other interests which they have in relation to any business under consideration at the meeting and to withdraw at the appropriate time. Such a declaration may be made under this item or at such time when the interest becomes known.	JR	Note	Verbal
A3	Actions from previous meeting	JR	Review	A3
B	**PRESENTATION**			**9:25**
B1	DBTH Therapy Services Working at System, Place and Neighbourhood (20 minutes) Suzanne Bolam, Head of Therapies, Clinical Specialist Services Division	SB	Note/ Discuss	Verbal
C	**STRATEGY**			**9:45**
C1	Committees in Common	JR	Note	C1
D	**QUALITY**			**9:50**
D1	Quality and Performance Report	RJ	Note	D1
D2	Maternity Clinical Negligence Scheme for Trusts (CNST)	MH/LM	Approve	D2
D3	The NHS Patient Safety Strategy	SS	Note	D3
D4	Board Assurance Framework & Corporate Risk Register Quarterly Update – Q1	JR	Note	D4

BREAK				**10:45**
E	**CAPACITY AND CAPABILITY**			**11:00**
E1	Workforce / Recruitment Plan	KB	Note	E1
E2	Workforce Race Equality Standards and Workforce Disability Equality Standards Reports	KB	Approve	E2
E3	Learning Lessons to Improve our People Practices	KB	Note	E3
E4	Estates and Facilities Report - Q1	KEJ	Note	E4
F	**FINANCE AND CONTRACT MATTERS**			**12:00**
F1	Finance Report - 30 June 2019	AC/NR	Note	F1
F2	Use of Trust Seal	RP/JR	Note	F2
F3	Chairs Assurance Logs for Board Committees Audit and Risk Committee 18 July 2019 Finance and Performance Committee 23 July 2019	KS/NR	Note	F3
G	**INFORMATION ITEMS**			**12:30**
G1	Chair and NEDs' Report	SBE	Note	G1
G2	Chief Executive's Report	RP	Note	G2
G3	Minutes of the Management Board, 13 May 2019	JR	Note	G3
G4	Minutes of the Quality Effectiveness Committee, 24 April 2019	PD	Note	G4
G5	Minutes of the Finance and Performance Committee, 20 May 2019	NR	Note	G5
G6	Board Work Plan	JR	Note	G6

H	**OTHER ITEMS**			**12:35**
H1	Minutes of the meeting held on 25 June 2019	JR	Approve	H1
H2	Any other business (to be agreed with the Chair prior to the meeting)	SBE	Note	Verbal
H3	**Governor questions regarding the business of the meeting**	SBE	Note	Verbal
H4	Date and time of next meeting: **Date: 24 September 2019** **Time: 9.15am** **Venue: Fred and Ann Green Board Room, Montagu Hospital**	NR	Note	Verbal
H4	**Withdrawal of Press and Public** Board 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.	SBE	Note	Verbal
MEETING CLOSE				**12:45**

Suzy Brain England
Chair of the Board

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

A3

Action Update – From Previous Board Meetings

Meeting: Board of Directors

Date of update: 30 July 2019

No.	Minute No	Action	Responsibility	Target Date	Update
1.	**19/1/12**	Nicole Chavaudra of Bassetlaw CCG to be invited to present an update on Bassetlaw Place Plan in six months.	**JR**	~~**July 2019**~~ **September 2019**	Close - On Board forward work plan for September 2019.
2.	**19/1/65**	Each committee chair to refresh their TOR in terms of Health and Safety responsibilities and provide a recommendation to Board on how to proceed going forward.	**KS, LP, NR, JR**	~~**May 2019**~~ **July 2019**	Close – The chairs of the Board Committees met with Jeannette Reay on 23 July 2019 to ensure that each risk area would be reported to a Committee. Jeannette would capture the outcome of the discussions. Relevant reports would be provided to the Committees with immediate effect (included on the Committee work plans) and the risk areas would be included in the Terms of Reference at the next update.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

No.	Minute No	Action	Responsibility	Target Date	Update
3.	**19/1/66**	Environmental Issues workshop or seminar for Board on Capital Programmes and Environmental impacts to be arranged.	**KEJ**	**October 2019**	Close – On Board forward work plan for October 2019 (following the Board of Directors Meeting).
4.	**19/3/21**	Set Aspiration to sign up to the living wage and discuss this at ISC/PLACE level.	**KB**	**July 2019**	Initial discussions held at ICS HR Directors – only Sheffield Health and Social Care Trust have signed up to the Living Wage Foundation. This matter will be explored further when all HRD's present.
5.	**19/4/35**	A deep dive to be undertaken in Finance and Performance Committee to understand A&E attendances and for its solutions to manage the increase be presented to a future Board of Directors Meeting.	**RJ**	**July 2019**	Close – Added to F&P forward work plan (suggested September 2019).
6.	**19/6/5**	'Development of Primary Care Networks' to be added to the Board Forward Plan for inclusion on a future agenda.	**JR**	**July 2019**	Close – Added to Board forward work plan (suggested November 2019).

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

C1

Title	**Terms of Reference for Committees in Common**		
Report to	**Board of Directors**	**Date**	**30 July 2019**
Author	**Richard Parker, Chief Executive**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues
In June 2017 the Board agreed to approve the establishment of a Committee in Common which would be a Committee of the Board, and also to appoint to it the Chair and Chief Executive for the Acute Vanguard in order to build a confederated approach that supported the development and implementation of a high level clinical strategy for the Working Together Partnership. The Board also approved a draft Joint Working Agreement and a generic set of Terms of Reference for the Committee – which were approved at the Board meeting in September 2017. The Terms of Reference were developed from a template provided by Capsticks and aligned to the Terms of Reference of the other Acute Federation CICs. The Terms of Reference are being taken through the Acute Federation CIC Board of Director's during June and July 2019, and the DBTH branded set is attached again here for reference.
Key questions posed by the report
Is the Trust Board content with the Terms of Reference?

How this report contributes to the delivery of the strategic objectives
A key risk highlighted by the new arrangements is the risk of existing Trust Boards losing sovereignty through the delegation of power to the CiC. This has now been mitigated through the revised 'decision rights' document which requires Trust Boards to be sighted on any proposals for service change and all proposals with strategic impact.
How this report impacts on current risks or highlights new risks
NA
Recommendation(s) and next steps
The Board is asked to note the attached Terms of Reference.

TERMS OF REFERENCE FOR DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST COMMITTEES OF THE BOARD TO MEET IN COMMON WITH COMMITTEES OF OTHER TRUSTS

TERMS OF REFERENCE

1 Introduction

1.1 In this terms of reference, the following words bear the following meanings:

South Yorkshire and Bassetlaw Acute Federation Partnership or "Acute Federation Partnership"	the partnership formed by the Trusts to work together to improve quality, safety and the patient experience; deliver safe and sustainable new models of care; and make collective efficiencies. This operates within the South Yorkshire and Bassetlaw Integrated Care System.
South Yorkshire and Bassetlaw Integrated Care System or "SYB ICS"	The Health and Care Partnership across South Yorkshire and Bassetlaw administrated via Programme Office based at 722 Prince of Wales Road Sheffield. The Acute Federation operates within the SYB ICS.
Acute Federation Executive	the Group, represented by Acute Federation Trust Chief Executive Officers, to provide strategic leadership and oversight of the delivery of agreed collaborative activities;
Acute Federation CiCs	the committees established by each of the Trusts to work alongside the committees established by the other Trusts and "**Acute Federation CiC**" shall be interpreted accordingly;
DBTH CiC	the committee established by Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust, pursuant to these Terms of Reference, to work alongside the other Acute Federation CiCs in accordance with these Terms of Reference;
"Joint Working Agreement" or "JWA"	the agreement signed by each of the Trusts in relation to their joint working and the operation of the DBTH CiC together with the other Acute Federation CiCs;
Meeting Lead	the CiC Member nominated (from time to time) in accordance with paragraph 7.6 of these Terms of Reference, to preside over and run the other Acute Federation CiC meetings when they meet in common;
Member	a person nominated as a member of an Acute Federation CiC in accordance with their Trust's Terms of Reference, and Members shall be interpreted accordingly;

DBTH CiC Chair	The DBTH CiC Member nominated (in accordance with paragraph 7.5 of these terms of reference) to chair the DBTH CiC meetings;
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust	Doncaster and Bassetlaw Teaching Hospitals NHS Foundation, Armthorpe Road, Doncaster, South Yorkshire, DN2 5LT;
Trusts	Barnsley NHS Foundation Trust, Chesterfield Royal Hospital NHS Foundation Trust, Doncaster and Bassetlaw Hospitals NHS Foundation Trust, The Mid Yorkshire Hospitals NHS Trust, The Rotherham NHS Foundation Trust, Sheffield Children's NHS Foundation Trust, Sheffield Teaching Hospitals NHS Foundation Trust and "**Trust**" shall be interpreted accordingly;
Working Day	A day other than a Saturday, Sunday or public holiday in England;
Acute Federation Partnership Programme Lead	Named Lead Officer or any of subsequent person holding such title in relation to the Acute Federation Partnership;
Acute Federation Partnership Programme Support	Administrative infrastructure supporting the Acute Federation Partnership;

1.2 The Doncaster and Bassetlaw Hospitals NHS Foundation Trust (DBTH) is putting in place a governance structure, which will enable it to work together with the other Trusts to implement change.

1.3 Each Trust has agreed to establish a committee which shall work in common with the other Acute Federation CiCs, but which will each take its decisions independently on behalf of its own Trust.

1.4 Each Trust has decided to adopt terms of reference in substantially the same form to the other Trusts, except that the membership of each Acute Federation CiC will be different.

1.5 Each Trust has entered into the Joint Working Agreement on 25 August 2017 and agrees to operate its Acute Federation CiC in accordance with the Joint Working Agreement.

2 Aims and Objectives of the DBTH CiC

2.1 The aims and objectives of the DBTH CiC are to work with the other Acute Federation CiCs to:

2.1.1 provide strategic leadership, oversight and delivery of new models of care through the development of the Acute Federation Partnership and its workstreams;

2.1.2 set the strategic goals for the Acute Federation Executive, defining its ongoing role and scope ensuring recommendations are provided to Trusts' Boards for any changes which have a material impact on the Trusts;

2.1.3 consider different employment models for service line specialities including contractual outcomes and governance arrangements;

2.1.4 review the key deliverables and hold the Trusts to account for progress against agreed decisions;

2.1.5 ensure all Hosted and Managed Clinical Networks or other collaborative forums have clarity of responsibility and accountability and drive progress;

2.1.6 establish monitoring arrangements to identify the impact on services and review associated risks to ensure identification, appropriate management and mitigation;

2.1.7 receive and seek advice from the relevant Reference Groups, including Clinical, Finance, Human Resources;

2.1.8 receive and seek advice from the ICS Boards in South Yorkshire and Bassetlaw; West Yorkshire and Derbyshire;

2.1.9 review and approve any proposals for additional Trusts to join the founding Trusts;

2.1.10 ensure compliance and due process with regulating authorities regarding service changes;

2.1.11 oversee the creation of joint ventures or new corporate vehicles where appropriate;

2.1.12 review the Terms of Reference for the Acute Federation Executive on an annual basis;

2.1.13 improve the quality of care, safety and the patient experience delivered by the Trusts;

2.1.14 deliver equality of access to the Trusts service users; and

2.1.15 ensure the Trusts deliver services which are clinically and financially sustainable.

3 Establishment

3.1 The DBTH NHS Foundation Trust's board of directors has agreed to establish and constitute a committee with these terms of reference, to be known as the DBTH CiC.

These terms of reference set out the membership, remit, responsibilities and reporting arrangements of the DBTH CiC.

3.2 The DBTH CiC shall work cooperatively with the other Acute Federation CiCs and in accordance with the terms of the Joint Working Agreement.

3.3 The DBTH CiC is a committee of DBTH NHS Foundation Trust's board of directors and therefore can only make decisions binding DBTH NHS Foundation Trust. None of the Trusts other than DBTH NHS Foundation Trust can be bound by a decision taken by DBTH CiC.

4 Functions of the Committee

4.1 Paragraph 15(2) and (3) of Schedule 7 of the National Health Service Act 2006 allows for any of the functions of a Foundation Trust to be delegated to a committee of directors of the Foundation Trust. This power is enshrined in paragraph 4.3 of DBTH NHS Foundation Trust's Constitution.

4.2 DBTH CiC shall have the following function: decision making in accordance with Appendix A to these Terms of Reference.

5 Functions reserved to the Board of the Foundation Trust

Any functions not delegated to the DBTH CiC in paragraph 4 of these Terms of Reference shall be retained by DBTH NHS Foundation Trust's Board or Governors, as applicable. For the avoidance of doubt, nothing in this paragraph 5 shall fetter the ability of DBTH NHS Foundation Trust to delegate functions to another committee or person.

6 Reporting requirements

6.1 On receipt of the papers detailed in paragraph 13.1.2, the DBTH CiC Members shall consider if it is necessary (and feasible) to forward any of the agenda items or papers to DBTH NHS Foundation Trust's Board for inclusion on the private agenda of DBTH NHS Foundation Trust's next Board meeting in order that DBTH NHS Foundation Trust's Board may consider any additional delegations necessary in accordance with Appendix A.

6.2 The DBTH CiC shall send the minutes of DBTH CiC meetings to DBTH NHS Foundation Trust's Board, on a monthly basis, for inclusion on the private agenda of DBTH NHS Foundation Trust's Board meeting.

6.3 DBTH CiC shall provide such reports and communications briefings as requested by DBTH NHS Foundation Trust's Board for inclusion on the private agenda of DBTH NHS Foundation Trust's Board meeting.

7 Membership

7.1 The DBTH CiC shall be constituted of directors of DBTH NHS Foundation Trust. Namely:

7.1.1 The DBTH NHS Foundation Trust's Chair; and

7.1.2 The DBTH NHS Foundation Trust's Chief Executive,

and each shall be referred to as a "Member".

7.2 Each DBTH CiC Member shall nominate a deputy to attend DBTH CiC meetings on their behalf when necessary ("**Nominated Deputy"**).

7.3 The Nominated Deputy for DBTH NHS Foundation Trust's Chair shall be a Non-Executive Director of DBTH NHS Foundation Trust and the Nominated Deputy for DBTH NHS Foundation Trust's Chief Executive shall be an Executive Director of DBTH NHS Foundation Trust.

7.4 In the absence of the DBTH CiC Chair Member and/or the DBTH CiC Chief Executive Member, his or her Nominated Deputy shall be entitled to:

7.4.1 attend DBTH CiC's meetings;

7.4.2 be counted towards the quorum of a meeting of DBTH CiC's; and

7.4.3 exercise Member voting rights,

and when a Nominated Deputy is attending a DBTH CiC meeting, for the purposes of these Terms of Reference, the Nominated Deputy shall be included in the references to "Members".

7.5 The chair of the DBTH CiC shall be nominated by the DBTH CiC. In the absence of the DBTH CiC Chair the Nominated Deputy of DBTH NHS Foundation Trust's Chair shall chair the meeting.

7.6 When the Acute Federation CiCs meet in common, one person nominated from the Members of the Acute Federation CiCs shall be the Meeting Lead and preside over and run the meetings on a rotational basis for an agreed period.

8 Non-voting attendees

8.1 The Members of the other Acute Federation CiCs shall have the right to attend the meetings of DBTH CiC.

8.2 The Meeting Lead's Trust Company Secretary shall have the right to attend the meetings of DBTH CiC to support the provision of governance advice and ensure that the working arrangements comply with the accountability and reporting arrangements of the Acute Federation CiCs.

8.3 The Acute Federation Partnership Programme Lead shall have the right to attend the meetings of DBTH CiC.

8.4 Without prejudice to paragraphs 8.1 to **Error! Reference source not found.** inclusive, the Meeting Lead may at his or her discretion invite and permit other persons relevant to any agenda item to attend any of the Acute Federation CiCs' meetings, but for the avoidance of doubt, any such persons in attendance at any meeting of the Acute Federation CiCs shall not count towards the quorum or have the right to vote at such meetings.

8.5 The attendees detailed in paragraphs 8.1 to 8.4 (inclusive) above, may make contributions, through the Meeting Lead, but shall not have any voting rights, nor shall they be counted towards the quorum for the meetings of DBTH CiC.

9 Meetings

9.1 Subject to paragraph 9.2 below, DBTH CiC meetings shall take place monthly.

9.2 Any Trust CiC Chair may request an extraordinary meeting of the Acute Federation CiCs (working in common) on the basis of urgency etc by informing the Meeting Lead. In the event it is identified that an extraordinary meeting is required the Acute Federation Partnership Programme Lead shall give five (5) Working Days' notice to the Trusts.

9.3 Meetings of the DBTH CiC shall be held in private.

9.4 Matters to be dealt with at the meetings of the DBTH CiC shall be confidential to the DBTH CiC Members and their Nominated Deputies, others in attendance at the meeting and the members of DBTH NHS Foundation Trust Board.

10 Quorum and Voting

10.1 Members of the DBTH CiC have a responsibility for the operation of the DBTH CiC. They will participate in discussion, review evidence and provide objective expert input to the best of their knowledge and ability, and endeavour to reach a collective view.

10.2 Each Member of the DBTH CiC shall have one vote. The DBTH CiC shall reach decisions by consensus of the Members present.

10.3 The quorum shall be two (2) Members.

10.4 If any Member is disqualified from voting due to a conflict of interest, they shall not count towards the quorum for the purposes of that agenda item.

11 Conflicts of Interest

11.1 Members of the DBTH CiC shall comply with the provisions on conflicts of interest contained in DBTH NHS Foundation Trust Constitution/Standing Orders, and NHS Conflicts of Interest guidance. For the avoidance of doubt, reference to conflicts of interest in DBTH NHS Foundation Trust Constitution/Standing Orders also apply to conflicts which may arise in their position as a Member of the DBTH CiC.

11.2 All Members of the DBTH CiC shall declare any new interest at the beginning of any DBTH CiC meeting and at any point during a DBTH CiC meeting if relevant.

12 Attendance at meetings

12.1 DBTH NHS Foundation Trust shall ensure that, except for urgent or unavoidable reasons, DBTH CiC Members (or their Nominated Deputy) shall attend DBTH CiC meetings (in person) and fully participate in all DBTH CiC meetings.

12.2 Subject to paragraph 12.1 above, meetings of the DBTH CiC may consist of a conference between Members who are not all in one place, but each of whom is able directly or by secure telephonic or video communication (the Members having due regard to considerations of confidentiality) to speak to the other or others, and be heard by the other or others simultaneously.

13 Administrative

13.1 Administrative support for the DBTH CiC will be provided by Acute Federation Partnership Programme Support (or such other person as the Trusts may agree in writing). The Acute Federation Partnership Programme Support will:

13.1.1 draw up an annual schedule of Acute Federation CiC meeting dates and circulate it to the Acute Federation CiCs;

13.1.2 circulate the agenda and papers three (3) Working Days prior to Acute Federation CiC meetings; and

13.1.3 take minutes of each DBTH CiC meeting and, following approval by the Meeting Lead, circulate them to the Trusts and action notes to all Members within ten (10) Working Days of the relevant DBTH CiC meeting.

13.2 The agenda for the DBTH CiC meetings shall be determined by the Acute Federation Partnership Programme Lead and agreed by the Meeting Lead prior to circulation.

13.3 The Meeting Lead shall be responsible for approval of the first draft set of minutes for circulation to Members and shall work with the Acute Federation Partnership Programme Support to agree such within five (5) Working Days of receipt.

APPENDIX A – DECISIONS OF THE DBTH CIC

The Board of each Trust within the Acute Federation Partnership remains a sovereign entity and will be sighted on any proposals for service change and all proposals with strategic impact.

Subject to DBTH NHS Foundation Trust's Scheme of Delegation, the matters or type of matters that are fully delegated to the DBTH CiC to decide are set out in the table below.

If it is intended that the Acute Federation CiCs are to discuss a proposal or matter which is outside the decisions delegated to the DBTH CiC, where at all practical, each proposal will be discussed by the Board of each Trust prior to the DBTH CiC meeting with a view to DBTH CiC requesting individual delegated authority to take action and make decisions (within a set of parameters agreed by DBTH NHS Foundation Trust's Board). Any proposals discussed at the DBTH CiC meeting outside of these parameters would come back before DBTH NHS Foundation Trust's Board.

References in the table below to the **"Services"** refer to the services that form part of the joint working between the Trusts and may include both back office and clinical services.

	Decisions delegated to DBTH CiC
1.	Providing overall strategic oversight and direction to the development of the Acute Federation Partnership programme ensuring alignment of all Trusts to the vision and strategy;
2.	Promoting and encouraging commitment to the Key Principles;
3.	Seeking to determine or resolve any matter within the remit of the DBTH CiC referred to it by the Acute Federation Programme Office or any individual Trust;
4.	Reviewing the key deliverables and ensuring adherence with the required timescales including; determining responsibilities within workstreams; receiving assurance that workstreams have been subject to robust quality impact assessments; reviewing the risks associated in terms of the impact to the Acute Federation Partnership Programme and recommending remedial and mitigating actions across the system;
5.	Formulating, agreeing and implementing strategies for delivery of the Acute Federation Partnership Programme;
6.	In relation to the Services preparing business cases;
7.	Provision of staffing and support and sharing of staffing information in relation

	Decisions delegated to DBTH CiC
	to the Services;
8.	Decisions to support service reconfiguration (pre consultation, consultation and implementation), including but not limited to: a. provision of financial information; b. communications with staff and the public and other wider engagement with stakeholders; c. support in relation to capital and financial cases to be prepared and submitted to national bodies, including NHS England and/or NHS Improvement; d. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; e. support in relation to any competition assessment; f. provision of staffing support; and g. provision of other support.
9.	Decisions relating to information flows and clinical pathways outside of the reconfiguration, including but not limited to: a. redesign of clinical rotas; b. provision of clinical data, including in relation to patient outcomes, patient access and patient flows; and c. developing and improving information recording and information flows (clinical or otherwise).
10.	Planning, preparing and setting up joint venture arrangements for the Services, including but not limited to: a. preparing joint venture documentation and ancillary agreements for final signature; b. evaluating and taking preparatory steps in relation to shared staffing models between the Trusts; c. carrying out an analysis of the implications of TUPE on the joint arrangements; d. engaging staff and providing such information as is necessary to meet each employer's statutory requirements; e. undertaking soft market testing and managing procurement exercises; f. aligning the terms of and/or terminating relevant third party supply contracts which are material to the delivery of the Services; and g. amendments to joint venture agreements for the Services.
11.	Services investment and disinvestment as agreed within Trust Board parameters and delegated authority;

	Decisions delegated to DBTH CiC
12.	Reviewing the Terms of Reference and Joint Working Agreement of the CiC on an annual basis.

D1

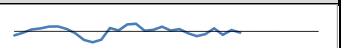
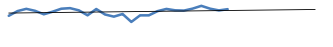
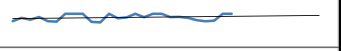
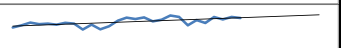
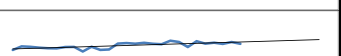
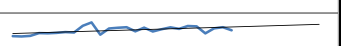
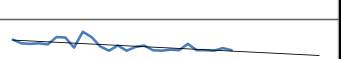
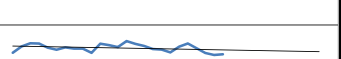
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

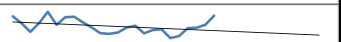
Title	**Integrated Performance Report**		
Report to	**Board of Directors**	**Date**	**30th July 2019**
Author	**Rebecca Joyce, Chief Operating Officer** **Sewa Singh, Medical Director** **Moira Hardy, Director of Nursing, Midwifery and AHPs** **Karen Barnard, Director of People and Organisational Development**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	x
	Information	

Executive summary containing key messages and issues
This report highlights the key performance and quality targets required by the Trust to maintain NHSI compliance. The report focuses on the main performance area for NHSi compliance: • Cancer 62 day classic, measured on average quarterly performance • 4hr Access, measured on average quarterly performance • 18 weeks measured on monthly performance against active waiters, performance measured on the worst performing month in the quarter • Diagnostics performance against key tests • Infection control measures, C Diff and MRSA Bacteraemia The Quality report highlights the ongoing work with Care Groups and external partners to improve patient outcomes and a focus on mortality rates. The report contains a review of 7 day services against the National Standard. The Workforce report identifies vacancy levels, sickness rates, appraisals and SET training. • At a glance charts showing

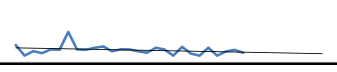
Key questions posed by the report
Key Questions for the Board are: • Is the Trust maintaining performance against agreed trajectories with our CCGs and in the context of national standards? • Is the Trust providing a quality service for the patients? • Are NEDs assured that the actions being undertaken to address underperformance and maintain current standards are robust and deliver the agreed improvements?
How this report contributes to the delivery of the strategic objectives
This report supports all elements of the strategic direction by identifying areas of good practice and areas where the Trust requires improvements to meet our expectations.
How this report impacts on current risks or highlights new risks
F&P6 Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards **F&P15** Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction **F&P5** Failing to address the effects of the agency cap
Recommendation(s) and next steps
The Board is asked to consider the report.

Category	Indicator	Latest Month Reported	National Target	Peer Benchmarking	National Benchmarking	CURRENT MONTH			YEAR-TO-DATE			YEAR END FORECAST			Trend Graph (April 17 - stated month)	Trend Rating (In Development)	NOTES 2
						Local Target	Actual	Variance	Local Target	Actual	Variance	Target	Actual	Variance			
NHSI Compliance Framework	A&E: Max wait four hours from arrival/admission/transfer/discharge	Jun 19	95%	85.6%	86.4%	92.5%	91.4%	-1.1%	92.0%	91.47%	-0.5%	*95.0%*	*90.8%*	-4.2%			
	Max time of 18 weeks from point of referral to treatment- incomplete pathway	Jun-19	92%	88.8%	86.5%	89.3%	86.6%	-2.7%	*90.0%*	*86.6%*	-3.4%						
	Waiting list size (from 1/4/19) - 18 Weeks referral to treatment -Incomplete Pathways	Jun-19	.N/A	.N/A	.N/A	31,423	32,235	812	31,423	32,235	812						
	% waiting less than 6 weeks from referral for a diagnostics test	Jun-19	99%	91.4%	96.4%	99.0%	98.7%	-0.3%	*99.0%*	*98.7%*	*-0.3%*	*99.0%*	*99.1%*	*0.1%*			
Cancer	Two week wait from referral to date first seen: all urgent cancer referrals	May-19	93.0%	92.2%	89.9%	93.0%	*93.0%*	*0.0%*	93.0%	*92.3%*	*-0.7%*	93.0%	*94.7%*	*1.7%*			
	Two week wait from referral to date first seen: symptomatic breast patients	May-19	93.0%	69.3%	75.5%	93.0%	*95.6%*	*2.6%*	93.0%	*83.5%*	*-9.5%*	93.0%	*85.1%*	*-7.9%*			
	31 day wait for diagnosis to first treatment- all cancers	May-19	96.0%	95.8%	96.3%	96.0%	*100.0%*	*4.0%*	96.0%	*100.0%*	*4.0%*	96.0%	*100.0%*	*4.0%*			
	31 day wait for second or subsequent treatment: surgery	May-19	94.0%	94.1%	91.3%	94.0%	*100.0%*	*6.0%*	94.0%	*100.0%*	*6.0%*	94.0%	*99.4%*	*5.4%*			
	31 day wait for second or subsequent treatment: anti cancer drug treatments	May-19	98.0%	99.8%	98.9%	98.0%	*100.0%*	*2.0%*	98.0%	*100.0%*	*2.0%*	98.0%	*100.0%*	*2.0%*			
	62 day wait for first treatment from urgent GP referral to treatment	May-19	85.0%	80.1%	79.4%	85.0%	85.1%	0.1%	85.0%	*87.1%*	*2.1%*	85.0%	*87.7%*	2.7%			
	62 day wait for first treatment from consultant screening service referral	May-19	90.0%	91.8%	89.7%	90.0%	89.7%	*-0.3%*	90.0%	*94.2%*	*4.2%*	90.0%	*89.1%*	*-0.9%*			
Activity	Daycase Activity - Discharges	Jun-19	.N/A	.N/A	.N/A	3,983	4,151	168	12,148	12,414	266						
	Other Elective Activity - Discharges	Jun-19	.N/A	.N/A	.N/A	657	741	84	2,004	2,267	263						
	Outpatient new activity (Contracted levels achieved)	Jun-19	.N/A	.N/A	.N/A	11,038	11,150	112	33,666	33,863	197						
	Outpatient Follow Up activity (Contracted levels achieved)	Jun-19	.N/A	.N/A	.N/A	22,370	22,883	513	68,225	70,189	1,964						
Ambulance Handover Times	Ambulance Handovers Breaches -Number waited >15 & <30 Minutes	May-19			.N/A		766			1,589							
	Ambulance Handovers Breaches-Number waited >30 & < 60 Minutes	May-19			.N/A		75			112							
	Ambulance Handovers Breaches -Number waited >60 Minutes	May-19			.N/A		1			6							
Stroke	Proportion of patients scanned within 1 hour of clock start (Trust)	Apr-19	48.0%	.N/A	.N/A	48.0%	*43.9%*	*-4.1%*	48.0%	*43.9%*	*-4.1%*	48.0%	*48.4%*	*0.4%*			
	Proportion directly admitted to a stroke unit within 4 hours of clock start	Apr-19	90.0%	.N/A	.N/A	75.0%	*53.6%*	*-21.4%*	75.0%	*53.6%*	*-21.4%*	75.0%	*56.3%*	*-18.7%*			
	Percentage of all patients given thrombolysis	Apr-19	20.0%	.N/A	.N/A	20.0%	*5.3%*	*-14.7%*	20.0%	*5.3%*	*-14.7%*	20.0%	*6.6%*	*-13.4%*			

	Percentage treated by a stroke skilled Early Supported Discharge team	Apr-19	40.0%	.N/A	.N/A	24.0%	*72.3%*	*48.3%*	24.0%	*72.3%*	*48.3%*	24.0%	*70.6%*	*46.6%*			
	Percentage discharged given a named person to contact after discharge	Apr-19	95.0%	.N/A	.N/A	80.0%	*91.5%*	*11.5%*	80.0%	*91.5%*	*11.5%*	80.0%	*95.0%*	*15.0%*			
Theatres & Outpatients	Cancelled Operations (For non-medical reasons)	Jun-19			1.0%	0.8%	*0.9%*	*0.1%*	0.8%	*0.9%*	*0.1%*	0.8%	*1.0%*	*0.2%*			
	Cancelled Operations-28 Day Standard	Jun-19		.N/A	.N/A	0	*1*	*1*	0	*2*	*2*						
	Out Patients: DNA Rate	May-19	7.5%	6.30%	.N/A	7.6%	*10.2%*	*2.6%*	7.6%	*9.9%*	*2.3%*	7.6%	*10.2%*	*2.6%*			
	Out Patients: Hospital Cancellation Rate	May-19		.N/A	.N/A	4.5%	*13.2%*	*8.7%*	4.5%	*13.8%*	*9.3%*	4.5%	*13.7%*	*9.2%*			
Effective	Emergency Readmissions within 30 days (PbR Methodology)	May-19		.N/A	.N/A		5.5%			*6.5%*							
Safe	Infection Control C.Diff	Jun-19		.N/A	.N/A	3	4	*1*	15	9	*-6*						
	Infection Control MRSA	Jun-19		.N/A	.N/A	0	0	0	0	0	*0*				**N/A**		
	HSMR (rolling 12 Months)	Mar-19	100			100.0	96.6	-3.4	100.0	96.6	*-3.4*						
	HSMR : Non-Elective (rolling 12 Months)	Mar-19	100						100.0	96.7	*-3.3*						
	HSMR : Elective (rolling 12 Months)	Mar-19	100						100.0	87.6	*-12.4*						
	Never Events	Jun-19				0	0	0	0	0	0						
	Sis	Jun-19					5			16							
	Avoidable Pressure Ulcers Cat 3&4	Jun-19					1			1					**N/A**		
	Unavoidable Pressure Ulcers Cat 3&4	Jun-19					1			11					**N/A**		
	Falls that result in a serious Fracture	Jun-19					0			3					N/A		

SPECIFIC THEMES :

Fractured Neck of Femur	% of patients achieving Best Practice Tariff Criteria	Jun-19					59.5%			46.2%			47.1%				
	36 hours to surgery Performance	Jun-19					59.5%			51.0%			51.8%				
	72 hours to geriatrician assessment Performance	Jun-19					97.3%			91.6%			92.4%				
	% of patients who underwent a falls assessment	Jun-19					97.3%			94.4%			93.4%				
	% of patients receiving a bone protection medication assessment	Jun-19					97.3%			95.8%			94.5%				

	% who underwent a pre-operative AMTS Assessment	Jun-19					100.0%			96.5%			95.4%				
	Mortality-Deaths within 30 days of procedure	Jun-19					2.7%			4.2%			4.8%				

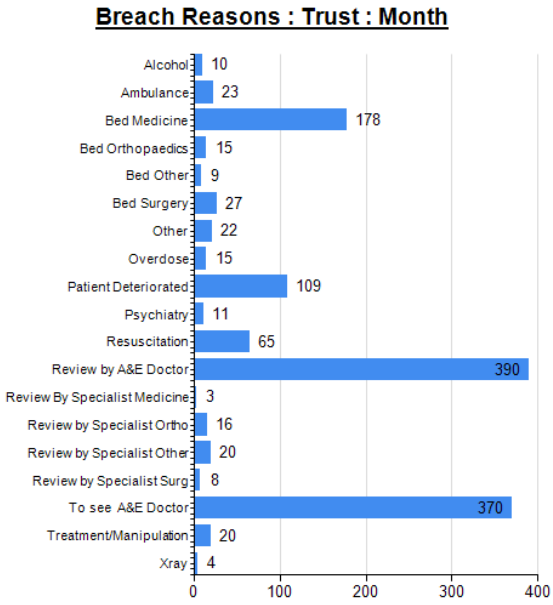
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

(A) 4hr Access Target

Trust

In June 2019 the Trust achieved performance of 91.41% against the 4hr access standard of 95%, in comparison to 94.79% in June 2018. This is below the locally agreed CCG trajectory of 92.5%.The Trust managed 15350 ED attendances across sites and streams, during June 2019. This is 480 more patients than in June 2018.

1319 patients were not treated within 4 hours – this is 543 more than in June 2018:-



Weekly pathway meetings continue to occur to analyse the Emergency pathway and how we collaborate to support the 4 hour target.

The Quality Improvement 'Navigation Nurse Pilot' project at DRI which commenced in May 2019 continues and is demonstrating excellent improvement through a set metrics demonstrating how it supports flow through the department by streaming patients to the right place quickly. The team are writing up a case to embed this as business as usual, along with changes to the CDU model and some small scale estates work to facilitate better flow for winter. A similar model is being discussed with partners for Bassetlaw.

The key challenge in the current position is the number of breaches caused by Doctor waits. Significant work is taken place to fill medical rota gaps in the short term through liaison with HOLT and in the medium term with a number of new starters commencing in summer and autumn. Additionally the team are reviewing the shape of the rota to ensure shift patterns are best planned to meet demand.

Doncaster Royal Infirmary

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

In June 2019 DRI achieved performance of 88.42% against the 4hr access standard of 95%, in comparison to 93.97% in June 2018. DRI managed 9241 ED attendances across streams, during June 2019. This is 484 more patients than in June 2018 seeing an increase of 5.23%.

Bassetlaw District General Hospital

In June 2019 BDGH achieved performance of 94.38% against the 4hr access standard of 95%, in comparison to 93.99% in June 2018

BDGH managed 4431 ED attendances across streams during June 2019. This is 322 more patients than in June 2018 seeing an increase of 7.27%.

To note, the conversion rate continues to increase at BDGH against the previous year's figure, but has reduced by 1% from last month, which continues to demonstrate the increase of acuity of patients attending the department.

(B) Referral to Treatment (RTT)

The Trust has not achieved the 92% Incomplete Pathways Target at Trust Level. It has not been achieved in some specialties as detailed in the table below.

The Trust Level month end performance for June 2019 is **86.6%** which is lower than in May 2019.

The total number of Incomplete Pathways has increased slightly between May and June, however the number of incomplete pathways over 18 weeks has increased too, hence the performance has fallen. The total number of Incomplete Pathways with a decision to admit for treatment is almost the same in June as it was in May. The number of new RTT periods in June is fewer than in May but June was a shorter month. There were fewer Non Admitted and fewer Admitted clock stops in June than in May.

The specialty groups with the largest increase in the number of waiters over 18 weeks are:

- ENT – increase of 68 over 18 weeks
- Urology – increase of 58 over 18 weeks
- General Surgery – increase of 43 over 18 weeks
- General Medicine – increase of 36 over 18 weeks
- T&O – increase of 32 over 18 weeks

At the end of June 2019 there were no Incomplete Pathway reported over 52 Weeks

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

Specialty Group	Under 18 Weeks	18 Weeks & Over	Total	Percentage
General Surgery	2368	467	2835	83.5%
Urology	1343	313	1656	81.1%
T&O	5216	956	6172	84.5%
ENT	2760	601	3361	82.1%
Ophthalmology	2774	262	3036	91.4%
Oral Surgery	1618	163	1781	90.8%
General Medicine	1619	447	2066	78.4%
Cardiology	1789	224	2013	88.9%
Dermatology	1626	109	1735	93.7%
Thoracic Medicine	891	98	989	90.1%
Rheumatology	784	205	989	79.3%
Geriatric Medicine	190	41	231	82.3%
Gynaecology	1471	62	1533	96.0%
Others	3467	371	3838	90.3%
Trust Total	**27916**	**4319**	**32235**	**86.6%**

Significant work is taking place across the Trust to address the position:

- Information, finance and operations have been working closely to complete capacity and demand modelling to demonstrate the trajectories required to reach 92 %
- A set of initial delivery plans by specialty have been developed to increase capacity and improve performance. Some of the detail of these plans is illustrated in the table below.
- A set of confirm and challenge events will be held with specialties to help strengthen the delivery plans

The table below provides a summary of some of the key actions by specialty:

Specialty	Action
All specialties	Validated down to 12 weeks
	Validated missing outcomes 60 days +
	RTT E-learning (11 modules) for clinical admin bands 3 & 4 – to be completed by September 2019
	Weekly PTL meetings with Secretary & Consultant to review long waiters & agree plans for all patients 35 weeks +
	Business Case for 'pump primed' RTT training & substantive trainer agreed (separate implementation / training plan produced) – awaiting start date of training company in the first instance.
	Update & Relaunch of Access Policy -
	Review & relaunch of performance meetings (Performance Assurance

	Framework) – commenced June 2019
General Surgery	Recruitment of 2 x consultants to meet increase in demand – to be in post October 19
Trauma & Orthopaedics	Locum to be requested to back fill trauma lists – to free up substantive consultants to minimise elective cancellations
	Explore options to outsource spinal patients
Cardiology	Recruitment of 2 x consultants (1 additional + 1 replacement) to meet demand – to be in post November 19
	Service taking part in NHSE improvement programme - SY&B ICS – first event – July 2019
Urology	Additional theatre stacker to be sourced to reduce cancellations due to equipment problems
	Review of Urodynamics provision due to service pressures & delays
Rheumatology	1 extra clinic planned per month to see long waiters
Gastroenterology	Breath Testing at DRI – pilot to commence August 2019 – will reduce waiting times for this cohort of patients
Dermatology	Recruitment of additional consultant for 'ad hoc' clinics to meet demand – to start August 2019
Diagnostics	Tender process for Nerve Conduction Service – underway

(C) Diagnostics

In June 2019 the Trust achieved 98.67% against the 6ww Diagnostic performance standard of 99% (98.75% at NHS Doncaster and 98.23% at NHS Bassetlaw).

There were 111 trust level breaches; the majority of these were Nerve Conduction (48). All of these breaches have been validated and confirmed by each service. This is an improved position on last month and all services have assured the target will be met for July 2019. The table below shows the position by service:

Exam Type	<6W	>=6W	Total	Performance	Longest Wait (weeks)
MRI	1476	4	1480	99.73%	9
CT	1966	6	1972	99.70%	8
Non-Obstetric Ultrasound	2984	2	2986	99.93%	7
Barium Enema	0	0	0		-
DEXA	215	2	217	99.08%	7
Audiology	360	24	384	93.75%	30
Echo	220	3	223	98.65%	15
Nerve Conduction	133	48	181	73.48%	11
Sleep Study	32	1	33	96.97%	6

Urodynamic	84	19	103	81.55%	11
Colonoscopy	254	0	254	100.00%	-
Flexible Sigmoidoscopy	81	0	81	100.00%	-
Cystoscopy	161	2	163	98.77%	11
Gastroscopy	243	0	243	100.00%	-
Total	**8209**	**111**	**8320**	**98.67%**	

Further work is taking place to strengthen delivery and ensure proactive processes by service. The 99% threshold of the target means performance is vulnerable when there are staffing issues within small services that cause delays. Hence we have introduced a peer review process on the services with a higher number of breaches to ensure we are sharing good monitoring, validation and escalation practice across the organisation.

Performance for the Trust, NHS Doncaster & NHS Bassetlaw:

	Waiters <6W	Waiters >=6W	Total	Performance
Trust	8209	111	8320	98.67%
NHS Doncaster	5200	66	5266	98.75%
NHS Bassetlaw	2107	38	2145	98.23%

Missed Targets:

- Audiology – 93.75% - 24 breaches out of 384 waiters - this is an improving position on last month. A member of staff who was off sick is now back, the team have introduced some additional short term capacity to manage the backlog of patients and are establishing improved monitoring information with the central Information team.

- Nerve Conduction – 73.48% - 48 breaches out of 181 waiters, this is an improvement on last month's performance. The issues here relate to a national shortage of nerve services and staff – and a local long term sickness issue. To mitigate this additional lists have been arranged for July and the target should be achieved for July 2019 onwards. The team are utilising an external company in advance of a new tender being issued for the service.

- Urodynamic – 81.55% -19 breaches out of 103 waiters, this is an improvement on last month's position. An urgent review of the continuing challenges in urodynamics around staffing, equipment and estate issues will be undertaken week commencing 22nd July and plans put in place to address current breaches, whilst developing a sustainable workforce plan.

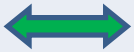
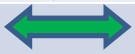
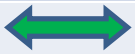
- Cystoscopy – 95.07% - 7 breaches out of 142 waiters – The team are working on improved monitoring and validation processes to ensure tight and proactive delivery each month.

(D) Cancer Performance

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

The following information relates to Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust performance for May 2019. It should also be noted that DBTH has been confirmed in late July as a national pilot for the new cancer standards, one of two Trusts within SYB ICS.

Cancer Performance – May 2019

Standard	Local Performance %	Position from Previous Month
TWW	93%	
31 day	100%	
62 day – IPT scenario split	82.1%	New report - April 2019
62 day – 50/50 split	84.9%	
31 day Sub – Surgery	100%	
31 day Sub – Drugs	100%	
31 day Sub – Other	100%	
62 day Screening	89.3%	
62 day Con Upgrades	93.8%	
Breast Symptomatic	95.6%	
Day 28 – shadow monitoring	*80.5%*	New report from April 2019

Cancer Performance by Specialty – May 2019

	2ww	Non 2ww Symptomatic Breast Referrals	31 Day - Classic	31Day Sub - Surgery	31 Day Sub - Drugs	31 Day Sub - Palliative	*62 Day – Classic 50/50 split*	*62 Day – Day 38 IPT split*	62 Day Screening	62 Day Consultant Upgrades	***Day 28 Shadow Reporting***
Operational Std	93%	93%	96%	94%	98%	94%	85%	85%	90%	TBA	TBA
Breast	98.2%	95.6%	100%	100%			100%	100%	100%		98.4%
Gynaecology	95.7%		100%	100%			80%	80%			65%
Haematology	100%		100%		100%		100%	100%			35.3%
Head & Neck	59%		100%				57.1%	50%			74.1%

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

Lower GI	97.7%		100%				77.8%	70%	50%	100%	69.8%
Lung	100%		100%				66.7%	50%		100%	69.4%
Sarcoma							0%	0%			
Skin	97.7%		100%				100%	100%			86.2%
Upper GI	95%		100%				90.9%	90.9%		66.7%	71.2%
Urological	75.1%		100%	100%	100%		80%	76.2%		100%	70.2%

Cancer Performance Exceptions – May 2019

CWT Standard	Tumour Group	Performance against CWT standard	High Level View
Two Week Wait	H&N	59%	**25** Patients – 9 patient choice, 9 administrative delay - unable to contact patient , 2 Clinic cancellations , 5 elective capacity
	Urology	75.1%	**44** Patients – 4 patient choice, 34 administrative delay - unable to contact patient, 6 Clinic cancellations ,
62 day	Gynae	80%	**1** Patient – Local pathway – medical reason
	H&N	57.1%	**3** Patients – All shared care, 1 complex planning for treatment, 1 OPD capacity for 1st OD (DBTH) 1 Pathway delays to IPT
	LGI	77.8%	**3** Patients – 1 Local pathway – medical reason for delay. 2 Shared Care Pathways - 1 treatment delayed for medical reasons, 1 Pathway delays to IPT
	Lung	66.7%	**2** Patients – Both shared care – medical reasons for delay to IPT
	Sarcoma	0%	1 **P**atient– Shared care - complex diagnostic pathway
	Urology	80%	**8** Patients – 2 Shared Care – both patient choice. 6 Local pathways 1 elective (OPD) capacity inadequate, 2 patient choice , 1 pathway reasons delay to MRI, 1 pathway delayed for medical reasons, 1 complex diagnostic pathway
62 day Screening	Lower GI	50%	**2** Patients – 1 Local Pathway - medical reason for delay. 1 Shared Care Pathway - delay within Bowel Screening service element
62 day Con Upgrade	Upper GI	66.7%	**1** Patient – shared care –complex diagnostic pathway

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

62 Day Cancer Performance by CCG – May 2019

	Number of Breaches per Tumour Group
02Q - Bassetlaw CCG – Total number of 62 day Classic Pathway Breaches = 7	
Head and Neck	1
Sarcoma	1
Upper Gastrointestinal	1
Urological (Excluding Testicular)	4
02X – Doncaster CCG – Total number of 62 day Classic Pathway Breaches = 12	
Gynaecological	1
Head and Neck	2
Lower Gastrointestinal	3
Lung	2
Urological (Excluding Testicular)	4
02Y - CCG – Total number of 62 day Classic Pathway Breaches = 1	
Cancer of Unknown Primary	1
Grand Total	20

Cancer Performance Comments & Action Plans

All Tumor Groups – The trust has agreed to pilot the day 28 cancer target for 2019/20 – this should support all aspects of cancer performance by expediting where possibile the initial consultation and diagnostics. This is currently being monitored in shadow form – April 2019 achievement at 80.5% (target not yet agreed)

2WW – Head & Neck – OMFS Surgeon Business Case now been agreed

Elective Capacity - ++ ENT surgeons off together due to leave / unexpected absence

2WW – Urology - continuing challenges in urology around staffing / estate / capacity. Issues continue around Urodynamics capacity – service investigating options for alternative methods of provision – recovery plan to be produced by 30.6.19.

Administrative delays due to unforeseen & exceptional issues within the admin team for Urology – a new team structure has now been put in place to mitigate against any such further delays in the 2ww booking process"

(E) Stroke

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

Performance April 2019

The Trust level percentage for Direct Admission to the Stroke Unit was 53.6% against a 90% target. This is an improvement on last month's figures

1. Direct Admission	Target = 75%			
	CCG			
Direct Admission within 4 Hours	Bassetlaw	Doncaster	Other	**Total**
Yes	5	22	3	**30**
No	6	17	3	**26**
Grand Total	**11**	**39**	**6**	**56**
Performance	45.5%	56.4%	50.0%	**53.6%**

1. Direct Admission			
Category	Sub Category		Total
Organisational	Beds		0
	Staff Availability		1
	Pathway	Delay in Transfer from ED	3
		Delay - transport BDGH to DRI	1
Clinical	Patient Presentation: secondary / late diagnosis of stroke.		15
	Patient Needs		5
Patient Choice	Declined		0
Awaiting further validation			1

The Trust level percentage for Scan within 1 hour was 43.9% against a 48% target. Breach reasons strongly reflect the above for direct admissions.

2. Scan within 1 Hour	Target = 48%			
	CCG			
Scan 1 hr	Bassetlaw	Doncaster	Other	**Total**
Yes	5	16	4	**25**
No	6	24	2	**32**
Grand Total	**11**	**40**	**6**	**57**
Performance	45.5%	40.0%	66.7%	**43.9%**

One other stroke performance indicator was not met:-

- % of all patients given thrombolysis – 5.5% against a target of 20%.

(F) Cancelled Operations

In June 2019 45 (0.92%) of Trust operations were cancelled.

CCG Name	CCG Code	Apr-19	May-19	Jun-19
TRUST		0.83%	0.98%	0.92%

Of which Theatre Cancellations		*0.39%*	*0.52%*	*0.59%*
Of which Non-Theatre Cancellations		*0.43%*	*0.46%*	*0.33%*
NHS DONCASTER CCG	02X	0.77%	1.11%	1.06%
Of which Theatre Cancellations		*0.38%*	*0.56%*	*0.65%*
Of which Non-Theatre Cancellations		*0.38%*	*0.56%*	*0.40%*
NHS BASSETLAW CCG	02Q	1.02%	0.79%	0.86%
Of which Theatre Cancellations		0.65%	0.44%	0.76%
Of which Non-Theatre Cancellations		0.37%	0.35%	0.10%

The Trust has experienced a small increase in on the day cancellations in theatre for non-clinical reasons, due to equipment issues, relating to the recent change to an outside supplier. This has also impacted on list overruns. In addition, there has been a small increase in the number of cancellations due to staffing availability, which is continually monitored. Vacancies rates are improving for theatre staff, but anaesthetic staff sickness continues to be a problem which the Division are sighted on and addressing. The table below provides the full breakdown:

Non-Clinical Reasons for Cancellations – June 2019

Row Labels	Main Reason	Sub Reason	ENT	GI	Gynaecology	Orthopaedics	Rotherham ENT	Urology	Vascular	Community Dental	Bariatric	Grand Total
BDGH	**Equipment**	Equipment not available									1	1
	Insufficient Time	Problems with previous case		4				1				5
		Oversubscribed list				2					1	3
	No HDU/DCC Bed	N/A		1								1
BDGH Total				**5**		**2**		**1**			**2**	**10**
DRI	**Equipment**	Equipment failure						3				3
		Equipment not available	1					2				3
		HSDU issue	1								1	2
	Insufficient Time	Problems with previous case	1			2	1		1			5
		Oversubscribed list				1						1
		Late start - Anaesthetist						1				1
	No Elective Bed	N/A	1									1
	No Staff	Anaesthetist						1		1		2
		Surgeon			1							1
	Other Urgent Case	Emergency		1								1
DRI Total			**4**	**1**	**1**	**3**	**1**	**7**	**1**	**1**	**1**	**20**
Grand Total			**4**	**6**	**1**	**5**	**1**	**8**	**1**	**1**	**3**	**30**

There was 1 case which breached the 28 day rebooking target in June. The original cancellation related to an incorrect lens being ordered for the surgery. The correct lens was therefore ordered from a new supplier which wasn't in stock and caused the delay for the rebooking. The surgeon and waiting list team have agreed a new process for the surgeons to order the lens directly to reduce the risk of such errors.

Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust
PERFORMANCE EXCEPTION REPORT – June 2019

Length of Stay

To be included in July 2019 report

Pulmonary Rehabilitation

To be included in July 2019 report

Executive Summary - Safety & Quality - June 2019 (Month 3)

HSMR:

The rolling 12 month HSMR continues to show a slow rise compared to last year but still remains within expected range. This is mainly due to the recent rebasing of the risk . However we have had 2 particular rises in July 2018 and January 2019 which would have contributed to the overall picture and will continue to do so for some time until the said 2 months drop off the run chart. A review of a random sample of deaths, confirms the high preponderance of respiratory conditions causing death is in line with the population risk profile for the area. There was no evidence of poor quality care which would have led to the deaths. There were some issues with coding both in terms of the % based on signs and symptoms and with the recording of comorbidities. Both areas are being addressed through the Learning from Deaths action plan which includes Medicine and the re-engineering of the allocation of FCE that will commence in September as it requires a change in job plans. Coding of comorbidities is being actively pursued by both major acute specialities where the main issues lie. In terms of elective deaths the numbers are small and therefore the HSMR though still within the expected range would show a disproportionate rise for a small change. Assurance can be provided through the Learning from deaths group that ALL elective deaths are scrutinised and while some have been incorrectly classified due to well known vagaries in the system, there were no instances where concerns were identified with the care which contributed to the death. Finally the crude death rate shows a continuing drop while remaining within the expected variation suggesting that changes in HSMR are more likely to be the result of coding and recording of comorbidities rather than to an increase in death rates .Work on these 2 aspects remains ongoing and will be likely to come to fruition by the autumn.

Fractured Neck of Femur:

The mortality from fracture neck of Femur remains low when considering the co-morbidity of this patient group and the imperative to operate to provide good pain relief. In terms of Best Practice Tariff in respect of surgery within 36 hrs access to orthogeriatrician within 72 hrs the situation appears to have improved. The unit has recently appointed a new lead for #NOF who will ensure that current arrangements will be enhanced and continue to show improvement

Serious Incidents:

There has been a slight decrease in Serious incidents reported this month. With respect to care issues we have seen a slight increase this month including the reporting of 1 never event (wrong site urectic stent)

Executive Lead:

Mr S Singh

C-Diff

The data shows that as expected due to changes in reporting, we have a higher number of cases than at the same period last year, but remain within trajectory for 2019/20

Fall resulting in significan harm:

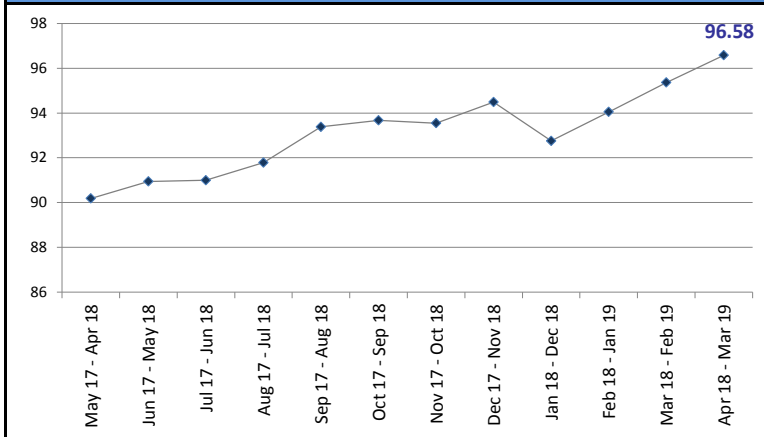
The data shows a lower position for the same period last year but a higher YTD position. Falls remain above trajectory

Hospital Acquired Pressure Ulcers:	The data shows that as expected due to changes in reporting, we have a higher number of cases than at the same YTD period last year, but remain within trajectory for 2019/20
Complaints and Concerns	Complaints and concerns remain within normal variation. CNST and LTPS claims are both bleow the same period last year
Friends & Family Test:	Response rates for both inpatient and ED are below the Regional rates, but remain better when comparing positivity of response

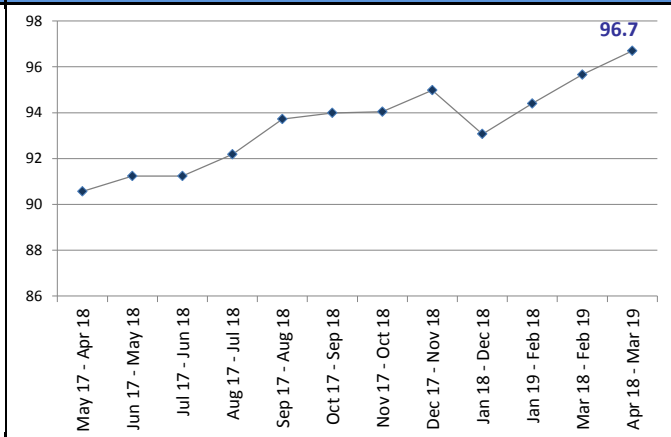
Executive Lead:
Mrs M Hardy

Hospital Standardised Mortality Ratio (HSMR) - March 2019 (Month 12)

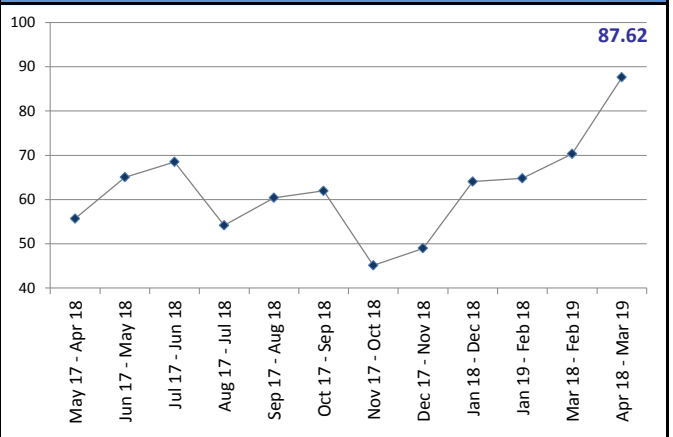
Overall HSMR (Rolling 12 months)



HSMR - Non-elective Admission (Rolling 12 months)



HSMR - Elective Admission (Rolling 12 months)

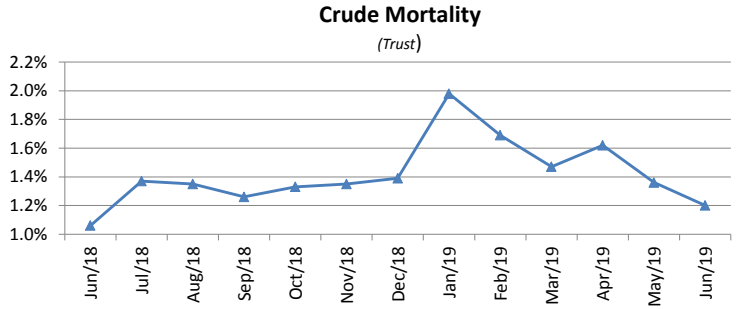


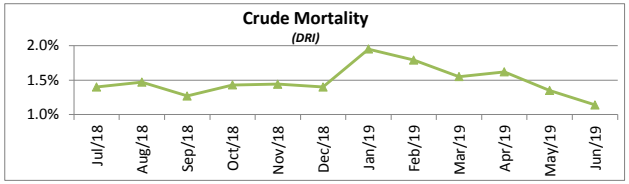
HSMR Trend (monthly)

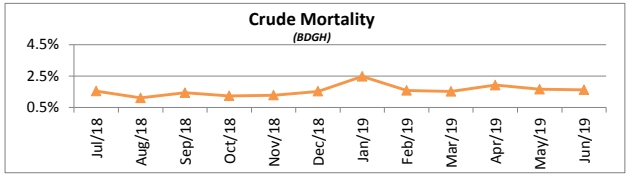
	2016	2017	2018	2019
January	116.80	99.21	94.86	106.12
February	99.94	97.73	105.44	98.09
March	90.54	97.37	88.42	96.58
April	105.91	88.50	99.07	
May	101.15	96.60	92.24	
June	80.27	93.67	90.46	
July	92.56	97.73	107.89	
August	100.27	87.52	95.19	
September	90.26	95.34	90.48	
October	90.29	88.66	97.12	
November	88.98	82.30	99.57	
December	82.30	93.52	80.78	

Crude Mortality (monthly) - Jun 2019 (Month 3)

(number of deaths/number of patient discharged)



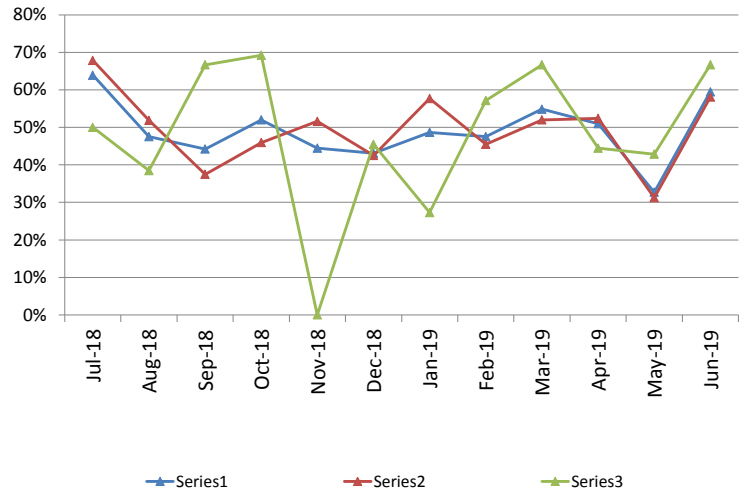




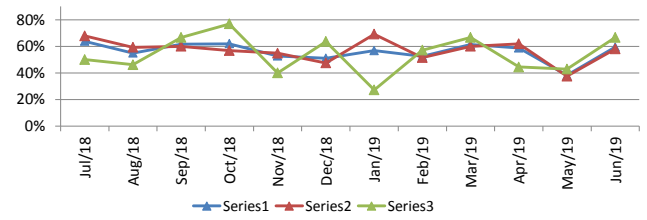
	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Trust	1.37%	1.35%	1.26%	1.33%	1.35%	1.36%	1.98%	1.69%	1.47%	1.62%	1.36%	1.20%
DRI	1.40%	1.47%	1.27%	1.43%	1.44%	1.45%	1.95%	1.79%	1.55%	1.62%	1.35%	1.14%
BDGH	1.53%	1.10%	1.43%	1.23%	1.27%	1.26%	2.47%	1.58%	1.51%	1.91%	1.65%	1.62%

NHFD Best Practice Pathway Performance -June 2019 (Month 3)

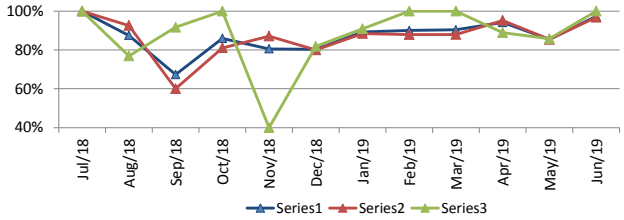
Best Practice Criteria Performance



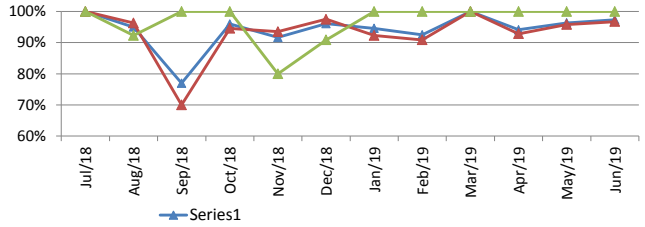
36 Hours to Surgery Performance



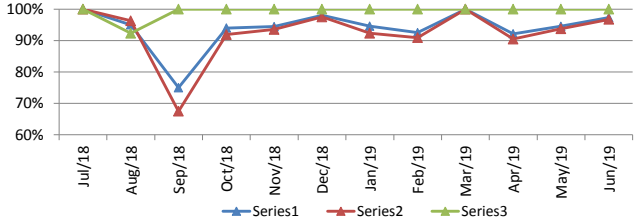
72 hours to Geriatrician Assessment Performance



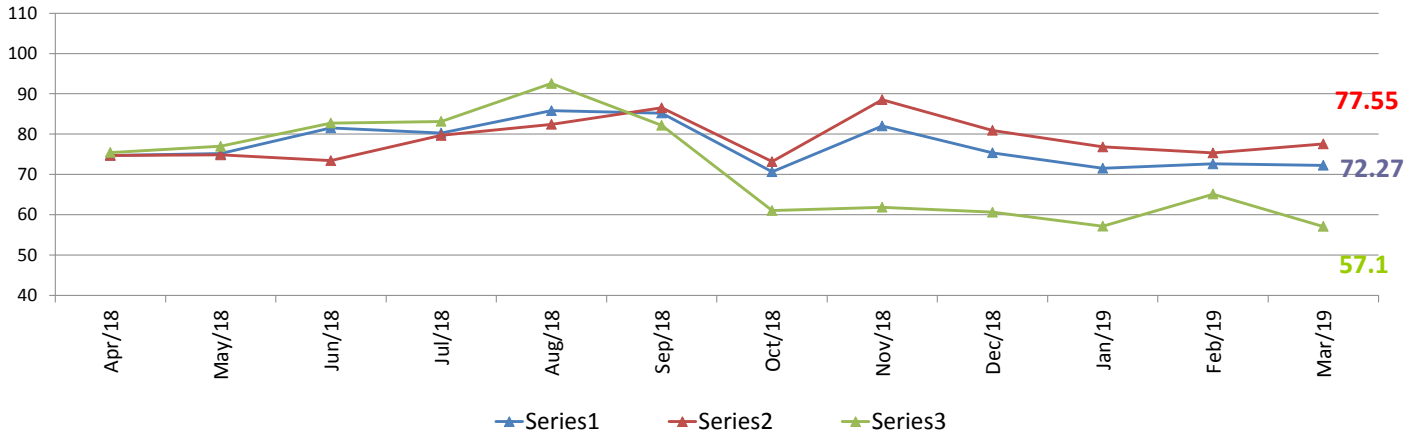
Bone Protection Medication Assessment



Falls Assessment Performance



Relative Risk Mortality (HSMR) - Fractured Neck of Femur
Rolling 12 month



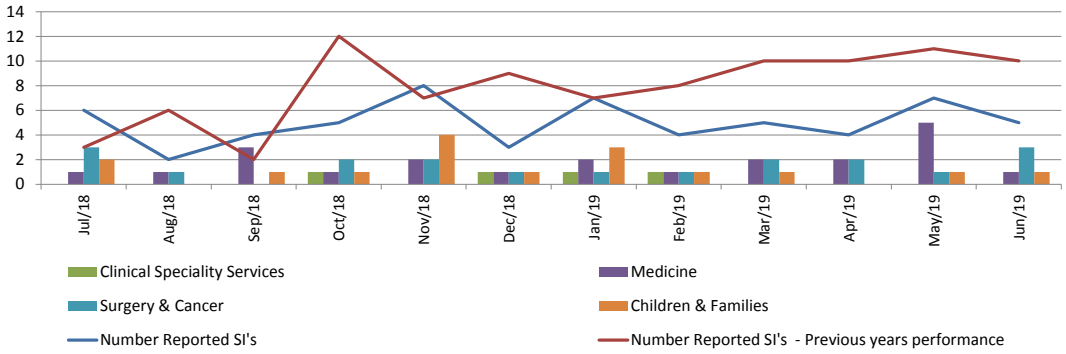
Serious Incidents - June 2019 (Month 3)

(Data accurate as at 05/07/2019)

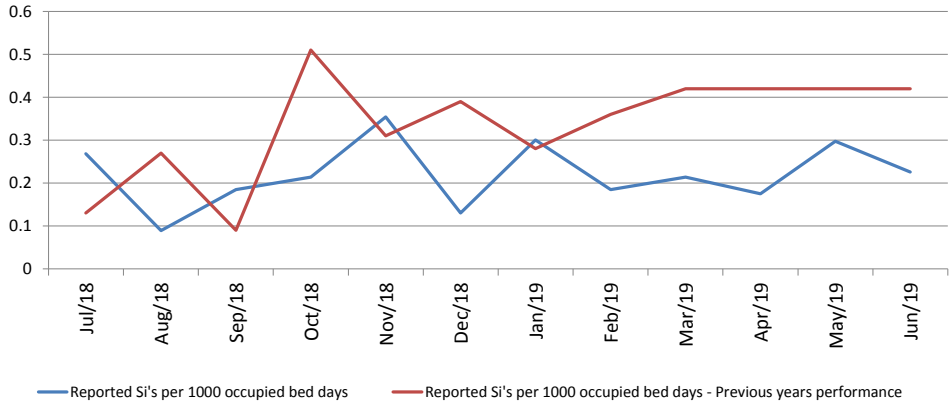
Please note: At the time of producing this report the number of serious incidents reported are prior to the RCA process being completed.

Overall Serious Incidents

Number Serious Incidents Reported
(Trust & Divisions)



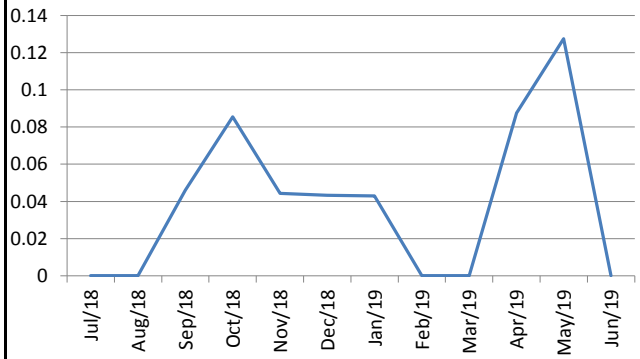
Serious Incidents per 1000 occupied bed days



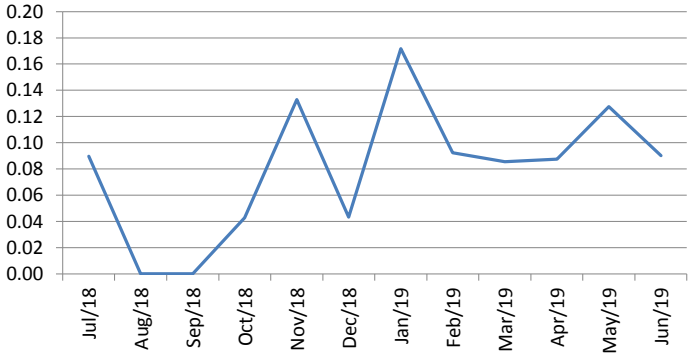
Current YTD reported SI's (April-Jun 19)	16	Number reported SI's (Apr-Jun 18)	10
Current YTD delogged SI's (April-Jun19)	0	Number delogged SI's (Apr-Jun 18)	0

Themes

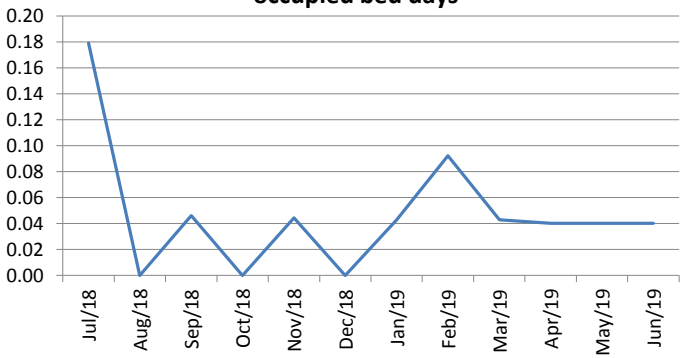
Serious Falls per 1000 occupied bed days



Care Issues per 1000 occupied bed days

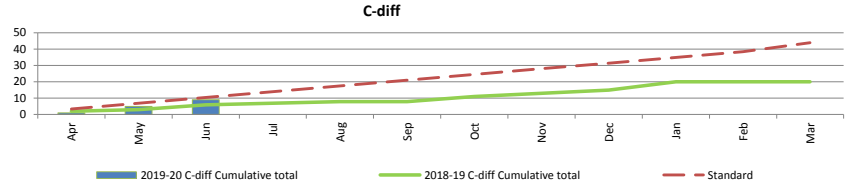


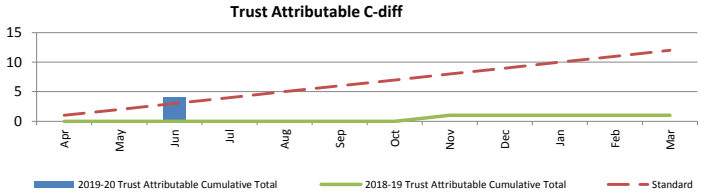
Pressure Ulcers - Grade 3 & 4 (HAPU) per 1000 occupied bed days



Infection Control C.Diff - June 2019 (Month 3)
(Data accurate as at 05/07/2019)

	Standard	Apr	May	Jun	Qtr 1	YTD
2019-20 Infection Control - C-diff	44 Full Year	1	4	4	9	9
2018-19 Infection Control - C-diff	39 Full Year	2	3	3	8	8
2019-20 Trust Attributable	12	0	0	4	4	4
2018-19 Trust Attributable	12	0	0	0	0	0

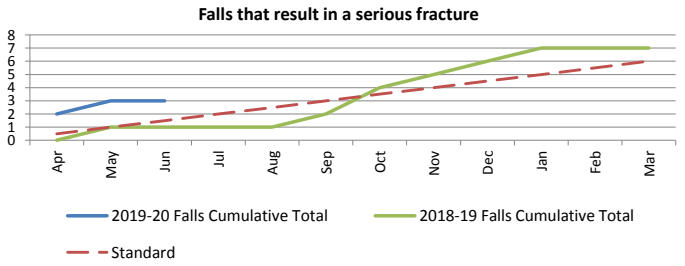




Pressure Ulcers & Falls that result in a serious fracture - June 2019 (Month 3)
(Data accurate as at 05/07/2019)

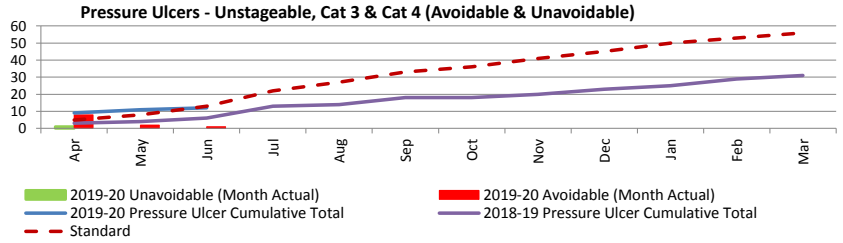
	Standard	Apr	May	Jun	Qtr 1	YTD
2019-20 Serious Falls	6 Full Year	2	1	0	3	3
2018-19 Serious Falls	10 Full Year	0	1	1	2	2

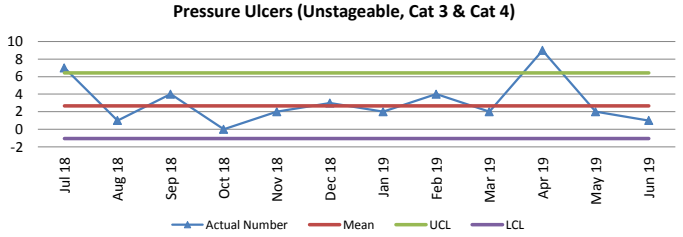
Please note: At the time of producing this report the number of serious falls reported are prior to the RCA process being completed.



	Standard	Apr	May	Jun	Qtr 1	YTD
2019-20 Pressure Ulcers (Unstageable, Grade 3 & Grade 4)	56 Full Year	9	2	1	12	12
2018-19 Pressure Ulcers	21 Full Year	3	3	3	9	9
2019-20 Pressure Ulcers - **UNAVOIDABLE** (Unstageable, Grade 3 & Grade 4)		1	0	0	1	1
2019-20 Pressure Ulcers - **AVOIDABLE** (Unstageable, Grade 3 & Grade 4)		8	2	1	11	11

Please note: At the time of producing this report they are 11 PU's still subject to the RCA process.



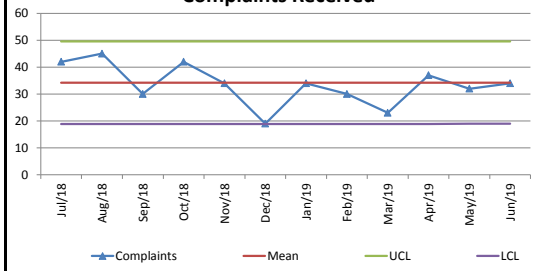


Complaints & Claims - June 2019 (Month 3)

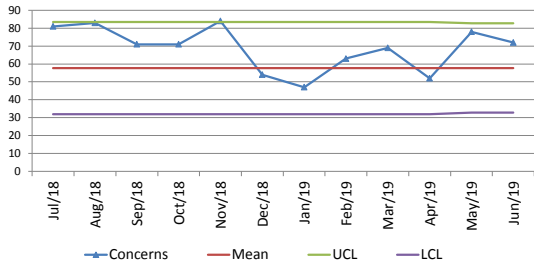
Data accurate as at 05/07/2019

Complaints

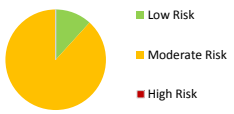
Complaints Received



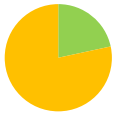
Concerns Received



June 2019 Complaints Received Risk Breakdown

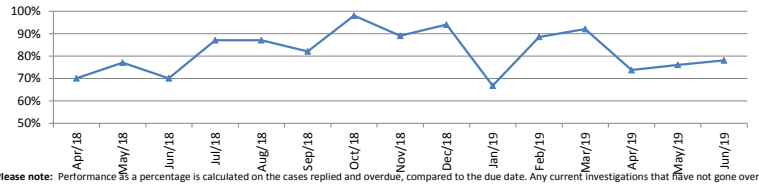


Year to Date Complaints Received Risk Breakdown



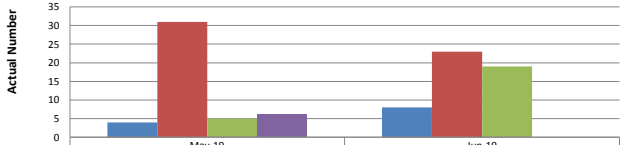
Complaints - Resolution Perfomance *(% achieved resolution within timescales)*
Complaints Closed - Outcome

Complaints Resolution Performance



Please note: Performance as a percentage is calculated on the cases replied and overdue, compared to the due date. Any current investigations that have not gone over deadlines are excluded data.

Closed Complaints - Outcomes



	May-19	Jun-19
Complaints Upheld	4	8
Complaints Partially upheld	31	23
Complaints not upheld	5	19
Outcome not reported	6	0

Parliamentary Health Service Ombusdman (PHSO)

Month	Number of cases referred for investigation	Number Currently Outstanding
Jun-19	0	6

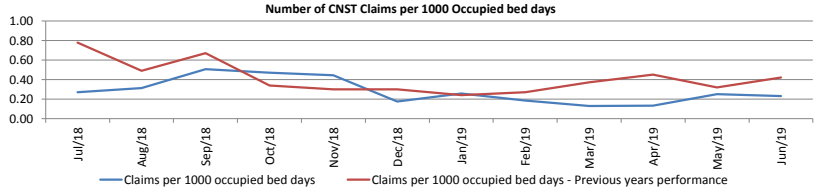
	Number referred for investigation YTD	Outcomes YTD	
2017/18	7	Fully / Partially Upheld	3
		Not Upheld	1
		No further Investigation	0
		Case Withdrawn	0
		Not Investigated	3
		Outstanding	0
2018/19	9	Fully / Partially Upheld	3
		Not Upheld	1
		No further Investigation	0
		Not Investigated	1
		Case Withdrawn	0
		Outstanding	4
2019/20	2	Outstanding	2

Claims

		Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Clinical Negligence Scheme for Trusts (CNST) Not including Disclosures	2019/20	3	3	10										16
	2018/19	10	7	9	6	7	11	11	4	10	6	4	3	88
Liabilities to Third Parties Scheme (LTPS)	2019/20	4	2	1										7
	2018/19	2	6	1	1	7	0	2	0	2	3	9	2	35

Please note: At the time of producing this report the number of claims reported are provisional and prior to validation

Number of CNST Claims per 1000 Occupied bed days



Hard Truths - June 2019 (Month 3)

(Data accurate as at 10/07/2019)

						Planned v Actual		Safe	Effective	Caring	Responsive
DIVISION	Ward	WARD	No of	Work-	Quality	CHPPD	Variance	Total score	Total score	Total score	Total
Surgery & Cancer	HD	B5	24.0		7.5	6.7	102%	1.5	0.0	1.5	2.0
	JW	B6	21		8.5	7.1	103%	2.5	1.0	1.0	2.0
	AK	St Leger	35		8.5	6.5	94%	2.0	0.5	2.0	1.5
	VB	1&3	23		6.0	9.1	105%	0.5	1.0	1.0	1.5
	SB	20	27		4.0	5.5	105%	0.0	0.5	1.5	1.0
	RW	21	27		5.5	5.5	113%	1.5	1.0	0.5	1.0
	FN	S10	20		6.0	5.5	100%	0.0	0.5	1.0	1.5
	JP	S11	19		6.0	6.4	98%	3.0	0.0	0.0	0.5
	HB	S12	16		4.0	5.8	101%	0.0	1.5	0.0	1.0
	SS	SAW	21		8.5	7.9	99%	2.0	0.5	2.0	2.0
							102%				
Medicine	SM	A4	22		7.0	6.1	103%	2.0	0.5	2.0	0.5
	MC	C1	16		8.5	6.5	127%	3.5	1.0	2.0	1.0
	KD	CCU/C2	18		9.5	6.1	102%	0.5	3.5	2.0	0.5
	SC	ATC	21		6.5	7.5	95%	0.5	1.0	1.0	2.0
	ZC&KJ	AMU	40		9.5	7.6	102%	4.0	1.0	1.5	1.0
	LB	FAU	16		9.0	8.5	102%	1.5	2.5	3.5	1.0
	JB	16	24		10.0	8.3	102%	4.0	1.5	1.0	2.0
	JW	17	16		12.0	6.6	103%	2.0	3.0	4.0	1.5
	AB	18 Haem	12		2.0	7.2	98%	0.5	0.0	0.0	0.5
	LS	18 CCU	12		5.5	7.1	99%	0.0	0.5	0.5	2.0
	MN	24	24		7.5	6.0	122%	1.5	1.5	1.0	2.0
	DF	25	16		7.0	7.4	115%	1.5	2.0	0.5	1.0
	TM&JC	Respiratory unit	52		11.0	5.9	101%	4.0	2.0	2.0	1.0
	TM	32	18		14.5	6.3	100%	4.0	1.0	5.0	1.5
	LAS	Mallard	16		6.5	8.2	103%	1.5	0.0	1.5	2.0
	RM	Gresley	32		5.5	5.7	98%	1.0	1.5	1.0	1.5
	EW	Rehab 2	18		8.5	5.9	108%	0.0	0.5	3.5	2.5
	GW	Rehab 1	29		6.5	5.2	113%	0.0	1.5	3.0	0.5
							105%				
Clinical Speciality Services	LC	ITU DRI	20		1.5	26.7	97%	0.5		0.0	0.5
	LW	ITU BDGH	6		4.5	23.5	98%	0.5		3.0	0.5
							97%				
Children and Families	CD	SCBU	8		0.5	24.9	99%				
	IB	NNU	18		0.0	10.5	95%				
	EJ	CHW	18		0.5	9.4	100%				
	LM	CHOU	12		0.0	10.5	100%				
	KR	G5	16		10.0	6.6	94%	1.0	0..5	3.5	1.5
	TM	M1	24		5.5	7.5	71%	0.0	1.0	3.5	1.0
	RW	M2	18		6.5	7.3	83%	0.0	2.0	3.5	0.5
	SR	CDS	14		9.0	31.2	87%	0.5	4.5	3.0	0.5
	KC	A2	18		9.0	8.1	82%	0.0	4.5	3.0	1.0
	KC	A2L	6		10.5	23.3	87%	0.0	4.5	4.5	1.0
							89%				
							100%				

The workforce data submitted to UNIFY provides the actual hours worked in June 2019 by registered nurses or midwives, and health care support workers compared to the planned hours. The Trusts overall; planned versus actual hours worked was 100% in June 2019, similar to May and April 2019 (both 101%).

The data for June 2019 demonstrates that the actual available hours compared to planned hourse were:

27 wards (67.5%) within 5% of the planned staffing level, 6 more than last month

3 wards (7.5%) bewtween 5-10% of planned staffing level, 8 less than last month

5 wards (12.5%) <10% higher than planned staffing level, 1 more than last month

5 wards (12.5%) >10% lower than planned staffiing level, 1 more than last month.

All paediatric and neonatal wards were within 5% of the planned staffing level.

In June 2019 the wards where there were deficits in excess of 10% of the plannced hours are; M1, M2, CDS, A2 and A2L. This month maternity staff have been redeployed to areas of higher activity to maintain a safe service ,triage and ward M2 have merged overnight on a number of occasions to improve the skill mix and provide a safe service. Community Midwives on call have been called into the unit as required to maintain a safe service, due to activity and short notice sickness. Maternity have not diverted services in June, however, Maternity services have been suspended on 2 occasions; on the 1st June due to high activity and staffing shortages on both sites. 5 women were diverted to neighbouring trusts during the suspension, 1 delivered at Nottingham and the other 4 were discharged home. Maternity services were also suspended on the 3rd June due to high activity across both sites. 1 women was diverted to Barnsley where she delivered.

In June 2019 the wards with greater than 10% of actual staffing over planned staffing are; Ward 24, Ward 25, Ward 21, C1 and Rehab 1. Rehab 1 was due to enhanced care needs with the remaining wards requiring additional staff due to acuity and having escalation and closed beds open.

Quality and Safety Profile; The Quality Metric data for June 2019 has not identified any wards as red for Quality.

Care Hours Per Patient Day (CHPPD) - June 2019 (Month 3)

(Data accurate as at 04/07/2019)

Utilising actual versus planned staffing data submitted to UNIFY and applying the CHPPD calculation the care hours for June 2019 are shown below

Site Name	Registered midwives/ nurses	Care Staff	Overall
BASSETLAW HOSPITAL	4.58	3.29	7.86
DONCASTER ROYAL INFIRMARY	4.56	3.32	7.88
MONTAGU HOSPITAL	2.23	3.26	5.48
TRUST	4.42	3.31	7.72

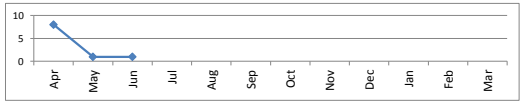
The data for June 2019 shows an increase in registered nurse hours at all siteswith non-registered staff hours remainng similar to last month. The overall CHPPD figure is therefore higher than last month although the registered nurse and midwife profile continues to be lower than national and peer rates, with the Healthcare support worker rate slightly higher than peers and national rates. The overall CHPPD rate shows a fluctuating rate, lower than peer and national rates.

Childrens & Young People - Quality Metrics
June 2019 (Month 3)

(Data accurate as at 05/07/2019

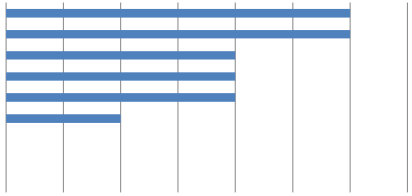
Complaints

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of complaints received - 2019/20	8	1	1										10
Number of complaints received - 2018/19	5	3	3	2	3	1	3	1	0	0	1	2	24



Thematic breakdown (Apr 19 - Jun 19)

j	3
Staff attitude & behaviour	3
Diagnostic Tests	2
Diagnosis	2
Nursing - ADL	2
Other	1



There are two main complaint themes for June 2019. The first is "Staff Attitude and Behaviour" (17.7%) which breaks down to (1) conduct/deposition. (1) Insensitive to needs/unhelpful (1) an allegation of rough patient handling The second main complaint theme is around "communication" (17.7%) which break down into lack of information to relatives (3).

Please note that a direct correlation between the number of complaints received and the subjects within thematic breakdown can not been made as most of the complaints have more than one subject noted.

Datix Incidents & Serious Incidents

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of Datix Incidents Reported - 2019/20	33	30	35										98
Number of Datix Incidents Reported - 2018/19	25	31	42	34	27	27	25	52	34	26	32	34	389

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Number of Serious Incidents Reported - 2019/20 *(including de-logged)*	0	0	0										0
Number of Serious Incidents Reported - 2018/19 *(including de-logged)*	0	0	0	0	0	0	0	0	0	0	0	0	0

Duty Of Candour (Doc)

There have been 1 incident within Children and Young Persons which has triggered Duty of Candour to be completed.

This was reported, the Verbal discussion and Letter 1 has been completed (incident is still open therefore Letter 2 not yet applicable).

Compliance 100%

Investigation ongoing.

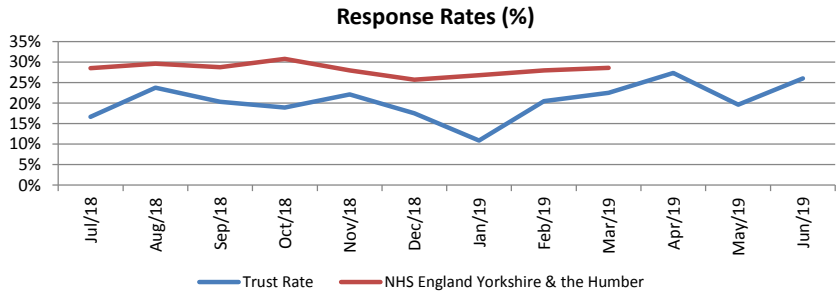
Please note: An incident which has caused moderate, severe or patient death requires DoC to be completed

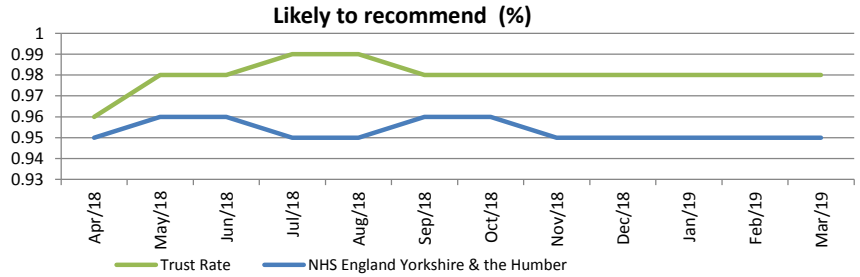
Friends & Family - June 2019 (Month 3)

(Data accurate as at 08/7/2019)

Inpatients

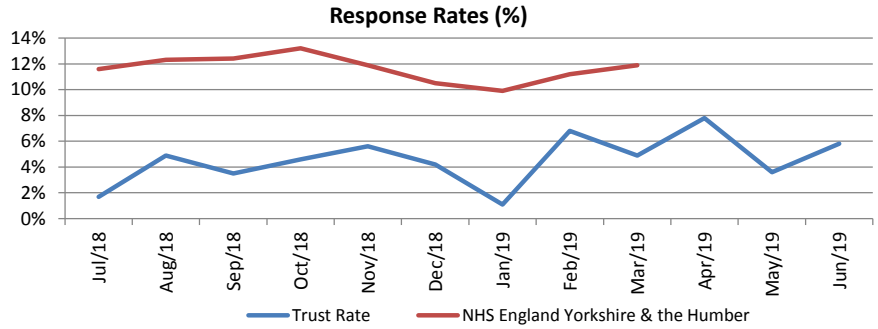
Please note: At the time of producing this report no further benchmarking data is available from NHS England.

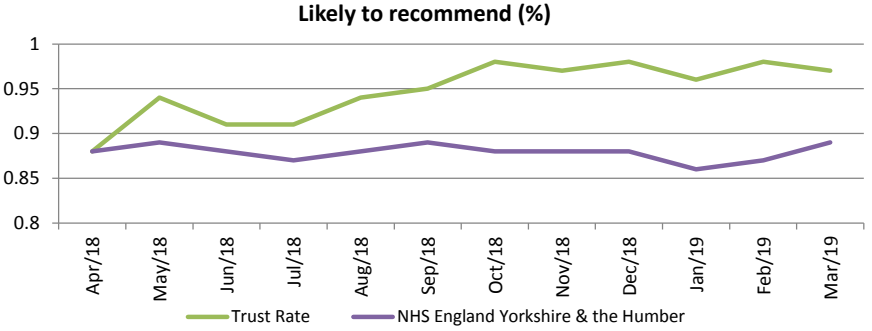




Accident & Emergency

Please note: At the time of producing this report no further benchmarking data is available from NHS England.





Executive summary - Workforce - June 2019 (Month 3)

Sickness absence

June 2019 is similar to May at 4.18% with the cumulative position being 4.37% - these rates are slightly higher than this period last year. Short term absence has risen this month whilst long term sickness absence has reduced with absences in excess of 6 months now having reduced.

Appraisals

The appraisal season was set as April to June with a view to there being particular focus outside of the winter and summer months. We recognise that some clinical areas have had significant pressures and as such have agreed that they continue with this focus during July. The 12 month reported rates for non medical staff is 73.55% at the end of June. At the time of running the report we are aware that not all appraisals have been recorded on ESR. This is being discussed with those areas to ensure they are adequately supported. In addition to ensuring staf have an appraisal we have sought feedback on the quality of that appraisal - we have received feedback from 289 members of staff which is being collated as a number were paper/emails rather than the survey monkey. Following discussion at the Workforce, Education and Research Committee (WERC) discussions will take place with those divisions/teams who have achieved less than 70% to develop an action plan; those areas between 70 and 90% will be expected to achieve 90% by August.

SET

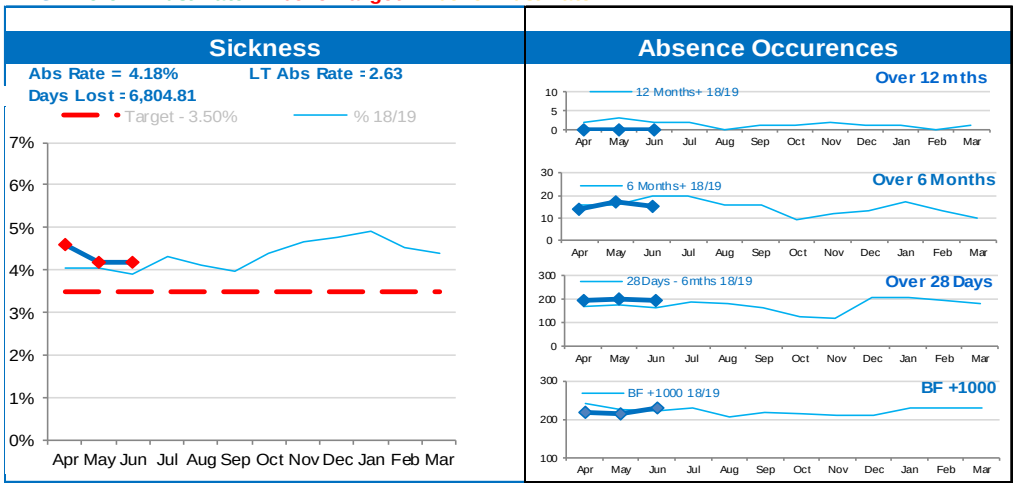
SET compliance has seen an ongoing increase to 84.73% as at the end of June which is reassuring. Divisional feedback at WERC is that staff are sighted on the training they are required to undertake.

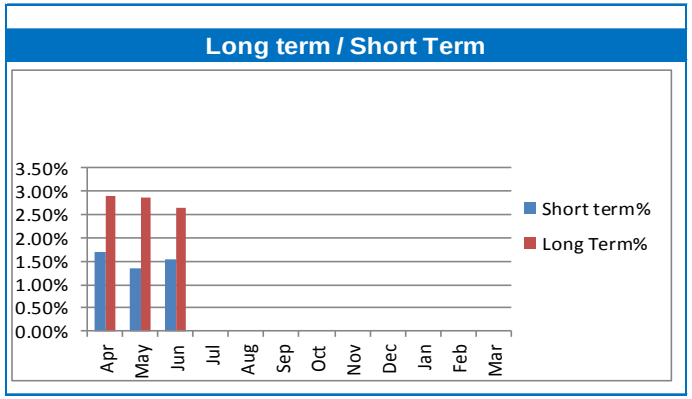
Staff in post

Staff in post by staff group is shown as at month 2 with similar levels of staff in post.

CG & Directorate Sickness Absence - June 2019 (Q1)

RAG: Below Trust Rate - Above Target - Above Trust Rate

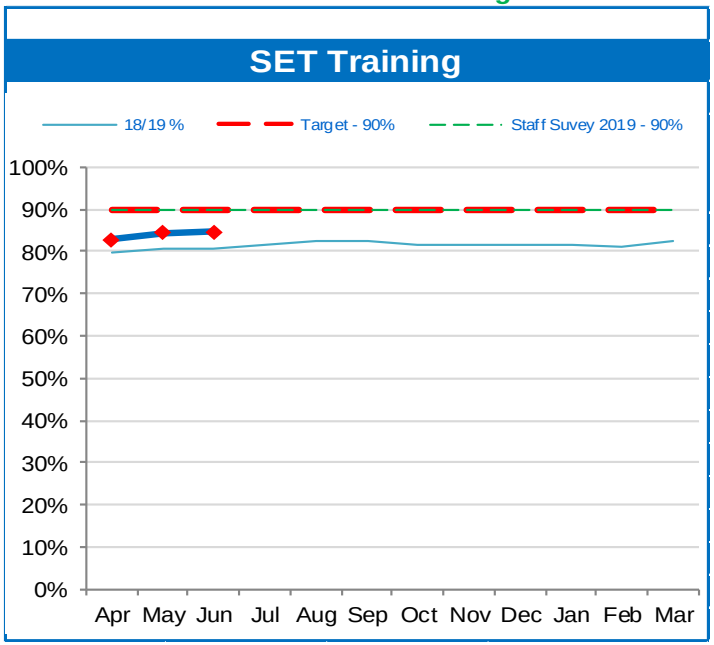




	Apr-19		May-19		Jun-19		Cumulative	
	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate	Days Lost	% Rate
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**7472.02**	**4.59%**	**7048.71**	**4.19%**	**6,804.81**	**4.18%**	**21,556.61**	**4.37%**
Chief Executive Directorate	0.00	0.00%	0.00	0.00%	3.00	0.57%	**36.00**	**2.32%**
Children & Families Division	1071.72	6.17%	760.56	4.22%	859.39	4.93%	**2,744.67**	**5.20%**
Clinical Specialist Division	2022.81	4.88%	2007.09	4.62%	1,703.88	4.04%	**5,677.17**	**4.46%**
Directorate Of Strategy & Improvement	16.19	5.16%	3.73	1.21%	4.00	1.44%	**23.92**	**2.52%**
Estates & Facilities	955.75	6.82%	954.29	6.76%	838.10	6.22%	**2,592.74**	**6.23%**
Executive Team Board	54.00	2.13%	40.00	1.55%	81.40	3.31%	**190.40**	**2.51%**
Finance & Healthcare Contracting Directorate	13.97	0.34%	10.27	0.25%	86.61	2.12%	**214.74**	**1.74%**
IT Information & Telecoms Directorate	30.23	1.55%	32.84	1.68%	20.92	1.05%	**89.30**	**1.52%**
Medical Director Directorate	0.00	0.00%	0.00	0.00%	0.00	0.00%	**0.00**	**0.00%**
Medicine Division	1747.65	4.04%	1602.56	3.60%	1,704.19	3.99%	**5,177.44**	**3.98%**
Nursing Services Directorate	59.12	2.84%	16.90	0.79%	11.80	0.56%	**107.42**	**1.70%**
People & Organisational Directorate	142.80	4.36%	87.52	2.52%	97.35	2.84%	**364.77**	**3.57%**
Performance Directorate	288.54	5.68%	285.40	5.46%	259.95	4.96%	**881.22**	**5.71%**
Surgery & Cancer Division	1069.25	4.06%	1247.56	4.57%	1,134.23	4.28%	**3,456.83**	**4.31%**

CG & Directorate SET Training - June 2019 (Q1)

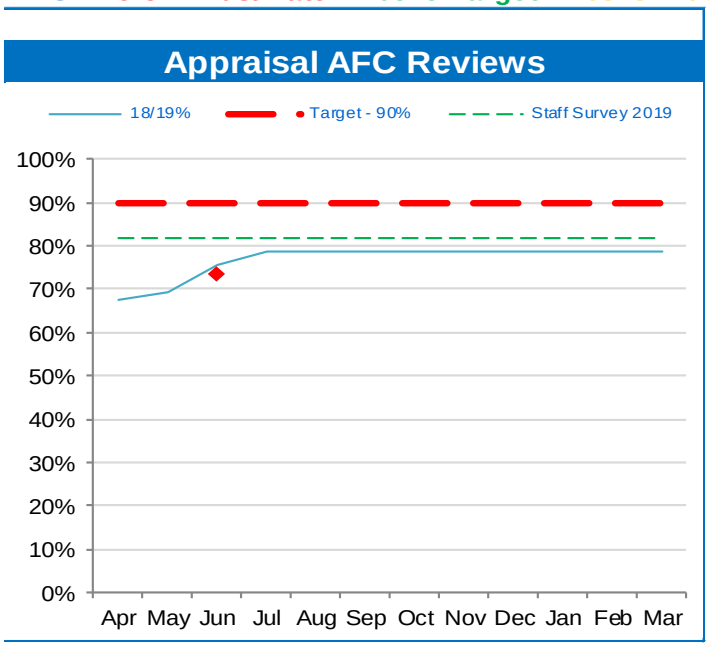
RAG: Below Trust Rate - Above Target - Above Trust Rate



	% Compliance
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**84.73%**
Chief Executive Directorate	**93.59%**
Children & Families Division	**81.59%**
Clinical Specialist Division	**87.54%**
Directorate Of Strategy & Improvement	**95.37%**
Estates & Facilities	**85.76%**
Finance & Healthcare Contracting Directorate	**95.57%**
IT Information & Telecoms Directorate	**88.51%**
Medical Director Directorate	**94.05%**
Medicine Division	**82.05%**
Nursing Services Directorate	**93.66%**
People & Organisational Directorate	**97.01%**
Performance Directorate	**89.11%**
Surgery & Cancer Division	**80.84%**

CG & Directorate Appraisals - June 2019 (Q1)

RAG: Below Trust Rate - Above Target - Above Trust Rate



AFC 12 Months (NHSI)

	% Completed
Doncaster & Bassetlaw Teaching Hospitals NHS FT	**73.55**
Chief Executive Directorate	**100.00**
Children & Families Division	**51.45**
Clinical Specialist Division	**82.43**
Directorate Of Strategy & Improvement	**100.00**
Estates & Facilities	**69.98**
Finance & Healthcare Contracting Directorate	**90.76**
IT Information & Telecoms Directorate	**87.50**
Medical Director Directorate	**55.56**
Medicine Division	**69.41**
Nursing Services Directorate	**72.73**
People & Organisational Directorate	**92.93**
Performance Directorate	**88.26**
Surgery & Cancer Division	**73.02**

	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount	FTE	Headcount
Staff Group	**Jul-18**		**Aug-18**		**Sep-18**		**Oct-18**		**Nov-18**		**Dec-18**		**Jan-19**		**Feb-19**		**Mar-19**		**Apr-19**		**May-19**		**Jun-19**	
Add Prof Scientific and Technic	170.63	188.00	172.02	190.00	172.07	190.00	172.89	190.00	175.49	191.00	175.23	193.00	175.23	193.00	169.56	186.00	167.69	184.00	169.49	186.00	167.29	184.00	166.04	183.00
Additional Clinical Services	1,171.05	1,414.00	1,172.67	1,415.00	1,179.29	1,421.00	1,164.05	1,405.00	1,165.06	1,409.00	1,166.15	1,417.00	1,166.15	1,417.00	1,179.19	1,422.00	1,171.11	1,417.00	1,171.01	1,417.00	1,180.63	1,427.00	1,184.53	1,432.00
Administrative and Clerical	1,047.67	1,278.00	1,045.17	1,272.00	1,045.71	1,274.00	1,033.17	1,259.00	1,033.15	1,258.00	1,048.69	1,329.00	1,048.74	1,276.00	1,049.10	1,276.00	1,049.52	1,275.00	1,053.74	1,281.00	1,055.49	1,277.00	1,074.21	1,296.00
Allied Health Professionals	321.56	375.00	323.12	376.00	322.84	375.00	323.24	376.00	323.81	375.00	323.76	387.00	325.26	377.00	321.74	373.00	319.46	371.00	319.30	371.00	318.84	371.00	313.30	366.00
Estates and Ancillary	480.84	686.00	480.84	686.00	476.40	680.00	474.36	678.00	474.06	676.00	478.66	682.00	481.56	690.00	482.56	686.00	483.25	688.00	479.25	684.00	472.53	681.00	453.50	654.00
Healthcare Scientists	122.66	139.00	120.78	137.00	122.78	139.00	123.72	140.00	123.72	140.00	123.03	139.00	123.03	139.00	122.59	139.00	122.58	139.00	120.99	138.00	121.23	138.00	121.53	138.00
Medical and Dental	508.07	581.00	554.01	633.00	551.15	633.00	559.68	642.00	561.04	639.00	559.44	591.00	557.81	590.00	555.43	587.00	556.57	589.00	555.17	587.00	557.18	589.00	554.67	587.00
Nursing and Midwifery Registered	1,573.47	1,840.00	1,564.47	1,828.00	1,570.41	1,835.00	1,603.36	1,868.00	1,599.93	1,863.00	1,581.97	1,873.00	1,578.21	1,845.00	1,580.60	1,848.00	1,574.57	1,842.00	1,568.95	1,835.00	1,570.37	1,836.00	1,561.56	1,827.00
Students	0.00	0.00	0.00	0.00	0.00	0.00	8.80	9.00	2.00	2.00	1.00	1.00	19.00	19.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00	0.00
Grand Total	**5,398.65**	**6,502.00**	**5,395.95**	**6,501.00**	**5,428.64**	**6,531.00**	**5,447.40**	**6,554.00**	**5,456.17**	**6,558.00**	**5,461.86**	**6,558.00**	**5,478.83**	**6,638.00**	**5,471.05**	**6,529.00**	**5,461.47**	**6,519.00**	**5,440.75**	**6,501.00**	**5,431.19**	**6,496.00**	**5,427.95**	**6,482.00**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

D2

Title	Maternity CNST incentive scheme		
Report to	Board of Directors (Part 2)	Date	24th July 2019
Author	Lois Mellor – Head of Midwifery		
Purpose			Tick one as appropriate
	Decision		✔
	Assurance		
	Information		

Executive summary containing key messages and issues
This paper updates the Board of Directors on the compliance with the Year 2 Maternity CNST incentive scheme standards. Confirming that the Trust can provide evidence to support the compliance of 10 of the 10 safety actions. The CNST scheme has a financial value of £556K
Key questions posed by the report
• Is the Board adequately assured that the maternity service can submit compliance of 10/10 standards to the NHSLA?
How this report impacts on current risks or highlights new risks
• Submission for 10/10 compliance attracts a saving 10% saving on CNST contribution (rebate) of £556k • Submission of less than 10/10 compliance attract a significantly smaller rebate in the region of £20k • There is a national driver to improve outcomes in maternity, and compliance with the safety actions demonstrates the Trust has systems in place to improve outcomes for mothers and babies. • Litigation claims in maternity are expensive, and the safety actions assist the service to deliver improvements to reduce future claims
Recommendation(s) and next steps
• The Board of Directors is asked to confirm their declaration on 10 of the 10 standards being achieved.

Board report on Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust progress against the Clinical Negligence Scheme for Trusts (CNST) incentive scheme maternity safety actions

1. INTRODUCTION

NHS Resolution, formerly the NHS Litigation Authority, have set out a new approach to target improvement in Maternity services, with an incentive scheme based on a 10% reduction in the Maternity component of the CNST premium for the year. For DBTH this value is £5656k. It is dependent on full compliance with 10 specific safety actions which are externally verified through some existing systems and some declarations and evidence of compliance. The details of the standards and reporting arrangements are set out here: https://resolution.nhs.uk/maternity-incentive-scheme/

The Trust position against the 10 standards for the Maternity CNST incentive scheme are provided in this report, and will be included in the Clinical Governance Committee dashboard for ongoing monitoring purposes. The summary of the current position is shown in section A

Section B is a declaration statement to be provided by the Board through the Chief Executive for sign off.

Appendix 1 contains the evidence available, recognising some external validation is from secure portal database links, so cannot be illustrated in detail.

Final submission is on 15/08/2019.

2. ASSESSMENT

The Trust has achieved 10 out of 10 standards.

This is subject to the 2 Anaesthetists attending training for skill and drills on the 29.7.19 (after this report has been submitted). They have been taken off the rota, and are booked to attend with a plan in place if they do not. Recovery is possible even after this date by bespoke training as submission is not due until 15.8.19 the training team & senior members are aware of the need of these individuals to attend training and have assured me that this will occur before the date of submission.

The presenter of the paper will be able to confirm attendance at training for the Board on the 30th July 2019.

Training position on 24th July 2019

	Percentage Compliance			
MDT Role	**Skills and Drills Current**	**Skills and Drills Predicted if no DNAs**	**Face to Face CTG**	**K2 training**
Consultants and Staff Grades	94.7%	94.7%		94.7%
SPRs + SHOs	91.6%	91.6%		100%
Midwives	94.05%	99.4%	93.5%	95.6%
Anaesthetists	83.8%	93.9%		
Maternity Theatre ODPs	100%	100%		

Please see the attached Draft Report from KPMG after reviewing evidence for assurance

SECTION A: Evidence of Trust's progress against 10 safety actions:

No.		Requirement	Actions	Evidence
Safety Action 1	**CNST**	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death'.	Quarter 3 PMRT report 2018 Quarter 4 PMRT report 2018 Quarter 1 (2019) Draft report PMRT log example Learning from death minutes
	CNST	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death.	
	CNST	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought.	
	CNST	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans	
Safety Action 2	**CNST**	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 22	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)	Exel sheet recording compliance with NHS digital MSDS submission

	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 23	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales	State of readiness questionnaire
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 24	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019	MSDS Version 2 submission (successful upload)
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 25	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019	MSDS submission to Jan 2019 (compliance) See email confirming compliance
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 26	January 2019 data contained valid smoking at booking for at least 80% of bookings	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 27	January 2019 data contained valid smoking at delivery for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 28	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 29	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)	

	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 30	January 2019 data contained method of delivery for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 31	January 2019 data contained valid baby's first feed for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 32	January 2019 data contained valid in days gestational age for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 33	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 34	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 35	January 2019 data contained valid place type actual delivery for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 36	January 2019 data contained valid site code for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 37	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births	

	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 38	January 2019 data contained valid Apgar score at five minutes for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 39	January 2019 data contained valid fetus outcome code for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 40	January 2019 data contained valid birth weight for at least 80% of births	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 41	January 2019 data contained valid figure for previous live births for at least 80% of bookings	
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 42	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance	Email from NHS Digital stating we have met criteria 2
	CNST	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 43	January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.	MSDS submission to Jan 2019 (compliance) See email above
Safety Action 3	**CNST**	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Have pathways of care for admission into and out of transitional care been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care.	Transitional care

	CNST	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Is a data recording process for transitional care established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2.	Excel sheet for Jan – April 2019 Scanned lists from May to June 2019
	CNST	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Has an action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews.	LMS Board Minute for 2.7.19 (none yet written) DRI Annual ATAIN report & action plan
	CNST	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Has progress with the agreed action plans has been shared with your Board and your LMS & ODN	BDGH Annual report & Action plan ATAIN action plan and GAP analysis LMS safety Forum agenda ATAIN Highlight report
Safety Action 4	**CNST**	Can you demonstrate an effective system of medical workforce planning to the required standard?	Do you have a formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: 'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.' In addition, a plan produced by the trust to address lost educational opportunities due to rota	Obs and Gynae GMC report GMC 2018 survey Trainee Forum Minutes 30.8.18

			gaps?	GMC for Workforce & Education committee QEC exert then when to Board
	CNST	Can you demonstrate an effective system of medical workforce planning to the required standard?	Is an action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6. (see below)?	
	CNST	Can you demonstrate an effective system of medical workforce planning to the required standard?	Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff	
	CNST	Can you demonstrate an effective system of medical workforce planning to the required standard?	A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident	
	CNST	Can you demonstrate an effective system of medical workforce planning to the required standard?	The duty anaesthetist for obstetrics should participate in labour ward rounds	Handover Audit Handover powerpoint presentation
Safety Action 5	**CNST**	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A systematic, evidence-based process to calculate midwifery staffing establishment has been done	Workforce paper Feb 2019 Workforce paper June 2019
	CNST	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service	Additional NLS midwives at DBGH to assist this Birthrate + acuity sheets for DRI Feb to April 2019 (shows adequate staffing for the ward)

				Birthrate + acuity sheet for BDGH Feb to April 2019 (shows adequate staffing) Maternity Service Escalation Policy Red flag trigger lists for DATIX reporting Position statement
	CNST	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Women receive one-to-one care in labour (this is the minimum standard that Birth-rate+ is based on)	Birth stats for Feb to march 2019 Position statement
	CNST	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A bi-annual report that covers staffing/safety issues is submitted to the Board	Workforce paper Feb 2019 Workforce paper June 2019 QEC workforce paper C & F Board Minutes (March & July)

Safety Action 6	**CNST**	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Has Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) been undertaken in a way that supports the delivery of safer maternity services.	C & F Board minutes
	CNST	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Has each element of the SBL care bundle been implemented or is an alternative intervention in place to deliver against element(s).	C & F Board Minutes
Safety Action 7	**CNST**	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Has user involvement has an impact on the development and/or improvement of maternity services.	PEEC report Feb 2019 MVP involvement in AN event Bassetlaw MVP PEEC report June 2019 ANC QI event Buzz update Tweet from MVP chair
Safety Action 8	**CNST**	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Does training include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops?	YMET agenda Skill & drills presentations
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Are training syllabus' based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas?.	Scenarios run Selection of registers for MDT training
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants	Training stats

	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: • Obstetric consultants	Training stats
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota	Training stats
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: Obstetric anaesthetic consultants	Training stats
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota.	Training stats
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives)	Training stats
	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit)	Training stats

	CNST	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum)	Training stats
Safety Action 9	**CNST**	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Is the Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) actively engaging with supporting quality and safety improvement activity within: I. the trust	C & F Board minutes with Exec Sponsor leads Trust clinical governance minutes SMT meeting minutes CRQC minutes Board minutes
	CNST	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Is the Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) actively engaging with supporting quality and safety improvement activity within: ii. the Local Learning System (LLS)	LLS system attendance Mate neo work
	CNST	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Have the Board level safety champions implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues?	Poster for staff feedback sessions New email to address safety concerns
	CNST	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Have the Board level safety champions taken steps to address named safety concerns and that progress with actioning these are visible to staff	C & F Board minutes demonstrating issues discussed

				HOM Newsletter March , April/May and June 2019 AN QI event Visioning document
Safety Action 10	**CNST**	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Are you reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria	5 letters confirming our submission to NHSR Email confirming 4 cases to report

Author – Lois Mellor (Head of Midwifery)

Version 2

24th July 2019 2019

Section B

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

NHS Resolution

Maternity incentive scheme – year two

Conditions of the scheme

Ten maternity safety actions with technical guidance

Questions and answers related to the scheme

Contents

Introduction

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved **all** of the **ten** safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that **do not meet** the ten-out-of-ten threshold will **not** recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

This document provides guidance on the safety actions for year two of the maternity incentive scheme.

Maternity incentive scheme year two: conditions

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form (see Appendix 1) to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019 and must comply with the following conditions:

- Trusts must achieve all ten maternity safety actions
- The Board declaration form must be signed and dated by the trust chief executive to confirm that:
    - The Board are satisfied that the evidence provided to demonstrate achievement of the ten maternity safety actions meets the required standards as set out in the safety actions and technical guidance document.
    - The content of the Board declaration form has been discussed with the commissioner(s) of the trust's maternity services.
- The Board must give their permission to the chief executive to sign the Board declaration form prior to submission to NHS Resolution.

Evidence for submission

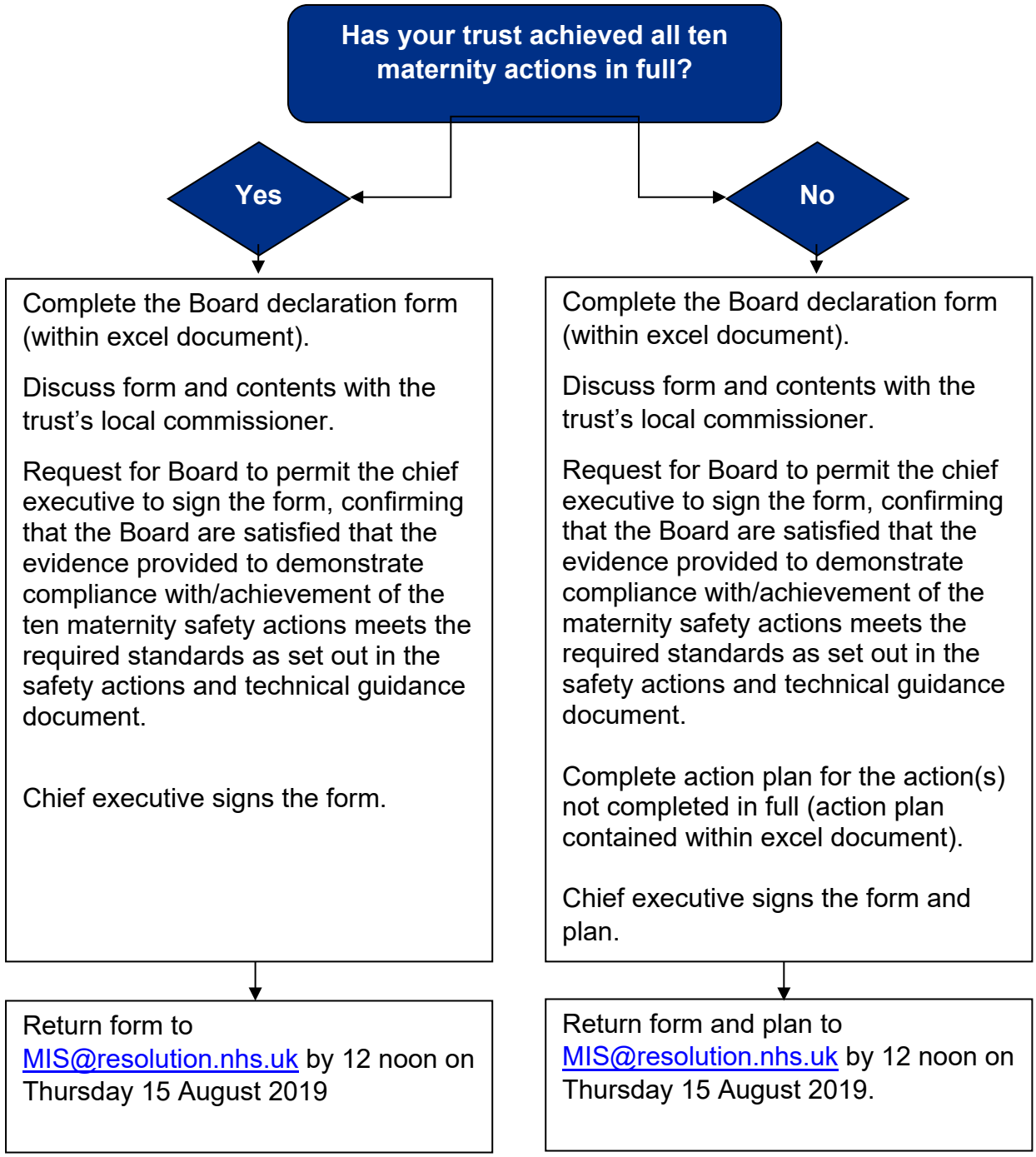
- The Board declaration form must not include any narrative, commentary, or supporting documents. Evidence should be provided to the trust Board only, and will not be reviewed by NHS Resolution.
- Trust submissions will be subject to a range of external verification points, these include cross checking with: MBRRACE-UK data (Safety action 1), NHS Digital regarding submission to the Maternity Services Data Set (Safety action 2), and against the National Neonatal Research Database (NNRD) for number of qualifying incidents reportable to the Early Notification scheme (Safety action 10)
- Trust submissions will also be sense checked with the Care Quality Commission (CQC).

Timescales and appeals

- Any queries relating to the ten safety actions must be sent in writing by e-mail to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date.
- The Board declaration form must be sent to NHS Resolution (MIS@resolution.nhs.uk) by 12 noon on Thursday 15 August 2019. An electronic acknowledgement of trust submissions will be provided within 48 hours.
- Submissions and any comments/corrections received after 12 noon on Thursday 15 August 2019 will not be considered
- Trusts will be notified of results by the end of September 2019.
- Appeals must be submitted in writing by the trust chief executive and sent to NHS Resolution (MIS@resolution.nhs.uk) by Monday 14 October 2019. Further detail on the appeals process will be communicated at a later date. The payments to be made under the maternity incentive scheme will be communicated to trusts by the end of November 2019.

For trusts who have not met all ten maternity actions

Trusts that have not achieved all ten actions may be eligible for a small amount of funding to support progress. In order to apply for funding, such trusts must submit an action plan together with the Board declaration form by 12 noon on Thursday 15 August 2019 to NHS Resolution (MIS@resolution.nhs.uk). The action plan must be specific to the action(s) not achieved by the trust and must take the format of the template (see Appendix 1). Action plans should not be submitted for achieved safety actions.



Send any queries relating to the ten actions to NHS Resolution (MIS@resolution.nhs.uk) prior to the submission date

Safety action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

Required standard	a) A review of 95% of all deaths of babies suitable for review using the Perinatal Mortality Review Tool (PMRT) occurring from Wednesday 12 December 2018 have been started within four months of each death. b) At least 50% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018 will have been reviewed, by a multidisciplinary review team, with each review completed to the point that a draft report has been generated, within four months of each death. c) In 95% of all deaths of babies who were born and died in your trust (including any home births where the baby died) from Wednesday 12 December 2018, the parents were told that a review of their baby's death will take place and that their perspective and any concerns about their care and that of their baby have been sought. d) Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans.
Minimum evidential requirement for trust Board	A report has been received by the trust Board each quarter from Wednesday 12 December 2018 until Thursday 15 August 2019 that includes details of the deaths reviewed and the consequent actions plans. The report should evidence that the required standards a) to c) above have been met.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will use MBRRACE-UK data to cross-reference against trust self-certification the number of eligible deaths from Wednesday 12 December until Thursday 15 August 2019.
What is the relevant time period?	**From Wednesday 12 December until Thursday 15 August 2019**
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 1
Are you using the PMRT to review perinatal deaths?

Technical guidance	
What should we do if we do not have any deaths to review within the time period?	If you do not have any babies that have died from Wednesday 12 December to Thursday 15 August 2019 then you should partner up with a trust to which you have a referral relationship to participate in case reviews. NHS Resolution will verify with MBRRACE-UK data the number of deaths occurring in your partner trust in the relevant period.
How does the involvement of the Healthcare Services Investigation Branch (HSIB) in investigations affect meeting this action?	It is recognised that for a small number of cases (intrapartum stillbirths and early neonatal deaths) investigations will be carried out by HSIB that will contribute to the report generated by the PMRT for a baby. Achieving section b) of the standard may therefore be impacted on by timeframes beyond the trust's control. This should be noted in the quarterly report and if this is the case, those babies not included in calculating the 50%.
What does multidisciplinary review mean?	Helpful guidance can be found at the following website: www.npeu.ox.ac.uk/mbrrace-uk
We have contacted parents, but they do not want to be involved - what should we do?	Please document accordingly within the review in the PMRT.
Parents have not responded to our messages, and therefore we are unable to discuss the review - what should we do?	Parents should guide the process and advise how involved they would like to be. The trust should record the attempts made to make contact with the parents within the review in the PMRT.
Is the quarterly review of the Board report based on a financial or calendar year?	This can be either financial or calendar year.

Safety action 2: Are you submitting data to the Maternity Services Data Set to the required standard?

Required standard	This relates to the quality, completeness of the submission to the Maternity Services Data Set (MSDS) and readiness for implementing the next version of the dataset (MSDSv2).
Minimum evidential requirement for trust Board	NHS Digital will issue a monthly scorecard to data submitters (trusts) that can be presented to the Board. The scorecard will be used by NHS Digital to assess whether each MSDS data quality criteria has been met and whether the overall score is enough to pass the assessment. It is necessary to pass all three mandatory criteria and 14 of the 19 other criteria (please see table below for details).
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form. NHS Resolution will cross-reference self-certification against NHS Digital data.
What is the relevant time period?	The assessment will include data from the MSDS from January 2019. This data needs to be submitted to MSDS for the deadline of 31 March 2019. One MSDS criterion relates to data for six months, from October 2018 to March 2019, which needs to be submitted to MSDS for deadlines between 31 December 2018 and 31 May 2019. One criterion relates to the submission of data for the first month of MSDSv2. This data relates to April 2019 and needs to be submitted to the deadline of 30 June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 2
Are you submitting data to the Maternity Services Data Set to the required standard?

Technical guidance	
What do we do if we are unable to submit data to MSDS for a particular category	If a trust feels that there are exceptional circumstances, they should raise this with NHS Digital at an early stage. This might include evidence of a fall in birth rate, or of services covered in the assessment not being available at the trust.

Assessment to cover January 2019 data submitted for the deadlines of March 2019, one criteria relates to data between October 2018 and March 2019, submitted to deadlines December 2018 - May 2019, and one around MSDSv2 data for April 2019 being submitted to the deadline of June 2019	
	Mandatory categories 1-3 must be met to pass Safety action 2
1	January 2019 data contained at least 90% of HES births expectation, based on number of days in month (unless reason understood)
2	MSDSv2 readiness questionnaire completed and returned to NHS Digital within required timescales
3	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019
	14 of the 19 optional categories 4-22 must be met to pass Safety action 2
4	Made a submission in each of the six months October 2018 - March 2019 data, submitted to deadlines December 2018 - May 2019
5	January 2019 data contained valid smoking at booking for at least 80% of bookings
6	January 2019 data contained valid smoking at delivery for at least 80% of births
7	January 2019 data contained all of the tables 501, 502, 404, 409, 401, 406, 408, 602 (unless justifiably blank)
8	January 2019 data contained all of the tables 101, 102, 103, 104, 112, 201, 205, 305, 307, 309, 511 (unless justifiably blank)
9	January 2019 data contained method of delivery for at least 80% of births
10	January 2019 data contained valid baby's first feed for at least 80% of births
11	January 2019 data contained valid in days gestational age for at least 80% of births
12	January 2019 data contained valid presentation at onset for at least 80% of births where onset of labour recorded
13	January 2019 data contained valid labour induction method (including code for no induction) for at least 80% of births where onset of labour recorded
14	January 2019 data contained valid place type actual delivery for at least 80% of births
15	January 2019 data contained valid site code for at least 80% of births
16	January 2019 data contained valid genital tract trauma code for at least 80% of vaginal births
17	January 2019 data contained valid Apgar score at five minutes for at least 80% of births
18	January 2019 data contained valid fetus outcome code for at least 80% of births
19	January 2019 data contained valid birth weight for at least 80% of births
20	January 2019 data contained valid figure for previous live births for at least 80% of bookings
21	MSDSv2 event or webinar attended in late 2018 / early 2019, or had 1:1 call with one of the NHS Digital team in lieu of attendance
22	January 2019 data contained valid (including "Not Stated") ethnic category (Mother) for at least 80% of bookings.

Safety action 3: Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?

Required standard	a) Pathways of care for admission into and out of transitional care have been jointly approved by maternity and neonatal teams with neonatal involvement in decision making and planning care for all babies in transitional care. b) A data recording process for transitional care is established, in order to produce commissioner returns for Healthcare Resource Groups (HRG) 4/XA04 activity as per Neonatal Critical Care Minimum Data Set (NCCMDS) version 2. c) An action plan has been agreed at Board level and with your Local Maternity Systems (LMS) and Operational Delivery Network (ODN) to address local findings from Avoiding Term Admissions Into Neonatal units (ATAIN) reviews. d) Progress with the agreed action plans has been shared with your Board and your LMS & ODN
Minimum evidential requirement for trust Board	Local policy available which is based on principles of British Association of Perinatal Medicine (BAPM) transitional care where: 1. There is evidence of neonatal involvement in care planning 2. Admission criteria meets a minimum of HRG XA04 but could extend beyond to BAPM transitional care framework for practice 3. There is an explicit staffing model 4. The policy is signed by maternity/neonatal clinical leads Data is available (electronic or paper based) on transitional care activity which has been recorded as per XA04 2016 NCCMDS. An audit trail providing evidence and a rationale for developing the agreed action plan to address local findings from ATAIN reviews. Evidence of an action plan to address identified and modifiable factors for admission to transitional care. Action plan has been signed off by trust Board, ODN and LMS and progress with action plan is documented within minutes of meetings at Board ODN/LMS.

Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) By Sunday 3 February 2019 b) By Sunday 3 February 2019 c) By Sunday10 March 2019 d) By Sunday 19 May 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 3
Can you demonstrate that you have transitional care facilities in place and are operational to support the implementation of the ATAIN Programme?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: www.bapm.org/sites/default/files/files/TC%20Framework-20.10.17.pdf www.bapm.org/sites/default/files/files/NCCMDS.%20Neonatal%20HRGs%20and%20Reference%20Costs%20-%20A%20Guide%20for%20Clinicians%20Dec%202016.pdf
What is the suggested time period for transitional care pathways?	We would expect that all trusts should at least have pathways agreed by 31 January 2019.
What is the definition of transitional care?	Transitional care is not a place but a service and can be delivered either in a separate transitional care area, within the neonatal unit and/or in the postnatal ward setting. Principles include the need for a multidisciplinary approach between maternity and neonatal teams; an appropriately skilled and trained workforce, data collection with regards to activity, appropriate admissions as per HRGXA04 criteria and a link to community services.

Safety action 4: Can you demonstrate an effective system of medical workforce planning to the required standard?

Required standard	a) Formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey question: *'In my current post, educational/training opportunities are rarely lost due to gaps in the rota.'* In addition, a plan produced by the trust to address lost educational opportunities due to rota gaps. b) An action plan is in place and agreed at Board level to meet Anaesthesia Clinical Services Accreditation (ACSA) standards 1.2.4.6, 2.6.5.1 and 2.6.5.6.
Minimum evidential requirement for trust Board	a) Proportion of trainees formally recorded in Board minutes and the action plan to address lost educational opportunities should be signed off by the trust Board and a copy submitted to the Royal College of Obstetricians and Gynaecologists (RCOG) at workforce@rcog.org.uk b) Board minutes formally recording the proportion of ACSA standards 1.2.4.6, 2.6.5.1 and 2.6.5.6 that are met. Where trusts did not meet these standards, they must produce an action plan (ratified by the Board) stating how they are working to meet the standards.
Validation process	Self-certification by the trust Board and submitted to NHS Resolution using the Board declaration form
What is the relevant time period?	a) 2018 GMC National Training Survey (covers the period 20 March to 9 May 2018) b) Six month period between January 2019 and June 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 4
Can you demonstrate an effective system of medical workforce planning?

Technical guidance	
What if training opportunities are not being lost due to rota gaps and action plan not deemed necessary?	If training opportunities are not being lost due to rota gaps, then a copy of the trust Board minutes acknowledging and recording this, including the relevant 2018 GMC National Training Survey results, should be submitted to RCOG instead.
Anaesthesia Clinical Services Accreditation (ACSA) standards and action	
1.2.4.6	**Where there are elective caesarean section lists there are dedicated obstetric, anaesthesia, theatre and midwifery staff**
2.6.5.1	**A duty anaesthetist is available for the obstetric unit 24 hours a day, where there is a 24 hour epidural service the anaesthetist is resident**
2.6.5.2	**A separate anaesthetist is allocated for elective obstetric work**
2.6.5.3	**Where the duty anaesthetist has other responsibilities, an anaesthetist must be immediately available (within five minutes) to deal with obstetric emergencies**
2.6.5.4	**Medically-led obstetric units have, as a minimum, consultant anaesthetist cover the full daytime working week (equating to Monday to Friday, morning and afternoon sessions being staffed)**
2.6.5.5	**There is a named consultant anaesthetist or intensivist responsible for all level two maternal critical care patients (where this level of care is provided on the maternity unit)**
2.6.5.6	**The duty anaesthetist for obstetrics should participate in labour ward rounds**
How is an elective caesarean section list defined?	A scheduled list, resourced separately from the general workload of the delivery unit. A separately run list requires a full theatre team and should include a consultant obstetrician and a consultant anaesthetist. The list should be managed in the same way and to the same standards as other elective surgery lists. This may not be cost effective in units with a low elective workload (e.g. one or fewer elective caesareans per weekday or approximately 250 planned operations per year) but for all other units, separate resources should be allocated.

What is level two care or a level two maternal critical care patient?	Since 2007, the obstetric population has been included in the Intensive Care Society (ICS) definitions of levels of care in the adult population. Levels of care as defined by the ICS: **Level 0** Patients whose needs can be met by normal ward care **Level 1** Patients at risk of deterioration, needing a higher level of observation or those recently relocated from higher levels of care **Level 2** Patients requiring invasive monitoring/intervention that includes support for a single failing organ (excluding advanced respiratory support i.e. mechanical ventilation) **Level 3** Patients requiring advanced respiratory support alone or basic respiratory support in addition to support of one or more additional organs
Please access the following for further information on the ACSA standards	https://www.rcoa.ac.uk/system/files/ACSA-STDS2018.pdf

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Required standard	a) A systematic, evidence-based process to calculate midwifery staffing establishment has been done. b) The obstetric unit midwifery labour ward coordinator has supernumerary status (defined as having no caseload of their own during that shift) to enable oversight of all birth activity in the service c) Women receive one-to-one care in labour (this is the minimum standard that Birthrate+ is based on) d) A bi-annual report that covers staffing/safety issues is submitted to the Board
Minimum evidential requirement for trust Board	A bi-annual report that includes evidence to support a-c being met. This should include: •A clear breakdown of BirthRate+ or equivalent calculations to demonstrate how the required establishment has been calculated. •Details of planned versus actual midwifery staffing levels. •An action plan to address the findings from the full audit or table-top exercise of BirthRate+ or equivalent undertaken. Where deficits in staffing levels have been identified, maternity services should detail progress against the action plan to demonstrate an increase in staffing levels and any mitigation to cover any shortfalls. •The midwife: birth ratio. •The percentage of specialist midwives employed and mitigation to cover any inconsistencies. BirthRate+ accounts for 9% of the establishment which are not included in clinical numbers. This includes those in management positions and specialist midwives. •Evidence from an acuity tool (which may be locally developed) and/or local dashboard figures demonstrating 100% compliance with supernumerary labour ward status and the provision of one-to-one care in active labour and mitigation to cover any shortfalls

	•Number of red flag incidents (associated with midwifery staffing) reported in a consecutive six month time period within the last 12 months, how they are collected, where/how they are reported/monitored and any actions arising (Please note: it is for the trust to define what red flags they monitor. Examples of red flag incidents are provided in the technical guidance).
Validation process	Self-certification to NHS Resolution using the Board declaration form
What is the relevant time period?	Any consecutive three month period between January to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon.

Technical guidance for Safety action 5
Can you demonstrate an effective system of midwifery workforce planning?

Technical guidance	
What midwifery red flag events could be included (examples only)?	• Delayed or cancelled time critical activity. • Missed or delayed care (for example, delay of 60 minutes or more in washing and suturing). • Missed medication during an admission to hospital or midwifery-led unit (for example, diabetes medication). • Delay of more than 30 minutes in providing pain relief. • Delay of 30 minutes or more between presentation and triage. • Full clinical examination not carried out when presenting in labour. • Delay of two hours or more between admission for induction and beginning of process. • Delayed recognition of and action on abnormal vital signs (for example, sepsis or urine output). • Any occasion when one midwife is not able to provide continuous one-to-one care and support to a woman during established labour. Other midwifery red flags may be agreed locally. Please see the following NICE guidance for details: www.nice.org.uk/guidance/ng4/resources/safe-midwifery-staffing-for-maternity-settings-pdf-51040125637

Safety action 6: Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?

Required standard	Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) in a way that supports the delivery of safer maternity services. Each element of the SBL care bundle implemented or an alternative intervention in place to deliver against element(s).
Minimum evidential requirement for trust Board	Board minutes demonstrating that the SBL bundle has been considered in a way that supports delivery and implementation of each element of the SBL care bundle or that an alternative intervention put in place to deliver against element(s).
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts at end July 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 6
Can you demonstrate compliance with all four elements of the SBL care bundle?

Technical guidance	
Where can we find guidance regarding this safety action?	SBL care bundle and guidance: www.england.nhs.uk/wp-content/uploads/2016/03/saving-babies-lives-car-bundl.pdf
Further guidance regarding element 2 of the SBL care bundle	In reference to element 2 of the Saving Babies' Lives care bundle, compliance with the intervention for surveillance of low-risk women does not mandate participation in the Perinatal Institute's Growth Assessment Protocol (GAP) or the use of customised fundal charts. Providers should however ensure that for low risk women, fetal growth is assessed using antenatal symphysis fundal height charts by clinicians trained in their use. All staff must be competent in measuring fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated.

Safety action 7: Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?

Required standard	User involvement has an impact on the development and/or improvement of maternity services.
Minimum evidential requirement for trust Board	Evidence should include: Acting on feedback from, for example a Maternity Voices Partnership. User involvement in investigations, local and or Care Quality Commission (CQC) survey results. Minutes of regular Maternity Voices Partnership and/or other meetings demonstrating explicitly how a range of feedback is obtained, the action taken and the communications to report this back to women.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	From January 2019 to July 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Safety action 8: Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Required standard	90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year.
Minimum evidential requirement for trust Board	Evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year through Board sight of a staff training database or similar.
Validation process	Self-certification to NHS Resolution using the Board declaration form.
What is the relevant time period?	The scheme will take into account the position of trusts by Thursday 15 August 2019.
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 8
Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?

Technical guidance	
What training should be included?	Training should include fetal monitoring in labour and integrated team-working with relevant simulated emergencies and/or hands-on workshops.
What training syllabus should be used?	Training syllabus should be based on current evidence, national guidelines/recommendations, any relevant local audit findings, risk issues and case review feedback, and include the use of local charts, emergency boxes, algorithms and pro-formas.
Should there be feedback?	There should be feedback on local maternal and neonatal outcomes.
Which maternity staff attendees should be included?	Maternity staff attendees should be 90% of <u>each</u> of the following groups: • Obstetric consultants • All other obstetric doctors (including staff grade doctors, obstetric trainees (ST1-7), sub speciality trainees, obstetric clinical fellows and foundation year doctors contributing to the obstetric rota • Obstetric anaesthetic consultants • All other obstetric anaesthetic doctors (staff grades and anaesthetic trainees) contributing to the obstetric rota. • Midwives (including midwifery managers and matrons, community midwives; birth centre midwives (working in co-located and standalone birth centres and bank/agency midwives) • Maternity theatre and maternity critical care staff (Including operating department practitioners, anaesthetic nurse practitioners, recovery and high dependency unit nurses providing care on the maternity unit) • Maternity support workers and health care assistants (to be included in the maternity skill drills as a minimum) There will be other relevant clinical members of the maternity team that for best practice should be included in maternity emergency training for example neonatal clinical staff however evidence of their attendance is not required to meet the safety action.

What if staff have been booked to attend training after 15 August 2019	Only staff who have attended the training will be counted toward overall percentage. If staff are only booked onto training and/or have not attended training, then they cannot be counted towards the overall percentage.
Will we meet the action if one of our staff group is below the 90% threshold?	No, you will need to evidence to your Board that you have met the threshold of 90% for each of the staff groups before Thursday 15 August 2019.

Safety action 9: Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?

Required standard	a) The Executive Sponsor for the Maternal and Neonatal Health Safety Collaborative (MNHSC) is actively engaging with supporting quality and safety improvement activity within: i. the trust ii. the Local Learning System (LLS) b) The Board level safety champions have implemented a monthly feedback session for maternity and neonatal staff to raise concerns relating to relevant safety issues c) The Board level safety champions have taken steps to address named safety concerns and that progress with actioning these are visible to staff
Minimum evidential requirement for trust Board	• Evidence of executive sponsor engagement in quality improvement activities led by the trust nominated Improvement Leads for the MNHSC as well as other quality improvement activity for trusts in waves one and three • Evidence that the trust Board have been sighted on the local improvement plan, updated on progress, impact and outcomes with the quality improvement activities being undertaken locally • Evidence of attendance at one or more National Learning Set or the annual national learning event • Evidence of engagement with relevant networks and the collaborative LLS • Evidence of a safety dashboard or equivalent, visible to staff which reflects action and progress made on identified concerns raised by staff • Evidence that safety concerns raised by staff feedback sessions are reflected in the minutes of Board meetings and include updates on progress, impact and outcomes relating to the steps and actions taken to address these concerns
Validation process	Self-certification to NHS Resolution using the Board declaration form

What is the relevant time period?	a) All Board level safety champions and exec sponsor for MNHSC must have set up the required mechanisms for supporting quality and safety improvement activity in both the trust and LLS by Sunday 27 January 2019 b) Must be implemented by Wednesday 27 February 2019 c) Must be implemented by Wednesday 27 March 2019 with ongoing feedback to staff on a monthly basis
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 9
Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?

Technical guidance	
Where can we find guidance regarding this safety action?	Helpful guidance can be found at the following websites: • https://improvement.nhs.uk/documents/2440/Maternity_safety_champions_13feb.pdf • https://improvement.nhs.uk/resources/maternal-and-neonatal-safety-collaborative/ • https://improvement.nhs.uk/documents/2956/MatNeo_Collaborative_Driver_Diagram_June_2018.pdf • https://improvement.nhs.uk/resources/patient-safety-collaboratives/

Safety action 10: Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Required standard	Reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria.
Minimum evidential requirement for trust Board	Trust Board sight of trust legal services and maternity clinical governance records of qualifying Early Notification incidents and numbers reported to NHS Resolution Early Notification team.
Validation process	Self-certification to NHS Resolution using the Board declaration form NHS Resolution will cross reference Trust reporting against the National Neonatal Research Database (NNRD) number of qualifying incidents recorded for the Trust.
What is the relevant time period?	1 April 2018 to 31 March 2019
What is the deadline for reporting to NHS Resolution?	Thursday 15 August 2019 at 12 noon

Technical guidance for Safety action 10
Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?

Technical guidance	
Where can I find information on the Early Notification scheme?	Early Notification scheme guidance has been circulated to NHS Resolution maternity contacts. Please contact ENTeam@resolution.nhs.uk to request further copies.
What are qualifying incidents?	Qualifying incidents are term deliveries (≥37+0 completed weeks of gestation), following labour, that resulted in severe brain injury diagnosed in the first seven days of life. These are any babies that fall into the following categories: • Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE) **[OR]** • Was therapeutically cooled (active cooling only) **[OR]** • Had decreased central tone **AND** was comatose **AND** had seizures of any kind.

	The above definition is based on the criteria set by the Each Baby Counts (EBC) programme of the RCOG. As a guide, if any incident of severe brain injury occurs which meets the above criteria and is accepted by EBC, then NHS Resolution will treat it as a qualifying incident. Incidents of intrapartum stillbirth or neonatal death as defined by EBC do not need to be notified.
General Data Protection Regulations points	We strongly recommend that all families be told of NHS Resolution involvement at the outset. NHS staff are bound by the statutory Duty of Candour. This includes an obligation to advise the 'relevant person' (i.e. the patient/their family) what further enquiries into the incident the trust believes are appropriate, one of which will be the Early Notification process. The NHS Constitution states that patients have the right to an open and transparent relationship with the organisation providing their care. This is central to maintaining the relationship of trust between the trust and family and in promoting an open and safe learning culture. NHS Resolution's Early Notification scheme involvement should be communicated soon after the incident, to coincide with notification that an internal investigation will take place. For more information please see *Saying Sorry* leaflet https://resolution.nhs.uk/wp-content/uploads/2017/04/NHS-Resolution-Saying-Sorry-2017.pdf NHS Resolution are able to seek disclosure of medical records without the consent of the patient/family. However it is important that individuals know that their personal data is being shared with NHS Resolution, even if you are not asking for their consent. It may also, in some circumstances, be helpful to have an indication of their authority/agreement to their information being used. However, this should not be conflated with 'consent' as the legitimising condition under GDPR. Footnote: under the General Data Protection Regulation, processing is necessary for (1) the management of healthcare systems and services (under Article 9(2)(h) GDPR/Schedule 1 paragraph 2 of the Data Protection Act 2018); (2) the establishment, exercise or defence of legal rights (under Article 9(2)(f) GDPR); and/or (3) undertaken in the substantial public interest (that is, the discharge of functions conferred on NHS Resolution further to s. 71 of the NHS Act 2006 – further to Article 9(2)(h) GDPR).

What if we are unsure whether a case qualifies for the Early Notification scheme?	If the case meets the above criteria and has been accepted by Each Baby Counts, it will be treated as a Qualifying Incident. Should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We are unsure about how to grade an incident, what should we do	The risk assessment wording has recently been amended to bring it in line with assessments used regularly by front-line staff. It is hoped that this makes the process of grading risk more straightforward. However, should you have any queries, please contact a member of the Early Notification team to discuss further. (ENTeam@resolution.nhs.uk)
We have reported all qualifying incidents, but have not reported within the required 30 day timescale. Will we be penalised for this?	Trusts are strongly encouraged to report all incidents within the 30 day timescale set out in the reporting guidelines however there will be no penalty for reporting incidents from 2018/19 outside of the 30 day timescale. Trusts will meet the required standard if they can evidence to the trust Board that they have reported all qualifying 2018/19 incidents to NHS Resolution and this is corroborated with data held by NNRD.

FAQs for year two of the CNST maternity incentive scheme

Does 'Board' refer to the trust Board or would the Maternity Services Clinical Board suffice?	We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. It is recommended that all executive members e.g. finance directors are included in these discussions If subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of governance which we may escalate to the appropriate arm's length body/NHS system leader.
Where can I find the trust reporting template which needs to be signed off by the Board?	Please follow the link to the Board declaration form **(see link below).**
What documents do we need to send to you?	Send the Board declaration form to NHS Resolution. Ensure the Board declaration form has been approved by the trust Board, signed by the chief executive and, where relevant, an **action** plan is completed **(see link below)** for each action the trust has not met. **Please do not send your evidence or any narrative related to your submission to us.** Any other documents you are collating should be used to inform your discussions with the trust Board.
Do we need to discuss this with our commissioners?	Yes, your submission should be discussed with commissioners prior to submission to NHS Resolution.
Will you accept late submissions?	We will not accept late submissions. The Board declaration form and any action plan will need to be submitted to us no later than **12 noon on Thursday 15 August 2019**. If a completed Board declaration form is not returned to NHS Resolution by **12 noon on Thursday 15 August 2019**, NHS Resolution will treat that as a nil response.

Will NHS Resolution be cross checking our results with external data sources?	Yes, we will cross reference results with external data sets from MBRRACE-UK, NHS Digital and the NNRD for the following actions: Safety action 1, Safety action 2 and Safety action 10 respectively. Your overall submission may also be sense checked with CQC maternity data.
What happens if we do not meet the ten actions?	Only trusts that meet **all ten** maternity safety actions will be eligible for a payment of at least 10% of their contribution to the incentive fund. Trusts that do not meet this threshold need to submit a completed action plan for each safety action they have not met. Trusts that do not meet **all ten** safety actions may be eligible for a small discretionary payment to help them to make progress against one or more of the ten safety actions.
Our trust has queries, who should we contact?	Any queries prior to the submission date must be sent in writing by e-mail to NHS Resolution via MIS@resolution.nhs.uk
Please can you confirm who outcome letters will be sent to?	CNST maternity incentive scheme outcome letters will be sent to chief executive officers, finance directors and your nominated leads.
What if my trust has multiple sites providing maternity services	Multi-site providers will need to demonstrate the evidential requirements for each individual site. The Board declaration should reflect overall actions met for the whole trust
Will there be a process for appeals this year?	Yes, there will be an appeals process and trusts will be allowed 14 days to appeal the decision following the communication of results.

Q&A regarding Maternity Safety Strategy and CNST maternity incentive scheme

Q1) What are the aims of the CNST incentive scheme and why maternity?

The Maternity Safety Strategy sets out the Department of Health and Social Care's ambition to reward those who have taken action to improve maternity safety.

Using CNST to incentivise safer care received strong support from respondents to our *2016 CNST consultation* where 93% of respondents wanted incentives under CNST to fund safety initiatives. This is also directly aligned to the Intervention objective in our *Five year strategy: Delivering fair resolution and learning from harm.*

Maternity safety is an important issue for all CNST members as obstetric claims represent the scheme's biggest area of spend (c£500m in 2016/17). Of the clinical negligence claims notified to us in 2017/18, obstetric claims represented 10% of the volume and 48% of the value of new claims reported. These figures do not take into account the recent change to the Personal Injury Discount Rate.

Q2) Why have these Safety actions been chosen?

The ten actions have been agreed with the national maternity safety champions, Matthew Jolly and Jacqueline Dunkley-Bent, in partnership with NHS Digital, NHS England, NHS Improvement, the Care Quality Commission (CQC), Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries (MBRRACE), Obstetric Anaesthetists Association, Royal College of Anaesthetists, Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives. The Collaborative Advisory Group (CAG) previously established by NHS Resolution to bring together other arm's length bodies and the Royal Colleges to support the delivery of the CNST maternity incentive scheme has also advised NHS Resolution on the safety actions.

Q3) Who has been involved in designing the scheme?

The National Maternity Safety Champions were advised by a group of system experts including representatives from:

- NHS England
- NHS Improvement
- NHS Digital
- MBRRACE-UK
- Royal College of Obstetricians and Gynaecologists
- Royal College of Midwives
- Royal College of Anaesthetists
- Care Quality Commission

- Department of Health and Social Care
- NHS Resolution
- Clinical obstetric, midwifery and neonatal staff

Q4) Who does the scheme apply to?

The scheme will only apply to acute trusts in 2018/19. However, given the schemes aim to incentivise the improvement of maternity services in all settings, we will consider extending it in future years.

Q5) How will trusts be assessed against the safety actions and by when?

Trusts will be expected to provide a report to their Board demonstrating achievement (with evidence) of each of the ten actions. The Board must consider the evidence and complete the Board declaration form for result submission.

Completed Board declaration forms must be discussed with the commissioner(s) of the trust's maternity services, signed off by the Board and then submitted to NHS Resolution (with action plans for any actions not met) at MIS@resolution.nhs.uk **by 12 noon on Thursday 15 August 2019.**

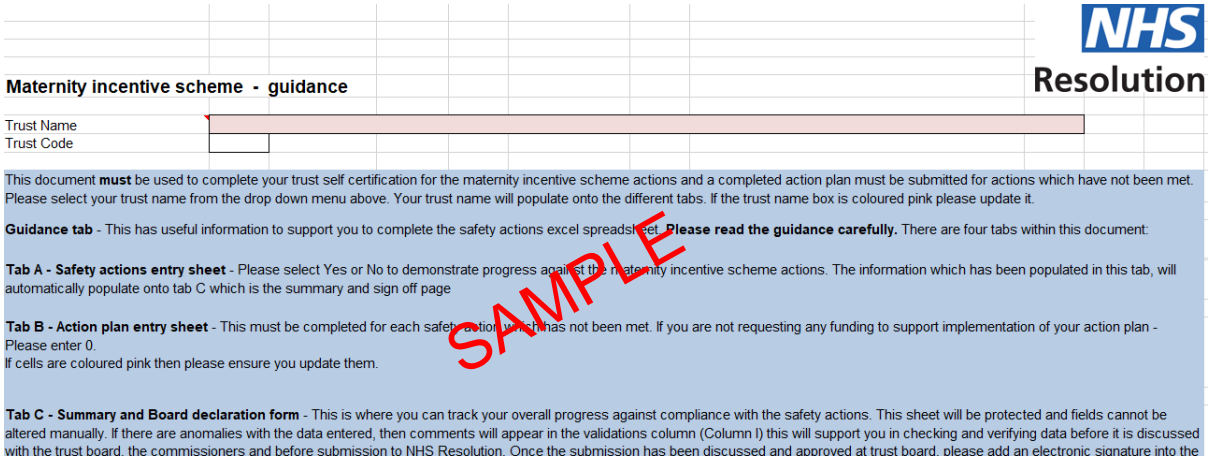
Please note that:

- Board declaration forms will be reviewed by NHS Resolution and discussed with Collaborative Advisory Group.
- NHS Resolution will use external data sources to validate some of the trust's responses, as detailed in the technical guidance above.
- **If a completed *Board declaration form* is not returned to NHS Resolution by 12 noon on Thursday 15 August 2019, NHS Resolution will treat that as a nil response.**

Appendix 1: Board declaration form and action plan template

To access the combined *Board declaration form and action plan template* visit:

https://resolution.nhs.uk/resources/board-declaration-form-and-action-plan-template



Maternity incentive scheme - guidance

NHS Resolution

Trust Name

Trust Code

This document **must** be used to complete your trust self certification for the maternity incentive scheme actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate onto the different tabs. If the trust name box is coloured pink please update it.

Guidance tab - This has useful information to support you to complete the safety actions excel spreadsheet. **Please read the guidance carefully.** There are four tabs within this document:

Tab A - Safety actions entry sheet - Please select Yes or No to demonstrate progress against the maternity incentive scheme actions. The information which has been populated in this tab, will automatically populate onto tab C which is the summary and sign off page

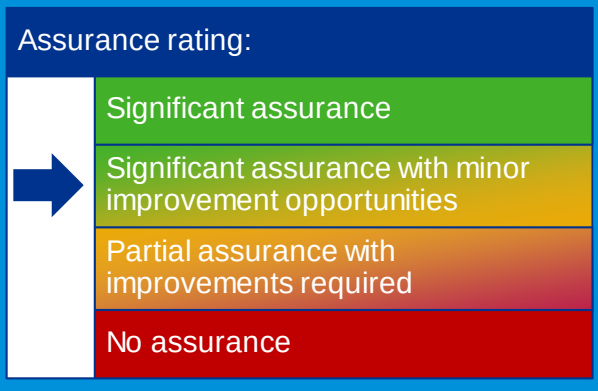
Tab B - Action plan entry sheet - This must be completed for each safety action which has not been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0.
If cells are coloured pink then please ensure you update them.

Tab C - Summary and Board declaration form - This is where you can track your overall progress against compliance with the safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, the commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the

SAMPLE

KPMG

CNST Maternity Incentive Scheme Spot Check



Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
Internal Audit 2019-20

DISCUSSION DRAFT

July 2019

Contents

The contacts at KPMG in connection with this report are:

Clare Partridge
Partner
T: +44 7990 551 735
E: clare.partridge@kpmg.co.uk

Robert Fenton
Manager
T: +44 7990 572 392
E: robert.fenton@KPMG.co.uk

Patrick Cree
Audit Assistant
E: Patrick.cree@KPMG.co.uk

Status of report	
Discussion draft issued	22 July 2019
Management responses received	XX July 2019
Final report issued	TBC
Presented to Audit Committee	TBC

Distribution	
To (for action):	CC (for information):
— Karen Barnard, Director of People & Organisation Development — Lois Mellor, Head of Midwifery	— TBC

Section 1

Executive Summary

Section one

Executive summary

Conclusion

On the basis of this review, we have reached an overall assessment of significant assurance.

Using the Trust's Action Plan assessment, we have reviewed at least one requirement from each of the ten safety actions prescribed in the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme.

We have reviewed the evidence provided for each action, to determine whether we agree with the Trust's self-assessment. Note this has only been done for a sample of requirements, we have not reviewed evidence of all. We also sought to provide assurance over the management preparedness and oversight to ensure compliance is achieved. Our view is the arrangements are robust and the overall assurance rating, reflects that there is sufficient evidence in place to show compliance (to date) with the sample of scheme requirements reviewed with a suggested minor control improvement regarding training monitoring. This review provides an assessment at a point in time, and therefore subject to change prior to the August 2019 deadline. We cannot provide complete assurances the requirements reviewed will be fully compliant at this date.

Meetings with key stakeholders and the evidence reviewed indicated that arrangements are in place to provide significant assurance that the standards have been met and will do so within the necessary timeframes. Working with the CNST Action Plan Stocktake we were able to see the level of evidence required for each safety action to be met. This helps to ensure that key risks and concerns can be tracked throughout the period and the Trust ensures they comply what requirements. There has been overall improvement in issues identified in the prior period, specifically around training as seen within our testing. The tracking of the completion of training is manual which leads to a risk of human error, however there is further checks in place to ensure the 90% criteria is met across the required trainings. In all other areas the required evidence was provided to ensure they were meeting the CNST criteria.

DBTH and KPMG agreed a testing approach that required at least one safety action from each area of the CNST Action Plan to be audited this year. This is set out in our terms of reference and a list of the safety actions tested has been provided in this report (see Appendix A). These safety actions have been chosen on the basis of key areas of risk from reviewing prior year issues.

We would also like to note that the views expressed in this report are limited to the agreed scope and this report is not intended to give a comprehensive opinion on likely project success or otherwise.

Background

NHS Resolution is operating a second year of the Clinical Negligence Scheme for Trusts (CNST) maternity incentive scheme to continue to support the delivery of safer maternity care.

The maternity incentive scheme applies to all acute trusts that deliver maternity services and are members of the CNST. As in year one, members will contribute an additional 10% (circa £580k) of the CNST maternity premium to the scheme creating the CNST maternity incentive fund.

As in year one, the scheme incentivises ten maternity safety actions. Trusts that can demonstrate they have achieved all of the ten safety actions will recover the element of their contribution relating to the CNST maternity incentive fund and will also receive a share of any unallocated funds.

Trusts that do not meet the ten-out-of-ten threshold will not recover their contribution to the CNST maternity incentive fund, but may be eligible for a small discretionary payment from the scheme to help them to make progress against actions they have not achieved. Such a payment would be at a much lower level than the 10% contribution to the incentive fund.

In order to be eligible for payment under the scheme, trusts must submit their completed Board declaration form to NHS Resolution by 12 noon on Thursday 15 August 2019.

The Trust have requested we carry out a spot check on the arrangements in place to assurances that the standards have been met and will do so within the necessary timeframes.

Section one

Executive summary

Objectives

The objectives of our work are:

Objective	Description of work undertaken
Assessment of the arrangements in place to ensure compliance with the CNST MIS standards	We will carry out a high level review of the processes in place to manage the Trust's compliance with the standards: This will include consideration of the following: • Understand the process and controls in place to monitor the delivery of the requirements; • Spot check of the evidence across a sample of individual requirements. There are 10 safety actions, we propose sampling at least on requirement from each safety action.

Areas of good practice

- ✓ In all instances of the safety actions selected to be tested, DBTH had readily available evidence to support the requirements of the CNST.
- ✓ There is an improved level of training completed to meet specific requirements. This has been supported by an increase in checks and chasing by Lois Mellor and further ward management overview in place to check training has been completed.
- ✓ Consistently meeting required deadlines for submissions such as MSDSv2 data, even with IT issues from NHS Digital delays.
- ✓ The relevant boards of DBTH (The Trust board, The Children and Families board and The LMS board) have all been notified and discussed relevant safety actions when required to ensure the CNST requirements have been achieved.

Areas for Improvement

- **Safety Action 8** Staff training tracking is currently very manual and ensuring the listings are complete is difficult. To ensure further improvement of tracking and an audit trail going forward it would support the process if this became more automated. This will increase the effectiveness of the controls in place, decreasing the risk of human error. One low priority recommendation will be made in respect of this as current tracking has proven to still be working effectively but there is a lack of an audit trail.

Recommendation Summary

	High	Medium	Low	Total
Made	0	0	1	**1**
Accepted	0	0	0	**0**

Acknowledgement

We thank the staff involved in this review who helped us complete our work.

Section 2

Recommendations

Section two

Recommendations

This section summarises the recommendations that we have identified as a result of this review. We have attached a risk rating to these recommendations as per the following table:

Risk rating for recommendations raised		
❶ **High priority (one):** A **significant** weakness in the system or process which is putting the Trust at **serious risk** of not achieving its **strategic** aims and objectives. In particular: significant adverse impact on **reputation**; non-compliance with key statutory requirements; or substantially raising the likelihood that any of the Trust's strategic risks will occur. Any recommendations in this category would require **immediate attention**. For example, in operational terms the issue has major effects on operational procedures throughout the organisation. Alternatively, for example, in financial terms the impact exceeds 5% of annual revenue or 5% of the value of the capital base.	❷ **Medium priority (two):** A **potentially significant** or **medium level** weakness in the system or process which **could** put the Trust at risk of not achieving its strategic aims and objectives. In particular, having the potential for adverse impact on the Trust's reputation or for raising the likelihood of the Trust's strategic risks occurring, **if not addressed.** For example, in operational terms the issue has significant effect on operations at a team/divisional level only i.e. there is only minor impact outside the effected team/division. Alternatively, for example, in financial terms the impact is up to 5% of annual revenue.	❸ **Low priority (three):** Recommendations which could **improve** the efficiency and/or effectiveness of the system or process but which are **not vital** to achieving the Trust's strategic aims and objectives. These are generally issues of **good practice** that we consider would achieve better outcomes. For example, in operational terms the issue may only affect a single section or process i.e. there is little impact on overall operational control arrangements. Alternatively, for example, in financial terms the impact is low or non-existent.

Recommendations

No.	Priority	CNST Safety Action	Recommendation and risk	Management response, officer responsible and deadline
1	3	8) Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	**Training controls – tracking and audit trail** **Finding** Overall the process for recording and monitoring staff completion is very manual as the ESR system lacks the ability to track training accurately. The Trust use a manual register system to track Skills and Drills and face to face CTG training completion across the Trust. The tracking is different for the K2 online training where completion is logged on the system. With both manual registers and online completion logs these are then inputted manually into an excel training database which is used to log all training required by staff. The initial tracking is done by maternity services teams and then further checks are completed by the training teams to ensure completeness and accuracy. Samples of these registers and K2 reports have been provided with 25/25 tested agreeing to the training database. **Risk** There is a risk of human error, that could lead to staff being logged as having completed the training when they have not. This could overstate the Trust's completion rate. **Recommendation** A more automated tracking system would increase the effectiveness of the controls around tracking completion of training. This would also improve the audit trail ensuring clear evidence could be followed through each stage.	**Response:** **Name and Job Title of Responsible Officer:** **Deadline:**

KPMG

Appendices

Appendix A

Summary of work undertaken and requirements reviewed

Below we set out our assessment of both the DBTH's current and target scores for the sample of CNST Safety Actions requirements reviewed.

DBTH RAG Assessment

Green – DBTH believes that they have met the individual assertions for the requirement.

Amber - DBTH believes that they have partially met the individual assertions for the requirement.

Red – DBTH believes that they have not met the individual assertions for the requirement.

Overall KPMG Assessment

Agree	Understated	Overstated	Agree – but insufficient
From the evidence available we are able to agree the score recorded as a reasonable assessment of current performance.	From the evidence provided it is our assessment DBTH are performing at a level higher than recorded.	From the evidence provided it is our assessment DBTH are performing at a lower level than recorded.	From the evidence available, we agree with DBTH's' current position. However, further work is required to meet the requirement.

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment and evidence reviewed	Overall Assessment
1	Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths to the required standard?	Quarterly reports have been submitted to the trust Board that include details of all deaths reviewed and consequent action plans	Green	Quarterly reports were provided that are discussed within the Trust Mortality Board using the PMR tool. Minutes were also provided evidencing discussion and action plans in place to address issues that have arisen. MMBRACE-UK reports are developed from the PMRT reviews and are published on a regular basis. The National tool (PMRT) is updated on receipt of these reports. The PMRT tool generates local issues to review whilst they are waiting for the full national report.	Agree
2	Are you submitting data to the Maternity data set (MSDS) to the required standard? Mandatory 1-3 Optional 14/19 to achieve number 4 to 24	Submit MSDSv2 data for April 2019 by the submission deadline of end of June 2019	Green	Extension emails and confirmation from NHS Digital were provided due to IT issues with the upload of initial reports. A sample of submission confirmations were provided with a relevant MSDS Readiness questionnaire, as well as January 2019 data which included all relevant information. As per the CNST terms and conditions they have to submit a monthly return as seen in examples provided. The NHSLA will pull this electronically as cross referenced with confirmations. The Trust have met 17/19 criteria for submissions within safety action 2 with the minimum required being 14. Having met sufficient submissions, safety action 2 has been achieved.	Agree

Appendix A

Summary of work undertaken and requirements reviewed (cont.)

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment Comment	Overall Assessment
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Has progress with the agreed action plans has been shared with your Board and your LMS & ODN	Amber	No LMS board minutes available yet for July 2019, however email confirmation provided from the board confirming ATAIN action plans were shared and discussed. This can also be seen within the agenda and report provided for LMS. Within the Trust board minutes and Children & Families minutes the progress and action plans were agreed. These action plans were also provided for June 2019. (Seen within DRI Annual ATAIN report & action plan) Other evidence to support ATAIN was also seen within; BDGH Annual report & Action plan, ATAIN action plan and GAP analysis and ATAIN Highlight report. All evidence provided apart from the LMS board minutes which have not yet been finalised. Confirmation has instead been provided but not currently completed this action with all supporting documents.	Agree
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Do you have a formal record of the proportion of obstetrics and gynaecology trainees in the trust who 'disagreed/strongly disagreed' with the 2018 General Medical Council National Training Survey	Green	Both the survey and plan have been provided for obstetrics and gynaecology. The formal record is shown within the survey and plan in place and ensures the Trust addresses lost educational opportunities. (Obs and Gynae GMC report and GMC 2018 survey) This safety action has therefore been met.	Agree
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	A systematic, evidence-based process to calculate midwifery staffing establishment has been done	Green	February and June 2019 midwifery workforce planning reports provided. They use a robust tool called Birthrate Plus® to calculate figures. This tool is explained and further explanation is provided to ensure this tool appropriate to evidence the planning. (Workforce paper Feb 2019 and Workforce paper June 2019). It can then be seen within the reports that a systematic process is in place to establish staffing of the midwifery workforce.	Agree

Appendix A

Summary of work undertaken and requirements reviewed (cont.)

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment Comment	Overall Assessment
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Has Board level consideration of the Saving Babies' Lives (SBL) care bundle (Version 1 published 21 March 2016) been undertaken in a way that supports the delivery of safer maternity services.	Green	The audit and agreement of outcomes were discussed in 04/01/2019 minutes of Children & Families Board showing compliance. Both birth stat reports and Birthrate Plus reports were provided as examples of the information discussed within the Children & Families Board. Clear Board level considerations in place around the SBL care bundle.	Agree
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Has user involvement has an impact on the development and/or improvement of maternity services.	Green	There is active staff on site working to recruit members. An Antenatal Quality Improvement (ANQI) event completed with Maternity Voice Partnerships (MVP) involvement & further intrapartum event completed in June 2019. This has all been documented within a range of evidence; PEEC report Feb 2019 and June 2019, emails regarding MVP involvement in AN event, ANC QI event documentation, Buzz updates and Tweets from MVP chair advertising the events. There are also reports showing improvements or planned changes to match surveys and feedback. All evidence sufficient to show user involvement improving/developing services.	Agree

Appendix A

Summary of work undertaken and requirements reviewed (cont.)

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment Comment	Overall Assessment
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: Obstetric consultants, All other obstetric doctors, Obstetric anaesthetic consultants, All other obstetric anaesthetic doctors, Midwives, Maternity theatre and maternity critical care staff, Maternity support workers and health care assistants.	Green	To meet the CNST criteria, different levels of training are required for different groups. This is split out into; Consultants and Staff Grades, SPRs + SHOs, Midwives, Anaesthetists, Maternity Theatre ODPs and HCAs/MSWs. Once staff are split into the specific groups as per the ESR system and confirmed the listings are complete back to maternity services teams they are allocated the trainings required and invites/trainings are sent. There is then 3 different levels of training that are set out to be completed as per Doncaster Trusts training policy to meet the CNST criteria. Firstly, training involves face to face CTG trainings that is only required by Midwives (as it is relevant to their role only). This will be monitored by each maternity service and has been agreed to training registers. The 90% level in this area has already been reached according to CNST overview report. This is confirmed with registers and signed off by trainers. The results of our sample testing is explained below. Secondly, there is group training for skills and drills which is required by all staff groups. Training is set according to the Trust training policy to meet CNST requirements. This is tracked through manual registers and further courses enforced by teams to ensure attendance. Examples of these trainings have been provided along with registers where a sample has been agreed back to the training database, as explained below, giving assurance over the total percentages of training completed. At the 26th July all Skills and drills will be compliant with the 90% target after the final adhoc sessions. There have been specific issues within the MSW group where for 4 individuals their rota has not facilitated the Skills and Drills training. Face to face meetings have been organised on the 26th July to ensure the 90% target is surpassed with chase letters witnessed to ensure completion.	Agree

Appendix A

Summary of work undertaken and requirements reviewed (cont.)

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment Comment	Overall Assessment
8 cont.	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: Obstetric consultants, All other obstetric doctors, Obstetric anaesthetic consultants, All other obstetric anaesthetic doctors, Midwives, Maternity theatre and maternity critical care staff, Maternity support workers and health care assistants.	**Green**	The final training type is completed online through the K2 platform where by different training modules are set for individuals. This online training is required by Consultants and staff grades, SPRs + SHOs and Midwives. Training is created and set by the Trust training team to ensure compliance with CNST. Completion is then tracked by the maternity service teams checking reports to ensure staff completion of online training. Those who have not completed are chased up to make sure 90% is reached. Chase letters have been provided stating completion is mandatory before the end of July (2 key consultants/Staff Grade doctors not compliant with K2 – so they are being chased to reach the 90% target). There is also small number of midwives that have not yet completed the K2 trainings. They have already reached the target of 90% but they want to surpass this and make sure as many as possible have completed the trainings. A list of issues is being tracked by Head of Midwifery and this has been provided as evidence. A K2 report has also been provided to show completion of trainings and those that still need to complete. A sample has been agreed to the training database document which tracks all trainings required for all staff. *Sample testing – we selected a haphazard sample of 25 individuals across the 3 types of trainings (skills and drills, Face to face CTG and K2). We ensured they signed the relevant register or were on a K2 report as having competed the training. These were then agreed to the training database used to reach the final training figures. No issues were identified.*	**Agree**

Appendix A

Summary of work undertaken and requirements reviewed (cont.)

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment Comment	Overall Assessment
8 cont.	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Maternity staff attendees should be 90% of each of the following groups: Obstetric consultants, All other obstetric doctors, Obstetric anaesthetic consultants, All other obstetric anaesthetic doctors, Midwives, Maternity theatre and maternity critical care staff, Maternity support workers and health care assistants.	**Green**	Overall the process for recording and monitoring is very manual as the ESR system lacks the ability to track training accurately. The Trust use a manual register system to track Skills and Drills and face to face CTG training completion across the Trust. This is then input manually into the training database which tracks all training required by staff. Whilst this does provide a risk of human error, however, this has proven to be more accurate than any other current method accepted by the Trust. The initial tracking is done by the maternity services teams and then further checks completed by the training teams to ensure accuracy with a database kept by the Head Midwifery Educator.	**Agree**

Appendix A

Summary of work undertaken and requirements reviewed (cont.)

Safety Action	Requirement	Actions	DBTH's Assessment	KPMG Assessment Comment	Overall Assessment
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bimonthly with Board level champions to escalate locally identified issues?	Have the Board level safety champions taken steps to address named safety concerns and that progress with actioning these are visible to staff	**Green**	Children & Families Board minutes were provided demonstrating that issues were discussed and actions taken on all safety concerns. Issues are identified with the safety champions raising issues in HOM Newsletters as seen for March, April, May and June 2019. An email was also sent and an email ion created for anyone to contact regarding safety concerns. They have also held a AN QI event with multiple dates and meetings set up and completed to raise any further safety concerns that are then passed onto the board. Sufficient actions in place to identify and report on safety concerns.	**Agree**
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Are you reporting of all qualifying incidents that occurred in the 2018/19 financial year to NHS Resolution under the Early Notification scheme reporting criteria	**Green**	External confirmation provided through HSIB to confirm they have reported 100% of the incidents. The track of the initial case and submission is supported by email evidence. The trust will then complete any further supporting documentation required. A checklist of steps is completed and further questionnaire to ensure adherence. From the 5th December these cases are investigated by an external body called HSIB. For this submission there were 4 cases meeting the criteria but the Trust submitted 5. They will not be penalised for over submission of cases as seen within email confirmations. No issues identified with the reporting of incidents.	**Agree**

Appendix B

Staff involvement and documents reviewed

We held discussions with the following staff as part of the review:

Name	Job title
Lois Mellor	Head of Midwifery

During our testing, we reviewed the following documents:

- Quarterly Reports of Stillbirths and Neonatal Deaths
- Mortality Trust Board minutes
- MSDSv2 data submission email
- NHS Digital submission report
- MSDSv2 Readiness Questionnaire submission and email
- ATAIN action plan and gap analysis
- ATAIN report
- Schedule for ATAIN training
- Obs and Gynae GMC report and GMC 2018 survey
- Midwifery staffing reports
- Birth statistics example report
- Birthrate Plus report
- Meeting of the Children & Families Board January and May 2019
- Antenatal Quality Improvement Event documents
- Patient Experience & Engagement Committee care group report February and June 2019
- Social media advertising examples
- Antenatal Clinic (ANC) Quality Improvement Event January 2019
- CNST training statistic overview
- CNST training database and registers for trainings
- Skills and drills training schedule
- K2 Non compliance letter
- K2 training reports
- Training Non compliance letter
- Skills and Drills registers
- Skills and Drills trainings documents
- Training database listings
- K2 staff training completion listings
- HOM newsletters March and June 2019
- Safety concerns email
- Safety concerns session schedule
- Intrapartum QI Rapid Improvement Event Visioning documents
- NHS Resolution's Early Notification scheme submission emails

Maternity incentive scheme - Guidance

Resolution

Trust Name	**Doncaster and Bassetlaw Hospitals NHS Foundation Trust**
Trust Code	**T581**

This document **must** be used to complete your trust self certification for the maternity incentive scheme safety actions and a completed action plan must be submitted for actions which have not been met. Please select your trust name from the drop down menu above. Your trust name will populate each tab. **If the trust name box is coloured pink please update it.**

Guidance Tab - This has useful information to support you to complete the maternity incentive scheme safety actions excel spreadsheet. **Please read the guidance carefully.** There are three additional tabs within this document:

Tab A - Safety actions entry sheet - Please select 'Yes' or 'No' to demonstrate compliance with each maternity incentive scheme safety action. Note, entering 'Yes' denotes full compliance with the safety action as detailed within the condition of the scheme. The information which has been populated in this tab, will automatically populate onto tab C which is the board declaration form

Tab B - Action plan entry sheet - This must be completed for each maternity incentive scheme safety action which has **not** been met. If you are not requesting any funding to support implementation of your action plan - Please enter 0. **If cells are coloured pink then please update them.**

Tab C - Board declaration form - This is where you can track your overall progress against compliance with the maternity incentive scheme safety actions. This sheet will be protected and fields cannot be altered manually. If there are anomalies with the data entered, then comments will appear in the validations column (Column I) this will support you in checking and verifying data before it is discussed with the trust board, commissioners and before submission to NHS Resolution. Once the submission has been discussed and approved at trust board, please add an electronic signature into the document. If you are unable to add an electronic signature, the board declaration form can be printed, signed then scanned to be included within the submission.

Any queries regarding the maternity incentive scheme and or action plans should be directed to **MIS@resolution.nhs.uk**

Technical guidance and frequently asked questions can be accessed here :
https://resolution.nhs.uk/resources/maternity-incentive-scheme-year-two

Submissions for the maternity incentive scheme must be received no later than **12 noon on Thursday 15 August 2019** to **MIS@resolution.nhs.uk**

You are required to submit this document (and a signed copy of the board declaration form, if there is no electronic signature added). Please do not send evidence to NHS Resolution.

NHS Resolution

Section A : Maternity safety actions - Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Action No.	Maternity safety action	Action met? (Y/N)
1	Are you using the National Perinatal Mortality Review Tool to review and report perinatal deaths to the required standard?	Yes
2	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes
3	Can you demonstrate that you have transitional care services to support the Avoiding Term Admissions Into Neonatal units Programme?	Yes
4	Can you demonstrate an effective system of medical workforce planning to the required standard?	Yes
5	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Yes
6	Can you demonstrate compliance with all four elements of the Saving Babies' Lives care bundle?	Yes
7	Can you demonstrate that you have a patient feedback mechanism for maternity services and that you regularly act on feedback?	Yes
8	Can you evidence that 90% of each maternity unit staff group have attended an 'in-house' multi-professional maternity emergencies training session within the last training year?	Yes
9	Can you demonstrate that the trust safety champions (obstetrician and midwife) are meeting bi-monthly with Board level champions to escalate locally identified issues?	Yes
10	Have you reported 100% of qualifying 2018/19 incidents under NHS Resolution's Early Notification scheme?	Yes

Section B : Action plan details for Doncaster and Bassetlaw Hospitals NHS Foundation Trust

An action plan should be completed for each safety action that has not been met

Action plan 1

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 2

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the*		
Lead executive director	*Does the action plan have executive*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**		**When?**	
Monitoring					

Action plan 3

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 4

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 5

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 6

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 7

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 8

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 9

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Action plan 10

Safety action		**To be met by**	
Work to meet action	*Brief description of the work planned to meet the required progress.*		
Does this action plan have executive level sign off		**Action plan agreed by head of midwifery/clinical director?**	
Action plan owner	*Who is responsible for delivering the action plan?*		
Lead executive director	*Does the action plan have executive sponsorship?*		
Amount requested from the incentive fund, if required			
Reason for not meeting action	*Please explain why the trust did not meet this safety action*		
Rationale	*Please explain why this action plan will ensure the trust meets the safety action.*		
Benefits	*Please summarise the key benefits that will be delivered by this action plan and how these will deliver the required progress against the safety action. Please ensure these are SMART.*		
Risk assessment	*What are the risks of not meeting the safety action?*		

	How?	**Who?**	**When?**
Monitoring			

Maternity incentive scheme - Board declaration Form

Trust name	**Doncaster and Bassetlaw Hospitals NHS Foundation Trust**
Trust code	**T581**

An electronic signature must also be uploaded. Documents which have not been signed will not be accepted.

	Safety actions	Action plan	Funds requested	Validations
Q1 NPMRT	Yes		-	
Q2 MSDS	Yes		-	
Q3 Transitional care	Yes		-	
Q4 Medical workforce planning	Yes		-	
Q5 Midwifery workforce planning	Yes		-	
Q6 SBL care bundle	Yes		-	
Q7 Patient feedback	Yes		-	
Q8 In-house training	Yes		-	
Q9 Safety Champions	Yes		-	
Q10 EN scheme	Yes		-	
Total safety actions	**10**	**-**		
Total sum requested			**-**	

Sign-off process:

Electronic signature	
For and on behalf of the board of	Doncaster and Bassetlaw Hospitals NHS Foundation Trust

Confirming that:

The Board are satisfied that the evidence provided to demonstrate compliance with/achievement of the maternity safety actions meets standards as set out in the safety actions and technical guidance document and that the self-certification is accurate.

The content of this form has been discussed with the commissioner(s) of the trust's maternity services

If applicable, the Board agrees that any reimbursement of maternity incentive scheme funds will be used to deliver the action(s) referred to in Section B (Action plan entry sheet)

We expect trust Boards to self-certify the trust's declarations following consideration of the evidence provided. Where subsequent verification checks demonstrate an incorrect declaration has been made, this may indicate a failure of board governance which the Steering group will escalate to the appropriate arm's length body/NHS System leader.

Name:	
Position:	
Date:	

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

D3

Title	**The NHS Patient Safety Strategy**		
Report to	**Board of Directors**	**Date**	**31 July 2019**
Author	**Mr Sewa Singh, Medical Director** **Mrs Cindy Storer, Acting Deputy Director Nursing, Midwifery, AHPs**		

Purpose		Tick one as appropriate
	Decision	
	Assurance	
	Information	✓

Executive summary containing key messages and issues
Patient safety has made great progress since the publication of "To err is human" 20 years ago but there is much more to do. The NHS does not yet know enough about how the interplay of normal human behaviour and systems determines patient safety. More can be done to share safety insight and empower people – patients and staff – with the skills, confidence and mechanisms to improve safety. Getting this right could save lives and costs each year. The new patient safety strategy published July 2019 is an attempt to address these challenges to enable the NHS to achieve its safety vision; to continuously improve patient safety. To do this the NHS will build on two foundations: a patient safety culture and a patient safety system. Three strategic aims will support the development of both: • improving understanding of safety by drawing intelligence from multiple sources of patient safety information **(Insight)** • equipping patients, staff and partners with the skills and opportunities to improve patient safety throughout the whole system **(Involvement)** • designing and supporting programmes that deliver effective and sustainable change in the most important areas **(Improvement).**
Key questions posed by the report
How far has the Trust already gone to fulfil the recommendations in the new strategy? What has been achieved? What is still to be achieved?

How this report contributes to the delivery of the strategic objectives
To be the safest Trust In England, Outstanding in all we do
How this report impacts on current risks or highlights new risks
Risks to not improving the staff survey should be identified as these will be measured nationally as a barometer of culture. Risks to the capacity of clinicians to deliver the improvements required
Recommendations
The board is asked to note the new patient safety strategy with the national and local recommendations.

The new Patient Safety strategy describes how the NHS will continuously improve patient safety, building on the foundations of a safer culture and safer systems. Launched on 2 July 2019, the revised definition of patient safety is summarised as:

"*maximising the things that go right and minimising the things that go wrong for people experiencing healthcare"*

The new strategy also describes how patient safety is integral to the NHS's definition of quality in healthcare, alongside effectiveness and patient experience.

It is human to make mistakes so we – the NHS – need to continuously reduce the potential for error by learning and acting when things go wrong. Safety is not an absolute concept and has neither a single objective measure nor a defined end point. Rather, it responds to patient needs and system priorities.

The strategy focuses on 3 key areas:

Insight
Involvement
Improvement

Insight

1. The importance of measurement in improving safety is now widely acknowledged, but while there is now significant activity associated with this, variation in approach has emerged, which does not always support improvement. Effective safety measurement can be underpinned by the following principles:

    a) Be clear about the purpose of each measure, 'dashboard' or 'scorecard'.
    b) Be clear when a change is an improvement.
    c) Don't use too many measures – this can crowd out the important ones.
    d) Measures of culture, infrastructure, process and outcomes are all useful.
    e) Use the same measure for the same purpose across all organisations.
    f) Make data collection easy, using existing data where possible.
    g) The terms 'avoidable' and 'unavoidable' are unhelpful for patient safety.
    h) Incident reporting is never a measure of actual harm.
    i) The design of data presentation is critical to how it is interpreted.
    j) Work in partnership with analysts, patients, improvers and clinicians.

2. Development of the Patient Safety Incident Management System (DPSIMS) project will define and deliver the successor to the National Reporting and Learning System (NRLS) and the Strategic Executive Information System (STEIS)

3. A new national patient safety incident response framework (PSIRF) will replace the Serious Incident Framework

4. Healthcare Safety Investigation Branch (HSIB) will continue to generate expert insight into system level causes of harm

5. New medical examiner system will scrutinise all deaths to identify and act on issues with quality of care, provide a better service for the bereaved and improve the quality of death certification and ensure appropriate direction to coroners.

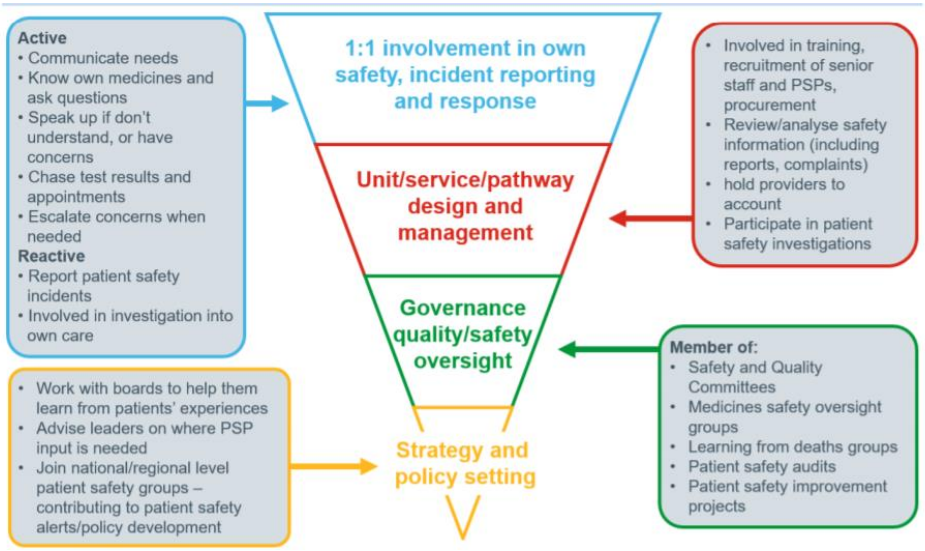
6. National clinical review and response AND National Patient Safety Alerts committee (NaPSAC) will use national data to identify new and under-recognised issues, issue alerts where this will help and offer clear and effective actions.

7. Clinical Negligence and Litigation scheme will improve learning from claims and share what is learned across the system. The aim is to improve early incident management to reduce claims – by being open and honest (saying sorry and dispatching Duty of Candour) also the Get It Right First Time (GIRFT) litigation workstream.

8. Overall – patient safety information will be pulled together from as many sources as possible with a shared taxonomy.

Involvement

1. Giving patients, staff and partners the skills and opportunities to improve safety
2. Patient Safety Partners (PSPs) to be recruited, ideally people who have experienced harm during NHS care, trained according to national syllabus



3. Patient safety education and training – not to rely on a handful of patient safety experts but to train the whole workforce in safety science.

4. National patient safety syllabus – with explicit patient safety training within all professional education programmes, making patient safety training accessible to everyone in the NHS

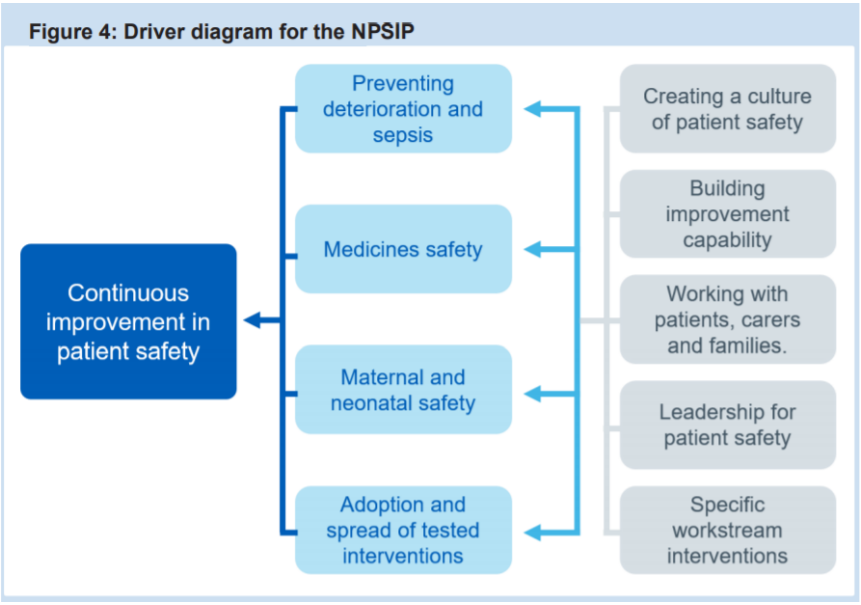
5. Develop a strong network of Patient Safety Specialists within organisations.

6. Safety I (look at when things have gone wrong) Safety II (look more at the majority of times that things have gone right. Develop a Safety II mindset

Improvement

1. Deliver the national patient safety improvement programme (NPSIP), building on the existing focus on preventing avoidable deterioration and adopting and spreading safety interventions, focusing on four national proprieties because of their potential to enable the most significant impact on patient safety.

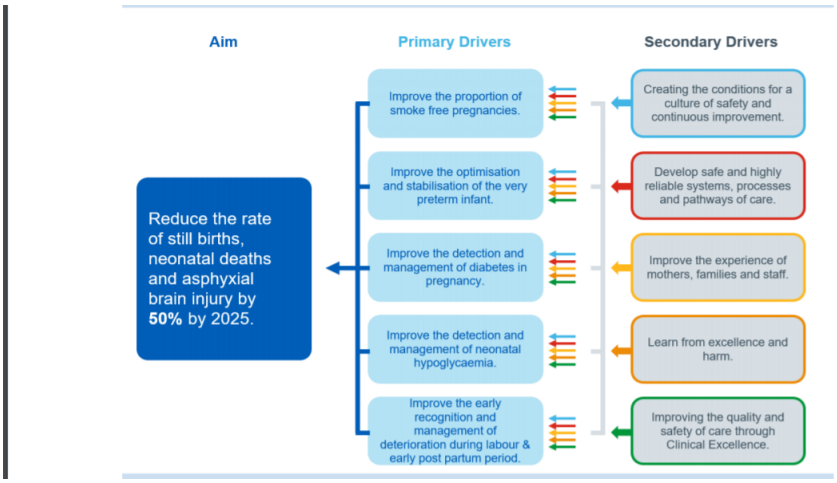
Figure 4: Driver diagram for the NPSIP



2. Priority 1 – preventing deterioration and sepsis, focusing on improved recognition, timely response and reliable escalation

3. Priority 2 – adoption and spread of tested interventions (reducing cerebral palsy in preterm babies through use of magnesium sulphate, emergency laparotomy care bundle, COPD care bundle, ED safety checklist)

4. Priority 3 – maternal and neonatal safety gets its own improvement programme (MNSIP) with a national ambition to reduce the rate of stillbirths, neonatal deaths and asphyxia brain injury by 50% by 2015



5. Priority 4 – Medication Safety, focusing on high risk drugs, high risk situations & vulnerable patients. The Medicine Safety Improvement Programme (MSIP) has set some initial priority projects based on the known risks (below)

Project	Success measures
Develop an exemplar to illustrate best practice in transition of patients on anticoagulants from hospital to care home	% anticoagulant monitoring delivered within a specified time % complete records arriving with patient % appropriate prescribing
Improve drug administration safety in care homes through regular medication review	Reduction in wasted medicines Medicines delivered on time Fewer omitted medicines
Commission shared decision-making (SDM) training for clinical pharmacists moving into PCNs, to work with patients with atrial fibrillation (AF) on anticoagulants	Number of pharmacists trained in SDM % of patients in PCN within safe range % AF patients with stroke risk assessed on anticoagulants Use of patient 'self-efficacy/engagement' measure
SDM/self-management support for clinical pharmacists starting with people on opioids	Number of pharmacists trained in SDM Reduction in opioid prescribing (120 mg morphine equivalent) in patients with chronic, non cancer-related pain Evidence of good pain control
Enabling structured medicines reviews across an advanced STP/ICS starting with population at risk due to polypharmacy	% structured reviews of at-risk population – resulting in change/no change Problematic polypharmacy in people with frailty Number of medicines taken by each patient

6. Mental health safety improvement programme to work collaboratively with partners in mental health trusts on complex safety problems.

7. Safety issue that particularly affect older people including:
    a. Falls collaboratives
    b. Proactive management of frailty
    c. Reducing avoidable admissions through crisis response and same day emergency care services
    d. Stop the Pressure
    e. Nutritional improvement collaboratives
    f. Developing safety dashboards for indicators linking to long term use of sedatives with admissions for falls and fractures
    g. Developing similar metrics around bone health issues

8. Safety and Learning Disabilities (LD) consultation on mandatory training for NHS staff on LD and Autism, Learning Disabilities Mortality Review (LeDeR), STOMP-STAMP (Stopping over medication of people with a learning disability, autism or both-Supporting Treatment and Appropriate Medication in Paediatrics), Ask Listen Do, Care and treatment reviews.

9. Antimicrobial resistance (AMR) and health care associated infection (HCAI). Includes new national AMR action plan, right care urology project looking at UTI management, GIRFT SSI survey, Flu vaccination, CQUINS UTI and colorectal antibiotic prophylaxis

10. Research and Innovation – National Institute for Health Research (NIHR) funded patient safety translational research centres

Summary of recommendations and progress July 2019

	Recommendation	Progress against achieve	Action	Executive Owner	Time for progress/update
1	Improve Safety Culture – this will be monitored through the NHS staff survey (q17 fairness and effectives of reporting and q 18 staff confidence and security in reporting)	National Staff Survey is completed each year.	Action Plan on long term improvement to change perception of questions (q17 and q18)	Director of P&OD	September 2019
2	Embed the principles of a safety culture, including a Just Culture guide and adherence to the well led framework	Already integrated into new SI policy	Just Culture guide written into new serious incident policy. Launch in August SHWC newsletter and share with clinical teams NHS_0690_IC_A5_web_version (1).pdf Workshop in SHWC conference 2020	Medical Director/ Director of Nursing, Midwifery, AHP's	August 2019
3	Recruit and train patient safety partners	New action	Recruit and train patient safety partners as part of new patient and pubic engagement strategy	Deputy Director of Quality and Governance	May 2020
4	Local systems to connect to the replacement for NRLS and STEIS by the end of Q4 in 2020/21	New Action	Waiting for lead from NHSi	Deputy Director of Quality and Governance	Q4, 2020/21

5	Identify Patient Safety Incident Response Framework (PSIRF) leads in local systems by Q4 2019/20		Patient Safety Team identified to lead this	Deputy Director of Quality and Governance	January 2020
6	Development of organizational level strategic plans for patient safety and review by the end of Q2 2020/21		Develop new patient safety strategy	Deputy Director of Quality and Governance	September 2020
7	Leaders and staff to be appropriately trained in responding to patient safety incidents, including investigation, according to their roles by the end of Q2 2020/21	Waiting for National work	Curriculum and syllabus to be developed in collaboration with HEE and the Royal Colleges in partnership with the HEI's	Deputy Director of Education	September 2020
		Local Training to be commenced for ward and department managers	Develop local curriculum for half day training for investigation training for beginners	Deputy Director of Education	September 2019
8	Eliminate inappropriate dashboard measures from all dashboards by Q2 2020/21		Dashboards and Quality Metrics have all been refreshed in April 2019 as part of a yearly review progress.	Deputy Director of Nursing, Midwifery, AHPs, Medical Director	Review again April 2020
9	As part of clinical governance monitor the balance of resources for investigation versus improvement (e.g falls and HAPU now investigated and monitored through iQAT)		Work to move frequently occurring harms (falls and HAPU) moved into Qi streams with agreement of local CCG and monitored through new accreditations	Deputy Director of Nursing, Midwifery, AHPs, Medical Director	Review Again April 2020

10	Recruitment of medical examiner (already underway) scrutinizing all deaths by end of Q4 2019/20		Recruitment underway to be in place by the end of Q3 2019	Medical Director	December 2019
11	Develop network of patient safety specialists – at least one per organization by the end of Q4 2019/20		Patient Safety Team, includes deputy director of quality and governance, head of patient safety and experience and Patient Safety Leads.	Director of Nursing / Medical Director	July 2019
12	Training for patient safety specialists identified by Q4 2021/22 (already started with consequence UK and joining the action learning set)		Patient Safety/ Investigation training for 60 key leads completed in 2019, provided by Consequence UK.	Deputy Director of Quality and Governance	May 2019
			DBTH now part of the action learning set for Yorkshire and the Humber	Head of patient safety and experience	October 2019
13	**NPSIP priorities :** NEWS2 adoption, emergency laparotomy care bundle PRcCePT for eligible mothers to receive MgSO4 by Q4 2019/20	NEWS 2	Implemented	Director of Nursing, midwifery and AHPs	September 2018
		Emergency Laparotomy Care Bundle	Monitored through the National Emergency Laparotomy Audit (NELA) Improvements still being monitored	Medical Director	March 2020
		PRcCePT for eligible mothers to receive MgSO4 by Q4 2019/20	PReCePT is currently ongoing in maternity at DRI and BDGH	Medical Director	March 2020

14	COPD discharge bundle by Q4 2019/20		In place and monitored through National COPD Audit Programme	Director of Nursing, midwifery and AHPs	Review March 2020
15	ED checklist by Q4 2019/20		Discharge bundle already in place – work to commence to integrate into full ED checklist	Director of Nursing, Midwifery & AHPs	Review March 2020
16	Deliver the maternity and neonatal safety improvement program (MNSIP)		Already part of MatNeo Collaborative. A three-year programme to support improvement in the quality and safety of maternity and neonatal units across England.	Director of Nursing, Midwifery & AHPs/ Medical Director	Review March 2020
17	Deliver the medication safety improvement program (MSIP)		New patient safety initiative to build on existing medicines management work	Chief Pharmacist	Review March 2020
18	Work with partners to address safety concerns with mental health on the mental health safety improvement program (MHSIP)		Build on networks with RDaSH partners on mental health programmes	Director of Nursing, Midwifery, AHPs	Review March 2020

19	Address safety issues that affect older people (falls, frailty, medication and falls, pressure ulcers, nutrition)		The new inpatient Quality Accreditation Tool (iQAT) is deigned to capture proactive quality improvement in falls, IPC, skin integrity & nutrition as part of accreditations. Medication safety is being reviewed as part of this work	Director of Nursing, Midwifery & AHP	Review March 2020
20	Work with partners on issues that affect patients with learning disabilities (LeDeR and LD improvement standards)		LeDeR programme established and learning shared with all Trust members through SHWC	Director of Nursing, Midwifery, & AHPs	Review March 2020
21	Local action plan for antimicrobial resistance including how to halve associated Gram-negative blood steam infections by 2024 and reduce community antibiotic use by 25% by 2024, improve management of lower UTI in older people (CQUIN) and improve antibiotic prophylaxis for colorectal surgery (CQUIN)	Halve associated Gram-negative blood steam infections by 2024	Improve partnership working across Doncaster Place	Medical Director	Review March 2020
		Reduce community antibiotic use by 25% by 2024	Improve partnership working across Doncaster Place	Medical Director	Review March 2020
		Improve management of lower UTI in older people (CQUIN)	Monitored through new 2019/20 CQUIN – needs work to improve poor practice	Medical Director	Review quarterly as part of CQUIN return
		Improve antibiotic prophylaxis for colorectal surgery (CQUIN)	Monitored through 2019/20 CQUIN	Medical Director	Review quarterly as part of CQUN return

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

D4

Title	**Board Assurance Framework & Corporate Risk Register**		
Report to	**Board of Directors**	**Date**	**30 July 2019**
Author	**Jeannette Reay, Head of Corporate Assurance and Company Secretary**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues

BAF

Risks added since last meeting
None.

Risks removed since last meeting
None.

Updates

The Head of Corporate Assurance / Company Secretary met with Executives during June and July to undertake a review of the Board Assurance Framework.

Updates are highlighted in red font and a note of major changes is included in column Y.

The BAF was approved at Management Board on 15 July 2019.

RISK REGISTER

Risks added since last meeting
None.

Risks removed since last meeting
None.

Updates

The Head of Corporate Assurance / Company Secretary met with Executives during June and July to undertake a review of the Risks on the Register.

Updates are highlighted in red font.

The Risk Register was approved at Management Board on 15 July 2019.

Key questions posed by the report
• N/A
How this report contributes to the delivery of the strategic objectives
The attached BAF highlights the key risks to the strategic objectives. The attached Risk Register shows corporate risks scoring 15 or above.
How this report impacts on current risks or highlights new risks
The report highlights all corporate and strategic risks to the Trust.
Recommendations
The Board is asked to note the attached Board Assurance Framework and Corporate Risk Register.

Strategic Aim 1 - We will work with patients to continue to develop accessible, high quality and responsive services.														
RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	PROGRESS TIMELINE	TARGET RR
Failure to protect against cyber attack leading to (i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	F&P11	Chief Information Officer	L3 x I5 = 15	⟷	15				(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied (ix) Monthly cyber security report (x) Pilot trust for NHS Digital work (xi) Digital garage work (xii) Regular returns to the centre (xiii) DSP Toolkit Review	(i) Trust unaffected by cyber attack in May 2017 (ii) Governors briefing June, 2017 (iii) Cyber maturity audit and action plan reported via ANCR to Board, September 2017 and updated March 2018 (iv) Annual IT audit (v) Report to Audit Committee on IT Security - Penetration Test of Trust sites update, September 2018 Report shared with Audit Committe.	(i) Progress against Internal Audit action plan to be presented to ANCR every six months (ii) Change to Data Security & Protection toolkit	(i) Phishing exercise. (ii) DSP Toolkit review taking place. (iii) Audit by KMPG. Results to Audit Committee following March results.		L3 x I4 = 12
Failure to ensure adequate medical records system leading to (i) Impact on safety (ii) Impact on reputation	Q&E4	Chief Operating Officer	L2x I3 = 6	⟷	6				(i) Review of bays and action plans in place (ii) RFID business case agreed (iii) Plans to make DRI a closed library (iv) RFID System operational (v) IM&T Strategy	(i) Storage bays reviewed (ii) Presentation before Board in August 2017 on RFID (iii) RFID installed, October 2017 (iv) Draft information strategy in place (v) Presentation from Nervecentre at ET and Governor Forum, October 2018	(i) Elecrtonic Patient Record System (ii) Development of Business Case for EPR (iii) Resolution of paper records	(i) Progress towards EPR System (ongoing) (ii) Work around paper records (to be determined following EPR implementation)		L2 x I2 = 4
Failure to engage with patients and staff around the quality of care and proposed service changes leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation (iii) Impact on staff morale (iv) Risk of long-term recruitment issues (v) Risk of delay to any service changes	Q&E5	Director of Nursing, Midwifery and AHPs/ Medical Director	L3 x I3 = 9	⟷	9				(i) Consultations on major service changes (ii) CCC report to Board (iii) Friends and Family Test (iv) Monitoring through Patient Engagement & Expderience Committee (including CCG & Healthwatch membership) (v) Training on communication (vi) Work on learning from deaths (vii) Governor walkabouts (viii) Ward QAT (ix) Picker national surveys (x) Social media e.g. Facebook, Twitter (xi) Media & social media policy (xii) Governor/ NED briefings (xiii) MP briefings/ meetings (xiv) Governor training (xv) Meetings with local journalists (xvi) Face to face briefings with services (xvii) Staff engagement events, briefings and workshops (xviii) Communications with staff on Hospital Services Review (xix) Internal staff surveys	(i) Consultation on HASU and children's tier 2 surgery (ii) Consultation on new strategic direction (iii) Bassetlaw Governors engagement work with the public (iv) Case law and advice taken in respect of service changes (v) F4H Strategy special, September 2017 (vi) Strategy stand at AMM (vii) Communications team is responsive on traditional and social media (viii) New, engaging website (ix) Invested in strong relationships with local journalists and MPs (x) Ensuring internal and external communications are aligned and staff engagement is considered in external comms process (xi) Communications Strategy approved by Board, October 2017 (xii) Ongoing meetings with commissioners and primary care across the patch (xiii) Medical Director's discussions with governors (xiv) CEO and MD meeting with Blaw CCG and John Man Bassetlaw MP on plans at BDGH. (xv) Becky McCoomb working with ICS on the retention of working staff.	(i) Improve patient engagement and listening activities to strengthen patients and public voice (ii) Adopt ReSPECT process Trust wide (iii) Launch and embed #hellomynameis (iv) Implementation of "Always events" (v) Identify opportunities for quality improvement through feedback (vi) HSR consultation (vi) Outcomes of improvement practice work.	(i) Increase engagement activities Q1-Q4 2018-19 (ii) Process adopted Trust wide Q1 2019 (iii) hellomynameis relaunched and embedded Q4 2017-18 - Q4 2018-19 (iv) Increased activities 2019 onwards (v) Increased opportunities for feedback Q1-4 2018-19 (vi) Finalisation of improvement practice work (commenced Q3)	Cindy Storer and Fiona Dunn will have more information on this - JR to meet with and update	L2 x I2 = 4
Failure to adequately prepare for CQC inspection leading to (i) Sub-optimal performance in inspection (ii) Risk of regulatory involvement (iii) Impact on reputation	Q&E7	Director of Nursing, Midwifery and Allied Health Professionals	L3 x I2 = 6	↑	6				(i) Self-assessment and mock inspection processes (ii) Engagement meetings with CQC (iii) Nottinghamshire Looked after Children and Safeguarding monitored by Trust Safeguarding People's Board (iv) Action plans montiored by Clinical Governance Committee	(i) IRMER inspection and action plan in place (ii) Reports to Board and QEC (iii) CQC Insights (iv) Positive mock inspections (v) CQC report received July 2018 (vi) Board and QEC consideration of action plans (vii) Action plan following inspection sent to CQC	(i) Action plan to move to 'outstanding' (ii) Mock inspections Internal Audit to undertaken unannounced inspection of ED (Spring 2019) Internal Audit to undertaken unannounced inspection of Maternity (Summer 2019)	(i) Action plan in development (Autumn 2018) (ii) Workshop on moving to outstanding (October 2018) (iii) LEAN work informing True North statement (Autumn 2018) (iv) Mock inspections in progress (v) Internal audit review to be presented to ARC on 18 July 2019 (vi) Comms leaflet developed for staff - for launch at end of July 2019 (vii) Comms strategy to be developed including comms leaflet for staff - for launch at end of July 2019 (viii) CQC workshops to be provided		L1 x I2 = 2
Failure to achieve complaint reply performance standards leading to (i) Impact on reputation (ii) Impact on patient experience	Q&E8	Director of Nursing, Midwifery and Allied Health Professionals	L2 x I2 = 4	⟷	6				(i) Live complaints tracker developed (ii) Weekly PET/CG meetings to monitor progress/review agreed timescales and manage the complainants expectations. (iii) Weekly meetings with the Head of Patient Safety & Experience, Deputy Director of Quality & Governance and DoN which includes escalation. (iv) Quality dashboard includes CG performance presented at Clinical Governance Committee on a monthly basis. (v) Monitored through Patient Experience & Engagement Committee.	(i) Patient Experience Strategy approved (ii) Positive Q3 and Q4 results presented to Board in January 2017/18 and Q1 2018/19 (iii) Positive performance reported to Board throughout Summer 2018	(i) Consistent improved performance in complaints handling (ii) Complaints procsses subject to improvement practice work (A3)			L2 x I1 = 2
Failure to deliver GDPR mandated subject access requests due to increased demand against existing resource leading to (i) ICO intervention (ii) Regulatory fines (iii) Reputational impact	F&P17	Chief Information Officer	L4 x I3 = 12	⟷	12				(i) Historical baseline assessment (ii) Monitor impact for first three months (iii) Information Governance Committee monitoring (iv) Finance and Performance Committee report in initial months (v) Suitably qualified Data Protection Officer appointed (vi) Suitably trained staff (vii) Communications campaign and processes in place	(i) DPO appointment made (ii) Report to Finance and Performance Committee, April and May 2018 (iii) Report to Board of Directors, May 2018 (iv) Active action plan in place (v) Notices to members, staff and patients regarding GDPR Shared with Governor Brief. (vi) Paper provided to ANCR re DSP. (vii) Presentation and paper shared at Governor Brief	(i) As set out in action plan sent to Board, May 2018 (ii) Internal audit (to be scheduled later in 2019). (iii) Change to Data Security & Protection toolkit.	(i) DPO taking forward actions and reporting into IG Committee (2018/19) and ANCR.		L2 x I2 = 4

Failure to adequately treat patients due to unavailability and lack of supply of medicines leading to (i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement (vi) Financial impact for the Trust	Q&E9	Chief Operating Officer	L4 x I4 = 16		15			(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Databse of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	(i) Temporary improvements to the supply chain (ii) Updates from CMU (Commercial Medicines Unit of NHSE) (iii) Risk interrogation to QEC (April 2018) (iv) Government technical notes (v) Letter and guidance on 'No Deal' Brexit, August 2018	(i) Longer term improvements to supply chain (ii) Awareness amongst relevant staff (iii) Set out in QEC risk interogation report, reported April 2018	(i) Gaps to be added to database (ongoing) (ii) Action plan as set out to QEC during risk interrogation (Autumn 2018)		L3 x I3 = 9
Failure to mitigate the impact of an ambitious effectiveness and efficiency programme on quality of care leading to (a) Poor patient and family experience (b) Regulatory action (c) Impact on Trust's reputation (d) Low staff morale	Q&E11	Medical Director / Director of Nursing, Midwifery and Allied Health Professionals	L3x I4 =12		12			(i) Medical Director and Director of Nursing involved in Quality Impact Assessment process (ii) DNS, COO and MD involved in Efficiency and Effectiveness Committee (iii) DNS, COO and MD in agreeing the effectiveness and efficiency measures through ET (iv) Friends and Family Test (v) PLACE assessments (vi) CQC inspections and mock-inspections (vii) Regular meetings with NHS Improvement (viii) Ward visits programme (ix) Patient Experience Committee	(i) Reports to Clinical Governance Committee and Quality and Effectiveness Committee (ii) Recent quality accounts continuing to show good performance (iii) Trust has track record of delivering effectiveness and efficiency measures (iv) No wards 'red' for quality in previous month (v) QPIA process and outcomes reported to QEC and CGC. (vi) Positive PLACE assessments. (vii) QEC Meeting reviewed process and example cases (October 2018)	(i) Not yet identified EEPs (ii) QPIA on all schemes that come through or which change (iii) QEC exmaination of CIP process	(i) QPIA process 2018/19 (ongoing)		L1 x I4 = 4

Strategic Aim 2 - We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.

RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	PROGRESS TIMELINE	TARGET RR
Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications leading to (i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	F&P1	Director of Finance	L4 x I4= 16	⟷	16				(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Detailed monitoring by Finance and Performance Committee. (vii) Budgets set on recurrent outturn resulting in a more robust financial plan. (viii) Budgets signed off by divisions and corporate departments. (ix) Monthly monitoring at Board and directorate level. (x) Uncommitted general contingency reserve. (xi) Regular finance meetings with budget holders. (xii) Performance review meetings with NHSI. (xiii) All directorates signed up to control total. (xiv) Appointment of suitably quaified Efficiency Director. (xv) Formation of Efficiency and Effectiveness Committee. (xvi) Full Capital Monitorring Committee (xvii) Cash Committee monthly (xviii) Robust Cash Forecasts	(i) Exceeded control total in 2018/19 (ii) Production of 2019/20 budget (iii) Unqualified opinion on 2017/18 accounts (vi) Accounts submitted to NHSI by deadline (v) Financial plans submitted to NHSI (vi) Board approval of budgets (vii) Budget setting approved by Finance and Performance Committee (viii) Minutes of accountability and NHSI meetings (ix) External Audit review of financial performance (within Annual Accounts work) (x) Regular finance reports to F&P (xi) Good performance over the last quarter (xiii) Significant assurance audit with limited number of improvements on core financial systems (xiv) External audit 2018/19 (xv) Efficiency Director and team recruited (xvi) Financal performance regime implemented (xvii) Regulator standing down fortnightly reporting (xviii) Regulator standing down finance review meetings with Chief Finance Officer	(i) Achievement of strategic projects (ii)Lack of clear clincal strategy from the ICS (iv) Unidentified CIP (v) Workforce Plans (vi) Demand and capacity planning (vii) Lack of clear clinical strategy from ICS	(i) Project groups established and cases being brought to Board (ii) Plan to address the unidentified CIP and workforce (ongoing) (iv)Performance Assurance Framwork. (v) Deep Dives undertaken at F&P (vi) Appointment of clear strategic lead at Executive Level and use of Monitor Toolkit to assess strategic position	Updated with DOF - 27 June 2019.	L2 x I4 = 8
Failure to deliver Cost Improvement Plans in this financial year leading to (i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of PSF funding	F&P3	Director of Finance	L4 x I4 = 16	⟷	16				(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by EEC and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement ICS Eff programme. (vi) PMO led by new Eff Director, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress. (ix) Regenerated E&E Committee with CEO chair meeting 2/52 (x) CIP recovery meetings (fortnightly) with each group. (xi) Escalation of schemes to F&P Committee (xii) Appointment of suitably qualified Efficiency Director. (xiii) NHSi & Qii continuous improvement	(i) Performance against CIP for 18/19 of £12.2m. (ii) Monthly CIP reports to Finance and Performance and Board. (iii) Assurance provided to NHSI at quarterly meetings. (iv) New PMO governance processes agreed and implemented. (vi) Schemes in place for 2019/20. (viii) KPMG report on CIPs - significant assurance. (ix) CIP gap closed to £800k (from £2.5m). (x) £1m of schemes now in delivery, not planning. (x) IPR for Board updated.	(i) Outstanding recurrent CIP target to be found (ii) Consistent reporting of on track CIP schemes (iii) See F&P1	(i) Work with Executive Team on high risk and unidentified schemes (ii) Schemes to be reported to F&P each month (ongoing) (iii) See Risk F&P1 (iv) Performance Assurance Framework (v) Workforce plan to be produced by DP&OD for end of Q1.	Updated with DOF - 27 June 2019.	L1 x I4 = 4
Failure to achieve income targets arising from issues with activity leading to (i) the Trust not being paid for the work it is doing and subsequent impact on the financial plan (ii) reputational impact arising from a financial shortfall (iii) potential regulatory action arising from a financial shortfall	F&P19	Director of Finance	L3 x I5 = 15	⟷	10				(i) PTL meetings. (ii) Accountability meetings. (iii) Meetings with CCGs. (iv) Holding to account through Finance and Performance Committee. (v) Regular monitoring of activity plans. (vi) Care groups signed up to deliver activity. (vii) Enhanced PTL Meetings* (viii) Use of GOOROO (ix) Monitoring of prospective booking (x) Qii scheduling programme (xi) QPIA Process (xii) Doncaster PLACE Transformation Board and Efficiency Committee	(i) Accountability meetings taking place. (ii) Audit of maternity income. (iii) Delivery of income from M1 - 6.	(i) Capacity and demand plan (ii) Activity modelling	(i) Capacity and demand plan and actvity modelling (Autumn 2018) - elective and outpatient firsts	07/05/19 - Meeting held with DOF. Risk position reviewed and increase to 15 from 10. Additional control and assurances added. Updated with DOF - 27 June 2019.	L1 x I4 = 4
Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register. leading to (i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	F&P4	Director of Estates and Facilities	L4 x I5 = 20	⟷	20				(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017) (ix) Emergeny Capital Theatre Bid	(i) Presentations to Finance and Performance and Governors Briefings (ii) Catering contract agreed May 2017 (iii) New service assistants in post April 2017 (iv) Completed 6/7 facet survey (v) Asbetos and window surveys complete (vi) Asbestos management plan up to date (vii) Window risk assessments complete (viii) Water management protocols complete and progress commenced (ix) Electrical infrastructure surveys complete (xii) Waste contract completed and delivered (xii) New catering contract signed (xiv) New gas main (xv) Continuously premise assurance model (xvi) Estates Strategy approved by Board and capital plan (xvii) Estates strategy audited (significant assurance) (xviii) Capital programme 18/19 agreed (xix) PAM agreed April 2018 - good requires minimal improvement (xx) 6/7 facet survey work agreed (xxi) Seven year investment plan in place (xxii) Regular EFM KPI Reports to BoD and six monthly H&S KPI reports t ANCR (xxiii) PAM and ERIC completed	(ii) EFM transformation project	(ii) Seek additional funding to rectify condition and backlog maintenance issues (iii) £137m bid unsuccessful at wave 3, emergency capital bids being developed for fire compliance and main theatre and womens and childrens compliance. (iv) Work due to start 1 July for fire compliance and 1 sept for theatres. (v) Potential re-submit wider bid wave 4 2021. (vi) NHSi requests for reduction in Capital Spend across SYB ICS of 25% in total.	Updated with DOF - 27 June 2019.	L2 x I5 = 10
Risk of critical lift failure leading to (a) Reduction in vertical transportation capacity in the affected area (b) Impact on clinical care delivery (c) General access and egress in the affected area	F&P20 / Q&E12	Director of Estates and Facilities	L4 x I5 = 20	⟷	20				(i) Reporting to Estates Committee and Clinical Governance Committee (ii) PLACE assessments (iii) Contract monitoring arrangements (iv) Issues raised through Governor Forum and Patient Experience Committee (v) Issues and complaints statistics (vi) Service contract with Lift service provider which includes X 2 resident lift engineers on site permanently (vii) Lift refurbishment complete (lifts 4, 5, 6 and East Ward Block)	(i) Report to Part 2 Board, 26 June 2018 (ii) Confirmation of ability to use STF funding (iii) Catering updates to F&P, Board and Council of Governors (iv) Communication through ET and to Governors (v) Lifts down now back in commission	(i) Full lift survey to be undertaken in 2019/20 to develop capital for replacement	(i) Full site survey of lift conditions being undertaken in order to develop modernisation of programme.	Updated with DE&F - 19 June 2019. No change.	L2 x I5 = 10

Failing to address the effects of the agency cap leading to (i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	F&PS	Director of People and OD/ Chief Operating Officer/Medical Director	L4 x I4 = 16	⟷	16				(i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) Grip & Control work including scrutiny of qualified nurses. (xiv) Use of alternative workforce.	(i) Recruitment report to Board May 2017. (ii) Workforce and Education Committee assurance reports to QEC & F&P. (iii) Agency spend and breaches going to Exec Team and F&P. (iv) Improved rate-to-fill and fill rates. (v) Latest GMC Survey, in upper quartiles for a number of specialties. (vi) F&P monitoring agency spend and reporting to Board. (vii) Agency spend to F&P. (viii) Weekly flash reports and meetings. (ix) Bassetlaw@ work. (x) QiMET process. (xi) Nursing workforce within 3% cap. (xii) Report to Board July 2018. (xiii) KPMG audit report and institution of grip and control measures. (xiv) Use of model hospital data. (xv) NHS Professionals collaborative contract in place. (xvi) Medical bank in place. (xvii) Additional grip and control for agency spend. (xviii) Reviewing NHSi Model Hospital Portal data.	(i) Develop new service model to mitigate medical staff shortage, working across the Trust. (ii) Develop and progress workforce from using alternative workforce for service delivery. (iii) Agree with Trusts in WTP to minimise cap breaches. (iv) Decrease local agency spend. (v) Flexible use of staff across ICS system. (vi) Results from collaborative bank pilot to review. (vi) NHSP Collaborative Bank worked up for implemented. (vii) New grip nd control measures in operation. Divisional workforce plans need to adress exisiting shortfalls.	(i) Hospital@ work - T&O issues (Autumn 2018). (ii) In discussion with recruitment agencies to fill gaps (ongoing). (iii) Local Workforce Action Board work taking place. (iv) Grip and control meetings taking place weekly. Nursing and medical staff.		L3 x I2 = 6
Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards leading to (i) Regulatory action (ii) Impact on reputation	F&P6	Chief Operating Officer	L4 x I4 = 16	⟷	16				(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF.	(i) Full and unconditional registration with CQC. (ii) Business Intelligence and Performance Reports . (iii) Annual Report & Quality Account. (iv) CE quarterly objectives report (BoD - quarterly). (v) Internal audit of CQC readiness. (vi) CQC Intelligent Monitoring reports & risk ratings. (vii) In Group 2 on four hour waits. (viii) A&E Improvement Progarmme North - showcasing best practice. (ix) System Perfect. (x) Removal of breach fo licence. (xi) Estates performance reported to Board (April 2018). (xii) CQC inspection report and action plan. (xiii) Winter Plan considered by Board, September 2018. (xiv) High evel presentation to Board on CQC outstanding. (xv) Elective care work - feedback from NHSI positive.	(i) Action plan towards outstanding. (ii) 62 day cancer acton plan - urology	(i) Action plan for outstanding due Autumn 2018. (ii) 62 day action plan end Q3 - Completed. Q4 in progress.	Need to update with RJ.	L3 x I3 = 9
Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are conatained within this overarching entry. For further details please consult the EF risk register. leading to (i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) lack of quality of care and service delivery	F&P12	Director of Estates and Facilities ~~/ Medical Director~~	L4 x I5 = 20	⟷	20				(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee (xi) Emergency Capital Bids to NHSI to accelerate fire improvement programme	(i) Physical works to DRI and MMH (ii) Fire safety action plan (iii) Report to Board in June 2017 (iv) Fire safety training scheduled July 2017 (v) Staff trained in fire safety - June 2017 (vi) Compartmentalisation, fire stopping, fire doors, fire dampers to the East Ward Block (DRI) basement, ground floor and level seven and other areas across the site (vii) Upgrade of existing, and provision of additional, fire alarm and detection systems at DRI and Montagu Hospital. (viii) Approval of evacuation strategies for W&Cs and East Block. (ix) HSE inspections of Women's Block (x) Montagu evactuation strategy approved, December 2017 (xi) Priority list for fire strategies presented to Board (xii) Fire training delivered to deputy directors across organisation (xii) Training on evacuation strategies	(i) Full compliance with requirements of Fire Service (ii) Actions to address Deficiency Notice at Bassetlaw - partially complete	(i) Training to be rolled out across 2018/19 (Rolling programme). (ii) GMs and Hons to be fire trained.	15/04/19 - Clinical Risk paper reviewed as part of Management Board and further concerns highlighted to include; HASU refurbishment, windows on ward 17 and East Ward block, expansion of A&E and Sensor Taps in Childrens Hospital. Management Board agreed to joint responsibility with Medical Director. Updated with DE&F - 19 June 2019. No change.	L2 x I5 = 10
Inability to meet Trust's needs for capital investment leading to (i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	F&P13	Director of Finance	L4 x I4 = 16	⟷	16				(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritisation of schemes. (v) Range of capital groups established and led by directors. (vi) CT Decision made	(i) DBTH part of bidding process for ICS funds and ET to agree priorities. (ii) Five year review of capital requirements which have been prioritised. (iii) Submitted bid for rebuild and IT. (iv) ICS Capital Group	(i) Development of ICS schemes - business cases. (ii) Approval of CT scheme by DOH.	(i) Working on emergency capital bids for key areas and looking at ways to find and develop larger schemes with ICS support following unsuccessful bid in 2018/19. (ii) NHSI/E requesting reduction of Capital Spend by 25% in SYB to meet national shortfall of capital	Updated with DOF - 27 June 2019.	L1 x I4 = 4
Lack of adequate CT scanning capacity at DRI leading to (i) Negative impact on patient safety. (ii) Inability to safely manage the emergency and inpatient activity.	Q&E2	Chief Operating Officer	L3 x I3 = 9	⟷	9				(i) Allocation within 2017/18 capital programme. (ii) Engagement with care group directors. (iii) Mobile CT. (iv) HASU project steering group.	(i) Business case cleared at CIG. (ii) Initial dicussions at F&P and ICS level. (iii) Case approved at Board, February 2018. (iv) CT donation. (v) Positive feedback from NHSI. Work commenced on two new CT scanners - discussed at BoD in Jan 2019 Utilisation of Bassetlaw CT scan and van days Mobile CT scanner.	(i) Approval from DOH. (i) CT scanning implementation.	(i) Awaiting approval from DOH (October 2018) (ii) CT Build Janaury 2019		L2 x I2 = 4
Uncertainty over ICS financial regime including single financial control total leading to (i) Impact on Trust's finances and control total (ii) Negative impact on reputation	F&P16	Director of Finance	L2 x I4 = 8	⟷	8				(i) Chair and exec attendance at ICS meetings. (ii) Leadership at ICS level. (iii) Developing governance structure.	(i) Ongoing discussions with ICS and at national level. (ii) Framework approved June 2018. (iii) Paper to board explaining options (Summer 2018). (iv) Decision by Board to agree option 2. (v) Initial governance workshop took place September 2018. (vii) Monitorring at FD meeting (viii) Exec Steering Group	(i) Uncertainty over ICS governance structure.	(i) Further governance work taking place (ongoing) (ii) Ambiguity of national guidance on application of surplus to the SYB system control total.	Updated with DOF - 7 May 2019. No change.	L2 x I2 = 4
Risk of fraud leading to (i) Impact on Trust's finance (ii) Negative impact on reputation	ANCR1	Director of Finance	L2 x I4 = 8	⟷	8				(i) Local Counter Fraud Specialist work plan and investigations (ii) Fraud awareness training. (iii) DH Counter-Fraud regime and oversight (iv) Liaison with DOF and Chair of ANCR (v) Staff fraud questionnaire. (vi) Board level awareness	(i) Quarterly and annual LCFS reports (ii) Achievement of satisfactory NHS CFA Quality Assessment Outcome via SRT. (iii) Full completion of 2018/19 operational fraud plan and 2019/20 plan in place (iv) Completion of fraud staff survey (vii) 96% completed fraud awareness training in 2018/19 (viii) NHS Protect assurance report to Board (x) Appropriate Fraud, Bribery and Corruption Policy in place	N/A	N/A	Updated with DOF - 7 May 2019. Review of assurances to include new training percentages and review of Fraud, Bribery and Corruption Policy.	L1 x I4 = 4

Strategic Aim 3 - We will increase partnership working to benefit people and communities.														
RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	PROGRESS TIMELINE	TARGET RR
Breakdown of relationship with key partners and stakeholders leading to (i) Negative impact on strategic objectives (ii) Negative impact on reputation	F&P9	Director of Strategy and Improvement	L3 x l4 = 12	⇔	12				(i) Partnership working processes - Working Together, STP, Accountable Care Systems, HWB. (ii) Engagement with commissioners & other local trusts. (iii) Attendance at CCG governing body meetings. (iv) CE meetings with NHS England. (v) Regular briefings to Members of Parliament. (vi) Partner Governor seats on the Council of Governors. (vii) Regular Item on Exec Team for feeding back.	(i) CE Reports to Board. (ii) Updates on HWB activity. (iii) Updates regarding Working Together and STP programme via CE report (BoD). (iv) Committees in common and STP MoUs. (v) Support from commissioners. (v) Bassetlaw and Doncaster Place Plans endorsed. (vii) Well Led Governance Review reinforces the Trust's partnership arrangements. (viii) ACS Conference for Governors taken place, October 2017 and with NEDs, May 2018. (ix) CIC meetings underway. (x) Collaborative Partnership Agreements with Doncaster and Bassetlaw signed, April and May 2018. (xi) Outcome of legal challenges known and not, as yet, affecting ICS. (xii) ICS MoU considered by Board, September 2018. (xiii) CEO commenced formal secondment with ICS. (xiv) ICS MoU signed.	(i) ACS events planned with MPs and councillors. (ii) Joint meetings with SCH and RDaSH.	(i) Engagement at PLACE level under consideration (Autumn 2018) (ii) Engagement meetings with SCH and RDaSH (Autumn 2018)		L2 x l4 = 8
Failure to deliver strategic direction leading to (i) Negative impact on patients (ii) Inability to configure services in the best interests of patients (iii) Negative perception of partners and staff	F&P18/QEC10	Director of Strategy and Improvement	L2 x l5 = 10	⇔	10				(i) Process for strategy review based on quarterly exception reporting and annual report to Board. (ii) Quarterly discussion at Executive Team on strategy. (iii) LEAN Programme work. (iv) Capital steering groups set up to consider approach to clinical site development work. (v) Operational groups taking forward individual enabling strategies (IT Steering Group, Estates Group, etc). (vi) Board committees with certain enabling strategies under their remit. (vii) Dedicated resource within Strategy and Transformation.	(i) Overall strategic direction agreed, Summer 2017. (ii) Enabling strategies approved by Board, 2017/18. (iii) Board process for reviewing strategies agreed, April 2018. (iv) Strategy review within board committee terms of reference. (v) Key milestones agreed by ET, April 2018. (vi) Strategy communicated to staff through Buzz and Foundations for Health. (vii) Deep dives and exception reporting mechanism established (June 2018)	(i) Firmer arrangements for committee review of milestones and KPIs to be agreed. (ii) Achivement of strategic milestones. (iii) Capital to achieve long term aims. (iv) Realisation of Improvement Practice work.	(i) Process for milestones and KPIs in development. (ii) Monitoring and achivement of action plans agreed at Board (2018-19) (iii) ICS capital bids (Autumn 2018). (iv) Improvement Practice Programme 2018-19.		L1 x l5 = 5
Failure to ensure business continuity / respond appropriately to major incidents leading to (i) Negative impact on reputation (ii) Regulatory enforcement (iii) Negative impact on performance	F&P10	Chief Operating Officer	L2 x l4 = 8	⇔	8				(i) Business continuity plans (ii) Business Continuity Policy (iii) Statement of Compliance against National Core Standards for EPRR (iv) BRSG which monitors BC planning progress (v) Business Continuity Group linked to operational structures (vi) Major Incident Plan (vii) Training of A&E staff on CBRN incidents (viii) Emergency response plans in place (annually reviewed) - Evacuation of a hospital site - Mass Casualty Plan - Pandemic Influenza Plan - Severe Eeather Plan - Prison Plan - CBRNE plan (ix) Incident Control Rooms in line with EPRR Command and Control guidelines (x) Communications exercises undertaken twice yearly as required by statute (xi) Command & control training for BoD & senior managers on-call (xii) Revision of plans following test exercises. (xiii) On-call senior mangement trained - Leading in a crisis and public enquiry simulation (xiv) New generator and power witchover (Childrens completed).	(i) Power outage testing Summer 2017 (ii) Annual confirmation of compliance against National Core Standards for Emergency Preparedness, Resilience and Response (BoD, Nov 2016) (iii) Test exercises: Sickness, fuel (2016) (iv) Internal Audit follow-up review of business continuity arrangements (v) Risk assessment of major incident and business continuity plans with NHS England (2015) (vi)Y&H peer review of major incident plans 2016. (vii) External review of HAZMAT - compliant (September 2015) (viii) Hazardous Substances policy agreed by Board 29.11.2016 (ix) Tabletop exercises undertaken, SY risk assessment completed and two power cuts (x) Working with Care Groups to develop relevant desktop exercises. (xi) Trust unaffected by system-wide cyber attack, May 2017 (xii) Winter planning agreed by Board in July 2017 (xiii) Compliance with Annual Statement of Compliance against the NHS Core Standards for Emergency Preparedness, Resilience and Response (2017/18) (xiv) Presentation to Board on Emergency Planning, November 2017 (xv) Business continuity exercise (mostly completed), December 2017 (xiv) Further review of processes following power outage (Winter 2018). - work undertaken (xv) Cold weather plan tested. Significant assurance agaisnt latest core standards. (xvi) Esclation Policy for management of major incident - Trust/Council. (xvii) June 2018 testing complete. (xviii) Policies agreed by MB. (xix) EPRR action plan agreed by Board.	(i) Testing by internal audit. (ii) Brexit plan. (iii) LHRP ratification.	(i) Internal audits (end of 2018/19) (ii) Brexit planning ongoing. (iii) East block tower work to be undertaken in March 2019.		L2 x l3 = 6

Strategic Aim 4 - We will support the development of enhanced community based services, prevention and self-care.													
RISKS	LINK TO CRR	EXEC	CURRENT RR	DIRECTION OF TRAVEL	Q1	Q2	Q3	Q4	CONTROLS	ASSURANCE	GAPS IN ASSURANCE	ACTION TO ADDRESS GAPS	PROGRESS TIMELINE	TARGET RR
Inability to sustain the Paediatrics service at Bassetlaw leading to (i) Withdrawal of overnight service (ii) Negative impact on local community	Q&E3	Chief Operating Officer	L2 x I2 = 4	⇔	4				(i) Consultant led paediatric assessment unit in place. (ii) Arrangements for transferring overnight stays to DRI. (iii) Communication with CCG and HOSC. (iv) Arrangements with Sheffield Children's Hospital. (v) Ongoing paediatric nurse recruitment.	(i) Reports on transferrals (ii) Positive response to recruitment (iii) Discussions with Notts Health O&S Committee in July 2017 (iv) Report to Board, August 2017 regarding future of overnight paediatric service (v) CEO's presentation to Governors, September 2017 (vi) Decision taken by Bassetlaw CCG, October 2017 (vii) Overview and Scrutiny Committee in January 2019 to update on current plans.	(i) Recruitment of medical and nursing staff.	(i) Regular recruitment exercises. (ii) Review of peadiatric competencies for ED - Additional training for Adult Nurses in Bassetlaw ED. (iii) Continue to advertise nursing posts. Paediatrics being review as part of Hospital Services review.		L1x I2 = 2
Reduction in hospital activity and subsequent income due to increase in community provision leading to (i) Increased pressure on acute services (ii) Negative impact on financial plan	F&P14	Director of Finance	L3 x I3 = 9	⇔	9				(i) Measures to ensure ward base matches with cost base (ii) Contract negotiation (III) Nursing workforce report (iv) Agency bank report (v) Corporate Investment Group processes (vi) Business change processes for associated service changes (vii) Contract changes to go to F&P (viii) Monitorring and bidding against appropriate services.	(i) DBTH input into Place Plan (ii) Assessment received for MoU	(i) Understanding of impact of Place Plan and ICS (ii) Lack of clarity over Doncaster Place Plans.	(i) Meetings taking place with Council and other partners to assess impact (ongoing) (ii) Doncaster Place Meeting	Met with DOF - 27 June 2019. No change.	L4 x I2 = 8
Commissioner plans do not come to fruition and do not achieve the required levels of acute service reduction leading to (i) Increased pressure on acute services (ii) Negative impact on strategic direction (iii) Negative impact on financial plan	F&P15	Chief Operating Offcer	L4 x I3 = 12	⇔	12				(i) Potential to dual run services (ii) Contractual negotiations (iii) External advice on contractual changes (iv) Consideration of changes through ACPs (v) Gooroo work (vi) Meetings between DOFs of Trust and CCGs	(i) Active monitoring of position (ii) Place Plans in place (iii) Clinical services strategy in place (iv) Both sides committed to outputs from Gooroo work.	(i) Alignment of expectations between Trust and CCG	(i) Ongoing negotiations and plans (Autumn 2018) (ii) CCG agreed to fund additional activity which needs to be undertaken to maintain contract and activity.		L2 x I3 = 6

Strategic Aim 5 - As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.														
RISKS	**LINK TO CRR**	**EXEC**	**CURRENT RR**	**DIRECTION OF TRAVEL**	**Q1**	**Q2**	**Q3**	**Q4**	**CONTROLS**	**ASSURANCE**	**GAPS IN ASSURANCE**	**ACTION TO ADDRESS GAPS**	**PROGRESS TIMELINE**	**TARGET RR**
Inability to recruit right staff and have staff with right skills leading to (i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	F&P8	Director of People & OD	L4 x I4 = 16	⟺	16				(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes - bolstered. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles. (xii) Nurse associate roles - exploration. (xiii) Increasing the attractiveness of the website, social media and open days. (xiv) Open days for recruitment (June 2019)	(i) Increased fill-rate, above national averages in most areas. (ii) Recruitment report to Board, May 2017. (iii) Regular NHSI reporting which is reported to Exec Team, increased to bank as well as agency. (iv) Benchmarking work. (v) WTP work. (vi) New style agency report reported monthly to Exec Team. (vii) Work with ICS Local Workforce Action Board. (viii) Accountability arrangements embedded. (ix) Regular reports to F&P. (x) Review of cohort recruitment. (xi) Work on apprenticeships. (x) We Care for Junior Doctors work. (xi) People & OD Strategy. (xii) QiMET work. (xiii) P&OD structure in place. (xiv) Hall Cross Foundation School work. (xv) Pilot for international recruitment for Junior Drs. (xvi) Expanding Medical Training Initiative recruitment.	(i) Leadership Strategy. (ii) Radiographers work ongoing. (iii) Actions identified in strategic milestones. (iv) LWAB work taking place.	(i) Recruitment for radiographers in place - skill mix (Autumn 2018). (ii) LWAB actions. (iii) Q4 2018/19 (iv) Refreshing recruitment material and branding. (v) Recruitment with Napal. (vi) Open days for recruitment (June 2019)		L2 x I4 = 8
Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development leading to (i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Q&E1	Director of People & OD	L4 x I4 = 16	⟺	16				(i) Process to engage with LNC. (ii) Process to engage with Partnership Forum. (iii) HR policies and procedures. (iv) Staff engagement project strands. (v) Staff experience group. (vi) Listening events by CEO. (vi) E&E Committee communications plan. (vii) One-page strategy summaries. (viii) Staff social media sites. (ix) Staff Experience Meetings	(i) Suspensions/exclusions reports to ANCR. (ii) P&OD reports to Board. (iii) Briefings regarding staff engagement during restructures. (iv) Records of ongoing engagement via Partnership Forum. (v) Staff Survey results. (vi) Grievance and employment tribunal rates. (vii) Outcomes of negotiation & work with staff side. (x) Delivery of engagement plan KPIs. (xi) Listening events - Autumn 2018. (xii) Buzz and social media interaction. (xi) Meetings with staff regarding Hospital Services Review. (xii) Staff survey action plans to Board, May 2018. (xiii) Partnership Board meetings with executive directors. (xiv) Update on progress agaisnt action plan at Board in December 2018.	(i) Staff survey action plans fully signed up to. (ii) Relationship with new chair of Partnership Forum. (iii) Actions identified in strategic milestones. (iv) Actions identified in deep dive risk interrogation, QEC (August 2018) (v) Relaunch staff experience group.	(i) Divisional action plans to be implemented and monitored through accountability meetings. (ii) Development of staff side relationships (Autumn 2018). (iii) Q4 2018-19		L2 x I4 = 8
Failure to improve staff morale leading to (i) Recruitment and retention issues (ii) Impact on reputation (iii) Increased staff sickness levels	Q&E6	Director of People and OD	L3 x I4 = 12	⟺	12				(i) Monitoring by staff experience group. (ii) Revised appraisal process. (iii) Chief Executive's listening exercises and 'you said, we did'. (iv) Staff involved in strategy engagement. (v) Management passport qualification developed. (vi) Localised action plans. (vii) Staff survey action plan monitored by Board and QEC. (viii) Revamped staff brief. (xi) 'Bugbears and bright ideas' approach. (x) Agreed approach to staffside - management meetings. (xi) Achievment of teaching hospital status.	(i) Feedback from Friends and Family Q2. (ii) Feedback from CEO's listening events and lunchtime meetings with consultants. (iii) Bugbears and bright ideas outcomes. (iv) Report to QEC and Board, June 2017, on staff survey action plan. (v) People and OD Strategy approved by Board in October 2017. (vi) Improvements in staff survey results. (vii) Action plans approved by Board (April 2018). (viii) Progress update on actions to Board in December 2018.	(i) Consistent positive scores for staff Friends and Family Test. (ii) Consistent positive scores for staff survey. (iii) Actions identified in strategic milestones. (iv) Active monitoring against departmental action plans. (v) Conclusion of clinical admin review.	(i) Additional listening exercises. (ii) P&OD action plans (Various). (iii) Q4 2018-19. (iv) BPs to update on progress against each of action plans. (v) Clinical admin review concluded (January 2019 - interviews held recruitment ongoing). (vi) Planning future actions for 2019. (vii) Staff Survey to be highlighted under new PAF.		L2 x I4 = 8

No.	Description of Risk		Exec owner	Relevant committee	Original Risk Score 1:Low…5:Extreme		Overall Original Risk Score	Controls	Current Risk Score 1:Low 5:Extreme		Overall Current Risk Score	Target Risk Score 1:Low 5:Extreme		New and developing controls	Owner and target date
	Source (Lack of….Failure to ….)	Consequences (Results in ….Leads to ….)			Like-lihood	Impact			Like-lihood	Impact		Like-lihood	Impact		
F&P1	Failure to achieve compliance with financial performance and achieve financial plan	(i) Adverse impact on Trust's financial position (ii) Adverse impact on operational performance (iii) Impact on reputation (iv) Regulatory action	Director of Finance	Finance & Performance	4	5	20	(i) Business and budget planning processes. (ii) Financial governance policies and procedures. (iii) Monthly monitoring of financial performance. (iv) Data analysis of trends and action to address deterioration. (v) Continued liaison with budget holders to identify risks to delivery. (vi) Detailed monitoring by Finance and Performance Committee. (vii) Budgets set on recurrent outturn resulting in a more robust financial plan. (viii) Budgets signed off by divisions and corporate departments. (ix) Monthly monitoring at Board and directorate level. (x) Uncommitted general contingency reserve. (xi) Regular finance meetings with budget holders. (xii) Performance review meetings with NHSI. (xiii) All directorates signed up to control total. (xiv) Appointment of suitably quaified Efficiency Director. (xv) Formation of Efficiency and Effectiveness Committee. (xvi) Full Capital Monitorring Committee (xvii) Cash Committee monthly (xviii) Robust Cash Forecasts (xix) Lack of clear clinical strategy from ICS	4	4	16	2	4	(i) Additional grip and conrol mechnaisms. (ii) Performance Assurance Framework. (iii) Deep Dives undertaken at F&P	Director of Finance / Each Month
F&P3	Failure to deliver Cost Improvement Plans in this financial year	(i) Negative impact on Turnaround (ii) Negative impact on Trust's financial positon (iii) Loss of STF funding	Director of Finance	Finance & Performance	4	5	20	(i) Full Quality Risk Assessment and operational deliverability assessment of plans. (ii) Regular consideration of schemes by EEC and Executive Team. (iii) Collaboration with other providers, to identify joint opportunities. (iv) CIP tracker developed to provide visibility of progress agianst plan. (v) Engagement ICS Eff programme. (vi) PMO led by new Eff Director, with associated management processes, key deliverables, risk logs and reporting to Finance and Performance Committee. (vii) Implementation of innovation from external reviews. (viii) Regular meetings with NHSI to track progress. (ix) Regenerated E&E Committee. (x) CIP recovery meetings (fortnightly) with each group. (xi) Escalation of schemes to F&P Committee (xii) Appointment of suitably qualified Efficiency Director. (xiii) NHSi & Qii continuous improvement	4	4	16	1	4	(i) Additional grip and conrol mechnaisms. (ii) Performance and Assurance Framework.	Director of Finance / Each Month
F&P4	Failure to ensure that estates infrastructure is adequately maintained and upgraded in line with current legislation, standards and guidance. **Note:** A number of different distinct risks are contained within this overarching entry. For further details please consult the E&F risk register.	(i) Breaches of regulatory compliance and enforcement (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation (v) Reduced levels of business resilience (vi) Inefficient energy use (increased cost) (vii) Increased breakdowns leading to operational disruption (viii) Restriction to site development	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Annual business plan supports identification of issues by Care Groups / Directorates (ii) Risk-based capital investment plans (iii) Maintenance and support service contracts (iv) Independent Authorising Engineers appointed for key services, providing annual audits and technical guidance (v) Revised business planning process for all capital investments (vi) Estate condition and backlog maintenance assessment undertaken via 6-7 facet survey (vi) Progress and monitoring of actions undertaken through compliance committees e.g. health and safety committee (vii) Board level health and safety training undertaken, October 2017 (viii) Completion of in-depth high voltage scheme (June 2017) (ix) Emergeny Capital Theatre Bid	4	5	20	2	5	(i) Test buisness continuity and disaster recovery plans (ii) Rolling programme of Board / Senior Staff training (iii) Seek additional funding to rectify condition and backlog maintenance issues	DP - ongoing KEJ - ongoing
F&P5	Failing to address the effects of the medical agency cap	(i) Negative patient and public reaction towards the Trust (ii) Impact on reputation	Director of People and OD/ Chief Operating Officer/Medical Director	Finance & Performance	5	4	20	(i) Teaching hospital status communicated through recruitment. (ii) Care Group to escalate recruitment difficulties to MD/COO. (iii) Use of Trust staff in first instance to address gaps wherever possible. (iv) Signed memo of understanding between all Trusts in the WTP to abide by a standard set of principles. (v) P&OD / Workforce reports to BoD. (vi) Workforce and Education Committee. (vii) Agency spend and breaches going to Exec Team and Finance and Performance. (viii) Better system around rate-to-fill and fill rates. (ix) Use of social media to attract new candidates. (x) Relationships with universities. (xi) GMC Survey. (xii) Medical agency locum panel. (xiii) BDO Grip & Control work. (xiv) Use of alternative workforce.	4	4	16	3	2	(i) Develop new service model to mitigate medical staff shortage. (ii) Develop and progress workforce from using alternative workforce for service delivery.	KB/SS/DP - ongoing As above

F&P6	Failure to achieve compliance with performance and delivery aspects of the Single Oversight Framework, CQC and other regulatory standards	(i) Regulatory action (ii) Impact on reputation	Chief Operating Officer	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	5	4	20	(i) Performance Management and Accountability Framework. (ii) Business planning processes (iii) Relevant policies and procedures. (iv) Daily, weekly & monthly monitoring of targets. (v) Regular monitoring of compliance. (vi) Data analysis of trends and action to address shortfalls. (vii) Continued liaison with leads to identify risks to delivery. (viii) CQC Compliance Governance and Assurance Process. (ix) External reviews policy. (x) Monitoring at monthly Care Group accountability meetings. (xi) A&E QAT process. (xii) Demand and capacity planning proccesses. (xiii) Weekly review of A&E Action plan in accountability meeting chaired by COO. (xiv) Licence to Operate linked to SOF	4	4	16	3	3	(i) Review of front door streaming	DP - Autumn 2018
F&P8	Inability to recruit right staff and have staff with right skills	(i) Increase in temporary expenditure (ii) Inability to meet FYFV and Trust strategy (iii) Inability to provide viable services	Director of People & OD	Finance & Performance	5	4	20	(i) HR policies and procedures. (ii) Monitoring of use of agency staff through robust processes to stay within cap. (iii) Medical staff recruitment action plans. (iv) Care Group Business Plans – workforce plans. (v) E-Rostering processes. (vi) VCF processes - bolstered. (vii) Consultant appointment approval processes. (viii) NHS Professionals processes & management information. (ix) Pilot of Assistant Practitioner role. (x) Links with universities, increasing local placements. (xi) Developing bands 1-4 nursing roles. (xii) Nurse associate roles - exploration. (xiii) Increasing the attractiveness of the website, social media and open days. (xiv) Open days for recruitment (June 2019)	4	4	16	2	4	(i) Agency report development (ii) Care group management development (iii) Relaunch of Trust values	(i) Autumn 2018
F&P11	Failure to protect against cyber attack	(i) Trust becoming non-operational (ii) Inability to provide clinical services (ii) Negative impact on reputation	Chief Information Officer	Finance & Performance	5	5	25	(i) Penetration test of systems to identify gaps and risks; (ii) Firewalls, passwords, anti-virus equipment. (iii) Policies and reinforcement through communication to staff; (iv) Staff awareness through Certified Security Professional course and other training; (v) Trigger alerts; (vi) Care Cert system at NHS Digital (vii) All servers and systems patched to appropriate level (viii) Computers and network infrastructure get security patches automatically applied (ix) Monthly cyber security report (x) Pilot trust for NHS Digital work (xi) Digital garage work (xii) Regular returns to the centre	3	5	15	1	4	Controls proposed by recent cyber security audit including ongoing changes to systems and new patches being applied. Undertaking windows 10 rollout and software replacement	SM - ongoing March 2020 (regrade)
F&P12	Failure to ensure that estates infrastructure is adequately maintained and upgraded in accordance with the Regulatory Reform (Fire Safety) Order 2005 and other current legislation standards and guidance. **Note:** a number of different distinct risks are contained within this overarching entry. For further details please consult the EF risk register.	(i) Breaches of regulatory compliance could result in Enforcement or Prohibition notices issued by the Fire and Rescue Services (ii) Claims brought against the Trust (iii) Inability to provide safe services (iv) Negative impact on reputation	Director of Estates and Facilities	Finance & Performance	5	5	25	(i) Regular external inspections from SYRS and Notts Fire Service (ii) Improved fire safety risk assessments and evacuation strategies (iii) Improved Fire Safety Training (iv) Programme upgrade of fire detection systems (v) Programme upgrade of structural fire precautions (compartments) (vi) External Audit Fire Authorised Engineer (vii) Fire safety training Trust Board and Exec Team (viii) Further Development of Fire Safety Response Team structure (ix) Risk based Capital Investment plans identified by estate condition and backlog maintenance assessments via 6 - 7 facet surveys (x) Progress and monitoring of actions undertaken through compliance committees eg health and safety committee (xi) Emergency Capital Bids to NHSi to accelerate fire improvement programme	4	5	20	2	5	(i) Ongoing training on fire safety with staff	KEJ - ongoing. JR to update this row with information from BAF.
F&P13	Inability to meet Trust's needs for capital investment	(i) Inability to sustain improveemnts in Trust's estate. (ii) Negative impact on patient safety. (iii) Negative impact on reputation.	Director of Finance	Finance & Performance	5	4	20	(i) Finance reports to Board and Finance and Performance Committee. (ii) Capital governance governance structure - Corporate Investment Group and Capital Monitoring Group. (iii) Guidance and templates for investment and disinvestment. (iv) Proactive prioritiation of schemes. (v) Range of capital groups established and led by directors. (vi)Trust investigating application for emergency capital to DOH	4	4	16	1	4	Clarity around process over STP capital projects.	Autumn 2018
Q&E1	Failure to engage and communicate with staff and representatives in relation to immediate challenges and strategic development	(i) Deterioration in management-staff relationships (ii) Negative impact on performance (iii) Negative impact on reputation	Director of People & OD	Quality & Effectiveness	5	4	20	(i) Process to engage with LNC. (ii) Process to engage with Partnership Forum. (iii) HR policies and procedures. (iv) Staff engagement project strands. (v) Staff experience group. (vi) Listening events by CEO. (vi) E&E Committee communications plan. (vii) One-page strategy summaries. (viii) Staff social media sites. (ix) Staff Experience Meetings	4	4	16	2	4	Proactive communications around particular issues	Ongoing

Q&E9	Failure to adequately treat patients due to inavilability and lack of supply of medicines	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on trust reputation (v) Increased workload in pharmacy procurement	Chief Operating Officer	Quality & Effectiveness	5	4	20	(i) Support from Regional Procurement Team (ii) Arrangement of substitute drugs and medicines (iii) Databse of supply issues managed by RPT (iv) Daily updates on shortages (v) Holding to account of wholesalers for non-delivery of their contractual obligations and monitoring the performance of wholesalers in the region (vi) Local holding to account through account business managers (vii) Escalation measures to Deputy Chief Pharmacist for persistent and acute issues (viii) Logistics team communicating shortages to the ward and pharmacy team if stock not available for supply	4	4	16	2	3	(i) Adoption of a regional procurement online tool to track, manage and communicate supply shortages (ii) Updated workflows, process and procedures to ensure that internal communication and engagement is optimised, collaboration is enhanced and action plans and solutions are documented better (iii) Support sought from Regional QA teams to help quality assure imported or unlicensed medicines.	Autumn 2018
F&P20 / Q&E12	Risk of critical lift failure	(i) Reduction in vertical transportation capacity in the affected area (ii) Impact on clinical care delivery (iii) General access and egress in the affected area	Director of Estates and Facilities	Finance & Performance (impact on performance) Quality & Effectiveness (impact on quality)	4	5	20	(i) Reporting to Estates Committee and Clinical Governance Committee (ii) PLACE assessments (iii) Contract monitoring arrangements (iv) Issues raised through Governor Forum and Patient Experience Committee (v) Issues and complaints statistics (vi) Service contract with Lift service provider which includes X 2 resident lift engineers on site permanently. (vii) Lift refurbishment complete (lifts 4, 5, 6 and East Ward Block)	4	5	20	2	4	(i) Full lift survey to be undertaken in 2019/20 to develop capital for replacement	(i) ongoing
Q&E13	Initial ED triage assessment processes Following an unannounced CQC inspection involving the commissioned Front Door Assessment Service it has been identified that the initial triage and clinical assessment processes and clinical oversight of the waiting area, unwell children and adults may not be provided with the full assessments required to provide high quality care, which could potentially cause harm to patients.	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on patient harm (v) Impact on reputation	Director of Nursing	Quality & Effectiveness	4	4	16	(i) Previous traige model revised and changed to check in implemented (ii) Nurse with triage skills now undertaking initial assessment within a targeted 15minutes (iii) Triage includes relevant assessments for physiological observations where indicated (iv) Triage assessment location reviewed (v) Responsive escalation process to ensure staff resource (vi) Clinical Oversight of waiting rooms (vii) Report to ET. (viii) Governance process for escalation of concerns, Board, CGC, QEC ~~(ix) Reporting to CQC fornightly since 27 December 2018 (2months) - satisified with information received.~~ (x) Working group established December 2018 and meets weekly.	4	4	16	2	3	~~(i) Report to CQC fortnightly.~~ (ii) Mock CQC inspection unannounced by internal audit to be undertaken. IA report to be provided to ARC on 18 July 2019. (iii) Standing item to ET weekly	(i) ongoing
F&P21	Inadequate Edge Protection on Flat Roofs	(i) Increased risk of falls from height (ii) Increased risk of harm, resulting in death	Director of Estates and Facilities	Finance & Performance	3	5	15	(i) Communication to Estates staff warning of the risk (ii) Signage fitted to doorways (iii) Staff advised not to work closer than 2.5m to the end without risk assessment	3	5	15	1	5	(i) Cost pressure agreed by Executive Team to install Edge Protection to highest risk areas across all sites.	KEJ to ask Matt Gleadall who the owner is and what the target date for the installation of edge protection is.
F&P22	Assessment of ligature points	(i) Impact on patient safety (ii) Impact on patient harm (iii) Compliance with EFA/2018/005 (iv) Unidentified ligature points existing within the Trust with the potential to lead to an adverse incident occuring	Director of Estates and Facilities / Director of Nursing, Midwifery and Allied Health Professionals	Finance & Performance	3	5	15	(i) Clinical risk assessment of patients for risk of self harm undertaken annually by Ward Manager (ii) Anti ligature equipment utilised in areas previously identified as posing high risk being reviewed by clinical staff to ensure identification of high risk areas. (iii) EFA alert promulgated to Deputy Director of Nursing, Midwifery & Allied Health Professionals for wider distribution to clincal stakeholders.	3	5	15	1	5	(i) Current high risk areas have been identified as ED and Childrens wards. Work underway to reduce ligature risks in ED at DRI and Bassetlaw to be completed during 2019. (ii) Continue to assess patient risk.	(i) Ongoing (KEJ to get an update from Howard Timms),
F&P23	Inability to test fire dampers (DRI East Ward block)	(i) Impact on operational ability (ii) Compliance with Fire Safety legislation (iii) Compromised fire compartmentation of the building leading to an increase spread of fire and smoke (iv) Increased risk to life	Director of Estates and Facilities	Finance & Performance	3	5	15	(i) Annual fire training for DBTH staff (ii) Automated fire detection and alarms (iii) Dampers are in place (iv) Fire Safety Advisor (v) Fire extinguishers installed throughout the site (vi) Dry riser installed in East Ward block (vii) Existing compartment provides protection (viii) Building constantly occupied (ix) Included in Estates capital plan	3	4	15	1	5	(i) Compartmentation under review and improvement works proposed	This is now included in the Trust's Capital Plan.
Q&E14	Staffing for registered children's nurses in ED on DRI and BDGH sites Risk of insufficient workforce for providing care for unwell children, including registered children's nurse (RCN) on duty to the level expected by RCPCH standards expanding on previous Royal College of Nursing guidance, being unavailable 24/7, could lead to patient harm due to the absence of appropriately skilled staff.	(i) Impact on safety of patients (ii) Impact on patient experience (iii) Potential delays to treatment (iv) Impact on patient harm (v) Impact on workforce Impact on reputation	Director of Nursing	Quality & Effectiveness	4	4	16	(i) Senior oversight, management and escalation of RCN Staffing levels across ED and the Children's ward and departments. (ii) (iii) (iv) Temporary staffing set up with cascade arrangements for agency.Some dual trained RN's. Reviewing alternative agencies to improve temp staff with support from procurement. (v) Paediatric Module additional training for some staff. (vi) PAWS training provision (vii) Paediatric resuscitation training at L4 (APLS, EPALS) and L3 (PILS) (vii) Report to ET. (viii) Governance process for escalation of concerns, Board, CGC, QEC. (ix) (x) Enrolment of RGN (Adult) to Paediatric Courses at SHU. ~~(xi) Reporting to CQC fornightly since 27 December 2018 (2months) - satisified with information received.~~ (xii) 15 RCN's in recruitment process of which 6 are Band 6 and 9 are Band 5. 5 comenced in post February 2019. Further interviews undertaken in March 2019 joint recruitment for ED and inpatient wards (Need an update from KC and Sam S). (xiv) Working group established December 2018 and meets weekly.	4	4	16	2	3	~~(i) Report to CQC fortnightly.~~ (ii) Standing item to ET Weekly	(i) Ongoing

E1

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Workforce Plan 2019-21		
Report to	Board of Directors	**Date**	July 2019
Author	Karen Barnard, Director of People & Organisational Development		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✓
	Information		

Executive summary containing key messages and issues

The NHS Long Term Plan(2019) identifies national actions and priorities, including:

- Expanding the number of nursing and other undergraduate places, including funding;
- Backing new routes into nursing and other disciplines, including apprenticeships, nursing associates, online qualification, and 'earn and learn' support;
- Expanding international recruitment;
- Incentivising recruitment into hard-to-recruit specialities;
- Improving the mental health and wellbeing of the workforce;
- Establish new NHS career pathways.

These priorities have been further developed in the Interim NHS People Plan. The plan includes how to:

- Make the NHS the best place to work
- Have an improved leadership culture
- Addressing urgent workforce issues in nursing
- Deliver 21st century care
- Introduce a new operating model for workforce.
-

The attached workforce plan has been developed with particular focus on how we

- Retain our staff, making Doncaster and Bassetlaw Teaching Hospitals the employer of choice
- Develop existing talent into new and existing roles;
- Attract new workers, from current and future generations of working adults, into priority health, care and support careers;
- Introduce a robust approach to workforce planning

We will monitor the success of this plan through the Workforce, Education and Research Committee reporting to Finance & Performance and Quality & Effectiveness Committees reporting on the key performance indicators of:

- Vacancy rates
- Turnover and retention rates
- Sickness absence rates
- Staff engagement rates

Key questions posed by the report

Is the Board assured of our plans to fill vacancies and retain our staff?

How this report contributes to the delivery of the strategic objectives

People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.

How this report impacts on current risks or highlights new risks

F&P 8 Inability to recruit right staff and have staff with right skills leading to:
(i) Increase in temporary expenditure
(ii) Inability to meet FYFV and Trust strategy

(iii) Inability to provide viable services

Q&E 6 Failure to improve staff morale leading to:

(i) Recruitment and retention issues
(ii) Impact on reputation

(iii) Increased staff sickness levels

Recommendation(s) and next steps

Members of the Board are asked to receive the workforce plan and provide feedback on it.

E1

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

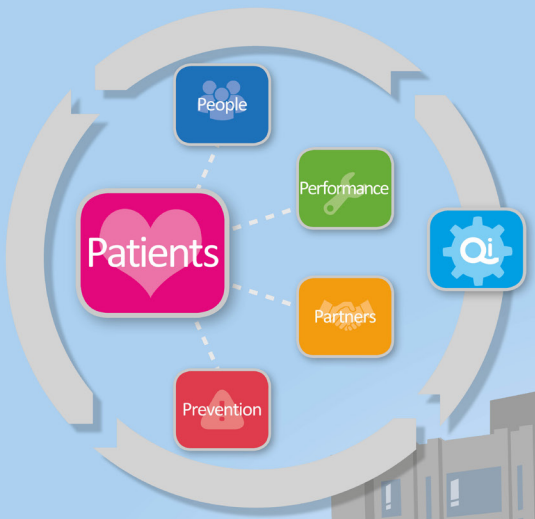
DBTH Workforce Plan

2019 to 2021

E1

Our vision: To be the safest trust in England,

outstanding in all that we do.



Our strategic objectives which will help us get there:

Patients — Work with patients to continue to develop accessible, high quality and responsive services.

People — As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.

Performance — We will ensure our services are high performing, developing and enhancing elective care facilities at Bassetlaw Hospital and Montagu Hospital and ensuring the appropriate capacity for increasing specialist and emergency care at Doncaster Royal Infirmary.

Partners — We will increase partnership working to benefit people and communities.

Prevention — Support the development of enhanced community based services, prevention and self-care.

Qi — Working together using methods, tools, data measurement, curiosity and an open mindset to make improvements (Health Foundation).

Introduction and Context E1

This plan has been developed to ensure, as a Trust, we have a robust workforce plan. This has been informed by our 'We Care' values, our vision to be the 'Safest Trust in England, outstanding in all that we do' as well taking into consideration respective Doncaster and Bassetlaw Place Plans.

The purpose of this plan is to demonstrate how we are addressing our current workforce gaps and how in the longer term our workforce needs to adapt and change in line with our strategic direction.

We know that Doncaster and Bassetlaw share many of the challenges faced across the country - workforce growth has not kept up with the increasing demands on the NHS and other health and care services; an ageing workforce; insufficiency of the right people with the right experience and qualifications to meet growing and changing need; staff leaving due to workload pressures and other employment issues and more recently the impact of pensions on our medical staff in particular.

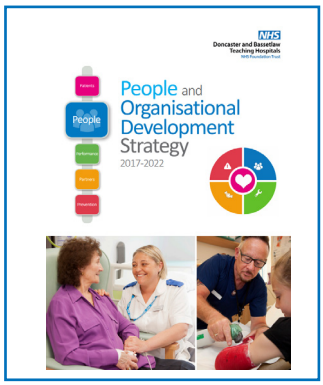
As a Trust we have developed our five year strategic direction together with a number of enabling strategies, including our People and Organisational Development Strategy within which we identified our priorities as staff engagement, delivering great management and leadership, promoting a healthy and safe environment, ensuring every role counts, supporting personal development and training, and workforce planning - supply, upskilling, new roles, new ways of working.

In all, this document sets out the Trust's key workforce challenges, the key actions being taken either by the Trust or within the two ICPs or the Integrated Care System (ICS), as well as the actions that the partners across Doncaster and Bassetlaw will take, delivering in-line with the priorities for this plan, which are to:

1. Retain the workforce, making Doncaster and Bassetlaw Teaching Hospitals the employer of choice
2. Develop existing talent into new and existing roles;
3. Attract new workers, from current and future generations of working adults, into priority health, care and support careers;
4. Introduce a robust approach to workforce planning

Karen Barnard
Director of People and Organisational Development

Our supporting resources



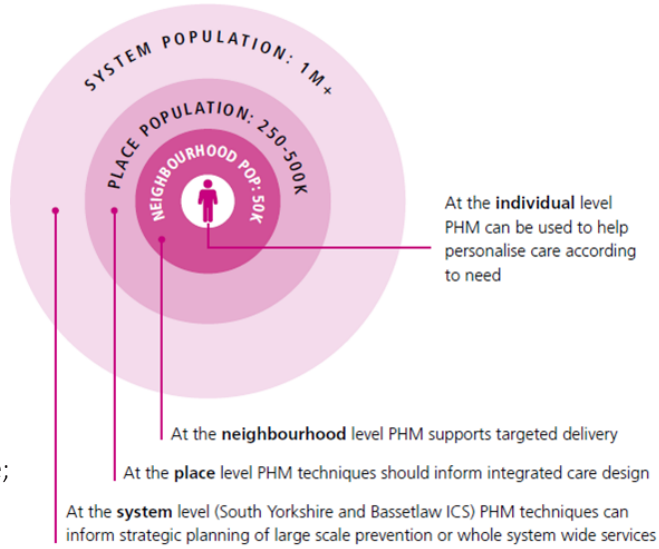
E1

Strategic context

Doncaster and Bassetlaw Teaching Hospitals (DBTH) works as part of the South Yorkshire & Bassetlaw ICS and within both Doncaster and Bassetlaw ICPs.

Nationally the NHS Long Term Plan (2019) identifies national actions and priorities, including:

- Expanding the number of nursing and other undergraduate places, including funding;
- Backing new routes into nursing and other disciplines, including apprenticeships, nursing associates, online qualification, and 'earn and learn' support;
- Expanding international recruitment;
- Incentivising recruitment into hard-to-recruit specialities;
- Improving the mental health and wellbeing of the workforce;
- Establish new NHS career pathways.



These priorities have been further developed in the NHS 'Interim People Plan'. The plan includes how to:

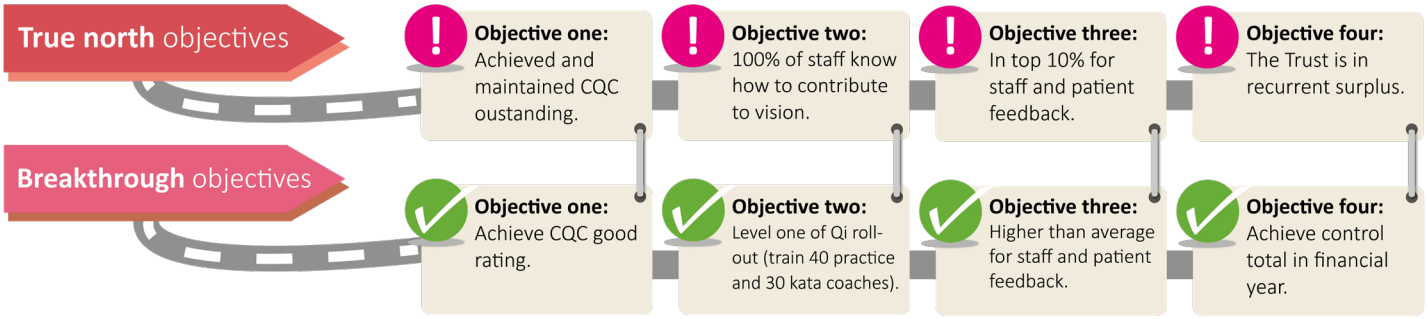
- Make the NHS the best place to work
- Have an improved leadership culture
- Address urgent workforce issues in nursing
- Deliver 21st century care
- Introduce a new operating model for workforce.

The workforce work-streams within each ICP and the ICS are determining what is best placed to be delivered at ICS, Place and organisational level– to reduce duplication, and complement developments happening at national, system and neighbourhood population levels.

At system level, the South Yorkshire and Bassetlaw ICS (SYBICS), and Health Education England (HEE) have established a Workforce Hub. The Hub is facilitating advanced practice, provides an excellence centre for workers in bands 1 to 4 and for primary care training, and is recruiting advanced practitioners.

The agreed priorities of this workforce plan is to:

- Retain our staff, making the Trust the local employer of choice
- Develop existing talent into new and existing roles
- Attract new workers, from current and future generations of working adults, into priority health and care careers;
- Introduce a robust approach to w



Retaining the workforce E1

Whilst sections of this plan focus on recruiting to our workforce we must also concentrate on retaining and developing the staff we already employ and being the employer of choice, recognising our responsibilities as a local 'anchor organisation'.

The Trust recognises that the quality of people's experience as a member of Team DBTH is influenced by far more than their pay and terms and conditions. The experience staff have whilst at work directly correlates with the experience that patients have of our services.

Promoting flexibility, wellbeing (both mental and physical), career development, and redoubling efforts to address discrimination, violence, bullying and harassment are priorities for the NHS' new 'Chief People Officer'. There is also much that can be done locally. As such, a priority in DBTH is giving our workforce the best possible experience in their roles.

We commit to:

- **Investing time and resources in employee wellbeing**, so that whether someone works in primary care, voluntary sector or within DBTH, they and their managers have access to wellbeing support to build resilience;
- **Recognising achievement and effort**, through our appraisal process, our Star Awards – at divisional and Trust level (monthly and annual); other celebratory events such as Sharing How We Care, iQAT, and learning achievements ceremony together with thank you cards and long service awards;
- **Developing the skills and competence of leaders and managers** across the Doncaster and Bassetlaw places, through training and organisational development. Locally we have introduced our 'Develop, Belong, Thrive, Here' programme, along with various 'Soundbite' topics and our 'Leading to Outstanding' programme – at the heart of these programmes is inclusive and compassionate leadership;
- **Ensuring service leaders plan intelligently for sufficiency of staff** on all shifts so that staffing levels are safe and sustainable;
- **Engaging and responding to the views and insights of our workforce** in shaping priorities and service developments through staff, learner, trainee and trainer surveys. Involving our colleagues in quality improvement initiatives;
- **Flexible working policies**, that achieve the best possible balance of service needs and the home lives of staff;
- **Provision of training and development opportunities** for staff at all levels, working with the SYB Workforce Hub and local colleges and Universities. As part of our nursing retention programme we have developed the next page as a poster describing the potential career journey for qualified nurses (as seen in this document, see overleaf)
- **Tackling violence, bullying and harassment** within all workplaces ensuring that everyone feels able to contribute regardless of their protected characteristic and able to raise concerns openly.
- **Promoting and embedding our values and behaviours** throughout the organisation so they genuinely become the bedrock of our culture
- **Celebrating and promoting difference** so that all staff regardless of their difference have a positive experience and are able to progress in their career.

E1

Registered Nurse Careers

At DBTH, we offer many opportunities for you to specialise and progress throughout your career.

NHS
Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Newly Qualified **Registered Nurse**

Preceptorship

Medicine
- Emergency Department
- Medical Assessment
- Care of Older People
- Speciality Medicine

Surgery
- Surgical Assessment
- Inpatient Surgical Specialities
- Outpatient Specialities
- Cancer services

Paediatric Nursing
- On the Ward
- Neonatal Unit
- Emergency Department
- Outpatients specialities

Clinical Specialities
- Critical Care
- Outpatients
- Theatres

Hospital
Community
GP

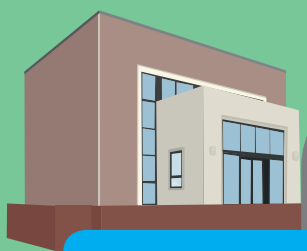
Leadership
- Junior sister
- Ward/ department Manager

Advanced Clinical Practice
- Advanced Clinical Practitioner
- Clinical Nurse Specialist

Research
- Research Sister
- Clinical Academic Post

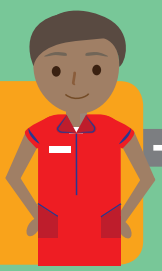
Education
- Clinical Skills, Simulation & Educators Education lead

Corporate Nursing
- Infection Prevention & Control
- Skin Integrity Team
- Safeguarding
- Patient Safety & Experience



Matron
Lead Specialist Nurse

Head of Nursing
Associate Director of Nursing
Deputy Director of Quality and Governance/Education



Deputy Director of Nursing, Midwifery and AHPs

Director of Nursing, Midwifery and AHPs

Chief Executive

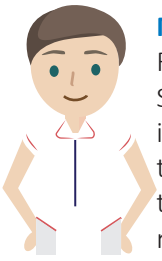
We care

Look for your next role at:
www.dbth.nhs.uk/join-the-team

Current workforce gaps E1

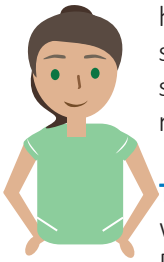
In developing the Trust workforce plan a review has been undertaken of the current vacancy position together with an analysis of the ease by which these gaps can and will be filled during 2019/20. It should be noted that in many staff groups we benchmark favourably in terms of the number of vacancies we have and our retention rates.

Nursing and midwifery: whilst the Trust currently has 144wte (8%) qualified nurse and midwifery vacancies across various specialties these gaps will in the main be filled in September/October 2019 through newly qualified nurses and midwives together with further cohorts of Trainee Nursing Associates and Assistant Practitioners. The area of greatest concern is paediatric staffing – the local training provider has increased its cohort of trainees from 45 to 90, however this will not result in additional staff until 2022. The Trust will therefore introduce Paediatric Nurse Practitioners and Nursing Associates to fill the gaps in our establishment. Support worker vacancies are able to be recruited to – recent movement has been due to the TNA and TAP programmes. An ongoing programme is also in place with NHSP trainees which can result in them moving to become Trust employees at the end of their training programme. We are progressing discussions with Derby University to 'pilot' supporting their elective and final year pre-registration paediatric nursing students to come and have placements with us. This is a comparable model tested with Lincoln University last year which resulted in a 19 learners coming to gain employment with us as RGNs. As an ICS the Chief Nurses are working together to review whether international recruitment is required across the ICS or only within certain individual Trusts and nurse apprenticeships with DBTH taking the lead on trainee Nursing Associates



Medical imaging: 12 newly qualified Radiographers are due to commence August/ September 2019 – this together with the introduction of Band 2 assistants will remove the use of agency staff within the plain film team. However there remains difficulty in recruiting to specialist areas and therefore training programmes are in place together with ongoing reviews of the workforce model to deliver the service.

Admin and clerical: following the conclusion of the clinical admin review posts are now being recruited to and training programmes put in place to ensure standardisation of operating models and development of the supervisory level (Progress programme). Professional groups such as Finance and HR have experienced difficulty in recruiting to senior posts resulting in the use of agency staff within the former. These roles are now recruited to.



Theatres: there are circa 10wte vacancies which can be a mixture of nurses and Operating Department practitioners.

Plans are in place to introduce Assistant Practitioners and Apprentice ODPs in autumn.

Clinical Therapies: there appears to be no significant issue in recruitment other than Orthotics where a 'grow your own' plan is being finalised; however our turnover amongst therapists benchmarks less well than other Trusts- this forms part of our engagement work with this group of staff. Within the HASU model we have increased our therapy complement along with Advanced Clinical Practitioners and support workers.

Estates and Facilities: there is currently a gap of 26wte service assistants (7% vacancy rate) – the shift pattern of 15 hours a week working before 9am and after 5pm appears to restrict the pool of interested applicants. In addition the time it has traditionally taken over pre employment clearances has resulted in significant withdrawals – a revised one stop recruitment event is now being trialled.

Information Technology: Recruitment and retention of specialist technical posts has been particularly problematic over the past 18 months, particularly the recruitment of suitably qualified individuals for senior positions. As identified in the Topol Review, IT skills are nationally and locally in high demand. This is at a time when the Trust is seeking to deliver a major Digital Transformation Programme. It is evident that the Trust is competing with major private and public sector (e.g. NHS Digital) IT employers in Leeds and with local NHS Trusts within daily travel to work patterns. We are currently seeking to recruit into seven positions including; IT Technical Operations Manager, Systems development Manager. Should this not result in successful recruitment we will explore alternative recruitment strategies.

E1

Doctors in training: The Trust has a funded establishment of 270 doctors in training – we are allocated trainees through the deanery – on the whole it does appear that we receive a fair allocation when reviewing data across the region – however there are specialties where nationally there is a shortage (eg O/G); in addition trainees may go out of area on placements resulting in not all places being filled. These posts must then be filled by locums or MTIs (medical training initiative through the relevant royal college). Through the Guardian for Safe Working reports to the Board we monitor the gaps. In June we had 16 gaps, we anticipate 34 gaps in August which is similar to earlier in the year.

Through the work of the Guardian for Safe Working and the College Tutors we work to ensure that trainees have a good experience so we can attract trainees into the Trust. Where appropriate we also explore where alternative roles can work alongside doctors, eg Advanced Neonatal Practitioners.

Consultant gaps:

The Trust has a number of challenges but are looking at a number of strategies to improve recruitment and be innovative in our approach to fill gaps.

- Gastroenterology (two posts) - currently being filled through additional sessions, an ACP has recently commenced who will undertake some work – recruitment campaign required
- Stroke – remaining vacancy will be filled in September but further capacity required due to HASU – recruitment campaign required
- Respiratory – two posts have been filled through additional sessions and a locum – recruitment campaign required for substantive recruitment
- Acute Medicine – three vacant posts of which two will commence in September; remaining gap covered through additional sessions
- Cardiology – the two gaps currently covered through NHS locums – two posts advertised one of which is a joint post with STH
- Care of the Elderly – a recruitment campaign is required due to ongoing difficulty in filling this post
- Diabetes & Endocrinology – the one vacancy has been recruited to this month and is able to commence immediately.
- Renal – the one vacancy has been recruited to and will commence in September
- Rheumatology – a recruitment campaign is required for the one vacancy – a senior SpR will commence in August who will provide some additional capacity
- Obstetrics/Gynaecology – currently there are two gaps which could be difficult to recruit to due to the sub specialism – on the whole recruitment into this speciality has been good.
- ENT – we have 2 vacancies which have been difficult to recruit to - an interim solution is looking possible with locum cover. A recruitment campaign is required.
- Ophthalmology – Ongoing difficulties to recruit to 2.71wte gaps – recent offer affected by uncertainty of Brexit. Recruitment campaign to be reviewed along with options around service delivery
- Paediatrics – The Trust has recently recruited a Community Paediatrician leaving one post vacant. As this is a role which is difficult to recruit to a review is being undertaken to scope out our requirements.
- Histopathology – ongoing difficulties to recruit and future planned retirements – the Trust will be advertising posts shared with STH and local posts.
- Intensive Care – We have three vacancies with an advert about to close - we expect to fill one of these posts. The introduction of Advanced Critical Care Practitioners is being explored with visits to other sites to determine how they can be introduced.

Specialty/Associate Specialty/Local Employed Doctors:

Changes to service models and opportunities for recruitment are being taken forward.

- Trauma and Orthopaedics – posts located at Bassetlaw as trust employed doctors have continued to be difficult to recruit to – the need for these four doctors will reduced by the introduction of Hospital@.
- Emergency Medicine: Our key pressure is related to the SAS level (Specialty and Associate Specialist doctor) six doctors will be commencing in November through the QiMET programme but will commence at 'SHO' level in the first instance; ongoing successful recruitment to CESR programme. The service are reviewing their workforce model to reduce reliance on this level of doctor
- We will continue to explore the introduction of Physicians Associates, Advanced Nurse/Clinical Practitioners to fill places on medical rotas.

Other factors affecting staffing levels:

- Maternity leave cover – we currently have 147 members (2.22% of the total workforce) of staff on maternity leave of which 67 (4% of this group of staff) are nurses and midwives and 35 nursing support workers
- Closed and escalation beds being open which are not built into the current ward establishment and result in the use of bank and agency staff. Current work is in place to improve flow thereby reducing length of stay which will facilitate the closure of these beds.
- Enhanced care where additional support is required for some patients. A programme of work is underway to ensure that staff are appropriately skilled to support complex patients together with the introduction of the role of activity co-ordinator.

Improving recruitment E1

As a Teaching Hospital we are proud of our track record in training undergraduate and postgraduate students including doctors in training.

In developing our approach to research we have been able to attract Consultants who have a particular interest in research but also other groups of staff who wish to undertake an academic research pathway such as nurses and allied health professionals. This will continue to be developed as part of our Teaching Hospital Phase 2 programme of work along with the development of academic directorates with our surgical directorate being part way along that journey. We will promote and celebrate difference and recruit a workforce that is representative of the population we serve.

.

- **Service Assistant recruitment –** As a result of applicants obtaining alternative roles during our pre employment process, leaving gaps in rotas we have developed a one stop shop recruitment day to reduce the time to employment. These recruitment days also enable us to have discussions with applicants regarding the available shift patterns to maximise shift fill rates.

- **Healthcare Support Workers and Associate Nurses –** as a Trust we run successful campaigns when recruiting support workers. In order to ensure we target prospective candidates with an interest in specific specialties, for example paediatrics, we are developing cohort recruitment for each division. We are expanding our recruitment of apprentices alongside candidates already working in the care sector.

- **Student nurses –** We have increased placements to support the increase in cohorts of student nurses from various universities; we are exploring a range of options for student nurse training – a case of need is being developed jointly between the Education and Nursing teams. Our preceptorship offer across the ICS is being reviewed by the ICS Chief Nurses group involving Health Education England. DBTH will be leading the TNA programme on behalf of the ICS.

- **Apprentices –** We have agreed that the default position for entry level posts will be an apprentice unless the service can demonstrate it is unable to support an apprentice, for example they already have a number of apprentices, or a single post within a team. In addition we offer existing staff apprenticeships to undertake advanced qualifications.

- **Pharmacy -** Has a development programme in place at an apprenticeship level and at Band 4 to ensure staff are ready to move into more senior vacancies as they arise. The service continues to be able to recruit newly qualified pharmacists – our risk is around the increase in pharmacist roles within the community and primary care.

- **Midwifery –** Discussions are in train with the University to offer year 3 students Band 3 work as Midwifery Aides (bank workers). A review of their preceptorship programme has been undertaken to support and ensure we retain the newly qualified midwives.

- **Consultants –** We are exploring options for a recruitment campaign for those posts which are proving difficult to recruit which will include whether international recruitment is suitable. We retain links with doctors towards the end of their training programme in order to encourage them to return to us as a Consultant

Attracting new workers E1

The NHS is the largest employer in the country. However, the NHS workforce does not have enough capacity to meet demand, and employers across Doncaster and Bassetlaw in the health and care sector are facing a recruitment challenge.

Increasingly, areas which share a border are competing for a limited supply of the right labour. As such working at system level is critical, in addition to ensuring that Doncaster & Bassetlaw Teaching Hospitals is an employer of choice, so that the right health and care workforce is attracted to work in the area.

The next generation of working age adults are key to meeting the current and future workforce challenges, and attracting children and young people into health and care careers is a priority. Therefore, the workforce Work Stream Groups across Place will work with schools, further education (FE) and other partners, as a critical partner to promote health and care careers, and attract young people into the roles of the future. The South Yorkshire and Bassetlaw Integrated Care System has also established a schools engagement team. DBTH will work with the schools engagement team to optimise working at system level to attract new talent, and to track progress and routes for young people.

Having access to the right qualifications is also a priority. As such, partners will work with schools and FE to ensure the right level 2 and 3 qualifications are available, and meet the needs of students. For higher education, Bassetlaw young people are currently required to leave the district to train. As such, Bassetlaw partners will develop new and progressive relationships with the universities locally, to secure level 4 and above qualification provision for health and care careers within Bassetlaw, through a variety of routes.

We also recognise that there is untapped potential within the current population of existing working age adults, including disadvantaged groups. Positive action will be taken to promote and attract such adults into health and care careers, such as through adult apprenticeships. Furthermore, where adults need support to be work-ready, Doncaster and Bassetlaw partners will collaborate with local employment initiatives such as Building Better Opportunities, Working Win, Assisted Internships, Employability programmes and via the Department of Work and Pensions.

There will also be a focus on the workforce of the district's care homes through development of a sector-based work academy to support individuals who may have gaps in employment or be unemployed with an opportunity to get back into work.

We continue to work with our higher and further education providers to maximise our placement opportunities and to ensure students have excellent placements and return to us once qualfied.

Our changing service models - and the future workforce E1

This workforce plan is presented in the context of significant strategic change. We need to consider the service changes within the organisation, at place and across the region – to guide our future workforce plan. The key strategic changes themes for our workforce are as follows:

1. A Growing Specialist Service Portfolio

As the second largest acute provider in SYB, we can expect a greater specialist portfolio for DBTH. This includes:

- DBTH as one of two Hyper Acute Stroke Unit in SYB
- A partnership model of care for Vascular across Sheffield Teaching Hospitals (STH)/ DBTH
- Potential development of a Diagnostic Centre for Cancer
- As the HSR hosted networks mature we expect to develop other hospital services which support this vision

In these areas, we can expect growth of services, and the opportunity to attract and develop specialist staff to DBTH at all levels. This will help build on our reputation as a teaching and research centre, and will be important to our attraction strategies. These models will require increasingly mobile working of particularly our senior staff across the region as part of a workforce contributing to regional models of care across SYB. We will need to plan and prepare our workforce for this.

2. Greater regional partnership working

Greater regional working also offers opportunities to develop networks where this improves quality and the resilience of our service and workforce models. For example:

1. A hub and spoke model for Pathology across SYB
2. A partnership model for paediatric care across Sheffield Children's/ DBTH

Our workforce will need to become increasingly agile, with senior posts likely to work across sites, and a workforce skilled up to work remotely and through networks. These partnerships offer opportunity for joined up career pathways and opportunities to address the challenging vacancy context we face.

3. Consolidation of services and teams within DBTH to provide safe, sustainable care

Our clinical site strategy, in our True North journey towards Outstanding, has prompted a series of questions about consolidating services within the organisation to improve safety, quality, sustainability and address workforce challenges. These include:

- The delivery of Paediatric Services, with the piloting of the consolidation of out of hours care at DRI
- The potential strengthening and consolidation of services
- Joint nursing services for Place plans

These changes offer the opportunity to consolidate our staff on fewer sites and address some key vacancy challenges by reducing multi site working in and out of hours. Our workforce plan needs to consider how we plan for the workforce change associated with this, and develop a workforce increasingly willing to adapt how and where they work.

4. Responding to Place – More Integrated Multi-Agency Working

Our local Place Plans focus on the development of more integrated working across agencies. Local examples include (next page):

E1

- A new model of care for the front door, with greater collaboration with primary care, council and mental health.
- A future more community based model of Dermatology and Diabetes
- A more integrated model of care for frailty

More integrated care will mean the development of more generic skills and roles at junior level (for example within therapy and nursing), and increasing appreciation of different parts of the system. Our staff will need to become more familiar with the changing offer across place (for example the growth of social prescribing) and develop greater skills in areas such as mental health and prevention. We will work in partnership to develop more joined up training and development and career pathways to support these models of care.

5. New Roles and Role Extension

As the next sections outline, our recruitment challenges are leading to innovation in service models and new roles. We are seeing increasing examples of role extension and new roles to fill areas of shortage. Examples include:

- Increasing use of technicians to report plain film
- Increasing use of Advanced Nurse Practitioners to contribute to junior doctor rotas (for example Hospital @ Night, Critical Care, Urology, General Surgery, Vascular)
- Growth of the Medical Training Initiative (MTI) and increasing use of MTI doctors in Anaesthetics and Quality improvement Medical Education and Training (QIMET) doctors in ED
- The likely growth in use of Physician Associates
- The growth of the Nursing Associate and the opportunity to extend Pharmacist roles
- Changing training needs (for example all Core Medical Trainees to spend 3 months in critical care)

Our service and workforce models are increasingly being redesigned to accommodate these new roles. This has impact on our existing and future workforce. We need to be aware of the:

- Greater supervisory time that our senior staff will spend with a trainees from diverse professional backgrounds
- The greater focus for our senior staff on the "top of the license" work (rather than for example reporting plain films)
- We need to develop meaningful career pathways for our new roles to attract, develop and retain the best

6. Changing Skills– The Organisational Development Challenge

This context of strategic change means we need a different set of skills within our workforce. Therefore our workforce plan needs to ensure we systematically develop the following skills:

- Quality improvement skills needs to review service models , plan change and understand current and future workforce
- Greater digital skills to accommodate more digitally enabled models of care (for example in OP, and working in networks across SYB)
- Ability to work in an agile way across departments, places, systems and organisations
- Greater understanding of system leadership- the different skills that are required to work effectively within networked models of care
- "Shared, distributed and adaptive" leadership skills across our organisations – the skills to engage teams to redesign their workforce and sensitively and effectively lead associated organisational change.

7. Strategic workforce planning

- We will agree the model of workforce planning by November (informed by discussions with the ICS and HEE)
- Workforce redesign skills to map out how new roles and new teams will look to support the new model of care
- Link to the ICP and ICS workforce planning streams
- Ensure there is a joined up approach to quality improvement and workforce planning
- Ensure all divisions have the capacity and skills to develop local workforce plans with the opportunity to network.

Developing talent into new and existing roles

E1

Develop, Belong, Thrive, Here

Enabling work experience is critical to developing talent from the district's local universities. DBTH will work with ICS to increase placement capacity by 7% across a range of clinical professions. DBTH has tested a new model of placements with wider HEI providers and will expand this model during 2019 to include Derby as well as Lincoln University pre-registration nursing students.

We are aligned and prepared for the new NMC pre-registration education standards. DBTH is also working with DN and RNN FEI college groups to prioritise and support learners on appropriate academic programmes to be undertake work experience e.g. Health and Social care Foundation degree students.

Developments such as the Primary Care Networks (PCNs) offer unprecedented opportunities for creating clear and agile career pathways for Doncaster and Bassetlaw people in health and care services, working as part of a multi-disciplinary team.

As such, the creation of, and enablement of people into, a new and diverse range of roles, including in primary care and in specialist areas, and areas of shortage, such as the Emergency Department (ED), paediatrics and others is priority for the Workforce Work Stream Groups.

DBTH is already offering and sharing educational programmes (previously delivered in house and only available to DBTH staff) with the wider place based partners (through the SYREC partnership model).

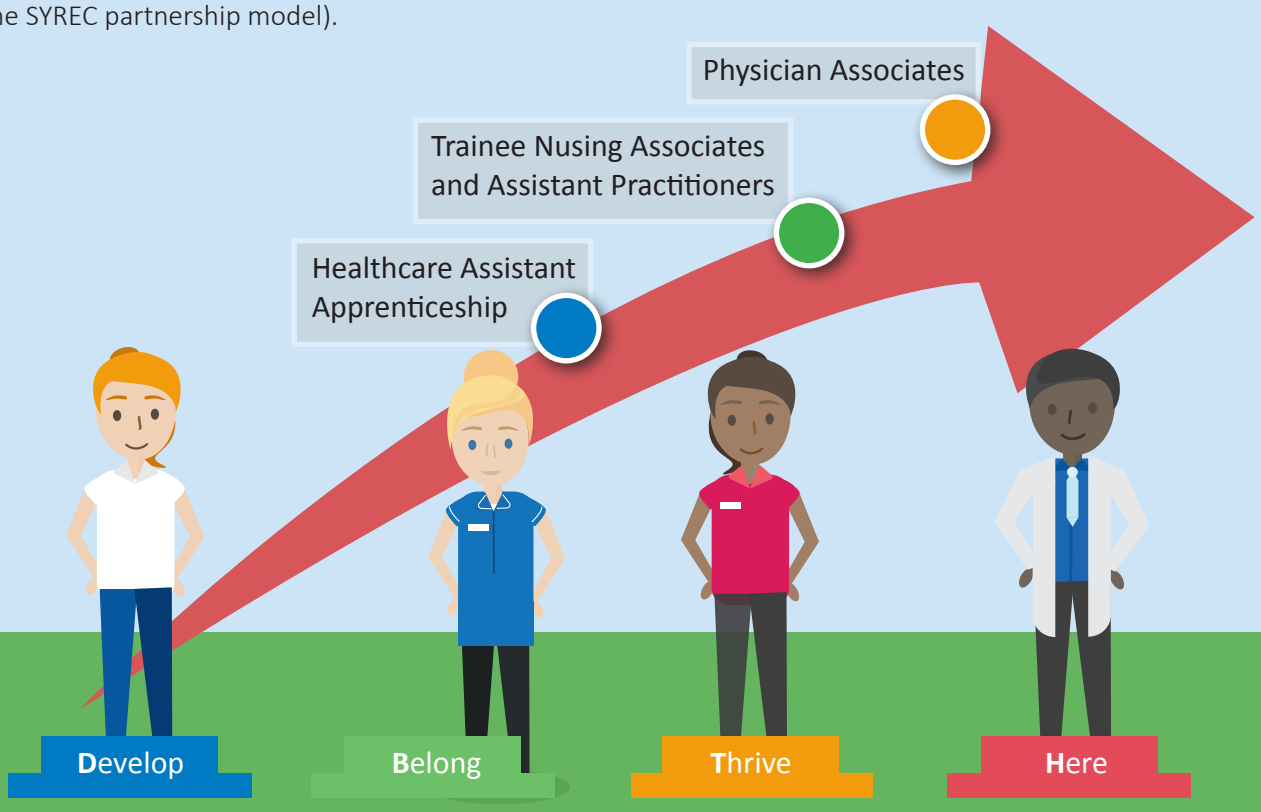
Opportunities to use existing resources better, and to make better use of digital technology to support the workforce will be exploited. This will include use of digital training tools, such as ECHO, and sharing of training between agencies.

Through the use of the apprenticeship levy and funding from HEE we will provide development opportunities to existing members of staff at foundation degree level, and at advance levels such as masters qualifications.

As increasingly our leaders and staff will work across Place and the system (ICS), we will provide development opportunities to ensure everyone is equipped appropriately, for example our OD leads are building system leadership into our programmes.

It is our goal to give those who join Team DBTH the tools and opportunities in order to grow their career, so whether they spend just one year or fifty with us, it's our pledge to help colleagues **Develop**, **Belong** and **Thrive**, **Here**.

Overleaf are examples of the development nurses and support workers can expect in their roles - this poster approach is being developed across the Divisions so that staff can see more easily the opportunities open to them



Career mapping

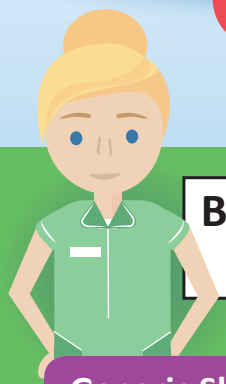
S12

E1

NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust



Band 2 roles:

Example

Generic Skills

Vital Signs
Blood Glucose monitoring
React to Red

Specialist Skills

Tracheostomy/ Laryngectomy Care
DATIX

Leadership Skills

Support new starters
Support students
Support Trainee Nursing Associates

Educational Skills

SET
Care Certificate
Nutrition
Tracheostomy package

Research/Qi

Link role
Audits

Additional notes

Enhanced Care
Telephone skills

Band 5 roles:

Example

Generic Skills

Vital Signs
Blood Glucose monitoring
React to Red
Cannulation
Venepuncture
Urinary Catheterisation
ECG
IV administration
Medicines Management
SEPSIS

Specialist Skills

Enteral Feeding
End of Life Care
Deteriorating patient
CVAD
Airway Management
Tracheostomy/Laryngectomy Care
PEG/RIG care
Ward attenders
DATIX

Leadership Skills

Support new starters
Support students
Support Trainee Nursing Associates
Preceptor
Team leader/Co-ordinator
Professionalism

Additional notes

Enhanced Care

Educational Skills

Mentorship
Link Nurse
SET
CCAST
Preceptorship

Research/Qi

Through preceptorship
Audits

We care

Career mapping E1 S12

Band 6 roles:

Example

Generic Skills

- Vital Signs
- Blood Glucose monitoring
- React to Red
- Cannulation
- Venepuncture
- Urinary Catheterisation
- ECG
- IV administration
- Medicines Management
- SEPSIS

Specialist Skills

- Enteral Feeding
- End of Life Care
- Deteriorating patient
- CVAD
- Airway Management
- Tracheostomy/Laryngectomy Care
- PEG/RIG care
- Ward attenders
- E-Roster
- Governance
- DATIX

Leadership Skills

- Support new starters
- Support students
- Support Trainee Nursing Associates
- Preceptor
- Team leader/Co-ordinator
- Professionalism
- NHSP
- Surgical bleep
- Appraisals

Educational Skills

- Mentorship
- Link Nurse
- SET
- CCAST
- Preceptorship

Research/Qi

- Audits

Additional notes

- Enhanced Care

Band 7 roles:

Example

Generic Skills

- Vital Signs
- Blood Glucose monitoring
- React to Red
- Cannulation
- Venepuncture
- Urinary Catheterisation
- ECG
- IV administration
- Medicines Management
- SEPSIS

Specialist Skills

- Enteral Feeding
- End of Life Care
- Deteriorating patient
- CVAD
- Airway Management
- Tracheostomy/Laryngectomy Care
- PEG/RIG care
- Ward attenders
- DATIX

Leadership Skills

- Support new starters
- Support students
- Support Trainee Nursing Associates
- Preceptor
- Team leader/Co-ordinator
- Professionalism
- NHSP
- Appraisals
- Escalation
- Team leader

Educational Skills

- Mentorship
- Link Nurse
- SET
- CCAST
- Preceptorship

Research/Qi

- Audits

Additional notes

- Enhanced Care

We care

E1

Conclusion

In summary this plan demonstrates how we will address the current gaps and recruit better; how we will retain better; attract new workers and adapt our workforce to our changing service models.

In order to reduce our requirement to recruit we will retain and develop our existing talent. The next steps will be to translate this strategic workforce plan into specific service plans which outline how we attract, recruit and retain staff to meet the current operational gaps and meet the future service needs. This process will be embedded into our business planning processes.

How will we know we are making a difference?

We will monitor progress against our key performance indicators for:

- Vacancy rates (target of 5%)
- Bank and agency spend

{ **Monitor through Finance & Performance Committee**

- Turnover (target 10%) and retention rates (target 90%)
- Sickness rates (target 3.5%) and staff engagement (target 4.00)

{ **Monitor through Quality and Effectiveness Committee**

Each of these KPIs will also be monitored through the Divisional Accountability meetings with reports being discussed at the Workforce, Education and Research Committee.

E1

NHS

Doncaster and Bassetlaw Teaching Hospitals

NHS Foundation Trust

E2

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Workforce Race Equality Standards (WRES) Workforce Disability Equality Standards (WDES)		
Report to	Board of Directors	**Date**	July 2019
Author	Karen Barnard, Director of People & OD		
Purpose			Tick one as appropriate
	Decision		✓
	Assurance		
	Information		

Executive summary containing key messages and issues

Overview

To deliver our vision to be an outstanding organisation, we need to attract, retain and develop a racially, culturally and ethnically diverse workforce. Recent evidence indicates that diversity is associated with:

- improved access to care for minority ethnic patients
- health care professionals with BME backgrounds are more likely to serve minority and medically under-served communities than their white peers
- greater patient choice and satisfaction
- better educational experiences for all health professions students
- interactions between health care professionals helping to challenge assumptions and broaden perspectives regarding racial, ethnic and cultural differences
- different problem-solving skills found by combining those with diverse ethnic and cultural backgrounds leads to more creative thinking about clinical, research, patient satisfaction and/or cost problems.

The Standard NHS Contract mandates that all NHS provider organisations implement the Workforce Race Equality Standards (WRES) and the Workforce Disability Standards (WDES). Both sets of standards are important because studies show that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety/mortality. All NHS providers are expected to show progress against a number of indicators of workforce equality and disability.

This following report pulls together an overview of the 2018/2019 Workforce Race Equality Standards (WRES) data for DBTH alongside the Workforce Disability Equality Standards (WDES) data which has been collated for the first time.

Workforce – WRES

The data presented in the table below reflects that we have a % BME staff in the workforce of 8.5%. We have slightly increased the number of BME staff appointed to roles within our organisation. However this increase in BME representation, a total 9 across a workforce of 6710 is not significant. We have 4.5% of staff with ethnicity unknown, however this is an improvement on 2018 which was 8%.

DBTH Staff	White 2018	White 2019	BME 2018	BME 2019	Ethnicity Unknown 2018	Ethnicity Unknown 2019
Headcount	5809	5833	564	573	551	304
% of total workforce	83.9%	86.9%	8.1%	8.5%	8%	4.5%

It is positive that we are closing the gap on the % of staff where we have the ethnicity recorded but there is still work to do, to improve our data capture and quality. We anticipate that ESR manager self-service may help to drive improvements in this area.

Trust Board WRES

Board Members	White 2018	White 2019	BME 2018	BME 2019	Unknown 2018	Unknown 2019
Headcount	10	11	1	2	1	0
Exec Boards Members	4	5	1	1	1	0
Exec board members by % ethnicity	66.7%	71.4%	16.7%	14.3%	16.7%	0%
Non-Exec Board members	6	6	0	1	0	0
Non-Exec board members by % ethnicity	100%	85.7%	0%	14.3%	0%	0%

The make-up of Trust board reflects there has been a slight positive shift in the representation of BME staff within the Non-Executive Director roles. A requirement of the WRES is that the ethnicity of all board members is captured and it is positive that we have no 'unknowns' at Board level.

Workforce –WDES

At DBTH we currently employ 3.3% of staff with a Disability.

Criteria	Headcount	%
Non-disabled staff	5144	96.7% (declared status)
Disabled	174	3.3% (declared status)
Not Known	1183	23% (not known)

However we have 23% of staff with a Disability status not recorded, which is significantly higher than the Ethnicity 'unknown' data.

The report presents the detailed data from the WRES and WDES data, the key highlights are below.

Key messages for the Organisation:

- There are gaps in the data we hold regarding Ethnicity of staff (4.5% unknown) and Disability status (23% not known)
- There has been a significant deterioration in the likelihood of BME staff being appointed from shortlisting (2.44 from 1.06)
- Disabled applicants have a 44% chance of successful appointment from shortlisting (20 shortlisted applicants in total)
- The likelihood of BME staff being in a formal disciplinary process is 0.74 as compared to white staff – this is almost within the 'normal' range of 0.8-1.25

- Consultant and Non Consultant career grade doctors have a much higher representation of BME staff than other grades of staff.
- Disabled staff are 1.48 times more likely to be in formal capability process compared to non-disabled staff
- Both disabled and BME staff experience more bullying, harassment and abuse than white and non-disabled staff – there has been a rise since 2018
- 37.9% of disabled staff say that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties as opposed to 29.7% of non-disabled staff.
- 32.2% of disabled staff reported that they are satisfied with the extent to which their organisation values their work as opposed to 45.1% non-disabled staff.
- 63.8% of disabled reported that their employer has made adequate adjustment(s) to enable them to carry out their work.

The summary findings from the WRES and WDES suggest that there is further work in respect of data capture, the recruitment of disabled and ethnically diverse staff and improving their overall experience and inclusivity and support within our organisation. The actions identified below are critical in our journey to a more tolerant, inclusive culture where civility and respect is the 'way we do business'.

Actions to address areas raised in this report:

- The Staff Equality, Diversity and Inclusion Group meets quarterly which is an inclusive staff network to engage with all staff and address issues
- Unconscious Bias training available for all staff
- Educate managers in supporting staff with disabilities and making adequate adjustments (understand what the data is telling us)
- Living the DBTH values and behaviours training
- Inclusive and Compassionate Leadership embedded in all leadership programmes
- Staff engagement forums to listen and act on staff feedback and experiences
- Implementation of actions plans in response to Staff Survey results
- Visible organisational support for Doncaster Pride and have an active role in engaging with the local community
- The Rainbow Badge initiative gives healthcare staff a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means inclusive of all identities, regardless of how people define themselves). Rainbow Badge initiative to train and educate staff around appreciating diversity and LGBT+, this will be launched in September
- Project Choice is a supported internship programme for people with learning disabilities, difficulties or autism (LDDA). NHS Health Education England, support NHS Trusts to deliver the programme nationally. The focus is 'work readiness' and matching skills to employment. The project teams ensure there are placements across the Trusts looking specifically at entry-level jobs to make sure the right learner is allocated to this role. They also work closely with managers to confirm that tasks are clearly understood.
- Develop role models at all levels within the organisation for BME and disabled staff
- Explore how to reach out into the wider community to engage and attract people from diverse backgrounds, cultures and with disabilities into our organisation
- Explore how we ensure that we attract and recruit staff, volunteers and governors from diverse backgrounds, cultures and groups into our organisation and how we can create opportunities for future

or potential employees to engage with our organisation with a view to proactively generating interest when future vacancies arise
Key questions posed by the report
There is a requirement to design and develop a joined up strategic approach to increase the diversity of the DBTH workforce throughout all levels of the organization and prove the experience of our disabled and ethnically diverse staff. Does the Board feel that the correct priorities have been determined?
How this report contributes to the delivery of the strategic objectives
People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care. This report directly links to our Trust Values 'WE CARE', in particular Everyone counts – We treat each other with courtesy, honesty, respect and dignity and Encouraging and valuing our diverse staff and rewarding ability and innovation.
How this report impacts on current risks or highlights new risks
F&P 8 Inability to recruit right staff and have staff with right skills leading to: I. Increase in temporary expenditure II. Inability to meet FYFV and Trust strategy III. Inability to provide viable services. Q&E 6 Failure to improve staff morale leading to: I. Recruitment and retention issues II. Impact on reputation III. Increased staff sickness levels.
Recommendation(s) and next steps
The Board are asked to receive this report and approve the publication of this data and provide feedback on how we might address the challenges of increasing the cultural, racial and ethnic diversity, disability of people working in, volunteering in and governing our organisation.

Introduction

To deliver our vision to be an outstanding organisation, we need to attract, retain and develop a racially, culturally and ethnically diverse workforce. Recent evidence indicates that diversity is associated with:

- improved access to care for minority ethnic patients
- health care professionals with BME backgrounds are more likely to serve minority and medically under-served communities than their white peers
- greater patient choice and satisfaction
- better educational experiences for all health professions students
- interactions between health care professionals helping to challenge assumptions and broaden perspectives regarding racial, ethnic and cultural differences
- different problem-solving skills found by combining those with diverse ethnic and cultural backgrounds leads to more creative thinking about clinical, research, patient satisfaction and/or cost problems.

The Standard NHS Contract mandates that all NHS provider organisations implement the Workforce Race Equality Standards (WRES) and the Workforce Disability Standards (WDES). Both sets of standards are important because studies show that a motivated, included and valued workforce helps deliver high quality patient care, increased patient satisfaction and better patient safety/mortality. All NHS providers are expected to show progress against a number of indicators of workforce equality and disability.

This report pulls together an overview of the 2018/2019 Workforce Race Equality Standards (WRES) data for DBTH alongside the Workforce Disability Equality Standards (WDES) data which has been collated for the first time

Workforce Race Equality Standard – WRES

The standard comprises nine indicators:

For each of these four workforce indicators, we compare the data for White and BME staff:

1. Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce
2. Relative likelihood of staff being appointed from shortlisting across all posts
3. Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
4. Relative likelihood of staff accessing non-mandatory training and CPD.

National NHS Staff Survey indicators (or equivalent) – for each of the four staff survey indicators, compare the outcomes of the responses for White and BME staff:

5. Percentage of staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
6. Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months
7. Percentage believing that trust provides equal opportunities for career progression or promotion
8. In the last 12 months have you personally experienced discrimination at work from any of the following: Manager/team leader or other colleagues

Board representation indicator – For this indicator, we compare the difference for White and BME staff

9. Percentage difference between the organisations' Board voting membership and its overall workforce

DATA SUBMISSION

The data for the submission is obtained through reports off ESR and the results of the most recent staff survey.

The data presented in the table below reflects that we have a % BME staff in the workforce of 8.5%. We have slightly increased the number of BME staff appointed to roles within our organisation. However this increase in BME representation, a total 9 across a workforce of 6710 is not significant. We have 4.5% of staff with ethnicity unknown; however this is an improvement on 2018 which was 8%.

DBTH Staff	White 2018	White 2019	BME 2018	BME 2019	Ethnicity Unknown 2018	Ethnicity Unknown 2019
Headcount	5809	5833	564	573	551	304
% of total workforce	83.9%	86.9%	8.1%	8.5%	8%	4.5%

It is positive that we are closing the gap on the % of staff where we have the ethnicity recorded but there is still work to do, to improve our data capture and quality. It is suggested that ESR manager self-service may help to drive improvements in this area.

Trust Board WRES

Board Members	White 2018	White 2019	BME 2018	BME 2019	Unknown 2018	Unknown 2019
Headcount	10	11	1	2	1	0
Exec Board Members	4	5	1	1	1	0
Exec board members by % ethnicity	66.7%	71.4%	16.7%	14.3%	16.7%	0%
Non-Exec Board members	6	6	0	1	0	0
Non-Exec board members by % ethnicity	100%	85.7%	0%	14.3%	0%	0%

The make-up of Trust board reflects there has been a slight positive shift in the representation of BME staff within the Non-Executive Director roles. A requirement of the WRES is that the ethnicity of all board members is captured and it is positive that we have no ‘unknowns’ at Board level.

Data Tables - Comparison data 2018 /2019

Table 1 - Non Clinical Staff

Staff Group Non Clinical Band	Total Number of white staff 2018	Total Number of white staff 2019	Total Number of BME staff 2018	Total Number of BME staff 2019	Number of staff without declared status 2018	Number of staff without declared status 2019
Under Band 1	12	16	1	1	1	3
Band 1	561	552	9	11	25	24
Band 2	552	555	14	13	26	15
Band 3	412	387	2	2	14	9
Band 4	149	144	3	3	6	5
Band 5	51	56	1	0	1	1
Band 6	52	65	2	2	1	2
Band 7	58	44	3	3	1	2
Band 8a	39	43	0	0	0	0
Band 8b	13	18	0	0	0	0
Band 8c	16	14	0	0	0	0
Band 8d	7	9	0	0	0	0
Band 9	0	0	0	0	0	0
VSM	7	9	0	0	7	0

Table 2 - Clinical Staff

Staff Group Clinical workforce Band	Total Number of white staff 2018	Total Number of white staff 2019	Total Number of BME staff 2018	Total Number of BME staff 2019	Number of staff without declared status 2019
Under Band 1	10	3	0	0	0
Band 1	3	3	0	0	0
Band 2	956	965	28	31	29
Band 3	239	291	2	3	7
Band 4	94	93	2	1	5
Band 5	1104	1064	128	122	34
Band 6	779	789	24	28	26
Band 7	371	382	12	9	10
Band 8a	79	75	7	7	2
Band 8b	12	11	0	2	0
Band 8c	13	14	0	0	0
Band 8d	2	3	0	0	0
Band 9	1	1	1	1	1
VSM	0	0	1	0	1

Table 3 – Senior Medical Staff

Staff Group	Total Number of white staff 2018	Total Number of white staff 2019	Total Number of BME staff 2018	Total Number of BME staff 2019	Total staff without declared status 2018	Total staff without declared status 2019
Consultants	109	101	160	148	329	109
Senior Medical Manager	0	0	1	1	0	0
Non-consultant career grade	70	79	147	170	19	18
Trainee Grades	38	47	17	16	5	1
Other	0	0	0	0	0	0

Table 4 - Recruitment and Selection

Recruitment and Selection	White 2018	White 2019	BME 2018	BME 2019	Ethnicity unknown 2018	Ethnicity unknown 2019
Number of shortlisted applicants	592	647	102	107	329	7
Number appointed from shortlisting	277	266	45	18	2	0
Relative likelihood of appointment from shortlisting	46%	41%	44%	16%	20%	0
Relative likelihood of white staff being appointed compared to BME staff	1.06	2.44				

Table 5 - Conduct

Conduct	White 2018	White 2019	BME 2018	BME 2019	Unknown 2018	Unknown 2019
Number in workforce	5809	5833	564	573	551	304
Number of staff entering the formal disciplinary process	54	55	2	4	2	1
Likelihood of staff entering the formal disciplinary process	0.009	0.009	0.003	0.006	0.003	0
Relative likelihood of BME staff entering the formal disciplinary process compared to White staff		0.38	0.74			

Table 6 - Non-Mandatory training

	White 2018	White 2019	BME 2018	BME 2019	Unknown 2018	Unknown 2019
Number of staff in workforce	5809	5833	564	573	232	304
Number of staff accessing non-mandatory training CPD	5529	5353	499	485	232	189
Relative likelihood of white staff accessing non-mandatory training CPD	0.95	0.9	0.88	0.8	0.42	0.6

Table 7 - Bullying and Harassment

Criteria	White respondents 2108	White 2019	BME 2018	BME 2019
% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	26%	26%	29%	35%
% of staff experiencing harassment, bullying or abuse from staff in the last 12 months	22%	22%	32%	31%
% of staff personally experienced discrimination from manager/team leader or other colleague	6%	6%	19%	15%

Table 8 - Career progression

	White respondents 2108	White 2019	BME 2018	BME 2019
% of staff believing that the Trust provides equal opportunities for career progression or promotion.	83%	86%	74%	76%

WDES Data 2019

The ten metrics have some similarity to those for the WRES but are detailed below:

Workforce Metrics:

- For the following three workforce Metrics, compare the data for both Disabled and non-disabled staff. Metric 1 Percentage of staff in AfC paybands or medical and dental subgroups and very senior managers (including Executive Board members) compared with the percentage of staff in the overall workforce.
- Metric 2 Relative likelihood of Disabled staff compared to non-disabled staff being appointed from shortlisting across all posts.
- Metric 3 Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure.

National NHS Staff Survey Metrics : For each of the following four Staff Survey Metrics, compare the responses for both Disabled and non-disabled staff:

- Metric 4 Staff Survey Q13 a) Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse from: i. Patients/service users, their relatives or other members of the public ii. Managers iii. Other colleagues b) Percentage of Disabled staff compared to non-disabled staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.
- Metric 5 Staff Survey Q14 Percentage of Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion.
- Metric 6 Staff Survey Q11 Percentage of Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.
- Metric 7 Staff Survey Q5 Percentage of Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work.
- Metric 8 Staff Survey Q28b Percentage of Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.
- Metric 9 a) The staff engagement score for Disabled staff, compared to non-disabled staff and the overall engagement score for the organisation. b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard? (Yes) or (No)

Board representation:

- Metric 10 Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By voting membership of the Board. • By Executive membership of the Board.

This is the first time this data has been collected and reported.

At DBTH we currently employ 3.3% of staff with a Disability.

Criteria	Headcount	%
Non-disabled staff	5144	96.7% (declared status)
Disabled	174	3.3% (declared status)
Not Known	1183	23% (not known)

However we have 23% of staff with a Disability status not recorded, which is significantly higher than the Ethnicity 'unknown' data.

Table 1 – Non clinical staff

Staff Group (Clusters)	Total Number of staff with declared status	Total Number of Disabled staff	% Disabled ratio	Number of staff without declared status	% staff without declared status
Cluster Bands 1 -4	1424	55	3%	268	16%
Cluster Bands 5 -7	153	7	4%	18	11%
Cluster 8a – 8b	50	0	0%	10	17%
Cluster 8c – 9 VSM	25	1	3%	6	19%

Table 2 - Clinical staff

Staff Group (Clusters)	Total Number of staff with declared status	Total Number of Disabled staff	% Disabled ratio	Number of staff without declared status	% staff without declared status
Cluster Bands 1 -4	1161	36	3%	247	18%
Cluster Bands 5 -7	1935	67	3%	496	20%
Cluster 8a – 8b	83	2	2%	13	14%
Cluster 8c – 9 VSM	19	0	0%	2	10%
Cluster 5 Med and Dental, Cons	198	4	2%	60	23%
Cluster 6 Medical and Dental Non-consultants career grade	203	2	1%	63	24%
Cluster 7 Medical and Dental Medical and dental trainee grades	64	0	0%	0	0%

Table 3 - Recruitment and Selection

Criteria	Headcount Number of Disabled	Total number of applicants Shortlisted
Number of shortlisted applicants	20	706
Number appointed from shortlisting	10	273
Relative likelihood shortlisting and appointed	Disabled staff 0.50 (50%)	
Relative likelihood of disabled staff being appointed compared to non-disabled	0.77 (77%)	

Table 4 - Capability (ie sickness absence procedures)

Criteria	Headcount Disabled	Non-Disabled
Number in workforce	174	5144
Number of staff entering the formal capability process	17	340

Likelihood of staff entering the formal capability process	0.10	0.07
Relative likelihood of Disabled staff entering the formal capability process compared to Non-Disabled staff	1.48	

It is evident from the above table that disabled staff are 1.48 times more likely to be in formal capability process compared to non-disabled staff. This would be an area which requires further exploration and investigation and is potentially concerning as to the reasons why staff find themselves in this situation and is it related to their condition. In understanding this data we must also review the adjustments being made with regard to the capability procedure such as an increase in targets being set with regard to level of absence.

Table 5 - Bullying and Harassment

Criteria	Number of disabled respondents	%	Number of non-disabled respondents	%
% of staff experiencing harassment, bullying or abuse from patients/service users, their relatives or other members of the public in the last 12 months	512	29.3%	2608	26.6%
% of staff experiencing harassment, bullying or abuse from managers in the last 12 months	504	17.1%	2576	10.1%
% of staff experiencing harassment, bullying or abuse from other colleagues in the last 12 months	501	25.9%	2574	15.9%
% of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it in the last 12 months	212	36.3%	821	42.4%

It appears that from the above data that the experience of disabled staff is worse in terms of bullying and harassment from members of the public, managers and staff.

Table 6 - Career progression

Career Progression	Headcount Disabled	%	Non-disabled Headcount	%
% of staff believing that the Trust provides equal opportunities for career progression or promotion.	318	73.3%	1711	87.1%

Table 7 - Pressure to come to work

Criteria	Number of disabled staff	%	Non-disabled staff	% non-disabled
% of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties.	385	37.9%	1462	29.7%

Table 8 - Values their work

Criteria	Number of disabled staff	% disabled staff	Number non-disabled staff	% non-disabled staff
% staff saying that they are satisfied with the extent to which their organisation values their work.	512	32.2%	2606	45.1%

Table 9 - Adequate Adjustments

Criteria	Number of disabled staff	% reporting adequate adjustment
% of disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work.	268	63.8%

It is apparent from the above table that disabled staff perceive their opportunities for career progression less favourably than non-disabled staff, they have felt more pressure to come to work despite not feeling well, feel less valued by the organisation and only 63.8% report that the adequate adjustments have been made to enable them to carry out their work.

Key messages for the Organisation

- There are gaps in the data we hold regarding Ethnicity of staff (4.5% unknown) and Disability status (23% not known)
- There are low numbers of applicants who are shortlisted for jobs from both BME (107 applicants) and Disabled (20 applicants) members of the community as compared with white and able bodied colleagues
- Disabled applicants have a 44% chance of successful appointment from shortlisting (20 shortlisted applicants in total)
- BME applicants have a 50% chance of successful appointment from shortlisting however numbers of applicants are very low (107 shortlisted applicants in total)
- White staff are 2.44 times more likely to be appointed compared to BME staff - this is a significant reduction from the previous year and therefore requires further exploration
- The relative likelihood of BME staff being in the formal disciplinary process compared to white staff is 0.74 which is positive; however this is double the figure in the previous year (4 members of staff as compared with 2 the previous year)
- Within Non-Clinical roles the highest numbers of BME staff sit in pay bands 1 and 2 (NB this data was provided prior to the transition of Band 1 staff into Band 2). In Clinical roles the majority of BME staff sit in Bands 2 and Band 5. This would suggest Health Care Assistant roles and Band 5 Registered Nurses roles.
- The data suggests that 3% of disabled staff sit in Bands 1 – 7 and we have only 1 declared disabled member of staff in 8c- 9 VSM and none in medical and dental trainee grade positions.
- Consultant and Non Consultant career grade doctors have a much higher representation of BME staff.
- BME staff are slightly less likely to access non-mandatory training that white staff (but this is in the non-adverse relative likelihood zone)
- Disabled staff are 1.48 times more likely to be in formal capability process compared to non-disabled staff
- Both disabled and BME staff experience more bullying, harassment and abuse than white and non-disabled staff
- 29.3% of disabled staff reported harassment, bullying and abuse from patients/relatives, 25.9% reported harassment, bullying or abuse from another colleague and 17.1% reported it from managers.
- 15% of BME staff have personally experienced discrimination from manager/team leader or other colleague.
- 37.9% of disabled staff say that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties as opposed to 29.7% of non-disabled staff.
- Ethnic diversity within the Non-Executive Board roles had slightly improved
- There is an absence of declared disabled staff at Trust Board level
- 32.2% of disabled staff reported that they are satisfied with the extent to which their organisation values their work as opposed to 45.1% non-disabled staff.
- 63.8% of disabled reported that their employer has made adequate adjustment(s) to enable them to carry out their work.

The summary findings from the WRES and WDES suggest that there is further work in respect of data capture, the recruitment of disabled and ethnically diverse staff and improving their overall experience and inclusivity and support within our organisation. It also suggests we continue on our journey to a more tolerant, inclusive culture where civility and respect is the 'way we do business'.

Actions to address areas raised in this report:

- The Staff Equality, Diversity and Inclusion Group meets quarterly which is an inclusive staff network to engage with all staff and address issues
- Unconscious Bias training available for all staff
- Educate managers in supporting staff with disabilities and making adequate adjustments (understand what the data is telling us)
- Living the DBTH values and behaviours training
- Inclusive and Compassionate Leadership embedded in all leadership programmes
- Staff engagement forums to listen and act on staff feedback and experiences
- Implementation of actions plans in response to Staff Survey results
- Visible organisational support for Doncaster Pride and have an active role in engaging with the local community
- The Rainbow Badge initiative gives healthcare staff a way to show that their place of work offers open, non-judgemental and inclusive care for all who identify as LGBT+ (lesbian, gay, bisexual, transgender, the + simply means inclusive of all identities, regardless of how people define themselves). Rainbow Badge initiative to train and educate staff around appreciating diversity and LGBT+, this will be launched in September
- Project Choice is a supported internship programme for people with learning disabilities, difficulties or autism (LDDA). NHS Health Education England, support NHS Trusts to deliver the programme nationally. The focus is 'work readiness' and matching skills to employment. The project teams ensure there are placements across the Trusts looking specifically at entry-level jobs to make sure the right learner is allocated to this role. They also work closely with managers to confirm that tasks are clearly understood.
- Develop role models at all levels within the organisation for BME and disabled staff.
- Explore how to reach out into the wider community to engage and attract people from diverse backgrounds, cultures and with disabilities into our organisation.
- Explore how we ensure that we attract and recruit staff, volunteers and governors from diverse backgrounds, cultures and groups into our organisation and how we can create opportunities for future or potential employees to engage with our organisation with a view to proactively generating interest when future vacancies arise.

If the Board agrees with these as our priorities for action they will be developed into an action plan and published with our data.

E3

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	Improving People practices		
Report to	Board of Directors	**Date**	July 2019
Author	Karen Barnard, Director of People & Organisational Development		
Purpose			Tick one as appropriate
	Decision		
	Assurance		✓
	Information		

Executive summary containing key messages and issues

In May 2019 all Trusts received a letter from Baroness Dido Harding, Chair of NHSI entitled Learning lessons to improve our people practices (Appendix 1). Subsequently a letter was received from Prerena Issar, Chief People Officer of NHSI and NHSE entitled *'A fair experience for all'* (Appendix 2).

Within the P&OD team we have a casework team who co-ordinates all matters relating to non-medical disciplinary action. They have undertaken a review of our current disciplinary policy and practice in light of the guidance contained within the letter from Dido Harding detailing where they consider improvements could be made. The team has identified some improvements that can be made to our policy and the process (marked in blue). In light of this letter a review will also be undertaken of current open cases to review their status within the process and the questions within Dido Harding's letter applied, namely

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage?
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Within 'A fair process for all' four models of good practice are encouraged (included within the report) – the first two suggestions (decision tree checklist and post action audit) will be added to our internal processes and an analysis undertaken of some recent cases to determine whether the 3rd option of a pre hearing check by a Director level person would have altered the decision to take a case forward to a disciplinary hearing.

The outcome of both these pieces of work will be reported to QEC.

In respect of Prerana Issar's letter, as members of the Board will note from the WRES report on the Board agenda this month, BME staff within the Trust are less likely to enter formal disciplinary processes than their white colleagues. The most recent data now almost sits within the 'non-adverse relative likelihood zone' of 0.8-1.25 at 0.74 whilst previously the data indicated that white staff were more likely to enter the formal disciplinary process. We have been advised that there will be two related goals over the coming 3 years:

1. To ensure that the relative likelihood for BME staff entering the formal disciplinary process compared to white staff is within the non-adverse range of 0.8 – 1.25. – our data indicates we are close to meeting this
2. To reduce the overall likelihood and number of staff entering the formal disciplinary process for both white and BME staff. – we will review comparator data on the model hospital portal to determine how we compare with other similar Trusts.

The report therefore also details the numbers of conduct cases and resulting action by Division. Circa 50% of cases result in either no action or informal action and as such a review will be undertaken as to whether the first and third suggestions in the model above would make a difference. This will be included in the report to QEC.

Key questions posed by the report

Does the Board feel assured in respect of the assessment undertaken and the planned actions to improve our processes.

How this report contributes to the delivery of the strategic objectives

People – As a Teaching Hospital we are committed to continuously developing the skills, innovation and leadership of our staff to provide high quality, efficient and effective care.

How this report impacts on current risks or highlights new risks

F&P 8 Inability to recruit right staff and have staff with right skills leading to:

i. Increase in temporary expenditure
ii. Inability to meet FYFV and Trust strategy
iii. Inability to provide viable services

Q&E 6 Failure to improve staff morale leading to:

i. Recruitment and retention issues
ii. Impact on reputation
iii. Increased staff sickness levels

Recommendation(s) and next steps

The Board are asked to receive this report.

Assessment against guidance contained within Dido Harding's letter

1. Adhering to Best Practice

(a) Underpinned by Best Practice

- Trust Policy is written in line with and more than meets the requirements of the ACAS Code of practice.
- Policy is approved in conjunction with staff side and is regularly reviewed. Reviews may occur sooner around lessons learnt or changes in employment law.
- When a related grievance or complaint of bullying is received, a conduct process can be suspended (where appropriate and taking into account ACAS guidance) so that the grievance can be addressed in the first instance.
- The individual is told the nature of the allegations against them and has full opportunity to state their case before any decision is made. The individual has the opportunity to be advised and supported by their union or work colleague at all stages of the process
- As well as the main policy, appendix 3 of the policy provides guidance to managers on how to apply the policy. This includes the role of the investigating officer, scoping the investigation and the steps that should be taken during investigation, guidance on decisions around suspension, taking witness statements, the procedure that will be followed at a hearing and decision making. It also provides additional guidance on clinical investigations and the additional considerations that should be reviewed. An improvement is that this guidance is incorporated into a manager's checklist to ensure that managers have fairly followed requirements of the policy.
- The section on decision making refers the responsible manager to the 7 questions a tribunal would review to ensure a decision is fair and reasonable. This sets out the decision making methodology but it is not set out in the form of a matrix or checklist. This will be developed alongside the above.
- The policy/procedure has not been reviewed around GMC's "Principles of a good investigation" or the NMC's "Best practice guidance on local investigations" (Not yet published). However, the policy will be reviewed against these and amended if required.

(b) Independent and Objective

- Policy states that an investigating officer can neither adjudicate at the hearing nor be in any way involved/connected with the allegation.
- No manager may dismiss an immediate subordinate.
- Where a potential conflict of interest may arise, a decision may be made to ask an impartial manager either to investigate the matter or to be the responsible manager. This would generally be identified at the point the case is opened or, if a concern is raised by the individual, at that stage. This is practiced but is not explicit in the policy.
- Support is available from HR at all stages if required.
- The policy is silent on the use of independent external advice and expertise. However, this approach has been used by the Trust on previous occasions.
- The policy also has a section on ensuring the presence of a union rep does not prejudice the hearing.

2. Applying a rigorous decision-making methodology

(a) Decision making on what action is appropriate

- The procedure should not be viewed primarily as a means of imposing sanctions but to help employees to achieve and maintain standards of conduct, attitude and job performance and to ensure that every employee reflects the values and behaviours expected. Therefore, there is a process of working with the individual to set standards followed by warnings and individuals would not generally be dismissed for a first offence. The exception to this would be cases of gross misconduct.
- Where appropriate and possible, problems should first be resolved through support/retraining/counselling referring to other policies before resorting to formal disciplinary processes
- Matters of a minor nature can be resolved through counselling, without the need to resort to formal disciplinary processes.
- The policy refers to a prima facie decision being made on whether the matter should be addressed formally. However, there is limited information in the policy on these preliminary steps and what should happen following them, e.g., on what should be considered when making this decision. This area of the guidance will be improved to include decision making methodology. Guidance can be sought from People Business Partners on what should be addressed informally and formally. However, many managers open a formal case without any reference to their People Business Partner. The case forms have recently been reviewed and a new section has been added to ensure that the manager has discussed the issue with their PBP before opening the case.
- In Appendix 3 in the Disciplinary Procedures, the section on decision making refers the responsible manager to the 7 questions a tribunal would review to ensure a decision is fair and reasonable. This sets out the decision making methodology but it is not set out in the form of a matrix or checklist. This will be adapted to be more explicit in the form of a matrix.
- With more serious matters, where dismissal would be warranted, action short of dismissal can be considered to include transfers or demotion. In practice this is applied through thorough discussion between the decision maker and Human Resources, taking into account risks, benefits, action plans and a clear rationale. However, it may be appropriate to develop additional guidance for managers as to when this may be suitable and reasonable.

(b) Plurality

- Support and advice from P&OD
- Individuals have the opportunity to appeal decisions that have been made and these would be considered by an independent panel. There have previously been delays and this is being monitored.
- Use of experts or managers with the correct or complimentary skills at decision making stages of the procedure – e.g. a nurse manager considering concerns about a nurse.
- There is a clear schedule of who should address disciplinary matters.

3. Ensuring people are fully trained and competent to carry out their role

- "New Leader" training – commencing July 2019
- DEVELOP training content includes addressing conduct issues – a review of this training is scheduled and changes will be made to include more information and greater emphasis on the preliminary decision making stage.
- Trust Equality Training - mandatory
- Managers can request 1-2-1 training from HR if required.
- It is not currently a mandatory requirement that individuals receive specific case manager, case investigator or panel member training. However, one of this year's objectives for the case team is to develop modular training which is specific to roles and responsibilities within employee relations case work and to build a tiered profile of competent managers.

4. Assigning sufficient resources

- This is an area of concern as many managers, in particular clinical managers, do not have the non clinical time to dedicate to addressing these matters quickly. There are some options to consider embedding to help support this:
  - The responsible manager should scope the investigation and agree a terms of reference. This would create an understanding of the complexity of the investigation so that adequate resource can be allocated.
  - A clear case tracker and KPIs for each specific case should be reviewed with the responsible manager to ensure timescales are adhered to.
  - Clear escalation routes between People BP/ CaseTeam to the responsible manager where there are concerns regarding timeliness or quality so that joint management and decision making can be made regarding resource allocation and prioritisation.

5. Decisions relating to the implementation of suspensions/exclusions

- Must only take place should there be no other option that would ensure the safety of patients and employees, protect the integrity of the investigation and ensure the alleged offence does not take place again. Alternative options will include restricted duties, alternative work environment, working from home or in non-clinical duties.
- Recognising that suspensions cannot be a neutral act, the Trust only uses suspensions where this is absolutely necessary. (We currently have two member of staff suspended and one on alternative duties)
- Consideration of suspension would be by the Responsible Manager. However, advice on potential suspensions should also be sought from the P&OD Department.
- Clearer delegation of responsibilities for decision making about suspension referencing the process for both within hours and out of hours will be included in the policy. Currently the policy is silent on the process out of hours.
- In addition, a risk assessment template will be developed to aid with the decision making process for suspensions and to support robust records of decisions that are made.

E3

- The individual is given full details of why the suspension is necessary and its duration. They are also signposted to appropriate sources of support such as their Trade Union, and Advocate (if required - the Trust can also help to find an appropriate advocate), a supportive mentor, OH, and HELP (the Trust's EAP scheme).
- Suspensions are reviewed every 2 weeks and fortnightly contact maintained with the individual. However, improvements can be made regarding the oversight and scrutiny of the process and whose responsibility it is to ensure reviews are undertaken, recorded, and communicated to the staff member.
- Where an individual becomes ill during a process, advice is sought from Occupational Health regarding their ability to engage. Their sickness absence takes precedence over their suspension, with the suspension being placed on hold until they are well enough for the process to continue.

6. Safeguarding people's health and wellbeing

(a) OH Support and Welfare

- At meetings and hearings, staff are provided with details of the HELP Employee Assistance support.
- OH support is available to them and is discussed if it is required.
- Pastoral support from someone not involved or a mentor is now offered where it is deemed to be required.
- Individuals have a statutory right to be accompanied by a companion at a hearing. Their companion is allowed to participate as fully as possible. This right does not extend to other meetings such as investigation meetings. However, if it does not cause undue delays, individuals are offered the opportunity to be accompanied at other meetings too.
- Where an individual is not a member of a union or requires additional support, advocates can be identified as support for them or may attend on their behalf. This is generally where the individual may struggle to understand or engage with the process, or where mental health issues require this.
- Legal representation at appeals where the outcome may impact on or exclude the individual from their practice or profession.
- We will reschedule meetings on one occasion to allow the individual to be accompanied.
- Where the individual accepts and acknowledges the allegations they may opt for a sanction outside of a hearing that precludes the full disciplinary process and shortens the timescale from the issue occurring to the resolution and outcome.
- Where an individual becomes ill during a process, advice will be sought from OH regarding their ability to engage. Absence will be managed in the normal manner.
- There is a risk that where somebody goes off sick during an investigation, the absence management process may be overlooked, as the focus is on the conduct matter. Triangulation of actions will be undertaken to ensure that matters progress in a timely manner.
- There is particular difficulty and potential time delays when the disciplinary process relates to a criminal matter, particularly when the police do not want internal procedures to commence so that their investigations are not hindered, and also where the police deem it inappropriate to share information with the Trust.

(b) Communication and Terms of Reference

- Terms of Reference are already used for medical staff (in line with MHPS) and will be introduced for other staff.
- At the moment, we do not produce communication plans or have a formal, supportive process for providing regular updates to staff who are going through an investigation process, or formal checks on their wellbeing. This will be incorporated into the Terms of Reference and processes going forward.

(c) Never Events

- Individuals suffering any form of harm being classed as never events is not made reference to in the Trust's Disciplinary Process. This will require a review of the policy.

7. Board-level oversight

- Statistical information is provided regularly by the Case Team to the Director of P&OD and the Director of P&OD reports regularly to QEC on these statistics (six monthly). However, KPI's and this data is currently being reviewed and developed by the case team. The policy sets out information the board requires on an annual or exceptional basis. A review will take place as to the level of information being provided – the next report to QEC is due in August.

Volume of disciplinary cases and resultant action

Appendix 3 details the data we have for the last 3 years since 2016. There have been 243 cases over the 3 year period. From the data it can be seen that approximately 50% of cases result in no case to answer or an informal sanction – from the data currently available it has not been possible to determine at what stage of the process this decision is made. Members will also note that the majority of cases relate to 'inappropriate behaviour' – I am advised that this covers a range of allegations from attitude and behaviour (including inappropriate behaviour), alcohol related offences, matters relating to safeguarding, fraud, dishonesty/theft, unprofessional practice, inappropriate use of social media/internet

Within 'A fair process for all' four models of good practice are encouraged (table below)- the first two suggestions will be added to our internal processes and an analysis undertaken of recent cases to determine whether the 3rd option would have altered the decision to take a case forward to a disciplinary hearing.

E3

Table 6. Four models of good practice for reducing the disproportionate gap in BME and white staff entering the formal disciplinary process

Model	Pros	Cons
1. **Decision tree checklist –** The tool comprises an algorithm with accompanying guidelines and poses a series of structured questions to help managers decide whether formal action is essential or whether alternatives might be feasible. (Developed by the National Patient Safety Agency (NPSA)).	Keeps responsibility for considering all evidence with managers. Offers managers a very clear, evidence-based framework for considering the evidence.	Subjective variations in decisions are not likely to be reduced.
2. **Post action audit –** Managers are made aware that all decisions to place staff through the formal disciplinary process will be reviewed on a quarterly or bi-annual basis using robust information on each case to discern any systemic weaknesses, biases or underlying drivers of adverse treatment of any staff group.	Keeps responsibility with managers. Can help embed better practice in those areas identified as needing support.	In the short term it cannot prevent unnecessary formal disciplinary action.
3. **Pre-formal action check by a director level member of staff and/or panel –** An executive board member of the organisation – or a panel that includes an executive board member – review all cases and decide whether they should go to formal action.	Consistency of approach.	Reduces responsibility of managers to make the appropriate decision and take responsibility for it.
4. Pre-formal action check by a trained lay member – A trained lay member reviews cases and challenges any perceived bias in the process before cases go to formal action.	External scrutiny approach further reduces risks of bias and adds objectivity to the process.	Increased risk of loss of confidentiality. Requires consistency in approach.

Within the data in Appendix 3 the number of current open cases have been included – these will be reviewed as to their status within the process and the questions within Dido Harding's letter applied, namely

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?
- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage?
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

The outcome of both these pieces of work will be reported to QEC.

Compassionate and learning culture

In reviewing these cases and our approach to cases of misconduct we will take account of the following section from Prerana's letter "We know that workforce race equality requires organisations to go beyond operational change because of compliance and regulation against processes and targets. Whilst these features are critical, the parallel challenge here is that of cultural and transformational change on this agenda. It is essential that every leader at every level of the organisation ensures they promote and model both compassion and inclusion in all their interactions. Only then will everyone who works in, and uses, health services see that these values are the lived genetic structure of the NHS. Research and evidence show that to improve in this area organisations need to have several conditions in place:

- First, we need compassionate leaders who pay attention to those they lead. They must seek to understand through talking with their staff the challenges they face in delivering care. Their focus must be how they can help those they lead to provide the high quality, compassionate care they wish to offer.
- Second, it is important that every team has clear, agreed upon and challenging objectives aligned with the organisation's vision and that every individual is clear about their role and what they are required to do in their work.
- Third, we must create an environment of enlightened people management, nurturing the engagement and positive emotions that ensure staff thrive and enjoy their work place interactions.
- Fourth, we must continue to create the conditions for quality improvement and innovation in our organisations. Changing culture also means ensuring that all leaders understand the central role inclusion plays in the efficiency and effectiveness of our health services.
- Fifth, building effective teams ensures team members feel a sense of cohesion, optimism and efficacy in their work. Effective teams have dramatically reduced stress levels which in turn means less aggression, harassment and discrimination."

E3

Appendix A - Dido Harding Letter

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trust and NHS foundation trust chairs and chief executives

24 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

E3

Appendix B - A fair experience for all

A fair experience for all:

Closing the ethnicity gap in rates of disciplinary action across the NHS workforce

NHS Workforce Race Equality Standard (WRES) strategy

NHS England and NHS Improvement

A fair experience for all:

Closing the ethnicity gap in rates of disciplinary action across the NHS workforce

Version number: 1

First published: July 2019

Prepared by: The WRES Implementation team

Classification: OFFICIAL

Other formats of this document are available on request. Please send your request to: england.wres@nhs.net

E3

Foreword

Organisations across the NHS are working diligently to improve workforce race inequality, but we all know we need to do more and at pace. Black and minority ethnic (BME) staff constitute almost a fifth of the total NHS workforce, yet the experiences they often face do not correspond with the values upon which the NHS proudly stands. It cannot be right that some of our hardworking staff are still more likely than their colleagues to face unfair treatment and discrimination in the workplace.

We cannot afford the cost to staff and patient care that comes from unfairness for a large section of the NHS workforce. The "business case" for race equality in the NHS is now a powerful one. NHS England and NHS Improvement, with their partners, are committed to tackling race discrimination and creating an NHS where all staff are fully engaged and supported – not least for the sake of our patients.

At the NHS People Conference, in May 2019, I announced that together, across the NHS, we will have a concerted focus to reduce the disproportionate ethnicity gap in entry into the formal disciplinary process – and to reduce the overall rate of unnecessary disciplinary action. We will do this by setting clear aspirational goals for ourselves and by undertaking robust support and advice – including through the sharing of replicable good practice in this area.

This helpful document presents us with the opportunity to make a real difference in this area. It presents stretching but achievable goals in this area for NHS organisations, and highlights good practice and recommendations for to bring about improvements to the culture of the health service – supporting organisations to shift from, the often, toxic environment of blame to one of support and learning.

I encourage all NHS staff to read this document and reflect on what we can all do to help deliver on its ambitious objectives. I look forward to seeing continuous improvements on this critical agenda over the coming period.

Prerana Issar
Chief People Officer
NHS England and NHS Improvement

01 The case for workforce race equality

The NHS is the practical expression of a shared commitment by all that make up our diverse British society. Every day, nurses, doctors, other clinical and non-clinical staff impact the lives of people all over the country and beyond.

Ever since its inception in 1948, the NHS has depended on the talents of its diverse workforce, including those from other countries. Yet, the experiences and opportunities that black and minority ethnic (BME) staff in the NHS face, do not always correspond with the values of the NHS Constitution.

To be a model employer, the NHS needs to be an inclusive employer with a diverse workforce at all levels. However, having a diverse workforce at all levels is not the end game for organisations; staff also need to feel fully engaged and supported within the workplace. This is critical as it impacts upon patient care, patient safety as well as organisational efficiency.

We know that one of the main factors believed to affect patient satisfaction is the experience of staff working in the NHS. Research shows that the extent to which an organisation values its minority staff is a good barometer of how well patients are likely to feel cared for[1]. Increased staff engagement also leads to lower levels of absenteeism, decreased spend on agency staff, and increased organisational efficiency and productivity[2].

This document is not a definitive blueprint to this agenda, but an evolving guide to help support local practices in promoting workforce race equality.

1. https://www.england.nhs.uk/publication/links-between-nhs-staff-experience-and-patient-satisfaction-analysis-of-surveys-from-2014-and-2015/

2. https://www.england.nhs.uk/publication/employee-engagement-sickness-absence-and-agency-spend-in-nhs-trusts/

02 The need for accelerated improvement

Since its introduction in 2015, the Workforce Race Equality Standard (WRES)[3] has required NHS trusts and clinical commissioning groups (CCGs) to self-assess annually, on nine indicators of workforce equality, including on an indicator that looks at the relative likelihood of BME staff entering the formal disciplinary process compared to their white staff counterparts in the same organisation.

In 2018, 10,818 white staff and 3,363 BME staff entered the formal disciplinary process across NHS trusts in England. These are lower overall figures than those observed in 2017, when 11,857 white staff and 3,854 BME staff entered the formal disciplinary process.

Table 1: The relative likelihood for BME staff entering the formal disciplinary process compared to white staff in NHS trusts

	2016	2017	2018
All NHS trusts	1.56	1.37	1.24

For the period 2016 to 2018, there has been continuous improvement for this indicator. The relative likelihood for BME staff entering the formal disciplinary process compared to white staff has improved from 1.56 in 2016 to 1.24 in 2018.

Within 176 (76.2%) NHS trusts in England, in 2018, the relative likelihood of BME staff entering the formal disciplinary process compared to white staff was outside the 0.8 – 1.25 non-adverse relative likelihood zone, based on the 'four-fifths rule'[4].

For 41 NHS trusts, the relative likelihood was less than 0.8; white staff in these trusts were more likely to be adversely impacted by the formal disciplinary process. For 135 NHS trusts, the relative likelihood was higher than 1.25; BME staff, especially those working in certain parts of the workforce, including frontline staff, those in clinical roles and junior administration in these trusts were more likely to be adversely impacted by the formal disciplinary process.

Whilst the data show continuous improvement over time in this area, there is still more to do to overcome the scale of the challenge.

3. https://www.england.nhs.uk/about/equality/equality-hub/equality-standard/

4. http://uniformguidelines.com/uniformguidelines.html#18

03 Variation in rates of disciplinary action

When we look at NHS trusts grouped by geographical regions in England, we find that there have been improvements in reducing the likelihood of BME staff entering the formal disciplinary process across all regions over the past three years. However, we also find that trusts in the London region remain the most challenged. In comparison, NHS trusts in the south region appear to be doing better.

Table 2: The relative likelihood for BME staff entering the formal disciplinary process compared to white staff in NHS trusts, by region

Region	2016	2017	2018
London	1.99	1.80	1.77
Midlands & East	1.56	1.28	1.18
North	1.42	1.27	1.36
South	1.17	1.16	1.12

Variation in performance on this indicator is not just restricted to region. We also find variation by the type of NHS trust. Acute and mental health trusts have seen year-on-year improvements in reducing BME entry into the formal disciplinary process. In general, community provider and ambulance trusts have not shown the scale of improvement that we would like to see.

Table 3: The relative likelihood for BME staff entering the formal disciplinary process compared to white staff, by trust type

Trust type	2016	2017	2018
Acute	1.45	1.26	1.14
Mental Health	1.80	1.73	1.69
Community Provider	2.48	3.35	2.70
Ambulance	1.33	1.58	1.74

The data presented above relate to NHS trusts; the data for the national healthcare arm's length bodies show similar patterns, and CCG data (to be collected and published from 2019 onwards) are likely to be no different. To close the ethnicity gap in disciplinary action, and to reduce the overall levels of unnecessary disciplinary action across the NHS, we need ambitious goals underpinned by effective and evidence based replicable good practice.

04 Our ambition: closing the ethnicity gap in disciplinary action

The WRES team provides direction and tailored support to NHS trusts, CCGs and increasingly to the wider healthcare system, enabling local NHS and national healthcare organisations to:

- identify the gap in treatment and experience between white and BME staff;
- make comparisons with similar organisations on level of progress over time;
- take remedial action on causes of ethnic disparities in indicator outcomes.

There is robust evidence for the effectiveness of having an ambition that is based upon a commitment to specific goals, monitored by frequent feedback.[5] Organisations are more likely to focus on an issue at hand if an official goal or aspiration exists to act as a reminder of what needs to be achieved. Aspirational goals should embody challenge, specificity, and need to be reinforced by accountability.

Overarching aspiration for the NHS

Statistical analyses based upon WRES data and trajectory, for the likelihood of BME staff entering the formal disciplinary process within NHS trusts, help to inform the national aspirational goals in this area for 2020, 2021 and 2022 These national aspirations are set-out in table 4 below and relate to all NHS trusts, CCGs and national healthcare arm's length bodies (ALBs).

5. Jayne, M.E., & Dipboye, R.L. (2004). Leveraging diversity to improve business performance: Research findings and recommendations for organisations. Human resource management, 43(4), 409-424

Table 4: Expected rate of improvement in closing the gap in the likelihood of entry into the disciplinary process between BME and white staff across NHS trusts, CCGs and the national ALBs

2020	2021	2022
51% of NHS organisations within the non-adverse range of 0.8 and 1.25*	76% of NHS organisations within the non-adverse range of 0.8 and 1.25*	90% of NHS organisations within the non-adverse range of 0.8 and 1.25*

*0.8 and 1.25 refers to the relative likelihood of BME staff entering the formal disciplinary process compared to white staff as measured by WRES indicator 3

A stretching and yet achievable, aspiration for the NHS would be to reach equality in terms of the likelihood of staff entering the disciplinary process for both white and BME staff across at least 90% of all NHS organisations by 2022.

This will be measured by the proportion of organisations with a relative likelihood for BME staff entering the formal disciplinary process compared to white staff within the non-adverse relative likelihood range of 0.8 and 1.25. The ambition considers trusts with small numbers of BME staff whose data can be easily skewed by a single person entering the formal disciplinary process. Where there are very small numbers, statistical testing will be used to check if there are significant differences.

Aspirations at organisational level

At an organisational level, there will be two related goals:

1. to ensure that the relative likelihood for BME staff entering the formal disciplinary process compared to white staff is within the non-adverse range of 0.8 – 1.25.

2. to reduce the overall likelihood and number of staff entering the formal disciplinary process for both white and BME staff.

The above national model, and the 2022 timeframe (table 4), can be applied to local NHS organisations, considering their respective workforce composition. In table 5, all three organisations aspire to locate the relative likelihood of BME staff entering the formal disciplinary process compared to white staff between 0.8 and 1.25. However, because of their distinct baselines for this indicator, they are likely to face different challenges in achieving the aspirational target.

Table 5: Goal setting: the example of three NHS organisations

Organisation	Likelihood of white staff entering the formal disciplinary process	Likelihood of BME staff entering the formal disciplinary process	Relative likelihood of BME staff entering the formal disciplinary process compared to white staff at 2018	Ambition: relative likelihood of BME staff entering the formal disciplinary process compared to white staff by 2022
A	1.17%	0.41%	0.35	0.8 - 1.25*
B	0.45%	1.72%	3.79	0.8 - 1.25*
C	1.50%	4.55%	3.04	0.8 - 1.25*

* 0.8 and 1.25 refers to the relative likelihood of BME staff entering the formal disciplinary process compared to white staff as measured by WRES indicator 3

Organisation A will have to reduce the likelihood of white staff entering the formal process to levels similar to those of BME staff.

Organisation B will have to achieve the same goal by doing the opposite e.g. reducing the relative likelihood for BME staff entering the formal disciplinary process compared to white staff, from 3.79 to less than 1.25, by 2022. This will be achieved by reducing the likelihood of BME staff entering the formal process to levels similar to those of white staff.

Organisation C will have to reduce the relative likelihood for BME staff entering the formal disciplinary process compared to white staff, from 3.04 to less than 1.25, by 2022. But it will also have to reduce the likelihood of both BME and white staff entering the formal process so that it is in line with the national median/averages.

Disciplinary data are available to each NHS organisation, and each organisation will be able to calculate the scale of their challenge. We also acknowledge that individual trusts and CCGs will know their workforce processes and will therefore be ideally placed to develop their own robust action plans to support this agenda.

Organisations are expected to discuss these matters at board meetings, and to develop and agree the following with the national WRES team:

- understanding of their aspirational goals in this area for the next three years: to close the gap on white and BME staff, and to reduce the overall likelihood of both BME and white staff entering the formal process;
- a robust action plan to deliver the change required;
- how to work with the national WRES team and track progress against these aims.

Arm's length bodies leading the way

As employers, the national healthcare ALBs should be leading the way on the workforce race equality agenda. In the same spirit of transparency and continuous improvement, the ALBs should also work towards the system-wide aspiration of closing the gap in disciplinary action between BME and white staff in their respective workforce – and in doing so, decreasing the overall rate of unnecessary disciplinary action.

05 Supporting delivery of the ambitions

The WRES team will support the wider system to focus on driving improvements in closing the ethnicity gap in entry into the formal disciplinary process – and in reducing the overall level of unnecessary disciplinary action across the NHS. A clear focus will be upon both sharing replicable good practice as to what works in this area at a practical level, as well as supporting the transformation of cultures within organisations to those that are underpinned by learning and compassion.

E3

Replicable good practice

Table 6. Four models of good practice for reducing the disproportionate gap in BME and white staff entering the formal disciplinary process

Model	Pros	Cons
1. **Decision tree checklist –** The tool comprises an algorithm with accompanying guidelines and poses a series of structured questions to help managers decide whether formal action is essential or whether alternatives might be feasible. (Developed by the National Patient Safety Agency (NPSA)).	Keeps responsibility for considering all evidence with managers. Offers managers a very clear, evidence-based framework for considering the evidence.	Subjective variations in decisions are not likely to be reduced.
2. **Post action audit –** Managers are made aware that all decisions to place staff through the formal disciplinary process will be reviewed on a quarterly or bi-annual basis using robust information on each case to discern any systemic weaknesses, biases or underlying drivers of adverse treatment of any staff group.	Keeps responsibility with managers. Can help embed better practice in those areas identified as needing support.	In the short term it cannot prevent unnecessary formal disciplinary action.
3. **Pre-formal action check by a director level member of staff and/or panel –** An executive board member of the organisation – or a panel that includes an executive board member – review all cases and decide whether they should go to formal action.	Consistency of approach.	Reduces responsibility of managers to make the appropriate decision and take responsibility for it.
4. Pre-formal action check by a trained lay member – A trained lay member reviews cases and challenges any perceived bias in the process before cases go to formal action.	External scrutiny approach further reduces risks of bias and adds objectivity to the process.	Increased risk of loss of confidentiality. Requires consistency in approach.

Guidance relating to the management and oversight of local investigation and disciplinary procedures

In 2019, NHS England and NHS Improvement made recommendations that all NHS boards should consider how they oversee investigations and disciplinary procedures. The seven key recommendations are presented below:

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Advisory, Conciliation and Arbitration Service (ACAS) 'code of practice on disciplinary and grievance procedures' and other non-statutory ACAS guidance; the General Medical Council's 'principles of a good investigation'[6]; and the National Midwifery Council's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied (as cited in the previous section) that provides for full and careful consideration of context and prevailing factors when determining next steps.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with sufficient resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

6. https://www.gmc-uk.org/-/media/documents/dc11437-principles-of-a-good-investigation_pdf-75546780.pdf

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

Compassionate and learning culture

We know that workforce race equality requires organisations to go beyond operational change because of compliance and regulation against processes and targets. Whilst these features are critical, the parallel challenge here is that of cultural and transformational change on this agenda.

It is essential that every leader at every level of the organisation ensures they promote and model both compassion and inclusion in all their interactions. Only then will everyone who works in, and uses, health services see that these values are the lived genetic structure of the NHS.

Research and evidence[7] show that to improve in this area organisations need to have several conditions in place:

First, we need compassionate leaders who pay attention to those they lead. They must seek to understand through talking with their staff the challenges they face in delivering care. Their focus must be how they can help those they lead to provide the high quality, compassionate care they wish to offer.

Second, it is important that every team has clear, agreed upon and challenging objectives aligned with the organisation's vision and that every individual is clear about their role and what they are required to do in their work.

Third, we must create an environment of enlightened people management, nurturing the engagement and positive emotions that ensure staff thrive and enjoy their work place interactions.

Fourth, we must continue to create the conditions for quality improvement and innovation in our organisations. Changing culture also means ensuring that all leaders understand the central role inclusion plays in the efficiency and effectiveness of our health services.

Fifth, building effective teams ensures team members feel a sense of cohesion, optimism and efficacy in their work. Effective teams have dramatically reduced stress levels which in turn means less aggression, harassment and discrimination.

7 https://www.hsj.co.uk/workforce/bme-staff-are-still-struggling-heres-what-you-can-do-about-it/7024327.article

Conclusion and next steps

In the management of people-related issues and conduct of workplace relationships, there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances.

Whilst there will always be some occasions when disciplinary action is necessary and appropriate, the differential rate of disciplinary action between BME and white staff in the same organisations is striking.

We have set the NHS, and ourselves, an ambitious challenge of closing the ethnicity gap in entry into the formal disciplinary process by 2022 and have outlined a holistic set of interventions to help guide us.

Demonstrable leadership, accountability and support interventions will help organisations to continuously improve on workforce race equality. Progress in this area will be monitored and benchmarked for continuous improvement over time as part of the annual WRES data collection and publication.

This document will help you deliver the twin priorities of reducing the ethnicity gap in entry into the formal disciplinary process, as well as reducing the overall levels of disciplinary action amongst all staff. It is however guidance, it is recognised that many organisations are already working to reduce the gap in experience of their BME and white staff across all nine WRES indicators. The issues existing in the race inequality agenda are ingrained, multifactorial and complex, needing many different, innovative and creative solutions for us to employ in order to ultimately reach the goal of a fully inclusive and fair NHS for all our staff.

Appendix C - Disciplinary cases

E3

SUMMARY OF CONCLUDED DISCIPLINARY/CONDUCT CASES

Year 2016 (01/07/2016 – 31/12/2016)	Area of work/Division									
Allegation	**Children & Families**	**Diagnostics & Pharmacy**	**Emergency**	**Estates & Facilities**	**MSK & Frailty**	**Performance Management**	**P&OD**	**Speciality**	**Surgical**	**Total**
Inappropriate Behaviour	5	1	7	2	3	0	0	1	1	**20**
Working Practice	2	0	0	0	0	0	0	0	0	**2**
Registration Breaches	1	0	0	0	0	0	0	0	0	**1**
Bullying	0	0	0	0	0	0	0	0	0	**0**
Confidentiality	1	0	0	0	0	0	0	0	0	**1**
Drug Errors	2	0	0	0	0	0	0	0	0	**2**
Total Cases	**11**	**1**	**7**	**2**	**3**	**0**	**0**	**1**	**1**	**26**
Outcomes										
No case to answer	0	0	2	0	1	0	0	0	0	**3**
Informal outcome	4	1	1	0	0	0	0	1	0	**7**
Formal Outcome	7	0	2	0	2	0	0	0	1	**12**
Dismissed	0	0	0	1	0	0	0	0	0	**1**
Resigned	0	0	1	1	0	0	0	0	0	**2**

E3

Year 2017 01/01/17-31/12/17	Area of work/Division										
Allegation	**Children & Families**	**Diagnostics & Pharmacy**	**Emergency**	**Estates & Facilities**	**Finance & Healthcare**	**MSK & Frailty**	**Performance Management**	**P&OD**	**Speciality**	**Surgical**	**Total**
Inappropriate Behaviour	5	4	20	6	4	8	3	1	7	6	**64**
Working Practice	2	0	1	2	0	1	0	0	1	1	**8**
Registration Breaches	1	0	0	0	0	0	0	0	1	2	**4**
Bullying	0	0	0	0	0	0	0	0	1	0	**1**
Confidentiality	0	0	3	1	0	1	0	0	0	1	**6**
Drug Errors	5	0	0	0	0	0	0	0	0	0	**5**
TOTAL CASES	**13**	**4**	**24**	**9**	**4**	**10**	**3**	**1**	**10**	**10**	**88**
Outcomes											
No case to answer	3	1	2	3	1	1	1	0	3	2	**17**
Informal outcome	3	1	7	3	2	1	1	0	0	1	**19**
Formal Outcome	4	1	6	2	0	5	0	0	5	7	**30**
Dismissed	2	1	4	0	0	3	0	0	2	0	**12**
Resigned	1	0	5	1	1	0	1	0	0	0	**9**

Year 2018 01/01/18-31/12/18	Area of work/Division										
Allegation	**Children & families**	**Diagnostics & Pharmacy**	**Emergency**	**Estates & Facilities**	**Finance & Healthcare**	**MSK & Frailty**	**Performance Management**	**P&OD**	**Speciality**	**Surgical**	**Total**
Inappropriate Behaviour	6	2	19	11	1	6	2	0	2	10	**59**
Working Practice	2	1	0	0	0	0	0	0	0	1	**4**
Registration Breaches	1	0	0	0	0	0	0	0	0	2	**3**
Bullying	0	0	0	0	0	0	0	0	0	0	**0**
Confidentiality	1	3	0	0	0	1	0	0	0	0	**5**
Drug Errors	0	0	3	0	0	1	0	0	0	0	**4**
TOTAL CASES	**10**	**6**	**22**	**11**	**1**	**8**	**2**	**0**	**2**	**13**	**75**
Outcomes											
No case to answer	3	2	7	5	0	2	0	0	0	3	**22**
Informal outcome	2	0	2	1	0	1	0	0	0	3	**9**
Formal Outcome	2	3	8	5	1	4	2	0	2	5	**32**
Dismissed	2	1	3	0	0	1	0	0	0	2	**9**
Resigned	1	0	2	0	0	0	0	0	0	1	**4**

E3

Year 2019 01/01/19-30/06/19	Area of work/Division								
Allegation	**Children & families**	**Corporate Nursing**	**Medicine Division**	**Estates & Facilities**	**Finance & Healthcare**	**Performance Management**	**Clinical Specialities**	**Surgery & Cancer**	**Total**
Inappropriate Behaviour	4	1	7	6	1	1	1	6	**27**
Working Practice	0	0	0	1	0	0	0	2	**3**
Registration Breaches	0	0	0	0	0	0	0	1	**1**
Bullying	0	0	0	0	0	0	0	0	**0**
Confidentiality	0	0	0	0	1	1	1	0	**3**
Drug Errors	0	0	0	0	0	0	0	0	**0**
TOTAL CASES	**4**	**1**	**7**	**6**	**2**	**2**	**2**	**9**	**33**
Outcomes									
No case to answer	0	1	1	4	0	1	0	3	**10**
Informal outcome	4	0	1	1	0	0	0	0	**6**
Formal Outcome	0	0	2	1	1	1	0	1	**6**
Dismissed	0	0	2	1	1	0	0	2	**6**
Resigned	0	0	1	0	0	0	1	2	**4**

E3

CURRENT OPEN & ONGOING CONDUCT/DISCIPLINARY CASES 2019

Year 2019 (Part year)	Area of work/Division								
Allegation	**Children & families**	**Corporate Nursing**	**Medicine Division**	**Estates & Facilities**	**Finance & Healthcare**	**Performance Management**	**Clinical Specialities**	**Surgery & Cancer**	**Total**
Inappropriate Behaviour	6	0	9	1	1	1	2	12	**32**
Working Practice	0	0	0	0	0	0	0	1	**1**
Registration Breaches	1	0	0	0	0	0	0	0	**1**
Bullying	0	0	0	0	0	0	0	0	**0**
Confidentiality	2	0	1	0	1	0	0	0	**4**
Drug Errors	0	0	0	0	0	0	0	0	**0**
TOTAL CASES	**9**	**0**	**10**	**1**	**2**	**1**	**2**	**13**	**38**
Outcome									
No case to answer									**0**
Informal outcome									**0**
Formal Outcome									**0**
Dismissed									**0**
Resigned									**0**

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

E4

Title	**Q1 Estates & Facilities Performance Report**		
Report to	**Board of Directors**	**Date**	**30th July 2019**
Author	**Kirsty Edmondson-Jones**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		X
	Information		

Executive summary containing key messages and issues
The Quarter 1, April - June, Estates and Facilities Performance report provides Board of Directors with a quarterly review of performance. The report shows performance in Q1 in the following areas: • Progress against appraisal is positive at 70% within the 'season' and more data to be added • EFM SET training is the highest it has been for many years at 86%, with action plans in place to exceed 90% • Sodexo continue to achieve their KPI of 95% Patient Satisfaction, with a Complaints/Datix rate of 0.0005%. Further work is required to: • Achieve Trust SET target of 90% • Reduce sickness rates • Develop Business case from NHSi/Qii review of estates workforce and skill-mix

Key questions posed by the report
Are Board of Directors assured of progress made during Q3 to improve the performance of Estates and Facilities services?
How this report contributes to the delivery of the strategic objectives
The paper updates BOD in the wider Corporate Risk (F&P4) relating to the failure to ensure a suitable estates infrastructure is in place.
How this report impacts on current risks or highlights new risks
Recommendation(s) and next steps
Board of Directors are asked to note the content of this paper and progress made.

Doncaster and Bassetlaw
Teaching Hospitals
NHS Foundation Trust

Quarter 1. April-June 19 Estates and Facilities Performance Report

Estates and Facilities Q1 Performance Report
April - June 2019

1. Executive Summary

This performance report provides Board of Directors with a quarterly update against the performance of Estates and Facilities Services (E&F) for Quarter 1, April to June 2019.

The report provides assurance to Board of Directors of the performance of Estates & Facilities services in line with the Trust's 5 'P' strategic objectives, and the Trust North Statement to be the safest trust in England, outstanding in all we do.

At A Glance

Performance Measure	KPI/Target	Actual	Variance	RAG		Comments
Appraisal	90%	70%	20%		↓	Season figure, to include in date before 1st April
SET	90%	86%	-4%		↑	
Sickness	3.50%	6.22%	2.72%		↑	
Catering Satisfaction	95%	95%	0%		↑	
Compliance	Good	85%	N/A		↑	Increase of 5% no reds
Cleaning DRI	90%	96%	6%		→	
Cleaning BDGH	90%	91%	1%		↑	
Cleaning MMH	90%	90%	0%		→	
Portering DRI	Complete within 30m	60%	N/A		→	
Portering BDGH	Complete within 30m	87%	N/A		→	
Portering MMH	Complete within 30m	74%	N/A		↑	up by 12%
Estates PPM DRI/MMH	Increase Completion					catagories under review
Estates PPM BDGH	Increase Completion					catagories under review
Estates Reactive DRI/MMH	90% Cat 1	100%	10%		→	
Estates Reactive BDGH	90% Cat 1	N/A	N/A			
MTS DRI	100%	83%	17%		N/A	
MTS BDGH	100%	100%	0%		N/A	
MTS MMH	100%	100%	0%		N/A	

Status Legend Reference		
Status	*Value*	*Icon*
Worse	-1	↓
Same	0	→
Improve	1	↑
Worse than target	Red	
Better than target	Green	

2. Management Information

2.1 Appraisal

The Q1 appraisal rates presented within this paper relate to the appraisal season from 1st April 19 to 30th June 19 only. EFM achieved 70% within this first three months, however data is to be included of all staff whose appraisals are still in date but were completed before 31st March 19. We expect to continue to exceed the organisations KPI of 90%, in line with previous year's performance since 2016/17, as can be seen below.

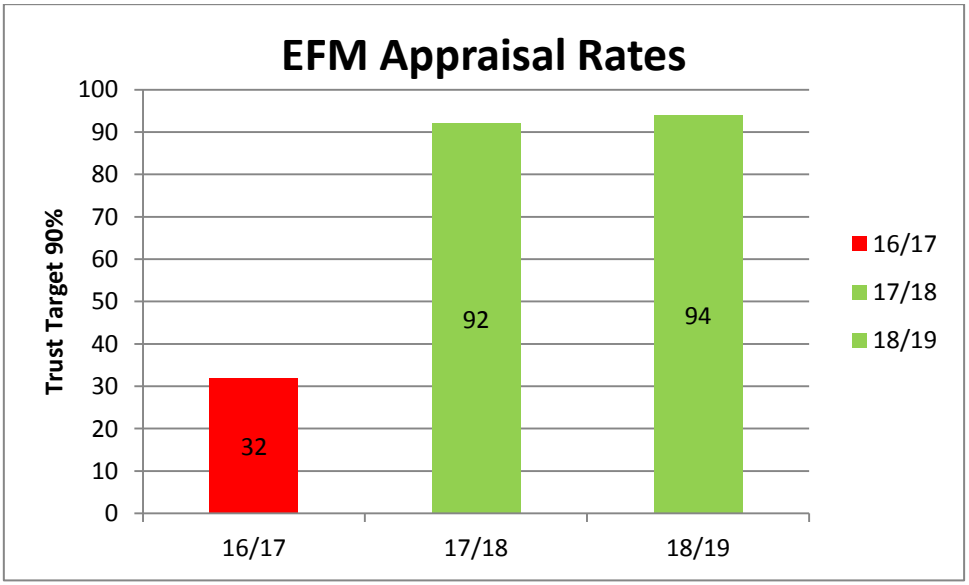


Table 1

2.2 Statutory and Essential Training (SET)

SET data for Q1 shows that the Directorate has improved performance achieving 86% against a Trust target of 90%. This is the highest SET completion rate the Directorate has achieved for a number of years, as can be seen in the table below, with plans in pace to exceed the SET target within Q2.

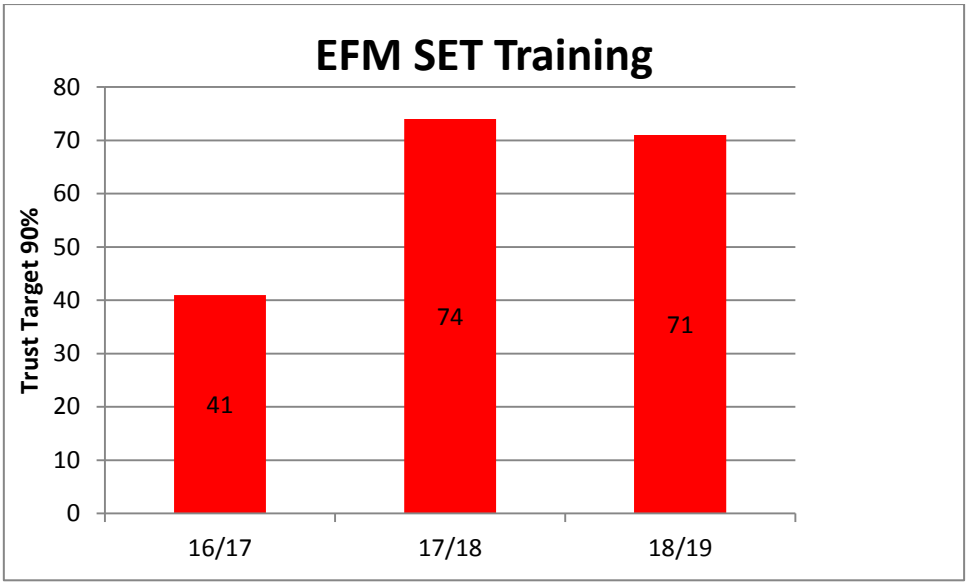


Table 2

2.3 Sickness

The Directorate ended Q1 with a sickness rate of 6.22%, this is consistent with previous performance and is being reflected within a review of sickness targets by area.

3 Facilities Performance

3.1 Hospital Cleanliness

Both DRI and BDGH exceeded the KPI target of 90% cleanliness in the first quarter, with MMH underformign in April by 1%. This performance then improved in May and June with MMH achiving the Trust target for the remainder of the quarter.

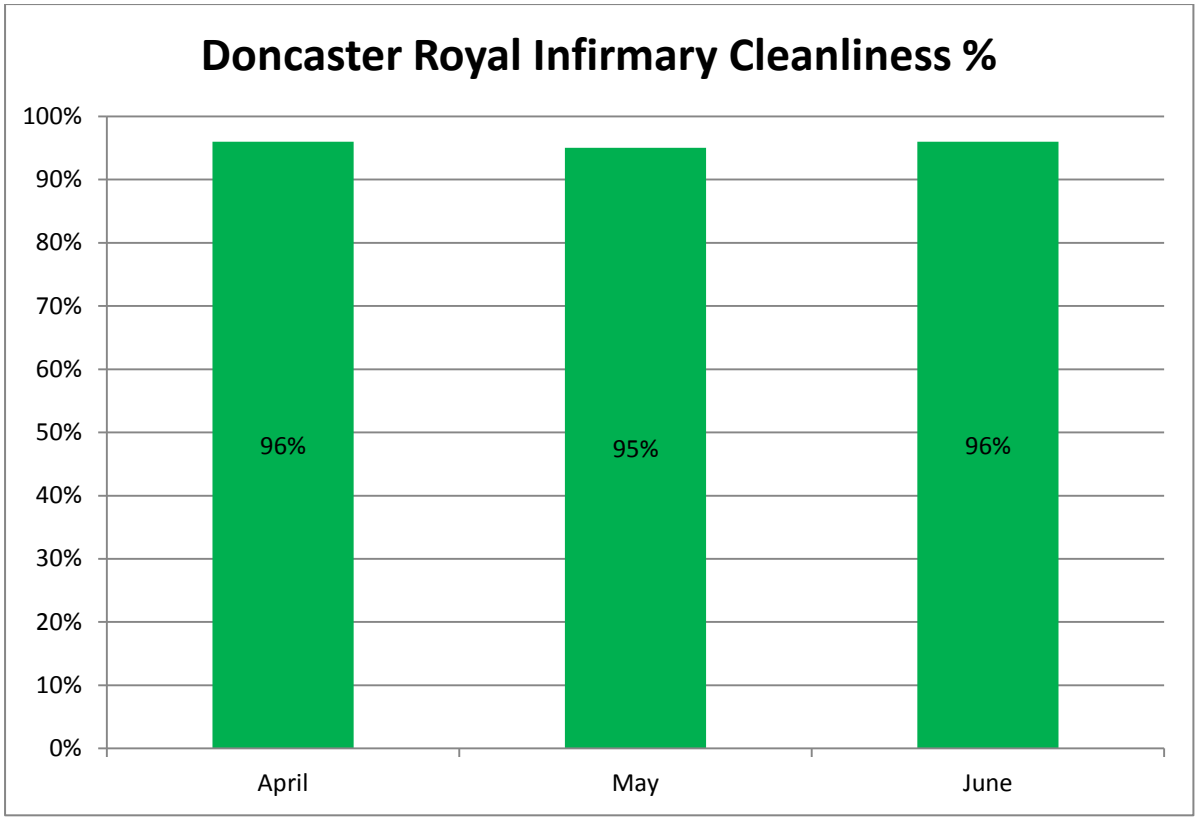


Table 3

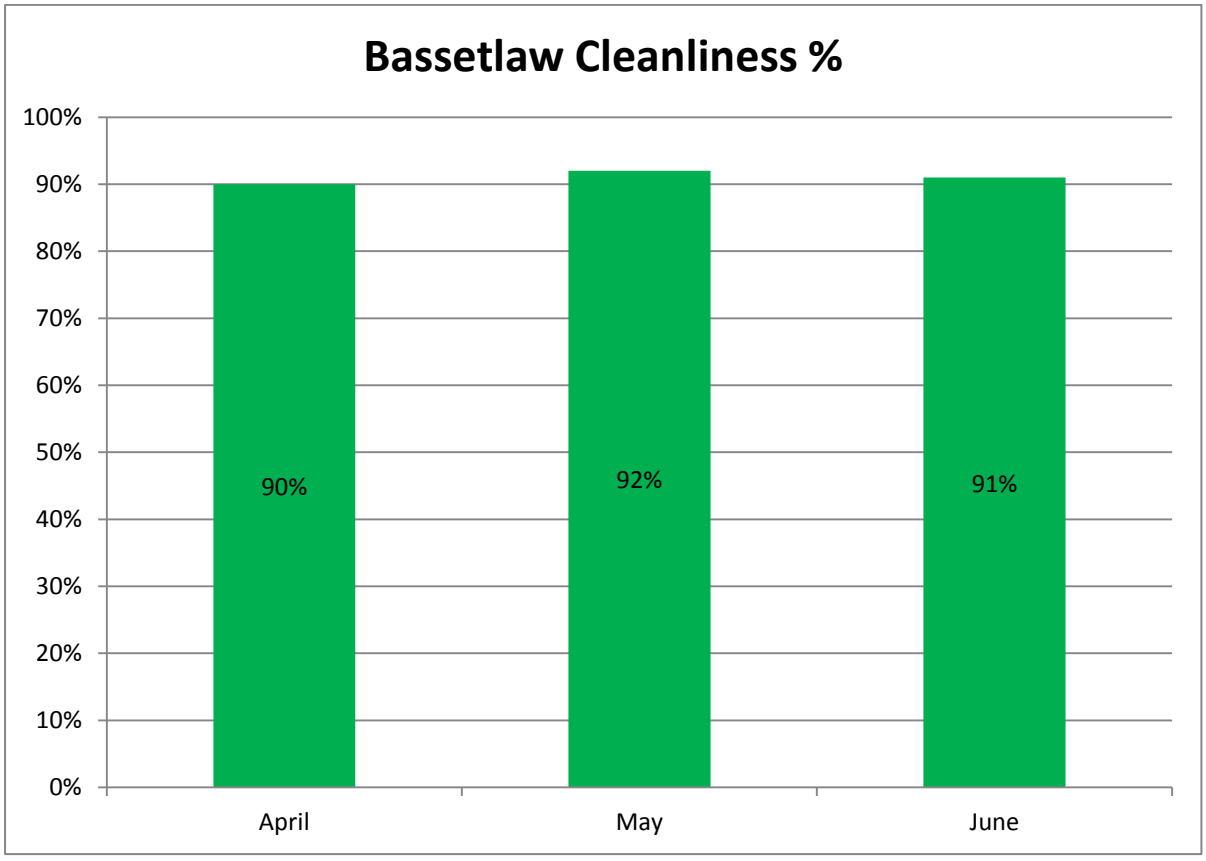


Table 4

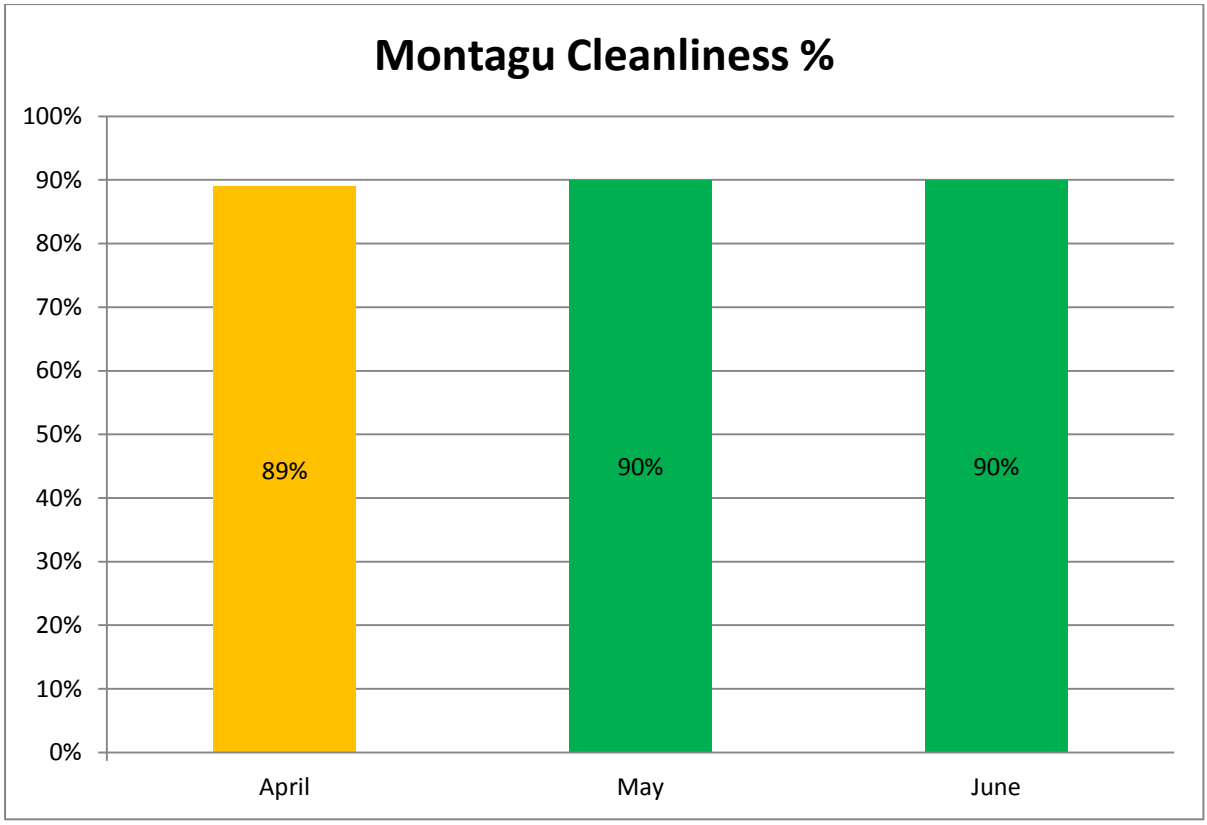


Table 5

3.2 Portering Response

In this first quarter DRI maintained performance with 60% of jobs completed within 30 minutes, with BDGH maintaining very similar performance with only 1% fall to 87%. However, MMH improved performance significantly from 62% to 74% in the quarter, which is as a result of a refinement of the shift patterns against peaks in activity. Following a request during the presentation of the EFM KPI Annual Performance Report to Board of Directors in May, a Portering Deep Dive presentation was delivered to Finance and Performance Committee on 23rd July. The purpose of the deep dive was to provide additional assurance regarding the percentage of jobs completed outside of the KPI of 30 minutes, and of the systems and processes used to deliver the portering service. The data provided demonstrated that in one quarter, Q4 18/19, 31,856 requests were logged, with an average dispatch time of 14.05 minutes, and average completion time of 31.91 minutes. The greatest impact of performance times at DRI are delays due to locating wheelchairs, a project we are currently working with IT to improve with the use of RFID and a 'Find my wheelchair' app.

The performance data below provides the basic information on the percentage of jobs completed within 30 minutes, however the Teletracking system used to receive and allocate

tasks is much more sophisticated and provides 10 categories ranging from 'Urgent – Immediate' to 'Low Priority – Within the Day'. As jobs are requested they are assigned to categories according to urgency and nature of the task.

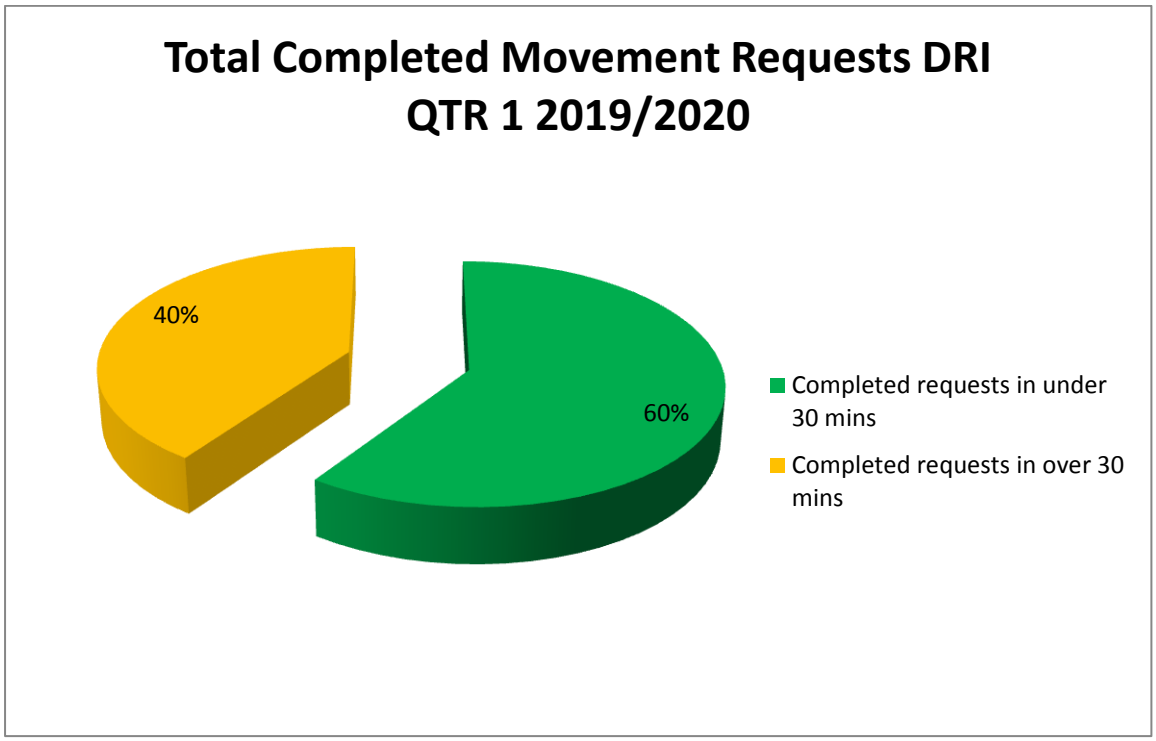


Table 6

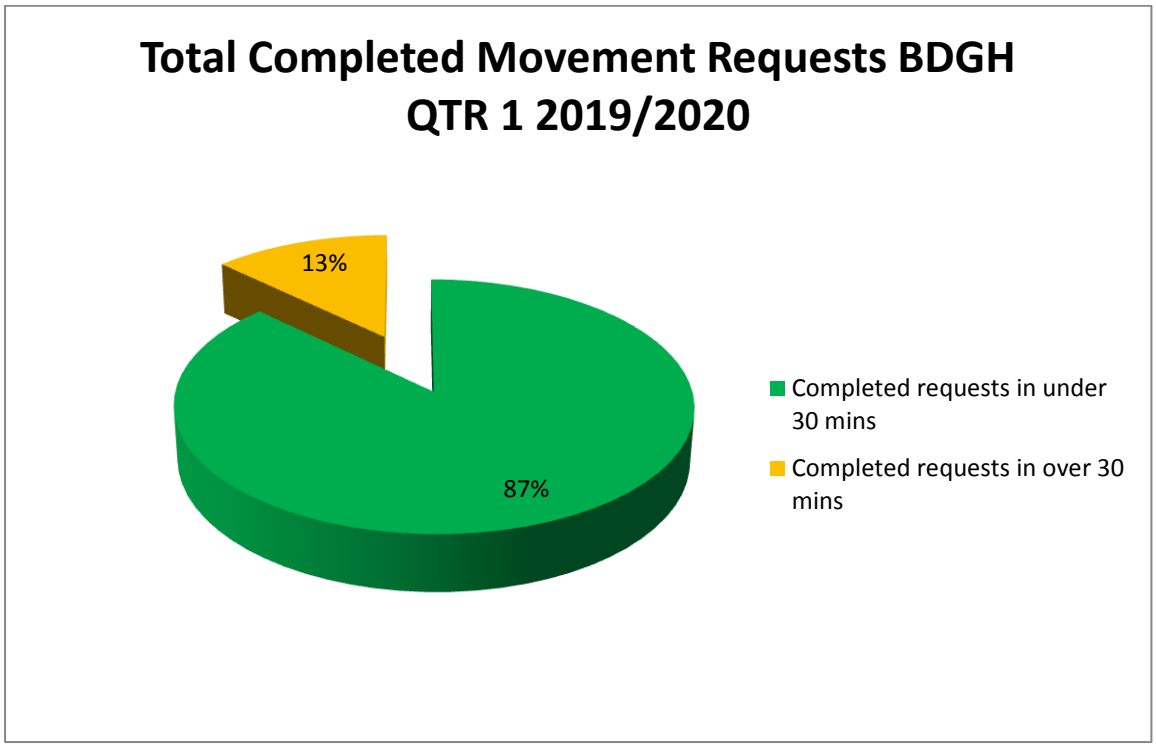


Table 7

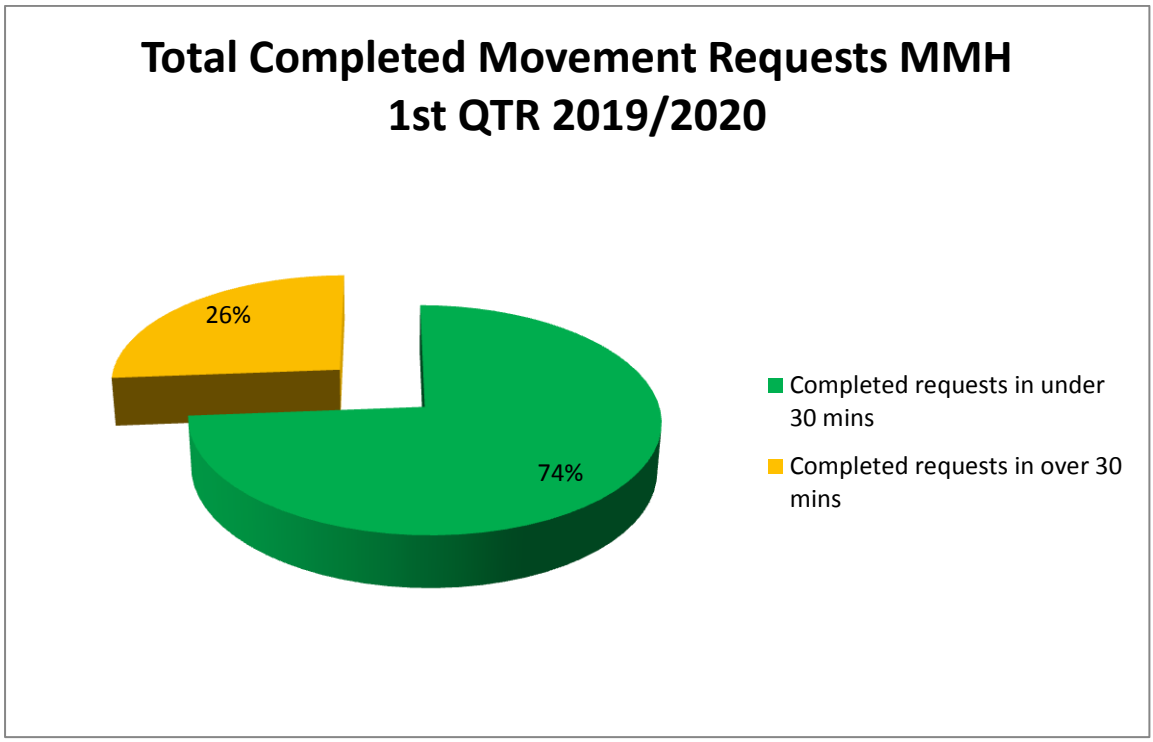


Table 8

4 Catering

4.1 Patient Satisfaction

As can be seen in the table below, Patient Satisfaction Surveys for the quarter show that, as well as Sodexo continuing to hit their monthly target of >500 surveys completed, they have continue to achieve their Contract KPI 7 of 95% patient satisfaction.

	April 19	May 19	June 19
How would you rate the Hospital Food?	96%	96%	95%
Were you offered a suitable choice of food?	95%	95%	97%
Overall how satisfied were you with the catering service?	91%	91%	95%

Combined satisfaction score KPI 7	**95%**	**95%**	**96%**

Table 9

4.2Complaints/Datix

As can be seen at table 10, overall the number of incidents/complaints being received via Datix has reduced from a height of 60 in one week in early September and a monthly total of 143, to monthly totals of just 41 for April, 27 for May, and 38 for June. This is in the context of having delivered circa 210,000 meals in the quarter, a percentage rate of less than 0.0005%.

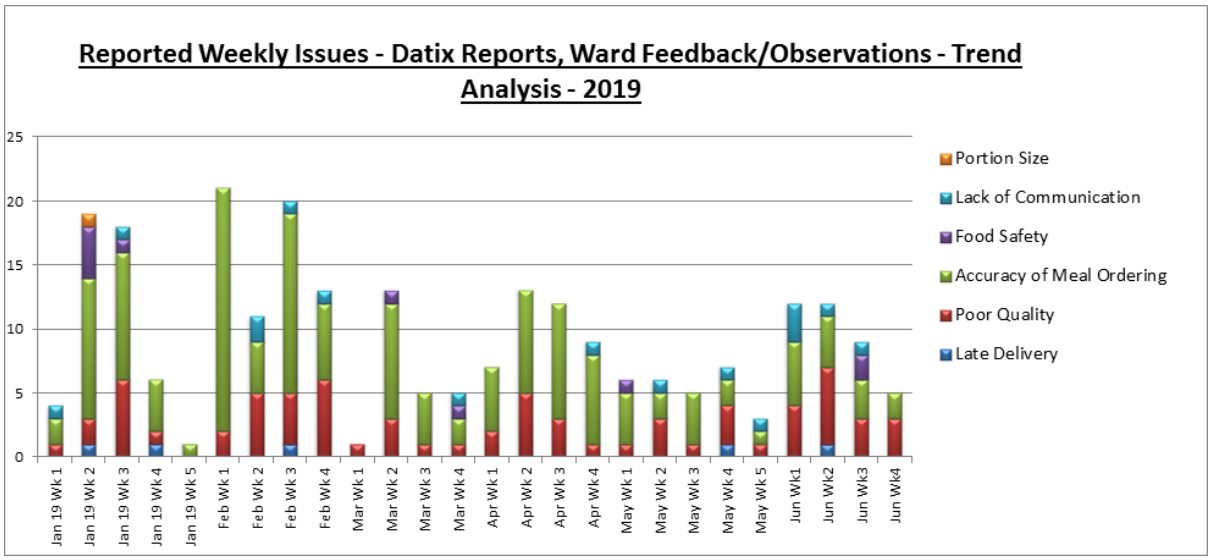


Table 10

5 Estates Performance

5.1 Planned Preventative Maintenance (PPM)

The completion of PPM's ensures the aged estate is being maintained appropriately, and where risks have been identified, PPM's are increased as mitigation to manage the risk. For Q1 DRI/MMH (table 11) and BDGH (table 120, circa 60% of jobs were completed on time, with circa 40% completed late or missed and is a continuation of the trend seen in 2018/19.

In addition to cleansing the PLANET system, work has continued against the Directorate objective for 2019/20 to review the Estates workforce and skill-mix across all sites utilising NHSi/Qii methodology and support from regional EFM NHSi Leads. As previously reported, LEAN tools have already been adopted by the Department and are proving effective in streamlining processes and driving out waste in order to improve overall Estates performance including PPM and reactive maintenance.

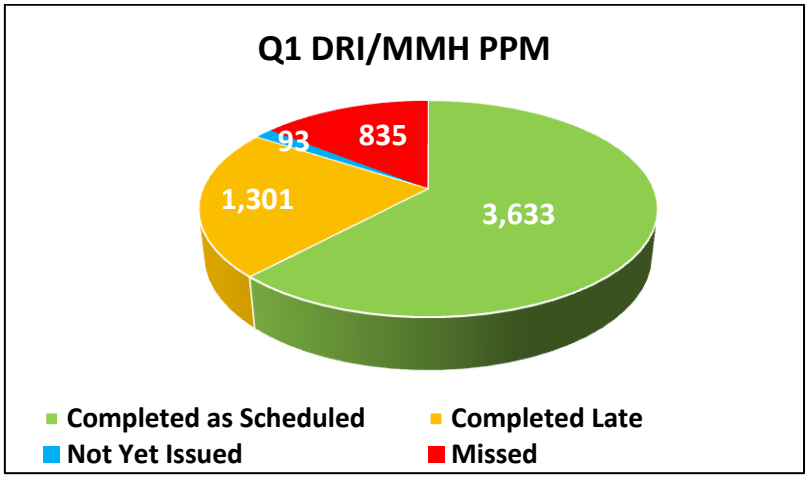


Table 11

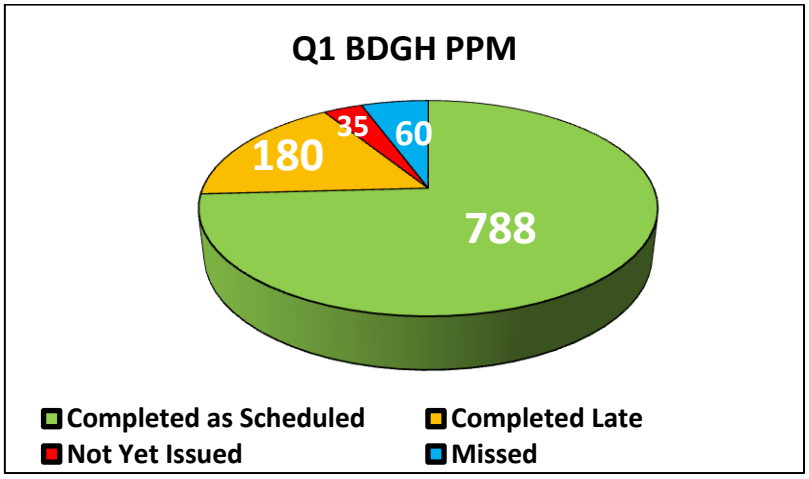


Table 12

5.2 Reactive Maintenance

Completion of Reactive Maintenance tasks was maintained in Q1 with 100% of Cat 1 jobs being competed on time at DRI and no category 1 jobs at BDGH. The data at table 14 also

shows that 88% of Cat 2 jobs were completed within the required timeframe at DRI, with table 16 showing that 81% were completed on time.

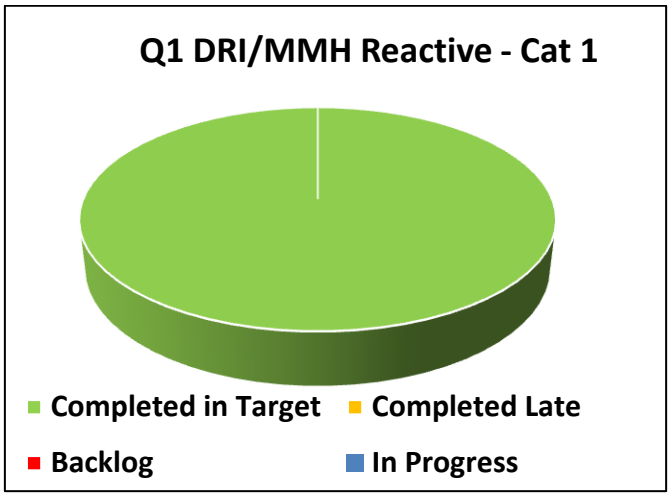


Table 13

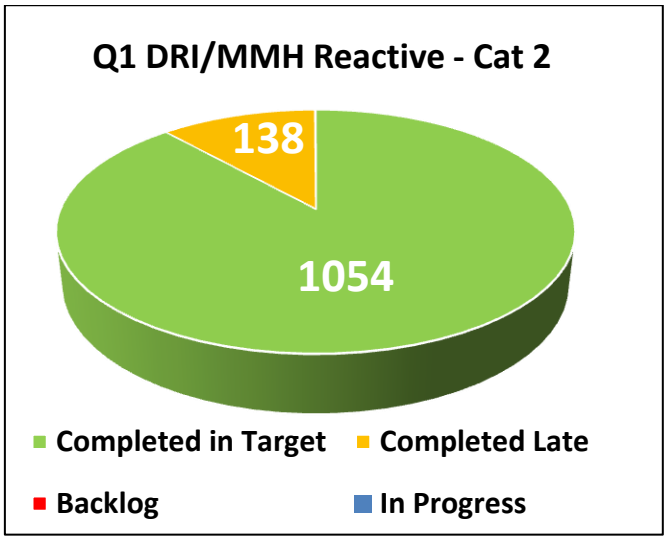


Table 14

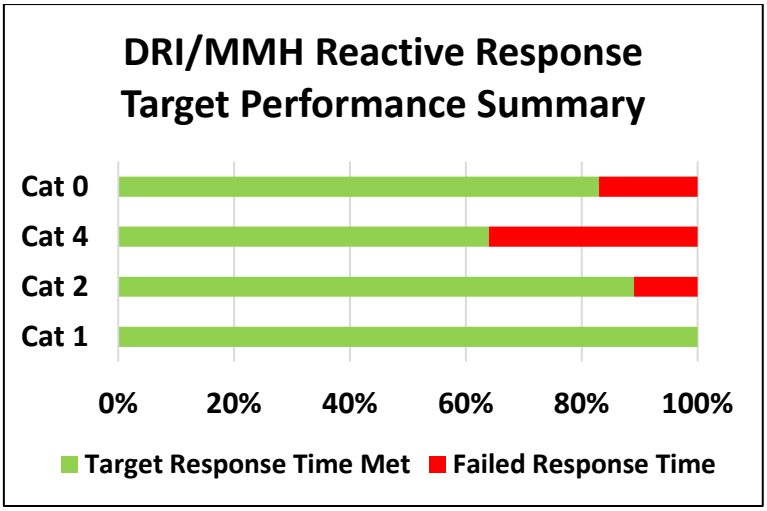


Table 15

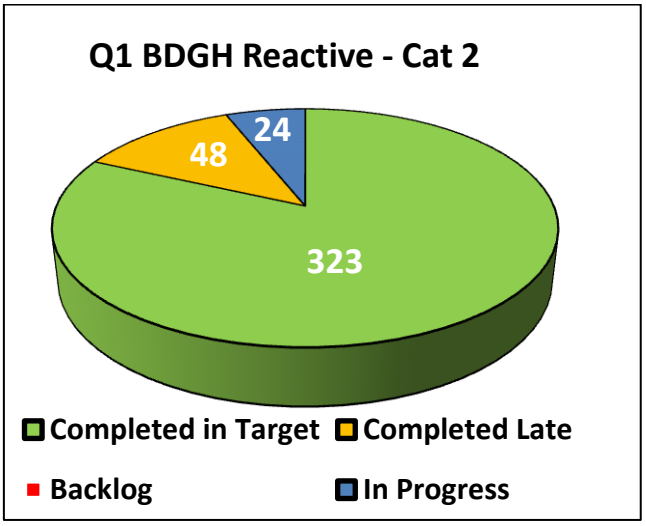


Table 16

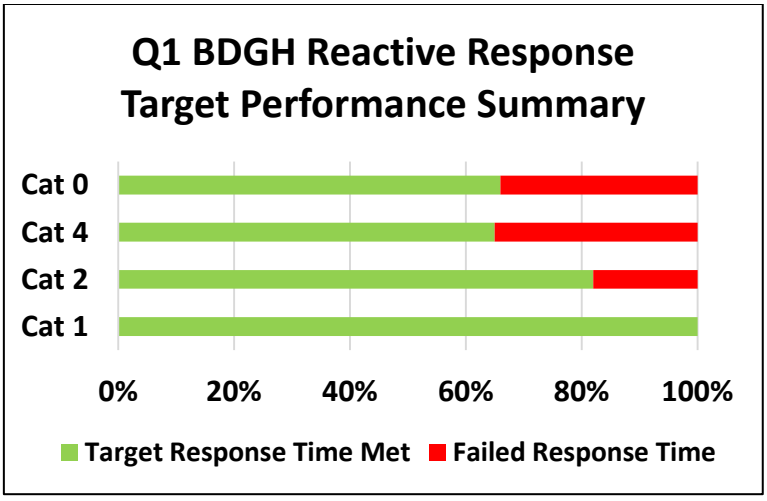


Table 17

6 Medical Technical Services (MTS)

At the end of 2017/18 a new target was identified by the MTS team of completion of Corrective Repairs tasks within 4 days. Previously the average completion rate was between 8 and 14 days, at the end of Q1 the average completion time is 7 days, work continues to stabilise performance at 4 days, as was achieved in June.

Qtr1

Month	Corrective repairs	Average completion time	Inspection /preventative maintenance jobs logged
April	139	6 days	243
May	140	10 days	271
June	110	4 days	233

Table 18

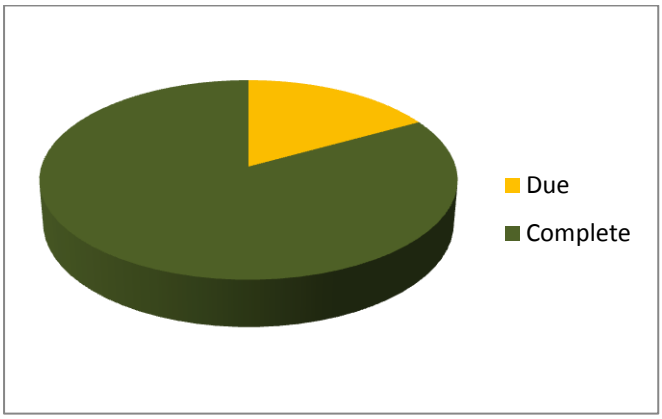
Total number of new assets commissioned and entering service this quarter **172**

Total number of assets condemned and disposed of this quarter **192**

6.1 Inspection/Preventative Maintenance Program for Medical Devices

There are 109 wards/departments encompassing the Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust sites, including outlying areas. The inspection program involves MTS staff attending each clinical area on an annual basis checking, testing and carrying out routine maintenance on all medical devices found. A risk reduction report is issued following each completed inspection with recommendations and actions required.

Examples of the types of equipment seen during these inspections are: oxygen flowmeters, suction equipment, defibrillators, infusion devices and syringe pumps. ECG recorders, thermometers and basic observation equipment such as non-invasive blood pressure machines and pulse oximetry are also checked. The addition of a second IPM technician in January 2019 has meant that we are able to target difficult areas with more flexibility.



Site	% in date or complete in qtr 1 19/20
MMH	100
DRI	83
BDGH	100

6.2 Re-Turn Centre

The innovative 'Re-Turn Centre' run by Medical Technical Services is an in-house 'e-bay' for goods and items that would have previously been disposed of. The disposal of goods and items costs the Trust significant expenditure in the removal of waste in skips, and in the purchase of new equipment which could have been avoided. Soft launched in April, the momentum has gradually built and the department is becoming more able to manage supply and demand and the storage of surplus assets.

Recent publicity has increased the utilisation of the Re-Turn centre which to date has Re-Turned 288 assets back to use with an estimated total value of £65,000 on cost avoidance. Chairs and desks remain the most requested item.

7 Conclusion and Recommendations

The data presented shows the performance achieved in Q1 of 19/20 for Estates and Facilities, with the highest SET percentage achieved for a number of years of 86%, and good progress against appraisal completion within the 'Season' of 70%, with further opportunity to include current appraisals completed prior to 1st April 19. Work to review the Estates Workforce and Skill-mix using NHSi/Qii continues, with a business case planned to go to Corporate Investment Group and Management Board in early September.

The Board of Directors is asked to note the content of this E&F Q1 Performance report.

F1

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Financial Performance – Month 3 – June 2019**		
Report to	**Trust Board**	**Date**	**30th July 2019**
Author	**Alex Crickmar – Deputy Director of Finance** **Jon Sargeant - Director of Finance**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		X

Executive summary containing key messages and issues

The Trust's deficit (before PSF, FRF and MRET) for month 3 (June 2019) was £2,783k which is a favourable variance against plan of £189k. The cumulative position to the end of month 3 is a £7,680k deficit before PSF, which is £12k favourable variance to plan (£5,178k deficit including PSF, which is £12k favourable to plan).

There are still significant risks to delivery of the Trust's financial control total, including:

- The underlying under performance in clinical income in month was £412k, driven by emergency income being below plan. This is being investigated by Divisions and correlated with other data sources to understand any root causes e.g. LoS, delayed discharges etc.
- Whilst the gap to deliver the planned £13.2m CIPs has reduced, there is still a gap of £1.3m which requires identification and robust plans for all schemes required. The delivery of CIPs moving into quarter 2 will be key as the plan is phased to increase significantly as the year progresses.
- Modelling of required activity to deliver 92% RTT performance has been completed. However robust capacity plans are still outstanding and are required from Divisions in order to deliver in line with plan for elective and outpatients.
- Aligned to capacity plans, robust workforce plans are still outstanding. Control and reduction of agency and additional sessions spend linked to challenging and robust plans and following SOPs needs to be a priority for the Trust. Updated SOPs are required for the Grip and Control and VCF process.

- Resolution of the payback of non-recurrent support received from CCGs (£1.7m) and the ICS (£1.5m) in 18/19.
- Significant pressures on National Capital budgets mean that the ICS has been asked to reduce overall capital budgets by 25%. The Trust will come under pressure to reduce its spend as the ICS's current position remains above its control total for capital.
- The audit of emergency coding is a potential risk to income, however the Trust believes that any such funds need to be reinvested and should not cause an in year problem.

Key questions posed by the report

Is the Board assured by actions taken to bring the financial position back in line with plan?

How this report contributes to the delivery of the strategic objectives

This report relates to strategic aims 2 and 4 and the following areas as identified in the Trust's BAF and CRR.

- F&P 1 - Failure to achieve compliance with financial performance and achieve financial plan and subsequent cash implications
- F&P 3 - Failure to deliver Cost Improvement Plans in this financial year
- F&P 19 - Failure to achieve income targets arising from issues with activity
- F&P 13 - Inability to meet Trust's needs for capital investment
- F&P – 14 - Reduction in hospital activity and subsequent income due to increase in community provision
- F&P 16 - Uncertainty over ICS financial regime including single financial control total

How this report impacts on current risks or highlights new risks

Update on risk relating to delivery of 2019/20 financial plan.

Recommendation(s) and next steps

The Board is asked to note:

- The Trust's deficit (before PSF, FRF and MRET) for month 3 (June 2019) was £2,783k which is a favourable variance against plan of £189k. The cumulative position to the end of month 3 is a £7,680k deficit before PSF, which is £12k favourable variance to plan (£5,178k deficit including PSF, which is £12k adverse to plan).
- The achievement with regards to the Cost Improvement Programme.
- The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

FINANCIAL PERFORMANCE

P3 June 2019

DONCASTER AND BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

P3 June 2019

1. Income and Expenditure vs. Plan

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	Plan £'000
I&E Perf Exc Impairments	1,949	(205) F	5,223	(15) F	15,491
Income	(31,821)	(2) F	(100,135)	(1,065) F	(411,669)
Donated Asset Income	0	16 A	(45)	3 A	(195)
Operating Expenditure	33,615	(77) F	100,759	1,226 A	407,492
Pay	22,618	(26) F	67,528	132 A	273,143
Non Pay & Reserves	10,997	(50) F	33,231	1,094 A	134,349
Financing costs	990	(126) F	3,171	(177) F	4,177
I&E Performance excluding PSF	**2,783**	**(189) F**	**7,680**	**(12) F**	**15,296**
PSF / FRF / MRET	(834)	0	**(2,502)**	0	(15,296)
I&E Performance including PSF	**1,949**	**(189) F**	**5,178**	**(12) F**	**0**

F = Favourable A = Adverse

Financial Sustainability Risk Rating	Plan	Actual
Risk Rating	3	3

2. CIPs

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Actual £'000	Variance to budget £'000	Actual £'000	Variance to budget £'000	Plan £'000
Employee Expenses	218	(95) F	383	(81) F	7370
Drugs	158	(108) F	438	(287) F	861
Clinical Supplies	2	9 A	3	21 A	347
Non Clinical Supplies	0	0 A	0	0 A	0
Non Pay Operating Expenses	79	13 A	221	37 A	3685
Income	20	15 A	36	33 A	937
Total	**477**	**(166) F**	1,081	**(277) F**	**13,200**

3. Statement of Financial Position

All figures £m	Opening Balance	Closing balance	Movement in year
Non Current Assets	**206,773**	**206,141**	**-632**
Current Assets	56,797	56,808	**11**
Current Liabilities	-57,515	-59,088	**-1,573**
Non Current liabilities	-82,091	-82,091	**0**
Total Assets Employed	**123,964**	**121,770**	**-2,194**
Total Tax Payers Equity	**-123,964**	**-121,770**	**2,194**

4. Other

Performance Indicator	Monthly Performance		YTD Performance		Annual
	Plan £'000	Actual £'000	Plan £'000	Actual £'000	Plan £'000
Cash Balance	1,900	12,257	1,900	12,257	1,900
Capital Expenditure	417	406	1,037	1,026	22,768

5. Workforce

	Funded WTE	Actual WTE	Bank WTE	Agency WTE	Total in Post WTE
Current Month	5953.74	5,412	254.32	105.62	5772.00
Previous Month	5955.11	5,444	256.52	102.81	5802.84
Movement	1.37	31.45	2.20	-2.81	30.84

Key

Income		Expenditure	
Over-achieved	F	Overspent	A
Under-achievement	A	Underspent	F

1. Executive Summary

The Trust's deficit (before PSF, FRF and MRET) for month 3 (June 2019) was £2,783k which is a favourable variance against plan of £189k. The cumulative position to the end of month 3 is a £7,680k deficit before PSF, which is £12k favourable variance to plan (£5,178k deficit including PSF, which is £12k favourable to plan).

The month 3 income position is £2k favourable to plan and £1,065k favourable to plan YTD. The income movement from month 2 is due to £120k under performance in clinical income and £122k over performance in non-clinical income. The underlying under performance in clinical income, in month is £412k when excluding the impact of non-PbR drugs.

The reasons for the clinical income variance against plan in month is due to an over performance in elective (£63k), outpatients (£66k including outpatient cap adjustment) and non-PbR Drugs (£292k). There were under performances against plan in daycase (£53k), emergency (£435k including A&E and the blended tariff adjustment). The emergency under-performance of £435k includes an A&E over-performance of (£112k) and the blended tariff adjustment of £8k (blended tariff adjustment is calculated on an YTD basis).

Non NHS Clinical Income and Other Income is (£122k) ahead of plan in month 3 and (£313k) YTD. The over-achievement in month is related to over achievements against plan in Education, IGI and RTA Income. Car parking is £39k under budget in month (IGI) and is offset by minor over-achievements in other areas.

Income Group	Annual Budget	In Month Budget	In Month Actual	In Month Variance		YTD Budget	YTD Actual	YTD Variance	
Commissioner Income	-337,760	-27,160	-26,748	412	A	-82,346	-82,520	-174	F
Drugs	-19,299	-1,423	-1,715	-292	F	-4,571	-5,149	-578	F
PSF, FRF and MRET	-15,296	-834	-834	0	F	-2,502	-2,502	0	F
Trading Income	-39,120	-3,237	-3,359	-122	F	-9,651	-9,964	-313	F
Grand Total	**-411,474**	**-32,653**	**-32,655**	**-2**	**F**	**-99,071**	**-100,135**	**-1,065**	**F**

Note : The income figure excludes £744k relating to 18/19 post accounts allocation of PSF

The in month the expenditure position was £77k favourable to plan, of which pay was £26k favourable to plan, non-pay £416k adverse to plan and reserves £466k favourable to plan. The YTD expenditure position at the end of Month 3 is £1.2m adverse to plan. (with pay £132k adverse to plan and non-pay £2.3m adverse to plan). Within non-pay, non-PbR drugs are higher than planned levels (c. £0.7m which is offset by over performance on income).

Expenditure type	In Month Budget	In Month Actual	In Month Variance		YTD Budget	YTD Actual	YTD Variance		Annual Budget
Pay	22,644	22,618	-26	F	68,825	68,957	132	A	277,625
Non-Pay	10,162	10,578	416	A	29,233	31,531	2,299	A	106,458
Reserves	885	419	-466	F	2,904	1,700	-1,204	F	14,391
Total Expenditure Position	33,692	33,615	-77	F	100,962	102,188	1,226	A	398,474

Capital expenditure is £11k behind plan YTD with spend of £1,026k against the YTD plan of £1,037k. The in-month capital spend for month 3 was £406k against an in-month plan of £417k, an underspend in-month of £11k.

The cash balance at the end of June was £12.3m against a plan of £1.9m. The over performance against plan is as a result of the favourable performance in Q4 of 18/19, including the achievement of Q3 18/19 PSF, which was paid before year end. The Q4 PSF and 18/19 PSF bonus have not yet been received (expected July/August). Cash decreased by £3m in June as a result of a number of annual invoices being paid in the month, as well as overdue creditors reducing. Overdue debtors and has remained stable in month, both in terms of type and age profile.

In June 2019, CIP savings of £477k are reported, against a plan of £310k, therefore an over achievement of £166k in month. Year to date the Trust has delivered £1,081k versus the NHSI plan of £802k an over-delivery of £279k.

2. Conclusion

The Trust's deficit (before PSF, FRF and MRET) for month 3 (June 2019) was £2,783k which is a favourable variance against plan of £189k. The cumulative position to the end of month 3 is a £7,680k deficit before PSF, which is £12k favourable variance to plan (£5,178k deficit including PSF, which is £12k favourable to plan).

There are still significant risks to delivery of the Trust's financial control total, including:

- The underlying under performance in clinical income in month was £412k, driven by emergency income being below plan. This is being investigated by Divisions and correlated with other data sources to understand any root causes e.g. LoS, delayed discharges etc.
- Whilst the gap to deliver the planned £13.2m CIPs has reduced, there is still a gap of £1.3m which requires identification and robust plans for all schemes required. The delivery of CIPs moving into quarter 2 will be key as the plan is phased to increase significantly as the year progresses.
- Modelling of required activity to deliver 92% RTT performance has been completed. However robust capacity plans are still outstanding and are required from Divisions in order to deliver in line with plan for elective and outpatients.
- Aligned to capacity plans, robust workforce plans are still outstanding. Control and reduction of agency and additional sessions spend linked to challenging and robust plans and following SOPs needs to be a priority for the Trust. Updated SOPs are required for the Grip and Control and VCF process.
- Resolution of the payback of non-recurrent support received from CCGs (£1.7m) and the ICS (£1.5m) in 18/19.
- Significant pressures on National Capital budgets mean that the ICS has been asked to reduce overall capital budgets by 25%. The Trust will come under pressure to reduce its spend as the ICS's current position remains above its control total for capital.
- The audit of emergency coding is a potential risk to income, however the Trust believes that any such funds need to be reinvested and should not cause an in year problem.

3. Recommendations

The Board is asked to note:

- The Trust's deficit (before PSF, FRF and MRET) for month 3 (June 2019) was £2,783k which is a favourable variance against plan of £189k. The cumulative position to the end of month 3 is a £7,680k deficit before PSF, which is £12k favourable variance to plan (£5,178k deficit including PSF, which is £12k adverse to plan).
- The achievement with regards to the Cost Improvement Programme.
- The risks set out in this paper.

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Use of Trust Seal**		
Report to:	**Board of Directors**	Date:	**30 July 2019**
Author:	**Jeannette Reay – Head of Corporate Assurance / Company Secretary**		
For:	**For approval**		

Purpose of Paper: Executive Summary containing key messages and issues

The purpose of this report is to advise of use of the Trust Seal in accordance with section 14: Custody of Seal and Sealing of Documents of the Standing Orders of the Board of Directors:

Seal No.	Description	Signed	Date of sealing
111	Lease of 15 Shaw Lane Industrial Estates, Ogden Road, Doncaster. Agreement between DBTH and Trifords Limited t/a Auto Windscreens.	Richard Parker Chief Executive	24th July 2019
		Jon Sargeant Director of Finance	
112	License to underlet unit 15 Shaw Lane Industrial Estate, Ogden Road, Doncaster. Agreement between Redwood (light industrial) Propco S.A.R.L and DBTH and Trifords Limited t/a Auto Windscreens	Richard Parker Chief Executive	24th July 2019
		Jon Sargeant Director of Finance	

Recommendation(s)

The Board is requested to approve use of the Trust Seal.

Chair's Log – Audit and Risk Committee (ARC) – 18 July 2019

Overview

The meeting was attended by 2 NEDs and the DoF, and invited management along to talk through more specialised areas, including Cyber Security arrangements, the CQC ED Audit and Discharge Audit work.

Board members should note that following a discussion on Declaration of Interest and Fit & Proper Persons Test that they will be required to update their declarations this Summer.

Assurance area - Cyber Security

As per a request from the Trust Chair, ARC followed up on the Boards Cyber Security Session on 26/3/2019, David Linacre attended to talk ARC members through the controls in place at DBH. The Committee found this useful and a positive source of assurance and a further update on the Trusts compliance with Cyber essential standards will come back to November ARC.

Assurance area – Internal Audit Progress Report

Four Audit Reports have been finalised, these are listed below:-

Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust

Progress against the Internal Audit Plan

Introduction

The 2019/20 Internal Audit plan was presented to the Audit and Risk Committee (ACR) on 19 March 2019. This report summarises the progress of the work to date against that Plan.

Internal Audit Plan 2018/19 and 2019/20

We have finalised 4 reports since the last A&R Committee meeting:

	Assurance Rating
Risk Management	Significant Assurance with minor improvement opportunities
Discharge Planning	Partial Assurance with improvements required
CQC Emergency Department Action Plan	Partial Assurance with improvements required
Medical HR Recruitment	Significant Assurance with minor improvement opportunities

All audit reports have an agreed action plan with dates and will be followed up by KPMG and reported to ARC. It was re-inforced that any challenge to audit findings needed to occur before the report was finalised and an Executive lead assigned to each Audit within the audit papers.

The two audit reports with "partial assurance" were discussed thoroughly and theDoN

was present to answer Committee members queries and provide an update on progress to date.
Management and ARC members expressed disappointment at the outcome of the CQC Emergency Action Plan review, assurances were given that many of the actions have been complete since the audit and a quick follow up is planned. The report was referred into QEC for oversight as this area is crucial to the work of QEC.

A follow up on previous audit recommendations due had been carried out and a number remained outstanding as evidence was yet to be provided. It was discussed and agreed that Internal Audit recommendations need to go for Executive Team review earlier in the process.

Assurance area – External Audit

The final Annual Audit Letter from EY was presented which contained a summary of the detail report considered at the May meeting and will be presented to CoG at its next meeting.

Follow up on missing documentation was requested by ARC and will be reported to the next meeting.

Assurance area – Local Security Management Arrangements

The Committee considered a comprehensive annual report 2018/2019 and progress for Q1 2019 which outlined assurances on the security standards being maintained, and how security risks were continually being managed.

Assurance Area – Local Counter Fraud Arrangements

The Committee reviewed the comprehensive annual report 2018/2019 and progress for Q1 2019 which outlined positive assurances that counter fraud standards & requirements being maintained, and how fraud risks were continually being managed.

The committee noted that procurement had been added to the national counter fraud prevention programme and the Trust had submitted its return on time.

Kath Smart
Chair – Audit and Risk Committee – 19th July 2019

Chair's Log - Finance and Performance Committee 23.7.19

Overview

My July report is positive. Although I set it out in more detail below the headlines are –

- Delivery against financial profiling is on track currently. Management grip and understanding of the hospital's activity and delivery position is better significantly than it was two years ago.
- We approach a pivotal point in the year at the September meeting, when the second quarter has been delivered. By then the outstanding £1m of CIP needs to have been both identified and planned for delivery in the second half of the year. Additionally, the schemes where savings have been identified but planning for delivery not completed in a compelling manner need to cross the confidence threshold and then begin to deliver.
- Performance remains broadly acceptable, but there are concerns around RTT where our performance has led us to request an in-depth report re action planning to improve the position for the September meeting.
- Deep dives planned for September meeting are GIRFT (Get It Right First Time) and Outpatients.

Assurance area – Performance

Performance Report

The Board meeting will receive a separate performance report which will give a more detailed appreciation of the picture.

Although DBTH continues to benchmark well against the national picture and peers in some key metrics, there were areas of concern this month.

The principal concern is around RTT where we are failing to hit the national target, lower than our local target, below peer hospitals and only just scraping into the top half of the national table. There is a long term downward trend. An in-depth report re action planning to improve the position has been requested for the September meeting and we will watch this area carefully. We were, however, reassured by Rebecca Joyce's outline of action plans being implemented to address the situation.

Assurance area – Workforce Management

We considered the Workforce report that addressed –

- The profile of vacant posts
- Agency spend
- Staff sickness

In summary we heard that we have a vacancy rate in month 3 of 9% against a target of 5%; when taking into account the use of temporary staff we have a 4.87% vacancy rate, although this does vary by staff group.

Agency targets have been set for each Division which have also been split by staff group. Updated benchmark data has been provided from the model hospital portal for both vacancies and agency and bank spend which on the whole indicates that we benchmark favourably although there are areas which require focus. Within the refreshed efficiency programme the workforce workstream has its focus on recruitment to vacancies, reduction in sickness absence, reduction in need to cover enhanced care needs, and agency prices and demand.

Sickness absence rates for June have reduced to 4.18% with the cumulative year to date rates being 4.37%

Assurance area – Overall Financial Picture, Delivering CIPs, and Meeting the Control Total

A more detailed picture of finances is set out in the separate finance paper.

F+P received and approved a proposed approach for generating the submission to NHSi in relation to PLICS. We will receive the substantive report, post submission, at the next committee meeting.

We approach a pivotal point in the year at the September meeting, when the second quarter will have been delivered. By then the outstanding £1m of CIP needs to have been both identified and planned for delivery in the second half of the year. Additionally, the schemes where savings have been identified but planning for delivery not completed in a compelling manner need to cross the confidence threshold and then begin to deliver.

Assurance area – Governance and Risk

F+P received and noted the current risk register. The relevant risks had been considered actively with each paper received at the meeting.

Assurance area - Strategy

The committee received highlight reports providing updates in relation to the IT Strategy and Estates and Facilities Strategy. It also received a report presented by Ruth Bruce setting out an overview of all enabling strategies. Following detailed questioning about the resetting of dates and rolling forward of activity from previous years, F+P will seek to assure itself over coming months that Management Board is exerting real scrutiny and grip in relation to delivery.

Neil Rhodes

Chair – Finance and Performance Committee
23.7.19

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Title	**Chair's and NEDs' Report**		
Report to	**Board of Directors**	**Date**	**30 July 2019**
Author	**Suzy Brain England, Chair of the Board**		
Purpose			Tick one as appropriate
	Decision		
	Assurance		
	Information		x

Executive summary containing key messages and issues
The report covers the Chair and NEDs' work in June & July 2019.
Key questions posed by the report
N/A
How this report contributes to the delivery of the strategic objectives
The report relates to all of the strategic objectives.
How this report impacts on current risks or highlights new risks
N/A
Recommendation(s) and next steps
That the report be noted.

Chair's and NEDs' Report – July 2019

Star of the Month Award

At the start of the month I was delighted to award Debbie Beresford-Smith and her team on Rehab 2, the Star of the Month Award. Colleagues were commended on their exceptional teamwork during the weekend of 11/12 May by General Manager and Senior Manager on Call, Lesley Hammond. Two separate situations arose, firstly a small appliance fire which resulted in a carefully managed evacuation of Rehab 1 & 2, followed by a disruption to the site's water service the following day. Despite these setbacks colleagues worked together to ensure the safety of patients and continued delivery of first class patient centered care. What a great example of team work – Well Done!

Governor Brief

Following the recent decision to restructure governor meetings, the first afternoon Governor Brief took place on 2 July. These sessions provide an excellent opportunity to keep informed and as always the agenda provided a good balance between information sharing and interaction. Governors were able to hear from Becky Joyce, who joined DBTH as Chief Operating Officer on 3 June, followed by presentations from Hazel Brand, Cindy Storer and Fiona Dunn

In her role as Lead Governor Hazel shared her observations and learning from NHS Providers Governor Focus 2019 conference. This conference is the leading event for NHS Governors and allows colleagues to understand key national issues facing the health service, it facilitates the sharing of best practice and provides an opportunity to network with peers. At the event delegates heard from Yvonne Coghill CBE OBE, Director of NHS Workforce Race Equality Standard (WRES), who outlined the challenges facing governors to ensure diversity across their Boards and Council of Governors. Diversity which reflects both the provider's workforce and the community it serves was recognised to lead to better health outcomes. Linked to the same topic of equality and diversity Hazel also shared the presentation from the recent HEAR Masterclass, delivered by Simon Fanshawe OBE, for those governors who had been unable to attend on the day.

Cindy Storer, Acting Deputy Director of Nursing, Midwifery & Allied Health Professionals presented the launch of the Inpatient Quality Accreditation Tool (iQAT), which firmly focused on delivery of our vision "To be the safest trust in England, outstanding in all we do". Governors heard about all aspects of patient safety and experience, including sight oof supporting data, identified themes and a whole range of improvements and initiatives to support the provision of great care, including Making Mealtimes Matter, Shhh Sleep Helps Healing, Sharing How We Care for You and Pets as Therapy.

Finally, Fiona Dunn, Acting Deputy Director of Quality and Governance, spoke of the role of a governor in CQC inspections, the trust's schedule of mock inspections and the associated key lines of enquiry.

NHS Providers Events

In the first week of July I attended NHS Providers Board meeting, followed by a trustee training session. During the evening Board members also attended a farewell dinner for the Chair, Dame Gill Morgan and other outgoing trustees. Dame Gill steps down at the end of her second term of office later this year; the appointment of Sir Ron Kerr, as her successor, has subsequently been confirmed with effect from 1 January 2020. Ron has a long and distinguished career in health service management, including ten years as one of the country's leading provider chief executives.

The following day was NHS Providers quarterly Chair and Chief Executive Network meeting, During the morning session colleagues heard from the Chair of the CQC about their strategic aims and from John Ashworth MP, Shadow Secretary of Health and Social Care regarding the priorities for a Labour government.

I was also kept busy during the lunch break when I was involved in the filming of a short introductory video clip to be used as part of NHS Providers Annual Conference in October. Please keep your eyes peeled for this footgae either at the conference, should you get the opportunity to attend, or on social media – I'll keep the content under wraps until then!

The afternoon's focus turned to a panel discussion, led by Dame Gill Morgan, created in response to requests to hear about STP/ICS developments. Colleagues from a more advanced ICS and also from a system seeking to appoint a single leader for the trust and the CCG, supported by a committee in common, spoke candidly about their journeys to date. To close Chris Hopson, NHS Providers Chief Executive, presented on policy and strategic issues, supported by a Q&A session.

The final NHS Providers meeting of the month took place on 23 July when I attended the Governor Advisory Committee, chaired by Peter Abell.

Governor Induction

In order to support the recently elected governors who were unable to attend the April induction session an additional date was arranged ahead of this month's Council of Governors on 25 July. Alongside myself, Richard Parker, Jeannette Reay, and Hazel Brand welcomed governors, briefing them on a variety of trust matters, it's board, committee and assurance structure, workforce, finance, vision, values and objectives. The role, expectations and code of conduct for governors were shared and governors were briefed by Jayne Collingwood, Head of Leadership and Organisational Development on living the values and equality and diversity. The story of the trust's quality improvement journey was described by Beccy Vallance, Clinical Lead Quality Improvement.

Other Meetings

Throughout the month I have also met with Sam Debbage, Deputy Director of Education, Ken Anderson, who will shortly take up the post of Interim Chief Information Officer and an introductory meeting with Julie Thornton, Head of Performance. I met with Hazel Brand in her role as Lead Governor, a meeting that will take place on a monthly basis with both Lead and Deputy Lead Governor.

Opportunities Doncaster Launch Event

On 16 July I joined over 250 representatives from Doncaster's education providers, business sector and local authority at the launch of "Opportunities Doncaster" at the Hilton Garden Inn.

Co-created by Doncaster Chamber and Doncaster Metropolitan Borough Council the initiative offers students "cradle to career" support by building partnerships between schools and businesses that will raise young people's awareness and aspirations to pursue the different careers and education pathways available to them, and to gain the soft skills they need to be work-ready.

Following on from the launch an interactive event, Opportunities Doncaster Live, will be held in February 2020 and will enable employers and education providers the opportunity to engage with over 3,000 young people to inform and inspire them about the variety of career pathways available to them in Doncaster.

NED Reports

Pat Drake

Pat attended her first Quality & Effectiveness Committee planning meeting to discuss the way forward and agree an agenda to reflect the new objectives. She also attended the Finance & Performance Committee and subsequent meetings to discuss the terms of reference for Board Committees.

Out in the divisions Pat observed the Paediatric Clinical Governance Meeting and visited the Medical wards, supported by Marie Hardacre, Head of Nursing. She participated in a mock CQC inspection of OPD , Minor Injuries, and Diagnostic Imaging at Montagu Hospital.

Alongside, her colleague, Kath Smart, Pat attended an excellent Allied Healthcare Professionals Conference with participants from across South Yorkshire & Bassetlaw, it was great to see the contribution to patient care this group of professionals make.

On behalf of the Chair, Pat attended a SY&B ICS event to begin to develop the strategy for the next 5 years

Finally, she attended July's Council of Governors, where the new style NEDs assurance presentations took place.

Sheena McDonnell

This was an extremely busy couple of months with the Trust. Sheena attended NHS Providers Quality Conference and heard all about the difference that quality improvement and colleague engagement is having on other organisations' improvement journeys.

Sheena attended June's Board day, which as well as Board business started with a presentation about the Doncaster Place plan and finished with a development session on the progress the trust is making on its digital journey.

Sheena had a great demonstration of the SmartER project and has heard about the developments for phase 2 which will enhance the current capabilities strengthening the interface with current systems and make it more patient friendly.

She met with Jeanette Reay, as the new Head of Corporate Assurance and Company Secretary and Becky Joyce, Chief Operating Officer. She also participated in her first trust appraisal with the Chair.

Sheena attended the second of two leadership masterclasses, the latter of which focused on the subject of diversity and its benefits for the Trust, delivered by Simon Fanshawe OBE. It was a very engaging session.

The Quality & Effectiveness Committee was held and Sheena tried out the opportunity to dial into the meeting from London which was very successful and allowed full participation.

The NHS Confed 19 conference was held in Manchester over two days and Sheena attended day two where she heard lots of discussions about the climate within the NHS, the landscape and what is on the horizon and in particular a keynote speech on diversity and the work Trusts still need to do to embrace it.

As the new chair of the Fred and Ann Green Advisory Group as well as the Charitable Funds Committee Sheena took the opportunity to meet up with Peter Brindley who is the remaining relative of Fred Green involved in the advisory committee.

Kath Smart

As Audit Committee Chair, this month Kath attended the agenda planning session, had a pre-met with KPMG, our Internal Auditors and chaired the Audit Committee on 18 July.

Along with Pat Drake and members of DBTH senior team, Kath attended the SY&B Allied Health Professionals Conference and was delighted to hear the presentation and key messages from Suzanne Bolam to all AHPs.

As part of her continued buddying with the Medicine Division, Kath visited ED and AMU with Lesley Hammond and Hugh Wilson to see more about how they have jointly developed technology for staff and patient benefit. She also had chance to talk with teams who are using the new systems and the IT team who are supporting the new developments.

Kath also attended Doncaster CCG's AGM on behalf of Suzy, and chaired the panel for a Consultant in Obstetrics & Gynaecology.

Finally, she attended the July Finance & Performance Committee and Council of Governors meeting.

Chief Executive's Report
30 July 2019

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

G2

Care Quality Commission (CQC) inspection

As part of their inspection methodology, the CQC have requested focus groups for a range of staff groups (including consultants, junior doctors and midwives) on 8 – 29 August 2019. This suggests that an unannounced inspection is likely to take place in September. We have also received the CQC pre-inspection notification of the well-led inspection, which will take place 8-10 October 2019.

As a Trust, it's our intention to be well prepared for when the inspectors arrive, which is why we have developed a simple, four page booklet to help staff get ready for the upcoming inspection, as well as continuing with our programme of mock inspections.

It's crucial that we view the inspections as an opportunity to highlight what a fantastic job everyone within Team DBTH does every single day. We don't need to put on a show, we simply have to be proud of what we stand for, and deliver, as a Trust.

It's our vision to be the safest Trust in England, outstanding in all that we do. When the inspectors arrive later this year, we want to ensure we share this ambition with them, showing exactly why we think Team DBTH is one of the best within the NHS.

Hospital@ launched as part of digital transformation

After months of preparation, Hospital@ has been officially launched in both the division of medicine and the surgical division.

Hospital@ is a system provided by Nervecentre which replaces evening and weekend non-urgent bleeps. By logging tasks via this new service, doctors receive these alerts in real-time via a mobile device, marking them as closed when complete.

Hospital@ helps us to better communicate between doctors and health professionals, enhancing task management and ultimately improving the care we provide for our patients by making the best use of technology.

The implementation is going well with few issues reported and lots of colleague engagement with this new way of working. Support and training will continue throughout the next few weeks, via the Trust's Digital Team.

We care Into the Future event

The 'We Care into the Future' conference, which took place earlier this month, was a great example of forward thinking work by the Trust to address future workforce challenges.

More than 250 professions were showcased to more than 1,000 year eight (12 to 13 year old) students in Doncaster, establishing the Trust very early as a local employer of choice for a range of opportunities.

Thank you to all the teams who coordinated, supported and attended this inspiring event. Plans are being put in place to replicate the event in Bassetlaw.

Bedside booklets introduced

Wipe-clean folders have been introduced to bedsides across the Trust, to further improve patient safety and experience.

Based on patient feedback, the 'Sharing How We Care For You' a5 booklet contains 36 pages, outlining to patients, their families and visitors what they should expect when receiving care and treatment at the Trust. Delivered in partnership with clinicians, as well as patients, the handy guide covers everything from staff uniforms to day-to-day activities on wards and in services, as well as how to access the organisation's Wi-Fi and other facilities.

The folders have been designed to ensure patients feel as comfortable and informed as possible, helping them to feel at home and to ensure that friends, families and carers know how the hospital operates and how they can support care and treatment.

Text reminder to go live

A text reminder service is due to go live on 1 August, which will help patients and carers to monitor and keep their clinical appointments, as well as access service specific information.

Known as 'DrDoctor', this new system will go-live within Ophthalmology, Gastroenterology and Respiratory services. All patients receiving a new appointment with the organisation will receive a text message containing all relevant details, as well as an invitation to use the new online portal.

Using a patient's registered mobile number, or email addresses, DrDoctor sends out regular reminders for upcoming appointments, while also providing a platform which contains all relevant information, maps and the ability to cancel or rearrange, should they need to.

Around one in 10 appointments made are missed every year in England, costing the health service millions of pounds. Unfortunately, DBTH is within the highest 25% of all trusts in the country for patients not attending appointments, recording around 140 missed appointments a day or 50,000 each year.

To understand why this problem was occurring, the Trust, alongside local partners in the NHS and Healthwatch Doncaster, spoke with over 1,600 residents back in 2018, investigating why so many appointments were being missed. Collated into a report published in the same year, around 38% said they had missed a date with the hospital, with many outlining the need for the Trust to implement technology in order to make cancelling or rearranging appointments more accessible.

After going live in the three specialties, the service will roll-out across the Trust by the end of 2019.

Project ECHO launch

Project ECHO is an interactive training package designed to facilitate the sharing of knowledge and change practice. It uses a live video network to host mentoring sessions and present case studies.

Within the Doncaster and Bassetlaw Accountable Care Partnerships, organisations have come together to make this available for Care Home staff to support their work in caring for residents at the end of life.

Part of our End of Life Care commitment at DBTH is that we honour our patients' choices about their own death and quite often, when our patients have chosen to die at home, this means it will be in a local care home.

Typically, care home workers find it hard to access training and can feel isolated in their learning. The ECHO project brings together the experts in the area of end of life care to deliver the curriculum, with input from the Care Home's to ensure the learning meets their needs and can be transferred into their practice to improve End of Life Care.

Award winning teams and individuals

We had two teams recognised in the first ever regional AHP awards. **The Clinical Therapies Team won the AHP Research Impact Award 2019** and the **Adult Speech and Language Therapies Team won the AHP Quality Improvement Award: System 2019**.

Receiving two of the eight awards, run by the South Yorkshire and Bassetlaw Integrated Care System (ICS) is a remarkable achievement, demonstrating the excellent work of our AHP staff group at the Trust.

Procurement Manager, Sonia Simpson, has been named 'Professional of the Year' by the NHS Skills Development Network (Yorkshire and Humber).

In her role as E-Procurement Manager, Sonia has overseen the implementation of a number of challenging projects, which has allowed the Trust to streamline and transform the way it purchases essential supplies. As a leader within the team, the procurement specialist has worked closely with colleagues across the organisation as well as the region, ensuring the Trust is able to deliver the best deal possible for the NHS

The Procurement Team were also named as 'Team of the Year' by the NHS Skills Development Network.

This achievement caps a particularly successful year for the team. Focusing on a number of core objectives, the department has overseen improvements to purchasing processes, as well as enhancing inventory management within the organisation, ensuring that colleagues have the right products, at the right time in order to provide efficient and effective patient care.

The South Yorkshire and Bassetlaw Nursing Bank Management scheme, which launched in April 2018 was awarded the '**Workforce Contribution in Health & Social Care Systems'** category at the Healthcare People Management (HPMA) Awards.

The award centred on the innovative use of joint procurement of a single nurse bank provider (NHS Professionals) and collaborative agency management. By using one single joint provider, our local NHS had saved £1.2m between April 2018 and January 2019 (compared to the same period in the previous year) and an additional £520k was saved in administration costs. These savings have been directly reinvested into local healthcare, allowing an extra 87,000 hours of support to frontline care.

Annual Members' Meeting

The Trust's Annual Members' Meeting will take place Thursday 26 September. An opportunity to hear about the work and achievements of the organisation in 2018/19, the event will start at 4.00pm at the Keepmoat Stadium, Doncaster.

The formal meeting will begin at 5.00pm and feature presentations of the Trust's Annual Report and Accounts 2018/19. There will also be an opportunity to hear from the DBTH Executive Team and Governors, as well as time to ask questions of the hospitals' performance. In all, the event will run for around two hours.

As an expression of DBTH's commitment to inclusivity, the meeting will be signed by a British Sign Language interpreter.

Local appointments

Julie Mepham has been appointed as Director for Children's Social Care Services at Doncaster Children's Services Trust

Proud@DBTH

Launched earlier this month, through the staff Facebook group, members of Team DBTH were asked to share what they were most proud of from the past seven days. In just 24 hours, over 125 colleagues got involved, explaining what had given them pause for thought, celebrating individuals, teams and services at the Trust.

The following Saturday, another 80 comments were made. The campaign for people to highlight their moments of pride will continue each Saturday on social media and highlights will be included in the Buzz to share the positivity.

DBTH Star Awards

The annual STAR awards will take place on September 19 at Doncaster Dome. We have received more nominations than ever before across all categories, making judging extremely difficult and competitive.

I would like to congratulate all staff who were nominated and those who are lucky enough to make the shortlist. I would encourage as many of you as possible to attend what is one of the most inspiring and important events of the year, celebrating our hard-working staff.

UNAPPROVED

G3

Minutes of the Meeting of the Management Board
of
Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust
on
Monday 13 May 2019 at 2:00pm
in the Boardroom, Bassetlaw Hospital

Present:

David Purdue (Chair)	Deputy Chief Executive & Chief Operating Officer
Karen Barnard	Director of People & Organisational Development
Jon Sargeant	Director of Finance
Antonia Durham Hall	Divisional Director – Surgery & Cancer
Eki Emovon	Divisional Director - Children and Families
Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
Sewa Singh	Medical Director
Jochen Seidel	Divisional Director – Clinical Specialities
Nick Mallaband	Divisional Director – Medicine

In attendance:

Gareth Jones	Trust Board Secretary
Simon Marsh	Chief Information Officer
Howard Timms	Deputy Director of Facilities & Estates *(for Kirsty Edmondson Jones)*
Mandy Espey	General Manager – Surgery & Cancer *(Part)*
Claire Jenkinson	Deputy Chief Operating Officer – Clinical Specialities *(Part)*
Kate Carville	General Manager – Medicine *(Part)*
Lesley Hammond	General Manager (Emergency) – Medicine *(Part)*
Julie Thornton	Head of Performance

Apologies:

Richard Parker OBE	Chief Executive
Marie Purdue	Director of Strategy & Improvement
Kirsty Edmondson-Jones	Director of Estates & Facilities

Action

Welcome, Introductions and apologies

MB/19/5/1 Apologies as recorded above were noted.

It had previously been arranged to discuss the Bassetlaw Clinical Site for the second half of the meeting. Since that time this discussion had been deferred to the June meeting, instead, the second half of the meeting would be dedicated to discussing progress with annual plans. Divisional Senior

Management Teams (SMTs) would attend from 3pm to contribute towards the discussion.

Actions last meeting

MB/19/5/2 The action log was discussed and updates acknowledged.

3 – Risk 2003 relating to Unsustainable situation to provide out of hours cover in anaesthesia was to be escalated to the corporate risk register managed. This would be covered as part of the discussion to take place in June about the Bassetlaw Clinical Site. The Deputy Chief Executive/Chief Operating Officer gave an update on discussions between the Chief Executive (CE) and Medical Director (MD) with the CE of Bassetlaw CCG Briefly discussed. The Trust had agreed to write formally to the CCG with its intentions regarding service provision at Bassetlaw Hospital. It was noted that any changes would be taken though Management Board, then Board and would include risks / mitigations. Some pre-work for the Bassetlaw Clinical Site workshop in June would be shared with Divisions. **DP**

Strategy

Clinical Site Strategy

MB/19/5/3 Deferred to June for wider discussion. **ALL**

Finance & Commercial Strategy

MB/19/5/4 Management Board considered a presentation from the Director of Finance (DoF) on progress with the Finance & Commercial Strategy. He provided an overview of the 2018/19 targets, additional work, and targets for 2019/20. He provided further background and contextual information relating the business case for a Wholly Owned Subsidiary (WoS) which had been due to changes in regulations around approvals imposed by the Department of Health (DoH) / NHS Improvement (NHSI). He noted that the business case was still valid with an option to review later in year if required and if the rules changed again, but the current annual plan did not have the WoS in it, although it did have the smaller Pharmacy WoS to replace Well Pharmacy.

MB/19/5/5 Management Board were advised that the Trust's current provider of the outpatient pharmacy service, Well Pharmacy, had notified the Trust that it no longer wished to continue to provide the service past the expiry of the current contract. Therefor an alternative methodology was required. A number of options had been considered with the establishment of a subsidiary, wholly owned by the Trust, identified as the preferred option. The Finance & Performance Committee (F&P) had been updated on the range of options in March 2019 and in April 2019 F&P had recommended to Board for approval the full business case for the development of a wholly owned subsidiary to provide the Trust's outpatient pharmacy service.

MB/19/5/6 He provided further detailed updates on the contract and lease review with Parkhill Hospital, managed equipment scheme and capital funding sources.

MB/19/5/7 The update on capital funding sources led to a wider discussion about, amongst other things, how the Trust would be affected by the request from NHSI for Trusts to reduce their need for capital in annual plans, how existing bids, including those that had included an element to address some of the Trusts backlog maintenance, would be affected and, in light of this, what divisions should do about work they were already progressing for capital bids, for example work on the Children's department and Theatre bid. The Trust had been told it could not submit any bids greater than £15m and therefore there was work to do to re-work some bids and the DoF gave examples of what this meant in terms of changes to existing/planned capital bids. The letter from NHSI had set out that all Trusts must review / reduce capital expenditure and could not submit a revised plan with more capital funding than any original plan. Antonia Durham Hall made the point that given the age of the Trusts estate it was not sustainable to keep up the management of decades of backlog maintenance; the DoF agreed and noted that overall the Trusts capital plans for this would remain the same; For clarity/transparency he would circulate the letter from NHSI

MB/19/5/8 Management Board NOTED to Finance & Commercial Strategy Update.

Corporate Issues

ICS Update

MB/19/5/9 The Deputy Chief Executive/Chief Operating Officer provided an update on recent ICS meetings and discussions about proposed changes to the way in which the Trusts were managed in the context of the ICS and questions were raised about how this would impact on decision making at Trust level; it was clarified that Management Board would be kept up to date with any changes. There was also an update on ICS level 2018/19 performance for 4hr access, cancer and diagnostics and a more detailed update on ICS level financial performance for 2018/19; overall the ICS had ended 2018/19 ahead of combined plans. There was further discussion about how financial support could be accessed for work being done at Trust level to support the ICS and this led to a wider discussion about ICS level work.

MB/19/5/10 There was an in depth discussion about the potential for a hosted network for vascular services; The Medical Director shared details of the background to this and there was a candid discussion about key issues, progress of discussions with vascular surgeons, key issues and risks.

MB/19/5/11 The Medical Director noted that in terms of oversight of ICS work an

Efficiency Board looked at finance & performance but the ICS had only very recently described what would happen in terms of quality standards oversight and governance and he felt there had been a lost opportunity to engage more widely with clinicians on this. Management Board needed to have an open discussion around the Trusts strategy for Doncaster within the ICS, across a range of clinical specialities, and it needed to be clear about what was in the best interests of the Trust's patients and clinicians, similarly there needed to be a discussion around BDGH.

MB/19/5/12 The Update was NOTED.

Finance Report as at 31 March 2019

MB/19/5/13 Management Board received the report of the Director of Finance which set out the Financial Position at Month 12.

MB/19/5/14 Management Board NOTED:

- The draft year-end financial position shows that the Trust has delivered its control total for 2018/19, with a £23k favourable variance (before additional PSF of £10.7m). This position is subject to review by audit.
- The Trust's deficit for month 12 (March 2019) was £1.1m, which was an adverse variance against plan of £1.4m before PSF. This was however a favourable variance against forecast of £2.7m in month. The cumulative position to the end of month 12 is an £22.8m deficit before PSF, which is £23k favourable to plan and £3.9m favourable to forecast before and after PSF. Including PSF the Trust delivered a surplus of £4.6m in Month 12, reflecting that the full quarter of PSF has been accounted for in M12 due to the Trust achieving the Control Total and delivering A&E performance.
- The achievement with regards to the Cost Improvement Programme.

Corporate Risk Register

MB/19/5/15 Management Board considered a report of the Trust Board Secretary which set out the latest corporate risk register for consideration. Management Board were asked to consider 3 new risks, escalated via Datix, for escalation to the Corporate Risk Register (CRR). Detailed were set out in the covering report and were discussed:

Risk 2184 - Risk relating to a broken macerator – Howard Timms advised that this risk had been mitigated as the macerator had been replaced. The risk was referred back to the Division for review.

Risk 2191 – Risk relating to patient safety due to reduced diabetes specialist nursing staff – The risk was rated 20 (L5 x I4) and was discussed. The risk

related to funding which was due to be discussed later the same week. It was agreed to escalate the risk to the CRR but with a revised risk rating of 16 (L4 x I4).

Risk 2193 – Risk relating to no ward clerk for wards 1 & 3 resulting in poor or miss-filing of patient notes. The risk was discussed; although the risk was acknowledged it was agreed that the risk was already covered by an existing risk relating to medical records.

MB/19/5/16 Management Board NOTED the report.

Divisional Issues

Annual Plans

MB/19/5/17 The Executive Team were due to discuss progress with annual plans and to feed in to these discussions Management Board had invited General Managers (GMs), Deputy Chief Operating Officers (DCOOs) and Associate Directors of Nursing (ADoNs) to attend this part of the meeting to discuss how they were getting on and to determine whether the Divisions required any support with this work. Representatives from the Medicine, Surgery & Cancer and Clinical Specialties Divisions were present.

MB/19/5/18 There was a wide ranging discussion about overall progress with annual plans and key issues in terms of various elements of the plans. Key areas of discussion included:

Workforce Plans - There had been a workshop with HR colleagues about how to complete workforce plans but there was still uncertainty amongst some colleagues about expectations in terms of the level of detail required, how the plan should be presented and how plans should reflect/link to planned activity growth. This led to a wider discussion about how workforce planning across the organisation might evolve in the future. It was clarified that for this round of planning the planning documentations provided should be completed and should include what was needed, what and where the gaps were, details of staff that were due to leave the organisation.

Community Services - An update was provided on the expected closure of care home where the Trust utilised 15 beds and this led to a wider discussion about plans for community services and funding for community response.

Demand & Capacity Plans:

Not all colleagues were clear about detailed expectations for growth.

There was a detailed discussion about capacity planning during which the

Medicine division expressed concern about the tools being used for capacity planning: significant resource had been put in to populating the plans but the output figures did not look right and did not align to the previous year. Several colleagues had attended a training session on the NHSi tool and this had been very informative but, in practice, using the tool hadn't been as straight forward as expected and other colleagues shared the concerns expressed by Nick Mallaband about the accuracy of the information the tool produced. Colleagues discussed how best to go about determining capacity and issues they had experienced, for example how review lists would be fed in to the plans. Executives emphasised the need to complete capacity planning; Divisions needed to set out core capacity and then capacity from additional sessions. This could then be compared to contract expectations and divisions could then identify gaps. Nick Mallaband expressed some concern about this approach; the DoF would meet with Nick after the meeting to discuss this in more detail.

MB/19/5/19 Progress with Annual Plans was DISCUSSED and NOTED.

Information Items

MB/19/5/20 The following items for information were NOTED:

- Business Intelligence Report as at 31 March 2019
- Chief Executive's Report
- Minutes of the CIG Meeting held on 28 January 2019
- Elective Care Steering Group Report April 2019
- Children and Families Board Update April 2019

Minutes of the meeting held on 15 April 2019

MB/19/5/21 The minutes of the meeting held on 15 April 2019 were agreed as a true record.

Any Other Business

MB/19/5/22 **Academic Surgical Unit** – Antonio Durham-Hall shared details of extensive discussions between the Trust's surgical specialities with the University of Sheffield and Sheffield Hallam University about the requirements/standards for the becoming an Academic Surgical Unit. Feedback from the Universities suggested there were no barriers to this and Antonia Durham-Hall raised the question of how the Trust could progress this. The matter was discussed and it was agreed that the Trust would need to agree and set out its own standards/expectations. It was noted that Research & Development (R&D) had also been looking at such opportunities and was developing a paper; therefore there needed to be a joint response from R&D and the Surgical **KB**

Specialities. Karen Barnard would share the paper with Antonia Durham Hall.

MB/19/5/23 **Pension Tax Rules -** There had been a recent change to pension tax rules and the potential implications of this on consultants had raised concern amongst colleagues. Nick Mallaband and Antonia Durham-Hall shared some of the concerns raised with him noting that it had led to reluctance amongst some consultants to take on additional sessions and others asking to reduce their PAs. The felt this posed a potential risk in terms in terms of delivering contract levels and they raised the question of whether this should be escalated to the risk registers and this was discussed. It was noted that this was a National issue and the implications were not fully understood at this stage, the Trust would look in to the matter.

MB/19/5/24 **Email Etiquette –** There had been an instance where a colleague had set their email out of office (OOO) message to say that all emails received while they were on leave would be deleted and not read. It was felt by some that this was inappropriate and the matter was discussed. It was agreed to task the Communications & Engagement Team with setting out some guidelines for staff about email etiquette in general to cover the matter of a standard OOOs. **KB/Comms**

MB/19/5/25 **Annual leave for Non-Clinicians** – In response to a query it was clarified that annual leave for GMs and ADoNs should be approved by Divisional Directors.

Date and time of next meeting

MB/19/5/26 The next meeting of Management Board would take place 10 June 2019 at 2pm in the Boardroom at Bassetlaw Hospital.

FINAL

G4

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST

Minutes of the Quality & Effectiveness Committee
held at 2pm on Wednesday 24 April 2019
in the Boardroom, DRI

PRESENT	:	Linn Phipps, Non-executive Director (Chair) Pat Drake, Non-executive Director Karen Barnard, Director of People & OD Moira Hardy, Director of Nursing, Midwifery & Allied Health Professionals Sewa Singh, Medical Director
IN ATTENDANCE	:	Suzy Brain England, Chair of the Board Peter Abell, Governor Observer Jochen Seidel - Divisional Director Clinical Specialities *(part)* Fiona Dunn, Acting Deputy Director of Quality & Governance and Clinical Specialities Clinical Governance Lead *(part)* Kirsty Edmondson Jones, Director of Estates &Facilities *(part)* Kate Sullivan, Corporate Governance Officer Cindy Storer, Acting Deputy Director of Nursing, Midwifery & Allied Health Professionals Mandy Dalton, VS Pals Complaints Manager Gemma Wheatcroft, VS Pals Learning from Deaths Lead Becky McCombe, Practice Development Matron *(Observing)*
APOLOGIES:		Sheena MacDonnell, Non-executive Director Marie Purdue, Director of Strategy & Improvement Andrew Beardsall, Doncaster and Bassetlaw CCGs Clive Tattley, Governor Observer expecting

Action

Introduction

19/04/1 The Chair welcomed Suzy Brain England, Chair of the Board, Jochen Seidel, Divisional Director of Clinical Specialities and Fiona Dunn, Acting Deputy Director of Quality & Governance and Clinical Specialities Clinical Governance Lead.

19/04/2 **Agenda Review & Terms of Reference**

The Terms of reference were NOTED. The agenda was reviewed. The [Committee] Chair again appreciated, on behalf of QEC, the commitment of the Directors and their teams in producing excellent papers, especially the assurance-based cover papers and the increasing focus on strategic risk and links to the BAF. She noted that changes to the standing agenda had been made in response to previous meeting reflections, for example the time for the item for Divisional Director's Vision for Quality had been doubled to give this item optimal prominence and

attention.

19/04/3 Apologies

Apologies as recorded above were noted. Sheena McDonnell, Non-executive Director, had submitted a wide range of questions, which were played into the meeting wherever possible. Noting that this would be the last QEC meeting for Moira Hardy and Kate Sullivan, the Committee expressed their strong appreciation to both, for their enthusiastic contributions to co-designing the QEC Committee and its assurance focus, and to creating and sustaining its high standards. Good wishes were expressed to both Moira and Kate.

19/04/4 How Estates & Facilities Contributes to the Quality Agenda / Risks

The Committee received a presentation from Kirsty Edmondson Jones, Director of Facilities & Estates on how Estates & Facilities Contributes to the Quality Agenda / Risks. The presentation was included in the papers. Areas of particular focus and in depth discussion included:

- How the Trust's True North Objectives and Breakthrough Objectives, which included achieving and maintaining an overall CQC rating of outstanding, linked to Directorate Objectives.
- The performance metrics / indicators that linked directly to CQC lines of enquiry.
- Progress to achieve the 2018/19 Estates and Facilities Strategy Milestones and the 2019/20 Strategy milestones.
- Key challenges.
- Risks and the scale and risks around backlog maintenance and the critical infrastructure and plans to address and mitigate these risks.
- The KPI suite and problems/ mitigations around progressing less critical jobs.
- Staff perception, the link to staff morale, and ease of use of reporting systems.
- The low staff satisfaction evident in the staff survey (as noted by Sheena McDonnell)
- The benefits accrued already from using Qi approaches
- Vacancies and challenges with recruitment – Work was underway with P&OD colleagues to look at improving the timeliness of pre-employment checks as there had been instances where staff had accepted a conditional offer from the Trust but had subsequently accepted positions with other organisations offering a quicker start date.
- Specific issues with progressing works for Clinical Specialities Division - DCC, fire doors.

19/04/5 A key theme of discussion was around communication and how this could improve; Jochen Seidel and Fiona Dunn shared candid feedback from the Division on their experience of communication with Estates & Facilities colleagues about progress to complete works, responsiveness to requests for information and communication about why / when plans had changed. Peter Abell shared similar feedback from ward visits at Montagu Hospital. The Committee also had an in

depth discussion about the opportunity for closer involvement of Divisional staff in prioritising works using the 'Planet' system, which was suggested by the Medical Director. Kirsty Edmondson-Jones welcomed the feedback and the suggestion of utilising the 'Planet' system to improve engagement with department staff; she would take this away for consideration and arrange for a member of her team to work with the Medical Director to look at this.

19/04/6 Pat Drake raised the point that department staff were ultimately accountable for safety issues, for example in terms of outstanding work relating to fire safety issues, and the matter of improving and prioritising communication on these types of issues should be a priority; the Chair echoed this.

19/04/7 Sheena McDonnell had raised a number of questions about their staff survey results (via email) in the context of the contribution of these results to CQC scoring; the questions would be circulated to Kirsty Edmondson-Jones outside of the meeting for response. **LP**

19/04/8 The How Estates & Facilities Contributes to the Quality Agenda / Risks Report was NOTED.

19/04/9 My Vision for Quality – Jochen Seidel

The Committee received the report of Jochen Seidel, Divisional Director (DD) on his vison for quality for the Clinical Specialties Division. Jochen was supported by Fiona Dunn, Acting Deputy Director of Quality & Governance and Clinical Specialities Clinical Governance Lead. The report used an adaptation of the six assurance questions which had been agreed between the committee Chair and Medical Director. It also included a detailed summary of compliance against a range of statutory and regulatory body standards including the CQC, an update on a recent Internal Audit Reviews, a risk management update, quality metrics performance report, risks and staffing. The paper was discussed in detail.

19/04/10 Jochen Seidel described the great diversity of the Division, and the range of external regulators and standards bodies with which it must comply. Key areas of concern for the Division included Estates issues, Equipment and links to incidents, recruitment, capacity and demand, rehabilitation in critical illness, and a range of high risk areas. Discussion focussed on these and on areas where QEC could support the Division's drive for quality, such as concerns about Estates, Transport (outpatients), the VCF (vacancy control) process, and responsive IT. The importance of addressing many issues (e.g. digital systems and pathways) at ICS level was recognised. QEC welcomed the plan to move to a more bespoke set of quality metrics that were applicable to the division. QEC also welcomed the inclusion of a patient story and learning therefrom.

19/04/11 It was noted that the Divisional Senior Management team (SMT) had found some areas of concern in some departments in terms of outstanding risk reviews / dealing with complaints and under-reporting on Datix; Fiona Dunn had been working hard to improve this and Jochen was pleased to report some significant improvements although there was still more work to do. Another issue the Division was looking in to was the effectiveness of the use of risk registers and the

way in which they were being used, for example were they being used to manage risk or just log them. Work was also underway to consolidate overlapping and duplicated risks.

19/04/12 Jochen Seidel shared feedback from his Division on the Vacancy Control process (VCF); He felt that satisfying queries and requests to carry out further evaluations from the VCF panel was slowing down recruitment to key roles and was taking up significant time of senior staff. This was discussed and Executives shared their view; the key issue for Divisions was to ensure roles were budgeted for; the Division felt there had been some issues in terms of getting clarity on this. However, Karen Barnard gave assurance that the VCF panel did take a pragmatic view in the case of minor budget shortfalls, for example if the alternative was to use a locum to cover the vacancy. The committee agreed that it was appropriate to have a robust vacancy control process in place.

Kirsty Edmondson-Jones left the meeting

19/04/13 It was reported that a key issue for the Division was patient transport for day cases including delays in delivery and extended waits for patients. This triangulated with similar concerns raised by the Medicine Division at the previous meeting after which the (Committee) Chair had discussed the matter with the Chair of the Finance & Performance Committee where similar issues had been raised and the matter had then been escalated to the Chief Executive. Since that time Clinical Governance Leads had reported an improvement however Fiona Dunn reported that there were still issues in terms of outpatients, particularly in terms of transport home and she described some of the key problems. Suzy Brain England suggested this could be a piece of Quality Improvement (Qi) work It was agreed that, as a report had been requested for the Finance and Performance Committee, it would be followed up there. **FD**

19/04/14 Jochen Seidel described issues around IT communication; although there were issues in terms of responsiveness of IT to issues raised the key issues related more to communication between systems rather than people. The new patient portal had made things a lot easier for clinicians however significant time was still taken up logging in to multiple systems. There were also wider issues, for example on a regional level, in terms of sharing access to information particularly in light of issues around recruitment. If systems could be accessed across the region with could allow utilisation of, for example, capacity of pathology staff at other trusts.

19/04/15 The Clinical Specialties Division Vision for Quality Report was NOTED.

19/04/16 Action Log

The Action log was reviewed and updates noted.

LEADERSHIP AND IMPROVEMENT

19/04/17 Workforce & Education Assurance Report

The Committee received the report which used the assurance questions format

and was accompanied by an additional detailed report which included sets of data for each area. The Director of People & Organisational Development summarised the key areas of focus and areas for concern and gave assurance that mitigations were in place to address concerns.

19/04/18 A very extensive discussion took place. The report included a special item on the Workforce of the future, with examples of new roles which were developing. It was agreed to have further debate on this at a future QEC. The Chair asked about the process by which Divisions and Directorates produce annual plans on their workforce capacity and needs/demands. Karen Barnard described the planning process and it was noted that 3-5 year indicative plans were being progressed. Suzy Brain-England commented on the importance of considering style (e.g. how we work with schools to develop their aspirations to work in the NHS) as well as substance (how many of what types of employee we will need), and also the importance of locating our planning in the (sub-) regional context. It was agreed that Karen Barnard, Pat Drake and the (Committee) Chair would meet to develop the scope / assurance questions for this further debate. **KB/PD**

19/04/19 Plans and progress in addressing the response to the staff survey: it was agreed that the June QEC would have a full discussion on this. The questions raised outside of the meeting by Sheena McDonnell would be addressed at that time. Pat Drake commended the excellent work on guidelines in Maternity. **KB**

19/04/20 The Workforce and Education Assurance Report was NOTED.

QUALITY AND CARE

19/04/21 Learning From Deaths

The Committee received the Learning from Deaths Quarterly report that provided the committee with an update on the Review of Mortality work and the bereavement services. QEC welcomed Gemma Wheatcroft to her first meeting, Gemma would be job sharing with Mandy Dalton. QEC commended the impact of recent increases in staffing, the new patient bereavement information booklet, as well as the Trust's NACEL (National Audit of End of Life) scores. QEC probed the causes for concern set out in the paper with particular focus on how the proposed Medical Examiner (ME) role would work. The ME role would be statutory for all trusts from 2020. It was reported that the business case for the phased introduction of a ME team had been submitted. Once approved the Trust would go out to Consultants for expressions of interest but it was anticipated that recruitment to the ME role could be challenging as a considerable amount of on-line training must be completed first. Whilst the ME role(s) became established, existing processes must continue; potentially this could cause some confusion within both the bereavement office and mortuary/pathology departments. Mandy Dalton was due to attend a National conference on the ME role the following day and would take learning from this. The Medical Director shared feedback from a meeting with the Coroner about expectations of the ME role; the Coroner had expressed a wish to be involved with the recruitment process and this was being taken forward. It was agreed to provide learning from deaths patient story for the meeting in August 2019. **MD/CS**

19/04/22 The Committee commended the quality of the Learning from Deaths report which was NOTED.

Quality Assurance Report

19/04/23 The Committee received the report which comprised five parts:

a. Quality dashboard
b. Nursing Workforce Quality Metrics Assurance Report (Hard Truths)
c. Clinical Governance Report
d. Patient Story (Steven's Story; aftermath of knee surgery)
e. Patient Experience & Engagement Infographic

It brought together information across a range of areas and used the 6 assurance questions.

19/04/24 (a) Quality Dashboard

19/04/25 The quality dashboard brought together a range of performance indicators that reflected the processes or outcomes of care and patients. The data included benchmarking data using HealthCare Evaluation Data (HED) and local data from Trust systems.

19/04/26 The Committee probed particularly progress with improving the risk management process, how it was that staff were using the Quality Dashboard consistently, and the balance of process versus quality outcome measures; Pat Drake had attended 2 meetings and had observed the quality dashboard being used and this was welcomed. It was noted the continuing positive staff response to working towards the targets agreed at the Committee around reviewing deaths (Learning from Deaths) and closing older open incidents, and the continuing progress. Both Sheena McDonnell (via email) and the Chair welcomed the CGC objectives and specific measurable targets.

19/04/27 Staff claims and personal injury claims – Reflecting on the increase in the level of staff claims the Medical Director acknowledged that this was an area that needed to be better understood; it was noted that this came under Health& Safety but there were also links to Staff Health & Wellbeing; Pat Drake asked for more information on this and the Chair suggested a future separate report to QEC as the Committee had already created a process of 6 monthly reports on patient claims; it was agreed for the planning group to consider how this might best be reported on and who should lead on this report. **Planning Group**

19/04/28 (b) Nursing Workforce Metrics Assurance Report (taken before quality dashboard)

The report included detailed information relating to Nursing and Midwifery Workforce; highlighting issues which may impact upon the Trust's ability to provide appropriate staffing levels and skill mixes. It also provided an update on

the implementation of Care Hours per Patient Day (CHPPD), which had been a required national return since 01 May 2016 and the data submitted to UNIFY.

19/04/29 CHPPD metrics: At the June Committee a deep dive would be undertaken on this as remitted by the Board, and the Planning group would discuss the question(s) to address. **MH / Planning Group**
Pat Drake raised the issue of the need to scrutinise recurrent "red" scored areas that had not changed.

19/04/30 Moira Hardy reported that recruitment was now underway in maternity and this was welcomed. Pat Drake shared feedback from recent visits to the Maternity Departments reporting that the atmosphere in the department was much better and that feedback from staff about the Qii process been very positive. During a visit to paediatrics she had noted a high level of staff sickness absence and she asked how this was being monitored; Moira Hardy gave assurance that she would look in to this and it was agreed to consider Mini-Deep dive on Paediatrics for future meeting. **MH**

19/04/31 (c) Clinical Governance Report

19/04/32 The Committee received the Clinical Governance report which summarised the activity in the Clinical Governance Committee (CGC) in February and March 2019. It was noted that several aspects of the report had been considered and discussed in detail as part of discussion around other reports.

19/04/33 (d) Patient Story

19/04/34 The Committee received a detailed report on a patient story, Steven's Story and support for patients with Learning Disability. The report was welcomed. The committee Chair asked for learning from the Patient Stories (and what was being done differently as a result) to be more explicit. **CS**

19/04/35 (e) Infographic

19/04/36 The Committee noted the Patient Experience and Engagement Infographic: the committee Chair had been in discussion with Cindy Storer and team on this and commitments in the 2017 Quality Accounts. She welcomed the infographic and had sought consideration of how it could be used to measure and demonstrate improvement over time. **Planning Group**

19/04/37 The Quality Assurance Report was DISCUSSED and NOTED.

19/04/38 Governor questions regarding the first half of the business sections of the meeting:

Peter Abell expressed satisfaction with the Committee's probing on areas such as Workforce and echoed Pat Drake's comment in asking about red rated staffing in areas such as Children and Family and his concern that unchanged reds might not be probed. Moira Hardy commented on the difference between reds in RAG rating which indicated a major risk, versus red scores which reflected not hitting a

target but which nonetheless did not put patients at risk. It was agreed to take away how RAG ratings were calibrated and how and where they were communicated, to ensure that they were supported by an appropriate narrative. **CS**

19/04/39 GOVERNANCE AND RISK

Board Assurance Framework and Corporate Risk Register

19/04/40 The Trust Board Secretary updated the Committee on changes to the Board Assurance Framework (BAF) and Corporate Risk Register (CRR) since the last meeting of the Committee. A list of current risks and their alignment to the respective committees was provided for information. A review of risks had been undertaken by the Clinical Governance Committee, with support of the Medical Director and Clinical Governance Team, to identify any trends and re-occurrences of risks arising through operational committees. An extensive action plan was under development to review risk escalation, discussion of risk, volume and duplication and movement of clinical risks over time. A risk working group meeting now took place prior to the Clinical Governance Committee each month to progress the action plan. An update report by exception would be brought to the August QEC. **FD**

Moira Hardy left the meeting.

19/04/41 The Board Assurance and Corporate Risk Register were NOTED.

Progress with IA recommendations

19/04/42 The Committee received and NOTED the report that summarised Internal Audit (IA) recommendations relevant to QEC that remained outstanding at the time of reporting to the last Audit & Risk Committee (ARC) meeting.

Draft Quality Accounts & Annual Declaration of Compliance

19/04/43 As anticipated the Draft Quality Accounts & Annual Declaration of Compliance was not available in time for the meeting. As previously agreed, the report would be circulated to QEC members for comment as soon as it became available.

QEC Annual Report & Committee Effectiveness 2018/19

19/04/44 The Committee received and NOTED the QEC Annual Report for 2018/19. The report provided the Board of Directors with a summary of the work of the Quality and Effectiveness Committee ("the committee") for the year and would be taken to the next Board of Directors meeting.

ITEMS FOR INFORMATION

Minutes of sub-committees

19/04/45 The minutes of the following committees were NOTED:

- Clinical Governance Committee meeting held on 18 January 2019 & 15

February 2019
- Workforce, Education & Research Committee meeting held on 14 January 2019

It was welcomed that, in response to previous suggestions, CGC and WERC had initiated reporting back from QEC.

19/04/46 The Information items below were NOTED:

19/04/47
- CQC Update on actions from the December 2017 and November 2018 unannounced inspections
- Clinical Governance Strategy
- Patient Experience & Engagement Strategy
- CGC Risk Management Report
- Enabling Strategy Quarterly Exception Report (Q4 2018/19)

19/04/48 The following Clinical Governance Committee Sub-Committee Reports were NOTED:

19/04/49
- Drug & Therapeutics Committee Report
- Medicines Optimisation Strategy 2019-21 - The Chair commended the interesting segmentation of stakeholders into controllers and influencers.

19/04/50 National Reports / Areas of National Concern

19/04/51 NONE

19/04/52 New Internal Audit Reports referred by ARC to QEC

19/04/53 The Committee welcomed the inclusion of the Internal Audit (IA) Review of Complaints reports for information and noted that the majority of the recommendations were amber risks; and that a detailed action plan had been produced quickly.

Minutes of the meetings held on 20 February 2019

19/04/54 The minutes were APPROVED as a true record.

Work Plan

19/04/55 The Committee received and NOTED the Work Plan.

19/04/56 Any other business
None raised

Governor questions regarding the second half of the business sections of the meeting.

19/04/57 None

19/04/58 Items escalated form sub-committees
None

19/04/59 Items for escalation to the Board of Directors

None

19/04/60 Identification of New Risks

No new risks were identified

19/04/61 Time and date of next meeting:

19/04/62 Regular Bi-Monthly Meeting

Date: 19 June 2019
Time: 2pm
Venue: Boardroom, DRI

Signed:…….. **……**
Pat Drake **Date**

DONCASTER & BASSETLAW TEACHING HOSPITALS NHS FOUNDATION TRUST G5

Minutes of the Finance & Performance Committee held at 9:00am Monday 20 May 2019 in the Boardroom and then the Chief Operating Officer's Office, DRI

PRESENT	:	Neil Rhodes, Non-Executive Director (Chair) Pat Drake, Non-executive Director Jon Sargeant, Director of Finance *(Part)* Karen Barnard, Director of People & Organisational Development
ALSO IN ATTENDANCE:		Alex Crickmar, Deputy Director of Finance Kate Sullivan, Corporate Governance Officer Gareth Jones, Trust Board Secretary (Part) Julie Thornton, Head of Performance (for David Purdue) Sewa Singh, Medical Director (Part) Antonia Durham-Hall, Divisional Director, Surgery & cancer Division (Part) Mandy Espey, General Manager, Surgery & cancer Division (Part) Imran Hussain, Internal Audit (KPMG) Khurram Asif, Internal Audit (KPMG)
OBSERVERS	:	Bev Marshall, Governor Observer
APOLOGIES	:	Kath Smart, Non-Executive Director David Purdue, Deputy Chief Executive & Chief Operating Officer

Action

Agenda Review

19/05/1 The agenda was reviewed.

Agenda item 12 – F&P Committee Annual Report – The report was deferred to the next meeting to allow further review. The Chair requested that it be updated to reflect work the Committee had undertaken on, amongst other things, oversight of CIPs, the Catering Contract, workforce development and performance and work to co-develop the Integrated Performance Framework report. **JS / KB**

Apologies for Absence

19/05/2 Apologies as recorded above were noted. Gareth Jones, Trust Board secretary would attend for agenda item 11 - Corporate Risk Register & BAF Highlights.

Action Notes from Previous Meeting

19/05/3 The Actions were reviewed and updated.

Enabling Strategy Progress Reports – Throughout 2018/19 the F&P Committee and the Quality & Effectiveness Committee (QEC) had received regular presentations on progress to achieve enabling strategy milestones, as well as a quarterly Strategy Exception Report. The reports were received after scrutiny by Management Board (MB) In light of this, and considering the already heavy committee work plan for the year ahead, it had been suggested, by the Chairs of F&P and QEC, that going forward the Committees only received the quarterly exception report as a standing agenda item and that individual Enabling Strategy reports only be received if escalated by Executives from MB. This had

been put to the Executive Team who had endorsed the proposal providing all Committee Chairs were in agreement.

Capital Plan

19/05/4 The Committee received a presentation from the Director of Finance (DoF) which provided an overview of the 2019/20 Capital Plan.

19/05/5 The DoF provided a detailed update on the National position in the context of a recent letter received from NHSI requesting that all NHS bodies review their capital plans. Details were provided of changes to the plan which had been re-submitted to NHSi on 15 May 2019. The changes were noted. The main change to highlight was the assumed source of funding associated with the emergency bids for fire enhancement work and theatre upgrade work The revised requirement for 19/20 was £11.5m (from £24.1m) for both Fire and Theatres. £9.5m was to be funded from 18/19 bonus PSF, with an interim capital loan requirement of £2m.

19/05/6 Overall the 2019/20 capital plan had been revised from £35.3m to £22.7m. The DoF took the committee through a detailed analysis of movements for each capital scheme which were illustrated in the presentation.

19/05/7 The Committee received a detailed update on the robust, integrated and informed approach taken to 2019/20 capital planning. This included risk assessment and prioritisation of capital bids by the capital sub-committees, with plans challenged and reviewed by the Executive Team in line with affordability. The Trust had implemented governance arrangements to develop and monitor capital plans and ensure that schemes were consistent with clinical strategies, delivered safe and productive services and ensured that schemes were prioritised within, and between, categories. The DoF Provided details of the membership of key committees within the Governance structure including the roles of an additional sub-set of capital sub-committees created to ensure robust monitoring and planning, these were; the Medical Equipment Group, Estates Capital Group and IT Capital Group which all met monthly.

19/05/8 In response to several questions from Pat Drake and Neil Rhodes about the capital scheme governance process, particularly the prioritisation of schemes based on their risk rating; the DoF advised that he had confidence in the process in terms of prioritisation. He reported that the meetings were inclusive giving everyone chance to contribute and there was a good level of challenge particularly around risk. An illustration of the governance structure and committees was provided. There was further discussion about the level of schemes risk rated just below the schemes being taken forward, expected slippage, plans for bringing in reserve schemes and how well developed they were. It was clarified that medical equipment maintenance was dealt with separately and was included in budgets. There was a 5 year rolling plan for medical equipment but the DoF felt this needed to be improved and there was more work to do to better understand future requirements in terms of medical equipment.

19/05/9 The Committee NOTED the update and endorsed the plans. The Chair wished to better understand the Capital Governance process and see it in action; it was agreed to identify an appropriate meeting for him to attend. **JS/NR**

Finance Report

19/05/10 The Committee received the report of the Director of Finance which set out the Financial Position at Month 1 (April 2019) which was adverse against plan by £190k. The Trust's deficit for month 1 was £2.6m before PSF/FRF/MRET (£1.8m deficit after

PSF/FRF/MRET),

19/05/11 There had been an under-performance in clinical income of £75k due to some expected growth that hadn't happened. The Deputy DoF reported that operationally (on the ground) staff were reporting that the Trust had been very busy but this wasn't consistently reflected in terms of income despite medical spend and staffing being in line with budgets; this was being investigated and monitored closely. The Trust would also be investigating some areas of increased non-pay spend to determine whether there was a trend or possible phasing issues. The Deputy DoF gave an overview of variances and shared examples of areas of concern.

19/05/12 Savings (CIPS) - In April 2019 the Trust had delivered savings of £193k against the NHSI plan of £213k. This represented an under-delivery of £20k versus the submitted plan (91% achievement). The majority of schemes were up and running and a lot of work was going on to develop plans. The DoF reported that he felt there was better grip on plans this year than in previous years but there was still some concern in terms of the level of unidentified schemes and the Trust was working on this. The DoF described the oversight and governance process for CIPs, this included the fortnightly EEC meetings which were working well. The Chair welcomed the illustration of forecast savings on page 26 of the report, this had been helpful in highlighting where challenges were, he was also pleased to see that the bubble diagram illustrating the value and rag rating schemes, that had been so helpful to the Committee during the previous year, had been included. The Committee discussed local schemes and areas of key concern at this stage.

19/05/13 The Committee noted that the report related to strategic aims 2 and 4 and the areas of the Trust's BAF and CRR linked to the Committee. The Deputy DoF would check that these were still correct and relevant for 2019/20. **AC**

The Trust NOTED:

- The Trust's deficit for month 1 (April 2019) was £2.6m before PSF/FRF/MRET (£1.8m deficit after PSF/FRF/MRET), which was an adverse variance against plan of £190k.

- The progress in the development of the Trust's 2019/20 CIP programme.

Theatre Utilisation

19/05/14 The Committee received a detailed presentation from Antonia Durham-Hall, Divisional Director and Mandy Dalton, General manager for the Surgery & Cancer Division. The presentation focussed on three key areas:

Theatre Utilisation CIP Work stream – Detailed updates were provided on:

- Improving theatre scheduling specific to Trauma & Orthopaedics (T&O)
- Theatre scheduling actions (all specialities £47k)
- Improving productivity of cataract lists
- Reducing cancelations

Getting It Right First Time (GIRFT) - There were a lot of pipeline schemes but the division needed to focus on larger schemes; examples of GIRFT work were shared. Antonia Durham-Hall commented that GIRFT was a positive way to improve patient care and quality whilst trying to make services as cost effective as possible. It was noted that input from PLICS was required to take this work forward; the DoF noted that support was available to Divisions with PLICS and that, if help wasn't being received, the matter should be escalated.

Divisional CIP / CIP Gap – Local Schemes

- A Detailed update on local scheme targets was provided, these included schemes for vascular stents, breast implants and dentistry. It was noted that the GAP for local schemes was £337k and this was a key challenge.

19/05/15 There was a wide ranging and in depth discussion about work to ensure theatre scheduling rules were being observed and that rotas were populated 6 weeks in advance during which Mandy Dalton and Antonia Durham-Hall described the wide ranging work of the Division, progress to develop better working relationships across specialities, and how the Division was working with the Head of Performance to better understand performance and increase transparency with staff. In response to several queries Antonia and Mandy provided the Committee with candid and insightful updates on Fracture Neck of Femur (#NOF), how this linked to GIRFT, recent changes to #NOF guidance and how the new Trauma Board had improved planning of work across all 3 sites. The Trauma Board was now part of the electronic Bluespier system which meant everyone could see it; this had resulted in significant improvements in ways of working. In terms of the rota planning Antonia Durham-Hall gave assurance that there was good engagement with and adherence to rota rules, for example short notice leave requests, and regular meetings were taking place to monitor the position. Antonia Durham-Hall shared feedback form her own engagement with Consultants on this; broadly Consultants were on board with the rota rules.

19/05/16 The Medical Director provided an update on work to look back at previous theatre lists to identify missed opportunities in terms of theatre utilisation and identify any learning; this information was being considered by teams at meetings. Antonia Durham-Hall reported that there had been a significant improvement this year in terms of clinical engagement and there was now better support to help them understand their data, theatre utilisation and missed opportunities.

19/05/17 The Chair noted that the Theatre Utilisation CIP was a cross cutting scheme that also fell in to the remit of other Divisions and he asked for assurance about in-divisional relationships to ensure this work progressed. The Medical Director reported that linkages across clinical specialities were good and much better information was available to all Divisions. A key area of focus was pre-operative assessments and making these as efficient as possible and he gave details of this work. Antonia Durham-Hall gave assurance that the process for pre-operative assessments had already improved but she raised concern about staffing of the waiting list coordinators department, the recent restructure of the department had resulted in a number of vacancies, there were also a number of cases of long term sickness absence, and this was causing significant issues in terms of capacity to book patients for theatre. These staff were vital to the success of the theatre scheduling work and the current staffing issues were of significant concern.

19/05/18 The Committee thanked Antonia and Mandy for the detailed report which was NOTED.

Internal Audit

19/05/19 The Director of Finance (DoF) introduced colleagues from Internal Audit (KPMG) who presented a detailed presentation on key findings of their review of the Trust's Informatics department which had included a review of reporting. He noted that Informatics had been moved to his portfolio the previous year and he had commissioned the review, using some contingency days in the IA plan, in order to better understand key challenges in the department. He noted that the information produced by the informatics team was closely aligned to the work of the Board and its committees.

19/05/20 The Review had been conducted across 5 domains and detailed updates on key findings were provided by Internal Audit:

Strategy & Leadership – An informatics strategy did not currently exist and there was no clear vision of how information should be provisioned across the Trust and by whom. The Information Team leadership, whilst being regarded as capable and respected, was too insular and did not have sufficient engagement or presence with Divisions and within operational forums. Weak governance had allowed pockets of siloed informatics functions to be formed away from the central team. There was no formalised or ring-fenced training time has resulted in the Information Team not feeling invested in. The Informatics Team were highly capable but were not responsive enough, they are working incredibly hard but not necessarily delivering what the organisation needed and certain individuals were overburdened as they were better known across the organisation.

Resource Capacity & Capability – The informatics team was highly competent but the Head of Information needed to delegate more work as it was currently too hands on with the production of reports and this was impacting on the development of the Information Team as well as hindering team management tasks. The Information Team was currently lacking in resource capacity partly due to the fact that vacancies had not been filled and partly due to certain additional roles that were being performed, such as database administration (DBA).

Informatics Process – There were good SOPs and the team were maintaining an active log of requests however this was not being prioritised effectively. The team was working very hard but there was too much processing of information manually and there was a lack of automation of tasks.

Tools & Reporting – Trust information was currently not transparent and the organisational usage of information needed to mature to be more effective and embedded in operational practice. Many of the regular reports being produced were not fit-for-purpose for use by Divisions and Trust Executives and limited benchmarking data was being presented. There was an inconsistent approach to reporting with no centralised platform of choice nor any organisation-wide format and siloed informatics teams were creating reports without consultation from the central Information Team. The use of "freeware" software was commonplace and posed a governance risk to the Trust as it lacked IT support and may require specialist skills to operate.

Stakeholder Engagement - There was an over reliance on certain people as being the point of contact for information for the whole information team and stakeholders lacked confidence in the Team.

19/05/21 The Committee welcomed the candid update from the DoF and IA and they acknowledged that the Informatics Team was clearly highly competent and hardworking however there was some work to do to address the key findings of the review. 8 key areas for improvement had been identified and these would be taken forward as part of an action plan to be developed though workshops. This would also address actions relating to working practices such the use of freeware platforms. The action plan would be brought back to a future meeting (July/August 2019). **JS**

Jon Sargeant left the meeting

19/05/22 The Internal Audit Review of Informatics was NOTED

Draft 2018/18 Financial Accounts

19/05/23 Whilst the 2018/19 annual report and accounts were to be formally signed off at the Audit & Risk Committee on 23 May 2019, an updated set of draft annual accounts were presented at this Committee for information. It was noted that the Committee had considered a previous version in April 2019 which had been submitted to NHSI on 24 April, whilst the audit was still ongoing, a small number of changes had been put through the draft accounts since that time. The minor presentational adjustments included:

- Updating the Going Concern note on page 7 following the approval of the Going Concern paper at April Board.
- Resetting the cost/depreciation values on page 30 following the Land and Building revaluation. This is a disclosure adjustment and had no impact on expenditure or overall asset valuation.

None of the adjustments had had an impact on performance against Control Total.

19/05/24 The **Draft 2018/18 Financial Accounts were NOTED**

Integrated Performance Report

19/05/25 The Committee considered the Integrated Performance Report (IPR). The report was presented in two parts :

1. The Summary IPR – This summarised performance both in-month and year-to-date and provided a forecast to the year end.

2. Commentary on exceptions – this analysis was provided by operational teams where targets have not been met.

It was noted that, given the time lag in the generation and validation of elements of the data contained in the report, data was often a number of months behind for some elements. Therefore, a small number of the performance measures contained within the report had not been updated since the previous month. For completeness this could be shown as a further appendix to next month's report.

19/05/26 The Chair reiterated previous requests to include peer benchmarking information and it was agreed to ensure this was included, where possible, in future reports. JT/DP

19/05/27 Julie Thornton, Head of Performance, took the Committee though key areas of performance by exception and the report was considered In detail. Key points of discussion focussed on:

19/05/28 A&E / ED 4 Access target performance was 90.6% in month. Whilst this was below the national 95% target, it was noted that there had been a 6% & 8.7% increase in attendances at DRI and BDGH respectively. In response to a previous request from Pat Drake an update on winter performance had been included and this was briefly discussed. The Committee probed the reasons for fluctuations in performance within the month and across sites; this was multifactorial and included, amongst other things, the overall level of staffing on the day, including the level of locum (rather than substantive) staff, the level attendances and the acuity/complexity of cases, staffing, and beds. ED are looking at piece of QI work to speed up time for patients to get through diagnostics.

There had been a significant rise in the number of paediatric admissions to ED in March 2019 when compared to March 2018 (18% increase). Pat Drake reflected on this in the context of issues raised by the CQC at the most recent unannounced inspection in 2018 and she asked if the Trust understood the reasons for this.

Bev Marshall made the point that Governors should be made aware of this to enable a better understanding of the pressures the Trust was experiencing. Julie Thornton shared some anecdotal feedback from staff but, in order to understand the increase, the Trust would need to conduct a deep dive in to the presenting condition of patients.

19/05/29 RTT performance against the "18 week" target was 87.7%, this was lower than the previous month but this was as anticipated that due to validation work. Actions were in place, at speciality level, to improve performance against this measure into 2019/20. AN overview of RTT by exception was provided.

19/05/30 Diagnostics - The Diagnostics tests "6 weeks wait" target of 99% was not achieved with Trust wide performance at 93.93% after validation. The majority of the waits longer than 6 weeks related to Nerve Conduction and Urodynamics. Additional capacity was being sought from external sources for Nerve Conduction for May 2019 onwards. Pat Drake asked for assurance about how quickly after the 6 weeks those patients not meeting the target were being seen and this was discussed. This varied as patients were offered alternative dates, some would be seen within days while others may not been seen for several weeks. It was agreed to include details of the 'longest' wait in future reports. **DP/JT/AT**

19/05/31 Reflecting on other areas of the report the Committee welcomed reporting on numbers of patients, not just percentages. The report was discussed and the Committee requested that the report included updates on the following in future:

- An overview of patient transport performance and key issues including ambulant care.
- Delayed discharges **DP/JT**
- Delayed transfers of care
- An update on work to reduce Outpatient follow-up appointments.

The committee wished to receive a future deep dive on challenges to patient transport including inter hospital transfers of both adults and children. **DP**

19/05/32 The Integrated Performance Report was NOTED

Strategy

19/05/33 The Committee received the Strategy Exception Report that highlighted progress made with implementation of the Trust's Strategic Direction 2017 – 2022 (including enabling strategies) on an exception basis. Reflecting on the recent agreement to no longer receive the individual updates on enabling strategies, the Chair requested that, in future, this report include more thorough analysis in relation to strategy and transformation exceptions and assurance that these had been considered by Executives. **MP/ALL EXECS**

19/05/34 The Strategy Exception Report was NOTED

Corporate Risk Register and BAF Highlights

19/05/35 The Committee received and NOTED the Corporate Risk Register and BAF Highlights. The relevant risks had been considered actively with each paper received at the meeting. The Trust Board Secretary (TBS) advised that, following a request from the Committee to include more narrative to update them on ongoing work and discussions about risks and to track changes to risks, a new column 'progress timeline' had been included on the revised BAF. This column was yet to be fully populated and gaps would be filled in time for the next meeting. The Committee welcomed this new feature of the report but commented that some sections of the report, particularly assurances, remained out of

date. The Chair also pointed out that some assurances, for example reports received by Board Committees, were not reflected and some examples were shared.

19/05/36 The Chair emphasised that for the report to be fit for purpose and useful to the Committee it needed to be refreshed regularly and he requested Executives and the TBS to ensure this was addressed for the next meeting. The Chair also requested that the cover sheet included narrative to summarise the changes to the BAF & CRR since the last meeting and any proposed/planned work. **GJ/ALL EXECS**

Workforce Report

19/05/37 The Committee considered the report which provided data in relation to month 1 however due to the timing of the meeting it had not been possible to update data with regard to vacancy levels, sickness rates, and benchmarking data; this would be reported in June. It was noted that the agency spend had been considered as part of the Finance Report.

19/05/38 Pat Drake raised the point that at recent QEC meetings, senior Divisional colleagues, including a Divisional Director, had raised issues about the timeliness of the Vacancy Control (VCF) approval process and she asked for assurance that Divisions were not experiencing unnecessary delays in recruiting key staff. Key issues were discussed and Pat provided further details of the discussion at QEC. Executives reported that delays usually arose when extra funding (funding not already in budgets) was being requested via the VCF process rather than taking a business case though the Corporate Investment Group (CIG) first, which was the correct process in such circumstances. The VCF panel could only approve cases where a budget for a post was already in place, in these circumstances the process was very timely with VCF approval meetings being held on a weekly basis.

19/05/39 The Workforce Report was NOTED.

Sub-committee Minutes

19/05/40 The Minutes of the Capital Monitoring Group meeting held on 21 March 2019 were NOTED.

The minutes of the Efficiency & Effectiveness Committee (EEC) meetings held on 29 April and 13 May 2019 were DEFERRED to the next meeting to allow for them to be updated to reflect, at least once, the full names where acronyms had been used. **PM**

19/05/41 The minutes of the Cash Committee meeting held on 25 February 2019 were NOTED

Minutes of the meeting held April

19/05/42 The Minutes of the April meeting were APPROVED as a correct record.

19/05/43 **Meeting reflections** - Reflecting on the report from the Surgery & Cancer Division in the context of the IPF. Finance and Workforce Reports, the Chair felt it would be helpful if, when receiving updates from Divisions, the Committee could be briefed beforehand by Executives on key performance challenges to include questions / suggested areas the Committee might wish to probe further. The Deputy Director of Finance (DoF) would feed this back to the DoF. **AC/JS**

Work plan

19/05/44 The Work Plan was NOTED.

Items for escalation to the Board of Directors

19/05/45 None.

Time and date of next meeting:

Date: 21 June 2019
Time: 9:00am
Venue: Boardroom, DRI

Signed: ……. **…….**
Neil Rhodes **Date**

G6

Board of Directors – Work-plan
(Updated 21/05/19)

	SRO/Author	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Regular Reports for Assurance													
Finance Report	*DoF*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Performance Report	*COO (DP&OD/MD/DNMAHPs)*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Thematic P&OD Report	*DP&OD*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Executive Team Objectives	*TBS / Execs*	~~Q3~~	Q3		Q4						Q1/Q2		
ICS Update	*CE*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
BAF/CRR Quarterly	*TBS*	✓			✓			✓			✓		
Report from Guardian for Safe Working (QTRLY)	*DP&OD*		✓	✓ Annual Report		✓			✓			✓	
Estates & Facilities Report (Quarterly)		✓			✓			✓			✓		
Regular Reports for Information													
Presentations *(arranged by Chair/TBS)*	*Various*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chief Executives Report	*CE/TBS*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chair & NEDs' Report	*Chair/TBS*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Board Committee Assurance Logs	*F&P*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	QEC		✓		✓		✓		✓		✓		✓
	ARC			✓		✓		✓		✓		✓	
Minutes *(to Board after approval)*													
Finance & Performance Committee	*CGO*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Quality & Effectiveness Committee	*CGO*		✓			✓		✓		✓		✓	
Audit & Risk Committee	*CGO*			✓			✓		✓	✓		✓	
Management Board	*CGO*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Fred & Ann Green Legacy Advisory Group	*CGO*		✓										

	SRO/Author	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Charitable Fund Committee	*TBS*	~~✓~~	✓	✓			✓				✓		
Reports for Approval/Decision													
Minutes	*TBS*	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Budget Setting / Business Planning / Annual Plan	*DoF/DS&T*			✓ P2									
Annual Financial Accounts 2018/19 (April or May)	*DoF*				✓?	✓?							
NHSI Plan	*DoF/DS&T*			✓									
Staff Survey Improvement Plan (?P1/P2)	*DP&OD*		✓										
Staff Survey Results	*DP&OD*			✓									
Staff Survey Action Plan	*DP&OD*				✓								
Annual Report	*TBS*				Draft	✓							
Quality Account	*DNMAHPs Deputies Comms*				Draft	✓							
Standing Orders, SFI's, *standards of business conduct* and powers reserved for the Board *reviewed by ARC in march '19)*	*TBS/DOF*			✓									
"ISA 260" *(considered by ARC in May '19)*	*DoF*					✓							
Winter Plan	*COO*									✓			
BoD Work Plan	*CE/TBS*		✓										
Review ToRs	*TBS*		✓										
CCG Contracts	*DoF*			✓									
Reference Costs *(Date TBC)*	*DoF*												
Procurement Update – *KS to check with R Somerset (Date TBC)*	*DoF*												
Other Annual / Ad Hoc Reports													
EU Exit			✓										
Car Parking and Security Contract (approve)	*DF&E*		✓										

	SRO/Author	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Mixed Sex Accommodation	*DNMAHPs ??*												
Bassetlaw Place Plan Update	*CE*	✓								✓			
Doncaster Place Plan Update	*CE*							✓					
Meetings Dates for Information													
Finance & Performance		22/1	25/2	22/3	23/4	20/5	21/6	23/7	20/8	20/9	22/10	22/11	16/12
Quality & Effectiveness Committee			20/2		24/4		27/7		21/8		23/10		05/12
Audit & Risk Committee			19/3			23/5 or 28/5		26/7		17/9		19/11	
Council of Governors		30/1			11/4			25/7			30/10		
Annual Members Meeting										26/9			

Minutes of the meeting of the Board of Directors
Held on Tuesday 25 June 2019
In the Fred and Ann Green Boardroom, Montagu Hospital

Present:	Suzy Brain England OBE	Chair of the Board
	Karen Barnard	Director of People and Organisational Development
	Moira Hardy	Director of Nursing, Midwifery and Allied Health Professionals
	Sheena McDonnell	Non-Executive Director
	Richard Parker OBE	Chief Executive
	David Purdue	Deputy Chief Executive
	Pat Drake	Non-Executive Director
	Jon Sargeant	Director of Finance
	Sewa Singh	Medical Director
	Kath Smart	Non-Executive Director
	Neil Rhodes	Non-Executive Director
	Rebecca Joyce	Chief Operating Officer
In attendance:	Emma Shaheen	Head of Communications and Engagement
	Gareth Jones	Deputy Head of Corporate Assurance
	Jeannette Reay	Head of Corporate Assurance / Company Secretary
	Marie Purdue	Direct of Strategy and Transformation
	Doug Wright	Public Governor
	Clive Tattley	Partner Governor
	Phil Beavers	Public Governor
	Dr Kirsty Edmondson-Jones	Director of Estates and Facilities (Part)

ACTION

Welcome and apologies for absence

19/6/1 The Chair of the Board welcomed all Board Members and Members of the Public to the meeting. The Chair welcomed Anthony Fitzgerald of Doncaster Clinical Commissioning Group who was in attendance to provide a presentation to Board on the Doncaster Joint Commissioning Strategy and Place Plan Refresh. Three members of the public attended; Emma Challans, Suzanne Bolam and Gina Holmes.

Declarations of Interest

19/6/2 No interests were declared in the business of the public session of the meeting.

Actions from the previous minutes

19/6/3 The list of actions from previous meetings were noted and updated.

Presentation slot – Doncaster Joint Commissioning Strategy & Place Plan

19/6/4 The Board considered the presentation from Anthony Fitzgerald which outlined the updates on the CCG's plans for the Doncaster Joint

Commissioning Strategy. Mr Fitzgerald provided an update on the increasing approach to Health and Social Care Commissioning with partners at Doncaster Council and the work that had been undertaken locally as part of PLACE.

19/6/5 Mr Fitzgerald provided the Board with examples of practice and challenges to the implementation of the plan and discussed the set-up of the Primary Care Networks (PCN's). The Board invited Mr Fitzgerald to attend a future Board Meeting to discuss 'developments of Primary Care Networks'; this would be added to the Board forward plan. **JR**

19/6/6 Neil Rhodes queried what the blockages and challenges were around its implementation. Anthony Fitzgerald responded that the contracting and flow of finance posed the most significant problems, particularly around integrated care, however effective risk management and the run through of scenarios would provide sufficient support to overcome these issues.

19/6/7 Pat Drake expressed her pride to see the progress that had been made in the homelessness work and the difference that had been recognised since the implementation of the complex lives scheme, which had seen a reduction in rough sleeping around Doncaster. Pat felt that Social Care was an important part of the schemes within the Doncaster PLACE Plan and had a significant part to play in the future of integrated healthcare.

19/6/8 Pat Drake sought Anthony's view on the Child and Adolescent Mental Health Services of the future, noting the current national issues around mental health services. In response, Anthony advised that mental health had been included within the detail of the joint action plan that was underway with health and social care partners. This recognised the pressures across partner organisations that included finances for the collective mental health services. The Board were assured that mental health was part of the 'Living Well' strategy and the demand for services was being managed appropriately.

19/6/9 In response to a query raised by Karen Barnard around the integration of teams and how support was being given in respect of cultural change to enable effective partnership working across Doncaster, Anthony advised that a comprehensive work plan was in place to ensure effectiveness of integrated working which included infrastructure. Anthony spoke of the Integrated Doncaster Care Record (IDCR) that had seen an improvement in patient care across health and social care partners, which demonstrated good integrated ways of staff working.

19/6/10 Kath Smart queried the capacity within the PLACE plan for alternative treatment and population education for self-management of complex and long-term conditions. The Board were advised that more work would be required to influence patient and public behaviour to enable self-care and to understand what services were being accessed at what time. A discussion took place around the social requirements of being a 'now society' and the professional influence which would be required in order to

change public opinion. It was noted that this would be a long-term programme, with co-production required between the CCG and its partners.

19/6/11 Sheena McDonnell queried the impact on older people with regard to the time spent in hospital and what technological advances would be made available in their own homes going forward. The Board heard how the IDCR had been a groundbreaking development in the ability to view the same patient record across multiple organisations, which had supported informed decision-making and had the potential to expand further.

19/6/12 In response to a question from Rebecca Joyce around the level of integration in Primary Care Networks, it was said that the last couple of months had been spent on regulatory requirements and coterminous boundaries in which some had been out of kilter in terms of population number, rather than service providers; the boundaries had been set within local authorities. It was acknowledged that Primary Care had often been the missing partner in terms of PLACE however this had improved as part of the GP Federation that can collectively respond to the needs of the Doncaster population. The Board were advised of the recommendations for joint posts with the CCG and Local Authorities that would see the Business Intelligence Teams merge in the coming months. It would also be reviewed if the there is a need for the team to sit within the Primary Care Networks. The Medical Director felt that there was lack of data in terms of the work undertaken in Primary Care and therefore a data collection exercise undertaken by the Primary Care Network to enable a view of the requirements of future services would be welcomed.

19/6/13 The Chair of the Board stated the Trust supported the PLACE plan and is fully engaged in the process, particularly as the biggest employer in Doncaster and Bassetlaw, and would continue to be the willing partner in all areas of the Doncaster PLACE work.

19/6/14 Thanks were extended to Anthony for his presentation and the presentation was NOTED.

Reports for Decision

Use of Trust Seal

19/6/15 Board APPROVED the use of the Trust Seal in the following instances:

Seal No.	**Description**	**Signed**	**Date of sealing**
109	Park and Ride Service, the lease of 500 car parking spaces at Doncaster Racecourse.	Jon Sargeant Director of Finance	12th June 2019
		David Purdue Deputy Chief Executive	

110	Contract for design construction and handover of project 8 – new CT scanner building at Doncaster Royal Infirmary.	Jon Sargeant Director of Finance	15th May 2019
		David Purdue Deputy Chief Executive	

19/6/16 **Reports for Assurance**

Finance Report as at 31 May 2019

19/6/17 The Board considered a report of the Director of Finance that set out the Trusts financial position at month 2. The Trust's deficit for month 2 was £1.432k before PSF/FRF/MRET, which is an adverse variance against plan of £4k. The cumulative position to the end of month 2 was £4,910k deficit before PSF, which is £194k adverse to plan (£3,242k deficit including PSF, which is £194k adverse to plan).

19/6/18 The Director of Finance highlighted the significant risks to delivery of the Trust's 19/20 financial control total, including:

- Delivery of CIPs, there are still savings plans to be identified and subsequently delivered.
- Robust capacity plans are still outstanding and are required from Divisions in order to maximise income that deliver in line with plan for elective and outpatients.
- Aligned to capacity plans robust workforce plans are still outstanding. Control and reduction of agency and additional sessions spend linked to challenging and robust plans and following SOPs needs to be a priority.
- Resolution of the payback of non-recurrent support received from CCGs (£1.7m) and the ICS (£1.5m).
- Significant pressures on National Capital budgets mean that the ICS had been asked to reduce overall capital budgets by 25%. The Trust will come under pressure to reduce it's spend further.
- The audit of emergency coding is a potential risk to income, however the Trust believes that any such funds need to be reinvested and should not cause an in year problem.

19/6/19 The Chair of the Board queried what sanctions could be brought against the Trust from the Integrated Care System should the Cost Improvement Programmes fail. The Director of Finance advised that additional governance arrangements could be enforced however, provided assurance that the Trust was doing all that it could at the current time to ensure achievement of the CIP's. The Trust started with a £2.3m gap but that had reduced to approximately £900k.

19/6/20 Pat Drake drew the Boards attention to the 3.3% CIP target that the Trust had to achieve, which was noted to be the second largest across the

Integrated Care System, and team be recognised for the work that had already been undertaken to achieve this.

19/6/21 Following a question around capital budget pressures and the risks, which would be likely to cause an impact on the Trust, Jon assured the Board that the capital budgets had been funded and schemes were in place to address the fire and theatre works as part of an emergency bid. It was noted that there were national issues in relation to capital budgets and organisations had been asked to reduce their spend.

19/6/22 The Board NOTED:

- The Trust's deficit (before PSF, FRF and MRET) for month 2 (May 2019) was £1,432 which is adverse against plan of £4k. The cumulative position to the end of month 2 is a £4,910k deficit before PSF, which is £194k adverse to plan (£3,242k deficit including PSF, which is £194k adverse to plan).
- The achievement with regard to the Cost Improvement Programme.
- The risks set out in this paper.

19/6/23 **Performance Report as at 31 May 2019**

The Board considered a report of the Chief Operating Officer, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals and Director of People and Organisational Development that set out the operational and workforce performance at month 2, 2019/20.

19/6/24 Performance against metrics included:

- RTT – The Trust remained below target at 87%.
- Diagnostic wait is 97.67% against the standard of 99.5%.
- 2 week waits – The Trust achieved 93% and was compliant with the national target of 93%.
- The 62-day performance achieved 83.9%, which was below target.
- Four Hour Access Target – The Trust achieved 92.41% against national standard of 95%. This was below the national target of 95%.
- Appraisals – The Trusts appraisal season commenced on 1 April 2019 and would continue to 30 June 2019; therefore, no reporting would take place until the season had been concluded.
- SET Training – The Trust's SET training rate was 84.31% at the end of May.
- Sickness Absence saw an increase from 4.03% to 4.59% in recent

months but May had seen a reduction to 4.19%.

19/6/25 The Board were advised of one 52-week breach that had been reported at the end of May involving a trauma and orthopaedic patient that emerged through the validation process. Rebecca Joyce discussed the details of the issues. Board received assurance that the case had been thoroughly investigated with the Division and a full action plan had been implemented with learning identified. No harm had been caused as a result of the breach.

19/6/26 Pat Drake queried the increase in the number of falls seen within the Clinical Decisions Unit and the reason for these incidents occurring. Moira Hardy advised that the team had met to review current practices and concerns had been raised around how patients were being transported. As a result, CDU was now being treated as a ward environment and further exploratory work would be undertaken to address the issues, with feedback provided via the Quality and Effectiveness Committee.

19/6/27 The Medical Director presented the Seven Day Services Self-assessment for Board assurance on performance against the 7-day service clinical standards. The Medical Director was pleased to report that the Trust had self-assessed as 'green' across the range of criteria. The Board NOTED the self-assessment for assurance prior to submission on 28 June 2019.

19/6/28 The Board NOTED the Performance Report.

Interim NHS People Plan

19/6/29 The Board considered a report of the Director of People and Organisational Development that set out the key proposals of the Interim NHS People Plan.

19/6/30 The Board were advised of the approach taken locally that included the strong links with schools, education providers, and the number of careers events held around apprenticeship and health career opportunities at the Trust.

19/6/31 Sheena McDonnell advised of the conversations held at Quality and Effectiveness Committee around the leadership improvements at the Trust and felt encouraged by a recent NHS Professionals event that spoke of leaders being central to development of the NHS People Plan. Sheena expressed her interest in receiving the outcome of the Workforce Race Equality Standards when released as it had been recognised that challenges still existed in terms of the recruitment of BME staff.

19/6/32 The Board discussed the requirements of Equality, Diversity and Inclusion agenda and the need to personalise care plans and service delivery for patients and staff. It was noted that the Board had overall responsibility for EDI however this extended to the Council of Governors and staff where there needs to be greater representation of the communities served.

19/6/33 Pat Drake shared her concerns around the recruitment and retention of Nurses but was assured that the Trust had committed to a 10% increase in clinical placements and a further review would be undertaken in alternative routes for completing the student nurse training.

19/6/34 Kath Smart made reference to the presentation provided by Dr Rupert Suckling at the Annual Members Lecture in which he spoke of the organisation being an 'anchor organisation' and felt assured that the people plan would support this, however, Kath sought assurance that this had been considered within the finances of the Trust. Karen advised that there had been consideration locally however any additional funding would be unlikely to be received from the centre. The central Leadership budget with P&OD is £25k and the Chair asked the Board to consider if that was sufficient to respond to the priorities.

19/6/35 The Board NOTED update.

19/6/36 **Corporate Objective 2019/20**

The Board considered a report of the Chief Executive that set out the Executives and Associate Director Corporate Objectives for 2019/20.

19/6/37 The Chief Executive sought confirmation that BOD agree that the proposed objectives are consistent with the pursuance of an overall improvement in the Trusts quality, operational and financial performance in the context of the Trust True North and Breakthrough Objectives.

19/6/38 In addition to the key operational outcomes and standards, which are described in the relevant job descriptions, the proposed objectives for 2019/20 set out the actions, which will be taken to achieve the Breakthrough objectives in support of the Trust strategic aims.

19/6/39 The Board discussed the objectives and their alignment to SMART objectives, and how they would be monitored on a quarterly basis by submission of a report to the Board of Directors.

19/6/40 The Board AGREED the Corporate objectives.

Chairs Assurance Logs for Board Committee held 21 May 2019, 23 May 2019, 17th June 2019 and 21 June 2019

19/6/41 The Board considered an update from the Chairs of Charitable Funds Committee, Audit and Risk Committee, Finance and Performance Committee and Quality and Effectives Committee.

19/6/42 The Board NOTED the updates for assurance.

19/6/43 **2018/19 ERIC Return**

The Board considered a report from the Director of Estates and Facilities

that set out the Estates Return Information Collection (ERIC) that formed part of the central collection of Estates and Facilities data from all NHS Funded secondary care during the financial year ending 31st March 2019.

19/6/44 Kirsty Edmondson-Jones highlighted the backlog costs for the reporting had reduced and the overall level of backlog had seen a 17% reduction in high and significant risks. Jon Sargeant confirmed that the costs had been reconciled and had received financial sign off.

19/6/45 The Chief Executive noted the positive report but highlighted the potential interest around the value of the backlog maintenance costs.

19/6/46 Kath Smart noted the heating and electricity usage and raised her concerns around the cost of this. Kirsty Edmondson-Jones advised that building management services had been identified as a priority and as a CIP programme and would be reviewed throughout the year but that the major limiting factor was the age of the estate.

19/6/47 The Board APPROVED the information enclosed on the ERIC 2018/19 submission to be committed through the EFM Information, HSCIC (NHS Digital) on 28 June 2019 and CONFIRMED its release into the public domain in October 2019.

Reports for Information

19/6/48 The following items were NOTED:

- Chair and NEDS' report
- Chief Executive's report
- Bassetlaw Integrated Care Partnership Bulletin
- South Yorkshire & Bassetlaw ICS 2019/20 Operating System Plan Overview
- Minutes of the Charitable Funds Committee, 26 February 2019
- Minutes of the Audit and Risk Committee, 19 March 2019
- Minutes of the Management Board, 13 May 2019
- Minutes of the Finance and Performance Committee, 20 May 2019

Items to Note

19/6/49 The following item was NOTED:

- Board of Directors Agenda Calendar

Minutes

19/6/50 The minutes of the meeting of the Board of Directors on 21 May 2019 were APPROVED as a correct record.

Any other business

19/6/51 **Non-Executive Director Cover** – The Chair of the Board extended her thanks to the NED's for increasing their duties due to the absence of two NEDs. The Chair of the Board provided assurance that all Board Committees were quorate and were at the required level of attendance to operate effectively.

19/6/52 **Future of Chairs Assurance Logs –** It was agreed that the Chairs Assurance Log would be a verbal update going forward rather than a written report.

Governors questions regarding business of the meeting

19/6/53 Doug Wright queried the cost reduction at the CCG of 20% that had been confirmed in recent months and whether this meant a reduction or increase in funding for the Trust. The Director of Finance advised that the 20% reduction was in relation to the management costs of the CCG and would not result in an increase of funding for patient care. It was confirmed that Doncaster and Bassetlaw CCG's had identified money saving schemes over the year and would be reinvesting money into the Trust Services as part of the contract agreements for 2019/20.

19/6/54 Clive Tattley referenced the proportionate number of patients admitted to a stroke unit in 4 hours and whether Sheena McDonnell was content with the variance achieved to which Sheena confirmed she felt assured that there were no issues within the services.

Date and time of next meeting

19/6/55 9:15am on Tuesday 30 July 2019 in the Boardroom at Doncaster Royal Infirmary.

Exclusion of Press and Public

19/6/56 It was AGREED that representatives of the press and other members of the public be excluded from the remainder of the meeting having regard to the confidential nature of the business to be transacted, publicity on which would be prejudicial to the public interest.

Suzy Brain England **Date**
Chair of the Board